University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 5th August 2020 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 M Rhodes	Verbal	**BAF 1**
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 8th July 2020	Approval	Mr D Wakefield	Enclosure	
5 mins	5.	Matters Arising via the Post Meeting Action Log	Assurance	Mr D Wakefield	Enclosure	
20 mins	6.	Chief Executive's Report –July 2020 • Covid-19	Information	Mrs T Bullock	Enclosure	**BAF 6**
10:20	**GOVERNANCE**					
10 mins	7.	Accountability and Performance Framework	Approval	Miss C Rylands	Enclosure	
10 mins	8.	Board Development Programme	Assurance	Miss C Rylands	Enclosure	
10:40	**PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES**					
5 mins	9.	Quality Governance Committee Assurance Report (22-07-20)	Assurance	Ms S Belfield	Enclosure	**BAF 1**
10 mins	10.	Infection Prevention Assurance Framework Covid-19	Assurance	Mrs M Rhodes	Enclosure	**BAF 1**
10:55	**ENSURE EFFICIENT USE OF RESOURCES**					
5 mins	11.	Performance & Finance Committee Assurance Report (21-07-20)	Assurance	Mr P Akid	Enclosure	**BAF 9**
11:00	**ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT AND RESEARCH**					
5 mins	12.	Transformation and People Committee Assurance Report (29-07-20)	Assurance	Prof G Crowe	Enclosure	**BAF 2 & 3**
10 mins	13.	People Strategy Annual Report	Assurance	Mrs R Vaughan	Enclosure	
10 mins	14.	Workforce Disability Equality Report	Assurance	Mrs R Vaughan	Enclosure	
11:25	**ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS**					
40 mins	15.	Integrated Performance Report – Month 3	Assurance	Mrs M Rhodes Mr P Bytheway Mrs R Vaughan Mr M Oldham	Enclosure	
12:05	**GOVERNANCE**					
5 mins	16.	Audit Committee Assurance Report (31-07-20)	Assurance	Prof G Crowe	Enclosure	
10 mins	17.	Raising Concerns Report	Assurance	Mrs R Vaughan	Enclosure	
12:20	**CLOSING MATTERS**					
5 mins	18.	Review of Meeting Effectiveness and Business Cycle Forward Look	Information	Mr D Wakefield	Enclosure	
	19.	Questions from the Public **Please submit questions in relation to the agenda, by 12.00 pm 3rd August to nicola.hassall@uhnm.nhs.uk**	Discussion	Mr D Wakefield	Verbal	
12:25	**DATE AND TIME OF NEXT MEETING**					
	20.	**Monday 5th October 2020, 9.30 am, via MS Teams - PLEASE NOTE CHANGE OF DATE** **NB. UHNM's Annual General Meeting will take place on Wednesday 16th September at 1.00pm**				

University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 8th July 2020, 9.30 am to 11.40 am
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												
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												
Prof A Hassell	AH	Non-Executive Director												
Mr M Oldham	MO	Chief Financial Officer												
Dr J Oxtoby	JO	Medical Director												
Mrs M Rhodes	MR	Chief Nurse												
Mr I Smith	IS	Non-Executive Director												
Mrs R Vaughan	RV	Director of Human Resources												

Non-Voting Members:			A	M	J	J	J	A	O	N	D	J	F	M
Ms H Ashley	HA	Director of Strategy & Transformation												
Mr M Bostock	MB	Director of IM&T			HP									
Mrs J Dickson	JD	Interim Director of Communications												
Miss C Rylands	CR	Associate Director of Corporate Governance												
Mrs F Taylor	FT	NeXT Non-Executive Director												
Mrs L Whitehead	LW	Director of Estates, Facilities & PFI												

In Attendance:		
Mrs N Hassall	NH	Deputy Associate Director of Corporate Governance (minutes)
Mr J Mannion	JM	St John's Ambulance (item 1)
Miss E Sohnrey	ES	St John's Ambulance Volunteer (item 1)

Members of Staff and Public via MS Teams: 5

No.	Agenda Item	Action
1.	**Staff Story**	
096/2020	Mr Mannion referred to the way in which St John's had stepped up to support the NHS during the pandemic and in particular UHNM. He explained that 41 volunteers had supported Royal Stoke and County Hospital, and had delivered just over 5000 patient facing hours in the past 3 months. Miss Sohnrey recalled the way in which she had been asked to support front line workers at UHNM after undertaking some initial training and commenced on 1st April. She described her volunteer role in the Emergency Department, the types of jobs she had been involved in and described the way in which her skills had expanded during the course of volunteering which included learning how to	

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	undertake ECGs, being involved in nurse training and junior doctor simulations. Miss Sohnrey referred to a particular SHO, Sophie, who she wanted to thank for the way in which she had supported her during her time in the Department. She described the way in which the staff had helped her to celebrate her 21st birthday on shift and gave her thanks to Sister Beckett for her support and guidance. Miss Sohnrey stated that she welcomed the teaching and experience provided to her and explained that some of the newly qualified nurses seemed to be envious of the position she was in and the experienced provided to her. Mr Wakefield thanked Miss Sohnrey for her inspiring story and thanked her on behalf of the patients for the support she provided to them during such a difficult time. He also paid thanks to St Johns Ambulance for the providing the opportunity to her. Mr Bytheway referred to the partnership which had been formed with St Johns and that he hoped it would become more permanent. Mr Mannion commented that it was amazing to hear how Miss Sohnrey became one of the team and the way in which the senior leadership team had supported the partnership. He referred to the way in which both organisations had worked to address any issues raised and felt assured by the Trusts quality assurance processes. Mrs Bullock welcomed the story and thanked Miss Sohnrey for her time volunteering at the Trust. Mr Wakefield thanked Miss Sohnrey and Mr Mannion on behalf of the Board and welcomed the way in which Miss Sohnrey felt supported during her time at the Trust, whilst appreciating the number of hours provided by all the volunteers to the Trust. He added that he would like the Board to formally acknowledge the praise for Dr Sophie Burnage and Sister Beckett. **The Trust Board noted the story.** Miss Sohnrey and Mr Mannion left the meeting.	
2.	**Chair's Welcome, Apologies & Confirmation of Quoracy**	
097/2020	Mr Wakefield welcomed members of the Board to the meeting. Apologies were received as noted above and it was confirmed that the meeting was quorate. Mr Wakefield highlighted that the Trust had received correspondence from NHSIE which stated that virtual meetings needed to continue.	
3.	**Declarations of Interest**	
098/2020	The standing declarations were noted.	
4.	**Minutes of the Previous Meetings held 10th June 2020 & 23rd June 2020**	
099/2020	The minutes of the meetings from 10th and 23rd June were approved as an accurate record.	

5.	**Matters Arising from the Post Meeting Action Log**	
100/2020	PTB/382 – Mrs Rhodes stated that the dementia strategy would be considered by the Quality Governance Committee in October. Close from Board action log PTB/424 – Mrs Rhodes stated that the business case in relation to the neonatal unit was expected to go to the Performance and Finance Committee in August / September 2020. Close from Board action log, will be escalated rom PAF if appropriate. PTB/430 – Mrs Rhodes stated that this would be fed into business as usual as part of the re-launch of the It's OK to ask campaign. Close from Board action log PTB/415 – Dr Oxtoby referred to the flu research project which he had discussed further with infection prevention. He stated that given the current focus on Covid it had been decided that it was not the right use of the team's time and it was hoped that this could be considered next year. Close from Board action log.	
6.	**Chief Executive's Report – June 2020**	
101/2020	Mrs Bullock discussed the items from her report. She highlighted that by 29th June 2020, zoning had been completed. The number of elective cases had increased, and patients were required to isolate for 14 days before in line with national guidance. She stated that restoration and recovery plans were underway and paid thanks to the staff for their continued hard work. She explained that the Trust was waiting to receive the third letter from the centre regarding expectations in restoring services and embedding digital technology. Mrs Bullock thanked Mrs Dickson for her time acting as Interim Director of Communications, since Ms Duggan left the Trust in April and Mr Wakefield added his thanks. Mr Wakefield paid thanks to the staff involved in zoning both hospital sites. Professor Crowe welcomed the successes outlined within the report in terms of Consultant Appointments, continued work on the equality agenda and staff recognition. He referred to restoration and recovery and the requirement for patients to self isolate prior to their operation which could impact on attendance, and queried what action was being taken to increase attendance rates. Mrs Bullock stated that 1-1 discussions were ongoing with some patients, particularly if they decline appointments in order to allay their concerns. She added that social media was being utilised to reiterate the messages regarding the safety of the hospital and Mr Bytheway reiterated that regular contact was being made with patients. Mrs Dickson stated that the Trust communications had been launched to amplify the national campaign, stating that the hospitals were a safe place to visit. In addition, patient information had been adapted. Dr Griffin echoed the appreciation of Mrs Dickson for her time acting as Interim, particularly for the work provided to support the charity. He referred to elective recovery and prioritisation of urgent elective patients, and queried the number of	

	patients choosing not to attend. Mr Bytheway stated that there continued to be high numbers of patients who were worried about coming onsite and discussions were ongoing as to how those patients could be managed i.e. via a separate waiting list or referral back to the GP. He added that actions were being taken to reprioritise the whole of the waiting list by 15th July, via consultant triage and reviewing patients based on clinical urgency and priority. Professor Hassell welcomed the clinical prioritisation of patients. Mr Wakefield queried if patients were provided with feedback to explain why they may encounter further delays and Mr Bytheway stated that all urgent patients would be notified of where they were in the process and further consideration was required as to how to engage with routine patients and their extended wait. Dr Oxtoby added that the focus of clinicians was to ensure patients were aware of the prioritisation process and the balance of risk. Mr Wakefield referred to the preparation for any potential surges going forwards and the need to discuss this with Board members. In terms of a second surge it was note that the actions would be a replicate of the plans put in place for the initial surge but with the added advantage of having a blue zone which would act as a buffer in allowing plans to be enacted with a potentially phased approach. **The Trust Board approved the extension to the Master Vendor for Allied Health Professionals (REAF 3642) contract.**	
PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES		
7.	**Quality Governance Committee Assurance Report (25-06-20)**	
102/2020	Ms Belfield highlighted the following: • An executive update was provided in relation to Covid-19 • The Committee requested further assurance in relation to duty of candour and patient falls • The Committee noted some of the challenges in maternity in terms of categorisation of caesarean sections which was to be brought back to the Committee • Challenges regarding pharmacy and the impact of Brexit were noted Dr Griffin requested an update in terms of nosocomial infections and Mrs Rhodes stated that the number was reducing, although there continued to be infections but this was monitored on a daily basis. She stated that there had been no positive staff members identified since 29th June. **The Trust Board received and noted the assurance report.**	
ENSURE EFFICIENT USE OF RESOURCES		
8.	**Performance and Finance Committee Assurance Report (23-06-20)**	
103/2020	Mr Akid highlighted the following: • The Committee noted the rising number of patients on the waiting list and the prioritisation process being undertaken • Performance was noted in relation to cancer and urgent care • The Committee received an update in relation to Covid-19 and the capacity created to deal with any potential surges • The financial position was similar to month 1 due to the true up position although further guidance was expected for July onwards	

	Mr Bytheway referred to the statement within the report regarding resources being in place to do so, which related to Personal Protective Equipment (PPE) and efficiencies in theatres, given that they cannot operate at 100%. Mr Wakefield stated that the Trust needed to be open and honest with the public regarding the length of time they could be expected to wait and the reasons for this. However, it was noted the length of wait could not definitely be answered as this was dependent on moving variables such as key staff being able to return to work and national support in respect of providing resource to create additional capacity, along with the usual factors such as PPE and social distancing. **The Trust Board received and noted the assurance report.**	
ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT AND RESEARCH		
9.	**Transformation and People Committee Assurance Report (26-06-20)**	
104/2020	Professor Crowe highlighted the following: • The Committee welcomed the reports provided in relation to workforce • Positive assurance was received in terms of risk assessments for staff, supporting shielding staff back into work and the actions in respect of equality and inclusion • Ongoing work was being undertaken to provide assurance of the quality of risk assessments • The Committee approved the operational excellence in healthcare business case and noted the requirement to support the transformation agenda to ensure a coherent plan was put into place Mr Wakefield queried if the Committee had considered the capacity and capability in embedding transformation within the organisation and Mrs Bullock stated that this would be become clearer as part of the discussion regarding the operational excellence in healthcare business case. **The Trust Board received and noted the assurance report.**	
ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS		
10.	**Integrated Performance Report – Month 2**	
105/2020	Mrs Rhodes highlighted the following: • Whilst achieving duty of candour, the Trust was not meeting the 100% target in relation to sending duty of candour letters and action was being taken in respect of this • In terms of c-difficile, Public Health England were not typing the cases, but following review, the Trust did not consider these to be linked • The report identified sepsis screening compliance for paediatrics as a failure – this was in correct as 100% had been achieved. In addition the 0% related to no red flags for sepsis being identified, therefore no medication was required to be provided. • In terms of emergency caesarean sections this was being reviewed. It had been identified that the target should be 15% and not 11% and a deep dive was being undertaken. • In relation to falls per 1000 beds days, this had been discussed at the Quality Governance Committee and further assurance was to be provided following a deep dive	

- There had been no lapses in care during May in relation to pressure ulcers. A research trial in the Intensive Care Unit (ICU) had commenced, given that the majority of ICUs had seen increasing number of ulcers due to the proning of patients. In addition the Trust had re-launched the role of tissue viability champions
- There had been an increase in elective caesarean section sessions of 2 per week, therefore going forwards it was expected that the rate of emergency caesarean sections would improve. Mrs Rhodes explained that the threshold had been lowered during Covid due to being more risk averse, therefore the rates had slightly increased. In addition, there were occasions when an elective caesarean section was moved to a space on the emergency list, therefore documented as an emergency when it was not. It was agreed that further information in relation to the rates would be provided to the Quality Governance Committee.

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Dr Oxtoby referred to the number of patient safety incidents per 1000 bed days and stated that the level of harm had reduced, which demonstrated that the increase in reporting was not linked to the number of patients, but rather the number of staff reporting which was positive that reporting was being maintained.

Mr Wakefield summarised that performance in relation to paediatric sepsis screening was positive, despite being labelled incorrectly within the report, and that deep dives were being undertaken on falls and emergency caesarean sections.

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

- Flow through the Emergency Department had improved during May, as a result of changing the acute assessment area, with performance having improved by 5% at Royal Stoke and 2% at County Hospital
- During June the improvements had continued for the first two weeks but subsequent weeks proved more difficult as there became a step change in activity, which was up to 75% to 80% of pre-Covid levels at Royal Stoke, resulting in needing to manage the differences between blue and purple areas and flipping wards.
- All ward moves took place in the last 2 weeks of June and these were being held for 3 weeks to enable the changes to be embedded
- The specialised assessment unit had opened, in order to take patients directly from the Emergency Department whilst waiting to be assessed
- There continue to be focus on developing the right culture for urgent care across all divisions.

Professor Hassell referred to the visit by the Emergency Care Improvement Support Team (ECIST) and queried how they were helping the Trust to improve performance. Mr Bytheway stated that one of their analysts was working with the Trust to identify actions which could be undertaken to enable greater change. He stated that the 'yes' culture previously referred to, was in relation to ensuring all staff viewed the urgent care challenge as their own, and not just the Emergency Department.

Mr Wakefield referred to discharges and the target to increase these to 30% by noon and whether this was achievable. Mr Bytheway stated that the aim was to improve discharges via pathway redesign and improved planning.

Mr Bytheway highlighted the following in relation cancer performance:

- The Trust was achieving 5 / 8 standards, maintaining 2 week wait performance with 70% to 75% pre-Covid cancer referrals

- The challenge was moving the patients through in a timely manner. 104 day patients had reduced to 205, and diagnostic tests had started to be brought back online. The main challenge was the ability to provide lower clinical risk endoscopy. By the end of July and beginning of August the Trust would be utilising more of the independent sector to ensure the backlog and new work was being undertaken side by side based on clinical priority
- 62 day performance continued to be challenged, with continued prioritisation of the elective waiting list based on urgency for both cancer and non cancer patients

Dr Griffin appreciated the scale and complexity of performance and queried the number of patients in relation to 62 day performance and whether this had reduced. Mr Bytheway highlighted that there remained approximately 700 patients for 62 day wait. Mr Bytheway stated that new patient tracking lists had been created to enable patients to be regularly assessed and engaged with.

Mr Bytheway stated that the RTT position was similar, in terms of the challenges associated with numbers and size of the waiting list. He reiterated the clinical prioritisation being undertaken and added that endoscopy remained the biggest challenge.

Mr Wakefield referred to the recovery and restoration trajectories for diagnostic testing and whether they had been agreed. Mr Bytheway stated that the trajectories were being considered, and modelling had taken place. He stated that he was considering what information could be provided to the Board in terms of RTT and the diagnostic standards in order to articulate how things were changing and added that the trajectories would be caveated by the availability of PPE and productivity. Mr Bytheway added that discussions would take place with the Divisions in August, to consider what was agreed in the annual plan, what Divisions said could have been done, compared to what can now be done, in order to demonstrate the changes pre and post Covid.

Mrs Bullock clarified that the programme regarding restoration and recovery was based on use of the independent sector and the additional activity, therefore the length of time to get back to operating reflected the actions already being taken.

Mrs Vaughan highlighted the following in relation to workforce performance:

- During May there had been a decrease in absence rates, but this remained high at 5.92% in month
- Cumulative sickness was 5% and linked to Covid related absences, but when compared to underlying figures from the same period in 2019, if respiratory ailments were removed, the underlying position was 4% therefore the focus was to review and appropriately manage other reasons for absence as well as supporting management of Covid related absenteeism
- From the 1st August the Trust intended to support staff shielding, to return to the workplace safely
- Personal Development Review (PDR) rates continued to show a decline and Divisions had been asked for trajectories of improvement in order to achieve 95% by the end of the year. In addition, different ways of undertaking the appraisals were being considered.
- Statutory and mandatory training remained stable, but performance is not yet at 95%

Mr Wakefield queried what actions were to be taken to review the staffing models and rotas to ensure these were efficient. Mrs Vaughan stated that these had taken into account the requirements for social distancing, zoning of the hospital

	and the way in which departments now needed to operate. She added that Divisions had provided information on their workforce planning which brought a number of areas into scope and a risk based approach was being taken. Mr Oldham highlighted the following in relation to financial performance: • The Trust achieved a break even position for the month. £1.8 m of additional costs associated with Covid had been recognised and a 'trued up' adjustment of £1.2 m (negative) required to get to the break even position • The increase in Covid costs was primarily associated with students being paid in advance of normal placements. The movement on operating income improved as part of the provider to provider contract arrangements which had been clarified since month 1 • Adjusting for additional Covid costs, pay continued at the previous run rate and non-pay continued to underspend • There had been some slippage with capital, which was expected to catch up • Cash balance was better than plan • The emerging risks were in relation to having no confirmation about the capital spend associated with Covid and these risks would continue to be reported to the Performance and Finance Committee **The Trust Board received and noted the report.**	
GOVERNANCE		
11.	**Board Assurance Framework (BAF) Q1 2020/21**	
106/2020	Miss Rylands highlighted the following: • The BAF had been considered by each of the respective Committees • The document had been revised and some actions agreed at each of the Committees which would be addressed for Q2 • Following agreement of the strategic risks at the Board Seminar earlier in the year, these had been reflected on in light of Covid with the conclusion being that whilst the risks remained appropriate, the impact of Covid would form part of the risks. In addition, a risk in relation to restoration and recovery had been identified and was the most significant risk in terms of the possible impact on objectives Mr Wakefield referred to recovery and restoration and the future actions identified, with the due dates being in August and September and queried if these were correct. Miss Rylands stated that the action plans were being reviewed with each Executive, in terms of progress and dates and these would be improved going forwards. Mr Wakefield referred to the risk in relation to cyber security and the national position of phishing attacks increasing. He queried whether the Board appreciated the sophisticated nature of the attacks and whether it required additional assurance / discussion regarding the type of cyber security threats and how these had moved on. Mr Bostock agreed to consider this for the Board. Mr Wakefield referred to the emerging risks around supplies, particularly pharmaceutical supplies in light of Brexit. It was agreed to take further assurance to the Quality Governance Committee. Mr Oldham highlighted that 1000 product lines had been risk assessed previously in light of Brexit therefore plans were in place. Mr Wakefield referred to the existing stocks which may have been depleted due to Covid, and whether this posed an additional risk when	**MB** **JO** **MO**

	considering Brexit, and Mr Oldham agreed to consider. **The Board noted that the BAF had been considered by Committees of the Board with positive feedback received and approved the BAF as at Quarter 1.**	
CLOSING MATTERS		
12.	**Review of Meeting Effectiveness and Business Cycle Forward Look**	
107/2020	Nothing further was raised.	
13.	**Questions from the Public**	
108/2020	Mr Syme referred to the Chief Executive's Report and County Hospital becoming a Covid 'free' zone allowing the Trust to expand elective services at that unit. He questioned whether elective patients were informed or expected to self isolate (including those in their household) 14 days before a clinical procedure was undertaken. Mrs Bullock confirmed that this had been covered earlier in the meeting. Mr Syme referred to the difficulty in getting patients from the Royal Stoke locality to have their clinical procedures undertaken at County Hospital which could be further exacerbated as those who rely on public transport would have greater difficulty travelling to County Hospital due to Covid restrictions on public transport. He queried how the Trust was factoring this into the ability to access elective services at County and Royal Stoke. Mr Bytheway stated that most appointments were arranged and undertaken via telephone calls in order to minimise logistical issues and discus any issues at that time. He stated that changes would be made depending on patient circumstances. Mr Syme referred to the use of the Nuffield Hospital and that the Trust expected to continue to use it. He queried whether the Trust had obtained performance data as to usage of the Nuffield and if so whether the Trust was able to publicly publish the data. Mrs Bullock stated that the Trust would not specifically publish performance data from the Nuffield as they were required to report centrally and would therefore publish their own data. She stated that if the activity at the Nuffield was from the Trust then that would contribute to the Trusts overall performance targets and would not be segregated. In addition, she added that performance was not being compared like for like, in terms of activity at Nuffield as the activity the Nuffield was undertaking was depleted for the same reasons as the Trusts activity was e.g. PPE, social distancing etc. In addition, the private sector was being used differently by the Trust i.e. one area was converted to an oncology ward, therefore performance could not be compared the that of previous activity.	
DATE AND TIME OF NEXT MEETING		
14.	Wednesday 5th August 2020, 9.30 am – 11.30 am, via Microsoft Teams	

Trust Board (Open)

Post meeting action log as at 29 July 2020

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/382	14/08/2019	Patient Story	To take the revised dementia strategy to the Quality Assurance Committee.	Michelle Rhodes	21/10/2020	08/07/2020	Agreed at July's meeting to mark as completed - to be taken to the Quality Safety Oversight Group in September and to the QGC in October.	B
PTB/415	08/01/2020	Update on Influenza	To establish a research project into the numbers of staff with flu and whether they received the flu vaccine, linking in with Public Health England.	John Oxtoby	31/08/2020	08/07/2020	Update provided to July's meeting. Discussed with IPC and agreed not best use of time at the moment due to Covid. Agreed to reconsider 2021.	B
PTB/424	11/03/2020	Staffing Establishment Reviews	To articulate the timeline of the business cases and when they were to be expected to be undertaken and present this to Performance and Finance Committee.	Michelle Rhodes	30/09/2020	08/07/2020	Agreed at July's meeting to mark as completed. Neonatal business case to be taken to PAF in August/September.	B
PTB/425	11/03/2020	Staffing Establishment Reviews	To provide an update on the recruitment campaigns and implementation plan to the Transformation and People Committee.	Michelle Rhodes Ro Vaughan	30/09/2020		Delayed due to Covid-19. Update provided at May's meeting that recruitment to key posts continued to take place and recruitment would be increased as the pandemic started to wane.	GA
PTB/430	11/03/2020	Questions from the Public	To consider the ways the Trust could make it clearer of the routes available to patients when they have a concern or a complaint.	Michelle Rhodes	30/06/2020	08/07/2020	Agreed at July's meeting to mak as completed. This will be re-launched along with Its Ok to ask. Poster redesigned in easy read and including "Its ok to ask". To liaise with Comms to provide design and obtain patient feedback. Once ready will be publicised on new website as well as notice boards etc.	B
PTB/432	06/05/2020	Raising Concerns Report - Q4	To establish whether any benchmarking information is available from other hospitals in relation to proportion of concerns raised by staff group.	Ro Vaughan	31/07/2020	17/07/2020	National guardians office have published data for 2018/19 by staff group. Information to be included within the guardian report.	B
PTB/434	23/06/2020	Annual Report and AGS	To confirm the names of the various educational apps via communications.	Claire Rylands	10/07/2020	10/07/2020	Two apps had been developed, the names of which have been communicated.	B
PTB/435	08/07/2020	Integrated Performance Report – Month 2	To provide further information in relation to c-section rates to the Quality Governance Committee.	Michelle Rhodes	26/08/2020	22/07/2020	A report was taken to the Quality Governance Committee on the 22 July.	B
PTB/436	08/07/2020	Board Assurance Framework (Q1 2020/21)	To provide a briefing in relation to cyber security to Board members.	Mark Bostock	31/08/2020		Action not yet due.	GB
PTB/437	08/07/2020	Board Assurance Framework (Q1 2020/21)	To provide assurance to the Quality Governance Committee in relation to medication supply in light of Brexit.	John Oxtoby	31/08/2020		Action not yet due.	GB
PTB/438	08/07/2020	Board Assurance Framework (Q1 2020/21)	To consider the impact of Brexit on existing stocks which may have been depleted due to Covid, and whether this posed an additional risk.	Mark Oldham	31/08/2020		Action not yet due.	GB

University Hospitals of North Midlands NHS Trust

Chief Executive's Report to the Trust Board

FOR INFORMATION

Part 1: Trust Executive Committee

The Trust Executive Committee met on Wednesday 29th July. The meeting was held virtually using Microsoft Teams; there was no agenda or papers as the purpose of the meeting was to provide an opportunity for:

- The Chief Executive to thank our Divisional Teams for their work to date and flexibility to do what is required to support our preparations for a potential second Covid-19 surge
- Divisions to be updated on the national position, local position and next steps in relation to Recovery and Restoration
- Divisions to provide updates in terms of their latest position, next steps, staff wellbeing and any concerns/risks

Key points highlighted by the Executive Team were as follows:

- Continued focus on restoration and recovery including the implementation of virtual outpatients, validation of the follow up backlog, clinical prioritisation of the waiting lists and triaging of referrals
- Urgent care performance and the divisional plans being put in place to 'pull' patients from the Emergency Department
- Positive cancer performance whereby the Trust was maintaining delivery of the 2WW
- Compliance with new NICE planned care guidance which was being shared with the Independent Sector and the main change relating to diagnostics
- Continued focus on staff wellbeing, supporting staff with changes in quarantine arrangements and improving appraisal rates
- Confirmation of the financial framework going forwards remained outstanding
- The Trust had been successful in receiving some additional capital to help with critical infrastructure
- Improvements were being made in terms of refreshing IT equipment over the next 12 months in addition to updating Microsoft Office packages
- Feasibility studies were being undertaken in respect of a number of estates projects in order to utilise the additional available capital
- The Trust visiting policy was being reviewed
- A quality improvement movement 'Proud to Care' was to commence in August

Key points highlighted by Divisions were in relation to:

- Productivity being challenged for theatre lists due to the current period of isolation required prior to surgery
- A virtual wellbeing programme had been launched within the Specialised Division
- Preparations and planning for winter had commenced, including additional recruitment where required
- Continued focus on zoning areas and addressing the associated impact on flow

Any Board member seeking to obtain further information regarding the items considered by the Trust Executive Committee should contact Claire Rylands, Associate Director of Corporate Governance.

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 13th June to 12th July, 7 contract awards, which met this criteria were made, as follows:

- **Project STAR Partner Appointment (REAF 3723)** supplied by IHP Vinci Construction at a total cost of £6,594,231.40, approved on 08/07/2020
- **Car Park Management (REAF 3708)** supplied by APCOA at a total cost of £1,558,626.00 for the period 01/08/20 - 31/07/22, approved on 08/07/2020
- **Purchase of Modular Wards & Theatres (REAF 3702)** supplied by Portakabin at a total cost of £9,240,000.00, approved on 18/06/2020
- **Salary Sacrifice Home Electronics (REAF 3696)** supplied by Akira at a total cost of £600,000.00 for the period 01/04/20 - 01/06/20, approved on 01/07/2020
- **Master Vendor for Allied Health Professionals (REAF 3642)** supplied by Maxxima at a total cost of £1,000,000.00 for the period 08/08/20 - 07/08/21, approved on 15/06/2020
- **National Blood Service (REAF 3567)** supplied by NHS Blood at a total cost of £3,450,000.00 for the period 01/04/20 - 31/03/21, approved on 16/06/2020
- **Pharmacy Wholesale Agreement (REAF 3538)** supplied by various at a total cost of £4,078,244.00 for the period 31/03/20 – 30/06/20, approved on 15/06/2020

The Performance and Finance Committee approved REAF 3702 in July 2020 which had already received Board approval in respect of the business case. In addition, the following REAF was approved by the Committee and is brought to the Board for approval, given the value:

Pharmacy Wholesale Agreement (REAF 3538)

Contract Value £4,078,244.00 Inc. VAT
Extension of Contract
Duration 31/03/20 – 30/06/08/20
Supplier Various

This REAF has been raised for a 3 month extension against the HeathTrust Europe (HTE) framework.

Current framework ended 31st March 2020. HTE have however extended the framework by a further 3 months due to the current Covid19 situation. It is the intention for HTE to commence a new Framework agreement at the earliest opportunity. The majority of medicinal products purchased for use throughout UHNM are supplied via the wholesale distribution route using the four largest providers included within the Wholesaler market. Medicinal products are ordered via the Trusts Ascribe system and delivered to the Pharmacy Stores where they are stored and then distributed on-wards to the various Wards and Departments.

Savings – approximately £48k subject to further volume related validation.

2. Consultant Appointments

The following table provides a summary of medical staff interviews which have taken place during July 2020:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Locum Consultant Paediatrician with an interest in Gastroenterology	Vacancy	Yes	02/09/2020
Consultant in Acute Medicine	Vacancy	Yes	February 2021

The following table provides a summary of medical staff who have joined the Trust during July 2020:

Post Title	Reason for advertising	Start Date
Consultant Geriatrician with an interest in Major Trauma	New	01/07/2020
Senior Medical Practitioner in Clinical Oncology - Gynae, CNS & Urology	Vacancy	06/07/2020
Locum Consultant Cardiac Surgeon	Extension	14/07/2020
Consultant Community Paediatrician with an interest in Paediatric Gynaecology	Vacancy	15/07/2020
Clinical Lead for Immunology & Allergy	New	16/07/2020
Locum Colorectal Surgeon	Extension	17/07/2020
Consultant Anaesthetist General	Vacancy	20/07/2020
Locum Consultant Paediatrician - PICU	Extension	20/07/2020

The following table provides a summary of medical vacancies which closed without applications / candidates during July 2020:

Post Title	Closing Date	Note
Respiratory Consultant - Interstitial Lung Disease	07/07/2020	No Applications
Locum Consultant Obstetrician	14/07/2020	No suitable applications
Locum Consultant Medical Oncologist - Breast and Lung Cancer Sites	20/07/2020	No suitable applications

3. NHSEI Strategic Transformation and Recovery Board

In these unprecedented times and in order to radically improve health and care, NHSEI Midlands have created a Strategic Transformation and Recovery (STaR) Board. This will include partners across the system to drive improvement and change in the planning and delivery of:

- Clinical services and commissioning strategies
- Strategies and approach to addressing inequalities and prevention
- Timely and safe restoration and recovery of services
- How we lead, organise and run NHS Midlands

The four work groups are being established with each group being chaired by an organisation or STP/ICS chair. I am pleased to advise I have been invited to be a member of the group focussing on clinical services and I will continue to keep the Board appraised of this developing programme.

The STaR Board will operate until 31st March 2021, following which, the governance arrangements designed through this process will be implemented and jointly led by NHSE/I and the Integrated Care Systems.

4. System Performance Review

The Staffordshire and Stoke on Trent routine System Review Meeting took place on the 24th July 2020. No formal feedback or letter has yet been received however we covered the usual areas of:

Restoration and Recovery

- Governance
- Progress against essential services
- Capacity and demand
- Mental Health Services

Operational Performance

- Size of waiting lists

- Elective Care
- Ambulance handovers
- 4 hourly transit time performance
- Cancer performance

Key Risks and Challenges
- Flu Vaccination programme
- Surge planning for Winter and a potential Covid second surge

Feedback during the meeting was positive but we await formal feedback. A further system wide escalation meeting is to take place in September to undertake a specific review of ambulance handover delays and four hourly performance.

5. Thank You Week / 72nd NHS Birthday Celebrations

During July, we celebrated the 72nd birthday of the NHS which we co-ordinated this year with our Thank You week. I, along with so many others, took the opportunity to thank colleagues and key workers from our local communities who have helped us through the pandemic so we could continue to provide the best care to our patients when they needed them the most.

Our celebrations included a host of online activities and events on both hospital sites, to show our thanks to all staff for their hard work and compassionate care, as well as providing the opportunity for staff to reflect on their experiences and of course, to thank each other.

6. Contemplations Gardens

In concluding our Thank You Week, I was humbled to be able to open the UHNM Charity Contemplation Gardens which provide all staff with a welcome quiet space to reflect and relax from the day to day challenges we all face.

We have lost a number of colleagues in recent months, either through Covid-19 or for other reasons and I do hope colleagues will consider adding a leaf to the memorial trees at either Royal Stoke or County in their memory.

7. Wi-Fi for Staff and Patients

For some time, staff and patients have wanted free Wi-Fi, which before Covid was only available on a 'pay as you go' arrangement. Throughout the Covid lockdown, Wi-Fi has been funded through our Charity and this has been really appreciated but has also been vital for patients, particularly those at the end of life, who have been able to video conference their loved ones.

Going forward, I'm really pleased that we have managed to reduce the cost of the contract by a third and have therefore agreed to fund the ongoing costs making this free for staff and patients to use.

8. Recruitment Success

It is really pleasing that despite Covid, we have been able to recruit to some posts that have been previously difficult to recruit to. Over the last month alone we have recruited to a number of consultant and operational managements posts, including a new Associate Director of Medicine and Urgent Care. We are also launching a recruitment campaign in the near future where we hope to attract the same high calibre of staff who are keen to join the UHNM family because they too can see that our best years are ahead of us.

9. ‘Proud to Care – Our Journey’

When I joined the Trust over a year ago, my commitment was to review how we do business and work together, with a view to devolving control and decision making much closer to our clinical and non-clinical areas. To enable this, we need to ensure that the resource, capacity and capability is where it needs to be. Key to this is the launch of our quality improvement movement ‘Proud to Care – Our Journey’ which is focussed upon organisational culture, engagement and empowerment of staff.

We will be only the third Trust in the country to adopt an improvement movement that focuses on putting staff and patients first and building a positive can do culture. Having now been given approval of the Board and our regulators, I am looking forward to commencing the programme throughout August / September.

10. Culture and Leadership Programme

Before the Covid-19 pandemic began, we launched our Culture and Leadership programme - a two year NHS England and Improvement initiative which is supporting us in understanding our culture and developing it into something that enables continuous improvement around safe, compassionate and high quality care. A team of staff from across all disciplines and grades had been established to help us drive this forward and had already completed a number of face to face interviews with members of the Trust Board and as well as launching a staff-wide survey. Unfortunately this work was paused due to Covid but more recently the team were able to present some of their findings to myself and Ro Vaughan as the executive sponsors and are now gearing up their activities again. They will continue where they left off by speaking to people across the divisions with a view that reports will be presented to Board in the near future.

11. NHS People Pulse

Listening and responding to any concerns our staff may have is as important as ever and that is why, also in partnership with NHS England and Improvement, we have implemented a new staff ‘pulse check’ which is entirely anonymous and voluntary. ‘NHS People Pulse’ will give us another way to listen to the views of our workforce and help improve the support we provide during the Covid-19 response and recovery. Feedback will also inform local and national changes that improve the experiences of our people and patients.

12. High Potential Scheme

The High Potential Scheme is a system wide programme to develop leaders of the future across our Staffordshire and Stoke on Trent health economy. Four members of our staff at UHNM are taking part and I was delighted to be asked to do a presentation about my reflections of Covid-19 and the leadership behaviours and skills required at this time.

I really enjoyed taking part and was pleased with the positive feedback given. Leading through a pandemic has always been a possibility but not something I really thought I would do but I have been impressed and inspired by the way all our staff have managed the rapid changes we have had to introduce and the transformational ways of working we now will want to retain.

13. Ensuring the Safety of our Staff

As part our measures for keeping staff safe at work we have completed demographic risk assessments, particularly for those in vulnerable and at risk groups, such as Black and Minority Ethic (BAME). At the time of writing this report, our position with completion of risk assessments for BAME staff is as follows:

Division	RA Received / not required	RA Outstanding*	Total	% Returned
Medicine	649	26	675	96.14%
Surgery	491	58	549	89.43%
Specialised	288	0	288	100%
CWD	364	0	364	100%
Central Functions	78	31	109	71.55%
EFP	68	0	68	100%
Total:	1938	115	2053	94.39%

**process for follow up of outstanding assessments being co-ordinated via Human Resources Team*

We also have a process for ensuring that 'social distancing' risk assessments are undertaken for all areas of our hospitals. The risk assessments will help us to determine how best to keep staff safe while they work. For example, we have adopted more flexible agile working practices like home or remote working during the last four months and we want to keep some of these transformational ways of working. To better understand the experiences of our staff who have been working from home, we have launched a brief survey which will help to inform our approach going forward.

14. Reverse Mentoring Scheme

Prior to the pandemic, we agreed that we would launch a reverse mentoring scheme. In contrast to conventional mentoring schemes, reverse mentoring can bring mutual benefit to both involved. Mentees can potentially gain new skills and perspectives and mentors can gain insight into strategy, values and culture as well as tap into the wider experience of their mentee. I am excited that this has now been picked up again and we are now working on how this might be rolled out. A number of workshops are to be set up with a view to launch in September.

15. Visiting Policy

I am pleased that following changes in national guidance, we are now reviewing our Visiting Policy following the strict changes we needed to put in place during the early stages of the pandemic. Whilst we have been able to introduce video calls and a family contact service, I know that many of our patients have missed having their loved ones come to visit them in hospital and I'm keen that we find a balance between maintaining their safety and ensuring we provide our patients with the best experience we can.

Further information will be made available once we have agreed our policy; we anticipate we will have a decision before the end of Aug and expect that it will be a staged approach.

16. Strategic Supplier Relationship Management Programme

Earlier in the month our Executive Infrastructure Group approved a Business plan in partnership with Sodexo and our participation in the Government's Supplier Relationship Management (SSRM) Programme. The joint programme which is delivered by the Cabinet Office focusses on the practices and behaviours adopted to engage more collaboratively with strategic suppliers to improve delivery of government objectives and increase mutual value, beyond that originally contracted.

We were invited to join the programme in recognition of the successful collaborative working delivered by ourselves and Sodexo. This has involved the allocation of time and resource by both parties, towards creating a programme of activities designed to further enhance the relationship and to implement improvement and value initiatives.

17. Security Arrangements

This month our Executive Health and Safety Group received the annual report from our Local Security Management Specialist (LSMS). This covered a broad range of activities and initiatives undertaken by our security team over the last year and I'm delighted that their hard work and commitment has been recognised nationally as they were finalists in the 2020 Outstanding Security Performance Awards (OSPA's) in 3 categories – Outstanding Contract Security Manager, Outstanding Security Officer and Outstanding Partnership. A significant achievement where competition is high against the private sector!

18. Integrated Care System (ICS), Independent Chair

As we begin our transition towards becoming an ICS, the Staffordshire and Stoke on Trent system has commenced recruitment to the position of Independent Chair. The interviews are likely to be conducted in September and following this, recruitment to the role of ICS Executive Lead will take place.

These posts are pivotal in ensuring system partners maintain the progress made to date and accelerate the development of the ICS and the more local delivery units; Integrated Care Partnerships/providers (ICPs).

19. Recovery and Restoration

As the Senior Responsible Officer (SRO) for system wide R&R I am updating Board in respect of progress:

Simon Whitehouse, STP Director, led the initial 6 week R&R response to Simon Stevens letter of the 29th April. A submission was made as requested in late May and was updated mid-June. This submission outlined the systems position in respect of restoring 'essential services'.

As the SRO I am tasked with leading the recovery of services from July through to March 2021. As we know recover is far more complicated than turning off the services. As we recover services we need to do so whilst maintaining staff and patient safety and adhering to the new infection prevention and control measures, PPE requirements, along with social distancing and in some cases, a depleted workforce. This means that although services are coming back on line, the throughput (productivity) is significantly reduced.

Covid is also seen by system partners as an opportunity to change the way we deliver services and indeed, some of our services have already changed significantly as a result such as Out Patients. We have no desire to simply restart services as they were and where appropriate we will mainstream any changes made as a result of Covid or review pathways to provide an improved service to patients.

Since becoming the SRO I have met with system leaders from all sectors and a range of people from a variety of professions e.g. finance, operations, strategy, clinical, NEDs, Lay Members etc., to seek their views on where we feel we are now and our aspirations for the future. The CCG Communications and Engagement Team are also leading a piece of work to engage and seek views of a wider range of staff and the public

We are currently undertaking a stocktake and updating our initial submission from June and following this the work cells will be developed. However, from my discussions it is clear that collectively we wish to:

- We want to maintain the lighter touch governance
- We want to retain the benefits from the innovative developments that occurred quickly during the Covid-19 first surge
- We want transformation to be clinically led through the ICPs and see our newly developed PCNs as critical to this
- Ensure our work is driven by robust population health management and we need to take this unique opportunity to address our inequalities
- We want to retain the excellent partnership working

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	5th August 2020
Report Title:	Accountability and Performance Framework	**Agenda Item:**	7
Author:	Claire Rylands, Associate Director of Corporate Governance		
Executive Lead:	Tracy Bullock, Chief Executive		

Purpose of Report:

Assurance		Approval	✓	Information	

Impact on Strategic Objectives (positive or negative):		Positive	Negative
SO1	Provide safe, effective, caring and responsive services	✓	
SO2	Achieve NHS constitutional patient access standards	✓	
SO3	Achieve excellence in employment, education, development and research	✓	
SO4	Lead strategic change within Staffordshire and beyond	✓	
SO5	Ensure efficient use of resources	✓	

Executive Summary:

Situation

The enclosed document sets out the Accountability and Performance Framework for 2020/21, bringing together the key enabling structures and processes to support the delivery and achievement of our Vision and strategic objectives, our Annual Plan and our key 'enabling strategies' for quality, workforce, operational effectiveness and finance.

This is a new document which brings together at a high level, the accountabilities of the Board and Divisional Teams along with our Performance Management Framework and agreed Key Performance Indicators. It should be noted that whilst many aspects of the Framework are already in place, it is envisaged that it will continue to evolve as the systems and processes outlined within, mature and become embedded.

Background

A key aspect of the NHSI/CQC Well Led Framework is ensuring that there are 'clear responsibilities, roles and system of accountability to support good governance and financial management'. Whilst accountabilities, responsibilities and a performance management review process have been in place, these to date have not been described in an overarching Accountability and Performance Framework. This has been identified as a gap by the Board through annual self-assessments against the Well Led Framework and has therefore been included within the Board Development Programme to be addressed.

Assessment

Whilst, as highlighted above, it is recognised that the Framework will continue to evolve, it forms a key element of our corporate governance arrangements which have continued to be developed over the past twelve months, following a supportive developmental review undertaken by NHSI during 2019.

Section 6 of the Framework sets out our revised Corporate Governance Structure which was initially discussed by the Board at a Time Out in November 2019. This has been further developed and over recent months, implementation of the Executive Groups has progressed well (following a brief pause due to Covid-19).

Further work to develop the thresholds and overrides which underpin our performance oversight and

escalation arrangements is being carried out over the coming months and will supplement the Framework once complete. In addition, the Framework will be subject to an initial 6 month effectiveness review and will be reviewed and updated annually thereafter. This includes a review of the Key Performance Indicators outlined within appendix 2 to provide a process to determine the content of Integrated Performance Reporting to the Board on an annual basis.

Key Recommendations:

The Board is asked to approve the Accountability and Performance Framework whilst recognising that it will continue to evolve. This includes approval of the Corporate Governance Structure outlined within section 6 of the document.

