University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 3rd August 2022 at 9.30 am to 12.05 pm
Via Microsoft Teams

AGENDA

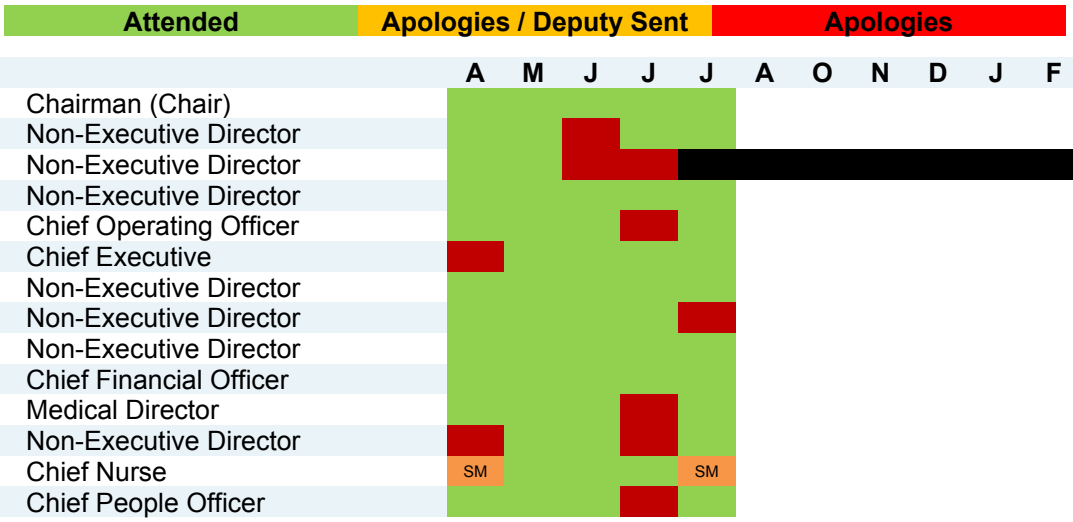
Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
09:30	**PROCEDURAL ITEMS**					
20 mins	**1.**	Staff Story	Information	Mrs R Vaughan	Verbal	
5 mins	**2.**	Chair's Welcome, Apologies and Confirmation of Quoracy	Information	Mr D Wakefield	Verbal	
	3.	Declarations of Interest	Information	Mr D Wakefield	Verbal	
	4.	Minutes of the Meeting held 6th July 2022	Approval	Mr D Wakefield	Enclosure	
	5.	Matters Arising via the Post Meeting Action Log	Assurance	Mr D Wakefield	Enclosure	
15 mins	**6.**	Chief Executive's Report –July 2022	Information	Mrs T Bullock	Enclosure	
10:10		**HIGH QUALITY**				
5 mins	**7.**	Quality Governance Committee Assurance Report (28-07-22)	Assurance	Prof A Hassell	Enclosure	**BAF 1**
10 mins	**8.**	IPC Board Assurance Framework –July 2022	Assurance	Mrs AM Riley	Enclosure	**BAF 1**
10:25		**PEOPLE**				
5 mins	**9.**	Transformation and People Committee Assurance Report (27-07-22)	Assurance	Prof G Crowe	Enclosure	**BAF 2, 3, 4, 6, 9**
10 mins	**10.**	Speaking Up – Board Brief Quarter 1 2022/23	Assurance	Miss C Rylands	Enclosure	**BAF 2**
10:40		**RESOURCES**				
5 mins	**11.**	Performance & Finance Committee Assurance Report (26-07-22)	Assurance	Dr L Griffin	Enclosure	**BAF 5, 7, 8**
10:45 – 11:00: COMFORT BREAK						
11:00		**RESPONSIVE**				
40 mins	**12.**	Integrated Performance Report – Month 3	Assurance	Mrs AM Riley Mr P Bytheway Mrs R Vaughan Mr M Oldham	Enclosure	**BAF 1, 2, 3, 5, 8**
11:40	**GOVERNANCE**					
5 mins	**13.**	Audit Committee Assurance Report (28-07-22)	Assurance	Prof G Crowe	Enclosure	
10 mins	**14.**	Board Assurance Framework Q1	Assurance	Miss C Rylands	Enclosure	
5 mins	**15.**	Board Development Programme	Assurance	Miss C Rylands	Enclosure	
12:00	**CLOSING MATTERS**					
5 mins	**16.**	Review of Meeting Effectiveness and Business Cycle Forward Look	Information	Mr D Wakefield	Enclosure	
	17.	Questions from the Public **Please submit questions in relation to the agenda, by 9.00 am 1st August to** Jason.dutton@uhnm.nhs.uk	Discussion	Mr D Wakefield	Verbal	
12:05	**DATE AND TIME OF NEXT MEETING**					
	18.	**Wednesday 5th October 2022, 9.30 am, via MS Teams** **Please note that the Annual General Meeting is to be held on 7th September 2022, 1.00 pm**				

University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 6th July 2022 at 9.00 am to 11.50 am via MS Teams

MINUTES OF MEETING



Voting Members:		
Mr D Wakefield	DW	Chairman (Chair)
Mr P Akid	PA	Non-Executive Director
Ms S Belfield	SB	Non-Executive Director
Mrs T Bowen	TBo	Non-Executive Director
Mr P Bytheway	PB	Chief Operating Officer
Mrs T Bullock	TB	Chief Executive
Prof G Crowe	GC	Non-Executive Director
Baroness S Gohir	SG	Non-Executive Director
Dr L Griffin	LG	Non-Executive Director
Mr M Oldham	MO	Chief Financial Officer
Dr M Lewis	ML	Medical Director
Prof K Maddock	KM	Non-Executive Director
Mrs AM Riley	AR	Chief Nurse
Mrs R Vaughan	RV	Chief People Officer

Non-Voting Members:		
Ms H Ashley	HA	Director of Strategy
Prof A Hassell	AH	Associate Non-Executive Director
Mrs A Freeman	AF	Director of Digital Transformation
Mrs L Thomson	LT	Director of Communications
Miss C Rylands	CR	Associate Director of Corporate Governance
Mrs L Whitehead	LW	Director of Estates, Facilities & PFI

In Attendance:		
Mrs N Hassall	NH	Deputy Associate Director of Corporate Governance (minutes)
Mr & Mrs Copeland		Patient representative (item 1)
Mr D Copeland		Patient (item 1)
Mr S Malton	SM	Deputy Chief Nurse (representing Mrs Riley)
Mrs L Marrow		Learning Disabilities Nurse (item 1)
Mrs R Pilling		Head of Patient Experience (item 1)

Members of Staff and Public: 5

No.	Agenda Item	Action
PROCEDURAL ITEMS		
1.	**Patient Story**	
109/2022	Mrs Copeland highlighted that her son, Declan, had been diagnosed with Angelman syndrome resulting in him requiring hospital care and support throughout his life and from numerous specialties, sometimes resulting in him becoming anxious. She stated that he was fed via a Percutaneous Endoscopy Gastrostomy (PEG) tube and described an experience whereby he required the PEG to be changed for the first time since having transitioned from paediatric to	

PROUD TO CARE

adult care.

Mrs Copeland described the way in which her son had been well supported previously by the paediatric team, and given the change of his PEG tube was being undertaken in adult care for the first time, she ensured she discussed his requirements with the dietetic team so that they were aware of her son's specific requirements. She explained that on the day of the procedure, her son was moved to an afternoon list despite having previously agreed to a morning list, in order to reduce Declan's anxiousness although this was subsequently moved back to a morning list. It was noted that on arrival to endoscopy, Mrs Marrow was present and Declan was put into a separate area but he had to wait for over 2 hours, which was causing him pain and anxiety which was also affecting other patients in the area.

Mrs Copeland explained that the Sister apologised for the experience, although the surgeon made a comment about the decisions on the order of the lists were the responsibility of the surgeons, and a further comment was made to the family, asking why Declan could not be calmed down. Mrs Copeland had explained to the clinical team that Declan had not been able to eat since 9 pm the previous day to which the clinician suggested feeding Declan although this would result in a further wait. Mrs Copeland explained that a surgeon also explained that they were to sedate Declan for 2 hours although this had not been discussed with the family beforehand, therefore she made the decision to take Declan home. She described the lack of empathy and reasonable adjustments made by the doctors, despite Declan's needs having been previously highlighted and stated that the following appointment to change the PEG was much improved; Mrs Marrow assisted further in ensuring the team were aware of Declan's needs and the change was supported by the paediatric team. Mrs Copeland added that the paediatric anaesthetist held a teaching session during the procedure with other adult anaesthetists in order to share learning which she welcomed.

Mr Wakefield apologised for the experience received.

Dr Lewis referred to principles of practice which must be followed in endoscopy and stated that the story demonstrated that these had not been followed. He referred to the importance of taking a multidisciplinary approach to providing care, as well as the need to link in with the patients, carers and relatives in terms of establishing the specific needs of the patient.

Dr Griffin expressed his disappointment in the treatment provided to Declan, and referred to the issues related to the transition between paediatric and adult care which had been highlighted previously and demonstrated that improvements were required. He welcomed the sharing of learning from the anaesthetists which he would welcome being shared more widely.

Professor Maddock referred to the move from paediatric to adult care and she queried whether Mrs Copeland felt a longer transition would be beneficial. Mrs Copeland stated that she would welcome a longer transition as it would help to reduce Declan's anxiety.

Mr Wakefield commented on the importance of identifying what went wrong in the care provided, in particular the lack of empathy described. Mr Wakefield thanked Mrs Marrow for her involvement and he also welcomed the involvement of paediatrics in subsequently undertaking the change of the PEG tube.

Mrs Copeland referred to the hospital passport which could work well if adhered to in particular when there was a cross-over from paediatrics to adult care, as the

	most vital information was included within the passport. Mrs Marrow referred to the way in which she had continued to raise awareness of the hospital passport and stated that the failings in the family's experience was due to a breakdown in communication, as although she had offered to support the endoscopy team this was declined. She stated that her involvement in the provision of care for the subsequent appointment demonstrated the importance of taking into account individual needs and how this could be successfully managed. Mrs Marrow highlighted that Dr Catherine Stewart had been instrumental in sharing learning which she welcomed. Mr Wakefield thanked Mr and Mrs Copeland and Declan for attending and sharing their story. The Trust Board noted the patient story. Mr and Mrs Copeland, Mr Copeland, Mrs Pilling and Mrs Marrow left the meeting.	
2.	**Chair's Welcome, Apologies and Confirmation of Quoracy**	
110/2022	Mr Wakefield welcomed members to the meeting and confirmed that the meeting was quorate. Mr Wakefield apologised for the short notice in moving the meeting back to Microsoft Teams, but explained that given the increase in cases of covid in the community, within the executive team and a rise nationally, a decision had been made to continue to hold meetings via Microsoft Teams for the foreseeable, in order to reduce the risk.	
3.	**Declarations of Interest**	
111/2022	There were no declarations of interest raised.	
4.	**Minutes of the Previous Meeting held 8th & 20th June 2022**	
112/2022	The minutes of the meeting from 8th June 2022 were approved as an accurate record, with the exception of an amendment to page 2, changing the reference to *receiving* treatment to *witnessed*. The minutes from the extraordinary meeting held on 20th June 2022 were approved as an accurate record.	
5.	**Matters Arising from the Post Meeting Action Log**	
113/2022	PTB/524 – It was agreed to discuss the new Covid guidance as part of the IPC BAF discussion. PTB/528 – Mr Wakefield queried if the analysis of pressure ulcers was on track to be provided to the Quality Governance Committee (QGC) in July to which Mr Malton confirmed.	

