University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 3rd February 2021 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	
5 mins	2.	Chair's Welcome, Apologies and Confirmation of Quoracy	Information	Mr D Wakefield	Verbal	
	3.	Declarations of Interest	Information	Mr D Wakefield	Verbal	
	4.	Minutes of the Meeting held 6th January 2021	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 – January 2021 • Covid-19	Information	Mrs T Bullock	Enclosure	**BAF 6**
10:20	**PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES**					
5 mins	7.	Quality Governance Committee Assurance Report (20-01-21)	Assurance	Ms S Belfield	Enclosure	**BAF 1**
10 mins	8.	IPC Board Assurance Framework	Assurance	Mrs M Rhodes	Enclosure	**BAF 1**
10 mins	9.	Ockenden Report: Assessment and Assurance Framework and Action Plan	Assurance	Mrs M Rhodes	Enclosure	**BAF 1**
10:45	**ENSURE EFFICIENT USE OF RESOURCES**					
5 mins	10.	Performance & Finance Committee Assurance Report (19-01-21)	Assurance	Mr P Akid	Enclosure	**BAF 9**
10:50	**ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT AND RESEARCH**					
5 mins	11.	Transformation and People Committee Assurance Report (21-01-21)	Assurance	Prof G Crowe	Verbal	**BAF 2 & 3**
10:55 – 11:10 – BREAK						
11:10	**ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS**					
40 mins	12.	Integrated Performance Report – Month 9	Assurance	Mrs M Rhodes Mr P Bytheway Mrs R Vaughan Mr M Oldham	Enclosure	
11:50	**GOVERNANCE**					
5 mins	13.	Audit Committee Assurance Report (21-01-21)	Assurance	Prof G Crowe	Enclosure	**BAF 2 & 3**
10 mins	14.	Board Assurance Framework – Quarter 3	Assurance	Miss C Rylands	Enclosure	
10 mins	15.	Speaking Up Report – Quarter 3 2020-21	Assurance	Mrs R Vaughan	Enclosure	
10 mins	16.	Risk Management Policy	Approval	Miss C Rylands	Enclosure	
12:25	**CLOSING MATTERS**					
5 mins	17.	Review of Meeting Effectiveness and Business Cycle Forward Look	Information	Mr D Wakefield	Enclosure	
	18.	Questions from the Public **Please submit questions in relation to the agenda, by 12.00 pm 1st February 2021 to** claire.rylands@uhnm.nhs.uk	Discussion	Mr D Wakefield	Verbal	
12:30	**DATE AND TIME OF NEXT MEETING**					
	19.	**Wednesday 10th March 2021, 9.30 am via Microsoft Teams**				

University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 6th January 2021, 9.30 am to 11.25 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												
Mr M Oldham	MO	Chief Financial Officer												
Dr J Oxtoby	JO	Medical Director							AW					
Prof P Owen	PO	Non-Executive 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									
Prof A Hassell	AH	Associate Non-Executive Director												
Mrs L Thomson	LT	Director of Communications												
Miss C Rylands	CR	Associate Director of Corporate Governance						Item 7 & 8						
Mrs F Taylor	FT	NeXT Non-Executive Director												
Mrs L Whitehead	LW	Director of Estates, Facilities & PFI												

In Attendance:		
Mrs C Hughes	CH	Deputy Associate Chief Nurse – Surgery (item 1)
Mrs N Hassall	NH	Deputy Associate Director of Corporate Governance (minutes)

Members of Staff and Public via MS Teams: 4

No.	Agenda Item	Action
1.	**Staff Story**	
001/2021	Mrs Rhodes introduced Mrs Hughes to Board members and explained that she had invited her to the meeting, to explain how she had found working within Critical Care during the pandemic, and to outline some of the staffing challenges during that time. Mrs Hughes highlighted the following: • During wave 1, resource was pulled together and due to 'business as usual' operating having been stood down nationally, other staff were able to be deployed. • Staff found it difficult and were exhausted but took time to reflect and take forward the learning from wave 1 in preparation for wave 2.	

PROUD TO CARE

- For the second wave, level 2 and 3 resources were pooled, similar to wave 1, but as the Trust needed to continue with 'business as usual' the same level of deployment was not available.
- Theatre staff were approached, although they were anxious having been through the first wave and having negative experiences, therefore a lot of reassurance was needed.
- Staff were also finding it difficult in treating their own colleagues, who were being admitted into ITU with Covid.
- During wave 2, a number of critical care patients needed to be transferred to other facilities which was a difficult decision to make
- Learning from wave 2 had been taken on board to prepare for the third wave, and there had been additional volunteers who were helping staff to prone patients
- A further challenge for wave 3 was identified, in that there would be minimal opportunity to transfer critical care patients out to others within the network, due to all hospitals experiencing the same challenges

Mrs Hughes concluded by referring to the family theme at UHNM and that she never felt on her own as there was always someone to call on. She added that staff continued to reflect on the learning from previous surges in order to make improvements for the future.

Mr Wakefield provided this thanks to Mrs Hughes and the critical care staff for their efforts during the pandemic. He queried the decision which was made to transfer patients and Mrs Hughes explained that the unit had reached maximum capacity in terms of staffing and in order to remain resilient for other patients there was a 12 day period whereby 27 patients were transferred, some of whom remained in hospital due to the severity of their condition. She added that this was a difficult decision to make as the unit was proud of only having needed to transfer a minimum number of transfers previously.

Dr Griffin thanked Mrs Hughes for the story and noted the challenges with workforce as opposed to number of beds. Mrs Hughes referred to the plans for the next wave in terms of increasing workforce by utilising additional support, although this was difficult due to ongoing business as usual activities and staff feeling anxious after the first surges.

Mrs Rhodes referred to the decision made to transfer patients and reiterated that this was a difficult decision, but was done for safety reasons. She highlighted that the Trust was presently on level 4 for critical care and similar situations and challenges were affecting other hospitals around the country.

Mr Bytheway referred to the first wave whereby the Trust had additional staff and space to deal with the increased numbers of patients and that in the second wave there was space in the region to utilise, but not the staffing. He stated that the challenge with wave 3 was that there was no additional space nationally, and therefore different plans were required in order to continue to treat patients safely as well as supporting those staff who were dealing with unprecedented pressures on a daily basis.

Mr Akid referred to the availability of the vaccine for frontline staff and queried if this would make a difference and help with staffing. Mrs Hughes agreed and stated that staff knowing that they will be vaccinated has provided them with some reassurance and they felt safer and was grateful that ITU staff were being vaccinated quickly as one of the priority groups.

	Professor Hassell queried whether Mrs Hughes or colleagues were able to outline ways in which others could help going forwards, and how the Non-Executives could help to boost morale. Mrs Hughes stated that following reflection, additional things had been put into place, but it was difficult to reflect at times, due to needing the head space to do so. She added that in terms of support from Non-Executives, knowing that they were there if needed was helpful. Mr Wakefield reiterated the Boards thanks and agreed to consider how staff could be provided with additional support for their health and wellbeing. He added that he was delighted to hear that the staff were some of the first to receive the vaccine. **The Trust Board noted the staff story.** Mrs Hughes left the meeting.	
2.	**Chair's Welcome, Apologies & Confirmation of Quoracy**	
002/2021	Mr Wakefield welcomed members of the Board and observers to the meeting and no apologies were received. It was confirmed that the meeting was quorate. Mr Wakefield provided the Boards thanks to staff and their continued commitment during the pandemic and offered sympathies to those affected by Covid. He noted that continued pressures were expected over the next few months therefore a decision had been made to focus the agenda on key issues and short and medium term actions for the time being.	
3.	**Declarations of Interest**	
003/2021	The standing declarations were noted. Mrs Bullock highlighted that she had been appointed as a Keele Council Lay Member for Keele University.	
4.	**Minutes of the Previous Meeting held 9th December 2020**	
004/2021	The minutes of the meeting from 9th December 2020 were approved as an accurate record.	
5.	**Matters Arising from the Post Meeting Action Log**	
005/2021	PTB/453 – Mrs Rhodes highlighted that no antimicrobial meeting was held in November. She stated that it had been agreed with the Chief Pharmacist that those areas not following policy would be reported to the Infection Prevention Committee and Quality and Safety Oversight Group through to Quality Governance Committee, as required. She explained that the gap in control related to the use of antibiotics rather than nosocomial infections.	
6.	**Chief Executive's Report – December 2020**	
006/2021	Mrs Bullock highlighted a number of areas from her report. Ms Belfield referred to Mrs Bullock being invited to join the national Independent Review of Human Resources and Organisational Development practices, and queried whether Mrs Bullock had the capacity to take part, given the current	

	challenges. Mrs Bullock highlighted that meetings were easier to attend, due to these being on Microsoft Teams and the panel were aware of the challenges faced by those involved, therefore her priority would continue to be focussed on UHNM and if she was unable to attend some meetings, this would be accepted by the panel. Mr Wakefield referred to staff risk assessments which were completed during wave 1 and referred to the risk of the new variant and queried whether the risk assessments were still valid. Mrs Bullock stated that the risk assessments were being reviewed on a regular basis to take into account any changes in circumstances. Mrs Vaughan added that the risk assessments followed national guidance and were backed up with input from Occupational Health, as well as reviewed by the Trust's clinical group. It was noted that risk assessments continued to be reviewed and updated based on any changes in national guidance/advice. Mr Wakefield queried whether the risk assessments needed to take into account that younger people were getting Covid due to the new variant, and Dr Oxtoby stated that younger people were at lower risk of getting a severe infection which the risk assessment takes into account. He added that as staff were being vaccinated the risk should reduce. **The Trust Board received and noted the report and approved EREAF 4028.**	
UPDATE FROM EXECUTIVE DIRECTORS		
7.	**Chief Nurse**	
007/2021	Mrs Rhodes highlighted the following in relation to the Infection Prevention Board Assurance Framework: • Risks 1 and 6 were the highest and there were some specific gaps in control which were to be addressed, therefore the risk score had not reduced. It was noted that actions were required to ensure training records were kept regarding doffing and donning consistently, in addition to further work required in ensuring patients were not moved unless they had 2 negative swabs. • In respect of risks 2, 7 and 9 the scores had worsened during the quarter and it was noted that assurance was required of the robustness of the associated action plans. In addition risk 7 had increased due to the impact of wave 3. It was noted that whilst policies were in place and these were audited, further assurance was required on the robustness of the audits undertaken and the escalation of the results. Mrs Rhodes highlighted the following in relation to patient safety incidents during the Christmas period: • It was agreed that the data needed to be supported by benchmark information where available and possible. When compared to last year, the Trust had reported less incidents in 2020 than 2019 and less incidents reported in relation to infection prevention. • The number of incidents reported were the lowest since the beginning of November, apart from falls which had increased, and those areas affected were those with staffing and sickness absence challenges Dr Griffin referred to the difference between policy and compliance and queried whether Mrs Rhodes was assured that staff were fully reporting incidents during current pressures. Mrs Rhodes referred to the increase in the number of incidents reported during the past year, which was positive, and the increase was	

	in low and no harm incidents, which demonstrated a positive reporting culture. She added that whilst there were some areas which were better at reporting than others, she felt that more focus was required in ensuring staff reported incidents regarding staffing levels. Mr Wakefield referred to the number of patients in critical care who were unable to be turned and queried if they got a pressure ulcer, whether it would be classed as an adverse incident. Mrs Rhodes confirmed that it would be reported and added that pressure ulcers for critical care patients, were usually as a result of being proned on their front, increasing the risk of a pressure ulcer on the face from tubes etc. Mrs Rhodes agreed to include benchmark information on the number of incidents reported to the Quality Governance Committee where this could be obtained. **The Trust Board received and noted the Infection Prevention Board Assurance Framework and patient safety update.**	**MR**
8.	**Chief Operating Officer**	
008/2021	Mr Bytheway highlighted the following: • The Trust declared level 4 in critical care for November • During the end of November and beginning of December, the number of Covid positive patients had increased up to 50 per day, although this reduced in the lead up to Christmas • Christmas and New Year saw a relatively stable bed position, due to the increase in simple discharges and there being a significant number of Covid beds available, although the number of beds for 'normal' emergency cases were limited • ED attendances stood at 80% of what had been planned for as part of the winter plan and admissions were 90% of that predicted in the winter plan, demonstrating that acuity had remained the same when compared to the previous winter, on a reduced bed base with high levels of occupancy • Additional space was to be created in order to treat the increase in Covid patients expected in the next week, which would require standing down of some elective work and turning some elective wards into 'purple' wards which would affect the waiting list. It was noted that the Trust was expected to get to a position where it was working on 'life and limb' treatments, although the Trust would continue to utilise independent sector capacity and work with partners to increase the number of discharges and keeping the number of Medically Fit for Discharge (MFFD) patients between 30 to 40 at Royal Stoke • The Trust was presently establishing how it could increase the number of critical care beds to 60, although the associated staffing needed to be identified Dr Griffin referred to the standing down of elective work and queried which patients would be continue to be seen. Mr Bytheway confirmed that it was the aim to continue to treat P1 and P2 patients, although there may be times at which only P1 patients would be treated. Mr Smith referred to the new variant and queried how this was expected to impact on UHNM, based on the experience of other Trusts. Mr Bytheway stated that Wolverhampton were struggling with flow through their hospital on a daily basis therefore having sufficient bed space was a key priority, in order to maintain flow through the Emergency Department. In addition, agreement was required in	

	terms of what the additional system beds would be utilised for i.e. MFFD and medically stable patients. Dr Oxtoby referred to the position in November and suggested that with the new variant the Trust could expect to see 1½ times as many patients as that in November. Mr Bytheway stated that the number of older people contracting Covid had reduced and anecdotally it seemed to be more prevalent in middle aged people, which may reduce the number of hospital admissions due to having less severe symptoms. Mr Wakefield queried if the new strain were to affect community and local authority staff, whether there would be enough capacity to release patients back into homes and if not, whether this had been planned for. Mr Bytheway confirmed that this had been considered and added that leisure services staff were to be utilised for social care needs, and other resources from the community were being utilised. **The Trust Board noted the update.**	
9.	**Director of Human Resources**	
009/2021	Mrs Vaughan highlighted the following: • Management of staff absence continued to be a priority in addition reviewing staffing levels • The Workforce Bureau had continued to operate since wave 1 although the intensity of work varied. The main areas of focus continued to be on the completion of risk assessments, staff wellbeing and testing as well as redeployment of staff to other areas of the Trust • Sickness absence continued to be monitored on a daily basis and each Division were aware of their own absence levels as part of their business continuity plans. In addition daily review of nurse staffing and pressure points was being undertaken. • 95% of risk assessments had been completed, 98% for Black and Minority Ethnic staff and modifications had been put into place as appropriate. These risk assessments were reviewed on an ongoing basis • The Trust continued to obtain support from system partners in terms of workforce support • Sickness absence had continued to plateau at circa 50%, and was presently at 48% although the impact of December was not yet known • There had been an increase in the number of absences related to stress and anxiety, which was unsurprising given the current circumstances • Guidance for staff shielding had changed and a further review was being undertaken to assess the impact of these changes • Lateral flow testing had been rolled out to over 9000 staff, which had helped to reduce the number of asymptomatic staff spreading the virus unknowingly • Staff testing had continued and the vaccination programme had commenced with prioritisation of patient facing and high risk staff first Professor Crowe queried the number of vaccinations provided to staff in the prioritised groups and queried the reporting levels for lateral flow tests. Mrs Vaughan agreed to provide the exact numbers of staff vaccinated in the prioritised groups to Professor Crowe and added that 1.5% of those reporting lateral flow tests were positive. Ms Ashley added that 35,000 lateral flow test	**RV**

	results had been reported to date. Professor Crowe referred to the health and wellbeing support for staff which continued to be a priority for the Board, and queried whether progress was being made on the provision of additional rest facilities. Mrs Vaughan stated that whilst there would always be more which could be done to support staff wellbeing, good progress was being made on the provision of rest facilities with the aim of opening these by the end of the month. She stated that additional work was required to help boost staff morale and increase motivation. Professor Hassell referred to staff testing and the total number of tests which had reduced which he assumed was due to the use of lateral flow testing and filtering out negative results, which was positive. Professor Owen referred to the increase in absence due to stress and anxiety and Mrs Hughes' earlier point of the importance of having the head space to reflect. She queried how plans were progressing with regards to supporting staff to take time out and pause and reflect, given the current workload. Mrs Vaughan stated that opportunities for staff to take time out had been put in place and further work was needed across the organisation although psychological support was provided on an individual and team basis and the demand for that support had increased. Mr Akid referred to workforce challenges and queried whether anything could be done to utilise staff from outside of the organisation i.e. those who had retired. Mrs Vaughan confirmed that the Trust were utilising those staff who had retired and recruitment processes were also being streamlined in order to speed up the ability to recruit staff and for these to commence in post. Mr Wakefield commented on Covid testing across the system and data which suggested that 70% of positive cases were asymptomatic. He queried if this was representative of the Trust cases, and stressed the importance of lateral flow testing. Mr Wakefield agreed to discuss this further with Mrs Vaughan/Ms Ashley. **The Trust Board received and noted the report.**	**DW**
10.	**Chief Finance Officer**	
010/2021	Mr Oldham highlighted the following from his report: • Due to the changes during 2020/21 the difference in targets had been explained in terms of original budget, plan and forecast • Whilst the Trust had a forecast agreed of £2.2 m deficit, the current position was ahead of plan to date and therefore the Trust was expected to reach break-even by the end of the year • A number of risks were highlighted in terms of the elective incentive scheme • The cost of carry forward of annual leave was to be factored into plans • 2021/22 letter had been issued towards the end of December which provided some indication of finances based on allocations which was being worked through, although further guidance was expected towards the end of January. It was noted that the delay in receiving this information could impact on budget setting **The Trust Board received and noted the report.**	

COMMITTEE ASSURANCE REPORTS		
11.	**Quality Governance Committee Assurance Report (16-12-20)**	
011/2021	Ms Belfield highlighted the following areas which the Committee continued to focus upon: • Difficulties experienced in critical care • Increase in the number of Covid positive patients • Commencement of the vaccination programme • Continued work on reducing patient falls It was noted that the Ockenden report for maternity services had been received and a review was being undertaken to consider the recommendations and the actions required and this was to be presented in detail at a future Committee, before being brought to the Board for consideration. **The Trust Board received and noted the assurance report.**	
12.	**Performance & Finance Committee Assurance Report (15-12-20)**	
012/2021	Mr Akid highlighted the following: • Rapidly changing scenario within the Trust, given the increases in number of Covid positive patients • The Trust was within the lower quartile for urgent care performance and issues with ambulance handovers had been highlighted, which was similar to other organisations • The impact on elective capacity was considered in terms of creating Covid wards as discussed earlier in the meeting • TSA funding had been confirmed which had reduced the anticipated deficit **The Trust Board received and noted the assurance report.**	
13.	**Transformation and People Committee Assurance Report (17-12-20)**	
013/2021	Professor Crowe highlighted that the usual meeting had been stood down and an informal meeting had been held to discuss progress and in particular absence management. Professor Crowe provided his thanks to the teams and the continued efforts in terms of actions being taken in respect of staff wellbeing. **The Trust Board received and noted the assurance report.**	
ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS		
14.	**Integrated Performance Report – Month 8**	
014/2021	The report was taken as read and no comments were raised.	
CLOSING MATTERS		
15.	**Review of Meeting Effectiveness and Business Cycle Forward Look**	
015/2021	No comments were raised.	
16.	**Questions from the Public**	

016/2021	Mr Syme referred to quality and safety and Covid mortality and the discussion at December's meeting regarding differences in mortality between surge 1 and 2. He suggested that data seemed to show mortality figures at UHNM for Covid surge 2 to have exceeded surge 1 with week 16/12/20-20/12/20 seeing significant weekly deaths. He queried whether this was an accurate mortality assumption and if so what seemed to be driving the increase in mortality numbers. Dr Oxtoby stated that for surge 1 mortality was between 31% and 32%, whilst for surge 2 mortality was at 20%, although this was a final figure due to the lag between admission and patients dying. He stated that the mortality numbers in surge 2 were higher, due to there being more Covid admissions, as wave 2 was much larger than wave 1 i.e. twice the size, therefore the percentage was lower than wave 1 and the initial view that mortality in wave 2 is less than wave 1 remains correct. Mr Syme referred to quality and safety and hospital acquired Covid cases and the Covid variant which was being described as far more 'transmissible'. He added that nosocomial Covid cases according to national data were rapidly increasing. He queried how UHNM could mitigate this and queried what extra infection prevention measures were in place or being put into place to significantly inhibit hospital Covid cross infection. Mrs Bullock stated that the number of side rooms had been increased and additional pods had been put onto some wards. She added that lateral flow testing was in place as well as improved turnaround times for PCR testing which were all helping to control the spread of the virus. In addition, more cleaning teams were being utilised and a specific cleaning team was in place within the Emergency Department. It was noted that three times daily infection control reviews were undertaken on wards and outbreak meetings took place when 2 or more patients contracted the virus, with mass testing undertaken on those wards. Mr Syme referred to the Quality Governance Committee report and pressures on critical care and transfers. He stated that it was nationally acknowledged that surplus Critical Care capacity was becoming limited and queried what the Trust's contingencies were when surplus Critical Care availability became limited or unavailable. Mr Bytheway referred to his earlier update and stated that this was being tackled by reorganising workload based on clinical priority and relaxing nursing ratios in line with national guidance to support ongoing demand in critical care.	
DATE AND TIME OF NEXT MEETING		
17.	Wednesday 3rd February 2021, 9.30 am, via MS Teams	

Trust Board (Open)

Post meeting action log as at **27 January 2021**

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/451	09/12/2020	Patient Story - December	To provide an update of the actions taken in response to the story, to a future Quality Governance Committee.	Michelle Rhodes	24/02/2021		Update will be provided at February's QGC.	GB
PTB/452	09/12/2020	Quality Governance Committee Assurance Report	To provide additional information and analysis of patient deaths attributed to Covid, including outcome of SJRs, comparisons between surges and analysis of pre-defined risk factors.	John Oxtoby	20/01/2021	20/01/2021	Included on the QGC Agenda for 20th January (item 7 – Nosocomial Death Reviews Process).	B
PTB/453	09/12/2020	Infection Prevention Board Assurance Framework (BAF) & Update following NHS England and NHS Improvement Visit	To confirm whether the action in relation to discussion of antibiotic usage at November's antimicrobial group had taken place	Michelle Rhodes	06/01/2021	11/01/2021	Update provdied at January's meeting. It was highlighted that the antimicrobial meeting was not held in November therefore it had been agreed with the Chief Pharmacist that those areas not following policy would be reported to the Infection Prevention Committee and Quality and Safety Oversight Group through to Quality Governance Committee, as required.	B
PTB/454	06/01/2021	Update from the Chief Nurse	To include benchmark information on the number of incidents reported to the Quality Governance Committee.	Michelle Rhodes	24/02/2021		Benchmarking to be included in the report which will include December data for February QGC.	GA
PTB/455	06/01/2021	Update from the Director of Human Resources	To confirm the exact numbers of staff vaccinated in the prioritised groups to Professor Crowe.	Ro Vaughan	03/02/2021		**Update to be provided.**	GA
PTB/456	06/01/2021	Update from the Director of Human Resources	To discuss lateral flow testing and asymptomatic staff with Mrs Vaughan/Ms Ashley.	David Wakefield	03/02/2021	27/01/2021	Complete.	B

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 27th January 2021. 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:

- Providing the latest position with regard to the second surge of Covid-19
- Divisions to provide updates in terms of their latest position, next steps, staff wellbeing and any concerns/risks

Key points highlighted were as follows:

- Progress with the vaccination programme which has seen the majority of staff vaccinated now, with plans for the second dose to be rolled out very soon. The vaccination hub will now be wound down as the community hubs take over. However there are concerns nationally around take up from those from a BAME background.
- Critical Care remains under intense pressure and is currently at around 200% occupancy, in line with the national ask – additional staff are being deployed to provide support.
- Nosocomial infections remain a key challenge and all staff are continually reminded of the measures that need to be adhered to in terms of hands, face, space.
- Delivery of key capital schemes for Specialist Decision Unit and Paediatrics in December with further developments, including rest facilities for staff now also complete.
- Sickness absence remains high with increasing numbers of staff with stress and anxiety being reported; staff counselling and wellbeing packages are in place to provide support where needed.
- Some changes have been made to the risk assessment process in line with national guidance; further communication is being issued around the personal responsibility of staff to ensure their assessments remain up to date and relevant.
- The financial position for this year remains on track with a forecast breakeven position.
- Voice over IP has been rolled out and there are further licences available for those who need them.
- Further lateral flow device testing kits have been received and are available to distribute to those staff who are ready for their second box.
- Arrangements remain in place with the Independent Sector who are providing capacity to support service delivery where needed.
- Positive media coverage, including nationally has been seen over recent weeks with a key focus on the tremendous efforts of our staff and also key messages around hands, space, face.
- Two new Clinical Directors have been appointed within Children, Women and Diagnostics Division.
- Significant focus on staff wellbeing being driven both corporately and localised programmes within the Divisions. Restoration and Recovery of staff will be an organisational priority as the organisation moves out of Covid.
- A response to the Ockenden Report has been prepared and is ready for approval of the Board. Whilst specific to maternity, there are key learning points which all specialities were asked to take note of.

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 11th December to 11th January, 1 contract award, which met this criteria, was made, as follows:

- **COVID19: Supply of Multiplex PCR reagents for detection of SARS CoV2/Influenza/RSV (REAF 4028)** supplied by Prolab Diagnostics at a total cost of £21,945,924.00, for the period 01/01/21 – 31/12/22, approved on 08/01/21

In addition, the following REAFs were approved by the Performance and Finance (PAF) Committee in January (additional information was requested on 7210 & 7188 which has subsequently been provided), and require Board approval due to their value:

Nursing Master Vendor Contract (REAF 7210) – Extension

Contract Value	£3,700,000.00 incl. VAT
Duration	01/04/21 – 31/03/22
Supplier	Medacs

Savings – £74,000.00 Negated Inflation Savings

Medical Locum Temporary Staffing (REAF 7188) – Extension

Contract Value	£6,078,655.00 incl. VAT
Duration	01/04/21– 31/09/21
Supplier	Various

Savings – £60,786.55 Negated Inflation Saving

CCN to Molecular testing system for Enteric Pathogens into Roche MES (REAF 3402)

Contract Value	£2,361,785.00 incl. VAT
Duration	01/04/21– 31/03/26
Supplier	Roche

Savings – No procurement related savings but there are VAT associated savings with this contract.

Patient Monitoring Trust Wide 10 year rolling Replacement (REAF 7192)

Contract Value	£6,609,806.98 incl. VAT
Duration	Capital Purchase
Supplier	Philips Healthcare Systems

Savings – £1,192,955.88 Cost Avoidance

The Trust Board are asked to approve the above REAFs.

2. Consultant Appointments

The following table provides a summary of medical staff interviews which have taken place during January 2021:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Deputy Director Research and Innovation	New	TBC	TBC
Consultant in Emergency Medicine	Vacancy	TBC	TBC
Locum Musculoskeletal Radiologist	New	Yes	TBC
Consultant Cancer Colorectal Surgeon	Vacancy	Yes	TBC
Consultant Vascular Interventional Radiologist with Thrombectomy x 2	Vacancy	Yes	TBC

The following table provides a summary of medical staff who have joined the Trust during January 2021:

Post Title	Reason for advertising	Start Date
Clinical Director T&O	Vacancy	01/01/2021
Clinical Director Obstetrics & Gynaecology	Vacancy	01/01/2021
Locum Consultant Cardiologist	Extension	01/01/2021
Locum Consultant Foot and Ankle Surgeon	Extension	02/01/2021
Consultant Anaesthetist	Extension	02/01/2021
Clinical Director of Paediatrics	Extension	04/01/2021
Locum Consultant Anaesthetist (TRA)	Vacancy	04/01/2021
Locum Consultant in General Surgery with interest in Colorectal Surgery	Extension	17/01/2021
Clinical Lead - Upper GI Surgery	Vacancy	21/01/2021

The following table provides a summary of medical vacancies which closed without applications / candidates during January 2021:

Post Title	Closing Date	Note
Locum Vascular Surgeon	03/01/2021	No applications
Consultant in Acute Medicine	03/01/2021	No applications
Clinical Lead for Neurology	03/01/2021	No applications
Locum Vascular Consultant	12/01/2021	No suitable applications

3. Support During Covid-19

During the month I have been delighted to welcome additional resource from a number of different external organisations including the armed forces and Stoke City Council who have stepped in to provide essential support on our medical wards and in critical care at a time when we are treating more Covid-19 patients in our wards and intensive care than ever before. They have brought positivity to our clinical areas when many of our staff are feeling weary and I am hugely grateful for their support.

Alongside this external support, I have to mention the huge efforts made by our own staff who have been working in areas they are unfamiliar with to support our patients and our colleagues. Thanks to this flexibility we have been able to continue to provide care to the sickest of our patients. However, I am also very much aware that many of our staff are still working tirelessly in their existing roles and have done so non-stop since the start of the pandemic.

4. Critical Care Capacity

We have answered the NHS England request to increase our intensive care capacity by 200% and during the month the executive team met all the divisions to go through their surge plans in preparation for a further potential peak in the last week of January, which would see even more significant challenges. More local modelling has indicated that we may already be at our peak although planning has continued should the national modelling be correct. Our staff are working hard to prepare for this next potential influx of Covid-19 patients while treating the significant number of patients we already have on our wards and in critical care. Amazingly, this is all while we still continue to treat urgent and cancer patients wherever possible.

5. Vaccination Programme

I was able to discuss some of our current pressures and the roll out of our vaccination programme in a podcast with Jack Brereton MP recently. Joined by Michelle Rhodes, it was great to highlight how many over 80 year olds, care home workers and indeed our own staff have now received their first dose of the vaccine. Our Hospital Hub has now vaccinated over 20,000 people which is fantastic.

I have thoroughly enjoyed being able to help deliver a significant number of vaccines and seeing the relief and gratitude of those receiving the vaccine and the camaraderie between vaccinators has been very rewarding.

A dash board is being developed to demonstrate progress whilst we recognise the numbers going through our Hospital Hub will diminish as we conclude staff vaccination. We are now starting to prepare for the delivery of second vaccines to all those we gave the first vaccine. We have also offered our hub as a resource to support the system vaccination plan but to date we are advised this is not required as they believe good progress is being made through the PCNs

6. Project STAR

The final approval for the demolition works at the old Royal Infirmary site has now been given and demolition on site has commenced. This represents a significant milestone in the delivery of Project STAR. This is about much more than removing risks associated with derelict buildings but it is also about selling surplus land that is no longer needed for clinical services and supporting system partners in regenerating this part of Stoke. My thanks go to local residents for the patience and understanding over many years whilst we have worked up these plans, to key external stakeholders for their support in developing our plans and to our Estates Capital Development Team for all their hard work on progressing this critical project.

7. Workforce Development

We have continued to look at ways of increasing our workforce and have recently seen a number of exciting developments. This year we will be supporting 30 of our Assistant Practitioners through a two year apprenticeship to become Registered Nurses and a further 10 nursing assistants on a four year apprenticeship to become Registered Nurses. We hope this will be the first of many and we will continue to grow some nursing assistants into nursing associates. Our first nursing associates are due to qualify in the next few months and I look forward to welcoming them into the workforce when their help is really needed.

In addition, 100 of our overseas qualified nurses currently working as nursing assistants have taken up the offer to support them through the English requirements to enable them to proceed with their registration with the NMC. This is a long awaited option and we wish them every success on their journey where we aim to give them every support.

Finally, working with Health Education England (HEE), we are also looking to recruit additional nurses from overseas. As a result of the financial support offered from HEE we have been able to significantly

increase the number we are able to recruit. Interviews have commenced and we look forward to welcoming new staff towards the end of April.

8. Who's Your Hero Campaign

Following on from the success of our virtual Christmas where we saw nearly 40,000 people view our videos, our UHNM Charity is launching an appeal to get everyone involved; 'Who's Your Hero'. There are many unsung heroes who provide support to their local communities' day in day out. People who empty our bins, deliver our post, work in our shops, provide healthcare and work here at UHNM are just some who have gone over and above during the pandemic. The charity want to recognise people who might be working in some of the essential services or might have volunteered to help someone in their hour of need with an act of kindness. We have asked all of our staff if they have a local hero, someone who has gone above and beyond, and they want to give a big shout out to them, to nominate them or let us know by using #UHNMYourHero in their social media posts.

9. Staff Rest Facilities

Earlier in the month, members of the critical care team were able to take time out from caring for Covid-19 patients to open the new staff rest areas at Royal Stoke as part of the first phase of generating improved staff facilities for all our staff.

UHNM Charity has funded the temporary staff rest areas outside the main entrance and the Trent Building (behind A-block) thanks to the generosity of our local communities who donated during our Wellbeing Appeal and grants from the National Association of NHS Charities and Denise Coates Foundation.

Additional facilities at Royal Stoke will open next month and proposals for a new rest area in Ward 7 at County Hospital are currently being worked up.

10. Community Rapid Intervention Service

I was delighted to finally spend some time with the Community Rapid Intervention Service (CRIS) which has being providing essential care and assessments in the community, supporting people at home and helping them avoid an admission to our hospitals. This valuable service has been up and running for two years but during winter and one when we are living through a pandemic and we need people to avoid coming to hospital unless they really need to, the service has come into its own. CRIS has seen a significant and continuing increase in the number of patients being referred to them which is great and gives alternatives to other professionals than sending patients to our Emergency Departments. As well as supporting our care homes in Stoke-on-Trent with infection control and PPE measures the team have worked tirelessly to care and treat people in their own homes and I thank them for welcoming me so warmly. I also look forward to hearing about their plans for the future development of their service.

11. Financial Special Measures (FSM)

In October 2019 our FSM position was reviewed by the national NHSE/I team where it was agreed that UHNM should exit FSM. Due to the pressures of the Pandemic we are yet to receive written confirmation however, after discussion with NHSE/I Midlands Regional Director, it was agreed that we could now publicise this position. I am grateful for the endeavours of our staff since 2017 when the Trust was put into FSM, as without them, we would not have achieved this.

We are all delighted to have achieved this although we do not underestimate the financial challenge going forward.

12. Changes to the Executive Team

I am saddened to announce the retirement of Mark Bostock, Director of IM&T. Mark will leave the Trust at the end of June 2021 after 7 years' service. We will have plenty time to say our goodbyes and to more formally recognise Mark's enormous contribution and leadership of the Trusts Digital Transformation agenda

Recruitment is underway and we will keep Board appraised of progress.

Quality Governance Committee Chair's Highlight Report to Board

20th January 2020

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Increased volume of Covid patients, including level 3 Critical Care; started to take London patients to ease their capacity challenges. • Matters of concern highlighted by NHSIE following their IPC visit although recognised that a number of additional actions were being taken in response • Number of nosocomial infections being observed • Increase in risk associated with Harm Free Care on the Board Assurance Framework • An increase in patient falls has been observed and a focussed review undertaken; this was considered by the Committee which outlined the actions being taken	• Significant, ongoing actions in place associated with Infection Prevention and Control – comprehensive presentation provided to the Committee covering all aspects as part of 'deep dive' session • Ongoing development and review of the IPC Board Assurance Framework, which is being underpinned by the establishment of a Task Force which is focussing at the outset on sources of assurance and they are reflected accurately within the BAF • Revised process / governance arrangements introduced for mortality reviews, which includes Duty of Candour, which was supported by the Committee • Quality and Safety Report continues to be developed and now includes staffing indicators which was positive for the Committee to see • Review of increase in Needlestick Incidents will be undertaken and reported to the Committee • The Committee requested the development of metrics to allow for oversight of changes in status of wards, i.e. blue / purple • Review of CQC Insights Report undertaken with responses to 'red' areas provided; this will be reflected within the next report
Positive Assurances to Provide	**Decisions Made**
• Lots of support from the City Council and the Military with Critical Care, to support staffing challenges. F1's have been deployed into Critical Care this week. • Significant efforts being made to deliver the vaccination programme which has been positive, with lots of volunteers helping out. • Comprehensive assessment and action plan and assurance framework completed in response to the Ockenden Report; overview being presented to the Trust Board in February • Strong relationships in place with Maternity Voices partners, with some very positive feedback received – a story will be shared with the Board in the near future • 100% written Duty of Candour reported for November 2020	• There were no matters requiring decision at the meeting
Comments on Effectiveness of the Meeting	
• Very comprehensive deep dive presentation in to Infection Prevention and Control • Recognise that number of members present was challenged towards the end of the meeting as a result of operational pressures	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Executive Directors Update including Covid-19	Information	8.	CQC Insight Report Update	Assurance
2.	Deep Dive: Infection Prevention Board Assurance Framework Q4 2020/21	Assurance	9.	Q3 Board Assurance Framework 2020/21	Assurance
3.	Covid-19 Mortality Update and Review Process	Approval	10.	Q3 Fire Report	Information
4.	Ockenden Report: UHNM Assessment and QI Plan	Assurance	11.	Infection Prevention HAI Report Q3	Information
5.	Ockenden Report: Assessment and Assurance Framework / Action Plan	Assurance	12.	Executive Health & Safety Group Highlight Report	Information
6.	Month 8 Quality and Safety Report	Assurance	13.	Quality and Safety Oversight Group Highlight Report	Information
7.	Review of Increased Falls during November 2020	Assurance	14.	Review of Meeting Effectiveness, Business Cycle and Matters for Escalation to the Trust Board	Approval

3. 2020 / 21 Attendance Matrix

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

Attended | Apologies & Deputy Sent | Apologies

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	3rd February 2021
Report Title:	Infection Prevention Board Assurance Framework Q4 2020/21	**Agenda Item:**	8.
Author:	Helen Bucior, Infection Prevention Lead Nurse Emyr Philips , Associate Chief Nurse Infection Prevention/Deputy DIPC Claire Rylands, Associate Director of Corporate Governance		
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

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

Background

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

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

Assessment

- There are a number of systems, 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 control are to be identified and implemented in order to reduce the level of risk
- 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.

Key Recommendations:

To update the Committee on Trust position against self-assessment compliance framework with 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 4 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	High 9	High 9		→
BAF 2 Page 13	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	Mod 6	Low 3	Mod 6		↑
BAF 3 Page 19	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	High 9	High 9	High 9		→
BAF 4 Page 22	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.	Mod 6	Mod 6	Low 6		→
BAF 5 Page 25	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	Low 3	Low 3		→
BAF 6 Page 28	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	High 9	High 9		→
BAF 7 Page 32	Provide or secure adequate isolation facilities.	Mod 6	Low 3	Mod 6		↑
BAF 8 Page 34	Secure adequate access to laboratory support as appropriate.	Mod 6	Mod 6	Low 3		↓
BAF 9 Page 38	Have and adhere to policies designed for the individuals and provide organisations that will help prevent and control infections.	Mod 6	Low 3	Mod 6		↑
BAF 10 Page 41	Have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	Mod 6	Mod 6	Low 3		↓

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	3	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 4
Consequence:	3	3	3			Consequence:	3	
Risk Level:	9	9	9			Risk Level:	3	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
1.1	Infection risk is assessed at the front door and this is documented in patient notes.	• On arrival in ED patients are immediately identified either asymptomatic for COVID -19 and apply infection prevention precautions. • ED navigator in place • Colour coded areas in ED to set out COVID and Non COVID areas. This has been revised in September mirror inpatient zoning. Purple ED with blue single rooms and respiratory assessment unit • Aerosol generating procedures in single rooms with doors closed • ED navigator records patient temperature and asked COVID screening questions. Patient then directed to either remain in purple or blue single room • ED pathways and SOP	• From June 2020 IP team to review patients that are found COVID positive and nursed in bay to ascertain compliance with pathway and IP control measures are in place Review pathways and identify theme • Theme report to IPCC • Pre AMS check COVID -19 screening results, if patient arrives in green area with no COVID screen a Datix is	

		• When ambulance identify suspected COVID patients are received in respiratory assessment Unit ED • All patients screened for COVID -19 when decision made to admit • Maternity pathway in place • Elective Pre Amms Plan to swab • Patients72 hours pre admission SOP in place • Radiology /interventional flow chart • Children's unplanned admission. ED Navigator asked COVID questions then child directed to either RED of Green Areas. • All children, symptomatic or asymptomatic are swabbed in child health. This is recorded within their medical records, placed onto the nursing and medical handover so that we are made of the results and whether we need to chase if not received within a timely manner. The patient flow reports to the Child Health tactical meeting every morning how many children have been swabbed result and any outstanding • All children swabbed are placed into a sideward upon receiving their result are either kept within a side ward or moved to a bay if the swab is negative. • Screening for patients on systematic anticancer treatment and radiotherapy • Out patient flow chart in place • Thermal imaging cameras in some areas of the hospital • Iportal alert in place for COVID positive	raised.	

		patients • Extremely vulnerable patient placement added into new COVID ward round guidelines (October 2020)		
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.	• All patients admitted to the Trust are screened for COVID -19 • All patients are rescreened on days 4-6 • Critical care plan with step down decision tree • COVID-19 Divisional pathways • Step down guidance available on COVID 19 intranet page	• Unannounced visits for clinical areas with clusters or HAI cases of COVID-19 • Review of HCAI COVID cases by IP Team • Datix /adverse incidence reports for inappropriate transfers	• NHSI key point 4 : Patients are not moved until at least two negative test results are obtained, unless clinically justified
1.3	Compliance with the national guidance around discharge or transfer of Covid-19 positive patients.	• Infection prevention step down guidance available on Trust intranet • All patients who are either positive or s are positives are advised to complete self –isolation if discharged or transferred within that time frame  guidance-on-screeni ng-and-testing-for-cc  Patient Information Lealfet - Contact 202 • All patients are screened 48 hours prior to transfer to care homes • New UHNM ward round guidance October 2020. This also included placement of the extremely vulnerable patient  covid-ward-rounds-g uidance-161020-final	• Datix/adverse incidence reports	

1.4	**All staff (clinical and non-clinical)** are trained in putting on and removing PPE, know what PPE they should wear for each setting and context and have access to the PPE that protects them for the appropriate setting and context as per national guidance. Linked NHSIE Key Action 3: Staff wear the right level of PPE when in clinical settings, including use of face masks in non-clinical settings.	• Key FFP3 mask fit trainers in place in clinical areas • PPE posters and information available on the Trust COVID -19 page. This provides the what, where and when guide for PPE • Infection Prevention Questions and Answers Manual include donning and 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 Clinical Group reviews any proposed changes in PPE from the clinical areas • Link to Public Health England donning and doffing posters and videos available on Trust intranet • Chief Nurse PPE video • Extended opening hours supplies Department • Risk assessment for work process or task analysis completed by Health and Safety • PHE announced from 11th June 2020 all staff to wear mask in both clinical and non-clinical health care setting	• Daily stock level of PPE distributed via email and agenda item for discussion at COVID-19 tactical group • IP complete spot check of PPE use if cluster/OB trigger • Records of Donning and Doffing training for staff trained by IP • A number of Clinical areas have submitted PPE donning an doffing records to the IP team • Donning and Doffing training also held locally in clinical areas • Cascade training records held locally by Divisions • Sodexo and Domestic service training records	• Training completed in areas - records are held locally by clinical areas, these include Divisional donning and doffing training records and Divisional FFP3 mask fit training records • FFP3 Training records require central holding/recording?
1.5	National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way.	• Notifications from NHS to Chief nurse/CEO • IP team COVID lead checks Public Health England webpage daily (Monday-Friday) for updates • Changes raised at -19 clinical groups which was held originally twice weekly, reduced to weekly and now increased	• Clinical Group meeting action log held by emergency planning	

		back to twice weekly due to surge of COVID. • Purpose of the Clinical Group - The Group receive clinical guidance and society guidance which is reviewed and if agreed used to advise clinical teams after approval at Exec COVID -19 meeting which is held twice monthly. • Tactical group – The tactical Group held daily. The Group made decided and agreed tactical actions into the incident. • Chief nurse updates • Changes/update to staff are included in weekly Facebook live sessions • COVID -19 intranet page • COVID -19 daily bulletin with updates • IP provide daily support calls to the clinical areas		
1.6	Changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted.	• Incidence Control Centre (ICC) Governance • Clinical Group , Divisional cells, Workforce Bureau , Recovery cells subgroup feed in to tactical group. • COVID Gold command , decisions /Assurance reported to Trust Board Via CEO Report/COO	• Meeting Action log held by emergency planning • Trust Executive Group Gold command – Overall decision making and escalation • Tactical, Operational Delivery Group - The delivery of the objectives and benefits, and programme communications COVID 19 response and R&R. Co - ordination of resources. Escalation forum for linked Groups and Cells ensuring that the interdependencies	

			are effectively managed, including system. Makes recommendations to Gold Command for key decisions. • Clinical steering Group – Coordinate clinical decision – making to underpin continual service delivery and COVID 19 related care • Workforce Group – Lead the plan and priorities for our people recovery . Health and Wellbeing. Agree significant pipeline changes in working practices. Agree the impact if change made during COVID and priorities to support recovery • Divisional Groups – Agree infection Prevention measures  COVID19RRGOVERNANCE NOV20v1.pptx	
1.7	Risks are reflected in risk registers and the Board Assurance Framework where appropriate. • Linked NHSIE Key Action 5: Daily data submissions have been signed off by the Chief Executive, the Medical Director or the Chief Nurse and the Board Assurance Framework is reviewed and evidence of reviews is available.	• Risk register and governance process • Datix incidents • Board assurance document standing agenda item Trust board and IPCC. • TOR • Outbreak IImarch submissions are copied to Chief Nurse/DIPC and exec Team • Outbreak areas are included in daily tactical meeting • Definite Nosocomial COVID 19 case	• IP risks are agenda item at Infection Prevention and Control committee (IPCC) • Definite Nosocomial COVID 19 case numbers are in included in Quality Performance Report • Nosocomial death review process – paper to Quality and Governance Committee 20th January 2021	

	• Linked NHSIE Key Action 9: Local Systems must assure themselves, with commissioners that a Trust's infection prevention and control interventions are optimal, the Board Assurance Framework is complete and agreed action plans are being delivered.	numbers are in included in Quality Performance Report • Nosocomial death review process		
1.8	Robust IPC risk assessment processes and practices are in place for non Covid-19 infections and pathogens.	• IP questions and answers manual • Section in IP questions and answer manual 2.1 priority of isolation for different infections and organisms • Sepsis pathway in place • Infection Risk assessment in proud to care booklets and admission documentation • C.diff care pathway • IP included in mandatory training • Pre Amms IP Screening • Birmingham paused ribotyping service for C.DIFF due to COVID-19. During periods of increased incidence ribotyping is useful to establish person to person transmission, Leeds Hospital are now undertaking this service • Proud to care booklets revised an reinstated August/September 2020	• MRSA screening compliance • Monthly Sepsis Compliance audits. Screening compliance for sepsis and time to antibiotics for Red flag patients • IP audits • Infection Prevention Health care associated infection report, including submitted to monthly to Quality and Safety. • Submission of Infection figures to Public Health England. Clostridium difficile, MRSA blood stream infections (bacteraemia) and Gram Negative blood stream infections • Seasonal influenza reporting • Audit programme for proud to care booklets	• Universal MRSA Screening of all emergency admission in emergency portals paused due to COVID -19. Only MRSA weekly screening continued on critical care/HDU both adult and paediatric, haematology/oncology wards and renal ward, this is under review.

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 4 Progress Report	BRAG
1.	1.1	Up- to- date COVID -19 Divisional pathways	ACN's	30/09/2020	Associate Chief Nurse contacted and request made for COVID -19 pathways 28th July 2020. ED pathways in place and also County to Royal transfer of COVID positive patients. Divisional restoration plans in progress	
2	1.1	Revised pathways to include actions for extremely vulnerable patients who are admitted into the Trust	ACN's	31/10/2020	4th September Chief Nurse DIPC request at senior meeting that extremely vulnerable patients are included in revised pathways. October 2020 Extremely vulnerable patient recommendations included into the COVID ward round guidance document. November 2020 – Confirmation from ED County highly vulnerable patients are admitted into single cubicle. Consultant ED Royal confirms the same process. Children's – highly vulnerable have direct access to ward	
3	1.2	NHSI key point 4 : Patients are not moved until at least two negative test results are obtained, unless clinically justified	Microbiologist/ ACN's	13/12/2020	Testing and re testing, Interpretation of swabs and step down of IP precaution process in place at UHNM. Suspected or positive patients are moved on clinical need/assessment and in line with UHNM step down process. For patients who test negative on admission re screening is undertaken. 17th November NHSI guidance recommended that the second test is taken on day 3 after admission and day 5-7 after admission. Implementation of the new guidance is underway and a manual prompt is provided to the clinical areas. (Days 4 and 6 admission day counted as day 1). Waiting for 2 negative before COVID negative and not suspected patients are moved does not always occur.	
3	1.3	Patient COVID -19 discharge information letter for patient who are discharged but contact of a positive case	IP Team	31/11/2020	Action at COVID weekly meeting was to create an information leaflet for patients and household members on discharge, with information on isolating, symptoms and useful information for informing the local authorities and the test and trace system. 6th November leaflet sent out for comments 22/12/2020 to Clinical Group for approval. Progressed to Outbreak Group and Tactical Group , minor changes made	

					12th December 2020 Submitted to Gold	
4	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. Health and Safety ESR will be up and running for the purpose of recording fit test records as soon as the Trust gives the go ahead to procure Portacount fit test systems, this is a project lead by Health and Safety 15th December – update from Health and Safety. Approval given to proceed to Business case	
5.	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). Current process that clinical areas hold their own training records and can also enter basic details on OLM. A number of clinical areas have also forwarded training records to the IP Team. IP Team. IP have a list of mask fit testers.	
6.	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	

7.	1.8	To complete an analysis (Advantages and disadvantages) to reinstating MRSA screening as per UHNM policy	Deputy Director Infection Prevention	31/12/2020	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 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. October MRSA screening is around 50% of pre COVID screening, laboratory does not have the capacity to process COVID work and level of MRSA screens pre COVID. Paper to November IPCC. This continues to be under review during COVID Pandemic.	
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 04/09/2020 we are experiencing problems in receiving ribotyping results back from Leeds. Usually they would arrive electronically. UHNM have contacted Leeds and are awaiting a resolution with their IT team and the PHE reference electronic reporting system. Ribotype now being received from Leeds and added to ICNET patient case	

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**	1	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 4
Consequence:	**3**	3	3			Consequence:	**3**	
Risk Level:	**6**	3	6			Risk Level:	**3**	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
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 own teams • Zoning of hospital in place with cleaning teams • UHNM clinical guidance available on the intranet • Trust COVID -19 clinical group established to discuss and agree clinical pathways • Nice Guidance and National Clinical Guidance COVID-19 available on the Trust intranet • Links to PHE guidance on assessing COVID-19 cases available on Trust intranet page	• Clinical Group action log • PPE training records which are held locally	

		• Education videos clinical and non - clinical videos on Trust intranet • Process and designated staff for ED to ensure cleans are completed timely		
2.2	Designated cleaning teams with appropriate training in required techniques and use of PPE are assigned to Covid-19 isolation or cohort areas.	• SOP and cleaning method statements for domestic teams/Sodexo • PPE education for Domestic /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	• Spot check assurance audits completed by Sodexo and retained during COVID period • 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 • High level disinfectant , Virusolve and Tristel in place	• C4C audits reinstated July 2020 these results are fed into IPCC • Spot checks • Terminal clean request log • Patient survey feedback	
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 process (barrier clean) included in Infection Prevention Questions and Answers manual • Process in place for clinical areas with clusters and HAI cases of COVID -19 requiring increased cleaning and /or terminal cleans	• Barrier clean request log held by Sodexo • IP spot checks for clinical areas with clusters of COVID -19 or HAI cases of COVID - 19 • Disinfectant check completed during IP spot	• NHSI visit highlighted cleaning issues both environment and nursing equipment • Environmental damage highlighted during NHSI visit - peeling edges of floor

			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 frequency) process in place which includes touch points		
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 • Virusolve wipes also used during height of pandemic	• Evidence from manufacture that these disinfectants are effective against COVID -19 • Evidence of Virusolve weekly strength checks , held locally at ward /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		
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 immediate after PPE removal by groups of staff (at least twice a day).	• Cleaning of frequently touch points included in Barrier clean process • Offices and back offices also supplied with disinfectant wipes to keep work stations clean. • Non- invasive medical equipment must be decontaminated after each use. IP Q+A manual	• IP checks • Barrier clean request log • Terminal clean request log	• To check protocol for none barrier clean areas and also electronic equipment

	Linked NHSIE Key Action 1: All high touch surfaces and items are decontaminated multiple times every day – once or twice a day is insufficient.			
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 • SOP for Visor decontamination in time of shortage	• 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 covers decontamination • Air powered hoods – SOP in place which includes decontamination process for the device • Re usable FFP3 Masks – Sundstrom/Elipse. SOP's in place which includes the decontamination process • Medical device policy • Availability of high level disinfectant in clinical areas • Sterile services process • Datix process	• 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 • UHNM has established a Ventilation Safety Group as recommended by the Specialised Ventilation for Healthcare Society in order to provide assurance to the Trust Board on the safe operation and reduction in risk of infection transmission through ventilation systems. TOR written • The Trust also appointed external authoring Engineers. This is in line with the NHS estates best practise and guidance from Health Technical Memorandum (HTM) namely 03/01 Specialised Ventilation for Healthcare Premises.	• Estates have planned programme of maintenance • The Authorising Engineer Ventilation will provide external independent specialist advice and support as well as carrying out an annual audit for system compliance.	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 4 Progress Report	BRAG
1.	2.3	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. 04/09/2020 The C4C audits programme are now covering all areas but are not fully multi-disciplinary audit team e.g. only CPM on them due to social distancing. (yet to invite Sodexo, Nurse) We are likely to expand this out during October 2020 December 2020 – email confirmation from Sodexo and retained that C4C audits are in place	

2	2.4	To address cleaning issues and environmental damage highlighted during NHSI visit	Head of CPM Estates, Facilities & PFI Division	14/12/2020	Feedback from NHSI provided to Sodexo and action plan devised  Action Plan Following NHS England NHS Im  NHSI action plan Jan 2021.docx	
3	2.4	To address dirty nursing equipment and commodes, plus computer on wheels	ACN'S / IP/ Deputy Head of IM&T	30/12/2020	Dirty nursing equipment and commodes found during NHSI Visit. These were address at time. Action for IM&T re computer. Terminal clean check list to be revisited to set out roles and responsibilities for cleaning. Full ward terminal clean check list agreed by IP , Sodexo /retained and County. IT have reviewed a number of computers on wheels and confirmed high level of dust. The computer is housed is a box and would require to be unlocked and vacuum, IT have identified that there is a danger that the cables can be disturbed during this process. The two companies used by UHNM Ergotron and Parity do not offer a cleaning service IT have contacted clinical technology to see if they can provide cleaning service For the air intakes that have dust collection this would require a wipe over	
4	2.8	All high touch surfaces and items are decontaminated multiple times every day – once or twice a day is insufficient. • Electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily. • Cleaning of communal toilets after each use inpatient areas – Letter -CEM/CMO /2020/043 24TH December 2020	Head of CPM Estates, Facilities & PFI Division IP Team		To revisit high touch points protocol to check frequency of clean for area that area not on barrier cleans Letter raised at IPCC 25/01/2020	

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	3	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:	2	End of quarter 4
Consequence:	3	3	3			Consequence:	3	
Risk Level:	9	9	9			Risk Level:	6	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
3.1	Arrangements around antimicrobial stewardship are maintained.	• 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 • Gap in control identified as there is no current escalation of areas not complying with antimicrobial guidelines.

			generating action plans for ward teams	
3.2	Mandatory reporting requirements are adhered to and boards continue to maintain oversight. Linked NHSIE Key Action 5: Daily data submissions have been signed off by the Chief Executive, the Medical Director of the Chief Nurse and the Board Assurance Framework is reviewed and evidence of reviews is available. Linked to NHSIE Key Action 10: Local systems must review system performance and data, offer peer support and take steps to intervene as required.	• Quarterly point prevalence audits maintained by AMS team at UHNM despite many regional Trusts not undertaking any more. • 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 4 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. Feedback meeting completed 4th September 2020. – Senior meeting. To review escalation of areas that are not compliant with antimicrobial guidelines. New point prevalence audits undertaken by AMS pharmacists during December 2020 to provide updated snapshot for ACNs	
2.	3.1	To review current escalation of areas that are not compliant with antimicrobial guidelines	DIPC	31/10/2020	Raised at September Antimicrobial Pharmacist Group and IPCC. Escalation process to be agreed. Meeting between Antimicrobial Pharmacist and Deputy DIPC undertaken. Escalation process to be discussed at November Antimicrobial Stewardship Group. January 2021 discussed at Trust Board to be discussed at ASG, then to IPCC	

					Following discussions between DIPC and AMS Pharmacist a draft escalation protocol has been produced and was presented at January ASG as the November meeting cancelled (clinical pressures) the group have 2 weeks to. Will thereafter be forwarded to IPCC for discussion and ratification.	

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	2	2		There is a substantial amount of information available to provide to patients this requires continuous update as national guidelines change	Likelihood:	1	End of Quarter 3
Consequence:	3	3	3			Consequence:	3	
Risk Level:	6	6	3			Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
4.1	Implementation of national guidance on visiting patients in a care setting.	• To help protect patients and staff from Covid-19, the NHS suspended all visiting to hospitals. This national suspension has now been lifted and visiting is to be introduced in some areas of our hospitals, subject to certain conditions. From Monday 17 August 2020 visiting will be phased in across some areas and will be allowed in the West Building at Royal Stoke and in Wards 7, 12, 15 at County Hospital. All visiting will have to be pre-booked and relatives will be provided with the correct information and contact details to book in advance. Visitors will be instructed to wear face masks and other PPE if they are providing	• Monitored by clinical areas • PALS complaints/feedback from service users	

		bedside care. We will continue to monitor prevalence and changes in visiting restrictions will be reinstated with immediate effect should it be necessary • The only exceptional circumstances where on visitor , an immediate family member or 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 • COVID-19 information available on UHNM internet page		
4.2	Areas in which suspected or confirmed Covid-19 patients are being treated are clearly marked with appropriate signage and have restricted access.	• ED colour coded areas are identified by signs • Navigator manned ED entrance • Hospital zoning in place	• Daily Site report for county details COVID and NON COVID capacity	
4.3	Information and guidance on Covid-19 is available on all trust websites with easy read versions.	• COVID 19 section on intranet with information including posters and videos	• COVID-19 page updated on a regular basis	
4.4	Infection status is communicated to the receiving organisation or department when a possible or confirmed Covid-19 patient needs to be moved.	• Transfer policy C24 in place , expires November 2020 • IP COVID step down process in place	• Datix process	

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 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. Policy for the Handover, Transfer and Escort Arrangements of Adults patients between wards and Departments which Expires November 2020. October IP have now submitted IP/COVID information for incorporation in to this Policy.	
2.						
3.						
4.						