NHS
University Hospitals of North Midlands
NHS Trust

Accountability and Performance Framework

2020/2021

Together Compassion Safe Improving

Contents

1. Introduction

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

This Accountability Framework sets out the key enabling structures and processes to support the delivery and achievement of our Vision and strategic objectives, our Annual Plan and our key 'enabling strategies' for quality, workforce, operational effectiveness and finance.

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

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

Kings Fund, 2011

2. Accountability and Responsibility

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

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

- The **accountable person** is the individual who is ultimately answerable for the activity or decision. This includes 'yes' or 'no' authority and 'veto' power. Only one accountable person can be assigned to an action.

- The **responsible person** is the individual/s who actually complete the task. The responsible person is responsible for action / implementation and this responsibility can be shared. The degree of responsibility is determined by the individual with accountability.

3. Well Led Framework

Whilst recognising that our strategy is under review and development, the table below describes how this Accountability Framework will support us to monitor, assure and improve performance against the Well Led Framework:

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

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

4. Culture of High Performance

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

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

5. Our Strategy and Objectives

5.1 Our 2025 Vision

In order for us to realise our ambition it is essential that all business and work programmes are clearly aligned to our Vision, Values, Strategic and Corporate Objectives. Clear lines of sight from these down to individual objectives will support all staff in identifying how to contribute to overall achievement. Our Vision is:

"To become a world-class centre of clinical and academic achievement and care. One in which our staff all work together with a common purpose to ensure patients receive the highest standard of care and the place in which the best people want to work."

2025 Vision

UHNM was formed in November 2014 following the integration of our two hospitals. We work as one organisation and both of our sites are integral to our plans for the future.

We updated our Vision during 2017 to recognise the changing requirements of UHNM and the wider NHS and as we move into ever more challenging times for the service. This requires us to think further than the here and now and look beyond the boundaries of our organisation for inspiration. We will then move towards the Vision and become the sustainable healthcare provider of hospital services we want to be in the future.

5.2 Our Strategic Objectives

Our Vision is underpinned by 5 key Strategic Objectives (SO):

SO1	Provide safe, effective, caring and responsive services
SO2	Achieve NHS constitutional patient access standards
SO3	Achieve excellence in employment, education, development and research
SO4	Lead strategic change within Staffordshire and beyond
SO5	Ensure efficient use of resources

5.3 Our Values

We refreshed our Values alongside our Vision, to set out our cultural and behavioural expectations of our staff:

Together	• We are a **team** • We are **appreciative** • We are **inclusive**
Compassion	• We are **supportive** • We are **respectful** • We are **friendly**
Safe	• We **communicate** well • We are **organised** • We **speak up**
Improving	• We **listen** • We **learn** • We take **responsibility**

5.4 Our Corporate Objectives

Our Vision, Strategic Objectives and Values are aligned and are reflected in our Corporate Objectives, which support the future strategic development of our hospital:

Strategic Objective 1: Deliver safe, effective, caring and responsive services

CO1:	Improved CQC inpatient survey scores for care and treatment and overall experience
CO2:	Reductions in the number of falls which cause harm, and the number of avoidable pressure ulcers
CO3:	Improved HSMR performance (mortality ratio), maintain strong performance in infection control and Patient Led Assessment of the Care Environment (PLACE)

Strategic Objective 2: Achieve NHS constitutional patient access targets

CO1:	Improving pathways in and out of hospital, including NHS constitutional targets
CO2:	Consistent implementation of best practice

Strategic Objective 3: Achieve excellence in employment, education, development and research

CO1:	Reduce staff sickness rates
CO2:	Increase the number of staff recommending UHNM as a place to work
CO3:	Increase the number of staff Performance Development Reviews
CO4:	Improve the perception of leadership engagement (measured via the staff survey)
CO5:	Roll out of seven day services across both hospitals
CO6:	Improved levels of overall satisfaction for Post Graduate Medical Training via the in the GMC National Training Survey
CO7:	Improved organisational ranking of Keele University for Undergraduate Medical Training via the in the National Student Survey
CO8:	Increasing number of open research studies that are actively recruiting patients into them

Strategic Objective 4: Lead strategic change within Staffordshire and beyond

CO1:	Increasing planned income by using County Hospital effectively as a centre for elective (planned) care
CO2:	Increasing income from NHS Specialised Commissioning Services (e.g. spinal surgery)
CO3:	Leading, via the STP, the development and implementation of cancer and end of life strategies
CO4:	Reducing the numbers of medically fit for discharge patients occupying acute beds
CO5:	Improving the UHNM NHS segmentation rating (NHSI measurement of performance)

Strategic Objective 5: Ensure efficient use of resources

CO1:	Reducing of any agency within the national ceiling
CO2:	Improved bed utilisation by reducing the average length of stay for both elective and non-elective treatment, and reducing overall bed occupancy to minimise cancellations
CO3:	Increase theatre utilisation for elective / planned surgery across both our hospitals to maximise income
CO4:	Improve procurement efficiency by reducing costs, increasing income and generating an increased return on investment, thus improving our position within the national league table
CO5:	Reduce estates and facilities running costs per metre square of estate
CO6:	Digitalisation of clinical notes

6. Corporate Governance

6.1 Policies and Procedures

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

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

6.2 Board Assurance Framework (BAF)

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

6.3 Corporate Governance Structure

Our Corporate Governance Structure was refreshed in 2019/20 for implementation 2020/21. The structure defines the meetings through which we monitor and seek assurance, from an operational level through to the Board.

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

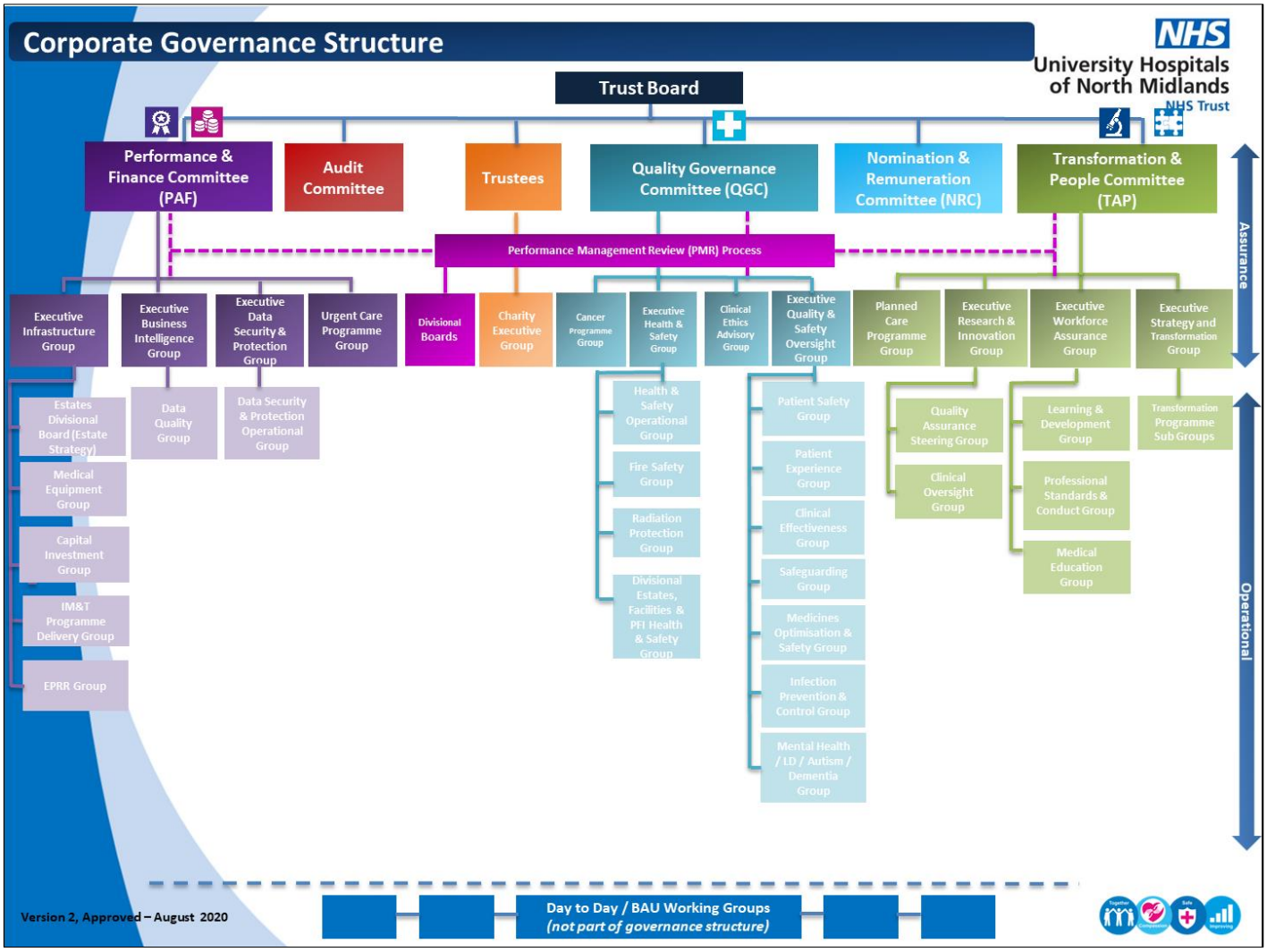
- Areas of concern / matters to escalate
- Areas of good practice
- Key actions agreed / work underway
- Decisions made

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

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

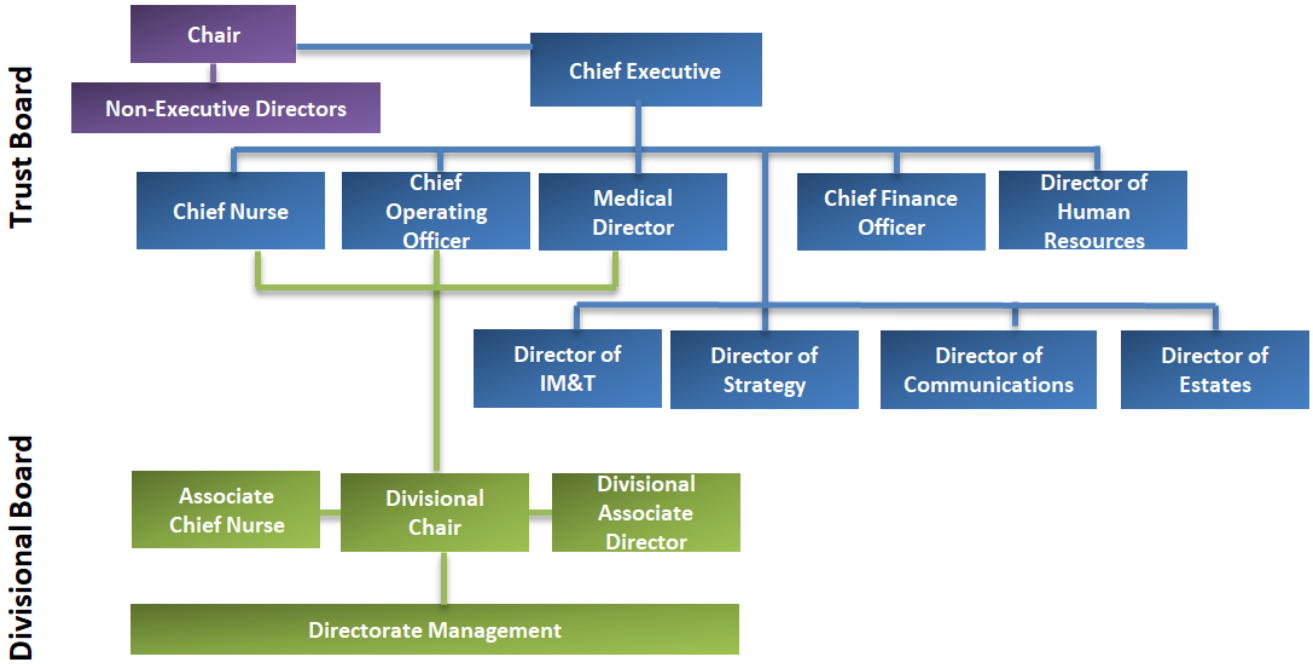
Terms of Reference and Membership are in place for all meetings identified within our structure, which define their objectives and responsibilities. An annual cycle of effectiveness reviews is undertaken to provide opportunity to reflect, learn and continuously improve.

The Corporate Governance Structure is illustrated below:



7. Accountabilities

Effective governance requires defined accountabilities, roles and responsibilities and clear ownership. The below diagram outlines the lines of accountability at Board and Divisional level.



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

	Chair	Chief executive	Non-executive director	Executive director
Formulate Strategy	Ensures board develops vision, strategies and clear objectives to deliver organisational purpose	Leads strategy development process	Brings independence, external skills and perspectives, and challenge to strategy development	Takes lead role in developing strategic proposals – drawing on professional and clinical expertise (where relevant)
Ensure Accountability	Holds CE to account for delivery of strategy Ensures board committees that support accountability are properly constituted	Leads the organisation in the delivery of strategy Establishes effective performance management arrangements and controls Acts as Accountable Officer	Holds the executive to account for the delivery of strategy Offers purposeful, constructive scrutiny and challenge Chairs or participates as member of key committees that support accountability	Leads implementation of strategy within functional areas
Shape Culture	Provides visible leadership in developing a positive culture for the organisation, and ensures that this is reflected and modelled in their own and in the board's behaviour and decision making Board culture: Leads and supports a constructive dynamic within the board, enabling contributions from all directors	Provides visible leadership in developing a positive culture for the organisation, and ensures that this is reflected in their own and the executive's behaviour and decision making	Actively supports and promotes a positive culture for the organisation and reflects this in their own behaviour Provides a safe point of access to the board for whistle-blowers	Actively supports and promotes a positive culture for the organisation and reflects this in their own behaviour
Context	Ensures all board members are well briefed on external context	Ensures all board members are well briefed on external context		
Intelligence	Ensures requirements for accurate, timely & clear information to board/ directors (and governors for FTs) are clear to executive	Ensures provision of accurate, timely & clear information to board/ directors (and governors for FTs)	Satisfies themselves of the integrity of financial and quality intelligence	Takes principal responsibility for providing accurate, timely and clear information to the board
Engagement	Plays key role as an ambassador, and in building strong partnerships with: • Patients and public • Members and governors (FT) • Clinicians and Staff • Key institutional stakeholders • Regulators	Plays key leadership role in effective communication and building strong partnerships with: • Patients and public • Member and governors (FT) • Clinicians and Staff • Key institutional stakeholders • Regulators	Ensures board acts in best interests of the public Senior independent director is available to members and governors if there are unresolved concerns (FTs)	Leads on engagement with specific internal or external stakeholder groups

7.1 Board Accountability

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

7.2 Trust Chair

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

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

7.3 Non-Executive Directors

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

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

7.4 Chief Executive Officer

The Chief Executive Officer is accountable for:

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

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

7.5 Executive Directors

Executive Directors are the executive 'arm' of the Board. They meet as a group weekly and have oversight of the efficient and effective management of the Trust by ensuring that there is robust strategic development and operational plans in place to facilitate the achievement of the Trust's objectives and Board decisions.

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

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

7.6 Divisional Triumvirate – Divisional Chair, Associate Director and Associate Chief Nurse

Our Clinical Divisions are managed by clinically led triumvirates comprised of a Divisional Chair, Associate Director and Associate Chief Nurse. These individuals have responsibility and accountability for specific aspects of the Divisional portfolio. The triumvirates are directly accountable to members of the Executive Team:

- The Associate Directors are directly accountable to the Chief Operating Officer
- The Divisional Chairs are directly and professionally accountable to the Medical Director
- The Associate Chief Nurses are directly and professionally accountable to the Chief Nurse

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

The Divisional Management Team comprises a wider team who are accountable to the Divisional Triumvirate including a Deputy Associate Director and Deputy Associate Chief Nurse who have a portfolio as agreed by the Division. However, there are individual members of the team also have professional accountability to the relevant members of the Executive team as follows:

- Divisional Business Advisor - professionally accountable to the Chief Finance Officer
- Human Resources Business Partner - professionally accountable to the Director of Human Resources

7.7 Directorate Management Teams – Clinical Director, Directorate Manager and Matron

Our Directorates are also led by triumvirates comprised of a Clinical Director, Directorate Manager and Matron. These individuals have responsibility and accountability for specific aspects of the Directorate portfolio. The triumvirates are directly accountable to members of the Divisional Triumvirate:

- The Directorate Managers are directly accountable to the Associate Director
- The Clinical Directors are directly and professionally accountable to the Divisional Chair
- The Matrons are directly and professionally accountable to the Associate Chief Nurse

Directorates are held accountable through Directorate Performance Management Review Meetings, which are led by the 'Divisional Triumvirate. The directorate triumvirate have responsibility for ensuring delivery of agreed organisational policies, objectives and key performance indicators and the governance, oversight and co-ordination of performance within and across all specialities within their Directorate. In addition, they are responsible for the development and implementation of robust remedial plans for areas of underperformance and escalating to the Divisional Board key areas of risk that may affect delivery of organisational objectives and strategy.

7.8 Clinical Leads

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

7.9 All Staff

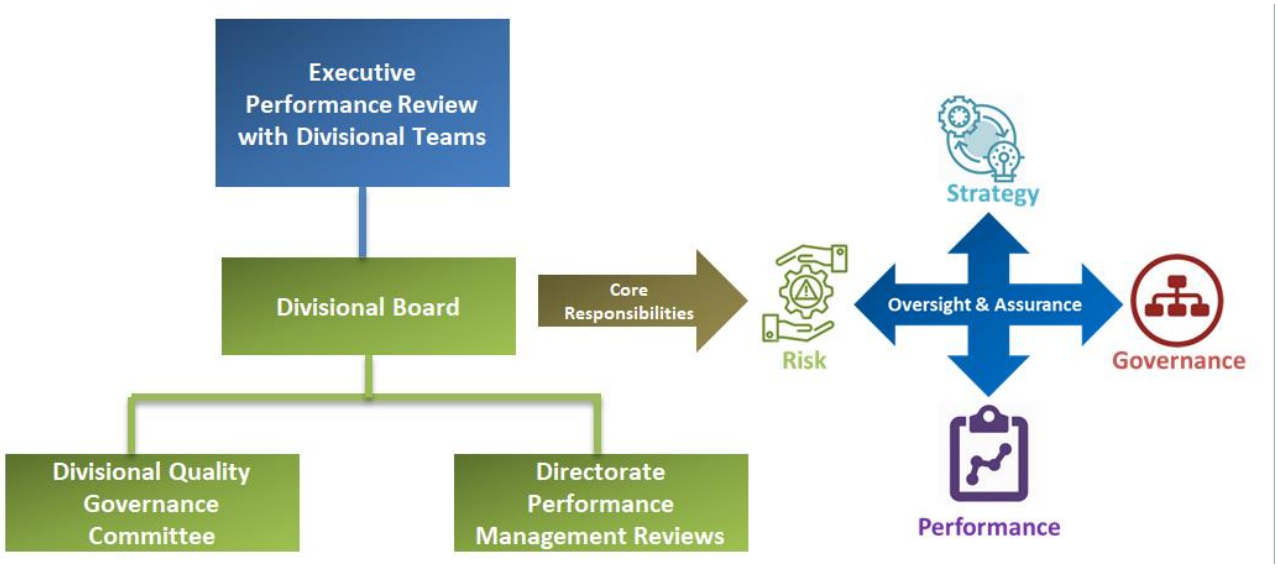
All staff have a responsibility for performance management and improvement, relevant to their role and are supported to identify improvement opportunities and to take action required.

8. Divisional Governance

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

- A clear line of accountability into the Corporate Governance Structure through the Divisional Performance Management Reviews
- A fully constituted Divisional Board comprising the Divisional Management Team, with documented and approved Terms of Reference and Membership, with meetings being held on a monthly basis covering all aspects of divisional strategy, performance, risk and governance (a template can be found at appendix 1)
- A Divisional Quality Governance Committee, with documented and agreed Terms of Reference and Membership, directly accountable to the Divisional Board
- A documented and approved process for the management, escalation and oversight of risk, in accordance with the Risk Management Policy
- Directorate Performance Management Reviews, which align with the Performance Management Framework set out within this document

The minimum structure required is illustrated below:



8.1 Divisional Board – Core Responsibilities

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

Strategy

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

Performance

- Receive assurance on the delivery of strategy and relevant key performance indicators, ensuring the appropriate allocation of resource

- Monitor the operational systems and processes which ensure competent management within the Division
- Identify, delegate and review relevant actions to improve performance
- Report any exceptions to the Annual Plan, delivery of strategy or areas of underperformance to the Executive Team via the Performance Management Review process

Risk Management

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

Governance

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

9. Performance Management Framework

9.1 Definition of Performance Management

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

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

9.2 Key Performance Indicators

Performance management is integral to our Corporate Governance Structure. We have agreed a broad range of Key Performance Indicators (KPI's) which form the basis of our performance management framework. These KPI's are aligned to our Strategic Objectives and take into account all NHS constitutional patient access targets and statutory obligations, along with targets we have agreed locally to support the delivery of our overarching 2025 Vision and supporting strategies. **The full selection of KPI's can be found at appendix 2.**

9.3 Statistical Process Control (SPC)

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

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

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

- **Variation:** Are we seeing significant improvement, decline or no significant change?
- **Assurance:** How assured of consistently meeting the target can we be?

The below key and icons are used to describe what our data is telling us:

Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

9.4 Board / Committee Oversight, Scrutiny and Accountability

As the **Board** has ultimate responsibility for performance of the organisation, we have determined a 'core set' of KPI's which are scrutinised and monitored by the Board through the Integrated Performance Report (IPR). The IPR is owned by the Executive Directors and is presented to the Board each month. This, along with a selection of other assurance reports agreed by the Board as part of their annual Business Cycle, form the basis upon which Executive Directors are held to account.

For **Committees** reporting to the Board, we have determined a more granular detail of KPI's which are specific to each element of our strategy (i.e. quality, workforce, finance, operational delivery). These are monitored by each of our core Committees through a monthly Strategic Performance Report (SPR), which is owned by the lead Executive Director/s and again presented each month for oversight and scrutiny, along with a selection of additional 'assurance reports' which have been agreed by the Board as part of the annual Business Cycle.

9.5 Performance Management Reviews of Central Functions / Estates, Facilities and PFI Division

A framework is being developed for Performance Management Reviews of non-clinical divisions, which are the responsibility of respective members of the Executive Team. These reviews will commence during 2020/21 and will be led by the Chief Executive, supported by representatives of clinical divisions. Reviews will focus on the effectiveness of these functions in their delivery of key priorities, management of risk and support provided to clinical divisions.

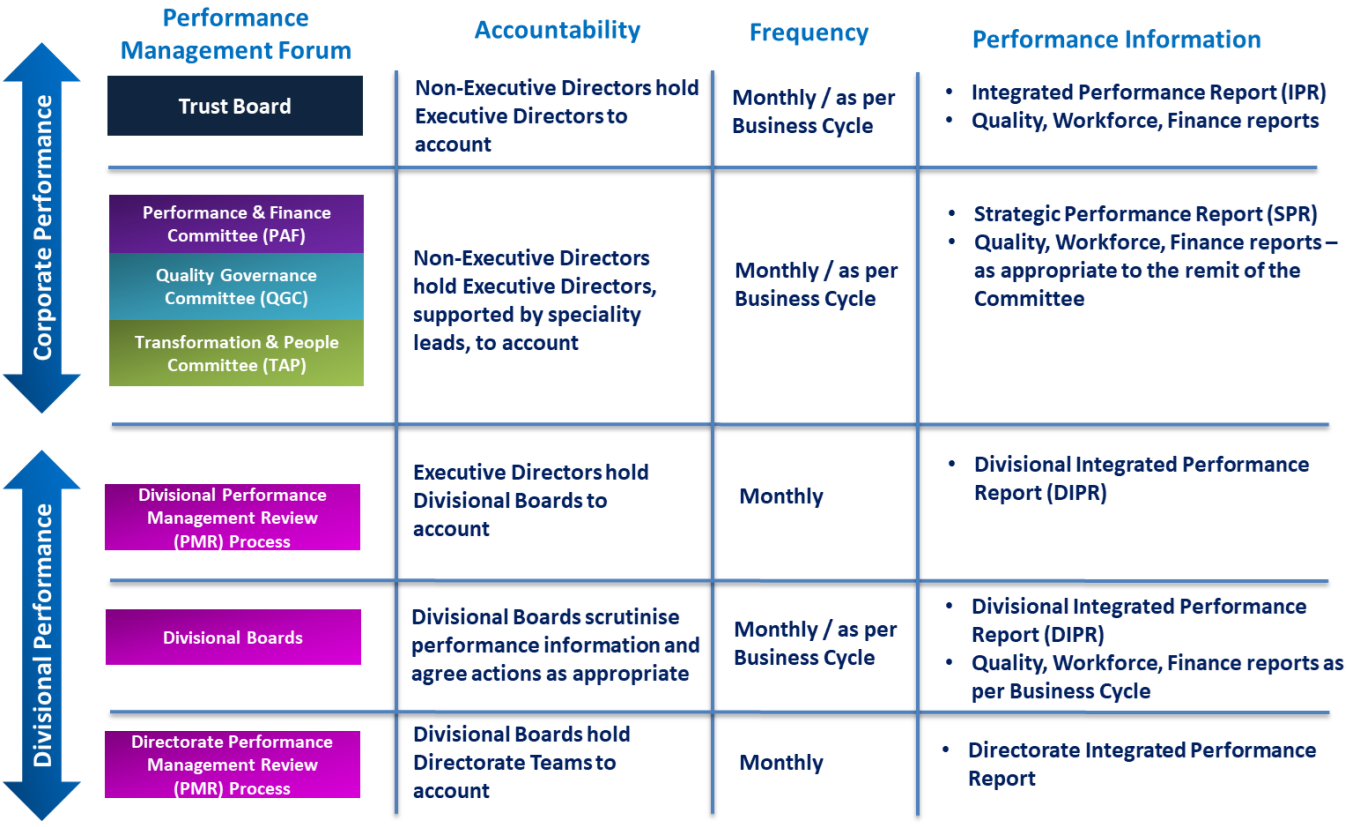
9.6 Divisional / Directorate Oversight, Scrutiny and Accountability

We have also determined the KPI's which form our divisional performance management arrangements. Again, this is an integrated selection of indicators, aligned to our Strategic Objectives and compiled into a monthly Divisional Integrated Performance Report (DIPR). The report is scrutinised by Divisions via their Divisional Board, ensuring that actions are identified to address any areas of underperformance. This report then forms one of the means by which Divisions (led by the Triumvirate) are held to account at their monthly Performance Management Review (PMR) with the Executive Team. This review should be divisionally led and is the Divisions opportunity to demonstrate improvement and assurance to the Executive Team.

This arrangement is repeated at a Directorate level, with Divisional Boards holding their Directorates to account for the performance of their Division, including any indicators determined as being applicable, by the Division.

The arrangements outlined above are illustrated below:

9.7 Overview of Performance Management Framework



9.8 Performance Management Reviews

Executive Performance Management Reviews between the Divisional Board and the Executive Directors are the formal checkpoint at which progress against the achievement of divisional KPI's / annual plans / key objectives are reviewed. Performance issues brought to the attention of Executive Directors through Operational / Executive Groups / Committees and the Board (as per Corporate Governance Structure) are also raised with Divisions through the Executive Performance Management Review process.

The reviews seek to ensure that each Division is balancing patient safety and staff wellbeing with the pressure of financial and operational delivery and the overall sustained health of the Division. At each review, the Divisional Board is required to identify areas of risk to delivery and to have identified appropriate actions to mitigate any risk and recover performance. It is expected that each Division will replicate the same discipline within its own Directorate Performance Management Reviews.

The Divisional Integrated Performance Report (DIPR) forms the standardised template for reviewing performance at these reviews and Divisions are expected to ensure there is no deviation from this.

9.9 Escalation, Oversight, Intervention and Support

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

A more detailed piece of work is being undertaken which will identify thresholds of performance and any overrides which may be applied in determining the performance level of a Division / Directorate.

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

10. Review of Accountability and Performance Framework

This Performance and Accountability Framework will be reviewed on an annual basis by the Associate Director of Corporate Governance and will be submitted to the Board for approval, for implementation each financial year.

However, as this framework is being introduced for the first year in 2020/21, a review of effectiveness will be undertaken at 6 months post implementation in order that any further changes identified can be made at the earliest opportunity.

The annual review will include a review of the KPI's identified as part of the Performance Management Framework, in order that any changes can be reflected within our performance reporting.

Appendix 1:
Divisional Board Template Governance Pack

A) Divisional Board Terms of Reference and Membership Template

Xx Divisional Board
Terms of Reference and Membership
Date

University Hospitals of North Midlands NHS Trust

Constitution and Authority

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

Membership

- Divisional Chair (Chair)
- Associate Director (Vice Chair)
- Deputy Associate Director
- Associate Chief Nurse
- Clinical Directors *(details of each per Directorate)*
- Directorate Managers *(details of each per Directorate)*
- Directorate Matrons *(details of each per Directorate)*
- Divisional Governance and Quality Manager
- Divisional Business Advisor
- Human Resources Business Partner

Attendance at Meetings

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

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

Quorum

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

Frequency of Meetings

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

Reporting

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

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

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

Administrative Support

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

- Calling of meetings
- Agreement of agendas with the Chair in line with the Business Cycle and preparation, collation and circulation of papers no later than five working days before the next meeting
- Ensuring that those invited to each meeting, attend or provide apologies / nominate a deputy in advance
- Taking the minutes for approval at the next meeting
- Keeping a record of matters arising and action points to be carried forward between meetings through use of the Post Meeting Action Log

Duties

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

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

Strategy

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

Performance

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

Risk Management

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

Governance

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

Relationship with Other Executive Groups

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

Approval and Review

These Terms of Reference were approved on xx 2020 and will be reviewed on xx 2021.

Annual Schedule of Meetings

Date	Time	Venue	Deadline for Papers

Annual Business Cycle

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Strategy												
Annual Plan												
Business Cases / Reviews												
Divisional Strategies												
Performance												
Patient / Staff Story or Reward / Recognition												
Divisional Integrated Performance Report												
Risk Management												
Risk Register												
Risk Management Audit Findings												
Governance												
Policies for Consultation												
Report from Divisional Governance Group												
Annual Effectiveness Review												
Terms of Reference and Membership												

B) Divisional Board Agenda Template

University Hospitals of North Midlands NHS Trust

Xx Divisional Board

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

AGENDA

Time	No.	Agenda Item	Purpose	Lead	Format
	PROCEDURAL ITEMS				
	1.	Chair's Welcome, Apologies and Quoracy	Information		Verbal
	2.	Declarations of Interest	Assurance		Verbal
	3.	Minutes of the Meeting held xx xx 2020	Approval		Enclosure
	4.	Matters Arising via the Post Meeting Action Log	Assurance		Enclosure
	STRATEGY				
	5.				
	6.				
	7.				
	PERFORMANCE				
	8.				
	9.				
	10.				
	RISK MANAGEMENT				
	11.				
	12.				
	13.				
	GOVERNANCE				
	14.				
	15.				
	16.				
	CLOSING MATTERS				
	17.	Any Other Business			
	18.	Review of Meeting Effectiveness			Verbal
	19.	Agreement of Items for Escalation			
	DATE AND TIME OF NEXT MEETING				

C) Divisional Board Minutes Template

University Hospitals of North Midlands NHS Trust

Xx Divisional Board

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

MINUTES OF MEETING

Members:	A	M	J	J	A	S	O	N	D	J	F	M
xxx												
xxx												
xxx												
xxx												
xxx												
xxx												

In Attendance:		
xxx	xx	Personal Assistant (minutes)
xxx	xx	xxx
xxx	xx	xxx

No.	Agenda Item	Action
1.	**Chair's Welcome, Apologies and Confirmation of Quoracy**	
2.	**Title**	
	xx	
3.	**Title**	
	xx	
4.	**Title**	
	xx	
5.	**Date and Time of Next Meeting**	
	Date / Date / Time / Venue	

D) Divisional Board Annual Effectiveness Evaluation Template

Annual Effectiveness Evaluation

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

Processes

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

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

Committee Effectiveness

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

Statement	Number of Respondents					Comments / Action
	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to answer	
Theme 1 – Focus						
The Divisional Board has set itself a series of objectives for the year						
The Divisional Board has made a conscious decision about the information it would like to receive						
Divisional Board members contribute regularly to the issues discussed						
The Divisional Board is aware of the key sources of assurance and who provides them						
Theme 2 –Team Working						
The Divisional Board has the right balance of experience, knowledge and skills to fulfil its role						
The Divisional Board ensures that the relevant members attend meetings to enable it to understand the reports and information it receives						
Management fully briefs the members on key risks and any gaps in control						
The Divisional Board environment enables people to express their views, doubts and opinions						
Members hold their assurance providers to account for late or missing						

Statement	Number of Respondents					Comments / Action
	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to answer	
assurances						
Decisions and actions are implemented in line with the timescale set down						
Theme 3 –Effectiveness						
The quality of papers received allows members to perform their roles effectively						
Members provide real and genuine challenge – they do not just seek clarification and/or reassurance						
Debate is allowed to flow and conclusions reached without being cut short or stifled						
Each agenda item is closed off appropriately so that the group is clear of the conclusion; who is doing what, when and how and how it is being monitored						
At the end of each meeting, the group discuss the outcomes and reflect on decisions made and what worked well or not so well						
Theme 4 –Engagement						
The Divisional Board challenges management and other assurance providers to gain a clear understanding of their findings						
Theme 5 –Leadership						
The chair has a positive impact on the performance of the group						
Meetings are chaired effectively						
The chair is visible within the Division and beyond and is considered approachable						
The chair allows debate to flow freely and does not assert his/her own views too strongly						
The chair provides clear and concise information to the relevant Board Committee on the Divisional Board's activities						

Appendix 2:
Performance Management Framework (KPI's)*

*subject to change due to Restoration and Recovery

Exec Lead	SO	Key Performance Indicator		Oversight / Scrutiny		
		Metric	Target	Board (IPR)	Committee / Exec Group (SPR)	Divisional Performance Review (DIPR)
MD/CNO		Patient Safety Incidents	n/a	✓	✓	✓
MD/CNO		Patient Safety Incidents per 1000 bed days	n/a	✓	✓	✓
MD/CNO		Patient Safety Incidents with moderate harm +	10	✓	✓	✓
MD/CNO		Patient Safety Incidents with moderate harm + per 1000 bed days	0.35	✓	✓	✓
MD/CNO		Harm Free Care (new harms)	95%	✓	✓	✓
MD/CNO		Patient Falls per 1000 bed days	5.6	✓	✓	✓
MD/CNO		Patient Falls with harm per 1000 bed days	1.5	✓	✓	✓
MD/CNO		Reported C Difficile Cases	8	✓	✓	✓
MD/CNO		Total Pressure Ulcers developed in UHNM care	0	✓	✓	✓
MD/CNO		Category 2 Pressure Ulcers with lapses in care	8	✓	✓	✓
MD/CNO		Category 3 Pressure Ulcers with lapses in care	4	✓	✓	✓
MD/CNO		Category 4 Pressure Ulcers with lapses in care	0	✓	✓	✓
MD/CNO		Unstageable Pressure Ulcers with lapses in care	0	✓	✓	✓
MD/CNO		Medication Incidents per 1000 bed days	n/a	✓	✓	✓
MD/CNO		Medication Incidents % with moderate harm or above	n/a	✓	✓	✓
MD/CNO		Serious Incidents reported per month	n/a	✓	✓	✓
MD/CNO		Never Events reported per month	0	✓	✓	✓
MD/CNO		Duty of Candour – verbal	100%	✓	✓	✓
MD/CNO		Duty of Candour – written	100%	✓	✓	✓
MD/CNO		VTE Risk Assessment Compliance	95%	✓	✓	✓
MD/CNO		Sepsis Screening Compliance	90%	✓	✓	✓
MD/CNO		IVAB within 1 hour (adult inpatients)	90%	✓	✓	✓
MD/CNO		Adult ED Sepsis Screening Compliance		✓	✓	✓
MD/CNO		Sepsis Screening Compliance (paediatric inpatients)	90%	✓	✓	✓
MD/CNO		IVAB within 1 hour (paediatric inpatients)	90%	✓	✓	✓
MD/CNO		Paediatric ED Sepsis Screening Compliance	90%	✓	✓	✓
MD/CNO		Emergency C Section rate % of total births	11%	✓	✓	✓
MD/CNO		Friends and Family Test – ED	n/a	✓	✓	✓
MD/CNO		Friends and Family Test – Inpatient	n/a	✓	✓	✓
MD/CNO		Friends and Family Test – Maternity	n/a	✓	✓	✓
MD/CNO		Written Complaints per 10,000 spells	35	✓	✓	✓
COO		ED 4 hour wait performance	95%	✓	✓	✓
COO		12 hour trolley waits	0	✓	✓	✓
COO		Cancer Rapid Access (2 week wait)	93%	✓	✓	✓
COO		Cancer 62 day GP referral	85%	✓	✓	✓
COO		Cancer 62 day screening	90%	✓	✓	✓
COO		31 day first treatment	96%	✓	✓	✓
COO		RTT incomplete performance	92%	✓	✓	✓
COO		RTT 52+ week waits	0	✓	✓	✓
COO		Diagnostics	99%	✓	✓	✓
COO		DNA rate	7%	✓	✓	✓
COO		Cancelled operations	150	✓	✓	✓

COO		Theatre Utilisation	85%	✓	✓	✓
COO		Same Day Emergency Care	30%	✓	✓	✓
COO		Super Stranded	183	✓	✓	✓
COO		Delayed Transfers of Care	3.5%	✓	✓	✓
COO		Discharges before Midday	30%	✓	✓	✓
COO		Emergency Readmission rate	8%	✓	✓	✓
COO		Ambulance Handover delays in excess of 60 minutes	10	✓	✓	✓
COO		Daycase / Elective Activity	Variable	✓	✓	✓
COO		Outpatients First Appointment	Variable	✓	✓	✓
COO		Outpatients Follow Up	Variable	✓	✓	✓
COO		Average income per spell - elective	£1,109	✓	✓	✓
COO		Average income per spell – non-elective	£1,918	✓	✓	✓
DHR		Staff Sickness	3.4%	✓	✓	✓
DHR		Staff Turnover	11%	✓	✓	✓
DHR		Statutory and Mandatory Training Rate	95%	✓	✓	✓
DHR		Appraisal (PDR) Rate	95%	✓	✓	✓
DHR		Agency Cost	n/a	✓	✓	✓
CFO		Trust Income	Variable	✓	✓	✓
CFO		Expenditure: Pay	Variable	✓	✓	✓
CFO		Expenditure: Non-Pay	Variable	✓	✓	✓

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	5th August 2020
Report Title:	Update on Board Development Programme	**Agenda Item:**	8.
Author:	Claire Rylands, Associate Director of Corporate Governance		
Executive Lead:	Tracy Bullock, Chief Executive		

Purpose of Report:

Assurance	✓	**Approval**		**Information**	

Impact on Strategic Objectives (positive or negative):		Positive	Negative
SO1	Provide safe, effective, caring and responsive services	✓	
SO2	Achieve NHS constitutional patient access standards	✓	
SO3	Achieve excellence in employment, education, development and research	✓	
SO4	Lead strategic change within Staffordshire and beyond	✓	
SO5	Ensure efficient use of resources	✓	

Executive Summary:

Situation

This paper is to provide the Board with an overview on progress against the Board Development Programme and to set out some proposed next steps for Board Development during 2020/21.

Background

The Board Development Programme was approved by the Board in June 2019. This comprised a range of development work / activities that had been identified by the Board through facilitated discussion, self-assessment and an externally led supportive developmental review. The Programme was structured around core areas of development, which focussed on Governance, Performance and Information, Strategy and Culture and Behaviours.

To support delivery of the programme, Board Seminars were held throughout the course of 2019/20 and the Board received a report in March 2020 which demonstrated that all of the agreed have been completed, with the exception of those items listed for the Seminar in March 2020 (Research and Education) and two further items (Commercial Strategy and Charity Strategy) which were deferred into the 2020 / 21 programme.

The Schedules of Seminar / Time Out activities are just one aspect of the Board Development Programme. A comprehensive plan was developed which underpins the Programme more broadly and brings together areas of development identified by the Board and the outputs of self-assessment and the supportive developmental review.

Assessment

A review of the Board Development Programme was undertaken in July 2020. This demonstrated that of the 58 developmental actions agreed as part of the programme, 30 are now complete with the remainder either underway or under development. Below provides a summary of progress to date:

Governance Developments

- Revised Corporate Governance Structure developed which streamlines our governance arrangements from an operational to Board level
- Introduction of Transformation and People Committee which held its first meeting in January 2020
- Development and implementation of a governance framework for Executive Groups reporting into Committee of the Board, covering Terms of Reference and Membership, Business Cycles and Effectiveness Review arrangements – all with a core set of responsibilities covering Strategy, Performance, Governance and Risk
- Revised Rules of Procedure which sets out the Board / Committee governance arrangements

- Revised Board Assurance Framework 2020/21 encompassing our Strategic Risks
- Review of Executive Portfolios completed
- Development of Accountability and Performance Management Framework
- Effectiveness reflection takes place at the end of each Committee meeting in order to inform further improvements
- Introduction of a Governance module delivered by Associate Director of Corporate Governance as part of the Connects Gold Leadership Programme
- Revised Quality Impact Assessment process developed and piloted
- Streamlining of Business Cycles to ensure the appropriate flow of information and to reduce duplication from operational / executive functions through to the Board
- Revised framework for the role and function of Divisional Boards (now part of the Accountability Framework)
- Committee Effectiveness Reviews underway which will be reported in full to the Board once complete
- Revised arrangements for escalation and oversight of risk, providing greater opportunity for Committees of the Board to scrutinise

Performance and Information

- Revised approach to reporting from Committees of the Board – Chair's Highlight Report introduced
- Training provided by NHS Providers and NHSIE on Effective Report Writing and Plot the Dots
- Revised Integrated Performance Report developed utilising Statistical Process Charts (SPC) – with positive feedback received from regulators on the progress made since the initial training
- Agreement of KPI's to be overseen at Board / Committee level
- Board Intelligence software procured and implemented for all Board, Committee and now Executive Group meeting papers
- Development of ward to Board framework for quality indicators, approved by the Quality Governance Committee
- Implementation of Data Quality Assurance process
- Process in place for review of CQC Insights Report

Strategy

- Clinical Service Review process commenced although was paused due to Covid; revised approach being developed
- Standing agenda item on System Working included on every Board agenda to enhance focus and engagement
- Stakeholder strategy under development

Culture and Behaviour

- Operational Excellence in Healthcare Business Case approved with programme due to commence August / September 2020
- Culture and Leadership Programme commenced and underway (although paused during Covid)
- Facilitated Board Session focussing on behaviours / preferences aligned to the Insights model
- Objectives being identified for all Board members to support their role as a 'Corporate Director'

Next Steps

- Continued implementation of the existing Board Development Programme – in particular around Strategy Development
- Refresh of the Well Led Self-Assessment, with an enhanced focus on outcomes, to inform the next phase of Board Development – this will be presented to the Board for discussion
- Updated schedule for Board Seminars (approved March 2020), taking into account the revised priorities agreed more recently, i.e. BAME focus and Executive / NED working post Covid

Key Recommendations:

The Board is asked to note the progress made with Board Development to date and to consider the Next Steps outlined above for agreement / implementation.

