University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 5th May 2021 at 9.30 am to 12.45 pm via Microsoft Teams

AGENDA

Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
09:30	**PROCEDURAL ITEMS**					
20 mins	1.	Staff Story – CRIS Team	Information	Mrs T Bullock	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 7th April 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 – April 2021	Information	Mrs T Bullock	Enclosure	**BAF 6**
10:20	**PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES**					
5 mins	7.	Quality Governance Committee Assurance Report (23-04-21)	Assurance	Ms S Belfield	Enclosure	**BAF 1**
5 mins	8.	Maternity New Serious Incident Report Summary	Assurance	Mrs S Wallis	Enclosure	
10 mins	9.	IPC Board Assurance Framework	Assurance	Mrs M Rhodes	Enclosure	**BAF 1**
10:40	**ENSURE EFFICIENT USE OF RESOURCES**					
5 mins	10.	Performance & Finance Committee Assurance Report (20-04-21)	Assurance	Mr P Akid	Enclosure	**BAF 9**
10 mins	11.	IM&T Strategy Progress Report	Assurance	Mr M Bostock	Enclosure	
10:55 – 11:10 : BREAK						
11:10	**ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT AND RESEARCH**					
5 mins	12.	Transformation and People Committee Assurance Report (21-04-21)	Assurance	Prof G Crowe	Enclosure	**BAF 2 & 3**
10 mins	13.	Speaking Up Report – Quarter 4 and Annual Report 2020-21	Assurance	Mrs R Vaughan	Enclosure	
11:25	**ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS**					
40 mins	14.	Integrated Performance Report – Month 12	Assurance	Mrs M Rhodes Mr P Bytheway Mrs R Vaughan Mr M Oldham	Enclosure	
12:05	**GOVERNANCE**					
5 mins	15.	Audit Committee Assurance Report (22-04-21)	Assurance	Prof G Crowe	Enclosure	
10 mins	16.	Board Assurance Framework Q4	Approval	Miss C Rylands	Enclosure	
5 mins	17.	Committee Effectiveness and Revised Rules of Procedure	Approval	Miss C Rylands	Enclosure	
10 mins	18.	G6 and FT4 Self-Certification	Approval	Miss C Rylands	Enclosure	
12:35	**CLOSING MATTERS**					
10 mins	19.	Review of Meeting Effectiveness and Business Cycle Forward Look	Information	Mr D Wakefield	Enclosure	
	20.	Questions from the Public **Please submit questions in relation to the agenda, by 5.00 pm 3rd May to nicola.hassall@uhnm.nhs.uk**	Discussion	Mr D Wakefield	Verbal	
12:45	**DATE AND TIME OF NEXT MEETING**					
	21.	**Wednesday 9th June 2021, 9.30 am via Microsoft Teams**				

University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 7th April 2021, 9.30 am to 12.25 pm
Via Microsoft Teams

MINUTES OF MEETING

Attended	Apologies / Deputy Sent	Apologies

Voting Members:			A	M	J	J	J	A	O	N	D	J	F	M
Mr D Wakefield	DW	Chairman (Chair)												
Mr P Akid	PA	Non-Executive Director												
Ms S Belfield	SB	Non-Executive Director												
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	JT											
Dr J Oxtoby	JO	Medical Director												
Dr K Maddock	KM	Non-Executive Director												
Mrs M Rhodes	MR	Chief Nurse	SP											
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												
Mrs F Taylor	FT	NeXT Non-Executive Director												
Mrs L Whitehead	LW	Director of Estates, Facilities & PFI												

In Attendance:		
Mrs A Grocott	AG	Head of Patient Experience (item 1)
Mrs N Hassall	NH	Deputy Associate Director of Corporate Governance (minutes)
Miss H Poole	HP	Deputy Director of IM&T (representing Mr Bostock)
Mr S Purser	SP	Deputy Chief Nurse (representing Mrs Rhodes)
Mrs S Thompson	ST	Patient (item 1)
Mr J Tringham	JT	Operational Director of Finance (representing Mr Oldham)
Mrs S Wallis	SW	Head of Midwifery (items 8, 9, 10)

Members of Staff and Public via MS Teams: 4

No.	Agenda Item	Action
1.	**Patient Story**	
049/2021	Mrs Thompson recalled her experience whereby she had recovered from Covid, had been walking in some fields in the Peak District and had been knocked down by a bull. She explained that although an Air Ambulance arrived, the crew determined that her injuries were not life threatening therefore she was transported by ambulance to Royal Stoke. She described the seamless way in which she was treated by the trauma team whilst they were assessing her injuries and highlighted that she was subsequently admitted to a cardiothoracic ward.	

PROUD TO CARE

	She paid thanks to Mr Ghosh, Mr Thomas and the maxillofacial team and the way in which her treatment was explained. She explained that she had continued to suffer with mallet finger and there were some issues and delays in treating this, although she had received an apology for this and had since received physiotherapy which had improved her dexterity. Mrs Thompson welcomed the joined up way in which her treatment was planned and stated the only slight issue related to lack of involvement and follow up by her General Practitioner (GP). Mr Wakefield referred to Mrs Thompson's wait in the Emergency Department and the need for her x-rays to have a further review. He queried whether she felt this was a good or bad thing. Mrs Thompson stated that while she was surprised, as she thought she may have been discharged home, she welcomed the second review before a final decision was made, and welcomed that this had determined she required a hospital admission. Mr Akid queried if Mrs Thompson was concerned about coming into hospital given she had already recovered from Covid, and whether she was worried about further risk of infection. Mrs Thompson stated that she felt safe and welcomed the rules of separating patients and protecting patients and staff from infection. Dr Oxtoby stated that when managing trauma cases, attention to detail was key and he noted the second check of x-rays was a routine procedure. He also thanked Mrs Thompson for the positive comments made. He referred to her comments regarding GPs and agreed that further work was required to improve joined up working within the local health economy. Mr Wakefield thanked Mrs Thompson for the story and he apologised for the delay in treating mallet finger and welcomed the positive comments made in respect of the ambulance staff, trauma team and particular recognition of Mr Ghosh, Mr Thomas, Mr Bhoora and Mrs Karen Murray. **The Trust Board noted the patient story.** Mrs Grocott and Mrs Thompson left the meeting.	
2.	**Chair's Welcome, Apologies & Confirmation of Quoracy**	
050/2021	Mr Wakefield welcomed members of the Board and observers to the meeting and the above apologies were received. It was confirmed that the meeting was quorate. Mr Wakefield reflected that it had been a year since the first virtual Board meeting had been held, and stated that the Executive team were considering a roadmap to returning to physical meetings, whilst continuing to adhere to social distancing. Mr Wakefield welcomed the continued work being undertaken by staff, including the progress made in the vaccination programme.	
3.	**Declarations of Interest**	
051/2021	The standing declarations were noted.	

4.	**Minutes of the Previous Meeting held 10th March 2021**	
052/2021	The minutes of the meeting from 10th March 2021 were approved as an accurate record.	
5.	**Matters Arising from the Post Meeting Action Log**	
053/2021	There were no further updates to the action log.	
6.	**Chief Executive's Report – March 2021**	
054/2021	Mrs Bullock highlighted a number of areas from her report. In addition she highlighted that the planning guidance had been received for which a system response was being considered. Mr Wakefield referred to the receipt of the planning guidance and queried whether the Executive Team were aware of the various requirements and submission details. Mrs Bullock stated that additional technical guidance had been provided which was being worked through. Professor Crowe welcomed the news on progressing with the vaccination programme and the continued efforts to reach staff who had not yet received their vaccine. He referred to the award received for the Smart with your Heart app, and queried whether this could be scaled up or applied to other settings. Mrs Bullock stated that a business case was being developed in order to take forward a similar approach to other settings, which included work by the Community Rapid Intervention Service (CRIS), utilising sensors in patient homes and utilising technology more widely. Dr Oxtoby added that these discussions were in their infancy in terms of widening the utilisation of technology to other areas. Dr Griffin commented on the continued efforts to ensure staff wellbeing and echoed the thanks to staff for the continued initiatives being put in place to support staff. Mrs Bullock stated that wellbeing support would continue throughout the year, and further updates would be provided to the Transformation and People (TAP) Committee in due course. Mr Wakefield welcomed the decrease in the number of Covid inpatients and referred to the Astra Zeneca vaccine, and whether new starters still had the ability to have their vaccine. Mrs Bullock stated that the vaccine continued to be provided through alternative centres, and that staff would continue to be urged to receive their vaccine, by providing staff with information on the vaccine enabling them to make an informed choice. **The Trust Board noted the update and approved EREAF 7336.**	
PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES		
7.	**Quality Governance Committee Assurance Report (24-03-21)**	
055/2021	Professor Hassell highlighted the following from the report: • An issue had been identified in terms of BD giving sets, and the Committee were assured of the actions being taken to mitigate the risk, by undertaking risk assessments whilst using the sets, and training staff in the use of other giving sets	

	• An update was received in relation to the actions taken and investigation into the patient story which was reported to the Board in 2020. The Committee welcomed recommendations made following the investigation Mrs Taylor queried if there was any Trust-wide work ongoing with regards to caring for transgender patients. Mr Bytheway referred to his role as Chair of the LGBT+ staff network, and added that the network were preparing a number of podcasts for staff and patients, which included trans awareness. He referred to the policy which was in place and referred to some of the actions being taken. Mrs Vaughan also highlighted that trans awareness training was being undertaken. **The Trust Board received and noted the assurance report.**	
8.	**Midwifery Continuity of Care Action Plan**	
056/2021	Mrs Wallis joined the meeting. Mrs Wallis highlighted the following from her report: • A number of trajectories had been changed due to Covid although the first continuity of care team commenced in January • The national target was 35% of women to be booked onto a continuity of care pathway, although the majority of Trusts found this challenging • Actions had been taken to provide continuity of care for particular patient groups within existing staffing • In terms of the Black and Minority Ethnic (BAME) population, continuity of carer for antenatal services was prioritised and a number of positive actions had been taken • It was noted that the action plan had been approved and noted by the Quality Governance Committee (QGC). Ms Belfield referred to the target of 35% and queried how much additional staffing would be required to deliver the target. Mrs Wallis highlighted that a management of change would be required in order to deliver the care in a different way, due to particular changes to shift patterns. She stated that work was ongoing to engage with the staff to promote continuity of care and that she felt a 'hybrid' version would be provided in the interim. Dr Griffin referred to the target of 35% and the aspiration of 51%, and queried, given the challenges to achieve this by other Trusts, whether this was realistic. He queried whether the timescale for achievement was to be revised and queried next steps and immediate priorities to make progress. Mrs Wallis stated that representations had been made to request that the target was revised and highlighted that the Trust needed to be realistic in what could be provided. Mr Wakefield recognised the challenges and requested this to be discussed further by QGC, in terms of the specific actions to be taken and anticipated dates of delivery for the revised trajectories. In addition, he requested information to be provided on peer group comparisons. **The Trust Board received and noted the action plan.**	**SW**
9.	**Midwifery Workforce Review**	
057/2021	Mrs Wallis highlighted the following from her report:	

	• Birthrate+ recommendations suggested 1:25 midwife to birth ratio and the Trust's budgeted establishment was 1:26 • Recruitment had been undertaken into specialist roles • The impact of the temporary suspension of the Freestanding Midwifery Birthing Unit (FMBU) had had a positive impact on increasing available senior midwifery staff • Staffing for wards in December highlighted that there were times when there were fewer staff, due to Covid, self-isolation and sickness • Work was ongoing to review staffing levels and the acuity of patients Mr Wakefield referred to the CNST standards and queried if the Trust was confident that these were being met. Mrs Wallis stated that she was confident that the Trust was achieving the standards and stated that she was not aware of any issues of non-compliance. Ms Belfield queried whether the analysis of staffing levels could be considered further at QGC and queried the demographics of current midwives. Mrs Wallis referred to previous discussions at QGC, in particular the diversity of midwives which was being addressed by positively advertising roles to the BAME community. Professor Hassell queried whether the training needs were to be revised as a result of the review, and whether this would impact on staffing numbers. Mrs Wallis confirmed that this was being reviewed in light of the Ockenden review and that there would be an uplift as required. It was agreed to discuss the report further at TAP and QGC in order to understand any implications of CNST and workforce numbers. **The Trust Board received and noted the paper which would presented for further discussion and consideration at the Transformation and People Committee and Quality Governance Committee.**	
10.	**Maternity New Serious Incident Report Summary Q4 2021**	
058/2021	Mrs Wallis referred to the report which was being provided to the Board in light of the recommendations from the Ockenden review, and highlighted the following: • Details of incidents reported in the last quarter had been provided • The report was to be amended going forwards in terms of the detail provided and making the content easier for the reader to understand • 10 incidents had been reported, 2 of which were retrospective, given the decision that all HSIB reportable incidents would be reported as a Serious Incident, and downgraded if required • It was noted that of the cases reported, all would be investigated in order to assess any lapses in care Mr Wakefield welcomed the report and stated that future reports needed to include the outcomes for the babies and mothers. In addition, he requested that the actions taken were made clearer within the report. Mr Wakefield queried how the Trust benchmarked against peers in terms of number of Serious Incidents and Mrs Wallis explained that the Trust had some of the lowest reported numbers to HSIB. She stated that as a result of the of Ockenden review, the region were to produce a dashboard which would provide a regional comparison going forwards as well as identifying opportunities to share	**SW**

	learning. **The Trust Board received and noted the update.** Mrs Wallis left the meeting.	
11.	**Infection Prevention and Control Board Assurance Framework (BAF)**	
059/2021	Dr Oxtoby highlighted the following: • Work remained ongoing in terms of monitoring mask fit testing • In terms of the key domains, there had been a sequential improvement in many areas, reflecting the work being undertaken • The highest risk area related to the optimisation of antibiotic use which continued to be a challenge in terms of improvement and utilising microbiology Mr Wakefield referred to four of the areas which had reduced, and stated that it was not clear of the rationale behind reducing the risk score, which would be helpful. Dr Oxtoby stated that the reduction in risk reflected the ongoing improvements in different areas but agreed this could be strengthened going forwards. Dr Maddock referred to the risk in relation to antibiotic usage and queried whether there were any particular areas of non-compliance or whether the issue was Trust-wide. Dr Oxtoby stated that there were some areas which were less compliant than others and there was challenge of individual use as well as providing ongoing education. He added that this was a challenge prior to Covid. Dr Maddock queried whether there was enough capacity within the microbiology team for them to assist clinicians in decision making, and Dr Oxtoby explained that the team were under establishment and that recruitment to such posts was a national issue. Professor Hassell referred to the non-compliance which were identified following the NHSI visit, and queried whether these had been addressed. Dr Oxtoby stated that actions had been taken to address the issues raised and Mrs Whitehead added that in respect of defects in the flooring, actions had been taken, and she agreed to discuss the issue of cleaning mobile computers and equipment with Mrs Rhodes, to ensure this had been addressed. Mr Wakefield referred to the statement regarding reinstating screening for MRSA and queried current levels of screening and the progress made. Dr Oxtoby stated that this was being reinstated and agreed that levels of screening should be identified in order to provide further assurance. Mr Wakefield welcomed the overall improvements made, but requested a further update to the meeting in May to provide further information on the actions which have been closed and implemented. **The Trust Board received and noted the document, and noted the ongoing work to strengthen the assurance framework going forwards, building upon the recommendations made by the Internal Auditors.**	**LW** **MR**
ENSURE EFFICIENT USE OF RESOURCES		
12.	**Performance & Finance Committee Assurance Report (23-03-21)**	

060/2021	Dr Griffin highlighted the following from the report: • The Committee considered the transition from managing Covid to full service recovery with some challenges noted and the approaches were outlined in terms of restoring urgent and elective activity • A positive presentation was provided by the Medical Division in terms of urgent care performance • The Committee welcomed the continued positive financial performance and anticipated year end projections • Assurance was provided in terms of catching up with the slippage on the capital programme • Some concerns had been expressed in terms of the timeliness of business case evaluations as there had been some slippage and the Committee agreed noted that the Executive were to determine timings for future evaluations **The Trust Board received and noted the assurance report.**	
ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT AND RESEARCH		
13.	**Transformation and People Committee Assurance Report (25-03-21)**	
061/2021	Professor Crowe highlighted the following: • No escalations were made in respect of the usual items of business • The majority of the meeting focussed on Delivering Exceptional Care programme and assurance was provided in terms of the progress made, the appointments made to the team and the approach being taken **The Trust Board received and noted the assurance report.**	
14.	**2020 NHS Annual Staff Survey**	
062/2021	Mrs Vaughan highlighted the following: • A number of questions had been included reflecting working during the pandemic • The Trust response rate was 44% and actions would continue to be taken to increase this for future surveys • There had been two statistically significant improvements in terms of health and wellbeing and a safe environment • There had been a continued improvement in terms of reporting near misses, errors and incidents and actions being taken as a result of reporting • There had been an improvement in two questions in relation to friends and family; in terms of recommending the Trust as a place to work and recommending the organisation as a place to receive care • One of the main challenges related to team working which could be due to the number of staff moves and changes to working as a result of the pandemic • Further work would be undertaken to improve staff morale, as well as improving management and leadership visibility and supporting managers in terms of their leadership and improving together to deliver exceptional care • More regular morale checks were to be undertaken in line with national requirements Mr Wakefield welcomed some of the improvements made, whilst recognizing the frustrations in lack of improvement in other areas, given the actions taken. Professor Crowe endorsed the actions outlined and referred to the discussion at	

	TAP in terms of some of the gaps and lower ratings in relation to line manager support which would be built upon as part of the cultural and leadership programme. Mr Akid referred to scores in relation to staff experiencing physical violence and given that the Trust did not have as many visitors / relatives due to the pandemic, whether this was expected. He also expressed his disappointment in terms of violence between staff and queried the actions taken to address. Mrs Vaughan stated that there had been an increase in incidents of violence in Covid areas which was in part due to the nature of the patients being treated and their conditions. She stated that there was zero tolerance in terms of violence and aggression and the Trust continued to work with teams to tackle this. **The Trust Board noted the progress made to date and approved the corporate priorities planned for 2021/22, aimed at continuing the improvements in organisational culture and maximising the potential of our people to improve patient outcomes.**	
ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS		
15.	**Integrated Performance Report – Month 11**	
063/2021	Dr Oxtoby highlighted the following: • There had been a decrease in nosocomial infections given the decrease in Covid patients in the hospital and reduction in admissions • There had been a slight increase in reporting of incidents but incidents of significant harm had not increased • Work was ongoing in terms of reducing patient falls • Work was ongoing in terms of sepsis screening and early provision of antibiotics and it was hoped this would improve once Covid numbers had reduced • Duty of candour compliance had improved but not all letters were being sent out within 10 days which needed to improve going forwards Mr Wakefield referred to sepsis screening and compliance and stated that assurance was required in terms of the actions being taken screen patients and provide them with the necessary antibiotics. Dr Oxtoby agreed that this area needed improvement and this was an area of focus and support. Mr Wakefield referred to comment regarding the number of NRLS reported events which were better than the national average which was a positive improvement. Professor Crowe referred to nosocomial infections and queried the actions taken to review nosocomial deaths. Dr Oxtoby referred to modified Structured Judgement Review process which had been put in place to review the deaths and added that national guidance was being adhered to, in terms of determining which cases required review. Dr Oxtoby stated that outcomes of the reviews would be provided to QGC in due course and noted that broadly, rates of nosocomial infections were consistent and lower than the national average, as a percentage of infections. Mr Bytheway highlighted the following in terms of urgent care performance: • During February there had been continued challenges in terms of the acuity of patients and the high number of Covid patients and patients in critical care • A number of key workstreams had been identified in terms of improving	

urgent care performance
- The number of attendances had risen, but time to treat and time to triage had improved with a number of small changes which had made a cumulative improvement in performance
- More recently, there had been a significant increase in attendances therefore this was a challenge in terms of keeping pace and seeing patients in a timely manner
- Bed occupancy remained static but there had been a continued improvement in the number of discharges taking place before 12 noon

Professor Hassell congratulated the team on the presentation of the data and the improvement in performance. Mr Bytheway stated that the main challenge was for teams to remain positive and this was being facilitated by continuing to engage with teams as well as communicating the improvements throughout the organisation.

Dr Griffin welcomed the improvements made in terms of the reduction in medically fit for discharge patients and the number of discharges made before noon. He recognised the challenges associated with the increase in attendances and subsequent impact on performance.

Mr Bytheway highlighted the following in relation to cancer performance:
- 5 cancer standards had been achieved in February
- A cancer safety assurance report had been commissioned, which was to be provided to the Performance and Finance Committee, although overall, it was felt that the right decisions were being made and clinicians were supportive of the actions taken
- Operating capacity had increased and there has been reduction in the number of 104 day patients and the overall cancer backlog due to theatres and endoscopy services coming back online
- The patient tracking list had remained relatively static, with 3500 patients, and trajectories were in the process of being reset

Mr Wakefield referred to patients who had breached their timescales for treatment and queried if they had been kept updated. Mr Bytheway stated that a designated a team had been put in place to keep in regular contact with patients and clinicians reviewed the patient lists to identify whether any patients needed to be seen sooner.

Mr Bytheway added that in terms of planned care, over 90% of business as usual was being completed, with the main challenge related to increasing non face to face activity to 30% of the total outpatient volume, which was being monitored by the outpatient transformation group. He stated that efforts were being focussed on reducing the length of time patients were waiting.

Mr Wakefield queried how the Trust aimed to treat patients waiting over 52 weeks and Mr Bytheway stated that treatment of these patients was implied within the national guidance and a broad view was to be provided in terms of anticipated capacity to do so.

Mrs Vaughan highlighted the following in relation to workforce performance:
- In terms of statutory and mandatory training, performance was 93.76% which had remained static
- In terms of appraisal rates, there had previously been a decrease in compliance, although some improvements had started to be made
- The Trust was continuing to promote wellbeing conversations and a number

	of managers had been trained in the RESPOND model • In terms of sickness absence, there had been a reduction to 4.70% in month 11, and more recently there had been a further improvement, given the return of staff who had previously been shielding Mr Wakefield welcomed the reduction in sickness absence and referred to appraisal rates and the temporary suspension of appraisals given the pressures on staff. Mrs Vaughan stated that the appraisal process was to be streamlined to aid future conversations and stated that she expected appraisal rates to have improved by the beginning of quarter 2. Mrs Vaughan agreed to provide additional information in terms of the RESPOND training to Professor Crowe outside of the meeting. Mr Tringham highlighted the following in relation to financial performance: • The Trust delivered an actual surplus of £4.4 m in month 11 which was better than planned • There was a year to date surplus of £8.4 m • The Trust continued to forecast a breakeven position although expected income for the Flowers case and increase in the annual leave provision would result in a surplus being recorded in the accounts • In terms of capital the Trust was £5.1m behind plan for month 11 although the Linac and IR2 replacement equipment arrived before 31st March which was positive • In terms of the cash position, the Trust had £110 m of cash at the end of month 11 and ended the year with a cash balance of £55 m Mr Wakefield requested clarification that the auditors were happy with the numbers and Mr Tringham stated that the auditors are in the process of undertaking their review and no issues had been identified to date. Mr Tringham referred to the planning guidance which had been received for 2021/22 and was being considered. He stated that the block arrangements would continue for the first 6 months of the year although the arrangements after that time were unclear. Mr Wakefield welcomed the work undertaken to achieve such positive performance and paid thanks to the finance team for a clear year end, as well as the efforts taken to manage and deliver such a large capital programme during 2020/21. **The Trust Board received and noted the performance report.**	RV
CLOSING MATTERS		
16.	**Review of Meeting Effectiveness and Business Cycle Forward Look**	
064/2021	No further questions were raised.	
17.	**Questions from the Public**	
065/2021	There were no questions raised in advance of the meeting.	
DATE AND TIME OF NEXT MEETING		
18.	Wednesday 5th May 2021, 9.30 am, via MS Teams	

Trust Board (Open)

Post meeting action log as at **28 April 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/457	03/02/2021	Chief Executive's Update	To invite representatives from the Community Rapid Intervention Service (CRIS) to a future meeting, to provide a staff story.	Tracy Bullock	05/05/2021	28/04/2021	Invited to May's meeting.	B
PTB/464	10/03/2021	Integrated Performance Report - M10	To outline the benefits accrued from the capital investments made during 2020/21 and highlight this within the annual report.	Lorraine Whitehead Nicola Hassall	30/04/2021	26/04/2021	Information provided for inclusion in the annual report.	B
PTB/465	07/04/2021	Midwifery Continuity of Carer Action Plan	To discuss the document further at QGC, in terms of the specific actions to be taken and anticipated dates of delivery for the revised trajectories. In addition, to provide information on peer group comparisons.	Sharon Wallis	26/05/2021		Action not yet due.	GB
PTB/466	07/04/2021	Maternity New Serious Incident Report Summary Q4 2021	To amend the report going forwards in terms of the detail provided and making the content easier for the reader to understand	Sharon Wallis	05/05/2021	05/05/2021	Complete - document updated and definitions included.	B
PTB/467	07/04/2021	Infection Prevention and Control Board Assurance Framework (BAF)	To confirm whether actions had been taken to address the issues raised by NHSI in terms of cleaning mobile computers and equipment	Lorraine Whitehead Michelle Rhodes	05/05/2021		Issue raised with IM&T and nursing team. Further actions identified and reflected within the BAF.	GB
PTB/468	07/04/2021	Infection Prevention and Control Board Assurance Framework (BAF)	To clarify in the next report, which actions had been closed and implemented.	Michelle Rhodes	05/05/2021	28/04/2021	Complete - updated report provided.	B
PTB/469	07/04/2021	Integrated Performance Report - M11	To provide additional information in terms of the RESPOND training to Professor Crowe outside of the meeting.	Ro Vaughan	05/05/2021	08/04/2021	Complete - provided by email.	B

Chief Executive's Report to the Trust Board

FOR INFORMATION

Part 1: Trust Executive Committee

The Trust Executive Committee met on 28th April 2021. The meeting was held virtually using Microsoft Teams; there was no agenda or papers as the general purpose of the meeting was to provide an opportunity to discuss current issues, key priorities and to hear from Divisions in terms of areas of focus / challenges:

Key highlights from the Executive Team were as follows:

- Preparations now underway for the **Care Quality Commission** Inspection
- An **outbreak** involving two patients has occurred which is currently under investigation
- The ongoing **crisis in India** and agreement amongst the Executive Team to help wherever possible
- **Restoration and Recovery** of services
- **Staff Wellbeing** remains a high priority, including those suffering the effects of Long Covid
- **Leadership Programme** is now back up and running using a hybrid model of virtual and face to face sessions
- **Project STAR** and demolition of the Royal Infirmary Site continues at pace; discussions are ongoing with regional regulators around the potential to secure funding for a new multi-story car park
- Celebrations to celebrate the legacy of Captain Tom Moore which involves the '**100 challenge'** to raise funds for the hospital
- Negotiations have been made with the film crew for **999 Critical Condition** with filming planned for early autumn
- Work continues on the development of clinical service strategies which will be consolidated into a **Trust Clinical Services Strategy**
- **Children's Hospital Strategy** has been considered by the Children's Hospital Board and will be brought to the Trust Executive Committee for consultation
- **Executive Recruitment** with appointments being made to the Director of Digital Transformation and the Chief Nurse
- Recruitment to **Non-Executive Director and Associate Non-Executive Director** process well underway
- **Improving Together** programme now underway with the Quality Improvement Academy Team meeting teams across the organisation as part of the roll out

Part 2: Chief Executive's Highlight Report

1. Contract Awards and Approvals

Department of Health Procurement Transparency Guidance states that contract awards over £25,000 should be published in order that they are accessible to the public. Since 12th March to 11th April, 2 contract awards, which met this criteria, were made, as follows:

- **Endoscopy Consumables (REAF 7336)** supplied by various at a total cost of £2,376,000.00, for the period 01/05/21 - 30/04/23, providing savings of £27,153.00, approved on 12/03/21
- **Blood Sciences Siemens Managed Service Contract - Year 9 (REAF 5162)** supplied by E Siemens Healthineers UK at a total cost of £4,055,212.40, for the period 01/10/21 - 30/09/21, approved on 11/03/21

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

Elective Hip and Knee - (eREAF 7575)

Contract Value £6,419,008.64
Duration 01/04/21 - 31/03/25
Supplier Smith & Nephew

Savings – £501,458.35

Extension of LIMS contract to Shrewsbury and Telford Hospital (SaTH) – (eREAF 7502)

Contract Value £3,088,201.00
Duration 01/12/19 - 30/11/29
Supplier Clinisys

Savings – £855,350.00 cost avoidance

National Blood Service – (eREAF 7474)

Contract Value £3,450,000.00
Duration 01/04/21 – 31/03/22
Supplier NHS Blood and Transplant Service

Savings – No Savings

Digital Pathology Sectra MSC – (eREAF 7255)

Contract Value £3,388,707.00
Duration 01/04/21 – 31/03/26
Supplier Sectra

Savings – No Savings, however, there will be negated inflation savings from year 2 and VAT will be reclaimed.

High Cost Tariff Devices (HCTED) Zero cost model to Visible cost model – (eREAF 7576)

Contract Value £14,490,291.08
Duration 01/04/21 – 31/03/22
Supplier NHS Supply Chain

Savings – No Savings. Noting that the HCTED pricing is set nationally by NHSE and therefore UHNM simply order the items via NHSSC at the nationally set pricing and have no other involvement in terms of pricing negotiations.

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 April 2021:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Consultant in Emergency Medicine	Vacancy	Yes	August 2021
Clinical Director Neurosciences	Vacancy	TBC	TBC

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

Post Title	Reason for advertising	Start Date
Locum Consultant Spinal Surgeon	Extension	01/04/2021
Locum Consultant Spinal Surgeon	Extension	01/04/2021
Locum Consultant Foot and Ankle Surgeon	Extension	01/04/2021
Consultant in Emergency Medicine	Vacancy	01/04/2021
Midlands ISDN Co-Clinical Lead (Acute)	New	01/04/2021
Locum Consultant Urology	Vacancy	05/04/2021
Consultant Vascular Interventional Radiologist with Thrombectomy	Vacancy	06/04/2021
Locum Consultant Gynaecologist with special interest in Gynae Oncology	Vacancy	06/04/2021
Consultant in Gynaecology Oncology	Extension	13/04/2021
Locum Consultant Orthopaedic surgeon	Extension	13/04/2021
Locum Vascular Surgeon	Vacancy	19/04/2021
Locum Consultant Orthopaedic Surgeon specialising in Fragility Fractures	Extension	20/04/2021

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

Post Title	Closing Date	Note
Consultant in Paediatric Gastroenterology and General Paediatrics	05/04/2021	No applications
Locum Consultant Paediatrician with an interest in Gastroenterology	05/04/2021	No applications
Consultant in Acute Medicine	11/04/2021	No applications

3. Covid 19

We are continuing to see the number of patients with Covid-19 needing hospital care reducing and as a result we have now stood down both our Covid-19 tactical and Gold Command response meetings. I want to personally thank everyone involved for their extraordinary efforts during the pandemic. These meetings involved representatives from every divisional team, infection prevention and control, as well as corporate teams, it took a mammoth joint effort to steer us safely through what were unprecedented times. Special thanks to go to the Emergency Preparedness, Resilience and Response Team (EPRR) for providing seven day a week support and guidance.

Although the Covid-19 numbers remain low at present, the Trust and system remain vigilant as the national lock down restrictions ease. The outbreak mentioned above at the last TEC meeting is a good indicator that the NHS is not yet in a position to completely relax its guard

4. Visiting

The Easter Bank Holiday weekend marked changes to visiting for relatives and loved ones at UHNM. Throughout the pandemic our teams have taken a pragmatic approach and where it was safe and possible many of our teams have enabled close members of a family to meet with their loved ones during this very difficult time. On Saturday 3 April we started the process of carefully reintroducing visiting at UHNM in all areas in a Covid-secure way. This is based on a number of key principles:

- Local arrangements for visiting should be clearly communicated with patients and their families and appropriate PPE provided,
- If visiting is taking place in a clinical area, all visitors need to wear the appropriate PPE for that area (surgical masks and eye protection) at all times
- Visiting should be limited to one close family contact for the duration of their hospital admission and NHS trusts are advised to keep a list of hospital visitors' names and contact details for Test and Trace purposes
- Limiting the time of each visit e.g. One Hour max to ensure equity of visiting particularly for patients in bays where the number of visitors at any one time will need to be monitored closely
- Visitors to UHNM will not be required to undertake lateral flow testing or be required to self-isolate after visiting

We know that allowing visiting will have a positive impact on our patients and we are committed to doing this safely. We will continue to put patient and staff safety first, and this calls for professional judgement and flexibility allowing senior sisters/charge nurses to use their discretion as required.

5. Welcoming New and Old Staff to UHNM

We have also been able to say a big welcome back to those members of the UHNM family who have been shielding but are now able to come back into our hospitals to work. We know that some staff are not yet able to return but we are focused on making it safe for everyone to be onsite when they need to.

In addition to welcoming back shielding staff, we are getting closer to welcoming 45 overseas nurses to the UHNM family. We were hoping they would be with us in April, but with the new national guidance and restrictions about movement and crossing borders we are now expecting the first of the overseas nurses to join us in early May although we recognise this may be flexible under the current climate. This is really exciting and we are looking forward to giving a big UHNM welcome when they arrive.

6. Thanking Staff on PICU

Continuing the thank you message, Helen Ashley, Director of Strategy and Performance, took time out to visit the children's team on the paediatric intensive care unit (PICU) at Royal Stoke and presented them with the team of the month award for their role in the pandemic which saw them caring for adult patients. The team opened their doors to adult intensive care patients not once but twice. It is not an easy task to transform an area which has been designed for children and for children's nurses to adapt their skills for adults. Like so many UHNM staff they embraced the changes they had to make to care for patients during the pandemic.

7. Care Quality Commission Inspection

As our situation improves and the pressures of Covid-19 ease, we look forward to welcoming an inspection team from the Care Quality Commission (CQC) in the very near future. This presents us all with an opportunity to shout about the amazing work which happens every day at UHNM. We know that the CQC inspection regime has again changed however, we continue with our preparation to allow us to demonstrate we are delivering the best possible care to our patients.

8. Improving Together Programme

After initial delays due to Covid-19, I am delighted to announce that during the month we launched our 'Improving Together' quality improvement programme. Improving Together will ensure that we are all focusing on the same key priorities and regardless of department or role, our staff will be equipped to drive change for the benefit of our patients. We have recruited an incredible team, the Quality Improvement Academy (QIA), from our existing internal talent who will be supporting us in this journey. Their work will initially be assisted by the KPMG team and our new way of doing things, called the 'Operational Improvement System', will embody our values of working together to improve. I am looking forward to seeing and sharing progress in the coming weeks and months.

9. Veteran Aware Hospital Status

During the month I learned that UHNM had been awarded Veteran Aware Hospital Status which is in direct recognition of our on-going commitment to improving NHS care for veterans, reservists, members of the armed forces and their families. We are now one of 64 providers that have been accredited as exemplars of the best care for veterans and leading the way in improving veterans' care within the NHS. We have a rich history of working with and caring for armed forces personnel, dating back to World War Two. Even today, we have a large number of staff that are both veterans or reservists. I am extremely pleased that our work to support veterans and those currently serving and their families has been recognised with this accolade.

10. Executive Director Appointments

In April we appointed two new Directors to our team; a Director of Digital Transformation and a Chief Nurse.

I am delighted to announce that Amy Freeman, a highly experienced IT support and digital specialist, will be joining us in August as our new Director of Digital Transformation. Amy joined the NHS in 2002 and is currently Chief Information Officer at Mid Cheshire Hospitals NHS Foundation Trust. She brings with her a wealth of knowledge both of ICT and the NHS

Also, Ann Marie Riley will join us at a date to be agreed as our new Chief Nurse. Ann Marie is currently the Director of Nursing at Walsall Healthcare NHS Trust and was previously the Deputy Director of Nursing at Nottingham University Hospital NHS Foundation Trust. Ann Marie has a wealth of NHS experience in both large and small acute hospitals

I am very much looking forward to welcoming them both to the UHNM family.

11. British Cardiovascular Intervention Society (BCIS)

The British Cardiovascular Intervention Society (BCIS), the national professional body for interventional cardiologists and allied health professionals, has singled out our very own Professor Jim Nolan, for a Lifetime Achievement Award at its annual national meeting. Only two people have previously received this award and it is the highest accolade offered by BCIS. This was given in recognition of Jim's contribution to propagation of the radial access technique in coronary intervention both nationally and internationally over three decades. In addition, Jim was also recognised for his significant contribution to education within the speciality. Congratulations Jim, an award well deserved.

Quality and Governance Committee Chair's Highlight Report to Board

23rd April 2021

1. Highlight Report

Matters of Concern or Key Risks to Escalate

- BD Pumps – risk regarding consumables not being available for a large number of pumps; national issue. Risk Assessment process undertaken for all areas where necessary and work remains in progress; Committee to be kept up to date.
- NG Tubes – two incidents related to NG tubes recently considered by the Coroner, who has identified lessons to be learned. Committee to be kept up to date with briefing paper and action plan.
- Cardiothoracic Incidents associated with high risk procedures currently under investigation and will be reported through to Risk Management Panel.
- 1 MRSA Bacteraemia reported during Quarter 4
- Expected to have a difficult winter in terms of Flu and Norovirus and children with respiratory illnesses which is to be factored into planning
- Patient Safety Standards were not achieved in March 2021 for patient falls, Duty of Candour, Inpatient Sepsis Screening and Emergency Portals IVAB in 1 hour
- An investigation into the use of Cytotoxic agents has been undertaken following concerns being raised; this has been shared with the Health & Safety Group and will be presented to the Committee at the next meeting

Major Actions Commissioned / Work Underway

- Antenatal and Newborn Screening Programmes annual report identified that action will be taken to ensure that the timeliness of sickle cell and thalassemia screening is to be improved in order to meet the expected standard.
- Evidence being collated to support compliance with the action plan in response to the Ockenden Report; this will be submitted on an ongoing basis to the national portal which opens in May.
- Implementation of an updated Health & Safety Annual Plan for 2021/22, which underpins the overarching Health & Safety Strategy.
- Further action needed in relation to Duty of Candour; noted that letters were being issued but not within the agreed timeframe – will be picked up with Divisions through the Performance Management Review Process
- Improving Together Programme has been launched which will be key in addressing some of our quality issues
- GIRFT Action Plan to be updated and presented to the Patient Safety Group
- Preparations ahead of the next Care Quality Commission inspection are now underway
- Sharps Analysis and Gap Analysis undertaken and will be presented to the Committee in May

Positive Assurances to Provide

- Pleasing to see the numbers of Covid significantly reduced with Covid related sickness now being at 10%
- In quarter 4, inpatient areas achieved the required 100% for treatment within an hour
- The annual staff flu vaccination campaign is now completed with 9197 staff vaccinated by the end of Q4
- Internal Audit of Infection Prevention and Control Board Assurance Framework concluded with Significant Assurance with Minor Improvement Opportunities
- Internal Audit have reviewed arrangements in response to the Ockenden Report and their initial findings have been very positive in terms of oversight / evidence
- Standard card in place for Duty of Candour in relation to patient falls – noted as good practice
- A desktop 'PLACE-lite' review was undertaken in February 2021 which concluded that the scores achieved in 2019 were likely to have remained the same should an inspection have been undertaken in 2020

Decisions Made

- Approval of the Quarter 4 Board Assurance Framework
- Approval of the revised Terms of Reference following completion of the Effectiveness Review

Comments on the Effectiveness of the Meeting

- Large agenda although managed to get through all of the necessary business

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Executive Directors Update including Covid-19	Information	11.	PLACE 2020	Assurance
2.	Q4 Infection Prevention Board Assurance Framework	Assurance	12.	Care Quality Commission Inspection / Actions Update	Assurance
3.	Clostridium Difficile Update	Assurance	13.	Visiting Healthcare Inpatient Settings during the Covid 19 Pandemic – updated guidance	Assurance
4.	Antenatal and New Born Screening Programmes Annual Report 2019/20	Assurance	14.	Q4 Board Assurance Framework	Approval
5.	Ockenden Report: Assessment and Assurance Framework and Action Plan Update	Assurance	15.	Quality Governance Internal Audit Report	Assurance
6.	Health and Safety Annual Plan / Strategy	Assurance	16.	Committee Effectiveness Review	Approval
7.	Month 12 Quality and Safety Report	Assurance	17.	Executive Health & Safety Group Highlight Report (April 2021)	Assurance
8.	Covid 19 Mortality Benchmark Report	Assurance	18.	Quality and Safety Group Oversight Report (April 2021)	Assurance
9.	GIRFT Covid Gap Analysis Summary	Assurance	19.	Quality Account	Information
10.	Medicines Optimisation Report Quarters 2-3 2020/21	Assurance	20.	Review of Meeting Effectiveness, Business Cycle and Items for Escalation to Trust Board / Audit Committee	Information

3. 2021 / 22 Attendance Matrix

			Attended	Apologies & Deputy Sent	Apologies

Members:			A	M	J	J	A	S	O	N	D	J	F	M
Prof A Hassell	AH	Associate Non-Executive Director												
Ms S Belfield	SB	Non-Executive Director (Chair)												
Mr P Bytheway	PB	Chief Operating Officer												
Mr J Maxwell	JM	Head of Quality, Safety & Compliance												
Dr K Maddock	KM	Non-Executive Director												
Dr J Oxtoby	JO	Medical Director												
Mrs M Rhodes	MR	Chief Nurse												
Miss C Rylands	CR	Associate Director of Corporate Governance												
Mrs R Vaughan	RV	Director of Human Resources												

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	5th May 2021
Report Title:	Maternity New Serious Incident Report Summary - April 2021	**Agenda Item:**	8.
Author:	Donna Brayford, Quality & Risk Midwife; Sharon Wallis, Head of Midwifery		
Executive Lead:	Michelle Rhodes, Chief Nurse		

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		

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

Situation:
Following the publication of the Ockenden review, Trust Boards are to have specific sight of Maternity Serious Incidents on a monthly basis. The report provides a summary of the numbers and types of Serious Incidents formally logged on STEIS (national reporting system) by Maternity during April (2021).

Assessment:

- 1 new Serious Incident was reported in April 2021

Category of Incidents:

- 1 Healthcare Safety Investigation Branch (HSIB) investigation

Immediate Actions:

- No immediate actions implemented

Areas of concern/escalation:

- No escalation required at present

Key Recommendations:

The Trust Board is asked to note and receive this report for assurance.

Maternity New Serious Incident Reporting Process

April 2021

The Maternity Team strive to declare Serious Incidents as soon as possible. The Quality and Risk Team are informed of the incident by Datix, a clinician's or mother's concern or on completion of an investigation such as a Perinatal Mortality Review Tool (PMRT). The Clinical Director (CD) and Head of Midwifery (HOM) are immediately informed. The incident will be discussed at the weekly Multi-disciplinary Obstetric Risk meeting to establish facts and ensure all immediate actions are implemeted. A 72 hour brief will be prepared and once approved by the HOM and CD will be escalated to the Divisional Team for approval by the Divisional Associate Chief Nurse and Divisional Governance Lead. The Serious Incident will be disclosed as soon as possible to the woman and her family.

HSIB Investigations and SI Reporting

There have been recent discussions regarding reporting all maternity cases that are reported to HSIB for investigation as Serious Incidents. There does appear to be some variation in practice across the country. Some Trusts are reporting all cases as SIs and some are reporting retrospectively following the HSIB investigation and patient safety recommendations. We have historically reported retrospectively following receipt of HSIB investigation reports. However, HSIB can take up to 12 months to complete an investigation which means a significant delay in SI reporting. Therefore, following correspondence from the Medical Director and Chief Nurse, as of 25/11/20 the decision was made to SI report and then de-escalate after if appropriate.

Definitions

- **Antepartum haemorrhage -** defined as bleeding from the genital tract
- **Cardiotocograph (CTG)** - is used during pregnancy to monitor fetal heart rate and uterine contractions.
- **Cooling Therapies are described as:**
- **Passive –** turning off heating equipment and removing covering from the baby
- **Active** – placing the baby on a temperature – controlled cooling mattress or using a temperature – controlled cooling cap
- **Therapeutic** - is a procedure where the infant is cooled to between 33 and 34 degrees celcius, with the aim of preventing further brain injury following a hypoxic (lack of oxygen) injury. Hypothermia is usually induced by cooling the whole body with a blanket or mattress
- **Forceps delivery -** a type of assisted vaginal delivery.
- **Healthcare Safety Investigation Branch (HSIB)** - national and independent investigating body
- **Hypoxic ischaemic encephalopathy (HIE) -** is a type of newborn brain damage caused by oxygen deprivation and limited blood flow.
- **Low cord pH –** may indicate a baby has suffered a significant hypoxic insult.

1. New Serious Incidents

Maternity have reported 1 Serious Incident (SIs) during April (2021). Table 1 gives a brief description of the incident and immediate actions taken. It has been agreed by the Directorate, Division and Trust Board all HSIB investigations will be reported as Serious Incidents, and then de-escalated if required.

Table 1 - Brief description of new Serious Incident and immediate actions taken

SI ID	Datix ID	Incident description	Immediate Actions	Outcome
Awaiting SI ID 72 hr brief submitted	243402 HSIB	• Unexpected term admission (38+2 weeks gestation) to the neonatal unit for therapeutic hypothermia (cooling) following a forceps delivery for abnormal electronic fetal heart monitoring (Cardiotocograph/ CTG). Cooling is a specialist treatment that lowers the baby's body temperature from 37 degrees to 33.5 degrees to aid with the healing process of the baby's brain.	• HSIB referral completed • Verbal and written Duty of Candour completed • Staff support arranged • All members of staff involved have already completed mandatory fetal monitoring training. • No further immediate actions have been taken	• Baby currently an inpatient on the neonatal unit • Diagnosis at present – moderate HIE – based on clinical presentation • Baby was re - warmed 2 days ago. • Awaiting MRI result

2. Current Serious Incidents in progress

Maternity have 11 ongoing serious incidents, of which 5 are awaiting local RCA, and 2 with HSIB. 4 incidents have had the investigation completed, awaiting to be presented and closed by CCG SI Group.

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	5th May 2021
Report Title:	Infection Prevention Board Assurance Framework Q1 2020/21	**Agenda Item:**	9.
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 continue to be 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 plans.
- There has been one change in risk score since previously reported; in relation to BAF 10 and this score has increased due to the ongoing actions being taken in respect of FFP3 mask fit training.
- Since the previous meeting, the document has been updated to clarify which actions have been completed and implemented and those which remain ongoing.
- A recent review undertaken by internal audit concluded with an assurance rating of Significant Assurance with Minor Improvement Opportunities; 4 recommendations were made (1 medium and 3 low) and these relate to:
    - Actions required to reduce gaps in assurance
    - Engagement with Divisions
    - Reflecting on best practice in terms of format of the document
    - Continuing to reflect risks onto the Trust's Risk Register

<u>Progress</u>

- Portacount fit test systems; Portacount machine and mask fit tester (on loan for 3 months) obtained by Infection Prevention Team via DHSC National test support team. The portacount is a quantitative test and uses specialised equipment to measure exactly how much air is leaking through the seal of a FFP3 mask. This will enable testing of staff who have been unable to taste Bitrex solution and therefore not able to be fitted using the current hood system. The tester is also providing extra support to areas to switch from 3m FFP3 masks.
- Head of Health and Safety Head continues with Portacount business case. Portacount also has the capability of

collecting mask fit test information

- Mask fit testing skill is now available on Health Roster. This will enable areas to record model of FFP3 mask and date of mask fit testing electronically and also compile compliance data using this system. The mask fit testing certificate must continue to be completed manually and filed in the staff member personal folder

Key Recommendations:

The Board is asked to note the document for information, and note the ongoing work to strengthen the assurance framework going forwards, building upon the recommendations made by the Internal Auditors.

NHS
University Hospitals of North Midlands
NHS Trust

Infection Prevention and Control Board Assurance Framework

Quarter 1 – 2021/22

Summary Board Assurance Framework as at Quarter 1 2020/21

Ref / Page	Requirement / Objective	Risk Score				
		Q4	Q1	Q2	Q3	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.	Mod 6	Mod 6			→
BAF 2 Page 15	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	Mod 6	Mod 6			→
BAF 3 Page 24	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	High 9	High 9			→
BAF 4 Page 27	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care, in a timely fashion.	Low 3	Low 3			→
BAF 5 Page 30	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	Low 3	Low 3			→
BAF 6 Page 33	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	Mod 6	Mod 6			→
BAF 7 Page 40	Provide or secure adequate isolation facilities.	Low 3	Low 3			→
BAF 8 Page 42	Secure adequate access to laboratory support as appropriate.	Low 3	Low 3			→
BAF 9 Page 47	Have and adhere to policies designed for the individuals and provide organisations that will help prevent and control infections.	Low 3	Low 3			→
BAF 10 Page 50	Have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	Low 3	Mod 6			↑

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

Risk Scoring								
Quarter	Q4	Q1	Q2	Q3	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2	2			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 2
Consequence:	3	3				Consequence:	3	
Risk Level:	6	6				Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
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 raised.	

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		• Out patient flow chart in place • Thermal imaging cameras in some areas of the hospital • Iportal alert in place for COVID positive patients • Extremely vulnerable patient placement added into new COVID ward round guidelines (October 2020)		
1.2	Patients with possible or confirmed Covid-19 are not moved unless this is essential to their care or reduces the risk of transmission. There are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically imperative That on occasions when it is necessary to cohort COVID or non-COVID patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per guidance.	• 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 • Barrier and Terminal clean process in place • IP PHE guidance • COVID Q+A available on Trust intranet	• 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	• Datix/adverse incidence reports	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		 Patient Information Lealfet - Contact 202  uhnm-guidance-on-testing-and-re-testing- • 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  4th-february-2021-covid-ward-round-gui		
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. Linked Key Infection Prevention points – COVID 19 vaccination sites Monitoring of IP practices, ensuring resources are in place to enable compliance with IP practice of staff adherence to hand hygiene?	• 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	• 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	• 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 improvement part of health and safety portacount business case

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	• Staff adherence to hand hygiene • Staff social distancing across the workplace • Staff adherence to wearing of fluid resistant surgical face masks • a) clinical • b) non clinical setting Monitoring of staff compliance with wearing appropriate PPE, within the clinical setting Consider implementing the role of PPE guardians/safety champions to embed and encourage best practice There are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace	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 • Matrons walk rounds • Specialised division summarised BAF and circulated to matrons • ACN's to discuss peer review of areas • Poster displayed in entrances and along corridors reinforcing the use of masks social distancing and one way systems • Catch it , bin in, kill it posters in ED waiting rooms	held locally by Divisions • Sodexo and Domestic service training records • IP assurance visits • Review of UHNM vaccination areas against key infection prevention points COVID -19 • Hand hygiene audits	
1.5	National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way.	• Notifications from NHS to Chief nurse/CEO • IP team COVID lead checks Public Health England webpage daily (Monday-Friday) for updates • Changes raised at -19 clinical groups which was held originally twice weekly, reduced to weekly and now increased back to twice weekly due to surge of COVID.	• Clinical Group meeting action log held by emergency planning	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		• Purpose of the Clinical Group - The Group receive clinical guidance and society guidance which is reviewed and if agreed used to advise clinical teams after approval at Exec COVID -19 meeting which is held twice monthly. • 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	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
			that 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	• Risk register and governance process • Datix incidents • Board assurance document standing agenda item Trust board and IPCC. • TOR	• IP risks are agenda item at Infection Prevention and Control committee (IPCC) • Definite Nosocomial COVID 19 case numbers are in	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	submissions have been signed off by the Chief Executive, the Medical Director or the Chief Nurse and the Board Assurance Framework is reviewed and evidence of reviews is available. • Trust Board has oversight of on going outbreaks and actions plans • Linked NHSIE Key Action 9: Local Systems must assure themselves, with commissioners that a Trust's infection prevention and control interventions are optimal, the Board Assurance Framework is complete and agreed action plans are being delivered. • There are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas	• Outbreak IImarch submissions are copied to Chief Nurse/DIPC and exec Team • Outbreak areas are included in daily tactical meeting • Outbreak areas included in Gold update slides • Outbreak meetings attended by CCG and PHE • Definite Nosocomial COVID 19 case numbers are in included in Quality Performance Report • Nosocomial death review process • Visiting /walk round of areas by executive/senor leadership team	included in Quality Performance Report • Nosocomial death review process – paper to Quality and Governance Committee 20th January 2021 • COVID themes report to IPCC	
1.8	Robust IPC risk assessment processes and practices are in place for non Covid-19 infections and pathogens.	• IP questions and answers manual • Section in IP questions and answer manual 2.1 priority of isolation for different infections and organisms • Sepsis pathway in place • Infection Risk assessment in proud to care booklets and admission documentation • C.diff care pathway • IP included in mandatory training • Pre Amms IP Screening	• MRSA screening compliance • Monthly Sepsis Compliance audits. Screening compliance for sepsis and time to antibiotics for Red flag patients • IP audits • Infection Prevention Health care associated infection report, including submitted	• 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

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		• Birmingham paused ribotyping service for C.DIFF due to COVID-19. During periods of increased incidence ribotyping is useful to establish person to person transmission, Leeds Hospital are now undertaking this service • Proud to care booklets revised an reinstated August/September 2020	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	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	Complete
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	Complete
3	1.2	NHSI key point 4 : Patients are not moved until at least two negative test results are obtained, unless clinically justified	Microbiologist/ ACN's	31/05/2020	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	Problematic – revised due date

					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 negatives swabs before moving for patients that are not COVID suspected does not always occur. April 2021 Chief Nurse reminded ACN's of testing guidance	
4	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	Complete
5	1.4	Improving staff FFP3 mask fit staff training data recording and retention of records.	Health and Safety	31/08/2021	Proposed Fit Testing compliance improvement Task and Finish Group. Inaugural meeting took place 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 systems, this is a project lead by Health and Safety As at 03/02/2021 People O&D have created FFP3 mask "classes" on ESR. Health and Safety are in the process of collating fit test records which were requested at Exec Health and Safety Groups from Divisional H&S Leads. Portacount Business case : Health and Safety Head continues with Business case with target date for completed revised for end of August 2021 <u>10/03/2020</u> Portacount machine obtained (on loan) by Infection	Problematic – revised due date

					Prevention Team via Midlands Coordinator for the FFP3 Mask Project. Plus mask fit tester will be available to test staff using the portacount machine. The portacount is a quantitative test and uses specialised equipment to measure exactly how much air is leaking through the seal of a mask. ACN'S informed and response requested to aid in identifying testing priority. Midlands Coordinator is meeting IP next week to work through plan. Mask fit testing also continues using hood and bitrex (qualitative, relies on taste) Mask fit testing option also added to e rostering to enable areas to identify staff member that have been tested and record mask model. A report can also be produced with compliance using this system. The mask fit testing certificate must also continue to be completed and filed in the staff member personal folder. Updated mask fit strategy to March which includes mask fit frequency.	
6.	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 Health Rostering including model of mask staff fitted with. A number of clinical areas have also forwarded training records to the IP Team. IP Team. IP have a list of mask fit testers, this is also available on the Trust COVID intranet page.	Complete
7.	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	Complete

8.	1.8	To complete an analysis (Advantages and disadvantages) to reinstating MRSA screening as per UHNM policy	Deputy Director Infection Prevention	14/06/2021	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 2020 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. <u>March 2021</u> Screening for elective high risk surgery to resume This action continues to be under review during COVID Pandemic and surveillance of MRSA bacteraemia cases is on-going. <u>20/04/2021</u> Due to wave 2 COVID 19 , paper deferred to May IPCC 2021	Problematic – revised due date
9.	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	Complete

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

Risk Scoring								
Quarter	Q4	Q1	Q2	Q3	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2	2			Whilst cleaning procedures are in place to ensure the appropriate management of premises further work required re computer on wheels cleaning	Likelihood:	1	End of Quarter 2
Consequence:	3	3				Consequence:	3	
Risk Level:	6	6				Risk Level:	3	

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
2.2	Designated cleaning teams with appropriate training in required techniques and use of PPE are assigned to Covid-19 isolation or cohort areas. Assurance processes are in place for monitoring and sign off terminal cleans as part of outbreak management	• SOP and cleaning method statements for 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 • Discussed at March Matrons meeting. To ensure terminal cleans are signed off by the Nurse in Charge	• Clinical teams sign off any terminal cleans requested to say that clean has been completed to the agreed standard. • Spot check assurance audits completed by Sodexo and retained during COVID period • Cleanliness complaints or concerns are addressed by completing cleanliness audit walkabouts with clinical teams, and CPM / Sodexo. • PPE and FFP3 mask fit training records with are held by Sodexo /retained services • GREAT training record cards are held centrally by Sodexo for all individual domestics • Key trainers record • Notes from Sodexo Performance Monthly meeting , Sodexo Operational meeting , Divisional IP Meeting and facilities/estates meeting	
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 and was reviewed in February 21.	• C4C audits reinstated July 2020 these results are fed into IPCC	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		• High level disinfectant , Virusolve and Tristel in place and used for all decontamination cleans • Dedicated terminal clean teams introduced during the 2/3 wave of COVID for ED, AMU/AMRA/FEAU as well as Lyme Building where main ITU beds are located to ensure that quick , effective decontamination of potentially infected areas could be completed 24/7.	• Completion of random 10% rooms each week by Sodexo to ensure that all rooms are cleaned to the agreed cleaning standards – Any rooms that are found to be below standard are rectified immediately. • Terminal clean electronic request log • Patient survey feedback is reviewed by joint CPM / Sodexo group and action plan completed if needed.	
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 electronic log held by Sodexo and circulated following any updates / removal of barrier cleans to Sodexo and Trust staff including IP Team. • IP spot checks for clinical areas with clusters of COVID -19 or HAI cases of COVID -19 • Disinfectant check completed during IP spot checks • Additional ad-hoc cleaning requests can be requested by clinical teams 24/7	• NHSI visit highlighted cleaning issues both environment and nursing equipment • Environmental damage highlighted during NHSI visit - peeling edges of floor

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
			should the environment become contaminated between scheduled cleans.	
2.5	Attention to the cleaning of toilets / bathrooms, as Covid-19 has frequently been found to contaminate surface in these areas.	• Cleaning schedules in place • Barrier cleans (increased cleaning frequency) process in place which includes sanitary ware and other frequent touch points	• Cleaning schedules are displayed on each ward • Additional ad-hoc cleaning requests can be requested by clinical teams 24/7 should the environment become contaminated between scheduled cleans.	
2.6	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	• Monthly on-going training is completed with all domestic staff to ensure that core competencies such as cleaning effectively with chemicals is trained out on a frequent basis. • Where outbreaks are identified, regular staff who clean in this area have competency checks to	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
			ensure that they are following GREAT card training • Spot checks completed by CPM includes observation of cleaning techniques by the domestic staff.	
2.8	As per national guidance: • 'Frequently touched' surfaces, e.g. door / toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated more than twice daily and when known to be contaminated with secretions, excretions and bodily fluid. • Electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily. • Rooms / areas where PPE is removed must be decontaminated, timed to coincide with periods immediate after PPE removal by groups of staff (at least twice a day). Linked NHSIE Key Action 1: All high touch surfaces and items are decontaminated multiple times every day – once or twice a day is insufficient.	• Cleaning of frequently touch points included in Barrier clean process • Offices and back offices also supplied with disinfectant wipes to keep work stations clean. • Non- invasive medical equipment must be decontaminated after each use. IP Q+A manual	• IP checks • Barrier clean request log • Terminal clean request log • Additional ad-hoc cleaning requests can be requested by clinical teams 24/7 should the environment become contaminated between scheduled / barrier cleans. • Non-clinical areas are cleaned at regular frequencies through the day especially sanitary ware, and if additional cleans are required between scheduled cleaning, these can be requested via the helpdesk.	• To check protocol for none barrier clean areas and also electronic equipment
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	• IP audits held locally by divisions • Datix reports/adverse incidents	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		• Red alginate bags available for infected linen in the clinical areas • Infected linen route		
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. Ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air	• 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	• Estates have planned programme of maintenance • The Authorising Engineer Ventilation will provide external independent specialist advice and support as well as carrying out an annual audit for system compliance.	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		• The 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.		
	Ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment Monitor adherence environmental decontamination with actions in place to mitigate any identified risk Monitor adherence to the decontamination of shared equipment	• Regular walkabouts of all non-clinical areas are completed, and any actions found are either emailed through to helpdesk to be logged as jobs to be completed or are noted by Sodexo at time of audit – follow-up visits are completed to ensure all jobs have been completed • Quarterly Environmental Audits are completed of all clinical areas by an independent auditor plus input from nursing, cleaning and estates to review environmental standards – reports produced after each visit, and re-audits completed if disciplines fail to achieve agreed %.	• Reports produced after each visit, and re-audits completed if disciplines fail to achieve agreed %.	