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	1	1		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 admission screening	Likelihood:	1	End of quarter Q2
Consequence:	3	3	3			Consequence:	3	
Risk Level:	9	3	3			Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
5.1	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 colour coded area • All patients who are admitted are now screened for COVID 19	• June 2020 IP team review patients that are found COVID positive and nursed in bay to ascertain compliance with pathway and IP control measures are in place Review pathways and identify theme . COVID 19 -Themes report to IPCC • ED pathways including transfer of COVID positive patient from County to Royal Hospital	
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	• Hospital entrances Mask dispensers and hand gel available	

		Monday15th June • ED navigator provide masks to individual in ED • Mask stations at hospital entrances • Covid-19 bulletin dated 12th June 2020 • 28th August updated guidance from PHE recommends in patients to also wear surgical masks if tolerated and does not compromise care		
5.3	Ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff. Linked NHSIE Key Action 6: Where bays with high numbers of beds are in use, these must be risk assessed, and where 2m can't be achieved, physical segregation of patients must be considered and wards are effectively ventilated.	• Colour coded areas in ED to separate patients, barriers in place. • Screens in place at main ED receptions • Colour coded routes identified in ED • Social distancing risk assessment in place • Perspex screens agreed through R+R process for other reception area • Social distance barriers in place at main reception areas • Chief Nurse/DIPC visited clinical areas to review social distancing within bays. A number of beds have been removed throughout the Trust.	• Division/area social distancing risk assessments	
5.4	For patients with new-onset symptoms, it is important to achieve isolation and instigation of contact tracing as soon as possible.	• Process for isolation symptom patient in place • Process for cohorting of contacts • Contacting patients who have been discharged from hospital then later found to be a close contact of a COVID-19 positive case , patient to be informed by the clinical area and self- isolation advice provided as per national guidance • https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance/stay-at-home-guidance-for-households-with-possible-coronavirus-covid-19-infection •	• If patient found to be positive in the bay and exposing other patient. IP liaise with clinical are, apply bay restrictions. • Patient who tested negative on admission and remain an inpatient are retested for COVID days 4 and 6	

5.5	Patients with suspected Covid-19 are tested promptly.	• All patients who require overnight stay are screened on admission. All patients that test negative for COVID 19 are retested on day 4 and 6	• 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 • COVID 19 positive patients are cared for on blue wards or single rooms or COVID 19 cohort areas on critical care unit	• Datix process • IP reviews	
5.7	Patients who attend for routine appointments and who display symptoms of Covid-19 are managed appropriately.	• Restoration and Recovery plans • Thermal temperature checks in imaging, plan to extent to other hospital entrances • Patient temperature checks in outpatient department • Mask or face coverings for patients attending appointments from Monday 15th June	• Datix process	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 4 Progress Report	BRAG
1.	5.1	Up- to- date COVID -19 Divisional pathways	ACN's	30/09/2020	Associate Chief Nurse contacted and request made for COVID -19 pathways 28th July 2020. ED pathways in place and also County to Royal transfer of COVID positive patients. Divisional recovery plans and identification of COVID wards due to second wave continues	
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	IP guide liaise with clinical areas to identify closed contacts, close contact are isolated for remainder of hospital stay for 14 day or if discharged home continue isolation at home. Clinical team inform patient who have already been discharged COVID intranet page. October COVID -19 ward round guidance	
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	3	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 Q4
Consequence:	3	3	3			Consequence:	3	
Risk Level:	9	9	9			Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
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 • SOP and training for reusable FFP3 masks • SOP and training for use of air powered hoods • Critical care - Elipse FFP3	• Training records • IP spot checks	

		reusable introduced • PPE posters are available in the COVID -19 section of trust intranet page		
6.3	A record of staff training is maintained.	Mask fit strategy in place	• 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 (Sundstrum))	• SOP 's available on Trust intranet • Training logs held divisionally for air powered systems • IP training log for air powered systems key trainers and distribution of reusable FFP3 masks (Sundstrum)	
6.5	Any incidents relating to the re-use of PPE are monitored and appropriate action taken.	• PPE standard agenda at COVID Tactical meeting • Datix process • Midlands Region Incident Coordination Centre PPE Supply Cell	• Tactical group action log • Datix process • Incidents reported by procurement to centre PPE supply Cell	
6.6	Adherence to the PHE national guidance on the use of PPE is regularly audited.	• 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	• Monthly hand hygiene audits completed by the clinical areas • Infection Prevention hand	

	Linked NHSIE Key Action 1: Staff consistently practices good hand hygiene.	• Poster for hand hygiene technique displayed at hand wash sinks and stickers on hand soap and alcohol dispensers • Alcohol gel availability at the point of care	hygiene audit programme. Overview of results fed into infection Prevention committee • Independent hand hygiene audits completed by IP Senior Health Care	
6.8	The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance Guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas	• Paper Towels are available for hand drying in the Clinical areas	• IP audits to check availability	
6.9	Staff understand the requirements for uniform laundering where this is not provided on site.	• Instruction for staff laundering available on the Trust COVID - 19 section of intranet • Dissolvable bags to transport uniforms home available for staff • Communications /daily bulletin to remind staff not to travel to and from work in uniforms	• Clinical areas to monitor • Reports of member of public reporting sighting of staff in uniform	
6.10	All staff understand the symptoms of Covid-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household displays any of the symptoms.	• 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 4 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. ESR will be up and running for the purpose of recording fit test records as soon as the Trust gives the go ahead to procure Portacount fit test system as this is part of the project lead by Health and Safety. December 2020 Health and Safety have agreement to proceed to Business case	
2	6.2	Spot audits of PPE on wards and Departments	Health and Safety IP	ongoing	Audits are required on a weekly basis	

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	1	2		Isolation facilities are available and hospital zoning in place. Further work is currently being undertaken during next wave of COVID to identify next blue ward	Likelihood:	1	Quarter 4
Consequence:	3	3	3			Consequence:	3	
Risk Level:	6	3	6			Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
7.1	Patients with possible or Covid-19 are isolated in appropriate facilities or designated areas where appropriate.	• Hospital zoning in place • Recovery and Restoration plans for the Trust – December 2020 – no in another increased wave of COVID 19 • COVID prevalence considered when zones identified • Purple wards • Blue COVID wards identified at both sites created during second wave • Green wards for planned screened elective patients	• June 2020 IP team to review patients that are found COVID positive and nursed in bay to ascertain compliance with pathway and IP control measures are in place Review pathways and identify themes which are presented at IPCC	
7.2	Areas used to cohort patients with possible or confirmed Covid-19 are compliant with the environmental requirements set out in the current	• Areas agreed at COVID-19 tactical Group • Restoration and	• Action log and papers submitted to COVID-19 tactical and Clinical Group	

	PPE national guidance.	Recovery plans		
7.3	Patients with resistant / alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement.	• Infection Prevention Questions and Answers Manual includes alert organisms/resistant organism • Support to Clinical areas via Infection Prevention triage desk • Site team processes • Clostridium *difficile* report  C diff report 2021.docx • Patients received from London to critical care unit – screening policy for resistant organisms in place	• RCA process for Clostridium *difficile* • CDI report for January Quality and Safety Committee and IPCC • Outbreak investigations • MRSA bacteramia investigations • Datix reports	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	**KLOE**	**Action Required**	**Lead**	**Due Date**	**Quarter 4 Progress Report**	**BRAG**
1.	7.1	ED to align with inpatient zoning model	ED leads	18/09/2020	Both sites have remodel ED areas. Corridor ED Royal review planned	
2.	7.1	Strict adherence to policy re patient isolation and cohorting	Site teams/ward teams	Daily process	RCA's to be completed on any inappropriate patient moves	
3.	7.3	Clostridium *difficile* report to Quality and Safety Committee and IPCC	IP	31/01/2021	Report prepared with antimicrobial analysis included and presented at both committee's Jan 2021	
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	2	1		Laboratory services for UHNM are located in the purpose built Pathology Laboratory on-site at RSUH. The Laboratory is United Kingdom Accreditation Service (UKAS) accredited. Work 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	End of Q4
Consequence:	3	3	3			Consequence:	3	
Risk Level:	6	6	3			Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
8.1	Testing is undertaken by competent and trained individuals.	• How to take a COVID screen information available on Trust intranet. This has been updated in November 2020 • Laboratory services for UHNM are located in the purpose built Pathology Laboratory on-site at RSUH. The Laboratory is United Kingdom Accreditation Service (UKAS) accredited.	• 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. Linked NHSIE Key Action 7: Staff Testing: a) Twice weekly lateral flow antigen testing	• All patients that require an overnight stay are screened for COVID-19 • Screening process in place for elective surgery and some procedures e.g. upper	• Empactis reporting • Team Prevent systems • Datix/adverse incidence reporting • Cluster /outbreak investigation procedures	

	for NHS patient facing staff is implemented. Whilst lateral flow technology is the main mechanism for staff testing, this can continue to be used alongside PCR and LAMP testing. b) If your Trust has a high nosocomial infection rate you should undertake additional targeted testing of all NHS Staff, as recommended by your local and regional infection prevention and control team. Such cases must be appropriately recorded, managed and reported back. Linked to NHSIE Key Action 8: Patient Testing: a) All patients must be tested at emergency admission, whether or not they have symptoms. b) Those with symptoms of Covid-19 must be retested at the point symptoms arise after admission. c) Those who test negative upon admission must have a second test 3 days after admission and a third test 5 – 7 days post admission. d) All patients must be tested 48 hours prior to discharge directly toa care home and must only be discharged when the test result is available. Care home patients testing positive can only be discharged to CQC designated facilities. Care homes must not accept discharged patients unless they have that persons test result and can safely care for them. **e)** Elective patient testing must happen within 3 days before admission and	endoscopy • Process in place for staff screening via empactis system and Team Prevent • Patients who test negative are retested after 5 days. • Patient who develop COVID symptoms are tested • Staff screening instigated in outbreak areas • November 2020 - Lateral flow device staff screening to be implemented to allow twice weekly • Questions and answers available on the COVID 19 page Trust intranet re lateral flow including actions to take for reporting both a negative or positive result • All patient discharged to care setting as screened 48 hours prior to transfer/discharge		

	patients must be asked to self-isolate from the day of the test until the day of admission.			
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 2 Progress Report	BRAG
1.	8.1	Champions 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. 1st September swabbing video recorded, minor changes to be completed week commencing 14th September then video will be circulated to key people for preview and comments. Child positioning included in video Screening video now complete and uploaded on to Trust intranet November 2020. A number of areas have identified swabbing Champions, request sent to ACN's. Implementation of champions in progress.	
2	8.2	NHSIE Key Action - Those who test negative upon admission must have a second test 3 days after admission and a third test 5-7 days post admission	Microbiologist/IP Team	07/12/2020	Following NHSI new guidance Those who test negative for COVID on admission are to be retested on day 4 and day 6, with admission day counted as day one. Implementation of this is underway and prompt is provided to clinical areas	
3	8.2	Those who test negative upon admission must have a second test 3 days after admission and a third test 5 days post admission	Deputy Chief Nurse	07/12/2020	Report received by Deputy Chief Nurse on a daily basis with list of patients that are due for re screen. Clinical areas then contacted and prompt to re screen.	
4.	8.3	To complete an analysis (Advantages and disadvantages) to reinstating pre COVID 19 UHNM screening policy	Deputy Director if infection Prevention	31/12/2020	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 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. October MRSA screening is around 50% of pre COVID screening; laboratory does not have the capacity to process COVID work and level of MRSA screens pre COVID. Paper to November IPCC. This continues to be under review during COVID Pandemic.	
3.						
4.						

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	1	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	Q4
Consequence:	3	3	3			Consequence:	3	
Risk Level:	6	3	6			Risk Level:	3	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
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	• NHSI visit highlighted a number of staff none compliant to wearing of masks , and Doctor non compliant with Bare below the elbow
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 • Incident control room established where changes are reported through • Chief nurse updates	• Clinical Group meeting action log held by emergency planning	

		• Changes/update to staff are included in weekly Facebook live sessions • COVID -19 intranet page • COVID -19 daily bulletin with updates		
9.3	All clinical waste related to confirmed or possible Covid-19 cases is handled, stored and managed in accordance with current national guidance.	• Waste policy in place • Waste stream included in IP mandatory training	The Trust has a Duty of Care to ensure the safe and proper management of waste materials from the point of generation to their final disposal (Cradle to Grave). This includes: • Ensuring the waste is stored safely. • Ensuring the waste is only transferred to an authorised carrier and disposer of the waste. • Transferring a written description of the waste • Using the permitted site code on all documentation. • Ensuring that the waste is 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 2 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. CEF audits reinstated.	
2.	9.1	Proud to care booklet audits paused. Plan for recommencing	Deputy Director of Quality and Safety	30/9/2020	Original proud to care booklets reinstated	
3.	9.1	Compliance with correct mask wearing and Doctors complaint with Bare Below the Elbow	Deputy DICP/Medical Director/ ACN's	31/12/2020	NHSI Action plan devised	
4.						

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	2	2		There are clear control in place for management of occupational needs of staff through team prevent to date	Likelihood:	1	End of Quarter 4
Consequence:	3	3	3			Consequence:	3	
Risk Level:	6	6	6		Adhere to social distancing gaps in adherence	Risk Level:	3	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
10.1	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 FFP3 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 care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance.	• Restore and Restorations plans	• Incidence process/Datix	
10.4	All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas. Linked NHSIE Key Action 2: Staff maintain social distancing in the workplace, when travelling to work (including avoiding car sharing) and to remind staff to follow public health guidance outside of the workplace.	• 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 commenced 15th June • Visitor face covering • COVID secure risk assessment process in place • November 2020 – Care sharing instructions added to COVID Bulletin	• 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 • Staff encouraged to keep to 2 metre rule during breaks • Purpose build rooms for staff breaks in progress	• Social distance monitor walk rounds • Social distance posters identify how many people allowed at one time in each room	

10.6	Staff absence and wellbeing are monitored and staff who are self-isolating are supported and able to access testing.	• Team Prevent available to offer guidance and treatment to staff presenting with onset of symptoms.	• Team prevent monitoring process • Work force bureau	
10.7	Staff who test positive have adequate information and support to aid their recovery and return to work.	• Team Prevent available to offer guidance and treatment to staff presenting with onset of symptoms. • Empactis line will first ask – is the absence related to coronavirus. To which the employee must say yes or no • Once the absence is reported to the employees manger via email, the manager will categorise the absence type specified in the flow 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	• Via emapactis • Staff queries' through workforce bureau or team prevent	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 4 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. ESR will be up and running for the purpose of recording fit test records as soon as the Trust gives the go ahead to procure Portacount mas k fit systems as this is part of the project lead by	

					Health and Safety . December 2020 Health and Safety are to proceed with Business case	
2.						
3.						
4.						

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

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	3rd February 2021
Report Title:	Ockenden Report: Assessment and Assurance Framework and Action Plan	**Agenda Item:**	9
Author:	Sharon Wallis, Head of Midwifery / Simon Cunningham, Consultant Obstetrician		
Executive Lead:	Michelle Rhodes, Chief Nurse		

Purpose of Report:					
Assurance	✓	**Approval**		**Information**	

Alignment to Strategic Objectives:			
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	

Summary of other meetings presented to and outcome of discussion:

Quality and Safety Oversight Group Meeting 11.01.2021. Quality Governance Committee 20.01.2021 CWD divisional board

Summary of Report, Key Points for Discussion including any Risks:

The Ockenden independent maternity review published on 10th December 2020 focused on all reported cases of maternal and neonatal harm at the Shrewsbury and Telford hospital NHS Trust between the years 2000 and 2019. This first report arises from the 250 cases reviewed to date; the number of cases considered so far includes the original cohort of 23 cases.

Every maternity unit had to submit an immediate response from the CEO and LMNS board chair on the regional Midwifery officer on 21st December 2020. This was then followed by the maternity assessment and assurance framework which had to be completed by 15th January 2021. The national team revised the submission date to 15th February 2021 so that governance process could be followed with oversight from trust executives and the LMNS board.

The maternity service at UHNM has completed the narrative assurance and identified areas for development mainly;

- Evidence of compliance through audit
- Increased board level oversight of maternity services
- Increased collaboration between trusts and LMNS

In addition the assurance framework asks that midwifery workforce gap analysis by 31st January with a plan of timescales for implementation.

- Mechanism for NICE guideline compliance & assurance of a robust assessment process where non-evidenced based
- Describe how the organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care
- A workforce gap analysis
- Compliance against CNST standards

Key Recommendations:

The Trust Board is asked to note and support the action plan from the assessment and assurance framework

Ockenden Report January 2021
UHNM Assessment & Assurance Framework and Action Plan

The Ockenden Report was published 10th December 2020. This independent review of maternity services at the Shrewsbury and Telford hospital NHS Trust focused on all reported cases of maternal and neonatal harm between the years 2000 and 2019. This first report reflects finding from the 250 cases reviewed to date.

These include cases of stillbirth, neonatal death, maternal death, hypoxic ischaemic encephalopathy (HIE) (grades 2 and 3) and other severe complications in mothers and newborn babies. In addition, a small number of earlier cases have emerged these are being reviewed by the independent team wherever medical records are available. The total number of families to be included in the final review and report is 1,862.

The review panel identified important themes to be shared across all maternity services as a matter of urgency. The themes have formed **Local Actions for Learning** and make early recommendations for the **wider NHS Immediate and Essential Actions**.

Immediate and Essential Actions to Improve Care and Safety in Maternity Services across England focused upon:

1. Enhanced Safety
2. Listening to Women and Families
3. Staff training and working together
4. Managing Complex Pregnancy
5. Risk assessment throughout pregnancy
6. Monitoring fetal wellbeing
7. Informed Consent

Each Trust also must complete an NHSE assessment & assurance framework by **15th February 2021** to the local LMNS board and the regional Chief Midwifery Officer based on the IEA's and include;

- Mechanism for NICE guideline compliance & assurance of a robust assessment process where non- evidenced based guidelines are used
- Describe how the organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care
- A midwifery workforce gap analysis by 31st January and timescales for implementation
- Compliance against CNST standards

An action plan against the identified gaps has also been developed and included. The next stage will be to provide the evidence of compliance to NHSE which is likely to be in April/ May 2021

A second report from Ockenden is scheduled for later in 2021

Maternity services assessment and assurance tool

We have devised this tool to support providers to assess their current position against the 7 Immediate and Essential Actions (IEAs) in the Ockenden Report and provide assurance of *effective* implementation to their boards, Local Maternity System and NHS England and NHS Improvement regional teams. Rather than a tick box exercise, the tool provides a structured process to enable providers to critically evaluate their current position and identify further actions and any support requirements. We have cross referenced the 7 IEAs in the report with the urgent clinical priorities and the ten Maternity incentive scheme safety actions where appropriate, although it is important that providers consider the full underpinning requirements of each action as set out in the technical guidance.

We want providers to use the publication of the report as an opportunity to objectively review their evidence and outcome measures and consider whether they have *assurance* that the 10 safety actions and 7 IEAs are being met. As part of the assessment process, actions arising out of CQC inspections and any other reviews that have been undertaken of maternity services should also be revisited. This holistic approach should support providers to identify where existing actions and measures that have already been put in place will contribute to meeting the 7 IEAs outlined in the report. We would also like providers to undertake a maternity workforce gap analysis and set out plans to meet Birthrate Plus (BR+) standards and take a refreshed view of the actions set out in the Morecambe Bay report. We strongly recommend that maternity safety champions and Non-Executive and Executive leads for Maternity are involved in the self-assessment process and that input is sought from the Maternity Voices Partnership Chair to reflect the requirements of IEA 2.

Fundamentally, boards are encouraged to ask themselves whether they really know that mothers and babies are safe in their maternity units and how confident they are that the same tragic outcomes could not happen in their organisation. We expect boards to robustly assess and challenge the assurances provided and would ask providers to consider utilising their internal audit function to provide independent assurance that the process of assessment and evidence provided is sufficiently rigorous. If providers choose not to utilise internal audit to support this assessment, then they may wish to consider including maternity audit activity in their plans for 2020/21.

Regional Teams will assess the outputs of the self-assessment and will work with providers to understand where the gaps are and provide additional support where this is needed. This will ensure that the 7 IEAs will be implemented with the pace and rigour commensurate with the findings and ensure that mothers and their babies are safe.

Section 1

Immediate and Essential Action 1: Enhanced Safety

Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

- Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.
- External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.
- All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months

Link to Maternity Safety actions:

Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 2: Are you submitting data to the Maternity Services Dataset to the required standard?
Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?

Link to urgent clinical priorities:

(a) A plan to implement the Perinatal Clinical Quality Surveillance Model
(b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
Clinical change embedded across the Trust with regional oversight. ▪ UHNM RM 01 Trust Risk Management Strategy ▪ UHNM RM 09 Analysis & Learning Policy ▪ UHNM RM13 Dissemination of Safety Alerts ▪ UHNM G14 Implementation of NICE Guidance ▪ UHNM G14 Clinical Audit Policy ▪ UHNM G25 Quality Impact Assessment Policy ▪ Electronic incident reporting	▪ Dissemination of information to share patient safety throughout the Directorate-Division-Trust-LMNS via multifaceted processes ▪ Governance reports ▪ Newsletters Responsive to hanges by: ▪ Reviewing and updating clinical	▪ Audit demonstrates compliance with standards and areas for improvement ▪ Incident reduction and evidence of compliance when routine incident triggers are investigated ▪ Complaints reduction and evidence good standards of care when complaints are reviewed	▪ Dashboard development currently in progress ▪ Strengthen floor to board relationships for maternity safety with the LMNS ▪ LMNS to collaborate with an additional maternity organisation with level 3 neonatal unit provision ▪ Secure data sharing	▪ HoM/ LMNS lead MW - Feb 2021 ▪ Board safety champions to attend LMNS board – Feb 2021 ▪ LMNS	▪ Additional support from corporate team for audits agreed ▪ LMNS Access to K2	▪ Additional support from corporate team for audit

What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
system ▪ Quarterly Governance reports for Obstetrics which are presented at Directorate-Divisional and Trust forums reflect: o Safety Alerts (local & national o NICE Guidance received and completed o Audits and action plans o CQC/MBRRACE/ HSIB recommendations and action plans o Maternity specific incidents/themes o Progress against CNST MIS o Good practice ▪ Quarterly Maternity Dashboard is shared alongside the Governance Report ▪ UHNM Maternity Teams are represented at the LMNS Quality & Safety Work Stream ▪ CD for O & G chair of the Q & S Work Stream ▪ Maternity Safety Champions (Board level and Non-executive level) ▪ NHSI collaboration with MatNeo project	guidance and policies ▪ Clinical audit ▪ Benchmarking outcomes against other Trusts ▪ Identifying trends in local outcome data for improvement & sustainability e.g. sepsis compliance ▪ Mandatory training ▪ Involvement of parents to improve information ▪ Collaborating with our MVPs ▪ Conducting gap analysis on national documents (CQC/MBRRACE/ NICE/HSIB ▪ QA frameworks ▪ Bi monthly meetings with NED safety champion ▪ Monthly walkabout by exec safety champion	▪ Claims reduction and evidence of effective reporting and collaboration with NHSR ENS ▪ Mortality & morbidity outcome data ▪ Positive local outcomes against national datasets e.g. MSDS/NMPA ▪ Specialised division has a professional nurse advocate role based on PMA role in maternity. This came through sharing approaches to just safety culture	agreements for our LMNS ▪ Establish Honorary contracts where appropriate for LMNS members ▪ Contribute to developing a 'learning system' & ensure that improvement actions are disseminated & shared across the organisation and, where relevant, the wider system, including on a national platform.	▪ IG – Jan 2021 ▪ HoM- Jan 2021 ▪ Corporate governance team – March 2021		
External clinical specialist opinion ▪ Multi disciplinary review using	▪ Dissemination of information to share	▪ PMRT investigation outcomes are scored A	▪ Establish a robust peer review	▪ CD to liaise with RWT to	▪ Support for visiting teams –	▪ Peer review

What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
PMRT for all stillbirths and neonatal deaths ▪ Cases that support HSIB reporting criteria are investigated with parental/relative consent by HSIB o Stillbirths o Neonatal Deaths o Therapeutic hypothermia o Maternal Death ▪ All cases that fulfil HSIB reporting criteria are reported to NHS Resolution Early Notification Scheme and reported as Serious Incidents ▪ Peer reviews facilitated between UHNM/ RWT in the past year ▪ External specialist independent reviews are commissioned where relevant ▪ A quarterly / annual report is presented Directorate-Division-Trust relating to all perinatal cases reviews and patient safety learning ▪ Standard Operating Procedure for the reporting and investigation of maternity incidents ▪ UHNM RM07 Reporting and Management of Incidents Including Serious Incidents ▪ UHNM RM012 Duty of Candour Policy ▪ 2 WTE Bereavement Midwives in post	patient safety throughout the Directorate-Division-Trust-LMNS via multifaceted processes detailed above ▪ Gap analysis against themed HSIB reports ▪ Operational specific perinatal mortality learning board ▪ Inviting parents to share their experiences with us to inform the PMRT investigation processes Responding to patient safety recommendations from local & HSIB investigations ▪ Developing additional patient information, PGDs ▪ Reviewing local guidelines & developing new guidance where indicated ▪ Appointed an additional PMA with a key role for quality	or B ▪ Care provided is in accordance with clinical guidance ▪ Parents experience of the care provided is positive ▪ Action plans are developed and monitored for completion in response to patient safety learning ▪ Good practice is shared and relevant individuals/teams are nominated under the Trust values recognition scheme ▪ Reduction in therapeutic hypothermia cases year on year ▪ Reduction in stillbirth to equivalent or lower than regional rate	process for PCRs for all cases across trusts ▪ Establish designated job plans for mortality reviews so NND are reviewed with obstetric and Neonatal consultant input at the same time	establish, supported by LMNS ▪ Directorate manager reviewing job plans to formally enable this – March 2021	PAs for consultants ▪ May need a data sharing agreement	facilitated on an ad hoc basis as requested ▪ Diary changes to enable consultant obstetrician to attend NND reviews

What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
	improvement ▪ Inviting women to share their experiences with us and the Chief Nurse					
Maternity Serious Incidents ▪ Trust Risk Management policies listed above ▪ Electronic incident reporting system ▪ Standard Operating Procedure for the reporting and investigation of maternity incidents ▪ On a monthly basis the Serious Incidents that are reported are included in monthly Quality Performance Reviews (QPR) to the Quality Governance Committee (QGC) which is a sub- committee of the Trust Board. ▪ In addition a quarterly UHNM Serious Incident (SI) report is presented to QGC members which summarises the key findings/learning from the investigated and or closed SIs. ▪ Maternity specific SIs are included in the above and added to the Quarterly Obstetrics and Gynaecology Governance report presented at Directorate, Divisional & Trust forums ▪ Quarterly Maternity Governance	▪ Dissemination of information to share patient safety throughout the Directorate-Division-Trust-LMNS via multifaceted processes detailed above ▪ Responding to patient safety recommendations from local & HSIB investigations – see above ▪ Liaising with HSIB and NICE regarding recommendations form NHSE in SBLCB V2 to accurately inform local guidance	▪ Number of incidents with moderate harm or above are reducing and sustainable ▪ Number of 'near miss' incidents are reducing & sustainable ▪ Patient safety recommendation themes are reducing e.g. sudden unexpected neonatal collapse associated with poor skin to skin positioning ▪ Rates of unexpected term admissions to the neonatal unit are sustainable ▪ Rates of babies receiving therapeutic hypothermia are reducing & are sustainable	▪ Confirm with Trust and LMNS format of reporting – Q2 report sent for benchmarking Review content and style of presenting data in governance reports to reflect 'run chart' with additional narrative to support data.	▪ LMNS lead MW/ Maternity Q& S manager - Feb 2021	▪ Data analyst support from LMNS	

What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
reports reflect SI investigations & are being shared with our LMNS ▪ Member of the national maternity risk team to share learning and recommendations						

Immediate and essential action 2: Listening to Women and Families

Maternity services must ensure that women and their families are listened to with their voices heard.

- Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.
- The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.
- Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.

Link to Maternity Safety actions:

Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?

Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Link to urgent clinical priorities:

(a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.

(b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.

What do we have in place currently to meet all requirements of IEA 2?	How will we evidence that we are meeting the requirements?	How do we know that these roles are effective?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?
Senior advocate role which reports to both the Trust and the LMS Boards ▪ UHNM does not currently have an employee in this senior advocate role. Awaiting further guidance						

What do we have in place currently to meet all requirements of IEA 2?	How will we evidence that we are meeting the requirements?	How do we know that these roles are effective?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?
Advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome. What do we have in place? ▪ Awaiting further guidance surrounding the role of the Advocate ▪ Two specialist bereavement midwives in post who attend postnatal counselling for bereaved parents ▪ Investigation feedback meetings can take place with a patient advocate currently arranged by the women themselves ▪ Invite parents to share their experiences with us to inform the PMRT investigation processes ▪ UHNM has various methods for collecting feedback from service users including o Picker maternity survey o Friends and Family o MVP feedback o Health Watch report and action plans in response to feedback o Parent involvement in investigations o MVP involvement co	▪ Staffordshire and Stoke-On-Trent MVP ▪ Terms of reference ▪ User Feedback SOP ▪ Co-production with service users for leaflets ▪ Service user attends quality and safety work stream meetings ▪ HoM attends MVP meetings and does recorded Q&A sessions which are shared on social media ▪ Co-production of videos and information by UHNM from MVP feedback and women's questions ▪ MVP champion identified as link to Non executive safety champion ▪ All MVP feedback collected and recorded on Datix and reports generated ▪ MVP rep on each sub group fro transformation programme	▪ Audit ▪ Complaints ▪ Patient experience feedback	▪ Develop written guidance on mechanism to correlate service user feedback from 'floor to trust board' and 'trust board to floor' by quarterly report ▪ Include the advocate role in the maternity Strategy	▪ UHNM patient experience lead / HoM/ Q&S team – March 2021	▪ Additional support from corporate team for audits	

What do we have in place currently to meet all requirements of IEA 2?	How will we evidence that we are meeting the requirements?	How do we know that these roles are effective?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?
production of PIL and clinical guidelines ▪ MVP attendance at LMNS Quality and Safety Work stream forum						
IEA 2 Listening to women & families **Non-executive Director** ▪ In addition to the identification of an Executive Director with specific responsibility for maternity services, UHNM has also confirmation a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard. ▪ Trust safety champions Consultant Obstetrician and Head of Midwifery meet bimonthly with Board level champions to escalate locally identified issues including: o Reviews of the maternity dashboard to determine progress with safety initiatives and related relevant priorities o Midwifery staffing establishment BR+ used at UHNM).	▪ Staffordshire and Stoke-On-Trent MVP Terms of reference ▪ User Feedback ▪ SOP ▪ Agenda and minutes of meetings ▪ Schedule of 'walk abouts' and feedback / actions ▪ Non-executive director has specific role and responsibility factored into job description ▪ Maternity Strategy ▪ Board Safety champion to LMNS Pathway	Visible presence of board level safety champions Staff awareness & engagement of role of safety champions Independent feedback on safety issues via board safety champions to maternity / Neonatal safety champions		▪ Non-Executive Director and Chief Executive		

What do we have in place currently to meet all requirements of IEA 2?	How will we evidence that we are meeting the requirements?	How do we know that these roles are effective?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?
○ Midwifery & clinical workforce planning analysis to inform an action plan which meets the required standard ○ Serious incident investigation reports; ensuring contributory factors are understood, action taken learning shared with all staff and impact monitored.						

Immediate and essential action 3: Staff Training and Working Together
Staff who work together must train together

- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.

- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.

- Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

Link to Maternity Safety actions:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

(a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
(b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place

What do we have in place currently to meet all requirements of IEA 3?	What are our monitoring mechanisms?	Where will compliance with these requirements be reported?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?
IEA 3 Training & working together **MDT training and working occurs evidence** **Evidence of external validation via the LMS, 3 times a year.** ▪ UHNM has a comprehensive 2 day training course for all team members that includes: o recognition of maternal	▪ Training database ▪ Training Programme ▪ Peer Declaration forms ▪ Quarterly compliance updates and trajectory for compliance ▪ Participant evaluation forms	▪ Directorate Governance meeting ▪ CWD assurance meetings ▪ HoM & Obstetric Clinical Lead meeting with Chief Nurse ▪ Senior Midwifery Team meetings ▪ Consultant meeting	▪ Establish a process to enable training to be validated by the LMNS; add to quarterly maternity dashboard for both board and LMNS awareness	▪ HoM- Jan 2021		

What do we have in place currently to meet all requirements of IEA 3?	What are our monitoring mechanisms?	Where will compliance with these requirements be reported?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?
collapse o human factors training o practical simulation training of obstetric emergencies with updates on techniques. ▪ The training is multidisciplinary and includes Post Anaesthetic Care Unit nurses and Operating Department Practitioners.						
IEA 3 MDT training and working together must always include twice daily (day and night through the 7-day week) consultant-led & present MDT ward rounds on the labour ward ▪ Monday to Friday there are four times a day consultant led ward rounds over a 24 hour period on labour ward ▪ Weekends there are three a day ▪ Monthly reporting on dashboard on consultant cover for maternity consistently 100%	▪ Medical staff rota ▪ CD reporting to medical director	▪ Directorate Governance meeting ▪ CWD assurance meetings ▪ Consultant meeting ▪ Board via dashboard every quarter	▪ Audit of K2 electronic maternity patient records for ward rounds	▪ Audit team – March 2021	▪ Additional support from corporate team for audits - agreed	
IEA 3 Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only. ▪ Training funding received from HEE is ring fenced for maternity						

Immediate and essential action 4: Managing Complex Pregnancy
There must be robust pathways in place for managing women with complex pregnancies

Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.

- Women with complex pregnancies must have a named consultant lead
- Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team

Link to Maternity Safety Actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.
b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.

What do we have in place currently to meet all requirements of IEA 4?	What are our monitoring mechanisms?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
IEA 4 Women with complex pregnancies must have a named consultant lead ▪ Consultant leads exist for specific medical conditions. These are allocated at booking (before 12 weeks) and review occurs throughout	▪ Incident reporting **SBLCBV2** ▪ Regional reporting to NHSE ▪ Audits of compliance	▪ Audits & action plans reported at: o Maternity Forum o Directorate meeting **SBLCBV2** ▪ NHSE regional team ▪ Directorate-	▪ Audit of K2 electronic patient records as an assurance of compliance **SBLCBV2**	▪ Corporate audit team – March 2021 **SBLCBV2**	▪ Support agreed **SBLCBV2**	**SBLCBV2**

What do we have in place currently to meet all requirements of IEA 4?	What are our monitoring mechanisms?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
pregnancy. ▪ Maternity uses an electronic patient record system Athena and ensures that MDT access is in place. ▪ Automatic pathways inbuilt into K2 ▪ Mothers also have direct sight of their electronic patient record, their consultant and management plans because of online access. ▪ UHNM has achieved compliance with all elements of SBLCBV1 for year one and year two and is currently working towards compliance with year 3 and the SBLCBV2. ▪ UHNM has two lead clinicians with designated responsibility for the implementation of SBLCB V2	against the individual 5 elements by designated specialist midwife for SBLCB 2 ▪ Training databases ▪ Quarterly compliance updates provided in the Obstetric Governance reports ▪ NMPA data to benchmark against compliance for Magnesium Sulphate	Divisional-Trust forums ▪ LMNS Quality and Safety work stream and steering group supported by LMNS midwife and project lead				
IEA 4 Early specialist involvement with complex pregnancy and management plans agreed between the woman and the team ▪ The maternal medicine centres have been in						

What do we have in place currently to meet all requirements of IEA 4?	What are our monitoring mechanisms?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
development for 2 years. At present NHSE are conducting a regional wide audit to establish scope. It is intended to be a hub and a bespoke model of care that promotes advice. UHNM is applying to be one of the centres given the experience and expertise of the consultant body, the existing infrastructure of level 3 neonatal, same site Intensive Care Unit, highly experienced anaesthetic team, interventional radiology hybrid operating theatre and level 2 fetal medicine facility.						

Immediate and essential action 5: Risk Assessment Throughout Pregnancy

Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.

- All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional
- Risk assessment must include on-going review of the intended place of birth, based on the developing clinical picture.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.

What do we have in place currently to meet all requirements of IEA 5?	What are our monitoring mechanisms and where are they reported?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
IEA 5 Risk assessment throughout pregnancy **Formal risk assessment at every antenatal contact** ▪ Risk assessments are undertaken at every contact ▪ Pathways in place for referral to consultant care/ fetal medicine ▪ Electronic triggers to enable correct care process e.g. growth scans ▪ Interactive record to support information sharing and inclusivity for women ▪			▪ Implement regular audit and report to directorate governance meeting	▪ Directorate Clinical audit lead – monthly from February 2021		▪ Staff to be reminded to ensure that all risk assessments are undertaken and recorded – email sent to matrons 07.01.2021

What do we have in place currently to meet all requirements of IEA 5?	What are our monitoring mechanisms and where are they reported?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
IEA 5 Risk assessment throughout pregnancy Formal risk assessment at every antenatal contact Regular audit mechanisms are in place to assess PCSP compliance. ▪ Place of birth is assessed for all women requesting home birth or midwife led care. ▪ PMA support for women choosing birth against usual guidance **Compliance with SBLCBV2** ▪ See above under action 4			▪ Implement regular audit and report to directorate governance meeting	▪ Directorate Clinical audit lead – monthly from February 2021		▪ Staff to be reminded to ensure that all risk assessments are undertaken and recorded - email sent to matrons 07.01.2021 ▪ PMA access for women

Immediate and essential action 6: Monitoring Fetal Wellbeing

All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.

The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: -

- Improving the practice of monitoring fetal wellbeing –
- Consolidating existing knowledge of monitoring fetal wellbeing –
- Keeping abreast of developments in the field –
- Raising the profile of fetal wellbeing monitoring –
- Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported –
- Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.
- The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training.
- They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. •
- The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

What do we have in place currently to meet all requirements of IEA 6?	How will we evidence that our leads are undertaking the role in full?	What outcomes will we use to demonstrate that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
IEA 6 Monitoring fetal well-being **Dedicated Lead Midwife and**	▪ Job descriptions	▪ Reductions & sustainability in	▪ Programmed activity (PA) to be factored in to	▪		

What do we have in place currently to meet all requirements of IEA 6?	How will we evidence that our leads are undertaking the role in full?	What outcomes will we use to demonstrate that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Lead Obstetrician **What do we have in place?** ▪ UHNM has two lead clinicians with designated responsibility for the implementation of SBLCB V2 ▪ Both with demonstrated expertise to focus on and champion best practice in fetal monitoring. ▪ CTG training reviewed and enhanced to online ▪ Recognised K2 CTG competency based training package being used ▪ Plans to incorporate review of cases into MDT training sessions from March 2021 ▪ Compliance with SBLCB (MIS year 1 & 2 V1) ▪ Compliance with 90% MDT training (MIS year 1 and 2	▪ Training agendas ▪ Training compliance figures ▪ Virtual presentations ▪ Face-to-face CTG training proforma ▪ Support for individuals in practice	unexpected term admissions to the neonatal unit ▪ Reductions & sustainability of babies requiring therapeutic hypothermia ▪ Reduction in short & long term neonatal morbidity & mortality ▪ Processes for following up staff who do not successfully complete K2 CTG training included in TNA	job plan of a newly appointed consultant who currently leads on CTG training within a large teaching hospital. ▪ Plans for additional lead midwife from April for 15 hours per week to support ▪ Commence MDT face-to-face CTG training ▪ Local CTG guideline need updating – commenced October 2021 ▪ Training compliance to be included in maternity dashboard quarterly and reported to board and LMNS			

Immediate and essential action 7: Informed Consent

All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.

All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care

Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care

Women's choices following a shared and informed decision-making process must be respected

Link to Maternity Safety actions:

Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?

Link to urgent clinical priorities:

a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.

What do we have in place currently to meet all requirements of IEA 7?	Where and how often do we report this?	How do we know that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
▪ UHNM website contains information for women ▪ Pathway assigned at booking and schedule visible to women via K2 online access ▪ All women will have interactive access to their individual care pathway from March 2021 via the						

What do we have in place currently to meet all requirements of IEA 7?	Where and how often do we report this?	How do we know that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
My Pregnancy Notes app. ▪ All women have complete access to their maternity records remotely translated into any Google language set by the woman						
IEA 7: Informed consent Provision to women of accurate contemporaneous evidence-based information as per national guidance. ▪ Maternity guidelines & PIL reviewed and updated every 3 years or when new national guidance is published. ▪ All guidelines & PIL benchmarked against national guidance ▪ All PIL are available on the UHNM intranet site ▪ MVP review guidelines and information leaflets	▪ Revised guidelines are disseminated via various Directorate & Divisional meetings to agree all updates ▪ Changes to guidelines are added to the Quality & Risk Newsletter ▪ Major guideline reviews are re-launched with change of practice memos and implementation date ▪ Update to website when new leaflets are produced ▪ Information, updates and videos throughout the COVID pandemic on website and social media	▪ Clinical audit ▪ Incident reviews ▪ Patient experience feedback ▪ MVP feedback & involvement				

What do we have in place currently to meet all requirements of IEA 7?	Where and how often do we report this?	How do we know that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
IEA 7: Informed consent **Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care** **What do we have in place?** ▪ UHNM website contains information for women ▪ Pathway assigned at booking and schedule visible to women via K2 online access ▪ All women will have interactive access to their individual care pathway from March 2021 via the My Pregnancy Notes app. ▪ All women have complete access to their maternity records remotely translated into any Google language set by the woman ▪ Access to PMA		▪ Patient experience reports and feedback	▪ Quarterly patient experience report for board and LMNS	▪ PMA/ Q&S – March 2021		▪ Actions from complaints; sharing compliments
IEA 7: Informed consent **Women's choices following a shared and informed decision-making process must be respected** **What do we have in place?** ▪ Two WTE PMA employed who can help facilitate and support both women and staff to ensure that women's birth choices are respected ▪ MVP representation on LMNS	▪ Annual PMA report	▪ Patient experience feedback ▪ Women supported in birth choices				

What do we have in place currently to meet all requirements of IEA 7?	Where and how often do we report this?	How do we know that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
groups ▪ PMA attends MVP meetings ▪ Positive feedback accessibility and responsiveness of HoM to queries						

Section 2

MATERNITY WORKFORCE PLANNING

Link to Maternity safety standards:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard
Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

We are asking providers to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st January 2020 and to confirm timescales for implementation.

What process have we undertaken?	How have we assured that our plans are robust and realistic?	How will ensure oversight of progress against our plans going forwards?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
▪ UHNM working towards compliance towards MIS safety actions 4 and 5 ▪ Birthrate Plus completed Spring 2019 ▪ Monthly midwife to birth ratio reported on dashboard ▪ Escalation guidance in place and enacted to maintain safe staffing including incident reporting on staffing levels ▪ Monthly 1-2-1 with HoM/ CN ▪ Workforce paper presented to board.	▪ Collaboration with MDT colleagues ▪ Monthly compliance status update meetings: ○ Midwifery teams ○ Anaesthetists ○ Neonatologists ○ Neonatal Nursing teams ▪ BR+ acuity tools for intrapartum and wards in situ ▪ Neonatal workforce benchmarked against BAPAM ▪ Minimum safe staffing in maternity services to include Obstetric cover on the delivery	▪ Maternity workforce plans, progress updates & action plans shared at Directorate meetings as standard agenda items. ▪ Any areas of risk are escalated to the Chief Nurse/Medical Director & NED by HoM and respective Consultant Clinical leads	▪ Updated midwifery workforce paper in progress	▪ HoM – 31st January 2021		

Currently being reviewed ▪ Current midwife to birth ratio on funded establishment 1:26.5	suite , gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively					

MIDWIFERY LEADERSHIP

Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director and describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care

Head of Midwifery is professionally accountable to the Chief Nurse. Any maternity matters/ reports required are presented by the HoM at board level meetings. Also HoM meets with board level safety champions alongside obstetric and neonatal leads.
Review of RCM manifesto; No consultant midwife currently within the organisation. Opportunity to create a post with public health remit going through process. Increase in specialist roles within midwifery over the past year including additional 0.8WTE band 7 for bereavement midwives on top of 1 WTE, second full time PMA, specialist roles for digital midwife and perineal care. Twins specialist midwife 1.0 WTE has also joined team alongside safeguarding midwife, infant feeding specialist and governance midwives.
Leadership development available in house but also funding available for master's degree level study where role requires or for individuals aspiring to senior roles in leadership / HoM posts.

NICE GUIDANCE RELATED TO MATERNITY						
We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.						
What process do we have in place currently?	**Where and how often do we report this?**	**What assurance do we have that all of our guidelines are clinically appropriate?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**
▪ UHNM has a clear pathway in place for the benchmarking and implementation of NICE guidelines ▪ Maternity has a guideline for developing clinical guidelines ▪ Administration lead for clinical guidelines	▪ Gap analysis on NICE guidance and any action plan/ divergence is presented at the Directorate Governance meeting and to the UHNM NICE implementation group	▪ All local guidelines are developed and reviewed against National guidance and publications including: ○ NICE ○ HSIB themed reports ○ MBRRACE ○ RCOG ○ PHE ○ NHS England ▪ New and revised clinical guidelines are circulated to the Directorate team for comments				

ABBREVIATIONS USED IN THIS DOCUMENT

BAPAM	British Association of Perinatal Medicine
CD	Clinical Director
CN	Chief Nurse
CTG	Cardiotocography
CQC	Care Quality Commission
CWD	Children's, Women's and Diagnostics Division
HEE	Health Education England
HoM	Head of Midwifery
HSIB	Healthcare Investigation Branch
K2	Maternity electronic records system
LMNS	Local Maternal and Neonatal System
MatNeo	Maternity and Neonatal Safety Improvement Programme
MBRRACE	Mothers and Babies Reducing Risk Audit and Confidential
MDT	Multi-disciplinary Team
MIS	Maternity Incentive Strategy
MVP	Maternity Voices Partnership
MW	Midwife
NED	Non-Executive Director
NHSE	NHS England
NHSR ENS	NHS Resolution Early Notification Scheme
NICE	National Institute for Health and Care Excellence
NND	Neonatal Death
O & G	Obstetrics and Gynaecology
PA	Programmed Activity
PCR	Perinatal Case Review
PGDs	Patient Group Directives
PHE	Public Health England
PIL	Patient Information Leaflet
PMA	Professional Midwifery Advocate
PMRT	Perinatal Mortality Review Tool (A score of A = no suboptimal care a score of B = suboptimal care that would not have made a difference to the outcome)
QA	Quality Assurance
QGC	Quality Governance Committee
QPR	Quality Performance Reviews
Q & S	Quality & Safety

RCOG	Royal College of Obstetricians
RM	Risk Management
RCM	Royal College of Midwives
RWT	Royal Wolverhampton Trust
SBLCB	Saving Babies Lives Care Bundle
SI	Serious Incident
SOP	Standard operating Procedure
TNA	Training Needs Analysis

UHNM Action Plan for maternity services assessment and assurance framework

Further Actions (to achieve 'Green' RAG rating / to mitigate risk)

No.	Ref.	Action Required	Lead	Due Date	Progress Report	BRAG
1.	IEA 1	Dashboard development currently in progress in collaboration with LMNS	HoM/LMNS lead MW	Feb 2021	Dashboard shared with LMNS lead midwife and data analyst	
2.	IEA 1	Strengthen floor to board relationships for maternity safety with the LMNS	Safety champion	Feb 2021	Non-executive safety champion attended LMNS board January 2021	
3.	IEA 1	LMNS to collaborate with an additional maternity organisation with level 3 neonatal unit provision	LMNS	March 2021		
4.	IEA 1	Secure data sharing agreements for LMNS	IG	Feb 2021	Email sent to IG lead for update on progress	
5.	IEA 1	Establish Honorary contracts where appropriate for LMNS members	HoM	Jan 2021		
6	IEA 1	Contribute to developing a 'learning system' & ensure that improvement actions are disseminated & shared across the organisation and, where relevant, the wider system, including on a national platform.	Corporate governance team	March 2021		
7	IEA 1	Establish a robust peer review process for PCRs for all cases across trusts	CD	March 2021	CD to liaise with RWT to establish, supported by LMNS	
8	IEA 1	Establish designated job plans for mortality reviews so NND are reviewed with obstetric and Neonatal consultant input at the same time	Directorate manager	March 2021	Directorate manager reviewing job plans to formally enable this	
9	IEA 1	Confirm with Trust and LMNS format of reporting – Q2 report sent for	LMNS lead MW/	Feb 2021	Q2 Q&S report sent to LMNS lead midwife for review	

No.	Ref.	Action Required	Lead	Due Date	Progress Report	BRAG
		benchmarking Review content and style of presenting data in governance reports to reflect 'run chart' with additional narrative to support data.	Maternity Q& S manager			
10	IEA 2	Develop written guidance on mechanism to correlate service user feedback from 'floor to trust board' and 'trust board to floor' by quarterly report	PMA/ patient experience lead/ MVP	Feb 2021	Quarterly report on family experience in maternity and NNU for board and LMNS	
11	IEA 3	Establish a process to enable training to be validated by the LMNS; add to quarterly maternity dashboard for both board and LMNS awareness	HoM	January 2021	To be included in Monthly board report	
12	IEA 3	Audit of K2 electronic maternity patient records for ward rounds	Audit team	Feb 2021	To be included in monthly audit proforma	
13	IEA 4	Audit of K2 electronic patient records as an assurance of compliance	Audit team	Feb 2021	Named consultant included in monthly audit proforma	
14	IEA4	Implement regular audit and report to directorate governance meeting	Audit team	Feb 2021	To be included as standing item on governance agenda	
15	IEA6	Programmed activity (PA) to be factored in to job plan of a newly appointed consultant who currently leads on CTG training within a large teaching hospital.	Directorate manager	March 2021		
16	IEA6	Plans for additional lead midwife from April for 15 hours per week to support	HoM	April 2021	Retiring band 7 coordinator to start in post April	
17	IEA6	Commence MDT face-to-face CTG training	Obs/ MW lead	Jan 2021	Format & Content agreed; confirm start date	
18	IEA6	Local CTG guideline need updating	Obs/ MW lead	May 2021	Commenced October 2021, currently in draft	

No.	Ref.	Action Required	Lead	Due Date	Progress Report	BRAG
19	IEA6	Training compliance to be included in maternity dashboard quarterly and reported to board and LMNS Quarterly patient experience report for board and LMNS	HoM	Feb 2021		
20		Updated midwifery workforce paper in progress	HoM	Feb 2021		

Performance and Finance Committee Chair's Highlight Report to Board

January 2021

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• In terms of critical care capacity, the Trust had increased capacity to 200% in order to manage the anticipated increase in patients, and as part of supporting the national effort in terms of caring for critical care patients from hospitals in the South East and London. It was noted that additional staffing had been provided from within the Trust to support the unit, alongside support from the military and staff from the local authority leisure industry. • Month 9 performance demonstrated continued challenges with urgent care performance and difficulties associated with differing demand for Covid/non Covid beds • The Committee challenged whether there were any potential single points of failure going forwards in relation to IM&T and it was noted that controls were in place to manage and mitigate risks as much as possible, although there were no single points of failure. • The risks associated with the uncertainty around Covid funding were highlighted although some mitigation was in place. • An update was provided in terms of the financial outlook for 2021/22 with the aim of rebasing the budget. A number of key risks were identified in addition to the associated difficulties with the number of outstanding elements which were to be confirmed via the planning guidance which was expected in February	• To work with Divisions in terms of the impact of the Fremanezumab business case on budget setting • To provide a detailed response of the approach taken to inform the decision to extend the nursing and medical locum contracts with the Chief Nurse and Medical Director in addition to providing assurance that the Procurement Lead was confident that the extensions continued to be provide value for money, prior to being approved by the Trust Board
Positive Assurances to Provide	**Decisions Made**
• Vaccinations were continuing at pace and all frontline staff had been offered a vaccine with significant uptake and vaccines were continuing to be provided to other staff and staff from partner organisations. Further consideration was being given as to ongoing priorities • In terms of elective care, 62 day cancer performance was continuing at 73% although a drop in performance was expected in January. Overall, the waiting list was being maintained and the total patient tracking lists were not growing. It was highlighted that for January and February some deterioration in metrics was expected. • Agreement had been reached with the Independent Sector regarding undertaking elective operating going forwards i.e. long wait patients and cancer. • An update was provided following an incident in 2020 affecting the Dell Component and associated passive data centre at Royal Stoke. It was noted that due to multiple reboots of the system a number of components malfunctioned and the actions taken at the time were outlined to the Committee. The Committee were assured that the data centres were operational and funding was in place to commission new storage. • In terms of month 9 financial performance, there continued to be positive performance with a cumulative surplus of £2.1 m year to date and £0.7 m surplus in month which was better than planned.	• The Committee agreed to amend the financial position to anticipated break-even as opposed to the planned £2.2 m deficit • The Committee approved the Board Assurance Framework for Quarter 3, recommending a number of amendments prior to being presented to the Board • The Committee approved Business Case BC-0393 in relation to NICE Guidance – Migraine – Fremanezumab • The Committee approved 2 EREAFs in relation to CCN to Molecular testing system for Enteric Pathogens into Roche MES (REAF 3402) and Patient Monitoring Trust Wide 10 year rolling Replacement (REAF 7192)

• In terms of capital, some slippage was highlighted although assurance was provided that this was expected to catch up. • In terms of the forecast, an upside had been identified and the Trust was forecasting £5.4 m surplus against the £2.2 m planned deficit. Some risks were highlighted in terms of annual leave accrual whilst recognising that this would be an issue nationally, and the risks associated with the elective incentive scheme could worsen the position. It was noted that the Trust was anticipating to break-even which would result in an over-performance for the Trust and a surplus for the system • The Board Assurance Framework for Quarter 3 was presented and it was highlighted that the risk in relation to financial sustainability had reduced. A number of queries were raised in respect of the actions identified for some of the risks and it was agreed to update these in preparation for presentation to the Trust Board. • Positive progress was being made in taking forward the newly introduced new Executive Business Intelligence Group	
Comments on Effectiveness of the Meeting	
• No specific comments on the effectiveness of the meeting	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Executive Director Update including Covid-19	Assurance	6.	Q3 Board Assurance Framework 2021	Approval
2.	Month 9 Performance Report	Assurance	7.	Business Case Approvals	Approval
3.	Dell Component Outage	Information	8.	Authorisation of New Contract Awards and Contract Extensions	Approval
4.	Month 9 Finance Report	Assurance	9.	Executive Business Intelligence Group Highlight Report	Assurance
5.	Financial Outlook 2021/22	Assurance			

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					JT	JT						
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			NH	NH	NH	NH		NH		
Mr J Tringham	**JT**	Director of Operational Finance												

Transformation and People Committee Chair's Highlight Report to Board

21st January 2021

1. Highlight Report

Matters of Concern / Key Risks / Escalations	Major Actions Commissioned / Work Underway
• Numbers of Covid remain high although it is believed that this is the peak; Critical Care is the most significant risk and arrangements have been made to deploy additional staffing. 8/9 transfers from London have taken place although it has not been necessary to continue • Latest absence data (month 9) demonstrates that sickness absence was significantly higher in December at 6.19% with nearly a third relating to chest / respiratory, and a further proportion being associated with stress / anxiety • A slight increase in disciplinary activity is now being seen having slowed down as a result of Covid 19; the report had been developed to include greater detail at the request of the Committee • There were 28 'Speaking Up' concerns raised during quarter 3, themes were largely in relation to attitudes and behaviours followed by policies, procedures and process • Committee received the GMC national training survey & action plan and will be ensuring an assurance focus on the medical education and teaching agenda. • Risk associated with sustainable workforce has increased within the Board Assurance Framework; reflecting the challenges associated with Covid-19 and sickness absence	• Vaccination Programme being progressed at pace, with around 800 per day being vaccinated and the majority of staff having now had their vaccine – slots are now being offered out to the community and work continues with system partners • Roadmap of Delivering Exceptional Care Programme has been developed and presented to the Committee; this captures the component parts of the programme and demonstrates how they sit alongside each other. Key appointments have been made and will commence in February. • Close work between the Delivering Exceptional Care Programme and the Organisational Development Team is taking place to ensure alignment • Arrangements to be made for a more focussed session on the Delivering Exceptional Care Programme / transformation at the end of March and if possible, the Staff Survey findings • Alignment of priorities identified within the Quality Account with the priorities identified within Delivering Exceptional Care • Consideration being given to a revised approach to PDR discussions and a proposal will come back to the Committee when available • Further details on the vaccination programme and the Wellbeing agenda are to form a key priority for the Committee going forward • Further assurance on closing the recruitment gap is to be included within the business cycle
Positive Assurances to Provide	**Decisions Made**
• Huge amount of work undertaken at a national level to support staff within Critical Care and UHNM have participated in this work; restoration and recovery of staff will be a key priority for the organisation • Work on strategy deployment, aligned to the Delivering Exceptional Care Programme is progressing • Staff Risk Assessment process remains ongoing and was recently shared with the Board; the Clinical Group are being consulted with on a revised Risk Assessment profile • Statutory and Mandatory Training was reported as 93.93% for December and PDR completion has seen a slight improvement at 76.26% • The Committee praised the way in which the Workforce Report has been developed over recent months • UHNM has been successful in receiving the funds for overseas recruitment and will	• Approval of the Board Assurance Framework

be working to a very tight timeframe in order to deliver • Very pleasing to see the progress that has been made with the Speaking Up agenda with compliments made by the Committee, clear demonstration of living the values – agreed that communication and recognition should be highlighted around this • Reverse Mentoring Programme has commenced with some very positive feedback • Lots of progress being made with regard to the Equality, Diversity and Inclusion agenda, particularly through the strengthening of the Networks	
Comments on Effectiveness of the Meeting	
• Decision to consolidate the meetings planned for February and March, with a deep dive focus on some key priorities • Good depth in the assurances received through the Committee	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Executive Directors Update including Covid-19	Information	7.	Progress Report on Workforce Equality, Diversity and Inclusion	Assurance
2.	Delivering Exceptional Care Roadmap	Assurance	8.	Midlands Charter	Approval
3.	Delivering Exceptional Care Highlight Report	Assurance	9.	GMC National Training Survey and Action Plan	Assurance
4.	M9 Workforce Report	Assurance	10.	Q3 Board Assurance Framework	Approval
5.	Q3 Formal Disciplinary Activity	Assurance	11.	Review of Meeting Effectiveness, Business Cycle and Items for Escalation to the Trust Board	Approval
6.	Q3 Speaking Up Report	Assurance			

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								MP		
Mr M Oldham	MO	Chief Finance Office												
Prof P Owen	PO	Non-Executive Director												
Mrs M Rhodes	MR	Chief Nurse			HI									
Miss C Rylands	CR	Associate Director of Corporate Governance	NH					NH	NH					
Mrs R Vaughan	RV	Director of Human Resources												

In addition, Mrs F Taylor joined the meeting.

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	3rd February 2021
Report Title:	Integrated Performance Report, month 9 2020/21	**Agenda Item:**	12.
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:

Situation

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

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

Assessment

The Trust continued to experience significant operational pressures in January 2021. Critical care continued to manage a high number of Covid-19 positive patients alongside side those that need elective procedures. Also, our general wards and departments became extremely challenged as the patients cared for were very sick patients and this is in addition to the workforce challenges.

Early in January, after discussions with the senior leadership teams, the infection prevention team, operational teams and system partners a decision was made to increase the incident level to Level 4 for the whole of the organisation. This was undertaken so that the Trust could proactively plan to ensure that everything was in place to be able to address the forthcoming challenges and to support the most challenged areas and ensure that services for those patients in need of urgent treatment continues. This decision undoubtedly meant the cancellation of more elective / planned work and redeployment of staff.

The wards continued to have more Covid-19 patients than anytime previously and the critical care unit also treated more patients than ever before with colleagues in the Paediatric Intensive Care Unit stepping in to provide adult care.

The weeks and months were set to get even more challenging and the Trust received instruction to increase capacity to support the health care systems in London and the South East. As a consequence the Trust was in a position to double the intensive care capacity and was able to take patients from the London area. To support the workforce staff were drafted in from the armed forces and local authorities.

Amid all this and supported by the Independent sector, the Trust has been able to continue to treat patients who are clinical urgent or have cancer.

Quality & Safety:

The Trust achieved following standards in December 2020:

- Harm Free Care 95.7% continues to be above the national 95% target
- Trust rolling 12 month HSMR and SHMI continue to be below and within expected ranges respectively
- 100% of patients/family informed verbally of incidents that are reported as meeting duty of candour threshold
- VTE Risk Assessment continues to exceed 95% target with 99.3% (via Safety Express audit)
- Zero avoidable MRSA Bacteraemia cases reported
- There has been one Category 3 pressure ulcers and one unstageable due to lapses in care in December, as validated at this point in time.
- Inpatient Sepsis Screening compliance (adult Inpatients) improved to 90.2% and above the target of 90%
- Sepsis Screening Compliance in Emergency Portals improved to 95.2% against target 90%
- Children's sepsis Screening Compliance 100.0%
- Inpatients IVAB within 1 hour achieved 100% for audited patients
- Zero Never Events

The Trust did not achieve the set standards for:

- Patient Falls rate per 1000 bed days higher than target in December 2020 at 7.1 falls per 1000 bed days
- C Diff target above trajectory target of 8 during November 2020 with 10 cases reported, which is a reduction from previous months. Full C Diff report to be provided to Quality Governance Committee in January 2021
- Emergency Portals IVAB in 1 hour decreased to 76.1%
- Maternity Sepsis Screening below target, although Sepsis Screening did improve to 46.2% and continuing action plan in place

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

- The rate of complaints per 10,000 spells has decreased to 23.71 and below (positive) the target of 35 but is within normal variation.
- Total number of Patient Safety Incidents decreased along with the rate per 1000 bed days
- Patient Safety Incidents with moderate harm or above and rate of incidents with moderate harm or above per 1000 bed days has remained low and around the long term average. National comparison taken from latest CQC Insight Report is that 26.1% of reported patient safety incidents to NRLS resulted in harm. UHNM latest results are 22.8%. UHNM is lower that national average (September 2019 – August 2020)
- Rate of falls reported that have resulted in harm to patients has increased from 1.8 in November to 1.9 for December. The rate of patient falls with harm continues to be within the control limits and normal variation despite the increase during December 2020
- The number and rate of pressure ulcers that have developed under our care continue to show a decreasing trend and is currently below the organisational mean.
- Medication related incidents rate per 1000 bed days has reduced from 4.0 to 3.9
- HAI E.Coli Bacteraemia cases for December 2020 noted 7 cases and below the mean of 9
- Nosocomial COVID Infections have reported decrease during December 2020 with 79 reported cases from 88 during November 2020
- Definite Nosocomial COVID-19 deaths increased to 30 and total of 82 since March 2020

Operational Performance:

December began with the same challenges faced in November. Attendances saw a significant decline in the 1st phase of covid (March & April) with a steady rise thereafter up to July. Numbers seen system-wide and at RS thereafter have remained steady (and show normal variation), albeit the numbers are below the average seen pre-covid. (Daily average at Royal Stoke: 270 and at County 94). The acuity of the patients attending remained high with ambulance attendances as a proportion of the overall RS attendances at 56%. The daily average attendances by ambulance at Royal Stoke were 151.

The performance for UHNM (system wide) in December was 68.2% (November 70%). Royal Stoke performance was 46.4%. The average daily admissions were slightly less than November at 115/ day with a conversion rate of 42.7%; a position similar to that seen in April/ May. Performance for admitted patients at Royal Stoke was maintained at 30%. The average daily number of medical beds occupied rose to 447 (November 445).

Think 111 began on the 1st December and monitoring of the proposed new ED standards has shown that there has been on average 32/day with 94% receiving clinical input.

The key issues affecting performance were: availability of appropriate beds through the high risk pathway, restricted / closed beds for infection prevention, staff sickness. Covid related absences were lower in the second half of December but overall averaged 513/ day which accounted for 52% of total absences. The highest proportion of absences was seen in the Medical Division.
The number of 12 hour trolley waits reduced to 64.

In following Infection Control guidelines for admission of patients with suspected/ confirmed Covid-19, the Trust continued to face huge challenges: closures and restrictions remained in place resulting in a consistently high number of beds unavailable for use. On average this was around 40/day but peaked at times to up to 70. Critical care capacity was extremely challenged to a point that the internal incident was raise to level 4. Staffing loses due to high sickness levels: 50% of which was covid-related.

The trust is predicted to achieve 4 cancer targets in December; 31 day sub anti-cancer; 31 day sub radiotherapy; 62 day screening and 28 day FDS.

The 104+ day backlog is showing normal variation at 45 for December and the 62 day backlog continues to be monitored and is currently at 296.

The trust is experiencing higher than pre-covid predicted demand, which has been addressed with extra clinics where appropriate. Capacity and demand modelling is being re-evaluated and worked through with the bureau and directorate managers to accommodate the 14 days standard.

Discussions with the IS are continuing for early Jan lists - to optimise theatre capacity available.

For the remaining elective care, the National ask for December was for total Outpatients to be at 100% of last year's business as usual and for Inpatients 90%. The trajectories for December were set 91.3% and 84.2% of BAU for last year respectively. The actuals for December, against the trajectories, was outpatients 845.5% and inpatients 68.2%.

For December, the total number of Referral To Treatment pathways grew to 49,011 (November 46,791). This is above the forecast 46,100. The number of new RTT clock starts rose steadily from May through to November when 13,000+ new RTT pathways/ periods were added. December saw a fall in new pathways partly due to a reduction in referrals. Potentially the reduction seen now may herald a return of referrals post covid that exceeds previous numbers. A Trust trajectory for this has been developed and monitored through the elective weekly assurance meetings. The Trust has 2,730 over 52 week breaches as a consequence of standing down elective work. This was over the forecasted position. Recovery plans for recovery of the long waiting patients will be reviewed. RTT performance in December is 65.78% (November 66.97%).

December saw a fall in diagnostic activity at 24,003. However all trajectories are on track and the data shows that recovery has been sustained. The diagnostic performance for December is currently 91.23%. The waiting list size is also showing a reduction: down to 11,668.

The strategic focus of our People Plan remains on supporting recruitment, workforce deployment, staff wellbeing, absence management and staff testing. The focus of the Workforce Bureau remains on risk assessments, staff wellbeing, staff testing, staff deployment and supporting the vaccination programme.
The daily sickness sitrep highlights wards and areas with high numbers of staff calling in as absent, which then triggers mitigating actions set out in business continuity plans. Redeployment processes are place to support areas of need and volunteer placements, including Military personnel and volunteers from local councils, are offering support. A system-led workforce demand and supply process is in place to manage redeployment of staff where required.

The key performance issues remain compliance with the sickness rate being above target and with PDR requirements although an Executive decision was taken to suspend PDR's unless there is capacity to continue to undertake them. The Non-Medical PDR compliance rate improved to 76.76% at 31st December 2020 (75.56% at 30th November).

The in-month sickness rate was 6.19% (5.85% reported at 30/11/20). The 12 month cumulative rate increased to 5.34& (5.23% at 30/11/20). Since the 21st October, absence episodes have increased in line with the second covid wave and, As of 4th January 2021, covid-related open absences numbered 463, which was 48.94% of all absences (50% at 21st December 2020).

Covid related absences and staff testing remains an area of focus, with additional resources being applied to manage staff testing. The Covid vaccination programme is well underway and has been opened to all staff. As at 19th Jan 21, 5811 staff had received the first dose vaccine, plus a further 3904 others who work in the trust. The 3904 includes staff who have not provided an employee number and are being verified to ESR, Sodexo, EZEC and Agency workers'

There is a Staff Wellbeing plan in place and wellbeing support has continued throughout the pandemic. The focus going forward will be on the continued provision of staff support to ensure the psychological wellbeing of staff. Rest Facilities for staff have been opened on the Royal Stoke Site and refurbishment of the rest facilities at County Hospital will be progressed soon

The Statutory and Mandatory training rate was 93.93% at 31st December 2020 (94.14% at 30/11/20). 89.86% of staff have completed all 6 core for all requirements (90.07% at 30/11/20)

For Finance, the key messages are:

- The Trust has received confirmation that it will receive £12.4m additional funding for M7-12 relating to the TSA agreement with its planned deficit being reduced from £14.6m to £7.2m and the Trust required to exceed this plan by a further £5m to deliver a year end deficit of £2.2m.
- The Trust has delivered a surplus of £0.7m in Month 9 against a planned deficit of £2m which is driven by additional DHSC funding, reimbursement of COVID-19 costs outside of the Trust's original allocation (for Months 8 & 9) and continued slippage against the original COVID-19 allocation and Winter plan.
- Activity delivered in Month 9 is significantly lower than plan although NHS income levels from patient activities have been maintained due to the temporary funding arrangements.
- The Trust estimates the impact of the Elective Incentive Scheme (EIS) to be a £0.9m reduction to income in Month 9; as for months 6 to 8 this is not reflected in the financial position in line with guidance from NHSI/E.
- The Pathology Network went live on 1 December with the financial impact included in the Month 9 position. Whilst there is a negligible impact on the bottom line financial position this is causing variances between the reporting categories (i.e. other income, pay and non-pay)
- The Trust incurred £1.6m of costs relating to COVID-19 which remains largely static in comparison to the prior period due to continued high sickness and testing as a result of the second wave.
- Capital expenditure for the year to date stands at £24.5m which is £7.3m behind plan with the main driver being slippage on the PDC funded ED scheme and phasing of Linac and IR2 bi-plane.
- The month end cash balance is £86.1m which is £0.7m more than plan

Key Recommendations:

To note performance.