6.	**Chief Executive's Report – June 2022**	
114/2022	Mrs Bullock highlighted a number of areas from her report. Professor Hassell congratulated the Estates Team on the planning approval received for the new car park and he referred to the Surgical teams providing food packages for those in hardship when discharged and queried if this was to be considered more widely. Mrs Bullock stated that this was considered in general as part of discharge planning, although the Surgical Division had gone above and beyond. Dr Griffin queried if the increase in covid cases could result in cancellation of electives and Mrs Bullock stated that there had been an increase in staff absence within theatres which was resulting in the cancellation of some electives. Mr Akid referred to the possibility of a flu epidemic following the experience in Australia and queried whether this was being planned for. Mrs Bullock stated that the Trust was expecting an influx of flu cases and the vaccination was yet to be determined nationally, as this was based on previous strains. She stated that separate flu and covid booster vaccinations would need to be provided. Dr Griffin referred to the successful bid of £500,000 made to NHS Charities Together, in relation to tackling loneliness and social isolation in partnership with community and voluntary groups and also paid thanks to Barlaston Golf Club for hosting a recent charity Corporate Golf Day. Professor Crowe referred to the commencement of the ICB and queried how the Trust Board were to receive strategic updates as well as considering performance at a system level going forwards. He also queried what work was ongoing at a system level to address urgent care pressures. Mrs Bullock highlighted that updates were regularly provided within the Chief Executives report, in addition to updates at the Closed Board meetings, regular updates at Executive Team meetings and consideration at Board Seminars. She stated that in terms of system support to tackle urgent care, several calls were held during the day, as a system, to discuss and consider the approach to tackling non-elective pressures. It was agreed to consider how the Board were to receive assurance from the system Urgent and Emergency Care Board. **The Trust Board received and noted the report and approved EREAFs 9363, 9355, 9212, 8847 and 9440.**	**PB**
HIGH QUALITY		
7.	**Quality Governance Committee Assurance Report (30-06-22)**	
115/2022	Professor Hassell highlighted the following: • A cyber security risk in relation to the Pharmacy EMIS system had been highlighted, whereby the proposed solution had failed and was being considered further by the Executive • The Committee welcomed the work of the Medical Examiner's office which was scrutinising coroners cases in order to ensure no delays in sharing any learning • Specialist input had been requested, in relation to paediatric sepsis screening to establish why performance was lower than the target • The Committee had agreed to review all covid deaths to identify any learning,	

	given it was the most robust methodology to follow **The Trust Board received and noted the assurance report.**	
8.	**Infection Prevention and Control (IPC) Board Assurance Framework (BAF) – June 2022**	
116/2022	Mr Malton highlighted the following: • The document had been updated and focussed on the processes and pathways being followed in line with national / UHNM guidance • An adjustment had recently been made in relation to the increasing number of covid cases, resulting in a risk assessed decision being made to reintroduce face masks in all areas, for an initial period of 2 weeks. He stated as PCR testing of admitted patients had continued, this had enacted a trigger due to the number of patients with covid on admission having increased. • It was noted that a number of other actions could be taken, should any further triggers be enacted, such as changes to visiting etc Ms Bowen queried what the Trust was doing differently to national recommendations and Mr Malton explained that the Trust was better able to predict at local level what was required as a result of changes in numbers of cases etc, prior to receiving national direction, which enabled local actions to be taken immediately. He stated that this approach had been taken by other Trusts in addition to being agreed with NHSEI. Professor Hassell queried the approach to patient testing and Mr Malton stated that patients on a surgery pathway were continuing with lateral flow tests, and PCR testing had continued for admitted patients, although national guidance was that lateral flow tests could be undertaken. **The Trust Board received and noted the updated IPC BAF.**	
9.	**Care Quality Commission Action Plan**	
117/2022	Mr Malton highlighted the following: • Of the 9 must do actions, the majority of the associated individual actions were on track for completion, with the exception of 2 which had been identified as problematic and these had been subject to confirm and challenge by the CQC Working Group • In addition, the majority of individual actions associated with the 19 should do actions were on track for completion **The Trust Board received and noted the action plan.**	
PEOPLE		
10.	**Transformation and People Committee Assurance Report (29-06-22)**	
118/2022	Professor Crowe highlighted that a shorter meeting was held with a focus on a deep dive into organisational culture which worked well and enabled a productive discussion on making the Trust a great place to work. Whilst the Trust was optimistic of the improvement plan, there was some concern around the delivery of the actions, availability of resource and capacity of staff, given that operational pressures could be an impact. It was noted that the Committee were encouraged by the heat map being produced, which would demonstrate the various key	

	performance indicators, enabling the Committee to effectively monitor progress. Ms Bowen welcomed the provision of a cultural heat map and queried whether this would be mapped by Division or themed. Mrs Vaughan stated that it was still being developed but the intent would be to consider on a divisional basis although themes would also be considered, such as staff engagement. Ms Ashley stated that she anticipated more deep dives being provided to Committees, in relation to the strategic initiatives, given the value in doing so. **The Trust Board received and noted the assurance report.**	
RESOURCES		
11.	**Performance and Finance Committee Assurance Report (28-06-22)**	
119/2022	Dr Griffin highlighted the following: • The Committee received a deep dive into Planned Care which was useful and identified some bold trajectories for improvement • Particular performance challenges were highlighted in relation to Colorectal and Pathology • The Trust had met the 104 week target for June, with a small number outstanding due to the complexity of their condition as well as patient choice • An update on the investment in the Emergency Department workforce was provided which demonstrated that whilst overall improvements had not yet been realised, there were a number of 'green shoots' • The Committee considered how it could receive benchmarking in the future and it was noted that the new reporting arrangements would assist with this • The approvals made by the Committee were highlighted in addition to the submission of the of the financial plan, noting the particular risks to delivery, as a result of the cost improvement plan **The Trust Board received and noted the assurance report.**	
RESPONSIVE		
12.	**Integrated Performance Report – Month 2**	
120/2022	Mr Malton highlighted the following areas of concern: • Falls had continued to be challenged, mostly within the emergency portals and some environmental work had been undertaken to remove doors which had been put in place due to covid, resulting in some initial improvement in reducing falls in month. Targeted work was continuing to be undertaken, which was being supported corporately, in terms of education of new staff • In terms of pressure ulcers, the first pressure ulcer champion conference was being held which aimed at triangulating the learning from deep dives. In addition, the work to recognise pressure ulcers earlier had continued as well as making investments in equipment • Some issues had been identified in terms of how data was collected for sepsis screening, in particular due to this being point prevalence, although the process was being worked through and reviewed in order to determine how a better view of sepsis across the organisation could be established. It was noted that any missed cases were being reviewed so that any levels of harm experienced as a result could be identified	

	Mr Wakefield queried if there was a direct link between the number of pressure ulcers and number of stranded / medically fit for discharge patients to which Mr Malton stated that the patients were usually the most at risk but it was difficult to determine any correlation.	
	Mr Wakefield referred to number of nosocomial infections in May and queried the latest data for June; Mr Malton agreed to confirm this.	**SM**
	Mr Bytheway highlighted that in terms of operational performance, the change in the primary care model and the transferring of patients direct to specialties was starting to result in an improvement in performance. Professor Maddock queried the metrics in place to determine the improvements as a result of the change in working and Mr Bytheway stated that this had resulted in reducing overcrowding and improvement in flow, resulting in a reduced number of ambulance holds, fewer 12 hour waits and improved time to triage.	
	Mr Wakefield stated that while flow had improved, overall performance had not improved and queried why a change had not been seen. Mr Bytheway stated that reducing the overall time in the department should ultimately provide an improvement in performance.	
	Mr Bytheway highlighted the following in relation to cancer performance: • Pathology, colorectal, breast and skin specialties remained challenged • An improvement was expected within the next 2 weeks in relation to the 62 day target for breast and pathology specialties, although colorectal and skin specialties would continue to be challenged • The overall number of cancer treatments had increased and activity and theatre utilisation was on an upward trend	
	Ms Bowen referred to staffing challenges and queried whether the Trust was confident in there being an improvement in performance. Mr Bytheway highlighted that he anticipated improvements due to the plans being put in place.	
	Mr Bytheway referred to the referral to treatment targets, whereby there had been an improvement as well as a reduction in the number of P2 patients and a reduction in 104 week waits, which had reduced to under 40, due to patient choice and the complexity of patients. In addition, the 78 week trajectory numbers continued to reduce.	
	Mr Wakefield referred to the ethnicity and deprivation charts included and stated that he felt these were difficult to interpret. Ms Ashley explained that the data was used for national planning purposes and whilst the accuracy of the deprivation data had been confirmed, the ethnicity data was caveated due to there being some issues with data recording. She stated that the aim of the charts was to demonstrate that patients from different backgrounds were not being negatively impacted by waits. Mr Wakefield requested further clarification and interpretation of the charts after the meeting.	**HA/PB**
	Mr Bytheway stated that in terms of diagnostics, outsourcing was taking place to support ultrasound delivery and additional MRI / CT capacity had been agreed in order to support recovery of the DM01 target.	
	Mr Wakefield referred to page 57 of the pack and the reference to an increase in non-obstetric ultrasound of 1.9% in month and Mr Bytheway agreed this was incorrect and he would amend. Mr Bytheway stated that in terms of recruiting to vacancies, this had particularly improved whereby 4 additional Consultants had	**PB**

	been recruited to support histology. Mrs Vaughan highlighted the following: • There had continued to be fluctuations in covid related absence which was currently at 34% • The profile of turnover and vacancies had increased which was being mitigated by bank and agency usage Mr Wakefield queried what mitigation was being put in place to address the anticipated workforce challenges due to the expected flu cases and further increase in covid cases and it was agreed to provide further feedback to Non-Executive Directors on the workforce planning being undertaken for winter. Mr Oldham highlighted the following: • The report demonstrated performance against the plan submitted for 2022/23 but as this had since been resubmitted on 20th June, Month 3 would report against that plan • In month the Trust reported a deficit of £3.2 m which was £4.4 m behind plan, mainly driven by the cost improvement programme (CIP) which continued to be highlighted as a risk, as well as a gap in the specialised commissioning contract and an element of elective recovery fund spend which needed to be re-profiled • The Trust demonstrated an underlying pay run rate which was in line with expectations • A break even plan had been submitted but significant risks had been identified given some of the planning assumptions made which were based on regional / national instruction. These related to covid costs being likely to continue, inflation and the instruction of not to increase costs, pay inflation of 2% being included within the plan and a further 1% covered nationally but it was not clear how any further increases would be funded • A revised forecast was to be undertaken in month 3 as well as reviewing provisions Mr Akid referred to the previous Project Management Office which was in place to help with specific CIP projects and given the risk, whether the team would be reintroduced. Mr Oldham stated that the office remained in place and would lead on driving programmes forward, but the main challenge related to the management capacity to identify the schemes. He stated that the situation was not unique to the Trust and CIP delivery had been escalated as driver metric so that this could be tracked with Divisions. Ms Ashley explained that the team had previously been deployed into other areas during the pandemic and had returned to focusing on assisting with CIP delivery. Mr Oldham referred to the revised capital plan which had been submitted as part of revised financial plan. He stated that positively the Trust had resolved the issue in relation to car parking funding, and also the inflationary issues for car parking and Trent had been addressed, although there were some risks to cash flow in year 2 and 3 which would need further consideration. **The Trust Board received and noted the report.**	**RV**
CLOSING MATTERS		
13.	**Review of Meeting Effectiveness and Business Cycle Forward Look**	
121/2022	No further comments were provided.	