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.	Complete

					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 01/10/20 – Fully disciplinary team are now invited to C4C audits with strict social distancing in place at all times. Audits remain fluid to allow maximum access during the 3rd wave of Covid.	
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 Feb 2021.docx	Complete
3	2.4	To address dirty nursing equipment and commodes, plus computer on wheels	ACN'S / IP/ Deputy Head of IM&T	31/05/2021 – re: Computers on Wheels	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 Visible parts of COW such as external casing, screen, and keyboard mouse to be cleaned by clinical staff.	Problematic – revised target date

					18/02/2021 – Feedback from IM&T. They are chasing cost associated with cleaning of COW's 03/03/2021 – Feedback from IM&T cost still awaiting. They are chasing. Outside of COW and parts that can be seen are cleaned by the clinical staff 15/03/2021 Cleaning of internal parts of COW IM&T have raised this to a COW provider and they are providing a cost to clean the devices. In addition reached out to an internal UHNMM cleaning team to gain a cost 16/03/2021 – Costing back from external company for cleaning internal parts of COW, next stage to be agreed 22/04/2021 – 2 costings back for comparison, next stage to be agreed 27/04/2021 chief nurse to present to execs	
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	30/04/2021	To revisit high touch points protocol to check frequency of clean for area that area not on barrier cleans – computers , mobile phones, keyboards Cleaning of communal toilets after each use inpatient areas – Letter -CEM/CMO /2020/043 24TH December 2020. This letter was raised at IPCC 25/01/2021. 16th February Meeting with IP & Facilities colleagues to discuss the NHS/NHSE/PHE facilities cleaning requests in line with COVID 19 – letter CEM/CMO 24th December 2020 Hefma network Responses/Scoping exercise completed Trust position work in progress. Paper to next March IPCC Additional cleaning resource in place for ED Royal Stoke and overnight at County this requirement has been extended for a further 3 months Wheelchair cleaning stations also installed across both sites Clinical areas aware of the need to decontaminate high touch points such as desk top phones and keyboards <u>April 2020</u> Lessons learnt poster uploaded into the Trust intranet, including clinical and non- clinical cleaning high touch points	Complete

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

Risk Scoring								
Quarter	Q4	Q1	Q2	Q3	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	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 1 2021
Consequence:	3	3				Consequence:	3	
Risk Level:	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 • Formal regional meetings and informal national network activities • AMS CQUIN further mandates key AMS principles to be adhered to • All national CQUINS currently suspended by NHSE / PHE • Monthly review of antimicrobial	• Same day escalation to microbiologist, if concerns. Outcome recorded on I portal • Metric available around the number of times App accessed by UHNM staff • Compliance with guidelines and other AMS metrics reported to Infection prevention and control Committee (IPCC) • Meeting minutes reviewed and actions followed up • Real time discussions / requests for support / advice enabled via regional and national social media accounts. National (incl. PHE) thought leaders members • Trust and commissioners require timely reporting on compliance	• Further controls due to elements of non - compliance with audits

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		consumption undertaken by AMS team. Available online at UHNM	with AMS CQUIN targets. • Wards showing deviation from targets are followed up by targeted AMS team ward reviews generating action plans for ward teams. On hold during COVID19 due to redeployment of duties	
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. These have restarted in December 2020 as held during COVID-19. Results online. • Results from all AMS audits and targeted ward reviews are reported at the Antimicrobial Stewardship Group and minutes seen by IPCC • CQUIN submissions completed in timely manner and generate action plans for AMS and ward teams to follow up concerns each quarter. Currently suspended.	• Whilst only a snap-shot audit the Trust value the output from these audits. Work is underway Q1 and Q2 20/21 to review potential change in data collection to optimise impact. • IPCC scrutinise results. Divisions held to account for areas of poor performance. Audit outputs will be used as basis of feedback on performance to individual clinical areas going forward. • Trust CQUIN contracts manager holds regular track and update meetings to challenge progress vs AMS CQUINS, Currently suspended.	

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	30/04/2021	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	Problematic – revised due date

					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. Results will be discussed at March IPCC meeting 31/03/2021 Following discussion of these results at March 2021 IPCC a meeting has been arranged between Chief Nurse, deputy DIPC, lead AMS pharmacist and lead AMS microbiologist to discuss ways in which divisions can be supported to improve their stewardship performance. Individual clinical areas can be identified from Pharmacy audit data. Meeting date 15.4.21 April 2021 Meeting held between ASG leads, CD Pharmacy, Deputy DIPC and DIPC on 15th April 2022. Action plan being written.	
2.	3.1	To review current escalation of areas that are not compliant with antimicrobial guidelines	DIPC	30/04/2021	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 review. Will thereafter to be forwards to IPCC for discussion and ratification at the March IPCC meeting. 31/03/2021 The draft escalation protocol was approved at March ASG. It will be shared with Chief Nurse and Deputy DIPC at meeting above (15.4.21) and target wards will be identified. Protocol approved at March 2021 ASG.	Problematic – revised due date

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

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
4.1	Implementation of national guidance on visiting patients in a care setting.	• 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	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		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 • EOL visiting guidance in place • March 2021 Visiting guidance inpatient during COVID 19 pandemic: principles discussed at Clinical Group and tactical • 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	

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

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

Risk Scoring								
Quarter	Q4	Q1	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	1	1			Whilst arrangements are in place ensure the screening of all patients. To continue to reinforce COVID screening protocol and monitor compliance	Likelihood:	1	End of Q4 – achieved
Consequence:	3	3				Consequence:	3	
Risk Level:	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. Screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases. Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from Non Covid-19 Staff are aware of agreed template for triage	• 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	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	questions to ask Triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible			
5.2	Mask usage is emphasized for suspected individuals. Face masks are available for all patients and they are always advised to wear them Provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients (particularly when moving around the ward) if this can be tolerated and does not compromise their clinical care Monitoring of Inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so)	• Use of mask for patients included in IP COVID -19 • question and answers manual • All staff and visitors to wear masks from Monday15th June • ED navigator provide masks to individual in ED • Mask stations at hospital entrances • Covid-19 bulletin dated 12th June 2020 • 28th August updated guidance from PHE recommends in patients to also wear surgical masks if tolerated and does not compromise care • IP Assurance visits • Senior walk rounds of clinical areas • Matrons daily visits	• Hospital entrances Mask dispensers and hand gel available	• Face mask leaflet produced for patients, awaiting approval • CAN/Matrons to monitor/process to monitor
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	• 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	• Division/area social distancing risk assessments	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	ventilated.	• Chief Nurse/DIPC visited clinical areas to review social distancing within bays. A number of beds have been removed throughout the Trust.		
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	• Datix process	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		• Mask or face coverings for patients attending appointments from Monday 15th June		

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.	Complete
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	Complete
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	Complete
4.	5.2	Face masks are available for all patients and they are always advised to wear them	IP/ACN's	31/03/2021 Revised target date 16th April	Face mask leaflet produced to be submitted for ratification on 14th April 2021. To be submitted to tactical /clinical group week beginning 15th March. Can be used prior to ratification as trial April 2021 Ratified by patient Group and available for use	Complete
5	5.4	Monitoring of Inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so)	ACN's/Matrons	31/03/2021	Assurance for monitoring of inpatient compliance with wearing face masks. Matrons daily walk round	Complete

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

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
	Separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas	• To be confirmed	• To be confirmed	
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	• Training records • IP spot checks	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		• Trust mask fit strategy • SOP and training for reusable FFP3 masks • SOP and training for use of air powered hoods • Critical care - Elipse FFP3 reusable introduced • PPE posters are available in the COVID -19 section of trust intranet page		
6.3	A record of staff training is maintained.	Mask fit strategy in place	• Option now available to enter FFP3 training onto Health Rostering 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 • Health and Safety leading on portacount mask fit business case which will also enhance mask fit training records
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	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
6.6	Adherence to the PHE national guidance on the use of PPE is regularly audited withactions in place to mitigate any identified risk.	• PPE Audits • PPE volume use discussed at tactical COVID-19 Group	• Spot audits completed by IP team	
6.7	Staff regularly undertake hand hygiene and observe standard infection control precautions. Linked NHSIE Key Action 1: Staff consistently practices good hand hygiene.	• Hand hygiene requirements set out in the infection prevention Questions and Answers manual • Poster for hand hygiene technique displayed at hand wash sinks and stickers on hand soap and alcohol dispensers • Alcohol gel availability at the point of care	• Monthly hand hygiene audits completed by the clinical areas • Infection Prevention hand hygiene audit programme. Overview of results fed into infection Prevention committee • Independent hand hygiene audits completed by IP Senior Health Care	
6.8	Hygiene facilities (IP measures) and messaging are available for all • Hand hygiene facilities including instructional posters • Good respiratory hygiene measures • Staff maintain physical distancing of 2 metres wherever possible in the workplace unless wearing PPE as part of direct care • Staff maintain social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace • Frequent decontamination of equipment and environment in both clinical and non-clinical	• Hand washing technique depicted on soap dispensers • Social distance posters displayed throughout the Trust • IP assurance visits • Matrons visits to clinical areas • Car sharing question forms part of OB investigation process • Communications reminding staff re car sharing • IP Q+A decontamination	• Hand hygiene audits • Spot checks in the clinical area • IP assurance visits	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	areas • clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas • Guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas	section • COVID Q+A • Wearing of mask posters displayed throughout the Trust • Advise and videos' on the Trust internet page • Hand hygiene posters /stickers on dispenser display in public toilets	• Cleanliness audits • IP environmental audits • Quarterly audits conducted and held by the clinical areas	
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	• For any new absences employee should open and close their usual absence via	• Cluster /outbreak investigations	

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

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 4 Progress Report	BRAG
1.	6.3	Improving staff FFP3 mask fit staff training data recording and retention of records	Health and Safety	31/08/2021	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	Problematic – revised due date

					agreement to proceed to Business case As at 03/02/2021 People O&D have created FFP3 mask "classes" on ESR. Health and Safety are in the process of collating fit test records which were requested at Exec Health and Safety Groups from Divisional H&S Leads. Business case : Head of Health and Safety's continues with business case with a revised due date end of August 2021 10/03/2020 Portacount machine obtained (on loan) by Infection Prevention Team via Midlands Coordinator for the FFP3 Mask Project. Plus mask fit tester will be available to test staff using the portacount machine. The portacount is a quantitative test and uses specialised equipment to measure exactly how much air is leaking through the seal of a mask. ACN'S informed and response requested to aid in identifying testing priority. Midlands Coordinator is meeting IP next week to work through plan. In additional Mask fit testing also continues using hood and bitrex (qualitative, relies on taste) Mask fit testing option also added to e rostering to enable areas to identify staff member that have been tested. A report can also be produced with compliance using this system. The mask fit testing certificate must also continue to be completed and filed in the staff member personal folder. Updated mask fit strategy to March IPCC	
2	6.2	Spot audits of PPE on wards and Departments	Quality and Safety Team IP	30/04/2021	Audits are required on a weekly basis – ongoing action	Complete

7. Provide or secure adequate isolation facilities

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
7.1	Patients with possible or Covid-19 are isolated in appropriate facilities or designated areas where appropriate. Restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff	• Hospital zoning in place • Recovery and Restoration plans for the Trust – • December 2020 –another increased wave of COVID 19 • COVID prevalence considered when zones identified • Purple wards • Blue COVID wards identified at both sites created during second wave • Green wards for planned screened elective patients • Recovery and Restoration plans • Ward round guidance available on COVID 19 intranet page	• June 2020 IP team to review patients that are found COVID positive and nursed in bay to ascertain compliance with pathway and IP control measures are in place Review pathways and identify themes which are presented at IPCC . • Themes report to IPCC	
7.2	Areas used to cohort patients with possible or confirmed Covid-19 are compliant with the environmental requirements set out in the current PPE national guidance.	• Areas agreed at COVID-19 tactical Group • Restoration and Recovery plans	• Action log and papers submitted to COVID-19 tactical and Clinical Group	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
7.3	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	Complete
2.	7.1	Strict adherence to policy re patient isolation and cohorting	Site teams/ward teams	18/09/2020 process	inappropriate patient moves reported via Datix. Daily process Discuss at outbreak meetings as necessary	Complete
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	Complete

8. Secure adequate access to laboratory support as appropriate.

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
8.1	Testing is undertaken by competent and trained individuals. • Regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	• How to take a COVID screen information available on Trust intranet. This has been updated in November 2020 • Laboratory services for UHNM are located in the purpose built Pathology Laboratory on-site at RSUH. The Laboratory is United Kingdom Accreditation Service (UKAS) accredited. • Turnaround times included in tactical slides	• Review of practice when patient tests positive after initial negative results	• 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 for NHS patient facing staff is implemented. Whilst lateral flow	• 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 endoscopy • Process in place for staff	• Empactis reporting • Team Prevent systems • Datix/adverse incidence reporting • Cluster /outbreak investigation procedures	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
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 to a 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	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. Staff are asked to submit results via text. Jan 2021 Recent communications on COVID bulletin to remind staff to submit results • Questions and answers available on the COVID 19 page Trust intranet re lateral flow including actions to take for reporting both a negative or positive result • All patient discharged to care setting as screened 48 hours prior to transfer/discharge • Designated care setting in place for positive patients requiring care facilities on discharge – Trentham Park		

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	patients must be asked to self-isolate from the day of the test until the day of admission. There is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control and testing document • That sites with high nosocomial rates should consider testing COVID negative patients daily. • That those being discharged to a care facility within their 14 day isolation period should be discharged to a designated care setting, where they should complete their remaining isolation.	• Reviewed as part of outbreak investigation • Matrons and ACN'S aware of retesting requirement • Not required currently but kept under review • Patients are tested as part or outbreak investigation • Designated home identified- Trentham Park		
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,	Complete

					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	Complete
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.	Complete
4.	8.3	To complete an analysis (Advantages and disadvantages) to reinstating pre COVID 19 UHNM screening policy	Deputy Director if infection Prevention	14/06/2021	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. Feb 2020 This continues to be under review during COVID pandemic March 2020 Elective screening for high risk surgery and overnight surgery to resume	Problematic – target date revised

					MRSA bacteraemia surveillance continues 20/04/2021 Due to wave 2 COVID 19 , paper deferred to May IPCC 2021	

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

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
9.1	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	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		• Changes/update to staff are included in weekly Facebook live sessions • COVID -19 intranet page • COVID -19 daily bulletin with updates		
9.3	All clinical waste and linen/laundry related to confirmed or possible Covid-19 cases is handled, stored and managed in accordance with current national guidance.	• Waste policy in place • Waste stream included in IP mandatory training	The Trust has a Duty of Care to ensure the safe and proper management of waste materials from the point of generation to their final disposal (Cradle to Grave). This includes: • Ensuring the waste is stored safely. • Ensuring the waste is only transferred to an authorised carrier and disposer of the waste. • Transferring a written description of the waste • Using the permitted site code on all documentation. • Ensuring that the waste is 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	• PPE availability agenda item on Tactical Group meeting	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		rooms • Donning and doffing stations at entrance to wards		

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.	Complete
2.	9.1	Proud to care booklet audits paused. Plan for recommencing	Deputy Director of Quality and Safety	30/09/2020	Original proud to care booklets reinstated	Complete
3.	9.1	Compliance with correct mask wearing and Doctors complaint with Bare Below the Elbow	Deputy DICP/Medical Director/ ACN's	Revised 31/03/2021	NHSI Action plan devised. Senior walk rounds of clinical areas in place.	Complete

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

Risk Scoring								
Quarter	Q4	Q1	Q2	Q3	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	1	2			There are clear control in place for management of occupational needs of staff through team prevent to date Monitoring of adhere to social distancing and PPE continues. Work in progress to further improve retention of FFP3 mask fit training records	Likelihood:	1	End of quarter 2
Consequence:	3	3				Consequence:	3	
Risk Level:	3	6				Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
10.1	Staff in 'at risk' groups are identified and managed appropriately, including ensuring their physical and psychological wellbeing is supported. That risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic and pregnant staff	• 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	• Mask fit strategy in place	• Training records for reusable	• Availability of locally held

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally Staff who carryout fit testing training are trained and competent to do so All staff required to wear an FFP respirator have been fit tested for the model being used and this should be A record of the fit test and result is given to and kept by the trainee and centrally within the organisation For those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods A documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health Following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using	• Mask fit education pack • SOP for reusable face masks and respiratory hoods in place • PHE guidance followed for the use of RPE • PPE poster available on the intranet • Training records held locally • Fit testers throughout the Trust • Complete and issue Qualitative Face Fit Test Certificate	masks • Training records held locally • Mask fit option now available on Health Rostering to record mask type and date	training records.

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	the nationally agreed algorithm and a record kept in staff members personal Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board			
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	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
10.5	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	31/08/2021	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 case As at 03/02/2021 People O&D have created FFP3 mask "classes" on ESR. Health and Safety are in the process of collating fit test records which were requested at Exec Health and Safety Groups from Divisional H&S Leads. Portacount Business case : Health and Safety Head continues with Business case with target date for completed revised for end of August 2021 10/03/2020 Portacount machine obtained (on loan) by Infection Prevention Team via Midlands Coordinator for the FFP3 Mask Project. Plus mask fit tester will be available to test staff using the portacount machine. The portacount is a quantitative test and uses specialised equipment to measure exactly how much air is leaking through the seal of a mask. ACN'S informed and response requested to aid in identifying testing priority. Midlands Coordinator is meeting IP next week to work through plan. In additional m ask fit testing also continues using hood and bitrex (qualitative, relies on taste) Mask fit testing option also added to e rostering to enable areas to identify staff member that have been tested. A report can also be produced with compliance using this system. The mask fit testing certificate must continue to be completed and filed in the staff member personal folder. Updated mask fit strategy to March IPCC	Problematic – revised target date

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.

Performance and Finance Chair's Highlight Report to Board

20th April 2021

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Whilst there had been some improvements in terms of urgent care performance, during March the Trust was unable to sustain performance with issues identified in respect of the number of non-admitted attendances and inconsistent delivery through the UCC pathway • In terms of cancer performance, 3 of the standards had been achieved but all standards were above the national average despite some of the referral challenges • The improving 52 weeks delivery was being reviewed but was noted to be a significant challenge, given the associated numbers. • In terms of the financial plan for 2021/22, there was some uncertainty as to the anticipated deficit, which was due to this being based on a number of assumptions given the uncertainty regarding funding after the initial 6 months. It was noted that there was a further challenge with regards to approval of future business cases, given the uncertainty in future funding	• To provide updated trajectories in the IPR from April 2021, in terms of operational planning guidance To include an update from the planned care cell at the next meeting • To circulate the spread sheet associated with the Business Intelligence Strategy detailing the associated work programmes • To review October to December financial plan later in the year and include on the business cycle • To amend the attendance matrix within the Committee annual report
Positive Assurances to Provide	**Decisions Made**

• A verbal update was provided to Committee members in respect of Covid whereby numbers of Covid positive patients in hospital had reduced to single figures and members noted the actions taken to return to 'business as usual'
• A positive update was provided in respect of data security and protection, whereby there had been continued increases in statutory and mandatory training, and no key risks highlighted in respect of meeting the requirements of the Toolkit which had been reviewed by the internal auditors with a positive conclusion
• An update was provided by the Executive Data Security and Protection Group whereby assurance was provided in terms of the cyber security assurance framework and plan which had been developed and was to be externally assessed
• A positive update was provided by the cancer team in respect of the actions taken to treat outstanding cancer referrals and analysis of data had demonstrated that the Trust had performed better than national averages in respect of reduction in definitive treatments. The Committee welcomed the assurance provided in terms of treating the backlog of referrals and actively monitoring patients going forwards and treating these according to clinical priority
• In terms of financial performance for month 12, the Trust delivered a surplus of £7.9 m against a planned deficit of £7.2 m. In month there had been a reduction in Covid related costs and capital expenditure had been spent in line with the plan. The Committee queried whether there were any implications for carrying a large amount of cash at the end of the year, and it was noted that although it could potentially impact upon emergency capital requests, no significant risks were highlighted.
• The Committee received an update from the Executive Infrastructure Group and noted the areas covered by the group and actions taken
	• The Committee approved the Business Intelligence Strategy
	• The Committee approved the setting of budgets for 2021/22 which had been set according to H1 assumptions, noting that planning for H2 could not be confirmed until further guidance had been received
	• The Committee approved the business case associated with BC-0398 Colorectal Cancer Pathway Redesign and BC-0407 Extension of Mobile MRI Rental
	• The Committee approved the following eREAFS:
	  ○ Elective Hip and Knee (eREAF 7575)
	  ○ Extension of LIMS Contract to Shrewsbury and Telford Hospital (SaTH) (eREAF 7502)
	  ○ National Blood Service (eREAF 7474)
	  ○ Digital pathology Sectra MSC (eREAF 7255)
	  ○ High Cost Tariff devices (HCTED) Zero cost model to Visible cost model (eREAF 7576)
	• The Committee approved the Board Assurance Framework for Quarter 4 which would be presented to the Trust Board for consideration and approval in May
	• The Committee approved the approach outlined in respect of business case reviews
	• The Committee approved the actions identified as a result of the Committee Effectiveness review and approved the revised Terms of Reference

Comments on the Effectiveness of the Meeting
• The Committee recognised that some clinical colleagues had to wait to discuss their business cases and it was agreed to consider these first on future agendas • The Committee welcomed the update in respect of cancer performance and the items covered within the meeting

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Data Security & Protection Update	Assurance	8.	Q4 Board Assurance Framework	Approval
2.	Executive Data Security & Protection Group Highlight Report (March 2021)	Assurance	9.	Business Case Reviews	Approval
3.	Month 12 Performance Report	Assurance	10.	Business Case Approvals: • BC-0398 Colorectal Cancer Pathway Redesign • BC-0407 Extension of Mobile MRI Rental	Approval
4.	Planned Care Safety Briefing / Cancer Services Gap Analysis	Assurance	11.	Authorisation of New Contract Awards and Contract Extensions	Approval
5.	Business Intelligence Strategy • Data Quality Strategy • Informatics Strategy	Information	12.	Committee Effectiveness Review	Approval
6.	Month 12 Finance Report	Assurance	13.	Executive Infrastructure Group Highlight Report	Assurance
7.	Financial Plan and Budgets 2021/22	Assurance			

3. 2021 / 22 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 & Transformation												
Mrs T Bullock	TB	Chief Executive												
Mr P Bytheway	PB	Chief Operating Officer												
Dr L Griffin	LG	Non-Executive Director												
Mr M Oldham	MO	Chief Finance Officer												
Mrs S Preston	SP	Strategic Director of Finance												
Mrs M Ridout	MR	Director of PMO												
Miss C Rylands	CR	Associate Director of Corporate Governance	NH											
Mr J Tringham	JT	Director of Operational Finance												

Executive Summary

Meeting:	Trust Board (Open)	Date:	5 May 2021
Report Title:	IM&T Strategy Update	Agenda Item:	11
Author:	Mark Bostock, Director of IM&T / IM&T Senior Management Team		
Executive Lead:	Mark Bostock Director of IM&T		

Purpose of Report:

Assurance	✓	Approval		Information	

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

Executive Summary:

As in many areas across the Trust, the last year has been challenging. There have been numerous required changes in the provision of ICT services, along with the challenges of increased staff sickness due to the pandemic, and infection prevention measures being required in many areas of operation.

As the year has progressed there has been a delay impact on some projects, including those in-flight and those in planning. However, none of the project delays have caused interruption to the services of the Trust, and none have exceeded their financial budget.

The Trust has however been able to progress a significant number of digitalisation enablers to support the organisation through this difficult period (e.g. Fever Detection technology, dynamic telephony, enhanced remote working, video consultations, video conferencing, appointment apps, vaccine apps and many more). The introduction of these supporting technologies has played a significant role in enabling the continuity and safe provision of Trust services through the pandemic. These are also technologies that will remain in place to provide an enhanced environment for business as usual service provision.

An area of development that has been progressing well is the modernisation of the trusts ICT infrastructure. When the Trust is able to move back to operating on a more business as usual footing, there are a number of emerging initiatives and improvements in foundation ICT services and service provision that will meet the most frequently identified requirements of clinical staff, whilst also laying a strong and agile technical foundation as a basis for progressing the digital agenda at pace.

The opportunity recently afforded to the Trust by NHSX, in supporting a Business Case for central NHS Digital Aspirant funding of up to £6m, gives the Trust a genuine opportunity to accelerate its clinical digital maturity at a much accelerated pace.

Key Recommendations:

The Board are asked to note progress made in the last period

IM&T Strategy Update March 2021

2.1 Infrastructure Services

2.1.1 Data Centre Refresh

The DELL Compellent Storage Area Network (SAN), is the Trusts main central file and data store. It stores data for line of business applications (e.g. MS Office and Email), and hosts data for some of the Trusts clinical systems. For the purpose of disaster tolerance and resilience, the Compellent is configured over three geographically separate sites or Data Centres (DCs). The County DC is self-contained, and the DCs at Royal Stoke are configured into a Primary and Passive configuration (Primary is the in use DC, Passive is the resilient 'mirrored' DC).

Due to the age of the DC infrastructure there is an increased risk of component failure and capacity issues.

Project Update

The programme of work commenced in August 2020 with a vendor selection process which resulted in a Hewlett Packard (HP) designed system being selected to replace the current infrastructure.

HP and Trust project teams completed the high level design work in November 2020 which enabled hardware to be ordered in December and delivered to UHNM in January. The hardware will be installed into Stoke and County Hospital throughout February to enable migration testing to start in March. The expectation is that migrations will run from March through to June 2021.

Over the past seven years (since the existing DC was commissioned), DC technology has significantly progressed. The replacement infrastructure will incorporate advanced technologies, proactive environmental and component monitoring and automated failover facilities that have significantly developed since the Trusts existing DC infrastructure environment was implemented.

Benefits include:

- The solution provides a single management system across all 3 datacentres allowing simpler management of the core infrastructure.
- The systems use Artificial Intelligence and Machine Learning to monitor the whole platform (Server's, Storage and network components). By integrating with the manufacturer cloud support platform the AI engine compares the configuration against over 40,000 other systems across the globe to anticipate possible problems before they are experienced at UHNM.
- The system is design to deliver 99.9999% availability. The data is protected using the highest and most secure levels of Disk RAID technology available (Triple + Parity data protection)
- All storage is provided using Solid State Disk (SSD) meaning there are no "spinning disk" which greatly increases performance and reduces risk of hardware failure.
- The platform is "Cloud ready" so if required can easily be extended to use cloud services whilst retaining the same management tools.
- The scalability of the solution is inherent due to its modular design

2.1.2 Microsoft Office 365

N365 is essentially "Office 365 for the NHS" and will provide the Microsoft Office product set including Word, Excel, PowerPoint, and Teams.

This is an essential upgrade for the Trust to maintain alignment with NHS Digital Cyber security requirements along with many functional enhancements.

The solution also provides a replacement for Microsoft SharePoint and Microsoft Exchange (email), on a central cloud based platform managed by NHS Digital.

Benefits

- Replace Office 2010 with licenced and cyber secure Office 365
- Replace SharePoint 2010 with a cloud based SharePoint solution
- Provides continued use of Microsoft Teams platform to support “remote working” requirements
- N365 includes all licensing required to implement a Bring your Own Device (BYOD) solution
- Migrate to a cloud based email platform (managed by NHSD)

Project Update

Working with commercial partners we have now secured the licensing required for the replacement programme to progress. A Trust project team has been formed and a third party (BDS Solutions) has been appointed to support the project. BDS is one of only two organisations recommended by central NHS to deliver such migrations. A major element of this project is ensuring that the new Office suite works with the current application estate and work is underway under the guidance of a dedicated Test Manager, to ensure this integration is understood and tested prior to the large scale rollout.

2.1.3 **Microsoft Windows Operating System upgrade to Windows 10**

The Microsoft Windows 7 Operating System went end of life (EOL) in January 2020 and is replaced by Microsoft Windows 10. NHSI have provided extended support for Windows 7 while Trusts migrate to windows 10.

Benefits

- Devices are designed and deployed based on security guidelines published by NHS Digital which are themselves based on National Cyber Security Centre (NCSC) best practices
- The infrastructure leverages the scalability of the Cloud technology for future projects
- The build process has been “industrialised and streamlined ” whereby all devices are pre-built to agreed build templates offsite in a 3rd party configuration centre

Project Update

The Windows 10 project has replaced >7,000 Windows 7 devices leaving <900 Windows 7 Devices remaining which are due to be replaced by April 30th 2021.

The device roll out has been impacted by the current COVID situation and access to some departments has had to be deferred. Therefore to enable the protection of the residual devices against cyber threats, support has been extended to cover off these remaining machines.

2. 1.4 **Single Sign On (SSO)**

The Trust currently uses the Imprivata Single Sign-on (SSO) within ED and the Outpatients department to enable users to login by “tap-on” of their ID Badge (the same as using “Tap” to pay using a credit card). The system removes the need for multiple user ID’s and passwords to remember and reduces those requirements to one 4 digit PIN code to access all systems whilst retaining corporate security guidelines. Single Sign On will also provide a mechanism for users to securely log in to a Virtual Desktop and to the Shared Health & Social Care Record when working remotely.

Funding challenges have meant that so far SSO has been available to a subset of the clinical teams. Thanks to support from charitable funding, we are purchasing an additional 2,500 licenses and 1,000 additional Tap-on readers to enable SSO to be deployed across the rest of the Trusts clinical areas.

Benefits

- Since ED SSO introduction has become the function most widely requested by clinicians
- As already proven within UHNM this solution enables faster login/logoff for users and reduced requirement to remember complex passwords.
- SSO has been recognised as adding direct clinical benefit in terms of productivity of clinical staff working in shared PC environments – particularly in busy patient areas.
- The system has also reduced calls to help desk for password resets, again improving clinical productivity.
- The Tap-on functionality also has the benefit that it can be configured to the working practices of clinicians so for example currently the user is only required to use a 4 digit PIN code every 4 hours, between those times it is simply a tap of the id badge to logon.
- This retains UHNM security requirements by providing two factor authentication whist minimising user effort thus streamline workflow.

Project Update

Following the gratefully received contribution of Coates family funding for this work a project and roll out plan have been developed, and work on implementation will begin in February and progress until May 2021. To implement SSO across the Trust.

2.1.5 **Medical device and non IT device Cyber protection**
There are a number of security challenges associated with today's interconnected medical devices. Many of these devices are high value capital investments. These devices have operating systems which are difficult to apply cyber patches to. This constraint means many could be vulnerable to cyber-attack. Disruption to such devices would have a significant detrimental impact to the operation of the Trust and patient care. We require a system which will enable proactive management and protection of devices and allow the mitigation of potential problems before they manifest into critical issues. The Ordr SCE (System Control Engine), solution enables the proactive control of connected medical devices by using sophisticated artificial intelligence (AI), technology to allow implementation of device management and threat mitigation.

The system:
- Discovers every connected device
- Profiles device behaviours
- Identifies any risks or vulnerability
- Automates a response.

Benefits
With a proven track record of usage in the US, the Ordr solution allows for proactive management and protection of medical devices (and other non IT devices that are network connected), against cyber-attack. This in turn will help assure the longevity of expensive and vital equipment and a better and more secure service for our patients.

Project Update
We have developed a plan with the clinical technology department for the implementation of a 30 day PoV (Proof of Value) deployment at our County site. This will run throughout March. We will look to demonstrate value by importing our existing medical device asset list into Ordr and using the solution to monitor:

- Legacy operating systems on devices
- Usage patterns
- Over saturated network links
- NHS Digital mandatory careCERT compliance

In parallel IM&T are working with KCOM to understand how and when the solution may be applied to the RSUH PFI managed network.

2.1.6 **Bring Your Own Device (BYOD)**
Bring your own device (BYOD) is a set of technologies that enables staff to use their personal devices to safely and securely access the Trust's clinical applications. The use of handheld devices such as iPod's, iPad's and iPhones is already embedded into the use of key applications such as Electronic patient observations and Nursing handover at the Trust. The adoption of BYOD is a key enabler in the further development of the Digitalisation roadmap and a natural evolution in the use of handheld devices by clinicians at the Trust, and one of the most frequently requested initiatives.

Previously the Trust has purchased application specific devices but this project is a response to staff requesting access on their own personal devices that they are familiar with. This also reduces the cost devices to the Trust, and provides the flexibility expected in a modern digital environment.

The platform will support multiple Operating Systems, including Apple, Android and Windows devices giving the users and application provider's flexibility to use alternative platforms should this be required.

The approach will also provide a "two way" security model:

1. For UHNM - protecting UHNM data
2. For Staff - protecting their personal data

The Trust can set policies on BYOD which can assure the security and health of all mobile devices connected to the network, before access is granted to any applications.

The solution creates a secure "corporate window" on a BYOD device which Trust can remotely manage and if needed remove without impacting the user's personal data. Staff will therefore be confident that information within the "corporate window" is restricted to the Trust access and only data in this area can be remotely wiped.

Benefits
Key Benefits that BYOD will bring include:

- Ability for clinicians to securely run mobile applications on their own devices thereby providing a better user experience and more efficient workflow. Including:
  - The Trusts clinical portal
  - Clinical and nursing handover
  - Electronic observations
  - Clinical messaging (to enable messaging between clinical teams)
  - Electronic Patient Records System mobile Apps (i.e. orders and results, EPMA).
- Better rotation support of junior doctors
- More care taken of devices
- Reduction of the current hardware requirements and costs
- Ability for personal devices to be managed centrally, ensuring reduced risk of compromise and / or cyber-threat.

Project Update
N365 includes the provision of a Microsoft BYOD solution. The solution uses cloud based technology and is built and maintained as a collaborative partnership between NHS Digital, Accenture and Microsoft. The Trust will use this platform to deliver appropriate and secure BYOD application access when it is made available by NHSD in the second quarter of the 2021 calendar year.

This N365 BYOD capability was originally due in 2020 but has not yet been released by NHS Digital.

However, IM&T will continue to work with NHSD in assessing, preparing and planning for the introduction of BYOD enabling technology, as soon as it is prudent and safe to do so.

2.1.7 **County Telephone System Replacement**
The analogue system is running on hardware which is now end of life and although the trust has a hardware contract, this presents a substantial risk.

Benefits
- The new solution will be a single joint Trust modern "voice over IP" technology system
- The system will be designed and built by recognised industry experts
- A new "red phone" system will be implemented

Project Update
The project commenced in January 2020 to replace both existing systems with a single Cisco solution designed to industry best practices to deliver a secure and resilient platform. The new Cisco infrastructure is in place and the majority of the 800 phones, with the exception of A&E and some COVID wards have been replaced. The remaining 70 phones (at time of writing), are in critical areas affected by COVID. IM&T are working with the clinical divisions to complete the roll out work by mid-March 21. This project was originally planned to culminate in Q3 19/20. However, logistical and safety constraints have meant that the project has incurred a significant delay to the roll out element.

There is however a contingency plan that if the analogue system should fail, the last few areas awaiting migration will not be without adequate telecommunication facilities.

3 Enabling Technology

3.1 Digitalisation programme

Implementation and roll out
The digitalisation programme was commenced in July 2017. It began in outpatients where a number of digital solutions were implemented.

The digitalisation programme has since commenced in inpatients', with the first stage being completed in April 2019. This programme stopped the routine requesting of case notes by wards and introduced the requesting of notes as and when clinically required.

The second stage of this programme is in development and is aimed at reducing the amount of paper being generated during an inpatient stay. This will be through the development of structured notes in iportal (the Trusts integrated clinical portal). Clinical engagement groups are in progress with various operational groups who are defining the new process and ways of working and identifying what hardware, integration and developments are required to enable this. This will also be combined with the implementation of speech recognition in inpatient areas. A new digital inpatient clerking document has been tested and due to commence pilot in early 2021 with AMU and SAU areas.

3.2 Sustainability & Transformation Programme (STP), Digital Work Stream

The digital programme now also encompasses the implementation of the Health Service Led Investment (HSLI) bids as detailed in Section 3.2 which includes the implementation of speech recognition to reduce the amount of remaining paper being generated and support the replacement of the current digital dictation solution.

The UHNM Bids include:-

3.2.1 Robotic Process Automation (RPA)

To implement an STP-wide intelligent automation platform releasing short-term benefit across a range of pilot automations. This scalable and high-secure platform will provide a foundation upon which to build additional processes through shared-learning and collaborative working across the local health economy.

Project update

The first process using this technology has now been developed and went live in Nov 2019. The process now automates the creation of network accounts for new starters once a call is logged with the service desk. This process now completes approximately 115 automatic account creations every month for new starters saving 10.5hours a service desk agent per month. As the process is automated and instantaneous it improves the experience for new starters to the Trust in relation to the access of UHNM systems; previously the average turnaround time was 60hours, this has significantly reduced to 1.5 hours.

In the response to the COVID pandemic a process has been developed and implemented for Midlands Partnership FT to upload the referrals in the E-Referral system into iportal, so clinicians would have the referral detail available where ever they did the clinic from and not have to rely on the paper forms.

Further processes have been mapped ready for development and include the automation of the NHS Data Base Tracing Service (DBS), trace and a process for extracting working lists from the ERS system into a report for monitoring and tracking the referrals.

Progress has also continued with the imaging department to develop a process in response to the COVID pandemic, for patients who are on a waiting list for an image, to receive a SMS and instructions to book an appointment as this can no longer be run as a walk in clinic; this is anticipated to go live in March 2021.

3.2.2 Electronic Patient Letter Access

This solution will facilitate patients accessing their own appointment letters via a patient portal (PHR).

This would initially be for UHNM, Midlands Partnership FT and North Staffordshire Combined Healthcare. However, this can be scaled for other organisations.

The solution design will notify the patient upon an appointment booked to then view the appointment letter details via the PHR and avoid the requirement/cost to print and post letters. The system solution will be extended to include the capability to view consultation letters and other correspondence following initial appointment letter deployment. The solution would be available to patients who have on-boarded to the patient portal who can then select a preference to receive letters electronically.

Project update

The business change teams have worked with Divisions and the Patient Experience Team to standardise attachments and leaflets that are sent to patients with appointment letters. These are configured within the 'fulfilment house service', and since August 2020 the Trust has used this service to outsource the printing and electronic letter management and also uploads the letters to the patient portal electronically.

Development continues to progress on the PHR with STP partners on the go-live of the app that will then allow the printing of the letters to be switched off once the letters are available in the PHR and the patients' preference has been set to receive electronically.

The project is scheduled to be completed in December 2021.

3.2.3 Speech Recognition

Project update
The speech recognition software has also been integrated with iportal (the UHNM clinical access portal), so it can be used in the iportal clinical noting solution and to navigate around the system. It will also be available to click and dictate in other clinical systems such as e-discharge.

The new integrated digital dictation and speech recognition software has been deployed across the organisation to all specialties within the roll-out plan. During December 2020 there were 444 clinicians using voice recognition. Further training is being offered to support clinical adoption and utilisation of the technology. Dermatology has already meant that typing no longer needs to be outsourced in areas such as.

An additional development has now been introduced to enhance the workflows for the clinicians, this allows the use of speech recognition to generate a letter and sign this off for the GP in on a simple workflow. This solution is now in pilot and will be reviewed in Q4 2020-21 for agreement to proceed to roll-out with training.

Further phases for development that are being investigated include the ability to use a structured note in iportal which will then auto generate a letter to the GP, and the option of using mobile speech recognition if being investigated.

3.2.4 Integrated Care Record
The project is to deliver an integrated and shared health and care record across Staffordshire and Stoke-on-Trent. The aim is to support the transformation of service delivery across the STP through innovative use of digital technology, providing health professionals with access to the information they need to deliver safe and efficient 'seamless' care, whilst empowering patients to control elements of their care.

An Integrated Care Record (ICR) allows doctors, nurses, pharmacists, other health care providers and patients to appropriately access and securely share a patient's vital medical information electronically—improving the speed, quality, safety and cost of patient care.

There are three main forms of health information exchange:
- **Directed Exchange**: ability to send and receive secure information electronically between care providers to support coordinated care
- **Query-based Exchange**: ability for providers to find and/or request information on a patient from other providers, often used for unplanned care
- **Patient Mediated Exchange**: ability for patients to aggregate and control the use of their health information among providers

These are accessed through a range of portal applications:
- **Clinical Portal:** Secure clinical view of an aggregated care record
- **Patient Portal:** Patients view into and control of their medical records
- **Reporting Portal:** Enterprise wide anonymised reporting

Progress Update
The first phase of the project to introduce the SystemC Graphnet went live in September 2020. Alongside this a link was enabled within the iPortal solution to provide an easier point of access for clinicians to the ICR.

Benefits
- Put the patient at the heart of care, empowering them to manage their own care and be part of decision-making.
- Provide clinicians with real-time, accurate information in order to improve patient outcomes.
- Make the shared patient data available to authorised clinicians and carers where and when it is needed.
- Support assessment and other data collection forms so that users from different care settings can add data.
- Support workflow so that clinicians and carers can perform tasks and then inform, refer or handover to others.

- There will be financial benefits, from areas such as reduction in Diagnostic tests, reduced Outpatient appointments, both first appointments and follow ups, reduced Admissions from A&E, and Admin savings by having more timely access to information.

Costs
First year costs for the solution across the STP have been secured from central funds, and additional sources of central funding will be underwritten by the Staffordshire and Stoke on Trent Clinical Commissioning Groups.

The ongoing costs for running the solution have been calculated at c£1.2m per annum. However, there will be no revenue cost to UHNM.

Next Phase
The next phases of the project that are currently in the review stages will include integrated care pathways and the design of the patient access portal.

4 Exploiting Technology

4.1 Electronic Observations (eOBS) – Vitals
Vitals is a mobile clinical system that monitors and analyses patients' vital signs giving clinicians accurate, real-time information for the safest possible patient care.

The National Early Warning Scores (NEWS2) functionality also supports the delivery of the Sepsis CQUIN. The system was implemented across the Trust in 2019, with further modular functionality being developed and introduced.

Project update
The project team have completed further rounds of user acceptance testing of an increased functional version of the software. The testing covers the general functionality of the system currently in use with additional Vitals+ functionality. This will allow the clinicians to capture and record the insertion of indwelling devices, and also the ED module. The upgrade and go-live of Vitals+ is due in February 2021, shortly followed by Vitalpac ED County in March 2021 and then Royal Stoke.

Discussions are underway with the Child Health Directorate for the development of a business case to support the implementation of Vitalpac for Paediatrics.

4.4 Medway Electronic Prescribing Medicines Administration System (ePMA)
The introduction of ePMA will enable the digitalisation of current paper based prescription charts across inpatients, ED and outpatients settings. This project supports the Trust's strategic objectives, IM&T Digital Transformation Strategy and UHNM Hospital Pharmacy Transformation Plan, as well as for the Staffordshire and Stoke-on-Trent Sustainability and Transformation Partnership (STP) for digital medicines optimisation. SystemC will be the supplier of the solution that will integrate to the current Medway patient administration system, discharge solution and iPortal.

The Medway ePMA solution is cloud based and System C have agreed to work collaboratively with UHNM as an agreed EPMA development partner. It is recognised that UHNM have the skills and experience to assess the requirements for a large acute Trust with complexities such as multiple specialties, sites and cross-boundaries. The Trust works closely with SystemC and other organisations for influence and inclusion in the design, development and testing on the product.

Benefits
- Reduced expenditure on Drug Charts
- Clear start/stop dates times required by EPMA reduce unnecessary drug use saving costs
- EPMA saves repeat prescriptions and prevents delays in treatments because it will only allow prescribing of drugs that are available
- Reduction in clinical incidents due to Adverse Drug Events leads to reduced litigation & penalty costs
- Provision PBR drugs data to mitigate future risk of income
- Staff productivity and efficiency gains by not collecting or processing paper drug chart equivalent of 4.0 full time equivalents. None cash-releasing benefit time that could be spent with patients and a consequent reduction in the need for agency staff.
- Patient experience and efficiency saving on patient flow and reduction on length of stay from time saved for Dr writing TTO but it is noted this is none cash releasing benefit

Project update
In collaboration with SystemC the ePMA roadmap is being revised due to technical and functionality developments need as well as organisational pressures. Consequently a revised timeline will be presented to meet the needs of the Trust ensuring the minimum functionality required is available to support a pilot go-live and deployment; this will be completed in Q4 2020-21 and shared with the Steering Group and Programme Board for approval.

A Project Initiation Document (PID), which specifies the scope of the project, and Terms of Reference have been completed and the project is now in its implementation phase. The project plan is being defined by both SystemC and the Trust to ensure all localised tasks are reflected. Focus continues on additional hardware for inpatient areas facilitated by the Estates and PFI department across both County and Stoke site; this will include additional computers on wheels and all-in-one devices within clinical rooms where prescriptions are collated by ward staff.

The EPMA environment is now available to the project team as a view-only system. This is allowing the core group to review the agile releases from SystemC that are received approximately every 6 weeks.

The Project team are continuing to monitor the functionality developments. Project timelines are in the process of being updated including the user acceptance testing cycles and pilot go-live.

Phase one of EPMA is scheduled to go-live in November 2022.

4.5 Laboratory Information Management System

A joint procurement against a national framework contract was undertaken between April and November 2019. This resulted in a Best and Final Offer which was within the estimated price included in the Outline Business Case. The Full Business Case was approved by the Board of each of the three Trusts during November 2019 and the LIMS contract with Clinisys (the supplier of the new LIMS) was signed in December 2019, alongside a Memorandum of Agreement between UHNM and MCHFT covering the Finances. Formal Project Initiation commenced in early January 2020 with a target go-live date of late June 2021 agreed

Project Governance arrangements were put in place, which mirror those of the established Pathology Network. The LIMS Steering Group is chaired by Helen Ashworth (LIMS Senior Responsible Officer and joint Chair of the Pathology Network Steering Group, the LIMS Programme Manager reports into both these Steering Groups

Project scope

- Replace the obsolescent Laboratory Information Management Systems at UHNM and Mid-Cheshire/ East Cheshire hospitals with Clinisys WinPath Enterprise, a new state of the art, single database LIMS network solution, in support of the nascent North Midlands and Cheshire Pathology Service across UHNM, Mid-Cheshire and East Cheshire Trusts
- Integrate the new LIMS, which is remotely hosted off premises in a fully managed service, with all third party clinical and corporate IT systems across the three Trusts
- Through a significant business change programme deliver improved laboratory flow and processes resulting in efficiencies supported by the delivery and operational use of:-
    - Real time sample tracking and sample location
    - Improve business reporting
    - Optimise workflows configured to maximise discipline efficiencies
    - Deliver dashboards to monitor sample status and turnaround times

Benefits

- Deliver a single database network LIMS solution that is more resilient and cyber-secure
- Foundation for expanding WinPath Enterprise (WPE)
- Enhanced patient experience – due to quicker turnaround times for results
- Improved business reporting
- Improved and expanded integration into partners' third party solutions.
- Ability to incorporate additional partners to expand the network to include additional Trusts (e.g. Shrewsbury and Telford Hospitals Trust)

Project update

- The Covid-19 pandemic has had an impact on the project with the first go-live slipped by 2 weeks (from late June to mid July) with a second phase go-live in October. The phased approach was necessitated by delayed building works delaying the availability of a centralised Microbiology Service in Stoke. The July go live is on an Amber status due to concerns over staff availability due to competing Covid-19 related pressures.

- Despite this, progress continued throughout the period. No key LIMS project milestones were missed and the amended go-live date of late July 2021 was maintained
- Although additional expenses have been incurred, the project remains within the budget agreed when the FBC was approved and is forecast to remain within budget next year
- The LIMS Programme Manager and the Pathology Directorate Manager have been working with the supplier and Shrewsbury and Telford Hospitals Trust on a full business case to enable SaTH to use the same instance of LIMS as a partner Trust within the North Midlands and Cheshire Pathology Service enabled by a DHSC capital grant of £1.6m which must be spent in year. This FBC was approved by the SaTH Trust Board on 11th February. Work has started on negotiating a partnership agreement which will need to be agreed by UHNM, ECT, MCHFT and SaTH. An
- At an operational level, the Low Level Design Phase is due to be completed in February. Confirm and Challenge sessions are underway before these Low Level Designs are formally approved and the relevant work stream is able to move into the Testing phase.

5 Data, Security & Protection (DSP)

The DSP Strategy outlines three obligations required to embed a culture of DSP; thereby providing confidence to our key stakeholders that personal and sensitive data is safe. Embedding these requirements ensures DSP is integral to the care of our patients and staff have the tools and techniques to apply data, security & protection principles into their daily activities. The DSP strategy supports the implementation of the IM&T strategy via these three obligations.

5.1 **People: We will ensure our staff maintain confidentiality of personal information**
Staff must complete DSP training on a yearly basis. Due to the current COVID19 pandemic NHS Digital extended the time frame for the completion of training (1st April 2019 to 30th September 2020) in readiness for submission September 2020. As at 30th September 2020 the Trust achieved 97%, which was a huge achievement considering Trust pressures. The launch of the DSP Toolkit (20/21) in October saw a revision to the training requirements, whereby staff are deemed in date between 1st April 2020 and 30th June 2021. Whilst the preferred method of training is on-line the use of DSP training workbooks are permitted during these extenuating circumstances. Reports are provided to the Divisional Management Teams to assess the current situation and address with their teams. Monitoring of performance is undertaken via the Divisional Performance Reviews, Executive DSP Group and IM&T Programme Board.

A DSP Training Needs Analysis is developed and reviewed on a yearly basis. In recognition of the growing awareness and importance of DSP the training needs analysis includes training for staff in specialist roles. These include SIRO, Caldicott Guardian, DSP Team, Information Asset Owner and staff involved with subject access requests. The DSP Team have developed these training modules with the yearly statutory and mandatory training module now live on ESR. Work is now underway to have SIRO and Caldicott training modules accessible via ESR. The current training report now incorporates the training position for all staff roles identified in the training needs analysis; together with a number of outcome measures to ensure staff understand their DSP responsibilities.

The need for staff to keep abreast of latest developments is imperative and one of the main approaches is access to policies and procedures. A suite of DSP policies and procedures are in place covering data protection, information security, cyber security and records management. These will continue to be reviewed following national updates from the national security centre or via the Information Commissioner's Office (ICO).

5.2 Technology: We will ensure the security and integrity of information held by the Trust
Brexit and the recent US Privacy Shield decision, stating it was longer deemed an adequate form of assurance to transfer data between the UK and offshore, have necessitated a review of all offshore data flows. As the UK is now deemed to be a third country work is underway to have appropriate contractual arrangements in place to transfer the data back to the UK. The UK Government is working closely with its counterparts to have an approved adequacy decision, ensuring the continuation of data flows between our offshore partners.

The Freedom of Information (FOI) Act provides anyone with the right to ask the Trust for a copy of any information that the Trust holds. It promotes openness, transparency, and accountability. The Trust has a legal responsibility to respond to all FOI requests within 20 working days. Whilst the Trust saw a slight fall in the response rate for April 2020, the Trust saw an improvement in the response rate during quarter two, sustaining the position during quarter 3. The DSP Team will continue to monitor the position in light of the lockdown measures in place during February and March 2021.

A collaborative programme of work, with Supplies and Procurement, has been initiated to review and strengthen the suppliers framework; undertaking due diligence, reviewing certification, having appropriate contractual and DSP documentation in place. This not only seeks to provide assurance as part of the yearly DSP toolkit self-assessment but it also seeks to strengthen our approach in monitoring and assessing DSP confidence with our suppliers.

Cyber security continues to be the key focus/ priority for the DSP Team. A cyber security assurance framework and improvement plan is being finalised, mapping to the DSP toolkit and incorporating national best practice. The improvement plan will be monitored via the Executive DSP Group, seeking assurance the plan is on track.

5.3 **Process: We will continue to monitor our processes and embed a process of continual improvement**
Monthly bulletins form part of the DSP Communications Plan, in keeping staff abreast of latest developments. A review of incidents and feedback from staff identified the need for further guidance and support on secure transfer of data. Secure data transfer and the use of technology, to communicate remotely with colleagues and patients (via the use of Apps) continue to be a key focus of the DSP bulletins.

Audit and observation is recognised as a key approach in seeking assurance that staff have understood their DSP responsibilities. In light of the current pandemic the DSP Team has reviewed the approach in conducting audits and spot checks. Service reviews and process reviews are now in place, incorporating a suite of DSP intelligence to identify areas for improvement.

5.4 **DSP Toolkit**
The 19/20 toolkit assessment was submitted 30th September 2020. The Trust was awarded a status of *Standards Not Fully Met – Plan Agreed*. An improvement plan has been submitted to NHS Digital with assurance the action plan will be implemented by March 2021.

6 Summary
Good progress continues to be made against the Trusts Digital Transformation Strategy with a number of new projects coming on line, and a busy deployment scheduled for 2021/22.

The protraction of COVID has contributed to the delay of some projects as documented above. However, none of these have brought additional cost to the Trust and all are progressing to revised time lines. Subsequently, a significant number of projects have been initiated / fast tracked through the pandemic, that have supported the Trust through this time, and accelerated certain areas of the Trusts Digital agenda ahead of time.

Projects that have seen some delay delay include:-

County Phone System Replacement Project
Original completion date December 2020.
Rescheduled completion date March 2021.
No additional risk or cost incurred to the Trust.

Windows 10 Project
Original completion date December 2020.
Rescheduled completion date April 2021.
No additional risk or cost to the Trust.

Laboratory Information Management System Replacement
Project originally scheduled June 2021.
Rescheduled completion date July 2021.
No additional risk or cost to the Trust.

Electronic patient letters project
Original completion date June 2020.
Revised completion date December 2021.

Electronic Prescribing & Medicines Administration Project
Original go-live date March 2022.
Rescheduled completion date November 2022.

Some of the additional projects that have progressed in the last period are included in Appendix 1 of the report.

There are a number of initiatives that have been recently delivered or that are currently in train that will provide for a number of significant enhancements in IM&T service provision at the Trust in the short term.

- **Cyber Protection of Clinical and Non IT Devices**
  As an integral part of the Trusts infrastructure refresh, AI driven Internet Of Things (IoT), and Medical Device cyber monitoring software will be installed to protect medical device and other network attached devices from malicious compromise.

- ***Additional Devices to access Clinical Systems**
  Use of COVID funding along with successful charity bids has significantly increased the number of mobile devices for front line staff and where appropriate patient usage.

- ***Schedule of Device replenishment**
  Developments in software and clinical functionality means that modern and adequate spec user devices are available. The move to a Device As A Service (DAAS), model means that end user devices will be replaced at scheduled intervals, ensuring that the Trusts device estate will be adequately functioning.

- ***Staff able to use their own devices to access the Trusts applications.**
  The move this year to Office 365 will incorporate Bring Your Own Device technology that will facilitate secure and safe access for staff personal devices to Trust systems.

- ***Free WiFi for staff and patients**
  The design of modern NHS Building can often restrict access to cellular networks.
  Aided with the support of the Trusts charity, UHNM now provides free of charge access for staff and patients to safely and securely access the internet, along with an array of multi-media patient entertainment amenities.

- ***High Performing Infrastructure**
  The more the Trust becomes clinically dependant on IT services, the more there is a requirement for 'always on' ICT. The implementation of a new state of the art Data Centre by HP in Q1 21/22, will provision UHNM with the latest technology in high performance, high capacity, disaster tolerance and self-diagnostics.

- **Resilient Network**
  A full review of network services undertaken at the end of the year is supporting the Trust in creating a Business Case for future Network & Comms provision to the Trust.

- **Enhanced Clinical Decision Support and Clinical productivity functionality**
  IM&T have been working with NHSX to attract funding via the NHS Digital Aspirant Programme. NHSX have provided the Trust with significant financial support for the creation of a Business Case that will give the Trust an opportunity to put a case forward for £5,750,000 digital maturity Investment in 2021/22.

*Initiatives that have most frequently been requested by the Trust clinical Local Negotiating Committee.

Whilst a number or projects have delayed through the COVID pandemic, the Trust has taken the chance to embed a number of digital enhancements that will remain and improve working practices indefinitely. Also, the modernisation and improvement initiatives that are progressing (listed above), and those on the IM&T roadmap for this year, will put the Trust in a strong position, with a robust and high performing infrastructure. This will facilitate the early acceleration of digital transformation, particularly for clinical services.

Transformation and People Committee Chair's Highlight Report to Board

April 2021

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The budgeted midwifery establishment is almost at Birthrate + recommendation from 2019 report. Additional funding bid from NHSE is being submitted to address this. Midwifery establishment will be included in the nursing workforce plan • Some concern regarding the challenges of obtaining records/data and information about the numbers of staff who have received the Covid vaccination outside of the Trust • 31 issues relating to attitudes and behaviours were raised through the Speaking Up route during quarter 4 although there are only 2 open cases from previous quarters	• Staff Story from AMU to be shared wider across the organisation • Beneath the 6 key priorities outlined within the Improving Together programme, a series of metrics have been identified to measure the success – discussions will be taking place around how that fits into the existing governance structure and what future reporting will look like • Consider Board Development Session on Improving Together Programme • Arrangements for ensuring pay progression can be delivered were outlined to the Committee • Arrangements to bring in overseas nurses following the recent recruitment programme continue although there are some additional challenges associated with quarantine requirements / funding which need to be addressed • Toolkit on Agile Working has just been launched, any member of staff can apply to work in an agile way if their work allows them to • A number of changes have been made to the disciplinary / investigation process following a gap analysis against the Imperial Disciplinary Policy • Cultural intelligence / awareness as part of the system to be covered as part of the Board Development Programme • Process for supporting innovation being developed
Positive Assurances to Provide	**Decisions Made**
• Staff Story shared from AMU around their experience of Covid, how they engaged support from the OD Team and delivered a programme of Wellbeing activity which has had an extremely positive impact on their team; improvements in PDP uptake and sickness absence have been seen as a result • Improving Together Programme has been launched with a promotional video to introduction the new team; rebranding has been completed following a recent review of terms / terminology used • From April 2021, the Workforce Bureau will operate virtually • Performance in completing PDRs and Statutory and Mandatory Training saw a slight increase in March • Staff Wellbeing and wellbeing support have continued as a priority • High level of student satisfaction confirmed through the National Student Survey along with high levels of preparedness for Foundation Year 1; 98% overall satisfaction score	• Approval of a number of actions proposed to further encourage and promote a culture of speaking up at UHNM • Approval of updated Terms of Reference for the Committee along with the Business Cycle which will be put forward to the Board for approval as part of the Rules of Procedure

Comments on the Effectiveness of the Meeting

- Fell behind slightly as more time was given to the beginning of the meeting to hear the AMU story and the Improving Together Programme
- Next year, consideration will be given as to how the Committee can dedicate more time to specific topics through a deep dive approach

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Executive Directors Update including Covid-19	Information	9.	Progress Report on Workforce Equality, Diversity and Inclusion	Assurance
2.	AMU Wellbeing Challenges	Information	10.	MBChB 2020 National Student Survey Summary	Assurance
3.	Improving Together Highlight Report	Assurance	11.	Q4 Board Assurance Framework	Approval
4.	Midwifery Workforce Review	Assurance	12.	Committee Effectiveness Review	Approval
5.	M12 Workforce Report	Assurance	13.	Executive Workforce Assurance Group Highlight Report	Assurance
6.	Q4 Formal Disciplinary Activity	Information	14.	Executive Research and Innovation Highlight Report	Assurance
7.	Imperial Disciplinary Policy – Action Plan / Review of Policy	Assurance	15.	2021 Contract Reform for SAS Doctors	Information
8.	Speaking Up Report – Q4 and Annual Report 2020-21	Assurance	16.	Review of Meeting Effectiveness, Business Cycle and Items for Escalation to the Trust Board	Information

3. 2019 / 20 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												
Mr M Oldham	MO	Chief Finance Officer												
Dr K Maddock	KM	Non-Executive Director												
Mrs M Rhodes	MR	Chief Nurse												
Miss C Rylands	CR	Associate Director of Corporate Governance												
Mrs R Vaughan	RV	Director of Human Resources												

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	5th May 2021
Report Title:	Speaking Up Report – Quarter 4 and Annual Report 2020-21	**Agenda Item:**	13
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 4 period of January – March 2021. An analysis of speaking up data for the year 2020-21 is included as Appendix 1.

Assessment – during the quarter 31 speaking up contacts were received. 26 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. 5 contacts were made to our Employee Support Advisors, and are included in our reportable speaking up data.

Progress against our FTSU Index action plan and benchmarking with our Model Hospital Group are included as appendices.

Key Recommendations:

Trust Board is asked to note:

- The speaking up data and themes raised during Quarter 4 and throughout 2020-21
- The actions proposed to further encourage and promote a culture of speaking up at UHNM.

Speaking Up
Quarter 4 and Annual Data Report 2020-21

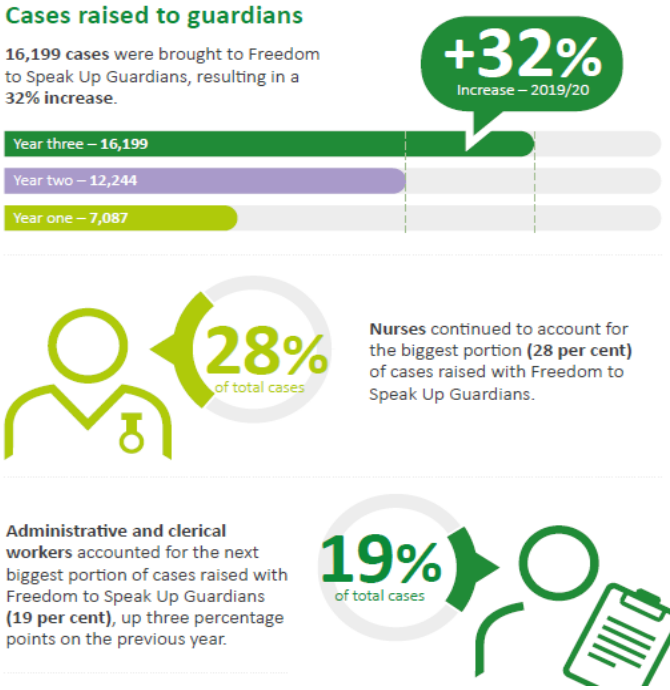
1. Introduction

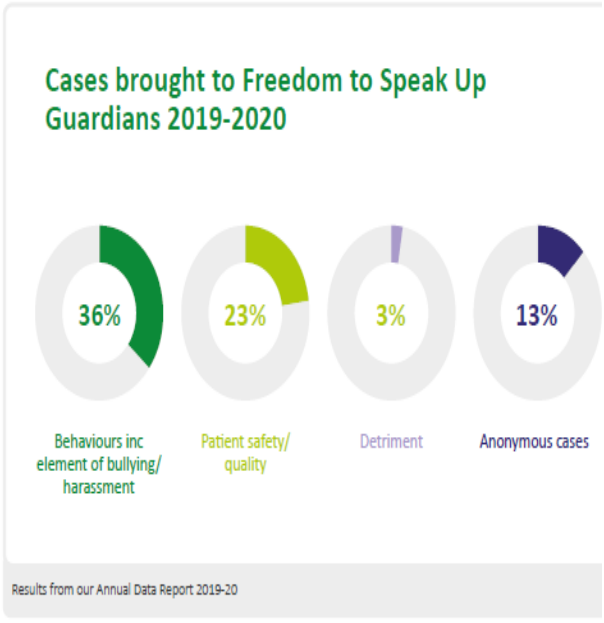
This Quarter 31 speaking up contacts have been made via the UHNM speaking up routes, which include 26 concerns recorded on the speaking up tracker which records issues raised with the Freedom to Speak Up Guardians; the Chief Executive's Office; within a division or via CQC/other routes that have then been notified to the FTSU Guardian for inclusion on the speaking up tracker. One of these concerns was raised anonymously. 5 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

National Guardians Office Annual Report – 2019-20

The National Guardians Office Annual Report was released on 18th March 2021 and showed that there has been an increase in cases raised through speaking up channels compared to the previous year:





National Guardians Office 5 Year Strategy

Henrietta Hughes, National Guardian has recently been presenting the NGO's draft five-year strategy at regional network meetings. Guardians have provided feedback and the final strategy document will be released in the near future.

Model Hospital and Benchmarking Data

Included as Appendix 3 is an updated benchmarking table demonstrating UHNM Quarter 1, 2 and 3 FTSU data compared with our Model Hospital group.