Quality Governance Committee Chair's Highlight Report to Board

July 2020

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Whilst a steady decline in Covid related absence is being seen, we continue to have an absence rate in Covid related absence/shielding (further detail will be shared with Transformation and People Committee) • 2 x Trust apportioned MRSA Bacteraemia reported during Quarter 1; both of which have been investigated (see positive assurance note below) • C Difficile is above trajectory; potential link between Covid and increased C Difficile as a result of antibiotics – continues to be monitored • Written Duty of Candour is below target (70%); work ongoing with Divisions to improve provision of 10 day notification letter • 9 areas have been identified as being problematic against the CQC action plan; work remains underway and these will be subject to scrutiny through the Confirm and Challenge process	• Hospitals have been reconfigured to accommodate green / purple / blue pathways although this has presented some challenges in terms of patient flow and impact upon ED performance • Work ongoing within Emergency portals to support Sepsis screening and compliance • Flu vaccination has been ordered and the campaign is now well underway although drop in sessions will not be possible this year and a booking system will be put in place • Review of Health and Safety Work Programme with a key focus on supporting Divisions / developing their infrastructures and training packages • Work being undertaken jointly between Health & Safety and the Infection Prevention Team to review FFP3 testing arrangements • Review of role descriptor for Falls Champions within wards / departments in order to ensure clarity and consistency • Review of patient safety reporting, triangulated with raising concerns data in order to identify challenges and any areas for improvement • Confirm and Challenge process in place with Core Services against their CQC Action Plans
Positive Assurances to Provide	**Decisions Made**
• Number of patients with Covid / in Critical Care continue to reduce with a discharge rate of around 67% which is positive progress • Improved infection control practices have seen a reduction in Nosocomial infections – no staff member showing positive since 9th July • Commended by regulators and CCG partners for the openness / completeness of the investigation process for MRSA bacteraemia • Interview has taken place with the CQC compliance inspector with lots of questions asked about the framework – no further assurance / evidence requested as a result of the discussion; very pleased with the work in progress • 0 Never Events report for a third consecutive month, 100% achieved for verbal Duty of Candour • Audit of Caesarean Section rate undertaken (following some concern raised at Board) which demonstrated alignment to the national average with no concerns identified • MHRA Action Plan now completed including the outstanding SOPs reported previously • Process in place to reinstate non-Covid related research as soon as possible	• Approval of Terms of Reference for the Executive Health & Safety Group

Comments on Effectiveness of the Meeting
• All pleased with the effectiveness of the meeting

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Executive Directors Update including Covid-19	Information	7.	CQC Action Plan Update	Assurance
2.	Month 2 Quality and Safety Report	Assurance	8.	Quarter 4 Compliance and Effectiveness Report	Assurance
3.	Infection Prevention HAI Quarter 1 Report	Assurance	9.	Research and Innovation Quality Update	Assurance
4.	CQC Infection Prevention and Control Assessment: Engagement and Support Call Summary Record	Assurance	10.	Clinical Audit Progress Report	Assurance
5.	Progress Report – Health & Safety Strategy / Objectives	Assurance	11.	Quality & Safety Oversight Group Highlight Report	Assurance
6.	Emergency Caesarean Sections	Assurance	12.	Health & Safety Executive Group Highlight Report / Terms of Reference and Membership	Assurance / Approval

3. 2020 / 21 Attendance Matrix

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

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												
Professor A Hassell	**AH**	Non-Executive Director												
Mr J Maxwell	**JM**	Head of Quality, Safety & Compliance												
Dr J Oxtoby	**JO**	Medical Director		GH										
Mrs M Rhodes	**MR**	Chief Nurse												
Miss C Rylands	**CR**	Associate Director of Corporate Governance												
Mr I Smith	**IS**	Non-Executive Director												
Mrs F Taylor	**FT**	Associate Non-Executive Director												
Mrs R Vaughan	**RV**	Director of Human Resources												

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	5th August 2020
Report Title:	Infection Prevention and Control Board Assurance Framework	**Agenda Item:**	10.
Author:	Emyr Philips, Associate Chief Nurse Infection Prevention/Deputy DIPC		
Executive Lead:	Michelle Rhodes, Chief Nurse/DIPC		

Purpose of Report:

Assurance	✓	**Approval**		**Information**	

Impact on Strategic Objectives (positive or negative):			Positive	Negative
SO1		Provide safe, effective, caring and responsive services	✓	
SO2		Achieve NHS constitutional patient access standards		
SO3		Achieve excellence in employment, education, development and research		
SO4		Lead strategic change within Staffordshire and beyond		
SO5		Ensure efficient use of resources		

Executive Summary:

Situation

The attached self- assessment has been undertaken in order to comply with the framework set by Public Health England and other Covid-19 related infection prevention guidance. This enables the Trust to identify any areas of risk and show corrective actions taken in response.

The framework is structured around the 10 existing 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 criterion has been risk scored and target risk level identified with date for completion and although work is in progress, the self-assessment sets out what actions, processes and monitoring the Trust already has in place.

Assessment

- There are a number of processes and controls in place, however evidence of assurance monitoring has demonstrated some gaps which will be addressed through the action plan
- Whilst there are controls and assurances in place to ensure appropriate antimicrobial use, some of the findings of the antimicrobial audits demonstrate areas of non-compliance therefore further controls are to be identified and implemented in order to reduce the level of risk
- The information available for patients is being continually updated as national guidance changes, and actions are to be taken to monitor the provision of this information going forwards
- Isolation facilities are available and further work has been completed to segregate the hospital into colour coded areas

Key Recommendations:

The Trust Board is asked to note the self- assessment and the framework against the Public Health England and other Covid-19 related infection prevention guidance.

NHS
University Hospitals of North Midlands
NHS Trust

Infection Prevention and Control Board Assurance Framework

Quarter 1 2020/21

Summary Board Assurance Framework as at Quarter 1 2020/21

Ref / Page	Requirement / Objective	Risk Score				
		Q1	Q2	Q3	Q4	Change
BAF 1 Page 3	Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users.	High 9				
BAF 2 Page 9	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	Moderate 6				
BAF 3 Page 14	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	High 9				
BAF 4 Page 15	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.	Moderate 6				
BAF 5 Page 17	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.	High 9				
BAF 6 Page 20	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.	High 9				
BAF 7 Page 23	Provide or secure adequate isolation facilities.	Moderate 6				
BAF 8 Page 25	Secure adequate access to laboratory support as appropriate.	Moderate 6				
BAF 9 Page 27	Have and adhere to policies designed for the individuals and provide organisations that will help prevent and control infections.	Moderate 6				
BAF 10 Page 30	Have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	Moderate 6				

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

Risk Scoring								
Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3				There are a number of controls in place, however evidence of evidence of assurance monitoring has demonstrated some gaps which will be addressed through the action plan	Likelihood:	1	End of Quarter 3
Consequence:	3					Consequence:	3	
Risk Level:	High 9					Risk Level:	Low 3	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
1.1	Infection risk is assessed at the front door and this is documented in patient notes.	• On arrival in ED patients are immediately identified as either asymptomatic for COVID -19 and apply infection prevention precautions. • Colour coded areas in ED to set out COVID and Non COVID areas identified in ED. • ED navigator records patient temperature and asked screening questions. Patient then directed to either RED or Green area • All patients screened for COVID -19 when decision made to admit • Maternity pathway in place • Elective Pre Amms Plan to swab patients 72 hours pre admission SOP in place • Radiology /interventional flow chart • Children's unplanned admission. ED Navigator asked COVID questions then	• June 2020 IP team review patients who are found to be COVID positive and nursed in bay to ascertain compliance with pathway and IP control measures are in place • Pre AMS check COVID -19 screening results • June 2020 Children's department audit of 10 patients to check the process • Monthly audit undertaken by Division	• A number of pathways on the COVID -19 intranet page require updating with current version • Awaiting up-to-date pathways from divisions / surgery /maternity ED/ imaging interventional radiography

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		**Controls in Place**	**Assurance on Controls**	**Gaps in Control or Assurance**
		child directed to either RED of Green Areas. • All children, symptomatic or asymptomatic are swabbed in child health. This is recorded within their medical records, placed onto the nursing and medical handover so that we are made of the results and whether we need to chase if not received within a timely manner. The patient flow reports to the Child Health tactical meeting every morning how many children have been swabbed result and any outstanding • All children swabbed are placed into a side ward 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 • Iportal alert		
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.	• Critical care plan • COVID pathways for divisions • COVID 19 critical care step down decision tree	• Unannounced visits for clinical areas with clusters or HAI cases of COVID-19 • Review of HCAI cases by IP Team • Datix /adverse incidence reports	
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	• Datix/adverse incidence reports	
1.4	**All staff (clinical and non-clinical)** are trained	• Key FFP3 mask fit trainers in place	• Daily stock level of PPE	• Training completed in

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		**Controls in Place**	**Assurance on Controls**	**Gaps in Control or Assurance**
	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.	• 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 doffing information. • Areas 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 group • Link to Public Health England donning and doffing posters and videos available on Trust intranet • Chief Nurse PPE video • Extended opening hours supplies • Risk assessment for work process or task analysis completed by Health and Safety	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 Doffing training for staff trained by IP • Cascade training records held locally by Divisions • Sodexo and Domestic service training records	areas - records are held locally by clinical areas, these include Divisional donning and doffing training records and Divisional FFP3 mask fit training records • Training records require central holding/recording? • Training records/figures • for each division?
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 COVID clinical group which is held twice weekly • Daily tactical group • Chief nurse updates • Changes/update to staff are included in weekly Facebook live sessions • COVID -19 intranet page • COVID -19 daily bulletin with updates	• Clinical Group meeting action log held by emergency planning	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		**Controls in Place**	**Assurance on Controls**	**Gaps in Control or Assurance**
1.6	Changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted.	• Clinical Group feeds in to Tactical group. • COVID Gold/strategic meetings	• Meeting Action log held by emergency planning	
1.7	Risks are reflected in risk registers and the Board Assurance Framework where appropriate.	• Governance process in place to consider risks on the risk register • Infection Prevention and Control Committee in place to consider IP related risks	• IP risks are agenda item at Infection Prevention and Control committee (IPCC) • Monitoring of Datix incidents	
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	• 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	• Current Emergency admission document in place which does not include MRSA decolonisation – place for documentation • Date to re instate admission documentation? • Audit of proud to care booklets paused– date for reinstating? • Universal MRSA Screening of all emergency admission in emergency portals paused due to COVID -19. Also weekly screening only continued on critical care/HDU both adult and paediatric, haematology/oncology wards and renal ward, this is under review.

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls	Gaps in Control or Assurance
				• 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

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 1 Progress Report	BRAG
1.	1.1	Up- to- date COVID -19 Divisional pathways are available on COVID-19 intranet page	ACN's	30/09/2020	Associate Chief Nurse contacted and request made for COVID -19 pathways 28th July 2020	
2.	1.4	Improving staff FFP3 mask fit staff training data recording and retention of records	/Health and Safety	31/12/2020	Proposed Fit Testing compliance improvement Task and Finish Group. Inaugural meeting planned for 29th July 2020	
3.	1.4	Divisions to retain current mask fit training records and compliance score for their areas whilst central recording and retention of records process is agreed	ACN'S	30/09/2020	Associate Chief Nurse contacted and request made for assurance with staff mask fit compliance. Compliance also added to Divisional papers for infection Prevention and Control Committee (IPCC)	
4.	1.8	Re instate admission proud to care documentation, currently emergency admission document in place	Deputy Director of Quality and Safety	30/09/2020	Original proud to care booklet reinstated now in most areas	
5.	1.8	To complete an analysis (Advantages and disadvantages) to reinstating MRSA screening as per UHNM policy	Deputy Director Infection Prevention	30/09/2020	MRSA screening had reduced temporarily due to the COVID pandemic but UHNM are still following PHE 2014 guidance. This was an agreed temporary change in UHNM practice. Previously the Trust were screening over and above the 2014 guidance. Due to the COVID pandemic less elective work is taking place therefore less elective screening. High risk areas all still screen on admission. Risk based screening is for lower risk areas. Prior to the 2014 guidance the DIPC at the time (supported by the CCGs) did not want to reduce the screening policy the Trust already had in	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	**KLOE**	**Action Required**	**Lead**	**Due Date**	**Quarter 1 Progress Report**	**BRAG**
					place. The CCG requested screening policy have to be approved by the CCGs. Discussed at IPCC. DIPC requested a pro's and con's exercise re screening changes due to the COVID pandemic. The Trust has not dropped below national guidance.	
6.	1.8	To explore an alternative laboratory for Clostridium difficile ribotying	Kerry Rawlin Laboratory	31/08/2020	Leeds Hospital has agreed to help with ribotyping Clostridium difficile specimens. Await first batch of results to gain assurance that process is working	

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

Risk Scoring								
Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2				Whilst cleaning procedures are in place to ensure the appropriate management of premises further evidence to confirm compliance e.g. c4c audits to be reinstated	Likelihood:	1	End of quarter 2
Consequence:	3					Consequence:	3	
Risk Level:	Mod 6					Risk Level:	Low 3	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
2.1	Designated teams with appropriate training are assigned to care for and treat patients in Covid-19 isolation or cohort areas.	• Higher risk areas with teams • Red /green areas in place • 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	• Clinical Group action log • PPE training records	
2.2	Designated cleaning teams with appropriate training in required techniques and use of PPE are assigned to Covid-19 isolation or cohort areas.	• SOP and cleaning method statements for domestic teams/Sodexo • PPE education for Domestic	• Spot check assurance audits completed by Sodexo and retained during COVID period	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		**Controls in Place**	**Assurance on Controls**	**Gaps in Control or Assurance**
		/Sodexo staff • 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	• Cleanliness complaints or concerns • PPE and FFP3 mask fit training records with are held by Sodexo /retained services • Key trainers record • Notes from facilities/estates meeting	
2.3	Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance.	• SOP for terminal and barrier cleans in place	• C4C audits • Spot checks • Terminal clean request log • Patient survey feedback	• The C4C auditing of wards and departments has been suspended temporarily whilst the hospital faces the challenges presented by covid19 due to the need for access to rooms where patients are isolated, the additional workload faced by our clinical colleagues as well as putting additional strains on PPE needed to be able to complete these audits safely. • Plan to reinstate C4C programme July 2020
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.	• Increased cleaning (barrier clean)included in Infection Prevention Questions and Answers manual • Process in place for clinical areas	• Barrier clean request log held by Sodexo • 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**	**Gaps in Control or Assurance**
		with clusters and HAI cases of COVID -19 requiring increased cleaning and /or terminal cleans	19 • Disinfectant check completed during IP spot checks	
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) process in place		
2.6	Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution 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.	• Virusolve and Tristel disinfectant used	• Evidence from manufacture that these disinfectants are effective against COVID -19 • Evidence of Virusolve weekly strength checks , held locally at ward /department level • IP checks that disinfectant is available during spot checks	
2.7	Manufacturers 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	• Audit programme	
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 at least 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 be cleaned at least twice daily. • Rooms / areas where PPE is removed must be decontaminated, timed to coincide with periods	• Included in Barrier clean process	• IP checks • Barrier clean request log • Terminal clean request log	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		**Controls in Place**	**Assurance on Controls**	**Gaps in Control or Assurance**
	immediate after PPE removal by groups of staff (at least twice a day).			
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 the clinical areas • Infected linen route	• IP audits held locally by divisions • Datix reports/adverse incidents	
2.10	Single use items are used where possible and according to single use policy.	• IP question and answers manual • Medical device policy	• IP audits held locally by divisions	
2.11	Reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance.	• IP question and answers manual • Medical device policy • Availability of high level disinfectant in clinical areas • Sterile services process • Datix process	• IP audits held locally by divisions • Datix reports/adverse incident reports	
2.12	Review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission.	• HTM hospital ventilation	• Estates have planned programme of maintenance	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	**KLOE**	**Action Required**	**Lead**	**Due Date**	**Quarter 1 Progress Report**	**BRAG**
1.	2.3	To re instate C4C cleanliness audits and patients survey	Head of CPM Estates, Facilities & PFI Division	30/09/2020	Soft FM cleaning services and Sodexo recovery plan in place which includes the process for reinstating the monitoring process and patient surveys which have commenced 6th July 2020.	

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

Risk Scoring								
Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3				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:	1	End of quarter 3
Consequence:	3					Consequence:	3	
Risk Level:	High 9					Risk Level:	Low 3	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
3.1	Arrangements around antimicrobial stewardship are maintained.	• Regular, planned Antimicrobial stewardship (AMS) ward rounds • Trust antimicrobial guidelines available 24/7 via intranet and mobile device App • 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 • AMS CQUIN further mandates key AMS principles to be adhered to • Monthly review of antimicrobial consumption undertaken by AMS team.	• Same day escalation to microbiologist if concerns • Compliance with guidelines and other AMS metrics reported to Infection prevention and control Committee (IPCC) • Meeting minutes reviewed and actions followed up • Real time discussions / requests for support / advice enabled via regional and national social media accounts. National (incl. PHE) thought leaders members • Trust and commissioners require timely reporting on compliance with AMS CQUIN targets. • Wards showing deviation from targets are followed up by targeted AMS team ward reviews	• Further controls required due to elements of non - compliance with audits

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		**Controls in Place**	**Assurance on Controls**	**Gaps in Control or Assurance**
			generating action plans for ward teams	
3.2	Mandatory reporting requirements are adhered to and boards continue to maintain oversight.	• Quarterly point prevalence audits maintained by AMS team at UHNM despite many regional Trusts not undertaking any more. • Results from all AMS audits and targeted ward reviews are reported at the Antimicrobial Stewardship Group and minutes seen by IPCC • CQUIN submissions completed in timely manner and generate action plans for AMS and ward teams to follow up concerns each quarter.	• 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. • Trust CQUIN contracts manager holds regular track and update meetings to challenge progress vs AMS CQUINS	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	**KLOE**	**Action Required**	**Lead**	**Due Date**	**Quarter 1 Progress Report**	**BRAG**
1.	3.1	Further controls are required to improve compliance	ACN'S	31/12/2020	Antimicrobial audits results discussed at IPCC 27th July 2020. Separate meeting with chief nurse/IP and ACN's to be arranged during August to discussed results and any corrective actions	

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	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2				There is a substantial amount of information available to provide to patients this is continually updated as nation guidance changes, however at present limit arrangement in place to monitor the provision of this information	Likelihood:	1	End of Quarter 3
Consequence:	3					Consequence:	3	
Risk Level:	Mod 6					Risk Level:	Low 3	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls	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.	• Visiting has been suspended with immediate effect until further notice • The only exceptional circumstances where on visitor , an immediate family member or care 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 partner accompany a women in established labour • 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	• Monitored by clinical areas • PALS complaints	• Feedback from service users • Feedback from patients
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 red and green areas are identified by signs • Navigator manned ED entrance	• Division checking signage • Daily Site report for county details red and	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		**Controls in Place**	**Assurance on Controls**	**Gaps in Control or Assurance**
			green 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	• Feedback from service users • Feedback from staff
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 , expires November 2020	• Datix process	• Transfer policy not specific to COVID-19

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	**KLOE**	**Action Required**	**Lead**	**Due Date**	**Quarter 1 Progress Report**	**BRAG**
1.	**4.4**	To include COVID-19 in transfer policy	Deputy Director of Quality and Safety	31/12/2020	3rd August Meeting arranged between IP and Quality and Safety to commence review of transfer policy to include COVID -19	

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	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3				Whilst arrangements are in place ensure the screening of all patients , there is a small number of patients who appear to have a delay in screening	Likelihood:	1	End of quarter Q2
Consequence:	3					Consequence:	3	
Risk Level:	High 9					Risk Level:	Low 3	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
5.1	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.	• ED navigator records patient temperature and asked screening questions. Patient then directed to either RED or Green area	• 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	• Awaiting up-to-date pathways from divisions / surgery /maternity ED/ imaging interventional radiography
5.2	Mask usage is emphasized for suspected individuals.	• Use of mask for patients included in IP COVID -19 • question and answers manual • All staff and visitors to wear masks from Monday15th June • ED navigator provide masks to individual in ED • Manned Mask stations at hospital entrances • Covid-19 bulletin dated 12th June 2020	• Manned hospital entrances to prompt mask wearing	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		**Controls in Place**	**Assurance on Controls**	**Gaps in Control or Assurance**
5.3	Ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff.	• Colour coded areas in ED to separate patients, barriers in place. • Red and Green routes identified in ED • Social distancing risk assessment in place • Perspex screens agreed through R+R process	• Division/area social distancing risk assessments	
5.4	For patients with new-onset symptoms, it is important to achieve4 isolation and instigation of contact tracing as soon as possible.	• Process for isolation symptom patient in place • Process for cohorting of contacts	• If patient found to be positive in the bay and exposing other patient. IP liaise with clinical are , apply bay restrictions	• Contacting patients who have been discharged from hospital then later found to be a close contact of a COVID-19 positive case
5.5	Patients with suspected Covid-19 are tested promptly.	• All patients who require overnight stay are screened on admission	• 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.	• Screening protocol discussed at Clinical group which includes re testing • Inpatient contacts are cohorted	• Datix process • IP reviews	
5.7	Patients who attend for routine appointments and who display symptoms of Covid-19 are managed appropriately.	• Restoration and Recovery plans • Thermal temperature checks in imaging and other areas • Patient temperature checks in outpatient department • Mask or face coverings for patients attending appointments from Monday 15th June	• Datix process	• Requested OPD SOP • Process to monitor

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	**KLOE**	**Action Required**	**Lead**	**Due Date**	**Quarter 1 Progress Report**	**BRAG**
1.	5.1	Up- to- date COVID -19 Divisional pathways are available on COVID-19 intranet page	ACN's	30/09/2020	Associate Chief Nurse contacted and request made for COVID -19 pathways 28th July 2020	
2.	5.4	Process for contacting patients who have been discharged home and have then been found to in close contact with a COVID -19 positive patient during their stay	Deputy of Director Infection	31/08/2020	Process to be added into COVID Q+A then add to the COVID intranet page	
3.	5.7	Process to monitor patients who attend routine appointments who display symptoms of COVID-19 are managed appropriately	ACN'S	31/07/2020	Thermal camera located in a number outpatient areas – with SOP if patient triggers. Script in place for scheduling outpatient/ investigations	

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	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3				Whilst information and communication/controls are in place to ensure staff are aware of their responsibilities spot audits undertaken have demonstrated some gaps in compliance	Likelihood:	1	End of Q3
Consequence:	3					Consequence:	3	
Risk Level:	High 9					Risk Level:	Low 3	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
6.1	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.	• 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	• 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.	• PPE and standard precautions part of the infection prevention Questions and Answers manual. • FFP3 train the trainer programme in place • Trust mask fit strategy • PPE posters are available in the COVID -19 section of trust intranet page	• Training records • IP spot checks	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		**Controls in Place**	**Assurance on Controls**	**Gaps in Control or Assurance**
6.3	A record of staff training is maintained.	Mask fit strategy in place	• FFP3 training records entered onto OLM and held on L drive for those trained by the infection prevention team • Training records held locally by the Clinical areas	• FFP3 Mask Training records held locally by divisions for training completed by key trainers in the clinical areas • OLM captures that staff member attended IP training session but not the outcome e.g. passed or failed mask fit training
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 (Sandstrum))	• 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 (Sandstrum)	
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.	• 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.	• Hand hygiene requirements set out in the infection prevention Questions and Answers manual • Poster for hand hygiene	• Monthly hand hygiene audits completed by the clinical areas • Infection Prevention hand hygiene audit programme.	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		**Controls in Place**	**Assurance on Controls**	**Gaps in Control or Assurance**
		technique displayed at hand wash sinks and stickers on hand soap and alcohol dispensers • Alcohol gel availability at the point of care	Overview of results fed into infection Prevention committee	
6.8	Hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hand 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.	• Paper Towels 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.	• For any new absences employee should open and close their usual absence via Empactis system • Symptom Advice available on Trust intranet	• Cluster /outbreak investigations	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	**KLOE**	**Action Required**	**Lead**	**Due Date**	**Quarter 1 Progress Report**	**BRAG**
1.	6.3	Improving staff FFP3 mask fit staff training data recording and retention of records	Health and Safety	31/12/2020	Proposed Fit Testing compliance improvement Task and Finish Group. Inaugural meeting planned for 29th July 2020	

7. Provide or secure adequate isolation facilities.

Risk Scoring								
Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2				Isolation facilities are available and further work is currently being undertaken to segregate the hospital in colour coded areas	Likelihood:	1	Quarter 2
Consequence:	3					Consequence:	3	
Risk Level:	Mod 6					Risk Level:	Low 3	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls	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.	• RED and GREEN areas • Higher risk areas identified such as critical care unit • Recovery and Restoration plans for the Trust	• 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	
7.2	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.	• Areas agreed at COVID-19 tactical Group • Restoration and Recovery plans	• Action log and papers submitted to COVID-19 tactical and Clinical Group	
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	• RCA process for Clostridium *difficile* • Outbreak investigations • MRSA bacteramia investigations • Datix reports	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 1 Progress Report	BRAG
1.						
2.						
3.						
4.						

8. Secure adequate access to laboratory support as appropriate.

Risk Scoring								
Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2				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 is currently in progress to improve COVID-19 swab screening for clinical staff to improve the risk of false COVID-19 negative results	Likelihood:	1	Q3
Consequence:	3					Consequence:	3	
Risk Level:	Mod 6					Risk Level:	Low 3	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
8.1	Testing is undertaken by competent and trained individuals.	• How to take a COVID screen information available on Trust intranet • 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.	• Review of practice when patient tests positive after initial negative results	• Key trainers for COVID screening technique to reduce risk of false COVID-19 negative results for clinical staff
8.2	Patient and staff Covid-19 testing is undertaken promptly and in line with PHE and other national guidance.	• All patients that require an overnight stay are screened for COVID-19 • Process in place for staff screening via empactis system and Team Prevent	• Empactis reporting • Team Prevent systems • Datix/adverse incidence reporting • Cluster /outbreak investigation procedures	
8.3	Screening for other potential infections takes place.	• Screening policy in place, included in the Infection Prevention Questions and Answers Manual	• MRSA screening compliance • Prompt to Protect audits completed by IP • Spot check for CPE screening	• Blanket screening for MRS A paused due to COVID -19

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	**KLOE**	**Action Required**	**Lead**	**Due Date**	**Quarter 1 Progress Report**	**BRAG**
1.	8.1	Key trainers for COVID-19 swabbing technique in clinical areas	Deputy Director if infection Prevention	31/12/2020	Training package and recording system to be devised. Work to commence	
2.	8.3	To complete an analysis (Advantages and disadvantages) to reinstating pre COVID 19 UHNM screening policy	Deputy Director if infection Prevention	30/09/2020	Discussed at July IPCC. Analysis to commence	

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

Risk Scoring								
Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2				There is a range of information, procedures , pathways available along with mechanism to monitor however, some of these mechanisms were paused and need to be re -instated	Likelihood:	1	Q2
Consequence:	3					Consequence:	3	
Risk Level:	Mod 6					Risk Level:	Low 3	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
9.1	Staff are supported in adhering to all IPC policies, including those for other alert organisms.	• IP included in mandatory update • Infection Prevention Questions and Answers manual with ICON on every desk top for ease of use • Infection Prevention triage desk which provides advice and support to clinical areas	• IP audit programme • Audits undertaken by clinical areas • CEF audits • Proud to care booklet audits	• CEF audits paused due to COVID -19? • Proud to care audits paused switched to emergency booklets during COVID -19
9.2	Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff.	• Notifications from NHS to Chief nurse/CEO • 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 • Chief nurse updates • Changes/update to staff are included in weekly Facebook live sessions	• Clinical Group meeting action log held by emergency planning	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		**Controls in Place**	**Assurance on Controls**	**Gaps in Control or Assurance**
		• COVID -19 intranet page • COVID -19 daily bulletin with updates		
9.3	All clinical waste related to confirmed or possible Covid-19 cases is handled, stored and managed in accordance with current national guidance.	• Waste policy in place • Infection route • 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 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	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	**KLOE**	**Action Required**	**Lead**	**Due Date**	**Quarter 1 Progress Report**	**BRAG**
1.	9.1	CEF Audits to recommence	Deputy Director of Quality and Safety	30/09/2020	Review of tool kit with Chief Nurse planned , aiming to trial during August and reinstate audits fully during September 2020	
2.	9.1	Proud to care booklet audits paused. Plan for recommencing	Deputy Director of Quality and Safety	30/09/2020	Original proud to care booklets reinstated in most areas	

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

Risk Scoring								
Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2				There are clear control in place for management of occupational needs of staff through team prevent to date Adhere to social distancing gaps in adherence	Likelihood:	1	Q3
Consequence:	3					Consequence:	3	
Risk Level:	Mod 6					Risk Level:	Low 3	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
10.1	Staff in 'at risk' groups are identified and managed appropriately, including ensuring their physical and psychological wellbeing is supported.	• 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	• 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	
10.2	Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained.	• SOP for reusable face masks and respiratory hoods in place	• Training records for reusable masks	• Availability of locally held training records. • Lack of central holding of FFP3 records
10.3	Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the crossover of	• Restore and Restorations plans	• Incidence process/Datix	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		**Controls in Place**	**Assurance on Controls**	**Gaps in Control or Assurance**
	care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance.			
10.4	All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas.	• Social distancing tool kit available on COVID 19 intranet page • 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 commending 15th June • COVID secure risk assessment process in place	• Social distance monitor walk round introduced Friday 5th June • 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	• 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.	• 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	• Via emapactis • Staff quires through workforce bureau or team prevent	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls	Gaps in Control or Assurance
		• Once the absence is reported to the employees manger via email , the 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 or staff returning to work available on COVID 19 section of intranet		

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 1 Progress Report	BRAG
1.	10.2	Improving Staff FFP3 mask fit recording and retention of records	Health and Safety	31/12/2020	Proposed fit testing compliance improvement task and finish group Inaugural meeting planned for 29th July 2020	

BRAG Rating for Action Plans		
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.

Performance and Finance Committee Chair's Highlight Report to Board

21 July 2020

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Phase 3 letter still awaited, expected to set out the financial architecture going forward and expectations re activity levels • Number of cancer patients waiting 104 days or over is decreasing and a harm review process is in place • Deterioration in Urgent Care performance during the second half of May and through to June • Cancer targets currently underperforming: 31 day subsequent surgery, 31 day subsequent chemotherapy / radiotherapy, 62 day standard, 62 day screening – Cancer Improvement Plan under development which focuses predominantly on administrative / pathway improvements and will be shared at a meeting with Non-Executive Directors • Significant impact on RTT as a result of the national guidance which mandated all routine treatments be stood down; 52 week waiters identified as a specific cause for concern. Harm reviews underway, no harm detected at current time • 67/96 information asset owners have signed the information asset acceptance form – actions in place to increase this number through the Data Protection Steering Group • Statutory / litigation implications for the Trust if the Maintenance Programme is not resumed as agreed, whilst recognising the conflict with restoration and recovery of services (as reflected on Corporate Risk Register) – being reviewed through Maintenance Operational Group	• Update on Capital Programme and associated risks to be included on the next agenda - Capital expenditure for the year to date stands at £12.6m which is £6.3m ahead of plan mainly due to the Trust completing the purchase of the Lyme Modular Wards and Theatres a month earlier than planned • Appointments being made within Medical Division, with specific positions focussing on Urgent Care • Continuous review of the zoning of the hospital as part of Restoration and Recovery Plans – bed modelling being worked upon to underpin this work • Work to understand the impact of Brexit on our Infrastructure being done through the Risk Register
Positive Assurances to Provide	**Decisions Made**
• Currently performing against the Cancer 2 week wait standard (98.65%), Breast Symptomatic (98.87%) and 31 Day first Treatment (97.4%) • Breakeven at Month 3 as a result of a top up of £4.3m (for Covid expenditure and the temporary financial framework) • £6.6m ahead of plan (month end cash balance £89.3m) • Value of an integrated approach to Infrastructure oversight has become very clear through the establishment of a formal group within the Governance Structure • The Trust, with partners at Sodexo has been selected by the Government for the Supplier Strategic Relationship Management programme, which reflects the success of the partnership approach	• Approval of Data Security and Protection Group Terms of Reference and Membership • Approval of Business Case for Modular Wards Isolation Pods (Covid) – subject to Chief Finance Officer review of the financial aspects • Approval of Contract Awards for: The purchase of Modular Wards & Theatres (REAF 3702); Extension of Cardiology Solutions Framework (REAF 3636); Pharmacy Wholesale Agreement (REAF 3538); Provision of car park management at Royal Stoke University Hospital (REAF 3708) • Approval of Business Case for Specialist Commissioning of Stereotactic Ablative Radiotherapy (SABR) subject to discussions with commissioners
Comments on Effectiveness of the Meeting	
• Observed that Microsoft Teams meetings work far better when individuals are based in their own offices • Authors of business cases to be brought to future meetings to support provision of information and decision making – supported by Committee members	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Executive Director Update – Covid-19	Information	5.	Business Case Approvals: • BC-0369 Modular Wards Isolation Pods • BC-0367 Specialist Commissioning of Stereotactic Ablative Radiotherapy	Approval
2.	Cancer Improvement Plan	Assurance	6.	Authorisation of New Contract Awards and Contract Extensions	Approval
3.	Month 3 Performance Report	Assurance	7.	Executive Infrastructure Group Highlight Report	Assurance
4.	Month 3 Finance Report	Assurance	8.	Executive Data Security and Protection Group Highlight Report / Terms of Reference	Approval

3. 2020 / 21 Attendance Matrix

Attended	Apologies & Deputy Sent	Apologies

Members:			A	M	J	J	A	S	O	N	D	J	F	M
Mr P Akid (Chair)	PA	Non-Executive Director												
Ms H Ashley	HA	Director of Strategy & Performance												
Mrs T Bullock	TB	Chief Executive												
Mr P Bytheway	PB	Chief Operating Officer												
Dr L Griffin	LG	Non-Executive Director												
Mr M Oldham	MO	Chief Finance Officer												
Mrs S Preston	SP	Strategic Director of Finance												
Mrs M Ridout	MR	Director of PMO												
Miss C Rylands	CR	Associate Director of Corporate Governance		NH										
Mr J Tringham	JT	Director of Operational Finance												

In addition, the following were in attendance: Mrs F Taylor, NeXT Director, Mr D Wakefield, Chair, Mrs L Carlisle, Head of Data, Security & Protection/ Data Protection Officer and Dr J Oxtoby, Medical Director.

Transformation and People Committee Chair's Highlight Report to Board

July 2020

1. Highlight Report

Matters of Concern / Key Risks / Escalations	Major Actions Commissioned / Work Underway
• Underperformance against key workforce indicators associated with Statutory and Mandatory Training, PDR (will be reported through the Integrated Performance Report) • Annual Human Resources Report will be presented to the Board as a separate agenda item (regarded by the Committee as a positive overview of achievements / challenges)	• Development of Transformation Roadmap which will be presented to the Committee in August 2020 • Arrangements underway for commencement of the Operational Excellence in Healthcare / Proud to Care quality and cultural improvement programme, including the establishment of a Centre of Excellence and arrangements for assurance / reporting • Reinstatement of research activity alongside a broadening of the research and innovation portfolio, strategy and structure • Wider listening and learning exercise planned to understand the transformation that has occurred as a result of Covid • Risk assessment process for vulnerable workers underway including follow up on those not yet completed; next steps to be reported back to the Committee • Staff planning / vacancy progress / uptake to the Apprenticeship Levy to be considered by the Committee a future meeting in more detail • Speaking Up Charter due to be launched which sets out the Boards commitment; recognised the importance of ensuring that BAME medical staff are appropriately represented on the Staff Network
Positive Assurances to Provide	**Decisions Made**
• Recruitment of 1959 patients to 'Covid related' trials which makes the Trust within the top 10/20 in the Country • Executive Research and Innovation Group established and starting to focus on the broader agenda • Increase in number of nominations for Values Awards, particularly during Covid with 50 individuals who have received nominations for all 4 values • Sickness figures associated with Covid have seen a continuous decrease and Divisions have been asked to develop sickness management plans • 95% BAME risk assessments now complete; Committee commended the work undertaken to achieve this • A wide range of positive developments associated with Widening Participation including system wide funding which has been secured for a number of projects • Overall encouraging report on WDES and Freedom to Speak Up Report with improvements seen in a number of areas	• Approval of key priorities within the People Strategy for 2020/21 whilst recognising that national priorities are yet to be released • Approval of Terms of Reference and Membership of the Executive Strategy and Transformation Group and the Research and Innovation Group

Comments on Effectiveness of the Meeting
• Another positive meeting, lots of assurances considered along with opportunities for acceleration of development

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Q1 Transformation Programme Update	Assurance	8.	Workforce Disability Equality Standard	Assurance
2.	Q1 Research and Innovation Update	Assurance	9.	Speaking Up Report – Quarter 1 2020/21	Assurance
3.	M3 Workforce Report	Assurance	10.	Q1 Formal Disciplinary Activity	Assurance
4.	Vulnerable Workers Risk Assessment Process Update	Assurance	11.	Executive Strategy and Transformation Group Highlight Report / Terms of Reference	Approval
5.	People Strategy 2019/20 Annual HR Report	Assurance	12.	Executive Research and Innovation Group Highlight Report / Terms of Reference	Approval
6.	HR Delivery Plan 2020/22	Assurance	13.	Summary of Items for Escalation to the Trust Board	Approval
7.	Learning, Education and Widening Participation Annual Report 2019/20	Assurance	14.	Review of Business Cycle and Meeting Effectiveness	Information

3. 2020 / 21 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												
Mr P Bytheway	PB	Chief Operating Officer												
Dr L Griffin	LG	Non-Executive Director												
Dr J Oxtoby	JO	Medical Director		GH										
Mr M Oldham	MO	Chief Finance Office												
Mrs M Rhodes	MR	Chief Nurse			HI									
Miss C Rylands	CR	Associate Director of Corporate Governance	NH											
Mrs R Vaughan	RV	Director of Human Resources												

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	5th August 2020
Report Title:	People Strategy 2019-20 Annual HR Report	**Agenda Item:**	13.
Author:	Claire Soper, Head of HR Governance and Workforce Information		
Executive Lead:	Ro Vaughan, Director of Human Resources		

Purpose of Report:

Assurance	✓	**Approval**		**Information**	

Impact on Strategic Objectives (positive or negative):			Positive	Negative
SO1		Provide safe, effective, caring and responsive services		
SO2		Achieve NHS constitutional patient access standards		
SO3		Achieve excellence in employment, education, development and research	✓	
SO4		Lead strategic change within Staffordshire and beyond		
SO5		Ensure efficient use of resources	✓	

Executive Summary:

The Trust's People Strategy is supported by an HR Delivery Plan, with improvement activities cascaded via Divisional People Plans. The People Strategy supports delivery of the Trust's Strategic Objectives.

This Annual HR Report sets out our progress towards achieving the priorities in delivering the People Plan was presented to the Transformation and People Committee on 29th July 2020 as providing positive assurance in mitigating the workforce risks identified in the Board Assurance Framework.

In 2019/20, the key focus for our People Plans was in line with our five objectives of:

- Developing the Organisation
- Planning the Workforce
- Learning, Education and Widening Participation
- Improving Staff Experience and Wellbeing, and
- Investing in our People Strategy and Transforming Human Resources

Developing the Organisation – of the 142 critical roles (Band 7 and above) identified for succession planning, 46 (33%) have succession plans in place.

798 Band 6 and 7 leaders completed a leadership development masterclass by 31 March 2020 (33% of the baseline position). Participants stated that their leadership development has driven improvements in 5 key areas: effectiveness in service, patient experience, areas of clinical improvements, staff experience and contributing to financial performance. Going forward, outcomes will be measured using the NHS Healthcare Leadership Model 360 process.

The main area of concern is the deterioration in the PDR compliance rate, which stood at 75.94% at 31st March 2020 and performance since March has deteriorated further due to the impacts of the covid-19 pandemic.

Positively, significant work was carried out to address any gaps in the treatment and experience of our Black, Asian and Minority Ethnic (BAME) workforce through the Workforce Race Equality Standard (WRES), and our Disabled workforce through the Workforce Disability Equality Standard (WDES) and this will remain a focus for 2020/21.

Planning the Workforce – Budgeted establishment was 13.3% greater than that planned and substantive workforce was 5.3% greater than plan. It should be noted that any business cases approved after the plan was submitted would not have been included, hence the variance. Agency spend was greater than target in part due to the number of hard to recruit to posts, which are covered by long term, high cost agency. Bank costs were reduced compared to 2018/19, but exceeded the 2019/20 target, mainly due to vacancies in nursing and healthcare support.

Learning, Education and Widening Participation – The main area of concern remains Statutory and mandatory training compliance which, at 90.73% was below the 95% target. During the year, there were 473 successful Work Experience placements and 184 apprentices in the Trust.

Improving Staff Experience and Wellbeing - Staff recommendation of the organisation as a place to work from improved from 57.20% 60.4%, but remained below the National average (*62.5% in 2019*). The staff engagement score was 6.9 and, although this was just below the acute trust average of 7.0, it was an improvement on the 2018 score of 6.8. The 12 month cumulative sickness rate for 2019.20 was 4.69% and meeting the internal Trust target of 3.4% continues to be a challenge. Going forward, the Staff Wellbeing and Engagement work remains focussed on the actions to address the workforce elements of the Trust's emergency response to Covid-19, including restoration and recovery

Investing in our People Strategy and Transforming HR - Throughout 2019/20, we have implemented new technology, such as the Empactis absence management system and continued to facilitate access to, and promote the benefits of the Employee Staff Record system (ESR). Human Resources continued to support line managers by delivering people management policies and procedures; by providing advice and guidance; training and development, and by supporting managers in effective case management.
Our priorities for 2020/21 have been reviewed in light of the performance set out in the report and the necessary focus on restoration and recovery post covid-19. Priorities for 2020/21 are outlined in the report and build on the work completed to date towards achieving the objectives of the People Strategy. It should be noted however, that the launch of the NHS National People Plan (delayed due to Covid-19) will impact and inform the HR Agenda going forward and this may necessitate some change in the priorities for 2020/21.

Key Recommendations:

The Trust Board is asked to note the progress made during 2019/20 and the priorities for 2020/21

PEOPLE STRATEGY 2019-2020 ANNUAL REPORT

July 2020

Claire Soper, Head of HR Governance and Workforce Information
Executive Lead: Ro Vaughan, Director of HR

1. Introduction

In 2019/20, the key focus for our People Plans was in line with our five objectives of:

- Developing the Organisation
- Planning the Workforce
- Learning, Education and Widening Participation
- Improving Staff Experience and Wellbeing, and
- Investing in our People Strategy and Transforming Human Resources

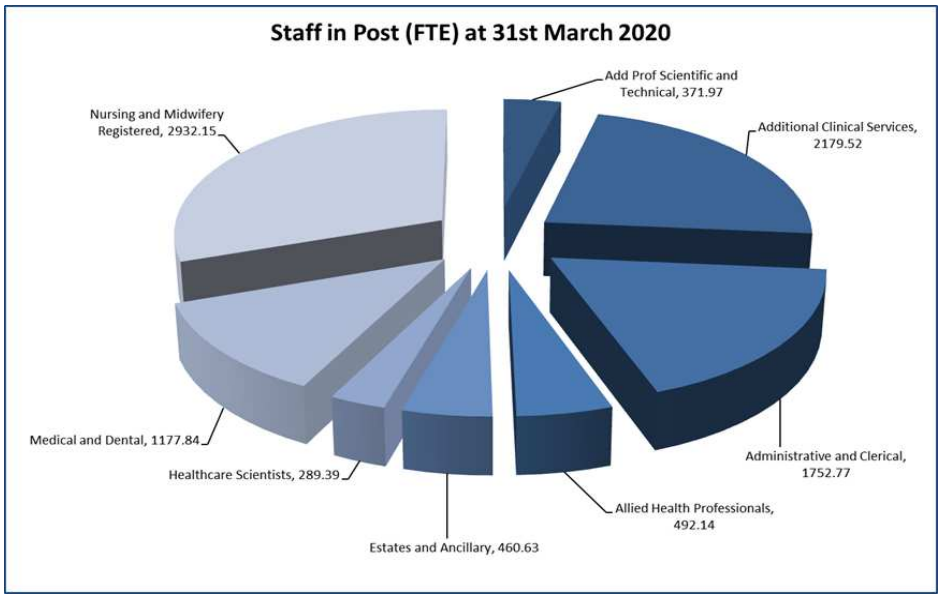
Our priorities for 2019/20 were set out as:

- Developing the organisation to deliver the Trust's vision and values by identifying all critical roles (Band 7 and above) and ensuring succession plans are in place for all those identified by 30th June 2020. We will also ensure 879 (40%) of identified Band 6 and 7 leaders have completed a leadership development masterclass by 31st March 2020
- Planning the workforce to support the recruitment of the right people, in the right numbers at the right time to deliver safe, high quality patient care by putting systems and controls in place which contribute to a reduction in Agency Costs from £18m to £13m and a reduction in Bank costs from £26m to £22m by 31st March 2020
- Improving Learning, Education and Widening Participation to continually enhance opportunities for staff to progress their careers and further develop their skills to be at the leading edge of healthcare provision. We will increase the number of apprenticeships from 167 to 200 by 31st March 2020 and support at least 300 Work Experience Placements in 2019/20.
- Enhance staff experience through improvements to staff wellbeing, reward and recognition and improve Staff recommendation of the organisation as a place to work from 57.20% to better than National average (*62.6% in 2018*) by 31st March 2020 (as evidenced in the NHS Staff Survey)
- Continuing to transform HR to improve efficiency and governance by deploying the Empactis Absence Management system by 30th September 2019, ensuring absence management call back and Return to Work compliance targets are met in more than 70% of episodes by 31st March 2020 and more than 80% of episodes by 31st March 2021

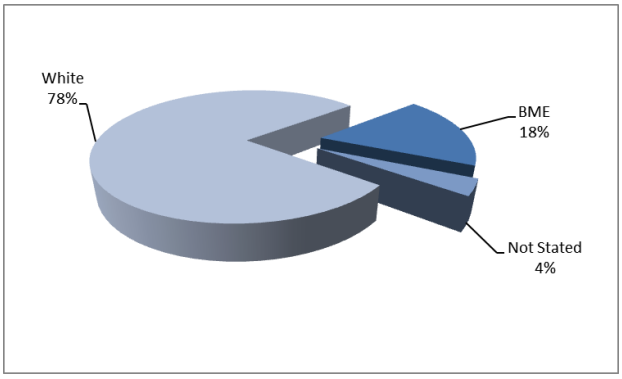
This Annual Report sets out our progress towards achieving these priorities, and our objectives.