14.	**Questions from the Public**	
122/2022	No questions from the public were provided.	
DATE AND TIME OF NEXT MEETING		
15.	Wednesday 3rd August 2022, 9.30 am, via MS Teams	

Trust Board (Open)

Post meeting action log as at **27 July 2022**

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

Ref	Meeting Date	Agenda Item	Action	Assigned to	Due Date	Done Date	Progress Report	RAG Status
PTB/513	09/03/2022	CQC Action Plan	To consider and establish a way of highlighting the performance metrics associated with the action plan going forwards within the IPR	Scott Malton Ann Marie Riley	05/10/2022		To be added into the next quarterly CQC update - due date moved.	GB
PTB/514	09/03/2022	CQC Action Plan	To update the action plan and expand on the points raised in terms of measures of implementation and delivery and provide future updates on a quarterly basis.	Scott Malton Ann Marie Riley	05/10/2022		To be added into the next quarterly CQC update - due date moved.	GA
PTB/528	04/05/2022	Integrated Performance Report – Month 12	To provide additional analysis of pressure ulcers to QGC including age profile.	Ann Marie Riley	28/07/2022		Verbal update to be provided July's QGC meeting.	GB
PTB/533	08/06/2022	Quality Strategy	To identify a time for further discussion with the Non-Executive Directors of the resourcing of the Improving Together team.	Ann-Marie Riley	31/07/2022		**Update to be provided**	GB
PTB/534	08/06/2022	IPC BAF May 22	To provide an update on ventilation system technology at a future Non-Executive Director meeting, and establishing any limitations.	Ann-Marie Riley	31/07/2022		**Update to be provided**	GB
PTB/546	08/06/2022	Integrated Performance Report - Month 1	To take an update to a future QGC meeting regarding measuring the impact on patients who had not received appropriate sepsis screening within the Emergency Department	Ann-Marie Riley	31/07/2022		**Update to be provided**	GB
PTB/547	08/06/2022	Integrated Performance Report - Month 1	To discuss the risk and mitigation associated with the Cost Improvement Programme at a future PAF meeting	Mark Oldham	31/07/2022		**Update to be provided**	GB
PTB/548	08/06/2022	Annual Evaluation of Committee Effectiveness & Rules of Procedure	To provide a summary of changes to the Code of Governance at a future Audit Committee	Claire Rylands	TBC		Action not yet due.	GB
PTB/550	08/06/2022	Review of Meeting Effectiveness	To work with Mrs Bullock and Ms Ashley regarding a regular update to the Board on system working.	Claire Rylands	07/09/2022		Conversation held with Mr Wakefield and to be considered further.	GA
PTB/552	06/07/2022	Chief Executives Report - June 2022	To consider how the Board could receive assurance from the system Urgent and Emergency Care Board.	Paul Bytheway	07/09/2022		Action not yet due.	GB
PTB/553	06/07/2022	Integrated Performance Report – Month 2	To confirm the number of nosocomial infections in June to Mr Wakefield.	Scott Malton Ann Marie Riley	03/08/2022		**Update to be provided**	GB
PTB/554	06/07/2022	Integrated Performance Report – Month 2	To provide further clarification to Mr Wakefield of the interpretation of the ethnicity and deprivation charts	Helen Ashley Paul Bytheway	03/08/2022		**Update to be provided**	GB
PTB/555	06/07/2022	Integrated Performance Report – Month 2	To update the table on page 58 in relation to non-obstetric ultrasound increase in %	Paul Bytheway	03/08/2022		**Update to be provided**	GB
PTB/556	06/07/2022	Integrated Performance Report – Month 2	To provide further feedback to Non-Executive Directors on the workforce planning being undertaken for winter.	Ro Vaughan	07/09/2022		Action not yet due	GB

Chief Executive's Report to the Trust Board

FOR INFORMATION

Part 1: Trust Executive Committee

The Trust Executive Committee met virtually on the 20th July 2022.

Executive Directors gave the following key updates:

- Recognition of the very difficult circumstances that staff had worked within during the Heat Wave with note that there had been some lessons learned with regard to infrastructure which would feed into the Heat Plan
- Details of the pay award which had been communicated nationally
- Recent increase in mileage allowance for staff in view of the rising fuel costs
- Discussions with Staff Side regarding the reintroduction of car parking charges
- Support for staff who are suffering financial hardship, including a system wide financial wellbeing toolkit
- Financial performance is off track at Month 3, work is underway to develop cost improvement plans as this is linked to the ability to invest
- Some difficult actions had been taken during the Heat Wave and discussions were underway around longer term sustainability
- Standards for referral and treatment of patients were in place although further work was needed to ensure it is embedded
- Two Deputy Medical Directors had been appointed; Dr Mark Poulson and Dr Zia Din
- 5 clinical leads were being appointed for the County Hospital Programme – interviews were being held
- An advert was due to be issued for the Deputy Chief Nurse position
- A review of the Royal Stoke Site from an estates perspective had been completed and would be shared
- Project STAR projects were now progressing at pace
- The Communications Team were visiting wards and departments to take a number of photographs in order to develop a central stock which is compliant; these would be used for the recruitment campaign
- Care Quality Commission had launched new Quality Statements which would replace the previous Key Lines of Enquiry – further details would be shared when they become available
- Progress with procurement of a single network service across Royal Stoke and County Hospital
- Opportunity to expedite a new electronic patient record

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

- Surgical Division raised ongoing challenges with regard to staff absence, how staff including theatres had coped during the Heat Wave, positive feedback following recent cancer peer reviews, improvements seen with regard to waiting times, challenges associated with the surgical emergency portal and plans to implement digital records within anaesthetics

- CWD raised significant pressures being seen within Maternity, key headlines of the Birth Rate Plus report, risks associated with workforce capacity for which a number of business cases had been developed, latest performance with regard to waiting lists, transfers of service following the reorganisation or Divisions, action plans associated with 'hotspot areas' identified through the culture review, development of cost improvement plans, training and adoption of Improving Together tools and staff recognition at regional / national level

- Network Services Division referred to work being undertaken following the restructure and engagement sessions being planned to welcome Oncology and Haematology into the Division, plans were also developed for Critical Care Services, risks associated with Trauma Care and actions taken which were anticipated to impact on waiting times, challenges with recruitment processes associated with winter planning and appointment to Heads of Nursing as part of the new structure and a new Clinical Lead for Orthopaedics

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 14th June to 12th July, xx contract awards, which met these criteria, were made, as follows:

- **County Modular Theatre** supplied by Portakabin, at a total cost of £2,078,341.76, approved on 06/07/22
- **Grindley Hill Multi Storey Car Park** supplied by IHP Vinci Construction, at a total cost of £32,975,157.45, approved on 06/07/22
- **Provision of Car Park Management** supplied by APCOA, for the period 01/08/22 - 31/07/24, at a total cost of £1,559,494.40, approved on 06/07/22
- **Supply of Instrumentation for the Da Vinci XI Robot** supplied by Intuitive Surgical, for the period 26/04/22 - 25/04/23, at a total cost of £648,711.84, providing savings of £16,055.62, approved on 29/06/22
- **Haemodialysis Consumables** supplied by various, for the period 01/07/22 - 30/06/23, at a total cost of £840,000.00, providing savings of £6,118, approved on 29/06/22
- **ELFS Shared Finance Systems** supplied by ELFS Shared Services, for the period 01/11/22 - 31/10/27, at a total cost of £2,708,676.00, approved on 06/07/22
- **Lease of an MRI Mobile** supplied by Fairford Medical, for the period 19/06/22 - 31/03/23, at a total cost of £665,160.00, approved on 14/06/22
- **Agency Nursing Master Vendor Contract** supplied by Day Webster, for the period 01/10/22 - 30/09/23, at a total cost of £35,603,419.00, approved on 06/07/22

In addition, the following eREAFs were approved at the Performance and Finance Committee on 26th July 2022, and also require Trust Board approval due to their value:

Pharmacy Wholesale Agreement (eREAF 9582)

Contract Value	£30,296,652.60 incl. VAT
Duration	01/07/22 – 30/06/24
Supplier	Various

CRM - Pacemakers (Low Power) (eREAF 9629)

Contract Value	£2,552,320.19 incl. VAT
Duration	01//09/22 - 31/08/25
Supplier	Various

The Trust Board is asked to approve the above eREAFs.

2. Consultant Appointments – July 2022

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

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Specialist Doctor in Anaesthesia	New	Yes	01/08/2022
Locum Stroke Consultant	New	Yes	08/08/2022
Consultant Paediatrician - Intensive Care	Vacancy	Yes	TBC
Consultant Paediatrician - Intensive Care	Vacancy	Yes	TBC
Consultant in Infectious Diseases/ Acute Medicine	New	Yes	19/09/2022
Locum Consultant Oncologist	Vacancy	Yes	TBC
Locum Consultant in Diabetes & Endocrinology / General Medicine	New	Yes	TBC
Specialist Doctor in Breast Radiology	New	Yes	TBC
Specialist Doctor in Microbiology	New	Yes	05/12/2022
Locum Consultant Neonatologist	Vacancy	No	n/a

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

Post Title	Reason for advertising	Start Date
Locum Stroke Consultant	Extension	01/07/2022
Locum Consultant Spinal Surgeon	Extension	01/07/2022
Consultant Colorectal Surgeon	Vacancy	01/07/2022
Locum Consultant Breast Radiologist	Extension	05/07/2022
Acute Medicine Specialist Grade	New	13/07/2022
Locum Consultant General Surgeon - Upper GI (HPB) Surgery	Vacancy	18/07/2022
Locum Consultant Cardiothoracic Anaesthetist	New	06/07/2022
Consultant Histopathologist	Vacancy	01/07/2022

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

Post Title	Closing Date	Note
Consultant Neurologist	13/07/2022	No suitable applicants
Consultant in Acute Medicine	14/07/2022	No Applications
Consultant Clinical Oncologist - Lung and Urology	05/06/2022	Applicant not suitable
Consultant Obstetrician with an Interest in Maternal / Fetal Medicine	23/06/2022	No applications

3. Internal Medical Management Appointments – July 2022

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

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Clinical Lead for Major Trauma	Vacancy	Unknown	TBC
Associate Medical Director for Postgraduate Medical & Dental Education	Vacancy	Yes	01/08/2022
Clinical Workstream Leads	New	Yes	TBC
Clinical Lead for Orthopaedics	Vacancy	Unknown	TBC

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

Post Title	Reason for advertising	Start Date
N/A	N/A	N/A

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

Post Title	Closing Date	Note
N/A	N/A	N/A

4. Covid 19 and Trust Pressures

Following my last Board meeting update noting the significant increase in Covid-19 positive patients in the Trust I can confirm the current number of Covid-19 positive patients is now stabilising, as at 27th July 2022 there were 206 patients Covid-19 positive within UHNM. Whilst stable and very slowly reducing, this number is high and is impacting on operational flow through the Hospitals, cancellation of elective procedures and increased staff absence, which in turn has continued to impact on ambulance waiting times at the hospital.