The National Guardians Office has released new reporting guidance, and the UHNM FTSU Guardian attended a training webinar in March 2021. The new guidance is effective from Quarter 1 2021. In summary, the following changes have been made to the guidance:

- 'Worker safety' has been added as a category (in addition to the existing 'patient safety/quality' and 'bullying and harassment' categories)
- The term 'detriment' has been replaced with 'disadvantageous and/or demeaning treatment'
- The definitions for various categories have been updated for added clarity
- A section has been added on how the data submitted by FTSU Guardians to the NGO is used for sharing and learning

3. Staff Survey 2020

A new question was introduced to the 2020 NHS Staff Survey specifically relating to a speaking up culture:

Question	Average for Acute Trusts	UHNM 2020 Result
I feel safe to speak up about anything that concerns me in this organisation	65.0%	63.6%

The other 2020 Staff Survey indictors relating to speaking up demonstrate that we have improved against all of the safety culture indicators, however UHNM under performs compared to the average for acute trusts on all indicators except 'when errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again' where we perform better than the average. It is positive that the gap with the acute trust average is reducing with the majority of indicators as demonstrated in the updated Speaking Up Index Action Plan (Appendix 2).

Question	Average for Acute Trusts	UHNM 2020 Result	UHNM 2019 Result	UHNM 2018 Result	UHNM 2017 Result
My organisation treats staff who are involved in an error, near miss or incident fairly	61.4%	58.7%	57.4%	55.9%	52.3%
My organisation encourages us to report errors, near misses or incidents	88.2%	86.2%	84.5%	82.4%	83.4%
If you were concerned about unsafe clinical practice, would you know how to report it?	94.6%	93.4%	92.7%	93.4%	93.3%
I would feel secure raising concerns about unsafe clinical practice	71.8%	69.8%	67.8%	65.6%	65.9%

Other safety culture indicators in the Staff Survey not included in the Speaking Up Index:

Question	Average for Acute Trusts	UHNM 2020 Result	UHNM 2019 Result	UHNM 2018 Result	UHNM 2017 Result
I am confident that my organisation would address my concern	59.1%	56.7%	56.1%	52.7%	52.7%
When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again	72.7%	73.1%	69.9%	67.6%	68.2%
We are given feedback about changes made in response to reported errors, near misses and incidents	61.9%	60.0%	58.9%	57.7%	53.9%

4. Supporting our Ethnically Diverse Staff to Speak Up

Associate FTSU Guardian Su Lapper attended the first Keele Medical School Raising Concerns meeting in February 2021, which was set up following a number of issues raised by students of an ethnically diverse background. Keele are implementing a system of student representatives in each year that medical students can go to with any issues. They will work with the service providers and FTSU Guardians and will raise awareness of behaviours that are not acceptable and signpost to the speaking up routes to raise issues.

5. 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 'Speaking Up' and 'Listen Up' are now live on ESR. These are pre-requisite training for the UHNM Gateway to Management programme. The material from both programmes has been adapted and 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 next phase of the NGO training is a Trust Board awareness package, which is anticipated later this year.

6. Internal Audit of Freedom to Speak Up

One of the actions from the KPMG audit of the UHNM freedom to speak up arrangements was for the Associate Freedom to Speak Up Guardians to access the NGO training as soon as it becomes available again (it had been paused due to Covid-19). Training dates have now been released for April, May and June and places have been reserved for our Associates.

7. Quarterly Speaking Up Cases – Quarter 4 – January – March 2021

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

Month	No. of contacts in the Quarter	Of which were raised anonymously	Of Which are Closed	Reports of detriment/ victimisation as a result of speaking up
January	5	0	1	0
February	10	0	4	0
March	11	1	1	0
Total	**26**	**1**	**6**	**0**

One case was reported anonymously to the FTSU Guardian. A signal of a healthy speaking up culture is that staff feel able to raise issues and concerns openly, as opposed to anonymously.

Theme	Number
Attitudes and behaviours	15
Equipment and maintenance	0
Staffing levels	0
Policies, procedures and processes	6
Quality and safety	3

Theme	Number
Patient experience	1
Performance capability	0
Service Changes	1
Other	0
Total	**26**

Summary of speaking up contacts recorded on the Speaking Up Tracker during Quarter 4 January - March 2021:

No.	Theme	Summary	Status
1.	Attitudes and behaviours	Reporter felt that they were treated differently to colleagues when reporting covid symptoms and felt pressurised to come into work.	Escalated to Division ACN who dealt with the issue and communications reiterated to the department on the correct management of staff with covid symptoms. Closed.
2.	Quality and safety	Clinical concerns raised about a service and patient experience.	Escalated to Chief Nurse. Meeting held and action plan developed including fact finding investigation – active.
3.	Attitudes and behaviours	Reporter has concerns about treatment by colleagues and manager.	Supported to raise issues through grievance process - active.
4.	Attitudes and behaviours	Reporter concerned about treatment of another staff member by line manager and culture in department.	Supported to raise issues with next level manager – action plan in place – closed.
5.	Attitudes and behaviours	Concerns raised within Division of inappropriate comments being made to colleagues	Fact Finding investigation underway – active.
6.	Quality and safety	Reporter raised concerns about safety of work colleagues and following of covid-19 work environment guidance.	Division undertook fact find and action plan in place to address issues.
7.	Attitudes and behaviours	Staff member raised issues about behaviour of colleague.	Discussed options about how to raise issues, reporter considering next steps.
8.	Attitudes and behaviours	Reporter raised concerns about experience as doctor in training.	Meeting held, escalated to training lead (see also 24 below).
9.	Attitudes and behaviours	Reporter raised concerns about treatment by manager.	Supported to raise grievance. Meeting held with Associate Chief Nurse for area. Fact finding investigation underway – active.
10.	Attitudes and behaviours	Reporter raised concerns about treatment by manager (related to 9, above).	Meeting held with Associate Chief Nurse. Fact finding investigation underway – active.
11.	Attitudes and behaviours	Reporter raised on-going issues with behaviours in their department.	Grievance process active, supported to raise further concerns.
12.	Patient experience	Concern raised by external doctor via FTSU Guardian about care of patients on a ward.	Clinical Director leading fact find review – active.
13.	Policies, processes and procedures	Reporter raised issues about recruitment process.	Supporting individual to raise issues with next level manager.
14.	Attitudes and behaviours	Anonymous letter sent in post to FTSU Guardian about bullying behaviours within their department.	Escalated to division. Informal listening events held in first instance. This has now progressed to a fact finding investigation - active.

15.	Policies, processes and procedures	Reporter raised issues about breach of information governance.	Reporter raised issues with manager. Fact find investigation underway.
16.	Attitudes and behaviours	Contact made to FTSU Guardian about behaviours.	Meeting arranged.
17.	Policies, processes and procedures	Reporter concerned about process followed for recent appointment.	Process reviewed, reassurance provided. Closed.
18.	Attitudes and behaviours	Reporter raised issues relating to allocation of work, opportunities for development and flexible working.	Supported to raise issues, changes implemented following meeting. Closed.
19.	Service Changes	Reporter feels unfairly treated about a service change.	Supported to raise issues and partly addressed. Further meeting planned.
20.	Policies, processes and procedures	Reporter raised issues about lack of flexibility within their department to enable time for prayer.	Supported to resolve with line manager and additional communications shared in advance of Ramadan. Closed.
21.	Policies, processes and procedures	Reporter felt that their sickness absence was not being recorded appropriately.	Issue resolved. Closed.
22.	Quality and safety	Reporter raised issues with way a Datix was managed.	Supported to raise with senior manager and Datix reopened and actioned appropriately. Team received training on managing incidents. Closed.
23.	Policies, processes and procedures	Reporter raised issues about recruitment process.	Meeting arranged to discuss issues.
24.	Attitudes and behaviours	Reporter raised issues about lack of induction, working relationships between teams on a specialty area, behaviours, lack of objective setting and teaching opportunities.	Feedback provided to the nursing teams by the Divisional ACN. Meeting held with the medical education lead which has resulted in an action plan. See 'learning from cases' section.
25.	Policies, processes and procedures	Reporter raised issues about process followed during recent recruitment.	Escalated to manager. Active.
26.	Attitudes and behaviours	Concerns raised about response given when reporter raised issues with training needs not being met, compared to colleagues.	Supported to raise issues through process – active.

Open Speaking Up Cases from Previous Quarters

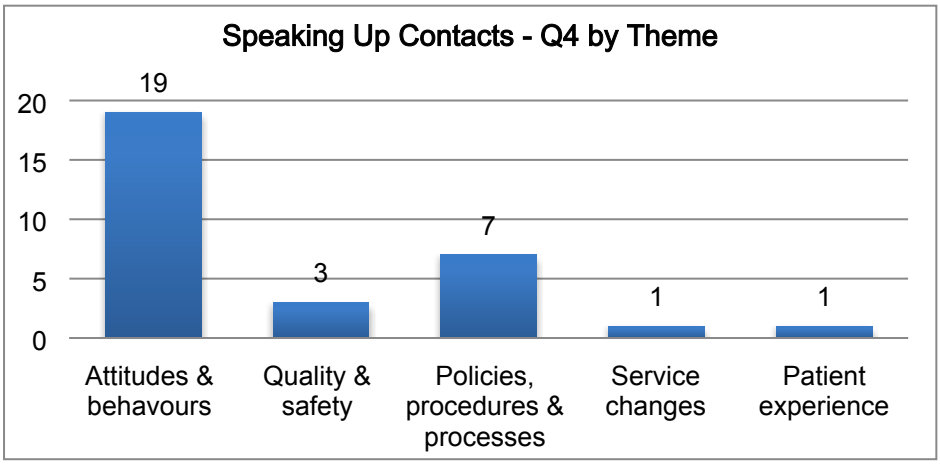
Theme	Summary	Month Case Raised	Status
Attitudes & Behaviours	Concerns raised about how a grievance is being managed.	June 2020	External Investigation into grievances agreed as way forward. Objection from the reporter to the proposed Investigating Officer, alternative sought and secured. Active investigation.
Attitudes & Behaviours	Grievances submitted relating to behaviours	November 2020	Grievance investigation active.

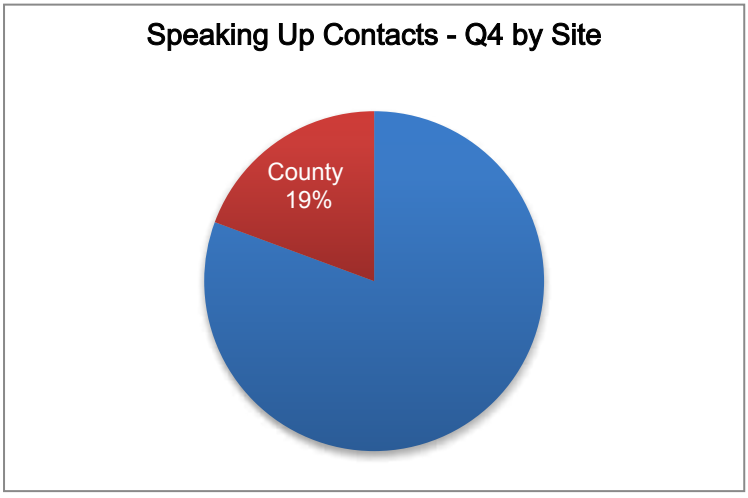
Issues raised with our Employee Support Advisors

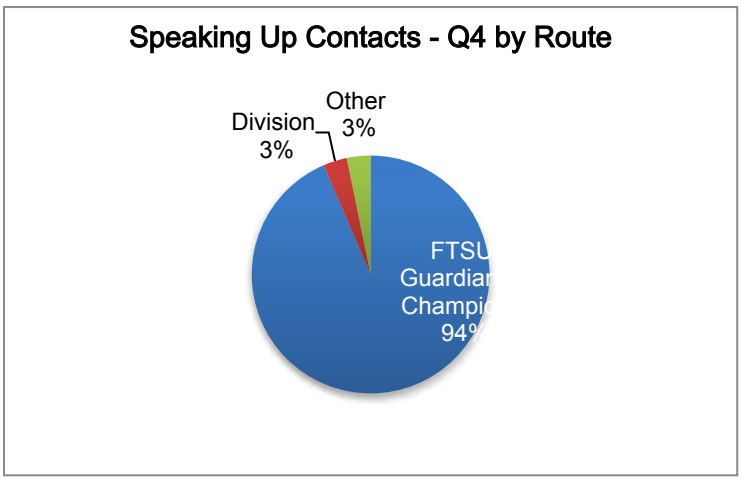
The NGO requests on a quarterly basis the number of concerns raised through freedom to speak up channels (i.e. Freedom to Speak Up Guardians and champions). Our Employee Support Advisors act as speaking up champions and therefore their activity is included in NGO data submissions. During the quarter our ESA's have received 5 contacts relating to the following themes:

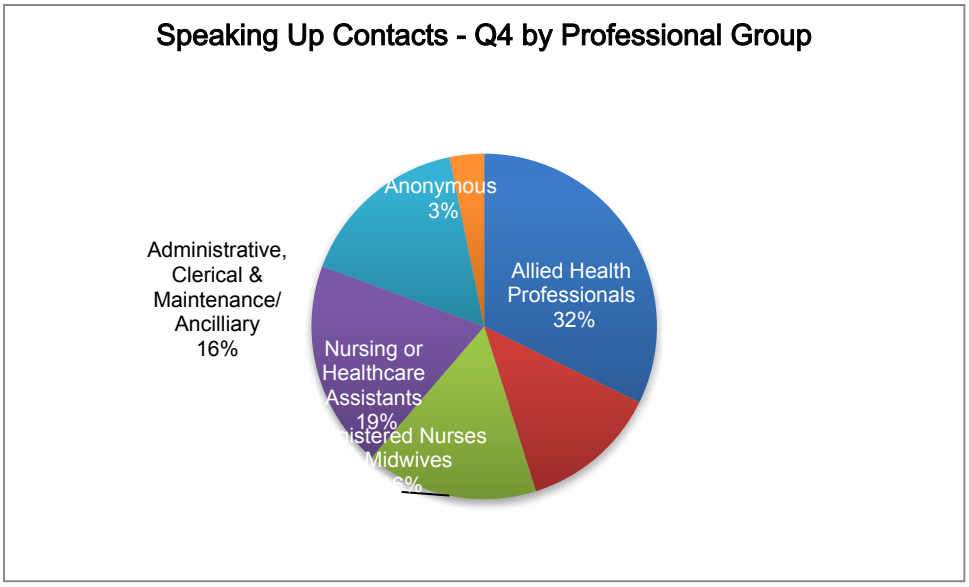
Theme	Number
Attitudes and behaviours	4
Equipment and maintenance	0
Staffing levels	0
Policies, procedures and processes	1
Quality and safety	0
Patient experience	0
Performance capability	0
Service Changes	0
Other	0
Total	**5**

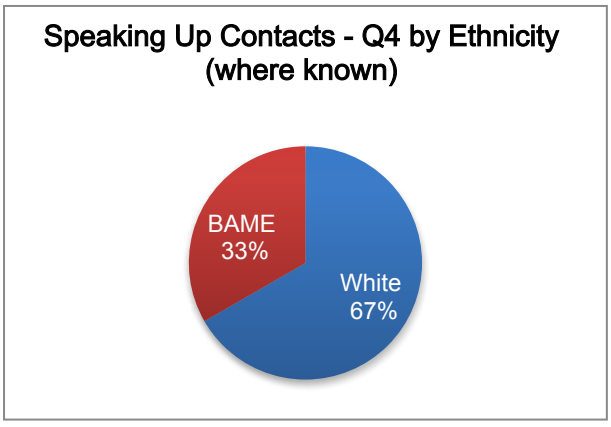
Quarter 4 Data Summary of All Speaking Up Contacts:











8. Learning from cases

One of the cases during the quarter related to the experiences of a doctor in training. The issues raised related to the induction in the specialty areas, working relationships between nursing and medical teams on a specialty area, behaviours, lack of objective setting and teaching opportunities. The reporter was supported to raise the issues with the Lead for Doctors in Training. An initial plan has been proposed, including:

- New cohorts of overseas doctors to have improved induction programme
- Lead to discuss behaviours and attitudes with consultant colleagues
- Opportunity for other junior doctors to share their experiences with the Lead

- Associate Chief Nurse for the area worked with nursing teams to learn from the experiences and improve communication between professional groups

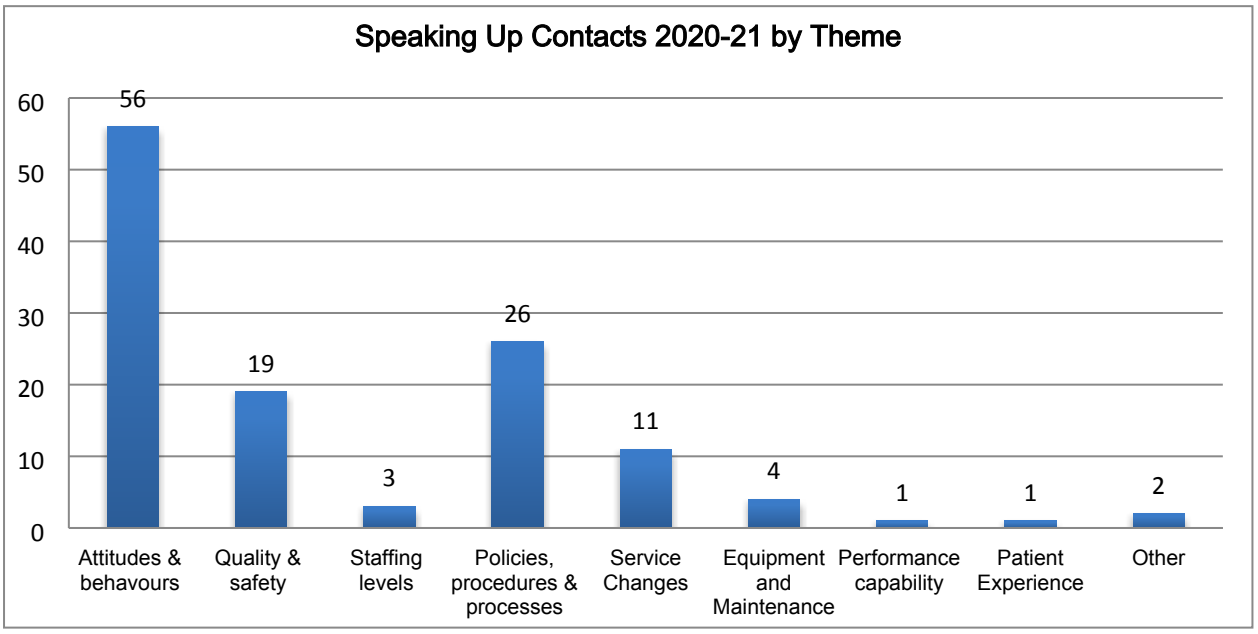
9. Recommendations

Trust Board is asked to note the activity and actions relating to speaking up undertaken in the Quarter 4 of 2020-21, and the focus going forward over the next quarter, which will be:

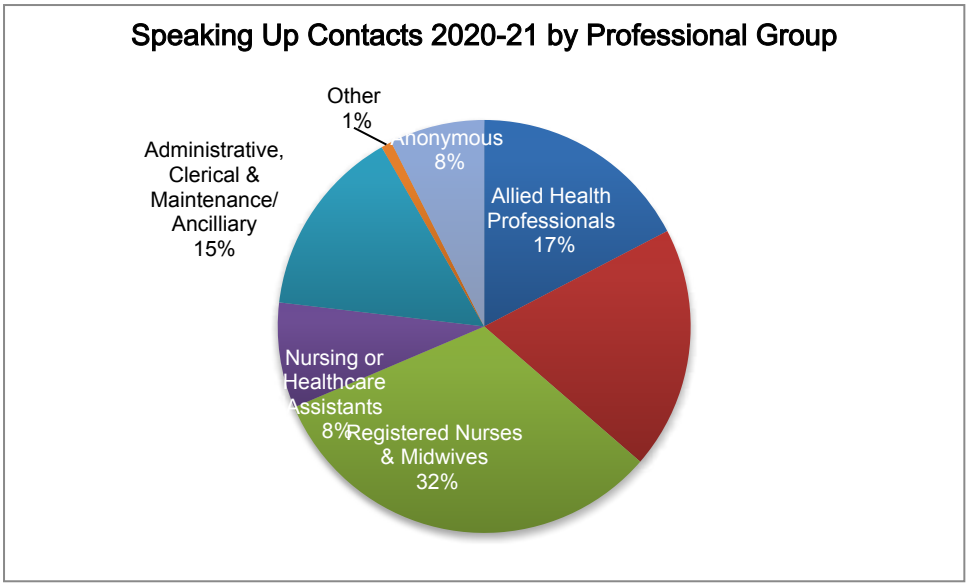
- Launch the 'Speaking Up' and 'Listen Up' training in the UHNM statutory and mandatory programme
- Advertise for a replacement Associate FTSU Guardian now that the job description has been reviewed
- Continue with the development plan for the Work in Confidence reporting system
- Introduce a 'Learning from Speaking Up' section on the Intranet to show the outcomes from speaking up cases

Appendix 1: Annual Data Report 2020-21

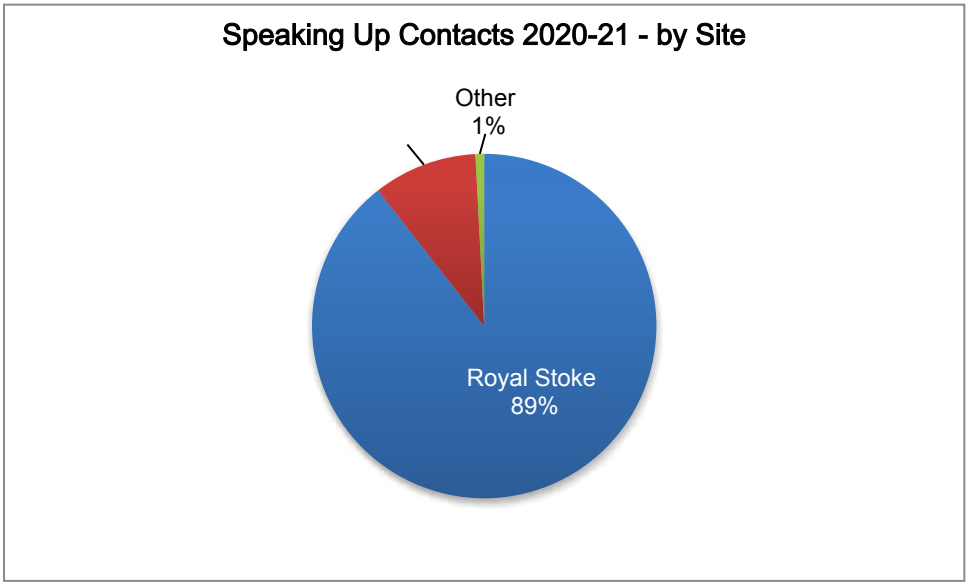
During 2020-21, 123 speaking up contacts were made via the UHNM speaking up routes:



Attitudes and behaviours, as in previous years is the most commonly reported theme, with 45% of contacts relating to workplace behaviours. Nationally, behaviours are also the most commonly reported theme of cases.



Like the national picture, registered nurses account for the biggest proportion of cases raised.



Appendix 2: 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% 2020: 58.7%	58.3% 59.6% 61.4%	2.4% 2.2% 2.7%	• 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. March 2021 'Listen Up' training released. Now pre requisite training for Gateway to Management. Next steps to incorporate this training into UHNM statutory and mandatory training.	~~May 2020~~ Revised timescale: May 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

FTSU Index Indicator	UHNM %	Acute Trust Average %	Gap %	Action / Recommendation	Timescale	Progress Rating
				• 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% 2020: 86.2%	87.9% 88.2% 88.2%	5.5% 3.7% 2.0%	• 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. March 2021 'Listen Up' training released. Now pre requisite training for Gateway to Management. Next steps to incorporate this training into UHNM statutory and mandatory training.	~~May 2020~~ Revised timescale: May 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. **Speak Up and Listen Up are required pre requisite modules for Gateway to Management delegates.**	~~May 2020~~ Updated timescale: NGO Listen Up training released March 2021. Target date of May 2021 for launch of UHNM stat & mand training	GB

FTSU Index Indicator	UHNM %	Acute Trust Average %	Gap %	Action / Recommendation	Timescale	Progress Rating
				• 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% 2020: 93.4%	94.3% 94.2% 94.6%	0.9% 1.5% 1.2%	• 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	~~May 2020~~ Updated timescale: NGO Listen Up training released	GB

FTSU Index Indicator	UHNM %	Acute Trust Average %	Gap %	Action / Recommendation	Timescale	Progress Rating
				package. **Speak Up and Listen Up are required pre requisite modules for Gateway to Management delegates.**	March 2021. Target date of May 2021 for launch of UHNM stat & mand training	
				• 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% 2020: 69.8%	69.3% 70.4% 71.8%	3.7% 2.6% 2.0%	• 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 3: Benchmarking Data

Freedom to Speak Up - National Guardian Reporting Data Q1, 2 and 3 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
Q3	28	112	11	32	29	10	45	No data	7	15
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
Q3	0	18	0	2	3	0	3	No data	0	3.3
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
Q3	6	13	1	1	5	1	6	No data	0	4.1
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
Q3	15	44	10	0	21	2	34	No data	0	15.8
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
Q3	1	1	0	1	2	0	2	No data	0	0.9
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%**

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	5th May 2021
Report Title:	Integrated Performance Report, month 12 2020/21	**Agenda Item:**	14.
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 gradual decline in the number of patients being admitted with Covid-19, seen in February, continued into March. The number of inpatients reduced further and by the middle of March the number was < 50, (from a peak of 349 in Jan). The number of covid-positive patients in critical care also reduced but more slowly. New daily new cases reduced to around 3/day. The number of patients who had had covid-19 and were discharged reached 3,602. The number of bed restrictions/ closures continued, however numbers reduced and through March the number reduced further and on some days there were zero restrictions

Quality & Safety:

The Trust achieved the following standards in March 2021:

- Harm Free Care improved to 97.8% and continues to be above the national 95% target
- Falls rate was 5.6 per 1000 bed days
- 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 99.2% (via Safety Express audit)
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- Serious Incidents have increased since start of COVID-19 Wave 2 in October 2021 with 14 reported in March 2021.
- Rate of falls reported that have resulted in harm to patients has remained relatively stable at 1.6 compared to 1.5 in previous month. The rate of patient falls with harm continues to be within the control limits and normal variation
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- COVID-19 deaths attributed to the 'Definite' category (according to the National definition of Nosocomial deaths) decreased to 3 in March 2021

Operational Performance:

The Trust system wide 4hour performance increased to 81.7% (February 78.3%) and for RS this was 65.2% (February 63.8%). In March 21 the Trust had zero 12hour trolley waits.

The National ask for elective care has been revisited and March saw the release of guidance for the first six months of 2021 and these will be displayed in next month's report. For March the actuals against BAU, was outpatients 94.3% and inpatients 72.7%. This demonstrates the efforts to maintain outpatient capacity.

The number of elective operations for UHNM (inpatients and day cases) increased in March. For RS & County, Elective operations increased to 7,077 (compared to February 5,676).

The indicative RTT performance for March is 62.5% (February is 63.52%). For March, the total number of Referral To Treatment pathways grew to 56,601 (February 53,295). This is above the forecast 46,100. The backlog is steadily increasing with a final March number of 21,244. The Trust has 4,591 over 52 week breaches as a consequence of standing down elective work.

For Cancer, the Trust is predicted to achieve against Rare cancers and the 28 day standard. The total PTL

remains steady although the backlog has fallen slightly. The 104+ day backlog is showing normal variation at 45 for March 21.

The 2ww PTL rose following the second phase of the pandemic , however from January the PTL reduced and has remained steady at a level below the mean, although the size of the waiting list is still higher than that seen pre-covid. Performance, whilst under achieved in March at 91.4%, remained steady and above that seen in January (88.16%). Significantly more patients were seen on the 2ww pathway, in month, than at any time in the previous year. Demand remains high in some specialties such as Breast, and overall numbers are slightly higher than the same time last year.

The latest data on 62 day performance is achieving 60.1%. Despite the third, most challenging wave of covid and significantly reduced theatre capacity, cancer surgeries and other cancer treatments were maintained in house and in the IS, and patients were dated according to their clinical priority rather than their clock start date, resulting in the lower performance. The 62 day PTL and backlog which had been reduced, has remained steady with levels now as seen pre-pandemic. Similarly the number of patients in the 63-103 days is also reducing. The corporate cancer team has completed a high level specialty comparator analysis of referrals and treatments 2020 compared to 2021 with an in depth clinical review of pathways over the next month to contextualise our cancer assurance/risk evaluation for the second covid19 surge response.

The Indicative DM01 performance for March 21 is 84.1% (February 90.1%).

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

From April 2021, the Workforce Bureau will operate as a “virtual workforce bureau” through the respective HR leads rather than meeting formally as a group. Monthly reports will be produced from the “virtual workforce bureau” and reported into the newly established Trust Operational Delivery Group.

Staff Wellbeing and wellbeing support remain a priority. The Wellbeing Plan has been refreshed and updated and the focus going forward is on the continued provision of staff support to ensure the psychological wellbeing of staff

Sickness and covid-related absences continue to be monitored daily. Staff showing symptoms, or with household members showing symptoms, are tested and results returned within 24-48 hours

Risk assessment processes remain in place and all ethnically diverse staff and Category C risk assessments continue to be reviewed and updated if necessary. The Empactis system is used to provide managers with health risk assessment reminders and work with Occupational Health continues to embed risk assessments into the pre-employment health assessment process. The Risk Assessment form continues to be updated as new guidance is received.

The rapid roll out of the Covid-19 vaccine among our own staff and frontline healthcare workers in our partner organisations, care workers and over 80 year olds closed on 1st April 2021. More than 41,539 doses were administered by the team of vaccinators at both the Royal Stoke and County Hospital since the hub launched in December last year.

The key performance issues are that the sickness rate remains above target and that compliance with PDR requirements is below target. The Executive decision taken to suspend PDR’s has been lifted with the expectation that overdue PDRs are scheduled from Q2.

Sickness
The in-month sickness rate was 4.42% (4.70% reported at 28/02/21). The 12 month cumulative rate reduced to 5.37% (5.43% at 28/02/21).

Appraisals

The Non-Medical PDR compliance rate was 75.56%* at 31st March 2021 (73.94% at 28th February 2021).

* This figure has been updated from that reported to Transformation and Performance Committee and reflects the PDR's input to ESR after 31st March, but relating to that period

Statutory and Mandatory Training
The Statutory and Mandatory training rate at 31st March 2021 was 93.85% (93.76% 28th February 2021). At 31st March 2021, 90.19% of staff had completed all 6 Core for All modules (89.89% at 28/02/21)

For Finance, the key messages are:

The Trust received confirmation that it will receive several non-recurrent revenue streams to support the financial position for 2021/21 including additional funding for M7-12 relating to the TSA agreement (£12.4m), funding of the annual leave accrual (£10.3m), reimbursement of other operating income losses (£7.4m) and funding for the Flowers vs East of England Ambulance case (£1m).

The above have supported the Trust to deliver a surplus of £7.9m for the year against a planned deficit of £7.2m. Aside from the above, the position is driven by underspends against the COVID-19 allocation, continued slippage against growth funding and the winter plan; all of these items are non-recurrent.

The Trust position in month 12 has also been impacted by NHSIE fully funded adjustments in respect of additional employers pension contributions (£21m) and DHSC issued PPE for the year (£16.3m) which have impacted both the income, pay and non-pay positions.

The Trust incurred £1.8m of costs relating to COVID-19 in month which is a reduction in comparison with Month 11 (£2.0m) primarily in non-pay due to reduced demands on testing. This remains within the Trust's allocation with £0.3m being chargeable on top of this allocation.

Capital expenditure for the year to date stands at £66.3m which is in line with the plan of £66.4m. Overall PDC schemes have expenditure in line with the funding available and therefore the Trust has been able to bring forward elements of the RI demolition work in to 2020/21 which offset underspends in expenditure for decant related schemes.

The month end cash balance is £55.8m which is £42.1m more than plan.

Key Recommendations:

To note performance.

NHS
University Hospitals of North Midlands
NHS Trust

Integrated Performance Report

Month 12 2020/21

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Contents

A note on **SPC**

University Hospitals of North Midlands NHS Trust

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

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

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

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

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

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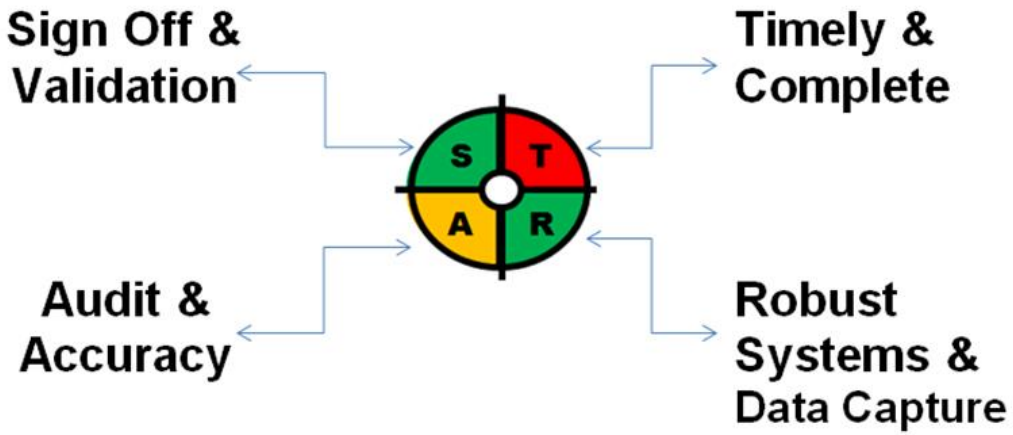
A note on **Data Quality**

University Hospitals of North Midlands NHS Trust

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



Explaining each domain

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

RAG rating key

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

Quality

Caring and Safety

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

Quality Spotlight Report

NHS University Hospitals of North Midlands NHS Trust

Key messages

The Trust achieved the following standards in March 2021:

- Harm Free Care improved to 97.8% and continues to be above the national 95% target
- Falls rate was 5.6 per 1000 bed days
- 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 99.2% (via Safety Express audit)
- Zero avoidable MRSA Bacteraemia cases reported
- C Diff target below trajectory target of 8 during March 2021 with 6 cases reported
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Quality Dashboard

NHS University Hospitals of North Midlands NHS Trust

Metric	Target	Latest	Variation	Assurance
Patient Safety Incidents	N/A	1535		
Patient Safety Incidents per 1000 bed days	N/A	44.69		
Patient Safety Incidents per 1000 bed days with no harm	N/A	31.24		
Patient Safety Incidents per 1000 bed days with low harm	N/A	10.89		
Patient Safety Incidents per 1000 bed days reported as Near Miss	N/A	1.66		
Patient Safety Incidents with moderate harm +	N/A	24		
Patient Safety Incidents with moderate harm + per 1000 bed days	N/A	0.70		
Harm Free Care (New Harms)	95%	97.8%		
Patient Falls per 1000 bed days	5.6	5.6		
Patient Falls with harm per 1000 bed days	1.5	1.6		
Medication Incidents per 1000 bed days	N/A	4.7		
Medication Incidents % with moderate harm or above	TBC	1.85%		
Patient Medication Incidents per 1000 bed days	N/A	3.8		
Patient Medication Incidents % with moderate harm or above	TBC	2.33%		

Metric	Target	Latest	Variation	Assurance
Serious Incidents reported per month	N/A	14		
Serious Incidents Rate per 1000 bed days	N/A	0.41		
Never Events reported per month	0	0		
Duty of Candour - Verbal/Formal Notification	100%	100%		
Duty of Candour - Written	100%	83.5%		
All Pressure ulcers developed under UHNM Care	TBC	50		
All Pressure ulcers developed under UHNM Care per 1000 bed days	N/A	1.46		
All Pressure ulcers developed under UHNM Care lapses in care	12	0		
All Pressure ulcers developed under UHNM Care lapses in care per 1000 bed days	0.5	0.00		
Category 2 Pressure Ulcers with lapses in Care	8	0		
Category 3 Pressure Ulcers with lapse in care	4	0		
Category 4 Pressure Ulcers with lapses in care	0	0		
Unstageable Pressure Ulcers with lapses in care	0	0		

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Quality Dashboard

NHS
University Hospitals of North Midlands
NHS Trust

Metric	Target	Latest	Variation	Assurance
Friends & Family Test - A&E	N/A	86.1%	H	?
Friends & Family Test - Inpatient	N/A	98.1%		P
Friends & Family Test - Maternity	N/A	N/A	H	?
Written Complaints per 10,000 spells	35	26.36		?
Rolling 12 Month HSMR (3 month time lag)	100	97.79	L	P
Rolling 12 Month SHMI (4 month time lag)	100	102.90	H	P
Nosocomial COVID-19 Deaths (Positive Sample 15+ days after admission)	N/A	3	H	
VTE Risk Assessment Compliance	95%	99.1%	H	?
Emergency C Section rate % of total births	15%	15.96%	H	?
Reported C Diff Cases per month	8	6		?
Avoidable MRSA Bacteraemia Cases per month	0	0		P
HAI E. Coli Bacteraemia Cases per month	N/A	8		
Nosocomial "Definite" HAI COVID Cases - UHNM	0	8		

Metric	Target	Latest	Variation	Assurance
Inpatient Sepsis Screening Compliance (Contracted)	90%	85.0%		?
Inpatient IVAB within 1hr (Contracted)	90%	100.0%	H	?
Children Sepsis Screening Compliance (All)	90%	79.6%	L	P
Children IVAB within 1hr (All)	90%	N/A	H	F
Emergency Portals Sepsis Screening Compliance (Contracted)	90%	95.1%		?
Emergency Portals IVAB within 1 hr (Contracted)	90%	81.5%		?
Maternity Sepsis Screening (All)	90%	90.0%	H	F
Maternity IVAB within 1 hr (All)	90%	100.0%	H	P

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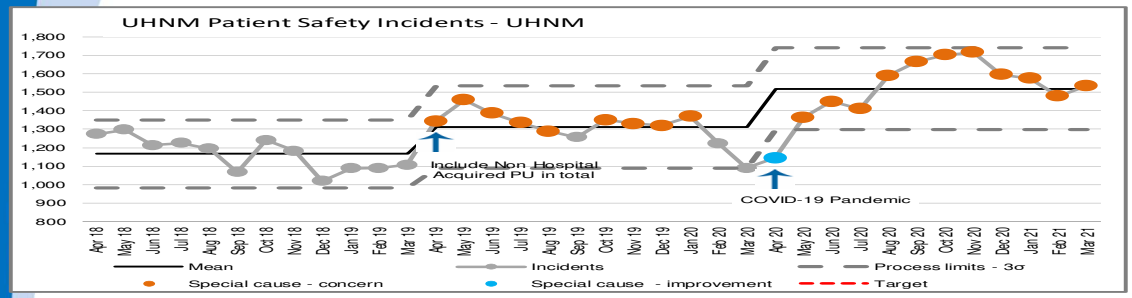
Reported Patient Safety Incidents

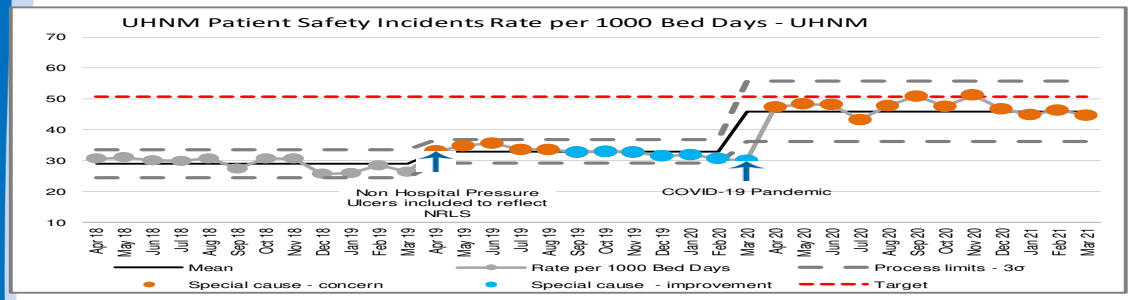


Variation	Assurance
	

Target	Jan 21	Feb 21	Mar 21
N/A	1575	1480	1535

Background

Total Reported patient safety incidents



Variation	Assurance
	

NRLS Mean	Jan 21	Feb 21	Mar 21
50.70	44.82	46.31	44.69

What is the data telling us:

The above data relates to **all** reported Patient Safety Incidents (PSIs) across the Trust. March 2021 has seen a slight increase in total number of reported PSIs compare to previous month and is also significantly higher than March 2020 and start of the COVID-19 pandemic period. The March 2021 total is within variation limits. The reporting of incidents and near misses should continue to be encouraged and promoted.

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

- Patient related Slip/Trip/Fall - 192 (215)
- Clinical assessment (Including diagnosis, images and lab tests) – 57 (68)
- Patient flow incl. access, discharge & transfer - 122 (77)
- Documentation – 56 (46)
- Treatment/Procedure - 70 (55)
- Medication incidents - 134 (128)
- Infection Prevention – 44 (52)

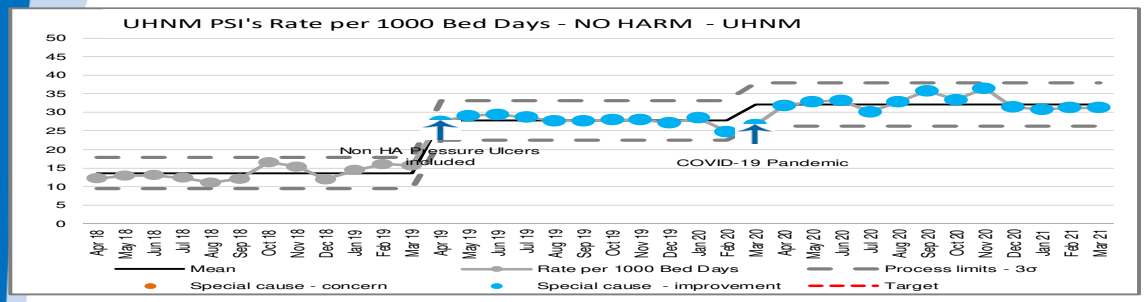
There have been increases in Treatment/Procedure related, Medication, Patient Flow and Documentation related incidents compared to February 2021 totals (in brackets). Reductions in number of Falls, Clinical assessment and Infection Prevention related incidents.
PSIs are reviewed and analysis undertaken on locations and themes.

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

The rate of reported PSIs per 1000 bed days has decreased compared to February 2021 but is higher than March 2020. UHNM have seen increases in the rate of PSIs from the start of the COVID-19 pandemic as result of increased reported PSI numbers and reduced activity. Recent rates have started to reduce slightly as more non COVID-19 activity increases.

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

University Hospitals of North Midlands NHS Trust

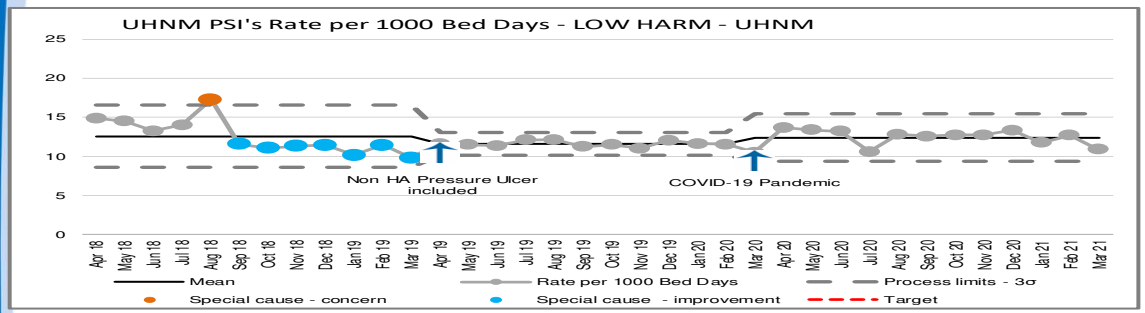


Variation	Assurance

Target	Jan 21	Feb 21	Mar 21
N/A	30.82	31.20	31.24

Background

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

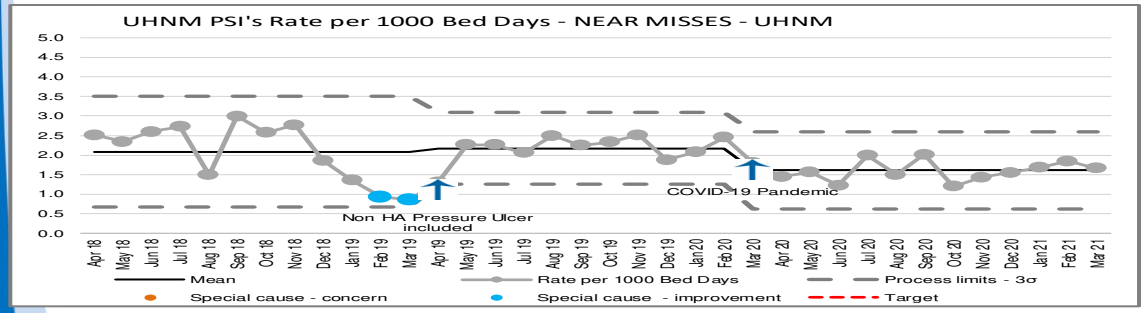


Variation	Assurance

Target	Jan 21	Feb 21	Mar 21
N/A	11.75	12.67	10.89

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	Jan 21	Feb 21	Mar 21
N/A	1.68	1.85	1.66

Background

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

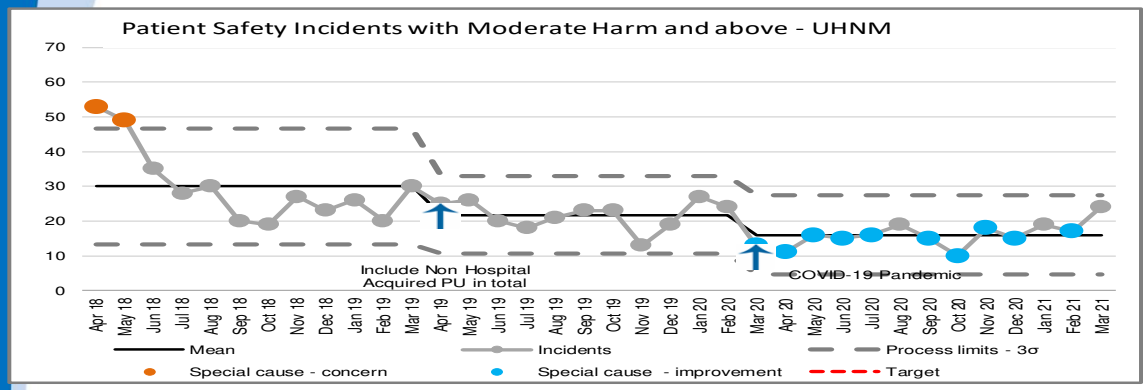
What is the data telling us:

The Rate of Patient Safety Incidents per 1000 bed days with no harm or low harm are showing consistent trends.

The rate of both no harm and low harm incidents have increased since the start of the COVID-19 pandemic. This indicates that there are higher numbers of no and low harm incidents being reported when compared to moderate harm and above (see next page) which has seen decrease in average rate since March 2020.

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

Reported Patient Safety Incidents with Moderate Harm or above

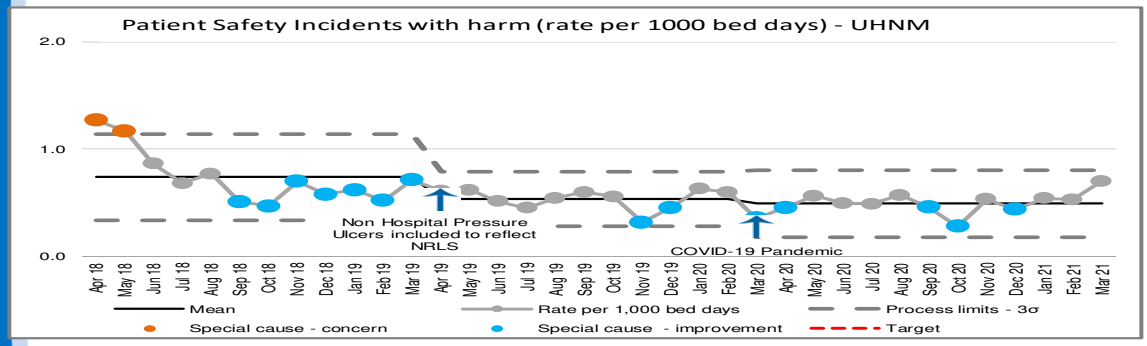


Variation	Assurance

Target	Jan 21	Feb 21	Mar 21
N/A	19	17	24

Background

Patient safety incidents with reported moderate harm and above



Variation	Assurance

Target	Jan 21	Feb 21	Mar 21
N/A	0.54	0.53	0.70

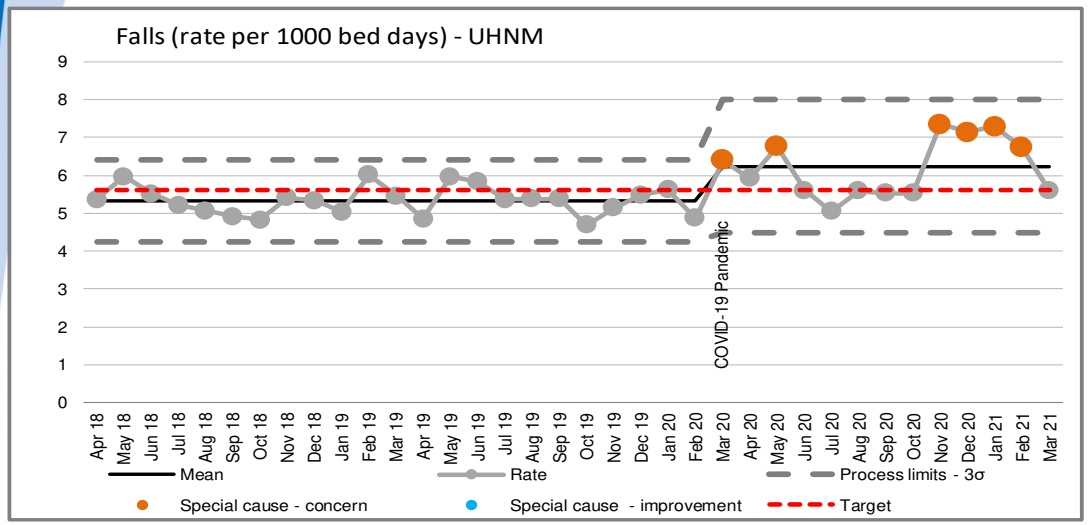
What is the data telling us:

The long term trend for Patient Safety Incidents reported with moderate harm or higher is reducing. March 2021 has seen increase in rate per 1000 bed days above the COVID-19 period mean rate but is within control limits indicating normal variation. The data shows that the Trust is continuing to have lower harm reported.

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 (1 difficult vascular access in NNU, unintended injury following insertion of umbilical catheter and CVC line was inserted in to artery in Theatres), Medication (incorrect Oxycodone dose prescribed, Denosumab medication had been omitted and Dalteparin injections not administered following discharge to care home) and Clinical Assessment.

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 than national average.

Patient Falls Rate per 1000 bed days



Variation	Assurance

Target	Jan 21	Feb 21	Mar 21
5.6	7.3	6.7	5.6

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.

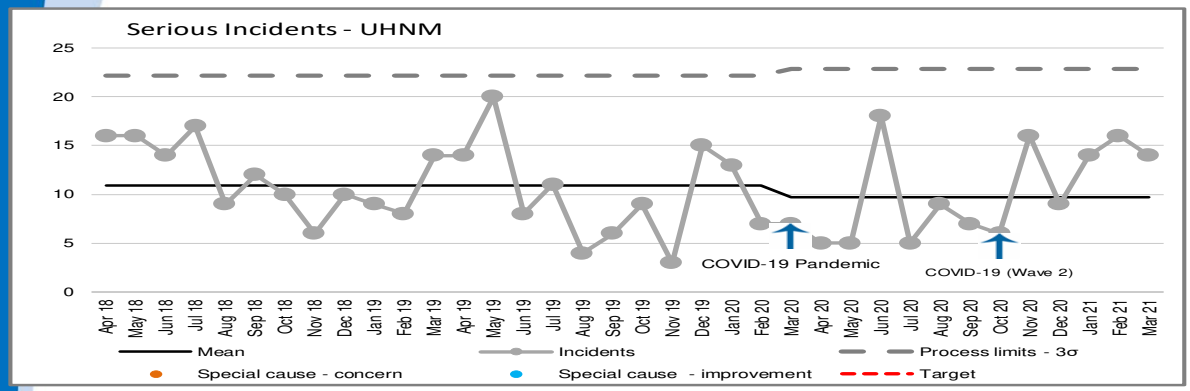
The rate in March has reduced to 5.6.

The Top areas for total falls in March were: AMU (Stoke), FEAU, ED (Stoke), ward 76a, ward 100

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

- The falls prevention/awareness presentation has been shared with the nurse bank and has been completed by 73 members of bank staff. This training has been recorded on E roster.
- AMU, FEAU and Ward 100 are currently going through a further period of movement. It is hoped these moves will improve falls numbers as the new areas address the current problems with ward lay out.
- Ward 225 have re-launched baywatch and are continuing with a new drive on cohorting patients.
- A project in ED has begun to increase patient visibility by replacing the doors on cubicles in majors. The new doors have larger windows to enable patients to be better observed.
- A project on assistive technology (bed/chair sensors) is to take place on AMU to add to the preventative measures available for falls across the unit.
- Ward 76a is new to the list – numbers will be observed and actions added if required.
- RITA devices have now arrived on ITU and devices have also been provided to Ward 100, Ward 124. We have devices ready to be delivered to Ward 111, SSU, Ward 122, Ward 113 and Ward 226.

Serious Incidents per month

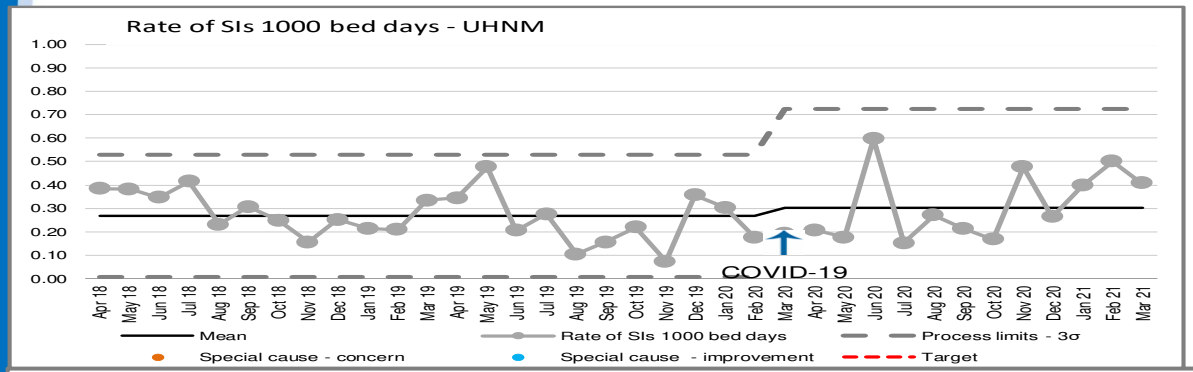


Variation	Assurance

Threshold	Jan 21	Feb 21	Mar 21
N/A	14	16	14

Background

The number of reported Serious Incidents per month



Variation	Assurance

Target	Jan 21	Feb 21	Mar 21
N/A	0.40	0.50	0.41

Background

The rate of Serious Incidents Reported per 1000 bed days

What is the data telling us:

During the COVID-19 second wave (October 2020 – February 2021) there has been 29% increase in number of reported Serious Incidents compared to same period 2019/20.

March 2021 saw 14 incidents reported with 12 at RSUH and 4 at County Hospital:

- 11 Falls related incidents
- 1 Maternity (mother & baby only)
- 1 Diagnostic related
- 1 Potential adverse media – patient tested and Brain Stem Death confirmed but patient noted to make spontaneous respiratory effort. This has been reported in local and national press articles

100% of the reported Serious Incidents during March 2021 were reported on STEIS within the agreed 2 working days timeframe from identification/confirmation that the incident met the serious incident reporting criteria. The rate of SIs per 1000 bed days for March 2021 is 0.41 which compares to organizational average rate of 0.30.

Serious Incidents Summary

University Hospitals of North Midlands NHS Trust

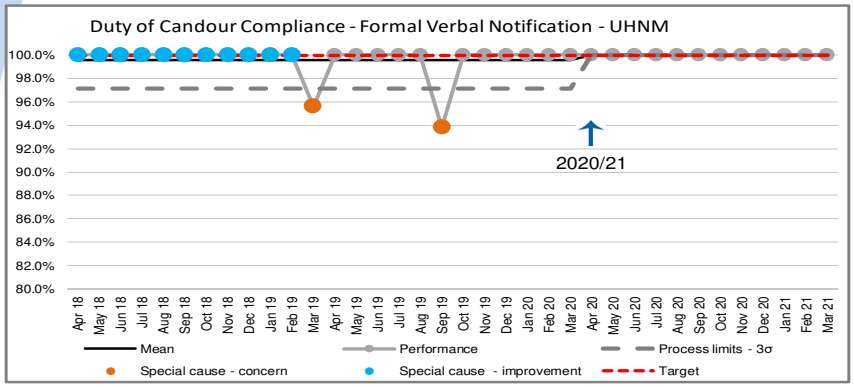
Summary of new Maternity Serious Incidents

Following the formal recommendations in the Ockenden Report, below is an outline of the Maternity related serious incidents reported during March 2021. The new recommendation requires the Trust Board to receive summary on the new Maternity related Serious Incidents along with previously reported summary of numbers and categories.

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

STEIS Ref. No.	Target Completion Date	SI Category	Incident Synopsis
2021/6701	23/06/2021	Maternity/Obstetric incident meeting SI criteria: mother and baby (this includes foetus, neonate and infant)	Failure of information flow: The rudimentary horn was diagnosed at UHNM in 2020. If this information on this rare abnormality had been more accessible, an appropriate management plan could have been initiated. Neither the dating scan at 12 weeks nor the fetal medicine scan at 16 weeks established that the lower part of the womb, the cervix was not directly connected to the rudimentary horn Patient admitted to Emergency Department via ambulance at 17+4 weeks pregnant with an antepartum haemorrhage, abdominal pain and maternal collapse. Patient transferred to Main operating theatres and underwent an emergency laparotomy for resection of ruptured rudimentary horn of uterus and unilateral salpingectomy (removal of fallopian tube). The surgery was performed by a Consultant Obstetrician, both babies were delivered with no signs of life; the estimated blood loss was recorded as 1500mls. Patient received 8 units of red blood cells and 7 units of fresh frozen plasma HW was transferred to HDU in main hospital.

Duty of Candour Compliance

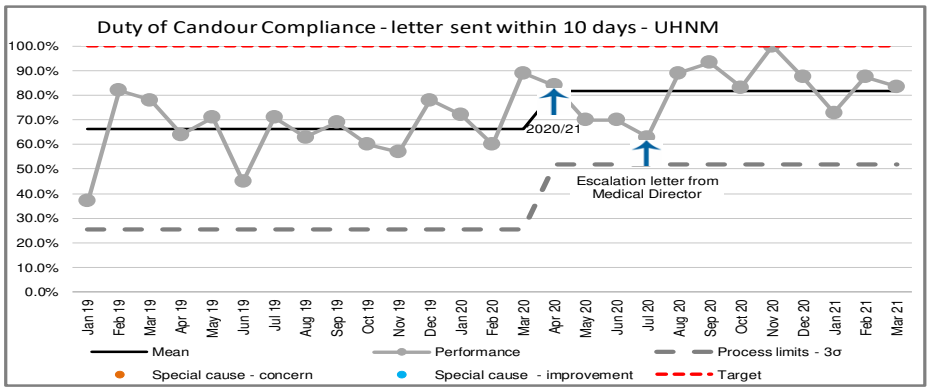


Variation	Assurance

Target	Jan 21	Feb 21	Mar 21
100%	100.0%	100.0%	100.0%

Background

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



Variation	Assurance

Target	Jan 21	Feb 21	Mar 21
100%	73.0%	87.5%	83.5%

Background

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

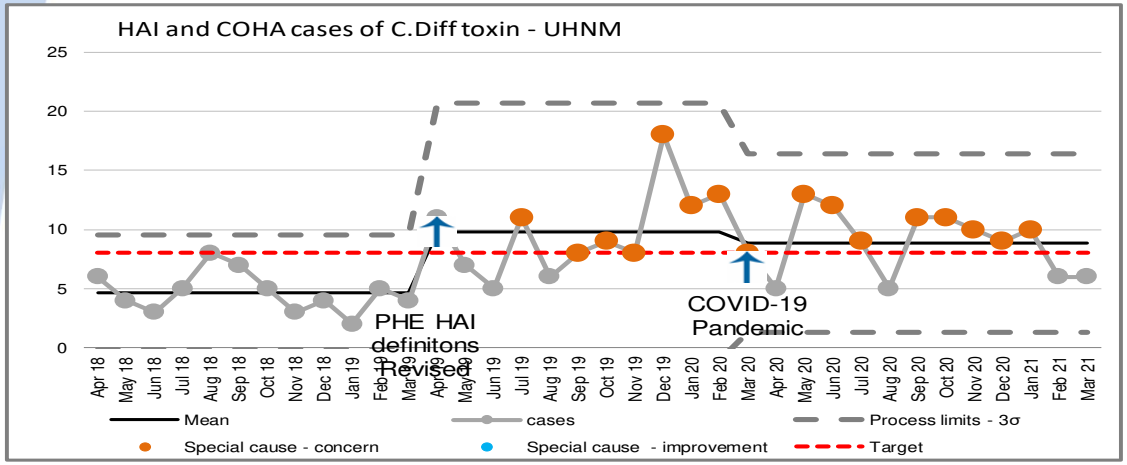
What is the data telling us:

During March there were 16 incidents reported and identified that have formally triggered the Duty of Candour. 15 of these cases have been formally notified of the incident and the other 1 case has attempted to be contacted but call was not accepted so staff have been unable to complete a direct conversation/verbal notification. Confirmed Follow up Written Duty of Candour compliance (i.e. receiving the letter within 10 working days of verbal notification) during March 2021 is 10 cases out of 16. 2 cases have exceeded the deadline and there are 4 cases under review and 10 working day deadline not yet reached following completion of the verbal notification. (3 in CWD and 1 in Surgery). Therefore, there is 83.5% compliance with receiving letter within 10 working days of the initial formal verbal notification.
The 2 cases not in 10 working days have been provided within 15 days.