2. Our Workforce

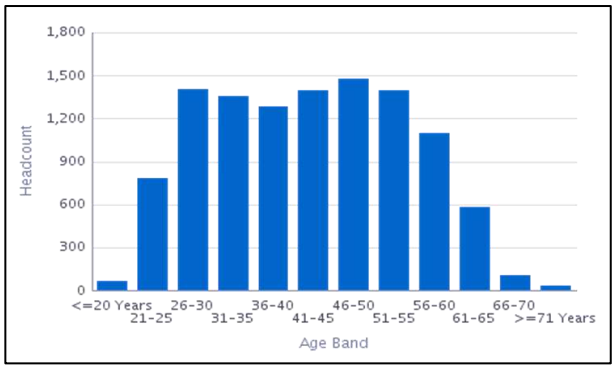
The profile of our workforce as at 31st March 2020 was as follows:



BAME Profile



Age Profile



3. Developing the Organisation

Priority:

Developing the organisation to deliver the Trust's vision and values by identifying all critical roles (Band 7 and above) and ensuring succession plans are in place for all those identified by 30th June 2020. We will also ensure 879 (40%) of identified Band 6 and 7 leaders have completed a leadership development masterclass by 31st March 2020

Performance

- 142 critical roles (Band 7 and above) were identified and 46 (33%) have succession plans in place.
- 798 identified Band 6 and 7 leaders had completed a leadership development masterclass by 31st March 2020 (33% of the baseline position)

Leadership Development

Our leadership development priority for 2019/20 continued via the Connects Leadership Programme with:

- Fifty six leaders completing the Connects Silver Award;
- Forty-one leaders completing Connects Gold and
- Fourteen leaders completing Connects Platinum

- Four of our UHNM staff accepted onto the Staffordshire High Potential Scheme out of the eleven who applied (36.4%)

100% of the participants said they would recommend the programmes they have accessed.

The current cohort is using the NHS Healthcare Leadership Model 360 process, pre and post Connects Gold & Platinum awards, to measure progress in leadership effectiveness and impact in terms of the 9 leadership domains which will give us significant insight into behavioural change impacted by the programme.

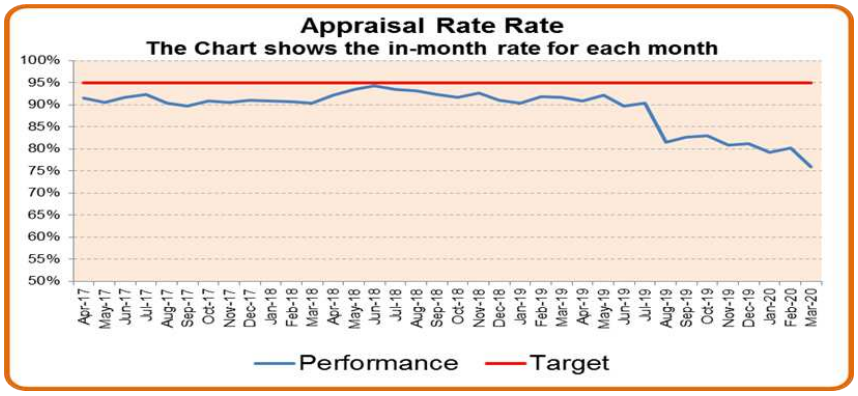
When surveyed in January 2020, participants stated that their leadership development has driven improvements in 5 key areas: effectiveness in service, patient experience, areas of clinical improvements, staff experience and contributing to financial performance; these clearly reflect our core strategic aims. Leaders from previous cohorts of Connects are providing Coaching and Mentoring to participants on current cohorts and are continuing to support our collective leadership approach.

On the current Connects Cohorts, there is 38% of BAME representation.

To help inform our future leadership strategy, 2019/20 saw the start of a two-year NHSI Culture and Leadership Programme, driven by a Change Team, and informed by evidence and feedback from both our staff and wider stakeholders. During 2019/20, we undertook the diagnostics and discovery phase of the programme. The programme has been suspended during the Covid-19 pandemic.

PDR Compliance

Overall, 75.94% of Non-Medical PDRs were recorded in ESR as at 31st March 2020



We continue to promote PDR processes to ensure that all staff receive supportive conversations from their team leaders/line managers and ensure clear trajectories for improvement are in place
As a result of social distancing requirements, different methods for holding meaningful PDR conversations with staff going forward are being investigated. The Appraisal toolkit for managers is being revised and updated and e-learning is being developed, together with a communications plan

Improving Equality and Diversity

We want everyone who comes into contact with UHNM to be treated fairly with respect dignity and compassion. We are proud of our diverse community of staff patients their friends and family and the communities we serve.

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

The Trust monitors how effectively we address any gaps in the treatment and experience of our Black, Asian and Minority Ethnic (BAME) workforce through the Workforce Race Equality Standard (WRES), and our Disabled workforce through the Workforce Disability Equality Standard (WDES). 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. We also participate in the Stonewall Workplace Equality Index as measure of our commitment to LGBTQ+ equality.

We have three active Staff Networks, the Black, Asian and Minority Ethnic (BAME) Staff Network, the LGBT+ Staff Network and the Disability Staff Network. Our Staff Networks each have an Executive Sponsor, and the Chairs of each group are members of the Equality, Diversity and Inclusion Group. During February 2020, we celebrated the work of these Networks for LGBTQ+ History Month. This included a 'Showcase Event' where our LGBTQ+ Network, BAME and Disability Networks showcased the work they're doing to support UHNM to be a more inclusive and diverse place to work.

UHNM supports the Staffordshire NHS Sustainability and Transformation Partnership (STP) first ever Black, Asian and Minority Ethnic (BAME) Leadership Programme – Staffordshire Stepping Up. The programme is aimed at existing and aspiring BAME leaders across Staffordshire healthcare and is designed to support participants to further develop leadership skills in their current roles as well as to develop enhanced skills to assist with career progression. To date, 39 UHNM staff have completed the programme.

During 2019/20 we:

- Established our active BAME staff network group chaired by our WRES Expert
- Raised the profile of race equality through the role of the WRES Expert and regular engagement activities such as Black History Month, BAME Staff Story to Trust Board, provision of celebratory cultural menus from our County and Royal Stoke Restaurants and "wear red' events to support the annual 'Show Racism the Red Card' initiative to combat racism and discrimination
- All of our Staffordshire Stepping Up Graduates have become members of the UHNM Leaders Network and we have run personal development sessions with the BAME staff network
- For Values Week in July 2019 we created an inclusivity video with members of our BAME staff network. This is now showed at every Trust Induction

In November 2019 we received from NHS I&E the aspirational targets for UHNM to increase BAME representation in senior leadership roles. Our priorities for 2020/21 will be to institutionalize diverse recruitment panels and to take steps to increase the diversity of delegates on our internal leadership development programmes.

To improve the experience of our disabled staff in the workplace we have:

- Launched the Tailored Adjustment Plan – a document designed to be a living record of adjustments agreed between an employee and their line manager. The Disability Staff Network was involved in the development of the plan, to ensure that the employee and line manager have a record of what has been agreed. The aim is to minimise the need to re-negotiate adjustments each time the employee changes jobs, is re-located, or assigned a new manager within the organisation and provide employees and their line managers with a structure for discussions about workplace adjustments
- Introduced the Special Leave policy, which includes our commitment to Disability Leave
- Reviewed our recruitment process in consultation with a representative of the Disability Staff Network to assure that it is inclusive and responsive to people's needs
- Launched the second cohort of Project Search which gives opportunity to young people with learning difficulties
- Highlighted disability in the workplace and the contribution and challenges of staff with disabilities and long term conditions in our July Values Week Inclusivity Video and raised awareness of the importance of disclosing disability status on ESR; promoted disabled role models in the workplace through our diversity and inclusion newsletters and supported the Trust Communications team in the introduction of accessibility functionality on both the new Intranet and Internet sites

- Involved the Disability Staff Network in the development of a Manager Awareness training package
- Showcased the work of the Disability Staff Network at the Staff Network Showcase Event in February 2020

Our priority for 2020/21 will be to launch the Disability Awareness training package as we recognise the importance of equipping line managers with the skills to manage staff with disabilities and long term conditions compassionately and effectively.

Our Gender Pay Gap report shows the difference in the average earnings between all men and women employed at UHNM and includes the actions we are taking to further reduce the gender pay gap. We submitted our third Gender Pay Gap report in March 2020. This showed a reduction (improvement) in the gap between men and women in both the mean and medium rates of pay. During 2019-20 we reviewed and updated:

- The Parental/Maternity Leave policy to include occupational shared parental pay and introduced a Special Leave Policy, including carer/domestic leave
- The Clinical Excellence Award Policy and continue to monitor the diversity of applications
- Our recruitment data to establish if there are gender imbalances, particularly for more senior positions in the organisation
- Launched the UHNM Inclusive Talent Management Strategy and ensured those accessing our internal leadership development programmes are representative of our workforce by gender

Throughout 2019/20, we have also engaged with our EU Workforce, providing support and communicating information on the EU Settlement Scheme and the wide range of support available.

4. Planning the Workforce

Priority

Planning the workforce to support the recruitment of the right people, in the right numbers at the right time to deliver safe, high quality patient care by putting systems and controls in place which contribute to a reduction in Agency Costs from £18m to £13m and a reduction in Bank costs from £26m to £22m by 31st March 2020

Performance

Agency Spend for 2019/20 was £18.4m *[£17.3m (2018/19)]*
Bank spend outturn for 2019/20 was £24.1m *[£26.2m (2018/19)]*

The profile of our workforce is changing and needs to change for the future. We have an ageing workforce and as retirements increase, we need to invest in retaining the knowledge and expertise of these experienced staff. Equally, it is also expected that more people will work for longer and therefore we need to create working environments that enable older workers to work within their capability. We also need to continually adapt to the motivations and desires of the younger generation of workers taking their place – often characterized as being altruistic or focused on the social benefits of the activities in which they get involved.

In planning the workforce, we have implemented systems to help ensure a consistent and cost effective approach is taken to deploying medical workforce across the Trust and to support improvements in medical productivity including:

- Locum on duty
- A 'Me' app for all medical staff to manage their leave requests and to see their rosters
- The first phase of the 2019 junior doctors contract
- Establishment of the A&C bank

At 31st March 2020, the budgeted establishment was 13.3% greater than the Workforce Plan and substantive workforce was 5.3% greater than planned.

Of permanent and fixed term staffing, and excluding staff on rotation, there was a net gain of new staff in 2019/20:

	Leavers	Starters	Net Gain
Headcount	886	1236	350
FTE	742.99	1086.25	343.26

Many issues contribute to the variance between actual staffing and that planned, including:

- Business cases approved after workforce plan submission
- TUPE transfer of staff from Royal Wolverhampton Trust

Agency spend was greater than target in part due to the number of hard to recruit to consultant posts, covered by long term, high cost agency. Bank costs were reduced compared to 2018/19, but exceeded the 2019/20 target, mainly covering vacancies in nursing and healthcare support while recruitment campaigns took place.

The Trust has worked with STP partners throughout 2019/20 towards collaborative recruitment and marketing schemes, and is engaged in the system wide STP Workforce Programme, planning and delivering schemes to improve the recruitment and retention of staff, to develop the future workforce, and working to address BME representation in leadership roles at UHNM and across the health economy.

Promoting UHNM as a place to work remains a priority. Towards future-proofing our workforce, we ensure our offer is clear, we include development of work experience opportunities and young volunteer programmes and have well-developed processes for redeployment, both within the Trust and wider STP.

We ensure the Trust's recruitment and selection processes are effective, streamlined, timely, and that they support the Trust's values. We continue to evolve our attraction strategy by developing innovative and competitive solutions to attract new employees making best use of technology and marketing techniques, and particularly focussing on those areas where there are "hard to fill" posts. As regards the Registered Nursing staff group, the Trust participates in the NHS England and NHS Improvement 'Retention Direct Support Programme' so that we can track and understand how turnover performance is changing over time and monitor the impact on retention.

Our Foundation Doctor Y3 programme supports our workforce by securing a further 12 months for the training doctor to undertake a 12 month career development opportunity by offering rotations across specialities and flexible enough to offer bespoke rotations. In addition, we offer significant development and learning opportunities in the role such as internal leadership and post graduate certificate. Year on year the programme has increased in numbers, although small scale, and it is our aim to increase F3 numbers and promote conversion into Core or Speciality roles at the Trust.

There continues to be a national shortage of registered nurses and the UHNM vacancy rate was 11.99% at 31st March 2020 compared to the Midlands Acute Trust vacancy rate of 11.1% *[Source: NHS England and NHS Improvement]*

During 2019/20, our risk mitigation strategy included:

- Targeted recruitment campaigns and open days, to attract new employees, particularly focussing on "hard to fill" posts
- Developing the recruitment and selection skills of managers to include values-based assessment techniques and improve recruitment processes
- Implemented a 'Grow our Own' strategy - implementation of Nursing Apprentice and Nursing Associate programmes
- Increased the number of student nurse placements at both Keele and Staffordshire University
- Provided support for retire and return of experienced staff, the return to practice programme and supported overseas nurses currently working as nursing assistants to gain access to the NMC register
- Integrated Registered mental health nurses and learning disability nurses into the ward establishments
- Used the apprenticeship levy to support higher apprenticeships such as ACP and offering placements to support other apprenticeship routes outside the organisation
- Develop a structured work experience week for students considering a career within UHNM

To ensure UHNM remains an attractive organisation, and to promote the use of our internal nurse bank we have:

- Directed effort at increasing the staff numbers on the nurse bank
- Introduced a transfer policy to support staff wishing to pursue new career pathways elsewhere within the organisation to improve our retention rate.
- Introduced more structured career pathway for our unregistered workforce and the introduction of additional roles, including apprentices

Workforce development also continued in respect of other roles, For example:

- Pathology staff being developed via the Bsc Biomedical Science apprenticeship in partnership with Staffordshire University.
- To address workforce supply issues in a number of hard to fill roles including 'Medical Physics' technicians; Nuclear Medicine Engineer and qualified Radiotherapy Engineers, we are using the apprentice levy, working in partnership with a local college, to "grow our own" engineers.

5. Learning Education and Widening Participation

Priority

Improving Learning, Education and Widening Participation to continually enhance opportunities for staff to progress their careers and further develop their skills to be at the leading edge of healthcare provision. We will increase the number of apprenticeships from 167 to 200 by 31st March 2020 and support at least 300 Work Experience Placements in 2019/20

Performance

There were 473 successful Work Experience placements between April 2019 and March 2020 and, as at 31st March 2020, there were 184 apprentices in the Trust.

Working closely with our education partners, we have continued to implement our Apprenticeship Strategy and Widening Participation initiatives in recognition of the need for clear educational pathways from schools and colleges into the NHS for clinical support, healthcare scientists, administration and nursing assistant roles

Apprentices and Work Experience

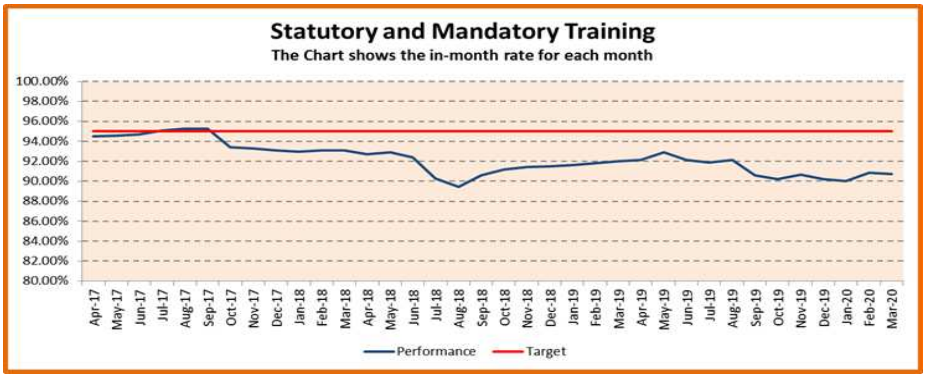
The apprenticeship opportunity has supported staff in a number of ways; by achieving competencies to move into a job role, career development such as aspiring or trainee posts, and supporting service requirements along with retaining staff and building effective succession planning. Integrated physiotherapy and occupational therapy apprenticeship roles have been introduced into current established Frail Elderly wards at Royal Stoke. The apprentices are trained in core therapy technician rehabilitation competences.

In 2019/20, we continued to expand and improve the quality of training and development opportunities for support workers and continued to offer work experience as widely as possible for young people and other talented members of our community. For example, the Trust developed a cohort approach for work experience with local colleges with the potential of offering 'young volunteer' roles.

The Trust is working with the Staffordshire STP on transferring the allocation of the Apprenticeship Levy to enable these funds to be used to support the development of a 'community ready' workforce comprising, for example, Nursing Assistants, Associates and Advanced roles.

Statutory and Mandatory Training

The Statutory and Mandatory training rate at 31st March 2020 was 90.73% and 84.27% of staff had completed all 7 Core of All modules.



An action plan to address Statutory and Mandatory training issues raised during the CQC inspection was presented to the Quality Governance Committee and compliance reports are provided each month to the HR Business Partners for them to follow up with their Divisions / Directorates

Medical staff compliance with the Core for All requirements remains an issue and this is being followed up with Medical leads.

6. Improving Staff Experience and Well-being

Improving Staff Experience:

Priority Enhance staff experience through improvements to staff wellbeing reward and recognition and improve Staff recommendation of the organisation as a place to work from 57.20% to better than National average (*62.6% in 2018*) by 31st March 2020 (as evidenced in the NHS Staff Survey)
Performance Staff recommendation of the organisation as a place to work from improved from 57.20% to 60.4%, but remained below the National average (*62.5% in 2019*).

Staff engagement activities have continued throughout the year with director visits to all wards and departments; long service awards, Staff Awards and a wellbeing day. During July, there was a special focus on Trust values in conjunction with the national 'Values Week', and to date, over 3000 staff have been nominated through our Values Recognition Scheme. Measured through the annual NHS Staff Survey, our staff engagement score was 6.9. Although this was just below the acute trust average of 7.0, it was an improvement on the 2018 score of 6.8.

A detailed report on the findings of the 2019 NHS Staff Survey was presented to Board on 11 March 2020. Overall, the Staff Survey indicated that staff provided more positive feedback in 2019 compared to the 2 previous years.

Towards building a culture of openness where staff feel confident to raise concerns:

We implemented a ***Just & Learning Culture*** approach promoting a culture of fairness openness and learning where staff feel confident to speak up supporting staff when things go wrong so errors can be prevented from being repeated

Our 2019 Staff Survey showed an increase in staff saying they experienced harassment, bullying and abuse from patients/service users (from 26.4% to 28.2%), and an increase in experience of violence (15.9% up to 16.5%) from patients/services users. Staff experience of harassment, bullying and abuse from managers reduced from 15.6% to 14.1%, but increased from colleagues (22.0% up to 22.9%). Experience of violence from colleagues reduced from 1.9% to 1.4%, which is now below the national average

November's Anti Bullying Week saw the launch of our "Cut it Out" campaign, which included impactful messaging about the personal effect of bullying and harassment in the workplace.

We have embedded our commitment to a Just and Learning Culture in both the Disciplinary Policy and Speaking Up Policy and set up review process overseen by a Just and Learning Panel that will include equality lead representation. Next steps include embedding the just and learning culture approach into disciplinary and capability processes and promoting civility and respect across all areas of the Trust. We will also introduce a 'Speaking Up' Staff Charter and embed 'Cut It Out' as ongoing messaging that violence, bullying and harassment are unacceptable behaviours.

Improving organisation and management interest in and action on health and wellbeing:

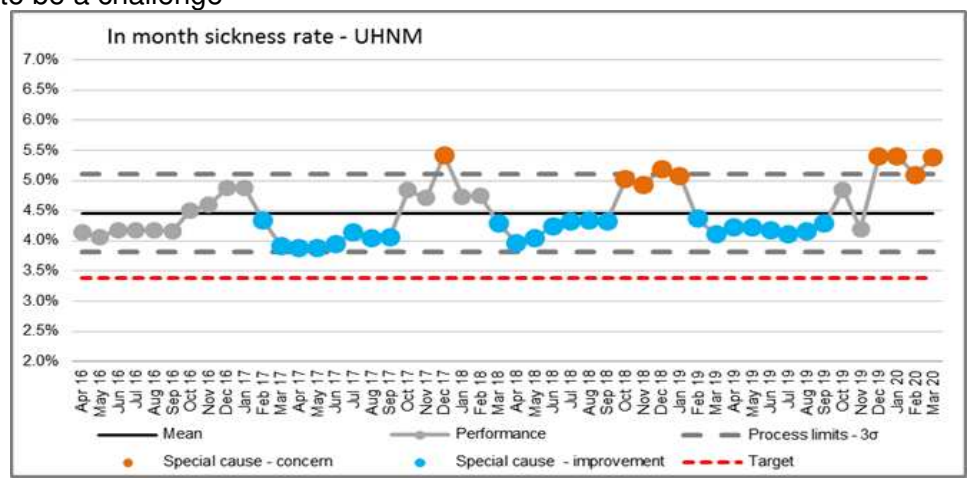
Our wellbeing governance structure is led by an Executive Director who oversees delivery of the wellbeing plan at corporate and local level.

We have improved Wellbeing leadership by establishing a 'Wellbeing Group' and appointing Divisional Wellbeing Ambassadors with funding support to develop and implement staff wellbeing plans for each Division

We have implemented an emotional wellbeing education programme, in partnership with Midlands Partnership Foundation Trust and incorporated self-awareness, self-care and suicide risk awareness in the medical education curriculum. We continue to promote stress management, resilience and emotional well-being offerings across the Trust.

We implemented a new Absence Management System 'Empactis', on 30th September 2019. This supports the delivery of a consistent approach to managing the key processes associated with health, absence and engagement. It also reduced risks and costs associated with absence by providing real-time visibility of all unplanned absence at every level within the organisation.

The 12 month cumulative sickness rate for 2019.20 was 4.69% and meeting the internal Trust target of 3.4% continues to be a challenge



To improve and evidence the positive action taken on health and wellbeing, we will continue to embed the Empactis system to support improvements to sickness absence case management and continue to promote staff wellbeing, including financial wellbeing, in line with the Trust's wellbeing plan. We will undertake specific work with the health and safety team and staff physiotherapy service to consider how we can provide further support to those staff members with musculoskeletal problems.

Going forward, the Staff Wellbeing and Engagement work remains focussed on the actions to address the workforce elements of the Trust's emergency response to Covid-19, including restoration and recovery.

7. Investing in our People Strategy and Transforming HR

Priority:
Continuing to transform HR to improve efficiency and governance by deploying the Empactis Absence Management system by 30th September 2019, ensuring absence management call back and Return to Work compliance targets are met in more than 70% of episodes by 31st March 2020 and more than 80% of episodes by 31st March 2021

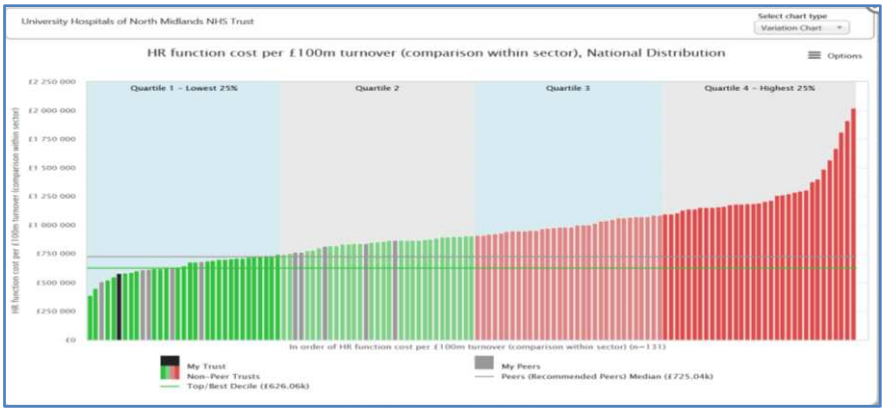
Performance
Phase 1 of Empactis was deployed by 30th September. For the period 30th September 2019 to 31st March 2020, there were 10,118 absence episodes reported in the system with 7,735 Return to Work interviews completed (76.45%)

As well as implementing the Empactis system, we have continued to facilitate access to, and promote the benefits of the new Employee and Manager self-service portals in ESR and this has included supporting managers to add Performance and Development Review (PDR) data, which is now only reported from the ESR System, and encourage staff to undertake their Statutory and Mandatory training requirements via their self-service portals

Throughout the year, HR has continued to support line managers by delivering people management policies and procedures; by providing advice and guidance; training and development, and by supporting managers in effective case management.

Model Hospital data

The latest Model Hospital data for the HR function is 2018/19, which show the cost per £100m turnover as being in the lowest quartile (comparison within sector)



8. Priorities for 2020/21

Our priorities for 2020/21 are:

- Workforce Restoration and Recovery linked to covid-19
- Promoting UHNM as employer, hospital of choice, promoting our brand and planning the workforce to support the recruitment of the right people, in the right numbers at the right time to deliver safe, high quality patient care to maintain actual substantive staffing levels within a tolerance level of +/-5% of that planned
- Continuing the development of the organisation to deliver the Trust's vision and values by completing the culture diagnostic work and beginning to implement findings from the survey
- Continue to support and offer management and leadership development through our internal and external offer, to ensure UHNM leaders and managers have the skills to carry out their roles effectively and also that their personal and professional development is supported
- To improve Equality and Diversity by promoting our inclusive culture and addressing the needs of our protected groups; institutionalizing diverse recruitment panels; increasing the diversity of delegates on our internal leadership development programmes; and launching the Disability Awareness training package to equip line managers with the skills to manage staff with disabilities and long term conditions compassionately and effectively
- Enhancing Staff Experience through improvements to Staff Wellbeing, Reward and Recognition to improve staff recommendation of the organisation as a place to work from 60.4% to better than National average (*62.5% in 2019*) by 31st March 2021 (as evidenced in the NHS Staff Survey)
- Improving Learning, Education and Widening Participation to continually enhance opportunities for staff to progress their careers and further develop their skills to be at the leading edge of healthcare provision
- Transforming HR to improve efficiency and governance to ensure absence management call back & Return to Work compliance targets are met in more than 80% of episodes by 31st March 2021

The launch of the NHS National People Plan (delayed due to Covid-19) will impact and inform the HR Agenda going forward and this may necessitate some change in the priorities for 2020/21.

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	5th August 2020
Report Title:	Workforce Disability Equality Standard (WDES)	**Agenda Item:**	14.
Author:	Raising Concerns & Workforce Equality Manager		
Executive Lead:	Director of HR		

Purpose of Report:

Assurance	✓	**Approval**		**Information**	

Impact on Strategic Objectives (positive or negative):			Positive	Negative
SO1		Provide safe, effective, caring and responsive services	✓	
SO2		Achieve NHS constitutional patient access standards	✓	
SO3		Achieve excellence in employment, education, development and research	✓	
SO4		Lead strategic change within Staffordshire and beyond	✓	
SO5		Ensure efficient use of resources	✓	

Executive Summary:

As set out in the NHS Long Term Plan, respect, equality and diversity are central to changing culture and are at the heart of the NHS England workforce implementation plan.

The Workforce Disability Equality Standard (WDES), commissioned by the Equality and Diversity Council is mandated through the NHS Contract. It is designed to improve workplace and career opportunities for Disabled people working, or seeking employment in the NHS. The WDES is a tool and enabler of change.

This is the second year of the WDES, which comprises 10 evidence based metrics which provide NHS organisations with a snapshot of the experiences of their disabled staff in key areas. In this second year of reporting the WDES it is positive that we can see improvement in 8 of the metrics when compared with the 2019 report.

The report also outlines the actions we intend to take to further close the gaps in career and workplace experience between our disabled staff and non-disabled staff at UHNM during 2020-21.

The Trust is required to publish our WDES indicators and action plan on our Trust Website by 31st October 2020.

Key Recommendations:

The Trust Board is requested to consider this WDES Report and the actions we intend to take to close the gaps in career and workplace experience between our disabled staff and non-disabled staff at UHNM during 2020-21.

Workforce Disability Equality Standard (WDES)
2020 Report
July 2020

1. Introduction

The Workforce Disability Equality Standard (WDES) has been introduced across the NHS to advance disability workplace equality. Previous initiatives have not reduced the longstanding gaps that exist between the workplace experiences and career opportunities of Disabled and non-disabled people.

The rationale for the WDES is founded upon the wider context of Disabled people and their experiences in employment and work. The WDES is underpinned by the Social Model of Disability, which proposes that people are disabled because of societal barriers, rather than a long-term health condition. With the social model in mind, the WDES will help inform year on year improvements in reducing those barriers that impact most on the career and workplace experiences of Disabled staff; driving changes in attitudes, increasing employment and career opportunities, and implementing long-lasting change for Disabled people.

The WDES is mandated to all NHS Trusts and Foundation Trusts in England through the NHS Standard Contract and comprises of 10 Metrics that incorporate data from the following primary sources: the NHS Electronic Staff Record (ESR), the NHS Staff Survey and local HR and recruitment systems.

There are three mandated reporting requirements for the WDES, which are to:
- verify, complete and submit our metric data on a pre-populated excel spread sheet;
- submit an online reporting form;
- Publish our WDES report on the trust's external website, which includes our metrics, evidence of engagement with Disabled staff and our action plan.

2019 was the first year of the WDES, and the key National findings from the 2019 WDES were that:

Overall, 3.6% of the non-clinical and 2.9% of the clinical workforce (excluding medical and dental staff) had declared a disability through the NHS Electronic Staff Record.	For medical and dental staff, 1.94% of trainee grades, 1.2% of non-consultants career grade and 0.8% of consultants had declared a disability.	Disabled people are less likely to be appointed. Non-disabled job applicants are 1.23 times more likely to be appointed from shortlisting compared to Disabled applicants.
Disabled staff are 1.1 times more likely to go through formal capability processes on the basis of performance compared to non-disabled staff.	Disabled staff are more likely to experience harassment, bullying and abuse. Disabled staff are 7 percentage points more likely from patients, 6.8 percentage points more likely from managers and 8.7 percentage points more likely from colleagues compared to non-disabled staff.	Disabled staff are 7.4 percentage points less likely to believe that their trust provides equal opportunities for career progression or promotion, compared to non-disabled staff. (75.3% vs. 82.7%).

Disabled staff are 9 percentage points more likely, compared to non-disabled staff, to be pressured to come into work despite not feeling well enough to perform their duties (32.0% vs. 23.0%).

Disabled staff are 10.7 percentage points less likely to say that they feel their organisation valued their work when compared to non-disabled staff (37.2% vs. 47.9%).

72.4% of Disabled staff felt that their employer had made adequate adjustments to enable them to carry out their work.

Disabled staff are less likely to feel engaged with the NHS Staff Survey, with an engagement score of 6.64, compared to 7.01 for non-disabled staff.

Overall 2.1% of board members were Disabled; 1 percentage point lower than the percentage of Disabled staff in the wider workforce.

2. WDES Metrics and UHNM Performance

A detailed analysis of the WDES Metrics is attached as Appendix 1 and includes comparison of our performance against benchmarking data where this is available from either the 2019 NHS Staff Survey, or the 2019 National WDES data analysis report. A summary of our 2020 WDES metrics is outlined below.

Note: data for Metrics 2 and 3 is auto calculated using the WDES pre populated excel spread sheet to produce a relative likelihood score. A relative likelihood of 1.00 indicates that there is no difference between Disabled and non-disabled staff. For example, for Metric 2, a result above 1.00 indicates that non-disabled staff have an increased likelihood of being appointed from shortlisting compared to disabled staff and for Metric 3 a result above 1.00 would indicate that disabled staff are more likely to enter the formal capability process than non-disabled staff.

	WDES Metric	2019	2020	Improved/ Deteriorated
Workforce Metrics				
1.	Percentage of staff in AfC pay-bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff:	1.54%	1.64%	**improved**
	Cluster 1: AfC Band 1, 2, 3 and 4	1.6%	1.9%	
	Cluster 2: AfC Band 5, 6 and 7	1.5%	1.6%	
	Cluster 3: AfC Band 8a and 8b	1.6%	1.9%	
	Cluster 4: AfC Band 8c, 8d, 9 and VSM (including Executive Board members)	1.4%	1.4%	
	Cluster 5: Medical and Dental staff, Consultants	0.8%	0.6%	
	Cluster 6: Medical and Dental staff, Non-consultant career grade	0.9%	0.4%	
	Cluster 7: Medical and Dental staff, Medical and dental trainee grades	0.7%	0.9%	
2.	Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts	1.29	1.26	**improved**
3.	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure This metric will be based on data from a two-year rolling average	17.07	0.00	**improved**

	WDES Metric	2019	2020	Improved/ Deteriorated
	of the current year and the previous year This metric applies to capability on the grounds of performance and not ill health			
NHS Staff Survey Metrics				
4a.	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from patients /service users, their relatives or other members of the public	30.7%	31.8%	**deteriorated**
	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Managers	22.0%	20.5%	**improved**
	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from other colleagues	28.9%	30.9%	**deteriorated**
4b.	Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	49.5%	45.4%	**deteriorated**
5.	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion	75.0%	80.0%	**improved**
6.	Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	38.9%	34.7%	**improved**
7.	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work	33.1%	34.0%	**improved**
8.	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work	70.2%	73.7%	**improved**
9.	a) The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation b) Has your organisation taken action to facilitate the voices of Disabled staff in your organisation to be heard?	6.5	6.6	**improved**
Board Representation Metric				
10.	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated: • By voting membership of the Board. • By Executive membership of the Board.	0%	0%	**no change**

Six of the WDES metrics are drawn from the national NHS Annual Staff Survey. The response rate for the 2019 staff survey was 45% with 19.5% of respondents answering yes to the question 'Do you have any physical or mental health conditions, disabilities or illnesses that have lasted or are expected to last for 12 months or more?'

UHNM uses recruitment monitoring and the ESR system to capture and record employee disability status. Nearly 41% of UHNM ESR staff records have not disclosed any status regarding disability. Nationally it is recognised that there is a significant under reporting across the country of the numbers of staff who declare themselves to be disabled on ESR, compared to those completing the Staff Survey.

3. Disability Equality Actions Undertaken in 2019/20

During 2019/20, we have undertaken the following actions:

Engaging with our Disabled staff to facilitate the voices of disabled staff being heard

- Worked with our Disability Staff Network in developing our 2019 WDES Action Plan
- Raised the profile of disability equality and workplace inclusivity through newsletters, personal stories and our Inclusivity at UHNM video filmed with members of our Disability Staff Network. Initially developed for July 2019's Values Week, the video is now shown at every Trust Induction
- In collaboration with the LGBT+ and BAME Staff Networks we held a Staff Networks Event where the three networks showcased the work they have been doing to further develop diversity and inclusion. Trust Chief Executive Tracy Bullock, and senior leaders including the Executive Sponsors of the Networks were all in attendance to celebrate the achievements of the groups and raise awareness of key issues
- Undertaken a Disability Staff Survey during Equality, Diversity and Human Rights Week in May 2019 to hear the views and experiences of our staff and in collaboration with the Disability Staff Network identified network priorities for the next 2-3 years

Improving workplace experiences of our disabled staff

- Launched the Tailored Adjustments Plan – a document designed to be a living record of adjustments agreed between an employee and their line manager. The purpose of this Plan is to:
  - Ensure that the employee and line manager have a record of what has been agreed
  - Minimise the need to re-negotiate adjustments each time the employee changes jobs, is re-located, or assigned a new manager within the organization
  - Provide employees and their line managers with a structure for discussions about workplace adjustments
- Embedded disabled workers rights to Disability Leave into our new Special Leave Policy
- Accessibility functionality is now available on the new version of hospital intranet and internet, which has been reviewed and shaped by our Disability Staff Network and Equality, Diversity & Inclusion Group
- Updated the Emotional Wellbeing and Mental Health Policy and launched Wellbeing Ambassadors
- Continued with our Wellbeing Strategy and held a series of wellbeing events including Mental Health Awareness Week
- Updated our Disability Guidance for staff and managers to include Disability Leave and the Tailored Adjustments Plan
- Increased our number of Freedom to Speak Up Guardians and continued to promote a culture where staff are empowered to speak out about staff experience, and risk to patient and staff safety
- Updated the Speaking Up Policy
- Developed and launched the "Cut it Out" anti-bullying and harassment campaign during November 2019s UHNM Anti Bullying Week using impactful slogan messaging about the effect of inappropriate banter, exclusion and harassment
- Set up comprehensive Staff Wellbeing and Disability Equality pages on the intranet for our employees and managers to access supportive and informative resources
- Created a new social media group aimed at connecting Disabled employees and improving membership numbers of the Disability Staff Network

Ensuring we are a fair and compassionate employer

- Reviewed the two cases of a disabled member of staff that entered the formal capability process due to performance related issues identified from last years WDES. The review was undertaken by the Employee Relations Manager and Chair of Staff Side. The review confirmed that the cases were managed appropriately and that learning was about the importance of job adverts being explicitly clear on the nature of duties and the proportion of time spent on those duties (for example, typewriting)

- Launched the Just and Learning Culture and decision tree across the organisation and our commitment to learning rather than blaming. This has been embedded into the revised Disciplinary Policy and Speaking Up Policy
- Reviewed and updated the Capability Policy and the Performance Capability Management toolkits and E-learning to ensure a performance management culture that is supportive, consistent and fair
- The HR Department continues to work closely with the Trade Unions to monitor consistency of approach to formal employee relations cases through a monthly joint meeting

Attracting and retaining staff with disabilities

- Continued our work with local schools and colleges to promote the various roles and routes into employment as part of our Widening Participation Strategy
- Continued to reach out to disabled and other protected groups, promoting UHNM as an employer of choice for people with disabilities and raising awareness of the various routes into NHS careers, such as apprenticeships
- Encouraged staff to declare their disability status on ESR through our newsletters explaining how and why declaring disability status is important and what we use the information for. We also contact staff directly via ESR messaging to encourage staff to declare their disability status, which will help us to enable us to better understand disability representation within our workforce
- A comprehensive recruitment and equality & inclusion e-learning package is a pre requisite for all staff who are undertaking the Trust's Gateway to Management leadership development programme
- Reviewed our recruitment processes with a member of our Disability Staff Network to consider the accessibility of our recruitment platforms and processes and to identify barriers faced by people with a sensory disability
- Welcomed our second cohort of Project Search students to UHNM

4. Conclusions

The WDES has been developed and continues to be underpinned by the ethos of 'nothing about us without us' this means that any decisions that impact on disabled people must involve disabled people. We are committed to ensuring that our disabled staff are involved in shaping our equality, diversity and inclusion work and have opportunities to influence and contribute our activities to improve disability equality at UHNM. We do this working collaboratively with our Staff Network and through a range of workforce engagement activities, for example surveys and awareness events in addition to the National NHS Staff Survey. We know that by working in partnership with our staff that we can develop human resource practices and policies that enable all of our employees to thrive.

The WDES is important because evidence shows that a well-motivated inclusive and valued workforce helps to deliver high quality patient care, increased patient satisfaction and improved safety for the people we care for. The aim of the WDES is to enable NHS Trusts to understand what they need to do to improve disability equality. We have identified a number of actions that we will focus on during 2020/21 to continue to close the gaps in career and workplace experience between our disabled staff and non-disabled staff, and this is outlined in the following Action Plan.

Progress will be measured by improved metric results in the 2021 WDES submission, 2020 NHS Staff Survey results and the monitoring of other relevant metrics.

UHNM WDES Action Plan 2020-2021			
WDES Metric	**Action / Recommendation**	**Timescale**	**Progress Rating**
Percentage of staff in AfC pay-bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.	Continue to act upon the under representation of staff declaring disability by regularly encouraging all staff to update their disability status. Provide further information within these communications about what conditions fall into the category of disability	Ongoing	GA
	Use staff with disabilities as role models to showcase UHNM's commitment to being an inclusive employer in promotional material	Ongoing	GA
	Introduce a disability section on the 'Working Here' section of the Trust Website to promote inclusivity and the support available to potential candidates with a disability	Q3	GB
Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts	Introduce Disability Awareness Training to improve knowledge and understanding of recruiting managers. To include personal stories from members of our Disability Staff Network	Q3	GA
	The Trust Recruitment Manager is a member of the Disability Staff Network and works with the group to improve recruitment practice based on feedback from the Network	Ongoing	GA
	Continue with our Widening Participation Strategy, Project Search and other recruitment initiatives	Ongoing	GA
Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure	Introduction of a Workplace Reasonable Adjustments Policy, or link into an existing policy which outlines processes, the support available and the role of different functions such as HR, occupational health and I.T.	Q4	GB
	Review the content of the capability training for line managers to ensure that it includes elements about performance management issues and disability	Q4	GB
	Continue to work closely with our Staff Side colleagues to ensure that all reasonable adjustments have been made available for disabled staff and that the capability policy has been applied in a consistent and supportive manner	Ongoing	GA
Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from • patients /service users, their relatives or other members of	Continue with our 'Cut it Out' anti bullying and harassment campaign	Ongoing	GA
	Launch of the Speaking Up Charter to promote the Trusts commitment to a healthy speaking up culture and how staff will be supported to raise issues	Q2	GA
	Increase the number of Employee Support Advisors and provide a development session to Freedom to Speak Up Guardians and Employee Support Advisors on disability to enable them to support individuals experiencing workplace difficulties relating to their disability more effectively	Q4	GB

UHNM WDES Action Plan 2020-2021			
WDES Metric	**Action / Recommendation**	**Timescale**	**Progress Rating**
the public • Managers • Other colleagues			
Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	Launch of the Speaking Up Charter Promotion of routes to raise issues and concerns	Q2 Ongoing	GA GA
Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion	Undertake an analysis of internal leadership development to understand disabled staff representation. Encourage all staff undertaking this development to declare disability status Work with our Disability Staff Network and Organisational Development Team to identify any barriers to accessing development Include staff with disabilities in the second cohort of the Reverse Mentorship Programme	Q3 Q3 Q4	GB GA GB
Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	Review the sickness absence training for line managers and ensure that it includes specific guidance on compassionate management of sickness absences of staff with disabilities	Q4	GB

UHNM WDES Action Plan 2020-2021			
WDES Metric	**Action / Recommendation**	**Timescale**	**Progress Rating**
Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work	Introduce Disability Awareness Training for line managers with a focus on the value of disabled employees, and address perceptions of workplace adjustments being costly and difficult	Q3	GA
	Introduce focus groups with disabled staff with differing conditions to understand the issues that matter to them and identify actions to increase their wellbeing and feeling of value: ➢ Sensory impairments ➢ Physical disabilities ➢ Mental health ➢ Learning difficulties ➢ Hidden disabilities	Q3/4	GB
	Launch and promote the UHNM Disability and Long Term Conditions Staff Facebook Group as a place to network, share experiences and good practice	Q1	B
Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work	Introduction of a Workplace Reasonable Adjustments Policy or link into an existing Policy, which outlines processes, the support available and the role of different functions such as HR, occupational health and I.T.	Q4	GB
	Further promotion and inclusion within leadership training material of the importance of the Tailored Adjustments Plan	Q3	GA
	Introduce Disability Awareness Training for line managers to provide improved support to both managers and staff on implementing and accessing reasonable adjustments	Q3	GA
The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation	Introduce focus groups with disabled staff with differing conditions to understand the issues that matter to them and identify actions to increase their wellbeing and feeling of value: ➢ Sensory impairments ➢ Physical disabilities ➢ Mental health ➢ Learning difficulties ➢ Hidden disabilities	Q3/4	GB

UHNM WDES Action Plan 2020-2021			
WDES Metric	**Action / Recommendation**	**Timescale**	**Progress Rating**
Percentage difference between the organisation's Board voting membership and its organisation's overall workforce	Encourage all Board members to declare their disabilities. Disability Network Executive Sponsor to continue to champion disability issues with the Trust Board	Ongoing Ongoing	GA GA

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

Appendix 1 – UHNM WDES 2020 Metric Analysis

Further detail is provided below on each of the WDES Metrics, including comparisons of our performance against benchmarking data where this is available from either the 2019 NHS Staff Survey, or the 2019 National WDES data analysis report.