The pressures during July were further compounded by the hot weather and in particular the extreme heat experienced on the 18th and 19th July. It is anticipated that further extreme hot weather will be seen in August and given the on-going global warming, we are likely to see future such extremes of weather. Our EPRR team are collating information from the recent events to ascertain the impact on infrastructure, services, patients and staff with a view to collating the learning and what we can do to better prepare for future events.

5. A Night Full of Stars (Staff Awards)

At the beginning of the month we launched our nomination process for our annual Staff Awards – A Night Full of Stars. The annual awards night is always a highlight in our calendar and a real opportunity to recognise and celebrate individuals and teams who have gone above and beyond to support our patients and each other. As usual we have a number of award categories and have sought submissions which demonstrate behaviours which align with our Trust Values. This year we are hoping to be able to hold a face to face celebration in November.

6. Mental Health & Learning Disabilities Conference

As well as supporting our staff, my main priority is ensuring our patients and families are given the highest quality care and treatment and it was therefore great to hear more about what we are doing for our patients at our very first Mental Health and Learning Disabilities Conference. I am grateful to Kirsty Smith, our nurse lead in this area, for organising the event and attracting such a high calibre of guest speakers including para-canoeist Ian Marsden who is from Stoke and a supporter of our hospitals. He gave an inspirational story about overcoming his physical disabilities to achieve Olympic success and myself, together with other delegates thoroughly enjoyed it. I am also grateful to the staff who prioritised attending this conference.

7. International Nurses

During the month I was able to get out and about to welcome the latest cohort of international nurses to work in our hospitals. It is great that this scheme has developed and become the success it has. Our first cohort are now very well settled and it is wonderful to see how they are developing careers and bringing new skills and enthusiasm to our wards and who can now share this with the latest recruits.

8. Divisional Operational Management Structure

After working closely with our divisions, we have now announced the revised divisional operational management structure. Specialised Division will now be known as Division of Network Services and our Children's, Women's and Diagnostics Division will be called Children's Women's and Support Services. There will be some moves of directorates, namely oncology and haematology which will move to Network Services; neonatal into maternity instead of child health and the North Midlands and Cheshire Pathology Service will be a division in its own right.

This comes with changes to the job titles of those in management roles but most importantly it further clarifies roles and responsibilities. It will take a period of time for all the changes to be embedded but the new structures are now in place.

9. Memorandum of Understanding with Shrewsbury and Telford NHS Trust (SATH)

We have developed and agreed a Memorandum of Understanding (MoU) with our partners at SaTH, which whilst not legally binding, summarises the expectations of collaborative working between us. The MoU sets out our joint working arrangements / Service Level Agreements, which are broken down by clinical speciality, alongside other development opportunities to be explored. The MoU also includes our governance arrangements for the Provider Leadership Board, whose function will ensure we align with NHS mandated expectations and key objectives for Provider Collaboratives.

We will monitor the MoU through the Executive Team.

10. NHS 74th Birthday Celebrations

This month saw another milestone in the history of the NHS as we celebrated its 74th birthday. After all we have been through during the last two years plus it was an opportunity to reflect and celebrate some of our fantastic achievements through the most challenging times but also an opportunity to eat lots of cake! I was delighted to join fellow executives to judge the UHNM Charity Bake Off and it was a delicious treat to be able to taste first-hand the winning offering at Royal Stoke whilst also being disappointed that I wasn't able to sample the very creative cakes at County Hospital. I know from Ro that they were as delicious as they looked. I am absolutely amazed at the hidden baking talent of so many of our staff on both sites and would like to thank everyone for getting into the spirit to raise money for our charity.

11. The George Cross

Thank you isn't enough when staff are going through yet another surge and coping with temperatures we have never experienced before in the NHS but seems apt that this month NHS England Chief Nurse picked up the George Cross on behalf of all staff who work in the NHS and have worked during the pandemic.

The George Cross, the highest civilian award for gallantry, recognises the incredible dedication, courage, compassion and skill shown by NHS staff – from nurses and doctors to porters, cleaners, therapists and countless other roles – particularly in the face of the Covid pandemic.

12. Orbeye

I was delighted to attend the launch event of a state-of-art piece of kit which we have been able to purchase thanks to the generosity of the Denise Coates Foundation to UHNM Charity. The Orbeye gives neurosurgeons 3D views of the brain and spine during surgery and will also allow others in the theatre to fully observe the procedure. It is an amazing robot and we are thrilled to be one of only four Trusts in the UK to have one to benefit our population.

13. BBC Radio Stoke Interview / HealthWatch

I recently did an interview with BBC Stoke Radio which covered a number of areas following a story and numerous call ins from relatives in relation to rules for visiting being unclear or mixed with relatives being denied visiting, some were concerned about the care of their relatives with dementia and 'do not attempt resuscitation' orders. Whilst on air we also had callers ringing to share their positive experience and appreciation but it does remind me that the small acts of kindness really to matter.

On the back of this, I was approached by the Chief Executive of Healthwatch, who had been listening to the interview and he has offered for Healthwatch to conduct a survey with our elderly patients and their families to help us understand their experiences further and take steps to improve their time in our hospitals. I very much welcome this and we will be welcoming Healthwatch in the near future.

14. Civility and Respect

Our Cultural Improvement Programme has now been approved and implementation of a range of cultural improvement activities is now underway. As part of this work, we are working with a number of teams to deliver a programme which focuses on Civility and Respect, supported by an independent external medical expert and it has been pleasing to see the levels of engagement with this approach.

We will be reporting on progress with our Improvement Programme through the Transformation and People Committee.

Quality Governance Committee Chair's Highlight Report to Board

28th July 2022

University Hospitals of North Midlands NHS Trust

1. Highlight Report

!	Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
	• The PLACE score for Privacy Dignity and Wellbeing for the Royal Stoke Site is lower than the County Hospital – the main reason for this was around more artwork being displayed at the County Hospital Site • The number of Platinum scored wards has decreased in the most recent round of Care Excellence Framework visits although this is a reflection of an enhanced, more rigorous approach • In our latest mortality data, SHMI has seen a slight increase (102.91 compared to 102.57) which is just over the national average of 100.65 although remains within 'expected ranges • A number of quality standards were not achieved during June 2022 including ED Friends and Family, falls rate per 1000 bed days, pressure ulcers with lapses in care, duty of candour, never events, C Difficile and sepsis screening (detail to be reported separately to the Board via the IPR) • A visit from the Health and Safety Executive took place recently to gather further information relating to an incident which had occurred within the Laboratory; the outcome of this visit is yet to be received and will be reported through our governance arrangements accordingly	• Full PLACE inspection to be undertaken towards the end of 2022; future reports to include further detail in terms of areas visited in order that support can be obtained from the Charity for any improvements relating to patient experience, reports will also detail any actions arising from the visit • NHSE have issued some new Infection Prevention and Control (IPC) guidance which will be reflected in the next version of the IPC Board Assurance Framework • 35 Care Excellence Framework (CEF) visits were undertaken during • Findings of CEF visits to be shown in a Heat Map so that it can be used as a visual management tool, similar to those produced for Freedom to Speak Up / Cultural Improvement • A review of how Platinum scored wards / departments are recognised and celebrated is being undertaken, linked to our Cultural Improvement Programme • Further work to be done on the Mortality Report to ensure a greater balance in terms of areas which require improvement • More quality indicators to be added to the Quality Dashboard, working in conjunction with the Quality Improvement Academy • Deep Dive into pressure ulcer care has been undertaken and will be presented to the next meeting • A new approach to the Friends and Family test is being developed with a view to improve feedback levels although our performance compared with peers is also going to be reviewed • The implementation date for the Patient Safety Investigation and Reporting Framework has been delayed nationally to September 2023 rather than April 2023 (action within the BAF)
✓	**Positive Assurances to Provide**	**Decisions Made**
	• PLACE-light exercise findings concluded that overall the Trust remains above the national average (which was reported in 2019) • There were no wards identified as Bronze following the most recent Care Excellence Framework Visits • HSMR remains below the national average • The outcomes from completed Structured Judgement Reviews demonstrate that the vast majority of reviews are assessed as 'good care' • Assurance was given that a more granular speciality level of mortality data is considered by the Mortality Review Group so that opportunities for improvement can be identified • A number of quality standards were achieved during June 2022 including Inpatient and Maternity Friends and Family, Harm Free Care, HSMR, VTE risk assessment completion, MRSA bacteraemia, category 4 pressure ulcers resulting in lapses in care and sepsis screening	• Approval of the Board Assurance Framework
	Comments on the Effectiveness of the Meeting	

- Agreed that whilst it was a slimmed down meeting, discussion had been very useful around items that would not usually get as much air time
- Noted that a number of items had now been deferred to the

2. Summary Agenda

No.	Agenda Item	BAF Mapping		Purpose	No.	Agenda Item	BAF Mapping		Purpose
		BAF No.	Risk				BAF No.	Risk	
1.	UHNM PLACE Lite 2021	**BAF 7**		Assurance	4.	Mortality Assurance Report Q1 2022/23	**BAF 1**		Assurance
2.	Infection Prevention Board Assurance Framework Q1 2022/23	**BAF 1**		Assurance	5.	M3 Quality & Safety Report • Sepsis Screening in Children Update • Additional analysis of pressure ulcers *(Trust Board Action PTB/528)*	**BAF 1**		Assurance
3.	Care Excellence Framework (CEF) Summary	**BAF 1**		Assurance	6.	Board Assurance Framework Q1 2022/23	-		Approval

3. 2022 / 23 Attendance Matrix

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

Executive Summary

Meeting:	Trust Board	**Date:**	3rd August 2022
Report Title:	Infection Prevention Board Assurance Framework	**Agenda Item:**	8.
Author:	Helen Bucior, Infection Prevention Lead Nurse		
Executive Lead:	Mrs Ann-Marie Riley, Chief Nurse/DIPC		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

	Identified throughout the document.	

Executive Summary:

Situation

To update the Committee on the self-assessment compliance with UKHSA and NHSEi regional COVID guidance

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.