Actions taken:

Escalations on outstanding letters are provided to relevant directorates and divisions via the Divisional Governance & Quality Managers and these are provided once identified and Duty of Candour required and where there has been no response prior to the deadline date. Continued support is being provided during increased COVID-19 pressures with the drafting of the 10 day notification letters for clinicians by the Divisional Governance & Quality team.
Compliance included in Divisional reports for discussion and action.

Reported C Diff Cases per month



Variation	Assurance

Target	Jan 21	Feb 21	Mar 21
8	10	6	6

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 predominantly 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 6 reported C diff cases in March which is below monthly trajectory.

1 of these were Hospital Associated Infection (HAI) cases and 5 Community Onset Healthcare Associated (COHA) cases.

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

COHA: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks

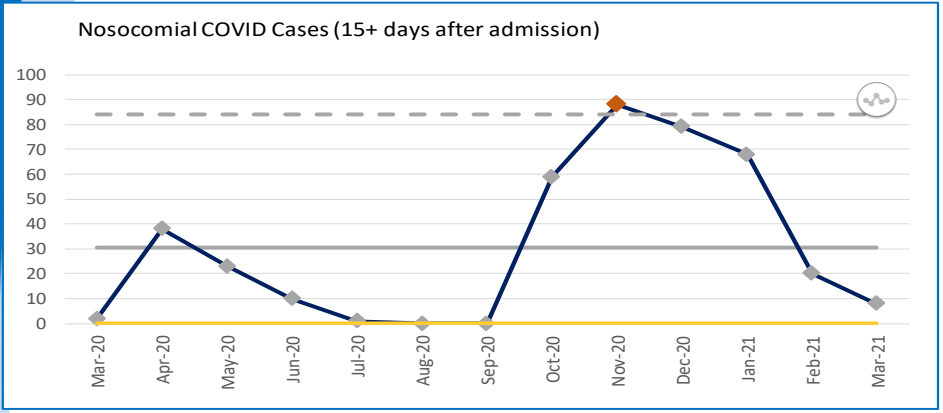
One clinical area has reported 2 cases Clostridium *difficile* toxin cases within a 28 day period (2 x COHA) Ward 80

CDI toxin cases year to date 64 HAI and 43 COHA = 107 versus trajectory YTD of 93

Actions:

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

HAI Nosocomial COVID Cases per Month



	Community COVID-19 rate per 100,000 population (as at month end)				UHNM		
	England	W Mids	Staffs	Stoke	Total Admissions	COVID cases	
						Prob	Def
Oct 20	232.1	273.7	352.2	373.3	17006	63	59
Nov 20	152.2	188.0	206.0	350.3	14956	107	88
Dec 20	526.0	404.1	370.2	318.7	14701	105	79
Jan 21	283.0	328.0	296.0	239.5	14255	128	68
Feb 21	86.60	113.2	104.6	125.2	14101	31	20
Mar 21	56.0	61.6	56.2	76.8	17105	11	8

Prob = Probable Hospital onset COVID (1st positive sample 8-14 days after admission)
Def = Definite Hospital onset COVID (1st positive sample 15+ days after admission)

What do these results tell us?

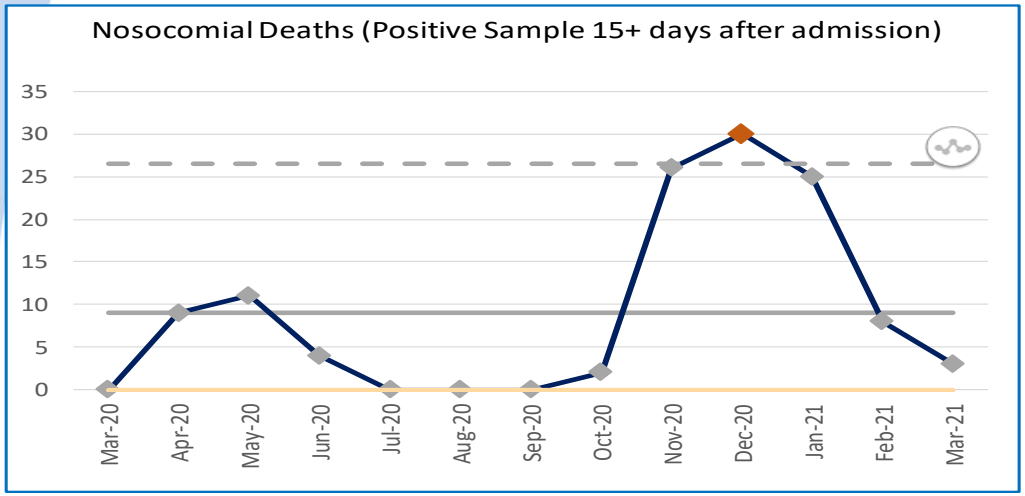
- The data shows an in month decrease in definite Healthcare Acquired COVID - 19 cases. The UHNM case numbers continue to reflect the changes in community rates on national, regional and local levels. It should be noted that Stoke community rate remains above the regional and national rate.
- COVID ward outbreaks were reported during March 2021 on:
  Ward 100/101
- All the outbreaks have now been closed and restrictions removed.

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

Percentage breakdown of COVID Cases per onset category per month				
Month	Community Onset	Indeterminate	Probable	Definite
Mar-20	89.4%	6.8%	2.5%	1.2%
Apr-20	73.5%	9.5%	9.7%	7.2%
May-20	65.6%	10.7%	14.6%	9.1%
Jun-20	67.2%	10.3%	13.8%	8.6%
Jul-20	92.3%	3.8%	0.0%	3.8%
Aug-20	78.6%	21.4%	0.0%	0.0%
Sep-20	100.0%	0.0%	0.0%	0.0%
Oct-20	66.7%	8.7%	12.7%	11.9%
Nov-20	67.9%	13.0%	10.5%	8.6%
Dec-20	68.7%	11.4%	11.3%	8.5%
Jan-21	66.8%	13.1%	13.2%	7.0%
Feb-21	70.8%	13.9%	9.3%	6.0%
Mar-21	73.8%	9.8%	9.8%	6.6%
Grand Total	69.6%	11.4%	11.1%	7.9%

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



What do these results tell us?

The data shows the total number of recorded deaths per month which are classified as 'Definite' hospital acquired COVID-19. The criteria for this is that the patient had **first positive** COVID-19 swab result 15 days or more following admission to UHNM.

- The data shows a decrease in definite Healthcare Acquired COVID -19 deaths during March 2021.
- Total recorded definite hospital onset COVID-19 deaths is 3 during March 2021
- All 3 recorded at RSUH
- Total 118 hospital acquired COVID-19 deaths with 1st positive results 15 days or more following admission recorded since March 2020.
- The mean number of deaths per month since March 2020 is 9, however following the in month reduction in March 2021 the monthly total is below the overall mean.

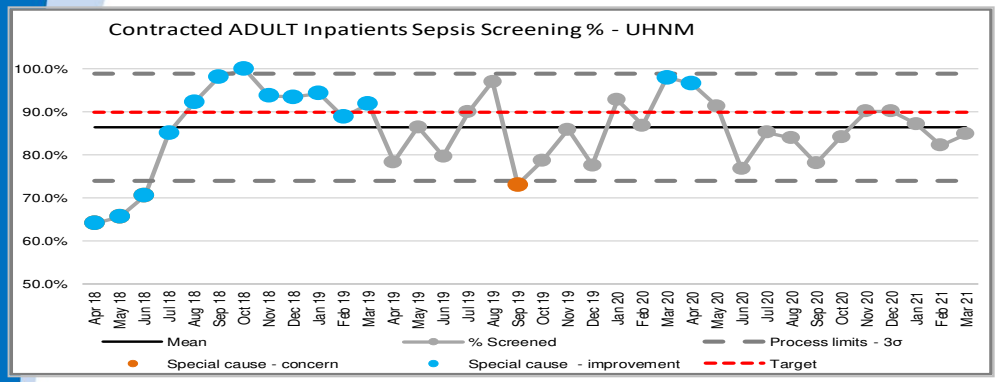
Actions :

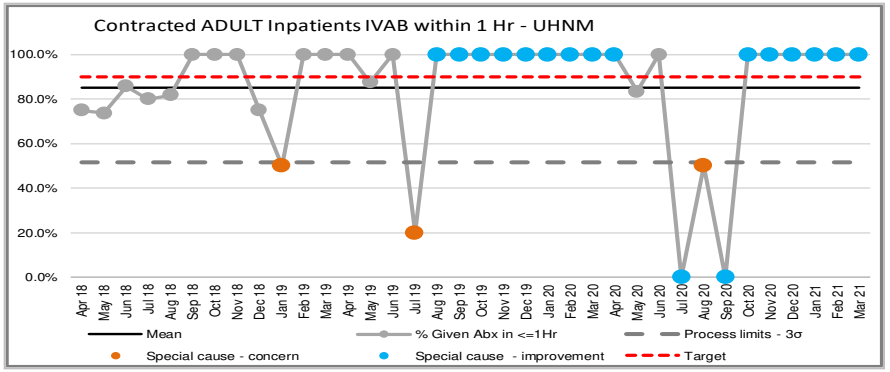
Ongoing work to identify the ward outbreaks and cross reference with patients involved is being undertaken with support from the Infection prevention Team to support the review of the nosocomial deaths.

The online SJR form has been adapted to include specific COVID related questions following pilot review by Deputy Medical Director.

Initial reviews are underway with notes requested for review.

Sepsis Screening Compliance (Inpatients Contract)





Variation	Assurance

Target	Jan 21	Feb 21	Mar 21
90%	87.2%	82.2%	85.0%

Background

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

Variation	Assurance

Target	Jan 21	Feb 21	Mar 21
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

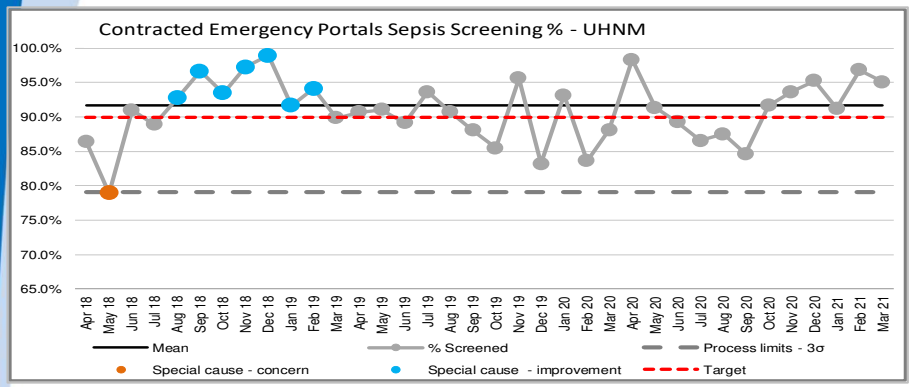
What is the data telling us:

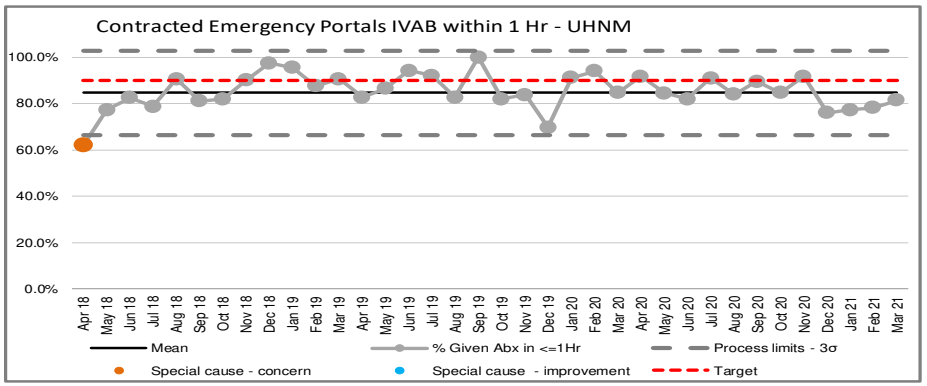
March results now show 85.0% for screening whilst Inpatient areas maintain 100% for IVAB within an hour. Of the 113 Inpatients that triggered a sepsis screen, 81 had sepsis red flags present, 3 of these patients were given IVAB within hour and of the remaining 78 patients, 38 had alternative diagnosis that were deemed as not sepsis related and IVAB were not indicated. The remaining 40 patients were already receiving IVAB 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, visiting ward areas to update clinical staff and promote awareness around sepsis whilst answering any queries they may have
- The Sepsis team regularly identify areas of poor compliance and prioritise those areas for more focused re-enforcement each month
- The team now offer 30 minute drop in sessions for particular areas of UHNM. The West building and Lyme building have benefitted from these in recent months and we have planned similar events for the Specialised areas and County in April and May.
- The Sepsis Team continue to work closely with the VitalPacs team in order to address issues such as staff access levels, sepsis alerts not showing and training needs.
- The Sepsis Team continue to provide unannounced ward visits out of hours to deliver reinforcement to those staff who work regular nights. The Sepsis Clinical Lead and Sepsis Team have continued to deliver yearly sepsis training to all level of clinicians via Microsoft Teams

Sepsis Screening Compliance (Emergency Portals Contract)





Variation	Assurance

Target	Jan 21	Feb 21	Mar 21
90%	91%	97%	95%

Background

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

Variation	Assurance

Target	Jan 21	Feb 21	Mar 21
90%	77%	78%	81%

Background

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

What is the data telling us:

Adult Emergency Portals screening in March 2021 achieved 95% for the 81 patients audited.

The performance for IVAB within 1hr co0ntinues to improve to 81.5%. There were 67 red flag sepsis patients identified from the 81 patients audited in the screening sample. Out of the 67 red flag patients, 22 received IVAB within an hour whilst 18 were already on IVAB and 22 had an alternative diagnosis).

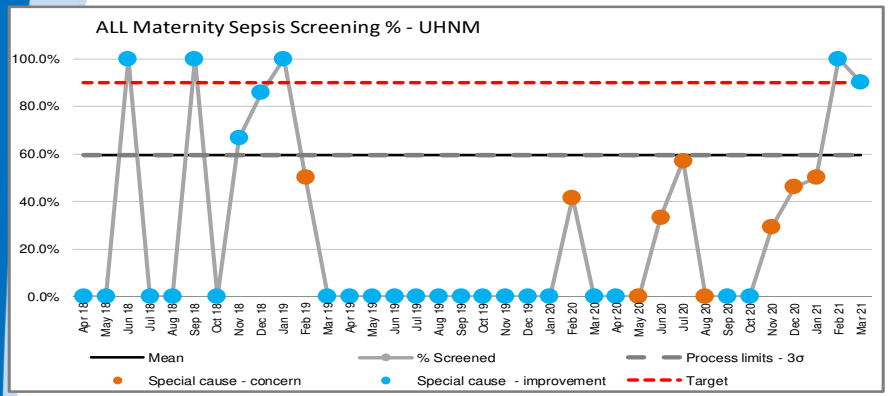
There were 5 late IVAB, 3 of which were administered within 2 hours. The remaining 2 were significantly late and have been escalated to the respective areas' senior teams.

Actions:

- The Sepsis Team continue to closely monitor the compliance by visiting the A&E regularly and offering department based sepsis reinforcement when staffing and acuity allows
- The A&E Education Team and A&E Sepsis doctor will continue to provided sepsis virtual education for both A&E sites as required. A 'Sepsis at UHNM' MS Teams training session was provided in March in collaboration with Dr Andrew Bennett
- The Sepsis Team is working collaboratively with the A&E Quality nurses, senior staff and A&E Sepsis clinical lead for providing solutions to late IVAB incidents although it is anticipated that as winter pressures ease there will be fewer incidents of late IVAB given within 2hrs. The late IVAB >2hrs have been addressed through escalation and training for individual staff involved

Sepsis Screening Compliance ALL Maternity

University Hospitals of North Midlands NHS Trust

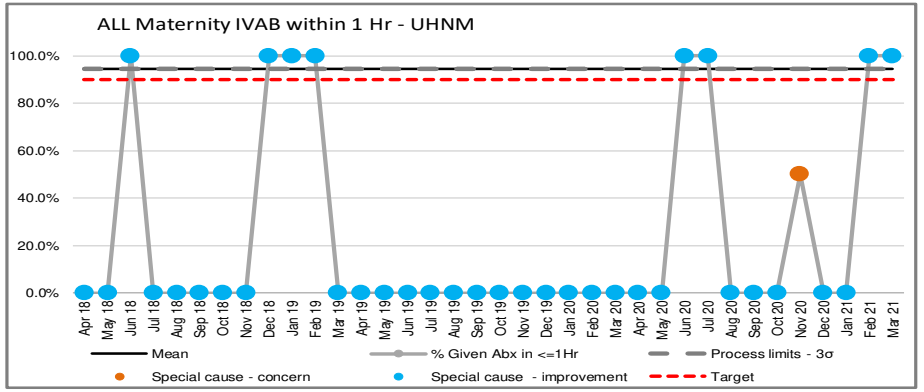


Variation	Assurance
H	F

Target	Jan 21	Feb 21	Mar 21
90%	50.0%	100.0%	90.0%

Background

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



Variation	Assurance
H	P

Target	Jan 21	Feb 21	Mar 21
90%	N/A	100%	100%

Background

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

What is the data telling us:

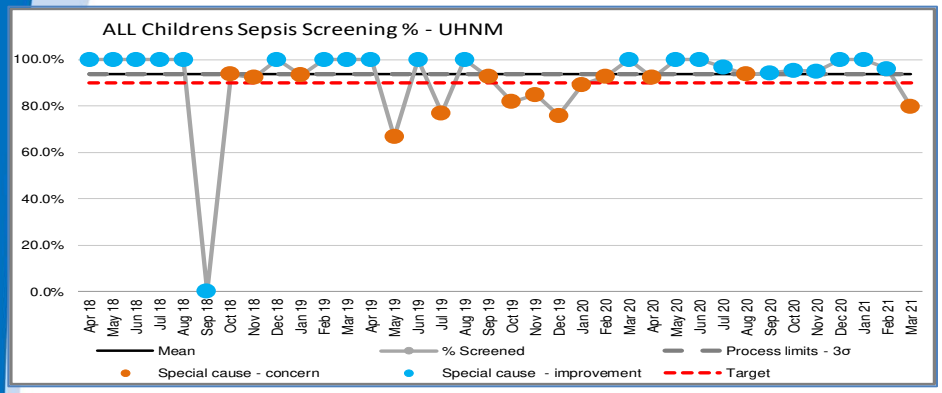
Maternity Inpatients and Emergency portal (MAU) audited by the Sepsis Team in March 2021 shows that 90% of patients that trigger with MEOWS >4 were audited and screens uploaded to the Maternity K2 system. This result was taken from 10 patients audited. The single missed screen was a patients with high MEOWS but no sepsis red flags and she had self discharged following initial assessment

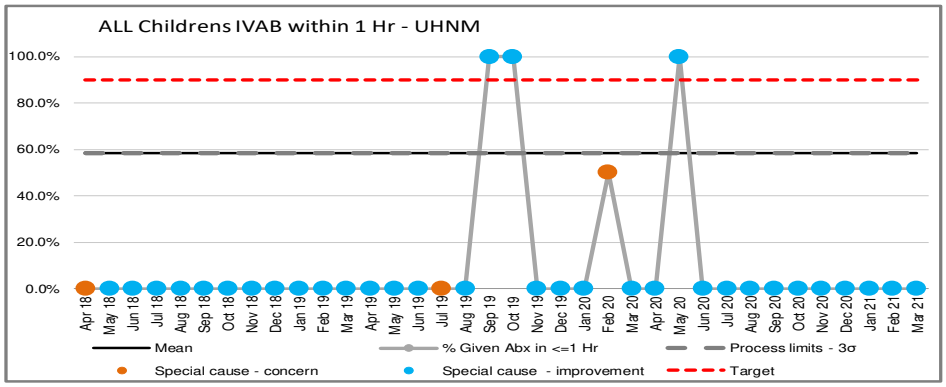
100% was achieved for IVAB within an hour.

Actions:

- The Maternity Senior Team have been working collaboratively with the sepsis team and following the creation an action plan and great improvements have been seen for the second consecutive month. The Sepsis Team provided training to all maternity staff in February and had an excellent uptake. The issue of attaching completed screening tools to the K2 system has been addressed internally and this is now standard practice.
- The new electronic version of maternity sepsis screening tool is due to go live in May and the Sepsis Team will provide further training during the same week to enhance staff awareness and understanding.
- The sepsis team will continue to audit Maternity comprehensively to ensure the maintenance of this newly achieved high standard of sepsis compliance.

Sepsis Screening Compliance ALL Children





Variation	Assurance
L	P

Target	Jan 21	Feb 21	Mar 21
90%	100.0%	96.0%	79.6%

Background

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

Variation	Assurance
H	F

Target	Jan 21	Feb 21	Mar 21
90%	N/A	N/A	N/A

Background

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

What is the data telling us:

The charts above show an uncharacteristic drop in sepsis compliance for March 2021, with a result of 79.6%.

Whilst CAU continued to sustain and maintain compliance of > 90% there has been a significant drop for Children's A&E for March with ten missed screens resulting in a screening compliance of 74% for that area. These missed screens were all over a single weekend and this has been escalated to the senior team.

Both Paediatric Inpatient wards have minimal admissions and patients mostly did not trigger PEWS >5.

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

Actions:

- In the absence of formal training and sepsis champion days, the Sepsis Team will continue to deliver re-enforcement to specific areas when falls in compliance are identified. Ward managers and seniors teams are encouraged to forward concerns and ad hoc training is offered to all areas when required. The subsequent audits suggest that the poor result for Children's A&E is an isolated incident and we are hopeful of better results in the coming month.
- We have adjusted our audit process to take smaller samples over a wider range of dates to give a more comprehensive perspective.
- Formal training will be planned when restrictions allow.

Operational Performance

2025 Vision "Achieve NHS Constitutional patient access standards"

Spotlight Report from Chief Operating Officer

NHS
University Hospitals of North Midlands
NHS Trust

Emergency Care
There has been a continued decline in Covid-19 with inpatients <50 (from a peak in Jan of 349) and subsequent downgrading of Covid incident status from the reduction to Critical Care occupancy and covid inpatients.

Operational performance improved and the Royal Stoke site continued to hit >60% or > 70 % most days. This contributed to the continued overall performance improvement with an increase from 63.8% in February to 65.2% in March. In addition, there was continued improvement in admission, discharge or transfer within 4 hours and therefore overall decision making and time in the department for the acute front door pathway – with zero 12 hour trolley waits for March.

The improvement trajectory is marked by some challenged days of performance attributed to high volume ambulatory attends and compounded by workforce challenges. There was an increase in sub 60 performance days at the end of March, with clear evidence in the acute front door pathway metrics of ambulatory, non admitted attends. This is being addressed with an audit of those attends to frame discussions with the system about GP, walk in centre and 111 First / SDEC pathways and management of unheralded patients. This is being addressed through the acute front door improvement work stream.

Cancer
The Trust is predicted to achieve against Rare cancers and the 28 day standard. The total PTL remains steady although the backlog has fallen slightly. The 104+ day backlog is showing normal variation at 45 for March 21.
The 2ww PTL rose following the second phase of the pandemic , however from January the PTL reduced and has remained steady at a level below the mean, although the size of the waiting list is still higher than that seen pre-covid. Performance, whilst under achieved in March at 91.4%, remained steady and above that seen in January (88.16%). Significantly more patients were seen on the 2ww pathway, in month, than at any time in the previous year. Demand remains high in some specialties such as Breast, and overall numbers are slightly higher than the same time last year.
The latest data on 62 day performance is achieving 60.1%. The 62 day PTL and backlog which had been reduced, has remained steady with levels now as seen pre- pandemic. Similarly the number of patients in the 63-103 days is also reducing. The corporate cancer team has completed a high level specialty comparator analysis of referrals and treatments 2020 compared to 2021 with an in depth clinical review of pathways over the next month to contextualise our cancer assurance/risk evaluation for the second covid19 surge response.

Planned Care
The National ask for elective care has been revisited and March saw the release of guidance for the first six months of 2021 and these will be displayed in next months report. For March the actuals against BAU, was outpatients 94.3% and inpatients 72.7%. This demonstrates the efforts to maintain out patient capacity. Theatre capacity at UHNM has been released from 29th March 2021 (24 theatres) with enhanced lists at County. The new Independent Sector contract has been drafted but sees another change to pathways and case-mix of activity with UHNM holding the contract and the Independent Sector doing the activity on our behalf. The volume of patients transferred is subject to clinical release and patient acceptance of movement.

RTT
The total number of Referral To Treatment pathways grew to 56,573 (February 53,295). This is above the forecast 46,100. The Trust has 4,563 over 52 week breaches (February 4417) as a consequence of standing down elective work. This was over the forecasted position. Recovery plans for recovery of the long waiting patients are being reviewed. RTT performance in March achieved 62.5% (February 63.54%).

Diagnostics
The diagnostic performance for March is 84.1% (February 21 88%). The waiting list size is 16,514 (February 14,819) 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

NHS
University Hospitals of North Midlands
NHS Trust

- The 4hr performance in ED improved again in March. System-wide the 4hr performance increased to 81.7% (February 78.3%), with Royal Stoke achieving >60% or > 70 % most days and an overall performance of 65.2%. County type 1 achieved 94.2% (February 80.6%).
- Attendances , which had fallen, showed an increase by an average of 37/day. Ambulances remained steady with an average of 157/day. Ambulances still accounted for 50% of attendances at Royal Stoke.
- Attendances were higher in the latter half of the month than the first half, with corresponding performance falling.
- Zero 12 hour trolley waits.
- At the beginning of March the Trust stood down from an incident level 4 to 3, although critical care remained on a level 4 for a while longer.

- The Urgent Care Programme metrics showed some changes particularly during the latter half of March:
  - At the front door, time to triage and median time to treatment increased in the last two weeks of March. The mean time in ED remained static (slide 7). A deep dive into the spike in attends for ambulatory and majors during this period, and optimising 111 pathways and the walk in centre is being undertaken.
  - For referral to discharge over the past 6 weeks being was at or below the control limit, this is a statistically significant improvement in spite of demand not decreasing.
  - MFFD and super stranded patients began to show a reduction. Discharges in Medicine started to see an increase.
  - NEL admissions remained around the same and the Site management has shown the number of patients discharged pre-noon has remained static. SDEC recovered the 30% position but this slipped slightly in the latter half of March.
  - The 1+ Los for emergency admissions showed normal variation from the previous month at 8.1 days.
  - NHS-111 continued and numbers have risen to a daily average of 40.

- The overall improved flow contributed to the improved performance, clinical care and experience for the patient. However, pressures within the hospital remained high in March, particularly in critical care, however for the first time since mid-Nov there was a significant fall in the numbers of covid-positive patients in the hospital. At the end of March the number had reduced to less than 50 compared to the maximum of 349 patients in January. At the end of February the daily new numbers of covid patients averaged 3/ day with nosocomial cases also reducing.
- Within the Medical bed pool, numbers showed a reduction with a daily average of 419 patients.
- The bed restrictions for Infection Prevention have continued but again a significant reduction was seen in March to under single figures.
- After a period of where consistently 50% of staff absences were due to covid, the proportion is decreasing.

Urgent Care Improvement Programme

University Hospitals of North Midlands NHS Trust

The Urgent Care Programme Board has agreed a number of improvement work streams aimed at Improving overall performance and improving the care and patient experience.

Work stream 1 - Acute Front Door

- Embed and sustain the changes seen in January and February through engagement with the team and recognising areas of challenge
- Complete business case for ED workforce to support the flow through the Department
- Implement streamlined referral process and review flow from ED to Acute Medicine and to wards
- Establish task and finish group to support quality improvement and the implementation of the new Urgent Care standards
- Redesign the Acute Medicine Model
- Acute Medicine Nursing Model review
- Deliver an ED specific set of metrix to support flow through the department
- Maintain progress with 111 First

1. Weekly Urgent Care Meetings within ED and Acute Medicine consolidated to reinvigorate the urgent care actions and support sustained improvement in a context of reducing covid capacity and de-escalation of winter capacity. Weekly Acute Front Door meetings featuring ED and Acute Medicine actions runs weekly with support from MProve
2. First draft workforce business case completed, requires additional input from finance, directorate and division for April submission to Medicine Board.
3. Electronic Referral from ED to Acute Medicine, AMRA and AEC drafted. Acute Medicine Dashboard ready and being tested for go live .

Work stream 2 - Patient Flow

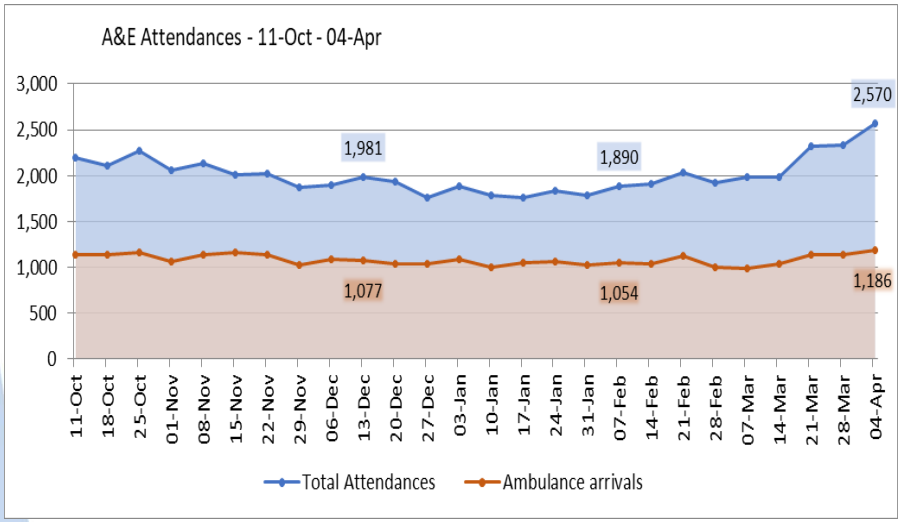
- Maintain focus of discharges before midday through improvement workshops
- Support length of stay by using directorate Teams – support improvements seen
- Review need for COVID discharge lounge to support earlier flow
- Importance of young persons rehab Unit working with MPFT
- Confirm In reach model with GP Federation that Support earlier step down
- Set up Task and Finish Groups with each division to support sustained improvements

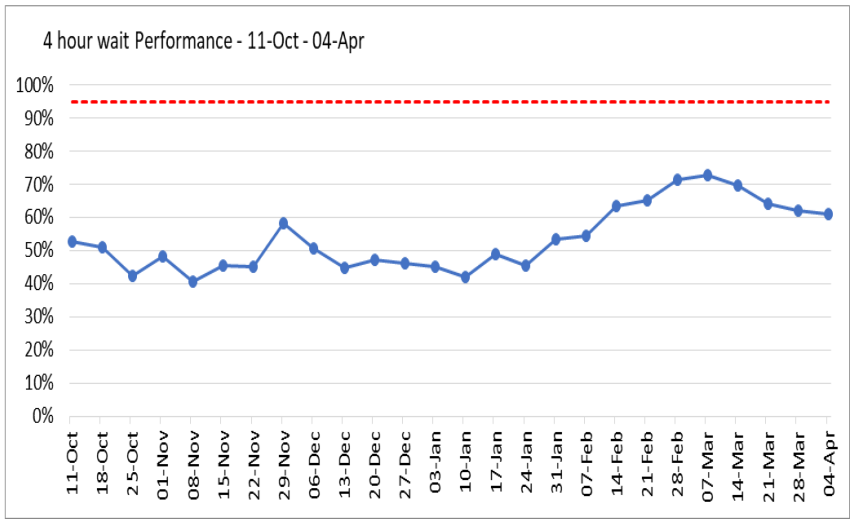
Work stream 3 -Clinical Site Management

- Confirm and agree the new 'battle rhythm' for the sites post COVID
- Agree workforce model that's Deliver clinical oversight
- Begin to map out ways of working that supports the delivery of the Urgent Care standards

The Urgent Care Improvement Programme has a number of projects aimed at improving current performance which in turn improves clinical care and patient experience.

This is set against the context of 4 hour performance and attendances.





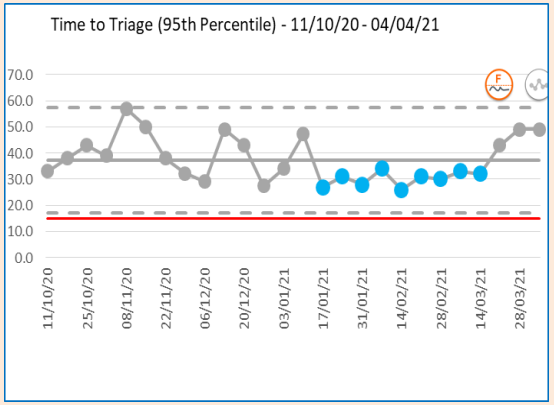
The Urgent Care Improvement Programme has a number of projects aimed at improving current performance.

NHS University Hospitals of North Midlands NHS Trust

Work stream 1: Front Door – timing metrics

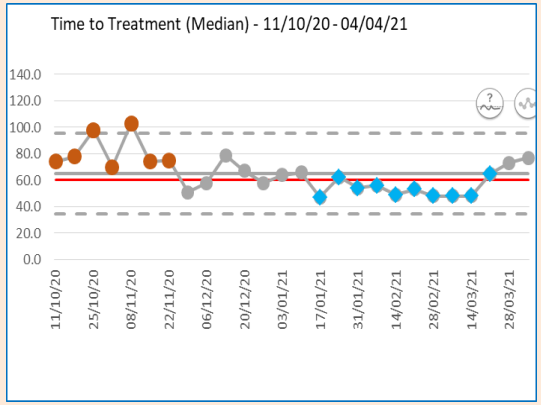
Time To triage – improve the time taken to triage patients so that patients are directed to appropriate care as quickly as possible. The aim is for 95% of patients triaged within 15 minutes.

The chart below shows that in the latter half of March the 95th percentile rose to 49mins attributed to a significant surge in attends.



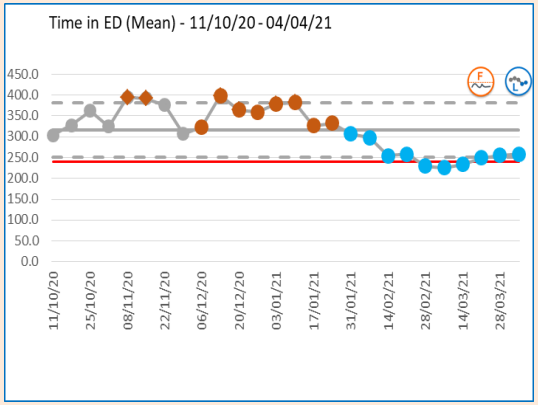
The median time to treatment - set at 60 minutes to ensure patients treated quickly and for those requiring referrals to other specialties are done so in optimum time.

Since the end of December the median time to treatment had shown sustained improvement. The latter half of March has indicated a slight rise with the median at 73mins.



The Mean time in the ED – The median time is set at 240 minutes as per national 4hour standard.

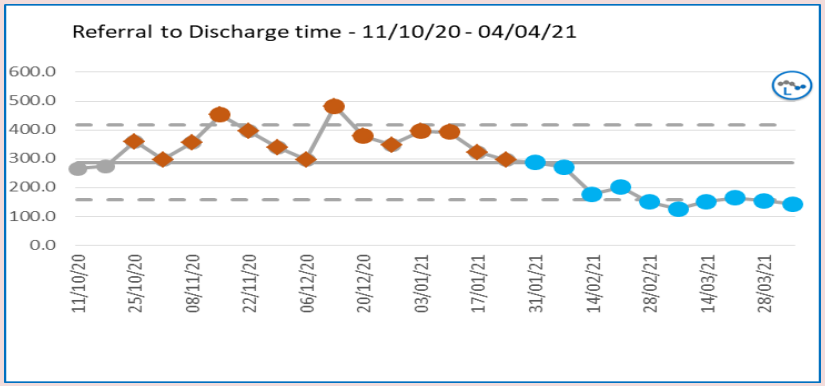
The mean time in the ED dramatically reduced through January and February, continuing in March.



Together Compassion Safe Improving

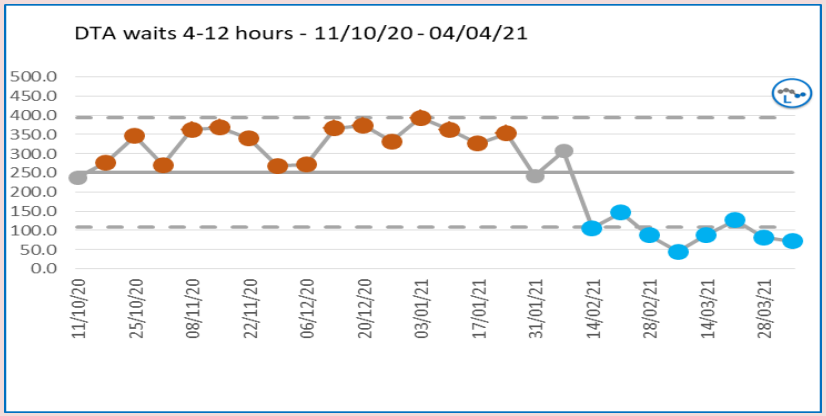
Quality | Operational | Workforce | Finance

Work stream 2: Flow



Referral to Discharge Time – improve the time taken from referral to specialties to discharge from ED either as admission or discharge home.

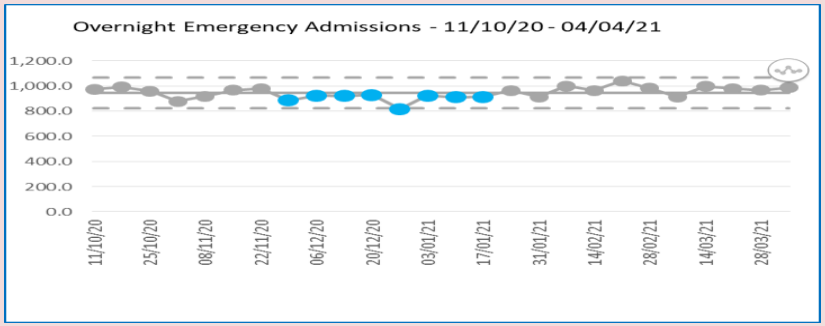
The reduction in time evidenced in January has been maintained. This reduction is the main driver for the improvement in performance seen. And with the last 6 weeks being at or below the control limit, this is a statistically significant improvement in spite of demand not decreasing. There has been a continued trend within control limits despite demand increasing.



The number of patients who have a decision to admit and have waited between 4 – 12hours.

The number of patients through the second phase of the pandemic was consistently > 300. This has reduced significantly with the latest data showing that a number of c100 is being held.

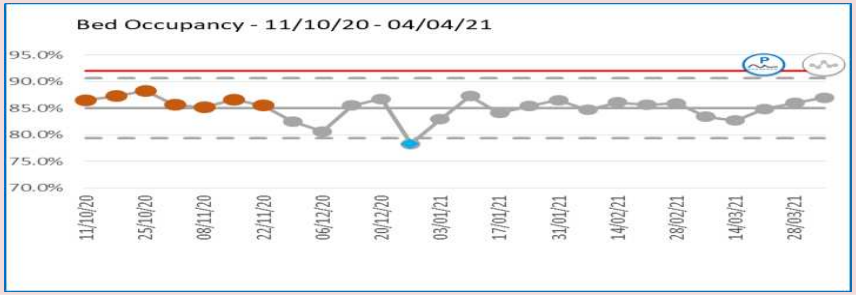
There is continued progress in the number of DTA waits between 4 - 12 hours despite the surge in attends.



Emergency admissions: the number of Non Elective admissions requiring a bed overnight (1+day LoS)

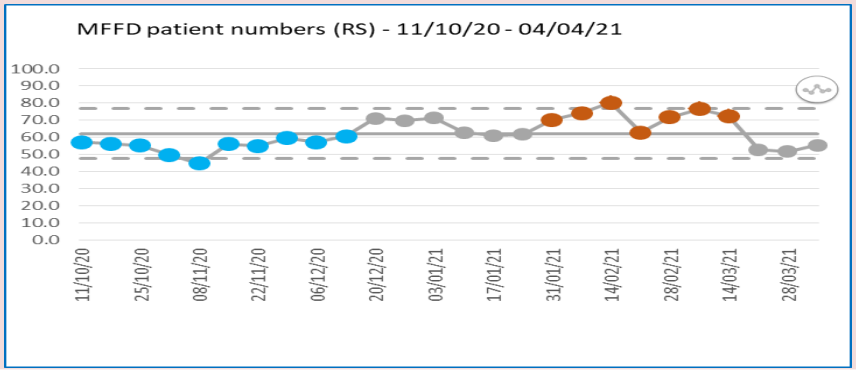
The number of NEL admissions has remained fairly static in March

Work stream 2: Flow cont.



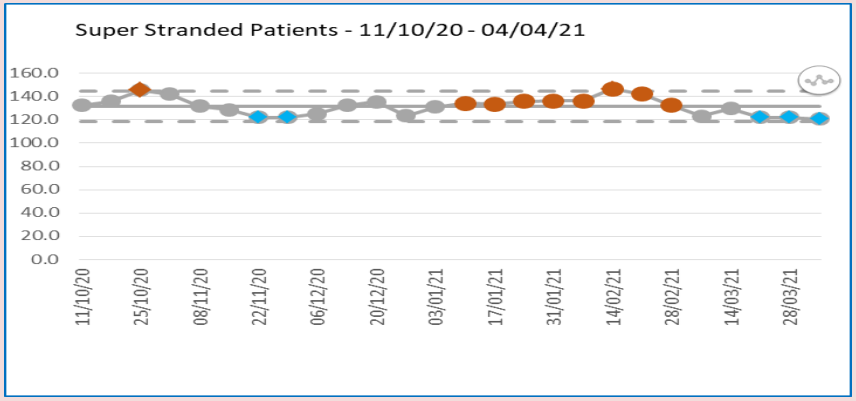
Bed occupancy:

Bed occupancy has shown some early indications of rising in March to above the mean.



MFFD.

After a period of increase in the numbers of Medically Fit For Discharge through January and February, March has seen a reduction to below 60.



Super Stranded patients: Reduce the number of patients with an extended stay over 21 days.

The number of patients in beds with a length of stay over over 21 days has remained fairly static with the latter half of March showing reduced numbers.

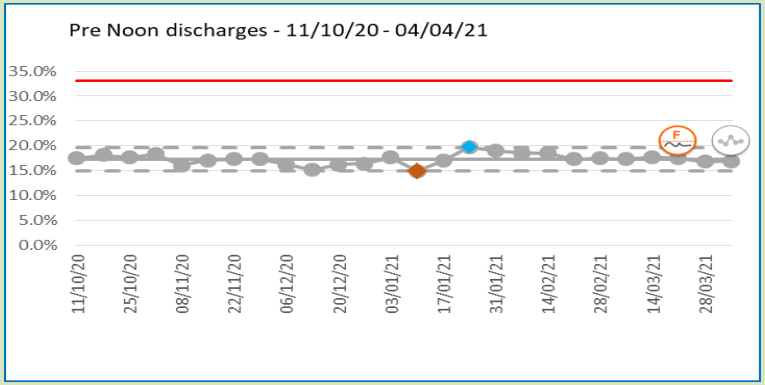
Work stream 3: Clinical Site Management

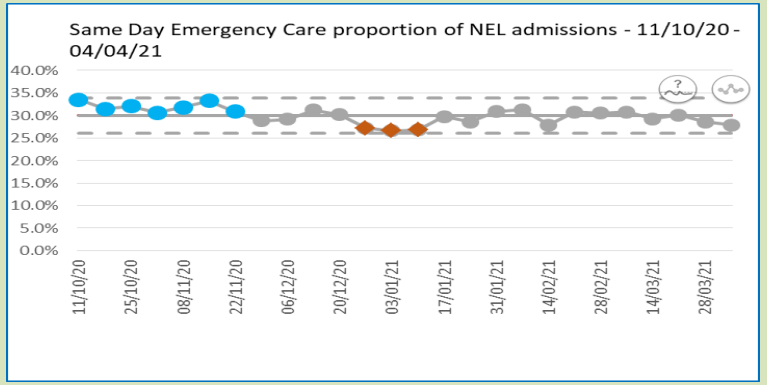
Pre-noon Discharges:
Maintain focus on the number of patients discharged from a hospital bed pre-noon to increase available capacity for admissions earlier in the day.

The percentage of pre-noon discharges has remained static.

Same Day emergency Care (SDEC):
Improve allocation of patients to most clinically appropriate clinical areas and clinical pathways.

The percentage of patients allocated to SDEC has remained static.





Cancer

University Hospitals of North Midlands NHS Trust

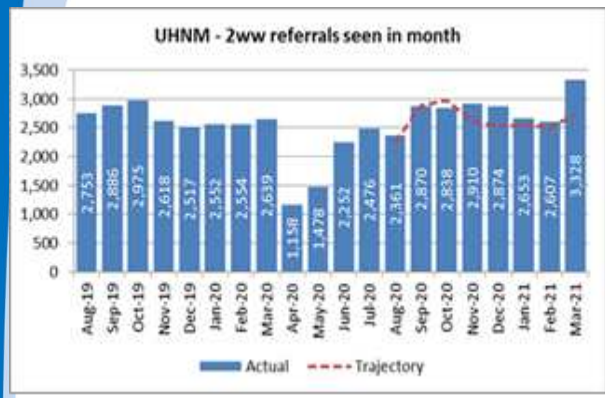
Summary:

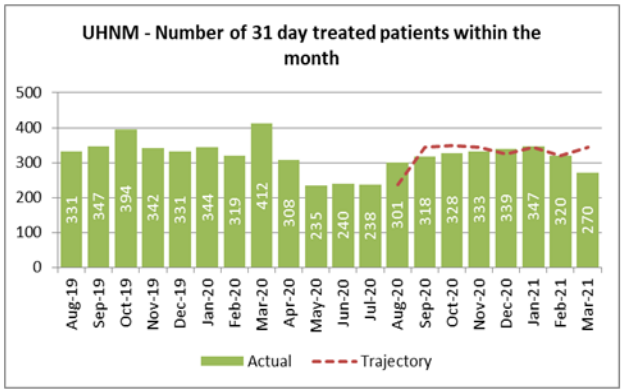
- In the past 3 months the overall Colorectal PTL and the 2WW Colorectal PTL have reduced by around half. The colorectal hub is working well with productive partnership between the corporate cancer team and the directorate. As part of the partnership, a new Colorectal navigator has been recruited, funded by cancer services but situated in the directorate, and will start in April. A bespoke training package is being developed and will be delivered by the CWT trainer in conjunction with the corporate team and directorate, to support this role.
- The Trust is predicted to achieve against the Rare cancers and the 28 day standard. The total Cancer PTL remains steady although the backlog has fallen slightly. The 104+ day backlog is showing normal variation at 45 for March 21.
- The 2ww PTL rose following the second phase of the pandemic , however from January the PTL reduced and has remained steady at a level below the mean, although the size of the waiting list is still higher than that seen pre-covid.
- 2WW performance, whilst under achieved in March at 91.4%, remained steady and above that seen in January (88.16%). Significantly more patients were seen on the 2ww pathway, in month, than at any time in the previous year. Demand remains high in some specialties such as Breast, and overall numbers are slightly higher than the same time last year.
- The latest data on 62 day performance is achieving 60.1%. Despite the third, most challenging wave of covid and significantly reduced theatre capacity, cancer surgeries and other cancer treatments were maintained in house and in the IS, and patients were dated according to their clinical priority rather than their clock start date, resulting in the lower performance. This clinical prioritisation of patients is continuing into April 21 and this is expected to be detrimental to performance which will not recover until the surgical backlog has been cleared. The 62 day PTL and backlog which had been reduced, has remained steady with levels now as seen pre- pandemic. Similarly the number of patients in the 63-103 days is also reducing.
- Delays are multifaceted including capacity in Endoscopy, Pathology and reduced theatre capacity. The new assurance framework highlights surgical category timeframes and ensures that patients are dated according to clinical priority.

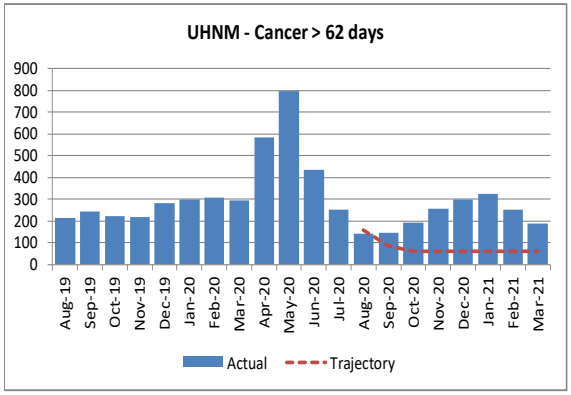
Actions:

- Work on the gap analysis of 2019 V 2020 in Cancer activity is on-going – bespoke data packs have been compiled to accompany a survey that has been sent to clinicians for comment.
- Vague symptoms pathway delivery group convened with excellent clinical engagement and follow on actions confirmed to create a non specific symptom service for suspected cancer patients.
- 2ww demand against bookings kept under review with escalations to teams for additional capacity to ensure pathway improvements are sustained.
- Action plans to address bottlenecks in Endoscopy and Pathology have been drafted as part of the Q1 capacity and demand plans. Cancer endoscopy has been prioritised now with 57 patients '@ 3 week wait.
- Capacity plans being drafted to support the 24 theatres coming on line at the acute together with the new contract with the IS from 1st April to start to treat patients to pathway and continue to improve performance.
- Specialty comparator analysis completed to evaluate quality indicators and activity between 2020 and 2021 Further deep dive with clinical input being conducted over the next 4 weeks to frame the cancer assurance/risk position statement with regard to the covid second surge management of patients.
- Deep dive into pathology data is on –going. Weekly meetings in place to keep pace of actions. Pathology dashboard is in development that will provide an understanding of the trusts true cancer pathology demand.
- Collection of Performance status, CNS and Stage metrics for the COSD audit have all improved since last month.

Cancer

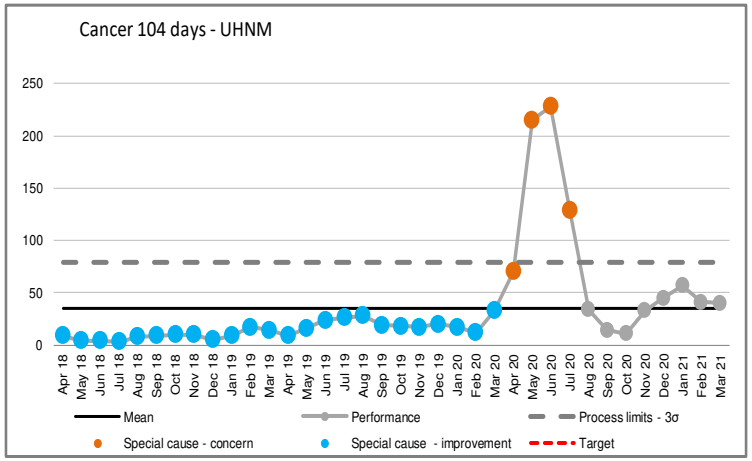






Provisional March Position:

Core Standard	Target	Trust Actu	Clock Stop	Breaches	Breaches Over	Needed Treatme
TWW Standard	93%	91.5%	3328	284	52	730
TWW Breast Symptomatic	93%	92.3%	39	3	1	4
31 Day First	96%	89.6%	270	28	18	430
31 Day Subsequent Anti Cancer Drug	98%	94.1%	17	1	1	34
31 Day Subsequent Surgery	94%	92.1%	38	3	1	13
31 Day Subsequent Radiotherapy	94%	87.0%	54	7	4	63
62 Day Standard	85%	60.1%	146.5	58.5	37	244.5
Rare Cancers - 31 Day RTT pathway	85%	100.0%	1	0	Achieved!	Achieved!
62 Day Screening	90%	73.1%	26	7	5	45
28 Day FDS Standard	75%	81.7%	2071	378	Achieved!	Achieved!
62 Day Consultant Upgrade	93%	78.5%	93	20	14	193
Closed Pathways > 104 Day			17			



Planned care - *Inpatients*

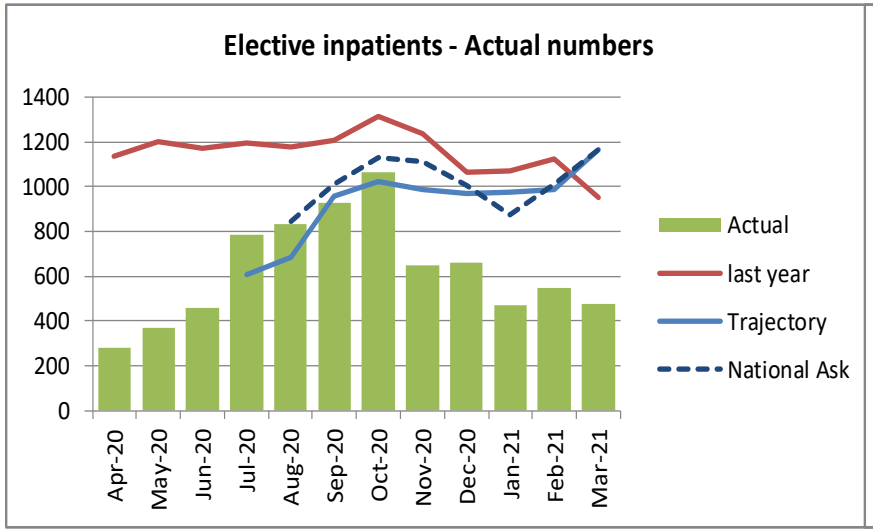
Elective inpatients Summary

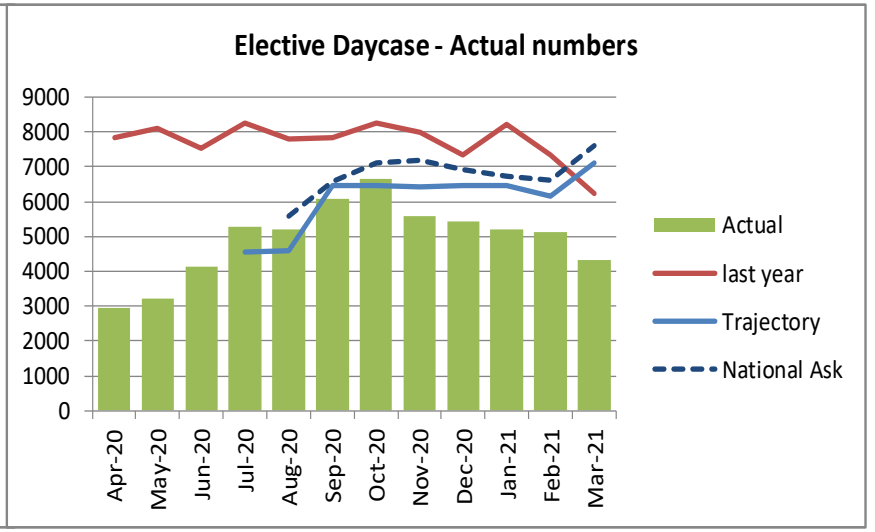
- The National ask for elective care has been revisited and March saw the release of guidance for the first six months of 2021 and these will be displayed in next months report. For March the actuals against BAU for inpatients was 72.7%.
- The number of elective operations for UHNM (inpatients and day cases) increased in March. For RS & County, Elective operations increased to 7,077 (compared to February 5,676). 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).
- The elective capacity plan has been modelled for both UHNM and the Independent Sector against the 2021/22 National Planning Guidance.
- From 19th April 2021 the Trust approved Operational Delivery Programme and Governance model will be implemented that will see restoration of the Trust Wide elective care programme based on scaling up of capacity for out patients, diagnostics and theatres with our expectation that by early May we will be achieving the same planned care activity that we did in September 2020.
- The risks currently are: the quantum of unknown demand in the community due to the limited non face to face appointment capacity in primary care for which out patient referred demand may escalate beyond our capacity and the volumes of patients who have deferred appointment/treatment offers during the last 12 months due to the Covid-19 risks who will require treatment once seen (that is a higher than average conversion rate for planned care treatments) together with the risk of a third Covid-19 spike that may confound current plans for scaling up of capacity.
- Modelling of timescales to reduce the waiting list demand down to reference numbers by P category is now under way using the new National Planning Guidance (March 2021) as a guide: 70% of activity compared with 2019/20 with a +5% increase each month. The performance profile for February 2021 was circa 50% for In Patients and 70% for Day case so with the additional capacity coming on line, we are confident we will be able to meet and improve on this recovery standard.

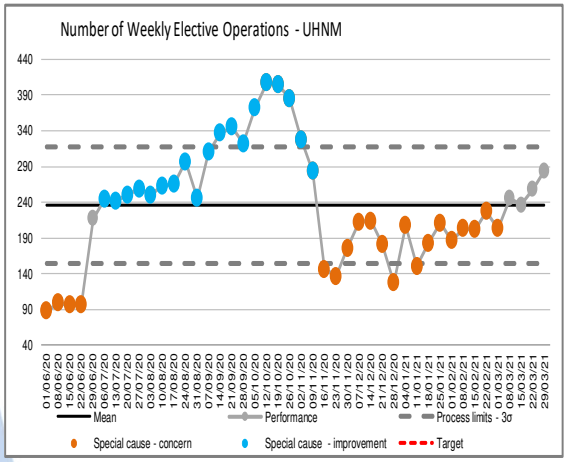
Actions

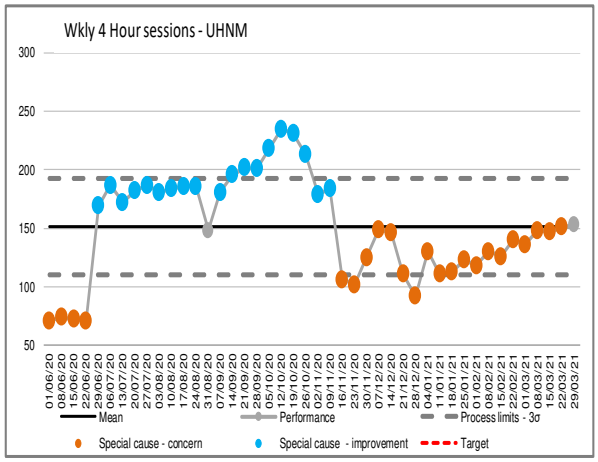
- Two outsourcing companies now in dialogue with specialties that have volume wait lists to identify expedited clearance (dermatology, ENT, gastroenterology and urology).
- Scaling up of theatres at Royal Stoke and County will progress to secure September operating volumes by May 2021.
- Independent Sector contracts confirmed and drafted with patients transferring over.
- Work continues on the 26 week pathway plans with the CCG to support a phased mail drop to patients around their waiting list status and a number of other test questions to support waiting list validation.

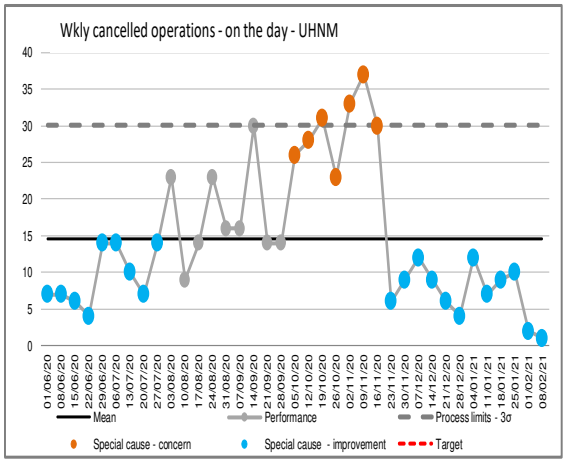
Planned care – *Inpatient Activity*











Planned care - *Outpatients*

NHS
University Hospitals of North Midlands
NHS Trust

Summary

- The National ask for elective care has been revisited and March saw the release of guidance for the first six months of 2021 and these will be displayed in next months report. For March the actuals against BAU for outpatients was 94.3% .
- March 21 numbers recorded increased 60,264 to 70,482. However this may increase further as the outstanding outcomes are completed.
- The overall Referral To Treatment (RTT) Waiting list continues to rise. For March the number of Incomplete pathways has risen to 56,573 (February 53, 295). 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, significantly above the levels seen pre-covid.
- The RTT waiting list shape has changed with the number of patients > 18 weeks remaining at a high level of 21,216 (February 19,429).
- The numbers of 52 week waits in March has risen to 4,563 (February 4417). 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.
- For outpatient appointments (appointment type) the Trust delivered **56.4%** F2F and **29.7%** non F2F(Telephone & Video). There were **13.9%** of appointments not set which is a **0.1%** increase on last month (for new appointment types F2F was **61.1%** & non F2F **24.4%** & follow ups F2F **54.0%** & non F2f **32.4%**). Work is underway to make the Media Type field in Medway mandatory which will eliminate 'Not Set'.
- March's performance for ASIs position declined to 83.8% within 3 days (from 87.8% in February).

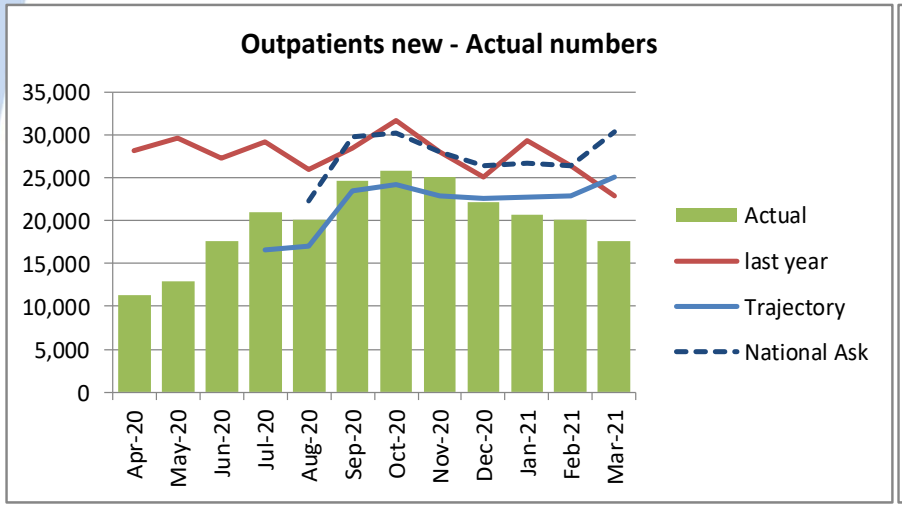
Actions

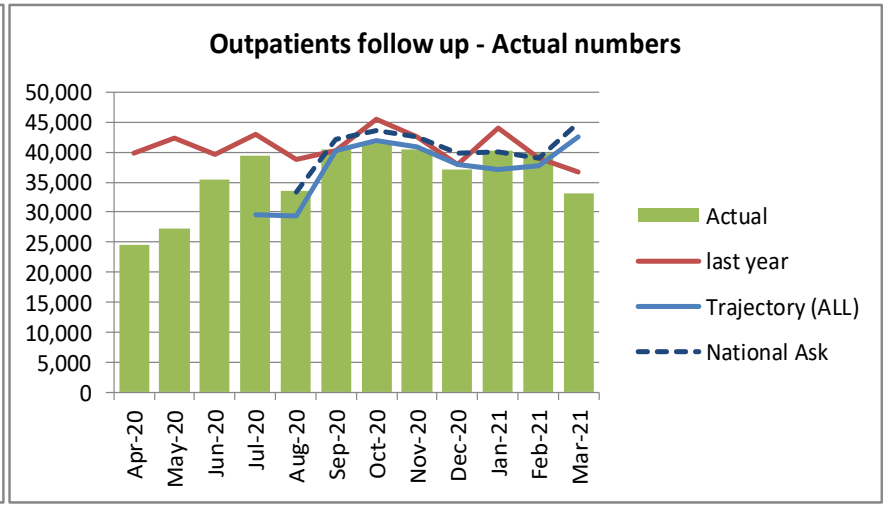
- Work is required on template reconfiguration based on Divisional assumptions - this needs to be aligned to the in patient and diagnostics plans for the purpose of substantive job planning.
- Revised 52 ww trajectory to be drafted once all cell plans confirmed to reduce the end of March 2021 delivery.
- 40+ week waiters are being planned with a combination of IS in/outsourcing and hospital capacity targeting categories 1, 1a, 2 and long waiters.
- UHNM is launching a centralised GP Advice Bureau utilising existing systems (Consultant Connect) and resources (the Outpatient Team). The Bureau will be a single point of access for GP's to access urgent administrative queries . UHNM's GP advice bureau will form part of the Trusts overarching vision to provide a front facing, single point of access to GP's with a specific focus on building, improving and sustaining mutually beneficial partnership working arrangements to ensure the safe, effective and sustainable delivery of services to our local population.