NHS
University Hospitals of North Midlands
NHS Trust

Integrated Performance Report

Month 9 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

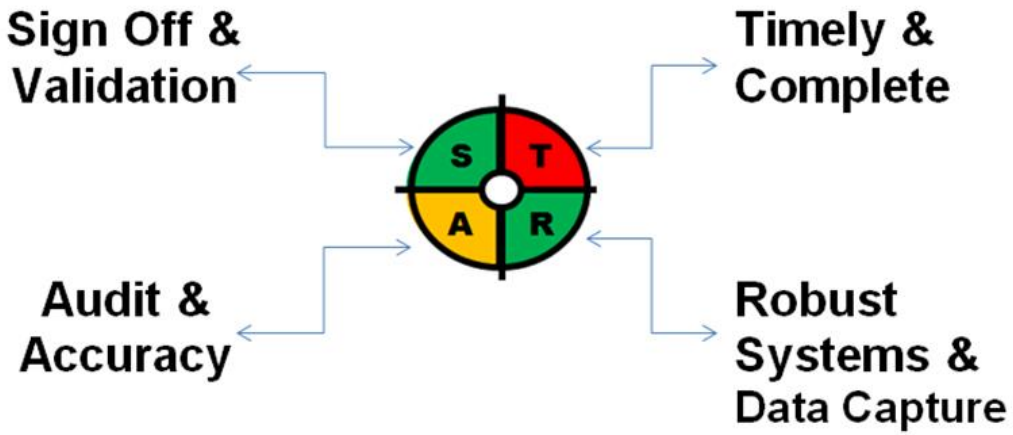
Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

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

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Quality Dashboard

NHS University Hospitals of North Midlands NHS Trust

Metric	Target	Latest	Variation	Assurance
Patient Safety Incidents	N/A	1546		
Patient Safety Incidents per 1000 bed days	N/A	45.24		
Patient Safety Incidents per 1000 bed days with no harm	N/A	29.94		
Patient Safety Incidents per 1000 bed days with low harm	N/A	13.11		
Patient Safety Incidents per 1000 bed days reported as Near Miss	N/A	1.64		
Patient Safety Incidents with moderate harm +	N/A	19		
Patient Safety Incidents with moderate harm + per 1000 bed days	N/A	0.56		
Harm Free Care (New Harms)	95%	96%		
Patient Falls per 1000 bed days	5.6	7.1		
Patient Falls with harm per 1000 bed days	1.5	1.9		
Medication Incidents per 1000 bed days	N/A	4		
Medication Incidents % with moderate harm or above	TBC	0.8%		
Patient Medication Incidents per 1000 bed days	N/A	2.9		
Patient Medication Incidents % with moderate harm or above	TBC	1.0%		

Metric	Target	Latest	Variation	Assurance
Serious Incidents reported per month	N/A	9		
Serious Incidents Rate per 1000 bed days	N/A	0.26		
Never Events reported per month	0	0		
Duty of Candour - Verbal/Formal Notification	100%	100%		
Duty of Candour - Written	100%	88%		
All Pressure ulcers developed under UHNM Care	TBC	58		
All Pressure ulcers developed under UHNM Care per 1000 bed days	N/A	1.70		
All Pressure ulcers developed under UHNM Care lapses in care	12	2		
All Pressure ulcers developed under UHNM Care lapses in care per 1000 bed days	0.5	0.06		
Category 2 Pressure Ulcers with lapses in Care	8	0		
Category 3 Pressure Ulcers with lapse in care	4	1		
Category 4 Pressure Ulcers with lapses in care	0	0		
Unstageable Pressure Ulcers with lapses in care	0	1		

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Quality Dashboard

NHS University Hospitals of North Midlands NHS Trust

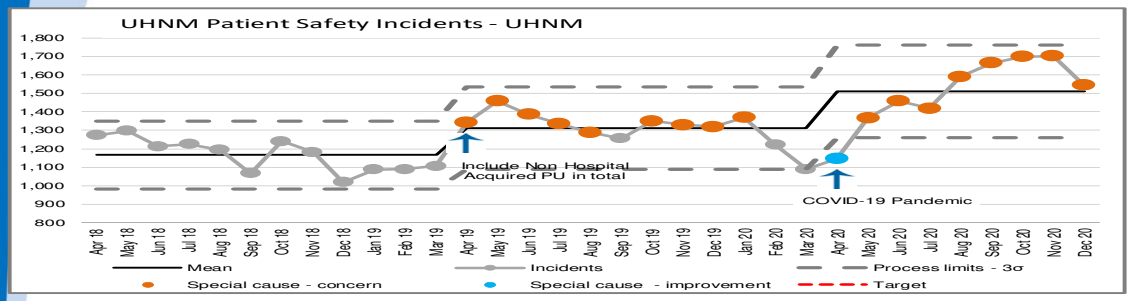
Metric	Target	Latest	Variation	Assurance
Friends & Family Test - A&E	N/A	N/A	H	?
Friends & Family Test - Inpatient	N/A	98.5%		P
Friends & Family Test - Maternity	N/A	N/A	H	?
Written Complaints per 10,000 spells	35	23.71		?
Rolling 12 Month HSMR (3 month time lag)	100	94.64	L	P
Rolling 12 Month SHMI (4 month time lag)	100	102.91	H	P
Nosocomial "Definite" COVID-19 Deaths	N/A	30	H	
VTE Risk Assessment Compliance	95%	99.3%	H	?
Emergency C Section rate % of total births	15%	18.6%	H	?
Reported C Diff Cases per month	8	9	H	?
Avoidable MRSA Bacteraemia Cases per month	0	0		P
HAI E. Coli Bacteraemia Cases per month	N/A	7		
Nosocomial "Definite" HAI COVID Cases - UHNM	0	79		

Metric	Target	Latest	Variation	Assurance
Inpatient Sepsis Screening Compliance (Contracted)	90%	90.2%		?
Inpatient IVAB within 1hr (Contracted)	90%	100.0%		?
Children Sepsis Screening Compliance (All)	90%	100.0%	H	P
Children IVAB within 1hr (All)	90%	N/A	H	F
Emergency Portals Sepsis Screening Compliance (Cor	90%	95.2%		?
Emergency Portals IVAB within 1 hr (Contracted)	90%	76.1%		?
Maternity Sepsis Screening (All)	90%	46.2%	L	F
Maternity IVAB within 1 hr (All)	90%	N/A	H	P

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Reported Patient Safety Incidents

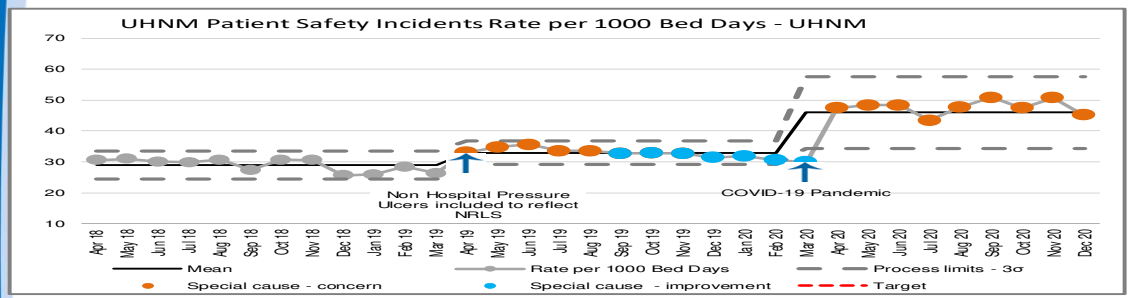


Variation	Assurance

Target	Oct 20	Nov 20	Dec 20
N/A	1699	1703	1546

Background

Total Reported patient safety incidents



Variation	Assurance

Target	Oct 20	Nov 20	Dec 20
N/A	47.49	50.71	45.24

What is the data telling us:

The above data relates to **all** reported Patient Safety Incidents (PSIs) across the Trust. November 2020 has seen an increase in total number of reported PSIs and is above variation limits. The increase in incidents is reflected by the increasing level of activity as Recovery & Restoration plans continue to increase activity. The reporting of incidents and near misses should continue to be encouraged and promoted.

The largest categories for reported patient safety incidents excluding Non Hospital acquired Pressure Ulcers are:

- Patient related Slip/Trip/Fall - 243 (247),
- Clinical assessment (Including diagnosis, images and lab tests) – 60 (57)
- Patient flow incl. access, discharge & transfer - 82 (79)
- Treatment/Procedure - 64 (64)
- Medication incidents - 99(120)
- Documentation – 51 (66)

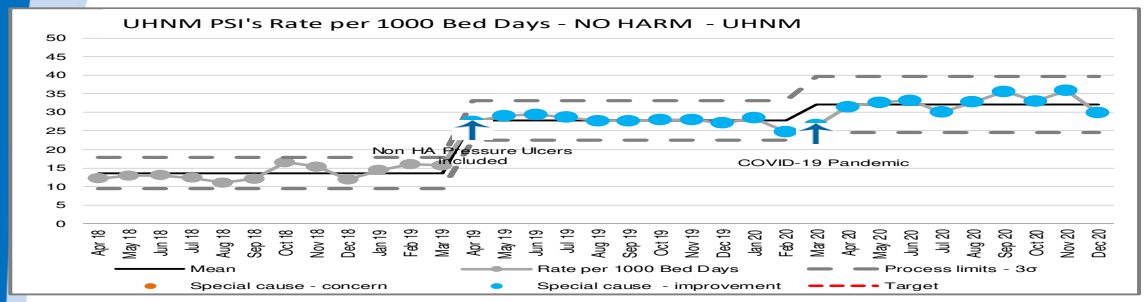
There have been decreases in Medication, Falls and Documentation incidents compared to November 2020 totals (in brackets). However, there have been increased incidents in relation to Clinical assessment and Patient flow incidents whilst there has been n change in Treatment/Procedure incidents reported.
Patient Safety Incidents are reviewed and analysis undertaken on locations and themes.

The Directorates reporting most PSIs are Emergency Medicine, General Medicine, Specialised Medicine, Anaesthetics Theatres & Critical Care, Obstetrics & Gynaecology and General Surgery & Urology. Specific incidents are reviewed at specialist forums for themes / trends as well at Divisional level.

The rate of reported patient safety incidents per 1000 bed days has decreased compared to November 2020 and is lower than previous 4 months and below the mean rate during the COVID-19 pandemic.

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

University Hospitals of North Midlands NHS Trust

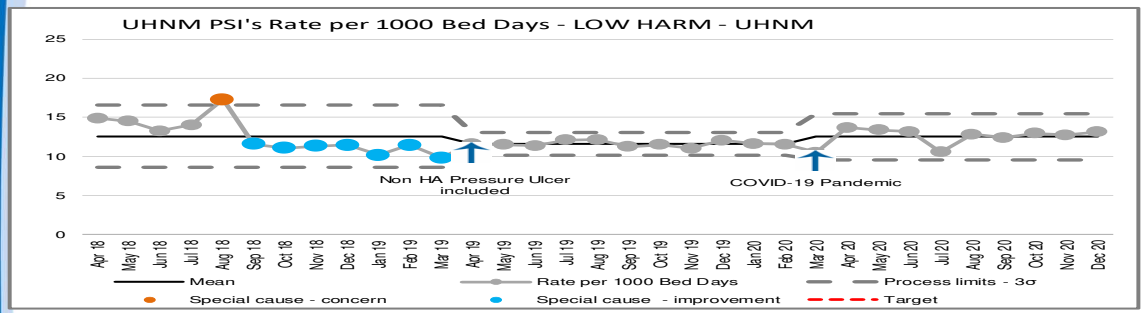


Variation	Assurance

Target	Oct 20	Nov 20	Dec 20
N/A	33.04	35.82	29.94

Background

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

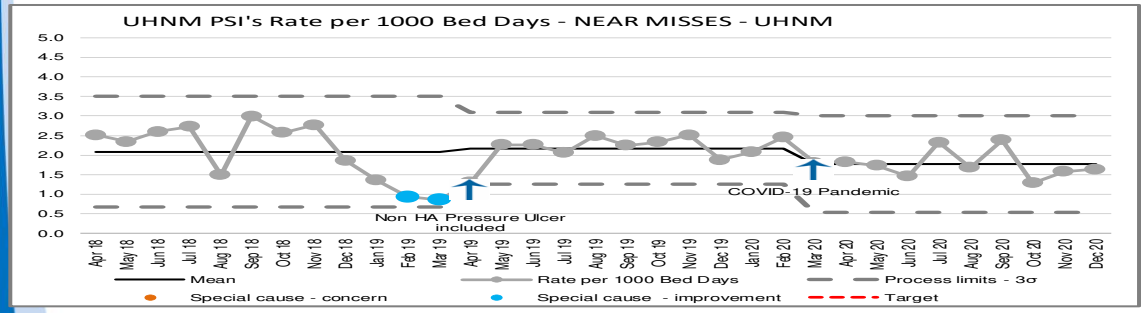


Variation	Assurance

Target	Oct 20	Nov 20	Dec 20
N/A	12.94	12.72	13.11

Background

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



Variation	Assurance

Target	Oct 20	Nov 20	Dec 20
N/A	1.29	1.58	1.64

Background

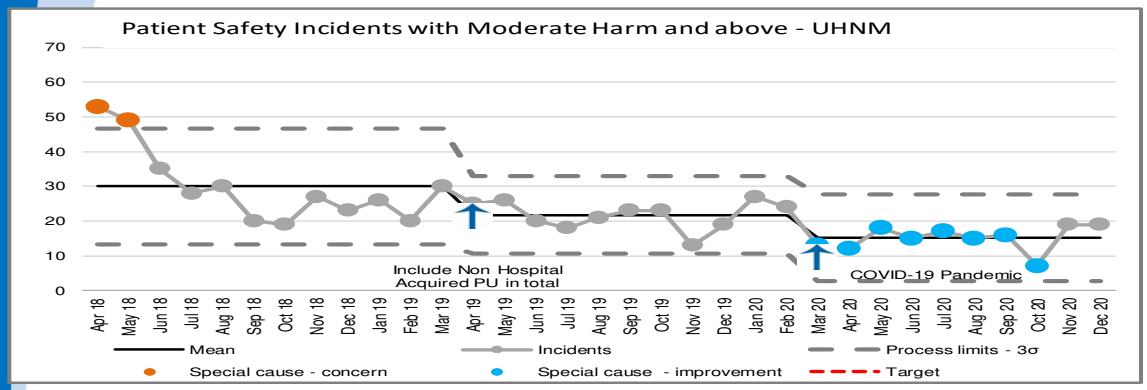
The rate of Patient safety Incidents per 1000 bed days that are reported as NEAR MISS

What is the data telling us:

The Rate of Patient Safety Incidents per 1000 bed days with no harm or low harm are showing consistent trends. The rate of incidents reported resulting in no harm is continuing the trend to increase and should be encouraged as reporting these incidents allows for actions and learning to be identified via potential trends of incidents.

Low harm rate has similar profile and is higher than pre pandemic although returned to long term organisational mean. Near misses rates had increased during earlier months of pandemic and have seen return to similar rates pre COVID.

Reported Patient Safety Incidents with Moderate Harm or above

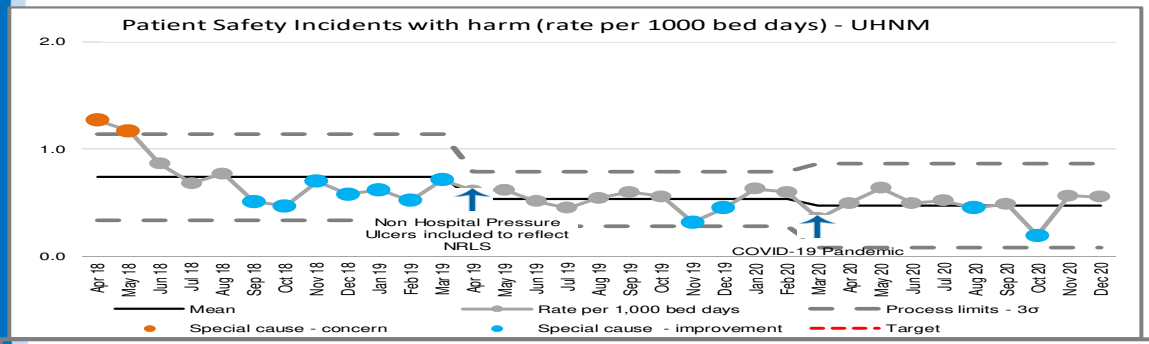


Variation	Assurance

Target	Oct 20	Nov 20	Dec 20
N/A	7	19	19

Background

Patient safety incidents with reported moderate harm and above



Variation	Assurance

Target	Oct 20	Nov 20	Dec 20
N/A	0.20	0.57	0.56

What is the data telling us:

The chart show that during December 2020 there has been same number of PSIs with moderate harm or above (at time of report 10/12/2020). The number of PSIs with moderate harm or above continues to be below the pre COVID mean. The second chart, shows the rate of PSIs with moderate harm or above per 1000 bed days and there are continued positive trends with reductions from pre COVID period. 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.

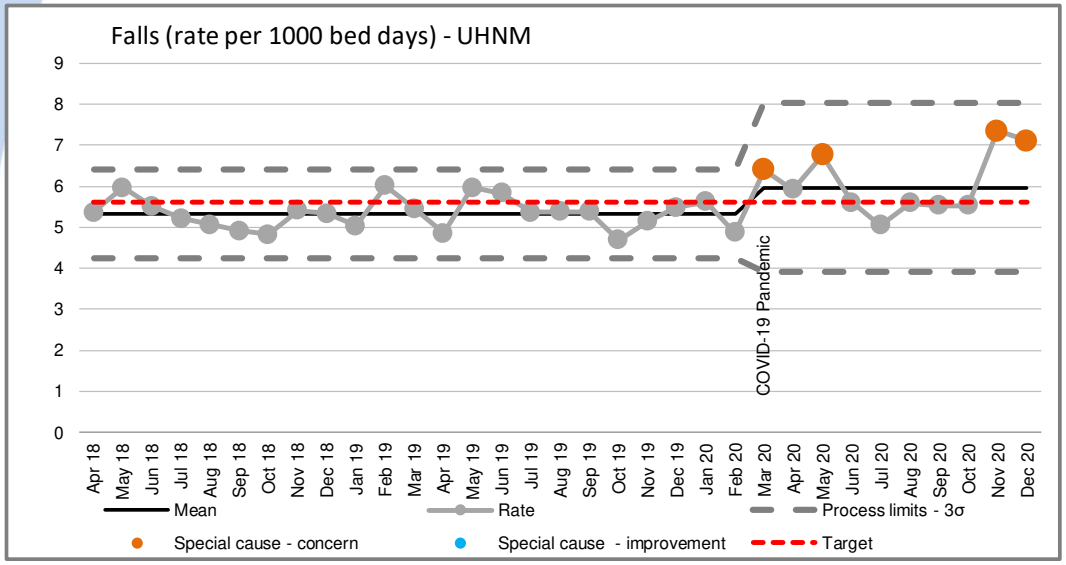
The top category of incidents resulting in moderate harm reflect the largest reporting categories with Slips/Trips/Falls being the largest category.

The second largest category is Treatment/Procedure (2 of these are extravasation injuries, 2 treatment delays and 1 complication of treatment resulting in pneumothorax following NG tube insertion)

Other categories with single incidents reported are Equipment fault, Medical Gas/Oxygen, Tissue Viability

National Comparison taken from latest CQC Insight Report is that 26.1% of reported patient safety incidents to NRLS resulted in harm. UHNM latest results are 22.8% . UHNM is lower that national average (September 2019 – August 2020)

Patient Falls Rate per 1000 bed days



Variation	Assurance
	

Target	Oct 20	Nov 20	Dec 20
5.6	5.5	7.4	7.1

Background

The number of falls per 1000 occupied bed days

What is the date telling us:

The date shows the Trust's rate of reported patient falls per 1000 bed days. Using the rate makes allowance for changes in activity/increased patient numbers. The Trust set a target rate, based on the Royal College of Physicians National Falls Audit published rate for acute hospitals, of 5.6 patient falls per 1000 bed days.

The chart shows the average rate since April 2018 is below the target. The rate in December remains above 7.

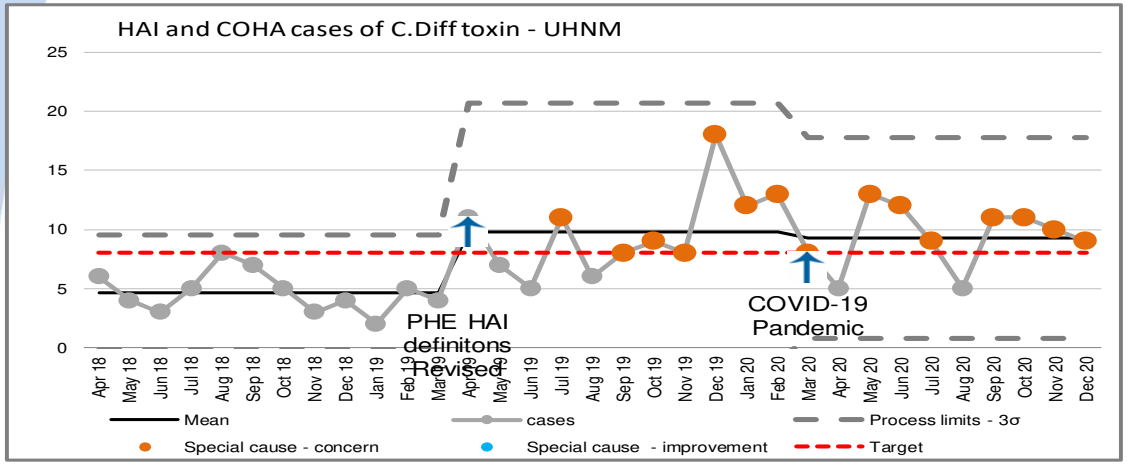
The Top areas for total falls in December were:

Ward 230/231 (AMU) ED(Royal Stoke) Ward 15(County) FEAU (Ward 232) Ward 228 – Neurosurgery

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

- Data shared with top falling wards to highlight their increase in falls numbers.
- Staff reminded of the importance of baywatch/cohorting for patients with known falls risk factors.
- Wards encouraged to red flag shifts and escalate the need for 1:1
- Hot debrief tool shared widely to help wards identify immediate actions to take to minimise risks.

Reported C Diff Cases per month



Variation	Assurance
	

Target	Oct 20	Nov 20	Dec 20
8	11	10	9

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 10 reported C Diff cases in November. 6 of these were Hospital Associated Infection (HAI) cases and 4 Community Onset Hospital Associated (COHA) cases.

Two clinical areas reported 2 cases Clostridium *difficile* toxin cases within a 28 day period, awaiting ribotypes to be confirmed.

For November 2020, UHNM is above trajectory for the year to date 2020/21 ,76 cases versus a year to date target of 63

Actions:

Continue surveillance for HAI C diff with continued immediate implementation of control measures to prevent transmission

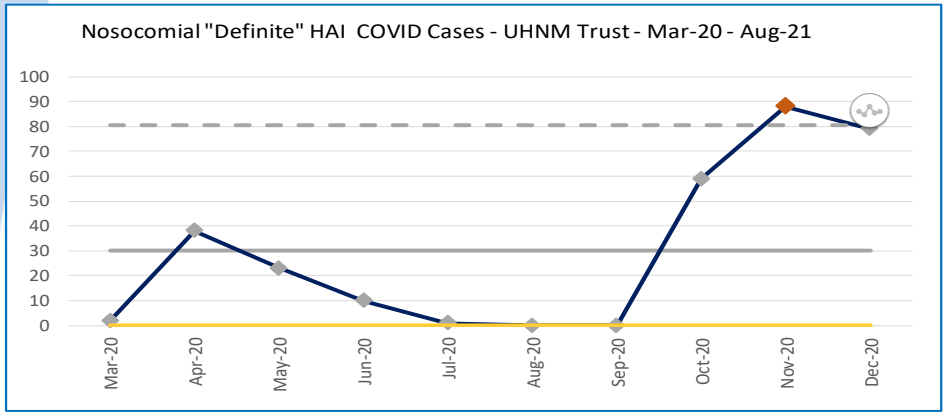
In all cases control measures are instigated immediately, and RCA's are reviewed by the CCG, this is paused due to COVID 19.

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 ribotyping of samples is now being undertaken at Leeds hospital. This will help determine if cases can be linked

A Clostridium *difficile* task and finish Group has been planned to review the CDI deep dive report with was presented at IPCC.

HAI Nosocomial COVID Cases per Month



	Metric Name	Latest Value	Lower process limit	Upper Process limit	Mean
1	Nosocomial "Definite" HAI COVID Cases - UHNM Trust	79	-20.5	80.5	30.0

What do these results tell us?

- The data shows an Increase in definite Healthcare Acquired COVID -19 cases. This increase started during the second wave of the COVID -19 pandemic and December 2020 saw a slight reduction compared to November 2020.
- A number of COVID ward outbreaks were reported during December 2020.
- Ward 127 / Ward 225 / Ward 100 & 101 / Ward 81 / Ward 123 / |Ward 124
- All the outbreaks have now been closed and restrictions removed.

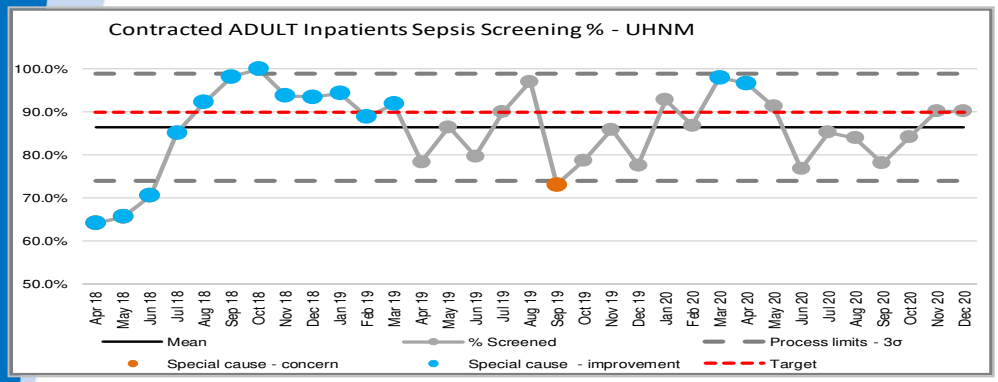
Definite healthcare acquired infection (HAI) | **SARS-CoV-2 detected ≥ 15 days into admission**

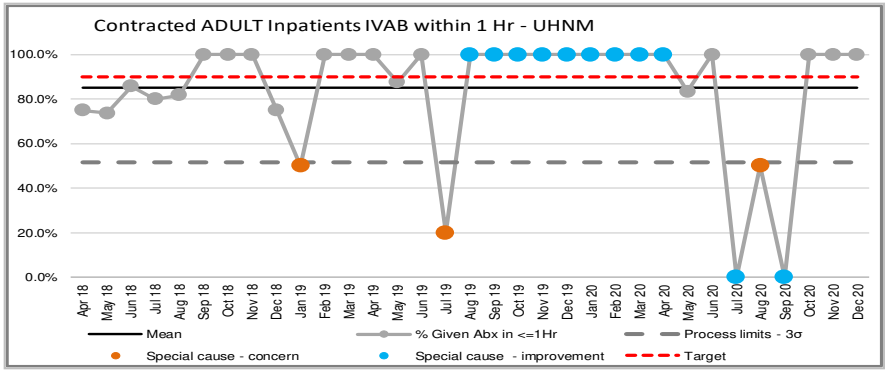
Actions :

- All Emergency patients screened for COVID 19 on admission to UHNM, screening programme in place for planned surgery/procedures.
- All inpatients who have received a negative COVID screen have a repeat COVID screen on day 4 and 6 as per NHS key actions
- COVID 19 themes report to IPCC
- UHNM Guidance on Testing and re-testing for Covid-19' plus step down of suspected/positive cases
- Isolate suspected patients on identification of symptoms
- Process for patients identified as contact of positive case via ICNet system
- Process in place for outbreak management and reporting
- Swabbing champions rolled out in a number of areas

Sepsis Screening Compliance (Inpatients Contract)

NHS
University Hospitals of North Midlands
NHS Trust





Variation	Assurance
	

Target	Oct 20	Nov 20	Dec 20
90%	84.3%	90.2%	90.2%

Background

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

Variation	Assurance
	

Target	Oct 20	Nov 20	Dec 20
90%	100.0%	100.0%	100.0%

Background

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

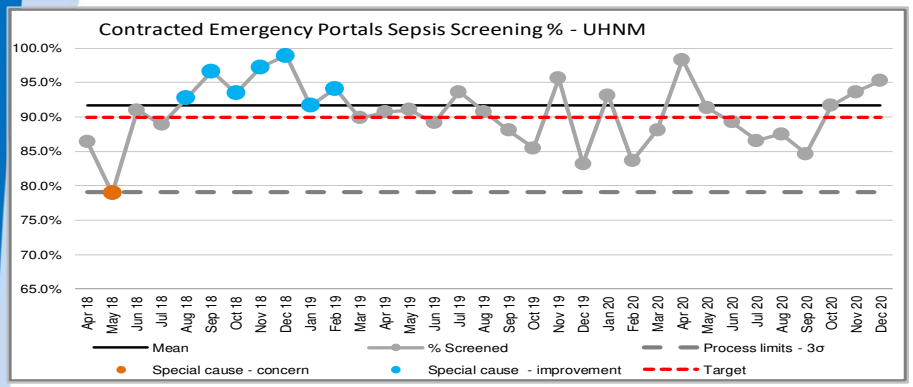
What is the data telling us:

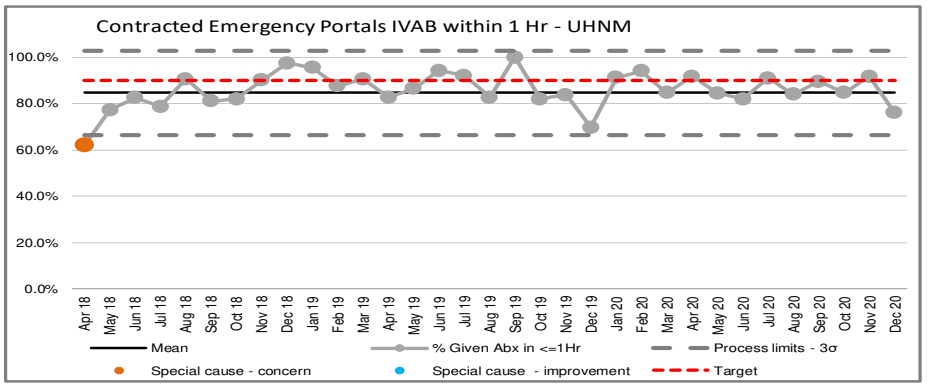
December results now at 90.2% which shows continued improvement from the previous months. Inpatient areas also achieved 100% for IVAB within an hour, Of the 122 Inpatients that triggered a sepsis screen, 46 were moderate risks and 76 patients with red flags (3 of these patients were given IVAB within hour and the remaining 73 patients, 32 had alternative diagnosis that were deemed as not sepsis related and IVAB were not indicated. The remaining 41 patients were already received treatment for sepsis and administration of IVAB initiated prior to the identified red flag trigger).

Actions:

- In the absence of formal practical training due to COVID-19 restrictions, the sepsis team have continued to provide sepsis re-enforcement which consists of visiting ward areas to update clinical staff and promote awareness around sepsis whilst answering any queries they may have as well as sepsis kiosks a 15-20 minutes drop in session (commenced already in prioritised areas, like older wards & other medicine areas , few areas from Surgery, Specialised & CWD).
- The sepsis team now input data weekly rather than monthly in order to identify Inpatient areas with poor compliance and prioritise those areas for sepsis re-enforcement/ kiosks- drop in session.
- The sepsis team continue to work closely with the VitalPacs team in order to address issues with staff access levels. This remain as one of the priorities to continue/ monitor closely to help improve this system.
- The missed screens for this month were the on-going problems with staff access levels for sepsis Vitals, lack of communications between HCA's and qualified staff and night shifts having higher occurrences. Therefore, the sepsis team had provided unannounced ward visits out of hours to deliver reinforcement to those staff who worked regular nights; this is done on an adhoc basis and we hope to see improvement as a result.
- Yearly consultants and all levels of clinicians departmental sepsis training already commenced via Microsoft Teams from Surgery division, Maternity (date already arranged), as well as for Renal department and Specialised.

Sepsis Screening Compliance (Emergency Portals Contract)





Variation	Assurance

Target	Oct 20	Nov 20	Dec 20
90%	92%	94%	95%

Background

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

Variation	Assurance

Target	Oct 20	Nov 20	Dec 20
90%	85%	92%	76%

Background

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

What is the data telling us:

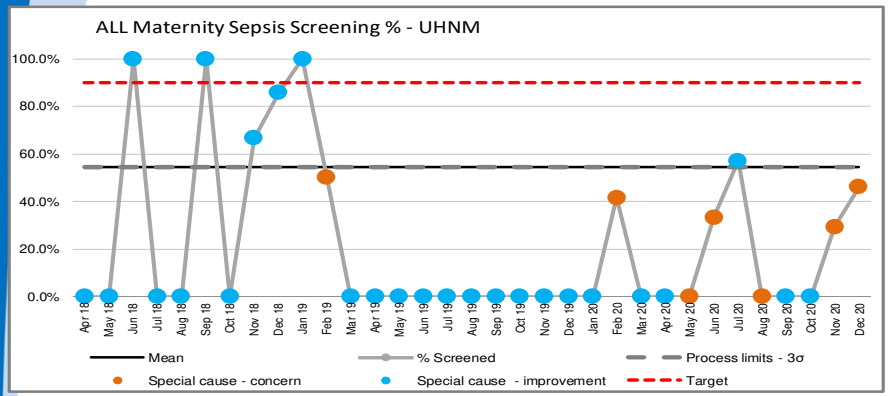
Adult screening in December achieved 95% for the 84 patients audited whilst IVAB within 1 hour decreased to 76% for the 72 red flag sepsis patients identified during the audit & 12 moderate risks sepsis triggers. Although out of the 72 red flags, only 46 required IVAB within an hour as (35 given within hour & 11 late IVAB). 13 had alternative diagnosis and were deemed as not sepsis related /IVAB were not indicated and 13 already on IVAB. This indicator currently relates to all Emergency Portals that had been audited (A&E Royal & County, AMU Royal & County, SAU, FEAU)

Actions:

- The sepsis team continued to closely monitor the compliance by visiting the department regularly and provided immediate sepsis reinforcement when required
- The A&E education team and A&E sepsis doctor will continue to provided sepsis virtual education for both A&E sites as required
- The delayed IVAB and missed screening already escalated and lesson learned discussed with A&E team, currently the sepsis team is working collaboratively with the A&E Quality nurses, senior staff and A&E sepsis clinician lead for providing sepsis reinforcement to all level of staff and doctors; still on-going action
- Sepsis team will work collaboratively with A&E department regarding management of patients with sepsis triggers whilst held in the ambulance due to capacity pressures this winter; on-going

Sepsis Screening Compliance ALL Maternity

University Hospitals of North Midlands NHS Trust

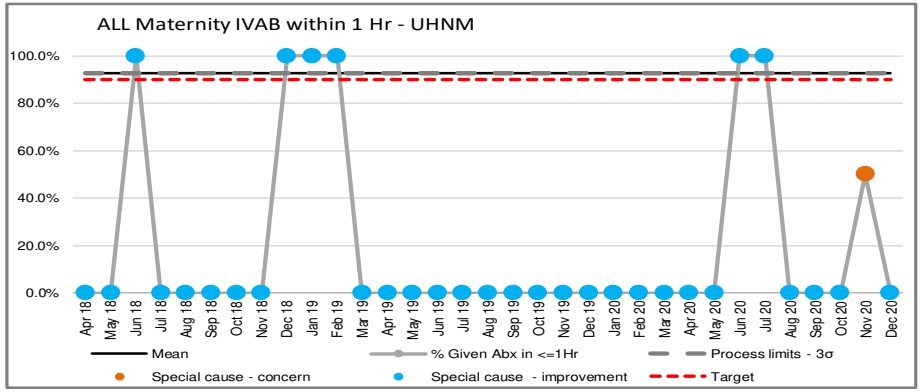


Variation	Assurance
L	F

Target	Sep 20	Oct 20	Nov 20
90%	N/A	N/A	29.4%

Background

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



Variation	Assurance
H	P

Target	Oct 20	Nov 20	Dec 20
90%	N/A	50%	N/A

Background

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

What is the data telling us:

Maternity Inpatients and Emergency portal (MAU) audited by the Sepsis Team in December 2020. All patients that trigger with MEOWS >4 were audited via the Maternity K2 system. The Inpatient wards screening compliance scored 50% (5 missed screening from a sample size of 10 patients) and MAU with 33% (only 1 missed screening from a small sample size of 3 patients) and overall total score of 46%. We have no red flags from MAU and Inpatients areas therefore it will be scored as N/A. However, few of the patients audited already received IVAB due to moderate risks triggers.

Actions:

The Sepsis team have been working closely with the Maternity education and senior team in regards of updating Maternity Sepsis guidelines and their new Maternity Inpatient and community screening tools. The trial plan aims to commence in January 2021, however this is now being delayed due to unavoidable problem with the system. The Maternity senior team have been working collaboratively with the sepsis team and have created an action plan to resolve/improve both screening and IVAB compliance. Currently the Sepsis Team is providing sepsis reinforcement or training as well as creating further awareness to ensure staff are aware of the process for attaching completed screening tools to the K2 system. Mainly, the maternity documentation and notes are all completed electronically except for the sepsis screening tool and prescription chart hence the issue of missing paper documentation. Furthermore, Microsoft Teams sepsis Training is currently available and will provided to all levels of clinicians from Feb-March as agreed/arranged.

Quality Indicator Peer Benchmarking

Indicator YTD (Sept 2020)	Date / Period	Target	University Hospitals of North Midlands	Nottingham University Hospitals	University Hospitals of Derby & Burton	University Hospitals of Leicester	Oxford University Hospitals	University Hospital Southampton	University Hospitals of Birmingham *
Clostridium Difficile (Hospital Acquired)	April - September 2020	Local []	55	86	50	39	60	39	78 *
MRSA bacteraemia (Hospital Acquired)	April - September 2020	0	0	2	1	0	3	0	0 *
Hospital Acquired Inpatient COVID-19 Infections (15+ days)	March - September 2020		74	Not reported	Not reported	Not reported	Not reported	65	Not reported
Patient Safety Incidents per 1000 bed days	April - September 2020		47.7	Not reported	68.74	Not reported	Not reported	Not reported	Not reported
NRLS Patient Safety Incident rate per 1000 bed days	October 2019 - March 2020		40.2	49.4	40	47.9	53.9	34.5	49.1
NRLS Patient Safety Incident Total (YTD)	April - September 2020		6316	12216	7867	11586	4705	6161	16337
NRLS Patient Safety Incident Total (month)	September 2020		1353	2490	1353	2467	1156	475	1389
Serious Incidents	April - September 2020		49	Not reported	54	Not reported	21	32	21 *
Never Events	April - November 2020	0	1	0	0	3	1	1	6
Falls per 1000 bed days	April - September 2020	5.6	5.7	Not reported	6.29	4.6	Not reported	Not reported	7.38 *
Falls with Moderate + harm per 1000 bed days	April - September 2020		0.12			0.07	Not reported	Not reported	Not reported
VTE Risk Assesment Completion	April - September 2020	95%	98.9%	92.7%	93.8%	98.8%	98.5%	Not reported	Not reported
Complaints Received	April - September 2020		264	286	Not reported	Not reported	317	Not reported	547
HSMR	September 2019 - October 2020	100	94.64	114.90	107.91	106.06	88.00	79.65	104
SHMI		1.00	0.99	1.02	0.90	0.97	0.91		1.00

* August Data

Data sources:
www.england.nhs.uk/statistics/statistical -work-areas
Public Board Reports

Operational Performance

2025 Vision "Achieve NHS Constitutional patient access standards"

Contents

A note on **SPC**

NHS University Hospitals of North Midlands NHS Trust

In some areas of the following report, statistical process control (SPC) methods are used 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;

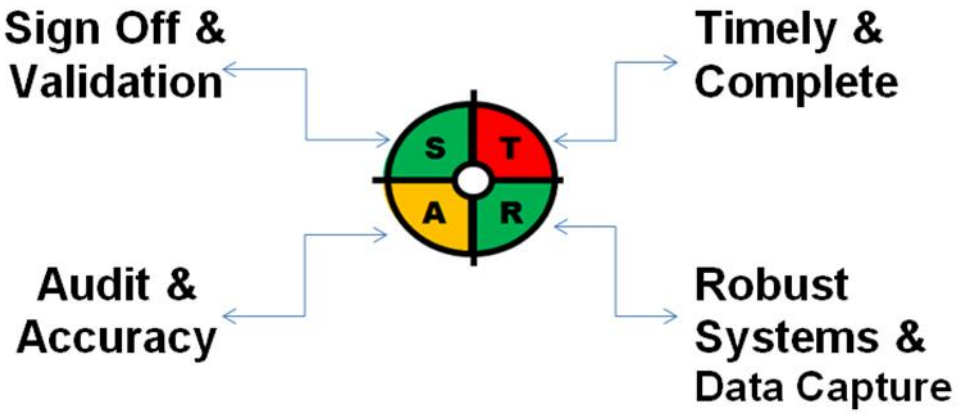
Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling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

ORANGE indicates **special cause variation** of particular concern and needing action
BLUE is where improvements are seen
GREY indicates no significant change (common cause variation)

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**

Restoration and Recovery

Spotlight Report from Chief Operating Officer

NHS University Hospitals of North Midlands NHS Trust

Emergency Care

December began with the same challenges faced in November. Attendances saw a significant decline in the 1st phase of covid (March & April) with a steady rise thereafter up to July. Numbers seen system-wide and at RS thereafter have remained steady (and show normal variation), albeit the numbers are below the average seen pre-covid. (Daily average at Royal Stoke: 270 and at County 94). The acuity of the patients attending remained high with ambulance attendances as a proportion of the overall RS attendances at 56%. The daily average attendances by ambulance at Royal Stoke was 151. The performance for UHNM (system wide) in December was 68.2% (November 70%). Royal Stoke performance was 46.4% . The average daily admissions were slightly less than November at 115/ day with a conversion rate of 42.7%; a position similar to that seen in April/ May. Performance for admitted patients at Royal Stoke was maintained at 30%. The average daily number of medical beds occupied rose to 447 (November 445).

Think 111 began on the 1st December with an average of 32/day.

The key issues affecting performance were: availability of appropriate beds through the high risk pathway, restricted / closed beds for infection prevention, staff sickness. Covid related absences were lower in the second half of December but overall averaged 513/ day which accounted for 52% of total absences. The highest proportion of absences were seen in the Medical Division.

The number of 12 hour trolley waits reduced to 64.

Cancer

The trust is predicted to achieve 4 cancer targets in December; 31 day sub anti-cancer; 31 day sub radiotherapy; 62 day screening and 28 day FDS.

The 104+ day backlog is showing normal variation at 45 for December and the 62 day backlog continues to be monitored and is currently at 296.

The trust is experiencing higher than pre-covid predicted demand, which has been addressed with extra clinics where appropriate.

Capacity and demand modelling is being re-evaluated and worked through with the bureau and directorate managers to accommodate the 14 days standard.

Discussions with the IS are continuing for early Jan lists - to optimise theatre capacity available.

Planned Care

The National ask for December was for total Outpatients to be at 100% of last years business as usual and for Inpatients 90%. The trajectories for December were set 91.3% and 84.2% of BAU for last year respectively. The actuals for December, against the trajectories, was outpatients 845.5% and inpatients 68.2%.

RTT

For December, the total number of Referral To Treatment pathways grew to 49,011 (November 46,791). This is above the forecast 46,100. The number of new RTT clock starts rose steadily from May through to November when 13,000+ new RTT pathways/ periods were added. December saw a fall in new pathways partly due to a reduction in referrals. Potentially the reduction seen now may herald a return of referrals post covid that exceeds previous numbers. A Trust trajectory for this has been developed and monitored through the planned care cell. The Trust has 2,730 over 52 week breaches as a consequence of standing down elective work. This was over the forecasted position. Recovery plans for recovery of the long waiting patients will be reviewed. RTT performance in December is 65.78% (November 66.97%).

Diagnostics

December saw a fall in diagnostic activity at 24,003. However all trajectories are on track and the data shows that recovery has been sustained. The diagnostic performance for December is currently 91.23%. The waiting list size is also showing a reduction: down to 11,668. Recovery plans are now being transacted and monitored via the Diagnostic Cell to end of March 2021, with investment requests approved for DMO1 modalities to support this recovery timescale.

Urgent Care - Summary

University Hospitals of North Midlands NHS Trust

Summary

- The challenges faced in November, with the second phase of the pandemic, continued into December. Attendances saw a significant decline in the 1st phase of covid (March & April) with a steady rise thereafter up to July. Numbers seen system-wide and at RS thereafter have remained steady (and show normal variation), albeit the numbers are below the average seen pre-covid. Daily averages at Royal Stoke: 270 and at County 94).
- The acuity of the patients attending remained high with ambulance attendances as a proportion of the overall RS attendances at 56%. The daily average attendances by ambulance at Royal Stoke was 151. The improvements in the triage wait times non ambulance patients was maintained. However , for ambulance there were days when crews were being held, although handovers > 30-60mins and > 60 mins have remained similar to November (209 & 241). The number of patients in majors showed normal variation with an average of 200/ day. The average daily admissions were slightly less than November at 112/ day with a conversion rate of 42.7%; a position similar to that seen in April/ May. Performance for admitted patients at Royal Stoke was maintained at 30%. The average daily number of medical beds occupied rose to 447 (November 445). Critical Care beds were exhausted and in the last few days extra capacity had to be created.
- The severity of patients remained as seen in November. The 7-day rolling average number of covid positive patients admitted remained steady through December reaching a maximum of 351 patients on 14th December (the highest number recorded). Up to the end of December the Trust had discharged 2217 +covid patients (1550 at the end of Nov).
- Beds across the Trust remained restricted/ closed for infection prevention.
- Of the complex caseload, the number of patients MFFD rose from an average of 54/day in November to 65/day in December, both stranded and super stranded patients similarly rising, suggesting challenges in providing care outside the acute setting.
- The performance for UHNM (system wide) in December was 68.2% (November 70%). Royal Stoke performance was 46.4% . Think 111 began on the 1st December with referrals via 111 averaging 32/day (includes both booked and walk-ins).
- The key issues affecting performance were: availability of appropriate beds through the high risk pathway, restricted / closed beds for infection prevention, staff sickness. Covid related absences were lower in the second half of December but overall averaged 513/ day which accounted for 52% of total absences. The highest proportion of absences were seen in the Medical Division. The ED faced challenges with understaffing which affected the WTBS.
- The number of 12 hour trolley waits reduced to 64.
- The average LoS for NEL medical patients admitted 1+ days rose continued at an average of 8 days (which is in line with the previous year).
- SDEC reduced to 29.3% of all NEL admissions.
- Bed occupancy and conversion rate is increasing month on month and expected to continue to increase into Winter. The conversion rate for December at RS was 41.6%.

Urgent Care - Actions

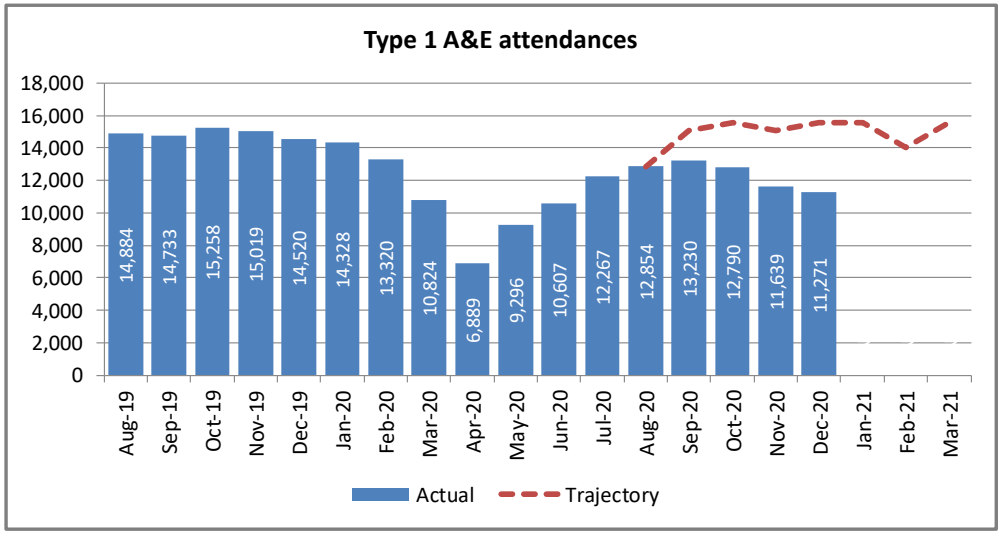
As January is expected to see a further increase in Covid-19 cases as a result of the new strain the Medical Division are focusing on safe and effective care by ensuring robust medical and nursing rotas are in place to support the care of patients. This is particularly challenging due to the high sickness and covid related absence. The winter escalation plans continue to be supported and enacted according to demand for blue / purple capacity.

The focus on ward based systems will continue with the stranded and super stranded patient reviews following on from the "Home for Christmas" initiative. The dedicated Nurse Co-ordinator to support complex discharges in the West Building will continue throughout January. The Medical Division will continue to embed the ECIST and Mprove pt flow principles within the ward areas alongside the reviews.

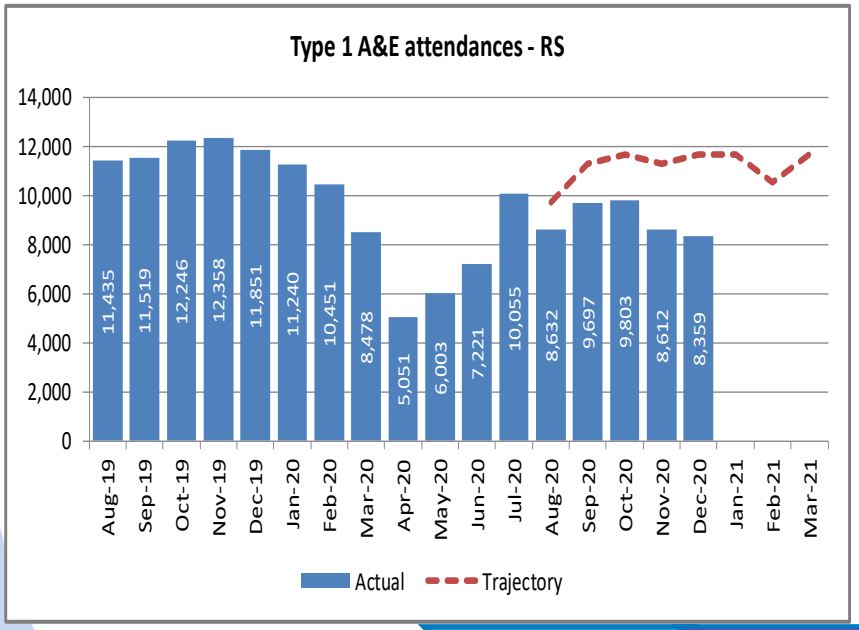
The Consultant Connect system went live in November with Frailty, Acute Med, Renal, Renal Therapies, T&O, Haematology and Cardiology all providing advice and guidance. Referral Lines are in place across both RSUH and County through Royal Stoke AEC and County MRU and Surgery SAU. A further launch in January 2021 is expected in the following specialities Paediatrics, Diabetes and Endocrinology, Ophthalmology, Dermatology and Neurology.

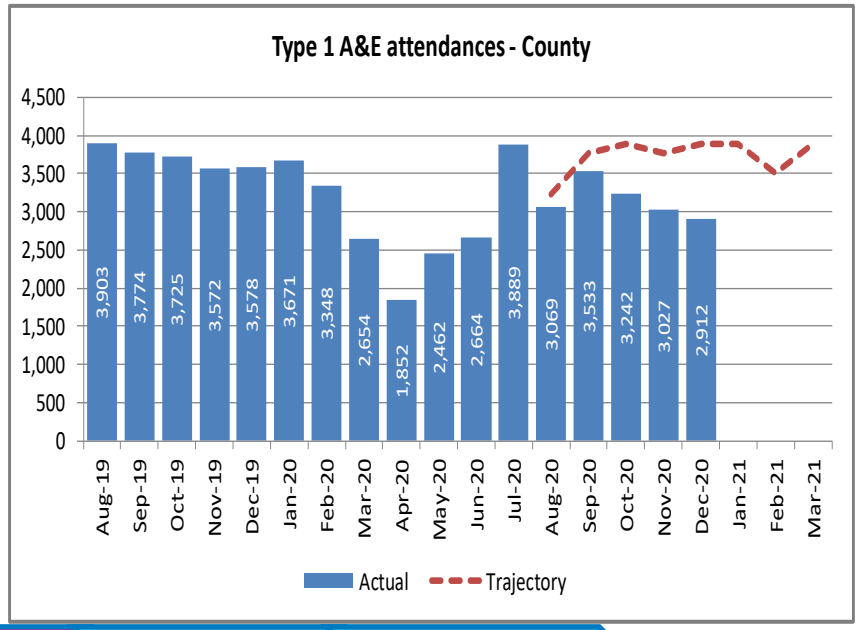
Think 111 – went live on 1st December as planned and January will see further work in order to support a Go live in paediatrics.

Urgent Care *(attendances)*

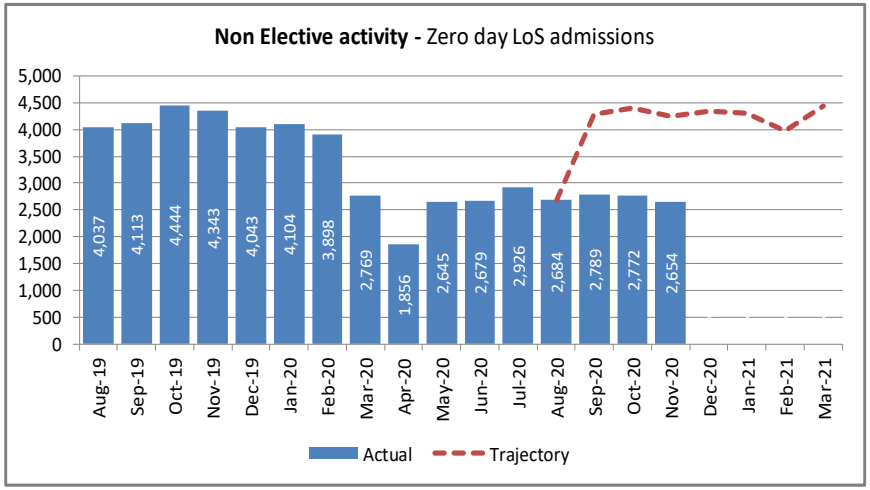


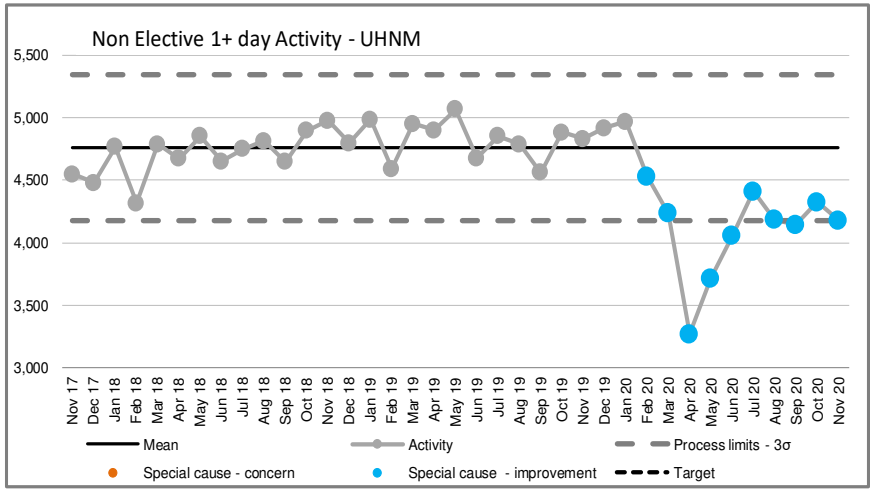
	% attendances vs. Nov 19
Type 1	77.6%
RS	70.5%
County	81.4%





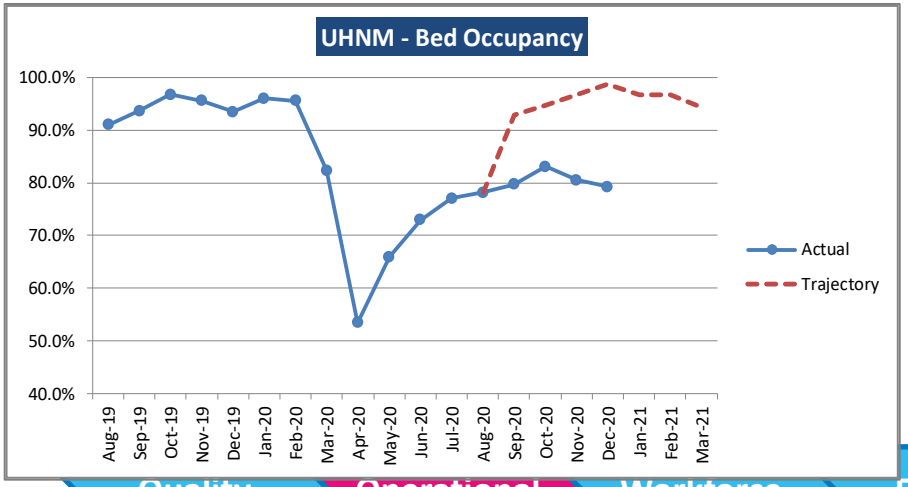
Urgent Care - *(admissions)*





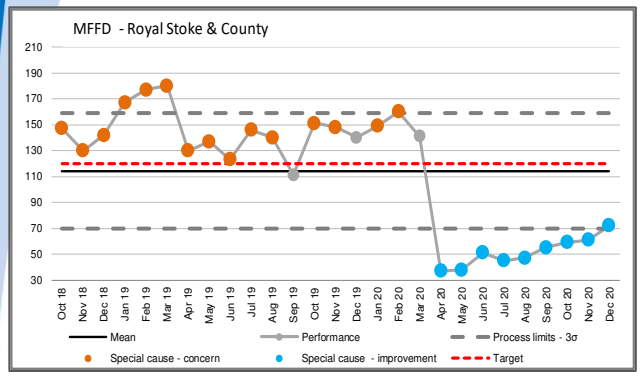
	Oct 20	Nov 20	Dec 20
Previous year	4,444	4,343	4,043
2020 Actual	2,770	2,647	2,548
% of BAU	62%	61%	63%

	Oct 20	Nov 20	Dec 20
Previous year	4,884	4,831	4,918
2020 Actual	4,322	4,160	4,204
% of BAU	88%	86%	85%



Quality | Operational | Workforce | Finance

URGENT CARE – *(Discharges)*



Variation	Assurance
L	?

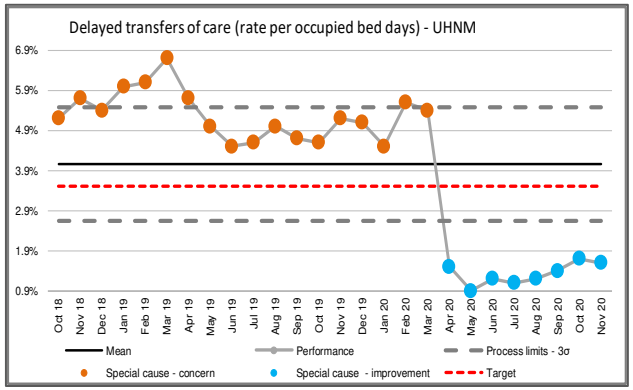
Target	Oct 20	Nov 20	Dec 20
120	59	61	72

Background

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

What is the data telling us?

There has be a series of data points indicating a sustained redduction in the number of MFFDs.



Variation	Assurance
L	?

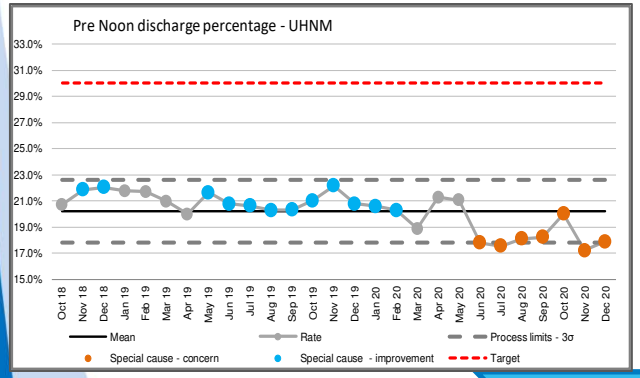
Target	Sep 20	Oct 20	Nov 20
3.5%	1.4%	1.7%	1.6%

Background

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

What is the data telling us?

The delayed transfers of care have been influenced by the actions taken in regards to Covid-19. There was a significant reduction from March when patients were discharged. To date the % remains below the national standard of 3.5%.



Variation	Assurance
L	F

Target	Oct 20	Nov 20	Dec 20
30%	20.0%	17.2%	17.9%

Background

The percentage of discharges complete before 12 noon.

What is the data telling us?

The Trust saw a reduction in the number of pre-noon discharges with an upturn seen in September.

Medically fit for discharge (MFFD):

The data is showing that the MFFD numbers are still in improvement i.e. the numbers are low. On average, the daily number of patients MFFD for RS & County is 72/ day.

Work streams are in place to reduce this again including

- an escalated emphasis on ward level management of discharges across the ward areas with strengthened review structure
- Seven day multi organisational management support in track and triage
- Robust daily challenge of patients waiting 1 day plus once medically fit
- Strengthened working relationship with ezec through ambulance liaison to maximise transport efficiency
- Introduction of MPFT tracking post to reduce failed discharge due to TTO process delays

Delayed Transfers of Care (DToC) – I month in arrears

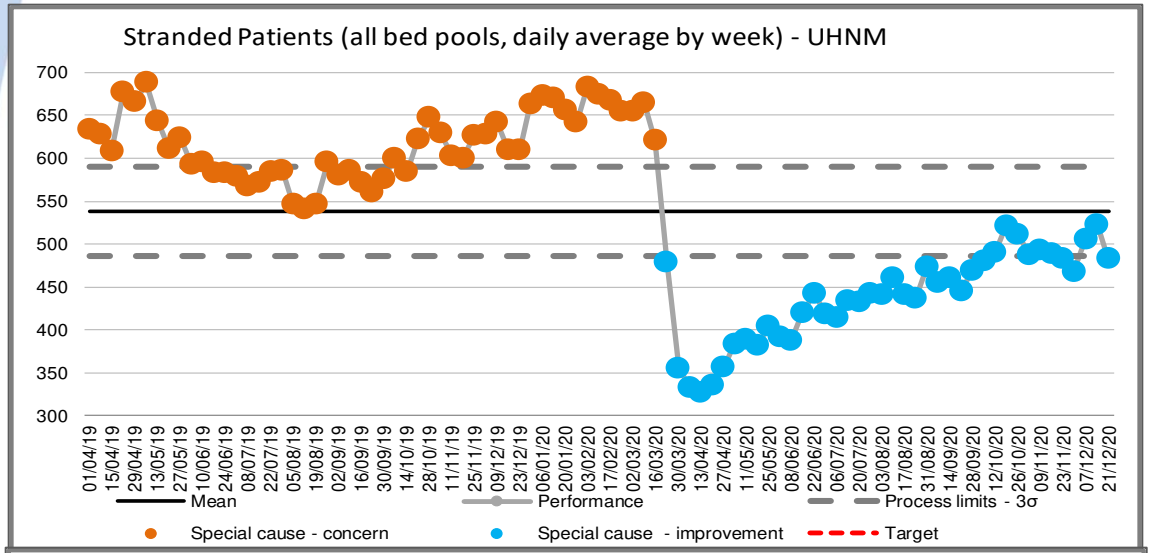
Again, whilst the data shows that for DToC the variation is low and this is still improvement, there are some early indications that percentages are rising. Although still well below the 3.5% national ambition.