Previous versions of the IP BAF are attached and shaded grey

Assessment/risks

- IP next steps letter - Universal wearing of masks in clinical areas continues. Masks in non- clinical areas reintroduced during July due to COVID wave
- Risk assessment undertaken to support deviating from national guidance. This approach has been supported by a recent document (Midlands Regional IPC principles) released by NHSE/I
- Visiting for patients has been increased to 2 visitors for each patient 2-4 pm, 6-8 pm. The 2 visits for the majority of cases do not need to be the same visitors

<u>Progress</u>

- External company continues to assist with mask fit testing
- Discussion and agreement with NHSEI the dismantling of beds to the level undertaken during the CPE would be considered during planned deep cleans/ ward refurbishments and continue with standard and terminal clean process as usual.
- Estates and IP are exploring the use of air scrubber technology
- May 2022 UV air system on trial ward 225 and business case in progress
- Monkey pox UK outbreak UHNM response in place

- Updated regional guidance published end of July 2022 – these will be reviewed and any changes reflected in next version of BAF

Key Recommendations:

Trust Board are asked to note the document for information, and note the on-going work to strengthen the assurance framework going forward.

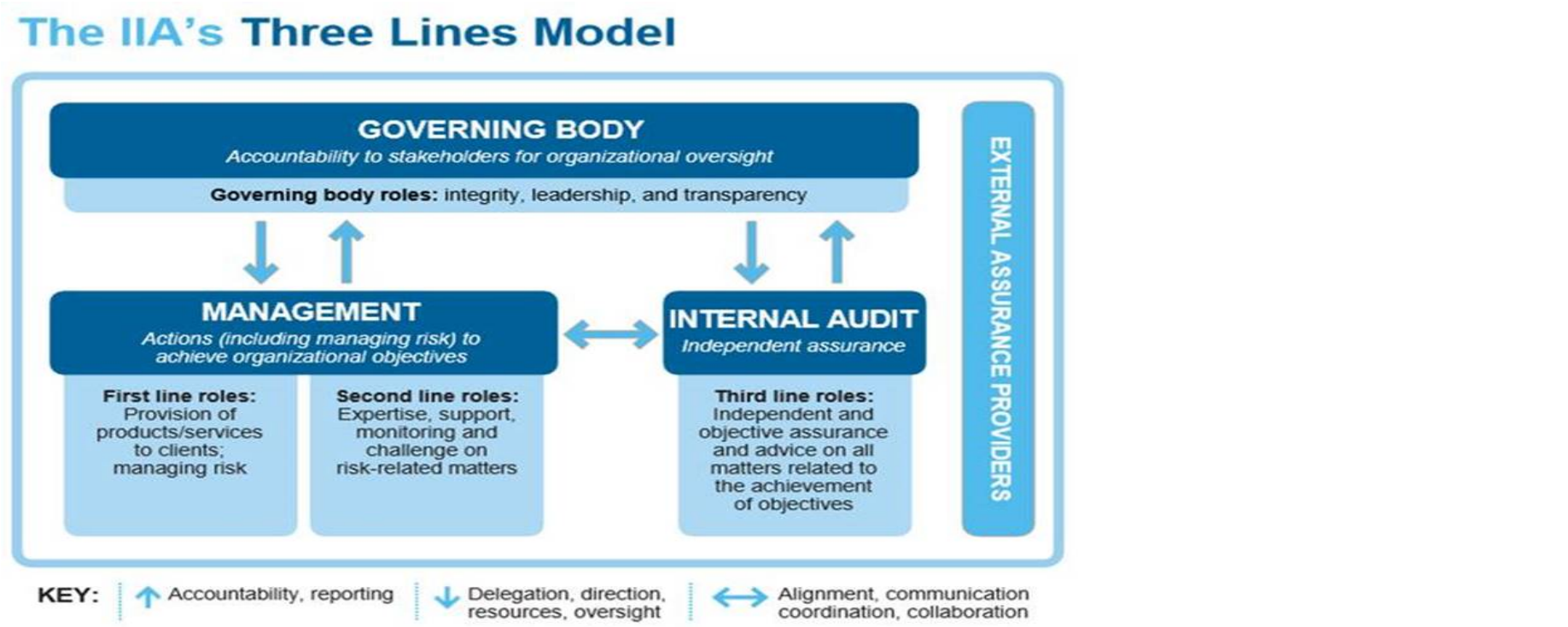
NHS
University Hospitals of North Midlands
NHS Trust

Infection Prevention and Control Board Assurance Framework

June 2022

Summary Board Assurance Framework

Ref / Page	Requirement / Objective	Risk Score					
		Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Change
BAF 1 Page 4	Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users.	High 9	Mod 6				↑
BAF 2 Page 19	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	Mod 6	Mod 6				→
BAF 3 Page 29	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	Mod 6	Mod 6				→
BAF 4 Page 32	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care, in a timely fashion.	Low 3	Low 3				→
BAF 5 Page35	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	Low 3	Low 3				→
BAF 6 Page41	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	Low 3	Low 3				→
BAF 7 Page 47	Provide or secure adequate isolation facilities.	Low 3	Low 3				→



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

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

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

Risk Scoring									
Quarter	Q4	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3					There are a number of controls in place. UHNM Risk assessment are in place where deviation from regional COVID guidelines and testing recommendations	Likelihood:	1	End of Quarter 3
Consequence:	3						Consequence:	3	
Risk Level:	9						Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
1.1	**Next Steps on Infection Prevention , date 1st June** **For health and care staff:** • Health and care staff should continue to wear facemasks as part of personal protective equipment required for transmission-based precautions when working in COVID-19/respiratory care pathways, and when clinically caring for suspected/confirmed COVID-19 patients. This is likely to include settings where un triaged patients may present such as emergency	• 14th June 2022 discussed at Clinical Group. Masks to continue in all clinical areas for staff, visitors and patients due to increase in admission portal positivity rate and within 2 weeks of jubilee celebrations decision to maintain routine wearing of face masks in all clinical areas. To revisit again at Clinical group every 2 weeks	• Datix • OB meetings • Monitoring COVID patient numbers at UHNM for any increase in cases • Monitoring the number of COVID outbreaks for any increase	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	departments or primary care, depending on local risk assessment. In all other clinical care areas, universal masking should be applied when there is known or suspected cluster transmission of SARS-CoV-2, eg during an outbreak, and/or if new SARS-CoV-2 VOC emerge.			
	• Universal masking should also be considered in settings where patients are at high risk of infection due to immunosuppression e.g. oncology/haematology. This should be guided by local risk assessment.	• To continue with universal wearing of masks		
	• Health and care staff are in general not required to wear facemasks in non-clinical areas e.g. offices, social settings, unless this is their personal preference or there are specific issues raised by a risk assessment. This should also be considered in community settings.	• Discussed at clinical Group 30/05/22 risk assessment completed. From 1st June the wearing of masks in non-clinical area no longer mandatory. Staff can continue to wear masks through personal choice or specific risk following a risk assessment. In additions From 9th June non wearing of masks in public corridors. To keep under review and reinstate when required. The wearing of in non-clinical areas was re- introduced 6th July wave of COVID		

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
For inpatients: • Inpatients with suspected or confirmed COVID-19 should be provided with a facemask on admission. This should be worn in multi-bedded bays and communal areas, e.g. waiting areas for diagnostics, if this can be tolerated and is deemed safe for the patient. They are not usually required in single rooms, unless, e.g., a visitor enters.	• Inpatient mask wearing where tolerated by patient continues		
• All other inpatients are not necessarily required to wear a facemask unless this is a personal preference. However, in settings where patients are at high risk of infection due to immunosuppression e.g. oncology/haematology, patients may be encouraged to wear a facemask following a local risk assessment.	• Inpatient mask wearing where tolerated by patient continues		
• • Patients with suspected or confirmed COVID-19 transferring to another care area should wear a facemask (if tolerated) to minimise the dispersal of respiratory secretions and reduce environmental contamination.	• Inpatient mask wearing where tolerated by patient continues		
• The requirement for patients to wear a facemask must never compromise			

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
their clinical care, such as when oxygen therapy is required or where it causes distress, e.g. paediatric/mental health settings. **For outpatients, UEC and primary care:** • Patients with respiratory symptoms who are required to attend for emergency treatment should wear a facemask/covering, if tolerated, or offered one on arrival. • All other patients are not required to wear a facemask unless this is a personal preference. **For visitors:** • In inpatient settings where patients are at high risk of infection due to immunosuppression, e.g. oncology/haematology, visitors may be asked to wear a facemask following a local risk assessment. • Visitors and individuals accompanying patients to outpatient appointments or the emergency department are not routinely required to wear a facemask unless this is a personal preference, although they may be encouraged to do so following a local risk assessment.	• mask wearing where tolerated by patient continues • Wearing of masks for visitors in clinical areas continues		

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	Emergency department Maintain at least 1 metre with areas for post testing and triaged respiratory infection For confirmed negative patients return to pre COVID -19 pandemic distancing	• On arrival in ED patients are immediately identified either asymptomatic for COVID -19 symptoms and infection prevention precautions applied. • ED navigator in place • Colour coded areas in ED to set out COVID and Non COVID areas in place • Aerosol generating procedures in single rooms with doors closed • Major's resuscitation area for all patients requiring this level of medical care. This area consists of single rooms with sliding doors and neutral pressure ventilation. Signage in place to set out level of PPE required for each room depending on infectious status of patient. • Patients are asked to wear face covering/mask  20220401 Midlands Regional IPC principl		
	Inpatient Settings Revert to pre COVID 19 pandemic bed spacing in all inpatient areas - ensure move to comply with all appropriate HTMs/HBNs if not currently the case	• UHNM risk assessment in place • Social distancing no returned to pre-pandemic spacing, a number of wards had beds removed to comply with 2 metre social distance rule		

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	Non clinical areas • Revert to pre COVID 19 pandemic desk/chair spacing OR • Consideration to ventilation of these areas should be taken into account when making decisions. • Compliance and risk assessments should be documented	• Emergency admission COVID PCR screening in place • Pre OP - Elective admission screening in place , lateral flow 72 hours pre admission and day of admission • Pre Op - PCR testing in place for patients that require critical care post operatively • Encourage patients to wear masks • Staff to continue mask wearing • Social distancing returned to pre-pandemic spacing in non- clinical areas • Advised window opening for a minimum of 10 minutes per hour • Cleaning of work station remains		