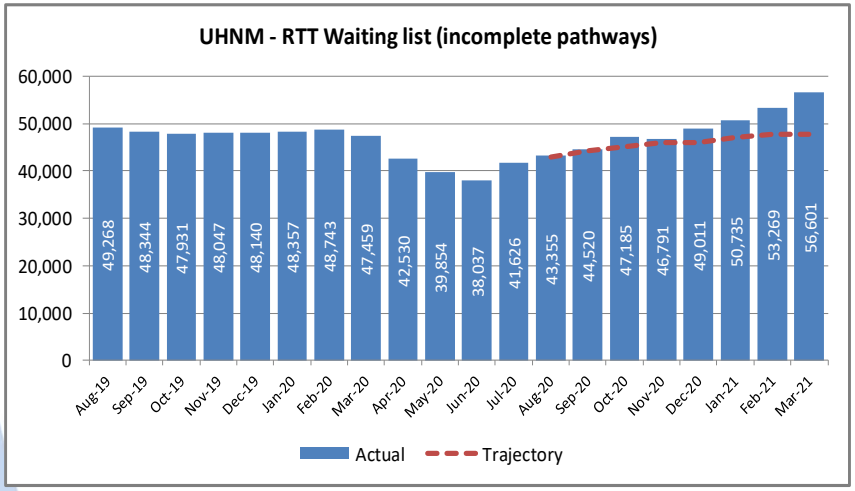
Risks:

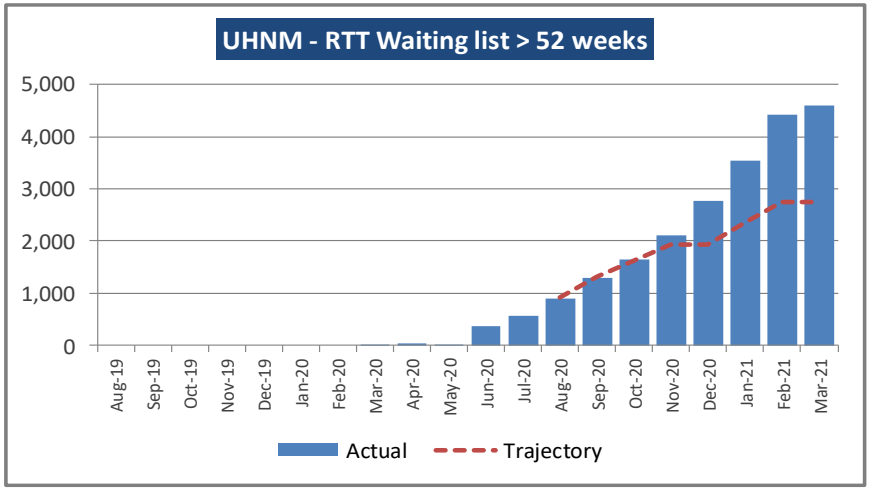
- Impact of stopping FTF activity in some areas to release staff to support frontline being monitored.

Planned care – *Outpatient activity & RTT*

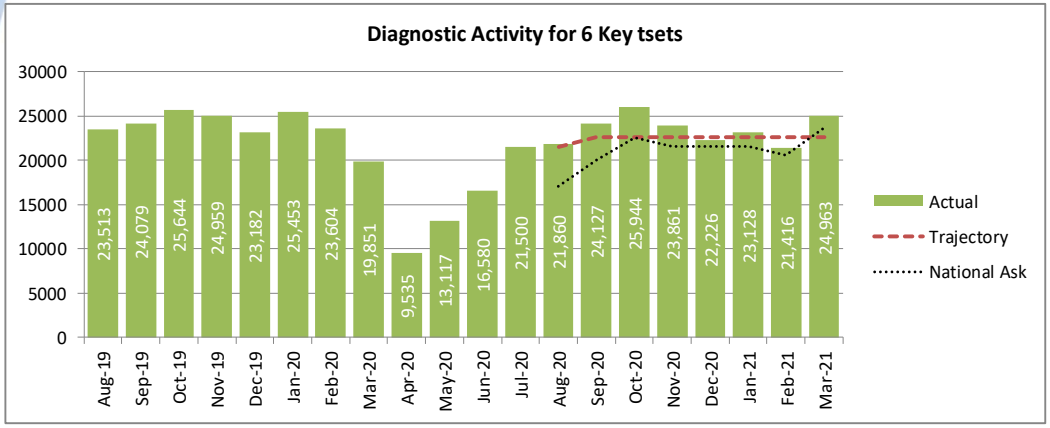








Diagnostic Activity



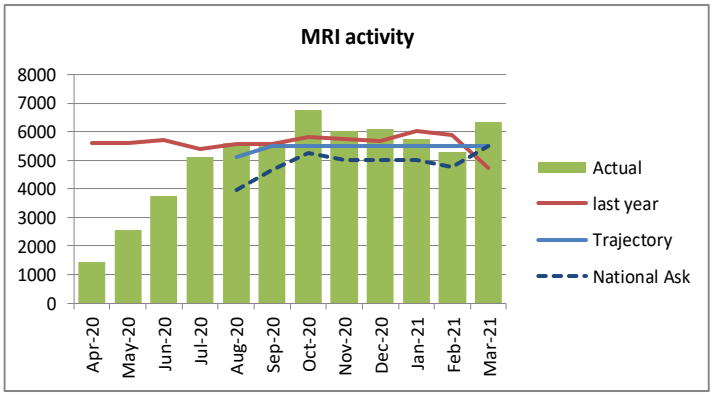
	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21
Trajectory	22,608	22,608	22,608	22,608	22,608
Actual	23,861	22,226	23,128	21,416	24,963
Varience	1,253	-382	520	-1,192	2,355

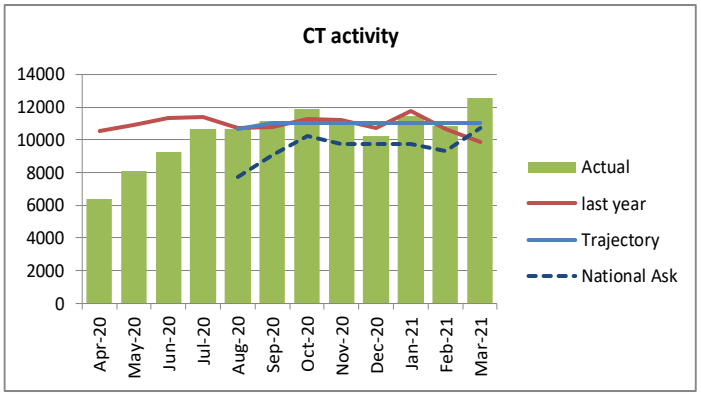
Background
Activity for the 6 key DM01 tests

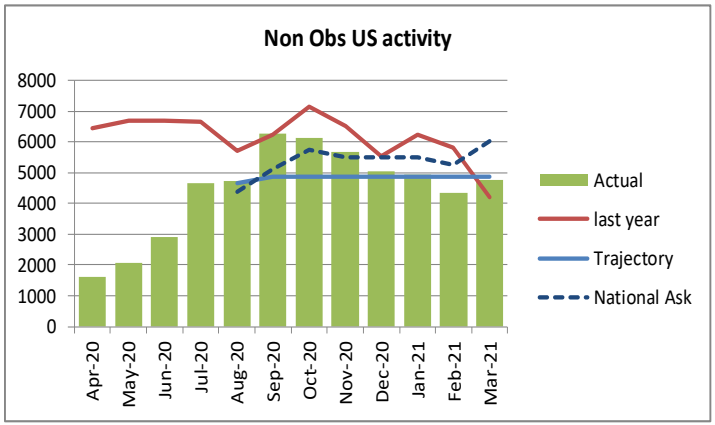
Summary

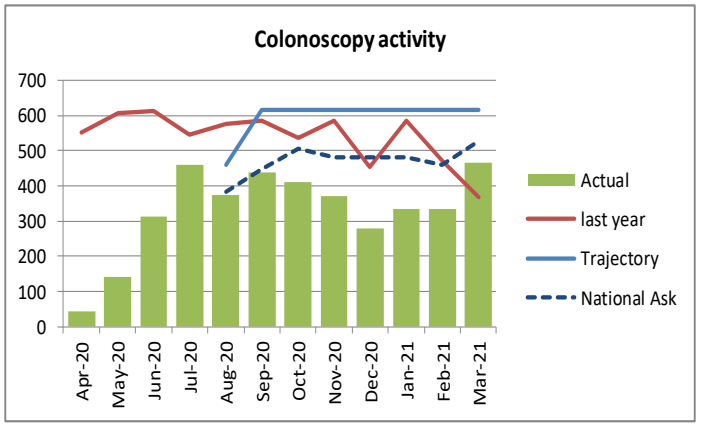
- For the 6 key diagnostic tests in phase 3, March saw an increase in activity which is in line with normal variation and is in line with expected for shorter/ longer working month.
- The diagnostic performance for March 21 is 84.1% (Feb 21, 90.1%). The waiting list size is 16,514 (February 14,819). Revised trajectories are now being transacted for 2021/22 and monitored via the Diagnostic Cell, with investment requests approved for DMO1 modalities to support this recovery timescale.
- There has been a significant Increase in activity for breast 2ww referrals impacting on performance. A working group is set up comprising of imaging, breast and the cancer to team to review the referral s and total capacity required,. One notable difference is that there seems to be an in crease in the number of referrals coming from Cannock which is impacting on capacity. In addition to this there also seems to be more referrals from Primary care for under 35 referrals. This is being reviewed and once analysis of the current referral demand is completed, we will engage with PCN and CCG accordingly. Immediate action to support the current demand is that additional clinics have been put in place – 3x week until end of June for now to support the backlog.
- As part of restoration and recovery , there has been a recommencement of CT guided Injections and emobilisations at County. The number of breaches have grown due to this activity not occurring

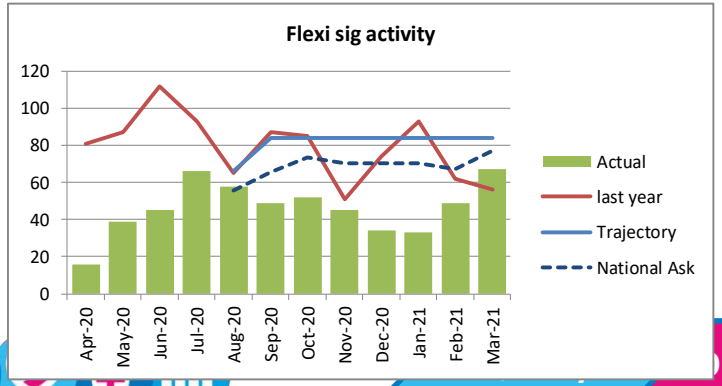
Diagnostics

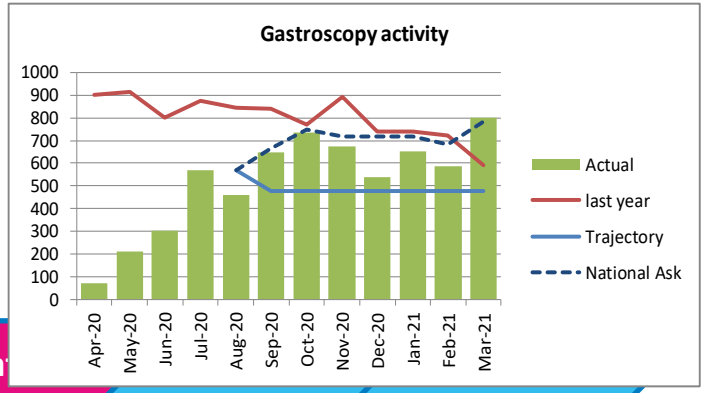












APPENDIX 1

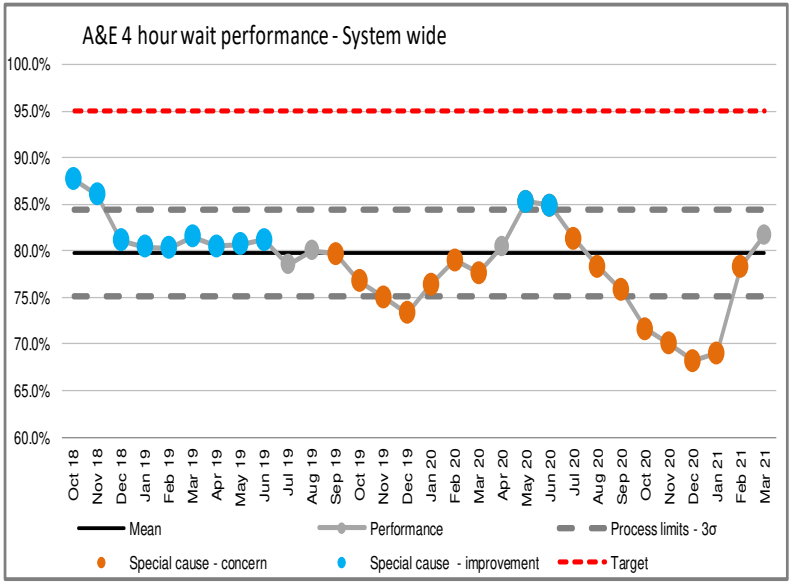
Operational Performance

Constitutional standards

	Metric	Target	Latest	Variation	Assurance	DQAI
A&E	A&E 4 hour wait Performance	95%	81.70%		F	
	12 Hour Trolley waits	0	0		?	
Cancer Care	Cancer Rapid Access (2 week wait)	93%	91.43%		?	
	Cancer 62 GP ref	85%	60.10%	L	?	
	Cancer 62 day Screening	90%	78.95%		?	
	31 day First Treatment	96%	89.00%	L	?	
Elective waits	RTT incomplete performance	92%	62.50%	L	F	
	RTT 52+ week waits	0	4563	H	F	
	Diagnostics	99%	84.06%		?	

	Metric	Target	Latest	Variation	Assurance	DQAI
Use of Resources	DNA rate	7%	7.2%		?	
	Cancelled Ops	150	58	L	?	
	Theatre Utilisation	85%	76.0%			
Inpatient / Discharge	Same Day Emergency Care	30%	29.0%	H	?	
	Super Stranded	183	127	L	P	
	DToC	3.5%	2.70%	L	?	
	Discharges before Midday	30%	19.4%		F	
	Emergency Readmission rate	8%	13.7%	L	F	
	Ambulance Handover delays in excess of 60 minutes	10	41		?	

URGENT CARE – 4 hour access performance



Variation	Assurance
	F

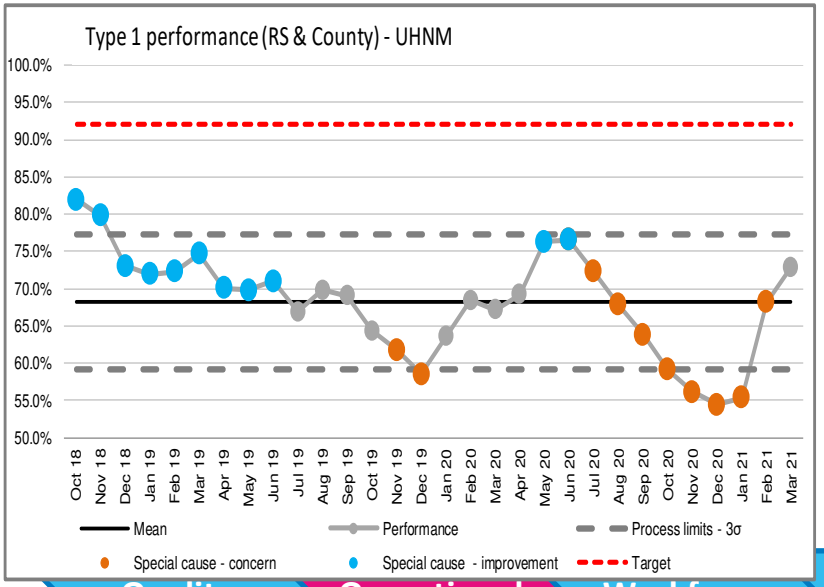
Target	Jan 21	Feb 21	Mar 21
95%	69.0%	78.3%	81.7%

Background

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

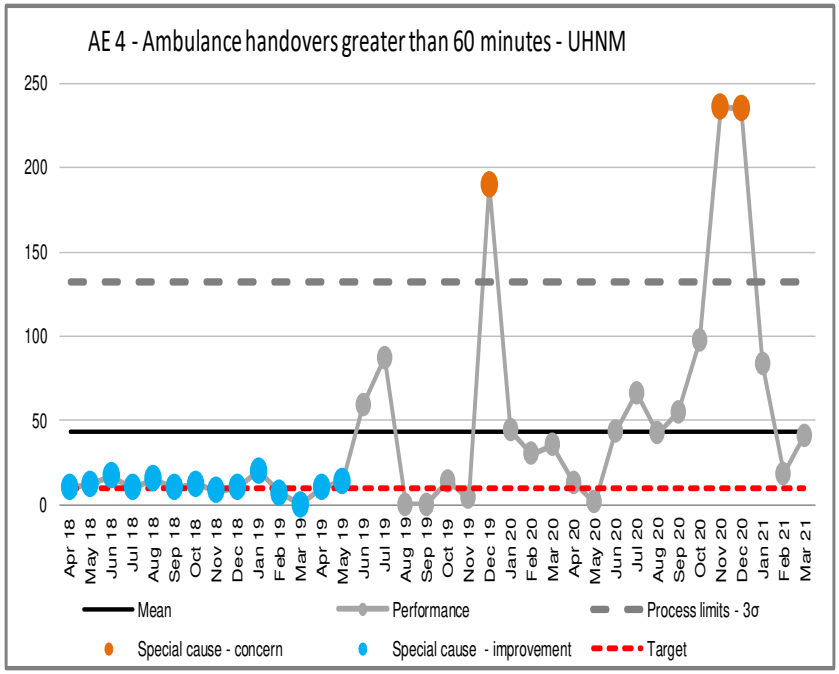
What is the data telling us?

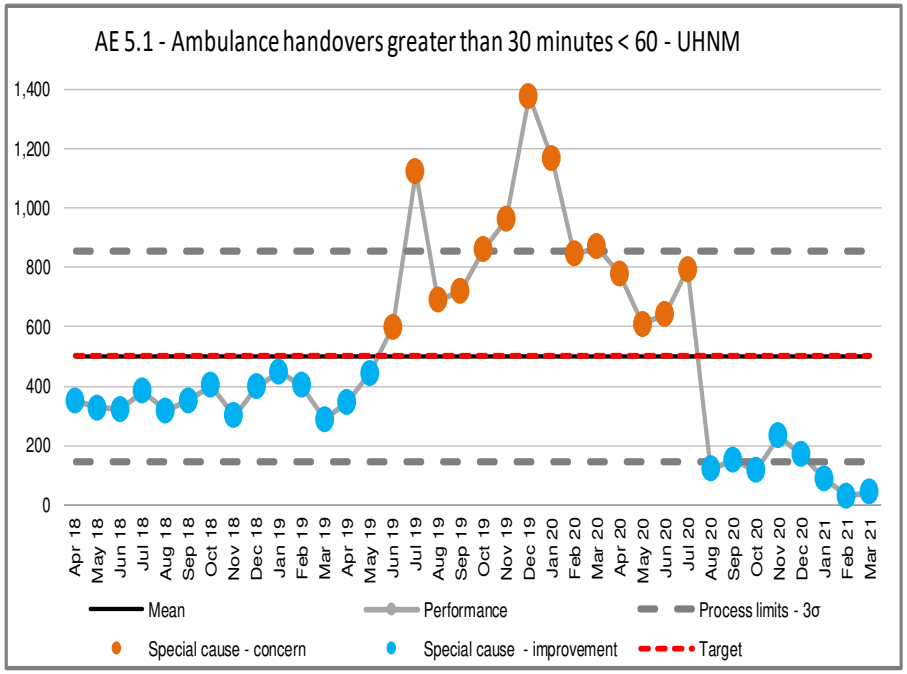
The improvemnets seen in May and June have not been sustained and performance is showing special cause concern. Performance has been below the lower control limit for 4 months.



Quality | Operational | Workforce | Finance

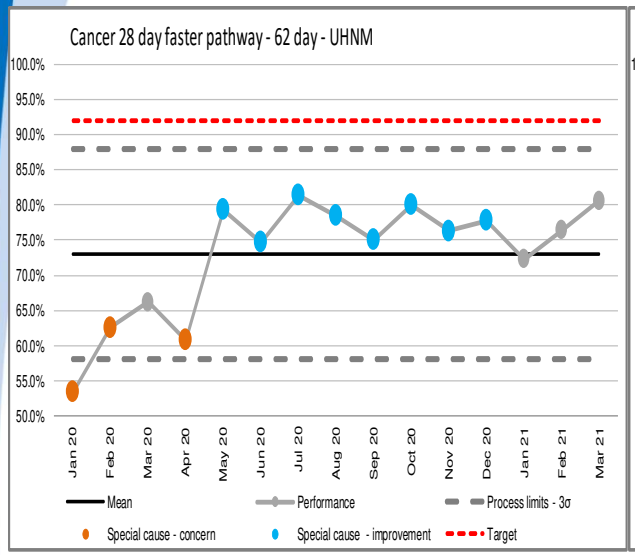
URGENT CARE – 4 hour access – ambulance handovers

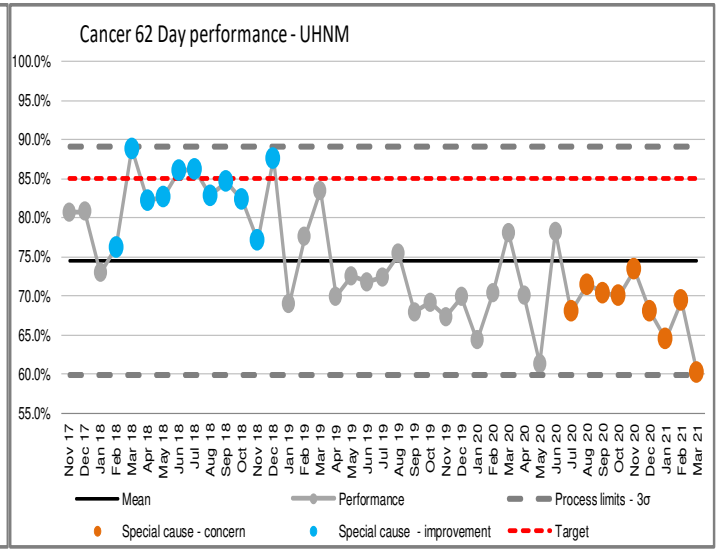




From August – internal validation of > 30 minutes

Cancer – 62 Day





Variation	Assurance
	

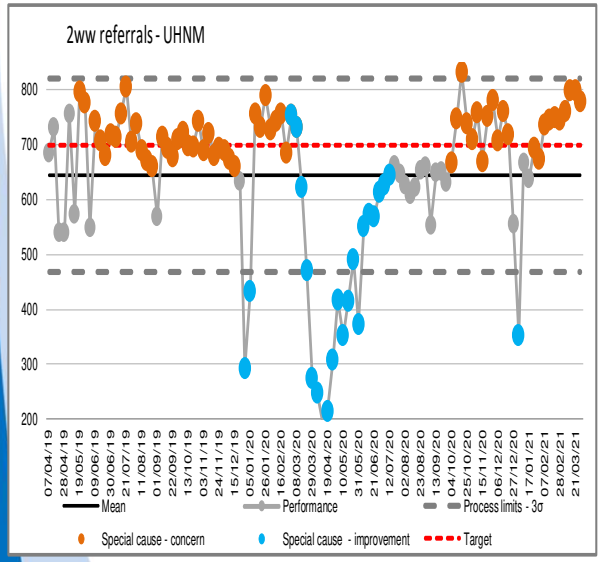
Target	Jan 21	Feb 21	Mar 21
85%	64.4%	69.3%	60.1%

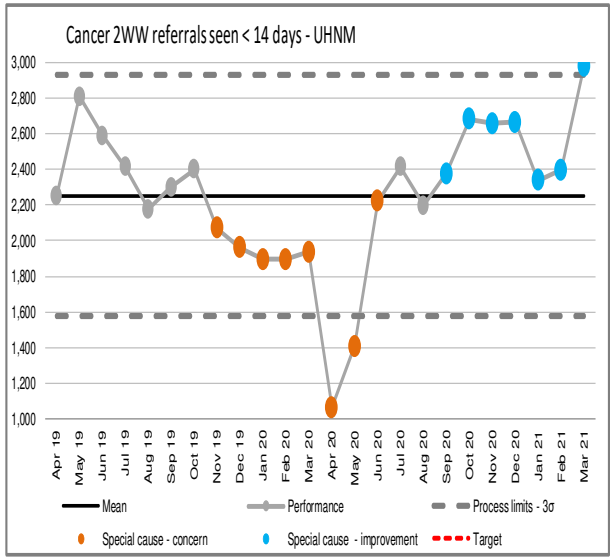
Background

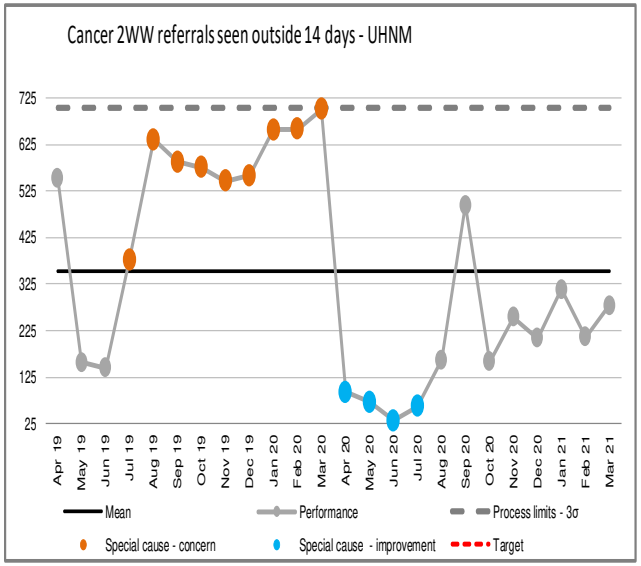
% patients beginning their treatment for cancer within 62 days following an urgent GP referral for suspected cancer

What is the data telling us?

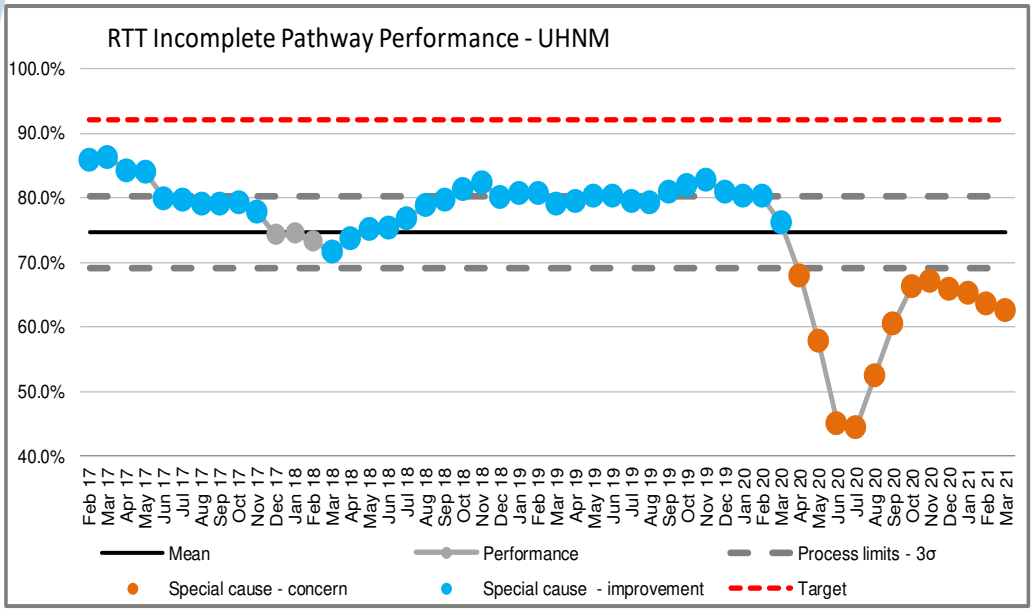
Apart from two occasions the standard has been below the mean since Sept-19. In March the standard fell to the lower control limit.







Referral To Treatment



Variation	Assurance
	

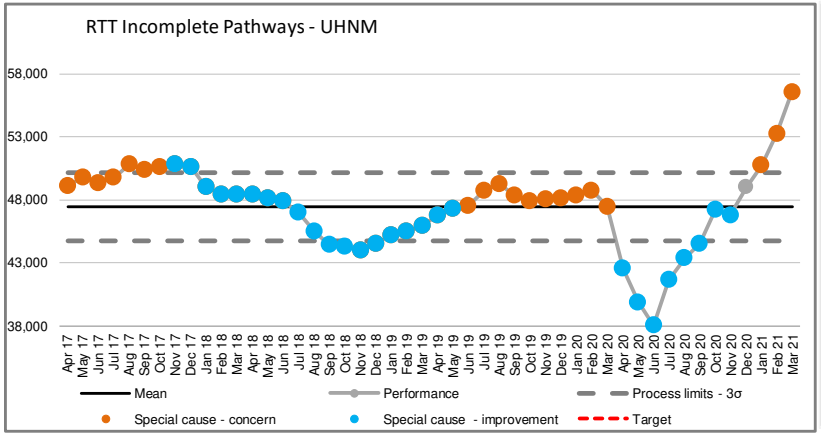
Target	Jan 21	Feb 21	Mar 21
92%	65.2%	63.6%	62.5%

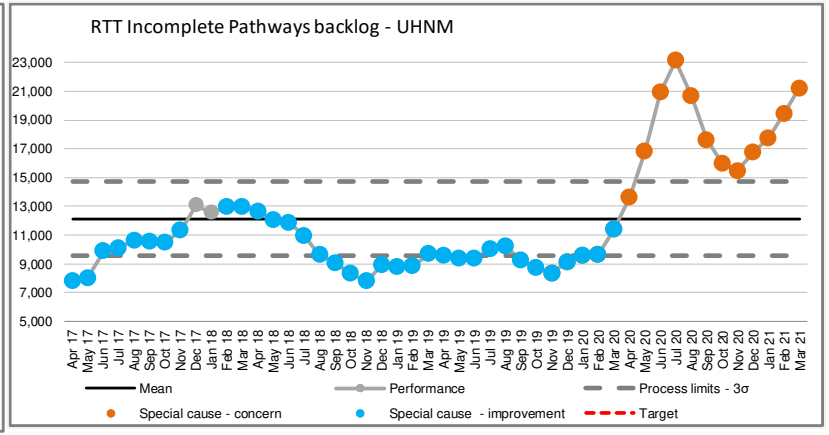
Background

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

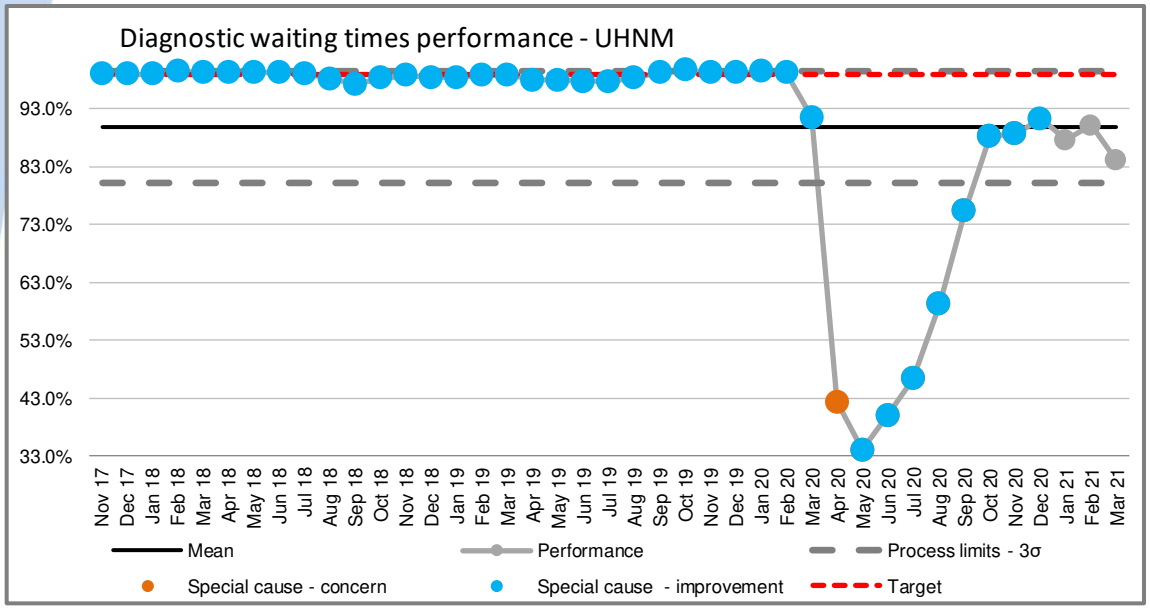
What is the data telling us?

The RTT performance deteriorated from March 2020 with the onset of Covid-19. Recovery was seen from July but has not reached pre-covid levels.





Diagnostic Standards



Variation	Assurance
	

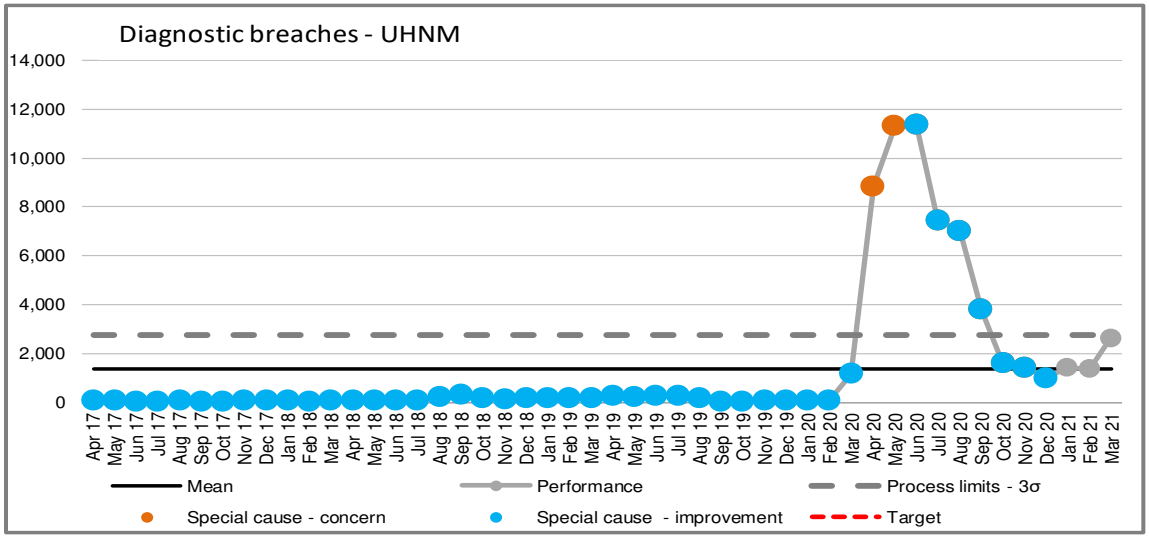
Target	Jan 21	Feb 21	Mar 21
99%	87.6%	90.1%	84.1%

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

UEC Standards - National proposal
March 2021

Introduction

Proposed New Bundle of Standards by the Clinically-led Review of Standards

Service	Measure
Pre-hospital	Response times for ambulances
	Reducing avoidable trips (conveyance rates) to Emergency Departments by 999 ambulances
	Proportion of contacts via NHS 111 that receive clinical input
A&E	Percentage of Ambulance Handovers within 15 minutes
	Time to Initial Assessment – percentage within 15 minutes
	Average (mean) time in Department – non-admitted patients
Hospital	Average (mean) time in Department – admitted patients
	Clinically Ready to Proceed
Whole System	Patients spending more than 12 hours in A&E
	Critical Time Standards

In June 2018 the Prime Minister asked for a clinically-led review of the NHS access standards to ensure they measure what matters most to patients and clinically. The published report also sets out a new approach to measuring what is clinically relevant, offering a holistic view of performance, developed with clinical system leaders.

The consultation covers the proposed measures themselves, but notes that depending on the outcome of the consultation, further work is needed to assess the appropriate
thresholds for each measure.

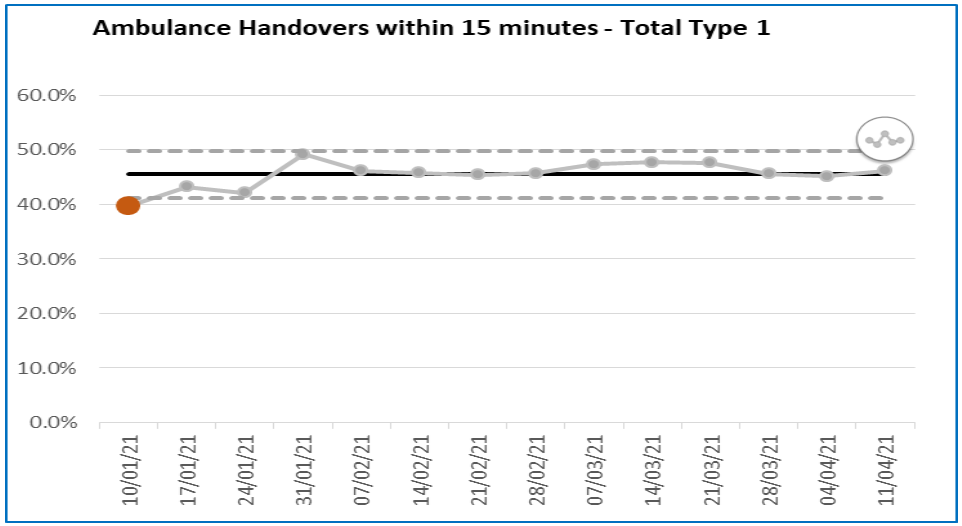
Governance

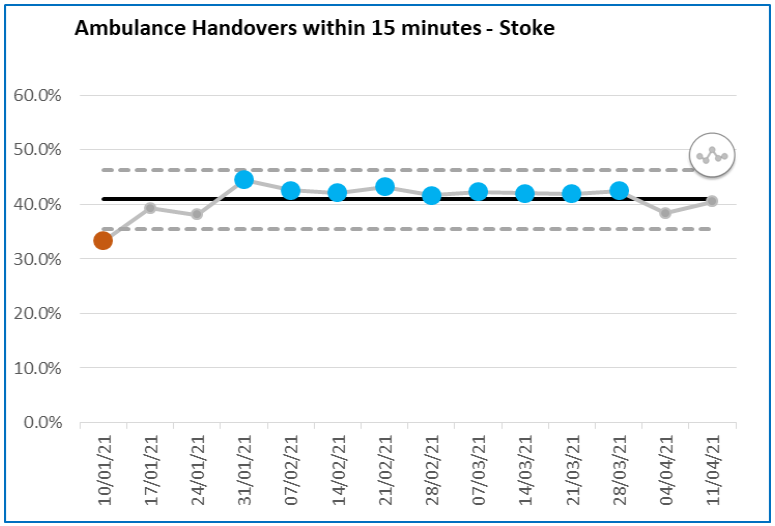
The newly proposed UEC standards will be monitored through both ED performance review and Medicine Divisional board meetings. Organisationally oversight will be through the Urgent Care Programme Board in addition to relevant trust committees

Assessment

Ambulance Handover Times	March remains **positive** with consistent performance above 40% with little variation. Little change
Initial Assessment within 15 minutes	The proportion of patients waiting under 15 minutes for their initial assessment fell towards the end of March to **under 70%.** This was more notable in the non-ambulance assessments.
Mean time in the department	Both Admitted and non admitted mean times in department increased through March. This was more notable in the non admitted.
Patients spending more than 12 hours in department	The number of patients spending over 12 hours in the department has been increasing through March but overall the number was an improvement on February and better than previous years' March

2. Percentage of Ambulance Handovers within 15 minutes



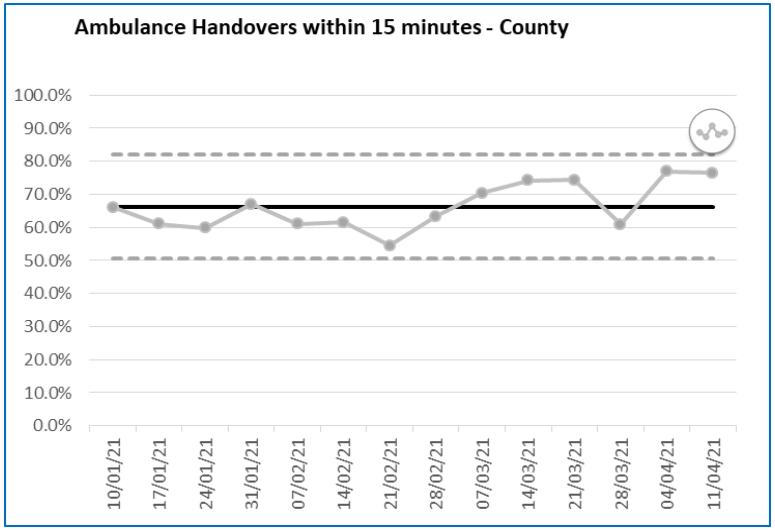


Internal collection of data for Ambulance handovers within 15 minutes began at the beginning of January 21. This is the time taken for the ambulance service to hand over the care to the ED.
N.B. this is un-validated performance and also includes handover time related to direct ambulance conveyance to any portal: maternity or cath lab

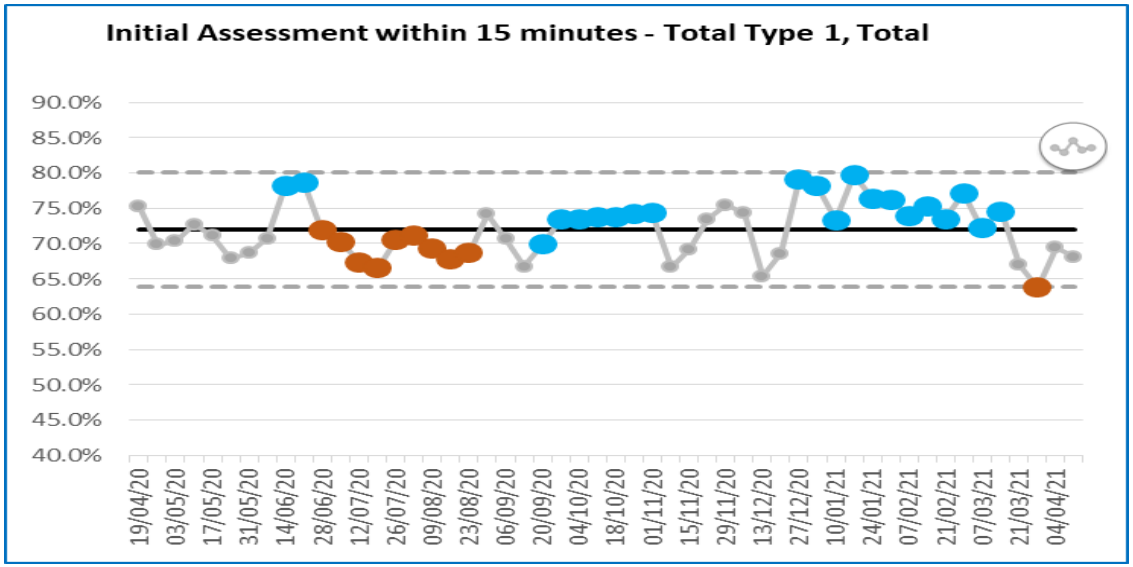
For total ambulance handovers at UHNM in March, the percentage within 15 minutes had increased to 47%. A local UHNM target of 48% has been set as the goal to improve to as part of the NEL Improvement programme.

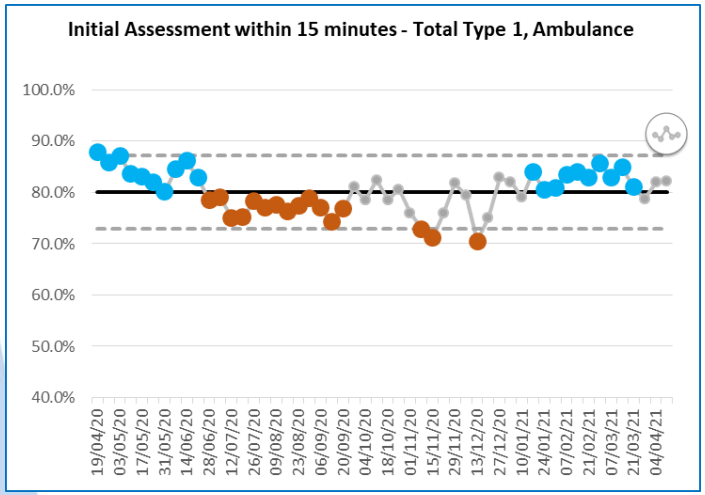
County have maintained a much higher percentage than Royal Stoke albeit with much smaller numbers.

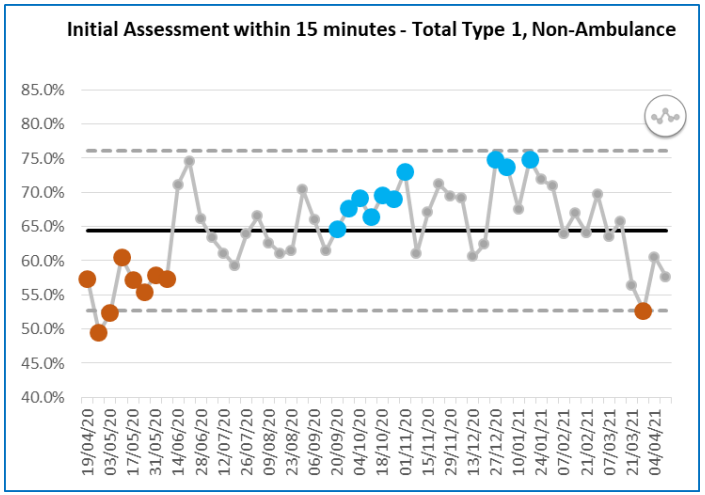
March has seen normal variation continue from last month.



3. Time To Initial Assessment – percentage within 15 minutes







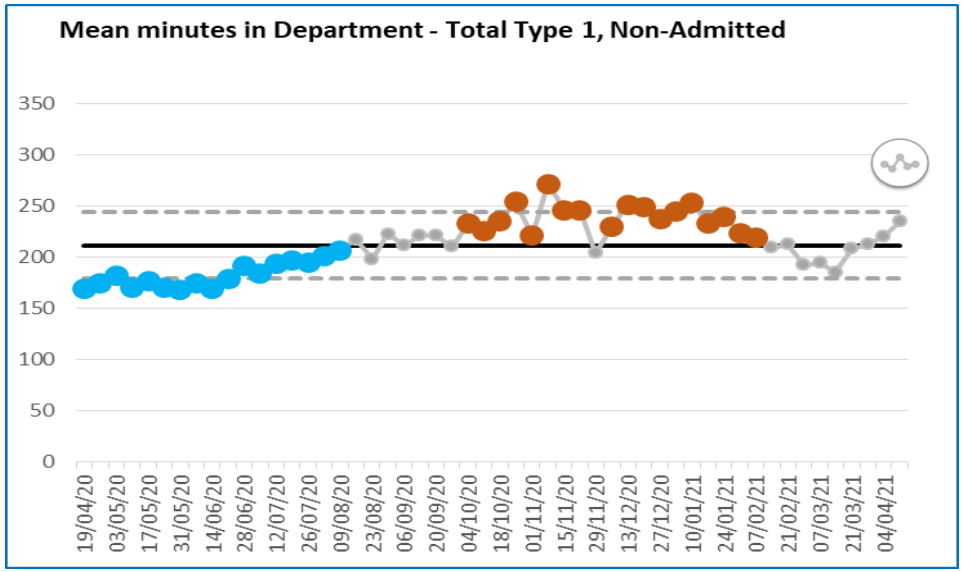
Time to Initial assessment is the time from arrival to when the patient is first triaged.

The proportion of patients waiting under 15 minutes for their initial assessment fell towards the end of March to **under 70%.**

This was more notable in the non-ambulance assessments which may be accounted for with the increase in attendances in this area.

A local UHNM improvement target of 85% has been set.

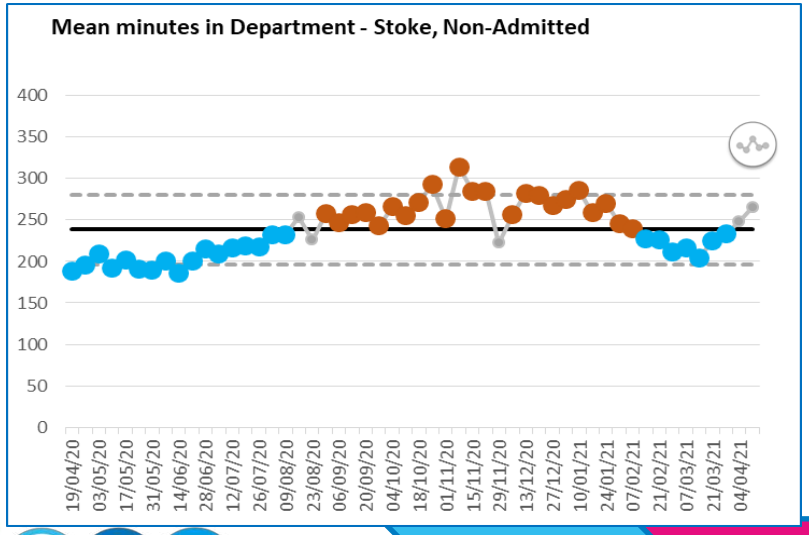
4. Average (mean) time in Department – non admitted patients

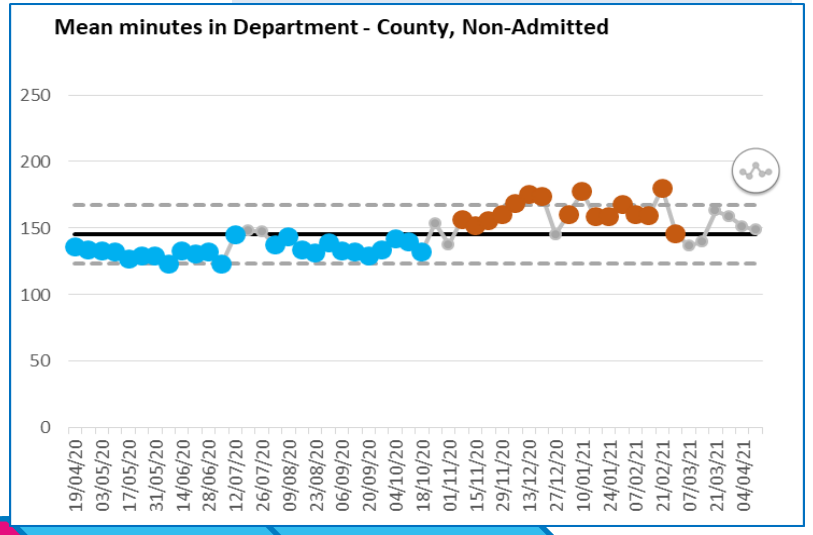


The mean time in the department at the end of March was 220 minutes. Some initial data for April is showing a rise in the mean minutes in Department.

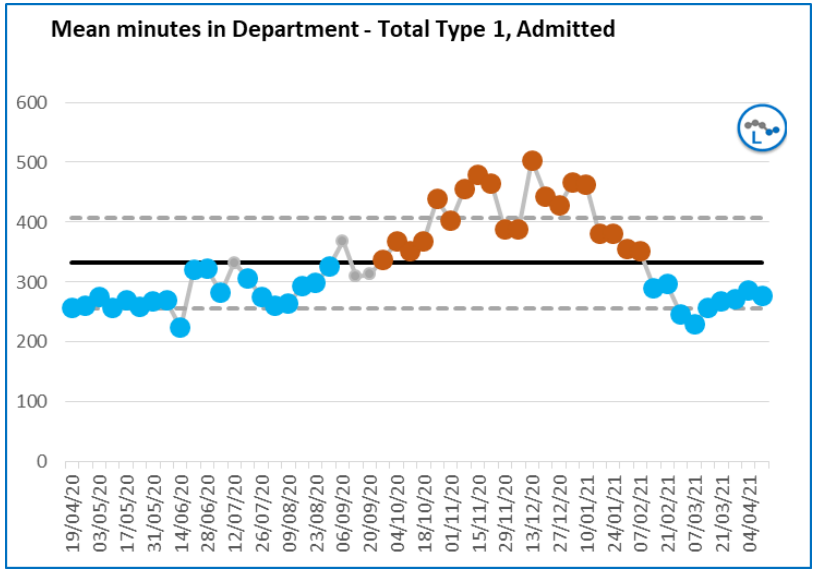
For Royal Stoke the mean time for March was held at below 250mins. For County the mean rose slightly to 150mins.

An improvement target for UHNM has been set at 160 minutes.





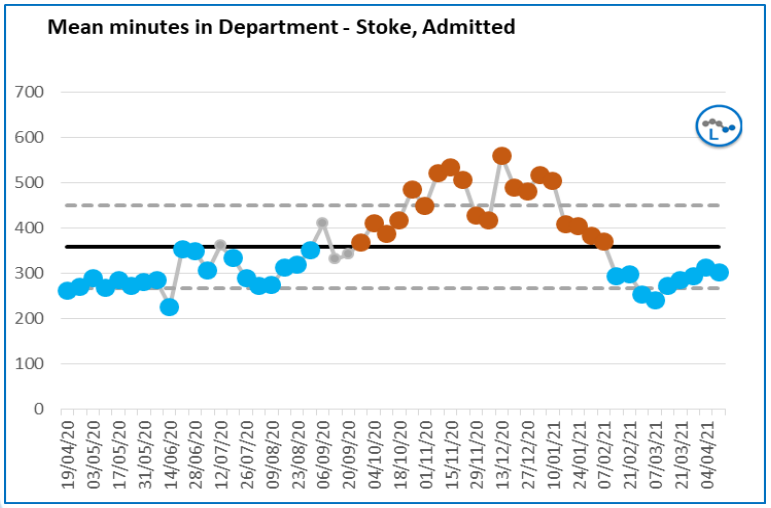
5. Average (mean) time in Department – admitted patients

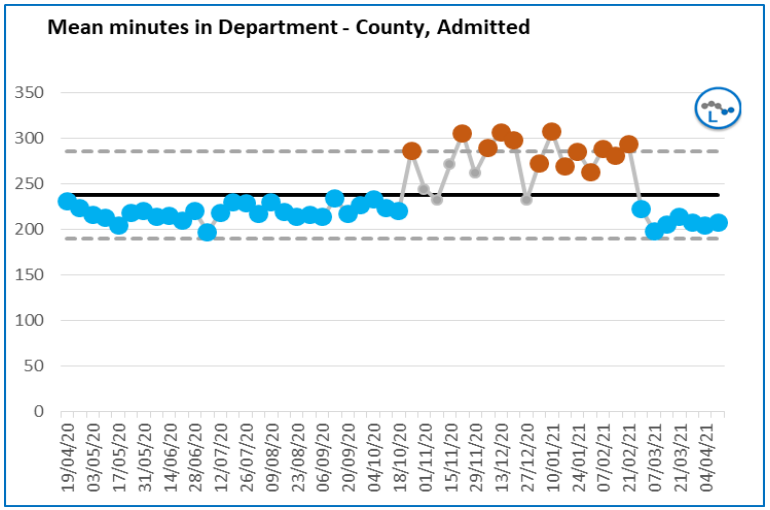


The reduced mean time in the department for admitted patients has been maintained through March at around 260mins.

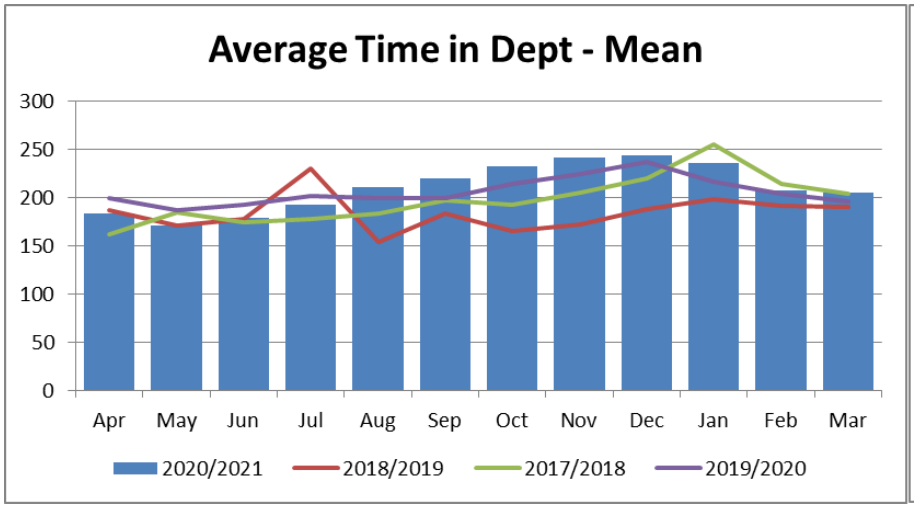
This was seen at both sites.

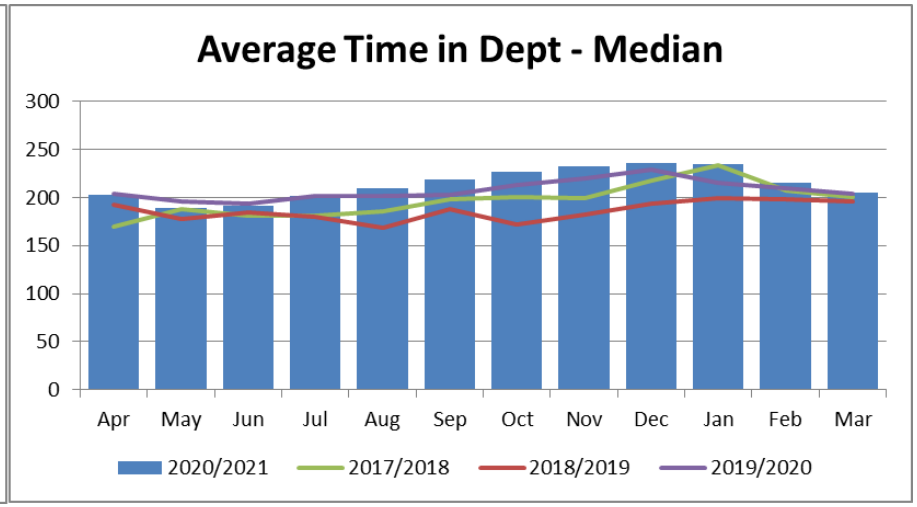
An improvement target for UHNM has been set at 240 minutes.