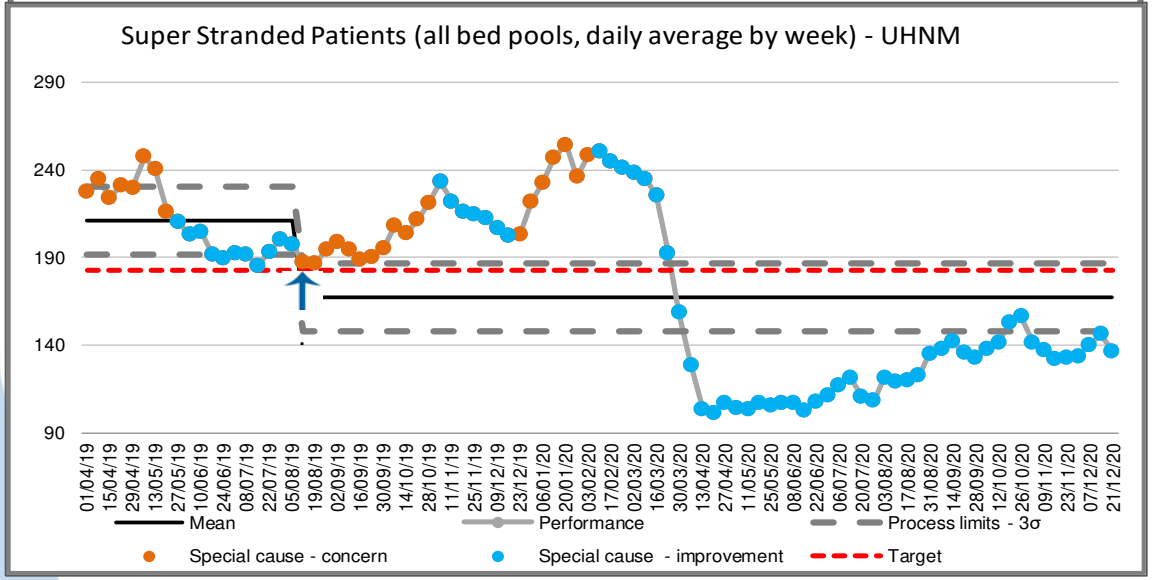
Although the Covid-19 pandemic has resulted in less beds occupied at the Trust , this measure shows that proportionately fewer occupied beds are patients waiting for transfer of care.

Discharges before midday

Discharges before midday has shown normal variation from and remains below the mean. Improvement forms part of the urgent care improvement actions.

URGENT CARE – *(Discharges)*





Summary

- There is evidence that the rolling weekly average for the complex caseload is increasing but are well below the numbers seen pre-covid
- Stranded patients across all bed pools continues to steadily rise.
- Super Stranded patient numbers have seen normal variation. Circa 25% of these are on COVID-19 wards. Discharge of COVID +ve patients can be delayed due to an inability to isolate in the follow on setting.

Actions

LOS reviews commissioned across all wards to check acuity and progress around discharge actions to support reduction of Stranded and Super Stranded, MFFD reduction plans being supported by cross system clinical MDTs to reduce delays.

Cancer

NHS University Hospitals of North Midlands NHS Trust

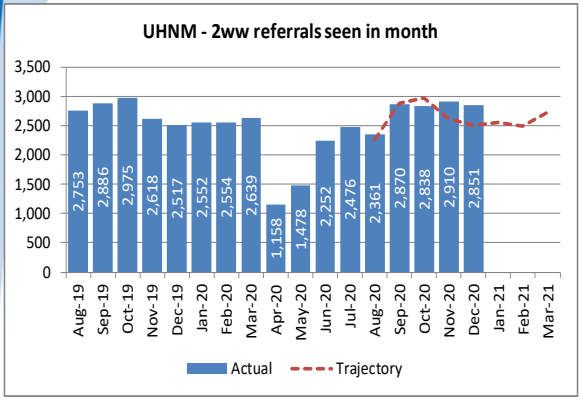
Summary:

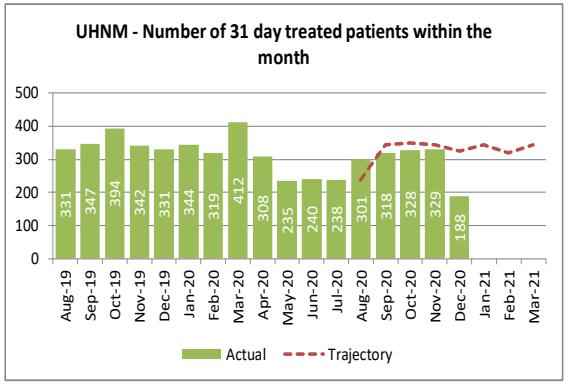
- The length of time patients are waiting to be appointed from receipt of referral is still at it's lowest in the past 4 months. The 48 hours KPI is still being met.
- 2WW referrals were showing special cause for concern as the numbers had been increasing for the past 12 weeks, with exception of last week in December which saw a significant fall. The numbers recorded showed a level higher than pre-covid suggesting that GPs are referring patients that may have been held back. Constructive discussions with the CCG identified support for the Breast team in particular to manage the spike in demand. Regional referral advice is being drafted to be communicated to GPs to reduce inappropriate referrals. The Breast team have completed extra clinics to match demand during the whole of quarter 3.
- At the end of December there were 45 patients in the 104+ day backlog. This is normal variation compared to previous numbers. However the agreed target is to be below 16 at December. Challenges have been capacity within the trust to progress outpatient appointments and diagnostics as quick as usual. We have seen an increase in DNAs over the Christmas period which has contributed to growth in 104+ numbers. Some treatment plans following MDT discussion have changed, due to the risk outweighing the benefit of treating small non-invasive tumours. The backlog is scrutinised weekly at a specific backlog PTL meeting to ensure robust escalations.
- The 62 day backlog is at 296, again this is normal variation and remains around the mean. However the aim is to be below 200 – the most challenged area is Lower GI with 123 currently over 62 days. A new Cancer Pathway Coordinator has been recruited to who will support this area. Increased DNAs have contributed to growth over Christmas and the PTL is currently being brought back up to date by the corporate cancer team following the Christmas bank holidays.
- Divisions are being encouraged to access mutual aid and are reviewing the surgical wait list with priority codes, to identify suitable patients for the independent sector and in house theatre capacity from Feb.
- Challenges ahead: Managing high demand with unsustainable Tis' Maintaining diagnostic activity to prevent PTL growth, Covid related pressures on specialties ,Critical care provision impacting theatre capacity optimisation

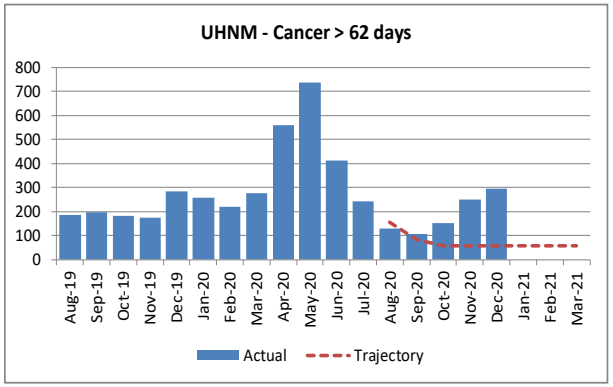
Actions:

- The trust has been awarded funds to implement Rapid Diagnostic pathways for it's most challenged areas – the investment in Endoscopy and Radiology will support the Lower GI pathway to become more efficient and deliver a definitive ruling out or diagnosis of cancer quicker, reducing the volume of patients waiting in the backlog.
- IS capacity will continue to be utilised throughout January. The current situation is that the cancer work will return to UHNM from February.
- The surgical division has oversight of the template sessional capacity for the Acutes and IS, and uses this to manage session fill.
- Clinical prioritisation meetings are focusing on options to optimise available in house theatre capacity and prioritise high risk and urgent cancers
- West Midlands Cancer Alliance Surgical Hub option escalated to and sent out to clinical and directorate colleagues. The Cancer Alliance have reinstated the weekly SITREP the corporate cancer team will report a narrative of themes affecting pathway delays and numbers on the PTL to the cancer alliance, and access mutual aid if needed. The Cancer Alliance are leading conversations between providers to identify bottlenecks and implement escalation processes to utilise theatre capacity on a wider footprint if required.
- Information dept are working on a theatre dashboard to describe booking activity and keep rebooking activities in line with surgical priority category timescales.
- Weekly assurance meetings with directorate managers will ensure patients surgical priority timescales clocks are managed through the cancer PTL and dated in time.
- Lead Cancer Nurse is advising on Health Education England investment in primary care and speaking with Macmillan GP colleagues, to improve education on cancer referrals, to improve referral completeness and criteria compliance.

Cancer

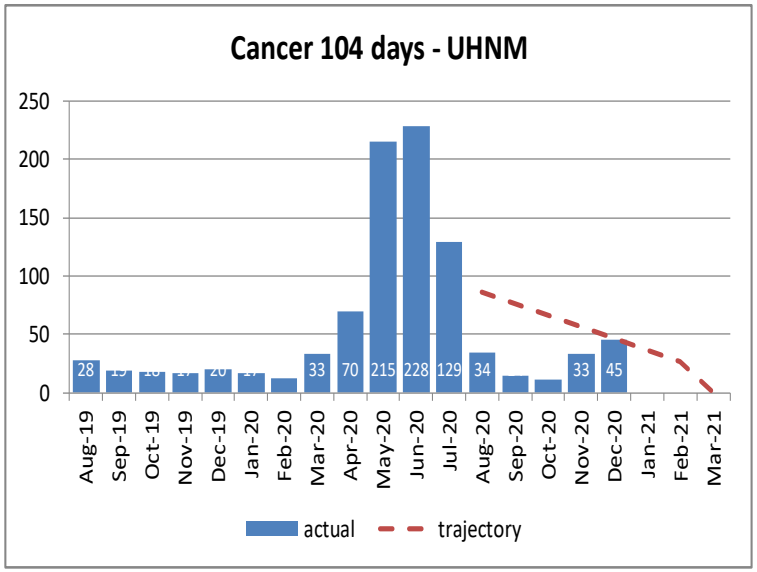






Nov-20	Target	Trust Actual	Clock Stops	Breaches	Breaches over	Needed treatment
2WW Standard	93%	88.1%	2828	349	152	2158
2WW Breast Symptomatic	93%	92.9%	45	5	2	27
31 Day First	96%	96.6%	148	4	*Achieved!*	*Achieved!*
31 Day Subsequent Anti-Cancer Drugs (inc. Chemo)	98%	100.0%	9	0	*Achieved!*	*Achieved!*
31 Day Subsequent Surgery	94%	89.7%	19	3	2	32
31 Day Subsequent Radiotherapy	94%	97.0%	27	1	*Achieved!*	*Achieved!*
62 Day Standard	85%	63.8%	78	31	20	129
Rare Cancers - 31 Day Pathway	85%		0	0	1	1
62 Day Screening	90%	75.0%	17	5	4	34
28 Day FDS Standard	75%	77.4%	1057	221	*Achieved!*	*Achieved!*
62 Day Consultant Upgrade	93%	88.2%	48	4	1	10
Closed Pathways > 104 Day			4.5			

as at 03/12/20



Planned care - *Inpatients*

University Hospitals of North Midlands NHS Trust

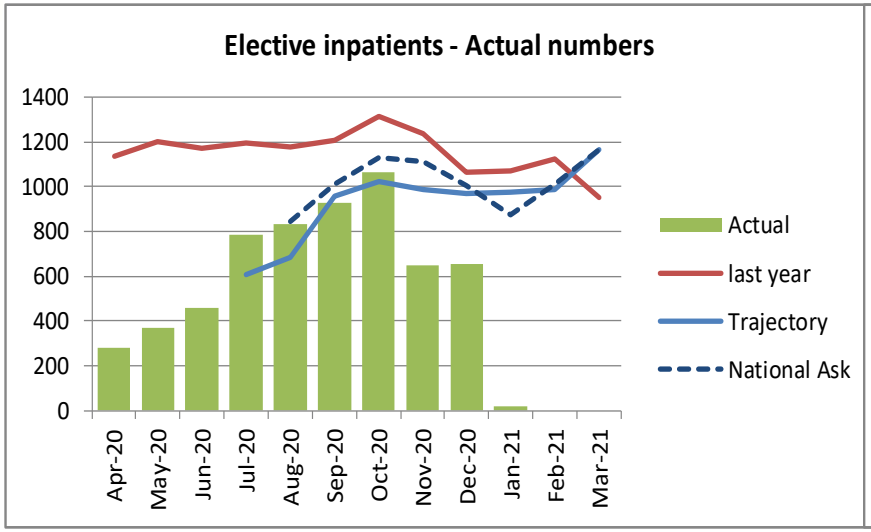
Elective inpatients Summary

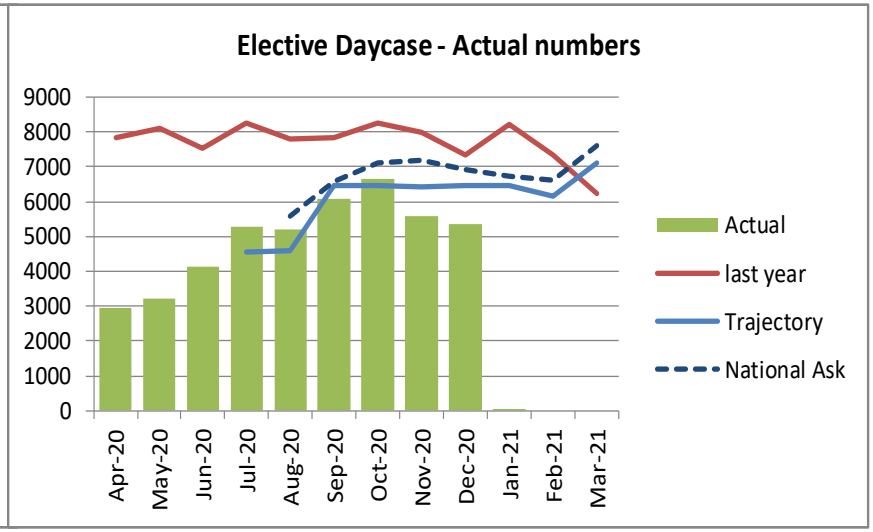
- Elective/Daycase activity combined had seen a steady rise since April 20 in line with restoration plans until November when special cause occurred (second wave Covid-19). Activity in December was similar to that in November. The trajectory was set at 84.2% of BAU and the actual achieved 68.2% (slightly higher than November 67.5%).
- For December, Elective inpatient activity (overnight) was **58.8%** vs. the trajectory which was set at 86.9%. This is set against the increasing pressures the Trust experienced in December with more Covid-19 patients seen and admitted and bed closures due to Infection prevention.
- Daycases achieved 69.6% vs. the trajectory set at 83.8%. Priority is always given to cancers and urgent waiters.
- The number of elective operations for UHNM are below the numbers seen pre-covid, although since July 20 the numbers are above the lower control limit meaning the numbers are within the range normally seen but below the average. RS Utilisation shows normal variation and is just below the performance levels seen pre-covid. For RS & County, Elective operations were 884 (compared to November 918). Cancellations on the day continued to show low numbers. These are being driven by a number of factors but can all relate back to the second surge in COVID cases i.e. patients testing positive, no SSCU/critical care beds, patients changing their minds about surgery. Backfilling short notice cancellations is very difficult due to the COVID secure pathways (patients requiring swabs and isolation).
- Insourcing for endoscopy through 18 week source group and SHS commenced in mid-December. Insourcing group provided a team of health cares, nurses, scrub nurses, surgeons, anaesthetists in collaboration with a booking team and receptionist. They will run theatre sessions at UHNM over the weekends to reduce theatre backlog. Contract was approved by the finance panel. First theatre session commenced 07/12/20.

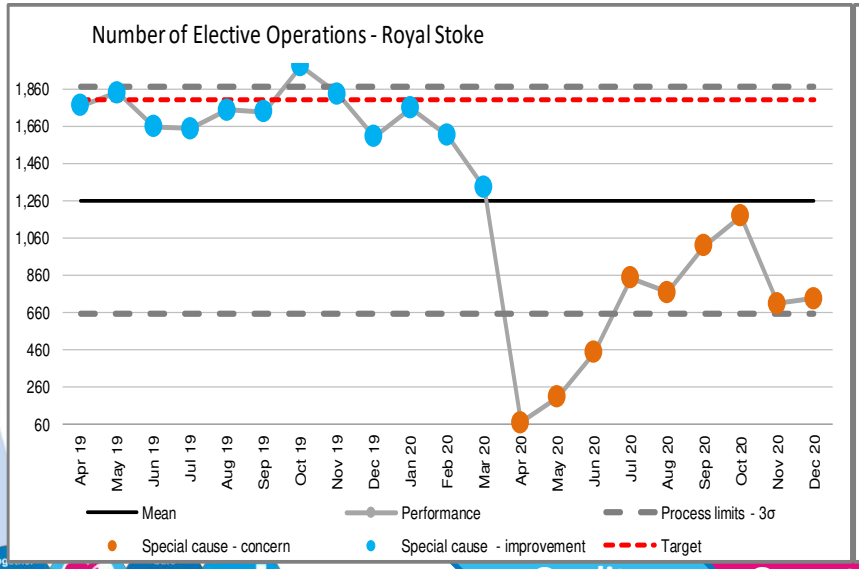
Actions

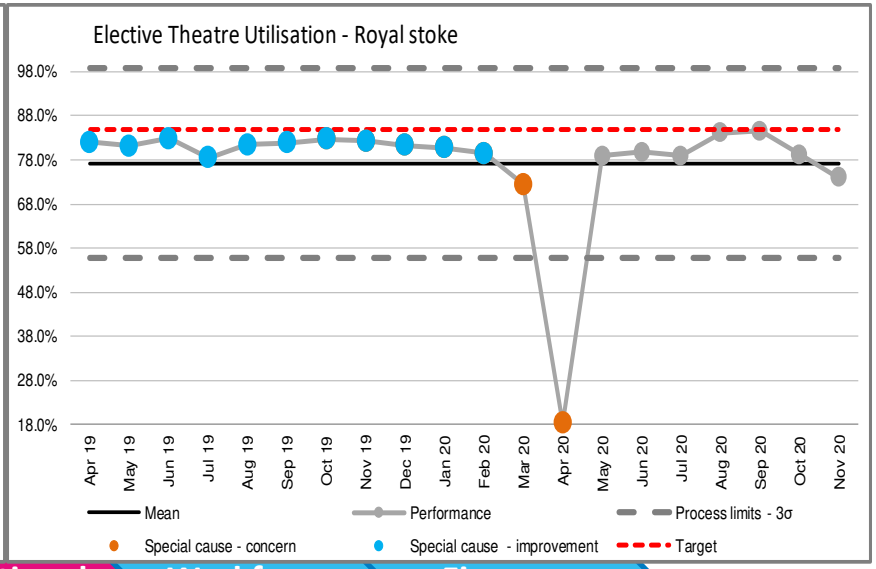
- **New Waiting list categories P5 and P6** were introduced in October. P5 for covid related delays and P6 for non covid related delays. We have c. 12000 patients to contact via telephone/letter to gain patients circumstances and change their priority category accordingly. This work is currently being spilled out into the divisions for completion. Surgery have linked with information services to develop a report to support the identification & prioritisation of urgent electives, and will keep Outpatient Cell informed of potential impact on OP activity.
- Long waiters governance assurance paper now complete. New weekly assurance meetings to take place from January to monitor long waits and specialty plans for the over 52 week patients. This is also supported by a clinical harm review process.

Planned care – *Inpatient Activity*









Planned care - *Outpatients*

NHS University Hospitals of North Midlands NHS Trust

Summary

- Outpatient activity had seen a steady rise since April 20 in line with restoration plans until November when numbers reduced due to the covid second wave. Overall for December, the Trust delivered 85.5% vs. trajectory set at 91.3%.
- December numbers recorded were 56,520 (below trajectory of -3,890) but this deficit may be cleared as the outstanding outcomes (as at time of report) are completed.
- The overall Referral To Treatment (RTT) Waiting list continues to rise. (December saw 49,054: a rise of 2263 from previous month). The Trust trajectory has been developed based on the assumption that referrals will return to 100% of last year demand (Phase 3 ask). The numbers of RTT pathways has exceeded the trajectory for the last 4 months suggesting more demand from General Practitioners/ clock starts following outpatient attendance, however it is too early to say if this is a trend likely to continue. We are however, at a level seen pre-covid.
- The waiting list shape has changed somewhat (U-shaped) in that there are now more patients < 18 weeks (32,241). There are, however more patients over 40 weeks and over 52 weeks where numbers are rising month on month due to the reduction in activity.
- The numbers of 52 week waits in December is 2,730 (November were 2,100). These are expected to grow further through the year and the Trust trajectory of 2756 for March 2021 has already been exceeded. Further reviews are to be undertaken to support the reduction.
- December's performance for ASIs improved position to 84.85% within 3 days (from 86.8% in November) despite Covid pressures.
- For outpatient appointments (appointment type) the Trust delivered 56.5% F2F and 33% non F2F(Telephone & Video) which are both a slight rise from November. There were 10.5% of appointments not set (for new appointment types F2F was 61% & non F2F 28% & follow ups F2F 54% & non F2f 36&). Work is underway to make the Media Type field in Medway mandatory which will eliminate 'Not Set'.

Actions

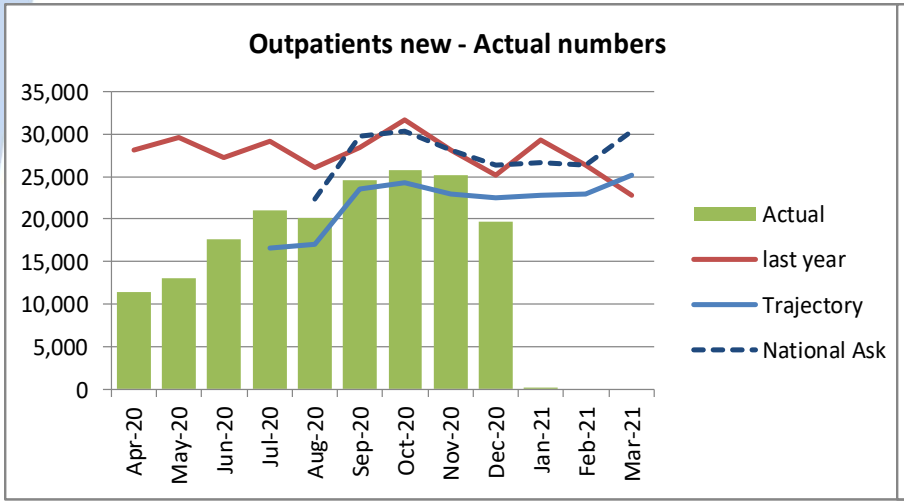
- Work is required on template reconfiguration based on Divisional assumptions - this needs to be aligned to the in patient and diagnostics plans for the purpose of substantive job planning.
- Revised 52 ww trajectory to be drafted once all cell plans confirmed to reduce the end of March 2021 delivery.
- 40+ week waiters are being planned with a combination of IS in/outsourcing and hospital capacity targeting categories 1, 1a, 2 and long waiters.

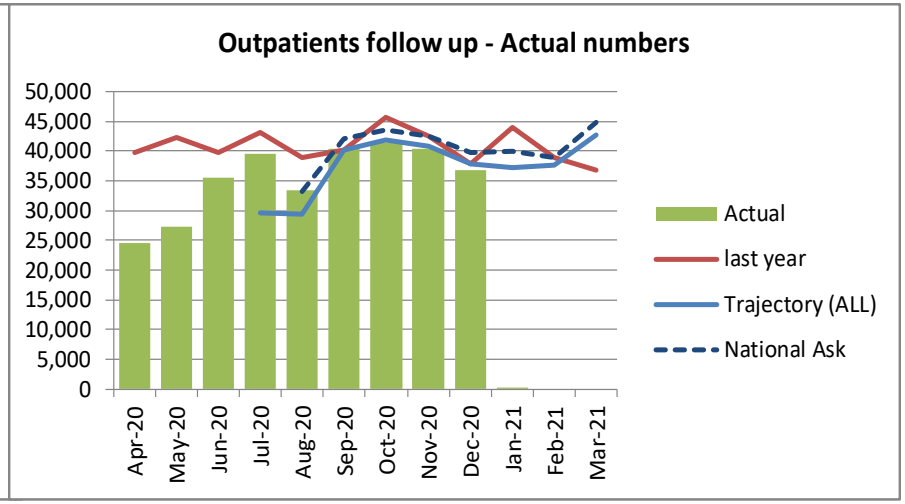
Risks:

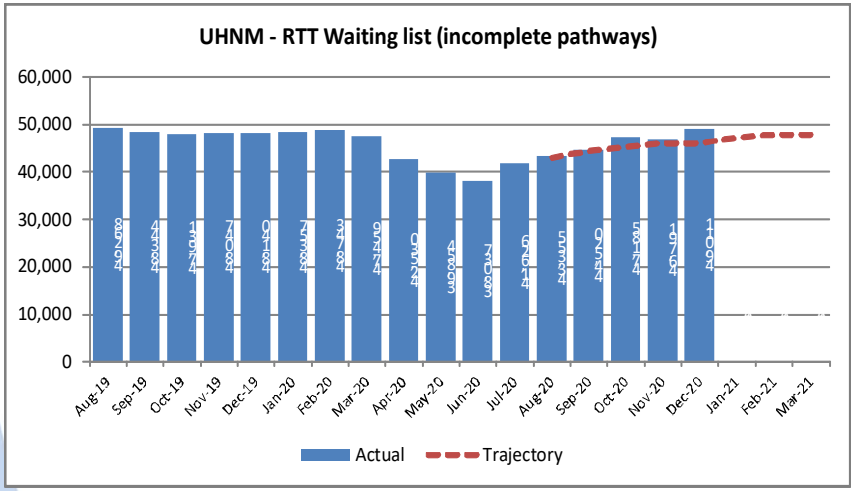
- Impact of stopping FTF activity in some areas to release staff to support frontline being monitored.

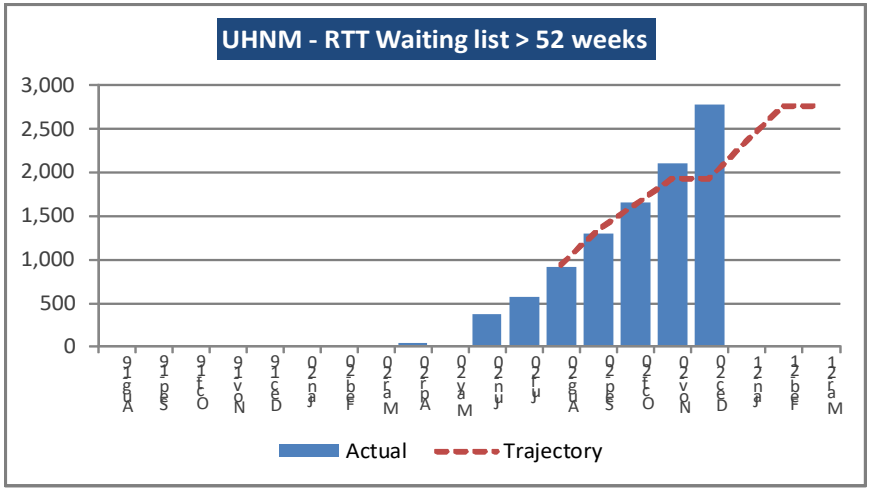
Together Compassion Safe Improving

Planned care – *Outpatient activity & RTT*

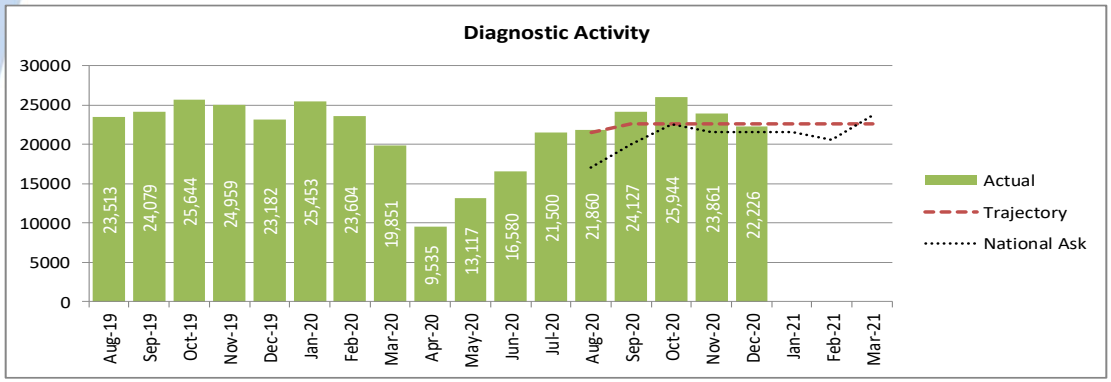








Diagnostic Activity



	Oct 20	Nov 20	Dec 20
Trajectory	22,608	22,608	22,608
Actual	25,944	23,861	22,226
Varience	**3,336**	**1,253**	-382
Background			
Activity for the 6 key DM01 tests			

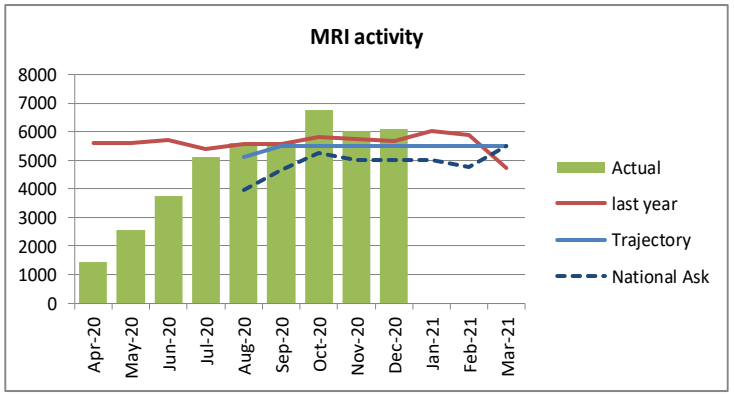
Summary

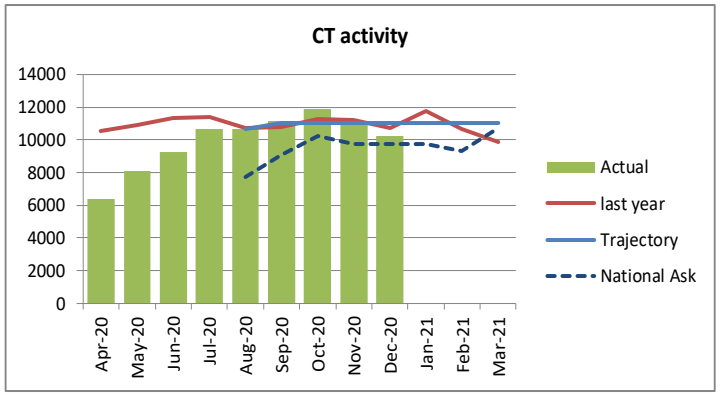
- For the 6 key diagnostic tests in phase 3, December saw a reduction in activity which appears to be normal variation (as is for all the DM01 tests) and is in line with expected reduced levels for December. The performance and number of breaches is showing special cause for improvement, meaning the improvements seen over the past months are being sustained (slide 27). The trust trajectory for activity has consistently met the national ask and would be on trajectory to deliver to the year end, accepting that any covid surge will impact on this position.
- The diagnostic performance for December is currently 88.9%,. The waiting list size is also showing a reduction: down to 11,668. Recovery plans are now being transacted and monitored via the Diagnostic Cell to end of March 2021, with investment requests approved for DMO1 modalities to support this recovery timescale.

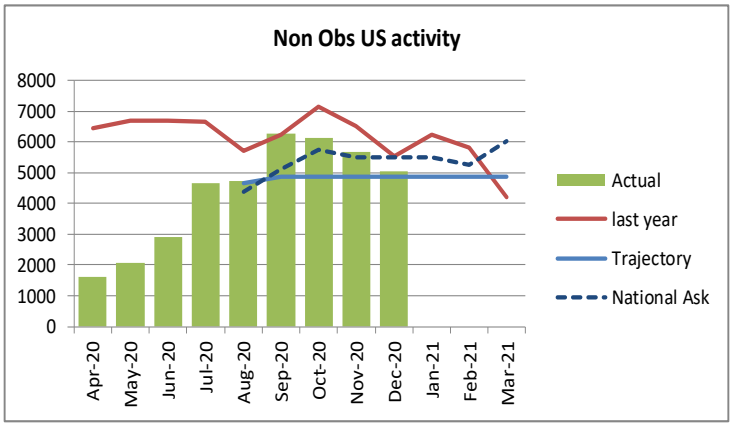
Actions

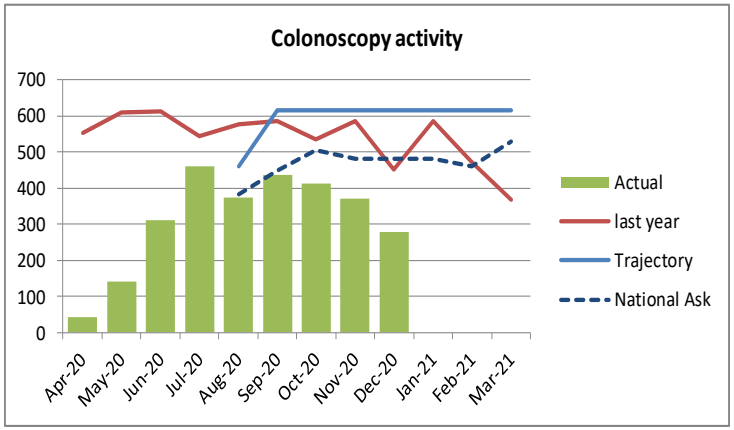
- The diagnostic work streams have made significant improvements and are working towards more initiatives to improve systems and processes.
    - Patient Connect is fully operational for pathology services and a scoping exercise underway to see if this can be transferred to other areas
    - Robotic Process Automation project is in train – to support with the auto scheduling of plain film imaging appointments that were previously 'walk in' but due to social distancing need to be booked - ongoing
- The Diagnostic cell continues to monitor plans and activity against trajectory.
- Mobile MRI to continue to end of March 21.
- Investment papers have been submitted to continue recovery and restoration.

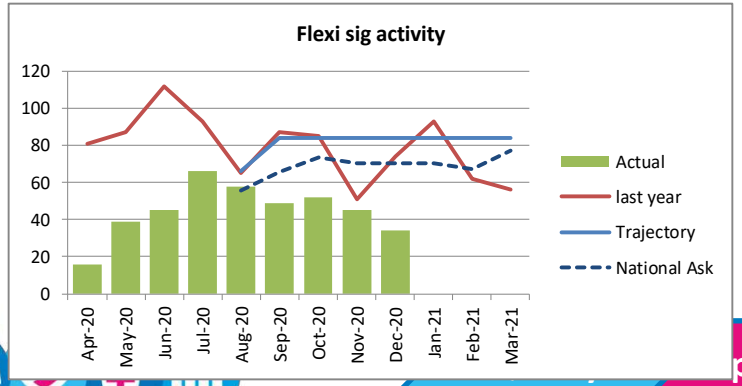
Diagnostics

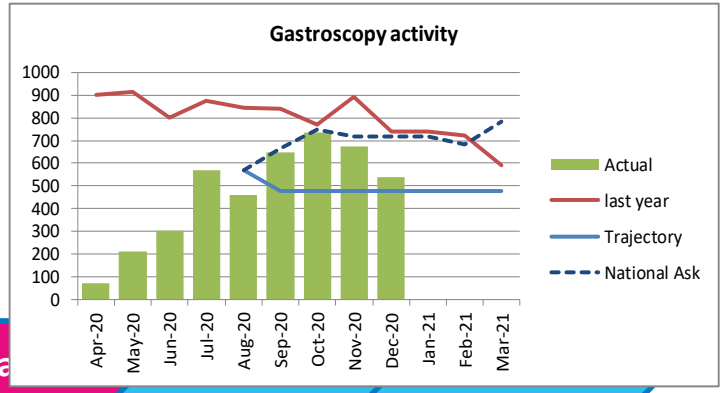












APPENDIX 1

Operational Performance

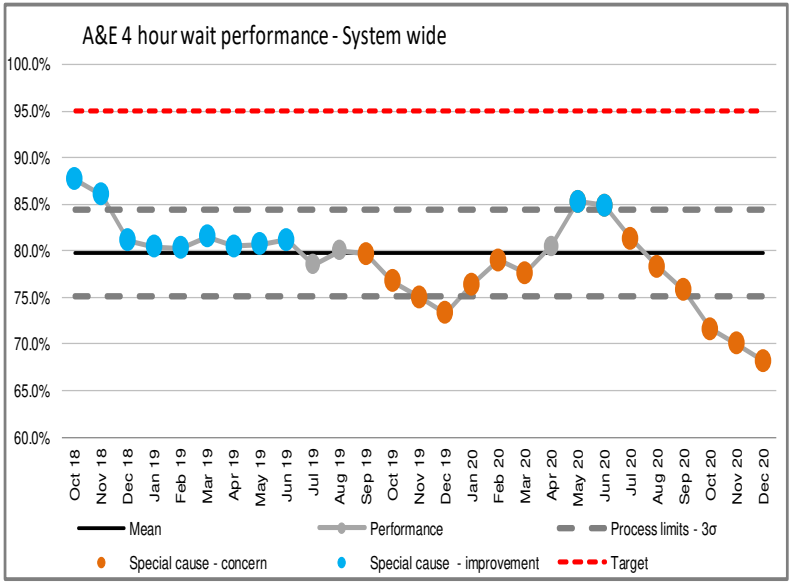
Constitutional standards

	Metric	Target	Latest	Variation	Assurance	DQAI
A&E	A&E 4 hour wait Performance	95%	68.20%	L	F	
	12 Hour Trolley waits	0	64		?	
Cancer Care	Cancer Rapid Access (2 week wait)	93%	90.71%		?	
	Cancer 62 GP ref	85%	63.07%		?	
	Cancer 62 day Screening	90%	100.00%		?	
	31 day First Treatment	96%	88.83%	L	?	
Elective waits	RTT incomplete performance	92%	65.73%	L	F	
	RTT 52+ week waits	0	2773	H	F	
	Diagnostics	99%	88.90%	L	?	

	Metric	Target	Latest	Variation	Assurance	DQAI
Use of Resources	DNA rate	7%	8.9%	H	?	
	Cancelled Ops	150	61	L	?	
	Theatre Utilisation	85%	76.0%			
Inpatient / Discharge	Same Day Emergency Care	30%	29.3%	H	?	
	Super Stranded	183	137	L	?	
	DToC	3.5%	1.60%	L	?	
	Discharges before Midday	30%	17.9%	L	F	
	Emergency Readmission rate	8%	13.0%	L	F	
	Ambulance Handover delays in excess of 60 minutes	10	241	H	?	

URGENT CARE – 4 hour access performance

University Hospitals of North Midlands NHS Trust



Variation	Assurance
L	F

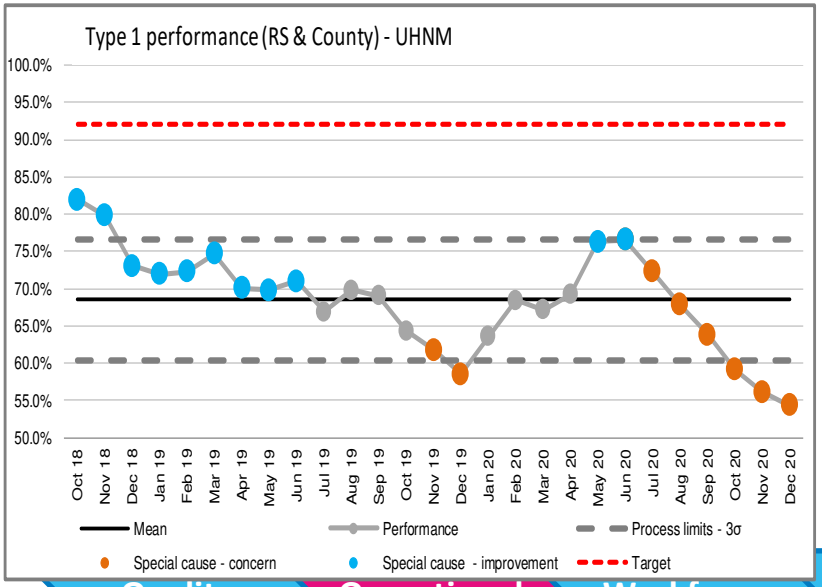
Target	Oct 20	Nov 20	Dec 20
95%	71.6%	70.0%	68.2%

Background

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

What is the data telling us?

The improvemnets seen in May and June have not been sustained. However performance is still within the control limits and remains around the mean.



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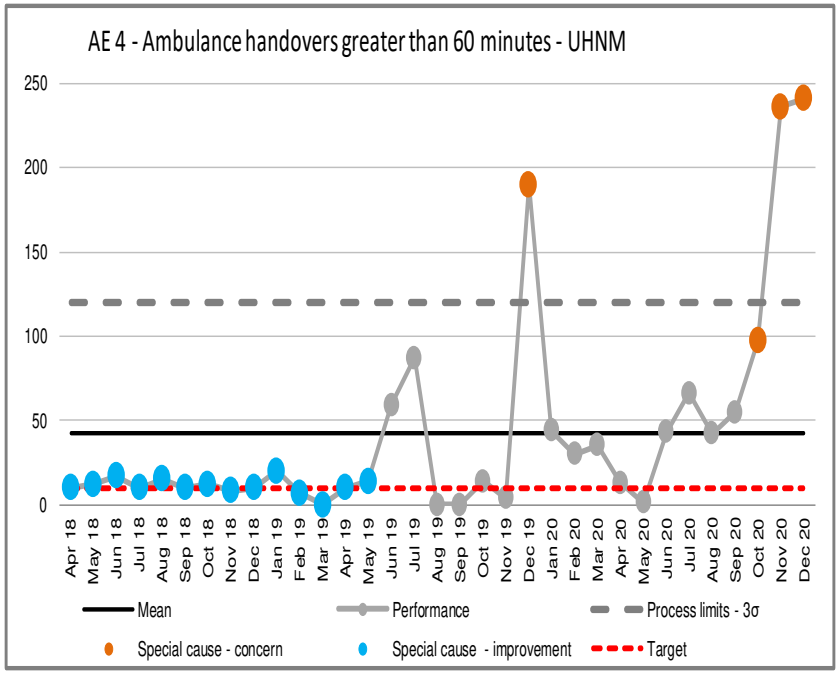
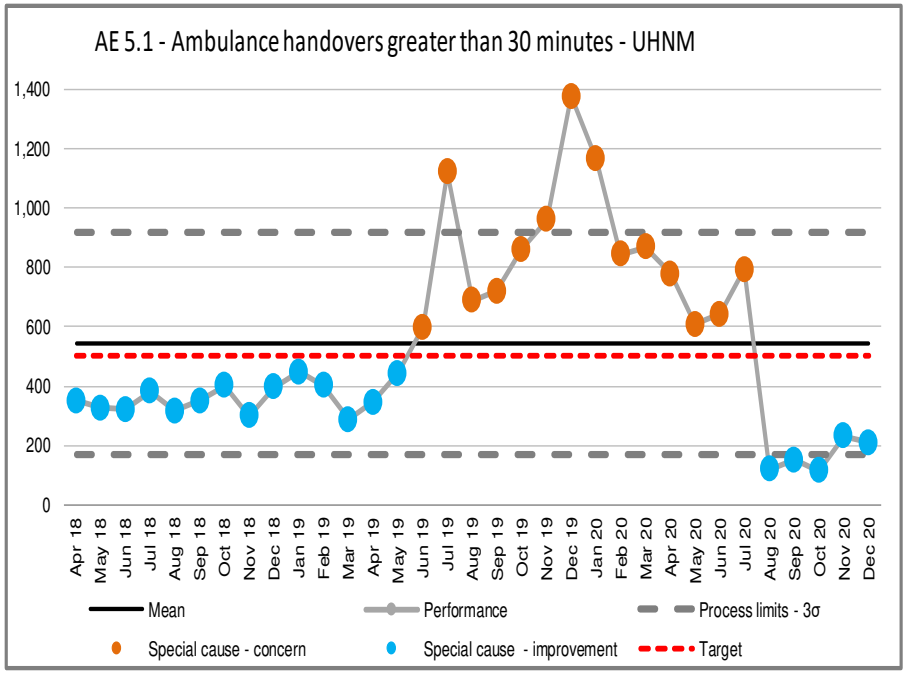
URGENT CARE – 4 hour access – ambulance handovers





From August – internal validation of > 30 minutes

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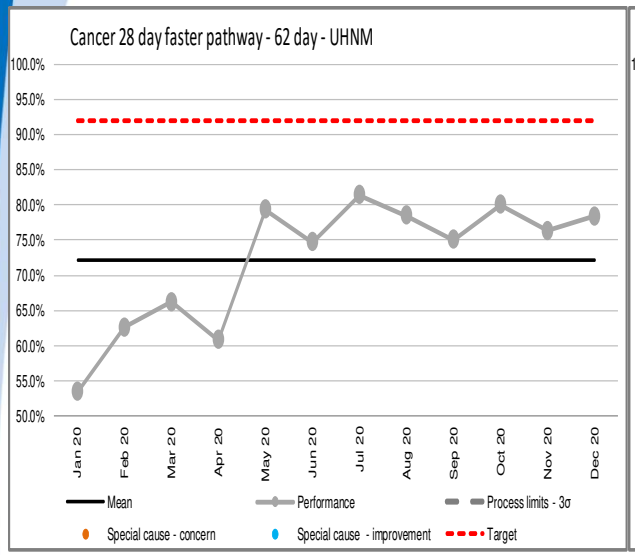
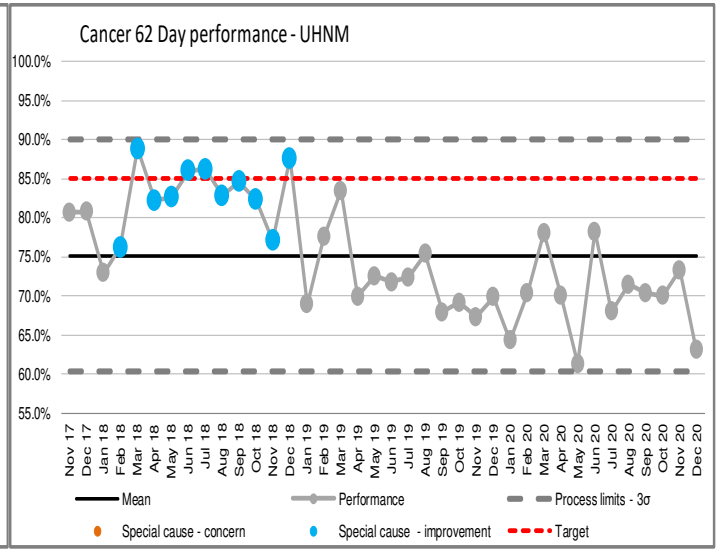
Cancer – 62 Day





Variation	Assurance
	

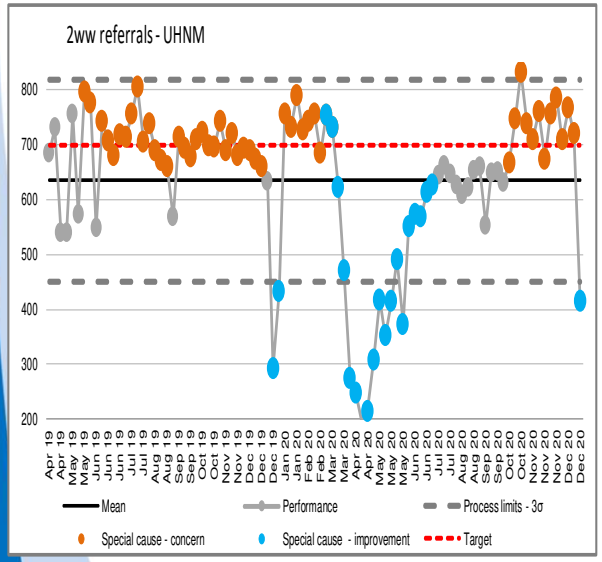
Target	Oct 20	Nov 20	Dec 20
85%	70.0%	73.3%	63.1%

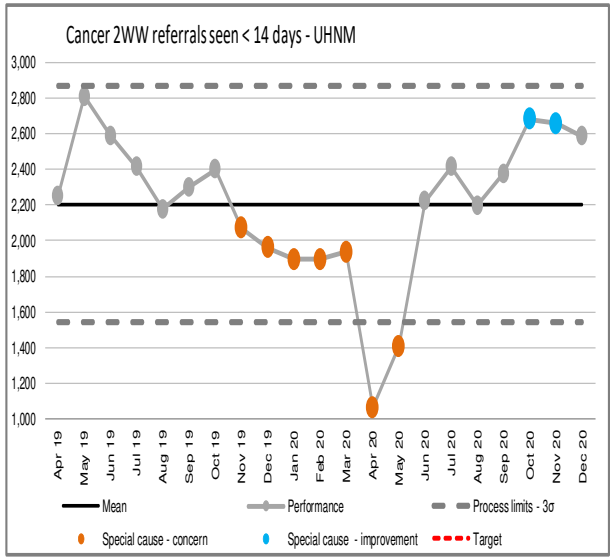
Background

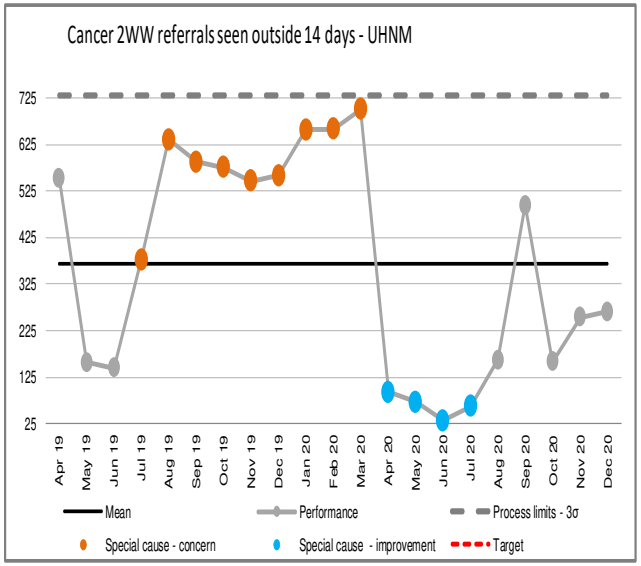
% patients beginning their treatment for cancer within 62 days following an urgent GP referral for suspected cancer

What is the data telling us?

Performance shows normal comon cause variation. However this has been consistently below the mean since April 2019 (with just two data points above the mean). This indicates that the target is unlikely to be met.







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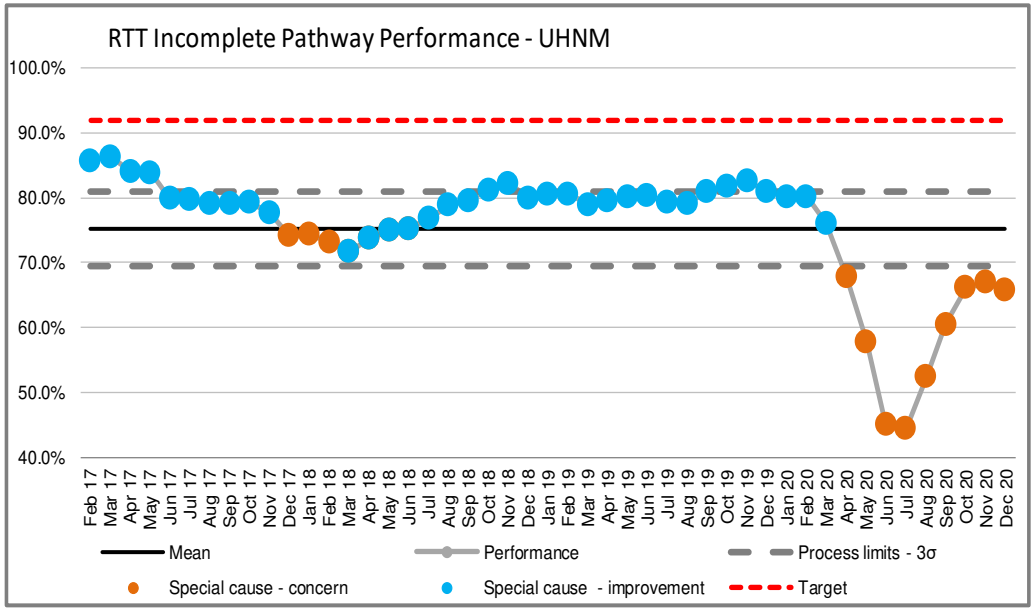
Referral To Treatment



Variation	Assurance
	

Target	Oct 20	Nov 20	Dec 20
92%	66.2%	67.0%	65.8%

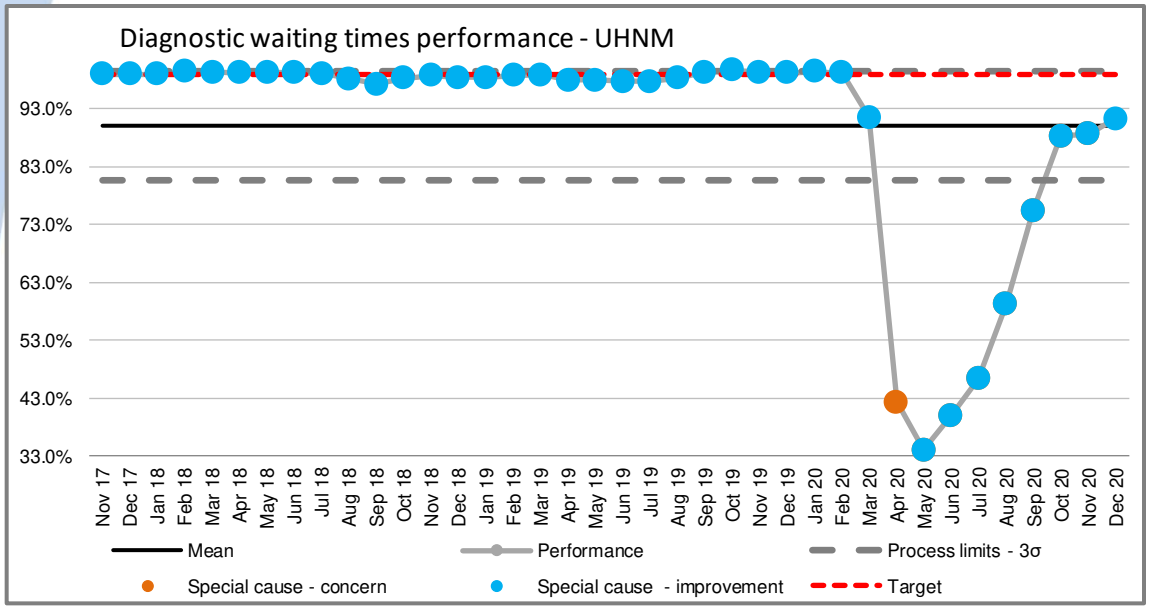
Background

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

What is the data telling us?

The RTT performance deteriorated from March 2020 with the onset of Covid-19. There is some early indication that performance is beginning to increase.

Diagnostic Standards



Variation	Assurance
	

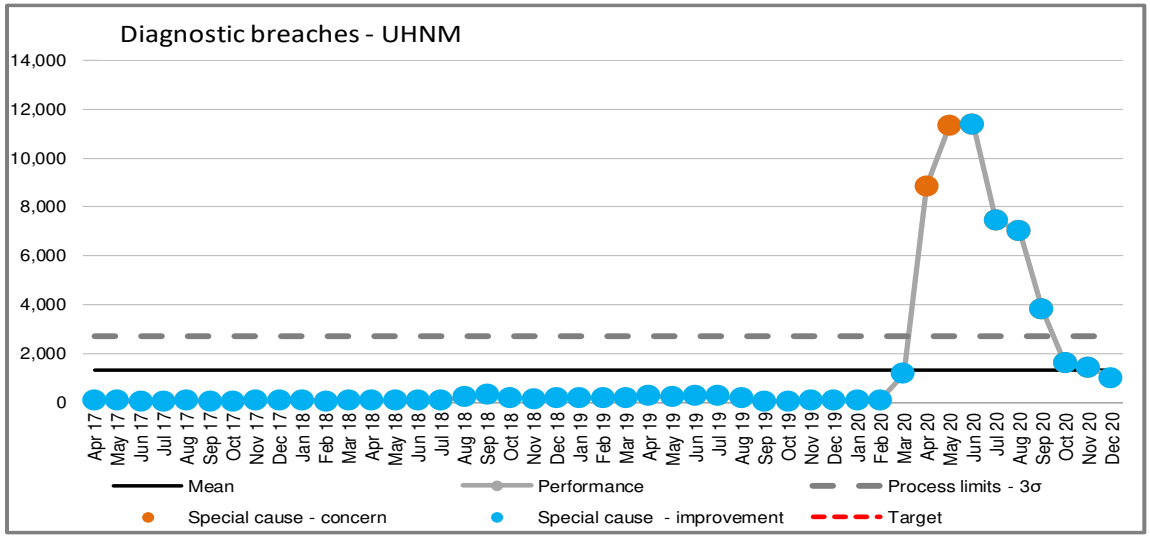
Target	Oct 20	Nov 20	Dec 20
99%	88.3%	88.6%	91.2%

Background

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

What is the data telling us?

The diagnostic performance has shown normal variation up until March 2020. Special cause variation occurred from March (COVID-19). Recovery has been evident since June 20.



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Appendix 2
COVID 19
Gold Briefing as at 25.01.2021

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Quality | Operational | Workforce | Finance

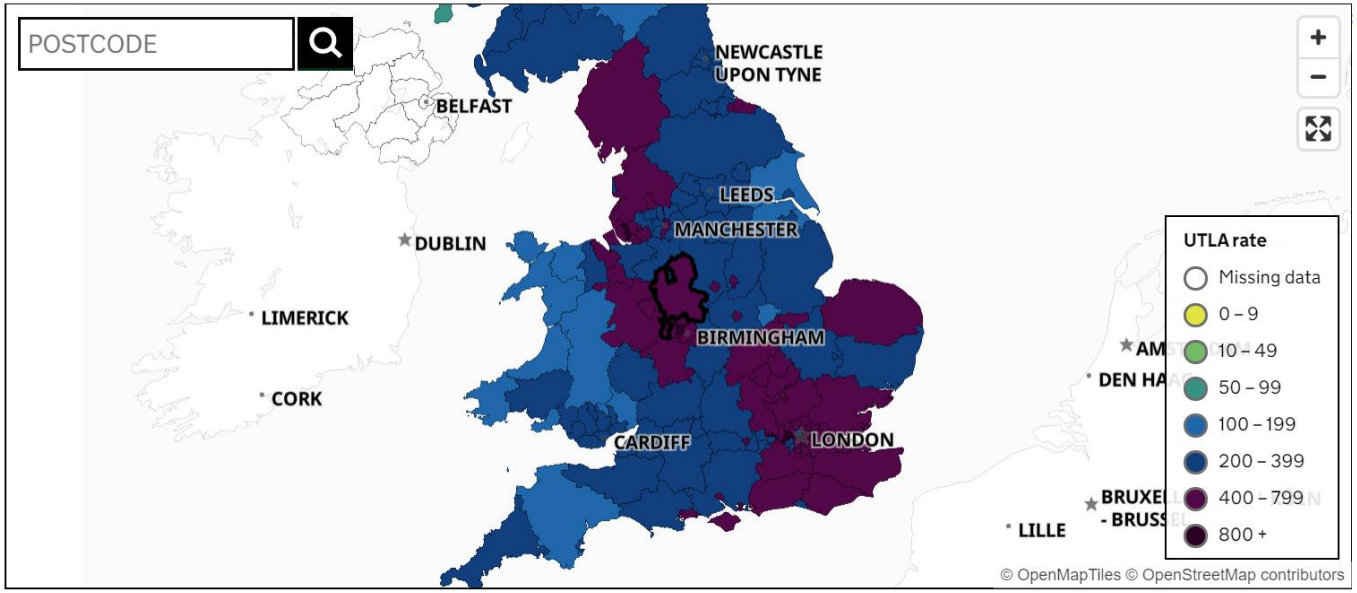
Contents

- Covid-19
  - Covid-19 prevalence
  - New cases / Nosocomial
  - Discharges / Deaths
  - Staffing
  - Testing
- R&R
  - A&E
  - Elective / Outpatient monitoring
  - Cancer performance
- Winter plan monitoring

Covid-19 community prevalence

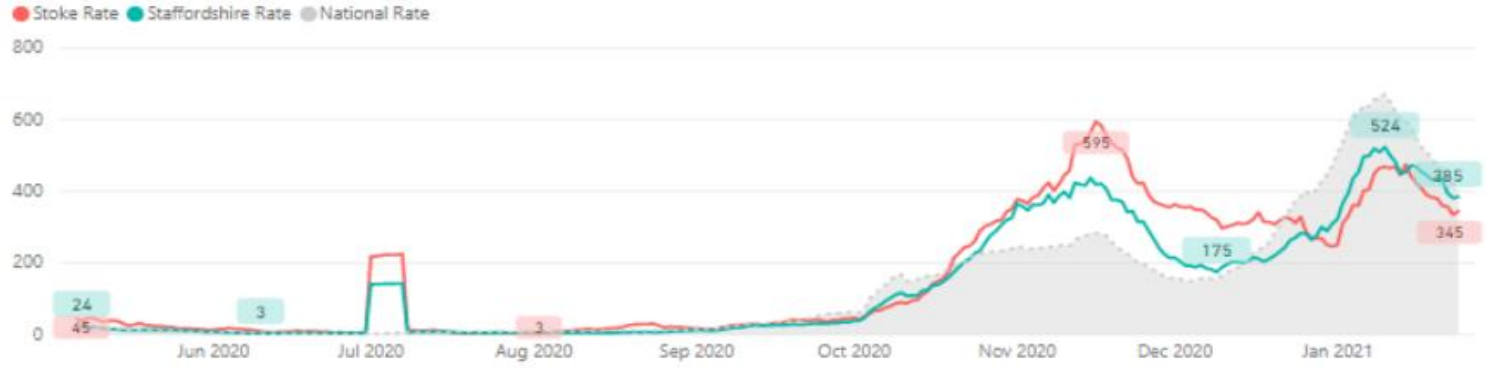
NHS
University Hospitals of North Midlands

National View



Local View

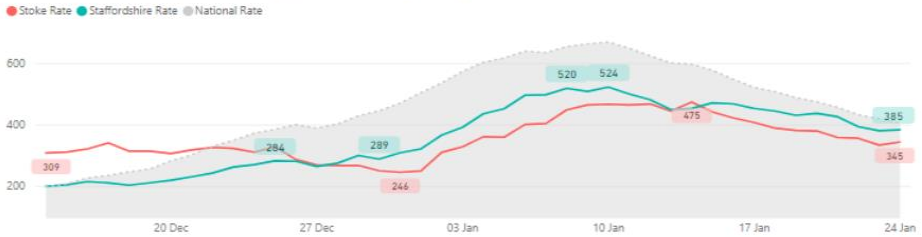
Positive Covid Cases per 100,000 population (7 day rolling rate)



22 January 2021	23 January 2021	24 January 2021
356.90	334.70	344.80

22 January 2021	23 January 2021	24 January 2021
394.90	381.30	384.70

Positive Covid Cases per 100,000 population (7 day rolling rate)



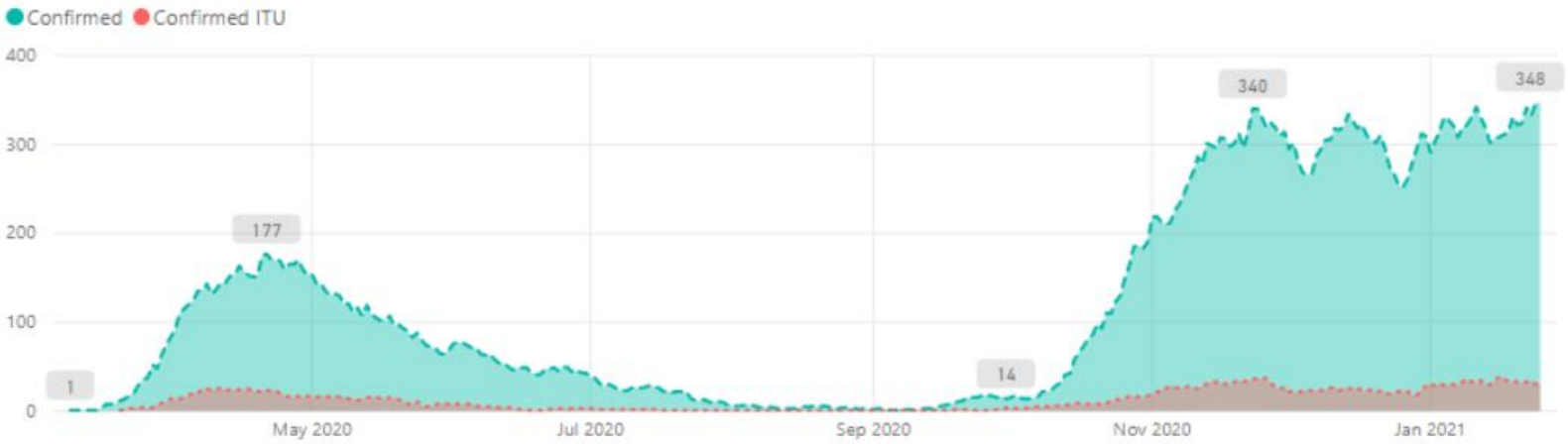
The growth in prevalence has slowed.
The case rate has plateaued.