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
1.2	Patient safety and governance • There should be systems in place to identify those harmed through acquiring COVID 19 in health care settings, or where harm had occurred through COVID -19 related interventions and report through existing organisational patient safety and organisational learning mechanisms • Outbreak reporting • Local deviation As in previous versions of the national IP guidance, organisations may choose to adopt practices that differ from these regional principles or nations guidance.	• Reporting of hospital onset COVID 19 infection in place • COVID 19 definite and probable mortality reviews • SI framework National definition of outbreak in place • Outbreak report • Outbreak meetings • UHNM outbreak closure time is 7 days after the last positive case - then ward monitored for the next 28 days • Staff to undertake daily lateral flow testing for 7 days from the date of outbreak declared • UHNM risk assessments in place • Screening options paper presented and option agreed with execs • 22nd April 2022 -To continue PCR testing on day 1 and day 4 – emergency admissions. Day 6 , 14 and weekly no longer in place. To continue PCR testing if patient develops COVID symptoms or in outbreak situation	• COVID outbreak • DATIX • Monitoring COVID patient numbers at UHNM for any increase in cases • Monitoring the number of COVID outbreaks for any increase	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		Risk Assessment COVID IPC reducing • Staff to continue with twice weekly lateral flow testing – UHNM positivity rates monitored • Flow chart in place with actions to take if test is positive – return to work guidance • Flow chart in place for staff who test negative by are symptomatic request a PCR test • Consultant Microbiologist monitors admission screening positivity rates		
1.3	• Testing of asymptomatic staff in non- outbreak settings Options 1 1 Clinical staff to continue to test using LFT twice weekly 2 As community prevalence decrease consider stepping down routine asymptomatic testing in some or all clinical areas	• Clinical staff to continue twice weekly LTF testing • Flow chart in place with actions to take if test is positive – return to work guidance • Flow chart in place for staff who test negative by are symptomatic request a PCR test • Consultant Microbiologist monitors admission screening positivity rates	• Datix • OB meetings • Monitoring COVID patient numbers at UHNM for any increase in cases • Monitoring the number of COVID outbreaks for any increase	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	National Infection Prevention Manual released • Changes in list of Aerosol Generating Procedures (AGP)	• Clinical Group to review and advise on revised APG list • Evidence supporting the AGP list to be reviewed.	• Audit • OB monitoring • Datix	
1.4	• Monkey pox outbreak in UK • Recommendations for the use of pre and post vaccination during a monkey pox incident	• Clinical group in place to review latest guidance and recommendations • Pathways in place for unanticipated monkey pox presentations at ED • GUM referrals for swabbing direct to ward 117 • IP measure in place • Monkey pox Trust intranet page in place • UHNM identified as vaccination hub • Vaccination pathways construction are in progress	• OB monitoring • Audit • Datix	

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

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

Risk Scoring									
Quarter	Q4	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2					Whilst cleaning procedures are in place to ensure the appropriate management of premises further work is in progress re cleaning standards and role and responsibilities	Likelihood:	1	End of Quarter 1 2022
Consequence:	3						Consequence:	3	
Risk Level:	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	**Intervention and Principles - Environmental Cleaning** In all clinical areas with asymptomatic patients , staff or visitor the 2021 National Standards of Cleanliness should apply • Respiratory - Enhanced environmental decontamination should be undertaken in clinical areas where respiratory transmission based precautions are practice • Outbreak –Enhanced environmental cleaning , touch point cleaning minimum 2 hourly	• National standards of cleanliness in place – options analysis paper submitted against the 2021 standards • SOP and cleaning method statements for cleaning teams • High level disinfectant , Virusolve and Tristel in place and used for all decontamination cleans • Increased cleaning process (barrier clean) included in Infection Prevention Questions and Answers manual • Process in place for clinical areas	• CEF audits • C4C audits • Audits and assurance visits by IP • Ward audits • Spot check assurance audits completed by cleaning supervisors/managers • Cleanliness complaints or concerns are addressed by completing cleanliness audit walkabouts with clinical teams, and CPM / domestic supervisors • Patient survey feedback is	• Decontamination of beds returned for repair process non conformities • Srengthen our assurance process on standards of cleanliness

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	• Designated nursing/medical teams with appropriate training are assigned to care for and treat patients in Covid-19 isolation or cohort areas.	with clusters and HAI cases of COVID -19 requiring increased cleaning and /or terminal cleans • Cleaning schedules in place • Barrier cleans (increased cleaning frequency) process in place which includes sanitary ware and other frequent touch points • Process and designated staff for ED to ensure cleans are completed timely	reviewed by joint CPM / Sodexo/EFP group and action plan completed if needed. • Reports produced after each visit, and re-audits completed if disciplines fail to achieve agreed %. • C4C report presented at IPCC • GREAT training record cards are held centrally by Sodexo for all individual domestics • Key trainers record • Notes from Sodexo Performance Monthly meeting , Sodexo Operational meeting , Divisional IP Meeting and facilities/estates meeting	
2. 2	Ventilation	• UHNM has established a Ventilation	• Estates have planned	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	• As part of heirachy of controls assessment : ventilation systems, particularly in, patient care areas (natural or mechanical) meets national recommendations for the minimum of air changes refer to specific guidance, In patients care health building note 04-01 Adult in-patient facilities • The assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations authorised engineer • A systematic review of the ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways • Where possible air is diluted by natural ventilation by opening windows and doors were appropriate • Review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission. • Where a clinical space has a very low air changes and it is not possible to increase dilution effectively , alternative technologies are considered with estates/ventilation group • Ensure the dilution of air with good	Safety Group as recommended by the Specialised Ventilation for Healthcare Society in order to provide assurance to the Trust Board on the safe operation and reduction in risk of infection transmission through ventilation systems. TOR written • The Trust also appointed external authoring Engineers. This is in line with the NHS estates best practise and guidance from Health Technical Memorandum (HTM) namely 03/01 Specialised Ventilation for Healthcare Premises. • Trust Estates Ventilation Aps attended week long Specialized ventilation in health care at Leeds University – Much of this content contact relates to airborne respiratory infections • Lessons learnt poster which encourage regular opening of windows to allow fresh air  ventilation-air-changes-per-hour-2021-06 • • IP and estates have worked with areas know to be undertaking aerosol generating procedures and completed the fallow times	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
	ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air	• IP have nominated point of contact re ventilation advise • Most wards have mechanical ventilation in core areas and natural ventilation in bays (window opening) • January 2022 Estates and IP are exploring the use of air scrubber technology • May 2022 UV air system on trial ward 225 • Business case proposal for UV air system in selected areas in progress		

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 1 Progress Report	BRAG
2	2.1	Review of cleaning standards	Divisions Facilities/ACN	12/11/2021 31/12/2021 End of quarter 1 2022	November 2021 Cleaning Collaborative work stream (multi-disciplinary representation) established and using Improving Together tools and methodologies to work through the actions needed to respond to the cleaning issues that were highlighted during the CPE Outbreak. Discussion and agreement with NHSEI the dismantling of beds to the level undertaken during the CPE would be considered during planned deep cleans/ ward refurbishments and continue with standard and terminal clean process as usual.	

	2.2	To explore alternative technologies to enhance ventilation in bays that have natural ventilation	Infection Prevention Team/Estates	End of Quarter 2 2022	May 2022 UV Light air technology on trial ward 225	

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

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

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
3.1	Arrangements around antimicrobial stewardship are maintained. Update V 1.8 Previous antimicrobial history is considered The use of antimicrobials is managed an monitored: Update V 1.8 • To reduce inappropriate prescribing • To ensure patients with infections are treated promptly with correct	• Regular, planned Antimicrobial stewardship (AMS) ward rounds • Trust antimicrobial guidelines available 24/7 via intranet and mobile device App • Antimicrobial action plan in place • Clostridium *difficile* Period of increased incidence and outbreaks are reviewed by member of AMS team and actions generated cascaded to ward teams	• 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	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	antibiotic	• 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 consumption undertaken by AMS team. Available online at UHNM	actions followed up • Real time discussions / requests for support / advice enabled via regional and national social media accounts. National (incl. PHE) thought leaders members • Trust and commissioners require timely reporting on compliance with AMS CQUIN targets. • Wards showing deviation from targets are followed up by targeted AMS team ward reviews generating action plans for ward teams. On hold during COVID19 due to redeployment of duties • The pharmacy team undertook a trust-wide point prevalence audit using a new electronic data capture tool. Results will be reviewed during January and shared with ACN's and Microbiologist.	
3.2	Mandatory reporting requirements are adhered to and boards continue to maintain oversight. Linked NHSIE Key Action 5: Daily data submissions have been signed off by the Chief Executive, the Medical Director and the Chief Nurse and the Board Assurance Framework is reviewed and evidence of reviews is available.	• 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	• 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	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	Linked to NHSIE Key Action 10: Local systems must review system performance and data, offer peer support and take steps to intervene as required. Update V 1.8 Risk assessments and mitigations are in place to avoid unintended consequences from other pathogens	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.	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.	

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

Risk Scoring									
Quarter	Q4	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	1					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						Consequence:	3	
Risk Level:	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	Continues use of Fluid resistant Surgical Masks in all patient facing and non –clinical setting (unless clinically exempt)	• Posters and signage in place • Mask available at hospital entrance	• Monitored by clinical areas • PALS complaints/feedback from service users • Outbreak meetings	
4.2	Patient visiting	• 30th May visiting updated .The majority of inpatients are permitted to have two visitors, between 2pm and 4pm and again between 6pm and 8pm. In the majority of cases these do not have to be the same two visitors.	• Monitoring of number of Outbreak	

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

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

						Risk Scoring			
Quarter	Q4	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	1					Whilst arrangements are in place ensure the screening of all patients. To continue to reinforce COVID screening protocol and work towards lateral flow testing for those patients that remain an inpatient	Likelihood:	1	
Consequence:	3						Consequence:	3	
Risk Level:	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	**Testing** • All NHS patients in a hospital setting requiring a test by a clinical to support clinical decisions during their care and treatment pathway should be offered a PCR test as part of their usual diagnostic pathway • Testing for asymptomatic in patients on day 3	• CR testing in place for all emergency inpatient admissions and symptomatic patients • PCR continues on day 1 and day 4 of inpatient stay, Risk assessment completed, no day 6 screens, 14 or weekly.	• COVID 19 -Themes report to IPCC • COVID screening spot check audits • Datix • Outbreak investigation	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	and days 5-7 of their stay should now be undertaken by lateral flow device LFD	• In addition PCR testing for patient who have or develop COVID 19 symptoms • No system in place for inpatient lateral flow testing (POCT) and recording of results on electronic system to allow for surveillance of cases and alert when possible or definite outbreak • PCR remains for outbreak screening, both patients and staff UHNM isolation period remains at 10 days - no POCT in place to release patients earlier • Planned elective admissions are now tested using lateral flow 72 hours prior to admission and on the day of admission • PCR testing for patients discharged to nursing/care home		

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

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 1 Progress Report	BRAG
5	5.1	Introduction of lateral flow testing for day 4 and 6 of inpatient stay	Deputy Chief Nurse	End of July	April 2022 Lateral flow testing introduced for elective cases. Meeting held to discuss the use of lateral flow (POCT) for patients who remain an in- patient. Challenge to ensure results are recorded electronically and feed into electronic system to enable reporting and to ensure the Infection Prevention Team are aware of positive cases and outbreak to enable outbreak actions to be instigated. In addition time and staff required to ensure compliance with POCT rules- explore swabbing team.	On- going

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

Risk Scoring									
Quarter	Q4	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	1					Information and communication/controls are in place to ensure staff are aware of their responsibilities spot audits continue.	Likelihood:	1	End of Quarter 2 2021
Consequence:	3						Consequence:	3	
Risk Level:	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:			

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
6.1	**Intervention and Principles PPE** • Non Respiratory - for symptomatic patients staff should follow standard infection control precautions • Respiratory - for caring for patients with respiratory symptoms direct contact staff should take respiratory transmission based precautions Consider the use of FFP3 for prolonged contact with positive symptomatic patients , especially in areas where ventilation is not complaint with ventilations standards	• Infection Prevention Questions and Answers manual, chapter Q1 standard precautions • PPE posters are available in the COVID -19 section of trust intranet page • UHNM recommend staff use of for highly suspected or confirmed COVID 19 patients • FFP3 mask /hood • Eye protection • Gloves • Apron(gown for AGP)	• Divisional FFP3 training records • Mandatory training records • Assurance visits/spot checks • Ward audits	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 1 Progress Report	BRAG
6						