Metric 1: Representation of Disabled staff in Agenda for Change (AfC) paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce

The following graph demonstrates disabled representation across pay bands and by clinical and non-clinical job roles, as defined by the WDES metrics:

Cluster 1: AfC Band 1, 2, 3 and 4 (also including apprenticeships)
Cluster 2: AfC Band 5, 6 and 7
Cluster 3: AfC Band 8a and 8b
Cluster 4: AfC Band 8c, 8d, 9 and VSM (including Executive Board members)
Cluster 5: Medical and Dental staff, Consultants
Cluster 6: Medical and Dental staff, Non-consultant career grade
Cluster 7: Medical and Dental staff, Medical and dental trainee grades

Disability Data (at 31/03/2020)	Disabled	Not Disabled	Not Declared/ Do not wish to disclose	Grand Total	Yes as % of total headcount
Cluster 1	92	2,697	1,991	4,780	1.9%
Cluster 2	74	2,647	1,923	4,644	1.6%
Cluster 3	8	213	211	432	1.9%
Cluster 4	1	36	32	69	1.4%
Cluster 5	3	294	221	518	0.6%
Cluster 6	1	163	66	230	0.4%
Cluster 7	4	354	108	466	0.9%
Total	**183**	**6,404**	**4,552**	**11,139**	**1.64%**

2.75% of non-clinical and 1.4% of the clinical workforce (excluding Medical and Dental) have declared a disability on ESR. This compares to a national picture of 3.6% of non-clinical and 2.9% of clinical staff in 2019. Nationally it is recognised that Medical and Dental staff are less likely to declare a disability compared to other clinical and non-clinical staff, and this is reflected at UHNM, where only 0.7% of this staff group has declared a disability.

Staff Group	Disabled	Not Disabled	Unknown/Not Stated
Non-clinical	2.8%	54.5%	42.8%
Clinical (excluding Medical & Dental)	1.4%	57.1%	41.5%
Medical & Dental	0.7%	66.8%	32.5%

Metric 2: The relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts

Disability Status	Applied	Shortlisted	Appointed
Not stated	386	375	305
Do not wish to disclose	431	129	19
No	26,062	7,599	1,488
Yes	1,023	398	62
Total	**27,902**	**8,501**	**1,874**

Disabled applicants (i.e. those that disclosed a disability on TRAC) represented 3.7% of all applicants; 4.7% of all shortlisted applicants, and 3.3% of all appointments during the period 1st April 2020 to 31st March 2021. This indicates a relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts score of **1.26**. (A figure below 1.00 indicates that Disabled staff are more likely than non-disabled staff to be appointed from shortlisting). Our result compares well with the available benchmarking:

2020 UHNM Result	2019 Result by Midlands Region	2019 Result for Acute Sector	2019 Result for Large Trust Size
1.26	1.34	1.34	1.25

Metric 3: The relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure

This metric is based on data from a two year rolling average of the current year and the previous year of entry into a formal capability process as recorded on the HR Case Tracker. (It is important to note that this metric is related to entry into the formal capability process due to performance issues only, and not ill health related issues). This metric was voluntary in year one but is now a mandatory requirement.

Our Capability Policy is designed to be supportive and encouraging to enable our employees to reach the desired performance level through informal processes and hence very small numbers of staff enter the formal stage of the Policy. Reasonable adjustments must have been implemented where these have been identified for staff with a disability.

Our data for the last two years tells us that only 12 individuals have entered the formal stage of the Capability Policy due to performance issues. None of these individuals had a declared disability. This results in a relative likelihood of Disabled staff entering the formal capability process compared to non-disabled staff score of **0.00**. Interpreting this data is very limited due to the extremely small numbers of staff that have entered the formal stage of the capability process.

2020 UHNM Result	2019 WDES analysis by Midlands Region	2019 WDES analysis by Acute Sector	2019 WDES analysis by Large Trust Size
0.00	1.72	1.11	2.11

Metric 4a: Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:

- **Patients/service users, their relatives or other members of the public**
- **Managers**
- **Other colleagues**

The following metrics are taken from the 2019 NHS Staff survey. The results show that our disabled staff have the perception that they are more likely than non-disabled staff to experience harassment, bullying or abuse:

Metric		UHNM Result	Staff Survey Acute Sector Average	2019 WDES analysis by Midlands Region	2019 WDES analysis by Large Trust Size
% of staff experiencing harassment, bullying or abuse from patients / service users	Disabled	31.8%	33.9%	32.39%	37.0%
	Non-Disabled	26.8%	27.3%	24.54%	26.6%
% of staff experiencing harassment, bullying or abuse from Managers	Disabled	20.5%	19.7%	18.74%	24.90%
	Non-Disabled	12.6%	11.0%	11.52%	22.12%
% of staff experiencing harassment, bullying or	Disabled	30.9%	28.1%	26.01%	32.70%

abuse from other colleagues	Non-Disabled	20.8%	18.4%	16.42%	27.70%

Metric 4b: Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it

Similar to the findings of the WDES analysis, our disabled staff are slightly more likely to report experience of harassment, bullying or abuse at work, however the metric indicates that both our Disabled and non-disabled staff are less likely than the average benchmarking to report harassment, bullying or abuse at work. This metric has deteriorated slightly from the previous year.

	UHNM Result	Staff Survey Acute Sector Average	2019 WDES analysis by Midlands Region
Disabled staff	45.4%	46.7%	47.44%
Non-Disabled staff	44.7%	45.6%	45.60%

Metric 5: Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion

This metric shows that our Disabled staff are less likely to believe that the Trust provides equal opportunities for career progression or promotion compared to non-disabled staff. However, this 2019 staff survey result is a 5% improvement to the previous year and is better than the acute sector average and also better than the 75.3% of disabled staff across England that felt that their trust provided equal opportunities for career progression or promotion.

	UHNM Result	Staff Survey Acute Sector Average	2019 WDES analysis by Midlands Region	2019 WDES analysis by Large Trust Size
Disabled staff	80.0%	79.1%	75.05%	75.90%
Non-Disabled staff	85.5%	85.6%	81.84%	80.30%

Metric 6: Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

This metric demonstrates that our Disabled staff are more likely to report feeling pressure from their manager to come to work, despite not feeling well enough to perform their duties compared non-disabled staff and is worse than the Staff Survey average. However, this metric has improved by 4 percentage points compared to the previous year.

	UHNM Result	Staff Survey Acute Sector Average	2019 WDES analysis by Midlands Region	2019 WDES analysis by Large Trust Size
Disabled staff	34.7%	32.7%	32.05%	36.0%
Non-Disabled staff	25.7%	22.4%	21.96%	27.2%

Metric 7: Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work

This metric demonstrates that Disabled staff are notably less likely to be satisfied with the extent to which the organisation values their work compared to non-disabled staff. The 2019 result is an improvement compared to previous year, for both disabled and non-disabled staff; but are worse than the acute sector average.

	UHNM Result	Staff Survey Acute Sector Average	2019 WDES analysis by Midlands Region	2019 WDES analysis by Large Trust Size
Disabled staff	34.0%	37.4%	35.80%	38.10%
Non-Disabled staff	46.8%	49.5%	46.38%	

Metric 8: Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work

This metric demonstrates that 73.7% of our disabled staff report that adequate adjustments were made to enable them to carry out their work. This is an improvement on the previous year figure of 70.2% and is better than the acute sector average. The national WDES analysis found that the average result for England in 2019 was 72.4% and that the size of an organisation did not have any impact on this metric.

UHNM Result	Staff Survey Acute Sector Average	2019 WDES analysis by Midlands Region	2019 WDES analysis by Large Trust Size
73.7%	73.3%	70.67%	No impact

Metric 9a: The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation

The Staff Engagement scores of for the Trust, and both our Disabled and non-disabled staff have improved on the previous year and are very similar to available benchmarking.

	UHNM Result	Staff Survey Acute Sector Average	2019 WDES analysis by Midlands Region	2019 WDES analysis of Large Trust Size
Disabled staff	6.6	6.6	6.62	6.61
Non-Disabled staff	7.0	7.1	7.08	

Metric 9b: Action to facilitate the voices of Disabled staff in the organisation to be heard

During 2019 we have worked to reinvigorate our UHNM Disability Staff Network and increase membership. The network meets on a quarterly basis, and has an Executive Sponsor, who champions disability at Board level. Key achievements of the Network during 2019/20 include the development of the Tailored Adjustment Plan, which was inspired by the experiences of members of the Network. Network members also participated in our July 2019 Inclusivity at UHNM video to raise awareness of disability in the workplace and celebrate the contributions of our disabled staff.

During Equality, Diversity and Human Rights Week in May 2019 a disability survey was undertaken to seek the views of our workforce on a range of disability issues, from recruitment processes and development opportunities to the support received in relation to reasonable adjustments. The survey findings were discussed by the network and priorities for action over the next two years were identified. We also asked one of our members with a visual impairment to 'mystery shop' our recruitment process and provide feedback on areas that could be improved upon.

Metric 10: The percentage difference between the organisations board voting membership and its overall workforce

Boards are expected to be broadly representative of their workforce. At UHNM there is no Board member, voting or non-voting with a disclosed disability.

Analysis from the 2019 WDES, showed that according to trust size, that large-sized trusts had an overall proportion of 2.8% Disabled members of staff on the board and had the highest proportions of Disabled staff across voting (2.8%), and non-executive (1.8%) staff members but had no Disabled non-voting board members.

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	5th August 2020
Report Title:	Integrated Performance Report, month 3 2020/21	**Agenda Item:**	15.
Author:	Performance Team		
Executive Lead:	Helen Ashley: Director of Strategy and Transformation /Deputy Chief Executive		

Purpose of Report:

Assurance	✓	**Approval**		**Information**	

Impact on Strategic Objectives (positive or negative):			Positive	Negative
SO1		Provide safe, effective, caring and responsive services	✓	
SO2		Achieve NHS constitutional patient access standards		✓
SO3		Achieve excellence in employment, education, development and research	✓	
SO4		Lead strategic change within Staffordshire and beyond	✓	
SO5		Ensure efficient use of resources	✓	

Executive Summary:

Background

The NHS Improvement (NHSI) single oversight framework was implemented from October 2016 and revised August 2019. The framework is comprised of 35 metrics across the following domains:
1. Quality of Care - safety, caring and Effectiveness
2. Operational Performance
3. Organisational Health
4. Finance and use of resources

Covid-19 remains to be a key part of the Trust's business, however our inpatient figures for Covid-19 positive patients are slowly falling but the Trust needs to be ready for a possible second surge, whatever Winter might bring as well as managing the elective waiting lists that have grown over this time. Planning for all is well underway.

The Trust has continued functioning as a hospital and increased activity where and when safe to do so. The Integrated Performance Report (IPR) includes activity charts for inpatients, outpatients and urgent care and activity continues to rise across all areas including technological solutions to providing better care for our patients.

Operational performance has started to show the effects of the systematic changes the Trust is making to provide improved care for the patients. The waiting lists for outpatient appointments (first new) is starting to increase as the referrals that had been held in primary care are now being logged, triaged and appointments assigned based on the clinical needs of the patient. The various technologies such as video calls / see anywhere are being fully utilised. The Partial Booking initiative for follow up appointments is underway and this will have significant impact on how follow up appointments are managed.

The number of Referral to Treatment pathways are starting to increase, however performance remains low at 45.04%. As more patients are seen and treated the performance should steadily rise. However the number of patients over 18 weeks is at 20, 907 with 366 patients over 52 weeks. Patients who are on the inpatient waiting list have been stratified into clinical urgency classifications so that patients can be treated

in clinical priority. Diagnostics also remains low at 39.97%.

For patients waiting to be seen, diagnosed and treated for Cancer the good news is that the picture is continuing to improve. The Trust achieved 4 of the 8 standards (2ww, Breast symptomatic, 31 day and radiotherapy). Those that underachieved did so but with an improved performance on previous months. The 62 day standard is the best recorded so far this year at 77.91% (against the 85% target). The 28 day standard that the Trust is shadow monitoring is now at 79.4% against a local target of 75%.

For urgent care, whilst attendances have been significantly lower they are now increasing and of those patients attending, a higher proportion remain to be by ambulance and are treated as majors, meaning a greater likelihood of being admitted. The Trust achieved a performance of 84.9% and whilst this is still below the standard there has been a steady and sustained improvement from December 2018 (< 75%).

Financially the Trust has delivered a breakeven for the month of June; this is after the receipt of £2.2m of funding for additional expenditure relating to COVID-19 and a £2.1m "top-up" from NHSI in line with the temporary financial framework established by NHSI. The increase in the value of the "top-up" from Month 2 is due to Clinical Supplies and Drugs costs being £2m higher due to increased activity levels as the Trust restores services.

Activity delivered in Month 3 is significantly lower than plan although income levels from patient activities have been maintained due to the temporary funding arrangements.

The Trust incurred £2.2m of additional costs relating to COVID-19 which was £0.4m more than in Month 2 mainly relating to an increase in the numbers of Undergraduate Nursing and Midwifery students joining the Trust in June

The pay run rate in Month 3 is £1.0m higher than Month 2 mainly as result of additional expenditure relating to COVID-19. Non pay expenditure is £1.8m underspent with Clinical Supplies £1.3m behind plan.

Capital expenditure for the year to date stands at £12.6m which is £6.3m ahead of plan mainly due to the Trust completing the purchase of the Lyme Modular Wards and Theatres a month earlier than planned.

The month end cash balance is £89.3m which is £6.6m higher than plan.

For Quality and Safety the key messages are that there was zero never events and the Trust rolling 12 month HSMR and SHMI continue to be below expected at 92.8 and 0.99 respectively. The patient Falls rate per 1000 bed days was back on target in June at 5.6 and 100% of patients/family informed verbally of incidents that are reported as meeting duty of candour threshold. The VTE Risk Assessment was 99.6% (via Safety Express audit).

Some areas, however did not achieve the standard. These included the 5 Hospital Associated (HAI) C-Diff Infection cases and 7 Community Onset Hospital Associated (COHA) C-Diff cases identified; the Trust was above the national average rate of 15% for Emergency C Sections, with a rate of 19.6%, however the threshold for C Sections was lower during the pandemic.

Sepsis Screening compliance (adult Inpatients), 76.7% against a target of 90%.

During June 2020, the following quality highlights are to be noted:

- June 2020 continued to see a significant reduction in patient activity compared to same period in 2019 which will have an effect on the rates of reported incidents.
- Patient Safety Incidents rate per 1000 bed days remains consistent with other months since start of COVID-19 pandemic however the rate of PSIs with moderate harm or above per 1000 bed days continues to show consistent lower levels . The data shows positive outcomes from the incidents being reported as there are lower rates of harm despite rate of reporting increasing.
- The increases in incident reporting rates can also be an indicator of positive reporting culture and staff who are willing and able to report incidents and near misses.

- Decreased rate of patient falls per 1000 bed days as well as reductions in falls resulting in harm to patients.
- Increase in reported Serious Incidents following review of RCAs and agreement on escalation to SI report.

Friends & Family Surveys have been suspended nationally during the COVID-19 Pandemic since March 2020 until September 2020. However, although we are not required to report patient feedback nationally, wards have continued to collect patient feedback where they can. FFT Targets are set to N/A during pandemic period as no national reporting required.

The strategic focus for the workforce remains on supporting recruitment, workforce deployment, staff wellbeing, absence management and staff testing. Plans are being developed for restoration and recovery to shape the "new normal"; to capitalise on new ways of working and transformation, and to reduce the risks of staff absence increasing and engagement reducing. Staffing models and rotas are being adapted to new ways of working to ensure the workforce is sufficient and available to deliver recovery and COVID-19 related activity.

Key issues include compliance with statutory and mandatory training and PDR requirements and the sickness being above target. The in-month sickness rate was 5.10% (5.92% at 31/05/20) and Covid related absences are decreasing week on week. The 12 month cumulative rate increased from 5.00% to 5.12% as this rate is calculated over a rolling 12m period which now includes a period of higher absence than previously.

Divisions are producing a 100 day restoration and recovery plan for absence; attendance reviews and Stage 3 Hearings have recommenced and local trends are being identified for intervention.

The PDR rate improved slightly in June across all staff groups and Divisions have produced trajectories to achieve the PDR compliance target, which is being managed via the performance review process.

The Statutory and Mandatory training rate at 30th June was 90.28% (90.74% 31st May 2020) and 84.29% of staff have completed all 6 Core for All modules. Staff in areas of low compliance will be emailed asking for an improvement in statutory and mandatory training compliance over the course of the next 2 months.

Key Recommendations:

The Trust Board is asked to note performance for month 3.

NHS
University Hospitals of North Midlands
NHS Trust

Integrated Performance Report

Month 3 2020/21

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Contents

A note on **SPC**

University Hospitals of North Midlands NHS Trust

The following report uses statistical process control (SPC) methods to draw two main observations of performance data;

Variation - are we seeing significant improvement, significant decline or no significant change

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

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

Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

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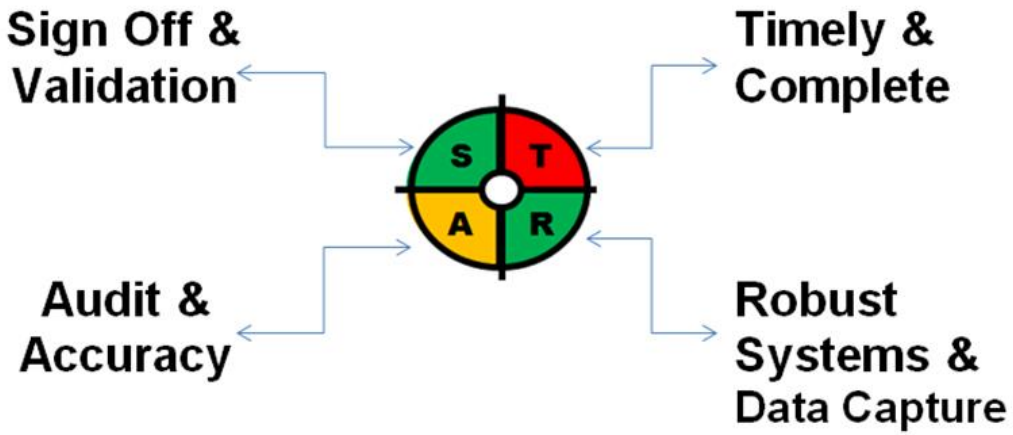
A note on **Data Quality**

University Hospitals of North Midlands NHS Trust

- 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 Spotlight Report

NHS University Hospitals of North Midlands NHS Trust

Key messages

The Trust achieved in June 2020:

- Zero never events
- Trust rolling 12 month HSMR and SHMI continue to be below expected at 92.8 and 0.99 respectively
- Patient Falls rate per 1000 bed days back on target in June at 5.6
- 100% of patients/family informed verbally of incidents that are reported as meeting duty of candour threshold
- VTE Risk Assessment 99.6% (via Safety Express audit)

The Trust did not achieve the set standards for:

- Written Duty of Candour was below the 100% target remaining at 70% (7 out of 10 cases). Work is on-going with Divisions to improve the provision of the 10 day notification letter being provided within the timeframe. To note that a further 10% (1 case) had letters sent but outside 10 day target and remaining 20% (2 cases) not had update recorded in Datix.
- There have been 5 Hospital Associated (HAI) C-Diff Infection cases and 7 Community Onset Hospital Associated (COHA) C-Diff cases identified. June 2020 is above trajectory (12 versus a target of 8) based on 2019/20 target and for the year to date 2020/21 UHNM is above trajectory with 30 cases versus a year to date target of 24.
- The Trust was above the national average rate of 15% for Emergency C Sections, with a rate of 19.6%.
- Sepsis Screening compliance (adult Inpatients), 76.7% against a target of 90%.

During June 2020, the following quality highlights are to be noted:

- June 2020 continued to see a significant reduction in patient activity compared to same period in 2019 which will have an effect on the rates of reported incidents.
- Patient Safety Incidents rate per 1000 bed days remains consistent with other months since start of COVID-19 pandemic however the rate of PSIs with moderate harm or above per 1000 bed days continues to show consistent lower levels . The data shows positive outcomes from the incidents being reported as there are lower rates of harm despite rate of reporting increasing.
- The increases in incident reporting rates can also be an indicator of positive reporting culture and staff are willing and able to report incidents and near misses.
- Increase in reported Serious Incidents following review of RCAs and agreement on escalation to SI report.
- Friends & Family Surveys have been suspended nationally during the COVID-19 Pandemic since March 2020 until September 2020. However, although we are not required to report patient feedback nationally, wards have continued to collect patient feedback where they can. FFT Targets are set to N/A during pandemic period as no national reporting required.

Quality Dashboard

Metric	Target	Latest	Variation	Assurance
Patient Safety Incidents	N/A	1437		
Patient Safety Incidents per 1000 bed days	N/A	47.55		
Patient Safety Incidents with moderate harm +	N/A	13		
Patient Safety Incidents with moderate harm + per 1000 bed days	N/A	0.43		
Harm Free Care (New Harms)	95%	98%		
Patient Falls per 1000 bed days	5.6	5.6		
Patient Falls with harm per 1000 bed days	1.5	1.5		
Reported C Diff Cases	8	12		
Avoidable MRSA Bacteraemia Cases	0	0		
Total Pressure Ulcers developed under UHNM Care	0	64		
Category 2 Pressure Ulcers with lapses in Care	8	0		
Category 3 Pressure Ulcers with lapse in care	4	0		
Category 4 Pressure Ulcers with lapses in care	0	0		
Unstageable Pressure Ulcers with lapses in care	0	1		

Quality Dashboard

NHS University Hospitals of North Midlands NHS Trust

Metric	Target	Latest	Variation	Assurance
Medication Incidents per 1000 bed days	N/A	5		
Medication Incidents % with moderate harm or above	N/A	-		
Serious Incidents reported per month	N/A	18		
Never Events reported per month	0	-		
Duty of Candour - Verbal	100%	100%		
Duty of Candour - Written	100%	70%		
VTE Risk Assessment Compliance	95%	99.6%		
Sepsis Screening Compliance (Adult Inpatients)	90%	76.7%		
IVAB within 1hr (Adult Inpatients)	90%	100.0%		
Adult A&E Sepsis Screening Compliance	90%	94.0%		
Sepsis Screening Compliance (Paediatric Inpatients)	90%	N/A		
IVAB within 1 hr (Paediatric Inpatients)	90%	N/A		
Paediatric A&E Sepsis Screening Compliance	90%	100.0%		
Emergency C Section rate % of total births	15%	19.6%		

Metric	Target	Latest	Variation	Assurance
Friends & Family Test - A&E	N/A	N/A		
Friends & Family Test - Inpatient	N/A	98.2%		
Friends & Family Test - Maternity	N/A	N/A		
Written Complaints per 10,000 spells	35	36.11		
Rolling 12 Month HSMR (3 month time lag)	100	92.80		
Rolling 12 Month SHMI (6 month time lag)	100	97.15		

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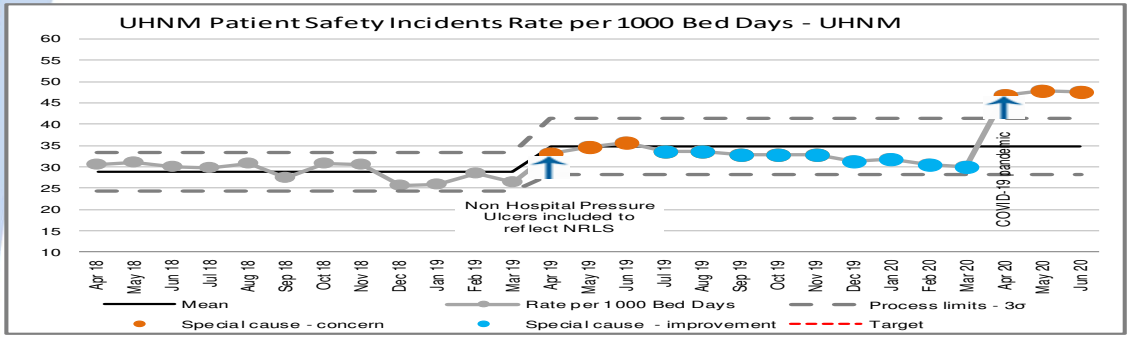
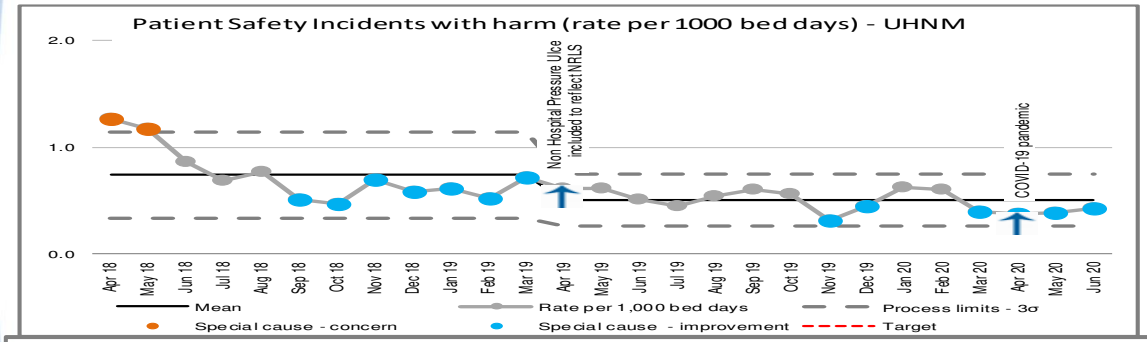
Reported Patient Safety Incidents per 1000 bed days



Variation	Assurance
H	

Target	Apr 20	May 20	Jun 20
N/A	46.83	47.76	47.55



Variation	Assurance
L	

Target	Apr 20	May 20	Jun 20
N/A	0.37	0.39	0.43

What is the data telling us:

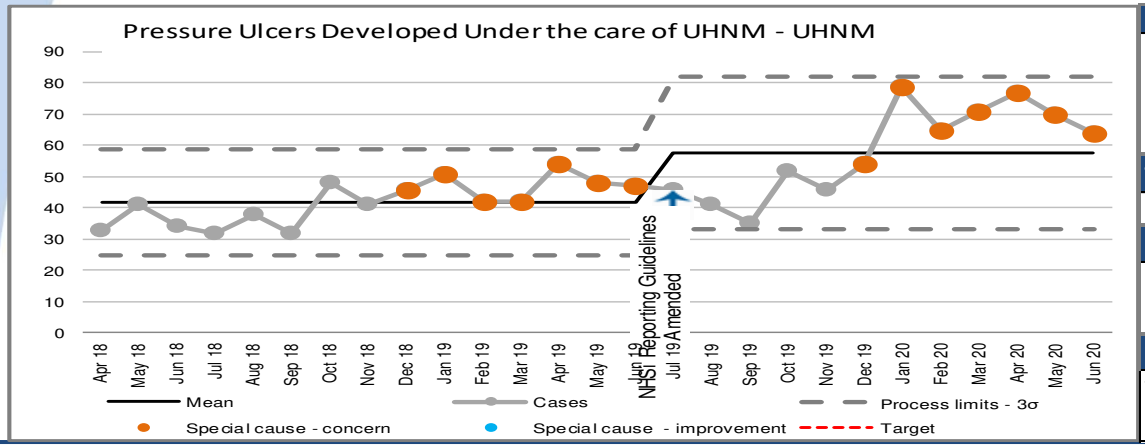
The Rate of Patient Safety Incidents per 1000 bed days allows Trust to compare levels of reporting by making allowances for changes in activity.

During June 2020, the rate of reported patient safety incidents per 1000 bed days has increased along with the previously noted rise in the total number of reported PSIs. The reporting of incidents and near misses should continue to be encouraged and promoted. The rate of PSIs has increased as the total number of reported incidents/near misses returns to pre COVID-19 levels but the activity levels (based on occupied bed days) is still lower. Compared to June 2019 activity is 22% lower in June 2020 but there have been 3.7% more incidents reported. From April 2020 this report includes Non Hospital Acquired Pressure Ulcers reported on attendance at UHNM. Previously these were not included in figures as the incident was not directly attributed to UHNM.

The second chart, shows the rate of PSIs with moderate harm or above per 1000 bed days and there are continued positive trends with 22 consecutive months below the mean. The data illustrates the positive outcomes from the incidents being reported as there are lower rates of harm despite rate of reporting increasing. This is an indicator of a potentially positive reporting culture and staff are willing and able to report incidents and near misses.

The top category of incidents resulting in moderate harm reflect the largest reporting categories with Slips/Trips/Falls (4 incidents) being the largest category followed by Hospital Acquired Pressure Ulcer (2 incidents) and Device related Pressure Ulcer (2 incidents)

Pressure Ulcers developed under UHNM care



Variation	Assurance
H	

Target	Apr 20	May 20	Jun 20
N/A	77	70	64

Background

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

What is the data telling us?

the data is showing that there has been a rise of pressure ulcers that are of special cause and not just normal variation.

What is the data telling us:

The above chart shows the seasonal rise in January due to the increased frailty of the patients admitted during the winter months.

The increase in March and April, reflects a national picture, where the UHNM Critical Care Pods saw a rise in patients sustaining multiple areas of pressure ulceration, as a result of the clinical need for repeated proning. Comprehensive documentation in the Critical Care Pods provided evidence that these incidents were not due to lapses in care and root cause analysis highlighted that the majority of the patients who sustained multiple pressure ulcers were of raised BMI, increasing the weight and pressure on devices during proning. The chart demonstrates that the gradual increase in pressure ulcers (Cat 2 to 4 including DTIs and unstageable) that developed under our care during the aforementioned rise in admissions, is now starting to decrease for May and June.

Actions:

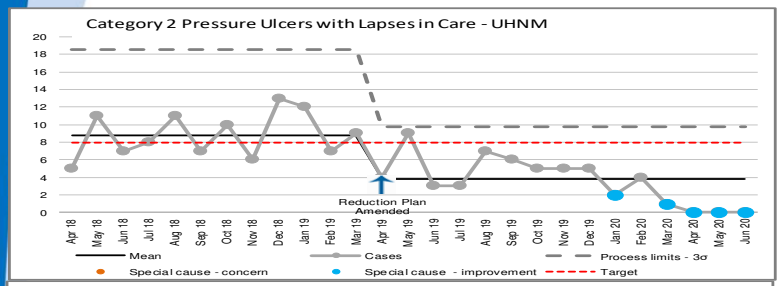
Critical Care

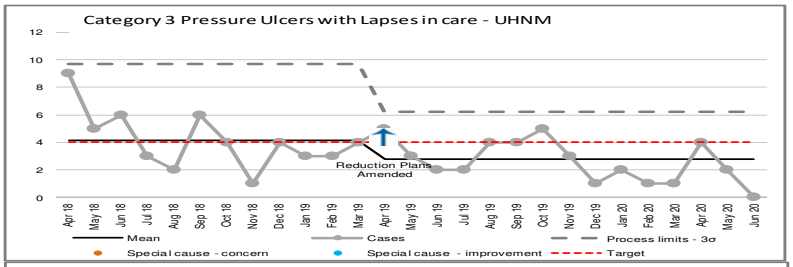
- ✓ To present findings of repose overlays at next TV steering group.
- ✓ Liaise nationally to share, compare and contrast findings related to preventing pressure ulcers during proning to inform future practice

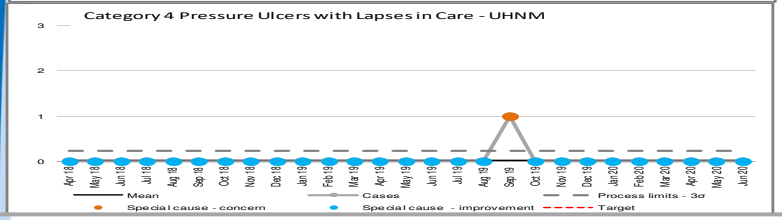
Trust wide

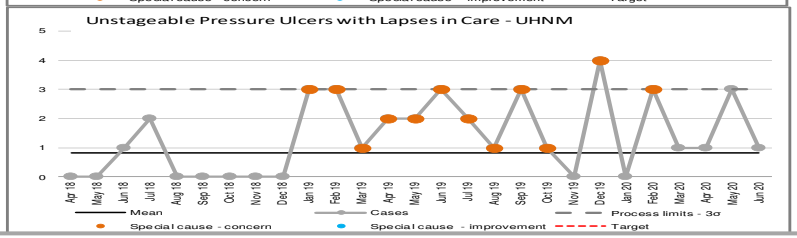
- ✓ Support continues to higher reporting areas i.e. 201 (Oncology), 124 (Renal) and the dedicated COVID wards, who alongside critical care are currently nursing some of the most vulnerable patients in the Trust.
- ✓ Following audit last month there has been a re-allocation of alternating air mattresses purchased in preparation for the COVID pandemic to the clinical areas who have a large number of very high risk patients, including 201, 124 and 225
- ✓ With support from the TV and Q & S team, ED are to complete a small evaluation of the Repose Companion overlay mattresses in on 13th August by following the patients through the department with the aim of gaining feedback on patient selection criteria, ease of use, safety with staff and patient feedback.
- ✓ Review and re-launch of the pressure ulcer prevention champions has now been approved by the Tissue Viability steering group and is now in the process of development.
- ✓ There will be a focus on avoiding, MASI, Medical Adhesive Skin Injuries July 27th – 31st with an education session & training pack distribution on Wednesday 29th July

Pressure Ulcers with lapses in care









What is the data telling us:

The data above shows that there have been reductions in the number of Pressure Ulcers (category 2 – 3) with lapses in care. Both categories are below their target numbers per month and UHNM is now working towards achieving a further 10% year on year reduction target for 2020/2021. Hospital acquired pressure ulcers reported in June are still under investigation so these numbers of lapses in care may change once RCA's are completed.

In May there were two Category 3 and three Unstageable pressure ulcers which developed due to lapses in care. Both category 3 pressure ulcers were less than 0.5cm in width and were validated as combination lesions due to moisture and sheering rather than pressure alone.

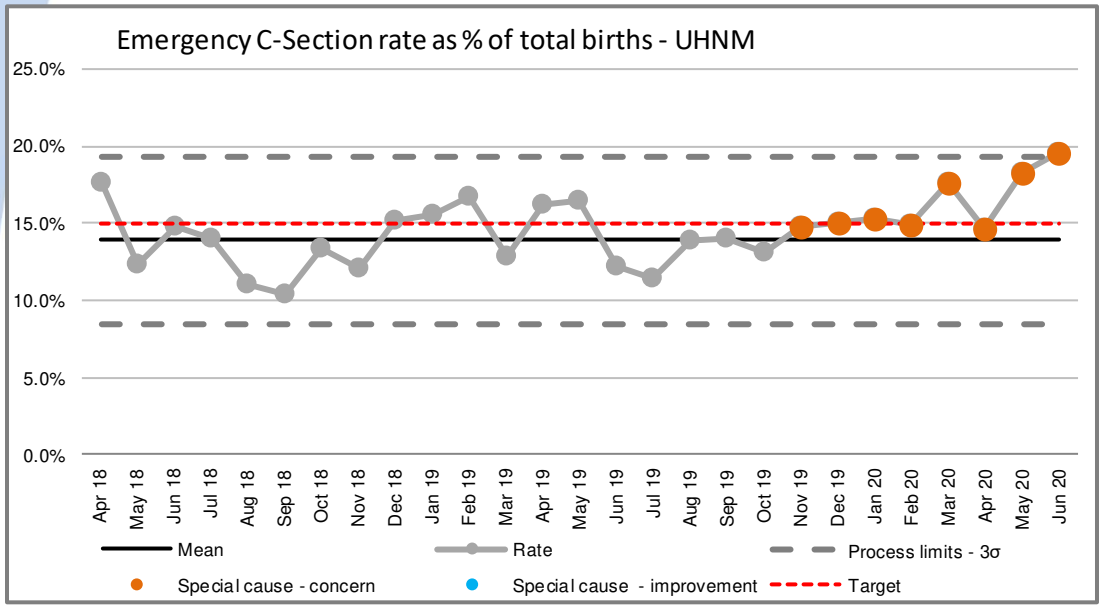
Similarly, two of the Unstageable pressure ulcers were also combination lesions that developed following severe moisture excoriation on patients who required periods of sitting upright due to respiratory conditions. However, in all these instances documentation on preventative measures was incomplete/in consistent.

The other unstageable pressure ulcer that developed in May and the one in June developed on the patients' heels and both were due to a failure to recognise risk and react to changes in skin condition by upgrading the heel offloading device.

Actions:

- ✓ The themes emerging from these incidents particularly surrounding the need to document if there is a clinical need for patient to remain upright, has been shared divisionally through governance meetings and in the clinical areas via the quality nurses.
- ✓ The clinical areas who were found to have inconsistent documentation, Wards 103, 113 and 14 are feeding back to staff and are currently engaged in developing their action plans to monitor improvement following this feedback. During this period skin bundle documentation is being monitored weekly by the Q & S team.
- ✓ AMU and Ward 227 are both reviewing their supply of inflatable heel offloading and ordered extra stock where required. Ward 227 are also to commence the use of parafricta bootees for their patients who are agitated and/or restless.
- ✓ The postponed roll out of the 'aSSKINg' bundle which has increased clearer location recording to highlight extended periods of pressure to the buttocks and a more comprehensive approach to moisture management has now commenced on Ward 201 and early indications are that his has improved the communication of risk and efficiency of repositioning.

Emergency C Section rate as % of total Births



Variation	Assurance
H	?

Target	Apr 20	May 20	Jun 20
15%	14.7%	18.3%	19.6%

Background

Emergency C-Section rate as % of total births

What is the data telling us:

Emergency C Section Rate as percentage of total births at UHNM is over the target rate of 15%. The latest available figures reports 19.6% Emergency C Section rate. During COVID-19 Pandemic there has been a lower threshold for Emergency C Sections which may have contributed to the higher rates during recent months. The rolling 12 month Emergency C Section rate is 14.48%

Emergency C sections are divided in to 2 categories;

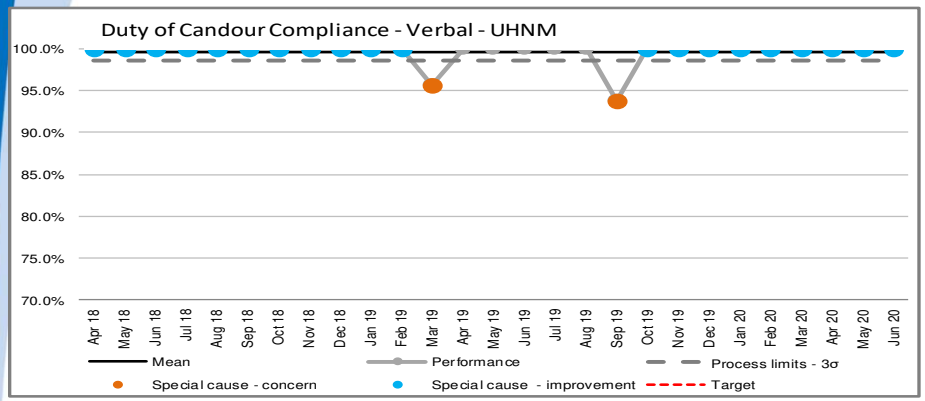
Category 1 - immediate threat to life of woman or fetus (delivery within 30 minutes of decision)

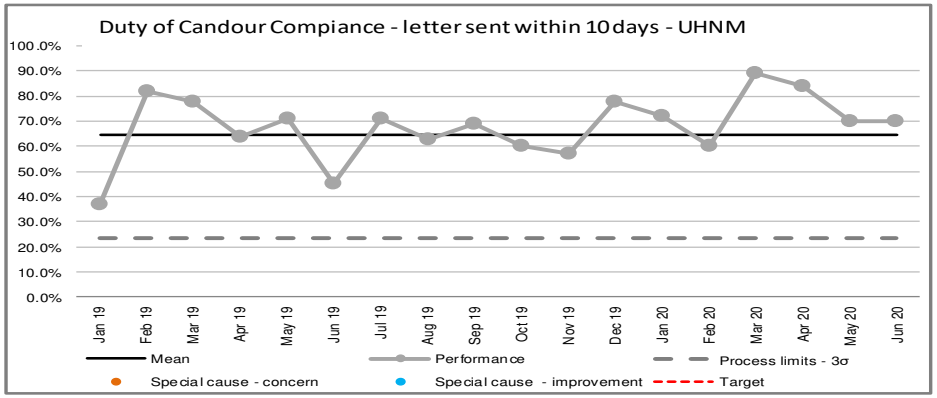
Category 2 – threat of maternal or fetal compromise (delivery within 90 minutes of decision)

A review of the category 2 sections in June 2020 showed that there were ten different primary clinical reasons for the decision to operate with delay in first or second stage of labour the most common, followed by presumed fetal compromise. All decisions were clinically indicated with good rationale to perform the operation.

The Emergency C Section rate fluctuates on a month by month basis; this demonstrates the fluctuation and variation which occurs in both C section rates and number of births. The department will undertake a 3 month audit of cases to better understand what is happening against our demographics and the local population in comparison to our peers.

Duty of Candour Compliance





Variation	Assurance
H	?

Target	Apr 20	May 20	Jun 20
100%	100.0%	100.0%	100.0%

Background

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

Variation	Assurance
	?

Target	Apr 20	May 20	Jun 20
100%	84.0%	70.0%	70.0%

Background

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

What is the data telling us:

Verbal Duty of Candour has been recorded in 100% of all incidents (13 cases) that have formally triggered meeting the threshold during May 2020.

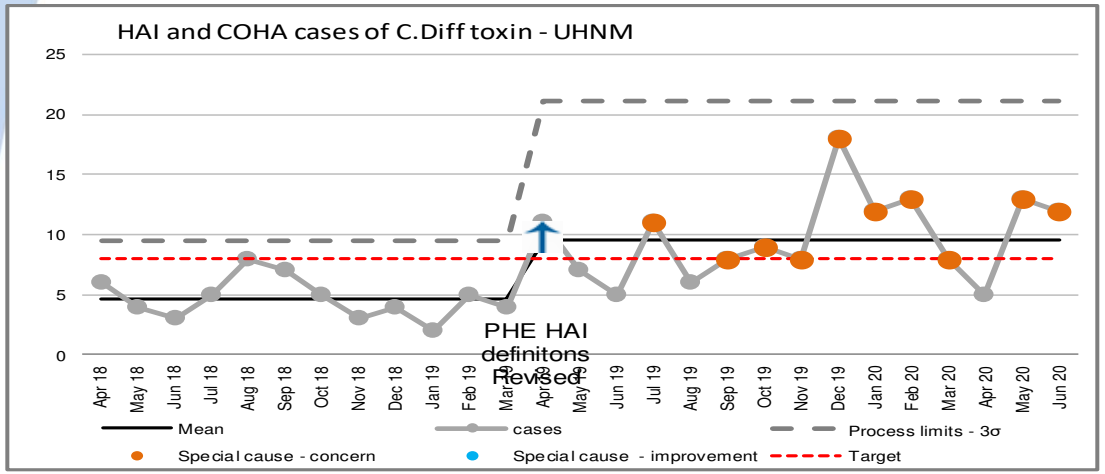
Written Duty of Candour Compliance for receiving the letter within 10 working days of verbal notification has been improving. During June 2020 the performance was 70% (7 cases) within 10 working days with further 10% (1 case) sent out after 10 working days and 2 further cases where the written notification is not yet updated within Datix.

Actions taken:

To support escalation, a letter from the Medical Director has been written to all Divisions outlining clinicians responsibilities in relation to completing duty of candour with written notification as well as verbal discussions.

Divisions, via the Divisional Governance & Quality Managers, will continue to support the drafting of the 10 day notification letters for clinicians. Compliance is included in Divisional reports with escalation .

Reported C.Diff Cases per month



Variation	Assurance
H	?

Target	Apr 20	May 20	Jun 20
8	5	13	12

Background

Number of HAI + COHA cases reported by month

What do these results tell us?

Chart shows the number of reported C Diff cases per month at UHNM. Previous 12 months are all above the Trust mean for monthly cases but within SPC limits since the change in healthcare associated infections definition by PHE in April 2019.

There have been 5 Hospital Associated Infection (HAI) cases and 7 Community Onset Hospital Associated (COHA) case s identified in June .