Current Covid-19 Inpatients

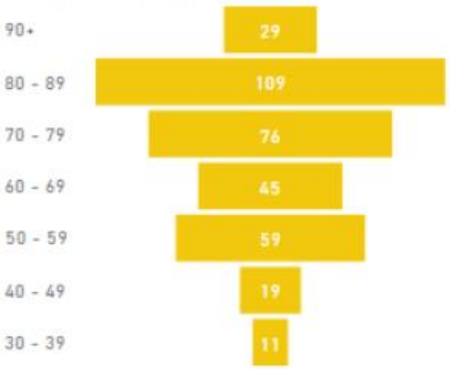
Bed type	23 January 2021	24 January 2021	25 January 2021
Total	**332**	**346**	**348**
Critical Care	34	30	32
Other	298	316	316

Site	23 January 2021	24 January 2021	25 January 2021
Total	**332**	**346**	**348**
County Hospital	41	41	41
Royal Stoke	291	305	307

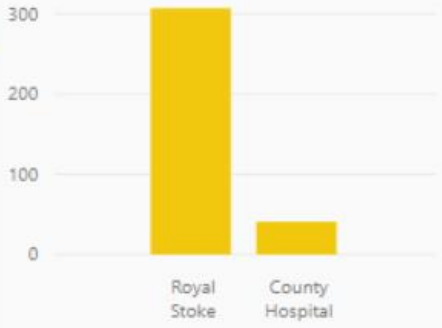
Covid inpatients



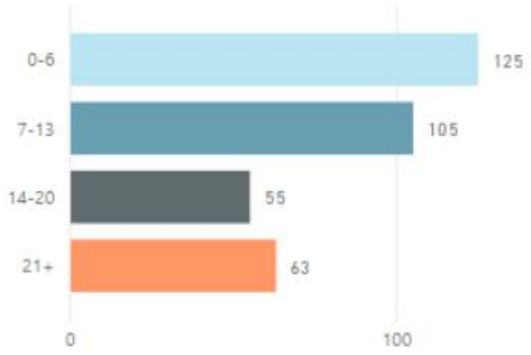
Age breakdown



Current inpatients by Site



Patients on Wards by total LoS banding



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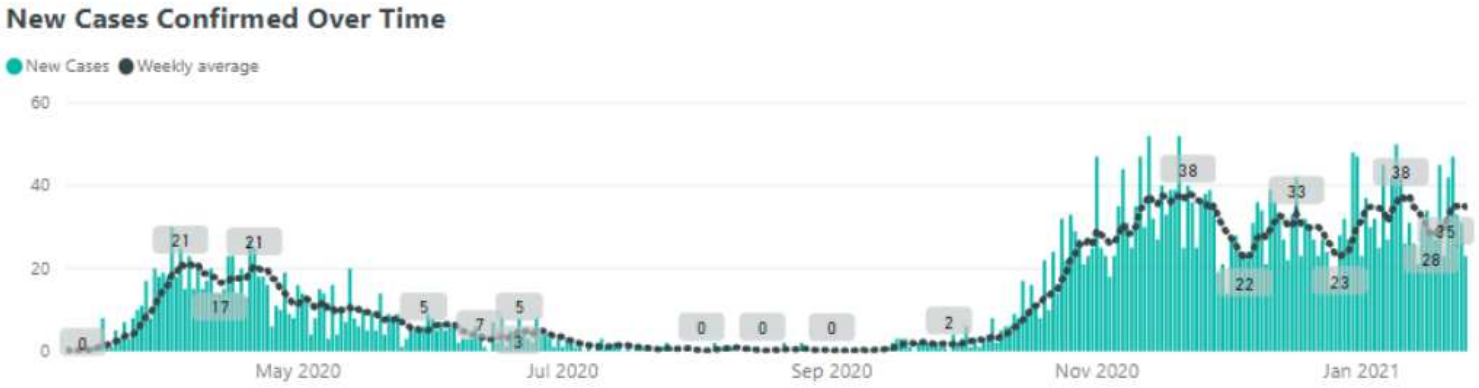
Covid-19 Demand (new cases confirmed)

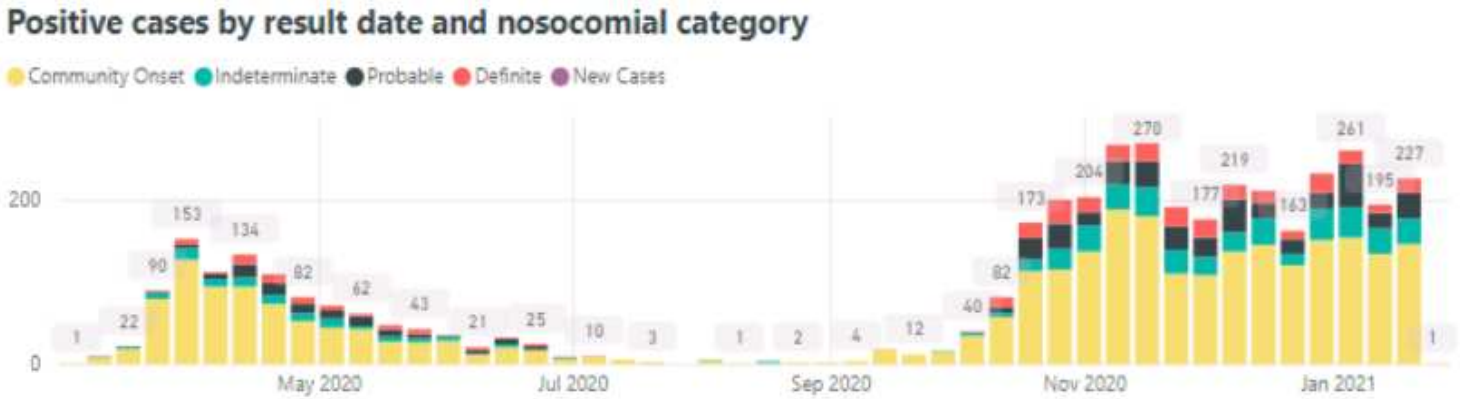
University Hospitals of North Midlands NHS Trust

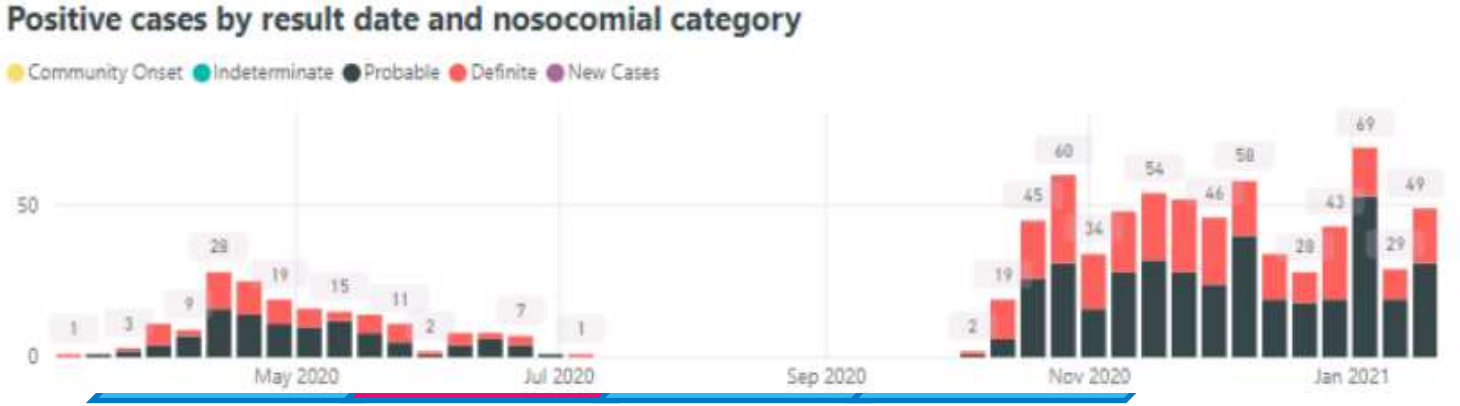
Averaging 35 new cases a day (7 day avg)

Increase in cases vs last week

49 Nosocomial cases last week







Nosocomial infections

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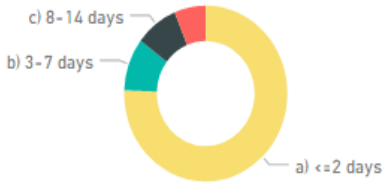
Wave 1 – (23 March – 10th May)

LoS before infection (group)	New Cases	%
a) <=2 days	570	75.60%
b) 3-7 days	73	9.68%
c) 8-14 days	64	8.49%
d) 15+ days	47	6.23%
Total	**754**	**100.00%**

Proportion by LoS



Last week

LoS before infection (group)	New Cases	%
a) <=2 days	147	64.76%
b) 3-7 days	31	13.66%
c) 8-14 days	31	13.66%
d) 15+ days	18	7.93%
Total	**227**	**100.00%**

Proportion by LoS

Nosocomial (3+ days) rate per 1,000 bed days up to 9.7

Nosocomial rate per 1000 bed days (3+ days LoS before infection)

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Covid-19 Discharges (excluding death)

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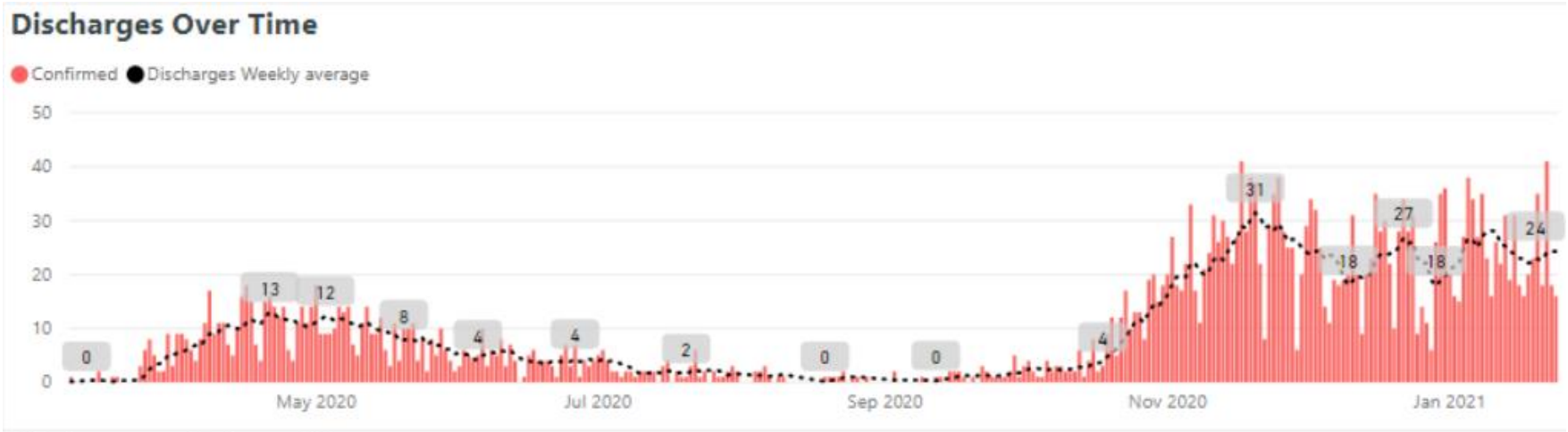
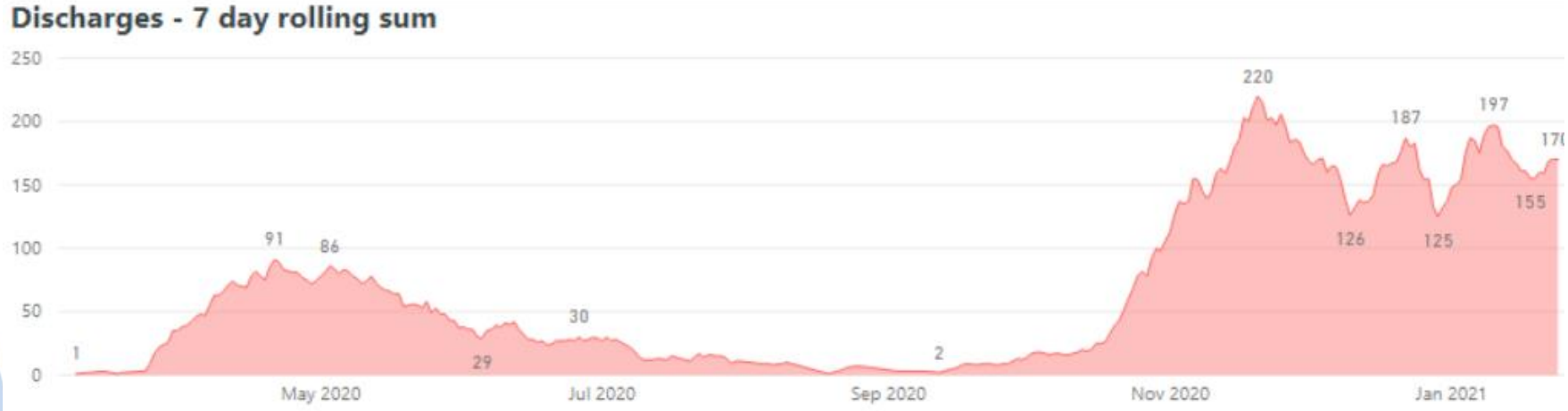
Rolling weekly total discharges at 170 last week.





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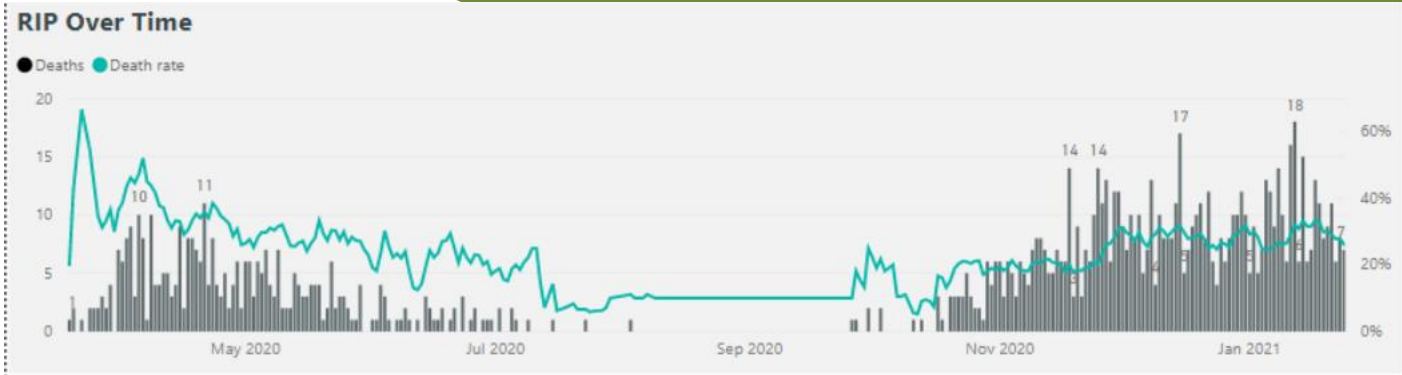
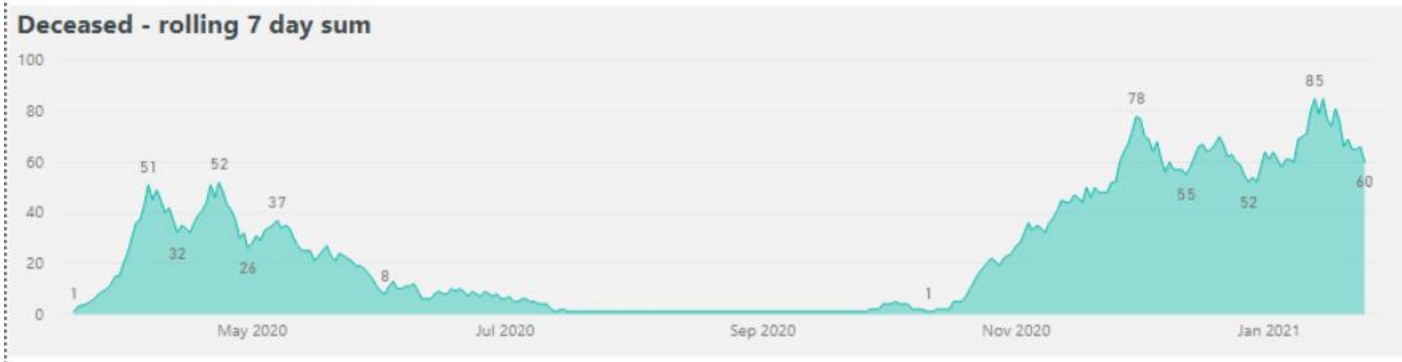
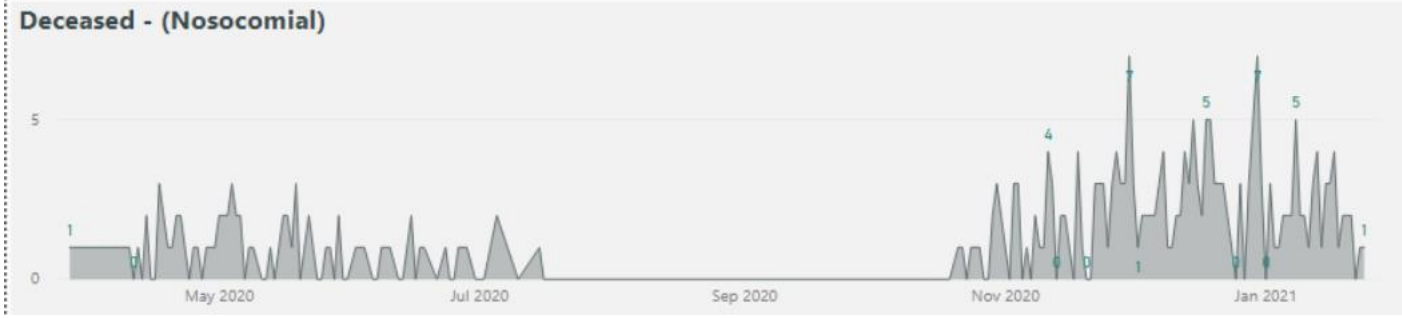
Covid-19 Deaths

The number of deaths being recorded remains in line with expectation based on previous weeks.







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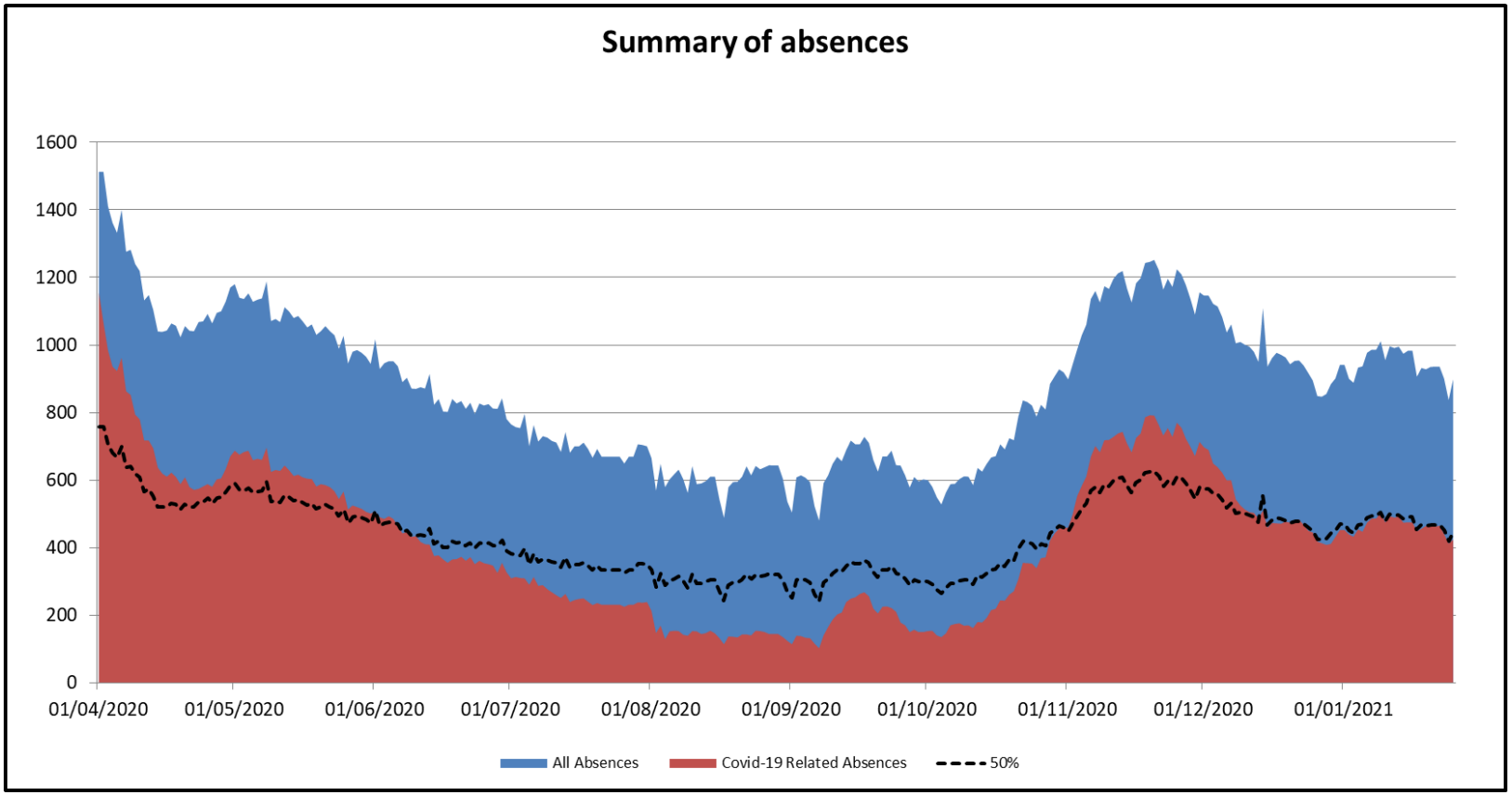
Staffing – absence over time

University Hospitals of North Midlands NHS Trust

Overall absence is lower than seen in peak of wave 1.
50% of absence is due to covid



Staffing

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8.5% absence overall with Medicine seeing the highest number off.

Staffing

971
Total staff sickness

8.5%
overall

486
Total Covid-19 related

50.1%
% Covid related

Sickness - Divisional and Directorate breakdown

Division	Absent	CV19 Related
205 Central Functions	63	22
205 Children's, Women's & Diagnostics	214	112
205 Estates, Facilities and PFI Division	50	26
205 Medicine Division	273	152
205 Specialised Division	117	57
205 Surgical Division	254	117
Total	**971**	**486**

Org Unit breakdown

Org Unit	Staff	absent %	Staff absent
205 A&E Education Nursing	4	50.0%	2
205 Emergency Planning	2	50.0%	1
205 General Mngt Team	2	50.0%	1
205 PFI Spec Flow Coordinators	2	50.0%	1
205 County Discharge Team	5	40.0%	2
205 County General Medicine Ward 7	55	34.5%	19
205 County Audiology Department	6	33.3%	2
205 County Gastroenterology Unit	3	33.3%	1
205 Leighton Satellite - Renal Unit	3	33.3%	1
205 Renal Home Therapies	23	30.4%	7
205 SSCU	65	27.7%	18
205 Hub Theatres (Th20-33)	11	27.3%	3
205 Medicine Night Practitioners	11	27.3%	3
205 Maternity Assessment Unit	15	26.7%	4
205 Medical Outpatient Clinics	30	26.7%	8
205 Elective Ortho Theatres	47	25.5%	12
205 County Shift Tradesmen	4	25.0%	1
205 Lymphodema Clinic	4	25.0%	1
205 Pathology Trials	4	25.0%	1
205 Respiratory Pleural Service	4	25.0%	1
205 Soft FM Management	4	25.0%	1
205 County Ward 12	49	24.5%	12
205 County Chemotherapy Department	17	23.5%	4
205 Urology and Gynaecology Ward	49	22.4%	11
205 County Community Midwives	9	22.2%	2
205 Midwife Birth Centre	18	22.2%	4
205 Organisation Dev Managers	14	21.4%	3
205 County Cleaning	87	20.7%	18
205 Ward 80 (Elderly Care)	34	20.6%	7
205 Child Health Cystic Fibrosis Supp	10	20.0%	2
Total	**11374**	**8.5%**	**971**

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Staff Testing (PCR)

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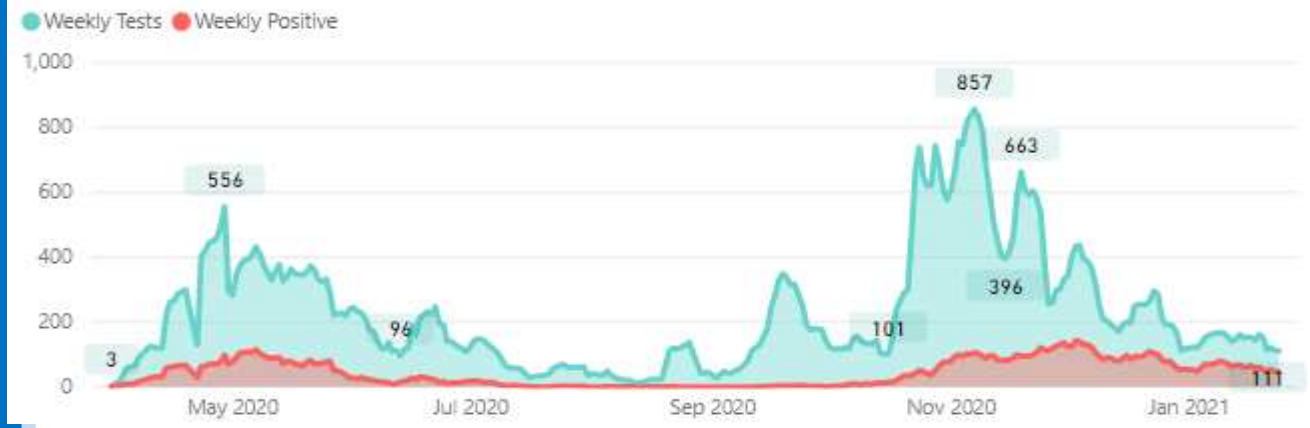
Last 7 days

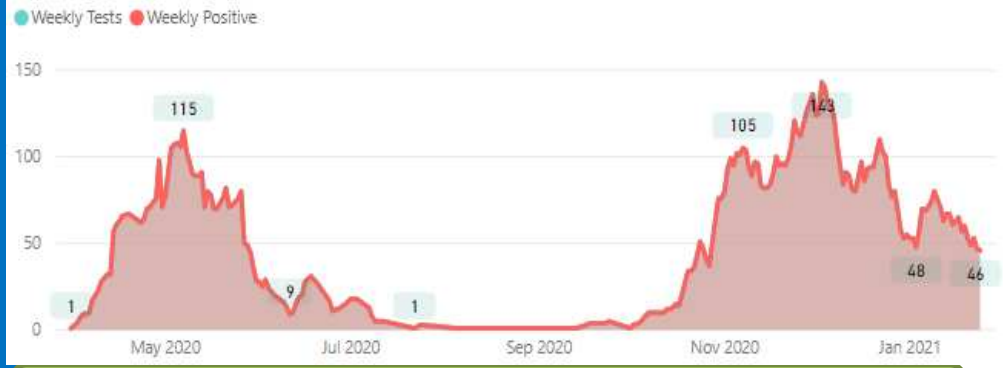
Total Tests	Positive Results	Positivity %	Symptomatic
111	46	41.4%	0 72 111

Weekly staff tests for UHNM staff



PCR Tests numbers falling. Impact of Lateral Flow home testing being seen

Weekly positive staff test results



Number of Staff testing positive down vs last week at 46

Lateral Flow – Subsequent PCR tests

Last 7 days

Total Tests	Positive Results	Positivity %
39	32	82.1%

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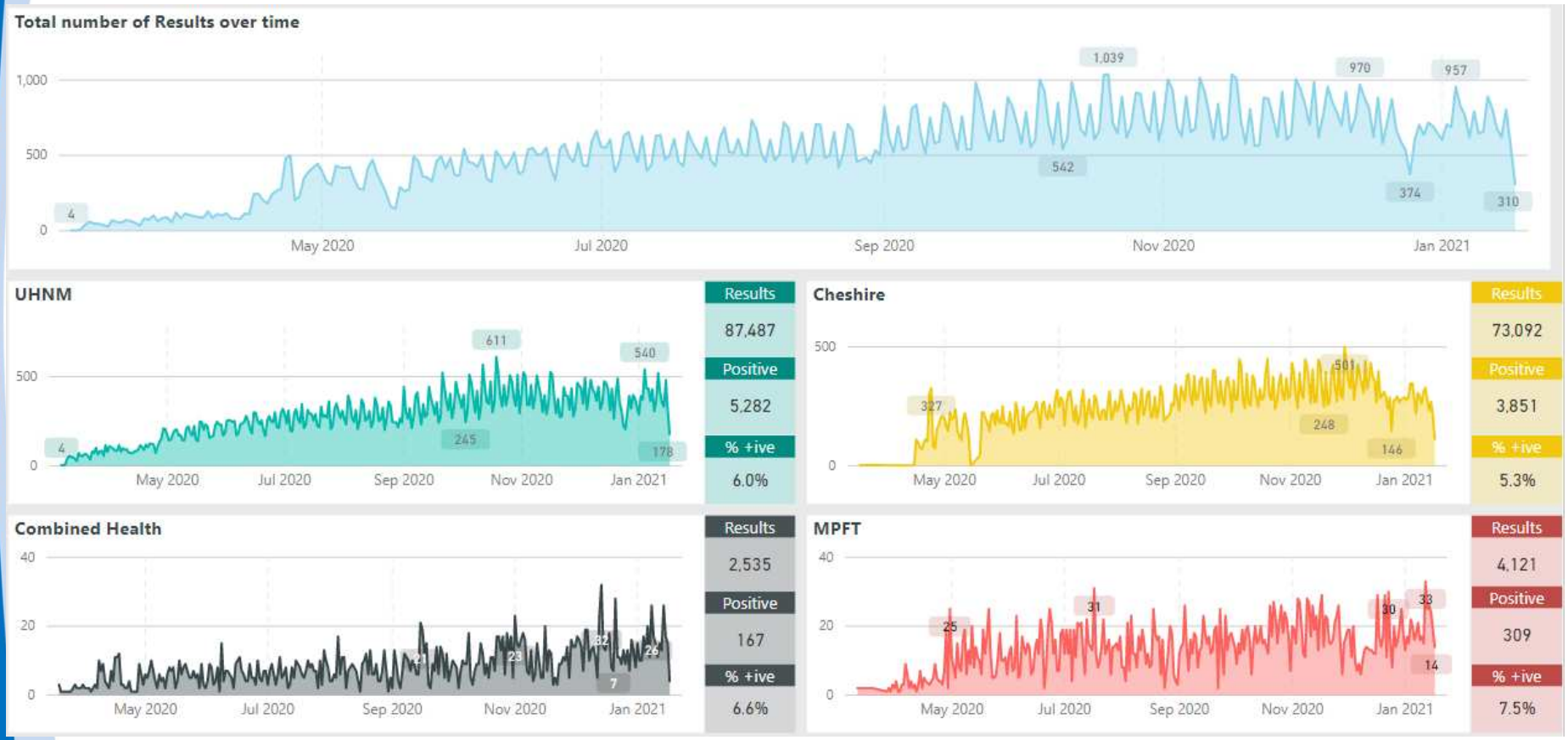
Tests resulted split by main requesting organisations



Covid Testing – UHNM only

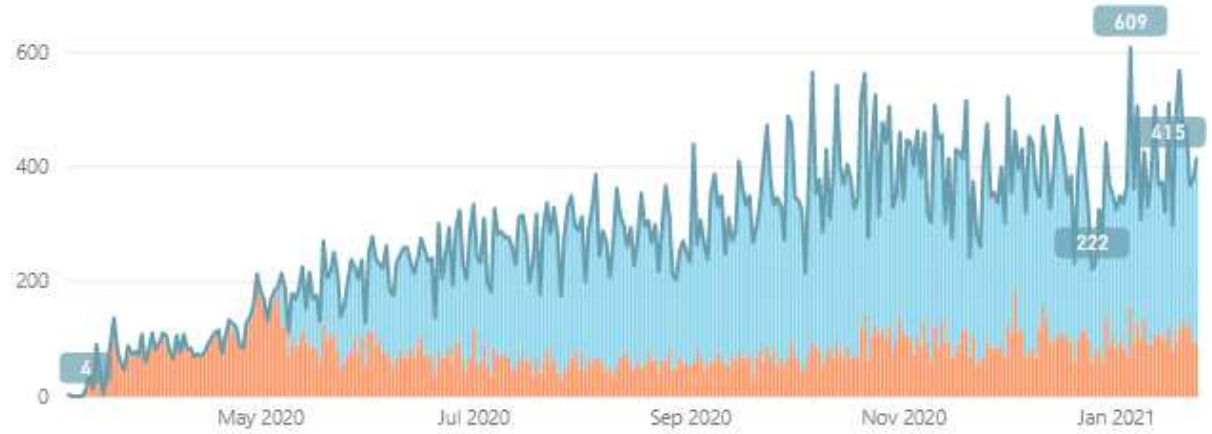
- Weekly test number increase from 2774 to 3,148
- Positivity up 0.2% this week

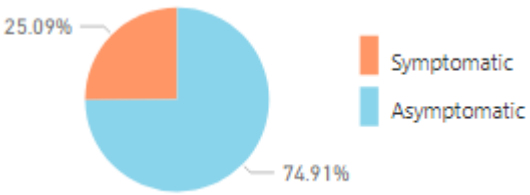
Yesterday

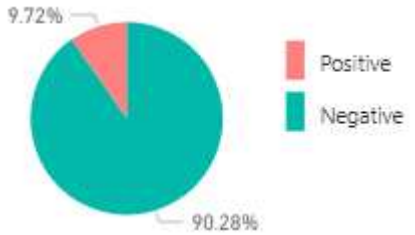
Total Tests	Positive Results	Positivity %	Symptomatic
415	36	8.7%	0 96 415

Last 7 days

Total Tests	Positive Results	Positivity %	Symptomatic
3,148	304	9.7%	0 783 3,148







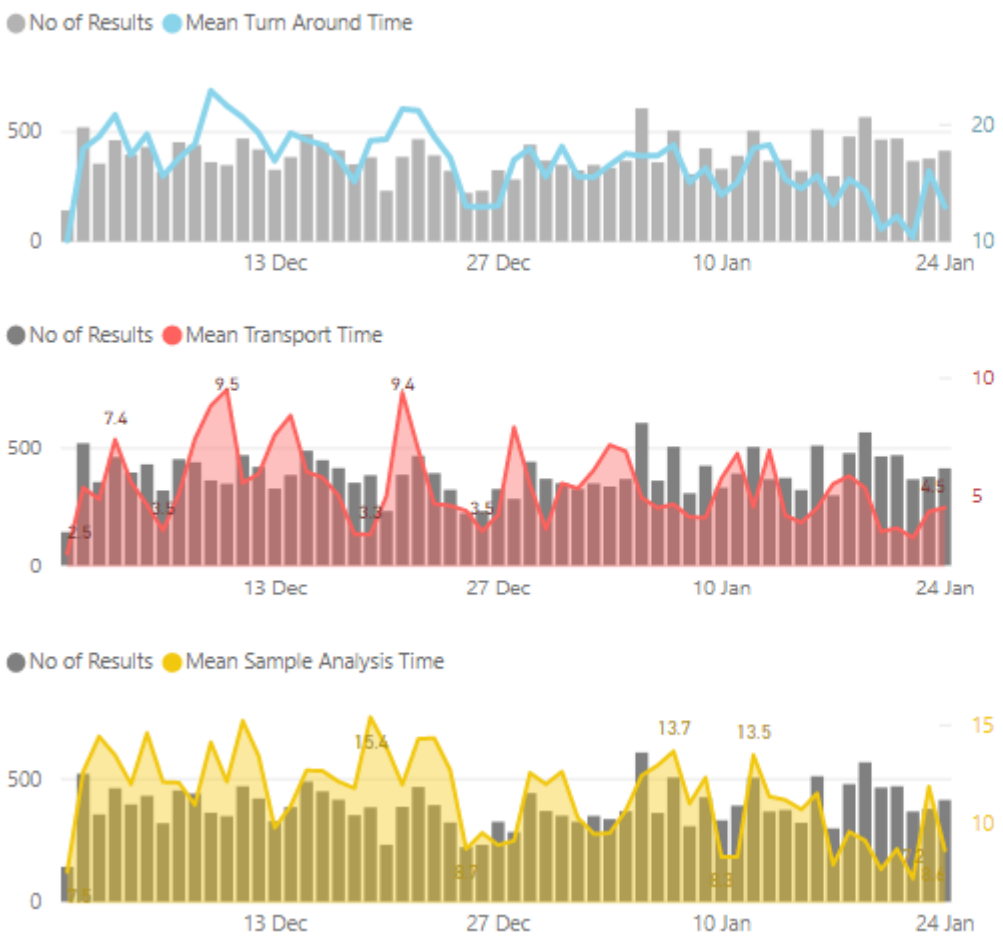
Finance

Covid-19 - Testing Turn around Times (UHNM Patients)

University Hospitals of North Midlands NHS Trust

UHNM patients (Royal Stoke & County, all patient tests)

Turn Around Times in Hours



Last 7 Days

Total TAT	
Mean	13.3
95%	25.7
Max	477

Transport Time	
Mean	4.4
95%	12
Max	465

Sample Analysis	
Mean	8.9
95%	19
Max	74

No <15 Hrs

2328

0 3,148

74%

Average turn around time for sample analysis (received by the lab – reported result) is 8.9 hours, this is below the national 15 hour ambition

Together Compassion Safe Improving

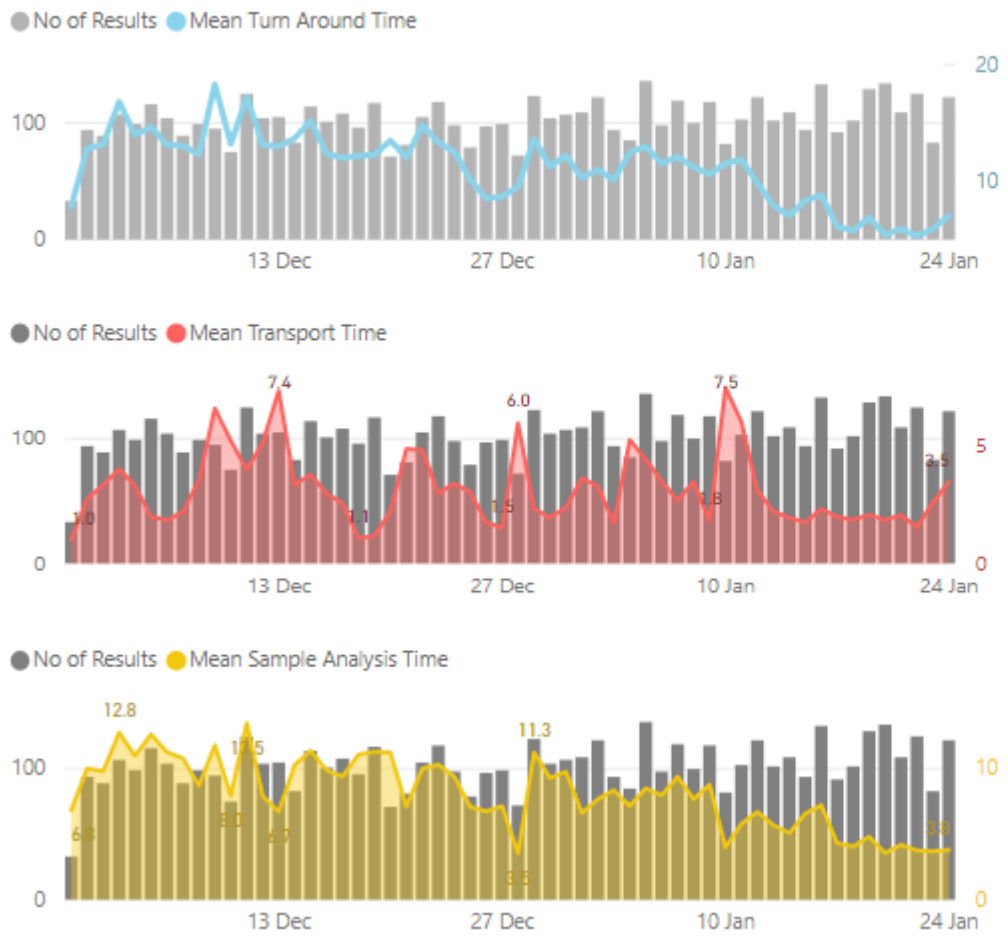
Quality | Operational | Workforce | Finance

Covid-19 - Testing Turn around Times (Royal Stoke A&E)

University Hospitals of North Midlands NHS Trust

Royal Stoke A&E category patients

Turn Around Times in Hours



Last 7 Days

Total TAT	
Mean	6.0
95%	14.4
Max	58

Transport Time	
Mean	2.2
95%	7
Max	31

Sample Analysis	
Mean	4.0
95%	11
Max	52

No <15 Hrs

778

0 804

96.8%

Transport time has seen a decrease last 7 days.

Sample analysis time reduction in the last 8 days

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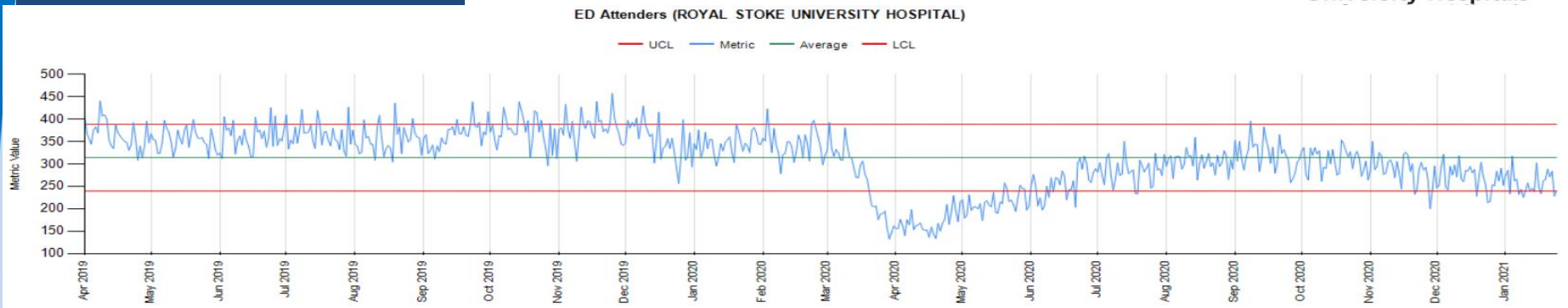
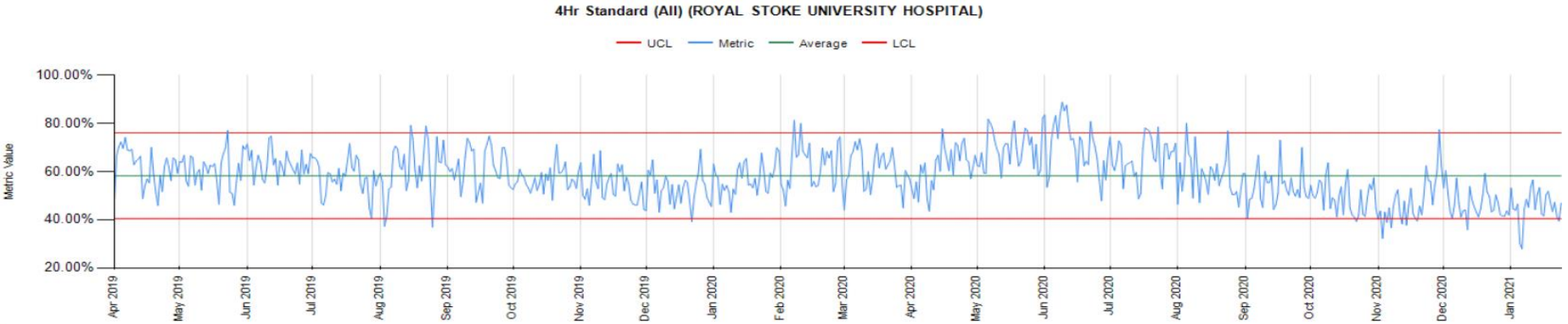
Emergency care Performance

NHS University Hospitals





12 Hour Trolley Waits

Breach Date	B
02/01/21	1
05/01/21	15
06/01/21	15
07/01/21	1
12/01/21	1
	33

- ED attendances remain lower than previous year with a slight decline
- 33 12 hour breaches confirmed in January to date

Sitrep (last week)

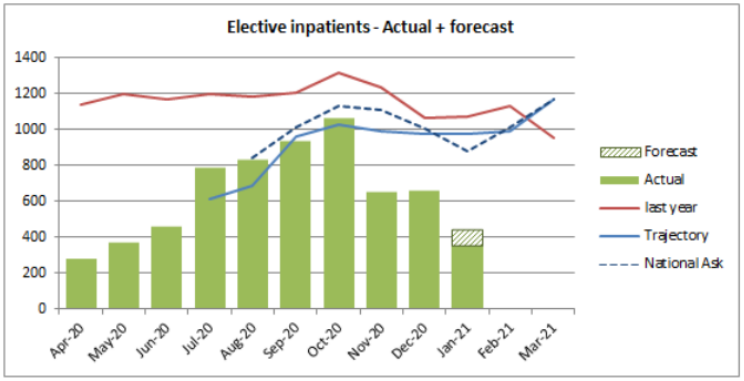
UHNM Trust				17/01	18/01	19/01	20/01	21/01	22/01	23/01	24/01	
Measure Name	Target	Last 6 Wks	Last Wk	Dir. Of Travel	*Sun*	*Mon*	*Tue*	*Wed*	*Thu*	*Fri*	*Sat*	*Sun*	*8 Day Trend*
Attendance Count - All Types		3469	3453	↓	431	512	509	516	492	538	436	450	
Attendance Count - Type 1		2420	2415	↓	292	351	365	369	350	377	297	306	
4 Hour Performance - All Types		67.9%	67.4%	↓	75%	69%	70%	62%	65%	67%	65%	73%	
4 Hour Performance - Type 1		54.0%	53.6%	↓	63%	55%	58%	47%	52%	54%	49%	62%	
Ambulance Arrivals		1260	1269	↑	160	188	203	208	172	175	172	151	
Minors 4 Hour Performance		85.8%	83.3%	↓	98%	96%	95%	76%	85%	86%	92%	70%	
GP Streaming		7.7%	7.7%	↑	10%	10%	6%	8%	6%	9%	8%	8%	
Simple & Timely Discharges		782	756	↓	76	86	130	125	116	135	83	81	
Complex Discharges		201	213	↑	19	28	41	48	27	42	14	13	
% Bed Occupancy		80.1%	80.8%	↑	78%	82%	82%	82%	81%	80%	79%	80%	
SDEC Admissions		406	446	↑	37	72	79	78	66	90	35	26	
Escalation Beds		50	79	↑	48	48	48	91	91	91	91	91	
Stranded 7+ days		481	473	↓	473	471	468	462	477	455	479	497	
Superstranded 21+ days		135	134	↓	136	140	139	133	137	125	129	132	
MFFD		73	70	↓	53	77	75	67	72	68	66	68	

Quality

NHS
University Hospitals of North Midlands Trust

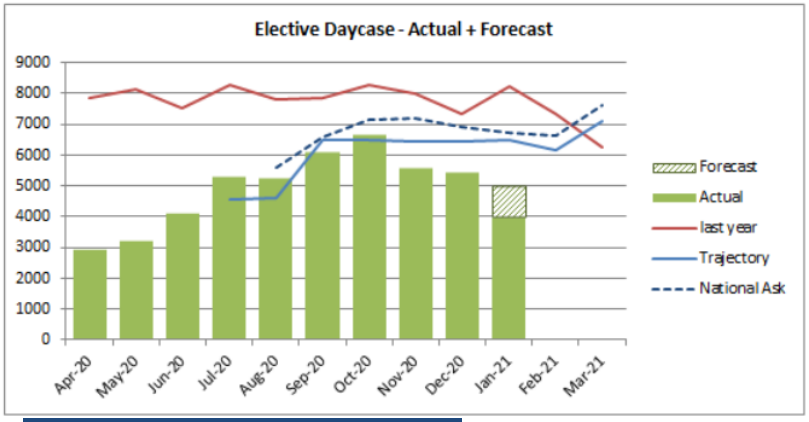
Elective Activity

Division	Last year	Phase 3 Plan	Forecasted actual	% planned	% forecasted	Distance from plan
Surgery	434	365	189	93%	48%	-176
Medicine	63	68	34	119%	59%	-34
CWD	183	160	110	96%	66%	-50
Specialised	391	329	108	93%	30%	-222
Stretch		54				
UHNM	**1,071**	**976**	**440**	**100%**	**45%**	**-536**



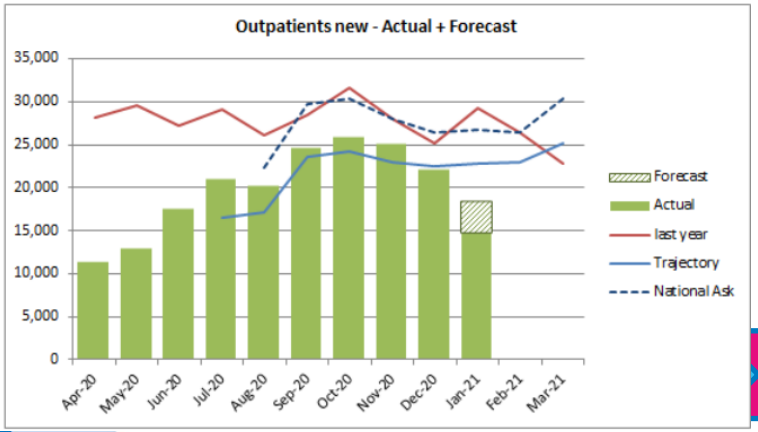
Daycase Activity

Division	Last year	Phase 3 Plan	Forecasted actual	% planned	% forecaste	Distance from plan
Surgery	1,900	1,079	746	62%	43%	-333
Medicine	2,016	1,619	1,414	88%	77%	-205
CWD	3,691	3,014	2,575	90%	77%	-439
Specialised	624	413	250	73%	44%	-163
Stretch		350				
UHNM	**8,231**	**6,475**	**4,985**	**87%**	**67%**	**-1,490**



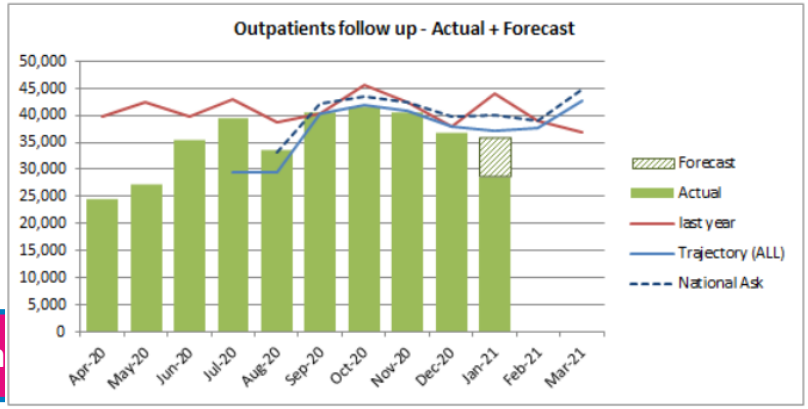
1st OP Activity

Division	Last year	Phase 3 Plan	Forecasted actual	% planned	% forecaste	Distance from plan
Surgery	10,110	7,831	5,748	85%	63%	-2,084
Medicine	4,316	3,647	3,240	93%	83%	-407
CWD	5,796	4,198	3,723	80%	71%	-476
Specialised	8,695	7,082	5,509	90%	70%	-1,573
Stretch		0				
UHNM	**28,917**	**22,758**	**18,219**	**87%**	**69%**	**-4,539**



Fup OP Activity

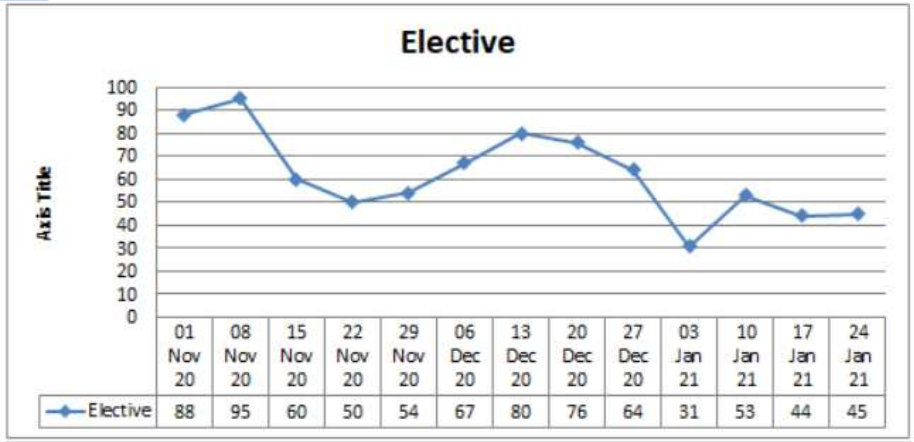
Division	Last year	Phase 3 Plan	Forecasted actual	% planned	% forecaste	Distance from plan
Surgery	14,215	11,389	12,126	88%	94%	737
Medicine	6,566	5,500	4,901	92%	82%	-599
CWD	9,699	9,006	8,588	102%	97%	-419
Specialised	13,030	10,305	9,598	87%	81%	-708
Stretch		1,000				
UHNM	**43,510**	**37,200**	**35,213**	**94%**	**89%**	**-1,988**

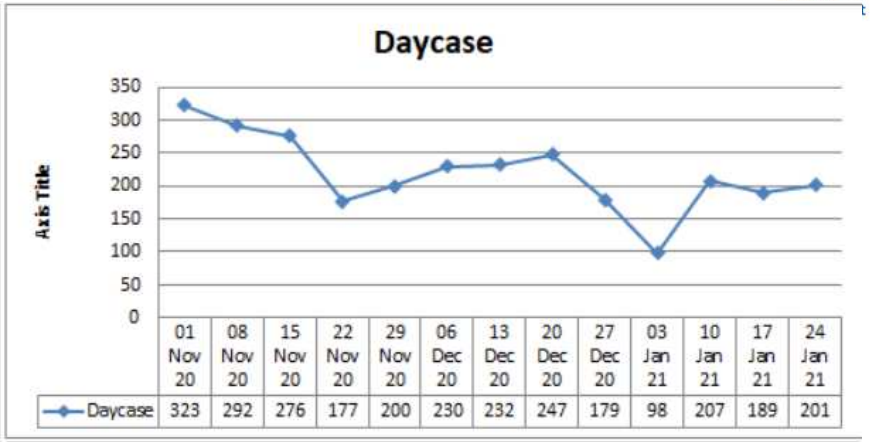


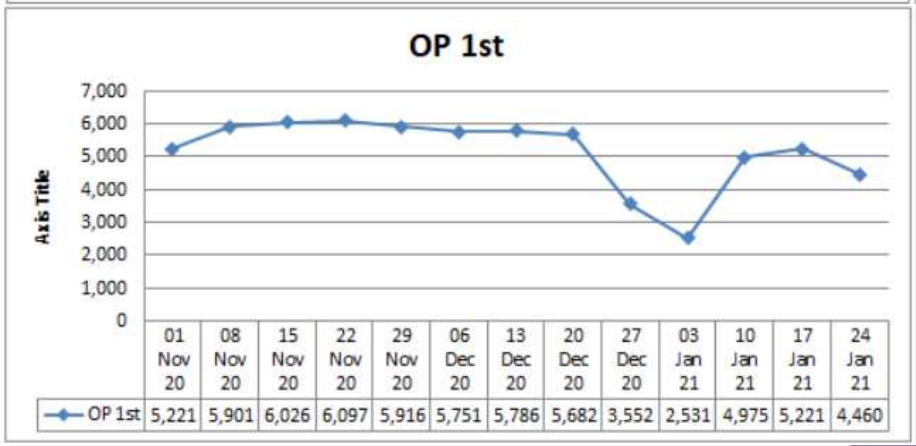
Operationa

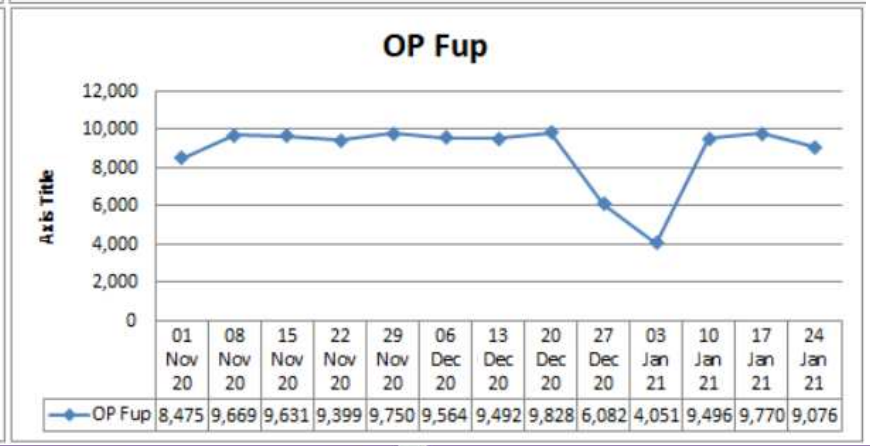
Weekly Actual Activity

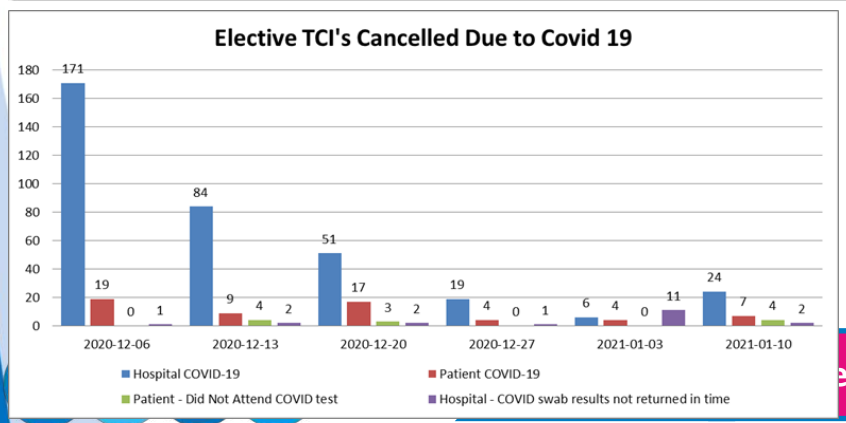
NHS
University Hospitals of North Midlands





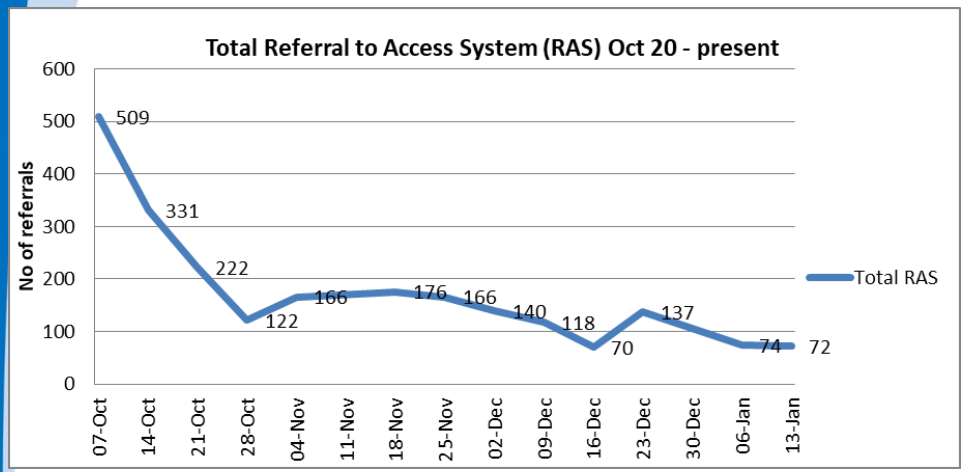




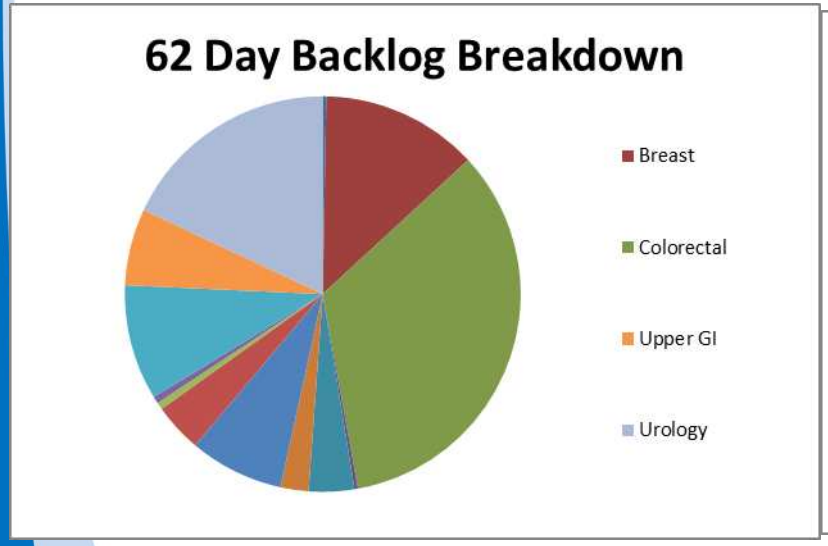


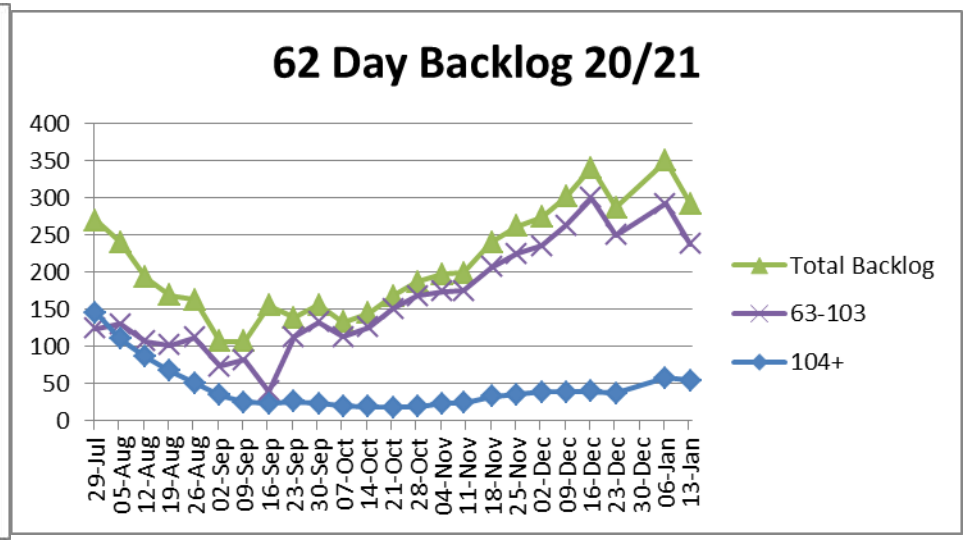
Prioritised Breach		Date				
UH_RCSGrade	UHDivision	31/08/2020	30/09/2020	31/10/2020	30/11/2020	31/12/2020
P1	Surgical	6	5	7	7	4
	Specialised	1	1	2	3	1
	Medical	2	10	11	11	10
	WCCS	4	7	11	13	1
P1 Total		13	23	31	34	16
P2	Surgical	375	527	456	268	320
	Specialised	147	137	174	237	209
	Medical	271	678	854	1,162	1,276
	WCCS	133	125	152	180	76
P2 Total		926	1,467	1,636	1,847	1,881
Grand Total		939	1,490	1,667	1,881	1,897