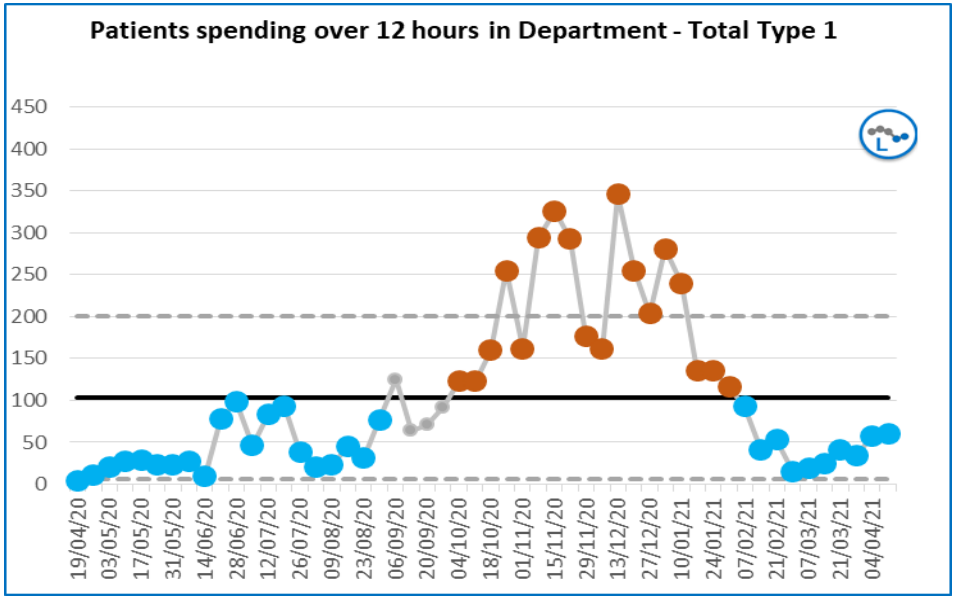


5. Average time in Department (mean vs median)



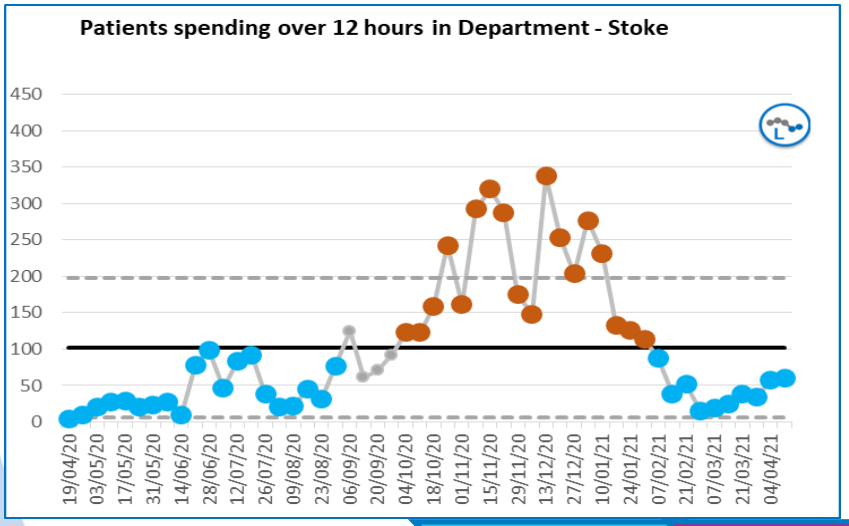


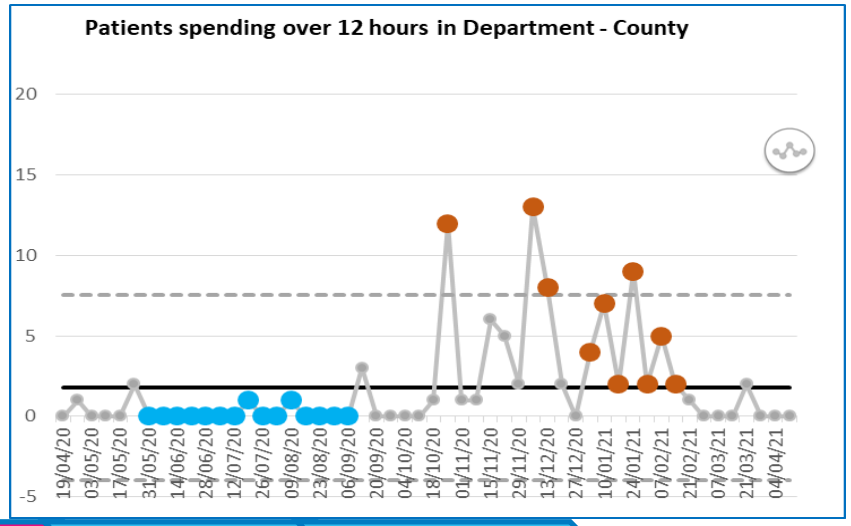
6. Patients spending more than 12 hours in the department



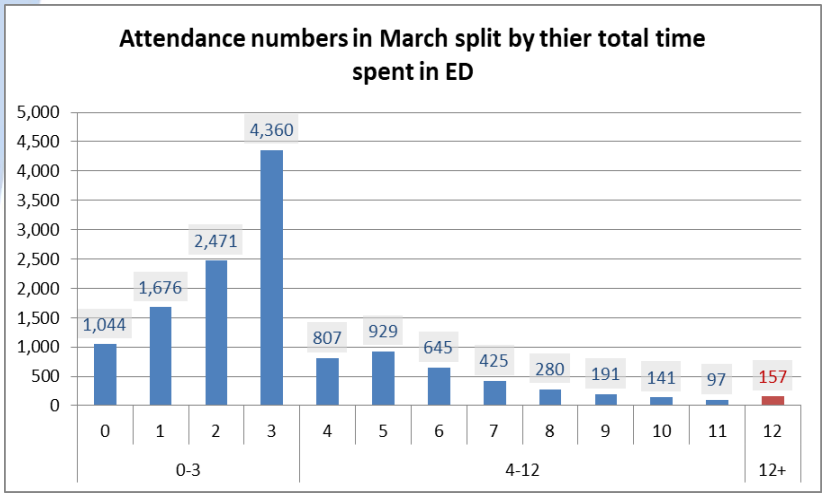
The reduced number of patients spending over 12 hours Tin the department has been maintained in March when compared to Nov/Dec 20.

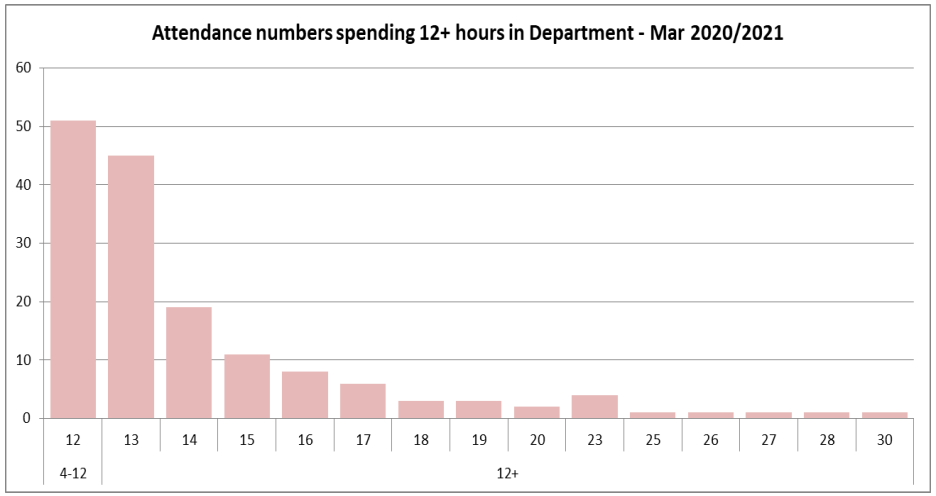
This standard is more applicable to Royal Stoke.





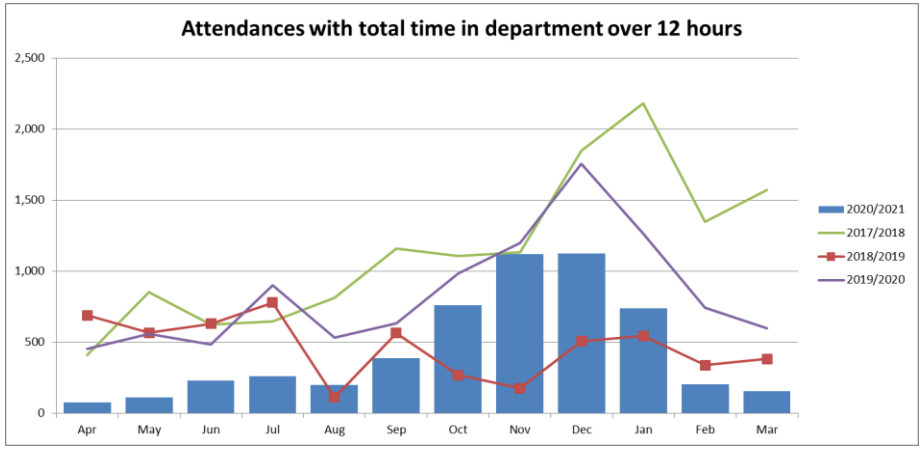
6. Patients spending more than 12 hours in the department





With the number of attendances very different across different trusts it is unlikely a national standard will be anything other than zero. No patient should be waiting in ED for over 12 hours.

Looking at previous years, although a rise in winter is common, 2018/19 shows the numbers over winter can be managed. A realistic improvement is set to be lower than 2018/19 in February and March with a long term goal of eradicating completely.



Workforce

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

Workforce Spotlight Report

Key messages

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

From April 2021, the Workforce Bureau will operate as a "virtual workforce bureau" through the respective HR leads rather than meeting formally as a group. Monthly reports will be produced from the "virtual workforce bureau" and reported into the newly established Trust Operational Delivery Group.

Staff Wellbeing and wellbeing support remain a priority. The Wellbeing Plan has been refreshed and updated and the focus going forward is on the continued provision of staff support to ensure the psychological wellbeing of staff

Sickness and covid-related absences continue to be monitored daily. Staff showing symptoms, or with household members showing symptoms, are tested and results returned within 24-48 hours

Risk assessment processes remain in place and all ethnically diverse staff and Category C risk assessments continue to be reviewed and updated if necessary. The Empactis system is used to provide managers with health risk assessment reminders and work with Occupational Health continues to embed risk assessments into the pre-employment health assessment process. The Risk Assessment form continues to be updated as new guidance is received.

The rapid roll out of the Covid-19 vaccine among our own staff and frontline healthcare workers in our partner organisations, care workers and over 80 year olds closed on 1st April 2021. More than 41,539 doses were administered by the team of vaccinators at both the Royal Stoke and County Hospital since the hub launched in December last year.

The key performance issues are that the sickness rate remains above target and that compliance with PDR requirements is below target.. The Executive decision taken to suspend PDR's has been lifted with the expectation that overdue PDRs are scheduled from Q2.

Sickness

The in-month sickness rate was 4.42% (4.70% reported at 28/02/21). The 12 month cumulative rate reduced to 5.37% (5.43% at 28/02/21).

Appraisals

The Non-Medical PDR compliance rate was 75.56%* at 31st March 2021 (73.94% at 28th February 2021).

* This figure has been updated from that reported to Transformation and Performance Committee and reflects the PDR's input to ESR after 31st March, but relating to that period

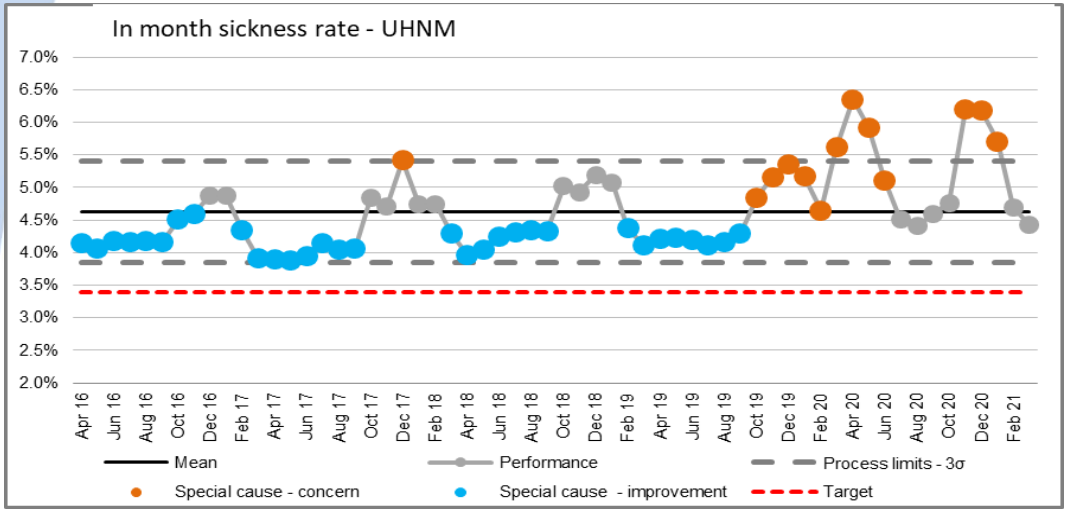
Statutory and Mandatory Training

The Statutory and Mandatory training rate at 31st March 2021 was 93.85% (93.76% 28th February 2021). At 31st March 2021, 90.19% of staff had completed all 6 Core for All modules (89.89% at 28/02/21)

Workforce Dashboard

Metric	Target	Latest	Variation	Assurance
Staff Sickness	3.4%	4.42%		
Staff Turnover	11%	9.32%		
Statutory and Mandatory Training rate	95%	93.85%		
Appraisal rate	95%	75.56%		
Agency Cost	N/A	2.55%		

Sickness Absence



Variation	Assurance
	F

Target	Jan 21	Feb 21	Mar 21
3.4%	5.7%	4.7%	4.4%

Background

Percentage of days lost to staff sickness

What is the data telling us?

Sickness rate is consistently above the target of 3.4%. The special cause variation seen from March through to July was a result of covid-19. Covid related absences reduced in January following the rollout of the lateral flow tests and vaccinations

Summary

The in-month sickness rate was 4.42% (4.70% reported at 28/02/21). The 12 month cumulative rate reduced to 5.37% (5.43% at 28/02/21).

As of 7th April 2021, covid-related open absences numbered 78, which was 16.8% of all absences (36.7% at 9th March 2021). Absence episodes continued to reduce throughout March with a significant reduction from 31st March 2021 with the return of staff who were previously shielding. To enable returning Clinically Extremely Vulnerable employees to work as safely as possible, managers were asked to review Risk Assessments, refer cases to Occupational Health if required and continue to support employees to work from home if appropriate. All employees have been reminded of the need to continue to follow national and local social distancing and PPE guidance even if both vaccine doses have been administered.

The rapid roll out of the Covid-19 vaccine among our own staff and frontline healthcare workers in our partner organisations, care workers and over 80 year olds closed on 1st April 2021. More than 41,539 doses were administered by the team of vaccinators at both the Royal Stoke and County Hospital since the hub launched in December last year.

Actions

March marked a period of rest and reflection for staff with various events taking place. In recognition that some may require longer-term support, the OD and wellbeing offer has been re-advertised and other longer term support from our Occupational Health service is being explored.

Information regarding women's safety and domestic abuse during COVID-19 has been communicated

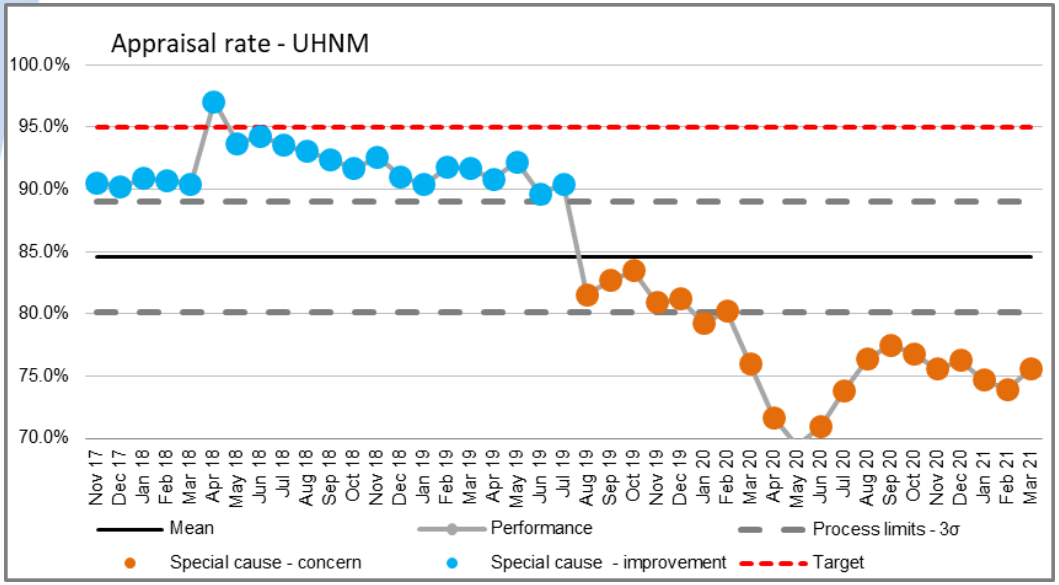
Work to redevelop and enhance staff wellbeing spaces at County Hospital has begun

Over 12000 thank you cards and badges have now been delivered to staff across all sites.

The Wellbeing Plan has been refreshed and updated.

The UHNM Health and Wellbeing event took place on 21st April, when staff could join a number of wellbeing sessions

Appraisal (PDR)



Variation	Assurance
	

Target	Jan 21	Feb 21	Mar 21
95.0%	74.7%	73.9%	75.6%

Background

Percentage of Staff who have had a documented appraisal within the last 12 months.

What is the data telling us?

The appraisal rate is consistently below the target of 95%. More recently the rate shows special cause variation. There has been a drop below the lower control limit since August 2019.

Summary

The Non-Medical PDR compliance rate was 75.56%* at 31st March 2021 (73.94% at 28th February 2021).

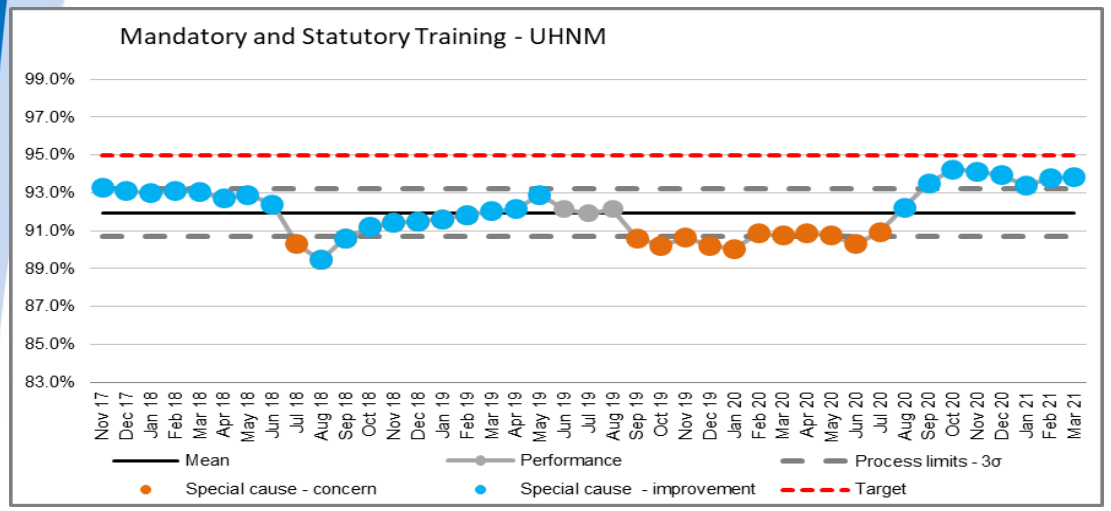
* This figure has been updated from that reported to Transformation and Performance Committee and reflects the PDR's input to ESR after 31st March, but relating to that period

Actions

Due to the surge in covid, an Executive decision was taken to suspend PDR's unless there is capacity to continue to undertake them. This suspension has been lifted with the expectation that overdue PDRs are scheduled from Q2.

Performance against the workforce kpi's is managed via the performance review meetings.

Statutory and Mandatory Training



Variation	Assurance
H	F

Target	Jan 21	Feb 21	Mar 21
95.0%	93.4%	93.8%	93.9%

Background

Training compliance

What is the data telling us?

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

Summary

The Statutory and Mandatory training rate at 31st March 2021 was 93.85% (93.76% 28th February 2021). At 31st March 2021, 90.19% of staff had completed all 6 Core for All modules (89.89% at 28/02/21)

Competence Name	Assignment Count	Required	Achieved	Compliance %
205|MAND|Security Awareness - 3 Years|	10809	10809	10159	93.99%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	10809	10809	10169	94.08%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	10809	10809	10062	93.09%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	10809	10809	10111	93.54%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	10809	10809	10151	93.91%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	10809	10809	10216	94.51%

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|	10809	10809	9114	84.32%
NHS|CSTF|Information Governance and Data Security - 1 Year|	10809	10809	9477	87.68%

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

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

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

Finance

2025 Vision "Ensure efficient use of resources"

Finance Spotlight Report

NHS University Hospitals of North Midlands NHS Trust

Key messages

- The Trust received confirmation that it will receive several non-recurrent revenue streams to support the financial position for 2021/21 including additional funding for M7-12 relating to the TSA agreement (£12.4m), funding of the annual leave accrual (£10.3m), reimbursement of other operating income losses (£7.4m) and funding for the Flowers vs East of England Ambulance case (£1m).
- The above have supported the Trust to deliver a surplus of £7.9m for the year against a planned deficit of £7.2m. Aside from the above, the position is driven by underspends against the COVID-19 allocation, continued slippage against growth funding and the winter plan; all of these items are non-recurrent.
- The Trust position in month has also been impacted by NHSIE fully funded adjustments in respect of additional employers pension contributions (£21m) and DHSC issued PPE for the year (£16.3m) which have impacted both the income, pay and non-pay positions.
- The Trust incurred £1.8m of costs relating to COVID-19 in month which is a reduction in comparison with Month 11 (£2.0m) primarily in non-pay due to reduced demands on testing. This remains within the Trust's allocation with £0.3m being chargeable on top of this allocation.
- Capital expenditure for the year to date stands at £66.3m which is in line with the plan of £66.4m. Overall PDC schemes have expenditure in line with the funding available and therefore the Trust has been able to bring forward elements of the RI demolition work in to 2020/21 which offset underspends in expenditure for decant related schemes.
- The month end cash balance is £55.8m which is £42.1m more than plan.

Finance Dashboard

	Metric	Target	Latest	Variation	Assurance
I&E	TOTAL Income	variable	129.7		
	Expenditure - Pay	variable	80.0	H	?
	Expenditure - Non Pay	variable	46.0	H	P
Activity	Daycase/Elective Activity	variable	7,077	L	?
	Non Elective Activity	variable	9,543	L	?
	Outpatients 1st	variable	24,632	L	?
	Outpatients Follow Up	variable	45,868		?

Income & Expenditure

University Hospitals of North Midlands NHS Trust

Income & Expenditure Summary Month 12 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	66.5	1.4	777.6	744.9	(32.7)
Other Operating Income	55.8	5.3	63.2	57.9	55.8	163.7	108.0
Total Income	833.3	70.4	129.7	59.3	833.3	908.6	75.3
Pay Expenditure	(522.0)	(45.0)	(80.0)	(35.0)	(522.0)	(553.2)	(31.2)
Non Pay Expenditure	(266.7)	(23.2)	(46.0)	(22.8)	(266.7)	(295.9)	(29.2)
Total Operational Costs	(788.7)	(68.2)	(126.0)	(57.8)	(788.7)	(849.1)	(60.4)
EBITDA	44.6	2.2	3.7	1.5	44.6	59.5	14.8
Depreciation & Amortisation	(29.2)	(2.6)	(2.5)	0.1	(29.2)	(29.0)	0.1
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	(5.7)	(5.6)	0.0
Finance Cost	(17.1)	(1.4)	(1.4)	(0.0)	(17.1)	(17.1)	(0.0)
Other Gains or Losses	0.0	0.0	0.0	0.0	0.0	0.1	0.0
Surplus / (Deficit)	(7.2)	(2.1)	(0.5)	1.6	(7.2)	7.9	15.1
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)	(2.1)	(0.5)	1.6	(7.2)	7.9	15.1

- Other operating income and pay are over budget in month due to the fully funded NHSIE adjustment in respect of the increase in employer pension contributions (£21m income and £21m pay impact) where the funding for the increase is held centrally.
- Other operating income and pay are also over budget in month due to the annual leave accrual made at Month 12. NHSIE have agreed to fund the impact to this up to a cap of 5 days which for UHNM amounts to £10.3m; within the position is additional other operating income of £10.3m and an additional £15.5m of expenditure.
- An accrual has been made within other operating income of £7.4m to account for lower levels of other operating income during the last 6 months which is being funded centrally; this adjustment may be amended after the submission of the Month 12 position.
- An adjustment was made to the position in respect of the centrally distributed PPE stock by the DHSC (During 2020/21 most PPE was procured National and distributed to Trusts). Both the cost of the PPE and corresponding income have been recognised in the position (£16.3m) although an adjustment has been made to the non-pay position for stock holding at year end resulting in a benefit to the position of £0.8m.
- Excluding the above pay is underspent in month primarily due to the reduction of the provision against the Flowers vs East of England Ambulance case (£1.7m) and slippage against the winter plan. Excluding the above non-pay is overspent in month largely due to the increases in clinical spend as elective activity has started to recover and pass through drugs as has been seen in prior months. There has also been a £2.2m provision made against the PFI in respect of descoped items and the MES equipment replacement scheme. Pathology Network costs in month amounted to £0.8m.

Capital Spend

Capital Expenditure as at Month 12 2020/21 £m	Revised Annual	In Month			Year to Date		
	Plan	Revised Budget	Actual	Variance	Revised Budget	Actual	Variance
PFI & finance lease liability repayment	(11.6)	(1.0)	(1.0)	-	(11.6)	(11.6)	-
Pre-ccommitted items	(11.6)	(1.0)	(1.0)	-	(11.6)	(11.6)	-
ICT Infrastructure	(3.0)	(0.5)	(0.7)	(0.2)	(3.0)	(3.0)	(0.0)
Estates Infrastructure	(2.3)	(0.2)	(0.5)	(0.3)	(2.3)	(2.4)	(0.1)
Medical Equipment	(2.6)	(0.8)	(1.2)	(0.4)	(2.6)	(2.6)	(0.0)
PFI lifecycle and equipment	(2.0)	(0.2)	(0.2)	(0.0)	(2.0)	(2.0)	0.0
Health & Safety Compliance	(0.2)	(0.1)	(0.0)	0.1	(0.2)	(0.1)	0.0
Project Star	(0.9)	-	(0.1)	(0.1)	(0.9)	(0.9)	0.0
Investment schemes	(0.1)	(0.1)	-	0.1	(0.1)	(0.1)	0.0
COVID-19 Trust funded	(0.9)	-	-	-	(0.9)	(0.9)	(0.0)
Linac	(2.3)	-	(2.1)	(2.1)	(2.3)	(2.3)	0.0
IR2 Bi Plane	(1.4)	(0.3)	(1.2)	(0.9)	(1.4)	(1.3)	0.0
LIMS	(0.5)	(0.2)	(0.1)	0.1	(0.5)	(0.5)	0.0
EPMA	(0.7)	(0.2)	(0.2)	0.0	(0.7)	(0.7)	0.0
IM&T additional projects	(0.3)	(0.3)	(0.3)	-	(0.3)	(0.3)	-
Medical devices fleet replacement	(0.9)	(0.9)	(0.9)	-	(0.9)	(0.9)	-
Pathology schemes	(0.6)	-	(0.2)	(0.2)	(0.6)	(0.6)	(0.0)
Trust funded capital programme	(18.6)	(3.7)	(7.6)	(3.9)	(18.6)	(18.5)	0.1
Royal Infirmary Site demolition	(5.2)	(0.7)	(2.0)	(1.3)	(5.2)	(5.9)	(0.7)
ED & RI Decant Accomodation Medical Records	(0.6)	-	(0.2)	(0.2)	(0.6)	(0.5)	0.1
COVID-19 PDC (approved)	(1.3)	-	-	-	(1.3)	(1.3)	0.0
PDC award for HSLI	(1.2)	(0.0)	(0.0)	(0.0)	(1.2)	(1.2)	-
Wave 4b funding - modular wards	(9.1)	-	-	-	(9.1)	(9.1)	-
Critical Risk Infrastructure	(3.2)	(1.7)	(1.4)	0.3	(3.2)	(3.2)	-
Emergency Department Schemes	(2.9)	-	(0.4)	(0.4)	(2.9)	(2.9)	(0.0)
ED Decant accomodation - Russell building	(0.7)	-	(0.3)	(0.3)	(0.7)	(0.4)	0.3
ED Decant accomodation - Trent scheme	(0.4)	-	-	-	(0.4)	-	0.4
Adapt & Adopt	(0.4)	(0.4)	(0.2)	0.1	(0.4)	(0.4)	-
Critical Care Resilience	(0.4)	(0.4)	(0.5)	(0.1)	(0.4)	(0.5)	(0.1)
Purchase of Grindley Hill Court	(5.4)	(5.4)	(5.4)	-	(5.4)	(5.4)	-
Pathology expansion	(0.5)	(0.5)	-	0.5	(0.5)	(0.5)	-
Rapid testing	(0.2)	(0.2)	(0.2)	-	(0.2)	(0.2)	-
Diagnostic equipment	(0.4)	(0.4)	-	0.4	(0.4)	(0.4)	-
Cyber Security	(0.1)	(0.1)	-	0.1	(0.1)	(0.1)	-
LIMS	(0.1)	(0.1)	(0.1)	-	(0.1)	(0.1)	-
PDC funded capital schemes	(32.0)	(9.9)	(10.7)	(0.8)	(32.0)	(32.0)	0.0
Donated/Charitable funds expenditure	-	(1.8)	(1.8)	-	(4.2)	(4.2)	-
Charity funded expenditure	-	(1.8)	(1.8)	-	(4.2)	(4.2)	-
Overall capital expenditure	(62.2)	(16.4)	(21.1)	(4.7)	(66.4)	(66.3)	0.1

At the year end the Trust has achieved the planned capital spend for both Trust and PDC funded schemes. For Trust schemes there is an overall underspend of £0.1m due slippage on a small number of schemes.

Overall PDC schemes have expenditure in line with the funding available, the Trust has been able to bring forward elements of the RI demolition work in to 2020/21 which offset underspends in expenditure for decant related schemes. The schemes have funding agreed in 2021/22 and total expenditure over the period of the scheme will be in line with plan.

The donated/charitable funds expenditure includes £1.192m in relation to assets donated by DHSC from the central store as part of the COVID-19 response.

Cash flow

Cash Summary at Month 12 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	76.8	110.6	33.8	26.7	26.7	-
Block mandate payments	763.0	-	19.7	19.7	763.0	791.7	28.7
Contract income 2019/20	(7.4)	-	-	-	(7.4)	(7.4)	-
Other Income (including other NHS)	80.3	15.0	12.0	(3.0)	80.3	82.3	2.0
Health Education England Training Income	23.5	-		-	23.5	23.6	0.1
PSF/FRF - 2019/20 Q4	9.7	-	-	-	9.7	9.7	(0.0)
Capital funding (PDC capital)	26.4	5.5	10.2	4.7	26.4	32.1	5.7
Total Receipts	895.5	20.5	41.9	21.4	895.5	932.1	36.5
Payroll (excluding agency)	(496.0)	(44.0)	(44.8)	(0.8)	(496.0)	(496.8)	(0.8)
Accounts payable	(356.7)	(30.9)	(38.3)	(7.4)	(356.7)	(356.9)	(0.2)
PDC Dividend	(6.7)	(3.4)	(3.5)	(0.0)	(6.7)	(6.7)	(0.0)
Capital payments	(49.2)	(5.3)	(10.1)	(4.8)	(49.2)	(42.7)	6.5
Total Payments	(908.5)	(83.7)	(96.7)	(13.0)	(908.5)	(903.0)	5.5
Closing Balance	13.7	13.7	55.8	42.2	13.7	55.8	42.1

- The revised cash flow budget above reflects the plan submission for the second half of the financial year on 22 October. The £13.7m planned cash balance reflected a planned deficit position of £14.7m at the year end. The actual cash balance of £55.8m at the year-end shows an increase of £29.1m on the opening balance of £26.7m and is £44.8m higher than plan for the second half of the financial year.
- The increase in cash reflects the actual revenue surplus of £7.9m and the increase in capital creditors at the year-end as a result the Trust holding cash relating to elements of the PDC funded expenditure at the year end. The remaining increase in cash is due to the impact of non-cash items within the £7.9m surplus such as the annual leave accrual £10m and movements in deferred income, accruals and provisions.
- Cash received for Block mandates is £19.7m higher than plan in month which reflects a block top up of £12.6m from NHSEI together with annual leave accrual funding of £5.5m. The year-end variance also includes the £7.4m received from Stafford and Surrounds CCG in month 9 relating to the transitional funding for the period months 7-12. These items were not included in the plan values.
- Other income is higher than plan at the year end and reflects cash received for pass through drugs received from NHSEI.
- Capital funding of £32.1m has been drawn down in year which is higher than plan and reflects PDC funding for the purchase of Grindley Hill Court and additional diagnostic funding received late in the financial year.
- Accounts payable payments are higher than plan in month reflecting the payment of invoices prior to year end and the payment of business rates to Stoke on Trent City Council for 2021/22, year to date payments are in line with plan. The Trust is continuing to comply with Treasury guidance for the prompt payment of suppliers and is paying invoices as they are approved.
- Capital payments are significantly lower than plan. Capital funding has been drawn down in line with the requirements of national deadlines. The lower than planned cash payments is mainly due the significant level of expenditure in month 12 on Project Star/RI demolition, the purchase of the linear accelerator and medical devices fleet replacement where final invoices were not received for authorisation before the year end.

Balance sheet (1)

NHS University Hospitals of North Midlands NHS Trust

Balance sheet as at Month 12	31/03/2020	31/03/2021				
	Actual £m	Original Plan £m	Revised Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment	483.0	499.0	495.0	536.8	41.8	Note 1
Intangible Assets	24.5	21.8	23.5	19.8	(3.7)	Note 1
Other Non Current Assets	-	-	-	-	-	
Trade and other Receivables	0.4	-	0.4	0.4	-	
Total Non Current Assets	507.9	520.7	518.9	557.0	38.1	
Inventories	13.3	12.3	13.1	15.0	2.0	Note 2
Trade and other Receivables	49.6	50.8	32.6	47.2	14.7	Note 3
Cash and Cash Equivalents	26.7	9.1	13.7	55.8	42.1	Note 4
Total Current Assets	89.6	72.1	59.3	118.0	58.7	
Trade and other payables	(74.8)	(59.7)	(69.0)	(98.2)	(29.3)	Note 5
Borrowings	(208.0)	(9.0)	(10.6)	(10.7)	(0.1)	
Provisions	(6.7)	(2.4)	(6.7)	(3.6)	3.1	Note 6
Total Current Liabilities	(289.5)	(71.1)	(86.3)	(112.6)	(26.3)	
Borrowings	(276.6)	(277.6)	(265.0)	(266.2)	(1.2)	Note 7
Provisions	(1.2)	(0.9)	(1.2)	(2.2)	(1.0)	Note 6
Total Non Current Liabilities	(277.7)	(278.4)	(266.1)	(268.4)	(2.2)	
Total Assets Employed	30.3	243.3	225.8	294.1	68.3	
Financed By:					-	
Public Dividend Capital	409.7	610.6	623.2	637.9	14.6	Note 8
Retained Earnings	(476.2)	(466.1)	(494.3)	(468.7)	25.6	Note 10
Revaluation Reserve	96.9	98.9	96.9	124.9	28.1	Note 9
Total Taxpayers Equity	30.3	243.3	225.8	294.1	68.3	

Balance sheet (2)

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 12 are explained below:

- Note 1 – The increase reflects higher capital expenditure funded by PDC received in year compared to the plan. The main addition from PDC funded expenditure is £5.4m for the purchase of Grindley Hill Court along with Critical Care resilience and the expansion of COVID-19 testing within pathology.
- The increase also includes £1.2m in relation to assets donated by DHSC from the central store as part of the COVID-19 response.
- The remaining movement of £28m is the estimated impact of the asset valuation at the year end, including the accounting for the land at the RI as a surplus asset. For assets valued in line with the modern equivalent asset approach there has been an increase associated with building indices and location factor.
  Note 2 - Inventories are £2m higher than plan due to a number of factors. The main factor is the inclusion of new stock balances relating to DHSC provided PPE (£0.8m) and stock held at Mid Cheshire for the pathology alliance (£0.3m). There have also been increased stock levels of £0.8m in Virology for COVID-19 testing kits and increased ward stock of £0.3m. The increases are partly offset by reductions in year of stock levels for pharmacy and pacemakers.
- Note 3 - Trade and other receivables are £14.7m higher than plan. Accrued income with NHSEI includes £7.4m for loss of operating income, £4.4m annual leave accrual and £1m in relation to the Flowers case (East of England Ambulance). The increases are partly offset by the £6m accrual for partially completed spells and deferred income for maternity pathway being settled with commissioners in line with NHSEI guidance.
- The sales ledger balance at 31st March includes outstanding invoices with DHSC £4.5m for transitional funding (cash received in April 21), Mid Cheshire £2.3m mostly relating to the Pathology Alliance and non NHS invoices raised in March of £0.9m, including £0.4m to Alliance Medical and £0.2m to Vocare.
- Note 4 - The £13.7m plan reflected a deficit position of £14.7m at the year end. The opening cash balance of £26.7m has increased by £29.1m at the year-end to £55.8m. This increase reflects the revenue surplus of £7.9m and an increase in capital creditors of £7m . The remaining balance is due to the impact of non-cash items within the £7.9m surplus such as the annual leave accrual £10m and movements in deferred income, accruals and provisions.
- Note 5 - Trade and other payables are £29.3m higher than plan. The higher than plan balance reflects the annual leave accrual of £15.5m made in line with the NHSEI guidance. The remaining £14m variance from plan relates to a higher level of goods received not invoiced, £10.5m, of which £8m relates to capital expenditure and is in line with expectations given the level of month 12 expenditure. The remaining increase is due to the level of general accruals and deferred income at the year end.
- Note 6 - Provisions are £2m lower than the balance at 31st March 2020 and reflect a number of changes in year, mainly the release of the provision relating to the Flowers case in line with NHSEI guidance.
- Note 7 - Borrowings are £1.2m higher than plan mainly due to the increase in lease liability of £1.1m for the IR2 bi-plane equipment included within the capital programme.
- Note 8 - Public Dividend Capital is £14.6m higher than plan and reflects additional capital funding that the Trust has received in year for Grindley Hill Court, the Emergency Department and Critical Risk Infrastructure.
- Note 9 – The Revaluation Reserve is £28.1m higher than plan and reflects the estimated impact of the land and building asset valuation at 31st March. The allocation of the asset movements between the Retained Earnings and the Revaluation Reserve is to be confirmed once the accounting for each individual asset is complete.
- Note 10 - Retained earnings show a £25.6m variance compared to plan which reflects the better than plan revenue position of £7.9m surplus compared to the planned deficit of £14.7m and a £3.1m difference between the cash received for Donated Assets and the amount of depreciation charged for Donated Assets.

*The balance sheet plan has not been updated by NHSI to reflect the additional TSA funding of £7.4m and therefore shows an I&E deficit position of £14.7m at Month 12 rather than the £7.9m year-end I&E surplus;

Expenditure - Pay and Non Pay

Pay Summary (£m)	Annual Plan	In Month			YTD		
		Plan	Actual	Variance	Plan	Actual	Variance
Medical	(160.5)	(13.9)	(26.1)	(12.2)	(160.5)	(172.0)	(11.6)
Registered Nursing	(155.3)	(13.5)	(21.9)	(8.4)	(155.3)	(160.0)	(4.7)
Scientific Therapeutic & Technical	(58.4)	(5.0)	(9.1)	(4.1)	(58.4)	(63.1)	(4.7)
Support to Clinical	(71.1)	(6.0)	(10.2)	(4.1)	(71.1)	(74.8)	(3.7)
Nhs Infrastructure Support	(76.8)	(6.5)	(12.8)	(6.3)	(76.8)	(83.4)	(6.6)
Total Pay	(522.0)	(45.0)	(80.0)	(35.0)	(522.0)	(553.2)	(31.2)

Pay - As noted above there have been three material adjustments to the pay position in month:

- Additional £15.5m cost for the annual leave accrual impacting all staff groups
- Additional £21m cost for additional employer pension contributions impacting all staff groups
- £1.7m impact of release of the Flowers vs East of England Ambulance case provision

Non Pay Summary (£m)	Annual Plan	In Month			YTD		
		Plan	Actual	Variance	Plan	Actual	Variance
Tariff Excluded Drugs Expenditure	(67.5)	(5.9)	(7.7)	(1.7)	(67.5)	(74.2)	(6.8)
Other Drugs	(19.8)	(1.7)	(1.9)	(0.2)	(19.8)	(20.6)	(0.8)
Supplies & Services - Clinical	(55.8)	(4.9)	(22.4)	(17.5)	(55.8)	(77.5)	(21.7)
Supplies & Services - General	(6.9)	(0.5)	(1.1)	(0.6)	(6.9)	(7.7)	(0.8)
Purchase of Healthcare from other Bodies	(16.3)	(1.9)	(0.9)	1.0	(16.3)	(12.1)	4.2
Consultancy Costs	(1.4)	(0.4)	0.2	0.6	(1.4)	(0.8)	0.6
Clinical Negligence	(22.3)	(1.2)	(1.9)	(0.7)	(22.3)	(23.0)	(0.7)
Premises	(29.4)	(2.5)	(3.6)	(1.1)	(29.4)	(31.0)	(1.6)
PFI Operating Costs	(34.7)	(2.9)	(5.2)	(2.3)	(34.7)	(37.1)	(2.4)
Other	(12.6)	(1.3)	(1.6)	(0.3)	(12.6)	(11.8)	0.8
Total Non Pay	(266.7)	(23.2)	(46.0)	(22.8)	(266.7)	(295.9)	(29.2)

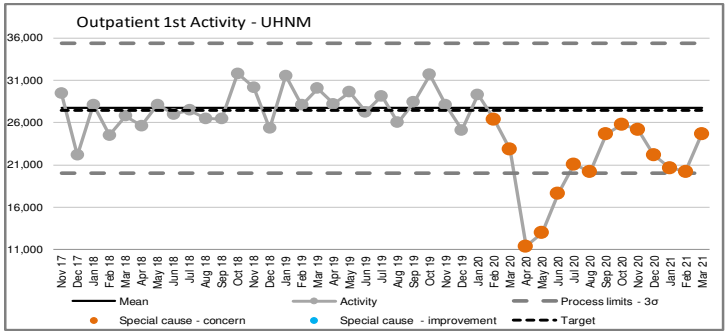
Non Pay key variances

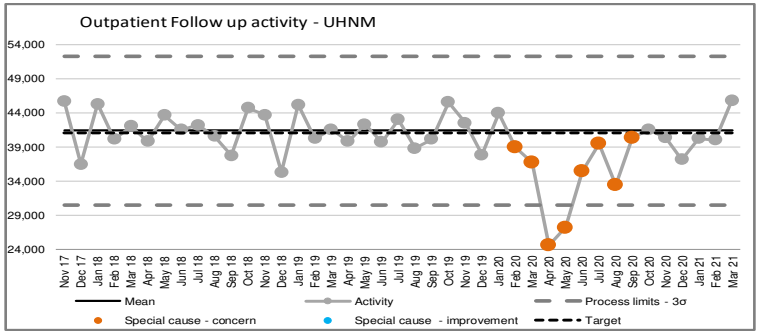
- Overspend on pass through drug expenditure largely in CWD which is an increase on prior month overspends.
- An adjustment in respect of the centrally distributed PPE stock by the DHSC of £15.5m for the year in clinical supplies.
- Overspend on supplies and services – clinical (aside from the PPE adjustment) driven by increased COVID-19 testing costs, the Pathology Network costs, and increased spend against elective procedure costs.
- Underspend on purchased healthcare due to the IS contract which was in the plan but the contract remained with the centre.
- Consultancy cost is showing an underspend against plan and a credit figure in month due to release of prior year provision (£0.4m)
- Within PFI operating costs there is a £2.2m provision made against the PFI in respect of descoped items and the MES equipment replacement scheme.

Activity

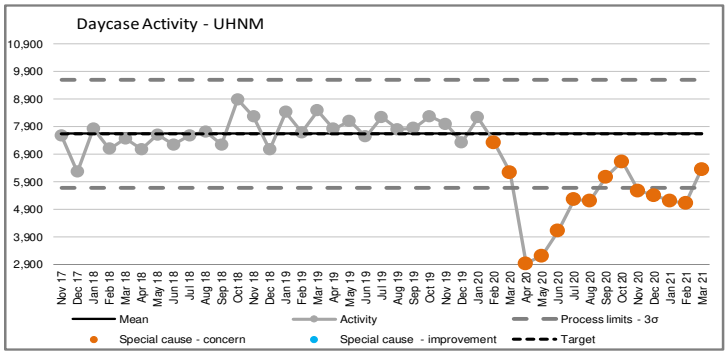
NHS University Hospitals of North Midlands NHS Trust

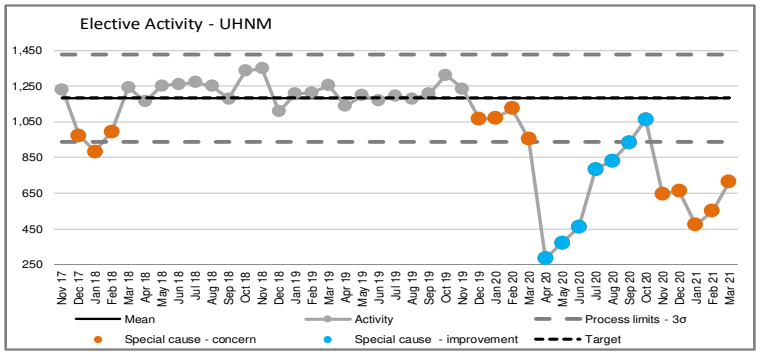
Planned care Outpatient



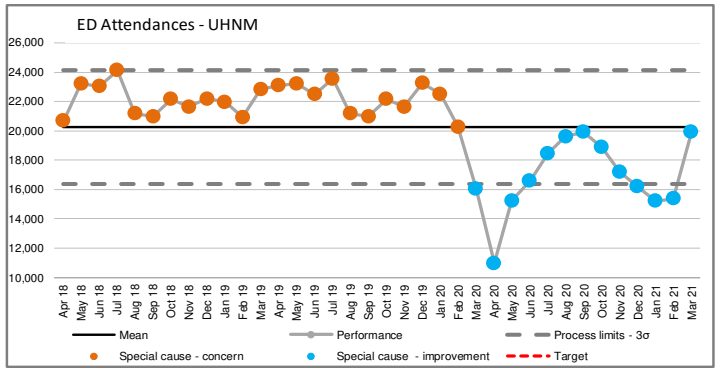


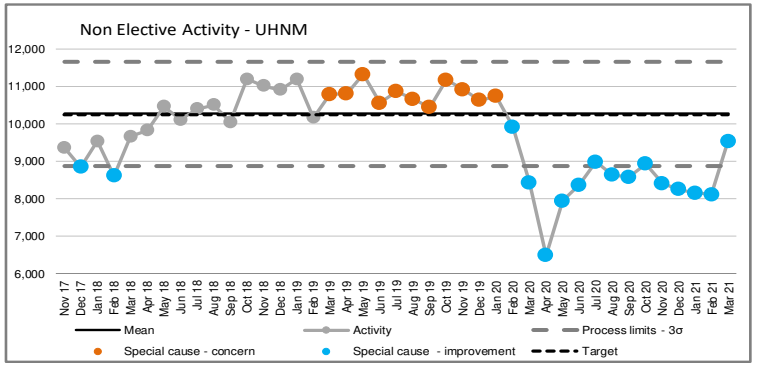
Planned care Inpatient





Urgent Care





Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Audit Committee Chair's Highlight Report to Board

22nd April 2021

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Some inconsistencies identified in relation to the management of risks at a Divisional level; this is being picked up through the agreed recommendations and will be monitored by the Committee • Internal Audit of Discharge Letters concluded with Partial Assurance as there were some concerns identified; the Committee were assured that plans are in place to address • Slippage noted in relation to recommendations associated with the review of Private Patients • External Audit have identified • £147k losses were made during the period January to March 2021with a year to date total of £609k	• The Internal Audit Programme for 2020/21 is almost complete, with 5 reports presented to the Committee and the outstanding planned for presentation in June • Internal Audit Plan for 2021/22 presented to the Committee, recognised that this had been produced within a very short timescale in order to reach the Committee deadline although would be subject to regular review to ensure it remains relevant to the organisations priorities • The Committee requested further consideration be given in the Internal Audit Programme to information / network • Draft Annual Report and Annual Governance Statement presented to the Committee and on track for completion • Session on Risk Appetite to form part of the Board Development Programme • Committee Effectiveness Reviews undertaken for all Committees, findings shared with the Audit Committee – cross Committee interaction / escalation will be a key focus moving forward • External Audit underway and Audit Risk Assessment undertaken • A deep dive into stock write off within Interventional Radiology has been undertaken and the findings were shared with the Committee including mitigating actions in place – progress was being made • Deep dive to be undertaken in relation to SFI breach associated with scrubs from the Alexander Hospital
Positive Assurances to Provide	**Decisions Made**
• Positive Head of Internal Audit Opinion issued which demonstrates satisfaction with governance arrangements in place • Significant Assurance with Minor Improvement Opportunities concluded by Internal Audit for Risk Management and the Board Assurance Framework (BAF), Infection, Prevention and Control BAF, Network Security, Data and Security Protection Toolkit • Very positive findings received following the review of effectiveness of Committees	• Approved the Internal Audit Programme as presented, whilst recognising that it would be subject to ongoing review • Approved the Board Assurance Framework at Q4 • Approval of Standards of Business Conduct Policy • Approval of Anti-Bribery and Anti-Fraud Policy • Approval of revised Terms of Reference for the Committee, which will be progressed to the Board for approval as part of the Rules of Procedure • Approval of the Counter Fraud Annual Plan
Comments on the Effectiveness of the Meeting	
• Large agenda but worked through in a timely manner	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Internal Audit Progress Report	Assurance	12.	Issues for Escalation from PAF, TAP, QGC	Assurance
2.	Internal Audit Annual Report and Opinion	Assurance	13.	External Audit Plan	Assurance
3.	Approval of Internal Audit Plan	Approval	14.	Informing the Audit Risk Assessment	Assurance
4.	Draft Annual Report 2020/21	Information	15.	Counter Fraud Action Plan	Approval
5.	Board Assurance Framework Q4	Approval	16.	Losses and Special Payments Q4 20/21	Assurance
6.	Internal Audit Recommendation Tracker	Assurance	17.	SFI Breaches and Single Tender Waivers Q4 20/21	Assurance
7.	Corporate Governance Report	Assurance	18.	Assurance from Third Party Providers	Assurance
8.	Standards of Business Conduct Policy	Approval	19.	Going Concern Assessment 20/21	Assurance
9.	Anti-bribery and Anti-Fraud Policy	Approval	20.	Review of Meeting Effectiveness	Information
10.	Audit Committee Effectiveness	Approval	21.	Review of Business Cycle	Information
11.	Committee Effectiveness Reviews	Assurance	22.	Items for Escalation to the Trust Board	Approval

3. 2019 / 20 Attendance Matrix

Attended | Apologies & Deputy Sent | Apologies

Members:		Apr	Jun	Jul	Oct	Jan
Prof G Crowe	Non-Executive Director (Chair)					
Mr P Akid	Non-Executive Director					
Ms S Belfield	Non-Executive Director					

Attendees:		Apr	Jun	Jul	Oct	Jan
Ms N Coombe	External Audit					
Mr G Patterson	External Audit					
Mr A Bostock	Internal Audit - KPMG					
Ms A Khela	Internal Audit - KPMG					
Mr S Stanyer	LCFS - KPMG					
Mr M Gennard	Internal Audit - RSM					
Mr A Hussain	Internal Audit - RSM					
Ms A Deegan	LCFS - RSM					
Mrs N Hassall	Deputy Associate Director of Corporate Governance					
Mr M Oldham	Chief Finance Officer					
Mrs S Preston	Strategic Director of Finance					
Miss C Rylands	Associate Director of Corporate Governance					

Executive Summary

Meeting:	Trust Board (Open)	Date:	5th May 2021
Report Title:	Q4 Board Assurance Framework 20/21	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 Quarter 4 Board Assurance Framework (BAF) is being presented to the Trust 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 April.

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 have been subject to further review in the past couple of months, in order to determine risks for 2021 / 2022 and these will be reported on from Q1 2021/22.

Assessment

The summary BAF is set out below. During quarter 4 there have been some key changes to levels of risk as highlighted below:

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	High 9	↓
BAF 2 Page 9	Leadership / Culture and Delivery of Trust Values and Aspirations		High 12	High 12	Ext 20	High 12	↓
BAF 3 Page 12	Sustainable Workforce		High 12	High 12	Ext 20	High 12	↓
BAF 4 Page 16	System Working – Vertical		High 12	High 9	High 9	High 9	→
BAF 5 Page 18	System Working – Horizontal		High 12	High 12	High 12	High 9	↓
BAF 6 Page 20	Restoration and Recovery		Ext 20	Ext 25	Ext 25	Ext 25	→
BAF 7 Page 22	Infrastructure to Deliver Compliant		Ext 16	Ext 16	Ext 16	Ext 16	→

	Services – IM&T						
BAF 8 Page 24	Infrastructure to Deliver Compliant Services - Estate		Ext 16	Ext 16	Ext 16	Ext 16	→
BAF 9 Page 27	Financial Sustainability		High 9	High 12	Mod 6	Mod 6	→

Comments made by Committees in considering the BAF were as follows:

Performance and Finance – the Committee challenged whether risk score for BAF 9 was reflective of the current financial position – it was agreed that the risk had reached the target risk score, due to the improved financial position.

Quality Governance – The Committee noted the reduction in risk score for BAF 1 which was due to easing of covid pressures.

Transformation and People – The Committee queried the reduction in risk score for BAF 2 and accepted the rationale in relation to reflecting upon the results of the staff survey, the ongoing culture and leadership work, and easing of pressures associated with Covid.

Further consideration has also been given to the scoring associated with BAF 3 and BAF 5, although it was confirmed that the Executive felt that these did not require changing.

The **Audit Committee** noted the gap between existing ratings and risk appetite and it was recognised that a future Board Development session was to consider this.

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 4 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 was reflected throughout the BAF. In addition, a specific risk was been included which focused 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'.

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.

In terms of risks for 2021/22, the Executive Team and Trust Board have considered and agreed the strategic risks which will form the BAF from April 2021 onwards and these will be reported on in July 2021.

2. Committee / Board Consideration of Risk

The Quarter 4 BAF for 2020/21 has been considered by Committees as follows:

- Performance and Finance Committee on 20th April 2021
- Transformation and People Committee on 21st April 2021
- Quality Governance Committee on 22nd April 2021
- Audit Committee on 22nd April 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?

3. Index and Summary Board Assurance Framework as at Quarter 4 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	High 9	↓
BAF 2 Page 9	Leadership / Culture and Delivery of Trust Values and Aspirations		✓	✓	✓	✓	✓	High 12	High 12	Ext 20	High 12	↓
BAF 3 Page 12	Sustainable Workforce		✓	✓	✓	✓	✓	High 12	High 12	Ext 20	High 12	↓
BAF 4 Page 16	System Working – Vertical		✓	✓	✓	✓	✓	High 12	High 9	High 9	High 9	→
BAF 5 Page 18	System Working – Horizontal		✓	✓	✓	✓	✗	High 12	High 12	High 12	High 9	↓
BAF 6 Page 20	Restoration and Recovery		✓	✓	✓	✓	✓	Ext 20	Ext 25	Ext 25	Ext 25	→
BAF 7 Page 22	Infrastructure to Deliver Compliant Services – IM&T		✓	✓	✓	✓	✓	Ext 16	Ext 16	Ext 16	Ext 16	→
BAF 8 Page 24	Infrastructure to Deliver Compliant Services - Estate		✓	✓	✓	✓	✓	Ext 16	Ext 16	Ext 16	Ext 16	→
BAF 9 Page 27	Financial Sustainability		✓	✓	✓	✓	✓	High 9	High 12	Mod 6	Mod 6	→

SO1: Safe, caring, effective, responsive

SO2: Achieve constitutional patient access targets

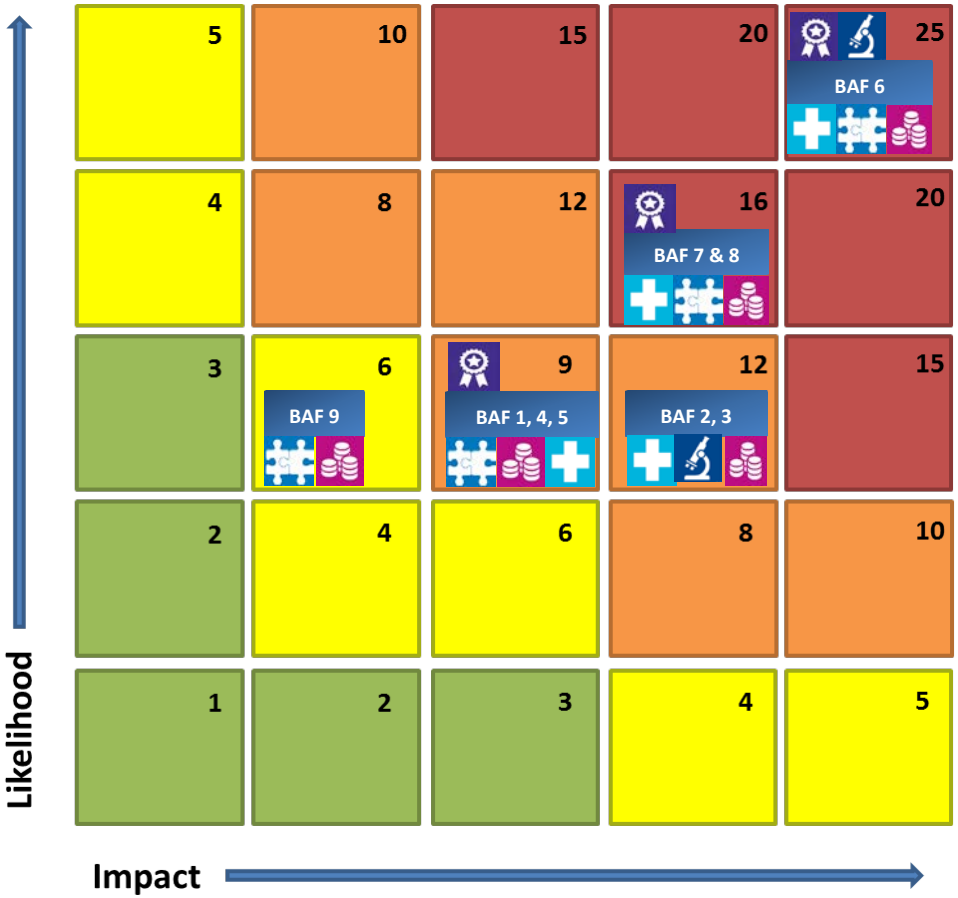
SO3: Excellent employment, education, teaching, research

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 the 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, and all risk have the potential to threaten the acheivement of Strategic Objective 5 – Ensure efficient use of resources.