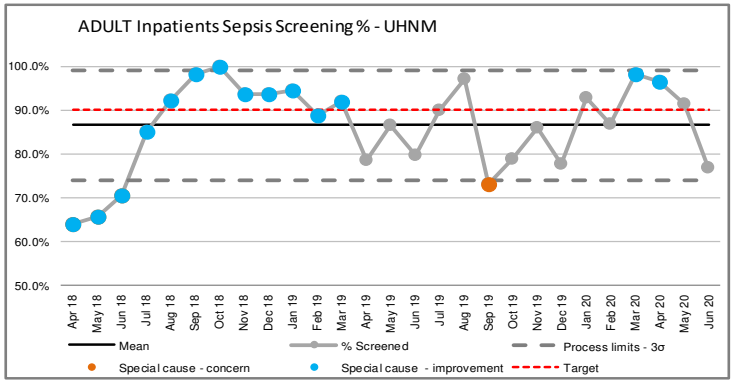
For June UHNM is above trajectory (12 versus a target of 8) based on 2019/20 target and for the year to date 2020/21 UHNM is above trajectory with 30 cases versus a year to date target of 24.

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, and RCA's are reviewed by the CCG. Each in-patient is reviewed by the C difficile nurse at least 3 times a week, and forms part of a weekly multi-disciplinary review. Routine typing is on hold due to COVID-19. There has been one clinical area that has had more than one case of HAI C difficile toxin to report within a 28 day period in June 2020. There have been several wards in the West Building that have had more than one case within 28 days – these areas are all undergoing a full terminal clean with Virusolve+, a review of antimicrobial prescribing and unannounced infection prevention audits to ensure compliance with the environment, hand hygiene and Cdiff control measures. A 'deep dive' into all cases in April and May has been undertaken and reported at July's IPCC – this analysis will continue.

Sepsis Screening Compliance (Adult Inpatient)

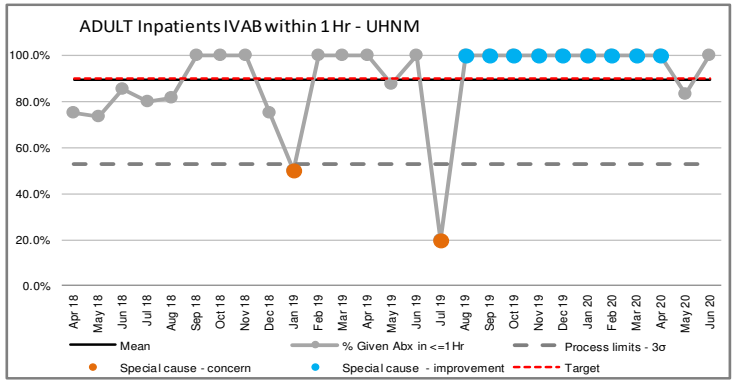


Variation	Assurance

Target	Apr 20	May 20	Jun 20
90%	96.6%	91.3%	76.7%

Background

The percentage of adult Inpatients with Sepsis Screening undertaken



Variation	Assurance

Target	Apr 20	May 20	Jun 20
90%	100.0%	83.3%	100.0%

Background

The percentage of adult inpatients receiving IV Antibiotics within 1 hour

What is the data telling us:

June results show Adult inpatient areas achieved 76.7% for sepsis screening for the 86 patients audited and 100.0% for antibiotics within an hour for the 1 patient identified as being red flag sepsis patients.

Actions:

The Sepsis Team continue to deliver training across all areas of the Trust to support the continued improvement in performance against this target. The Sepsis team are focussing on specific work and learning in the COVID wards around sepsis education for COVID related sepsis, where the drop has occurred.

Sepsis Team have produced educational tools in conjunction with the new Vitalpac system and these will be the focus of the August Sepsis Strategic committee to deliver the changes in processes and education. The sepsis team continue to monitor Inpatient wards with issue around sepsis vitals assessment as some staff are still completing paper screening instead of electronic. Sepsis & Vitals action plan has been created for all of the divisions to ensure improvement in compliance. A deep dive of June's compliance data is currently underway and the provision of ward based refresher training as required.

A Sepsis Specialist Nurse has been appointed, which will greatly strengthen the team.

Operational Performance

2025 Vision "Achieve NHS Constitutional patient access standards"

Spotlight Report Operational Performance from Chief Operating Officer

NHS University Hospitals of North Midlands NHS Trust

Emergency Care

The majority of the significant improvement in performance seen in May has been maintained, with UHNM Performance for June at 84.9%. This was against a backdrop of an increase in attendances and admissions at Royal Stoke compared to the previous month. Performance at both Type 1 departments continued to improve (RS 70.3%; County 94.6%). There were zero 12 hour Trolley waits in June.

Admitted performance deteriorated in the second half of the month compared to May (down from 58% – 47%) which in part accounts for performance being sustained rather than improving. The implementation of the complex zoning plan in the second half of the month hindered the movement of patients through the hospital-system. The process of swabbing patients has also injected further complexity impacting on flow.

Cancer (Provisional)

The Trust is currently performing against the Cancer 2WW (98.65%), Breast symptomatic (98.87%), 31 Day first treatment (97.4%),. The remaining standards are currently below: 31 day (subsequent surgery (80.85%), 31 Day subsequent chemotherapy (94.74%), 31 Day subsequent radiotherapy (93.48%), 62 Day standard (77.78%), 62 Day screening (0.0%). The 28 day FDS standard is currently at 74.2%. (as at 06/07/20).

There were 273 patients 104+ days reported at the end of June. This reduced to 228 by w/e 5th July (latest position 14/07 is < 200). Of the 228, 219 are Covid-related , six are related to patients who are too poorly to tolerate tests or treatments , whilst three remain non-compliant with the pathway.

RTT (Final)

The RTT Indicative Incomplete Pathway standard in June is 45.04%. Performance has been impacted by the fact that since the 23rd March 2020 central guidance has mandated all routine treatments to be stood down. The number RTT incomplete pathways is a key measure of performance and at the end of May the RTT waiting list size was 38,037. The Trust has 366 over 52 week breaches as a consequence of standing down elective work (currently invalidated). Recovery plans include prioritised actions for recovery of long waiters.

Diagnostics (Final)

The Diagnostic DM01 waiting time for June is 39.97% against a 99% threshold The waiting list size has grown to 20,287. Diagnostics linked to the DM01 have been particularly impacted on by the central mandate to cease routine activity and prioritisation of patients for the independent sector is a focus for the Trust recovery programme plan. The Diagnostic cell is progressing plans.

Covid-19 Recovery & Restoration summary

University Hospitals of North Midlands NHS Trust

A&E - Performance and Attendance levels compared to pre-Covid at the end of June

	Performance		Attendances daily avg.	
	pre-Covid (Feb 20)	June-20	pre-Covid (Feb-20)	June-20
Royal Stoke	63.8%	70.3%	360	261
County	86.8%	94.6%	115	96

Attendances are rising – up an average of 46/ day on May

Performance has improved by 0.7% on May

RTT Waiting List

- The RTT incomplete waiting list is currently at 38,054 this compared to an average of 45,000 pre-Covid.
- The Current amount of over 18 week waiting patients is 20,924 compared to an average of 9,500 pre-Covid.

Cancer

- 62 day backlog has seen a reduction from 739 in May to 400 in June.

DM01

- Comparing the waiting lists from May to June there has been an increase of 569 diagnostics added.
- The over 6 week waits have increased by 216 to 11,527.
- The main increases are seen in Non Obstetric U/S (+353); CT (+110); Neurophysiology (+135); Respiratory physiology (+118).

Total- Electives & Day Cases

	10 May 20	17 May 20	24 May 20	31-May-20	07-Jun-20	14-Jun-20	21-Jun-20	28-Jun-20
20/21 Plan	2189	2189	2189	2189	2189	2189	2189	2189
Pre-Covid	1538	1538	1538	1538	1538	1538	1538	1538
Baseline	702	711	721	731	741	750	760	770
R&R Plan	657	701	730	845	917	1023	1026	1042
Actual	677	750	740	883	921	987	1051	1102
% 20/21 Plan	30.9%	34.3%	33.8%	40.3%	42.1%	45.1%	48.0%	50.3%
% Pre-Covid	44.0%	48.8%	48.1%	57.4%	59.9%	64.2%	68.3%	71.7%
% Baseline	96.4%	105.5%	102.6%	120.8%	124.4%	131.6%	138.3%	143.1%
% R&R Plan	103.0%	107.0%	101.4%	104.5%	100.4%	96.4%	102.4%	105.8%

Total- New and Follow Up

	10 May 20	17 May 20	24 May 20	31-May-20	07-Jun-20	14-Jun-20	21-Jun-20	28-Jun-20
20/21 Plan	14932	14932	14932	14932	14932	14932	14932	14932
Pre-Covid	10707	10707	10707	10707	10707	10707	10707	10707
Baseline	7156	7223	7290	7358	7427	7496	7566	7637
R&R Plan	7412	7841	8212	8329	8793	9066	9198	9252
Actual	8794	9954	9970	8301	9976	10866	11319	11791
% 20/21 Plan	58.9%	66.7%	66.8%	55.6%	66.8%	72.8%	75.8%	79.0%
% Pre-Covid	82.1%	93.0%	93.1%	77.5%	93.2%	101.5%	105.7%	110.1%
% Baseline	122.9%	137.8%	136.8%	112.8%	134.3%	145.0%	149.6%	154.4%
% R&R Plan	118.6%	127.0%	121.4%	99.7%	113.4%	119.8%	123.1%	127.4%

Activity

- Electives were up (20%) with increases in Urology, T&O and ENT
- Day Cases were also up (2.5%) with increases in Gastro (64) and Paeds (8)
- Outpatients averaged 81% of pre covid levels in May
- Still on track to deliver the R&R plan

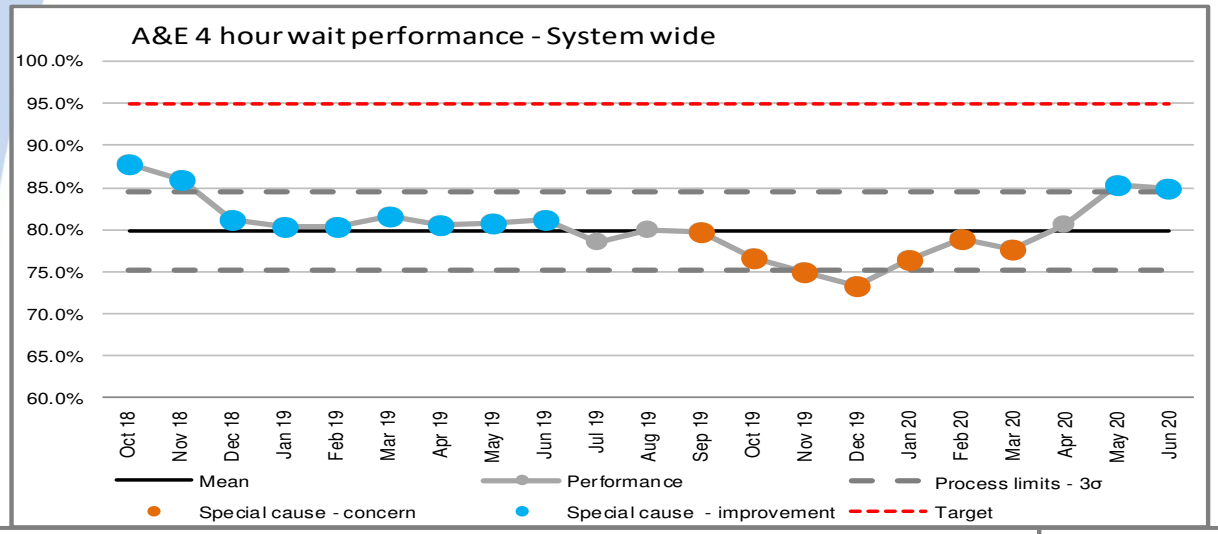
Together Compassion Safe Improving

Operational Performance Dashboard

	Metric	Target	Latest	Variation	Assurance	DQAI
A&E	A&E 4 hour wait Performance	95%	84.90%	H	F	
	12 Hour Trolley waits	0	0			
Cancer Care	Cancer Rapid Access (2 week wait)	93%	98.62%		?	
	Cancer 62 GP ref	85%	77.91%		?	
	Cancer 62 day Screening	90%	0.00%	L	?	
	31 day First Treatment	96%	97.10%		?	
Elective waits	RTT incomplete performance	92%	45.04%	L	F	
	RTT 52+ week waits	0	366	H	?	
	Diagnostics	99%	39.97%	L	?	

	Metric	Target	Latest	Variation	Assurance	DQAI
Use of Resources	DNA rate	7%	6.4%	L	?	
	Cancelled Ops	150	35	L	?	
	Theatre Utilisation	85%	80.7%		F	
Inpatient / Discharge	Same Day Emergency Care	30%	21.6%	L	?	
	Super Stranded	183	108	L	?	
	DToC	3.5%	0.90%	L	?	
	Discharges before Midday	30%	17.7%	L	F	
	Emergency Readmission rate	8%	13.6%		F	
	Ambulance Handover delays in excess of 60 minutes	10	43		?	

URGENT CARE – 4 hour access performance



Variation	Assurance
H	F

Target	Apr 20	May 20	Jun 20
95%	80.5%	85.3%	84.9%

Background

The percentage of patients admitted,transferred or discharged with in 4 hours of arrival at A&E

What is the data telling us?

Speacial cause improvement was seen in May and sustained in June. This statistically significant improvement in performance has been seen after a recent period of 7 months below the mean.

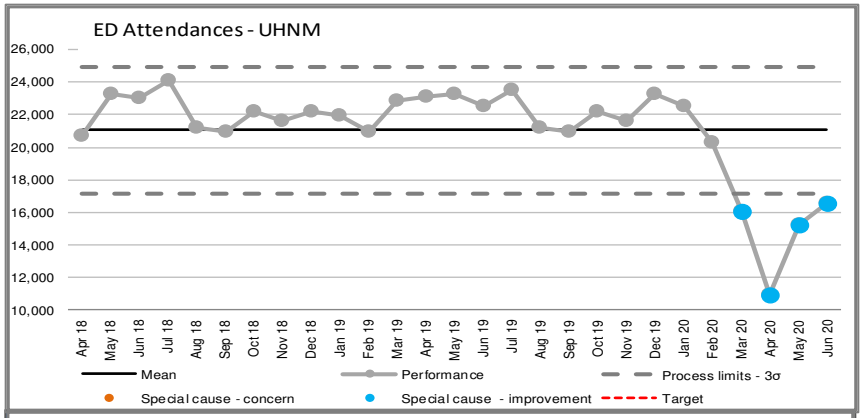
Summary

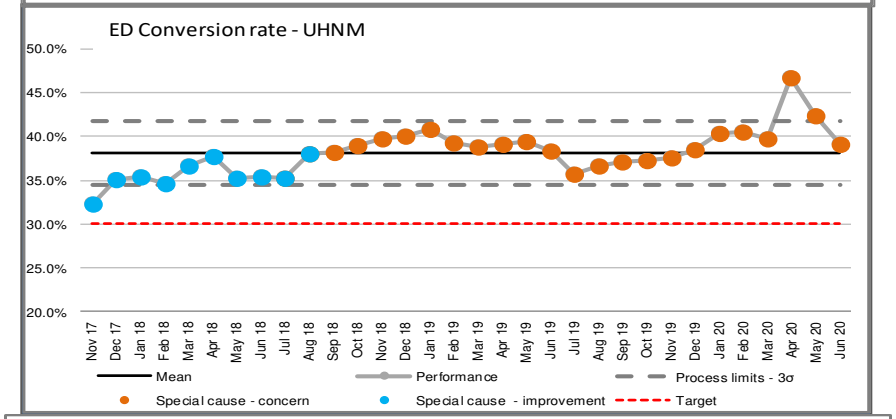
- The majority of the significant improvement in performance seen in May has been maintained, with UHNM Performance for June at 84.9%.
- This was against a backdrop of an increase in attendances and admissions at Royal Stoke compared to the previous month.
- Both Type 1 departments continued to improve (RS 70.3%; County 94.6%).
- There were zero 12 hour Trolley waits in June.
- Admitted performance deteriorated in the second half of the month compared to May (down from 58% – 47%) which in part accounts for performance being sustained rather than improving.
- The complex caseload increased with a rise in MFFD's and a slightly less number of discharges per day.
- The implementation of the complex zoning plan in the second half of the month hindered the movement of patients through the hospital-system. The process of swabbing patients has also injected further complexity impacting on flow.
- The SDU was implemented mid month, specialty referral to discharge has not shown any significant changes however the model remains in its infancy.
- Daily A&E Breach Review meeting in May has demonstrated that there are a number of breaches as a result of not having a CDU specifically MFFD and MHLT patients

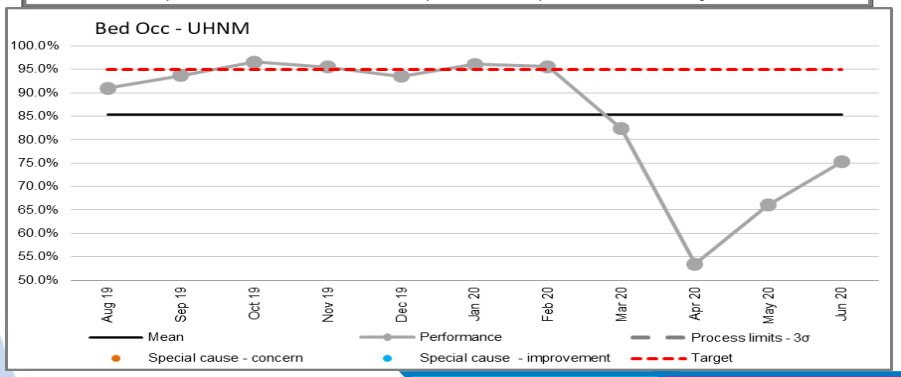
Actions

- Continue to embed and develop Specialised Decision Unit (SDU) pathways.
- Review ECIST recommendations and develop associated actions linked to the overarching urgent care improvement plan.
- Reconstitute the re-engineered Unscheduled Care Cell.
- Organisation-wide focus on improving 'culture' around urgent care with key messages from the organisation.
- "Pull" function to portals whereby when ED identify a referral to a specialty. SAU utilisation of Medway to "pull" patients from ED.
- Launch QI collaborative to support flow processes and changing behaviours at ward level.
- MFFD pathways and consideration of alternative use of discharge lounge for same day patient discharge with social care.
- Different process for the management of MHLT pathways.
- July will see the implementation of an Acute Medicine Floor with Blue and Purple AMU / SSU / HMU / AMRA which will drive efficiency.
- Review of Trust wide site team in preparation for winter.

URGENT CARE – 4 hour access - Demand







Attendances

- Total attendances across the system in June showed a slight rise on that seen in May and is currently 70% of what would be seen at this time of year.
- A shift was noted between attendances at Haywood & UCC (which fell) and the attendances at RS which rose by a daily average of 26 (overall > 500 more patients).
- Continue to focus on admission avoidance schemes – tracking and monitoring of schemes through the Unscheduled Care Cell

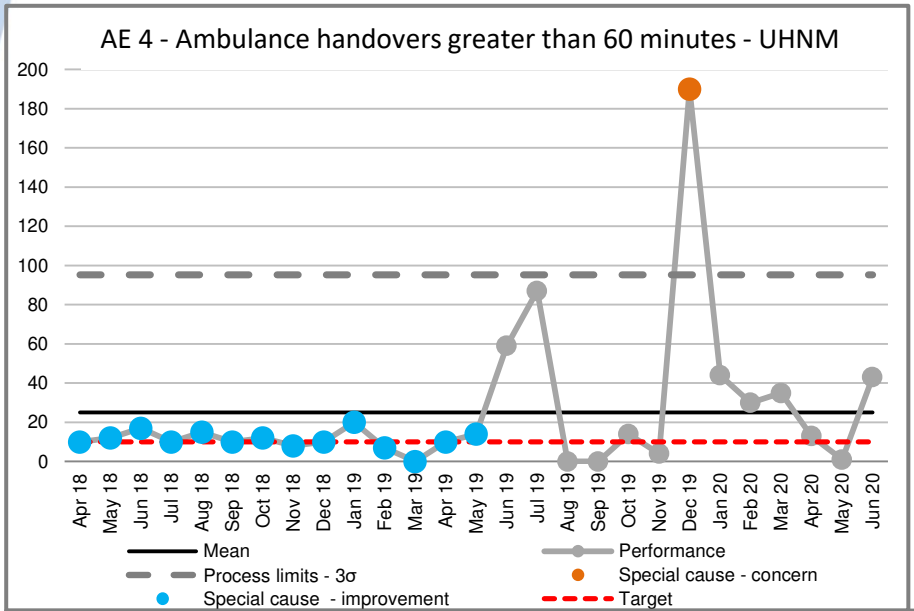
Conversion rate;

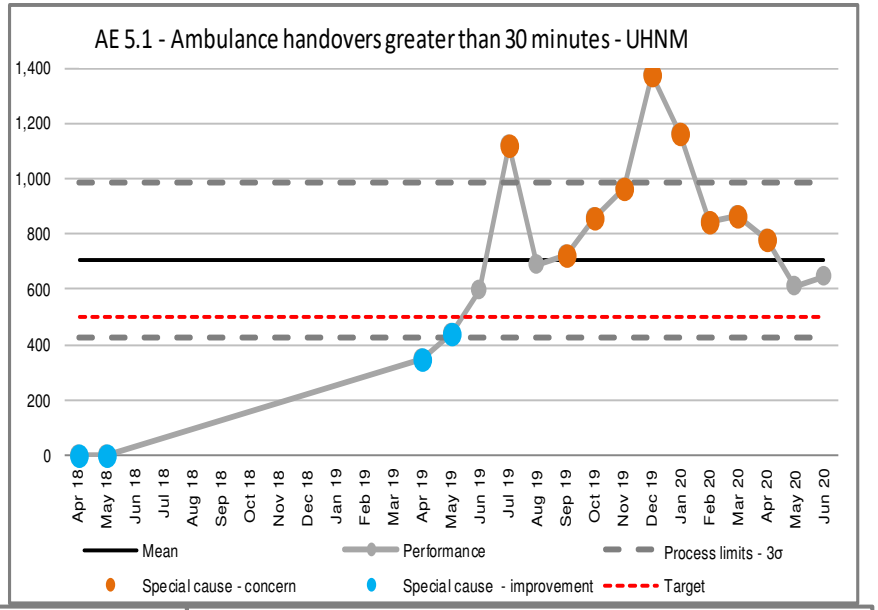
- As attendances rise, the conversion rate in June has reduced to 39.1%. This rate is now within the control limits, however further analysis demonstrates that with the significant change in number of minors attendances the conversion rate is not comparable with that seen previously
- Similarly, the conversion rate at Royal Stoke has also reduced.
- Reconfiguration of Zones within the Trust to support Blue / Purple / Green pathways with an revised Acute Medicine portal approach combining AMRA / AMU / HMU / SSU
- Further planning to support a “flex” ward to meet the increasing demand in ED

Bed Occupancy;

- The number of patients being admitted has continued to climb since the middle of March. June saw more patients being admitted on average per week than May (58 pts on average more per week).
- As attendances to ED increase and so too admissions, Bed occupancy in June has risen but remains well below the SPC lower control limit.
- Bed Modelling and review of medicine bed base to support the complexities of flow through blue and purple pathways

URGENT CARE – 4 hour access – ambulance handovers





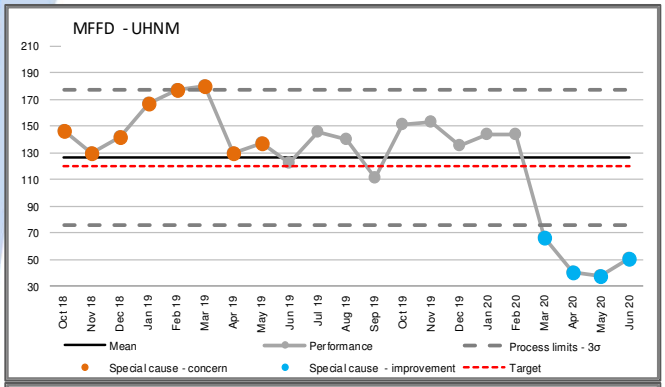
Summary

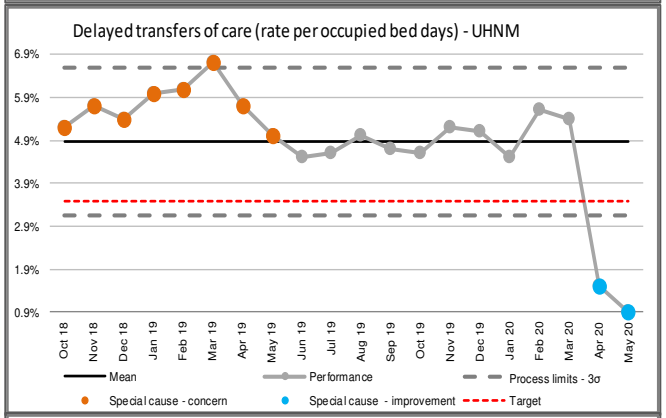
- In line with the increase in ED attendances, the number of ambulance arrivals in June continues to rise. On average at RS in June there were 14 more ambulance arrivals per day (3 more/ day at County).
- In spite of this increase, June saw zero patients waiting on the ambulance corridor overflow while handover delays over 30 minutes increased slightly by 34 over the month.
- The number of ambulance handovers > 60 minutes spiked in December 2019 but has since remained within the control limits showing normal variation. In June there were 43 delays > 60 minutes.
- Ambulance attendances continue to account for more than any other type of attendance which further indicates a greater acuity of patients (60% of attendances to RS are by ambulance).

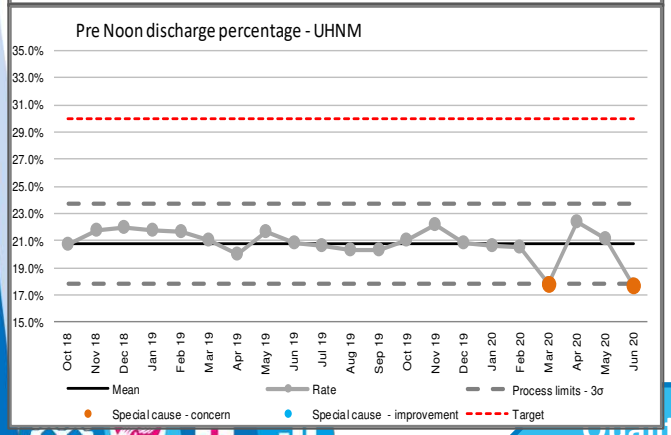
Actions

- An escalation policy is being modified to ensure there is timely and appropriate escalation in relation to any risk of ambulance handovers.

URGENT CARE – 4 hour access - Discharges







Variation	Assurance
L	?

Target	Apr 20	May 20	Jun 20
120	41	38	51

Background

The average daily number of patients Medically fit for discharge from an acute bed yet to be discharged.

Variation	Assurance
L	?

Target	Mar 20	Apr 20	May 20
3.5%	5.4%	1.5%	0.9%

Background

The Percentage of bed days occupied by delayed transfers of care. (1 month in arreas)

Variation	Assurance
L	F

Target	Apr 20	May 20	Jun 20
30%	22.4%	21.1%	17.7%

Background

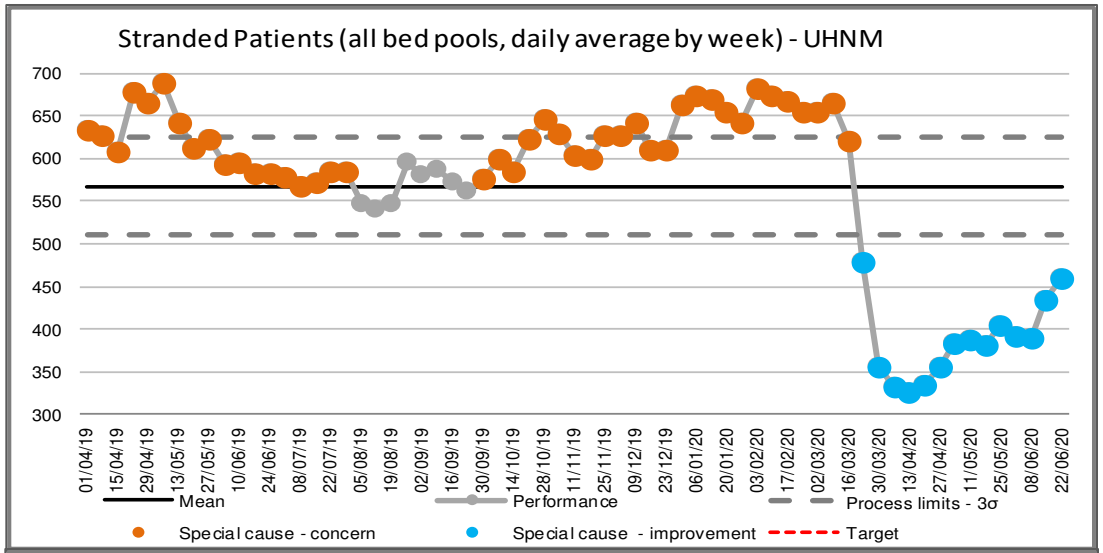
The percentage of discharges complete before 12 noon.

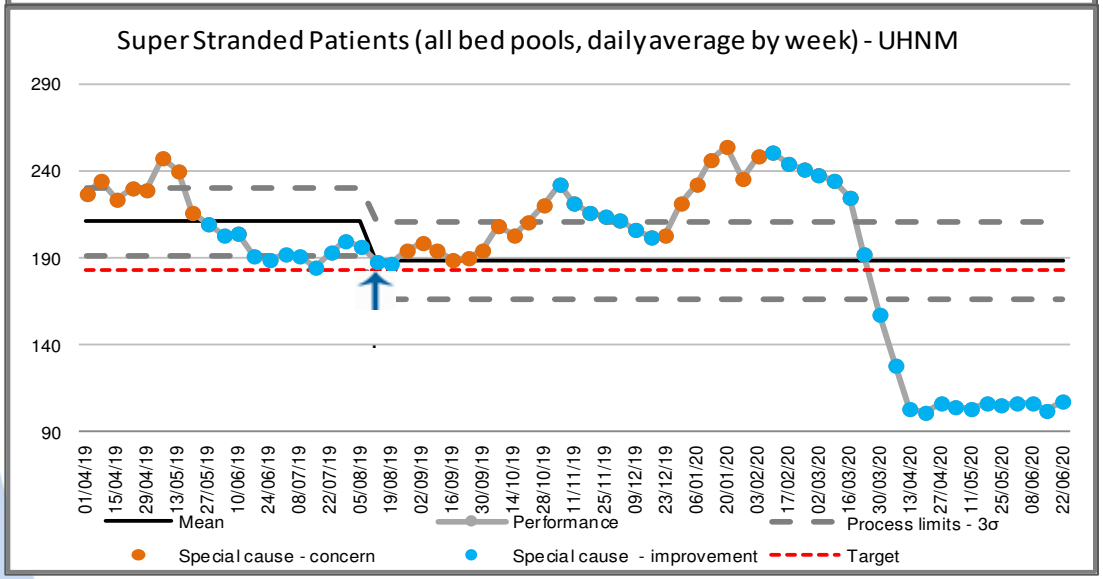
Medically fit for discharge (MFFD):
June is beginning to show an increase in the number of MFFD patients , with an average of 7 more per day compared to May. However the numbers are still significantly below those of pre-Covid. Of these the stranded patients are also increasing
Referrals for patients requiring support on discharge have increased in line with activity. The majority being discharged on day 0 or day 1 at the point of MFFD. System escalation is in place for patients waiting 2 or more days.

Delayed Transfers of Care (DToC) – I month in arrears
The rate has seen a significant improvement again for June and remains below the 3.5% national ambition. Although the Covid-19 pandemic has resulted in less beds occupied at the Trust in June, this measure shows that proportionately fewer occupied beds are patients waiting for transfer of care.
Complex discharges are down, although the overall caseload is reduced.

Discharges before midday
Discharges before midday has reduced by 3% compared to May. This is still an area for improvement and forms part of the urgent care improvement actions.

URGENT CARE – 4 hour access - Discharges





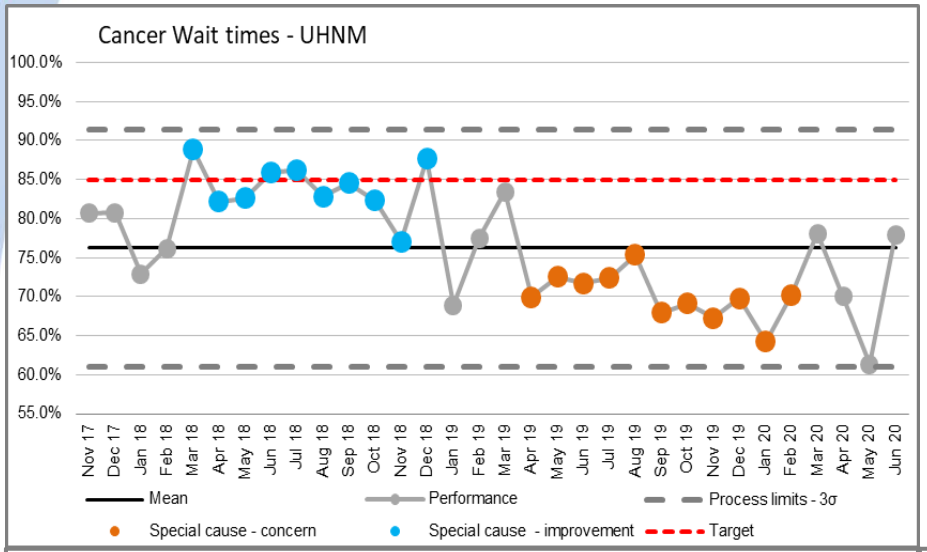
Summary

- There is evidence that the rolling weekly average for the complex caseload is increasing
- Stranded patients across all bed pools continues to rise although levels still significantly below that seen pre-Covid-19
- Super Stranded patient numbers remain static.

Actions

- LOS work within divisions in line with recovery and restoration is being restarted to increase controls on these figures

Cancer – 62 Day



Variation	Assurance

Target	Apr 20	May 20	Jun 20
85%	70.0%	61.3%	77.9%

Background

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

What is the data telling us?

Performance shows special cause concern from April 2019. The Trust is consistently falling short of the standard. The variation indicates consistently falling short of the standard.

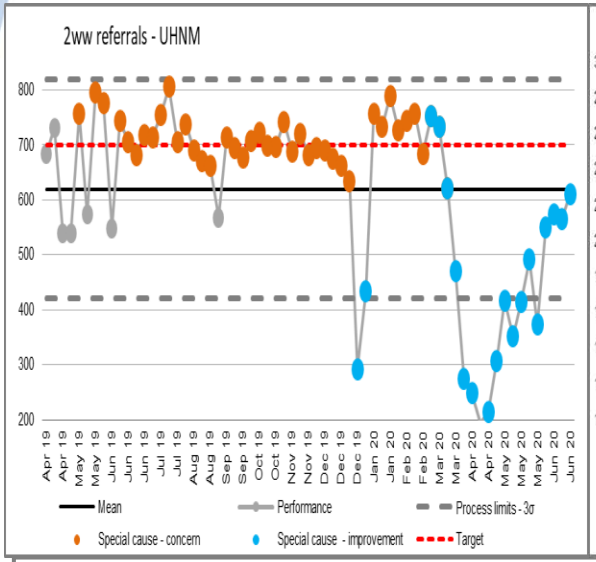
Summary

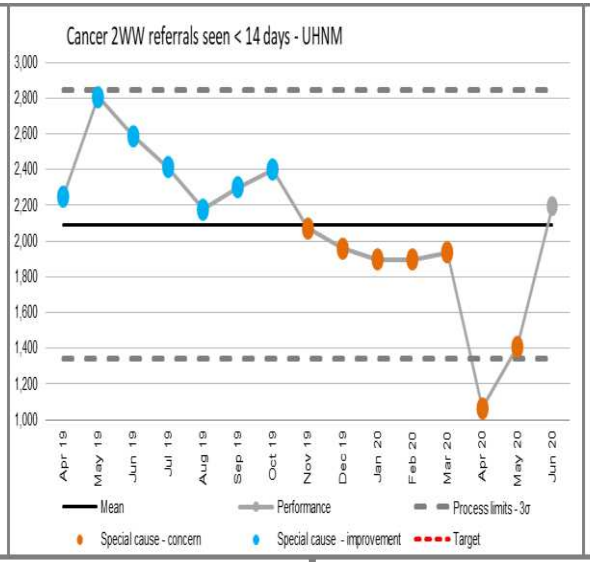
- 62 day first treatment achievement achieved 77.9% in June but there have been fewer total treatments in Q1 (400) compared to around 570 in Q4 due to patients either shielding or unwilling to attend hospital.
- The 62 day referral to treatment PTL has shown a similar trend to the 2ww demand with the total number of patients reducing from over 3000 down to less than 2000 during May 2020, there has been a slight increase throughout June and numbers in early July remain under 2500.
- The backlog had increased due to the pandemic but has now reduced to around similar numbers to that before COVID (a reduction from 730 to 356).
- Some procedures were stood down for covid19, some patients shielding and advised higher covid risk than cancer, some patient chose to defer .
- The majority of cancer pathways have continued throughout COVID and the independent sector has provided additional capacity for diagnostic and surgery although not enough to manage demand to time.
- Radiology and pathology waiting times have reduced due to less demand and a fall in the routine work. Endoscopy has been a challenge due to the restrictions placed on the service during COVID and the lack of capacity to meet the demand from the UGI and colorectal cancer pathways.

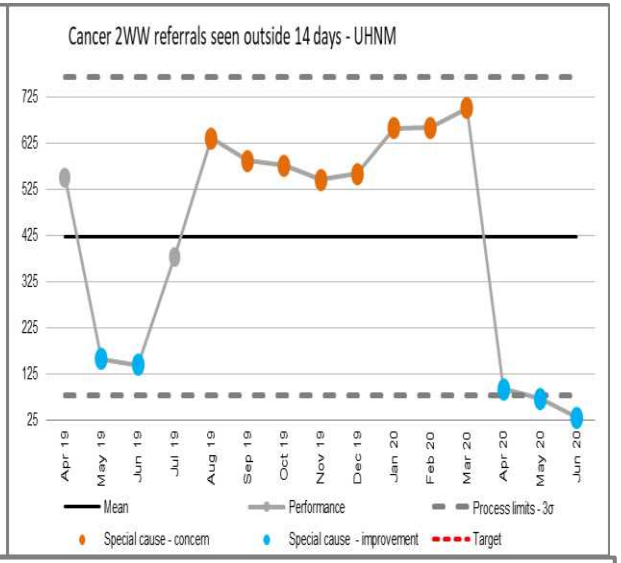
Actions

- All pathways to be tracked by Corporate Team from day 0 of refer receipt.
- The creation of specialty hubs a partnership model between divisions and the corporate team will be trialled for 12 weeks from 07th July 2020 in UGI and Lung to improve the management of patient pathways, improve efficiency, reduce duplication and use a one system approach to pathway management.
- A newly created backlog PTL is being tested and a period of training for a backlog coordinator to efficiently manage long waiting pathways including diagnostic delays has been introduced to support backlog clearance and sustainable PTL management.
- The Head of Cancer is developing a management of change paper around restructuring of the corporate cancer function to improve process and efficiency, to ensure joint working and common practices exist between corporate cancer and divisional cancer specialties, to develop services, improve training and deliver all cancer measures sustainably, and with a “one system” approach. Included in this paper will be details of the redefined role of the Corporate Team to include (after consultation) the new delivery KPI’s for the Corporate Cancer function.

Cancer – 2 Week Wait







Summary

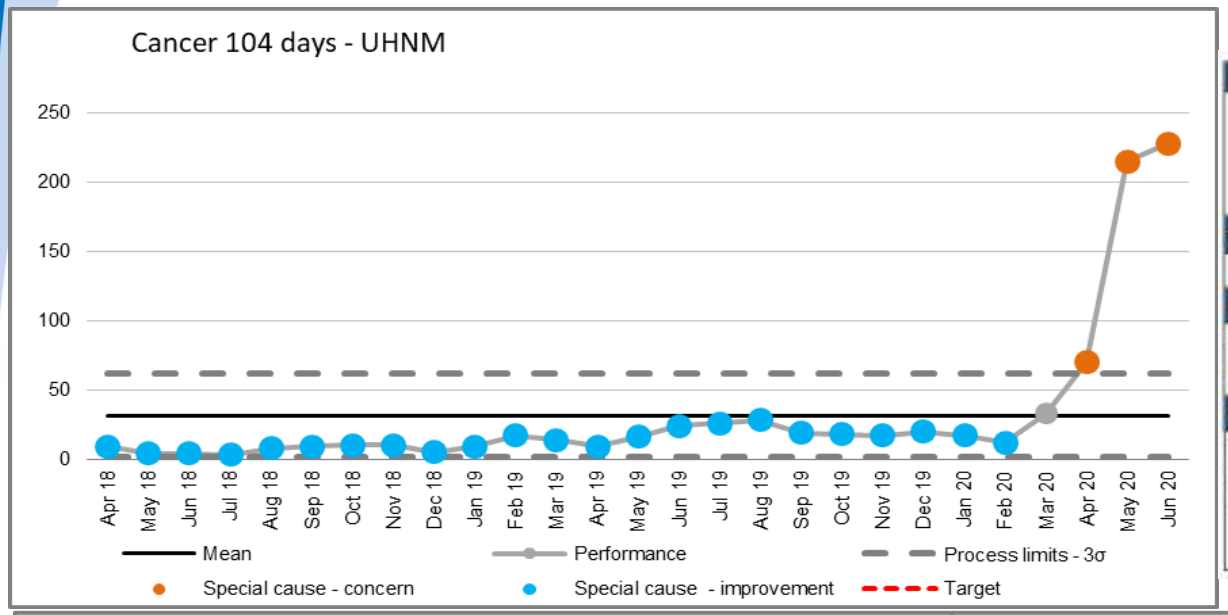
- 2ww compliance against the 93% standard has improved during Q1 to 96% (compared to 73.9% in Q4) due to a decrease in demand and also the ability to record telephone triage appointments as the first seen 2ww appointment during COVID.
- Demand in 2019 showed little variation (as seen in the SPC above) up until Covid-19 when referrals fell significantly (average wkly demand pre-Covid was 730/week whereas after Covid this reduced to 240/week.
- Two week wait referrals continue to increase significantly as the "lock down" measures ease.

Action

- In order to manage this increase effectively an analysis of all incoming 2WW referrals against NG12 criteria has taken place (optimised: 2ww referrals meeting the NG12 criteria and sub optimised: 2ww referrals not meeting the NG12 criteria). The referrals were individually validated and categorised into optimal, suboptimal and incidental findings. The plan for suboptimal is for CCG nominated clinicians to vet the referrals. Initial findings of this are shown in the table below.
- The 2nd phase of the audit is continuing through the month of July and further findings will be shared at the Planned Care Cell 29th July

Specialty	Number of 2ww ref validated	Number of 2ww optimal	Number of 2ww suboptimal	Incidental findings	% Sub optimal including incidental
Total	614	520	90	4	15%

Cancer – 104 day waits



Variation	Assurance
H	F

Target	Apr 20	May 20	Jun 20
0	70	215	228

Background

The percentage of patients waiting over 18 weeks for treatment since their referral.

What is the data telling us?

The data shows improvements up to Apr-20, following which the number of patients 104+ days has significantly risen, due to Covid-19.