Cancer Performance



- The length of time patients are waiting to be appointed is at it's the lowest in the past 4 months
- There are currently 54 patients in the 104 day backlog. Decrease of 4 since last week.
- 14 of these have received a diagnosis of cancer





Together Compassion Safe Improving

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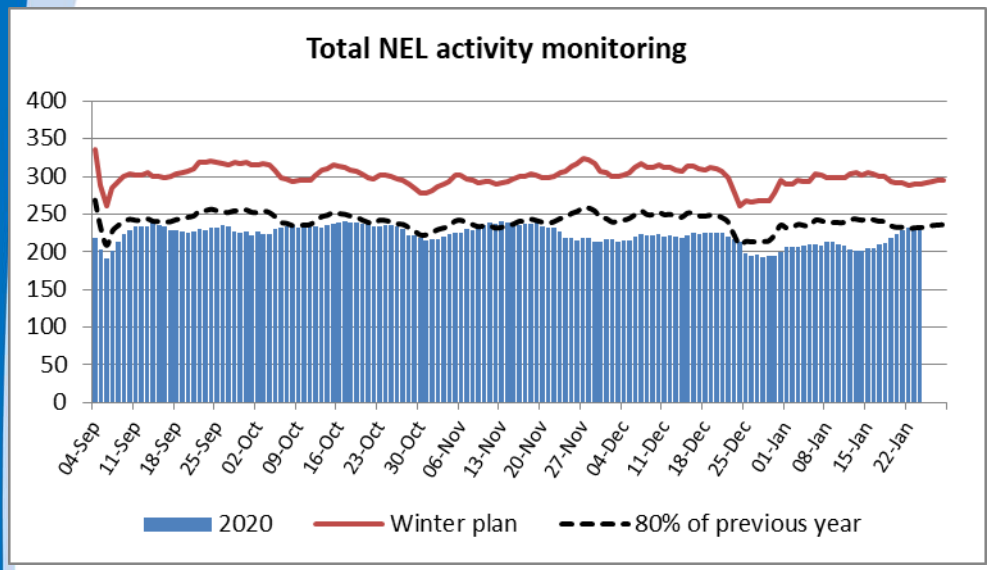
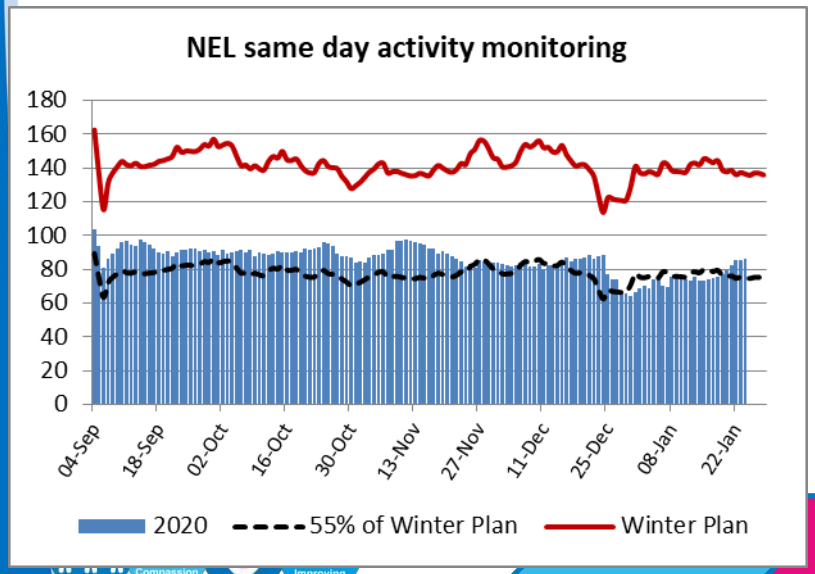
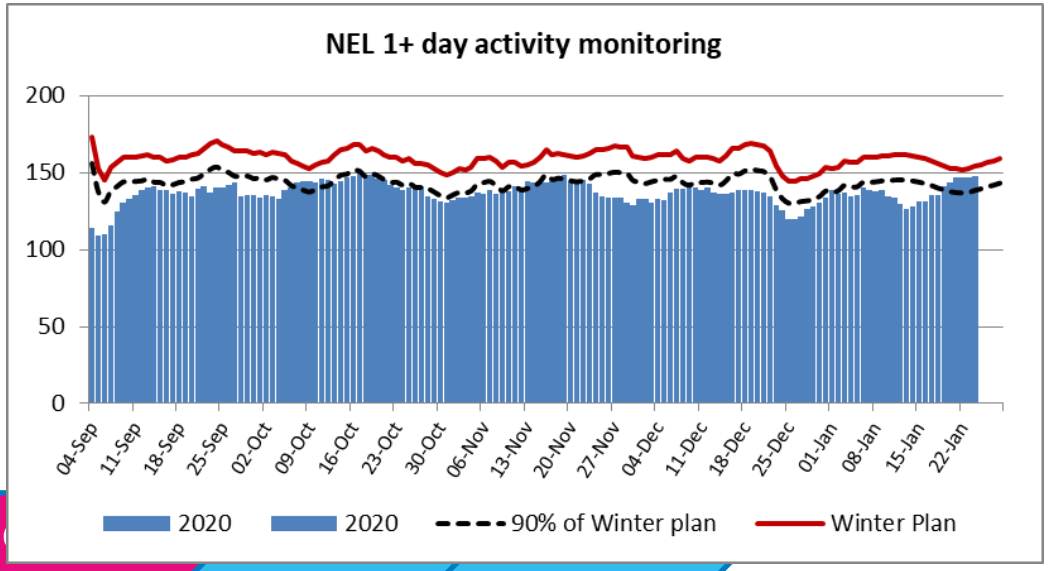
University Hospitals of North Midlands NHS Trust

Demand against Winter plan assumptions

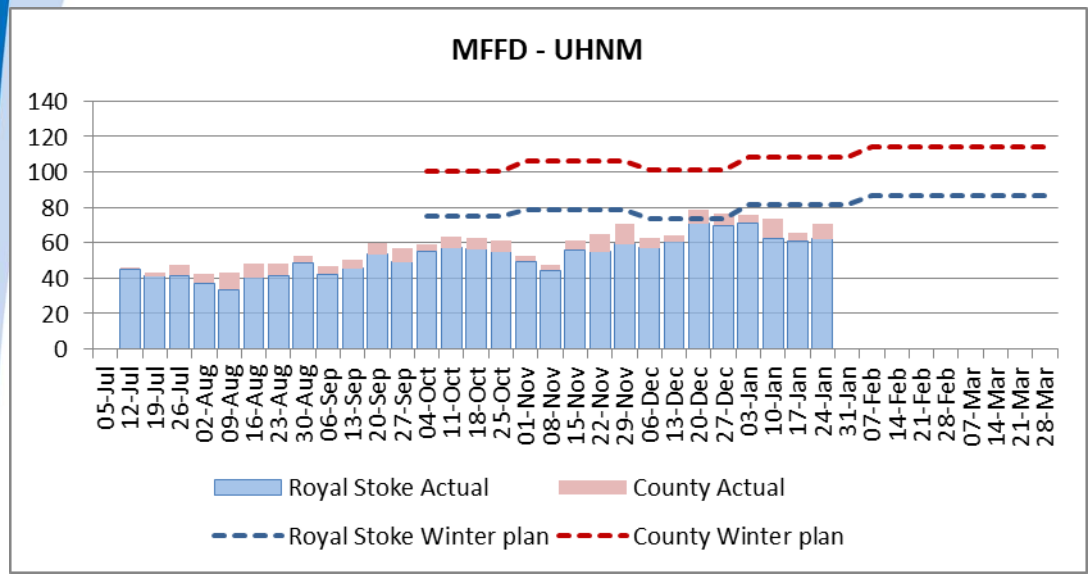


- NEL demand (NEL admissions to UHNM) recently has seen a widening of the gap between same day care and 1+ day care.
- Same day activity has fallen from around 66% of the demand modelled in the winter plan to 55%
- 1+ day activity continues to be around 90% of the winter plan. Although signs of this increasing are seen over the last few days.

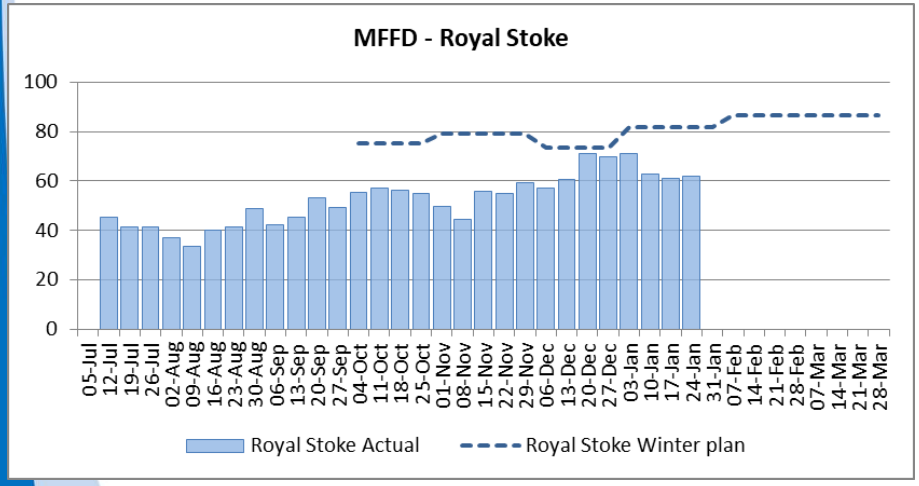


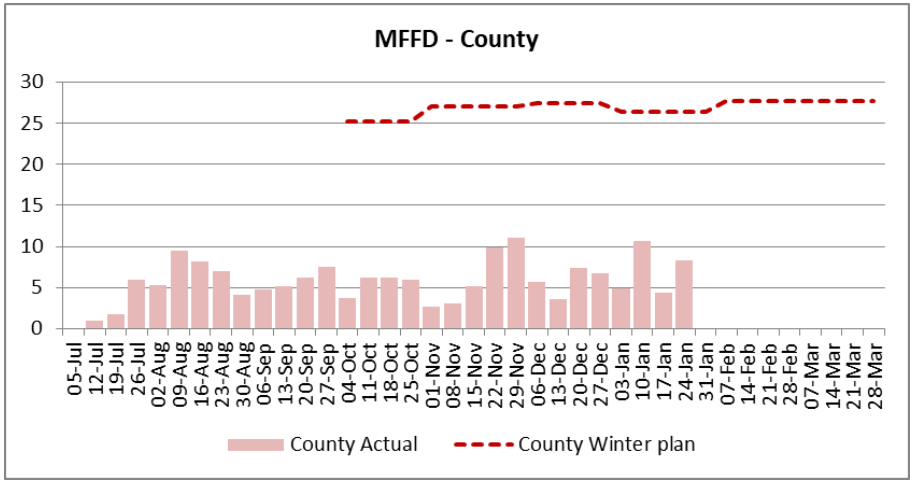


MFFD averages against the winter plan assumptions

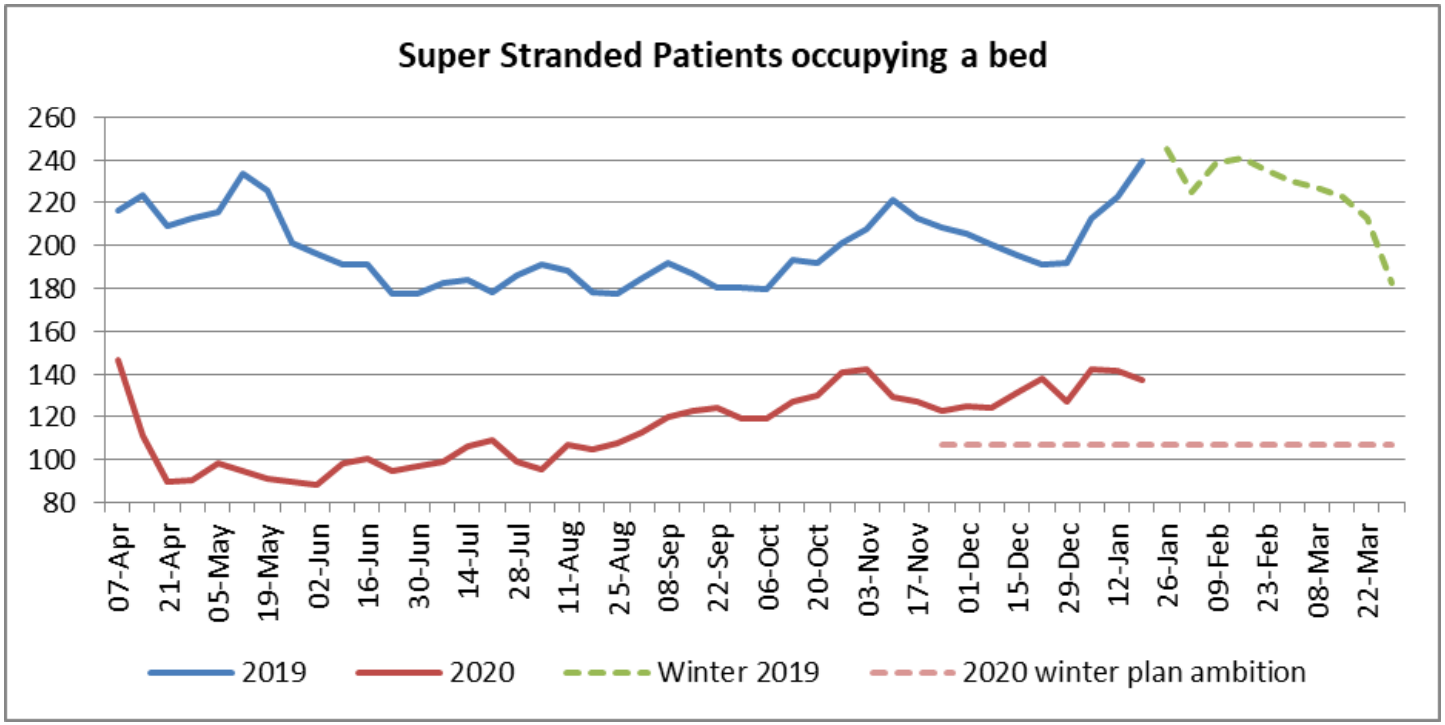


- For winter planning, MFFD levels were remodelled to reflect the drop from previous years.
- After a rise over the Christmas period, Royal Stoke MFFD numbers have recently fallen and remain below the level assumed in the winter plan.
- County MFFD numbers are well below the assumed level in the Winter plan





Super Stranded patients



- Super stranded patients were not adjusted for winter planning as it was assumed the adjustment for MFFDs would capture the reduction seen in this cohort of patients.
- In 2021 the number remains around 140 currently around 100 less than the previous year.

Workforce

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

Workforce Spotlight Report

NHS University Hospitals of North Midlands NHS Trust

Key messages

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

The focus of the Workforce Bureau remains on risk assessments, staff wellbeing, staff testing, staff deployment and supporting the vaccination programme.

The daily sickness sitrep highlights wards and areas with high numbers of staff calling in as absent, which then triggers mitigating actions set out in business continuity plans. Redeployment processes are place to support areas of need and volunteer placements, including Military personnel and volunteers from local councils, are offering support. A system-led workforce demand and supply process is in place to manage redeployment of staff where required.

The key performance issues remain compliance with the sickness rate being above target and with PDR requirements although an Executive decision was taken to suspend PDR's unless there is capacity to continue to undertake them.

Sickness

The in-month sickness rate was 6.19% (5.85% reported at 30/11/20). The 12 month cumulative rate increased to 5.34& (5.23% at 30/11/20)

Since the 21st October, absence episodes have increased in line with the second covid wave and, As of 4th January 2021, covid-related open absences numbered 463, which was 48.94% of all absences (50% at 21st December 2020)

- Covid related absences and staff testing remains an area of focus, with additional resources being applied to manage staff testing. The Covid vaccination programme is well underway and has been opened to all staff. As at 19th Jan 21, 5811 staff had received the first dose vaccine, plus a further 3904 others who work in the trust. The 3904 includes staff who have not provided an employee number and are being verified to ESR, Sodexo, EZEC and Agency workers'
- There is a Staff Wellbeing plan in place and wellbeing support has continued throughout the pandemic. The focus going forward will be on the continued provision of staff support to ensure the psychological wellbeing of staff
- Rest Facilities for staff have been opened on the Royal Stoke Site and refurbishment of the rest facilities at County Hospital will be progressed soon

Appraisals

The Non-Medical PDR compliance rate improved to 76.76% at 31st December 2020 (75.56% at 30th November).

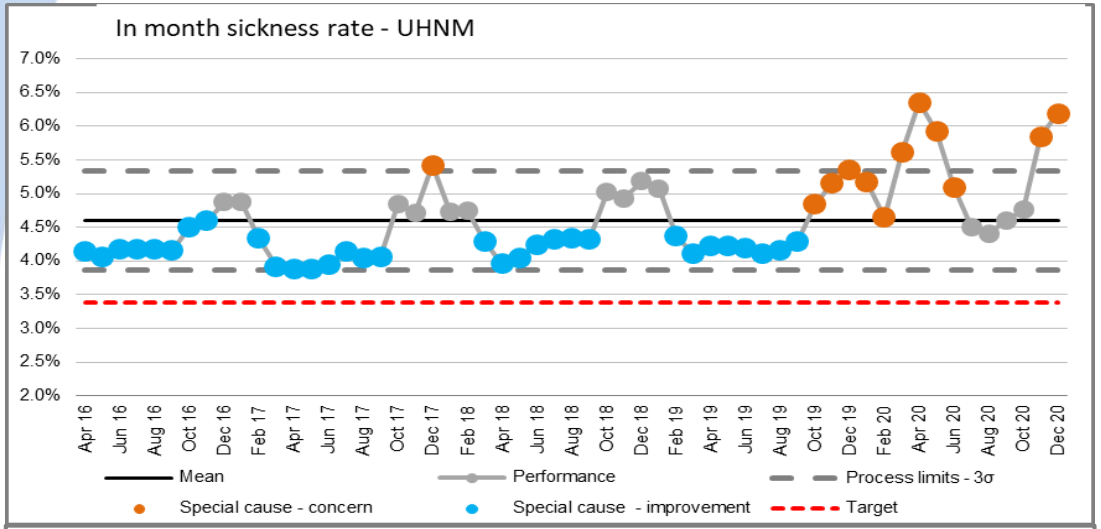
Statutory and Mandatory Training

The Statutory and Mandatory training rate was 93.93% at 31st December 2020 (94.14% at 30/11/20). 89.86% of staff have completed all 6 core for all requirements (90.07% at 30/11/20)

Workforce Dashboard

Metric	Target	Latest	Variation	Assurance
Staff Sickness	3.4%	6.19%		
Staff Turnover	11%	9.56%		
Statutory and Mandatory Training rate	95%	93.93%		
Appraisal rate	95%	76.26%		
Agency Cost	N/A	3.40%		

Sickness Absence



Variation	Assurance
H	F

Target	Oct 20	Nov 20	Dec 20
3.4%	4.8%	5.9%	6.2%

Background

Percentage of days lost to staff sickness

What is the data telling us?

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

Sickness rate is consistently above the target of 3.4%. The special cause variation seen from March through to July was a result of covid-19. Following a short respite, covid-related absences have increased in line with the second wave

Summary

The in-month sickness rate was 6.19% (5.85% reported at 30/11/20). The 12 month cumulative rate increased to 5.34& (5.23% at 30/11/20)

Since the 21st October, absence episodes have increased in line with the second covid wave and, As of 4th January 2021, covid-related open absences numbered 463, which was 48.94% of all absences (50% at 21st December 2020)

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- Rest Facilities for staff have been opened on the Royal Stoke Site and refurbishment of the rest facilities at County Hospital will be progressed soon

Actions

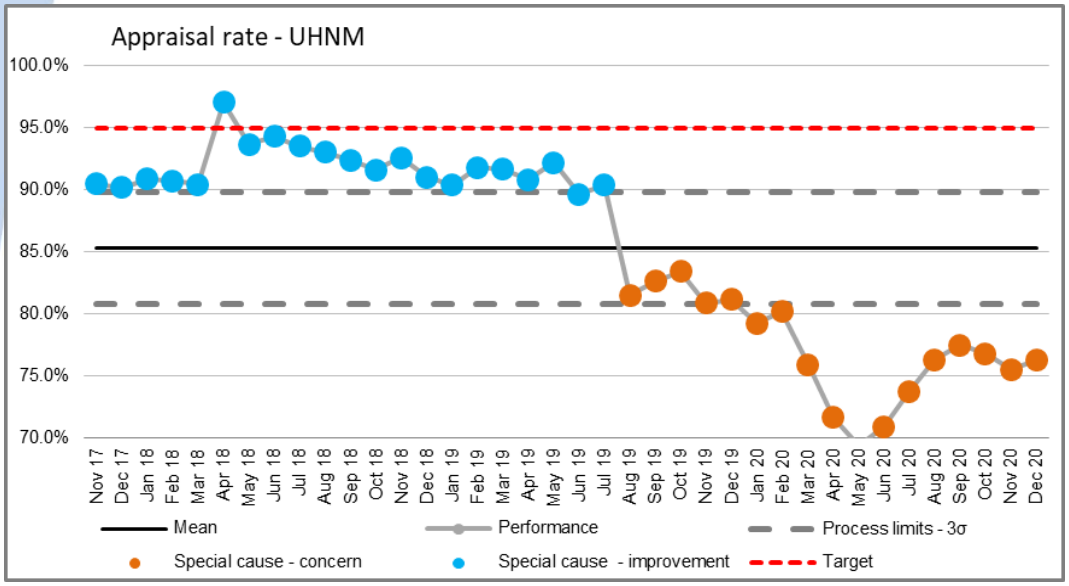
Covid related absences and staff testing remains an area of focus and the Lateral-Flow asymptomatic testing of frontline staff for Covid-19 to strengthen our efforts to prevent and control the spread of infection is continuing.

Phase 3 of the covid-19 risk assessment process has been completed

The covid vaccination programme is underway and open to all staff

Going forward, the wellbeing focus will be on ensuring the continued provision of staff support to ensure the psychological wellbeing of staff

Appraisal (PDR)



Variation	Assurance

Target	Oct 20	Nov 20	Dec 20
95.0%	76.8%	75.6%	76.3%

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

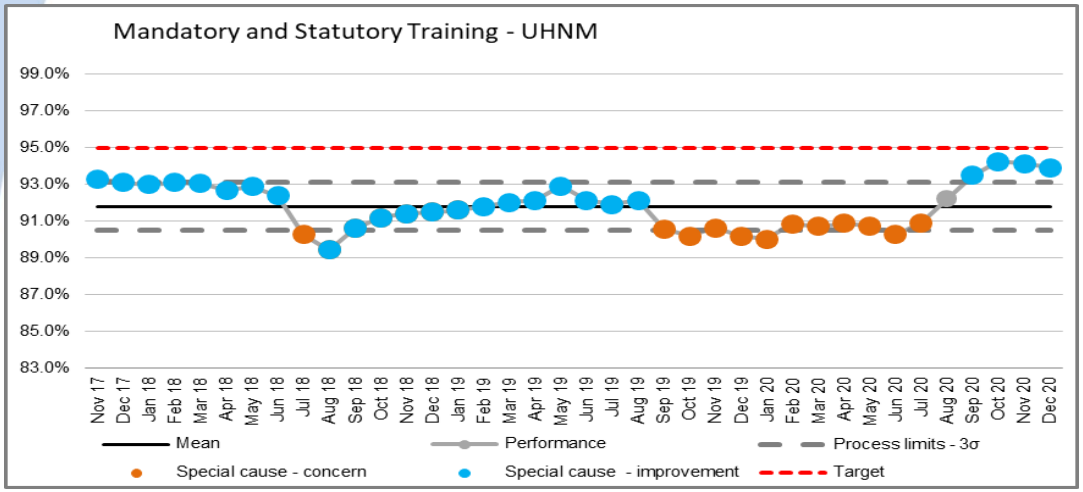
PDR Rates: The Non-Medical PDR compliance rate was 76.26% (75.56% at 30th November).

Performance against the improvement trajectories produced by all Divisions is managed via the performance review meetings. It is recognised that this time of year becomes more challenging to timetable PDR discussions due to operational pressures across the Trust.

Actions

Due to the surge in covid, an Executive decision has been taken to suspend PDR's unless there is capacity to continue to undertake them. An impact assessment is currently being completed to assess the potential effect on performance rates and service delivery.

Statutory and Mandatory Training



Variation	Assurance
H	F

Target	Oct 20	Nov 20	Dec 20
95.0%	94.3%	94.1%	93.9%

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

The Statutory and Mandatory training rate at 31st December was 93.93% (84,14% at 30th November and 89.86% of staff have completed all 6 core for all modules (90.07% at 30/11/20)

Competence Name	Assignment Count	Required	Achieved	Compliance %
205|MAND|Security Awareness - 3 Years|	10212	10212	9599	94.00%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	10212	10212	9630	94.30%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	10212	10212	9467	92.70%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	10212	10212	9568	93.69%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	10212	10212	9603	94.04%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	10212	10212	9687	94.86%

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|	10212	10212	8371	81.97%
NHS|CSTF|Information Governance and Data Security - 1 Year|	10212	10212	9163	89.73%

Note: The figures reported elsewhere to Board in respect of Information Governance and Data Security Training, have been adjusted for a 6 month extension due to COVID19. The figures reported in this report are unadjusted.

Actions

The Trust continues to offering new starters a Remote Corporate Induction which includes their "core for all" statutory & mandatory eLearning

Finance

2025 Vision "Ensure efficient use of resources"

Finance Spotlight Report

University Hospitals of North Midlands NHS Trust

Key messages

- The Trust has received confirmation that it will receive £12.4m additional funding for M7-12 relating to the TSA agreement with its planned deficit being reduced from £14.6m to £7.2m and the Trust required to exceed this plan by a further £5m to deliver a year end deficit of £2.2m.
- The Trust has delivered a surplus of £0.7m in Month 9 against a planned deficit of £2m which is driven by additional DHSC funding, reimbursement of COVID-19 costs outside of the Trust's original allocation (for Months 8 & 9) and continued slippage against the original COVID-19 allocation and Winter plan.
- Activity delivered in Month 9 is significantly lower than plan although NHS income levels from patient activities have been maintained due to the temporary funding arrangements.
- The Trust estimates the impact of the Elective Incentive Scheme (EIS) to be a £0.9m reduction to income in Month 9; as for months 6 to 8 this is not reflected in the financial position in line with guidance from NHSI/E.
- The Pathology Network went live on 1 December with the financial impact included in the Month 9 position. Whilst there is a negligible impact on the bottom line financial position this is causing variances between the reporting categories (i.e. other income, pay and non-pay)
- The Trust incurred £1.6m of costs relating to COVID-19 which remains largely static in comparison to the prior period due to continued high sickness and testing as a result of the second wave.
- Capital expenditure for the year to date stands at £24.5m which is £7.3m behind plan with the main driver being slippage on the PDC funded ED scheme and phasing of Linac and IR2 bi-plane.
- The month end cash balance is £86.1m which is £0.7m more than plan.

Finance Dashboard

	Metric	Target	Latest	Variation	Assurance
I&E	TOTAL Income	variable	74.3		
	Expenditure - Pay	variable	43.8	H	?
	Expenditure - Non Pay	variable	25.7		P
Activity	Daycase/Elective Activity	variable	6,013	L	?
	Non Elective Activity	variable	8,263	L	?
	Outpatients 1st	variable	19,721	L	?
	Outpatients Follow Up	variable	36,809		?

Income & Expenditure

Income & Expenditure Summary Month 9 2020/21	Annual Plan £m	In Month			Year to Date		
		Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Income From Patient Activities	777.6	65.1	66.9	1.8	582.2	585.3	3.2
Other Operating Income	55.8	5.3	7.4	2.1	40.1	44.9	4.8
Total Income	833.3	70.3	74.3	4.0	622.3	630.3	8.0
Pay Expenditure	(522.0)	(44.8)	(43.8)	1.0	(387.1)	(383.7)	3.4
Non Pay Expenditure	(266.7)	(23.4)	(25.7)	(2.3)	(198.9)	(205.2)	(6.3)
Total Operational Costs	(788.7)	(68.2)	(69.5)	(1.3)	(586.1)	(588.9)	(2.9)
EBITDA	44.6	2.1	4.8	2.7	36.2	41.3	5.1
Depreciation & Amortisation	(29.2)	(2.4)	(2.4)	0.0	(21.8)	(21.8)	0.0
Interest Receivable	0.1	0.0	0.0	0.0	0.1	0.1	0.0
PDC	(5.7)	(0.3)	(0.3)	0.0	(4.8)	(4.7)	0.0
Finance Cost	(17.1)	(1.4)	(1.4)	(0.0)	(12.8)	(12.8)	(0.0)
Other Gains or Losses	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Surplus / (Deficit)	(7.2)	(2.0)	0.7	2.7	(3.0)	2.1	5.1
MRET central funding	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Financial Recovery Fund	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	(7.2)	(2.0)	0.7	2.7	(3.0)	2.1	5.1

At Month 9 the Trust is £2.7m better than this plan in month and £5.1m better than plan year to date; this is summarised in the table above; key points to note are:

- Income from patient activities is better than plan in month by £1.8m of which £1.4m relates to additional pass through drug income within CWD and £0.4m for an accrual for COVID-19 expenditure relating to those costs incurred in month 8 which were incurred on top of the original COVID-19 allocation of £11.8m.
- The actual position includes £1.2m of TSA funding and £0.8m directly from the DHSC relating to Month 9 within other operating income. Only £0.8m of this is being reported as a variance as the revised plan figure has been noted in the table below (i.e. £7.4m TSA funding has been reflected in the plan figures)
- The underspend against Pay expenditure mainly relates to the additional investment to support winter where the Trust has not been able to recruit to all of the posts (£0.7m) and the underspend against COVID-19 pay expenditure plan (£1m).
- The Trust has seen higher than forecast levels of pass through drug activity as noted above which has impacted non-pay position as well as increased COVID-19 spend above plan (£0.4m).

Capital Spend

Capital Expenditure as at Month 9 2020/21 £m	Revised Annual	In Month			Year to Date		
	Plan	Revised Budget	Actual	Variance	Revised Budget	Actual	Variance
ICT Infrastructure	(2.9)	(0.5)	(0.1)	0.5	(1.2)	(0.5)	0.6
Estates Infrastructure	(2.5)	(0.1)	(0.1)	0.0	(2.2)	(2.1)	0.1
Medical Equipment	(2.3)	(0.4)	(0.2)	0.1	(1.4)	(1.2)	0.2
PFI lifecycle and equipment	(2.0)	(0.2)	(0.2)	-	(1.4)	(1.4)	-
Health & Safety Compliance	(0.2)	-	(0.0)	(0.0)	(0.1)	(0.1)	(0.1)
Other Central schemes	(0.4)	-	(0.1)	(0.1)	(0.0)	(0.1)	(0.0)
Project Star	(0.9)	-	(0.1)	(0.1)	(0.9)	(0.7)	0.2
Investment schemes	(0.1)	-	-	-	-	(0.1)	(0.1)
COVID-19 Trust funded	(0.8)	-	-	-	(0.8)	(0.8)	0.0
Linac	(2.2)	(1.9)	(0.0)	1.9	(1.9)	(0.0)	1.9
IR2 Bi Plane	(1.4)	(1.0)	(0.0)	1.0	(1.0)	(0.0)	1.0
LIMS	(0.8)	(0.1)	(0.0)	0.0	(0.6)	(0.3)	0.4
EPMA	(0.8)	(0.0)	(0.0)	0.0	(0.3)	(0.3)	0.0
Pathology schemes	(1.1)	(0.1)	(0.3)	(0.1)	(0.6)	(0.5)	0.1
Trust funded capital programme	(18.5)	(4.3)	(1.1)	3.3	(12.5)	(8.1)	4.4
Royal Infirmary Site demolition	(5.2)	(0.7)	(0.7)	0.0	(3.2)	(2.6)	0.7
ED & RI Decant Accomodation Medical Records	(0.6)	-	-	-	(0.3)	-	0.3
COVID-19 PDC (approved)	(1.3)	-	(0.0)	(0.0)	(1.3)	(1.3)	0.0
PDC award for HSLI	(1.2)	-	-	-	(1.1)	(1.1)	0.0
Wave 4b funding - modular wards	(9.1)	-	-	-	(9.1)	(9.1)	-
Critical Risk Infrastructure	(3.2)	(0.2)	(0.3)	(0.1)	(0.2)	(0.7)	(0.5)
Emergency Department Schemes	(2.8)	(0.1)	(0.7)	(0.6)	(2.8)	(1.5)	1.3
ED Decant accomodation - Russell building	(0.7)	-	-	-	(0.7)	-	0.7
ED Decant accomodation - Trent scheme	(0.5)	-	-	-	(0.5)	-	0.5
Adapt & Adopt	(0.3)	-	-	-	-	-	-
Critical Care Resilience	(0.4)	-	-	-	-	-	-
Other PDC funding	(0.6)	-	(0.1)	(0.1)	-	(0.2)	(0.2)
PDC funded capital schemes	(25.9)	(0.9)	(1.7)	(0.8)	(19.3)	(16.4)	2.9
Overall capital expenditure	(44.3)	(5.3)	(2.8)	2.5	(31.8)	(24.5)	7.3

At Month 9 the capital programme is £4.4m behind the revised plan on Trust funded schemes, mainly due to the phasing of the plan figures for the Linac and IR2 bi-plane. PDC funded schemes are £2.9m behind plan which is mainly due to the underspend in relation to the phasing of expenditure included in the Emergency Department scheme Memorandum of Understanding (MOU).

The expenditure elements of the capital programme are being forecast as accurately as is possible in order that we can ensure that all capital is spent by the year end. This also requires clarification on the income to be received in relation to the centrally funded COVID-19 costs of £1.1m. This is being discussed with regional colleagues.

Cash flow

Cash Summary at Month 9 2020/21		In Month			Year to date		
	Revised Budget £m	Revised Plan £m	Actual £m	Variance £m	Revised Plan £m	Actual £m	Variance £m
Opening balance	26.7	90.6	82.7	(7.9)	26.7	26.7	-
Block mandate payments (to 31st October 2020)	760.0	63.3	76.2	12.9	631.2	634.5	3.3
Contract income 2019/20	(7.4)	-	-	-	(7.4)	(7.4)	-
Other Income (including other NHS)	63.3	5.5	6.2	0.7	59.5	60.1	0.6
Health Education England Training Income	22.5	-	-	-	14.2	14.0	(0.2)
PSF/FRF - 2019/20 Q4	9.7	-	-	-	9.7	9.7	-
Capital funding (PDC capital)	26.4	1.4	-	(1.4)	12.1	9.1	(3.0)
Total Receipts	874.5	70.2	82.4	12.2	719.3	719.9	0.7
Payroll (excluding agency)	(492.5)	(40.7)	(41.4)	(0.7)	(365.4)	(366.0)	(0.6)
Accounts payable	(347.7)	(31.6)	(33.8)	(2.2)	(263.2)	(264.8)	(1.6)
PDC Dividend	(5.0)	-	-	-	(3.2)	(3.2)	-
Capital payments	(42.4)	(3.1)	(3.8)	(0.7)	(28.8)	(26.5)	2.2
Total Payments	(887.5)	(75.4)	(79.0)	(3.6)	(660.6)	(660.6)	0.0
Closing Balance	13.7	85.4	86.1	0.7	85.4	86.1	0.7

The cash flow budget above has been revised following the submission of the plan for the second half of the financial year on 22 October. The year-end forecast cash balance of £13.7m reflects the year end revenue deficit forecast of £14.7m in this plan and the assumption that the block contract cash received in advance during the financial year will be recovered in March 2021 this has not yet been confirmed by NHSI. This forecast does not include additional cash expected to be received from NHSI/E and DHSC in relation to transitional income.

At the end of December the cash balance of £86.1m is £0.7m higher than plan. In Month 9 the Trust has received the cash in relation to the validated Month 6 top-up of £7.9m. The Month 9 cash received for the block mandates is also higher than plan in month due to receiving the Trust 2 months of the top up COVID-19 block funding in Month 9. The year to date position is £3.3m higher than plan due elements of this being paid in advance, which was not anticipated in the cash plan figure.

Capital funding is £3m behind plan as it was expected that the Trust would have been able to draw down PDC funding in relation to COVID-19 capital and RI demolition works by Month 9.

Accounts payable in month and year to date are slightly higher than plan. The Trust is complying with Treasury guidance for the prompt payment of suppliers and is continuing to pay invoices as they are approved.

Balance sheet

Balance sheet as at Month 9	31/03/2020	31/12/2020			
	Actual £m	Revised Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment	483.0	487.9	487.3	(0.6)	
Intangible Assets	24.5	20.7	20.7	0.1	
Other Non Current Assets	-	-	-	-	
Trade and other Receivables	0.4	0.4	0.4	-	
Total Non Current Assets	507.9	508.9	508.4	(0.5)	
Inventories	13.3	13.1	14.0	0.9	
Trade and other Receivables	49.6	36.0	52.1	16.1	Note 1
Cash and Cash Equivalents	26.7	85.4	86.1	0.7	
Total Current Assets	89.6	134.4	152.1	17.7	
Trade and other payables	(74.8)	(131.5)	(138.6)	(7.1)	Note 2
Borrowings	(208.0)	(10.6)	(10.7)	(0.1)	
Provisions	(6.7)	(6.7)	(6.7)	(0.0)	
Total Current Liabilities	(289.5)	(148.8)	(156.0)	(7.2)	
Borrowings	(276.6)	(267.8)	(267.9)	(0.1)	
Provisions	(1.2)	(1.2)	(1.2)	-	
Total Non Current Liabilities	(277.7)	(269.0)	(269.0)	(0.1)	
Total Assets Employed	30.3	225.6	235.5	9.9	
Financed By:				-	
Public Dividend Capital	409.7	614.9	614.9	0.0	
Retained Earnings	(476.2)	(486.2)	(476.3)	9.9	Note 3
Revaluation Reserve	96.9	96.9	96.9	-	
Total Taxpayers Equity	30.3	225.6	235.5	9.9	

The revised balance sheet plan reflects the plan submitted to NHSI/E on 22 October which is based on the Month 6 balance sheet and expected movements for the remainder of the financial year. Variances to the revised plan at Month 9 are explained below:

Note 1 – The receivables figure includes accruals of £6.2m in relation to month 7-9 transitional funding relating to the Mid Staffs integration, confirmation has been received from NHSI/E that this cash will be received by the Trust for Months 7-12. The variance is also due to receivables including a £5m accrual in relation to specialised commissioners pass through funded drugs and an £0.8m accrual for Covid testing and the vaccination programme.

Note 2 - The payables balance reflects the receipt in advance of £68.4m for the December block income received on the 15th November as part of the national COVID-19 response, of this £5m is higher than the plan figure due to additional COVID-19 funding also being received a month in advance.

Note 3 - Retained earnings show a £9.9m variance compared to plan and reflects the better than plan revenue position compared to the original plan prior to confirmation of the transitional funding and a £1m difference between the cash received for Donated Assets and the amount of depreciation charged for Donated Assets.

Expenditure - Pay and Non Pay

NHS University Hospitals of North Midlands NHS Trust

Pay Summary (£m)	Annual Forecast	In Month			YTD		
		Forecast	Actual	Variance	Forecast	Actual	Variance
Medical	(160.5)	(13.9)	(13.9)	0.0	(118.7)	(118.4)	0.3
Registered Nursing	(155.3)	(13.4)	(12.5)	0.9	(114.7)	(112.3)	2.4
Scientific Therapeutic & Technical	(58.4)	(5.0)	(5.1)	(0.2)	(43.4)	(43.4)	0.0
Support to Clinical	(71.1)	(6.0)	(5.8)	0.2	(53.0)	(52.4)	0.6
Nhs Infrastructure Support	(76.8)	(6.5)	(6.5)	(0.0)	(57.4)	(57.3)	0.1
Total Pay	(522.0)	(44.8)	(43.8)	1.0	(387.1)	(383.7)	3.4

Pay - Although the pay spend has increased in month due to the staff who have TUPEd as part of the Pathology Network arrangements, the pay still remains underspent in month and YTD primarily as a result of underspends against the Winter Plan.

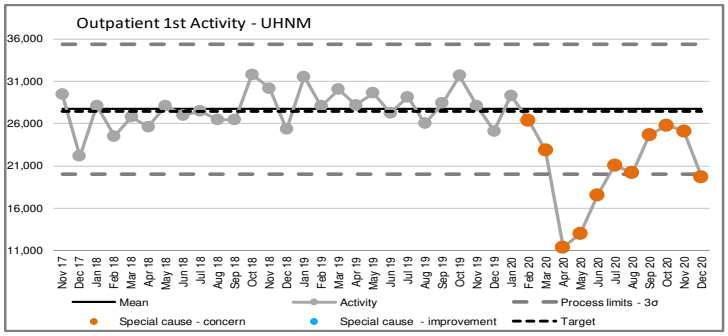
Non Pay Summary (£m)	Annual Forecast	In Month			YTD		
		Forecast	Actual	Variance	Forecast	Actual	Variance
Tariff Excluded Drugs Expenditure	(67.5)	(5.6)	(7.3)	(1.7)	(50.6)	(54.4)	(3.7)
Other Drugs	(19.8)	(1.7)	(2.2)	(0.5)	(14.7)	(15.5)	(0.8)
Supplies & Services - Clinical	(55.8)	(4.7)	(5.7)	(1.0)	(41.7)	(45.0)	(3.3)
Supplies & Services - General	(6.9)	(0.5)	(0.6)	(0.1)	(5.3)	(5.5)	(0.2)
Purchase of Healthcare from other Bodies	(16.3)	(1.9)	(1.2)	0.7	(11.1)	(8.8)	2.2
Consultancy Costs	(1.4)	(0.5)	(0.3)	0.2	(1.0)	(1.0)	0.0
Clinical Negligence	(22.3)	(1.9)	(1.9)	0.0	(17.2)	(17.2)	0.0
Premises	(29.4)	(2.6)	(2.5)	0.1	(22.3)	(22.6)	(0.3)
PFI Operating Costs	(34.7)	(2.9)	(2.9)	(0.0)	(26.1)	(26.1)	(0.1)
Other	(12.6)	(1.1)	(1.1)	0.0	(8.9)	(9.0)	(0.1)
Total Non Pay	(266.7)	(23.4)	(25.7)	(2.3)	(198.9)	(205.2)	(6.3)

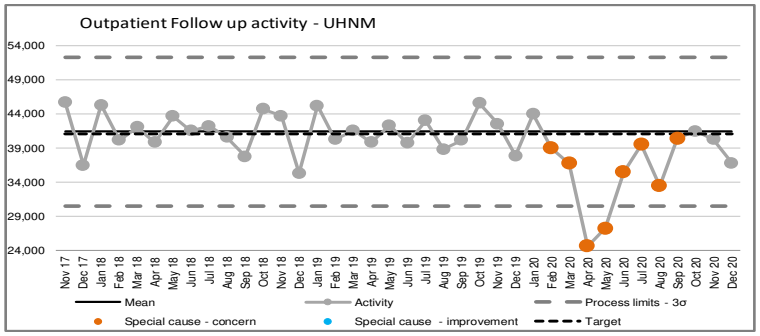
Non-pay -Non-pay expenditure is overspent by £2.3m in Month 9. This is primarily driven by pass through drug expenditure but there have also been higher than planned spend against other drugs and clinical supplies which is driven by increased COVID-19 testing costs and the Pathology Network costs. Both of these have limited impact on the bottom line due to the additional income arrangements for those costs outside of the original COVID-19 allocation and the billing arrangements across the Pathology Network.

Activity

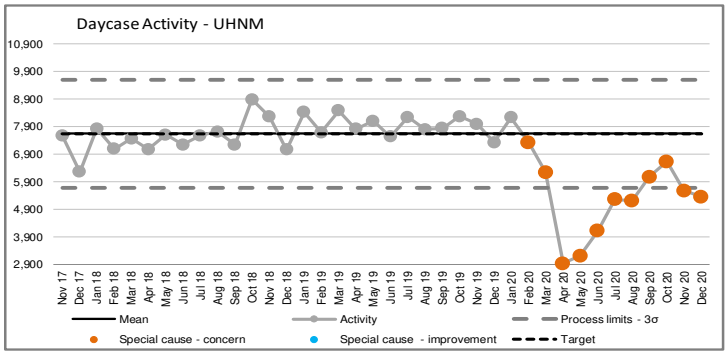
NHS University Hospitals of North Midlands NHS Trust

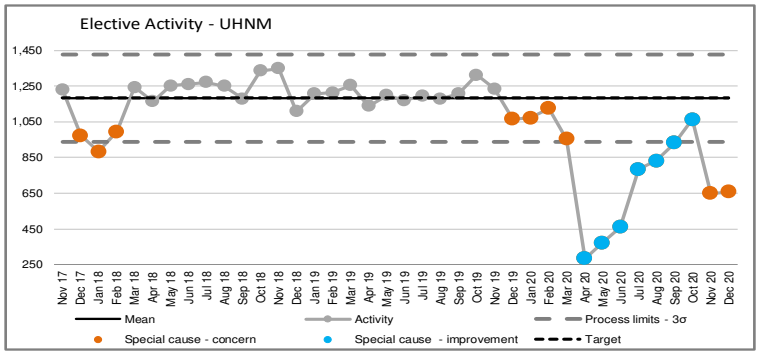
Planned care Outpatient



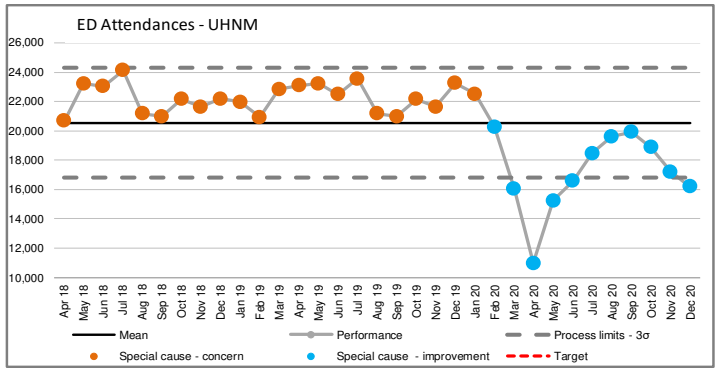


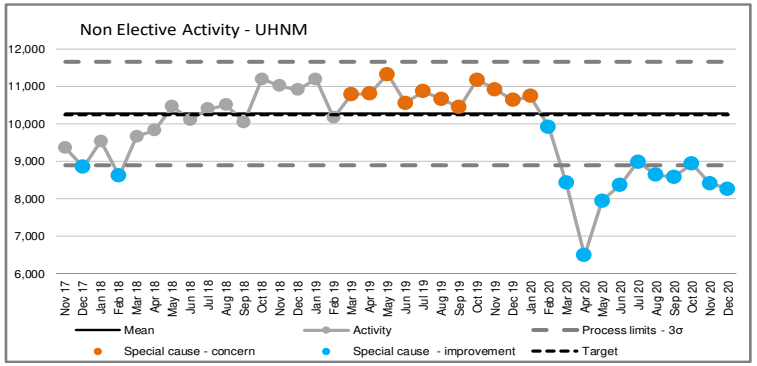
Planned care Inpatient





Urgent Care





Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Audit Committee Chair's Highlight Report to Board

21st January 2021

1. Highlight Report

Matters of Concern or Key Risks to Escalate

- The report on incident reporting has highlighted improvements needed in relation to learning from incidents; whilst systems and processes are in place this requires an organisation wide cultural shift which will be picked up through the Delivering Exceptional Care Programme
- Review of Quality Governance has identified that the Quality Strategy is currently out of date and requires review and will done alongside development of quality priorities at a divisional level aligned to the Delivering Exceptional Care Programme
- Recommendation Tracker has identified one recommendation in relation to Emergency Department Governance which remained outstanding although it was noted that a timeframe for completion had been confirmed for the end of January
- 12 policies are now out of date, delays are largely related to Covid 19 although the Committee were assured that there are systems and processes to follow up on these appropriately
- UHNM has been selected by the FRC for a review of the 2019/20 audit

Major Actions Commissioned / Work Underway

- Review of the Board Assurance Framework and Risk Management underway and will be reported to the next Audit Committee
- Work on the annual audit of accounts includes additional revised auditing standards in relation to annual leave provision and asset valuation
- National Fraud Initiative Exercise is released in February which aims to identify any staff working within the public sector and working elsewhere whilst on sickness absence
- Completion of risk and control matrix with the Counter Fraud Team is almost finalised and has not identified any significant concerns
- Annual Accounts Timetable has now been issued and work is underway to progress this

Positive Assurances to Provide

- All reports presented to the Committee, i.e. Governance of Executive Functions, Incident Reporting, Key Financial Control and Quality Governance concluded with assurance ratings of 'significant assurance with minor improvement opportunities'
- UHNM benchmarks very positively with regard to Data Security and Protection arrangements
- Review of previous recommendations in relation to incident reporting have been confirmed to have been positively implemented
- Many areas of good practice identified in relation to the Executive Governance Structure and Reviews of Effectiveness and very positive to note the progress made in embedding the new structure despite the challenges
- Positive findings noted on the review of Key Financial Controls and the Committee were reassured that the issues identified had already been recognised by the Finance Team

Decisions Made

- Approved deferral of internal audits regarding Access and Activity Data / Booking and Digital Strategy from the 2020/21 audit programme
- Agreed for finalisation of management comments in response to the review of Quality Governance to be done outside of the meeting and circulated for virtual approval
- Agreed deferral to April meeting for follow up of completed Internal Audit Recommendations
- Approval of the Quarter 3 Board Assurance Framework
- Approval of the Risk Management Policy
- Agreed revision to dates of Audit Committee to align with Accounts Timetable
- Supported the reintroduction of the Annual Leave Provision 20/21
- Approved the deferral to the full asset valuation to 31st March 2022 with a desktop assessment being undertaken in the interim

Comments on the Effectiveness of the Meeting

- Members of the meeting found the meeting to be effective despite a lengthy agenda

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Internal Audit Progress Report	Assurance	8.	Local Counter Fraud Progress Report	Assurance
2.	Internal Audit Recommendation Tracker	Assurance	9.	Losses and Special Payments Q3 20/21	Assurance
3.	Corporate Governance Report	Assurance	10.	SFI Breaches and Single Tender Waivers Q3 20/21	Assurance
4.	Board Assurance Framework Q3	Approval	11.	Annual Accounts Timetable	Assurance
5.	Risk Management Policy	Approval	12.	Annual Leave Provision 20/21	Assurance
6.	External Audit Progress Report and Sector Update	Assurance	13.	Asset Valuation 20/21 Annual Accounts	Approval
7.	External Audit AQR Review	Information	14.	Review of Meeting Effectiveness, Business Cycle and Items for Escalation to Trust board	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					
Ms A Khela	AK	Internal Audit	RC				
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					GP
Mrs S Preston	SP	Strategic Director of Finance					
Miss C Rylands	CR	Associate Director of Corporate Governance					
Mr S Stanyer	SS	LCFS					

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	3rd February 2021
Report Title:	Q3 Board Assurance Framework 20/21	**Agenda Item:**	14
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 Quarter 3 Board Assurance Framework (BAF) is being presented to the Board in accordance with the annual business cycle. Board members are asked to consider the content of the BAF, which has been scrutinised by each Committee during January.

Background

The BAF is updated on a quarterly basis by the Executive Team. The structure and content of the BAF is reviewed on an annual basis; the risks contained within the enclosed were agreed by the Executive Team and subsequently the Board, in early 2020. These will be subject to further review over the coming months, in order to determine risks for 2021 / 2022.

Assessment

The summary BAF is set out below. During quarter 3 there have been some key changes to levels of risk:

- BAF 1: Harm Free Care – increase in level of risk due to concerns regarding safety
- BAF 2: Leadership / Culture and Delivery of Trust Values and Aspirations – increase in level of risk due to a number of delays and restrictions on the delivery of development and talent activities due to Covid
- BAF 3: Sustainable Workforce – increase in level of risk due to challenges associated with staffing levels
- BAF 9: Financial Sustainability – decrease in level of risk as a result of latest financial position / system level progress

Ref / Page	Summary Risk Title	Strategic Objectives Under Threat	Change in Risk Score				
			Q1	Q2	Q3	Q4	Change
BAF 1 Page 6	Harm Free Care		High 9	High 9	High 12		↑
BAF 2 Page 9	Leadership / Culture and Delivery of Trust Values and Aspirations		High 12	High 12	Ext 20		↑
BAF 3 Page 12	Sustainable Workforce		High 12	High 12	Ext 20		↑

BAF 4 Page 15	System Working – Vertical		High 12	High 9	High 9		→
BAF 5 Page 17	System Working – Horizontal		High 12	High 12	High 12		→
BAF 6 Page 19	Restoration and Recovery		Ext 20	Ext 25	Ext 25		→
BAF 7 Page 21	Infrastructure to Deliver Compliant Services – IM&T		Ext 16	Ext 16	Ext 16		→
BAF 8 Page 23	Infrastructure to Deliver Compliant Services - Estate		Ext 16	Ext 16	Ext 16		→
BAF 9 Page 26	Financial Sustainability		High 9	High 12	Mod 6		↓

Key Recommendations:

1) The Trust Board is asked to scrutinise the BAF, taking the following considerations into account:

- *Are the levels of risk assigned to each risk appropriate, in particular when compared to other risks within the BAF?*
- *To what extent are the key controls (i.e. existing controls) effective?*
- *What are the gaps in the controls, how significant are they in relation to the current risk score?*
- *What internal assurances and independent external assurances are in place? Are they sufficient / adequate and are there any gaps? Are additional assurances required?*
- *Are there any areas where assurance is duplicated, repeated or excessive when compared to the activity undertaken?*
- *What actions are there in place to further mitigate the risk to the agreed tolerated level? Are they current and active? Are they adequate? Does more need to be done?*
- *Has the impact of Covid-19 been sufficiently drawn into the strategic risks identified?*

2) The Trust Board is asked to approve the Board Assurance Framework.

NHS
University Hospitals of North Midlands
NHS Trust

Board Assurance Framework (BAF)

Quarter 3 2020/21

1. Introduction

Situation

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

Background

The Strategic Risks contained within the 2020/21 BAF were identified by the Executive Team in January 2020 and agreed by the Board at a development session in February 2020. This saw a reduction in the number of Strategic Risks when compared to the BAF for 2019/20 in order to ensure that the focus was strategic as opposed to operational. However, shortly after that point, the organisation became faced with unprecedented challenges brought to us by the global pandemic, Covid-19. Whilst further work on the BAF was paused, in line with the interim governance arrangements approved by the Board, the Executive Team took the opportunity to reflect upon the appropriateness of the initial Strategic Risks agreed and concluded that whilst they remain relevant and appropriate, the impact of Covid-19 will alter some of the controls, assurances and actions to be taken and this has therefore been reflected throughout the BAF. In addition, a specific risk has been included which focuses on Restoration and Recovery.

Assessment

It should be noted that significant work has been undertaken to improve the format and function of BAF over recent years and this has resulted in two consecutive annual reviews undertaken by our Internal Auditors concluding with a rating of 'Significant Assurance with Minor Improvement Opportunities'. These findings have contributed to the positive and improved overall Head of Internal Audit Opinion for 2019/20 of 'Significant Assurance with Minor Improvement Opportunities'. A programme of risk management improvement remains an ongoing focus for the organisation and this will continue throughout the course of 2021/22.

In contrast to the findings from our Internal Audits which found that 'risks are clearly signposted to strategic and business objectives so that the BAF links through to the aims of the Trust'; feedback from the Care Quality Commission following their 2019 inspection highlighted that the BAF 'was not aligned to the strategic objectives and lacked clarity'. This has been taken into consideration within the development of the revised BAF for 2020/21 and has resulted in a change to the way in which risks are mapped to our Strategic Objectives. In the 2019/20 BAF, risks were broken down under the headings of each of our five Strategic Objectives whereas within this 2020/21 BAF, risks are mapped to multiple Strategic Objectives, relevant to their impact. This has been done through the inclusion of a simple mapping key within each section of the BAF as shown below:

The 'Strategic Risk Heat Map' at section 4 of this document is drawn from the content of the BAF and aims to illustrate at a high level the degree of risk exposure associated with the Strategic Objectives.

2. Committee / Board Consideration of Risk

The Quarter 3 BAF for 2020/21 has been considered by Committees as follows:

- Performance and Finance Committee on 19th January 2021
- Quality Governance Committee on 20th January 2021
- Transformation and People Committee on 21st January 2021
- Audit Committee on 21st January 2021

Committees were asked to consider the following questions, based on the evidence provided on the BAF for each objective:

- Are the levels of risk assigned to each risk appropriate, in particular when compared to other risks within the BAF?
- To what extent are the key controls (i.e. existing controls) effective?
- What are the gaps in the controls, how significant are they in relation to the current risk score?
- What internal assurances and independent external assurances are in place? Are they sufficient / adequate and are there any gaps? Are additional assurances required?
- Are there any areas where assurance is duplicated, repeated or excessive when compared to the activity undertaken?
- What actions are there in place to further mitigate the risk to the agreed tolerated level? Are they current and active? Are they adequate? Does more need to be done?
- Has the impact of Covid-19 been sufficiently drawn into the strategic risks identified?

3. Index and Summary Board Assurance Framework as at Quarter 3 2020/21

Ref / Page	Summary Risk Title	Strategic Objectives Under Threat	3 Lines of Defence					Change in Risk Score				
			1st Line of Defence		2nd Line of Defence		3rd Line of Defence	Q1	Q2	Q3	Q4	Change
			Controls	Assurances	Controls	Assurances						
BAF 1 Page 6	Harm Free Care		✓	✓	✓	✓	✓	High 9	High 9	High 12		↑
BAF 2 Page 9	Leadership / Culture and Delivery of Trust Values and Aspirations		✓	✓	✓	✓	✓	High 12	High 12	Ext 20		↑
BAF 3 Page 12	Sustainable Workforce		✓	✓	✓	✓	✓	High 12	High 12	Ext 20		↑
BAF 4 Page 15	System Working – Vertical		✓	✓	✓	✓	✓	High 12	High 9	High 9		→
BAF 5 Page 17	System Working – Horizontal		✓	✓	✓	✓	✗	High 12	High 12	High 12		→
BAF 6 Page 19	Restoration and Recovery		✓	✓	✓	✓	✓	Ext 20	Ext 25	Ext 25		→
BAF 7 Page 21	Infrastructure to Deliver Compliant Services – IM&T		✓	✓	✓	✓	✓	Ext 16	Ext 16	Ext 16		→
BAF 8 Page 23	Infrastructure to Deliver Compliant Services - Estate		✓	✓	✓	✓	✓	Ext 16	Ext 16	Ext 16		→
BAF 9 Page 26	Financial Sustainability		✓	✓	✓	✓	✓	High 9	High 12	Mod 6		↓

SO1: Safe, caring, effective, responsive

SO2: Achieve constitutional patient access targets

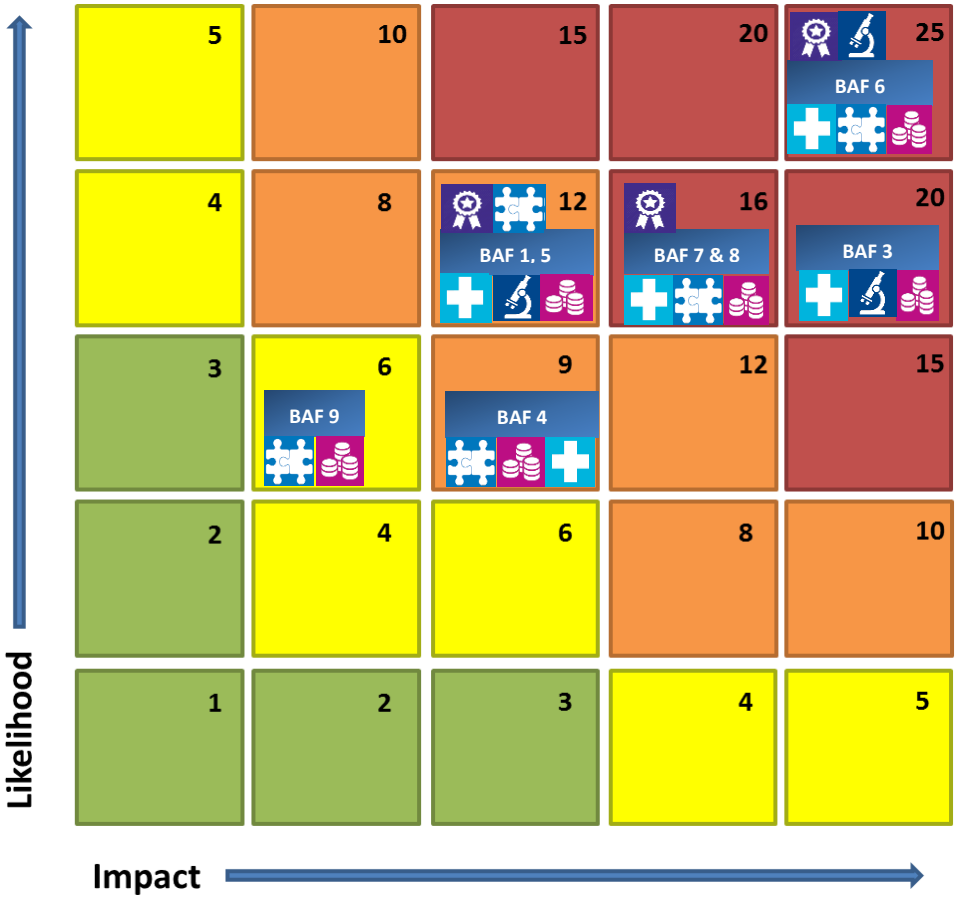
SO3: Excellent employment, education, teaching, research

SO4: Lead strategic change in Staffordshire and beyond

SO5: Ensure efficient use of resources

BAF Action Plans – Key to Progress Ratings		
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.