7. Provide or secure adequate isolation facilities

Risk Scoring									
Quarter	Q4	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	1					Isolation facilities are available and hospital zoning currently in place, however there is a need to explore increasing single room availability (pods).	Likelihood:	1	
Consequence:	3						Consequence:	3	
Risk Level:	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	Intervention and principles – Contact Isolation (assuming the patients area asymptomatic and have agreeing with the Trust testing protocol and have recent negative test) • 10-day isolation from time of last positive contact • 7-day isolation from time of last positive contact • 5- day isolation from time of last positive contact • Retain contacts on same clinical area with separate toilet and bathroom facilities to other patients • Patients with possible or Covid-19 are isolated in appropriate facilities or designated areas where appropriate.	• UHNM risk assessment with Exec sign off Considered related to risk within the organisation and system • UHNM have reduced patient COVID contact classification period from 10 days to 7 days if patient remains asymptomatic and tests negative PCR COVID screen on day 6 after exposure then contact isolation can discontinue	• If patient found to be positive in the bay and exposing other patient. IP liaise with clinical are, apply bay restrictions. • Contact tag to electronic records applied by IP Team • Spot check audits • Assurance obtained for monitoring of inpatient compliance with wearing face masks via Matrons daily walk round • 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	Work in progress to assess the need for more single room availability to facilitate patient flow and surgical pathway

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	Restricted access between pathways if possible,	• COVID contacts are cohorted with similar isolation periods to reduce risk • Where possible cohort nursing staff to provide care for the contact and the negative or positive patients separately • PPE changed when moving between cohorts • Clinical equipment where possible designed to cohort and decontaminated after use UHNM risk assessment • Mixing contact (negative) patients with non-contact (negative) patients when the Trust is on escalation level 4 with significant numbers of ambulances holding unable to offload, a significant number of specialties being held within the emergency portals and 90 or more medically fit for discharge patients are being held at the Trust. • Non-contact patients selection criteria for admission to a contact ward - this is contained in the risk assessment	at IPCC . • Themes report to IPCC • Inappropriate patient moves reported via Datix. Daily process Discuss at outbreak meetings as necessary	

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

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 1 Progress Report	BRAG
7	7.1	To assess the need for further single room isolation facilities (PODS) to facilitate COVID patients remaining on their original ward, facilitate flow and surgical pathway	DIPC	End of July 2022	May 2022 Request made to analyst to map/predict isolation need.	

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

Transformation and People Committee Chair's Highlight Report

27th July 2022

1. Highlight Report

! Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• During Quarter 1 there was activity against 42 formal conduct cases; MHPS cases remain an area of concern in terms of the time being taken to progress these • 49 concerns had been raised via the Freedom to Speak Up Guardian's office during Quarter 1, this was the highest number of reports to date with April being the highest number – this may be as a result of the increased profile • Aligned with recommendations following the Ockenden Report, dedicated listening events had taken place within Maternity which had led to staff feeling able to speak up • Sickness absence continues to fluctuate in line with Covid surges; concerns regarding staffing levels were escalated by the Divisions to the Executive Workforce Assurance Group • Recruitment Team remains under significant pressure with staffing challenges within the team combined with increases in recruitment activity • The workforce pay award has been announced which is less than expected and therefore poses a risk of industrial action – payments of the new award will be in September • Concerns raised around workforce planning and whilst it was recognised that plans were being worked upon for winter, there is a broader discussion to take place • Culture Review Group had identified some concerns that staff were not making the connection between actions being taken with the Cultural Improvement Plan – regular communication now in place • Concerns regarding the process for management of Freedom of Information Requests has been identified and a new process has been agreed although this requires close monitoring • Concerns highlighted in relation to implementation of Office 365 which were being acted upon • BAF Risk 3 Sustainability has the potential to increase given the winter and potential industrial action • Visit from the Health & Safety Executive into the Pathology Directorate has indicated concerns in relation to RIDDOR reporting which will likely result in enforcement action	• Formal disciplinary report to be updated so that there is a graphical representation of the stages of individual cases to aid easier monitoring of timescales; also further narrative to be included which identifies those cases with external involvement which therefore impacts upon timeframes • The main activities associated with the Equality and Diversity programme during the quarter have focussed on Civility and Respect and cultural improvement • The Equality and Diversity Report is to include progress with professional equity and a quarterly dashboard by Division around broader equality metrics is under development • A Task and Finish Group is in place which is currently looking at the recording of Trans data on our systems to ensure greater accuracy • Workforce winter planning remains ongoing and a more detailed discussion will take place at the August / September meetings on workforce planning specifically and more broadly • Cultural Assurance Map will be developed which sets out the sources of assurance which will be relied upon in seeking assurance against the Cultural Improvement Plan • Progress being made to assimilate alignment between transformation projects and the Improving Together Programme • Development of a delivery plan associated with the Research and Innovation Strategy is now underway and combined with utilisation of Improving Together tools, will support the shaping of future meetings of the Executive Research and Innovation Groups • A strengthened approach to Equality Impact Assessment is being developed
✓ Positive Assurances to Provide	**Decisions Made**
• Management of disciplinary case timelines has been a significant focus since the last meeting and the average time to close less complex cases has reduced as a result • New Resolution Policy has been approved via TJNCC and is being taken through ratification • Over 20 members of staff have put themselves forward to be a Disability Champion • Equality, Diversity and Inclusion Strategy has now been approved by the Executive Workforce Assurance Group and will be taken to TAP and the Board for approval • New style Freedom to Speak up Report provides a balance between providing meaningful information whilst ensuring that confidentiality is maintained; the new approach to reporting was applauded • 5 new Associate Freedom to Speak up Guardians have been appointed during Quarter 1 • Slight improvement has been seen with the PDR completion rate during M3 • The Quality Improvement Team is now fully established and the team are now being up skilled • Digital Advocates Network Programme is due to be launched which provides coaching / support in the use of digital	• Agreed that BAF 9 Research and Innovation should be reduced to High 9 - 12

Comments on the Effectiveness of the Meeting

- Very large agenda which has the potential to expand given that the Committee is responsible for the majority of risks on the BAF
- Pleased with the level of time given to Freedom to Speak Up and Equality and Diversity

2. Summary Agenda

No.	Agenda Item	BAF Mapping		Purpose	No.	Agenda Item	BAF Mapping		Purpose
		BAF No.	Risk				BAF No.	Risk	
1.	Formal Disciplinary Activity Q1 22/23	BAF 2		Assurance	8.	Executive Health & Safety Group Assurance Report	BAF 3		Assurance
2.	Equality, Diversity & Inclusion Progress Report	BAF 2		Assurance	9.	Transformation Programme Update	All		Assurance
3.	Equality, Diversity & Inclusion Annual Report 2021-22	BAF 2		Assurance	10.	Improving Together Highlight Report	All		Assurance
4.	Speaking Up Report Q1 22/23	BAF 2		Assurance	11.	Executive Research & Innovation Group Assurance Report	BAF 9		Assurance
5.	Month 3 Workforce Report	BAF 2/3		Assurance	12.	Executive Digital and Data Security & Protection Group Assurance Report	BAF 6		Assurance
6.	Executive Culture Review Group Assurance Report • Culture Improvement Programme Update	BAF 2		Assurance	13.	Staffordshire and Stoke-on-Trent Integrated Care System Monthly Newsletter	BAF 4		Assurance
7.	Executive Workforce Assurance Group Assurance Report	BAF 2/3		Assurance	14.	Board Assurance Framework Q1 22/23	All		Assurance

3. 2022 / 23 Attendance Matrix

Attended	Apologies & Deputy Sent	Apologies

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

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board	**Date:**	3rd August 2022
Report Title:	Speaking Up – Board Brief Quarter 1 2022/23	**Agenda Item:**	10.
Author:	Claire Rylands, Associate Director of Corporate Governance		
Executive Lead:	Tracy Bullock, Chief Executive		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

BAF 2	Leadership, Culture and Delivery of Values / Aspirations	**High 12**

Executive Summary

Situation

The enclosed report is our new style 'Board Brief' for Quarter 1 2022/23 which aims to provide the Board with a high level overview of Speaking Up activity during the quarter, including key headlines, a summary of concerns raised, key national and local developments and priorities for the next quarter.

Background

In April 2022, responsibility for the Freedom to Speak Up function moved from our People Directorate to the Corporate Governance Department. At this time, our new, full time Freedom to Speak Up Guardian also commenced in role.

There have been a number of national developments during the quarter, with resources issued by NHS England and the National Guardians Office (NGO) in relation to speaking up policies and practice. Further detail of these has been provided to our Transformation and People Committee and a summary of actions we will be taking in response to these resources is summarised at section 4 of the enclosed, aligned to our Strategic Priorities.

Assessment

- Quarter 1 2022/23 has seen an increase in the number of concerns raised, with 49 being raised, of which 68% relate to Attitudes and Behaviours
- 'Hotspot' areas for reporting during the quarter are Obstetrics and Gynaecology, Imaging and Trauma & Orthopaedics
- A number of actions have been taken to raise the profile of Speaking Up during this quarter, aligned with our Cultural Improvement Programme
- 5 Associate Freedom to Speak Up Guardians have been appointed on a voluntary basis during the quarter

Key Recommendations

The Board is asked to note the contents of the Board Brief and to approve the priorities outlined within section 4 of the report (which have been supported by the Transformation and People Committee).