Summary:

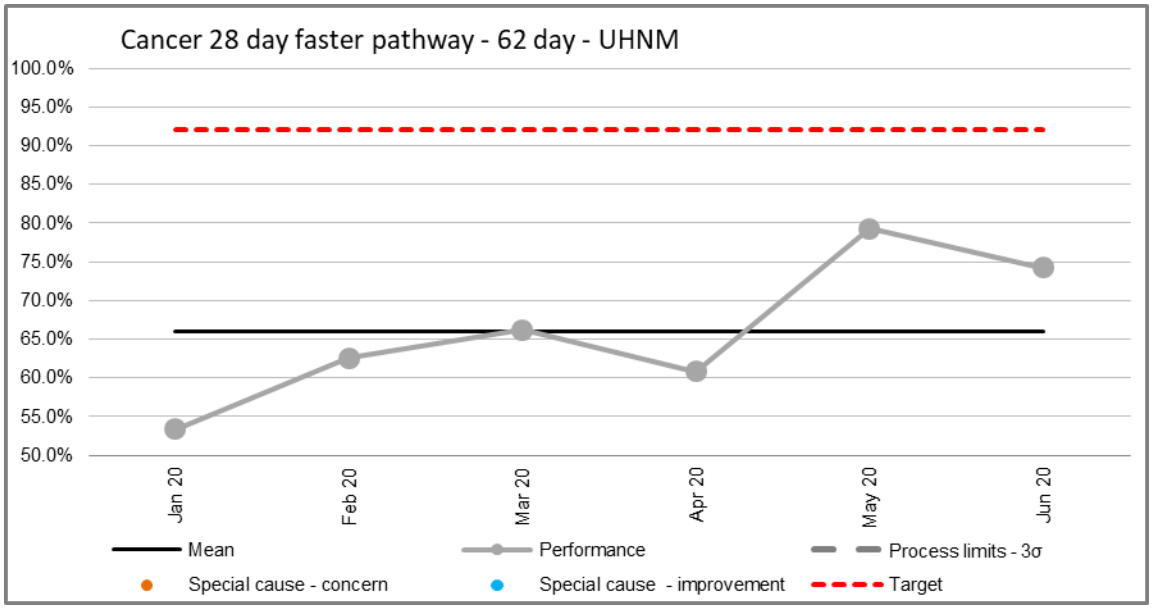
- There were 273 patients 104+ days reported at the end of June. This reduced to 228 by w/e 5th July (latest position 14/07 is < 200). Of the 228, 219 are Covid-related , six are related to patients who are too poorly to tolerate tests or treatments , whilst three remain non-compliant with the pathway.
- Of the 14 patients with a confirmed diagnosis of cancer and whose pathways exceeded 104+ days, six remain unfit to proceed with tests or treatments and eight are Covid related delays to the pathway as these patients are either clinically high risk or are shielding.

TOTAL	
FOR CLINCIAL REVIEW	72
AWAITING SURGERY	25
AWAITING DIAGNOSTIC PRCOEDURE	105
AWAITING OPA	7
AWAITING RESULTS	15
AWAITING CLINIC LETTERS	4
	228

Actions

- Daily analysis of all pathways beyond 62D by Head of Cancer.
- Use of newly created specific backlog PTL together with recruitment of a backlog co-ordinator with specific pathway expertise for the more complex pathways has now completed a two week training period and has gone live with the daily analysis to support the Head of Cancer from 14th July 2020
- Creation of individualised action plans for all patients 104+ days.
- Use of frailty PTL for patients who are to unwell to remain on a target pathway.
- Patients who are non-compliant with the pathway are referred to the clinical team for a safety review.
- Training planned for all MDTC's on validation of long waiting pathways.
- Newly refreshed escalation processes.

Cancer – 28 day faster pathway



Variation	Assurance

Target	Apr 20	May 20	Jun 20
92%	60.8%	79.3%	74.2%

Background

The percentage of patients who have reached a diagnosis by day 28.

What is the data telling us?

The Trust has been shadow monitoring the performance and an increase has been seen since March 18.

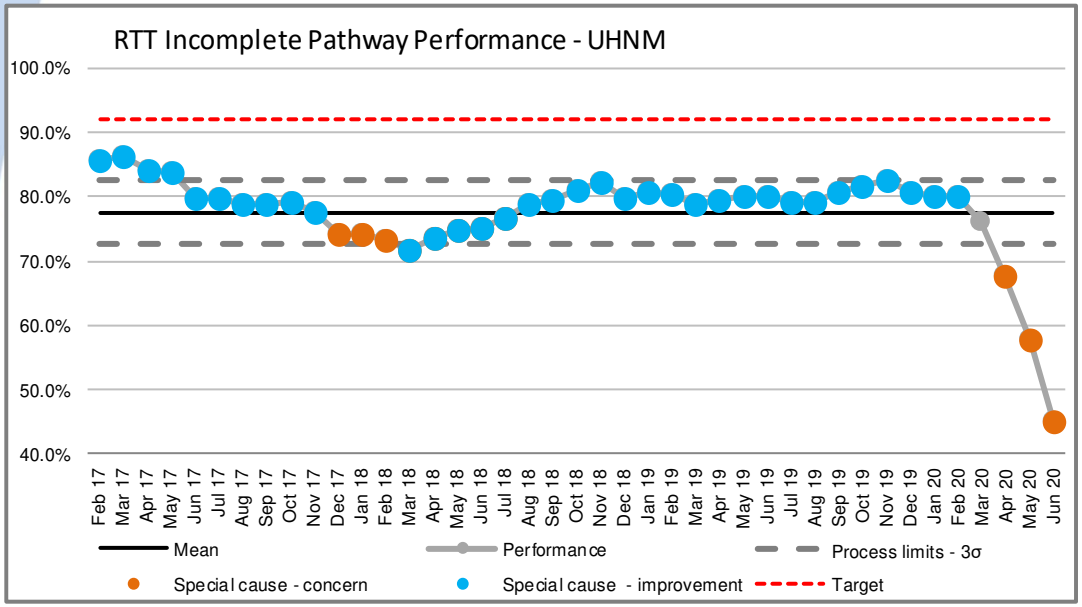
Summary

- The current measure for 28 Days is 74.3%.
- The FDT was due to be reportable from 01 April 2020, due to Covid 19 this is temporarily on hold and remains in shadow reporting until further advice is received.

Actions

- The work streams for the introduction of the optimal pathways to early diagnosis in Prostate, Colorectal and Oesophageal pathways which had halted due to the Coronavirus will re-commence from the end of June 2020 with a revised action plan and timetable.
- Additional early diagnosis pathways in Head and Neck and Gynaecology are currently being scoped. Head and Neck have received WMCA sponsorship, whilst Gynaecology case is being considered.

Referral To Treatment



Variation	Assurance
	

Target	Apr 20	May 20	Jun 20
92%	67.9%	57.8%	45.0%

Background

The percentage of patients waiting over 18 weeks for treatment since their referral.

What is the data telling us?

The RTT performance continues to deteriorate as more pathways reach 18 weeks and above.

Summary

- June continues to reflect the consequences of COVID-19 and the national mandate to stand down routine activity and referrals. The RTT waiting list size decreased to 38,037 (a reduction of 1800 since May).
- The number of patients over 18 weeks who were unable to be treated reached 20,907 a further rise of 4106 from May. The number of patients over 18 weeks has more than doubled since PRE-COVID.
- The Trust reported 366 > 52 week breaches and the number of patients over 40 weeks has risen to 2806. Key specialties include Surgical (Urology, Colorectal, UGI, ENT, Ophthalmology) and Specialised (T&O, Spinal, Neurology).
- Outpatients activity for new and follow ups is up.
- The patients on the IPWL are being stratified according to clinical priority – on-going. A rise in electives was up by 20%: T&O, Urology and ENT.
- Theatres plan for 80 % productivity at 75% utilisation due to PPE/Social Distancing criteria.

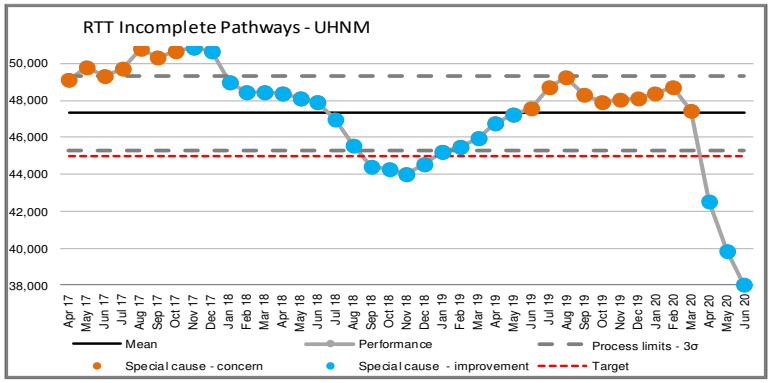
Actions:

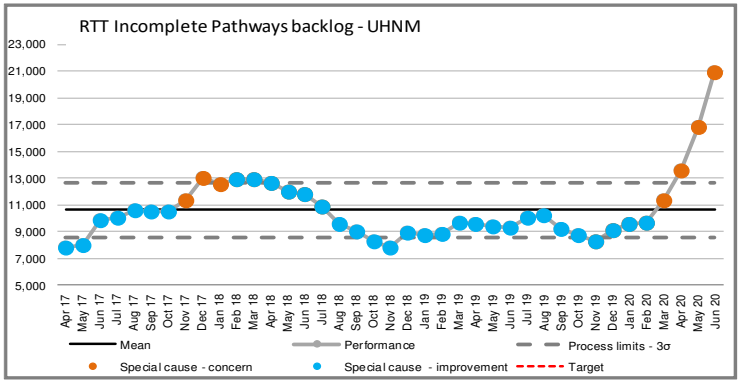
- ERS opened to referrals from 6th July 2020 (specialty level)
- Clinical teams supporting daily vetting and validation of referrals split into Advice and Guidance, Routine and Urgent bookings with SOP and flow chart issued to all Divisions.
- Review of out of county referrals with Divisions as high volumes have been received for some specialties during Covid which were retained by C&RC and returned but the Trust will be at risk now ERS is opened up without a pre-emptive solution.

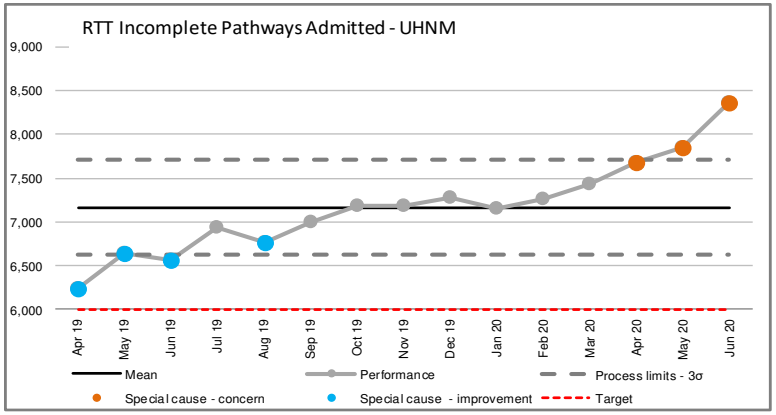
Risks:

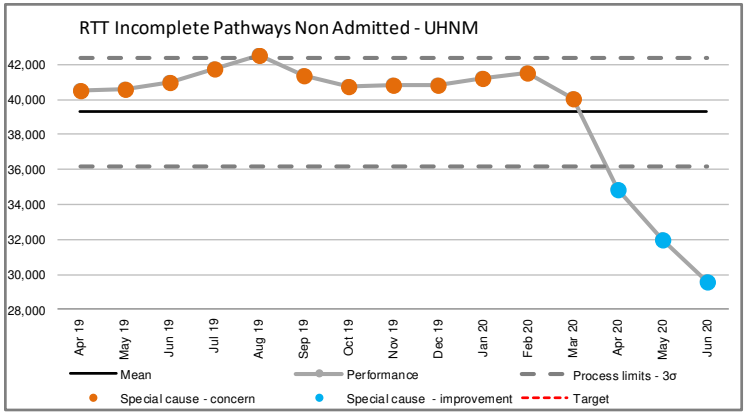
- Trust has significant number of patients categorised as urgent and deferred that need to be treated ahead of routines so performance will deteriorate further but risk stratification of the in patient waiting list is being conducted to ensure to align capacity to theatres and beds.

RTT Standards







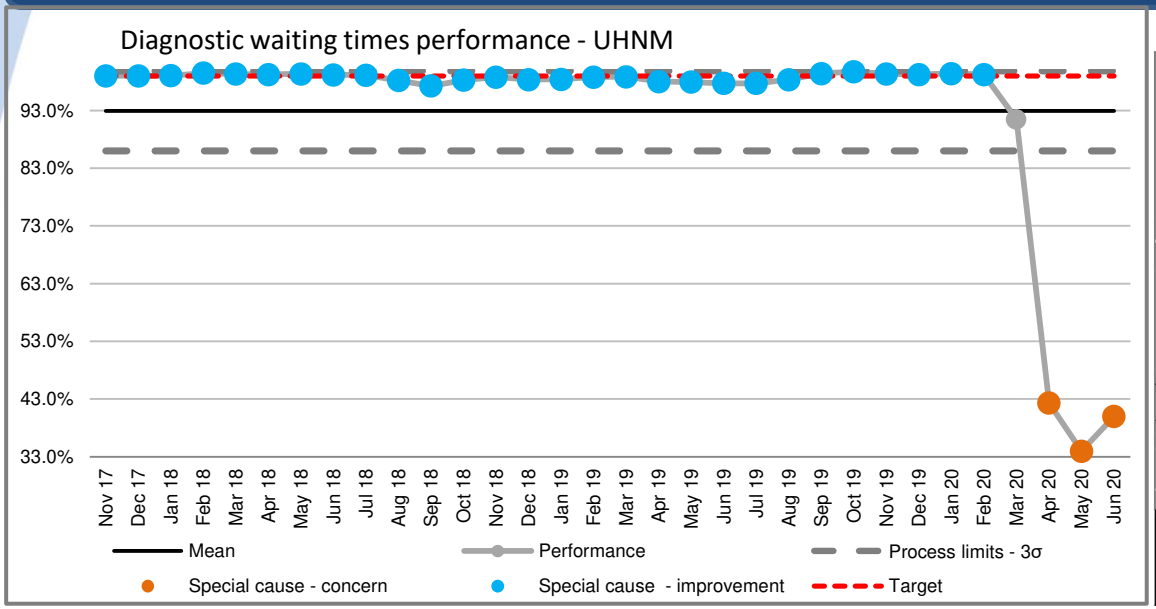


Summary:

The picture in June continues with that seen in May with the total Incomplete pathways reducing month on month. Whilst a reduction from the position the Trust had in June-19 was planned this has now been exceeded. As a consequence of routine patients not being treated (hence the RTT pathway ends) the number of patients > 18 weeks is growing.

The admitted patients (those with a decision to admit for treatment) is increasing which will need to be built into the theatres and capacity planning. Recovery plans for both the acute and County are being drafted to understand capacity required to treat against urgency.

Diagnostic Standards - May 2020



Variation	Assurance
	

Target	Apr 20	May 20	Jun 20
99%	42.3%	34.0%	40.0%

Background

The percentage of patients waiting less than 6 weeks for the diagnostic test.

What is the data telling us?

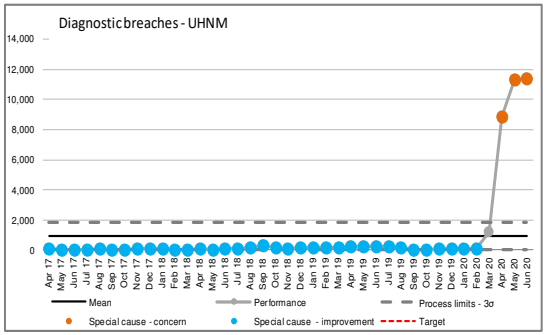
The diagnostic performance has shown normal variation up until March 2020. Special cause variation occurred from March (COVID-19).

Summary

- The Diagnostic performance is 39.97% . This is a direct result of the national mandate to cease elective activity, where patients are referred for tests and added to the waiting list but the Trust is unable to offer an appointment at this time.
- The diagnostic waiting list is significantly growing as patients are added. The waiting list size is currently at 20, 287 .The total number of patients > 6 weeks is 11,385. Of these 7,443 are in Imaging.

Actions:

- The R&R Diagnostic Cell formed and recovery plans being developed
- Recovery capacity is now understood and being planned to end of October 2020, initially with trajectories being worked through
- The Diagnostic tests which are more challenged include:
  Endoscopy; Echocardiography; Electrocardiography; MRI; Ultrasound
- Additional capacity (equipment, accommodation, staffing and consumables) are being sourced and approval process in train
- Clinical risks are being assessed and mitigation plans are being developed
- PPE requirements are all currently accommodated
- New ways of working are being implemented to gain efficiencies



Appendix 1 - ECIST Support

NHS University Hospitals of North Midlands NHS Trust

UHNM is being supported by the Emergency Care Improvement Support Team (ECIST) to drive improvement in urgent care performance at the Royal Stoke site. The first visit took place on 15th May 2020 and focused on what was driving performance despite a sharp reduction in attendances and bed occupancy. The visit focused on a 'walk-through' of the urgent and emergency care pathway, from patient arrival to the acute medical unit (AMU). Additionally, ECIST observed a site operational meeting and met with members of the site team. During this visit, ECIST observed many examples of 'excellent' practice. However, these observed examples where improvements could be made to patient flow and reduction in unnecessary waits for patients when moving from ED to urgent care portals and/or wards. Following this visit, three recommendations were made:

Opportunity 1: Creating a yes culture

Whilst ECIST observed some 'very good' practice, they concluded that it is 'very easy' for people to say 'no' and not accept a patient, or to delay the movement of patients to their department. Three actions identified:

- Address the cultural issues that drive some of the behaviours and move toward a 'yes' culture.
- Review the 'Internal Professional Standards' with clinical teams.
- Make more visual urgent care performance to departments/wards.

Opportunity 2: Develop the site management team & function

The site management meeting could be strengthened by better clarity of actions to free capacity (this in part has been delivered through the new "one-team" model of site management). ECIST are going to provide some additional support in the development of the site management function as they have developed a national tool that may be helpful.

Opportunity 3: Using information to drive improvement

ECIST have recommended that we improve the availability of information to 'the many' to help drive improvements across the board. Two actions have been identified:

- Review the current provision of information to support improvements and reduce delays across pathways.
- Availability and visualisation of information that demonstrate improvement at ward/department level ('Knowing how we are doing' Boards)

ECIST have agreed to provide further support, and the use of one of their senior analysts to take this work forward.

Next Steps:

- ECIST visited Royal Stoke for a second time on 28th May. They focused on the movement of patients through portals and wards to identify further opportunity to improve flow. The report from this visit is awaited.
- Divisions, OD&T and the PMP/Transformation Team to develop a QI initiative/framework to support the development of a 'yes culture'.
- ECIST to support ED workforce modelling
- ECIST are also going to examine whether or not we are trying to deliver too much in ED within the 4 hour standard and whether there is further opportunity to amend pathways and work differently.

Workforce

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

Workforce Spotlight Report

Key messages

The strategic focus remains on supporting recruitment, workforce deployment, staff wellbeing, absence management and staff testing. Plans are being developed for restoration and recovery to shape the "new normal"; to capitalise on new ways of working and transformation, and to reduce the risks of staff absence increasing and engagement reducing. Staffing models and rotas are being adapted to new ways of working to ensure the workforce is sufficient and available to deliver recovery and COVID-19 related activity

The key issues remain compliance with statutory and mandatory training and PDR requirements, and the sickness being above target.

Sickness

The in-month sickness rate was 5.10% (5.92% at 31/05/20) and Covid related absences are decreasing week on week.

The 12 month cumulative rate increased from 5.00% to 5.12% as this rate is calculated over a rolling 12m period which now includes a period of higher absence than previously.

Divisions are producing a 100 day restoration and recovery plan for absence; attendance reviews and Stage 3 Hearings have recommenced and local trends are being identified for intervention

Appraisals

The PDR rate improved slightly in June across all staff groups and Divisions have produced trajectories to achieve the PDR compliance target, which is being managed via the performance review process.

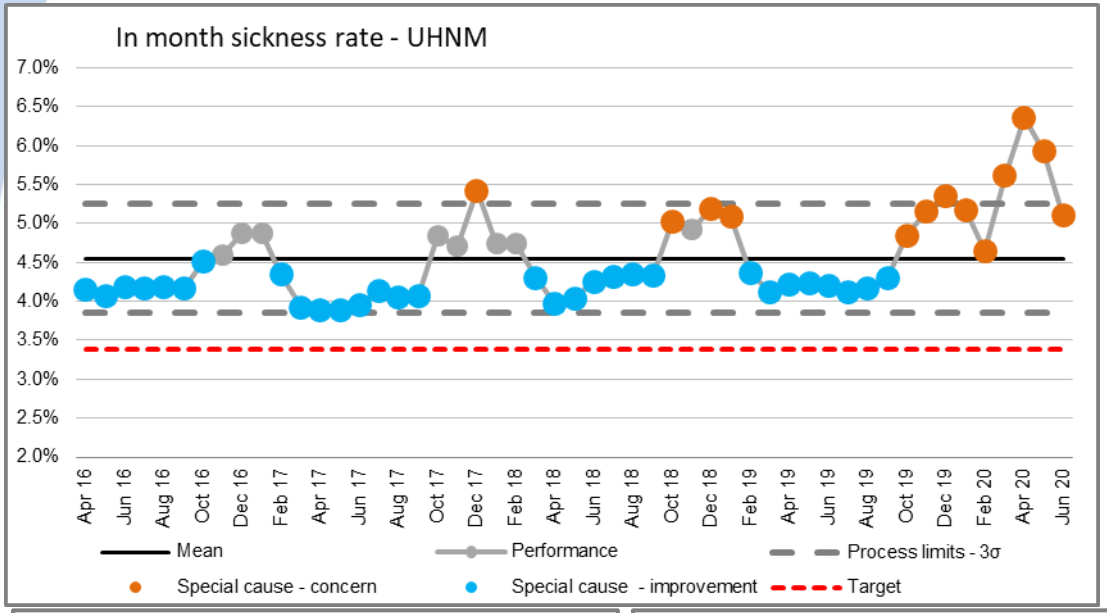
Statutory and Mandatory Training

The Statutory and Mandatory training rate at 30th June was 90.28% (90.74% 31st May 2020) and 84.29% of staff have completed all 6 Core for All modules. Staff in areas of low compliance will be emailed asking for an improvement in statutory and mandatory training compliance over the course of the next 2 months

Workforce Dashboard

Metric	Target	Latest	Variation	Assurance
Staff Sickness	3.4%	5.10%		
Staff Turnover	11%	7.68%		
Statutory and Mandatory Training rate	95%	90.28%		
Appraisal rate	95%	70.92%		
Agency Cost	N/A	2.66%		

Sickness Absence



Variation	Assurance
H	F

Target	Apr 20	May 20	Jun 20
3.4%	6.4%	5.9%	5.1%

Background

Percentage of days lost to staff sickness

What is the data telling us?

Sickness rate is consistently above the target of 3.4%. More recently special cause variation has been seen, with the increase from March through to June being a result of covid-19.

Summary

The in-month sickness rate was 5.10% at 30/06/20 (5.92% at 31/05/20). However, the 12 month cumulative rate increased from 5.00% to 5.12%

The focus has now turned to managing non-covid related absences with Divisions being required to produce a 100 day restoration and recovery plan for absence.

Actions

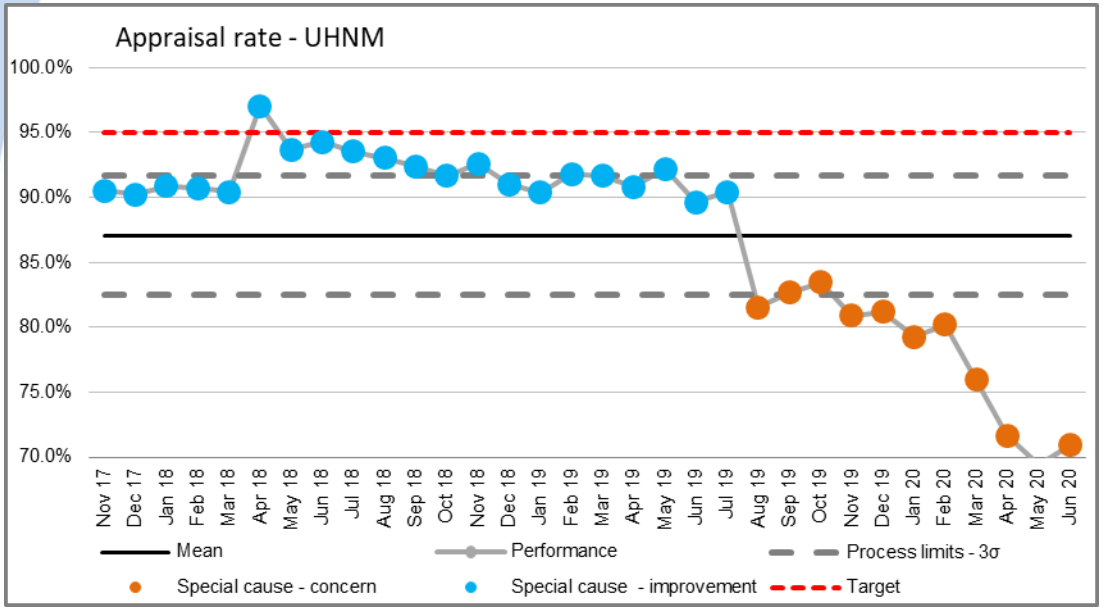
Attendance reviews and Stage 3 Hearings have recommenced with a number of hearings scheduled for August 2020. Local trends are being identified for intervention

Testing for covid-19 continues and Antibody testing has been rolled out.

The longer term actions for 2020/21 are:

- Revisit the "dragons den" ideas and agree with divisional representatives and Wellbeing Ambassadors what plans can still be implemented and how other plans can be revised to ensure they "fit" with new requirements.
- Work with charities and finance teams to support the allocation of funding to Ward / Departments to enhance environments in the interests of staff wellbeing
- Further develop the use of the Empactis absence management system to ensure that it supports absence and staff testing management in the most effective and streamlined way

Appraisal (PDR)



Variation	Assurance
L	F

Target	Apr 20	May 20	Jun 20
95.0%	71.7%	69.4%	70.9%

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%. More recently the rate shows special cause variation. There has been a drop below the lower control limit since August 2019.

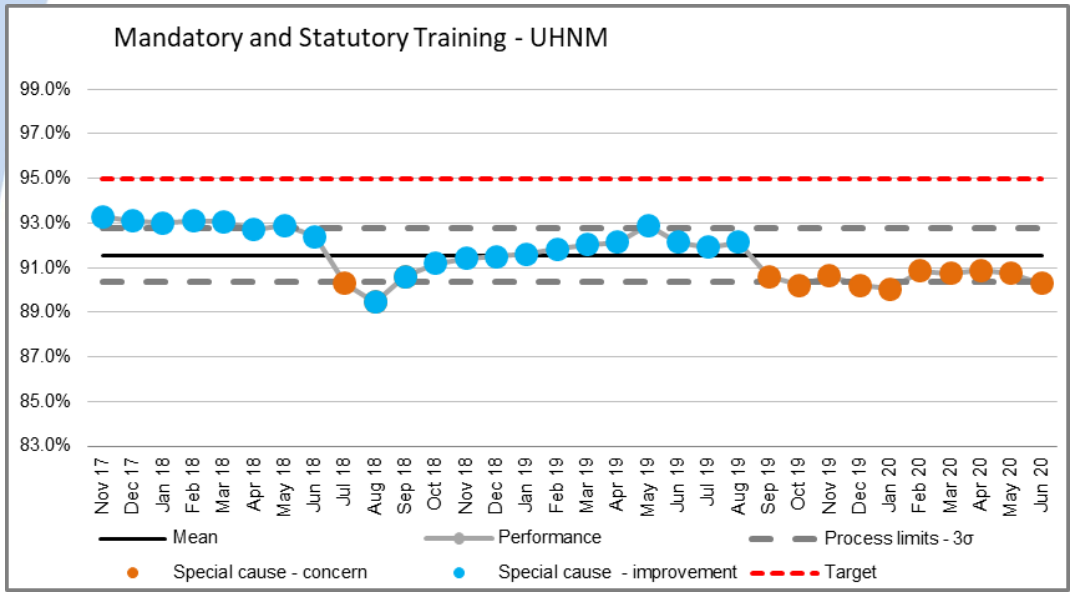
Summary

- The PDR rate improved slightly in June with 70.98% of Non-medical PDRs recorded in ESR compared to 69.4% at 31st May
- The level of sickness absence will have impacted on staff availability to complete a PDR, as will operational pressures due to covid

Actions

- We will provide support and development to line managers to enable them to operate as "virtual leaders" during the course of the next few months
- We have promoted PDR processes to ensure that all staff receive supportive conversations from their team leaders/line managers and ensure clear trajectories for improvement are in place
- We have re-issued guidance on adding PDRs to ESR and communicated a general offer of support to Managers to complete this task
- Work continues to assess different methods for holding meaningful PDR conversations with staff going forward due to social distancing requirements

Statutory and Mandatory Training



Variation	Assurance
	

Target	Apr 20	May 20	Jun 20
95.0%	90.9%	90.7%	90.3%

Background

Training compliance

What is the data telling us?

The Training rate is consistently below the 95% target. There is special cause variation since September 2019, which was the point at which local recording systems were no longer used.

Summary

Statutory and Mandatory Training: The Statutory and Mandatory training rate was 90.28%, down from 90.74% at 31st May. At 30th June, 84.29% of staff had completed all 6 Core for All modules (85.27% at 31/05/20)

Competence Name	Assignment Count	Required	Achieved	Compliance %
205|MAND|Security Awareness - 3 Years|	10626	10626	9638	90.70%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	10626	10626	9671	91.01%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	10626	10626	9445	88.89%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	10626	10626	9568	90.04%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	10626	10626	9606	90.40%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	10626	10626	9629	90.62%

Compliance with the annual elements of the Statutory and Mandatory Training requirements are as follows:

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 1 Year|	10626	10626	8366	78.73%
NHS|CSTF|Information Governance and Data Security - 1 Year|	10626	10626	9291	87.44%

Actions

Actions taken include:

- Staff self-isolating or working from home have been reminded to complete statutory and mandatory training.
- Emails will be sent from the Medical Director and Chief Nurse to staff in the above areas asking to see an improvement in compliance over the course of the next 2 months.

Finance

2025 Vision "Ensure efficient use of resources"

Finance Spotlight Report

NHS
University Hospitals of North Midlands
NHS Trust

Key messages

- The Trust has delivered a breakeven for the month; this is after the receipt of £2.2m of funding for additional expenditure relating to COVID-19 and a £2.1m "top-up" from NHSI in line with the temporary financial framework established by NHSI. The increase in the value of the "top-up" from Month 2 is due to Clinical Supplies and Drugs costs being £2m higher due to increased activity levels as the Trust restores services.
- Activity delivered in Month 3 is significantly lower than plan although income levels from patient activities have been maintained due to the temporary funding arrangements.
- The Trust incurred £2.2m of additional costs relating to COVID-19 which was £0.4m more than in Month 2 mainly relating to an increase in the numbers of Undergraduate Nursing and Midwifery students joining the Trust in June
- The pay run rate in Month 3 is £1.0m higher than Month 2 mainly as result of additional expenditure relating to COVID-19.
- Non pay expenditure is £1.8m underspent with Clinical Supplies £1.3m behind plan.
- Capital expenditure for the year to date stands at £12.6m which is £6.3m ahead of plan mainly due to the Trust completing the purchase of the Lyme Modular Wards and Theatres a month earlier than planned.
- The month end cash balance is £89.3m which is £6.6m higher than plan.

Finance Dashboard

	Metric	Target	Latest	Variation	Assurance
I&E	Trust Income	variable	65.9		
	Expenditure - Pay	variable	43.0		
	Expenditure - Non Pay	variable	21.4		
Activity	Daycase/Elective Activity	variable	4,551		
	Non Elective Activity	variable	8,374		
	Outpatients 1st	variable	17,366		
	Outpatients Follow Up	variable	34,812		
Activity income	Average income per Spell - Elective	£1,109	£1,110		
	Average income per spell - NEL	£1,918	£1,862		

Income & Expenditure

Income & Expenditure Summary Month 3 2020/21	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Income From Patient Activities	725.3	62.4	64.6	2.2	184.9	188.2	3.3
Other Operating Income	85.5	7.6	4.3	(3.3)	22.0	12.7	(9.3)
Total Income	810.8	70.0	68.9	(1.1)	206.9	200.9	(6.0)
Pay Expenditure	(508.8)	(43.4)	(43.0)	0.5	(128.4)	(126.3)	2.1
Non Pay Expenditure	(266.4)	(23.3)	(21.4)	1.8	(69.4)	(61.1)	8.4
Total Operational Costs	(775.1)	(66.7)	(64.4)	2.3	(197.8)	(187.4)	10.5
EBITDA	35.6	3.3	4.5	1.2	9.1	13.5	4.5
Depreciation & Amortisation	(29.2)	(2.4)	(2.4)	0.0	(7.3)	(7.3)	0.0
Interest Receivable	0.3	0.0	0.0	(0.0)	0.1	0.0	(0.1)
PDC	(7.6)	(0.6)	(0.6)	0.0	(1.9)	(2.0)	(0.1)
Finance Cost	(17.2)	(1.4)	(1.4)	0.0	(4.3)	(4.3)	0.0
Other Gains or Losses	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Surplus / (Deficit)	(18.0)	(1.2)	0.0	1.2	(4.3)	0.0	4.4
MRET central funding	4.2	0.4	0.0	(0.4)	1.1	0.0	(1.1)
Financial Recovery Fund	13.8	3.4	0.0	(3.4)	3.4	0.0	(3.4)
Total	0.0	2.6	0.0	(2.6)	0.1	0.0	(0.1)

- The Trust delivered a breakeven position for the month against a planned surplus of £2.6m. This position was after accounting for a “true up” payment from NHSI/E of £4.3m relating to additional COVID-19 costs of £2.2m and a payment of £2.1m to bring the Trust to a breakeven position for the month; these transactions are in line with NHSI/E temporary funding arrangements for NHS Trusts.

Cost Improvement Programme (CIP) / Capital Spend

University Hospitals of North Midlands NHS Trust

Cost Improvement

- The temporary funding arrangements in place assume that there is no CIP delivered and given the operational pressures on the organisation the development and delivery of the CIP has not been the main priority. There are a number of Divisional CIPs that have already been worked up and will deliver in 2020/21; these have been agreed with Divisions and will be transacted during quarter 1.
- A revised CIP was approved at the April Board which is summarised in the table to the right.

	Opening Budgets	Comments
	£m	
Divisional 2%		
To be transacted recurrently from 1/4/20	3.60	Will be transacted in Q1
To be transacted non recurrently in 2020/21	0.54	Will be transacted in Q1
To be transacted recurrently when start date agreed	0.40	Will be transacted in 2020/21
Additional productivity	6.47	Transacted M1
Productivity	5.00	Transacted M1
Corporate Schemes	4.00	£2.7m transacted M1; plans being developed for the balance
Non recurrent	5.00	Will be transacted in 2020/21
Share of system wide savings	12.25	Plans to be developed
Total Cost pressures	37.25	

Capital Spend

- The Trust funded capital programme for the year is £18.6m and this has been increased by a further £18.4m for PDC funded items. Funding of £5.5m for the demolition of the Royal Infirmary was approved as part of the Trust & STP capital submission on the 29th May however the signed memorandum of understanding from DHSC/NHSI has not yet been received.
- At Month 3 the capital programme is £1.4m behind plan on Trust funded schemes and £7.7m ahead of plan on PDC funded capital. On PDC funded capital this is mainly due to the Trust completing the purchase of the Lyme Modular Wards and Theatres ahead of planned.

Capital Expenditure as at Month 3 2020/21 £m	Annual	In Month			Year to Date		
	Plan	Budget	Actual	Variance	Budget	Actual	Variance
ICT Infrastructure	(3.0)	(0.9)	(0.0)	0.9	(1.1)	(0.1)	1.0
Estates Infrastructure	(2.3)	(0.2)	(0.3)	(0.1)	(0.4)	(0.4)	(0.1)
Medical Equipment	(2.2)	(0.3)	-	0.3	(0.4)	(0.0)	0.4
PFI Model	(1.9)	(0.2)	(0.2)	-	(0.5)	(0.5)	-
PFI enabling	(0.2)	-	-	-	-	-	-
Health & Safety Compliance	(0.2)	-	-	-	-	-	-
Other Central schemes	(1.8)	(0.1)	(0.1)	-	(0.1)	(0.1)	0.0
Project Star	(0.9)	(0.3)	(0.3)	0.0	(0.6)	(0.6)	0.0
Investment schemes	(0.5)	-	-	-	-	-	-
Linac	(2.3)	-	-	-	-	-	-
IR2 Bi Plane	(1.5)	-	-	-	-	-	-
LIMS	(0.9)	(0.1)	-	0.1	(0.1)	(0.0)	0.1
EPMA	(0.8)	(0.0)	(0.0)	(0.0)	(0.1)	(0.1)	(0.0)
Trust funded capital programme	(18.6)	(2.0)	(0.8)	1.2	(3.1)	(1.7)	1.4
Royal Infirmary Site demolition	(5.5)	-	-	-	-	-	-
Requested COVID-19 PDC	(2.6)	(0.9)	0.2	1.2	(2.5)	(1.2)	1.3
PDC award for HSLI	(1.2)	-	-	-	(0.6)	(0.6)	-
Wave 4b funding - modular wards	(9.1)	-	(9.1)	(9.1)	-	(9.1)	(9.1)
PDC funded capital schemes	(18.4)	(0.9)	(8.8)	(7.9)	(3.2)	(10.9)	(7.7)
Overall capital expenditure	(37.0)	(2.9)	(9.6)	(6.7)	(6.3)	(12.6)	(6.3)

Cash flow

Cash

- The Trust holds cash of £89.3m at the end of Month 3 which is £6.6m higher than plan
- At the end of June the expected cash balance of £82.7m reflects the opening cash balance of £26.7m, the receipt in advance of 1 month block payment £59m and the impact on accounts payable of the prompt payments to suppliers. The assumption is that the Trust is being provided with cash to break even during the first 7 months of the financial year and therefore the cash flow will be updated to reflect expenditure patterns in the following months.

Cash Summary at Month 3 2020/21		In Month			Year to date		
	Budget £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Opening balance	26.7	78.3	88.5	10.2	26.7	26.7	-
Block mandate payments (to 31st October 2020)	473.2	59.2	60.9	1.7	236.6	238.4	1.7
Contract income 2019/20	(9.6)	-	-	-	-	(5.7)	(5.7)
Other Income (including other NHS)	35.1	6.5	8.4	1.9	19.5	21.6	2.1
Health Education England Training Income	20.4	-	-	-	6.8	6.8	0.0
PSF/FRF - 2019/20 Q4	9.7	9.7	-	(9.7)	9.7	9.7	-
Department of Health and NHS England Deficit supp	-	-	-	-	-	-	-
Capital funding (PDC capital)	2.7	-	9.1	9.1	-	9.1	9.1
Total Receipts	531.5	75.4	78.4	3.0	272.7	279.9	7.2
Payroll (excluding agency)	(272.8)	(40.5)	(40.0)	0.5	(119.8)	(119.5)	0.3
Accounts payable	(219.0)	(29.0)	(27.5)	1.5	(93.4)	(86.2)	7.1
PDC Dividend	(3.6)	-	-	-	-	-	-
Capital payments	(10.7)	(1.5)	(10.1)	(8.6)	(3.5)	(11.6)	(8.1)
Total Payments	(506.1)	(71.0)	(77.6)	(6.6)	(216.7)	(217.3)	(0.6)
Closing Balance	52.2	82.7	89.3	6.6	82.7	89.3	6.6

Balance sheet

Note 1: Property, plant and equipment is £3.1m higher than plan. The Trust purchased the Lyme building modular wards and theatres on 29 June 2020, the plan expected the purchase to take place in July. The purchase cost of £9.1m was revalued to £5.7m in line with the valuation of the MEA notional asset at 31 March 2020 (an impairment of £3.2m). The capital plan excluding this PDC funded purchase is behind plan due to lower than anticipated spend on COVID-19 capital and IM&T expenditure at Month 3.

Note 2: Cash is £6.6m higher than plan and reflects higher than anticipated other income in Month 3 and lower than plan general payments which reflect the impact of COVID-19.

Balance sheet as at Month 3	31/03/2020	30/06/2020			
	Actual £m	Revised Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment	483.0	483.5	486.7	3.1	Note 1
Intangible Assets	24.5	22.4	22.9	0.6	
Other Non Current Assets	-	-	-	-	
Trade and other Receivables	0.4	0.4	0.4	(0.0)	
Total Non Current Assets	507.9	506.3	510.0	3.7	
Inventories	13.3	13.3	13.7	0.5	
Trade and other Receivables	49.6	39.6	38.0	(1.6)	
Cash and Cash Equivalents	26.7	82.7	89.3	6.6	Note 2
Total Current Assets	89.6	135.6	140.9	5.4	
Trade and other payables	(74.8)	(124.2)	(126.6)	(2.4)	Note 3
Borrowings	(208.0)	(9.0)	(9.0)	0.0	
Provisions	(6.7)	(6.7)	(6.7)	-	
Total Current Liabilities	(289.5)	(139.9)	(142.3)	(2.4)	
Borrowings	(276.6)	(274.9)	(275.2)	(0.2)	
Provisions	(1.2)	(1.2)	(1.2)	-	
Total Non Current Liabilities	(277.7)	(276.1)	(276.3)	(0.2)	
Total Assets Employed	30.3	225.8	232.3	6.4	
Financed By:				-	
Public Dividend Capital	409.7	605.7	614.8	9.1	Note 4
Retained Earnings	(476.2)	(476.7)	(479.4)	(2.7)	Note 5
Revaluation Reserve	96.9	96.9	96.9	(0.0)	
Total Taxpayers Equity	30.3	225.8	232.2	6.4	

Note 3: Payables are £2.4m higher than plan and reflect the receipt in advance for the July block income received on the 15th June as part of the national COVID-19 response and the levels of goods received not invoiced and NHS and Non NHS accruals being higher than plan.

Note 4: Public Dividend Capital is £9.1m higher than plan and reflects the PDC received in Month 3 relating to the purchase of the Lyme building modular wards and theatres; this was anticipated to be received in Month 4.

Note 5: Retained earnings show a variance of £2.7m as the Trust is showing a break even position at Month 3; the submitted NHSI plan had a cumulative deficit of £0.5m at 30th June. The variance is due to the impairment of the Lyme building modular wards of £3.2m which is excluded from the measurement of financial performance.

Expenditure - Pay and Non Pay

University Hospitals of North Midlands NHS Trust

Pay is £43.0m in Month 3 generating an underspend of £0.5m with the following table summarising the position by staff group.

WTE In month			Pay Summary (£m)	Annual	In month			YTD		
Plan	Actual	Variance		Plan	Plan	Actual	Variance	Plan	Actual	Variance
1,382	1,440	58	Medical	(149.9)	(12.5)	(12.9)	(0.4)	(37.7)	(38.1)	(0.4)
3,264	3,030	(234)	Registered Nursing	(156.9)	(13.5)	(12.8)	0.6	(39.2)	(37.7)	1.6
1,241	1,136	(105)	Scientific Therapeutic & Techni	(57.3)	(4.8)	(4.7)	0.1	(14.3)	(14.2)	0.1
2,340	2,549	209	Support to Clinical	(67.2)	(6.2)	(6.1)	0.0	(17.6)	(17.3)	0.2
2,424	2,278	(146)	Nhs Infrastructure Support	(77.4)	(6.5)	(6.4)	0.1	(19.5)	(19.0)	0.6
10,650	10,432	(218)	Total Pay	(508.8)	(43.4)	(43.0)	0.5	(128.4)	(126.3)	2.1

The pay run rate in Month 3 is £1m higher than the level seen in Month 2; this is mainly as a result of COVID-19 related Pay costs increasing by £0.6m due to an increase in the number of graduate Nursing & Midwifery students joining the Trust from 104 in May to 261 in June.

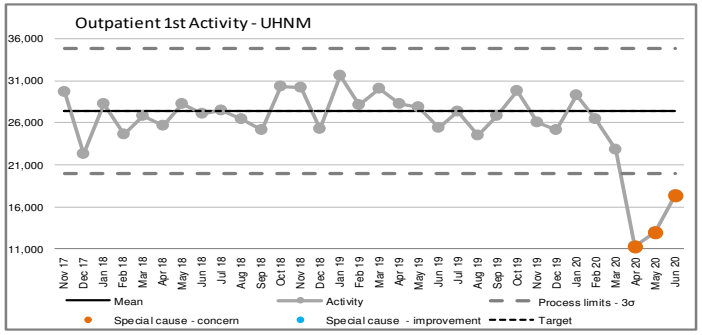
Non-pay underspent by £1.8m in Month 3 with the most significant variance relating to Clinical Supplies which is unsurprising given the reduced levels of activity being carried out in the Trust although the run rate increased by £2.3m from the level in May. Premises costs are underspent by £0.8m with the most significant variance relating to reduced charges for Catering costs for Quarter 1 from Sodexo.