4. Strategic Risk Heat Map



Review of Impact on our Strategic Objectives

The maps shown above aim to illustrate where the risks set out within the BAF impact upon the achievement of our Strategic Objectives. As shown within the summary on page 4, the most significant strategic risk is associated with Restoration and Recovery (BAF 6) . Not only does this risk have te highest score, it impacts upon all five of our Strategic Objectives.

The maps also show that 8 / 9 risks on the BAF have the potential to threaten the achievement of Strategic Objective 1 – Safe, caring, effective and responsive services.

5. Board Assurance Framework 2020/21

Risk Summary					
BAF Reference and Summary Title:	**BAF 1: Harm Free Care**			**SO's Impacted Upon**	
				✓	✓
Risk Description:	**If the Trust does not deliver harm free care, then the trajectory reduction in Pressure Ulcers, Patient Falls, Venous Thromboembolism (VTE) and infection rates (including Covid-19) may not be achieved, resulting in increased patient harm, increased mortality and poor patient experience.**				
Lead Director:	Chief Nurse and Medical Director	**Supported By:**	n/a		
Lead Committee:	Quality Governance Committee	**Executive Group:**	Quality and Safety Oversight Group		
Links to Risk Register:	**Title**	**Current Risk Score**			
	ID 8877 Risk of Avoidable Hospital Acquired Infections	**High 12**			

Risk Scoring							
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**	**Target Date**
Likelihood:	**3**	**3**	**4**		**COVID-19 Pandemic continues to raise pressures on Trust and its services which will impact on ability to reduce harm. Increases in falls and nosocomial infection numbers during Q3.**	**Likelihood:** **2**	**31 March 2021**
Consequence:	**3**	**3**	**3**			**Consequence:** **2**	
Risk Level:	**High 9**	**High 9**	**High 12**			**Risk Level:** **Mod 4**	

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	**2nd Line of Defence**	**3rd Line of Defence**
Controls:	• Senior leadership team in place for each ward and department, with overarching accountability for delivering quality and minimising hospital acquired harm • Falls Champion role in each Ward/Department. • Tissue Viability Link Nurses in each Ward/Department • Corporate Quality & Safety Team co-ordinate Improvement Programmes for Pressure Ulcers, Falls and VTE • Infection Prevention Team co-ordinate Improvement Programmes for infections, including • Specific governance arrangements in place for	• Validation of pressure ulcers undertaken by Corporate Tissue Viability Team • Validation of infections undertaken by Infection Prevention/Microbiology Teams • Datix and Root Cause Analysis (RCA) training available to ensure accurate reporting and investigation of patient harm • Root Cause Analysis (RCA) Scrutiny Panels in place for Pressure Ulcers, Patient Falls, Venous Thromboembolism (VTE) and Infections • Agreed reduction trajectories in place for each patient harm • Collaborative working in place with CCG representatives regarding harm reduction • Care Excellence Framework in place	• Annual External Audit of Quality Account • CQC Inspection Programme • Process in place with Commissioners to undertake Clinical Quality Review Meetings (CQRM) • NHSEI scrutiny of Covid-19 cases/Nosocomial infections/Trust implementation of Social distancing, Patient/Staff screening and PPE Guidance • Trust have nominated 6 new Patient Safety Specialists to work with NHSI as part of national NHS Patient Safety Strategy. Induction / Training to commence in October 2020 • Full compliance for years 1 & 2 against CNST 10 Standards

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
	Maternity Services, including compliance with CNST requirements. • Sepsis and Nosocomial Covid-19 infections. • Training Programmes in place for all key harms. • Patient experience team in place • Crude Mortality rates - monitoring and notification from Medical Examiner • Monthly Directorate Mortality and Morbidity meetings (M&M) are held to review deaths and discuss cases. • Clinical, Tactical and Gold Governance Processes well established to respond to changes in Regional and National Guidance in relation to Covid-19, with particular focus on social distancing, patient/staff screening, zoning of Ward/Department areas, visiting guidance and PPE Guidance	• Covid-19 deaths have been included in the Trust's SJR process to allow for review of care provided to patients and identify any potential areas for improvement/learning • New Mortality Review Panel for Definite Nosocomial COVID-19 deaths established by Deputy Medical Director to identify learning and good practice. • Nosocomial Covid-19 Infections will be subject to RCA and reported to the Infection Prevention Committee • A strengthened clinical governance framework including revised Terms of Reference for the Quality and Safety Oversight Group (QSOG) and Quality Governance Committee (QGC) have been introduced, with effect from April 2020	
Assurance:	• Quality dashboard available on Intranet • Quality dashboard and Patient Experience dashboard in place and included nosocomial infections during Q3 • Monthly Patient Safety Reports from Ward to Board • Training Records available at Ward and Corporate level • Care Excellence Framework Visit Reports shared with Ward and Divisional Teams • Mortality report to Mortality Review Group includes analysis of rates and outcomes from mortality reviews. • Monthly highlight reports from Trust Risk Management Panel to Patient Safety Group and QSOG • Presentation of annual M&M activity by Directorate Mortality leads at Mortality Review Group • Infection Prevention Board Assurance Framework – Covid-19 • COVID-19 Mortality report provided in December 2020	• Scrutiny of level of Patient Harm and Patient Experience within Executive-Led Divisional Performance Reviews on a monthly basis • Outcome of the Nursing Establishment review presented to the Trust Board in March 2020, action plan and associated business case to be developed. • Outcome letters as a result of RCA Panels sent to Senior Sisters/Charge Nurses, Matrons and Associate Chief Nurses • Audit programme to monitor compliance with relevant Trust policies • Quality Account developed and published according to NHSEI Guidance • Patient stories reported to the Trust Board on a monthly basis • Friends and family test results are reported and monitored on a regular basis • Internal Audit undertaken to review Trust's Incident Reporting and investigation processes. Final report awaited • Maternity Services Board Assurance Framework in place.	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 3 Progress Report**	**BRAG**
1.	Quality & Safety Improvement Strategy to be finalised	Chief Nurse and Medical Director	31/03/2021	New Quality Improvement Academy is being established and key posts have been recruited to and awaiting commencement in post. Strategy to be developed as move forward with academy and appointment of posts – target date revised.	**A**
2.	Outcome of the Nosocomial COVID-19 mortality reviews to be reported at Mortality Review Group / QSOG and Quality Governance Committee	Medical Director	31/03/2021	Divisions nominating senior clinicians to participate in review panel. Initial review Panels to be established in January 2021 and confirm cases for review	**GB**
3.	To develop Quality Performance Report further to include peer benchmarking where possible for quality indicators including nosocomial COVID-19 reporting	Chief Nurse	28/02/2020	QPR has developed and included revised quality indicators. Further developments to be included to identify and agree Peer Group Benchmarking	**GB**

Risk Summary					
BAF Reference and Summary Title:	**BAF 2: Leadership / Culture and Delivery of Trust Values and Aspirations**			**SO's Impacted Upon**	
Risk Description:	**If we fail to develop a leadership and culture that delivers Trust values and aspirations, then staff may become disengaged, which will impact on the delivery of services to our patients.**				
Lead Director:	Director of Human Resources	**Supported By:**	Chief Nurse, Medical Director and Chief Operating Officer		
Lead Committee:	Transformation and People Committee	**Executive Group:**	Executive Workforce Assurance Group		
Links to Risk Register:	***Title***	***Current Risk Score***	**Title**	**Current Risk Score**	
	ID 15525 Cultural issues within the department	**High 12**	ID 9151 Mismatch between Trust Culture and Values	**High 9**	
	ID 9149 If staff don't feel supported, listened to and valued	**Mod 6**			

Risk Scoring								
Quarter	**M1 of Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	**3**	**3**	**4**		• Covid-19 pandemic meant that a significant portion of development & talent activities to were postponed. • The impact of socially distanced training and suitably sized training space continues to impact People and OD capacity to deliver both leadership development training • There continues to be a significant uplift in Divisions requesting OD support. Plans have been created for each Division with limited capacity for direct OD consultant support • The 2020 Annual Staff Survey has recently been completed and the results are awaited	**Likelihood:**	**3**	**March 2021**
Consequence:	**4**	**4**	**5**			**Consequence:**	**3**	
Risk Level:	**High 12**	**High 12**	**Ext 20**			**Risk Level:**	**Mod 6**	

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	**2nd Line of Defence**	**3rd Line of Defence**
Controls:	• Annual NHS Staff Survey and periodic pulse checks • Actions to improve staff experience are detailed in the Corporate and Divisional Staff Engagement Plans • Programme launched to support the development of the STP High Potential Scheme participants	• People Strategy and supporting HR Delivery Plan, with performance reported to the TEC on a quarterly basis and annually to the Trust Board The HR Delivery Plan has been updated to take account of the actions required to address Restoration and Recovery, post covid-19 • Partnership working with the STP to introduce a range of Recruitment and Retention initiatives • The Trust has set targets for staff engagement rates, sickness and turnover and actual rates are monitored on a monthly basis against these targets.	• The Annual NHS Staff Survey and periodic pulse checks, along with staff forums and focus groups, test staff engagement and experience. – At 6.9, the 2019 staff engagement score remained just below the acute trust average of 7.0. – Actions to improve staff experience are detailed in Divisional Staff Engagement Plans. – The Annual NHS Staff Survey for 2020 has closed. Results are expected in February/March 21 – Periodic pulse checks – the Staff Friends and Family Test has been suspended during the covid-19 pandemic. • Trust wellbeing plan has been approved and Divisional
Assurance:	• Annual NHS Staff Survey – At 6.9, the 2019 staff engagement score remained just below the acute	• Monthly reports to Transformation and People Committee cover hard to recruit posts and long term agency	

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
	trust average of 7.0. The Trust has not yet been notified of the details of the 2020 NHS Staff Survey, although indications are that an abbreviated survey will be carried out. • HRBP's report actual performance to Divisional Boards and Divisions are held to account via Performance Reviews • The diagnostic phase of the NHSi Culture and Leadership Programme commenced in 2019/20 and will provide an additional indicator of staff engagement. However, this was suspended due to covid-19 and now needs to be reinstated as part of the recovery and restoration programme • Feedback from staff via listening events, Facebook live comments and senior leadership team walkabouts	• The Executive Workforce Assurance Group is in place • Agency costs are reported in the monthly Finance Report to Performance and Finance Committee 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). 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. 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. Analysis of data and historic trends, reported in monthly performance reports to TAP and Trust Board show: • At 30th November 20, the in-month sickness rate was 5.85% (4.88% 31/10/20). The 12 month cumulative rate increased to 5.23% (from 5.16%) • For the 12 months ending 30/11/20, the turnover rate was 9.90% • The vacancy level at 30/11/20 9.14% due to an uplift in the budgeted establishment for winter pressures rather than an increase in leavers	wellbeing leads appointed

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	Action Required	Executive Lead	Due Date	Quarter 2 Progress Report	BRAG
1.	Undertake a Trust-wide cultural analysis	Director of Human Resources	30/06/2021	***The programme has been suspended during the Covid-19 pandemic*** The first stage of the programme was completed, with feedback shared with the Executive Team in January 21. This will inform the OD plans going forwards.	A
2.	Implement a UHNM plan relating to the launch of the "Leadership Compact" document within the NHS People Plan	Director of Human Resources	31/03/2021	Development of the Leadership Compact will commence on completion of the Culture analysis, which has been ***suspended during the Covid-19 pandemic*** The Leadership Compact has not yet been released nationally	A
3.	Leadership and Management Development offer: Internal and External offer focus on managers across the Trust to ensure a competency level is embedded	Director of Human Resources	31/03/2021	All managers completed internal offer. Next steps are to potential platforms for these and other leadership programmes to be delivered in a "blended" manner or completely virtually so that all new managers into the Trust can complete GTM/GTL within 3 months of commencing.	GA

Risk Summary					
BAF Reference and Summary Title:	**BAF 3: Sustainable Workforce**			**SO's Impacted Upon**	✓ ✓ ✓
Risk Description:	**If our workforce becomes unsustainable, then premium pay costs will be incurred, staff sickness may increase and staff may become disengaged, all of which will impact on the delivery of services to our patients.**				
Lead Director:	Director of Human Resources	**Supported By:**	Chief Nurse, Medical Director and Chief Operating Officer		
Lead Committee:	Transformation and People Committee	**Executive Group:**	Executive Workforce Assurance Group		
Links to Risk Register:	**Title**	**Current Risk Score**	**Title**	**Current Risk Score**	
	ID 9739 Nurse Staffing in ED	**High 12**	ID 16633 Medical Division Workforce Plans	**Ext 15**	
	ID 10259 Clinical Vacancies in General Surgery & Urology	**High 12**	ID 8580 Medical Staffing in ED	**High 12**	
	ID 9458 NICU Consultant Rota	**High 12**	ID 12423 Nurse Vacancies in Medical Division	**High 12**	

Risk Scoring							
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**	**Target Date**
Likelihood:	**3**	**3**	**4**		• The Phase 3 Workforce plan which incorporates staffing required for the Winter Plan highlights a significant staffing need to March 2020 as do System Partner plans. • The risk level has been increased due to the current workforce challenges, combined with the need to open additional capacity and high levels of sickness. • Short term support from System partners is not easily available as the majority of 'business as usual' activities continue to be delivered.	**Likelihood: 3**	**March 2021**
Consequence:	**4**	**4**	**5**			**Consequence: 3**	
Risk Level:	**High 12**	**High 12**	**Ext 20**			**Risk Level: High 9**	

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	**2nd Line of Defence**	**3rd Line of Defence**
Controls:	• Workforce planning process ensures alignment with activity and financial plans • Actions to improve staff experience are detailed in Divisional Staff Engagement Plans • Ongoing recruitment processes underway • Rotas and rota coordinators management of roster processes • Directorate and divisional management teams to monitor staffing levels • Chief Nurse staffing reviews	• The Trust's People Strategy is supported by an HR Delivery Plan, with improvement activities cascaded via Divisional People Plans. With the release of the NHS People Plan in July 2020, the Trust's People Strategy and supporting HR Delivery Plan have been reviewed and updated to ensure alignment of objectives. • A consistent and cost effective approach to deploying medical workforce across the Trust and support improvements in medical productivity is in place (Medic On Duty, Medic Online, Activity Manager) • Partnership working with the STP continues on a range of Recruitment and Retention initiatives. System-wide processes	• The workforce planning process ensures alignment of workforce with activity and financial plans. A Phase 3 Restoration and Recovery Workforce Plan has been produced in line with NHSi requirements. The Plan was amalgamated with those of other system partners and submitted to NHSi as a system plan. For UHNM, this incorporates the resource required for the Winter Plan. • The *COVID-19 Staff Shortage Contingency Arrangements*, a sub-plan to the Trust's Business Continuity Plan, is in place. This specific Business Continuity plan details the processes that will be put in place within the operational settings of each Division to manage a disruption of service delivery as a

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
		are agreed for mutual aid and redeployment of staff to areas of need. • We work closely with our education partners and continue 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. • We have well-established Banks for Medical Staffing, Nursing, Nursing support and Admin and Clerical staff • There is a System Recruitment and Retention group in place to look at system-wide recruitment initiatives and the Trust continues to progress its own recruitment plans as well. • The Trust is supporting 30 of our Assistant Practitioners through a 2 year apprenticeship to become Registered Nurses and a further 10 nursing assistants on a 4 year apprenticeship to become Registered Nurses.	result of staff shortages and is supplemented by the *Disruptive Incident Staffing Plan and Operational Workforce Plan*. The plan has been noted as a specific source of assurance on the Board Assurance Framework • Internal redeployment and volunteer process are place to offer support to areas of need and partnership working with the STP continues with system-wide processes for mutual aid and redeployment of staff where possible. • The Annual NHS Staff Survey and periodic pulse checks, along with staff forums and focus groups, test staff engagement and experience. ○ At 6.9, the 2019 staff engagement score remained just below the acute trust average of 7.0. ○ Actions to improve staff experience are detailed in Divisional Staff Engagement Plans. ○ The Annual NHS Staff Survey for 2020 has closed. Results are expected in February/March 21 ○ Periodic pulse checks – the Staff Friends and Family Test has been suspended during the covid-19 pandemic. • Trust wellbeing plan has been approved and Divisional wellbeing leads appointed
Assurance:	• HRBPs report actual performance to Divisional Boards and Divisions are held to account via Performance Reviews • Chief Nurse regular reports on Staffing Levels and use of the safe staffing tools	• Monthly reports to Transformation and People Committee cover hard to recruit posts and long term agency • Agency costs are reported in the monthly Finance Report to Performance and Finance Committee • We have 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 • The wellbeing governance structure is led by an Executive Director who oversees delivery of the wellbeing plan at corporate and local level. • The Empactis Absence Management System supports the delivery of a consistent approach to managing the key processes associated with health, absence and engagement. • The first nursing associates are due to qualify in the next few months • 100 of our overseas qualified nurses currently working as nursing assistants have taken up the offer to support them through the English requirements to enable them to proceed with their registration with the NMC. • The Workforce Bureau has been stepped back up with a focus on risk assessments, staff wellbeing, staff testing and staff deployment. The covid-19 bulletins have been stepped up to daily communications.	

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
		• Monitoring of sickness absence takes place on a daily basis, with redeployment and system-wide mechanisms in place to support areas where staff absence levels hit levels which trigger business continuity plans • Covid related absences and staff testing remains an area of focus, with additional resources being applied to manage staff testing • Lateral-Flow asymptomatic testing of frontline staff for Covid-19 has been rolled out to strengthen- efforts to prevent and control the spread of infection, with home self-testing kits rolled out to staff who are in direct contact with patients. • The covid-19 risk assessments have been reviewed and updated. • The vaccination programme has commenced. • Analysis of data and historic trends, reported in monthly performance reports to TAP and Trust Board show: • At 30th November 20, the in-month sickness rate was 5.85% (4.88% 31/10/20). The 12 month cumulative rate increased to 5.23% (from 5.16%) • For the 12 months ending 30/11/20, the turnover rate was 9.90% • The vacancy level at 30/11/20 9.14% due to an uplift in the budgeted establishment for winter pressures rather than an increase in leavers An update on Sickness Absence was reported to Trust Board in January 2021	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	Action Required	Executive Lead	Due Date	Quarter 2 Progress Report	BRAG
1.	Proactive medical recruitment plans aligned to business planning process/ supply and demand. Consideration to redesigning of roles and recruitment initiatives	Director of Human Resources	31/03/2021	Development of Trainee Fellowship programme launch date agreed with advertising to commence April 2020 for start dates August 2020. Medical Division have procured BMJ Careers to support the attraction of national and international candidates to the Trust commencement to be confirmed likely April 2020.	GA
2.	Partnership working with the STP for Recruitment and Retention initiatives	Director of Human Resources	31/03/2021	Recruitment and attraction documentation has been updated We are working with System Partners on a joint approach with plans including: • Development of standard process for Retire and Return, Itchy feet and staff transfer • Corporate Campaigns, a wider Public Campaign and campaigns targeted towards B5 Nurses. There will also be consideration of International	GA

				Recruitment. • As a system, there is development of branding and marketing to build a reservist bank across Staffordshire, plus 3 pilots • Calls for nursing support for Critical Care, Therapists, Medical Staff, volunteers and admin support are placed with the STP. Weekly lists of students available to support are provided to UHNM and Stoke City Council is sourcing a number of volunteers. St Johns Ambulance is supported in ED.	
5.	Nursing recruitment plans to be put this in place to address shortfalls following Chief Nurse establishment review	Director of Human Resources	31/03/2021	A Business Case for international recruitment of Nurses has been approved Progressing with international recruitment plans with a view to them joining the Trust from April onwards.	GA

Risk Summary					
BAF Reference and Summary Title:	**BAF 4: System Working - Vertical**			**SO's Impacted Upon**	✓ ✓ ✓
Risk Description:	**If the Staffordshire and Stoke on Trent system do not collaborate and vertically integrate appropriate services then we will not be able to deliver high quality, safe, sustainable and VFM services for our population resulting in fragmented, poor quality, inefficient and ineffective services**				
Lead Director:	Chief Executive	**Supported By:**	Director of Strategy and Transformation		
Lead Committee:	Transformation and People Committee	**Executive Group:**	Strategy & Transformation Group		
Links to Risk Register:	**Title**	**Current Risk Score**			
	n/a	n/a			

Risk Scoring							
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**	**Target Date**
Likelihood:	**3**	**3**	**3**		Risk remains at the same level due to proven excellent system working as a result of Covid -19 and significantly improved relationships. Risk remains above target due to imminent and significant changes to the STP leadership and continued focus of Covid-19, R&R and planning for winter. Although Independent Chair appointed the Executive Lead role is yet to be resolved.	**Likelihood: 2**	**31 March 2021**
Consequence:	**4**	**3**	**3**			**Consequence: 3**	
Risk Level:	**High 12**	**High 9**	**High 9**			**Risk Level: Mod 6**	

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	**2nd Line of Defence**	**3rd Line of Defence**
Controls:	• STP Partnership Board in place, Shadow ICS Board in development • System Wide Executive Forum • New STP Independent Chair appointed and commenced in role • STP Director in post • Three ICP's in place- albeit embryonic in delivery and approach	• Transformation and Delivery Unit • STP Workstreams • Current system LTP in place • Organisational operational plan in place • ICS development Plan submitted December 2020 to regulators	• NHS E / I approval of system becoming an ICS
Assurance:	• UHNM Chair, Chief Executive and Director of Strategy are members of relevant system groups / meetings • CFO/COO & DoS are members of Finance & Operations system group • MD Chairs system wide Clinical Senate • Regular meetings take place between UHNM CEO and Northern PCN Clinical Leads	• Regular reports from the TDU to the Executive Forum, with escalations to the Shadow ICS Board as appropriate.	

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
	• System working regular UHNM Board agenda		

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	Action Required	Executive Lead	Due Date	Quarter 3 Progress Report	BRAG
1.	Appoint ICS Executive Lead	NSC Director of Human Resources	31/03/2020	To be commenced once Chair has commenced in post. Due Date revised	GA
2.	System becomes full ICS	STP Director / Chief Executive	01/04/2021	Went into Shadow ICS form from 1st April. Following this, one meeting took place before Covid-19 impacted. Therefore progress was paused. As of May Shadow ICS Partnership Board meetings recommenced to review single agenda items such as Covid-19 and Restoration and Recovery. Update – January 2021 - New Independent Chair Commenced ICS Development Plan submitted to regulators Significant work underway by CCG to ensure agreement to CCG merger	GA
3.	Develop a revised Integrated Strategy for Health and Social Care	STP Director / Chief Executive	01/04/2021	Meetings have taken place with a range of system partners to begin the R&R work through to March 2021. Directors of Strategy are developing a framework for ICP to undertake robust recovery and restoration. Update January 2021 – R&R work paused during second Covid surge H&C strategy review on hold until pressures across the system begin to ease	GA
4.	Development of the three ICPs.	STP Director / Chief Executive	31/03/2021	Ongoing	GA
5.	Review Long Term Plan workstreams in the light of Covid / Recovery and Restoration.	STP Director / Chief Executive	01/04/2021	Not yet started, paused due to Covid pressures. Due Date revised	GA

Risk Summary					
BAF Reference and Summary Title:	**BAF 5: System Working - Horizontal**			**SO's Impacted Upon**	
				✓	✓ ✓
Risk Description:	**If UHNM does not collaborate horizontally with other acute providers (both within & outwith the STP) then some specialist services will potentially not be sustainable and opportunity to achieve economies of scale within clinical support functions will be lost resulting in unsustainable, fragmented, poor quality, inefficient and ineffective services that are not VFM.**				
Lead Director:	Chief Executive	**Supported By:**	Director of Strategy and Transformation		
Lead Committee:	Transformation and People Committee	**Executive Group:**	Strategy & Transformation Group		
Links to Risk Register:	**Title**	**Current Risk Score**	**Title**	**Current Risk Score**	
	n/a	n/a			

Risk Scoring							
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**	**Target Date**
Likelihood:	**3**	**3**	**3**		The risk level remains at 12 due to the lack of progress as a result of: • Capacity from all partners due to meeting demands in relation to Covid-19, Restoration and Recovery and planning for Covid-19 resurgence and winter • Inability to engage due to regulatory / inspectorate pressures on some partners • Target date moved to March 2021 given impact of Covid	**Likelihood:** **2**	**31 Mar 2021**
Consequence:	**4**	**4**	**4**			**Consequence:** **3**	
Risk Level:	**High 12**	**High 12**	**High 12**			**Risk Level:** **Mod 6**	

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	**2nd Line of Defence**	**3rd Line of Defence**
Controls:	• Designated Lead for UHNM - Director of Strategy • Exec : Exec meetings - need to be formalised with SaTH and re-launched with MCHFT • DoS represents Trust on Spec Com discussions in respect of network development for Midlands	• Newly formed Transformation & People Committee • Strategy and Transformation Group to be established to oversee Strategic Partnerships • Informal Exec to Exec discussions to be re-established post COVID	• None available at present.
Assurance:	• Re-launch / development of governance and programmes of work will be reported through TAP with escalations to Trust Board • Trust clinical strategy development will be inclusive of strategic developments with other partners	• System working updates to the Board each month through the Chief Executive demonstrate that progress is in early stages of development.	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 3 Progress Report**	**BRAG**
1.	Exec: Exec discussion with MCHFT to establish joint status of the	Director of	01/04/2021	Discussions need to take place first to test the appetite before proceeding with	GA

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 3 Progress Report**	**BRAG**
	Stronger Together Programme.	Strategy		this. Update January 2021 – Exec:Exec with MCHFT scheduled for 17/11/20 postponed due to Covid pressures. Therefore due date revised for Exec:Exec mtg	
2.	Develop formal governance for a collaborative programme with SaTH	Director of Strategy	Post Covid	Work commenced through an initial meeting in February 2020 although paused due to Covid & SaTH pressures. Areas such as Critical Care were reinstated through Restoration and Recovery Programme. Update January 2021 - Exec:Exec to be re-established post Covid pressures	GB
3.	Utilise the Recovery & Restoration programme to develop improved relationships with Specialist Commissioners. Review of current network arrangements for Specialised Services to be completed by Specialised Commissioners.	Chief Executive / Director of Strategy	30/06/2020	Chief Executive is now part of the NHS Midlands Clinical Strategy Group which is largely related to specialist services and has agreed to be part of a Task and Finish Group in respect of specialist cancer services. Therefore ensuring UHNM is contributing to and influencing developments.	B
4.	Refresh / development and agreement of UHNM Trust wide Strategy.	Director of Strategy	31/12/2020	Clinical service reviews have commenced, new timeframe being developed by Helen Ashley. Progress may be impacted by Covid resurgence. Update January 2021 – Progress not made due to Covid pressures and Transformation Team supporting Covid operations e.g. vaccination programme	GR
5.	Strategies for each Trust to be reviewed to ensure that strategic developments between UHNM / MCHFT and UHNM / SATH are taken into account.	Director of Strategy	31/03/2021	To be undertaken when a UHNM strategy is agreed.	GA
6.	Ensure that Restoration and Recovery is taken into account in development of UHNM Strategy.	Director of Strategy	31/03/2021	To be done as part of the reinstated strategy development work.	GA
7.	Review and interpretation of national operational planning guidance for 21/22.	Director of Strategy	31/03/2021	Update January 2021 – Some national guidance received and being worked through whilst recognising some detail is still required, in particular around financial regime going forward	GA
8.	Review of current network arrangements for Specialised Services to be completed by Specialised Commissioners.	Chief Executive / Director of Strategy	31/12/2020	Update January 2021 – To align with action 3 above. Close action	B

Risk Summary					
BAF Reference and Summary Title:	**BAF 6: Restoration and Recovery**			**SO's Impacted Upon**	✓ ✓ ✓ ✓ ✓
Risk Description:	**If demand for Covid related services continues to fluctuate / increase, then the planning and delivery of non Covid services, taking into account changing national expectations and guidance, resulting in increased potential for patient harm, longer waits, increased waiting lists impacting upon RTT, poor patient experience.**				
Lead Director:	Director of Strategy and Transformation	**Supported By:**	Chief Operating Officer		
Lead Committee:	Performance and Finance Committee	**Executive Group:**	Executive Restoration and Recovery Group		
Links to Risk Register:	**Title**	**Current Risk Score**	**Title**	**Current Risk Score**	
	ID 17542 R&R IM&T	**Ext 16**	ID 18014 R&R Planned Care	**High 12**	
	ID 17570 R&R Outpatients	**High 12**	ID 18746 Phase 3 Workforce Availability	**High 12**	
	ID 18052 R&R Diagnostics	**High 9**	ID 17536 R&R Urgent Care	**High 8**	
	ID 17693 R&R Transformation	**High 8**	ID 17693 R&R Transformation	**High 8**	
	ID 17549 R&R Workforce	**Mod 6**	ID 17551 R&R Performance & Information	**Mod 6**	
	ID 18976 Elective Incentive Scheme	**High 9**			

Risk Scoring							
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**	**Target Date**
Likelihood:	4	5	5		**The level of risk remains unchanged as a result of the fluctuating / increasing levels of Covid, along with the anticipated 3rd wave as a result of the new variant / impact of Christmas.**	**Likelihood:** 3	**31 March 2021**
Consequence:	5	5	5			**Consequence:** 4	
Risk Level:	**Ext 20**	**Ext 25**	**Ext 25**			**Risk Level:** **High 12**	

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	**2nd Line of Defence**	**3rd Line of Defence**
Controls:	• Operational Lead for Restoration and Recovery agreed – Chief Operating Officer • Divisional Restoration and Recovery Plans in place • Systems and processes identified to aid monitoring of progress against individual workstreams • Planned Care Cell remains responsible for overseeing delivery of agreed activity levels	• Executive Lead for Restoration and Recovery agreed – Director of Strategy • Workstreams / Cells with nominated leads identified for Restoration and Recovery Programme • NHSEI Guidance on priorities for Restoration and Recovery – 'Trilogy' of correspondence issued	• Positive verbal feedback received from NHSEI in response to the submission of our Restoration and Recovery Plan on 5th October.
Assurance:	• Highlight Report from Operational Group covering concerns / key actions / positive assurance and decisions presented to each meeting of the	• Workstreams and associated governance arrangements approved by Transformation and People Committee in May 2020	

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
	Restoration and Recovery Executive Oversight Group, demonstrating the establishment of Restoration and Recovery Programme	• Ongoing updates provided to the Board outlining the Restoration and Recovery Programme and actions taken • Trust IPR now includes R&R trajectories and performance against them.	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	Action Required	Executive Lead	Due Date	Quarter 3 Progress Report	BRAG
1.	To evaluate implications of Phase 4 letter, ensuring that priorities of the organisation are reflective of those outlined nationally.	Tracy Bullock	14/01/2021	Board Seminar held on 14th January whereby Board members considered the priorities and sought assurance on plans outlined.	B
2.	Continued utilisation of the Independent Sector, as and where appropriate and in accordance with organisational priorities.	Helen Ashley	31/03/2021	Discussions remain ongoing with the Independent Sector in light of changing the nature of the contract.	GA

Risk Summary					
BAF Reference and Summary Title:	**BAF 7: Infrastructure to Deliver Compliant Services – IM&T**			**SO's Impacted Upon**	✓ ✓ ✓
Risk Description:	**If the organisations infrastructure and clinical systems do not receive or are not adequately protected from either a targeted or indirect attack then this could compromise the operation and delivery of care within the hospital resulting in a loss of IT systems for potentially a prolonged period, and potential cancellation of some services, as well as reputational damage, increased backlog of patients and operations and potential fines of up to 4% Trust budget by NHS England.**				
Lead Director:	Director of IM&T	**Supported By:**	Medical Director and Chief Finance Officer		
Lead Committee:	Performance and Finance Committee	**Executive Group:**	Infrastructure Group & Data Security and Protection Group		
Links to Risk Register:	**Title**	**Current Risk Score**	**Title**	**Current Risk Score**	
	n/a	n/a			

Risk Scoring								
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	4	4	4		The likelihood of the risk has remained static based on the actions that continue to progress as part of the IM&T Cyber Acton plan and the assessment of the impact of the risk. If the Trust was infected by a cyber-attack, it is possible that this may spread across every office and ward at both hospitals. The organisation has already been subject to a Cyber Attack (WannaCry) and Cyber Security remains a real and relevant threat to the NHS.	**Likelihood:**	2	**30 June 2021**
Consequence:	4	4	4			**Consequence:**	4	
Risk Level:	**Ext 16**	**Ext 16**	**Ext 16**			**Risk Level:**	**High 8**	

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	**2nd Line of Defence**	**3rd Line of Defence**
Controls:	• Investment already made in enhanced Cyber Tools and defence (Intercept-X) to protect against 'wannacry' type attacks. • Server and PC patching in place and enhanced network firewalls and other network perimeter controls. • Cyber Action plan in place • Dedicated Cyber defence lead role appointed to • Deployment of Microsoft Advanced threat detection to improve cyber defences • Infrastructure – the increasing move to cloud based services and infrastructure as a service revenue based models reduce the reliance on available capital.	• Implementation of National Cyber Security Centre recommendations on passwords • Raised staff awareness and understanding of cyber security through education and communication • NHS Digital accredited awareness training provided to Board members • NHS Digital Cyber essentials best practice being progressed • IM&T Programme Board in place • Infrastructure – warranty extensions can provide cover for infrastructure if funding is not available for replacement	• Auditing from NHS Digital and other agencies undertaken during 2018 to demonstrate good practice and areas for improvement (which have been addressed). • External Penetration Testing has been undertaken and a remediation plan developed

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
	• Moved to a service contract for PCs and Laptops		
Assurance:	• During Q1 there have been no significant threats to cyber security		

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	Action Required	Executive Lead	Due Date	Quarter 3 Progress Report	BRAG
1.	Deployment of Windows 10 with improved in built security and based on National Cyber Security Centre and Microsoft best practice	Director of IM&T	31/01/2021	This project is 92% with 650 devices remaining. The extended timeframe is required to avoid disruption in critical clinical areas. The due date has been revised by one month to the end of January.	GA
2.	Implementation of DarkTrace - uses Artificial Intelligence / Machine Learning to detect and respond to subtle, stealth attacks inside the network — in real time. Does not require previous experience of a threat or pattern of activity in order to understand that it is potentially threatening.	Director of IM&T	31/01/2021	HSLI Funding secured; Software implemented across both Royal Stoke and County Hospital sites. The Software changed from alerting of potential threats to blocking potential threats, and the next phase is to enable the autonomous mode of monitoring due to be enabled in January.	GA
3.	Continue work towards Cyber Essentials (plus) and ISO27001 compliance	Director of IM&T	30/06/2021	NHS Digital sponsored engagement with PA Consulting in progress to provide a readiness assessment for Cyber Essentials Plus.	GA

Risk Summary					
BAF Reference and Summary Title:	**BAF 8: Infrastructure to Deliver Compliant Services – Estate**			**SO's Impacted Upon**	
Risk Description:	**If we fail to invest sufficiently in our retained estate infrastructure/services and fail to undertake statutory maintenance/lifecycle within our PFI; then we will fail to deliver a healthcare environment that enables the delivery of high quality clinical services, provided within a safe, secure and compliant environment, consistent with the objectives of our Estate Strategy and our statutory obligations.**				
Lead Director:	Director of Estates Facilities & PFI & Director of IM&T	**Supported By:**	Medical Director & Chief Finance Director		
Lead Committee:	Performance and Finance Committee	**Executive Group:**	Infrastructure Group		
Links to Risk Register:	**Title**	**Current Risk Score**	**Title**	**Current Risk Score**	
	ID 8777: Retention of Royal Infirmary	**Ext 15**	ID 11152: Annual Statutory and Lifecycle Maintenance	**High 12**	
	ID 12720: Absence of side rooms in modular wards	**High 12**	ID 18396 Discrepancy in PFI Financial Model	**High 12**	

Risk Scoring								
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	4	4	4		• Infirmary Site (Project STAR) – Majority of buildings under control and responsibility of IHP. Small number of buildings remain with Trust (EF&PFI building, ICT building, Windsor House) including car parks. IHP increased security to reflect increased possession. Phased handover to IHP - Phases 1,2,3 (asbestos removal) completed. Phases 4 & 5 (asbestos removal) commenced. Demolition to commence in January 21. • Estate Condition – Key risks are funding constraints & physical access. 2020 PFI Statutory Maintenance/Testing/Lifecycle Programme stood down (other than areas, that do not require clinical decant. Decision made following review and balancing of risks of compliance against statutory regulations/PFI contractual requirements, against the delivery of R&R/Winter & Covid Surge Plans. Focus now on producing and agreeing the PFI 2021/22 Programme which will require area decant to allow for 5 year electrical fixed wire testing. Annual theatre ventilation validations have been agreed to commence from 8th January 2021 and Imaging area maintenance from 4th January 2021. Additional funds for backlog maintenance of £3.2M secured and programme of works being delivered by 31st March 2021. • COVID-19 impact – Specialist Decision Unit and Childrens Assessment/Waiting capital schemes completed. Continue to progress Pathology; Endoscopy; and Trent. Zoning Plans & Social Distancing Signage implemented. Risk Assessments completed and informed changes to the estate. • Estate configuration/utilisation/optimisation/adjacencies – Lower Trent, which is phase 2 of £17.6m capital funding additional ward scheme, stalled due to their being no	**Likelihood:**	**2**	**31 March 2022**
Consequence:	4	4	4			**Consequence:**	**4**	
Risk Level:	**Ext 16**	**Ext 16**	**Ext 16**			**Risk Level:**	**High 8**	

		• decant solution as a result of Market Testing Business Case and financial discrepancy affecting investment led solution of £3.5M. Alternative plans worked up and agreed and Russell building to be extended to accommodate element of displaced admin staff. • Clinical Service Strategy work restarting to inform further changes. • Fire/Security – Fire Safety KPI's developed to improve fire safety culture.	

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	Infirmary Site (Project STAR): • Emergency capital bids produced; fire Risk assessments completed, manned 24/7 security. Condition of the estate: • PPM; competent estates staff/APs; estates KPI's monitored through CEF/ Environmental Audits. • Maintenance Operational Board; Operational policies; Service Specifications PFI. COVID-19 Impact: • Capital schemes; social distancing methodology; zoning proposals agreed through ET & R&R. Estate configuration/optimisation/adjacencies • Clinical Service Strategy Review to conclude and inform changes to Estate Strategy/DCP. Fire / Security • Fire Safety/ Security Policies; Protocols; Guidelines; patrolling; CCTV; FRA's in place.	Infirmary Site (Project STAR): • Emergency capital bids approved and funding provided by NHSEI to remediate the site and to acquire GHC this financial year, work progressing on identifying funding streams for the car park development. • Full Business Case for car park approved by Trust Board and currently being reviewed by NHSEI. Condition of the Estate • Estates Capital bids submitted to Trust Capital Investment Group (CIG) from 7 facet findings, investment prioritised. • Secured £3.2M to support backlog maintenance/critical infrastructure and programme of works to be completed by 31st March 20201. COVID-19 Impact • Appropriate control of all schemes – ET & R&R. Estate configuration/optimisation/adjacencies • Prioritised clinical service developments, as identified by Clinical Divisions, used to inform Estate Strategy. Fire/Security • 'On the spot' fire improvement notices by Fire Officers. • Fire Safety KPIs & ad-hoc audits/inspections. • LSMS close working with local Police and visibility on site	• NHSEI Review of Progress on Project STAR • Regulatory inspection/validation programmes including: CQC, PLACE, PAM and ERIC • External audits including those undertaken by the Fire and Police Service and external audit i.e. KPMG • Authorising Engineers Audits, appointed to provide external audit and assurance (governance) of building services and associated maintenance regimes. • Participation in National Programme hosted jointly by Cabinet Office & HM Treasury, showcasing the most successful Private/Public Sector Strategic Partnerships.
Assurance:	Project STAR: • Project Team, PRINCE principles applied. Condition of the estate • Estate-code 7 facet property appraisals conducted; Maintenance Operational Board; estates maintenance/validation audits; PFI performance against Service Spec; Divisional Board review. COVID-19 Impact • Updates ET & R&R Clinical Service Reviews	Project STAR • Regular updates to Executive Team/Trust Board and external stakeholders including Regulators, STP, SOTCC & SHA. Condition of the estate • Estate Strategy, informed by Estate-code 7 facet property appraisal, Trust Strategy & clinical developments. • Regular reporting to CIG, H&S QGC, Infrastructure Committee, TEC, Infection Prevention Comm, TJNCC and LNC. • Strategic partnership - reviewed at Quarterly Liaison Committee, PAF and Infrastructure Committee.	

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
	• Clinical Service Reviews re-instated. Fire / Security • FRAs; ad-hoc inspections; on spot improvement notices; progress monitored Fire Safety Group and Executive Health & Safety Group.	COVID-19 Impact: • Regular updates on progress on Risk Assessments from R&R to COVID Exec and Trust Board. Clinical Service Reviews: • Agreed to re-instate Clinical Service Reviews Fire / Security: • FRAs monitored through Trust Fire Committee; Divisional Management Board and Divisional H&S Meetings.	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	Action Required	Executive Lead	Due Date	Quarter 1 Progress Report	BRAG
1.	RI Site - Asbestos removal/demolition	Director of E,F & PFI	2022	Asbestos removal Phase 1 - 5 handed over to the principle contractor IHP. Phases 1-3 completed removal	GA
2.	RI/COPD - Create a car parking solution	Director of E, F&PFI	2023	Project STAR Full Business Case approved, NHSEI provided funding to accelerate purchase of GHC and working with the Trust to identify potential funding streams for the construction of the car park.	GA
3.	RI/COPD - Release surplus land for land sale	Director of E,F& PFI	2023	Will be dependent on funding being made available to construct the new car park.	GA
4.	Lower Ground Floor Trent Business Case	Director of E,F&PFI	Jan 2021	Alternative decant solution identified and revised programme currently being worked up.	GA
5.	£3.2M Critical Infrastructure Funding	Director of E,F & PFI	March 2021	Additional funding provided to support backlog maintenance on Critical Infrastructure. Schemes to be delivered by 31st March 2021.	GA
6.	Market Testing Business Case (Financial Discrepancy)	Director of E,F&PFI	March 2021	Trust Board briefed; Commercial and Legal Advice commissioned; Sodexo's proposals to mitigate financial impact being reviewed through QIA assessment process. Financial Model Review commenced and due to conclude 31st January 2021. Update to be provided to Trust Board in March 2021.	GA
7.	Deferral of Elements of PFI Statutory Maintenance/Inspection/Lifecycle Programme 2020	Director of E,F&PFI	Jan 2021	Deferral of elements due to direct conflict with R&R/Winter/Covid. Theatres access agreed January (ventilation validations) and Imaging programmed for January. Focus on delivery of Programme for 2021/22 – must proceed and will require decant to support Electrical fixed wire testing as well as elements not completed during 2020.	GA
8.	COVID Capital Schemes, space requirements/reconfiguration plans	Director of E, F&PFI	March 2021	Capital schemes progressing to plan. Completed Specialist Decision Unit and Paediatric Assessment/Waiting, all other schemes on target to deliver consistent with programme. Continuing to respond to national guidance and looking at how we can improve social distancing particular in respect of Rest Facilities.	GA
9.	Strategic Supplier Relationship Management Programme (SSRM)	Director of E,F & PFI	2021	Continuation of programme (sponsored Cabinet Office and HM Treasury) and delivery of value release initiatives included within Joint Business Plan.	GA
10.	Introduce Fire KPI's to be monitored monthly through formal Divisional Performance Review Meetings	Director of EF & PFI	2021	KPI's have been developed and are now being used by the Clinical Divisions to achieve strong compliance against fire training, fire risk assessment and fire evacuation planning. Progress against achieving these KPI targets is being monitored by the Clinical Divisions and through the Trust's Fire Safety Group.	GA
11	Estates Ops Workforce Review & additional temporary staff)	Director of E, F&PFI	March 2021	Temporary project staff appointed to support capital developments. Estates Ops Workforce Review underway.	GA

Risk Summary					
BAF Reference and Summary Title:	**BAF 9: Financial Sustainability**			**SO's Impacted Upon**	
Risk Description:	**If we fail to operate within the resources available along with any flexibility agreed with the regulator then the services the Trust provides become financially unsustainable leading to increasing Cost Improvement Programmes / potential recovery action and a lack of ability to invest in the development of services in the future**				
Lead Director:	Chief Finance Officer	**Supported By:**			
Lead Committee:	Performance and Finance Committee	**Executive Group:**	Infrastructure Group		
Links to Risk Register:	**Title**	**Current Risk Score**	**Title**	**Current Risk Score**	
	ID 15065 Trauma delivery of CIP	**High 12**			

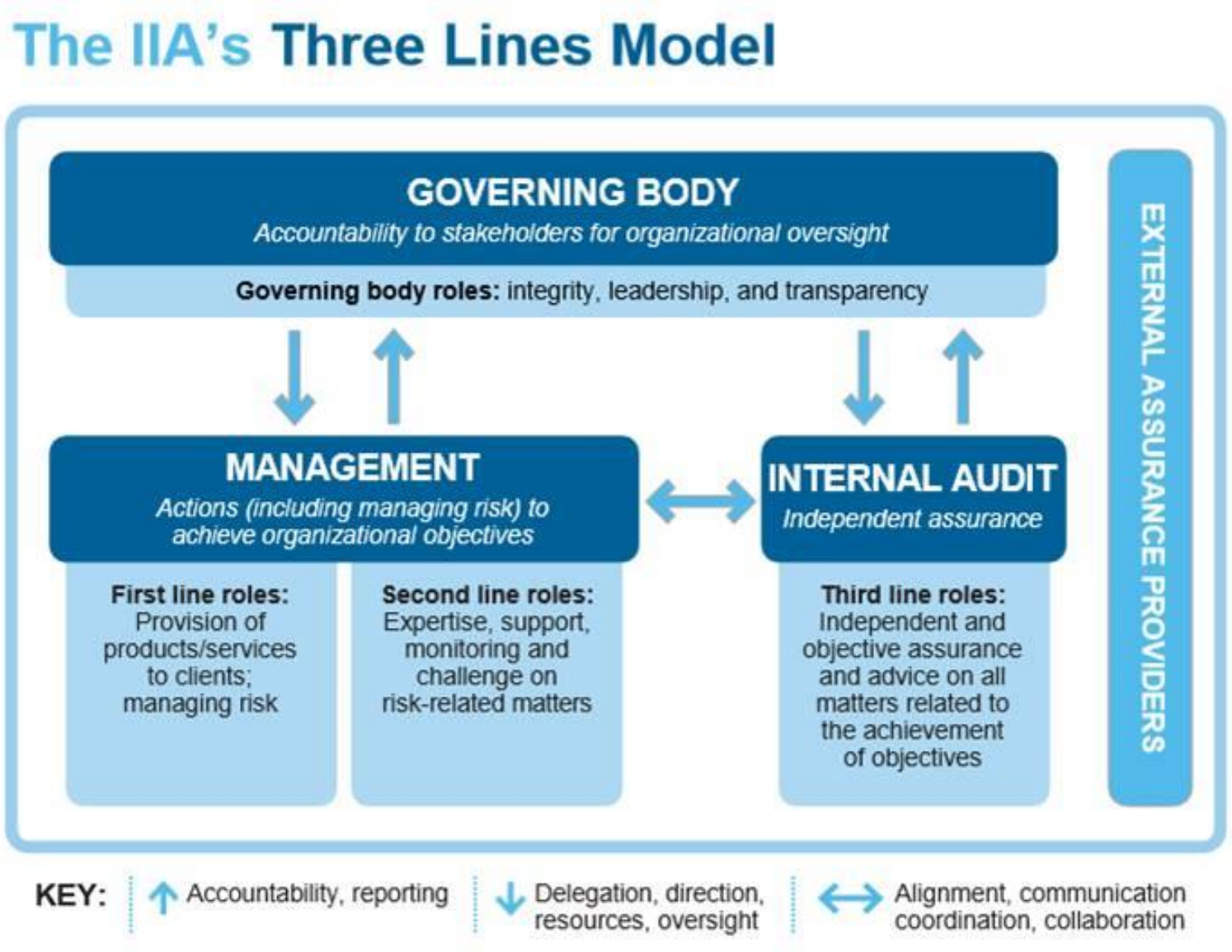
Risk Scoring								
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	**3**	**3**	**2**		Allocations have now been finalised for 20/21 and the original error on TSA funding has been rectified. Trust actual performance currently ahead of forecast. As we approach year end additional allocations from HEE and spec com being released potentially improving position further.	**Likelihood:**	**2**	**31 March 2021**
Consequence:	**3**	**4**	**3**			**Consequence:**	**3**	
Risk Level:	**High 9**	**High 12**	**Mod 6**			**Risk Level:**	**Mod 6**	

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	**2nd Line of Defence**	**3rd Line of Defence**
Controls:	• Performance Management meetings in place with Divisions • Financial codes and procedures • Restoration and recovery group scrutiny	• Finance report in place to performance and Finance Committee with associated scrutiny • Standing Financial Instructions	• Consideration of Internal audit programme to reflect changing risks on COVID • STP Capital Programme in place in Line with Capital Resource Limit (CRL) • External audit programme in place • NHSE/I allocations confirmed
Assurance:	• All COVID revenue costs reimbursed claimed to date	• Performance at Month 5 on track	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 3 Progress Report**	**BRAG**
1.	Develop processes to manage the Capital resource limit across the STP footprint	Chief Finance Officer	**31/07/2020**	Complete – Allocations agreed across the STP and sub group being established to track and deal collectively with variation.	**B**
2.	Develop financial reporting pack to support board oversight and scrutiny of financial performance	Chief Finance Officer	**30/06/2020**	Complete – Finance Pack now shows run rate performance.	**B**

				Need to rebase budget to ensure adequate system of financial control is in place once system allocations finalised. Spend now monitored against forecast for the remainder of the year. We will introduce revised budgets from 1st April now.	
3.	To understand the impact of the wider restoration and recovery programme on UHNM performance	Chief Finance Officer	**31/07/2020**	System submissions now made and impact evaluated against recovery trajectories.	**B**
4.	To conclude discussions with NHSIE in respect of errors in financial allocations.	Chief Finance Officer	**31/10/2020**	Complete.	**B**

Appendix 1 – Three Lines of Defence Model



The Three Lines of Defence model provides a simple and effective way to enhance communications on risk management and control by clarifying essential roles and duties.

To ensure the effectiveness of the risk management framework, the board and senior management need to be able to rely on adequate line functions – including monitoring and assurance functions – within the organisation.

As illustrated here, the Three Lines of Defence model provides a means of explaining the relationship between these functions and as a guide to how responsibilities should be divided:

- the first line of defence – functions that own and manage risk
- the second line of defence – functions that oversee or specialise in risk management, compliance
- the third line of defence – functions that provide independent assurance

From Quarter 2 2019/20, the Three Lines of Defence Model was incorporated into the BAF against each Strategic Risk. Whilst this is expected to evolve further, it provides an alternative 'lens' for Board and Committee members to consider – particularly around identifying areas of potential weakness.

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	3rd February 2021
Report Title:	Speaking Up Report – Quarter 3 2020-21	**Agenda Item:**	15
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:

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

Background - this quarterly Speaking Up Report provides an update to Trust Board on progress in relation to developing our speaking up culture, relevant national speaking up guidance published, and a summary of concerns raised at UHNM for the Quarter 3 period of October to December 2020.

Assessment – during the quarter 35 speaking up contacts were received. 28 concerns were recorded on the speaking up tracker, which includes concerns raised with the Freedom to Speak Up Guardians and those raised to the Chief Executive's Office, within a division, or via CQC/other routes that have then been notified to the FTSU Guardian for inclusion on the speaking up tracker. One of the concerns was raised anonymously. 7 contacts were made to our Employee Support Advisors.

Progress against our FTSU Index action plan is included as an Appendix.

Key Recommendations:

Trust Board is asked to note:

- The speaking up data and themes raised during Quarter 3 2020-21.
- The actions proposed to further encourage and promote a culture of speaking up at UHNM.

Speaking Up
Quarter 3 Report 2020-21

1. Introduction

This Quarter 35 speaking up contacts have been made via the UHNM speaking up routes, which include 28 concerns recorded on the speaking up tracker which records issues raised with the Freedom to Speak Up Guardians; the Chief Executive's Office; within a division or via CQC/other routes that have then been notified to the FTSU Guardian for inclusion on the speaking up tracker. One of these concerns was raised anonymously. 7 contacts have also been made to our Employee Support Advisors, who act as speaking up champions across the Trust.

2. National Guardians Office (NGO) Update

NGO Case Reviews – new process

From 1 January 2021, the NGO will launch its new case review process. The office is developing the way it decides what is reviewed. These changes seek to:

- Allow more workers to inform matters that are reviewed by the office, including workers who may face barriers to speaking up
- Ensure reviews undertaken by the office have the greatest impact on the greatest number of workers by focusing on areas of priority

Referrals submitted to the office on or before 31 December 2020 will continue to be assessed as part of the current case review programme.

From 1 January 2021, information shared by individuals with the office will add to the NGO's understanding of speaking up culture and arrangements. As described above, this information, along with other indicators, will inform potential areas for review.

Model Hospital and Benchmarking Data

Included as appendix 2 is an updated benchmarking table demonstrating UHNM Quarter 1 and 2 FTSU Guardian data compared with our Model Hospital group.

A new section on the Model Hospital - the Culture and Engagement compartment has been launched this quarter and includes speaking up data, enabling easy comparison with other organisations, and other metrics, for example, staff sickness or turnover.

The UHNM FTSU Guardian attended an online session where the Culture and Engagement compartment was presented and this will be used from this point forward for further speaking up data analysis.

3. Supporting our BAME staff to speak up

On 21st October the FTSU Guardians from all of the provider organisations in the Staffordshire & Stoke on Trent Integrated Care System attended a system wide BAME staff network event to discuss the psychologically safe channels to speak up and confidential support available for any workers with concerns or issues.

The NGO is working with NHS England/Improvement to help deliver the commitment in the People Plan relating to speaking up with training for Freedom to Speak Up Guardians and Workforce Race Equality Standard (WRES) experts.

On Wednesday 13th January 2021 the UHNM FTSU Guardian is participating in an NGO webinar for an initial discussion to help understand the equality and diversity training needs of FTSU Guardians. The discussion will help to inform the proposed national training plan for FTSU Guardians.

NGO Surveys have found that the FTSU Guardian network is predominantly white, and other ethnicities continue to be under-represented when compared with the NHS workforce as a whole. The NGO is commissioning research, to take place over Q4 2020/21, to shed light on whether the ethnicity of a guardian acts as a barrier to workers of other ethnicities speaking up. This work will include seeking opinions from workers and will be focused on a cross-section of organisations with a guardian.

The NGO has sought expressions of interest from guardians from all types of organisations and all ethnic backgrounds on this important piece of work and particularly welcomed expressions of interest from guardians from ethnic minorities. Our Associate FTSU Guardian and Chair of the Ethnic Diversity Staff Network/WRES Expert will be representing UHNM in this project.

The first Keele Medical School Professionalism Committee was held in December 2020 to look into the experiences of BAME doctors in training in teaching hospitals in our region, and the UHNM Freedom to Speak Up Guardian & Workforce Equality Manager is a member of this group. They will also attend the medical school Raising Concerns meeting to understand the issues medical students at UHNM are facing and to work with the organisation to address areas of poor practice and/or inappropriate behaviours.

4. Supporting a Speaking Up Culture – Update on Speaking Up Index Action Plan

UHNM Speaking Up Training Update

The new e-learning resources released by the NGO and Health Education England have been developed into a UHNM specific package for all staff which is currently being incorporated into the UHNM Statutory and Mandatory programme to ensure that all staff receive this essential training. There will be a requirement for all staff to repeat this training on a 3 yearly basis.

The NGO has indicated that the next phase of training for line managers will be released to organisations in the next 3 months.

Speaking Up Month

October saw national Speaking Up Month, the focus of the month was on further promotion of the UHNM Speaking Up Charter which is our core messaging about how staff are supported to raise issues. We also used the month to focus our awareness on harder to reach groups, and the Trust FTSU Guardian attended three ICS wide events for BAME, Disabled and LGBT+ staff network groups to raise awareness of speaking up, the role of freedom to speak up guardians and employee support advisors and the safe channels available for staff to raise issues.

Work in Confidence System

A project group has been established to plan the roll out of the work in confidence reporting platform across the organisation. An update will be provided on progress in the next quarterly report.

5. Internal Audit of Freedom to Speak Up

One of the actions from the KPMG audit of the UHNM freedom to speak up arrangements was to make some minor amendments to the Speaking Up policy. These amendments have been made and the policy will be considered at the January TJNCC meeting.

6. Quarterly Speaking Up Cases – Quarter 3 – October - December 2020

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

Month	No. of contacts in the Quarter	Of which were raised anonymously	Of Which are Closed	Reports of detriment/ victimisation as a result of speaking up
October	14	1	11	0
November	10	0	3	1
December	4	0	3	0
Total	**28**	**1**	**17**	**1**

One case was reported anonymously to the CQC. 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	14
Equipment and maintenance	0
Staffing levels	0
Policies, procedures and processes	9
Quality and safety	1
Patient experience	0
Performance capability	3
Service Changes	0
Other	1
Total	**28**

Summary of speaking up contacts recorded on the Speaking Up Tracker during Quarter 3 October - December 2020

No.	Theme	Summary	Status
1.	Performance capability	Worker raised concerns with FTSUG about management and leadership within team.	Support given to raise with next level manager.
2.	Attitudes & behaviours	Worker concerned about attitudes and behaviours in their department.	FTSUG escalated to next level manager. Plan in place to work through issues.
3.	Policies, processes & procedures	Worker submitted written concerns about workplace experiences and application of ER policy via FTSUG.	Independent fact finding investigation launched.
4.	Quality & safety	External concern received about clinical quality of a medic working in the Trust.	Fact finding undertaken. Concerns not upheld. Feedback provided to reporter.
5.	Attitudes & behaviours	Worker met with FTSUG to share negative experiences of the management of their disability. Worker	Worker signposted through options about raising their concerns. Way forward agreed. Awaiting written

		has secured employment elsewhere.	concerns from worker to be submitted.
6.	Attitudes & behaviours	Linked to 2 above. Supported to raise with line managers.	Supported to raise with line managers. Plan in place to work through issues.
7.	Attitudes & behaviours	Linked to 1 and 6 above.	Supported to raise with line managers. Plan in place to work through issues.
8.	Attitudes & behaviours	Anonymous statement sent to CQC regarding bullying in a department.	Limited information provided by the reporter. Triangulated with listen and learn feedback and other speaking up information.
9.	Policies, processes & procedures	Concerns raised by NSCNHST FTSUG on behalf of clinical colleagues about delays and rejection of samples sent to UHNM.	Laboratory manager working with the service to identify issues.
10.	Attitudes & behaviours	Staff member met with FTSUG about concerns that they may be being victimised following raising concerns in their department.	Advice and guidance provided. Issue resolved.
11.	Policies, processes & procedures	Worker concerned about management action following medication errors and experiences on their clinical area.	Support provided by 2 FTSUG's and escalated to senior manager. Support also provided by Practice Development Team. Support plan in place and learning to drive improvements.
12. 13. 14. 15.	Attitudes & behaviours	Concerns raised by 4 individuals about bullying and harassment in their work area.	Independent fact finding investigation launched.
16.	Performance capability	Linked to 1, above.	Guidance provided and support given to reporter to raise with next level manager. Reporter considering next steps.
17.	Policies, processes & procedures	Worker contacted FTSUG with concerns about recruitment process and workplace adjustments.	Guidance given, supported to raise with recruiting manager and issue addressed.
18.	Other	Contact made to FTSUG about issues reporter wished to raise about diversity.	Meeting being arranged.
19.	Attitudes & behaviours	Worker wished to raise issues about bullying behaviours of previous line manager.	FTSUG supported worker through options to raise issues.
20.	Attitudes & behaviours	Worker finding negative behaviours of a colleague difficult.	FTSUG supported worker to raise with line manager and support in place.
21.	Attitudes & behaviours	FTSUG contacted by worker following a breakdown in working relationship with colleague and allegations of bullying.	FTSUG supported worker through the dignity at work policy options and to raise with line manager.
22.	Policies,	Concerns raised by Union	Full response provided by senior

	processes & procedures	Representative on behalf of a group of staff at County hospital that other trust staff, non-clinical staff and staff in less high risk areas have received the Covid vaccine before this group.	leaders and assurances given.
23.	Policies, processes & procedures	Issues with manager who was not progressive and allowing the team to progress. Issues with civility and respect and PDR process.	Support provided by FTSUG and rota issues addressed. Other actions agreed and plan in place for PDR's.
24.	Attitudes & behaviours	Worker reporting concerns about behaviours of previous line manager.	Linked to 19 above.
25.	Performance capability	Worker concerned about capability management and breakdown in working relationship.	Meeting arranged.
26.	Policies, processes & procedures	Worker concerned about lack of opportunities for development and application of PDR policy.	Supported by FTSU/WRES lead to address actions.
27.	Policies, processes & procedures	Worker concerned about lack of induction and preceptorship and behaviours of others in their work areas.	Facilitated to transfer to an alternative work area, preceptor support in place and full training and induction package in place.
28.	Policies, processes & procedures	FTSUG contacted by a line manager to help support the experiences of ethnically diverse staff and recruitment practice.	Plans underway about role of allies, practical changes to recruitment and engaging with the diverse workforce.

Open Speaking Up Cases from Previous Quarters

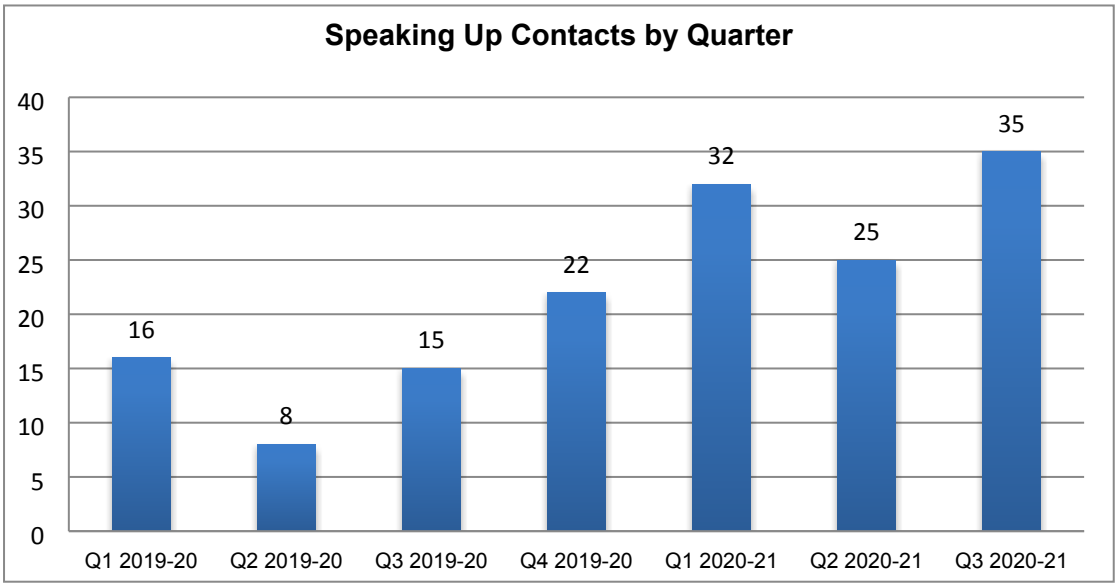
Theme	Summary	Month Case Raised	Status
Attitudes & Behaviours	Concerns raised about how a grievance is being managed.	June 2020	External Investigation into grievances agreed as way forward. Objection from the reporter to the proposed Investigating Officer, alternative sought and secured. Active investigation.
Attitudes & Behaviours	Concerns raised to CEO by member of staff regarding experiences.	March 2020	Formal investigation commissioned. Response provided to reporter who has requested further meeting – meeting held – concern now closed.