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	3	**The risk remains above target as work is ongoing with nosocomial reviews and noted increases during Wave 2 of COVID pandemic. Increase in reported Serious Incidents during COVID pandemic with largest category related to falls and although Quarter 4 saw improvements, still high risk due to ongoing pressures.**	**Likelihood:**	2	**31 March 2021**
Consequence:	3	3	3	3		**Consequence:**	2	
Risk Level:	**High 9**	**High 9**	**High 12**	**High 9**		**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 Maternity Services, including compliance with CNST requirements.	• 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, visits due to	• 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
	• Infection Prevention Team co-ordinate Improvement Programmes for infections, including Sepsis and Nosocomial Covid-19 infections • Training Programmes in place for all key harms. • Patient experience team in place • Crude Mortality rates - monitoring and notification from Medical Examiner • Monthly Directorate Mortality and Morbidity meetings (M&M) are held to review deaths and discuss cases. • 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	recommence in April 2021. Safety visits continued throughout Pandemic. • 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 • Quality Performance Report enhanced to include peer benchmarking where possible for quality indicators including nosocomial COVID-19 reporting	• 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	31/05/2021	Action delayed and target date revised. Draft Strategy has been developed pending review/comments	**A**

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 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**	**3**	• Target score not achieved - 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 has been challenging in the delivery of 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 • There has been no deterioration in staff engagement or other staff survey indicators. Staff sickness rates remain high, but stable. Turnover and vacancy rates remain steady.	**Likelihood: 3**	**31 March 2021**
Consequence:	**4**	**4**	**5**	**4**		**Consequence: 3**	
Risk Level:	**High 12**	**High 12**	**Ext 20**	**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:	• 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 2020 Staff Survey results showed there were two statistically significant improvements in the 2020 scores when compared to the previous year's data concerning Health and Wellbeing and Safe Environment – Bullying and Harassment. There was no statistically significant change in the remaining 8 themes. At 6.9, the staff engagement score remains just below the acute trust average of 7.0. This is unchanged from the previous year There was improvement in staff recommending the Trust as a place to work (from 60.4% to 64.3%) and in recommending the organisation as place to receive care
Assurance:	• Annual NHS Staff Survey – At 6.9, the 2020 staff	• Monthly reports to Transformation and People Committee	

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
	engagement score remained just below the acute trust average of 7.0. • 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	cover hard to recruit posts and long term agency • 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 28th February 21, the in-month sickness rate was 4.70% (5.71% reported at 31/01/21). The 12 month cumulative rate increased to 5.43% (5.42% at 31/01/21). • For the 12 months ending 28/02/21, the turnover rate was 9.50% • The vacancy level at 28/02/21 was 8.17% due to an uplift in the budgeted establishment for winter pressures rather than an increase in leavers	(from 73.8% to 76.2%). To address the findings of the Staff Survey, corporate priorities planned for 2021/22 are aimed at continuing the improvements in organisational culture and maximising the potential of our people to improve patient outcomes • A new quarterly 'morale checker' survey is being introduced to 2021/22 • Trust wellbeing plan is being refreshed and updated

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	TBC once the national Leadership Compact is released	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

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**
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	31/03/2022	Leadership and Management Development is in progress and will be on-going throughout 2021/22 Plans include for all new managers into the Trust to complete GTM/GTL within 3 months of commencing. Following the staff survey results regarding middle manager competencies, a business case is being developed to ensure existing managers are developed.	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**	
	ID17977: Reduced staffing in Cancer Centre Pharmacy	**Ext 16**	ID 8580: Medical staffing for the Emergency Department (both sites)	**High 12**	
	ID 8607: Medical Staff Anaesthetics	**High 12**	ID 18093: Nurse Staffing within the NNU	**High 12**	
	ID 19137: nurse staffing across the respiratory and infectious diseases ward	**High 12**			

Risk Scoring							
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**	**Target Date**
Likelihood:	**3**	**3**	**4**	**3**	Target risk score not achieved. Staff sickness rates remain high, but stable. There has been no deterioration in staff engagement or other staff survey indicators. Turnover and vacancy rates remain stable. The Trust will be welcoming 70 overseas nurses in April and is actively recruiting Healthcare Support Workers to reduce vacancies of this staff group to zero	**Likelihood: 3**	**31 March 2021**
Consequence:	**4**	**4**	**5**	**4**		**Consequence: 3**	
Risk Level:	**High 12**	**High 12**	**Ext 20**	**High 12**		**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 2020 Staff Survey results showed there were two statistically significant improvements in the 2020 scores when compared to the previous year's data concerning Health and Wellbeing and Safe Environment – Bullying and Harassment. There was no statistically significant change in the remaining 8 themes. At 6.9, the staff engagement score remains just below the acute trust average of 7.0. This is unchanged from the previous year There was improvement in staff recommending the Trust as a place to work (from 60.4% to 64.3%) and in recommending the organisation as place to receive care (from 73.8% to 76.2%). To address the findings of the Staff Survey, corporate priorities planned for 2021/22 are aimed at continuing the improvements in organisational culture and maximising the potential of our people to improve patient outcomes • A new quarterly 'morale checker' survey is being introduced to 2021/22 • Trust wellbeing plan is being refreshed and updated
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 Trust is welcoming 70 new overseas nurses in April and is taking part in a programme to reduce nursing support vacancies to zero by 31st March 2021 • The Workforce Bureau has been stepped down. Processes	

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
		are in place and well-established for covid risk assessments, staff wellbeing, staff testing and staff deployment. • Monitoring of sickness absence is still taking 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. • Lateral-Flow asymptomatic testing of frontline staff for Covid-19 is in place. • The covid-19 risk assessments have been reviewed and updated. • The 1st and 2nd dose vaccination programme has been completed at the hospital hub, with 76% of staff having been vaccinated. Remaining staff can receive a vaccination at the community hubs. • Shielding staff were able to return to the workplace from 1st April and, as a result, covid–related absence reduced to 19% of all absences on 6th April. Analysis of data and historic trends, reported in monthly performance reports to TAP and Trust Board show: • At 28th February 21, the in-month sickness rate was 4.70% (5.71% reported at 31/01/21). The 12 month cumulative rate increased to 5.43% (5.42% at 31/01/21). An update on Sickness Absence was reported to Trust Board in January 2021 • For the 12 months ending 28/02/21, the turnover rate was 9.50% • The vacancy level at 28/02/21 was 8.17% due to an uplift in the budgeted establishment for winter pressures rather than an increase in leavers	

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	The Trainee Fellowship programme commenced April 2020, with trainees commenced in August 2020. We are implementing the new Specialist Associate Contract, which will introduce a new role below the level of Consultant and which is likely to be more attractive for potential recruits who do not wish to progress to Consultant level Recruitment of medical staffing is aligned to the business planning process and approval of business cases	B

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**
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. Joint working with System Partners on recruitment and retention, paused during covid, is to be re-established	**B**
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	Following approval of the Business Case for international recruitment of Nurses, 70 overseas nursed are being welcomed to the Trust in April 2021. The Trust is also actively recruiting Health Care Support Workers, with the aim of having zero vacancies by 31st March 2021. This is a funded programme to offer assurance to NHS England and the NHS Improvement National Workforce Team of the workforce pipeline and associated future employment of HCSWs	**B**

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**	**3**	The target risk score has not been achieved. Although the new ICS Chair has been appointed the appointment to the ICS Executive lead remains outstanding. The ICS designation plan was approved but with 4 caveats – some of which remain of concern to the system. A number of workstreams are in place but the system lacks a cohesive strategy that maps out what is required to ensure a fully integrated and financially sustainable services	**Likelihood:**	**2**	**31 March 2021**
Consequence:	**4**	**3**	**3**	**3**		**Consequence:**	**3**	
Risk Level:	**High 12**	**High 9**	**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 • Long Term Plan workstreams reviewed in the light of Covid / Recovery and Restoration.	• Transformation and Delivery Unit • STP Workstreams • Current system LTP in place • Organisational operational plan in place • ICS development Plan submitted December 2020 to regulators • 3 ICPs developed	• ICS designation plan approved by NHSEI
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	• 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
	• MD Chairs system wide Clinical Senate • Regular meetings take place between UHNM CEO and Northern PCN Clinical Leads • 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	30/06/2021	Delay initiated by the new ICS Chair. Therefore still outstanding	**GA**
2.	Develop a revised Integrated Strategy for Health and Social Care	STP Director / Chief Executive	30/06/2021	Strategy development delayed due to Covid-19	**GA**
3.	ICPs to develop a clear, agreed, strategic approach to population health management	STP Director / Chief Executive	TBC		**GA**
4.	To revise workstreams in light of new planning guidance and ICS designation plan	STP Director / Chief Executive	31/05/2021		**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**	**3**	Target risk score not achieved, although substantial progress has been made in relation to the now concluded pathology collaborative. Work is also in progress to further extend our current hugely successful procurement collaborative with a further acute Trust. During Covid UHNM successfully supported other systems and Trust with CC, PICCU and other complex specialist services. However, these were as required services rather than through a strategic approach aligned to UHNMs strategy. UHNMs strategy has been delayed due to Covid-19	**Likelihood:** **2**	**31 Mar 2021**
Consequence:	**4**	**4**	**4**	**3**		**Consequence:** **3**	
Risk Level:	**High 12**	**High 12**	**High 12**	**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:	• 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 Stronger Together Programme.	Director of Strategy	Post Covid	Postponed due to Covid-19	A
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 April 2021 – No further progress made in quarter due to ongoing Covid-19 pressures	A
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	TBC	Delayed due to Covid-19. New date to be agreed for strategy development	A
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	Post Covid	As above, no progress made during previous quarter	A
6.	Ensure that Restoration and Recovery is taken into account in development of UHNM Strategy.	Director of Strategy	Post Covid	Good progress to date with R&R although not yet incorporated into strategy due to delay	GA
7.	Review and interpretation of national operational planning guidance for 21/22.	Director of Strategy	31/05/2021	Planning guidance was only released on 25th March therefore no progress in quarter. To be carried over into 21/22	GA
8.	Review of current network arrangements for Specialised Services to be completed by Specialised Commissioners.	Chief Executive / Director of Strategy	30/06/2021	No progress made in quarter. Some meetings with Spec Comm have taken place but little action as yet. To continue into 21/22	GA

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 17570 R&R Outpatients	**High 12**	ID 18014 R&R Planned Care	**High 12**	
	ID 18052 R&R Diagnostics	**High 9**	ID 18746 Phase 3 Workforce Availability	**High 9**	
	ID 17542 R&R IM&T	**High 8**	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**	

Risk Scoring							
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**	**Target Date**
Likelihood:	4	5	5	5	**Target risk score not achieved. The level of risk remains unchanged as at end of March 2021, given the scale of the challenge associated with restoration of services following wave 2.**	**Likelihood:** 3	**31 March 2021**
Consequence:	5	5	5	5		**Consequence:** 4	
Risk Level:	**Ext 20**	**Ext 25**	**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:	• Clinical and operational leads agreed to oversee and manage operational cells as part of Operational Delivery Group • Enhanced performance framework considered by the Operational Delivery Group which will in turn report to Performance and Finance Committee • Fortnightly review of performance against Operational Delivery Group as part of Executive meeting	• Operational Delivery Group governance structure in place, supported by Chief Operating Officer, Medical Director, Chief Nurse and Chief Finance Officer, to provide oversight • 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 Performance	• Specific cells in place to oversee quality and safety of planned care • Ongoing updates provided to the Board outlining the	

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
	and Finance Committee, demonstrating performance	Restoration and Recovery Programme and actions taken • Trust IPR includes R&R trajectories and performance	

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	Ongoing		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:** n/a	**Current Risk Score:** n/a	**Title:**	**Current Risk Score:**	

Risk Scoring								
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	4	4	4	4	**The likelihood of the risk continues to remain static whilst actions progress within the IM&T Cyber Acton plan. 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	4		**Consequence:**	4	
Risk Level:	**Ext 16**	**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 • Implementation of DarkTrace to detect and respond to subtle, stealth attacks inside the network — in real time. • IT Health dashboard implemented to provide real-time visibility and overview of the network and systems, identifying any potential cyber security issues that warrant attention and assurance on the cyber security environment		
Assurance:	• During Q4 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	30/04/2021	This project is 95% with just 338 devices remaining The due date is now the end of April. The extended due date is as a consequence of access issues in critical areas brought about by the Coronavirus pandemic.	**A**
2.	Continue work towards the toolkit Cyber Essentials (plus) and ISO27001 compliance. On-site cyber security assessment scheduled May 2021 in readiness for DSP toolkit submission	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	**High 12**	ID 18396: Discrepancy in the PFI Financial model and the impact on services provided	**High 12**	
	ID 18659: Lines of responsibility for building services where PFI interfaces with Retained Estate	**High 9**	ID 11152: Annual Statutory and Lifecycle Maintenance	**High 9**	

Risk Scoring							
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**	**Target Date**
Likelihood:	4	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 & 4 (asbestos removal) completed. Phases 5 (asbestos removal) commenced. Demolition underway with Phases 1, 2 & 3 now complete and within programme. • Estate Condition – Key risks are funding constraints & physical access. 2020 PFI Statutory Maintenance/Testing/Lifecycle Programme has now ended with some aspects not completed due to delivery of R&R/Winter & Covid Surge Plans. 2021/22 Programme now agreed and will require area decant to allow for 5 year electrical fixed wire testing. Additional backlog maintenance (£3.2M funding) on programme to be 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 decant solution as a result of Market Testing Business Case and financial discrepancy affecting	**Likelihood:** **2**	**31 March 2022**
Consequence:	4	4	4	4		**Consequence:** **4**	
Risk Level:	**Ext 16**	**Ext 16**	**Ext 16**	**Ext 16**		**Risk Level:** **High 8**	

investment led solution of £3.5M. Alternative plans worked up including extending Russell building to accommodate element of displaced admin staff.

- Clinical Service Strategy work restarting to inform further changes.
- Fire/Security – Fire Safety KPI's developed and now in place 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 which is now well underway. Also funding for purchase of GHC which is now complete • 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 • Clinical Service Reviews re-instated. Fire / Security • FRAs; ad-hoc inspections; on spot improvement	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. COVID-19 Impact: • Regular updates on progress on Risk Assessments from R&R to COVID Exec and Trust Board.	

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
	notices; progress monitored Fire Safety Group and Executive Health & Safety Group.	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 1-4 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 purchase 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	March 2022	Alternative decant solution identified and implications/revised programme currently being worked up.	GA
5.	Market Testing Business Case (Financial Discrepancy)	Director of E,F&PFI	June 2021	Trust Board briefed; Commercial and Legal Advice commissioned; proposals to mitigate financial impact being reviewed through QIA assessment process. Financial Model Review completed. Workshop to take place early April with all stakeholders to reach an understanding on how the UC gap can be closed. This will be followed by a commercial meeting (mid April) with all Senior stakeholders to negotiate and conclude a commercial deal.	GA
6.	Statutory Maintenance/Inspection/Lifecycle Programme 2020	Director of E,F&PFI	March 2022	Deferral of elements due to direct conflict with R&R/Winter/Covid. Programme agreed for 2021/22 – must proceed and will require decant to support Electrical fixed wire testing as well as elements not completed during 2020.	GA
7.	Strategic Supplier Relationship Management Programme (SSRM)	Director of E,F & PFI	March 2022	Continuation of programme (sponsored Cabinet Office and HM Treasury) and delivery of value release initiatives included within Joint Business Plan.	GA
8.	Introduce Fire KPI's to be monitored monthly through formal Divisional Performance Review Meetings	Director of EF & PFI	May 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
9.	Estates Ops Workforce Review & additional temporary staff)	Director of E, F&PFI	June 2021	Temporary project staff appointed to support capital developments. Estates Ops Workforce Review underway.	GA

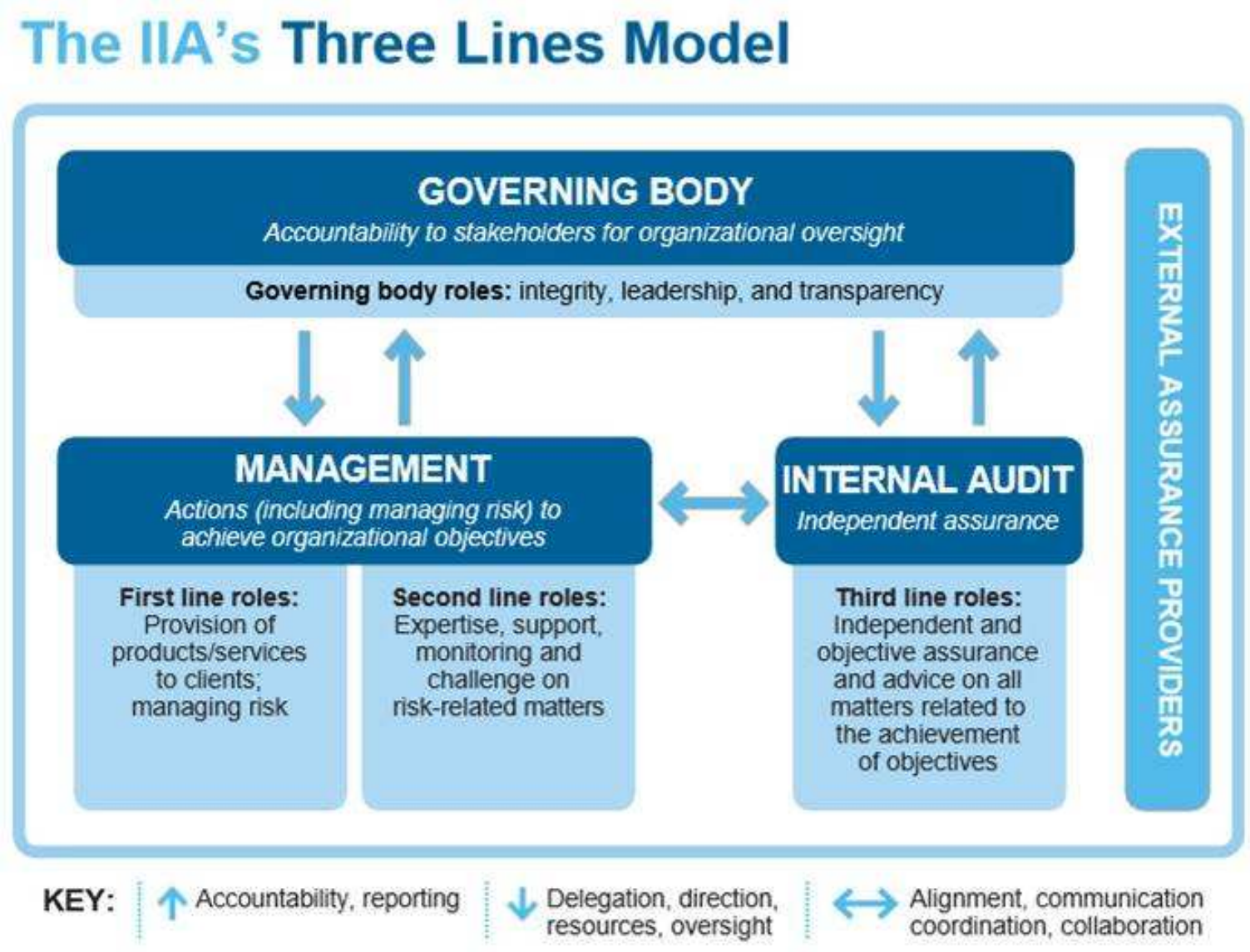
Risk Summary					
BAF Reference and Summary Title:	**BAF 9: Financial Sustainability**			**SO's Impacted Upon**	
					✓ ✓
Risk Description:	If we fail to operate within the resources available along with any flexibility agreed with the regulator then the services the Trust provides become financially 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**	

Risk Scoring								
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	3	3	2	2	**Target risk score achieved at Q3. Allocations have now been finalised for 20/21 and the original error on TSA funding has been rectified. Trust actual performance is ahead of plan at Month 11 with a breakeven position forecast for the year. In addition the Trust will receive income with regards to the Flowers case and Annual Leave accrual (both of which are already provided for within the breakeven forecast) resulting in a surplus for the year.**	**Likelihood:**	2	**31 March 2021**
Consequence:	3	4	3	3		**Consequence:**	3	
Risk Level:	**High 9**	**High 12**	**Mod 6**	**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 • Exec Team approval of additional investment up to £250k	• Finance report in place to performance and Finance Committee with associated scrutiny; enhanced to include run rate performance and analysis of additional COVID related expenditure • Standing Financial Instructions • Capital allocations agreed across the STP and sub group established to track and deal collectively with variation.	• 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 11 ahead of plan	

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**

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.

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	5th May 2021
Report Title:	Committee Effectiveness and Revised Rules of Procedure	**Agenda Item:**	17.
Author:	Deputy Associate Director of Corporate Governance		
Executive Lead:	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

In line with best practice, each Committee of the Trust Board annually reflects on their own performance and effectiveness. The review comprises of three parts; committee effectiveness comprising feedback from the Chair and Committee members, an annual summary of the key areas of work and achievements against the Terms of Reference and business cycle and revision of the Committee Governance Pack, taking into account any issues raised by the effectiveness review and annual report.

Background

Reviews for each Committee have been undertaken and presented to respective Committees, which included the approval of revised Terms of Reference for each Committee, taking into account the actions arising from the effectiveness reviews.

Assessment

Members and regular attendees of the various Board Committees were asked to complete a self-assessment questionnaire regarding the effectiveness of the Committees during 2020/21. In addition, a Committee Process checklist was completed by each Chair of the Committees and the Deputy Associate Director of Corporate Governance.

The results of the process indicate a broad consensus that all Board Committees have been effective in the discharge of their duties and this is further supported by the content of the Committee Annual Reports. The above processes identified a number of actions to be taken forward to further enhance effectiveness and these are detailed within the report.

Revised Rules of Procedure 2021/22

Following the review of Committee Governance Packs and their approval by respective Committees, the Rules of Procedure for 2021/22 has been revised. No major changes have been made to the Rules of Procedure and only minor changes have been made to the Terms of Reference, mainly in relation to the business cycles for each Committee.

It should be noted that the terms of reference for Trustees Committee have not yet been included as these are subject to further review and will take into account the comments made as part of the effectiveness review.

Key Recommendations:

The Trust Board is asked to note:

- the outcomes of the self-assessment process.
- that annual reports for each Committee have been considered by the respective Committees.
- that revised Committee Governance Packs have been approved by each Committee, and incorporated within the Rules of Procedure for 2021/22

The Trust Board is asked to approve the revised Rules of Procedure for 2021/22, incorporating the Trust Board Business Cycle and Committee Governance Packs.

Review of Board Committee Effectiveness 2020/21

April 2021

1. Introduction

As part of the Trust's governance arrangements, and as set out within the Trust's Rules of Procedure, members and regular attendees of Board Committees were asked to complete a self-assessment questionnaire regarding the effectiveness of the Committees during 2020/21.

The questionnaires were based upon good practice guidance which requires Boards to review the effectiveness of their Committees on an annual basis.

In addition, an annual report for each Committee was prepared which summarised the purpose of the Committee, membership and attendance, key issues covered and actions taken.

The outcomes of these reports have been considered by each Committee in addition to their revised Committee Governance Packs (which include terms of reference, business cycles and standard agendas).

2. UHNM Board Committees

Six formal Board Committees have been established and were in operation during 2020/21.

2.1 Nominations and Remuneration Committee

The Committee:
(a) Advises the Trust Board about appropriate remuneration and terms of service for the Executive Directors (i.e. Trust Board voting and no-voting members), the Chief Executive and posts assigned to the Very Senior Manager framework. This includes:
(i) All aspects of salary (including any performance-related elements/bonuses)
(ii) Provisions for other benefits, including pensions and cars
(iii) Arrangements for termination of employment and other contractual terms

(b) Monitors and evaluates the performance of individual Directors (with the advice of the Chief Executive)

(c) Advises on and oversees appropriate contractual arrangements for Executive Directors, and when required, consider issues relating to remuneration, terms of service and performance issues for senior management staff

The Committee Chairman shall make recommendations to the Trust Board regarding the Composition of the Trust Board to ensure there are robust processes in place to review the role and performance of Non-Executive Directors and the Chairman, and to advise the Chairman regarding the filling of Non-Executive Vacancies.

The Committee is also responsible for reviewing and advising the Trust Board on the appointment process for Non-Executive Directors.

2.2 Audit Committee

The Audit Committee supports the Trust Board in their responsibilities for issues of Integrated Governance, Risk Management and Internal Control, by reviewing the comprehensiveness of internal and external assurances in meeting the Trust Board and Accounting Officer's needs, in addition to reviewing the reliability and integrity of these assurances.

2.3 Quality Governance Committee

The Quality Governance Committee assures the Trust Board of the organisation's performance against quality and research objectives. This assurance is secured through the Assurance Framework, the Corporate Risk Register and the audit plans, which focus on the quality and research objectives of the Trust.

2.4 Performance and Finance Committee

The Performance and Finance Committee oversees all aspects of the Trust's financial, workforce and performance management arrangements, and provides robust assurance in these areas to the Trust Board. The Trust Board continues to have primary responsibility for the financial, organisational development and business performance of the Trust and all Trust Board Directors will continue to be accountable in this respect.

2.5 Transformation and People Committee

The Committee assures the Trust Board in relation to the strategic impact of the Transformation Programmes and People and Organisational Development Strategy on the delivery of the Trust's strategic objectives.

2.6 Trustees

The Committee:

(a) is responsible for all aspects of the management of the investment of funds held in the Trust (i.e. Charitable Funds) and for the effective utilisation of those funds

(b) Ensure Charities Commission requirements are fulfilled

(c) Provides assurance to the Trust Board that systems have been established to manage the funds ensuring that the identification, assessment and management of risk is linked to the achievement of the charity's operational objectives.

3. Committee Attendance

The average attendance of Committee members for 2020/21 was as follows:

Committee	Average Attendance of Members (%)					
	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Nominations and Remuneration Committee	76.0%	83%	89%	87%	73%	71%
Audit Committee	80.0%	83%	93%	77%	83%	87%
Quality Governance Committee	82.5%	86%	85%	79%	84%	83%
Performance and Finance Committee	71.0%	95%	83%	85%	82%	83%
Transformation and People Committee	N/A	N/A	N/A	N/A	94%	82%
Trustees	44.0%	42%	61%	78%	67%	79%

Attendance matrices for each Committee can be found in the individual Committee Annual Reports.

4. Responses from Committee Self-Assessment Questionnaires

Each Committee member (and regular attendee where required) were asked to complete a Committee Effectiveness questionnaire. The questionnaires were based upon good practice guidance which requires Boards to review the effectiveness of their Committees on an annual basis and included a number of questions covering the practice and conduct of the Committees. In addition a Committee Processes questionnaire was completed by the Deputy Associate Director of Corporate Governance on behalf of the Chair of the Committee.

A summary of the responses received against the questions posed in the questionnaires is listed below:

Committee	Positive Response					
	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Nominations and Remuneration Committee	75%	97%	92%	92%	Not undertaken	99%
Audit Committee	77%	85%	94%	88%	86%	98%
Quality Governance Committee	96%	98%	92%	91%	93%	98%
Finance and Performance Committee	84%	N/A	86%	82%	96%	99%
Transformation and People Committee	N/A	N/A	N/A	N/A	90%	100%
Trustees	88%	81%	78%	85%	79%	98%

- Negative statements made in relation to each of the Committees (including any associated comments and agreed actions) are listed below.

Question	Response	Comments	Actions Agreed
Nominations and Remuneration Committee			
The Committee has set itself a series of objectives for the year	1 respondent disagreed	• Difficult to do this given the nature of the committee	• To continue to improve upon the papers submitted for redundancy cases, providing 'best practice' cases with authors in order to clarify expectations • To continue to build upon the information provided to the Committee in terms of succession planning
Audit Committee			
The committee receives clear and timely reports from other Trust Board committees which set out the assurances they have received and their impact	1 respondent disagreed with this statement	No additional comments were provided	• To continue to build upon the reporting from TAP, PAF and QGC into the Committee. This will be assisted by prompts on agenda items referring items for escalation to the Audit Committee, to aid verbal reports to be subsequently provided to the Committee.
Internal audit contributes to the debate across the range of the agenda	1 respondent disagreed with this statement	No additional comments were provided	
Quality Governance Committee			
The Committee has set itself a series of objectives for the year	1 respondent disagreed	Objectives have been set for the meeting and included on the business cycle for reference	• Consideration is to be given as to improving the timeliness of reporting to the Committee • Committee members are asked to consider what actions could be taken to improve the balance of experience, knowledge and skills to fulfil its role
The Committee has the right balance of experience, knowledge and skills to fulfill its role	2 respondents disagreed	Generally yes, but lacks diversity Very different make up	

Question	Response	Comments	Actions Agreed
Performance and Finance Committee			
Members hold their assurance providers to account for late or missing assurances	1 respondent disagreed with this statement	• Operational pressures often cited for missed deadlines and prevents a real holding to account	• Chair and members to hold individuals to account for late / deferred papers, given these are highlighted on the business cycle. • As part of reviewing the business cycle and terms of reference for the Committee, members should outline whether any changes are required to the level of detail contained within the reports so that this can be incorporated from the beginning of the year
Transformation and People Committee			
No negative comments were made.			• Committee members are asked to consider the proposed business cycle and whether the scheduled updates in respect of transformation are sufficient – in addition to clarifying expectations in terms of future reporting
Trustees			
The Committee has the right balance of experience, knowledge and skills to fulfill its role	1 respondent disagreed	• The Committee lacks diversity	• Consideration is required in terms of reviewing the governance arrangements in terms of the Trust's role as Corporate Trustee versus the role of the Committee • Consideration and formulation of a charity strategy is required in terms of the focus of the charity and identifying projects which support the delivery of UHNM's strategy
The Committee has set itself a series of objectives for the year	1 respondent disagreed		
The quality of committee papers received allows committee members to perform their roles effectively	1 respondent disagreed	• This has been variable but improvements have now been made	
At the end of each meeting the Committee discuss the outcomes and reflect on decisions made and what worked well or not so well	1 respondent disagreed	•	

5. Conclusion

The output of the Committee effectiveness reviews and Committee annual reports have been considered by Committees, and actions have been agreed by each Committee. Terms of Reference have also been updated, and take into consideration any changes required for 2021/22 and these are included within the revised Rules of Procedure.

6. Key Recommendations

The Trust Board is asked to note:

- the outcomes of the self-assessment process.
- that annual reports for each Committee have been considered by the respective Committees.
- that revised Terms of Reference have been approved by each Committee, and incorporated within the Rules of Procedure for 2021/22

NHS
University Hospitals of North Midlands
NHS Trust

Rules of Procedure

April 2021

Together Compassion Safe Improving

PROUD TO CARE

Contents

About University Hospitals of North Midlands NHS Trust

What we do….

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

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

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

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

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

Our 2025Vision

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

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

Our Strategic Objectives

The 2025Vision is underpinned by five 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

Our Values

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

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

PROUD TO CARE

1. Introduction

The University Hospitals of North Midlands NHS Trust (the Trust) is a statutory body which came into existence on 4th November 1992 under The North Staffordshire Hospital NHS Trust (Establishment) Order 1992 No 2559 (the Establishment Order). On the 1st April 2003, via order No 792, the name of the hospital was changed to the University Hospital of North Staffordshire NHS Trust. On 1st November 2014, the name of the hospital was changed to the University Hospitals of North Midlands NHS Trust.

- NHS Trusts are governed by statute, mainly the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 (the 2006 Act) and the National Health Service Act 1977 (the 1977 Act and together with the 2006 Act, the NHS Acts).
- The functions of the Trust are conferred by this legislation.
- The Trust also has statutory powers to fund projects jointly planned with local authorities, voluntary organisations and other bodies.
- The Code of Accountability requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals.
- The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

All generalised reference within these Rules of Procedure to the male gender should read as equally applicable to the female gender and vice versa.

2. Definitions

Accountable Officer	The NHS Officer responsible and accountable for funds entrusted to the Trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.
Associate Member	A person appointed to perform specific statutory and non-statutory duties which have been delegated by the Trust Board for them to perform and these duties have been recorded in an appropriate Trust Board minute or other suitable record.
Board	The Chair, Executive Directors and Non-Executive Directors of the Trust collectively as a body.
Budget	Resource, expressed in financial terms, proposed by the Trust for the purpose of carrying out, for a specific period, any or all of the functions of the Trust. The budget should, where appropriate, also be supported by budgets relating to workforce and workload.
Budget Administrator	Employee with delegated authority from a Budget Manager (to a limit of £5,000 inclusive of VAT) to manage finances (income and expenditure) for a specific cost centre or group of cost centres
Budget Manager	Employee with delegated authority from a Budget Holder (to a limit of £25,000 inclusive of VAT) to manage finances (income and expenditure) for a specific cost centre or group of cost centres
Budget Holder	Director or employee with delegated authority from the Chief Executive (to a limit of £50,000 inclusive of VAT) to manage finances (income and expenditure) for a specific area of the organisation
Chair of the Trust	Is the person appointed by the Secretary of State for Health and Social Care to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression 'the Chair of the Trust' shall be deemed to include the Vice-Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.
Chief Executive	The chief accountable officer of the Trust.

Commissioning	The process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.
Committee	Means a committee or sub-committee created and appointed by the Trust.
Committee members	Means persons formally appointed by the Board to sit on or to chair specific committees.
Contracting and Procuring	The systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.
Employee (Officer)	Employee of the Trust or any other person holding a paid appointment or office with the Trust.
Executive Director (Officer Member)	An officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.
Funds held on trust	Those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under the NHS Act 2006, as amended. Such funds may or may not be charitable.
He/she or his/her	Where this term appears this term is to be taken as referring to the post holder and is interchangeable as the gender of that post holder changes
Member	Executive Director or non-Executive Director of the Board as the context permits.
Membership, Procedure and Administration Arrangements Regulations	NHS Membership and Procedure Regulations (SI 1990/2024) and subsequent amendments.
Non-Executive Director (Non-Officer Member)	A member of the Trust who is not an officer of the Trust and is not to be treated as an officer by virtue of regulation 1(3) of the Membership, Procedure and Administration Arrangements Regulations.
Scheme of Reservation and Delegation of Powers	Document which sets out the powers reserved by the Trust Board, while at the same time delegating to the appropriate level the detailed application of Trust policies and procedures.
SID Senior Independent Director	A non-executive director available to raise concerns whereby contact through the normal channels of Chair, Chief Executive, Executive Director or Associate Director of Corporate Governance has failed to resolve.
SO's	Standing Orders.
Standing Financial Instructions (SFIs)	Document detailing the financial responsibilities, policies and procedures adopted by the Trust.
Trust	University Hospitals of North Midlands NHS Trust.
Vice Chair	The Non-executive Director appointed by the Board to take on the Chair's duties if the Chair is absent for any reason.

3. Governance

The role of the Board is to set strategy, lead the organisation, oversee operations and to be accountable to stakeholders in an open and effective manner. Good governance provides the key to effective leadership, meaningful challenge, accountability and responsibility. Corporate governance is the system by which companies and other Board led organisations are directed and controlled. The Board is separate from the day to day operational management, which is the responsibility of the Executive Directors and the management structure they lead.

As described in NHS Improvement's Well-led Framework, NHS Trusts are operating in challenging environments characterised by the increasingly complex needs of an ageing population, growing emphasis on working with local system partners to create innovative solutions to longstanding sustainability problems, workforce shortages and the slowing growth in the NHS budget. Trust Boards need to ensure that their oversight of care, quality, operations and finance is robust in the face of uncertain future income, potential new models of care and resource constraints. Good governance is essential if they are to continue providing safe, sustainable and high quality care for patients.

NHS Trusts should conduct their affairs effectively and, in so doing, build patient, public and stakeholder confidence that they are providing high quality sustainable care. NHS Trust Boards are responsible for all aspects of performance and governance of the organisation.

4. Statutory Framework

The University Hospitals of North Midlands (UHNM) Board consists of:

- The Chair of the Trust appointed by NHS Improvement (NHSI) on behalf of the Secretary of State
- 6 Non-Executive Directors
- 6 Executive Directors including the Chief Executive and the Chief Finance Officer

The principal place of business of the Trust is the Royal Stoke University Hospital, Newcastle Road, Stoke-on-Trent, Staffordshire, ST4 6QG. The Trust also provides services at the County Hospital, Weston Road, Stafford, ST16 3SA.

An organisational chart of the Trust Board members and the Trust Boards Committee Structure can be found at appendices 1 and 2.

5. The Board and Exercise of Statutory Powers

The Board shares responsibility for:

- Ensuring that high standards of corporate governance are observed and encouraging high standards of propriety
- Establishing the strategic direction and priorities of UHNM
- The effective and efficient delivery of UHNM's plans and functions
- Promoting quality in UHNM's activities and services
- Monitoring performance against agreed objectives and targets
- Ensuring that Board members personally and corporately observe the seven principles of public life set out by the Committee on Standards in Public Life.

The Board has collective responsibility for the decisions made by it. Members of the Board shall be subject to the Code of Conduct set out in appendix 3.

Any member of the Board who significantly or persistently fails to adhere to these Rules of Procedure may be judged as failing to carry out the duties of their office and will be managed in accordance with current Trust Policy.

6. Meetings and Proceedings of the Board

6.1 Meetings of the Board

- Ordinary meetings of the Board shall be held at regular intervals at such times and places as the Board may determine and as set out within the annual Calendar of Business.
- The Board may invite any person to attend all or part of a Board meeting.
- Meetings will either be held virtually, via MS Teams, or at various locations within Royal Stoke University Hospital or County Hospital, as required.
- Members of the Board are expected to attend not less than 8 Board meetings (whether formal meetings or seminars) in any 12 month period.

6.2 Admission of the Public and Press

- The Board will operate in an open and transparent fashion, except where confidentiality requirements are concerned.
- The chair will give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and members of the press, subject to the provisions of the Public Bodies (Admission to Meetings) Act 1960, such as to ensure that the Board's business may be conducted without interruption or disruption. The Board may resolve to exclude the public and conduct its business in private, whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business being transacted or for other special reasons stated in the resolution.
- Members of the public and press are not admitted to meetings of committees or sub-committees except by specific invitation.

Business proposed to be transacted when the press and public have been excluded from a meeting
Matters to be dealt with by the Trust Board following the exclusion of representatives of the press, and other members of the public, shall be confidential to the members of the Board.

Directors or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

Use of mechanical or electrical equipment for recording or transmission of meetings
The Trust does not permit the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Board. Such permission shall be granted only upon resolution of the Chair and Chief Executive, in advance of the meeting.

6.3 Board Meeting Agenda and Papers

In normal circumstances, the agenda will be sent to members 5 working days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be dispatched no later than three clear days before the meeting, save in emergency. For meetings held in public, the agenda and supporting papers shall be published via the Trust website www.uhnm.nhs.uk at least three working days before the meeting.

The order of business at Board meetings shall follow the agenda issued for that meeting unless otherwise directed by the Chair, at whose discretion, or at the request of another member of the Board, the order may be altered at any stage. The agenda will be primarily based upon the Business Cycle approved by the Board (appendix 4).

Papers may only be tabled at a meeting of the Board with the permission of the Chair.

No other business other than that on the agenda will be taken except where the Chair considers the item should be discussed.

Members of the Board should treat those papers identified as private and confidential and not discuss them with persons other than Board members or employees unless this is agreed with the Chair. If so discussed, members of the Board should ensure that those with whom they have consulted are made aware of, and respect, the need for confidentiality.

Members must take care not to leave Board papers identified as private unattended or where others may obtain access to them.

6.4 Extraordinary Meetings of the Board

In the event of urgency the Chair may determine to hold a meeting to be known as an extraordinary meeting at such time as he/she may determine.

6.5 Power to Call Meetings of the Board

Where, in the opinion of the Chair, an urgent matter has arisen, the Chair may call a meeting of the Board at any time.

Where two or more members of the Board submit a signed request for a meeting to the chair, the chair shall, as soon as practicable but no later than seven calendar days from the date the request was submitted, arrange for the meeting to be held within 28 calendar days from the date the request was submitted.

6.6 Chairing of Meetings

The procedure at meetings shall be determined by the Chair presiding at the meeting. The Chair shall, if present, preside at all meetings of the Board. In the absence of the Chair, the Vice-Chair will preside.

In the absence of both the Chair and the Vice-Chair, a Non-Executive Director chosen by the other members will preside.

6.7 Procedure at Meetings of the Board

The Chair or person presiding over the meeting of the Board will:

- Preserve order and ensure that all members of the Board have sufficient opportunity to express their views on all matters under discussion
- Determine all matters of order, competency and relevancy
- Determine in which order those present should speak
- Determine whether or not a vote is required and how it is carried out

Written comments on agenda items submitted by any member of the Board who is not present when a particular agenda item is discussed may be circulated to those members of the Board who are present at the meeting and read out at the appropriate point in the meeting.

Decisions of the Board will normally by made by consensus rather than by formal vote. Failing consensus, decisions will be reached by means of a vote when:

- the person presiding over the meeting feels that there is a body of opinion among members of the board at the meeting who disagree with a proposal or have expressed reservations about it and no clear consensus has emerged; or
- when a member of the Board who is present requests a vote to be taken; or
- any other circumstances in which the person presiding at the meeting considers that a vote should be taken.

Voting will take place as follows:

- Where a decision of the Board requires a vote it shall be determined by a majority of the votes of the members of the Board present and voting on the question. The person presiding at the meeting shall declare whether or not a resolution has been carried or otherwise. In the case of an equal vote, the person presiding (i.e. the Chair of the meeting shall have a second, and casting vote).

- At the discretion of the Chair, all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chair directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.
- If at least one third of the members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot).
- In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.
- A manager who has been formally appointed to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Executive Director.
- A manager attending the Trust Board meeting to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. The status of Executive Directors when attending a meeting shall be recorded in the minutes.

No resolution of the Board will be passed if it is unanimously opposed by all of the Executive Directors present or by all of the Non-Executive Directors present.

The minutes of the meeting will record only the numerical results of a vote showing the numbers for and against the proposal and noting any abstentions. The minutes shall be conclusive evidence of the outcome. Votes will not normally be attributed to any individual member of the Board but any member may require that their particular vote be recorded, provided that he/she asks the secretary immediately after the item has concluded.

The Board may agree to defer a decision on an agenda item so that it can be provided with additional information or for any other reason. The decision to defer together with the reasons for doing so will be recorded in the minutes of the meeting together with the proposed time for returning the matter to the Board for its consideration.

The Board may decide to delegate decisions on agenda items to the Chair. Any decision to do so shall be recorded in the minutes of the meeting.

Where in the opinion of the Chair, and considering advice from the Chief Executive, or any other Executive Director, significant operational or other matters require approval by the Board between formal meetings, papers will be circulated by the secretary for approval by correspondence. Any matter capable of being passed by the Board at a meeting may instead be passed by written confirmation given by a majority of the members of the Board with the Chair having the power to cast a second casting vote.

Only exceptionally, where the process to reach a decision would not benefit from discussion in a meeting at which members views would inform debate or, if the issue is time critical will a Board decision be reached without a formal meeting.

6.8 Quorum of the Board

No business shall be transacted at a meeting unless at least six Directors with voting rights (including at least two Executive Directors and three Non-Executive Directors). Attendance of the Chair, shall count as one of the Non-Executive Directors.

An individual in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

If the Chair or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

Participation will usually be in person, but in exceptional circumstances members of the Board may participate by telephone or video-conferencing facility and be deemed to be present and constitute part of the board for that meeting.

When a Board meeting:

- Is not quorate within half an hour from the time appointed for the meeting or;
- Becomes inquorate during the course of the meeting;

the meeting shall either be adjourned to such time, place and date as may be determined by the members present or shall continue as an informal meeting at which no decisions may be taken.

6.9 Minutes of the Board

The minutes of the proceedings of a meeting along with a Post Meeting Action Log shall be drawn up and submitted for agreement at the next ensuing meeting where their approval will be recorded.

No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate (for example matters arising).

The record of the minutes shall include:

- The names of:
  - Every member of the Board present at the meeting
  - Any other person present
  - Any apologies tendered by an absent member of the Board
- The withdrawal from a meeting of any member on account of a conflict of interest and;
- Any declaration of interest

Minutes of any meeting of the Board will record key points of discussion. Where personnel, finance or other restricted matters are discussed, the minutes will describe the substance of the discussion in general terms.

Once agreed, the minutes will be published via the Trust website www.uhnm.nhs.uk.

6.10 Emergency Powers

The functions exercised by the Board may, in an emergency, be exercised by the Chair after having consulted the Chief Executive.

The exercise of such powers by the Chair must be reported to the next formal meeting of the Board in public session for ratification. The reasons for why an emergency decision was required must be clearly stated.

6.11 Delegation of Powers

The Board remains accountable for all of UHNM's functions, even those delegated to Committees, the Chair, Chief Executive, Executive Directors or employees, and will require information about the exercise of delegated functions to enable it to maintain a monitoring role.

The list of matters reserved for decision by the Board does not however preclude other matters being referred to the Board for decision. All powers delegated by the Board can be reassumed should the need arise and the Board reserves the right to deal with any matters previously delegated. The Board may also revoke or vary such delegation.

The Board delegates to each Committee the discharge of those functions that fall within their respective terms of reference other than any matters reserved to the Board.

The Chief Executive shall prepare a scheme of delegation (Trust Policy F02 Scheme of Delegation and appendix 6 of this document), identifying which functions he/she shall perform personally and which functions have been delegated to Committees and individual employees.

All powers delegated by the Chief Executive can be reassumed by them should the need arise.

Powers are delegated to the Committees and individual employees on the understanding that they will not exercise delegated powers in a matter which in their understanding is likely to be cause for public concern or which might have an effect on the reputation of the Trust.

The exercise of all delegated powers is on the basis that appropriate expert advice will be sought as necessary and that any costs involved can be met within the authorised budget.

The Corporate Governance Team shall keep a record of the powers, authorities and discretions delegated by the Board.

In the absence of an employee to whom powers have been delegated, those powers shall be exercised by the relevant Executive Director unless alternative arrangements have been approved by the Board. If the Chair is absent the powers delegated to him may be exercised by the Vice Chair in relation to the Board and the Chief Executive after taking advice as appropriate from the Board and Executive Directors.

6.12 Role of Accountable Officer and Standing Financial Instructions

The Chief Executive acts as the Accountable Officer. As Accountable Officer, she/he is responsible for ensuring that the public funds for which she/he is personally responsible are properly safeguarded and that functions are used effectively, efficiently and economically.

The standing financial instructions, (Trust Policy F01 Standing Financial Instructions), detail the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that financial transactions are carried out in accordance with the law and government in order to achieve probity, accuracy, economy, efficiency and effectiveness. They provide a framework of procedures and rules for employees to follow.

All proposed expenditure above £1 million must be formally approved by the Trust Board.

6.13 Personal Conflicts of Interest

If a member of the Board or a Committee member knowingly has any interest or duty which is material and relevant, or the possibility of such an interest or duty, whether direct or indirect and whether pecuniary or not, that in the opinion of a fair minded and informed observer would suggest a real possibility of bias in any matter that it brought up for consideration at a meeting of the Board or any Committee, he/she shall disclose the nature of the interest or duty at the meeting. The declaration of interest or duty may be made at the meeting or at the start of the discussion of the item to which it relates or in advance in writing to the Corporate Governance Team. If an interest or duty has been declared in advance of the meeting, this will be made known by the Chair of the meeting prior to the discussion of the relevant agenda item. In the event of the person not appreciating at the beginning of the discussion that an interest or duty exists, he/she should declare an interest as soon as he/she becomes aware of it.

If a member of the Board or a Committee has acted in accordance with the provisions above and has fully explained the nature of their interest or duty, the members of the Board or Committee present will decide unanimously whether and to what extent that person should participate in the discussion and determination of the issue and this will be recorded in the minutes and the extent to which the person concerned had access to any written papers on the matter. If it is decided that he/she should leave the meeting, the Chair may first allow them to make a statement on the item under discussion.

Where the chair of the meeting has a relevant interest then he/she must advise the Board or the Committee accordingly, and with their agreement and subject to the extent decided, participate in the discussion and the determination of the issue. This will be recorded in the minutes and the extent to which he/she had access to any written papers on the matter. If it is decided that the Chair should leave the meeting because of a conflict of interest, another member will be asked to chair the discussion of the relevant agenda item in accordance with the procedure set out above.

Employees who are not members of the Board or Committee, but who are in attendance at a meeting of the Board or a Committee should declare interests in accordance with the same procedures as for those who are members. Where the chair of a meeting rules that a potential conflict of interest exists, any employee so concerned should take no part in the discussion of the matter and may be asked to leave by the meeting chair.

A member of the Board, Committee or employee shall be subject to the arrangements for dealing with conflicts of interests as set out in the Trust Policy G16 Standards of Business Conduct.

6.14 Allowances for Non-Executive Members of the Board

Non-Executive members of the Board are entitled to seek reimbursement of reasonable expenses incurred in the exercise of duties in accordance with Trust Policy.

7. Meetings and Proceedings of Committees

Where no specific provisions are specified for Committees, these are the same as the principles and provisions for the Board, as set out above. Where there is any inconsistency between the said provisions and any provisions in the Terms of Reference for any Committee, the latter shall prevail.

Committee Governance Packs for each of the Committees, which include Terms of Reference and Membership, Business Cycles, Agenda and Reporting Templates and Self-Assessment Tools can be found at appendices 7 – 13.

7.1 Appointment of Committees

- The Board may establish a Committee for any purpose within its functions and shall determine the powers and functions of any such Committee.
- The Board shall appoint members of the Committees.
- The Board shall appoint, for every Committee, a Chair who shall be a member of the Board, unless there is a specific requirement that the Chief Executive, as Accounting Officer, should be chair.
- The Board shall keep under review, the structure and scope of activities of each Committee.
- The Board shall set out the Terms of Reference for each Committee (see appendices 7 – 13).
- The Board may at any time amend the Terms of Reference of any Committee.

7.2 Meetings of a Committee

A Committee shall hold meetings at such regular intervals as may be determined by the members of the Committee. The Committee shall determine the time and place of the meetings to be held.

7.3 Extraordinary Meetings of a Committee

In the event of urgency, the Committee chair may determine to hold an extraordinary meeting at such time and place as he/she may determine.

7.4 Attendance at Committee Meetings

A member of the Board may attend and speak with the permission of the chair of the Committee at any meeting of a Committee.

A member of the Board who is not a member of the Committee shall not vote on any matter before the Committee.

7.5 Chairing of Committee Meetings

The procedure at meetings shall be determined by the Committee chair presiding at the meeting.

The Committee chair shall, if present, preside at all meetings. In the absence of the Committee chair, a non-executive Board member, who is also a member of the Committee, or a Board member nominated by the Committee chair shall preside.

7.6 Quorum of Committees

The quorum for a Committee meeting shall generally consist of one half of the total membership of the Committee of which at least one non-executive member of the Board is present, unless stated otherwise within their Terms of Reference.

7.7 Minutes of Committees

A member of the Executive Suite shall act as Secretary to Committees or nominate a deputy. The Secretary shall record the minutes of every meeting of the Committee or nominate a deputy. The record of minutes shall be submitted to the Committee at its next meeting for agreement, confirmation or otherwise.

Minutes of all Committee meetings will be accessible to all Board members via the Corporate Governance Team.

7.8 Committee Reporting to the Board

The Corporate Governance Team will prepare a report following each Committee meeting, on behalf of the Committee chair, for presentation to the next Board meeting. This will include a section highlighting key points, and referral of items as appropriate as well as any recommendations to the Board.

Each Committee, led by the Chair, will undertake an annual effectiveness evaluation against their Terms of Reference and Membership. An evaluation template for each Committee can be found within their respective 'Governance Pack'. The outcome will be reported to the Board in accordance with the Annual Business Cycle.

7.9 Prohibition on Delegation of a Committee's Function

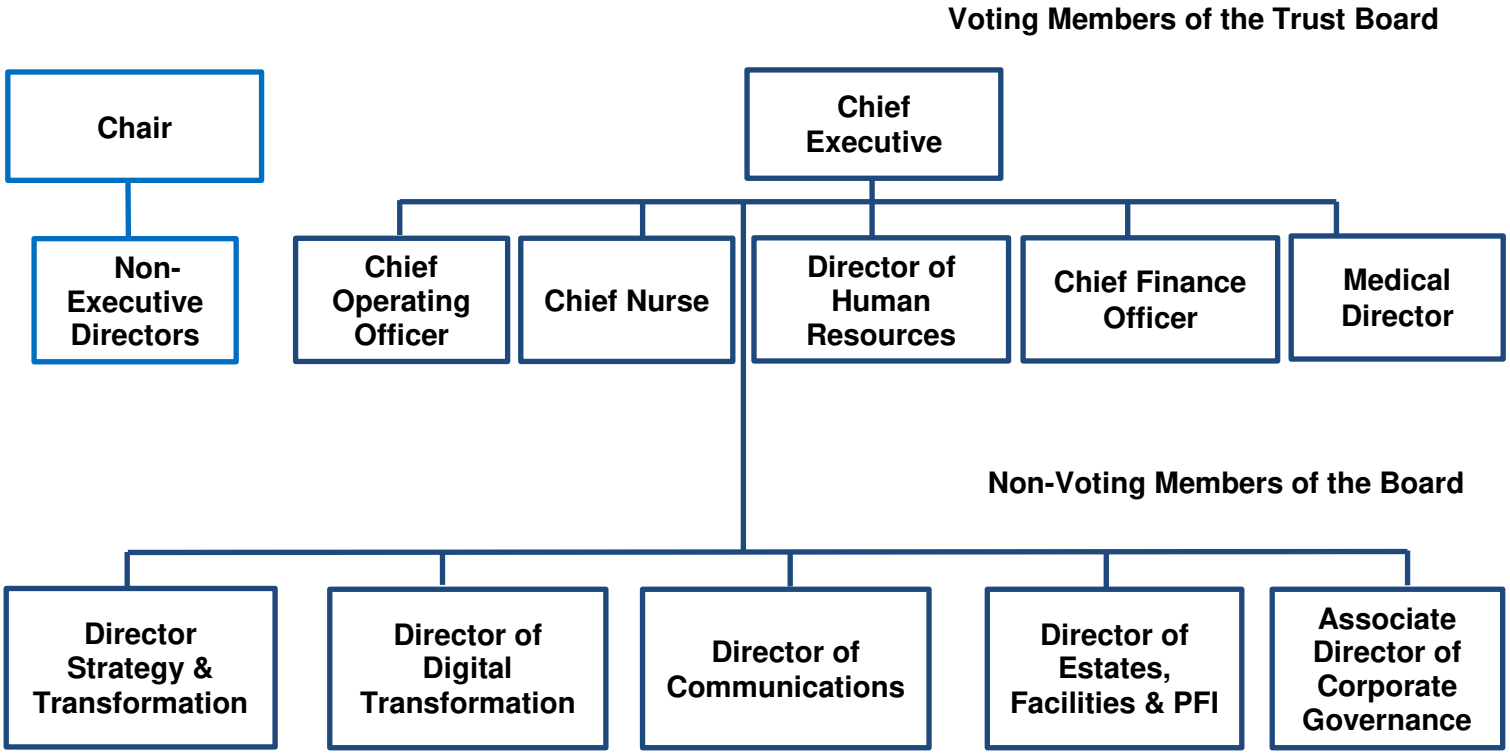
A Committee shall not delegate its functions to any other group established by the Committee or to any other person unless authorised by the Board in the Committee's Terms of Reference.

8. Other Documents Relevant to these Rules of Procedure

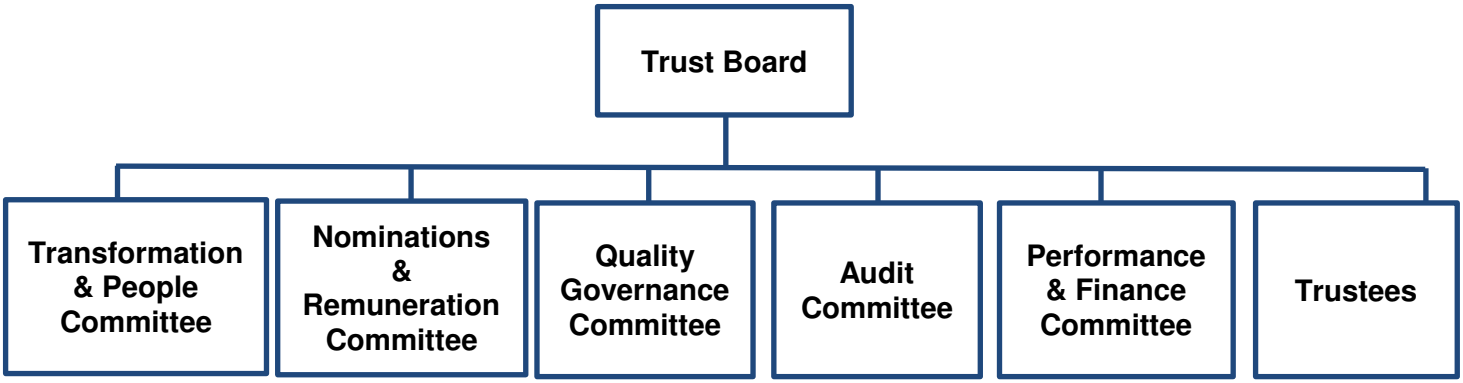
The following documents should be read in conjunction with the Rules of Procedure:

- F01 Standing Financial Instructions
- F02 Scheme of Delegation
- G19 Standing Orders
- G16 Standards of Business Conduct
- Trust Values, Behaviours and Standards Framework

Appendix 1 – Trust Board Organisation Chart



Appendix 2 – Trust Board and Committee Organisation Chart



Appendix 3 - Code of Conduct for Board Members

UHNM Trust Board: Code of Conduct

To justify the trust placed in me by patients, service users and the public, I will abide by these standards at all times when at the service of the NHS.

I understand that care, compassion and respect for others are central to quality in healthcare; and that the purpose of the NHS is to improve the health and wellbeing of patients and service users, supporting them to keep mentally and physically well, to get better when they are ill and when they cannot fully recover, to stay as well as they can to the end of their lives.

I understand that I must act in the interests of patients, service users and the community I serve, and that I must uphold the law and be fair and honest in my dealings.

1. Introduction

All members of NHS Boards are expected to work to the highest personal and professional standards and should understand and be committed to the practice of good governance and to the legal and regulatory frameworks in which they operate. As individuals they must understand both the extent and limitations of their personal responsibilities.

This Code of Conduct has been developed in line with a range of existing standards relevant to the healthcare sector. The standards set out within this Code are consistent with the Nolan Principles on Public Life and with existing regulatory frameworks applying to professionals and senior managers working in the NHS.

In addition, the Code of Conduct should be read alongside the Trusts Values, Behaviours and Standards Framework.

2. Purpose

Senior leadership roles can frequently require individuals to address dilemmas in difficult decisions. Their decisions must balance the potentially conflicting but legitimate needs of individuals, communities, the healthcare system and taxpayers.

- Part 1 of this Code of Conduct is designed to provide a framework to guide judgment in these circumstances, through a consistent application of values and principles.
- Part 2 sets out a modern etiquette for Board members, including behavioural expectations, to help ensure that Board meetings are effective and focused.
- Part 3 provides an outline of the individual and collective roles and responsibilities of Board members.

3. Part 1: Standards For Board Members

All Board members should understand and be committed to the practice of good governance and to the legal and regulatory frameworks in which they operate. As individuals they must understand both the extent and limitations of their personal responsibilities, such as the differences in role of executive and non-executive Board members. To justify the trust that has been placed in them by patients and the public they must adhere to these standards of personal behaviour, technical competence and business practice.

3.1 Personal Behaviours

In the treatment of patients and service users, their families and their carers, the community, colleagues and staff, and in the design and delivery of services for which they are responsible, Board members must commit to:

- The values of the **NHS Constitution** in the treatment of staff, patients and their families and carers and the community, and in the design and delivery of services for which they are responsible.
- Promoting **equality and diversity** in the treatment of staff, patients and their families and carers, and the community, and in the design and delivery of services for which they are responsible.
- Promoting **human rights** in the treatment of staff, patients, their families and carers, and the community, and in the design of services for which they are responsible.
- The **duty of candour** to ensure that 'patients/their families are told about patient safety incidents that affect them, receive appropriate apologies, are kept informed of investigations and supported to deal with the consequences'. This applies to patient safety incidents that occur during care provided and that result in moderate harm, severe harm or death. This also applies to suspected incidents which have yet to be confirmed, where the suspected result is moderate harm, severe harm or death.
- The requirements as set out by the Care Quality Commission in relation to the **Fit and Proper Persons Test**.

Board members must apply the following principles in their work and relationship with others:

Responsibility	I will be fully accountable for my work and the decisions that I make, for the work and decisions of the Board, including delegated responsibilities, and for the staff and services for which I am responsible.
Honesty	I will act with honesty in all my actions, transactions, communications, behaviours and decision-making, and will resolve any conflicts arising from personal, professional or financial interests that could influence or be thought to influence my decisions as a Board member
Openness	I will be open about the reasoning, reasons and processes underpinning my actions, transactions, communications, behaviours and decision-making and about any conflicts of interest
Respect	I will treat patients and service users, their families and carers, the community, colleagues and staff with dignity and respect at all times
Professionalism	I will take responsibility for ensuring that I have the relevant knowledge and skills to perform as a Board member and that I reflect on and identify any gaps in my knowledge and skills, and will participate constructively in appraisal of myself and others. I will adhere to any professional or other codes by which I am bound
Leadership	I will lead by example in upholding and promoting these Standards, and use them to create a culture in which their values can be adopted by all.
Integrity	I will act consistently and fairly by applying these values in all my actions, transactions, communications, behaviours and decision-making, and always raise concerns if I see harmful behaviour or misconduct by others.

3.2 Technical Competence

For themselves and the organisation, Board members must seek:

- To make sound decisions individually and collectively
- Excellence in the safety and quality of care, patient experience and the accessibility of services
- Long term financial stability and best value for the benefit of patients, service users and the community.

This will be done through:

- Always putting the safety of patients and service users, the quality of care and patient experience first, enabling colleagues to do the same.
- Demonstrating the skills, competencies and judgment necessary to fulfil their role and by engaging in training, learning and continuing professional development.
- Having a clear understanding of the business and financial aspects of the organisations work and of the business, financial and legal contexts in which it operates
- Making best use of expertise and that of colleagues while working within the limits of their own competence and knowledge.
- Understanding their role and powers, the legal, regulatory and accountability frameworks and guidance within which they operate and the boundaries between the executive and non-executive.
- Working collaboratively and constructively with others, contributing to discussions, challenging decisions and raising concerns effectively.
- Publicly upholding all decisions taken by the Board under due process for as long as they are a member of the Board.
- Thinking strategically and developmentally.
- Seeking and using evidence as the basis for decisions and actions.
- Understanding the health needs of the population served.
- Reflecting on personal, Board and organisational performance and how their behaviour affects those around them; and supporting colleagues to do the same.
- Looking for the impact of decisions on the services provided, on the people who use them and on staff.
- Listening to patients and service users, their families and carers, the community, colleagues and staff and making sure people are involved in decisions that affect them.
- Communicating clearly, consistently and honestly with patients and service users, their families and carers, the community, colleagues and staff, ensuring that messages have been understood.
- Respecting patients' rights to consent, privacy and confidentiality and access to information, as enshrined in data protection and freedom of information law and guidance.

3.3 Business Practices

For themselves and for the organisation, Board members must seek:

- To ensure the organisation is fit to service its patients and service users, and the community.
- To be fair, transparent, measured and thorough in decision making and in the management of public money.
- To be ready to be held publicly to account for the organisations decisions and for its use of public money.

This will be done through:

- Declaring any personal, professional or financial interests and ensure that they do not interfere with actions, transactions, communications, behaviours or decision making, removing themselves from decision making when they might be perceived to do so.
- Taking responsibility for ensuring that any harmful behaviour, misconduct or systems weaknesses are addressed and learnt from, and taking action to raise any such concerns identified.
- Ensuring that effective complaints and whistleblowing procedures are in place and in use.
- Condemning any practices that could inhibit the reporting of concerns by members of the public, staff or Board members about standards of care or conduct.
- Ensuring that patients and service users and their families have clear and accessible information about the choices available to them so that they can make their own decisions.
- Being open about the evidence, reasoning and reasons behind decisions about budget, resource and contract allocation.
- Seeking assurance that the organisations financial, operational and risk management frameworks are sound, effective and properly used and that the values in these standards are put into action in the design and delivery of services.
- Ensuring that the organisations contractual and commercial relationships are honest, legal, regularly monitored and compliant with best practice in the management of public money.
- Working in partnership and co-operating with local and national bodies to support the delivery of safe, high quality care.
- Ensuring that the organisations dealings are made public, unless there is a justifiable and properly documented reason for doing so.

4. Part 2: Board Meetings - Etiquette

The Trust Board is the predominant mechanism by which strategy is agreed, performance monitored and executive actions held to account on behalf of stakeholders. It is therefore essential that the Board conducts meetings with a view to optimising the use of the time and intellectual capital of members.

As such, the Board needs to focus on the purpose of the meeting, and all the elements that can contribute to an effective discussion, including the way members interact and work together to ensure sound decision-making.

An effective Board develops and promotes its collective vision of the Trust's purpose, culture, values and the behaviours it wishes to promote in conducting its business. In particular it:

- Provides direction for management;
- Demonstrates ethical leadership, displaying and promoting behaviours consistent with the culture and values it has defined for the organisation;
- Makes well-informed and high-quality decisions based on a clear line of sight into the business.

Ensuring robust and appropriate challenge depends on a number of factors being in place: the right information in the right format in advance of the meeting; an appropriate setting; length of the meeting; good Chairmanship; appropriate Boardroom behaviours and the encouragement of a culture where challenge is accepted.

If Board members are not fully engaged throughout the duration of a Board meeting, and behaviours are poor, decision-making will be impaired. It may be possible that Board papers are failing to engage members, consequently not stimulating directors to ask questions and challenge assumptions behind recommendations.

4.1 Before the Meeting

- Provide papers 5 days in advance of the meeting, to allow these to be circulated to members; late papers will only be allowed following discussion with the Chief Executive/Chair.
- Having received the Board papers before the meeting, read the agenda, and any supporting papers ahead of the meeting and prepare questions to be raised at the appropriate time, or think of suggestions to resolve problems.
- Be clear on the decision that is being asked for.
- Request further information ahead of the meeting or seek clarification from the Trust Secretary or report author (including highlighting typographical and other errors not of material consequence), where appropriate.
- Submit apologies, and where appropriate arrange for a deputy to attend (ensuring they are well-briefed).
- Arrive for the meeting on time, stay for its duration, and ensure regular attendance at all meetings.
- If you have to leave before the end of the meeting, inform the Chair beforehand. However, this should be avoided whenever possible.

4.2 During the Meeting

- Declare any potential or real conflicts of interest with regard to any matter on the agenda.
- If using an electronic device to make notes during the meeting of discussions and decisions made, it is advisable to inform fellow Board members of your intention and gain the permission of the Chair.
- Unless there are specific reasons for doing so, no part of the meeting should be visually or audio recorded. If such recording is agreed the Chair must inform the meeting beforehand.

4.3 Focussing on the Agenda

- Stay focused on agenda items.
- Dedicate attention to the purpose of the meeting and refrain from performing other duties at the same time.

- Turn off mobile phones/electronic communications device. When an electronic device must be kept on, turn to silent/vibrate. Should individuals need to answer an urgent call; attendees should be forewarned that and urgent call is expected and permission of the Chair to keep the electronic device on must be sought.
- Refrain from private conversations with others at the meeting (whether spoken or written), and the passing of notes.