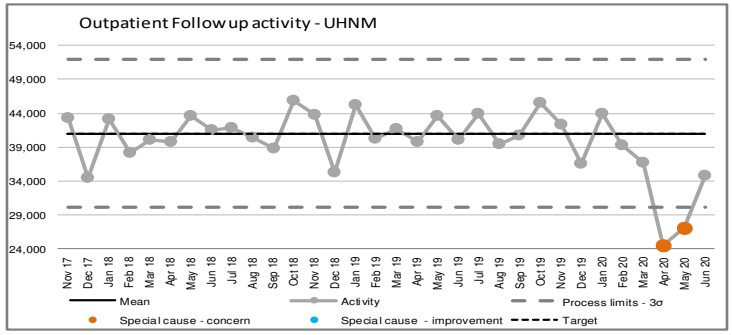
Non PaySummary (£m)	Annual	In Month			YTD		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance
Tariff Excluded Drugs Expenditure	(59.2)	(5.1)	(5.6)	(0.5)	(14.3)	(15.2)	(0.9)
Other Drugs	(21.5)	(1.8)	(1.6)	0.2	(5.4)	(4.7)	0.6
Supplies & Services - Clinical	(69.4)	(5.9)	(4.6)	1.3	(17.8)	(11.7)	6.0
Supplies & Services - General	(8.0)	(0.8)	(0.8)	0.0	(2.3)	(2.0)	0.3
Purchase of Healthcare from other Bod	(12.0)	(1.1)	(0.9)	0.2	(3.1)	(2.5)	0.6
Consultancy Costs	(2.3)	(0.2)	(0.1)	0.1	(0.6)	(0.1)	0.5
Clinical Negligence	(22.3)	(1.9)	(1.9)	0.0	(5.7)	(5.7)	0.0
Premises	(30.2)	(2.9)	(2.1)	0.8	(9.1)	(7.6)	1.5
PFI Operating Costs	(33.4)	(2.8)	(2.9)	(0.1)	(8.4)	(8.7)	(0.3)
Other	(8.0)	(0.7)	(0.9)	(0.3)	(2.8)	(2.8)	0.1
Total Non Pay	(266.4)	(23.3)	(21.4)	1.8	(69.4)	(61.1)	8.4

Activity

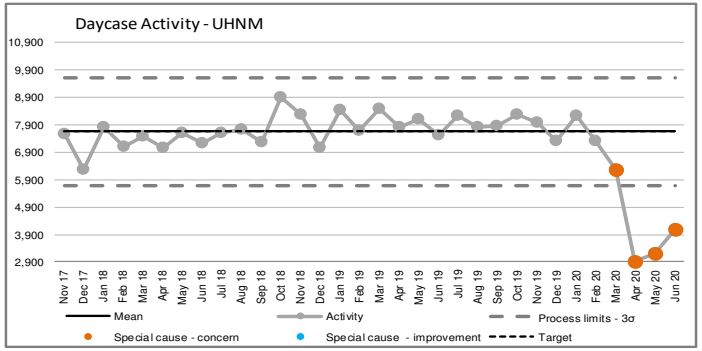
NHS University Hospitals of North Midlands NHS Trust

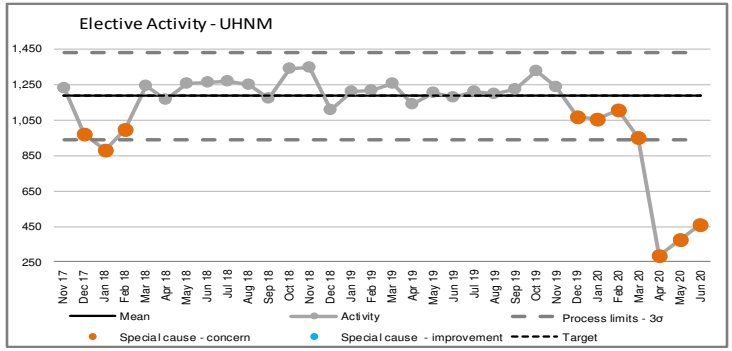
Planned care Outpatient



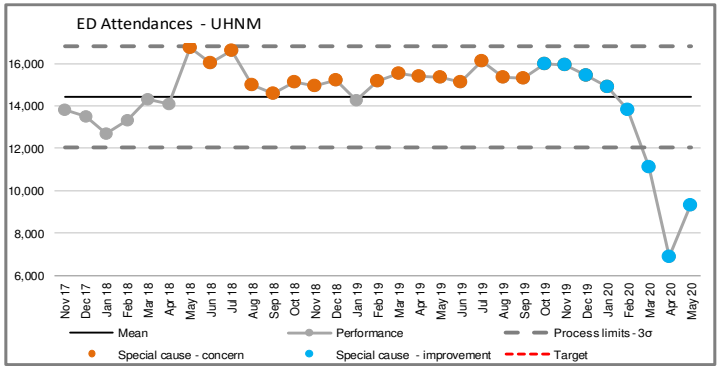


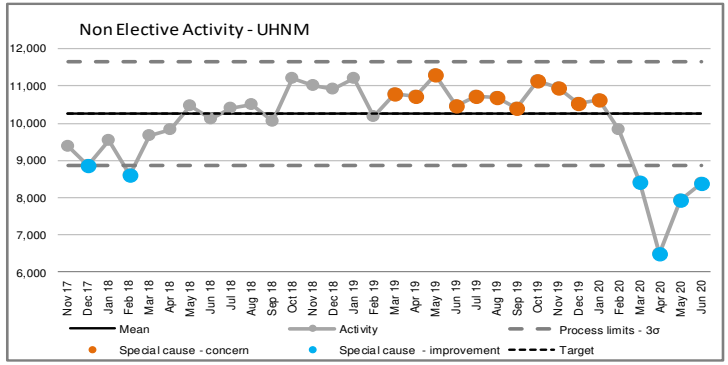
Planned care Inpatient





Urgent Care





Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Audit Committee Chair's Highlight Report to Board

31st July 2020

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Review of approval process for a sponsored staff post identified some areas of non-compliance including the involvement of procurement which was shared with the Committee; an update on actions taken were shared with the Committee and additional actions identified.	• Reflection to take place upon the initial priorities set for the Internal Audit plan for 2020/21 to establish whether these need to change. • Consideration of an electronic solution available to address some of the VTE reporting issues identified in Data Quality review. • Future reports in relation to the Clinical Audit Programme to outline the process undertaken to develop the plan, the robustness of the plan, whether the audits were being appropriately reported and whether the data was reliable. • Clinical audit to feature in future QGC reports to the Committee in order to provide assurance in relation to whether the plan was being delivered as planned. • Consideration of how the annual report from the Committees of the Board would report to the Committee and to agree the format. • Outcomes of Risk Management Audits to be presented to Executive Performance Reviews in order strengthen accountability arrangements. • An update of the future Value for Money approach to be brought to the next meeting by the External Auditors. • Review of the list of exceptions for SFI breaches and Single Tender Waivers to the next Audit Committee and strengthen accountability arrangements. • Additional information to be obtained to establish the number of cases referred to the Ombudsman to identify potential future cases for reimbursement. • Consideration of a deep dive and targeted review in terms of late 'termination and change forms' in addition to bringing into the Executive Performance Reviews.
Positive Assurances to Provide	**Decisions Made**
• The Internal Audit (IA) progress report was provided and the Committee and a delay in commencing audits for 2020/21 due to Covid-19 was noted, although assurance was provided in terms of the ability to complete the plan throughout the remainder of the year. • An IA advisory report was received into clinical audit whereby all recommend actions been accepted. In addition an IA into Data Quality was received, whereby a number of assurance ratings had been provided ranging from Significant Assurance and Partial Assurance with Improvements Required. • The Committee challenged whether the dates associated with the recommendations within the Data Quality review could be brought forward and it was noted that the aim was to complete as soon as possible. • Positive improvements made to the tracking of Internal Audit recommendations, particularly around ensuring clarity of defining actions to be taken.	• The Committee approved the Clinical Audit Programme 2020/21 welcoming the adoption of the IA recommendations & best practice and the establishment of a new Clinical Audit and Effectiveness Group to support effective delivery and governance. • The Committee approved the updated Policy FA05 Sales Ledger Credit Management

• Strengthened process for Declarations of Interest introduced whereby managers are required to confirm action being taken where potential conflicts have been declared. • The Annual Audit Letter was provided which reflected the previous audit findings report, and an update provided in terms of value for money and going concern. • An Annual Quality Review had been undertaken in respect of External Audit which was received and the actions noted. • Counter Fraud update in relation to work undertaken during the quarter and the way in which communications continued to be held with staff and Divisions, virtually. • Update for quarters 4 and 1 in respect of 'losses and special payments' and SFI breaches and 'single tender waivers'.	

Comments on the Effectiveness of the Meeting

- The ability to continue work remotely with internal and external audit welcomed by the Committee

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Internal Audit Progress Report	Assurance	6.	Report on Outcome of the External Audit AQR review – Update	Information
2.	Annual Clinical Audit Plan	Assurance	7.	Local Counter Fraud Progress Report	Assurance
3.	Internal Audit Recommendation Tracker	Assurance	8.	Losses and Special Payments	Assurance
4.	Corporate Governance Report	Assurance	9.	SFI Breaches and Single Tender Waivers Q4 2019/20 and Q1 2020/21	Assurance
5.	2019/20 Annual Audit Letter	Assurance	10.	FA05 Sales Ledger Credit Management Policy Update	Approval

3. 2019 / 20 Attendance Matrix

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

Members:			Apr	June	Jul	Oct	Jan
Prof G Crowe	GC	Non-Executive Director (Chair)					
Mr P Akid	PA	Non-Executive Director					
Ms S Belfield	SB	Non-Executive Director					
Attendees:			Apr	June	Jul	Oct	Jan
Mr A Bostock	AB	Internal Audit					
Mr R Chidlow	RC	Internal Audit					
Ms N Combes	EM/NC	External Audit					
Mrs N Hassall	NH	Deputy Associate Director of Corporate Governance					
Mr M Oldham	MO	Chief Finance Officer					
Mr R Percival	RP	External Audit					
Mrs S Preston	SP	Strategic Director of Finance					
Miss C Rylands	CR	Associate Director of Corporate Governance					
Mr S Stanyer	SS	LCFS					

In addition, Michelle Rhodes, Chief Nurse, Helen Ashley, Director of Strategy and Performance and Jamie Maxwell, Head of Quality, Safety and Compliance joined the meeting for items 1 and 2.

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	5th August 2020
Report Title:	Speaking Up Report – Quarter 1 2020-21	**Agenda Item:**	17.
Author:	Raising Concerns & Workforce Equality Manager		
Executive Lead:	Director of HR		

Purpose of Report:

Assurance	✓	**Approval**		**Information**	

Impact on Strategic Objectives (positive or negative):			Positive	Negative
SO1		Provide safe, effective, caring and responsive services	✓	
SO2		Achieve NHS constitutional patient access standards	✓	
SO3		Achieve excellence in employment, education, development and research	✓	
SO4		Lead strategic change within Staffordshire and beyond	✓	
SO5		Ensure efficient use of resources	✓	

Executive Summary:

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.

This quarterly Speaking Up Report provides an update to Transformation and People Committee 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 1 period of April - June 2020.

During the quarter 32 concerns were raised. 16 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. Two of the concerns were raised anonymously. 16 speaking up contacts were also made to our Employee Support Advisors, who act as speaking up champions across the organisation.

The second Freedom To Speak Up Index Report was published in July 2020, which has shown improvement in our rating from 74% to 75.5%. Progress against our FTSU Index action plan is included as an Appendix.

Key Recommendations:

The Trust Board is asked to consider the speaking up data and themes raised during Quarter 1 2020-21 and the actions proposed to further encourage and promote a culture of speaking up at UHNM.

Speaking Up
Quarter 1 Report 2020-21
July 2020

1. Introduction

This Quarter 32 speaking up contacts have been made via the UHNM speaking up routes. 16 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. Two of these concerns were raised anonymously. 16 speaking up contacts were also made to our Employee Support Advisors, who act as speaking up champions across the organisation.

2. Freedom to Speak Up Index 2020

Working with NHS England and NHS Improvement, the National Guardians Office brought four questions from the NHS Staff Survey together into a single measure of speaking up culture in the form of the Freedom to Speak Up Index. The index also includes CQC overall and well led ratings. The Index, which was first published in October 2019, has been updated in July 2020. The Index is designed for trust boards to use as a measure to learn more about their own Freedom to Speak Up culture, as experienced by their workforce, and as an opportunity for improvement.

UHNM has an index value of 75.5%, an improvement on our 2019 ranking of 74%. The acute trust average is 77.9%. The Index suggests a positive speaking up culture is associated with higher-performing organisations as rated by the CQC.

The Index is calculated as the mean average of responses to the following four questions from the 2019 NHS Annual Staff Survey about staff perception of feeling encouraged, knowledgeable and secure to speak up.

Question	FTSU Index Average	Average for Acute Trusts	UHNM 2019 Result	UHNM 2018 Result	UHNM 2017 Result
My organisation treats staff who are involved in an error, near miss or incident fairly	59.7%	59.6%	57.4%	55.9%	52.3%
My organisation encourages us to report errors, near misses or incidents	88.4%	88.2%	84.5%	82.4%	83.4%
If you were concerned about unsafe clinical practice, would you know how to report it?	94.6%	94.2%	92.7%	93.4%	93.3%
I would feel secure raising concerns about unsafe clinical practice	71.7%	70.4%	67.8%	65.6%	65.9%

The 2019 Staff Survey has demonstrated improvement in three out of the four the indicators related to speaking up measured by the Index Report. The indicator that has deteriorated slightly relates to staff awareness of how to report unsafe clinical practice. Further work will be undertaken to raise awareness of the routes to raise concerns.

As reported in the previous Speaking Up Report, it is encouraging that UHNM has seen improvements in the other safety culture indicators in the Staff Survey not included in the Speaking Up Index, including:

Question	Average for Acute Trusts	UHNM 2019 Result	UHNM 2018 Result	UHNM 2017 Result
I am confident that my organisation would address my concern	57.7%	56.2%	52.7%	52.8%
When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again	70.2%	70.0%	67.6%	68.3%
We are given feedback about changes made in response to reported errors, near misses and incidents	60.1%	58.9%	57.7%	54.0%

We continue to implement the actions from our UHNM Freedom to Speak Up Index Action Plan, which is attached as Appendix 1.

3. National Guardians Office Case Review – Whittington Health NHS Trust

The latest case review by the NGO undertaken at Whittington Health NHS Trust was released in June 2020. The Case Review carried out at the end of last year, revealed encouraging areas of good practice around speaking up. This included regular supervision of the Freedom to Speak Up Guardian; sufficient resource for the role to be undertaken full-time; and regular meetings with HR business partners to promote understanding and support speaking up. However, there were also 14 areas of improvement identified by the NGO case review that highlighted issues around the wording and application of the trust policy relating to speaking up, support and feedback to those who do speak up, and the way in which the trust manages grievances.

The NGO expects all NHS Trusts to consider their case review reports to identify whether they can adopt the recommendations within to help improve their speaking up culture. Recommendations from NGO case reviews are incorporated into a UHNM action plan, co-ordinated by the Freedom to Speak Up Guardian to ensure that all relevant learning is adopted by UHNM.

Key issues identified at Whittington were:

- The speaking up policy was not in accordance with the minimum standards or aligned with the national policy. At UHNM our Speaking Up Policy (HR30) was reviewed and updated in 2019 and is in accordance with national guidance. A review to the national policy is expected imminently.
- There was a lack of understanding of the purpose and remint of the FTSU Guardian from workers at different levels in the organisation. At UHNM the role description of the FTSU Guardian and their remit is available to view on our Speaking Up intranet page, and is also included in the Gateway to Management e-learning. Further awareness of the remit of the role will be included in the 'all staff' training when this is launched shortly.
- The designated board member with responsibility for speaking up did not feel adequately trained. Our UHNM Non-Executive Director with responsibility for speaking up has attended the NGO Freedom to Speak Up Training. This was also discussed with the NHS Improvement speaking up lead when they attended the UHNM Board Development session in 2019 that there is a need for specific non-executive director training, which they confirmed was being looked in to at a national level.
- Failure to provide meaningful feedback to those that had raised concerns. This has been a recurring theme throughout all of the NGO case reviews. Our UHNM Speaking Up policy sets the expectations around the provision of feedback and will also be a commitment in our Speaking Up Charter.
- There were a range of issues relating to the trusts grievance policy including delays in handling grievances which exceeded the stated timeframes, conflict of interests in grievance proceedings and a failure to disclose the details of a grievance to a group of staff who were told they were not entitled to know what the grievances made against them were about. The UHNM Grievance Policy (HR03) was reviewed and updated in August 2019 in collaboration with our Staff Side partners. This case review will be shared with the Head of Employee Relations to identify any learning.

4. Supporting Staff during Covid-19

Throughout the Covid-19 pandemic FTSU Guardians have participated in NGO Pulse Surveys. When asked about the types of issues workers were speaking up, the biggest percentage of respondents (79%) selected worker safety and wellbeing, which is reflected in this quarters speaking up themes. There was also a large increase in the percentage of respondents reporting that workers were speaking up about the impact of COVID-19 on black, Asian and minority ethnic workers.

Our BAME Staff Network has been actively involved in shaping the support for our BAME workforce during the Covid-19 pandemic, and we have worked with them as the emerging evidence indicated increased risk for BAME groups from Covid-19. We have encouraged the Network members to raise any issues of concern to the FTSU Guardians.

A report was provided to the June Transformation and People Committee on the actions the Trust has taken to support our BAME staff during the pandemic together with an update on our actions in relation to race equality in the organisation.

Supporting our BAME staff to speak up

Evidence tells us, and is even more prevalent during the Covid-19 pandemic that BAME workers are less likely to raise concerns, and are more likely to fear repercussions if they do.

These risks were acknowledged by the national Workforce Race Equality Standard (WRES) and Freedom to Speak Up Leads, who wrote to all Trusts on the 15th June 2020 about the collaborative work they have been doing to improve the experience of BAME staff across the NHS and the importance of making safe speaking up channels available and to promote these to those staff whose voices are not so often heard. They are encouraging WRES Experts and Freedom to Speak Up Guardians to work together in partnership so that all staff and in particular our BAME staff feel safe to speak up.

At UHNM our Freedom to Speak Up Guardian is also our Workforce Equality Manager and already has a very close working relationship with our WRES Expert/Chair of the BAME Staff Network who also, in January this year became an Associate FTSU Guardian.

Both individuals work with our BAME Staff Network to encourage our BAME staff to raise any issues and provide a safe and confidential route for staff to raise concerns. Regular communication has been ongoing throughout the Covid-19 pandemic to ensure that issues are identified and action taken.

Furthermore, we have an ethnically diverse set of Employee Support Advisors, who provide confidential peer support and advice to any member of staff who feels that they are being bullied or harassed.

UHNM Staff Networks

As referenced earlier in the report, our BAME Staff Network have been significantly involved in guiding the Trust in its response to effectively support our BAME colleagues and ensure their safety. The Network also identified that there is more need for line managers to hold supportive and compassionate conversations as part of the risk assessment process.

The LGBT+ Staff Network have also discussed the risks that the pandemic presents to members of the LGBT+ community including the heightened risk of LGBT people being subjected to emotional or physically abusive home situations during the lockdown.

Our June meeting of the Disability Staff Network enabled a number of issues to be identified, including situations whereby staff with disabilities were being deployed to other roles in the organisation due to Covid-19, but that in some cases these roles were not appropriate or had been inadequately assessed leading to distress for those individuals. These issues were escalated to Human Resources following the meeting to ensure temporary redeployment processes adequately consider a staff members disability or long term health condition.

5. Supporting a Speaking Up Culture

UHNM Speaking Up Charter

During Quarter 2 we will be launching the UHNM Speaking Up Charter which has been designed to demonstrate our commitment to supporting staff to raise concerns. The Charter, below, will be promoted across the Trust as part of our speaking up communications plan along with redesigned posters signposting staff to support from the FTSU team and Employee Support Advisors.

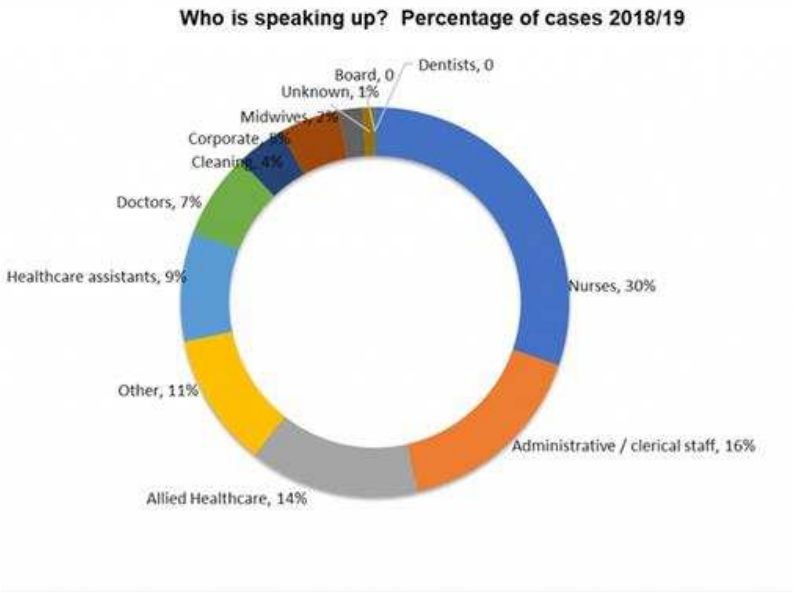
Freedom to Speak Up Training Update

The NGO is working with Health Education England to develop middle manager training resources which Trusts can then use to meet the national guidelines for training developed by the NGO last year. It is prudent to wait and use these materials to ensure consistency in our training provision for all staff and line managers. In the meantime we do however continue to require all line managers undertaking the Gateway to Management leadership development programme to complete two Health Education England online speaking up training packages. These have recently been updated and are of good standard. To date, 467 staff have undertaken the Gateway to Management programme.

Enhanced speaking up information and guidance has been developed to support the speaking up messaging given at Trust Induction and to all staff through the mandatory 3 yearly diversity and inclusion training. This is currently being incorporated into new training templates provided by the National Guardians Office this quarter and will be launched in the Trust during Quarter 2.

Benchmarking Information

An action arising from one of the divisional performance reviews was to understand if there is benchmarking information available on the staff groups that are speaking up. The National Guardians Office produces a summary of the data from all of the Trusts in England quarterly FTSU submissions. They have not released the 2019/20 data report yet, but the following image is professional group speaking up data from 2018/19:



This indicates that nurses, administrative and clerical staff and allied healthcare workers are speaking up the most. This is similar to the proportions of staff groups at UHNM using speaking up routes to raise issues.

The NGO Quarter 4 summary of speaking up activity has not yet been published, therefore benchmarking information will be provided in the next speaking up report when we benchmark UHNM speaking up activity with our Model Hospital Group.

6. Quarterly Speaking Up Cases – Quarter 1 – April - June 2020

The following information reflects concerns that have been recorded on the Speaking Up tracker. Concerns are recorded in accordance with guidance from the National Guardians Office. Concerns 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 concerns raised in the Quarter	Of which were raised anonymously	Of Which are Closed	Reports of detriment/ victimisation as a result of speaking up
April	2	0	2	0
May	8	1	6	0
June	6	1	5	1
Total	**16**	**2**	**13**	**1**

Two concerns were reported anonymously. A signal of a health speaking up culture is that staff feel able to raise issues and concerns openly, as opposed to anonymously.

Theme	Number
Attitudes and behaviours	3
Equipment and maintenance	0
Staffing levels	0
Policies, procedures and processes	2
Quality and safety	10
Patient experience	0
Performance capability	0
Service Changes	1
Other	0
Total	**16**

Summary of speaking up contacts recorded on the Speaking Up Tracker during Quarter 1 April – June 2020

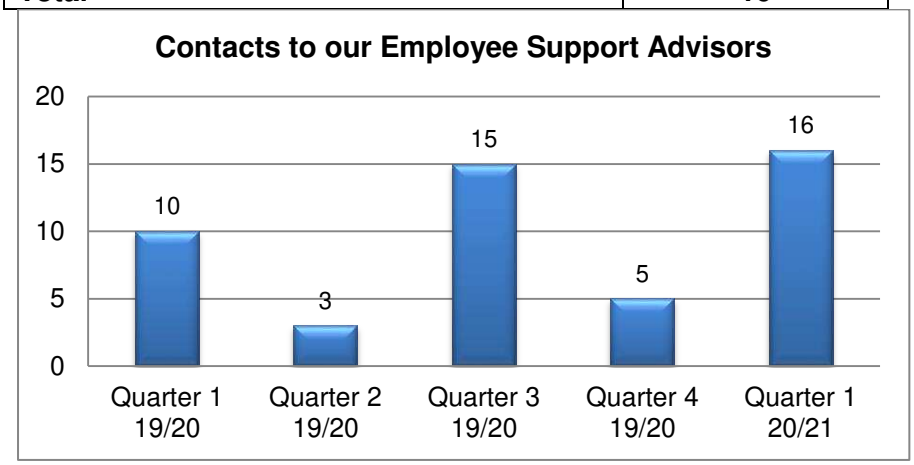
No.	Theme	Summary	Status
1.	Quality and Safety	Concerns about available stocks of FFP3 masks and impact on clinical staff when these are not available and the high fit test failure rate for other types of mask.	Escalated to Chief Nurse, who provided response to reporter. Update provided in Covid Bulletin and via Facebook Live session
2.	Quality and Safety	Concerns raised about stock of PPE and risks of using out of date PPE that has been re-dated	Thorough response provided outlining the practice is in accordance with available national guidance, with links to the information provided to Trusts on PPE use
3.	Quality and Safety	Concern about how the vulnerable worker risk assessment had been applied to an individual's circumstance	Advice provided signposted to Occupational Health for further support if needed
4.	Quality and Safety	Staff member informed that they should now work from their office, rather than home working. Individual concerned about safety risk and anxiety of returning to the workplace	Guidance provided to individual, advised to speak with line manager about anxieties and to seek support from Occupational Health
5.	Attitudes and behaviours	Concerns raised about behaviours on a ward, which have been long standing. Individual no longer working on area	Options given about the different routes to raise the issues and support available. Individual considering next steps and will confirm with FTSU Guardian
6.	Attitudes and behaviours	Concerns raised by an individual about the way a colleague is treated by their line manager	Information about bullying and harassment provided, signposted to support. Advice about options available provided. Awaiting decision from staff member
7.	Quality and Safety	Anonymous concerns received in CEO office relating to patient safety and patient and staff experience on covid wards in the Trust	Action plan produced in response to the 10 areas for patient experience, patient safety, infection control, hygiene, communication with patients and bullying behaviours of some staff. Action plan led by Chief Nurse and Deputy Chief Nurse and monitored at Patient Experience Group
8.	Quality and Safety	Staff member concerned about risk to family due to personal circumstances and working with Covid 19 patients	Risk Assessment undertaken and advice sought from Occupational Health
9.	Quality and Safety	Staff member concerned that action taken following vulnerable worker risk assessment is not sufficient due to their medical condition	Occupational Health guidance sought
10.	Service Changes	Issue raised about the future of a winter pressures ward and impact on service and staff	Chief Nurse provided response. Ward has been closed and staff deployed to other areas
11.	Policies, Processes and Procedures	Anonymous concern received in CEO Office regarding standards of dress and adherence to the uniform requirements of the Standards of Dress Policy	Chief Nurse raised with Matrons and reminder about adhering to uniform requirements included in Trust Communications
12.	Quality and Safety	Staff member concerned about their medical condition and difficulty wearing PPE impacting on their physical and	FTSUG raised with HR Business Partner and wellbeing review undertaken. Action taken to support

No.	Theme	Summary	Status
		emotional wellbeing	staff member and referral to Occupational Health for further guidance
13.	Policies, Processes and Procedures	Staff concern raised via CQC about occupational health screening and communication of results and the retention of this information	Response provided to CQC about occupational health processes in relation to the data management of occupational health screening
14.	Attitudes and Behaviours	Concerns raised about how a grievance is being managed	Independent investigation proposed
15.	Quality and Safety	Issue raised about the use of FFP3 masks for staff groups that are at increased risk due to covid-19	Escalated to Medical Director, response given about the need to ensure staff are risk assessed, and appropriate action, for example re-deployed to another area or work from home
16.	Quality and Safety	Staff concerns about feeling pressurised to return to work area when have been working from home and safety fears	Raised with HR Business Partners to raise awareness of staff anxieties. A Top Tips document in place to guide line managers in effectively supporting staff to return to the workplace

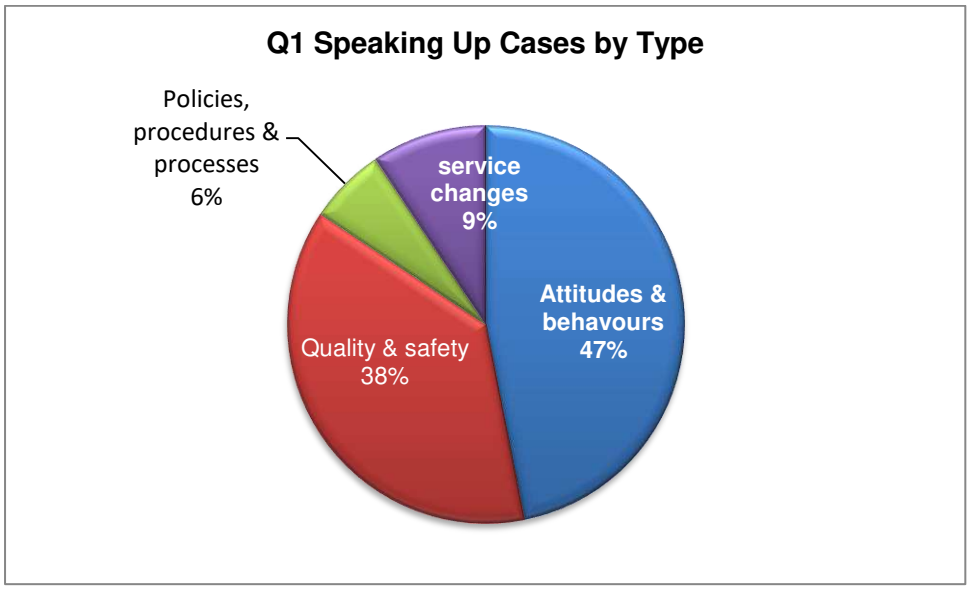
Issues raised with our Employee Support Advisors

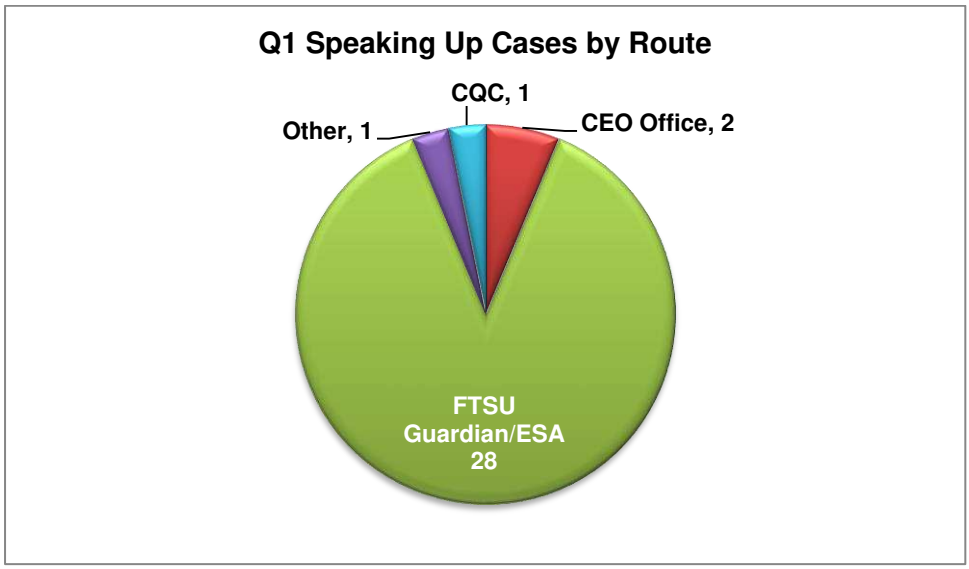
The NGO requests on a quarterly basis the number of concerns raised through freedom to speak up channels (i.e. Freedom to Speak Up Guardians and champions). Our Employee Support Advisors act as speaking up champions and therefore their activity is included in NGO data submissions. Where appropriate ESA's may escalate or signpost contacts to FTSU Guardians, and hence some of the contacts recorded below may also be reflected in concerns recorded on the raising concerns case tracker. During the quarter our ESA's have received 16 contacts relating to the following themes:

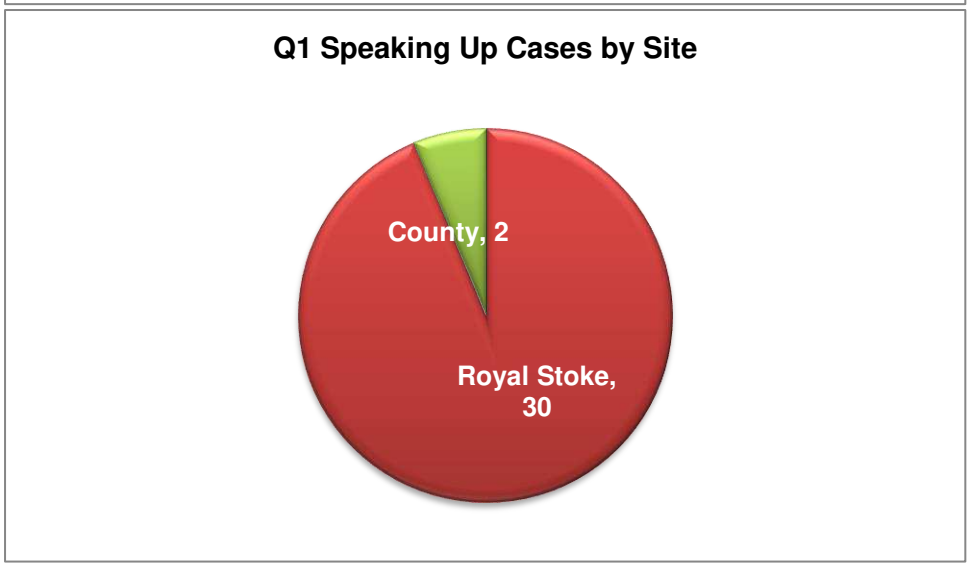
Theme	Number
Attitudes and behaviours	12
Equipment and maintenance	0
Staffing levels	0
Policies, procedures and processes	4
Quality and safety	2
Patient experience	0
Performance capability	0
Service Changes	2
Other	0
Total	**16**

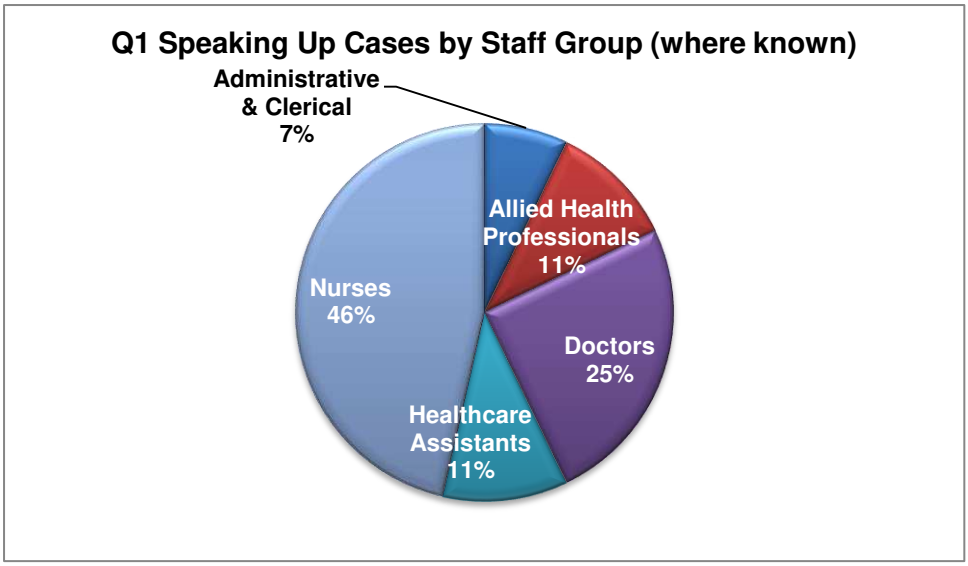


ESA activity is included in speaking up contacts reported to the National Guardians Office. The following charts include speaking up activity recorded from all speaking up routes including Employee Support Advisors:









7. Learning from cases

In May 2020 an anonymous concern was received from a staff member who had been working on Covid-19 wards in the Trust. The concern letter identified a number of issues relating to patient care quality indicators, staff deployment, PPE, infection control and communication.

Action taken has included the swift development of an action plan to respond to each of these issues. The Quality Team has been reviewing previous ward visits and monitoring on current visits regarding quality indicators for call bells, fluid availability and intake, skin bundles and oral care. Some variance in practice was discovered which is being addressed and the action plan will be monitored by the Patient Experience Group.

Good practice has included a letter for bank staff which details any restrictions on where they can work as a result of their vulnerable worker covid-19 risk assessment; iPads being made available on ward areas to support communication between relatives and patients and working closely with the Palliative Care Team. Ward managers have been made aware of the issues raised and actions to be taken.

8. Recommendations

The focus going forward over the next quarter will be:

- Continue to implement the actions from the Freedom to Speak Up Index Action Plan in particular introduce the all staff speaking up training
- Promote the UHNM Speaking Up Charter
- Raise awareness of the ways staff can speak up and the support available from the Freedom to Speak Up Guardians and Employee Support Advisors

Appendix 1: FTSU Index Gap Analysis and Action Plan (updated July 2020, with 2019 Staff Survey Results)

FTSU Index Indicator	UHNM %	Acute Trust Average %	Gap %	Action / Recommendation	Timescale	Progress Rating
% of staff "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss or incident fairly	2018: 55.9% 2019: 57.4%	58.3% 59.6%	2.4% 2.2%	• Ongoing communications promoting Speaking Up Policy, which is based on NGO best practice and enables concerns to be raised anonymously or confidentially and that the policy clearly states that the harassment or victimisation of workers that raise issues will not be tolerated, nor any attempt to bully a worker into not raising a concern.	Ongoing	GA
				• Ongoing promotion of the Just and Learning Culture framework. The Just and Learning Culture Framework Decision Tree is used to support the consistent, constructive and fair evaluation of the actions of workers involved in an incident.	Ongoing	GA
				• Introduce Speaking Up training as part of the statutory and mandatory provision for all workers in accordance with NGO national guidelines on Freedom to Speak Up training in the health sector in England (August 2019). To include the Just and Learning framework. Update: NGO templates for training material released June 2020. UHNM material is currently being updated to be consistent with these templates	May 2020	A
				• Ratify and communicate the updated Disciplinary Policy (including Just and Learning approach) across the organisation.	December 2019	B
				• Update all Speaking Up Policy supporting materials to ensure these include the Just and Learning approach and maintain focus on learning not blaming.	December 2019	B
				• Continue to promote our Speaking Up Plan as part of a regular communications strategy.	Ongoing	GA

				• Include information on detriment in FTSU quarterly reports.	January 2020	B
				• Widely promote Policy HR22 – Supporting Staff involved in an Incident, Complaint or Claim (the revised policy was approved at November 2019 TJNCC meeting).	January 2020	B
% of staff "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents	2018: 82.4% 2019: 84.5%	87.9% 88.2%	5.5% 3.7%	• Speaking Up training to be introduced for all workers as part of statutory and mandatory training with an emphasis on importance of speaking up and the routes available to do so.	May 2020	A
				• Continue to invest in compassionate leadership development, and update the Speaking Up training for line and middle management in line with the July 2019 NGO training guidance - Creating the right environment to encourage workers to speak up - Supporting speaking up and listening well - Conflicts - Induction and exit - Feedback	May 2020	GA
				• Further Board development session planned on FTSU to include NGO training for senior leaders to cover: - Regulation of speaking up - The benefits of speaking up - The role of senior leaders - Demonstrating leadership - Supporting FTSU Guardians - Measures - Protection - Communication - Learning - Continuous improvement	14.01.2020	B

				• On-going messaging encouraging a culture of speaking up from Board members, FTSU Guardian, HR and governance teams via electronic communications and face to face listening events such as ward and department visits, Care Excellence Visits CEO Time to Talk sessions and conferences and leadership events, such as Leaders Network.	Ongoing	GA
% of staff "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice they would know how to report it	2018: 93.4% 2019: 92.7%	94.3% 94.2%	0.9% 1.5%	• Review FTSU messaging at Induction. – Reviewed.	December 2019	B
				• Update and promote Speaking Up Page and Staff Experience section of new intranet.	December 2019	B
				• Launch revised 'all workers' FTSU training and revise training delivered through Gateway to Management and Connects to reflect NGO requirements for line and middle managers. To include the routes available and how to raise issues. Update: NGO to provide organisations with material for middle manager training. Await timescales for this. In the meantime, HEE updated e-learning provided to Gateway to Management delegates	May 2020	A
				• Review communications strategy to ensure a programme of regular messaging that reinforces the message that speaking up is welcomed and how to raise issues. This needs to take into account ways in which more inaccessible workers can be reached.	December 2019	B
% of staff "agreeing" or "strongly agreeing" that they would feel secure raising concerns about unsafe clinical practice	2018: 65.6% 2019: 67.8%	69.3% 70.4%	3.7% 2.6%	• Trust wide communications and divisional championing of the Just and Learning Culture Framework.	In place and ongoing	B
				• Promote zero tolerance approach to victimisation of workers who raise concerns.	December 2019	GA
				• Introduce newsletters and updates with a creative and engaging communication strategy to tell positive stories about speaking up	Quarterly	GB

				• Have a sustained and on-going focus on the reduction of bullying, harassment and incivility, which in November 2019 will include the launch of the 'Cut it Out' campaign.	November 2019 and ongoing	B

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.

Trust Board

2020/21 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 8	May 6	Jun 10	Jul 8	Aug 5	Sep 16	Oct 7	Nov 4	Dec 9	Jan 6	Feb 3	Mar 10	Notes
PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES														
Chief Executives Report	Chief Executive													
Patient Story	Chief Nurse													Public Trust Board meetings did not take place in April - June due to social distancing
Quality Governance Committee Assurance Report	Associate Director of Corporate Governance													
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer													Delayed due to Covid.
Care Quality Commission Action Plan	Chief Nurse													
Bi Annual Nurse Staffing Assurance Report	Chief Nurse													
Quality Account	Chief Nurse													Timing moved due to changes in national requirements regarding submission
7 Day Services Board Assurance Report	Medical Director													Timing TBC
NHS Resolution Maternity Incentive Scheme	Chief Nurse													Timing TBC
Winter Plan	Chief Operating Officer													
PLACE Inspection Findings and Action Plan	Director of Estates, Facilities & PFI													
ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS STANDARDS														
Integrated Performance Report	Various													
ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT & RESEARCH														
Transformation and People Committee Assurance Report	Associate Director of Corporate Governance													
Gender Pay Gap Report	Director of Human Resources													
People Strategy Progress Report	Director of Human Resources				→									Deferred to August's meeting due to Covid
Revalidation	Medical Director													Delayed due to Covid and change in national reporting timescales.
Workforce Disability Equality Report	Director of Human Resources													
Workforce Race Equality Standards Report	Director of Human Resources													
Staff Survey Report	Director of Human Resources													
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													
IM&T Strategy Progress Report	Director of IM&T													
Going Concern	Chief Finance Officer													
Estates Strategy Progress Report	Director of Estates, Facilities & PFI			→										Deferred due to Covid-19
Annual Plan 2020/21	Director of Strategy													Deferred due to Covid-19
Financial Plan 2021/22	Chief Finance Officer													
Capital Programme 2021/22	Chief Finance Officer													

Title of Paper	Executive Lead	Apr 8	May 6	Jun 10	Jul 8	Aug 5	Sep 16	Oct 7	Nov 4	Dec 9	Jan 6	Feb 3	Mar 10	Notes
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		Covid Assurance Framework included in CEO Report May 20
Raising Concerns Report	Director of Human Resources		Q4			Q1			Q2			Q3		
Annual Evaluation of the Board and its Committees	Associate Director of Corporate Governance													Deferred due to Covid-19
Annual Review of the Rules of Procedure	Associate Director of Corporate Governance													
G6 Self-Certification	Chief Executive													Deferred to June's meeting
FT4 Self-Certification	Chief Executive													
Board Development Programme	Associate Director of Corporate Governance													Deferred due to Covid-19