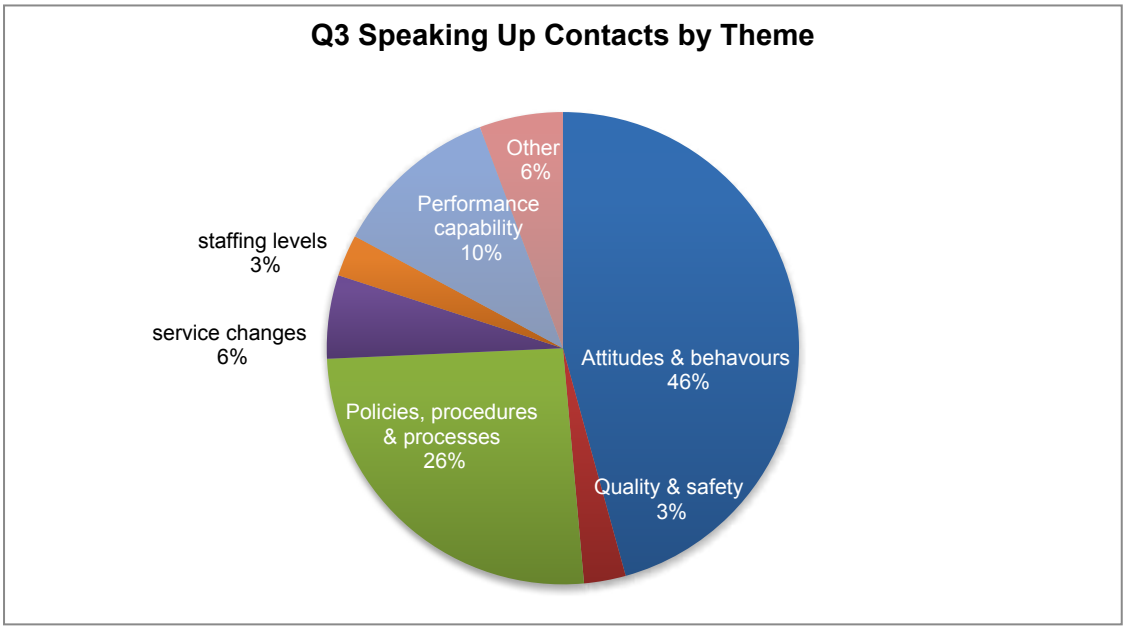
Issues raised with our Employee Support Advisors

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. During the quarter our ESA's have received 7 contacts relating to the following themes:

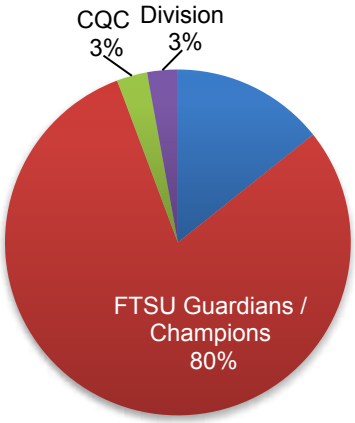
Theme	Number
Attitudes and behaviours	2
Equipment and maintenance	0
Staffing levels	1
Policies, procedures and processes	0
Quality and safety	0
Patient experience	0
Performance capability	1
Service Changes	2
Other	1
Total	**7**

Quarter 3 Data Summary of All Speaking Up Contacts:

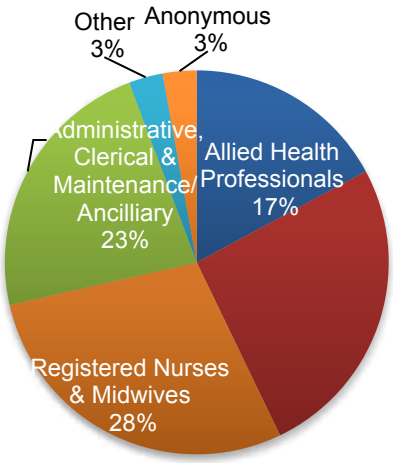




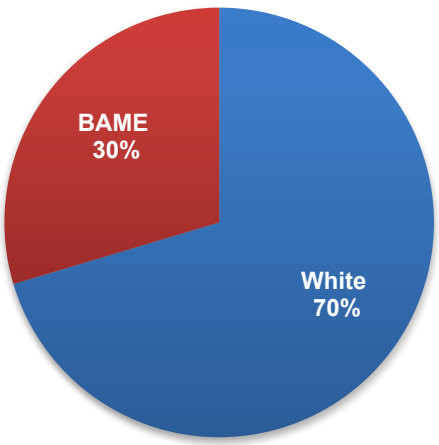
Q3 Speaking Up Cases by Route

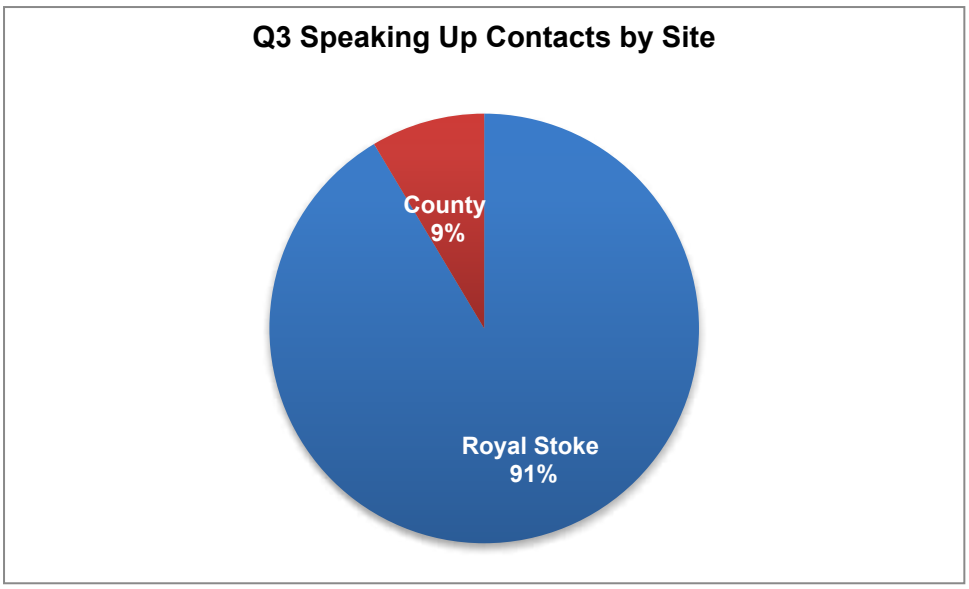


Q3 Speaking Up Contacts by Professional Group (where known)



Q3 Speaking Up Contacts by Ethnicity (where known)





7. Learning from cases

One of the cases during the quarter related to the experiences of a BAME nurse who had recently joined the organisation following joining the UK NMC register. The individual contacted a FTSU Guardian following a difficult shift where there had been a medication error.

Two FTSU Guardians supported this individual who was concerned about the level of induction, lack of support and negative workplace experiences on their clinical area. Whist supporting the individual it became apparent that they had not been put forward for the UHNM Preceptorship Programme, and had therefore not received a copy of the UHNM Safe Medicines Competency workbook, or the Preceptorship workbook, or who their assigned Preceptor was.

The Practice Development team, becoming aware of this situation invited the individual to the practical OSCE practice sessions, and a full package of support has been developed.

A meeting was held to review this speaking up case and to identify learning. Actions identified include working with the recruitment department to target communications to new starters of the preceptorship programme and increased awareness of the support available. Work will also be undertaken with the division about improving the ward based induction programme.

8. Recommendations

Trust Board is asked to note the activity and actions relating to speaking up undertaken in the Quarter 3 of 2020-21, and the focus going forward over the next quarter, which will be:

- Launch the 'Speaking Up' all staff training package
- Develop the 'middle manager' speaking up training offering
- Advertise for a replacement Associate FTSU Guardian following the stepping down of one of the post holders
- Recruit to our Employee Support Advisors once role description reviewed
- Develop and extend the work in confidence reporting system

Appendix 1: FTSU Index Gap Analysis and Action Plan

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. Update: Speaking Up Charter launched in August 2020	Ongoing	B
				• 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	B
				• 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: October 2020 E-learning for Health 'Speak Up' e-learning package released. Next steps to incorporate this training into statutory and mandatory training.	~~May 2020~~ Revised timescale: Feb 2021	GA
				• 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	B

				• 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. Update: October 2020 E-learning for Health 'Speak Up' e-learning package released. Next steps to incorporate this training into statutory and mandatory training.	~~May 2020~~ Revised timescale: Feb 2021	GA
				• 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 Update: NGO to provide organisations with material for middle manager training as part the 3 part Speak Up, Listen Up, Follow Up e-learning package. **In the meantime, HEE updated e-learning is currently a required module for Gateway to Management delegates.**	~~May 2020~~ Updated timescale: March 2021	GB

				• 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. Speaking Up Charter launched during August 2020	Ongoing	B
% 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 as part the 3 part Speak Up, Listen Up, Follow Up e-learning package. **In the meantime, HEE updated e-learning provided to Gateway to Management delegates.**	~~May 2020~~ Updated timescale: March 2021	GB

				• 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	B
				• Introduce newsletters and updates with a creative and engaging communication strategy to tell positive stories about speaking up – Newsletter for Speaking Up Month to be released during October	Quarterly	B
				• 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.

Appendix 2: Benchmarking Data

Freedom to Speak Up - National Guardian Reporting Data Q1 and 2 2020-21 - Model Hospital Group

	UHNM	Derby Teaching Hospitals	Gateshead Health	Nottingham University Hospitals	Royal Wolverhampton	Sheffield Teaching Hospitals	University Hospitals Southampton	University Hospitals Birmingham	University Hospitals Coventry and Warwickshire	Average quarterly
Total Concerns Reported										
Q1	29	95	11	No data	22	10	19	10	10	25.8
Q2	18	126	12	No data	35	3	18	19	11	30.3
Number raised anonymously										
Q1	0	5	6	No data	1	1	2	2	0	2.1
Q2	0	21	1	No data	1	0	1	0	1	3.1
Element of quality or safety										
Q1	11	3	2	No data	4	0	4	0	1	3.1
Q2	1	11	1	No data	4	0	3	2	1	2.9
Element of bullying and harassment										
Q1	15	42	9	No data	16	2	5	7	1	12.1
Q2	6	45	10	No data	28	1	7	10	3	13.8
Reporting detriment										
Q1	0	2	0	No data	2	0	1	2	0	0.9
Q2	0	2	0	No data	4	0	1	4	0	1.4
FTSU Index Score (2020)	75.5%	77.7%	82.8%	79.8%	78.0%	79.2%	81.2%	74.7%	80.5%	**Average Index Score: 78.2%**

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	3rd February 2021
Report Title:	Risk Management Policy	**Agenda Item:**	16.
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 Risk Management Policy has been updated as part of its 3 yearly review. A number of changes have been made which are summarised below, the key change being the inclusion of a revised Risk Appetite and Tolerance Statement.

Background

All policies are required to be reviewed at least on a 3 yearly basis. The Risk Management Policy was significantly overhauled in 2017, in order to strengthen the way in which risks were described and scored as well as improving the way in which assurances were articulated and overseen through the governance structure. Since this time, the Corporate Governance Department have worked with Divisions and Risk Owners to improve risk management within the organisation. The revised policy builds upon the work already undertaken, and looks to further strengthen risk management within the Trust, by introducing Risk Appetite and Tolerance along with greater oversight and scrutiny through Executive Governance Groups

Assessment

In April 2019, the Trust's Risk Appetite Statement was agreed. Since this time, target risk scores have been included on the Board Assurance Framework, and risk appetite has been included within the corporate training package. Aligned to this, the review of the Risk Management Policy has incorporated the Risk Appetite Statement and provides guidance in terms of how this is to be interpreted and utilised in day to day risk management activities.

The Risk Appetite Statement, has been considered alongside statements from other organisations and introduces the inclusion of a target risk score, which is based on the tolerance assigned to the Board's risk appetite.

Other changes which have been made the policy include:

- Addition of organisational responsibilities to include the Executive Assurance Groups
- Updated Risk Oversight Framework to include Executive Assurance Groups
- Inclusion of responsibilities regarding the review of risks and suggested frequency of reviews

Key Recommendations:

The Trust Board is asked to approve the revised Risk Management Policy, including the revised Risk Appetite Statement.

Policy Document

Reference: RM01

University Hospitals of North Midlands NHS Trust

Risk Management

Version:	**11**
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Policy Author:	**Associate Director of Corporate Governance**
Executive Lead:	**Chief Executive**

Version Control Schedule

Final Version	Issue Date	Comments
1	March 2004	
2	October 2005	
3	September 2008	Updated to complement risk management initiatives within the Trust and to promote integration of risk.
4	November 2009	Updated to reflect changes in the reporting of the Assurance Framework and to reflect the governance structure within the Trust.
5	March 2011	Revised to align with new Board and Sub-Committee structure and SLM and Directorate arrangements.
6	October 2012	Updated policy to reflect changes in NHSLA standards and G01
7	December 2014	Review of process and outcome following internal audit review undertaken in 2014.
8	April 2015	Update to flowchart to use risk assessment proforma
9	November 2015	Update to the policy following recommendations identified from the risk management review
10	March 2017	Complete rewrite of the policy.
11	January 2021	3 yearly review. Policy amended to clarify roles and responsibilities and to incorporate Risk Appetite and Tolerance.

Statement on Trust Policies

The latest version of 'Statement on Trust Policies' applies to this policy and can be accessed here

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1. INTRODUCTION

What is 'risk'?
Risk is defined as an uncertain event or set of events, which should it occur, will have an effect upon (i.e. threaten) the achievement of objectives. Risk consists of a combination of the likelihood of the 'threat' happening and the impact of that threat happening.

What is 'Risk Management'?
Risk Management is the term used to describe the activities required to identify, understand and control exposure to uncertain events which may threaten the achievement of objectives.

Why do we do it?
Risk Management is a key component of general management practice as it aims to ensure that:

- Achievement of objectives is more likely
- Adverse (damaging) events are less likely
- Costly re-work and 'fire-fighting' is reduced
- Capital and resources are utilised more efficiently and effectively
- Performance is improved (including quality, finance for example)
- Decision-making is much better informed
- Positive outcomes for stakeholders are increased
- Our reputation is protected and enhanced

2. POLICY STATEMENT

The Trust is committed to ensuring that the highest standards of service are provided and recognises the fundamental role that risk management has in enabling this.

3. SCOPE

This policy identifies the lines of accountability for management of risk throughout the organisation and is applicable to all staff. In addition, this policy should be read alongside the Trust's Accountability Framework, in terms of the accountabilities associated with risk management.

4. DEFINITIONS

There are a number of terms used when describing risk management. However, the following table sets out the key terms which are featured within this policy and are therefore applicable to our risk management process.

Key Term	Definition
Risk Management	Risk Management is the term used to describe the activities required to identify, understand and control exposure to uncertain events which may threaten the achievement of objectives.
Risk	Risk is described as the combination of: • Cause (If…(something happens)) • Event (Then…(this may occur)) • Effect (Resulting in….(the impact))
Control	Actions which are in place to assist in the mitigation of the risk and the achievement of an objective, by reducing the likelihood or impact. For example, a policy or training programme.
Assurance	Assurance is the evidence which describes how effective the controls are. For example, a report summary of incidents may tell us that we have very few patient falls, therefore

Key Term	Definition
	suggesting that our controls to prevent falls are working effectively.
Risk Appetite	Sets out the levels and types of risk we are prepared to accept, tolerate, or be exposed to at any point in time, in pursuance of our objectives.
Risk Tolerance	The amount (risk level/score) we are prepared to take to achieve our strategic and operational goals.
Risk Register	A record of all identified risks relating to a set of objectives, including their history, status and risk score. The purpose of a risk register is to evidence and drive risk management activities and it is used as a source or means of risk reporting.
Project / Programme Risks	Project and programme risks are managed in the same way as other risks in the Trust but there are slight differences in the approach. Risk registers or logs will still be maintained for risks to programmes or projects but these are held as part of the project documentation held within the Programme Management Office. However, this project documentation may be referred to as a source of control and/or assurance, within related risks held on the Risk Register.
Strategic Risks	These are reported via the Board Assurance Framework. These include strategic risks which concern the Trust's main purpose and could impact the achievement of key objectives (e.g. data loss, leadership capability as well as big external events/perils and how the Trust can become more resilient e.g. economic downturn, terrorist attack, extreme weather or cyber-attacks).
Cross-cutting Operational Risks	These are reported via the Corporate Risk Register. These include big cross-cutting internal risks over which the Trust has full or partial control and/or that can be managed through internal controls e.g. fraud, health and safety, capacity and capability and data security.
Directorate / Divisional Risks	These are reported via the Divisional Risk Register. These include local/delivery risks that could impact the achievement of directorate business plans.
Three Lines Model	This approach highlights the levels of assurance that has been obtained both internally and externally and is used when articulating the assurances within the Board Assurance Framework.

5. ROLES AND RESPONSIBILITIES

All staff have a responsibility for risk management and compliance with this policy, including awareness of the risks within their working environment, how their role impacts on those risks and taking reasonable steps to reduce the risk if possible.

The following provides an overview of those with specific responsibilities to ensure the implementation of this policy.

The **Chief Executive** has overall responsibility for risk management. As Accounting Officer, the Chief Executive has responsibility 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. Responsibilities in respect of risk management include:

- reviewing the strategic objectives of the organisation with the Board
- ensuring that the Trust has an effective structure and system in place to manage risks within the organisation
- ensuring that employees and the public are properly protected against exposure to risks arising out of or as a result of the Trust's activities
- signing the Annual Governance Statement in the annual report and accounts

Executive Directors are responsible for:

- ensuring delivery of the strategic objectives
- identification, control, monitoring and reporting of the risks which may threaten achievement of strategic objectives
- maintaining accurate and up to date risk registers, relevant to their objectives and report through the Board Assurance Framework
- providing oversight of operational risks which have been escalated to the Corporate Risk Register

The **Corporate Governance Department** is responsible for:

- development and review of the Risk Management Policy
- provision of education, support and expertise in relation to Risk Management
- provision of training on the Risk Management Policy
- monitoring and reporting compliance with the Risk Management Policy
- facilitating the reporting of appropriate risks to the Board, Committees and Executive Groups
- facilitating the provision of a Board Assurance Framework to the Board and Committees

The **Quality, Safety & Compliance Department** is responsible for:

- facilitating the reporting of appropriate risks to specialist corporate groups

Divisional Chairs, Associate Directors, Associate Chief Nurses (or equivalent for non-clinical divisions) and Clinical Governance Leads (medical) are jointly responsible for:

- leading and overseeing implementation of the Risk Management Policy at Divisional level which includes effective identification and ongoing review of, controls, monitoring and reporting of the risks which may threaten achievement of Divisional objectives
- facilitating the reporting and where necessary, escalation of appropriate risks to the Divisional Board and the Executive Groups

Clinical Directors and Directorate Managers (or equivalent for non-clinical divisions) are responsible for:

- leading and overseeing implementation of the Risk Management Policy at Directorate level which includes the effective identification and ongoing review of, control, monitoring and reporting of the risks which may threaten achievement of Directorate objectives
- facilitating the reporting and where necessary, escalation of appropriate risks to the Divisional Board from the Directorate
- maintaining accurate and up to date risk registers, relevant to their Directorate / service objectives

Divisional Governance & Quality Managers (or equivalent for non-clinical divisions) are responsible for:

- facilitating implementation of the Risk Management Policy at Divisional level which includes the effective identification and ongoing review of, control, monitoring and reporting of the risks which may threaten achievement of Divisional objectives, in accordance with the procedure set out within this policy
- monitoring and reporting compliance with the Risk Management Policy at a Divisional level, as identified by the Corporate Governance Department

'Risk Owners' including all Departmental / Ward / Service Managers are responsible for:

- identification and ongoing review of, control, monitoring and reporting of the risks which may threaten achievement of Directorate objectives, in accordance with the procedure set out within this policy
- maintaining accurate and up to date risk registers, relevant to Directorate objectives

Chairs of Specialist Corporate Groups (i.e. Safe Medications Group, Falls Steering Group etc.) are responsible for:

- identification, management and oversight of risks relevant to their specialist subject, ensuring appropriate action is taken

- reporting, where appropriate to the Executive Risk Oversight Group

Organisational Responsibilities

Assurance Mechanism	Responsibilities
Trust Board	The Trust Board is ultimately accountable for ensuring that the Trust has effective governance and risk management processes in place. The Board identifies the strategic risks that it considers are the key risks likely to impact on the delivery of the Trust's objectives and overall strategy. Board Committees have responsibility for monitoring the effectiveness of the controls and assurances in place to manage these risks.
Quality Governance Committee	The Committee shall consider the Trust's strategic risks of a clinical nature, particularly in relation to the strategic objectives of providing safe, effective, caring and responsive services and achieving NHS constitutional patient access standards. The relevant Executive Director responsible for managing each respective strategic risk shall be accountable at the Committee for responding to challenge and scrutiny of the Committee.
Performance & Finance Committee	The Committee shall consider the Trust's strategic risks of a non-clinical nature particularly in relation to the strategic objective of ensure efficient use of resources. The relevant Executive Director responsible for each strategic risk shall be accountable at the Committee for responding to challenge and scrutiny of the Committee.
Transformation & People Committee	The Committee shall consider the Trust's strategic risks of a non-clinical nature particularly in relation to the strategic objectives of achieving excellence in employment, education, development and research and lead strategic change within Staffordshire and beyond. The relevant Executive Director responsible for each strategic risk shall be accountable at the Committee for responding to challenge and scrutiny of the Committee.
Audit Committee	The Committee's primary role is to provide the Trust Board with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities.
Executive Quality & Safety Oversight Group	The Group will provide assurance to the Quality Governance Committee on the delivery of the Risk Management Strategy and operational management of risks. It is responsible for escalating to the Quality Governance Committee risks which link to key strategic risks on the Board Assurance Framework. The Group will consider key risks in relation to: • Patient Safety • Effectiveness • Service User and Carer Experience • Statutory Regulation and Requirements • National Guidance and Best Practice
Executive Health & Safety Group	The Group will provide assurance to the Quality Governance Committee on the delivery of the Risk Management Strategy and operational management of risks. It is responsible for escalating to the Quality Governance Committee risks which link to key strategic risks on the Board Assurance Framework. The Group will consider key risks in relation to: • Statutory Regulation and Requirements

Assurance Mechanism	Responsibilities
Executive Infrastructure Group	The Group will provide assurance to the Performance and Finance Committee on the delivery of the Risk Management Strategy and operational management of risks. It is responsible for escalating to the Performance and Finance Committee risks which link to key strategic risks on the Board Assurance Framework. The Group will consider key risks in relation to: • Estates infrastructure • Control of IM&T Assets • Business continuity • Value for money and sustainability • Contracting • Standing Financial Instructions (SFI's) and financial control • Fraud and negligent conduct
Executive Business Intelligence Group	The Group will provide assurance to the Performance and Finance Committee on the delivery of the Risk Management Strategy and operational management of risks. It is responsible for escalating to the Performance and Finance Committee risks which link to key strategic risks on the Board Assurance Framework. The Group will consider key risks in relation to: • Data quality
Executive Data Security & Protection Group	The Group will provide assurance to the Performance and Finance Committee on the delivery of the Risk Management Strategy and operational management of risks. It is responsible for escalating to the Performance and Finance Committee risks which link to key strategic risks on the Board Assurance Framework. The Group will consider key risks in relation to: • IM&T security • Data security
Executive Research & Innovation Group	The Group will provide assurance to the Transformation and People Committee on the delivery of the Risk Management Strategy and operational management of risks. It is responsible for escalating to the Transformation and People Committee risks which link to key strategic risks on the Board Assurance Framework. The Group will consider key risks in relation to: • Research • Innovation
Executive Workforce Assurance Group	The Group will provide assurance to the Transformation and People Committee on the delivery of the Risk Management Strategy and operational management of risks. It is responsible for escalating to the Transformation and People Committee risks which link to key strategic risks on the Board Assurance Framework. The Group will consider key risks in relation to: • Staff recruitment • Employment practice • Staff retention
Executive Strategy & Transformation Group	The Group will provide assurance to the Transformation and People Committee on the delivery of the Risk Management Strategy and operational management of risks. It is responsible for escalating to the Transformation and People Committee risks which link to key strategic

Assurance Mechanism	Responsibilities
	risks on the Board Assurance Framework. The Group will consider key risks in relation to: • Partnerships
Divisional Boards	Divisional Boards are responsible for reviewing and controlling the risks within their Divisions as part of the development of divisional and directorate risk registers and escalating risks to the relevant Executive Groups. Divisions are able to escalate risks to the Corporate Risk Register for additional oversight by an Executive Director.

6. EDUCATION/TRAINING AND PLAN OF IMPLEMENTATION

Type of Training	How to Access Training	Who Requires Training
Risk Assessment Template completion	• Step by Step Instructions included on the Risk Assessment Template (appendix 4) • Additional support is available from the Corporate Governance Department	Any staff member identifying a risk for inclusion on the Risk Register.
Risk Management Policy Training	1-1 Training available via the Corporate Governance Department Face to face sessions	• Associate Chief Nurses • Divisional Chairs • Clinical Directors • Clinical Governance Leads (medical) • Divisional Governance and Quality Managers • Matrons • Directorate Managers • Central Functions and Estates, Facilities & PFI risk register leads as determined by the Division
Datix Risk Register completion	Quality, Safety and Compliance Department	As listed above, or any staff member with delegated authority from the above to input risks directly onto the risk register.

Training records are held centrally within the Corporate Governance Department.

7. MONITORING AND REVIEW ARRANGEMENTS

7.1 Monitoring Arrangements

In addition to individual roles and responsibilities for monitoring risks:

Committee Assurance

- The Audit Committee is responsible for oversight of the Risk Management Policy and will receive quarterly reports in the form of the Board Assurance Framework.
- In addition, the Performance and Finance Committee. Quality Governance Committee and Transformation and People Committee, will consider quarterly Board Assurance Framework Reports

Audit

- The Corporate Governance Department will undertake audits of compliance against this policy, including data quality elements, which will be reported to Divisional Performance Reviews

- An annual audit of compliance will take place as part of the Internal Audit Programme and will be reported to the Audit Committee.

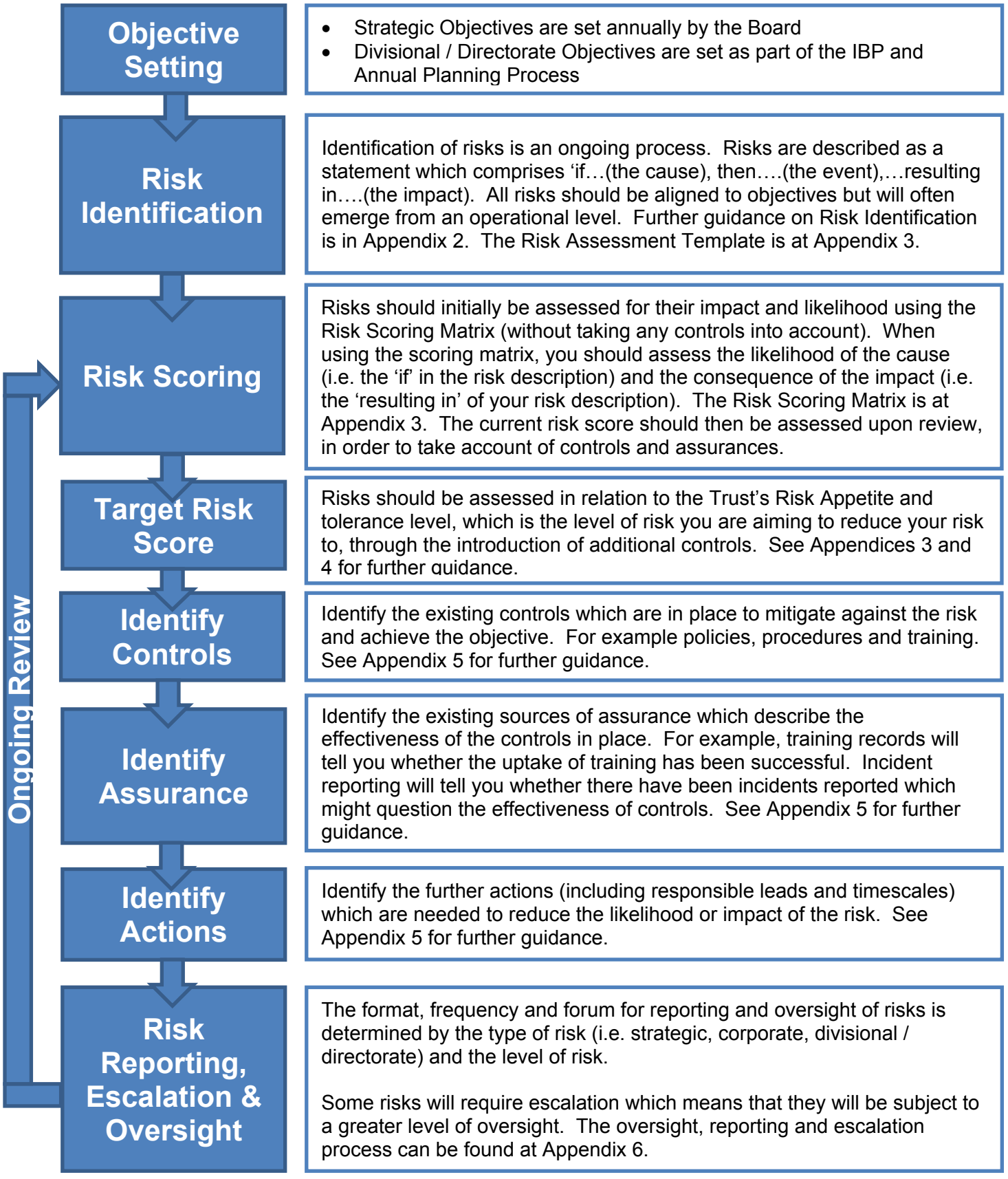
7.2 Review

This policy will be reviewed by the Corporate Governance Department at least every three years post ratification, unless it is deemed necessary to do so sooner.

8. REFERENCES

AmberWing Risk Management Training

Appendix 1 – Risk Management Process



Appendix 2 – Risk Identification

1. What is a risk and what is not a risk?

A risk is an **uncertain** event or set of events which, should it occur, will have an effect upon the achievement of objectives. Therefore:

Risk **is** 'uncertainty':	Risk **is not** 'certainty' which involves:
✓ an event that **might** happen	× an **incident**, which is an event which **has** happened an should be managed through RM07 Incident Reporting Policy. × an **issue** which **will** or **is** happening.

2. How is a risk described?

A risk should be described with three components, articulating the **'future risk'**:

If…..	**Then…..**	**Resulting in…..**
This part of the description should capture the **cause**. *There should only be **one** cause.*	This part of the description should focus on the **event** which will occur if the cause happens. *There should only be **one** event.*	This part of the description should describe the **effect** of the event. For example, this may be: • Impact upon strategic objectives • financial loss • reputational damage • quality / patient is compromised • operational disruption • legal / regulatory action
Example		
If there is a fire	**then** patients may not be evacuated safely	**resulting in** legal / regulatory action, compromised patient safety, service disruption and financial loss.

3. How risks should not be described

Failure of the Objective	Objective: To expand into more geographical territories Risk: Failure to expand into new territories
Questioning the Objective	Expanding into more geographical territories could place us in competition with other providers in those areas.
Composite Risks (i.e. using 'or')	Appropriate facilities may not be available **or** there may be resistance **or** we may not be able to recruit sufficient staff.
One-word risks	'Fraud', 'Fire', 'Reputation'
Statement of fact	There is a risk that projects may fail
Incident	Due to the computer system crashing
Issue	Because we don't have enough staff…. / when the new legislation is introduced…
Whinge	We've been told that a new computer system is being introduced, but nothing has been done to provide training to the staff
Essay	When the computer service centre was moved three years ago, various changes were made to working practices. Break times were extended, section leaders were appointed, cross training was provided as a back-up for absence. Now more changes are underway, so we are likely to have short term additional staffing costs. We are also spending more than planned on support for the new IT system, which may necessitate us to cut back in other areas, leading to an adverse impact on staff morale, lower

	service levels and damage to our reputation.

Appendix 3 – Risk Assessment Template

Risk assessments should be entered onto the Datix Risk Management Module. This includes identifying up to date controls and assurances, and identifying future actions.

A. RISK DESCRIPTION

Remember: risk is <u>uncertain.</u> There should only be one cause and one event but the risk may have multiple effects.

Cause: (the trigger leading to the event)	*If…..*
Event: (which might happen i.e. what are you worried about)	*Then…..*
Effect*:	*Resulting in……*

*when describing the 'effect', consider the following:

- Impact on the safety of patients, staff or public (physical / psychological harm)
- Impact on Quality / Complaints / Audit
- Impact on Human Resources / Organisational Development / Staffing / Competence
- Impact on Statutory Duty / Inspections
- Impact on Adverse Publicity / Reputation
- Impact on Business Objectives / Projects
- Impact on Finance including Claims
- Impact on Service / Business Interruption / Environment

B. LIKELIHOOD AND IMPACT ASSESSMENT

Step 1: To assess the likelihood of your risk, you must focus on the 'if…' section of your risk description.

Likelihood Descriptions		Likelihood Score	✓
Rare	This will probably never happen / recur.	**1**	
Unlikely	Do not expect it to happen / recur but it is possible it may do so.	**2**	
Possible	Might happen or recur occasionally.	**3**	
Likely	Will probably happen / recur but it is not a persisting issue.	**4**	
Almost Certain	Will undoubtedly happen / recur, possibly frequently.	**5**	

Step 2: To assess the impact of your risk, you must focus on the 'resulting in…' section of your risk description, using the Impact Score Matrix below

It is possible that your risk may have more than one impact, for example financial loss, service disruption and patient safety. You should use this table to impact score each of these categories separately and then select the one that has the **highest impact.**

Impact Domains	Risk Management Matrix - Impact Score and Examples of Descriptions				
	1	2	3	4	5
	Negligible	Minor	Moderate	Major	Catastrophic
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality / Equality / Complaints / Audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human Resources / Organisational Development / Staffing / Competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory Duty / Inspections / PFI Contracting	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse Publicity / Reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business Objectives / Projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including Claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service / Business Interruption / Environmental Impact	Loss/interruption of >1 hour Minimal or no impact on the environment No impact on other services	Loss/interruption of >8 hours Minor impact on environment Impact on other services within the Division	Loss/interruption of >1 day Moderate impact on environment Impact on services within other Divisions	Loss/interruption of >1 week Major impact on environment Impact on all Divisions	Permanent loss of service or facility Catastrophic impact on environment Impact on services external to the organisation
Information Security / Data Protection	Potential breach of confidentiality with less than 5 people affected Encrypted files	Serious potential breach of confidentiality with 6 – 20 people affected Unencrypted clinical records lost	Serious breach of confidentiality with 21 – 100 people affected Inadequately protected PCs, laptops and remote device	Serious breach of confidentiality with 101 – 1000 people affected Particularly sensitive details (i.e. sexual health)	Serious breach of confidentiality with over 1001 people affected Potential for ID theft

Step 3: To identify your initial risk score, you must take the result of your likelihood assessment and the result of your impact assessment and use the multiplication table below. This score is to be calculated before the introduction of any controls, and remains unchanged once calculated.

For example, if the likelihood score is '3' and the impact score is '4', when multiplied together, these you will give you a risk score of '12'.

		Impact Score				
		1	2	3	4	5
Likelihood Score	1	1	2	3	4	5
	2	2	4	6	8	10
	3	3	6	9	12	15
	4	4	8	12	16	20
	5	5	10	15	20	25

The numerical risk score will fall within a range as shown below, this will determine whether the risk is either, 'low, 'moderate', 'high' or 'extreme'.

Risk Score	
1 – 3	Low
4 – 6	Moderate
8 – 12	High
15 – 25	Extreme

Initial Risk Score (Likelihood x Impact)					
Likelihood:		Impact:		Score:	

C. EXISTING CONTROLS AND ASSURANCES

Step 4: Consider what existing controls and assurances are in place. Guidance on describing controls and assurances can be found at appendix 5.

Existing Controls (Controls should make a risk less likely to happen and/or reduce the impact if it does happen. Controls can also be a contingency to be enacted should the risk happen)	Existing Assurances (Assurances provide us with information or evidence about the effectiveness of our controls. An assurance description needs to state what the source of assurance is and more importantly what the assurance is telling you and if possible, the time period to which it relates)

Step 5: Identify your current risk score, taking into account existing controls and assurances and whether the controls have reduced the likelihood or impact of the risk.

Current Risk Score (Likelihood x Impact)					
Likelihood:		Impact:		Score:	

Step 6: To identify the target risk score, you must first identify the Trust's Risk Appetite, using the Risk Appetite Matrix (overleaf).

Consider the different sub-categories of risk and choose the most appropriate for your risk.

Depending on the tolerance assigned to that sub-category, consider the target likelihood and impact which would achieve a score within that range.

For example, if the risk score tolerance is between 4 and 6, the likelihood of the risk could be reduced to 2 and the impact to 3, achieving a score of 6. NB. It may not always be possible to reduce the impact of your risk therefore you should consider what actions could be taken to reduce the likelihood, before deciding on your target likelihood score.

Target Risk Score (Likelihood x Impact)					
Likelihood:		Impact:		Score:	

D. FURTHER ACTIONS

Step 7: Identify future actions which could be put in place to address any gaps in control or assurance, in order to reduce the likelihood and/or impact and reduce the risk score to the acceptable range.

Action	Person Responsible	Due Date

E. REVIEW

Step 8: Review your risk assessment, in order to close any actions, articulate new controls and up to date assurances. Recalculate the risk score, taking these into account. If the assurance is negative, or if the risk score has not yet been reduced to a 'tolerable' level, in line with the Trust's Risk Appetite, identify further actions. See Appendix 7 for further details.

Risk Appetite Matrix

If the organisation's collective appetite for risk is unknown, it may lead to erratic or inopportune risk taking, exposing the organisation to a risk it cannot tolerate.

Sub Category of Risk		Risk Appetite	Risk Score Tolerance
Impact on Quality	Patient Safety (e.g. patient harm, infection control, pressure sores, learning lessons)	Cautious	Mod 4 – Mod 6
	Effectiveness (e.g. outcomes, delays, cancellations or operational targets and performance)	Open	High 8 – High 12
	Service User and Carer Experience and the ability to manage quality (e.g. complaints, audit, surveys, clinical governance and internal systems)	Open	High 8 – High 12
Impact on Regulation & Compliance	Statutory Regulation and Requirements (e.g. Information Commissioner, Care Quality Commission, Health and Safety Executive, Professional Regulatory Bodies such as General Medical Council, Nursing & Midwifery Council, external certifications such as JAG and ISO).	Cautious	Mod 4 – Mod 6
	National Guidance and Best Practice (e.g. National Institute for Health and Care Excellence, GIRFT)	Open	High 8 – High 12
Impact on Reputation	Day to day activity (e.g. standards of conduct, ethics and professionalism and delivery of services)	Cautious	Mod 4 – Mod 6
	Risk as a result of protecting and improving the safety of patients	Seek	Ext 15 – Ext 25
Impact on Workforce	Staff recruitment (e.g. compliance with regulations such as visa requirements, Equal Opportunities and Diversity, that ensure staff are recruited fairly and competent to deliver services)	Cautious	Mod 4 – Mod 6
	Employment practice	Cautious	Mod 4 – Mod 6
	Staff retention (e.g. attractiveness of Trust as an employer of choice)	Open	High 8 – High 12
Impact on Infrastructure	Estates Infrastructure	Cautious	Mod 4 – Mod 6
	Security (e.g. access and permissions to systems and networks)	Cautious	Mod 4 – Mod 6
	Control of Assets (e.g. purchase, movement and disposal of ICT equipment)	Cautious	Mod 4 – Mod 6
	Business continuity (e.g. cyber-attack, maintenance of networks, alternative solutions)	Cautious	Mod 4 – Mod 6
	Data (e.g. integrity, availability, confidentiality and security, unintended release)	Cautious	Mod 4 – Mod 6
Impact on Finance & Efficiency	Value for money and sustainability (including cost saving)	Cautious	Mod 4 – Mod 6
	Standing Financial Instructions (SFI's) and financial control	Cautious	Mod 4 – Mod 6
	Fraud and negligent conduct	Minimal	Low 1 – Low 3
	Contracting	Seek	Ext 15 – Ext 25
Impact on Partnerships / Collaboration	Partnerships	Open	High 8 – High 12
Impact on Innovation	Innovation (e.g. new ways of working, new products, new and realigned services, new models of staffing and realignment of services, international recruitment, new ICT systems and improvements)	Seek	Ext 15 – Ext 25
	Financial Innovation (e.g. new ways of working, new products, new and realigned services)	Open	High 8 – High 12

Appendix 4 –Risk Appetite Statement

1. INTRODUCTION

The following Risk Appetite Statement makes clear the Trust Board's expectations in relation to the category of risks they expect management to identify and the level of such risk that is acceptable. If the organisation's collective appetite for risk is unknown, it may lead to erratic or inopportune risk taking, exposing the organisation to a risk it cannot tolerate.

The statement is based on the premise that the lower the risk appetite, the less the Board is willing to accept in terms of risk and consequently the higher levels of controls that must be put into place to manage the risk.

The higher the appetite for risk, the more the Board is willing to accept in terms of risk and consequently the Board will accept business as usual activity for established systems of internal control and will not necessarily seek to strengthen those controls. Risk appetite will therefore be set at one of the following levels:

LEVELS OF RISK APPETITE	
Avoid **Risk Score Tolerance 0**	We are not prepared to accept any risk.
Minimal **Risk Score Tolerance 1 – 3**	We accept that risks will not be able to be eliminated, therefore these should be reduced to the lowest levels, with ultra-safe delivery options, recognising that these may have little or no potential for reward/return.
Cautious **Risk Score Tolerance 4 – 6**	We are willing to accept some low levels of risk, while maintaining overall performance of safe delivery options, recognising that these may have restricted potential for reward/return.
Open **Risk Score Tolerance 8 – 12**	We are willing to accept all potential delivery options, recognising that these may provide an acceptable level of reward.
Seek **Risk Score Tolerance 15 - 25**	We are eager to be innovative, choosing options with the potential to offer higher business rewards.

2. CATEGORIES OF RISK

Risks at an operational level will be considered under the following categories:

- Quality – Safety, Effectiveness & Experience
- Regulation and Compliance
- Reputation
- Workforce
- Infrastructure (Estates & IM&T)
- Finance and Efficiency
- Partnerships/Collaboration
- Innovation

3. APPETITE FOR RISKS THAT MAY IMPACT UPON QUALITY

OUR STATEMENT ON QUALITY

Patient safety is our number one priority. While we aim to find a balance in our approach to achieve the best value for money in order to achieve financial sustainability for the future, we will not hesitate to spend money and apply resources to situations that present unacceptable risks to the safety of our patients.

We will protect patients from harm, giving them treatment that provides the best possible outcomes and make sure that they have a good experience of the treatment and care we provide. We have a moderate appetite to risks that may have an impact on any aspect of safety.

We will collect useful information on quality and share this information quickly with the people who are best placed to improve care. We will empower our staff to get things done and will be constantly vigilant in keeping quality standards high. We will take every opportunity to compare ourselves with other providers so that we continue to strive for excellence.

Sub Category of Risk	Risk Appetite	Risk Score Tolerance
Patient Safety (e.g. patient harm, infection control, pressure sores, learning lessons)	**Cautious**	**Mod 4 - Mod 6**
Effectiveness (e.g. outcomes, delays, cancellations or operational targets and performance)	**Open**	**High 8 – High 12**
Service User and Carer Experience and the ability to manage quality (e.g. complaints, audit, surveys, clinical governance and internal systems)	**Open**	**High 8 – High 12**

4. APPETITE FOR RISKS THAT MAY IMPACT UPON REGULATION AND COMPLIANCE

OUR STATEMENT ON REGULATION AND COMPLIANCE

We provide services within a highly regulated environment that must meet high levels of compliance expectations from a large number of regulatory sources. We will endeavour to meet those expectations within a framework of prudent controls, balancing the prospect of risk elimination against pragmatic operational imperatives.

Non-compliance with legal and statutory requirements undermines public and stakeholder confidence in the Trust, has the potential for harm and legal consequences and therefore the Trust has a moderate appetite in relation to those risks.

Sub Category of Risk	Risk Appetite	Risk Score Tolerance
Statutory Regulation and Requirements (e.g. Information Commissioner, Care Quality Commission, Health and Safety Executive, Professional Regulatory Bodies such as General Medical Council, Nursing & Midwifery Council, external certifications such as JAG and ISO).	**Cautious**	**Mod 4 – Mod 6**
National Guidance and Best Practice (e.g. National Institute for Health and Care Excellence, GIRFT)	**Open**	**High 8 – High 12**

5. APPETITE FOR RISKS THAT MAY IMPACT UPON REPUTATION

OUR STATEMENT ON REPUTATION

We accept that a level of reputational risk is inherent in all of our activities which include the effect of factors such as regulatory intervention; employee conduct, human resource practices, legal, licensing, policy decisions; fiscal responsibility and information security. Negative perceptions by patients, staff and other stakeholders may jeopardise our credibility and impede the achievement of delivering our strategic objectives.

We expect high standards of conduct, ethics and professionalism to be maintained at all times and we have a moderate appetite for risks that could cause reputational damage to the Trust or a loss in public confidence in our ability to deliver a quality service.

We will accept a significant level of risk to our reputation (where for instance we may spend above planned levels) in protecting and improving the safety of our patients, as this is the Board's highest priority.

Sub Category of Risk	Risk Appetite	Risk Score Tolerance
Day to day activity (e.g. standards of conduct, ethics and professionalism and delivery of services)	**Cautious**	**Mod 4 – Mod 6**
Risk as a result of protecting and improving the safety of patients	**Seek**	**Ext 15 – Ext 25**

6. APPETITE FOR RISKS THAT MAY IMPACT UPON WORKFORCE

OUR STATEMENT ON WORKFORCE

We believe that patient outcomes, safety and the quality of care we provide is influenced by the experiences and engagement of staff and the support they receive from colleagues and the Trust more widely. We will endeavour to ensure that the right numbers of properly qualified staff are in the right place at the right time.

As our greatest area of expenditure we expect that staff potential and performance is efficiently maximised while balancing this against opportunities for professional development, flexible working practices and the implementation of national agreements regarding terms and conditions. We have a moderate risk appetite for compliance risks relating to staff recruitment and the controls applied while in work.

We have high risk appetite to explore innovative solutions to future staffing requirements, our ability to retain staff and to ensure that the Trust remains as an employer of choice.

Sub Category of Risk	Risk Appetite	Risk Score Tolerance
Staff recruitment (e.g. compliance with regulations such as visa requirements, Equal Opportunities and Diversity, that ensure staff are recruited fairly and competent to deliver services)	**Cautious**	**Mod 4 - Mod 6**
Employment practice	**Cautious**	**Mod 4 - Mod 6**
Staff retention (e.g. attractiveness of Trust as an employer of choice)	**Open**	**High 8 – High 12**

7. APPETITE FOR RISKS THAT MAY IMPACT UPON INFRASTRUCTURE

OUR STATEMENT ON INFRASTRUCTURE

We are committed to providing patient care in a therapeutic environment and providing staff with an environment and supporting infrastructure in which to perform their duties. However, we have a moderate appetite for some risks related to our infrastructure and estate except where these adversely impact on patient safety, care quality and regulatory compliance.

Information Management and Technology (IM&T) plays an ever increasing role in supporting staff to deliver high quality services to patients. IM&T must support core Trust functions with sufficient capability, capacity, resilience and security from internal and external threats. The Trust relies on an increasingly mobile and technologically dependent workforce to carry out its core functions; we therefore expect that full business continuity plans are in place should services become unavailable.

We will collect personal and sensitive information to help us deliver services and improve their quality, ensuring that only those who have a legitimate purpose are given access to this data. We have a low risk appetite for IM&T risks relating to security, control of assets, business continuity and data.

Sub Category of Risk	Risk Appetite	Risk Score Tolerance
Estates infrastructure	**Cautious**	**Mod 4 – Mod 6**
Security (e.g. access and permissions to systems and networks)	**Cautious**	**Mod 4 – Mod 6**
Control of Assets (e.g. purchase, movement and disposal of ICT equipment)	**Cautious**	**Mod 4 – Mod 6**
Business continuity (e.g. cyber-attack, maintenance of networks, alternative solutions)	**Cautious**	**Mod 4 – Mod 6**
Data (e.g. integrity, availability, confidentiality and security, unintended release)	**Cautious**	**Mod 4 – Mod 6**

8. APPETITE FOR RISKS THAT MAY IMPACT UPON FINANCE AND EFFICIENCY

OUR STATEMENT ON FINANCE AND EFFICIENCY

To achieve the best value for money and to ensure our future financial sustainability we expect appropriate stewardship over our financial resources. This means that decisions regarding the pursuit of our strategic objectives must be balanced against the expectations of our regulators in meeting our financial plans and statutory duties.

We expect robust internal controls to be maintained which ensure compliance with applicable government and accounting standards. We will not tolerate risks that may lead to financial losses from fraud and negligent conduct as this represents a corporate failure to safeguard public resources.

Sub Category of Risk	Risk Appetite	Risk Score Tolerance
Value for money and sustainability (including cost saving)	**Cautious**	**Mod 4 – Mod 6**

Standing Financial Instructions (SFI's) and financial control	**Cautious**	**Mod 4 – Mod 6**
Fraud and negligent conduct	**Minimal**	**Low 1 – Low 3**
Contracting	**Seek**	**Ext 15 – Ext 25**

9. APPETITE FOR RISKS THAT MAY IMPACT UPON PARTNERSHIPS/COLLABORATION

OUR STATEMENT ON PARTNERSHIPS & COLLABORATION

We are committed to collaborating with our stakeholder organisations to bring value and opportunities across current and future services, through system-wide partnerships. We have a high risk appetite in developing partnerships with organisations who are responsible and have similar values, maintaining the required level of compliance with our statutory duties.

Sub Category of Risk	Risk Appetite	Risk Score Tolerance
Partnerships	**Open**	**High 8 – High 12**

10. APPETITE FOR RISKS THAT MAY IMPACT UPON INNOVATION

OUR STATEMENT ON INNOVATION

We have a significant appetite to pursue innovation in the delivery of services and challenge current working practices. The potential rewards in pursuing new solutions that may improve quality and provide business efficiencies must be balanced against the safety and wellbeing of our patients and staff.

We have a significant appetite to pursue innovation and challenge current working practices in support of the use of systems and technology developments, as well as new service design within the services it manages. We will therefore pursue options where innovation can provide higher rewards (despite greater inherent risks), but only where quality and compliance are not affected.

Although we cannot control or predict external factors that may affect our financial resources, we have a duty to protect cost saving through efficiencies and innovation. We are therefore willing to accept a high level of risk in pursuit of such activities but we expect prudent decisions to be made to mitigate the financial impact while providing optimal value for money.

Sub Category of Risk	Risk Appetite	Risk Score Tolerance
Innovation (e.g. new ways of working, new products, new and realigned services, new models of staffing and realignment of services, international recruitment, new ICT systems and improvements)	**Seek**	**Ext 15 – Ext 25**
Financial Innovation (e.g. new ways of working, new products, new and realigned services)	**Open**	**High 8 – High 12**

Appendix 5 – Identifying Controls, Assurances and Actions

1. Identifying Controls

Generally speaking the purpose of control is to constrain risk rather than to eliminate it. Control relates to any **action** taken to manage risk. These actions may be taken to manage the impact if the risk is realised, or to reduce the likelihood of the risk occurring. When you are identifying controls, these must already be in place. Any controls to further to constrain risk which are not in place should be addressed within your action plan. Once these additional actions are in place, they become a control.

Examples of controls can include:

- Policies and procedures
- People, for example, a person who may have a specific role in delivery of an objective
- Training programmes
- Processes / practices, for example, a specific process which ensures the delivery of an objective

2. Identifying Assurances

Assurances provide us with information or evidence about the effectiveness of our controls. Assurances can be from a range of sources and will include internal assurances (for example a clinical audit) and / or external assurance (for example a report from a regulatory body).

Assurances can be positive or negative, meaning that the assurance can indicate whether our controls are working well or whether we need to make further improvements.

For example:

- A report on training uptake statistics will tell us whether our training uptake is reaching those intended
- A report on adverse incident reports will tell us whether our policies, procedures and processes are working effectively and without incident
- An audit will tell us whether we are compliant with relevant requirements (which could be our local policies or a national mandate)

3. Describing Assurances

How to describe assurances:	How not to describe assurances:
An assurance description needs to state what the source of assurance is and more importantly what the assurance is telling you and if possible, the time period to which it relates. For example: • Incident report monitoring during Quarter 1 20/21 has confirmed that there have been very few adverse incidents of pressure ulcers.	An assurance description should not simply feature a list of documents, as this does not provide sufficient information on the effectiveness of your controls. For example: • Adverse incident reports • Minutes of meetings • Report to Patient Safety Forum

4. Identifying Actions

Once you have identified your controls and assurances, you will need to identify what further actions need to be taken to achieve your objective / reduce the risk if possible. These actions are sometimes referred to as risk control and usually fall under the following categories:

Types of Risk Control (the 4 'T's)	
Terminate	Eliminates the risk completely.
Transfer	Passes the risk to a third party, who bears or shares the impact.
Treat	**Containment:** Reduces the likelihood and / or the impact
	Contingent: Establishes a contingency to be enacted should the risk happen.
Tolerate	Accepts the risk if it has reached the target risk score, subject to monitoring.

When identifying actions, you must ensure that each action also has a designated person responsible for completing the action and a due date by which the action will be completed.

Appendix 6 – Risk Reporting, Oversight and Escalation

1. Risk Reporting

The majority of risks should be reported in the form of a Risk Register. A risk register is simply a record of all identified risks relating to a set of objectives, including their history and their status. For the purposes of the Board Assurance Framework, strategic risks will be reported in a standalone format and presented to Boards and Committees. Operational risks which are linked to any of the strategic risks will be taken from the Datix Risk Register.

A risk register is a tool designed to help managers achieve their objectives and to drive and provide evidence of risk management activities.

To ensure risk reporting is meaningful and effective, a Risk Register Report should include the following fields (all of which should be accurately completed within Datix).

ID	The unique identifier for your risk assessment, automatically generated by Datix.
Risk Owner	The person responsible for identification and management of the risk.
Primary Risk Subject	To identify the main category of risk i.e. Quality – Safety, Effectiveness & Experience, Regulation and Compliance, Reputation, Workforce, Infrastructure (Estates & IM&T), Finance and Efficiency, Partnerships/Collaboration, Innovation.
Strategic Objective	To identify which of the Trust's Strategic Objectives the risk will have an impact upon.
Title	The short title which describes the subject of the risk.
Risk Description	The risk description should include a risk description in line with the guidance set out within appendix 5. The risk description should include a composition of 'if…then…resulting in…'
Controls	To identify the actions being taken to manage the risk and achieve the objective (as set out within appendix 5).
Assurances	To describe the sources of assurance and what those assurances say in terms of the effectiveness of the actions taken (as set out within appendix 5).
Initial Risk Score	To confirm the risk score which was calculated when the risk assessment is first completed, without any controls/assurances in place. This remains unchanged once calculated.
Current Risk Score	To confirm the risk score which was calculated when reviewing the risk assessment taking into account controls and assurances. This is recalculated each time the risk assessment is reviewed.
Target Risk Score	To confirm the target risk score in line with the Trust's Risk Appetite Statement which should reflect the level of risk reduction required by introducing additional controls.
Actions	To identify the further action required.
Person Responsible	To identify who is responsible for carrying out the action.
Due Date	To identify when the action will be completed.
Completed Date	To confirm the date that the action has been completed.

2. Risk Oversight Framework

Risks are overseen at various levels throughout the organisation. The table below sets out the levels at which risks must be reported and overseen:

Level of Escalation / Oversight		Level / Types of Risk	Role and Purpose of Oversight	Style of Report
CORPORATE OVERSIGHT	**Board**	Risks identified against Strategic Objectives	• Scrutiny of the risks identified and holding responsible persons to account for the action being taken. • Assurance from the Audit Committee that the process is working effectively	Board Assurance Framework (BAF)
	Performance & Finance Committee / Quality Governance Committee / Transformation & People Committee	Risks identified against Strategic Objectives – relevant to their area of focus	Scrutiny of the risks identified and holding responsible persons to account for the action being taken.	Board Assurance Framework (BAF)
	Audit Committee	Risks identified against Strategic Objectives	Assurance from the Quality Governance Committee, Performance & Finance Committee and Transformation and People Committee that the process is working effectively	Board Assurance Framework (BAF)
	Performance Management Reviews	• Risks for escalation • Outcome of audit results	Holding responsible persons to account for the action being taken	Divisional Performance Management Review Presentation
	Executive Groups	All risks scoring 12 or above from Divisional or Corporate Risk Register	• Scrutiny, challenge of risks scoring 12 or above. • Referral to and assurance from key specialist corporate groups as appropriate. • Agreement of risks to be escalated to the Corporate risk Register	Risk Oversight Report (taken from Risk Registers)
	Specialist Corporate Groups	All 'corporate' risks relevant to their area of specialism.	Identification, management and oversight of risks relevant to their specialist subject, ensuring appropriate action is taken.	Corporate Risk Register
DIVISIONAL OVERSIGHT	**Divisional Boards**	All risks scoring 8 or above	• Challenge, review and monitoring of all risks scoring 8 or above. • Escalation of risks to Executive Groups.	Risk Register
	Divisional Governance Group	All risks	• Scrutiny, challenge, review and monitoring of all Divisional risks • Escalation of risks to Divisional Board	Risk Register
	Directorate / Operational Groups	All relevant risks	• Scrutiny, challenge, review and monitoring of all Directorate risks	Risk Register

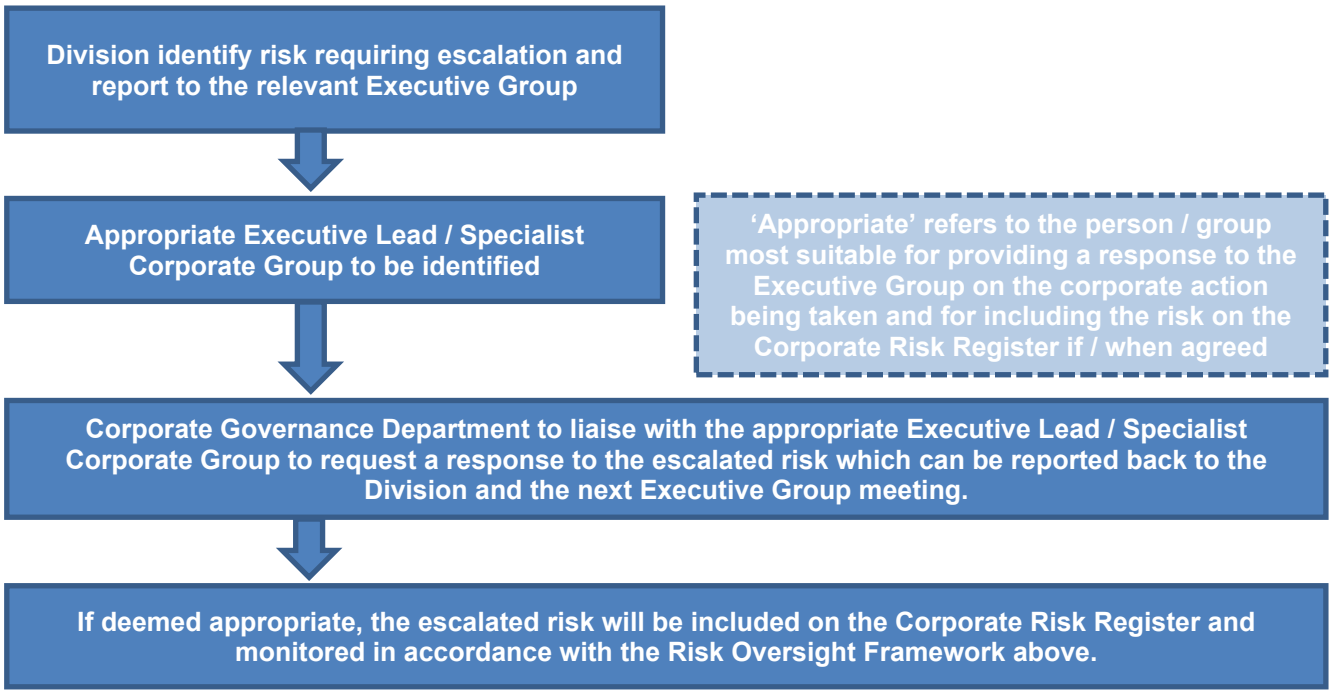
3. Risk Escalation to the Corporate Risk Register

Risk escalation to the Corporate Risk Register is where a risk is specifically drawn to the attention of an Executive Group for inclusion on the Corporate Risk Register.

Although the Executive Group will make a decision on those risks which will be included on the Corporate Risk Register, these will, in most circumstances be:

- Emergent risks which span across multiple divisions and are not already subject to corporate oversight
- Risks where the action required does not fall within the full control of the Division
- Risks which are overseen by the Specialist Corporate Groups due to their nature

4. Corporate Risk Register Escalation Process



Appendix 7 – Review of Risk

1. Risk Review

The Trust recognises that risk management should be embedded throughout the organisation. The review of risk should be an ongoing and iterative process which is part of day to day work. Risks should be reviewed by the Risk Owner, in order to:

- Enable key controls to be identified
- Identify whether the risk score is increasing, by articulating current assurance regarding the effectiveness of the controls
- Identify and implement actions for further mitigation
- Enable the opportunity to escalate risks
- Monitor implementation of actions and whether additional controls have had an impact on reducing the likelihood and/or impact
- Identify whether the actions taken have reduced the risk to a 'tolerable' level

2. Frequency of Reviews

Risks should be reviewed on a basis that is proportionate to the current risk rating. All risks should be reviewed by the Risk Owner and discussed at an appropriate governance meeting. Reviews should consider the risk description, current and target scores, identification of new controls, assurances and further actions. Updates should be made to the risk assessment on Datix in the respective fields.

NB. It is recognised that Progress Notes are utilised in some areas for providing updates on risks. It is imperative that information in relation to actions taken and current assurances are included within the controls, assurances and action planning fields. Progress Notes should therefore only be utilised to contain information not able to be provided within an existing field.

Risk Rating	Frequency of Review
Risks that have been closed but have a recurring theme	Annually
Risks scoring 3 or below	Six monthly
Risks scoring between 4 and 6	Quarterly
Risks scoring between 8 and 12	Bi-monthly
Risks scoring 15 or above	Monthly

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	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Notes
		8	6	10	8	5	16	7	4	9	6	3	10	
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. Considered in December.
Care Quality Commission Action Plan	Chief Nurse													
Bi Annual Nurse Staffing Assurance Report	Chief Nurse						→	→	→	→	→	→		Discussed at TAP in September 20, and agreed changes required prior to presentation to the Board.. Further report will not be complete until after the new year due to daily changes. Further update provided to TAP in November 20.
Quality Account	Chief Nurse													Timing moved due to changes in national requirements regarding submission
7 Day Services Board Assurance Report	Medical Director													Timing TBC due to national changes
NHS Resolution Maternity Incentive Scheme	Chief Nurse													Timing TBC due to national changes
Winter Plan	Chief Operating Officer													
PLACE Inspection Findings and Action Plan	Director of Estates, Facilities & PFI													Timing TBC due to national changes
Infection Prevention Board Assurance Framework	Chief Nurse					→								
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													Timing TBC due to national changes.
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													

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Notes
		8	6	10	8	5	16	7	4	9	6	3	10	
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 Jan: Schemes update circulated to Board members on 4th November 2020.
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													
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													Following discussion in August, number of next steps agreed, however given Covid restrictions, limited scope for Board Development sessions via MS Teams.