4.4 Contributing to the Discussion

- If appropriate, attract the Chair's attention when wishing to contribute to the discussion, and wait until the Chair indicates that you may speak so as to avoid interrupting a fellow Board member. Direct comments and discussion through the chair.
- When invited to speak by the Chair, do so clearly, concisely and at a volume that all attendees can hear (especially the minute-taker), without shouting. Avoid the use of jargon and acronyms.
- Throughout the meeting be respectful of the role of the chair in encouraging debate, summarising discussion and clarifying decisions made.
- Be constructive and professional in imparting an opinion or information.
- Listen attentively and respectfully to others, making notes of any points to raise when an opportunity to respond arises; do not interrupt when others are speaking.
- Ensure body language demonstrates participation and engagement in the meeting.
- Challenge inappropriate behaviour/language from other Board members at the time via the chair or after the meeting if more convenient.
- Treat attendees fairly and consistently, even if there is disagreement with another's point of view.
- Challenge and provide critique constructively, and ensure that any challenges are proportionate and based on fact. Challenge the issue being discussed, not the personality of other individuals taking part in the discussion.
- Seek clarification or amplification when necessary.

4.5 Unitary Board

- Board members should know and understand their role at the meeting and the need for the Board to act as a corporate body (i.e. not to pursue self-interest or the interest of another body).
- Board members should not act territorially/personally, and should remember the need to contribute to the corporate nature of the Board.
- Regard and welcome challenge as a test of the robustness of papers and arguments presented.
- Do not cause offence or take offence, accept the diversity of opinions and views presented.

4.6 Accountability

- Seek professional guidance/clarification from the Chair during the meeting (or Associate Director of Corporate Affairs outside the meeting) wherever there may be any concern about a particular course of action.
- Keep confidential matters confidential.

4.7 After the meeting

- Participate and contribute to any post-meeting review with a view to making future meetings more effective
- A summary of actions agreed will be produced and circulated by the Corporate Governance Team within 1 day of the meeting. Board members must read the action summary and complete any relevant tasks and report back appropriately on their completion in a timely manner. A central log of all actions agreed by the Board will be maintained by the Corporate Governance Team.
- Draft minutes will be produced within one working week after the meeting. These should be read with a view to clarifying matters and sending amendments to the Corporate Governance Team at the earliest opportunity. This should help to reduce the time taken approving the minutes at the next Board meeting.
- Observe the confidentiality and sensitivity of matters discussed at the meeting and ensure that all papers, both electronic and paper copies are stored safely.

- Remember that decisions were taken collectively by the Board and therefore that responsibility remains collective too.

Where there is evidence that the Board etiquette policy has been breached, the chair, with guidance from the Corporate Governance Team, will recommend the necessary action to be taken.

Any meeting to discuss breaches of Board etiquette will take place with the presence of the member accused of inappropriate behaviour, in accordance with the Board's code of conduct, where applicable.

Board behaviour and performance, collectively and individually, should be reviewed as part of an annual Board evaluation process.

All Board members share corporate responsibility for:
- formulating strategy
- ensuring accountability
- shaping culture
- ensuring the Board operates as effectively as possible

5.1 Chair and Chief Executive

The Chair and Chief Executive have complimentary roles in Board leadership. These are defined in more detail within the 'Memorandum of Understanding between the Chair and Chief Executive'. In essence, these two roles are:
- The **Chair** leads the Board and ensures the effectiveness of the Board (and Council of Governors once Foundation Trust status is achieved)
- The **Chief Executive** leads the executive and the organisation

5.2 Roles of Board Members

There are distinct roles for different members of the Board. These are set out in the following table:

	Chair	Chief Executive	Non-Executive Director	Executive Director
Formulate Strategy	Ensures Board develops vision and clear objectives to deliver organisational purpose	Leads vision, strategy development process	Brings independence, external skills and perspectives and challenge to strategy development	Takes lead role in developing strategic proposals – drawing on professional and clinical expertise (where relevant)
Ensure Accountability	Holds CEO to account for delivery of strategy Ensures that Board committees that support accountability are properly constituted	Leads the organisation in the delivery of strategy Establishes effective performance management arrangements and controls Acts as Accountable Officer	Holds the executive to account for the delivery of the strategy Offers purposeful, constructive scrutiny and challenge Chairs or participates as member of key committees that support accountability	Leads implementation of strategy within functional areas
Shape Culture	Provides visible leadership in developing a positive culture for the organisation, and ensures that this is reflected and modelled in their own and in the Boards behaviour and decision making	Provides visible leadership in developing a positive culture for the organisation and ensures that this is reflected in their own and the executive's behaviour and decision making	Actively supports and promotes a positive culture for the organisation and reflects this in their own behaviour Provides a safe point of access to the	Actively supports and promotes a positive culture for the organisation and reflects this in their own behaviour

	Chair	Chief Executive	Non-Executive Director	Executive Director
	Board culture: Leads and supports a constructive dynamic within the Board, enabling contributions from all directors		Board for whistle blowers	
Context	Ensures all Board members are well briefed on external context	Ensures all Board members are well briefed on external context		
Intelligence	Ensures requirements for accurate, timely and clear information to Board / directors are clear to executive	Ensures provision of accurate, timely and clear information to Board / directors	Satisfies themselves of the integrity of financial and quality intelligence	Takes principal responsibility for providing accurate, timely and clear information to the Board
Engagement	Plays a key role as an ambassador, and in building strong partnerships with: • Patients and public • Members and governors (FT) • Clinicians and staff • Key institutional stakeholders • Regulators	Plays a key leadership role effective communication and building strong partnerships with: • Patients and public • Members and governors (FT) • Clinicians and staff • Key institutional stakeholders • Regulators	Ensures Board acts in best interests of the public Senior independent director is available to members and governors if there are unresolved concerns	Leads on engagement with specific internal or external stakeholder groups

6. Monitoring Compliance with the Code of Conduct

Overall Board behaviour and performance, collectively and individually, will be reviewed as part of an annual Board evaluation process.

Individual performance against this Code of Conduct will be assessed as part of the appraisal discussion with the Chief Executive Officer / Chair as appropriate.

7. References

- ICSA: Specimen Board Meeting Etiquette, February 2012
- Cabinet Office: Code of Conduct for Board Members of Public Bodies, June 2011
- CHRE: Standards for members of Boards and governing bodies in England, (draft for consultation), January 2012
- Professional Standards Authority: Standards for members of NHS Boards and Clinical Commissioning Group governing bodies in England
- National Leadership Council: The Healthy NHS Board, Principles for Good Governance, February 2010

Appendix 4 – Trust Board Business Cycle 2021/22

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	7	5	9	7	4	8	6	3	8	5	9	9
Chief Executives Report	■	■	■	■	■	■	■	■	■	■	■	■
Patient Story	■	■	■	■	■		■	■	■	■	■	■
Quality Governance Committee Assurance Report	■	■	■	■	■	■	■	■	■	■	■	■
Emergency Preparedness Annual Assurance Statement and Annual Report				■								
Care Quality Commission Action Plan			■						■			
Bi Annual Nurse Staffing Assurance Report				■						■		
Quality Account									■			
7 Day Services Board Assurance Report												
NHS Resolution Maternity Incentive Scheme												
Saving Babies Lives Care Bundle			■									
Continuity of Care Action Plan	■											
Midwifery Staffing	■											
Maternity Family Experience Report		■			■			■			■	
Winter Plan								■				
PLACE Inspection Findings and Action Plan												
Infection Prevention Board Assurance Framework	■	■	■	■	■	■	■	■	■	■	■	■
Integrated Performance Report	■	■	■	■	■	■	■	■	■	■	■	■
Transformation and People Committee Assurance Report	■	■	■	■	■	■	■	■	■	■	■	■
Gender Pay Gap Report												■
People Strategy Progress Report					■							
Revalidation				■								
Workforce Disability Equality Report					■							
Workforce Race Equality Standards Report							■					
Staff Survey Report												■
System Working Update	■	■	■	■	■	■	■	■	■	■	■	■
Performance and Finance Committee Assurance Report	■	■	■	■	■	■	■	■	■	■	■	■
Revenue Business Cases / Capital Investment / Non-Pay Expenditure £1,000,001 and above	■	■	■	■	■	■	■	■	■	■	■	■

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	7	5	9	7	4	8	6	3	8	5	9	9
IM&T Strategy Progress Report												
Going Concern												
Estates Strategy Progress Report												
Annual Plan 2020/21												
Financial Plan 2021/22												
Capital Programme 2021/22												
Nomination and Remuneration Committee Assurance Report												
Audit Committee Assurance Report												
Board Assurance Framework		Q4			Q1			Q2			Q3	
Raising Concerns Report		Q4			Q1			Q2			Q3	
Annual Evaluation of the Board and its Committees												
Annual Review of the Rules of Procedure												
G6 Self-Certification												
FT4 Self-Certification												
Board Development Programme												

Appendix 5 – Annual Effectiveness Evaluations

NB. Separate checklists are in place for the Audit Committee.

Name of Committee:	
Chair:	
Date of Effectiveness Review:	

Processes

To be completed by the Chair with the assistance of the Corporate Governance Team if required, and presented to the relevant Board Committee.

Area / Question	Yes	No	Comments
Composition, establishment and duties			
Does the Committee have written terms of reference and have they been approved by the Trust Board?			
Are the terms of reference reviewed annually?			
Are committee members independent of the management team?			
Are the outcomes of each meeting reported to the Corporate Trustee?			
Does the committee prepare an annual report on its work and performance?			
Has the committee established a plan of matters to be dealt with across the year?			
Are committee papers distributed in sufficient time for members to give them due consideration?			
Has the committee been quorate for each meeting this year?			
Compliance with the law and regulations governing the NHS			
Does the committee review assurance and regulatory compliance reporting processes?			

Committee Effectiveness

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

Statement	Please tick (✓) one box for each question					
	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to answer	Comments/ action
Theme 1 – Committee Focus						
The committee has set itself a series of objectives for the year						
The committee has made a conscious decision about the information it would like to receive						
Committee members contribute regularly to the issues discussed						
The committee is aware of the key sources of assurance and who provides them						
Theme 2 – Committee Team Working						
The committee has the right balance of experience, knowledge and skills to fulfil its role						

Statement	Please tick (✓) one box for each question					
	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to answer	Comments/ action
The committee ensures that the relevant Executive Director attends meetings to enable it to understand the reports and information it receives						
The committee is fully briefed on key risks and any gaps in control						
The committee environment enables people to express their views, doubts and opinions						
Members hold their assurance providers to account for late or missing assurances						
Decisions and actions are implemented in line with the timescale set down						
Theme 3 – Committee Effectiveness						
The quality of committee papers received allows committee members to perform their roles effectively						
Members provide real and genuine challenge – they do not just seek clarification and/or reassurance						
The committee challenges management and other assurance providers to gain a clear understanding of their findings						
Debate is allowed to flow, and conclusions reached without being cut short or stifled						
Each agenda item is 'closed off' appropriately so that the committee is clear on the conclusion; who is doing what, when and how, and how it is being monitored						
At the end of each meeting the committee discuss the outcomes and reflect on decisions made and what worked well or not so well						
The committee provides a written summary report of its meetings to the Trust Board including items for escalation						
The Trust Board challenges and understands the reporting from the Committee						
Theme 4 – Committee Engagement						
Membership and attendance at the committee enables the committee to cover all aspects of its terms of reference						
Theme 5 – Committee Leadership						
The committee chair has a positive impact on the performance of the committee						
Committee meetings are chaired effectively						
The committee chair is visible within the Trust and is considered approachable						
The committee chair allows debate to flow freely and does not assert his/her own views too strongly						
The committee chair provides clear and concise information to the Trust Board on committee activities and gaps in control						

Appendix 6 – Annual Governance Report Template

Introduction

The xxx Committee is established under Board delegation with approved terms of reference that reflects best practice available nationally. The Committee consists of xx Non-Executive Directors, has met on xx occasions throughout xx and has discharged its responsibilities. An outcome summary of each meeting of the Committee is formally reported to the Public Trust Board via the Committee Chair. The report has highlighted key points of discussion, challenge, decisions made, referral of items as appropriate and recommendations to the Board.

During the year, the Committee comprised of the following membership:

- xx

Other individuals such as the xx have been invited to attend the Committee during xx, for all or part of meetings at the request of the Committee Chair.

Key Areas of Work and Achievements against the Terms of Reference

During the year the Committee has monitored the progress made in delivering the business cycle, as can be seen below:

Compliance with the key responsibilities is evidenced by the actions identified in the following sections:

- xxx

Review of the Effectiveness and Impact of the Committee

The Committee has been active during the year in discharging its responsibilities and has undertaken a self-assessment of its effectiveness.

Emerging Issues and Objectives for xxx

- xxx

Attendance Matrix

All the meetings of the Committee held during xx were quorate.

	Attended		Apologies Given – Deputy sent		Apologies Given		Not in Post

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

The average attendance of members (or deputies) at the Committee was xx%.

Conclusion

The Committee is of the opinion that this annual report is reflects the work of Committee during xx and that the Committee has reviewed xxx. In addition there are no matters that the Committee is aware of at this time that have not been disclosed appropriately.

University Hospitals of North Midlands NHS Trust

Title of Committee

Meeting held on xx at xx am to xx pm
Trust Boardroom, Springfield, Royal Stoke

AGENDA

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

PROUD TO CARE

University Hospitals of North Midlands NHS Trust

Title of Committee

Meeting held on xx at xx to xx
Trust Boardroom, Springfield, Royal Stoke

MINUTES OF MEETING

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

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

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

A. Terms of Reference

Constitution and Authority

The Board hereby resolves to establish a Committee of the Board to be known as the Audit Committee (the Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Membership

The Committee is appointed by the Board from amongst the Non-Executive Directors of the Trust and shall consist of not less than three members. One of the members will be appointed as Chair of the Committee by the Board and the Chair of the organisation shall not be a member of the Committee. In addition, other Non-Executives are invited to attend as required.

Attendance at Meetings

The Chief Finance Officer and appropriate internal and external audit representatives shall normally attend meetings. At least once a year, the Committee should meet privately with the external and internal auditors.

The local counter fraud specialist will attend a minimum of two committee meetings a year.

The Chief Executive should be invited to attend and should discuss at least annually with the Committee the process for assurance that supports the Annual Governance Statement. He or she should also attend when the Committee considers the draft annual report and accounts. All other Executive Directors should be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director.

The Corporate Governance team shall provide appropriate support to the Chair and Committee members.

Quorum

A quorum shall be two non-executive members.

Frequency of Meetings

The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. A benchmark of five meetings per annum at appropriate times in the reporting year and audit cycle is proposed. The External Auditors or Head of Internal Audit may request an additional meeting if they consider that one is necessary.

Reporting

The Committee shall report to the Board on how it discharges its responsibilities.

The minutes of the Committee meetings shall be formally recorded and made available to all members of the Committee.

The Corporate Governance Office will submit a report following each Committee meeting, on behalf of the Committee Chair, for presentation at the next Open Trust Board. The report will summarise the decisions made as well as highlighting any items for escalation.

The Committee, led by the Chair, will undertake an annual effectiveness evaluation against their Terms of Reference and Membership. The outcome will be reported to the Board in accordance with the Annual Business Cycle.

The Committee will report to the Board at least annually on its work in support of the Annual Governance Statement, specifically commenting on:

- The fitness for purpose of the assurance framework
- The completeness of and how embedded risk management is in the organisation
- The integration of governance arrangements
- The appropriateness of the evidence that shows compliance with regulatory requirements
- The robustness of the processes behind the quality accounts.

The annual report will describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

Administrative Support

The Committee shall be supported administratively by the Corporate Governance Team whose duties in respect of this include:

- Calling of meetings
- Agreement of agendas with the Chair and preparation, collation and circulation of papers no later than five working days before the next meeting
- Ensuring that those invited to each meeting, attend
- Taking the minutes and helping the Chair to prepare reports to the Trust Board
- Keeping a record of matters arising and action points to be carried forward between meetings
- Arranging meetings for the Chair
- Advising the Committee on pertinent issues/areas of interest/policy developments

Duties

The Committee's duties/responsibilities can be categorised as follows:

Integrated Governance, Risk Management and Internal Control
The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

In particular the Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit opinion, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.
- The underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.
- The policies and procedures for all work related to fraud and corruption as required by NHS Counter Fraud Authority.

In carrying out this work, the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

As part of its integrated approach, the Committee will have effective relationships with other key committees (Quality Governance Committee, Performance and Finance Committee and Transformation and People Committee) so that it understands processes and linkages.

Internal Audit
The Committee shall ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate assurance to the Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the provision of the internal audit service and the costs involved
- Review and approval of the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework.
- Consideration of the major findings of internal audit work (and managements response) and ensuring co-ordination between the internal and external auditors to optimise the use of audit resources.
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.
- Monitoring the effectiveness of internal annual and carrying out an annual review.

External Audit
The Committee shall review and monitor the external auditors' independence and objectivity and effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the appointment and performance of the external auditors, as far as the rules governing the appointment permit.
- Discussion and agreement with the external auditors, before the audit commences, of the nature and scope of the audit as set out in the annual plan, and ensuring co-ordination as appropriate, with other external auditors in the local health economy.
- Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.
- Review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.
- Ensure that there is in place a clear policy for the engagement of external auditors to supply non-audit services.

Other Assurance Functions
The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation and consider the implications for the governance of the organisation.

These will include, but will not be limited to, any reviews by the Department of Health's arms-length bodies or regulators / inspectors (for example, the Care Quality Commission, NHS Improvement etc.) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies etc.).

In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work. In particular this will include the Quality Assurance Committee and Finance and Efficiency Committee in terms of risk management.

Relationship with other Committees:
As a Committee of the Trust Board, it is important that the Committee minimises areas of overlap. Therefore, the following specific areas of responsibility will be excluded from the Committee agenda:

- Issues around clinical risk management including receiving assurance from the clinical audit function will be considered at the Quality Governance Committee
- The effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensuring that any such concerns are investigated proportionately and independently, will be considered at the Transformation and People Committee.

Counter Fraud
The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and security that meet NHS Counter Fraud Authority's standards and shall review the outcomes of work in these areas.

The Committee will refer any suspicions of fraud, bribery and corruption to the NHS Counter Fraud Authority.

Management
The Committee shall request and review reports and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the organisation (for example, clinical audit) as they may be appropriate to the overall arrangements.

Financial Reporting
The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

The Committee shall review the annual report and financial statements before submission to the Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee.
- Changes in, and compliance with, accounting policies, practices and estimation techniques.
- Unadjusted misstatements in the financial statements.
- Significant judgements in preparation of the financial statements.
- Significant adjustments resulting from the audit.
- Letters of representation.
- Qualitative aspects of financial reporting.

B. Annual Schedule of Meetings

Date	Time	Venue	Deadline for Papers
22nd April 2021	12.30 pm – 2.00 pm	Trust Boardroom, RSUH	15th April 2021
27th May 2021	12.30 pm – 2.00 pm	Trust Boardroom, RSUH	20th May 2021
22nd July 2021	12.30 pm – 2.00 pm	Trust Boardroom, RSUH	15th July 2021
21st October 2021	12.30 pm – 2.00 pm	Trust Boardroom, RSUH	14th October 2021
27th January 2022	12.30 pm – 2.00 pm	Trust Boardroom, RSUH	20th January 2022

C. Annual Business Cycle

Title of Paper	Apr	May	Jul	Oct	Jan
	22	27	22	21	27
Private Internal and External Audit Discussions	■	■	■	■	■
Board Assurance Framework	■	■		■	■
Annual Governance Statement		■			
Annual Report		■			
Committee Effectiveness	■				
Internal Audit Recommendation Tracker	■		■	■	■
Quality Account				■	
Review of the Risk Management System					■
Report from Transformation and People Committee				■	
Report from Performance and Finance Committee				■	
Report from Quality Governance Committee				■	
Analytical Review and Draft Accounts	■				
Losses and Special Payments and Stock Write Offs	■		■	■	■
Going Concern	■				
Audited Accounts and Financial Statements		■			
Single Tender Waiver / SFI	■		■	■	■
Annual Accounts Timetable					■
Assurance from Third Party Providers I.e ELFS and RWT					■
Internal Audit Progress Reports	■	■	■	■	■
Internal Audit Annual Report and Opinion	■				
Approval of Internal Audit Plan	■				
Effectiveness of Internal Audit					■
External Audit Plan	■				■
External Audit Progress Report	■		■	■	■
Audit Findings Report and Letter of Representation		■			
Annual Audit Letter			■		
Quality Account External Audit Report					
Effectiveness of External Audit					■
Informing the Audit Risk Assessment					■
Counter Fraud Annual Plan	■				
Trust's Assessment against NHS Protect's Standards	■				
Counter Fraud Annual Report	■				
Counter Fraud Progress Report			■	■	■
Effectiveness of LCFS					■
Annual Clinical Audit Plan			■		

Nominations and Remuneration Committee

Committee Governance Pack

March 2020

University Hospitals of North Midlands NHS Trust

A. Terms of Reference

Constitution and Authority

The Trust Board hereby resolves to establish a Committee of the Board to be known as the Nominations and Remuneration Committee (the Committee). The Committee has no executive powers, other than those specifically delegated in these terms of reference.

The Committee is authorised by the Trust Board to take action in respect of any activities with in its Terms of Reference. The Committee is authorised by the Trust Board to obtain, at the Trust's expense, outside legal or other professional advice on any matters within its terms of reference

Membership

The Committee shall comprise at least three members, all of whom shall be Non-Executive Directors. The Chair of the Trust Board may also serve on the Committee.

- Mr David Wakefield, Chairman (Chair)
- Mr Peter Akid, Non-Executive Director
- Ms Sonia Belfield, Non-Executive Director
- Professor Gary Crowe, Non-Executive Director
- Professor Andrew Hassell, Non-Executive Director
- Dr Leigh Griffin, Non-Executive Director
- Mr Ian Smith, Non-Executive Director

Appointments to the Committee are made by the Trust Board and shall be for a period of up to three years, which may be extended for further periods of up to three years. At such time when the Committee is required to consider matters in relation to the Chair i.e. consideration of successor, the Senior Independent Director will be invited to Chair the meeting.

Attendance at Meetings

Only members of the Committee have the right to attend committee meetings. However, other individuals, such as the Chief Executive and other advisers may be invited to attend all or part of any meeting as and when appropriate.

It is expected that the following members of staff will regularly attend Committee meetings in an advisory capacity:

- Director of Human Resources. The Director of Human Resources will be excluded from meetings when their own remuneration is being considered.
- Associate Director of Corporate Governance. The Associate Director of Corporate Governance will provide administrative support to the Committee and advise on points of governance.

Quorum

The quorum necessary for the transaction of business shall be two members.

Frequency of Meetings

The Committee shall meet at least four times a year, and otherwise as required.

Reporting

The Committee shall report to the Trust Board on how it discharges its responsibilities.

The minutes of Committee meetings shall be formally recorded, and the discussion will be summarised by the Corporate Governance Team for inclusion within a report to be submitted to the next available Trust Board meeting. This summary will also draw attention to the Trust board of any issues requiring disclosure or action.

The Committee will undertake an annual effectiveness evaluation against their Terms of Reference and Membership, the outcome of which will be reported to the Trust Board in accordance with the Annual Business Cycle.

Administrative Support

The Committee shall be supported administratively by the Associate Director of Corporate Governance, whose duties in respect of this include:

- Calling of meetings
- Agreement of agendas with the Chair and preparation, collation and circulation of papers no later than five working days before the next meeting
- Ensuring that those invited to each meeting, attend
- Taking the minutes and helping the Chair to prepare reports to the Trust Board
- Keeping a record of matters arising and action points to be carried forward between meetings
- Arranging meetings for the Chair
- Maintaining records of members' appointments and renewal dates
- Advising the Committee on pertinent issues/areas of interest/policy developments

Duties

Remuneration

- To agree the remuneration and terms of service arrangements for Executive Directors (i.e. Board voting and non-voting members), the Chief Executive and posts assigned to the Very Senior Manager framework.
- To oversee the contractual arrangements for Executive Directors and, when required, consider issues relating to remuneration, terms of service and performance issues for Very Senior Managers.
- To review additional non-pay benefits.
- To review severance packages which fall outside the standard provisions of the Contract of Employment*
- As appropriate, the Audit Committee will provide a Value for Money (VfM) view on severance packages as per the agreed thresholds set by NHS Improvement.
- To ensure that the Annual Report includes a report on the remuneration arrangements for Executive Directors and the Chief Executive, including those who have joined or left the Trust during the financial year.
- Receive assurance as to off-payroll and interim Board payments

*** Severance Packages approval levels**

Severance packages which fall outside the standard provisions of the Contract of Employment must be calculated using standard guidelines. Any proposal to make payments outside of the current guidelines are subject to the approval of HM Treasury, via NHS Improvement (NHSI).

Redundancy Payments
The Committee must consider/approve any redundancy payments which are £10,000 or above. Any payments below these thresholds can be agreed by the Chief Executive / Director of Finance / Director of Human Resources outside of the meeting with notification being made to the next meeting of the Committee.

Tribunal Settlements
The Committee must consider / approve tribunal settlements which are £10,000 or above. Any payments below this threshold can be agreed by the Chief Executive, Director of Human Resources and Director of Finance outside of the meeting with notification being made to the next meeting of the Committee. In circumstances where a decision regarding a settlement of £10,000 or above is urgent, a decision can be made through discussion with the Chairman. Again this would need to be reported to the next meeting of the Committee.

Nominations

- The appointment of the Chief Executive is the responsibility of the Chairman. This process will be supported by NHS Improvement. The Chairman shall assemble an appropriate panel with relevant expertise and experience in respect of the appointments process.
- To regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) required of Non-Executive Directors of the Board, and make recommendations to the Board with regards to any changes.
- To consider and make recommendations to the Trust's Board on any proposals to changes in the structure of the Board and any proposals to increase or decrease the number of voting Executive Directors and/or Non- Executive Directors. The Trust Board should approve such changes.
- When a decision is taken to change the structure of the Board and/or a vacancy arises on the Trust Board, the Committee may seek advice from the Director of Human Resources with regard to the recruitment process to be adopted.
- Before an appointment is made by the Board, the Committee will evaluate the balance of skills, knowledge, experience and diversity on the Board, and, in the light of this evaluation, prepare a description of the role and capabilities required for a particular appointment.
- To give full consideration to succession planning for all Board Members in the course of its work, taking into account the challenges and opportunities facing the organisation, and the skills and expertise needed on the Board in the future.
- To monitor and evaluate the performance of the individual Directors (with the advice of the Chief Executive).
- To develop, monitor and seek feedback on a process for the evaluation of performance and contribution on the part of the Chairman and Non-Executive Directors.
- To consider the person specification when Non-Executive vacancies arise.
- Prior to the appointment of a Non-Executive Director, the proposed appointee should be required to disclose any other interests that may result in a conflict of interest and be required to report any further interests that could result in a conflict of interest.
- To annually review the time required for Non-Executive Directors. Performance evaluation should be used to assess whether the Non-Executive Directors are spending enough time to fulfil their duties.
- To consider the re-appointment of any Non-Executive Directors at the conclusion of their specified term of office having given due regard to their performance and ability to continue to contribute to the Board in the light of the knowledge, skills and experience required
- To keep up to date and fully informed about strategic issues and commercial changes affecting the Trust and the environment in which it operates.
- To review the results of the Board performance evaluation process that relate to the composition of the Board.
- Receive the annual declaration of the Chair in respect of the Board Members complying with the Fit and Proper Persons regulation and receive evidence based assurance that all newly appointed executive directors including the Chief Executive are deemed Fit and Proper.
- Approve any remedial action plan to address non-compliance with the Fit and Proper Persons regulation.
- Approval of membership of Board Committees as appropriate, in consultation with the chairpersons of those Committees

B. Annual Schedule of Meetings

Date	Time	Venue	Deadline for Papers
12th May 2021	1.30 pm – 3.00 pm	MS Teams	4th May 2021
14th July 2021	1.30 pm – 3.00 pm	MS Teams	7th July 2021
15th September 2021	1.30 pm – 3.00 pm	MS Teams	8th September 2021
17th November 2021	1.30 pm – 3.00 pm	MS Teams	10th November 2021
12th January 2022	1.30 pm – 3.00 pm	MS Teams	5th January 2022
16th March 2022	1.30 pm – 3.00 pm	MS Teams	9th March 2022

C. Annual Business Cycle

Title of Paper	May	Jul	Sep	Nov	Jan	Mar
	12	14	15	17	12	16
Redundancy Payments £10,000 and above	■	■	■	■	■	■
Remuneration and terms of service for Executive Directors and Chief Executive	■	■	■	■	■	■
Remuneration Section of Annual Report	■					
Off-payroll and interim Board payments	■	■	■	■	■	■
Changes to the Composition of the Trust Board	■	■	■	■	■	■
Non-Executive Director Performance Reviews	■					
Non-Executive Director Succession Planning	■					
Review of Time Required for Non-Executive Directors	■					
Executive / Non-Executive Appointments	■	■	■	■	■	■
Succession Planning		■				
Executive Director Performance Reviews		■				
Fit and Proper Persons Declarations	■					
Committee Effectiveness						■

University Hospitals of North Midlands NHS Trust

A. Terms of Reference

Constitution and Authority

The Board hereby resolves to establish a Committee of the Board to be known as the Quality Governance Committee (the Committee). The Committee is a non-executive committee of the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference.

The Committee has no executive powers, other than those specified in these Terms of Reference or otherwise by the Trust Board in its Scheme of Delegation. The Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Trust Board to obtain legal or other independent professional advice and to secure the attendance of persons with relevant experience and expertise from within or external to the Trust as it considers necessary.

Membership

- Non-Executive Directors x3
- Medical Director
- Chief Nurse
- Chief Operating Officer
- Director of Human Resources
- Head of Quality Safety & Compliance
- Associate Director of Corporate Governance

Attendance at Meetings

Other Directors may be asked to attend by the Committee Chair.

Other individuals such as, but not restricted to, representatives of clinical governance, audit and risk, internal and external audit may be invited to attend all or part of any meeting as and when appropriate and necessary.

Members are required to attend at least 10 out of 12 meetings per year.

Quorum

A quorum for the Committee shall be four members, to include two Non-Executive and one Executive Director of the Board.

Frequency of Meetings

The Committee shall meet on a monthly basis.

Reporting

The Committee shall report to the Trust Board on how it discharges its responsibilities.

The minutes of Committee meetings shall be formally recorded, and the discussion will be summarised by the Corporate Governance Team for inclusion within a report to be submitted to the next available Trust Board meeting. This summary will also draw attention to the Trust board of any issues requiring disclosure or action.

The Committee will undertake an annual effectiveness evaluation against their Terms of Reference and Membership, the outcome of which will be reported to the Trust Board in accordance with the Annual Business Cycle.

Administrative Support

The Committee shall be supported administratively by the Corporate Governance Team whose duties in respect of this include:

- Calling of meetings
- Agreement of agendas with the Chair and preparation, collation and circulation of papers no later than five working days before the next meeting
- Ensuring that those invited to each meeting, attend
- Taking the minutes and helping the Chair to prepare reports to the Trust Board
- Keeping a record of matters arising and action points to be carried forward between meetings
- Arranging meetings for the Chair
- Advising the Committee on pertinent issues/areas of interest/policy developments

Duties

The purpose of the Committee is to assure the Trust Board of the organisation's performance against quality and research objectives. This assurance is secured through the Assurance Framework, the Corporate Risk Register and the audit plans, which focus on the quality and research objectives of the Trust.

The primary duties of the Committee are as follows:

- To provide assurance to the Trust Board, of the level, adequacy and maintenance of integrated governance, risk management and internal control across quality and research governance activities.
- In respect of this committee, quality is defined as made up of three elements patient safety, clinical best practice and patient experience.

Responsibility for Risk Management

The Committee shall consider the Trust's strategic risks of a clinical nature and for each strategic risk, on a quarterly basis through the Board Assurance Framework, assess:

- Current and target risk scores
- Impact that the risk has on strategic objectives
- Potential consequences of the risk
- Impact that the risk has on achieving Care Quality Commission standards
- Impact of operational risks on the risk
- Potential or actual origins that have led to the risk
- How the risk is controlled and reported
- The assurance mechanisms for the risk
- Gaps in controls or negative assurances for the risk
- The actions and timescales for mitigating the risk

The relevant Executive Director responsible for managing each respective strategic risk shall be accountable at the Committee for responding to challenge and scrutiny of the Committee.

Safe

- Using the assurance framework, the Committee will review the risk and adequacy of assurance of patient safety (the avoidance, prevention and improvement of adverse outcomes). Ensuring that internal and external assurances of patient safety are regularly reviewed and the strength of assurances evaluated.
- Receive assurance that external reports on patient safety that have an impact on acute care have been reviewed, considered and any learning adopted. This will include national inquiries; quality reports; safety alerts; Department of Health and Social Care reviews; NHS Improvement; and professional bodies with the responsibility for the performance of staff, (Royal Colleges, accreditation bodies etc)
- Review the risks and adequacy of assurance that statutory and mandatory training requirements are being met.

Effective (Patient Outcomes)
- Review the risks and adequacy of assurance of compliance with the CQC relevant Outcomes
- Review the assurance that the clinical audit programme is aligned with the key strategic and operational risks.
- Review the risks and adequacy of assurance of staff engagement in annual objectives improving patient safety, clinical best practice and patient experience.

Caring
- Review risks and the adequacy of assurance of patient experience, via review of the action plans to address the outcomes of patient surveys; patient experience tracker results; complaints and comments; patient stories; external reports such as CQC; Healthwatch; Overview and Scrutiny Committees etc.

Research Governance
- Review the risks and adequacy of assurance that research activity across the Trust is delivered within the national regulatory requirements and that research and innovation activity is driving improvement.

Other Assurance Functions
- Review the risks and assurances to compliance with the CQC registration requirements.
- Review the process and methodology for production of the quality account ensuring that it meets the Trust legal obligations and duties.
- Review any investigations of activities which are within its terms of reference.
- Review the findings of other significant governance and risk reports, both internal and external to the organisation, and shall consider any implications for the governance of the Trust.
- Monitor operational management and implementation of policies to ensure internal control and assurance of quality and research governance.
- Review details of the number and concerns raised on a quarterly basis
- To maintain oversight of the potential impact on quality arising from financial pressures, the Committee will review quarterly QIA reports

Management
- The Committee shall request and review reports and positive assurances from directors and managers on the overall accuracy of information in respect of governance, risk management and internal control.
- The Committee may also request specific reports from individual functions within the Trust as they may be appropriate to the overall arrangements set out above.

B. Annual Schedule of Meetings

Date	Time	Venue	Deadline for Papers
22nd April 2021	09:00 am – 11:30 am	MS Teams	15th April 2021
27th May 2021	09:00 am – 11:30 am	MS Teams	20th May 2021
24th June 2021	09:00 am – 11:30 am	MS Teams	17th June 2021
22nd July 2021	09:00 am – 11:30 am	MS Teams	15th July 2021
26th August 2021	09:00 am – 11:30 am	MS Teams	19th August 2021
23rd September 2021	09:00 am – 11:30 am	MS Teams	16th September 2021
21st October 2021	09:00 am – 11:30 am	MS Teams	13th October 2021
25th November 2021	09:00 am – 11:30 am	MS Teams	17th November 2021
16th December 2021	09:00 am – 11:30 am	MS Teams	9th December 2021
27th January 2022	09:00 am – 11:30 am	MS Teams	20th January 2022
24th February 2022	09:00 am – 11:30 am	MS Teams	17th February 2022
24th March 2022	09:00 am – 11:30 am	MS Teams	17th March 2022

C. Annual Business Cycle

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Executive Directors Update												
Quality & Safety Report	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11
Serious / Adverse Incident Report		Q4			Q1			Q2			Q3	
Infection Prevention Report												
Mortality Report												
Health and Safety Report												
Readmissions Update												
NHS Resolution Maternity Incentive Scheme												
Fire Report		Q4			Q1			Q2			Q3	
Annual Security Report												
Quarterly Maternity Dashboard		Q4			Q1			Q2			Q3	
Maternity Family Experience Report												
Saving Babies Lives Care Bundle												
Perinatal Mortality Review Tool												
Compliance and Effectiveness Report		Q4			Q1			Q2				Q3
Care Quality Commission Inspection Update												
Research and Development Update												
Get It Right First Time Update												
Clinical Audit Progress Report												
Annual Clinical Audit Plan												
Medicines Optimisation												
Organ Donation and Transplantation												
PLACE Inspection Findings and												

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Action Plan												
Patient Experience Report		Q4			Q1			Q2			Q3	
Safeguarding Children & Adults Annual Reports												
CQC Insight Report												
Litigation Report												
Quality Account												
Board Assurance Framework	Q4			Q1			Q2			Q3		
Infection Prevention Board Assurance Framework												
Assurance Report from Quality and Safety Oversight Group												
Assurance Report from Health and Safety Group												
Committee Effectiveness												
Quality Impact Assessment Report												

University Hospitals of North Midlands NHS Trust

A. Terms of Reference

Constitution and Authority

The Board hereby resolves to establish a Committee of the Board to be known as the Performance and Finance Committee (the Committee). The Committee is a non-executive Committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.

The Committee has no executive powers, other than those specified in these Terms of Reference or otherwise by the Board in its Scheme of Delegation. The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain legal or other independent professional advice and to secure the attendance of persons with relevant experience and expertise from within or without the Trust as it considers necessary.

Membership

- Non-Executive Directors x2
- Chief Executive
- Chief Financial Officer
- Chief Operating Officer
- Director of Strategy and Transformation
- Operational and Strategic Directors of Finance
- Director of PMO
- Associate Director of Corporate Governance

Attendance at Meetings

Other Directors may be asked to attend by the Committee Chair.

Other individuals may be invited to attend all or part of any meeting as and when appropriate and necessary.

Quorum

A quorum for the Committee shall be four members, to include two Non-Executive and two Executive Directors of the Board.

Frequency of Meetings

The Committee shall meet on a monthly basis.

Reporting

The Committee shall report to the Trust Board on how it discharges its responsibilities.

The minutes of Committee meetings shall be formally recorded, and the discussion will be summarised by the Corporate Governance Team for inclusion within a report to be submitted to the next available Trust

Board meeting. This summary will also draw attention to the Trust Board of any issues requiring disclosure or action.

The Committee will undertake an annual effectiveness evaluation against their Terms of Reference and Membership, the outcome of which will be reported to the Trust Board in accordance with the Annual Business Cycle.

Administrative Support

The Committee shall be supported administratively by the Corporate Governance Team whose duties in respect of this include:

- Calling of meetings
- Agreement of agendas with the Chair and preparation, collation and circulation of papers no later than five working days before the next meeting
- Ensuring that those invited to each meeting, attend
- Taking the minutes and helping the Chair to prepare reports to the Trust Board
- Keeping a record of matters arising and action points to be carried forward between meetings
- Arranging meetings for the Chair
- Advising the Committee on pertinent issues/areas of interest/policy developments

Duties

On behalf of Trust Board, the prime purpose of the Committee is to oversee progress in the delivery of financial and operational performance, receiving assurance from Executive Directors.

The Committee will also:

- Consider financial and operational strategies, prior to submission to Trust Board for approval
- Approve business cases in accordance with delegated authority from Trust Board, in accordance with the Scheme of Delegation
- Review progress against the delivery of business plans
- Oversee financial and operational related strategic risks, and their mitigation plans, through the Board Assurance Framework on a quarterly basis
- Escalation of matters to Trust Board as agreed by the Committee.

The duties of the Committee are as follows:

Financial and Operational Performance

- To consider and monitor progress against delivery of the Trust's Financial Plan
- To monitor delivery of the Trust's cost improvement programme
- To oversee and evaluate the development of the Trust's financial and operational performance to deliver the objectives as set out in the Annual Plan and to ensure delivery of the statutory financial and NHS Constitutional targets
- To ensure that the Trust has in place a comprehensive financial and operational performance management control framework
- To review the proposed annual financial plans for revenue and capital, working capital and cash management

Approval of Business Cases and Business Development

- To agree the Trust's Capital Programme for submission to the Trust Board
- To oversee, scrutinise and approve within delegated limits as specified by the Scheme of Delegation the investment appraisal of capital and revenue business cases

Contract and Income Monitoring

- To scrutinise the development of the Trust's contractual regime including contract portfolios and contracting processes
- To identify and scrutinise the systems to provide early warnings of potential risks and opportunities in the implementation of the contractual framework of the Trust
- To identify, monitor, prioritise and mitigate risks to in relation to the implementation of the model contract and the relationship between activity, income and costs
- To ensure the Trust Board is advised of any significant variation in activity and its impact on income and costs
- To review the systems in place to ensure compliance with the contract terms

Treasury Management
- To monitor cash, liquidity and working capital
- To approve relevant benchmarks for monitoring investment performance
- To review and monitor investment performance

Relationship with the Audit Committee
As a Committee of Trust Board, it is important that the Committee minimises areas of overlap with the Audit Committee. Therefore, the following specific areas of responsibility will be excluded from the Committee agenda:
- Audit – External and Internal
- Approval of Annual Report and Accounts
- Approval of Standing Financial Instructions and Scheme of Delegation
- Local Counter Fraud Specialist work
- Local Security Management Specialist work

Relationship with the Transformation and People Committee
As a Committee of Trust Board, it is important that the Committee minimises areas of overlap with other Committees. Therefore, the following specific areas of responsibility will be excluded from the Committee agenda:
- To oversee and evaluate the development of the Trust's workforce performance to deliver the objectives as set out in the Annual Plan
- To ensure that the Trust has in place a comprehensive workforce performance management control framework
- To ensure that any workforce implications of financial plans are thoroughly considered and taken into account
- To ensure that current and future workforce issues and developments are fully reflected in business and financial plans and forecasts
- To ensure the Trust is continually reviewing current ways of working and developing new ways of working that are designed to encourage staff to maximise their effectiveness in delivering the Annual Plan
- To review the impact of human resources and organisational development strategies and plans on business performance and associated targets

Responsibility for Risk Management
The Committee shall consider the Trust's strategic risks of a non-clinical nature and for each strategic risk, on a quarterly basis through the Board Assurance Framework, assess:
- Current and target risk scores
- Impact that the risk has on strategic objectives
- Controls and assurances in place for each risk
- The actions and timescales for closing gaps in controls and assurances and mitigating the risk

The relevant Executive Director responsible for each strategic risk shall be accountable at the Committee for responding to challenge and scrutiny of the Committee.

B. Annual Schedule of Meetings

Date	Time	Venue	Deadline for Papers
20th April 2021	9.00 am – 12.00 pm	MS Teams	13th April 2021
25th May 2021	9.00 am – 12.00 pm	MS Teams	18th May 2021
22nd June 2021	9.00 am – 12.00 pm	MS Teams	15th June 2021
20th July 2021	9.00 am – 12.00 pm	MS Teams	13th July 2021
24th August 2021	9.00 am – 12.00 pm	MS Teams	17th August 2021
21st September 2021	9.00 am – 12.00 pm	MS Teams	14th September 2021
19th October 2021	9.00 am – 12.00 pm	MS Teams	12th October 2021
23rd November 2021	9.00 am – 12.00 pm	MS Teams	16th November 2021
14th December 2021	9.00 am – 12.00 pm	MS Teams	7th December 2021
25th January 2022	9.00 am – 12.00 pm	MS Teams	18th January 2022
22nd February 2022	9.00 am – 12.00 pm	MS Teams	15th February 2022
22nd March 2022	9.00 am – 12.00 pm	MS Teams	15th March 2022

C. Annual Business Cycle

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
FINANCE												
Finance Report	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11
CIP Report		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11
Budget Setting												
Financial Plan 2022/23												
Capital Programme 2022/23												
Annual Plan 2022/23												
PERFORMANCE												
Operational Performance Report	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11
IM&T Strategy Progress Report												
Data Security and Protection Update												
GOVERNANCE												
Business Cases between £250,000 to £1,000,000												
Business Case reviews												
Authorisation of Contract Awards												
Supplies and Procurement Report												
Emergency Preparedness Annual Assurance Statement and Annual Report												
Board Assurance Framework	Q4			Q1			Q2			Q3		
Committee Effectiveness												
PFI Governance and Contract Performance												

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Management												
Annual Audit into Overseas Visitors Policy Compliance												
Assurance Report from Executive Infrastructure Group												
Assurance Report from Executive Business Intelligence Group												
Assurance Report from Data Security and Protection Group												
Assurance Report from Non-Elective Improvement Group												
Assurance Report from Operational Delivery Group												

Transformation and People Committee

Committee Governance Pack

April 2021

A. Terms of Reference

Constitution and Authority

The Board hereby resolves to establish a Committee of the Board to be known as the Transformation and People Committee (the Committee).

The Committee is a non-executive committee of the Trust Board and has powers to ensure that the Board is able to act in accordance with legislation, compliance or direction requirements inclusive of workforce legislation and to be fully appraised of the strategic impact of the Transformation Programmes and People and Organisational Development Strategy on the delivery of the Trust's strategic objectives.

The Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Trust Board to obtain legal or other independent professional advice and to secure the attendance of persons with relevant experience and expertise from within or external to the Trust as it considers necessary.

Membership

- Non-Executive Directors x 3 (one designated chair and one designated deputy chair)
- Director of Human Resources
- Chief Executive
- Chief Operating Officer
- Chief Nurse
- Director of Strategy and Transformation
- Associate Director of Corporate Governance

Attendance at Meetings

Other Directors may be asked to attend by the Committee Chair.

Regular Attendees

Other individuals such as, but not restricted to the following may be invited to attend all or part of any meeting as and when appropriate and necessary:

- Chief Finance Officer
- Deputy Director of Human Resources
- Assistant Director of Organisational Development
- Assistant Director of Human Resources Governance
- Director of PMO and Transformation
- Assistant Director of Learning and Education
- Medical Director
- Associate Director for Medical Education
- Guardian of Safe Working
- Freedom to Speak Up Guardian

Members are required to attend at least 10 out of 12 meetings per year. Regular attenders are expected to maintain a good standard of attendance and should attend meetings at least once per quarter.

If by exception members are unable to attend they must advise the Chair of the Committee and enquire whether a deputy is required (if a deputy attends they must be able to fully participate in the meeting but will have no voting rights).

Attendees who are deputising for members and/or regular attenders must be properly briefed by the person they are deputising for, on the content of the meeting and the item they are presenting.

The Trust's Chairman shall not be a member of the Committee but is authorised to observe any meetings of the Committee.

The Committee may also invite other senior officers of the Trust and other specialist advisors (internal or external) to present papers on an ad-hoc basis. Such attendees will hold no voting rights.

Quorum

A quorum for the Committee shall be four members, to include two Non-Executive and two Executive Directors of the Board.

Frequency of Meetings

The Committee shall meet on a monthly basis.

Reporting

The Committee shall report to the Trust Board on how it discharges its responsibilities.

The minutes of Committee meetings shall be formally recorded, and the discussion will be summarised by the Corporate Governance Team on behalf of the Chair for inclusion within a report to be submitted to the next available Trust Board meeting. This summary will also draw attention to the Trust board of any issues requiring disclosure or action.

The Committee will undertake an annual effectiveness evaluation against their Terms of Reference and Membership, the outcome of which will be reported to the Trust Board in accordance with the Annual Business Cycle.

Administrative Support

The Committee shall be supported administratively by the Corporate Governance Team whose duties in respect of this include:

- Calling of meetings
- Agreement of agendas with the Chair and preparation, collation and circulation of papers no later than five working days before the next meeting
- Ensuring that those invited to each meeting, attend
- Taking the minutes and helping the Chair to prepare reports to the Trust Board
- Keeping a record of matters arising and action points to be carried forward between meetings
- Arranging meetings for the Chair
- Advising the Committee on pertinent issues/areas of interest/policy developments

Duties

The Committee is responsible for ensuring that strategic transformation and people matters are considered and planned into Trust Strategy and service delivery and shall include the following duties:

Workforce and Organisational Development

- To ensure direction and priorities for the development of workforce strategies, including approval of the People and Organisational Development Strategy, Learning and Education Strategy and Workforce plan.
- To monitor the progress and effectiveness of workforce strategies against corporate strategy, organisational values and workforce experience, as measured by key workforce performance indicators.
- To approve new Workforce / OD projects and practices, paying particular attention to the impact on patient experience, quality, efficiency, equality and diversity and workforce.
- To receive assurance that workforce policies are regularly reviewed and updated as required and in line with current legislation.
- To monitor progress associated with Workforce recommendations arising from audits and the Audit Committee.
- To approve the development, implementation and evaluation of Leadership and Management Development, Talent Management & Succession Planning, Wellbeing Plans and Apprenticeship and Widening participation activity.
- To review and analyse the experiences of our staff and how we involve and engage with them to support successful and sustainable organisation and cultural change;
- To take an overview of the equality, diversity and inclusion policy and achievement of goals.
- To receive and consider the Quarterly Guardian of Safe Working Hours report on behalf of the Board.
- To receive and consider the Quarterly Speaking Up Report on behalf of the Board
- To consider clinical workforce transformation issues.
- To review and approve mandated workforce reporting returns including workforce equality, revalidation and Safe Staffing reports.
- To provide assurance to the Board that the Trust is compliant with relevant HR legislation and best practice.
- To ensure that the workforce implications of financial plans are thoroughly considered and taken into account
- To ensure that current and future workforce issues and developments are fully reflected in business and financial plans and forecasts
- To ensure the Trust is continually reviewing current ways of working and developing new ways of working that are designed to encourage staff to maximise their effectiveness in delivering the Annual Plan
- To review the impact of human resources and organisational development strategies and plans on business performance and associated targets

Transformation

- To ensure direction and priorities for internal and external system wide transformation, including partnership working, aligns with both the Trust's overall strategy and future developments and with the developing Integrated Care System Strategy.
- To scrutinise strategic transformation performance indicators on behalf of the Board, reporting to the Board via the integrated performance report to highlight good practice and outline areas for improvement on an exception basis.
- To ensure transformation interdependencies and risks are properly accounted for as part of the Trust's overall transformation programme of work and to remove obstacles to successful delivery.
- To ensure key enablers are properly considered as part of the implementation of transformation programmes (e.g. Information Management & Technology and Organisational Development).
- To monitor progress associated with Transformation recommendations arising from audits and the audit committee.
- To receive assurance delivery reports of transformation schemes (inclusive of progress and delivery).
- To scrutinise, challenge and develop workforce and transformation performance indicators on behalf of the Board, reporting to the Board via the integrated performance report as required.
- Horizon scanning for new developments and benchmarking to ensure practice is always in line with national / regional development
- Ensuring that ensuring new technologies / advances in digitalisation are embraced and considered along with service developments
- Ensuring alignment of research and education to service developments

General Committee Duties

- To prepare an Annual Report for the Board each year to review the Committee's work in discharging its duties against its Terms of Reference. The report will cover the previous financial reporting period.
- To ensure that the work of the committee liaises and consults with the divisions of the Trust in achieving the objectives of the Annual Work Plan and/or Strategy
- To identify any risks which may prevent the achievement of the Annual Work Plan and ensure that these are assessed and placed on the Trust's Risk Register/Board Assurance Framework as appropriate.
- To report any exceptions to the Annual Work Plan or Strategy to the Board.
- Review and approve the Annual Report, Annual Work Plan and Terms of Reference of any Groups that have a direct report to the Committee.

Responsibility for Risk Management

The Committee shall consider the Trust's strategic risks of a non-clinical nature and for each strategic risk, on a quarterly basis through the Board Assurance Framework, assess:

- Current and target risk scores
- Impact that the risk has on strategic objectives
- Controls and assurances in place for each risk
- The actions and timescales for closing gaps in controls and assurances and mitigating the risk

The relevant Executive Director responsible for each strategic risk shall be accountable at the Committee for responding to challenge and scrutiny of the Committee.

Relationship with Other Committees

The Committee will have a key relationship with other Committees of the Board, in particular:

- Quality Governance Committee
- Performance and Finance Committee

Matters for consideration / referral to other Committees of the Board will be done so via the Committee Assurance Reporting mechanism.

B. Annual Schedule of Meetings

Date	Time	Venue	Deadline for Papers
21st April 2021	09:00 am – 11:30 am	MS Teams	14th April 2021
26th May 2021	09:00 am – 11:30 am	MS Teams	19th May 2021
23rd June 2021	09:00 am – 11:30 am	MS Teams	16th June 2021
21st July 2021	09:00 am – 11:30 am	MS Teams	14th July 2021
25th August 2021	09:00 am – 11:30 am	MS Teams	18th August 2021
22nd September 2021	09:00 am – 11:30 am	MS Teams	15th September 2021
20th October 2021	09:00 am – 11:30 am	MS Teams	13th October 2021
24th November 2021	09:00 am – 11:30 am	MS Teams	17th November 2021
15th December 2021	09:00 am – 11:30 am	MS Teams	8th December 2021
26th January 2022	09:00 am – 11:30 am	MS Teams	19th January 2022
23rd February 2022	09:00 am – 11:30 am	MS Teams	16th February 2022
23rd March 2022	09:00 am – 11:30 am	MS Teams	16th March 2022

C. Annual Business Cycle

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
PEOPLE												
Guardian of Safe Working Report												
Learning, Education and Widening Participation Progress Report												
Workforce Disability Equality Standard												
Staff Survey Report												
Recruitment Strategy												
Apprenticeship Levy Progress Report												
Workforce Race Equality Standard												
Revalidation Report		Q4			Q1			Q2			Q3	
Equality, Diversity & Inclusion Progress Report												
Quarterly Vacancy Progress Report												
Nursing Establishment Review												
Employment Cases	Q4			Q1			Q2			Q3		
Speaking Up Report	Q4			Q1			Q2			Q3		
Workforce Performance Report	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11
HR Delivery Plan												
Annual Plan												
Succession Planning and Talent Management												
Gender Pay Gap Report												
MEDICAL EDUCATION												
National Student Survey & Action Plan												
NETS Survey Results												
GMC National Training Survey & Action Plan												
Postgraduate Medical and Dental Education Report												
Undergraduate Medical School Report												
TRANSFORMATION												
Transformation Programme Update		Q4			Q1			Q2			Q3	
Delivering Exceptional Care Highlight Report												
Research and Innovation Strategy Refresh												
GOVERNANCE												
Board Assurance Framework	Q4			Q1			Q2			Q3		
Committee Effectiveness												
Assurance Report from Executive Research and Innovation Group												
Assurance Report from Workforce Assurance Group												
Assurance Report from Executive Strategy and Transformation Group												

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	5th May 2021
Report Title:	G6 and FT4 Annual Declaration	**Agenda Item:**	18.
Author:	Claire Rylands, Associate Director of Corporate Governance		
Executive Lead:	Tracy Bullock, Chief Executive		

Purpose of Report:

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

NHS Trusts are required to self-certify that they meet the obligations set out in the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution) and that they have complied with governance requirements.

The enclosed FT4 and G6 declaration fulfils the self-certification obligation for 2020/21 and is presented for approval of the Board.

Background

Although NHS Trusts are exempt from needing the provider licence, directions from the Secretary of State require NHSIE to ensure that NHS Trusts comply with conditions equivalent to the licence as it deems appropriate.

The enclosed submission includes updated narrative for each section of the declaration. Board members are reminded that a response of 'not confirmed' was agreed for the 2019/20 self-certification for the G6 and FT4 (4) elements of the declaration. This was on the basis that the Trust was in financial special measures and had failed to achieve a number of constitutional targets.

Assessment

The Executive Team have considered the attached and recognised that the Trust's financial position has significantly improved when compared to the previous declaration, and the Trust has also exited Financial Special Measures. In addition, one of the 2 section 31 notices has been lifted by the Care Quality Commission. Bearing this in mind, the Board is asked to consider whether it confirms or not with each element of the declaration.

Key Recommendations:

The Board is asked to consider and agree whether the Board confirms, or not, with each element of the self-certification.

Worksheet "FT4 declaration"

Financial Year to which self-certification relates | **2020/21**

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.		The Board's corporate governance framework is set out within the Rules of Procedure, which is reviewed and approved by the Board. This is supported by a number of key policies, for example, Standing Orders, Scheme of Delegation, Standing Financial Instructions, Risk Management Policy and Standards of Business Conduct. Key risks are recorded on the organisation wide risk register in accordance with Trust policy and key strategic risks are reviewed and monitored by the Board and its Committees. During 2020/21, the Trust has continued to implement its strengthend Corporate Governance Structure, including the new Executive Groups, reporting through to Committees, with alignment to the organisations strategic objectives.	OK
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time		A process is in place to ensure that any guidance on good corporate governance issued by regulators, and other national arms lengh bodies, is considered by the Executive Directors. Each week, guidance is shared with relevant Executive and Operational Leads for consideration and action.	OK
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.		As referred to above, the Rules of Procedure set out the Board and Committee structures, responsibilities and reporting lines, along with an independent review being undertaken in year, which led to subsequent changes which were approved by the Board. The Rules of Procedure includes business cycles for the Board and its Committees, which identifies the reporting required by Executive Directors. Each Committee of the Board provides an exception based highlight report, to the Board at each meeting which is presented by the Non-Executive Chair. These reports provide a 2 page summary of items to escalate, key actions, positive assurance and decisions made, along with a summary agenda and attendance matrix. This reporting arrangement has also continued in year, for executive groups reporting into Committees. Clear reporting lines and accountabilities are in place, and these form part of a number of Trust-wide policies and procedures, set out in (1) above. In addition the Trust Board approved the Trust's accountability framework in August 2020.	OK
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.		The Trust's financial position has continued to improve during 2020/21, and as a result the Trust exited Financial Special Measures in October 2020. However, there have continued to be challenges in ensuring the achievement of NHS constitutional targets for Cancer, 4 hour wait and Referral to Treatment, particularly given the impact from the Covid Pandemic. The Trust has developed and is in the process of implementing Planned and Unplanned Care Improvement Programmes to address these challenges, and implementation will continue throughout the course of 2021/22. Assurance is scrutinised by the Performance and Finance Committee and the Trust Board each month through the Integrated Performance Report and more specific reports on progress against these programmes at the Performance and Finance Committee. During the year, the Care Quality Commission removed one of the Trust's 'Section 31' notices following their 2019 inspection; in relation to the care of detained mental health patients. The Trust continues to have a Section 31 notice in relation to the Emergency Department 15 minute triage time. Assurance based action plans continue to be updated and provided to the Care Quality Commission on a weekly basis. Progress against the action plans is scrutinised routinely by the Quality Governance Committee.	OK

5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.		The Chief Nurse and Medical Director jointly hold executive leadership for quality, both of whom are voting members of the Board. In addition, the 2025Vision sets out our key objectives, including the provision of safe, effective, caring and responsive services. This strategic objective is measured via a number of critical success factors covering CQC ratings, reductions in harm arising from falls and pressure ulcers, maintaining mortality rates, infection control measures and PLACE inspection performance. We have a Quality Impact Assessment process in place which provides assurance that the quality of care is not compromised for any financial planning decisions taken. The Annual Business Cycles for the Trust Board and the Quality Governance Committee provide a framework for reporting on all aspects of quality and this includes regular Patient Experience Reports and our Annual Quality Account, which demonstrate the mechanisms by which information from stakeholders and patients on the quality of our services, is taken into account. The Board has continued to enhance its processes for patient engagement through the scheduling of Patient Stories at each Public Board.	OK
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.		All Board members have been subject to a robust recruitment and selection process to ensure that they are suitably qualified both professionally and through experience. An ongoing process is in place to ensure compliance with the Fit and Proper Persons Test, with work undertaken in year to review and strengthen the processes in place. Appointments have been made in year to recruit to the positions of Non-Executive Director, Chief Nurse and Director of Digital Transformation. The Trust is also in the process of commencing recruitment to the substantive post of Medical Director.	OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature **Signature**

Name David Wakefield, Chairman **Name** Tracy Bullock, Chief Executive

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A Please Respond

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates | 2020/21 | Please complete the explanatory information in cell E36

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution. — Please Respond

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. — Please Respond

OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services. — Please Respond

OR

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate. — Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

[e.g. key risks to delivery of CRS, assets or subcontractors required to deliver CRS, etc.]

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	David Wakefield	**Name**	Tracy Bullock
Capacity	Chairman	**Capacity**	Chief Executive
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

Trust Board

2021/22 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 7	May 5	Jun 9	Jul 7	Aug 4	Sep 8	Oct 6	Nov 3	Dec 8	Jan 5	Feb 9	Mar 9	Notes
PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES														
Chief Executives Report	Chief Executive													
Patient Story	Chief Nurse													
Quality Governance Committee Assurance Report	Associate Director of Corporate Governance													
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer													
Care Quality Commission Action Plan	Chief Nurse													
Bi Annual Nurse Staffing Assurance Report	Chief Nurse													
Quality Account	Chief Nurse													
7 Day Services Board Assurance Report	Medical Director													Timing TBC
NHS Resolution Maternity Incentive Scheme	Chief Nurse													Timing TBC
Saving Babies Lives Care Bundle	Chief Nurse													
Continuity of Care Action Plan	Chief Nurse													
Midwifery Staffing	Chief Nurse													
Maternity Family Experience Report	Chief Nurse													
Winter Plan	Chief Operating Officer													
PLACE Inspection Findings and Action Plan	Director of Estates, Facilities & PFI													Timing TBC
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													
Revalidation	Medical Director													
Workforce Disability Equality Report	Director of Human Resources													
Workforce Race Equality Standards Report	Director of Human Resources													
Staff Survey Report	Director of Human Resources													
LEAD STRATEGIC CHANGE WITHIN STAFFORDSHIRE AND BEYOND														
System Working Update	Chief Executive / Director of Strategy													
ENSURE EFFICIENT USE OF RESOURCES														
Performance and Finance Committee Assurance Report	Associate Director of Corporate Governance													
Revenue Business Cases / Capital Investment / Non-Pay Expenditure £1,000,001 and above	Director of Strategy													
IM&T Strategy Progress Report	Director of IM&T		→											Deferred to May due to annual leave
Going Concern	Chief Finance Officer													
Estates Strategy Progress Report	Director of Estates, Facilities & PFI													
Annual Plan 2020/21	Director of Strategy													
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													

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Notes
		7	5	9	7	4	8	6	3	8	5	9	9	
Board Assurance Framework	Associate Director of Corporate Governance		Q4			Q1			Q2			Q3		
Raising Concerns Report	Director of Human Resources		Q4			Q1			Q2			Q3		
Annual Evaluation of the Board and its Committees	Associate Director of Corporate Governance													
Annual Review of the Rules of Procedure	Associate Director of Corporate Governance													
G6 Self-Certification	Chief Executive													
FT4 Self-Certification	Chief Executive													
Board Development Programme	Associate Director of Corporate Governance			→										Seminar topics to be discussed with Executive Team prior to being presented to the Trust Board.