Freedom to Speak Up
Your voice matters at UHNM

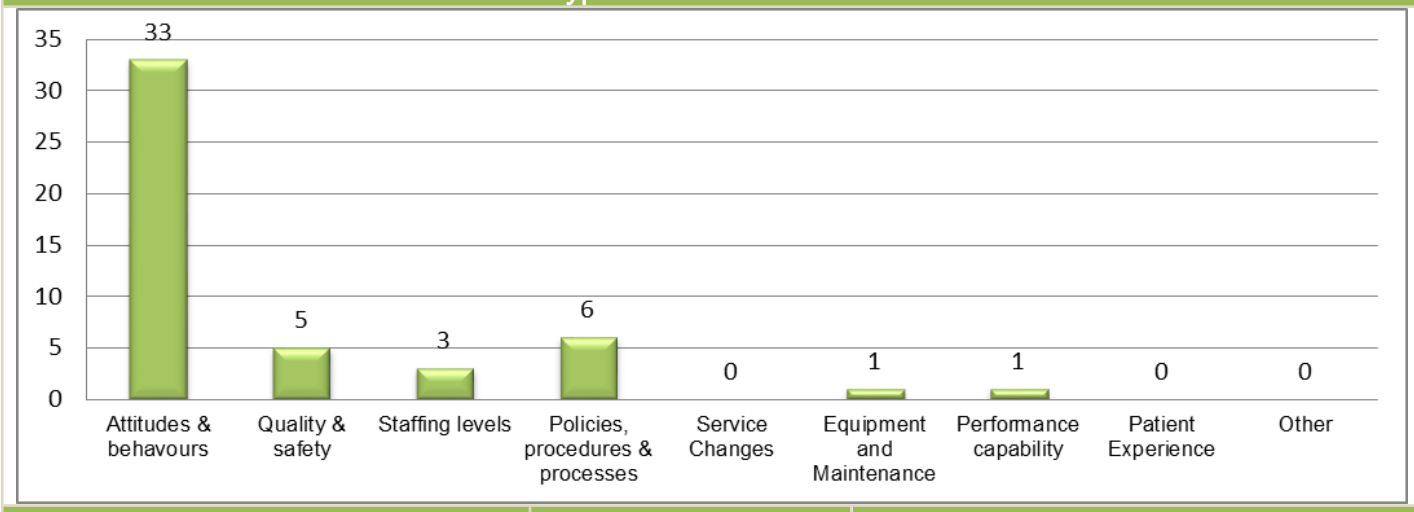
Speaking Up
Board Brief – Quarter 1 2022/23

1. Headlines

- 49 concerns raised through the Freedom to Speak Up (FTSU) Guardians Office during Quarter 1 2022/23, 20 of these were reported during April 2022 – these are our highest numbers to date
- 68% of these concerns were in relation to 'Attidudes and Behaviours' (33 concerns)
- 33% of these concerns were raised by Registered Nurses / Midwives (16 concerns)
- Top 3 'Hotspot' areas for the Quarter are Obstetrics & Gynaecology (14 concerns), Imaging (7 concerns) and Trauma & Orthopaedics (3 concerns)
- 10 cases where detriment reported as a result of raising a concern, which are being followed up

2. Summary of Concerns Raised During the Quarter

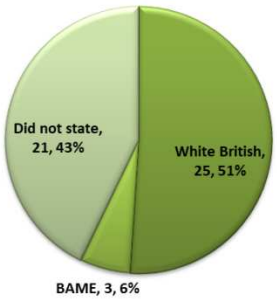
Types of Concerns Raised



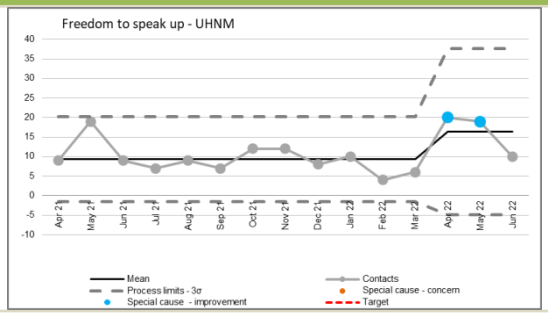
Outcomes

Ongoing review process / investigation	21
Reporter happy - no further action	14
Anonymous report – no feedback	5
Ongoing case handled by FTSUG	9

Ethnicity of Reporters



SPC – Concerns Raised



3. Key Developments During the Quarter

National Developments	Local Developments
NHSE: FTSU Reflection and Planing Tool Speaking Up Resources - National Guardian's Office	Transfer of FTSU Guardian portfolio from People Directorate to Corporate Governance
NHSE: FTSU Policy for the NHS NHS England » The national speak up policy	New and full time FTSU Guardian commenced post (April 2022)
NHSE: A Guide for Leaders in the NHS B1245_ii_NHS-freedom-to-speak-up-guide-eBook.pdf (england.nhs.uk)	Appointment of 5 Associate Freedom to Speak Up Guardians
NSHE: Speaking Up Support Scheme NHS England » Speaking Up support scheme	Digital tool for gathering Feedback on the Speaking up Process
NGO: FTSU E-Learning Package – Follow Up Freedom to Speak Up - elearning for healthcare (e-lfh.org.uk)	Utilisation of National Benchmarking to measure ourselves against other providers

NGO: FTSU Guardian Survey 2021 2021-FTSUGuardian-Survey-Report.pdf (nationalguardian.org.uk)		Promotion of our Freedom to Speak Up Arrangements using media / face to face	
Ockenden – Final Report OCKENDEN REPORT - FINAL (ockendenmaternityreview.org.uk)			

4. Priorities for the Next Quarter

No.	Source	Strategic Priorities	Action
1.	National Developments		Completion of FTSU Reflection and Planning Tool to determine current position and further developments needed. This will be a key focus at the Board Development Session
2.	National Developments		Review of FTSU Policy against revised national FTSU Policy for the NHS
3.	National Developments		Share FTSU Guide for Senior Leaders with senior leaders throughout the organisation and use in conjunction with review of local policy.
4.	National Developments		Identify appropriate individuals who may benefit from participation in the national Speaking Up Support Scheme
5.	National Developments		Develop Training Needs Analysis for staff based upon the national training packages available and communicate training and monitoring requirements within the organisation.
6.	National Developments		Hold Speaking Up Session within Maternity during July and thereafter.
7.	Local Developments		Continue to induct new Associate FTSU Guardians and communicate their role throughout the organisation.
8.	Local Developments		Continue to develop the digital feedback system ensuring as many staff as possible provide feedback on their experience of the process so that any lessons learned are translated into improvements.
9.	Local Developments		Develop new FTSU Strategy for UHNM.
10.	Local Developments		Plan for Trust Board Development Session, focussing on: • Self-Reflection Tool • FTSU Strategy • FTSU Priorities
11.	Local Developments		Continue to explore options to introduce a digital system for raising concerns, with opportunity for anonymised messaging and feedback.
12.	National Developments		Completion of Gap Analysis against previous FTSU Cases and development of action plan.

5. Key Conclusions

Whilst the reason for the increase in Speaking Up cases during this quarter is not yet confirmed, there could be a number of reasons for this, which we will continue to monitor, including:

- Increased publicity of the role and a proactive approach being taken by the new FTSU Guardian
- Increase in profile of maternity services following the Ockenden Review (the increase in concerns raised by Maternity staff is not isolated to UHNM)
- Publication of our Culture Report and subsequent communication and actions around this
- Continued concerns regarding staff disatisfaction, staffing levels and working through the pandemic.

NHSE have produced a number of resources which align with the NHS People Plan and these will be used to inform our strategic development of the FTSU function as set out in the priorities above.

	Where concerns regarding unacceptable attitudes and behaviours are identified, these will continue to be signposted to the appropriate HR processes and Executive support will be sought in ensuring that behaviours that do not align with our values are dealt with accordingly.
	National benchmarking demonstrates that UHNM is just above average in terms of the number of cases reported to the NGO during 2021/2022 in the Annual Speak Up Data Summary.

Performance and Finance Committee Chair's Highlight Report to Board

26th July 2022

University Hospitals of North Midlands NHS Trust

1. Highlight Report

!	Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
	• The Finance report demonstrated a £0.3 m deficit in month which was £2.9 m off plan and the exceptional items brought into the plan were highlighted in addition to the mitigation to close the CIP gap. In terms of the pay award, the whole of the award was to be funded via the NHS which will likely impact on national capital pots of money. • A three month post implementation review of the enhanced primary care business case was provided which demonstrated some improvements in triage times although until flow out of the department improved additional improvements in performance were not anticipated. It was noted that between 57-58 patients were being streamed to the service on some days, but the main limiting factor was space. It was recognised that it was early for benefits realisation to be undertaken and the Committee noted its frustration regarding impact • In terms of urgent care performance the Committee challenged the levels of performance, and impact of the actions being taken which were focussing on reducing occupancy to between 90% to 92%, in addition to increasing discharges. It was noted there was no easy solution with ongoing Covid impact and high MFFDs • Of the 60, 104 week wait patients outstanding at the end of June, it was confirmed that 5 of those were cancelled due to last minute covid related staff absence, the remainder were acceptable national exceptions. It was note that zero 104 week wait breaches were anticipated for July although this remained a challenge due to levels of covid related absence	• To confirm the details regarding the tender Pharmacy Wholesale Agreement • System financial risk register to be brought to the Committee in due course • To consider the minimum cash flow required on the balance sheet • To provide a further update on the EhPC business case as part of the business case review process • To update the BAF to reflect the discussion prior to presentation to the Board • To provide further assurance and information in relation to consultant to consultant referrals given this area was an outlier
✓	**Positive Assurances to Provide**	**Decisions Made**
	• The updated Board Assurance Framework for quarter 1 was presented, reflecting the updated strategic risks for 2022/23. The Committee challenged the scoring for BAF 9 whereby it was agreed to request that Dr Lewis reconsider the associated consequence scoring, and updates on a number of actions within BAF 3, BAF 5 and BAF 6 were agreed to be taken to the Transformation and People Committee. • In terms of planned care, 104% activity had been maintained in addition to the cancer workload, despite the restricted bed base, and overall the position had not deteriorated.	• The Committee approved Business Case BC-0480 Sustainability of Spinal Services which would be taken to the Trust Board for approval • The Committee approved the following eREAFs Pharmacy Wholesale Agreement (eREAF 9582), Radiometer Blood Gas Consumables (eREAF 9278) and CRM - Pacemakers (Low Power) (eREAF 9629) subject to clarification of final figures

Comments on the Effectiveness of the Meeting
• Further discussions to be held in respect of setting future agendas to ensure adequate discussion of items

2. Summary Agenda

No.	Agenda Item	BAF Mapping		Purpose	No.	Agenda Item	BAF Mapping		Purpose
		BAF No.	Risk				BAF No.	Risk	
1.	BC-0480 Sustainability of Spinal Services	BAF 5	ID23791 ID22531 ID15066	Approval	2.	Enhanced Primary Care Business Case (EhPC) Post Implementation Review	BAF 5	ID8442 ID24216 ID24215	Assurance
3.	Performance Report – Month 3 2022/23	BAF 5		Assurance	4.	Authorisation of New Contract Awards, Contract Extensions and Non-Purchase Order (PO) Expenditure	-		Approval
5.	Finance Report – Month 3 2022/23	BAF 8		Assurance	6.	Board Assurance Framework Q1 22/23	-		Approval
7.	Non-Elective Improvement Board Minutes	BAF 5		Information					

3. 2022 / 23 Attendance Matrix

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

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

Executive Summary

Meeting:	Trust Board	**Date:**	3rd August 2022
Report Title:	Integrated Performance Report, Month 3 2022/23	**Agenda Item:**	12.
Author:	Quality & Safety: Jamie Maxwell, Head of Quality & safety; Operational Performance: Warren Shaw, Strategic Director of Performance & Information; Matt Hadfield, Associate Director of Performance & Information. Workforce: Claire Soper, Assistant Director of Human Resources; Finance: Jonathan Tringham, Director of Operational Finance		
Executive Lead:	Anne-Marie Riley: Chief Nurse Paul Bytheway: Chief Operating Officer Ro Vaughan: Director of Workforce Mark Oldham: Director of Finance		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

Executive Summary

Situation

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

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

Assessment

Quality & Safety

Positive assurance for June 2022:

- Friend & Family feedback (Inpatients and Maternity) exceeds 95% target.
- VTE and Safety Thermometer above target
- Zero avoidable MRSA Bacteraemia cases reported.
- Inpatients and Maternity Sepsis Screening; and IV antibiotics given within 1 hr above target rate
- Pressure Ulcers per 1000 bed days developed under UHNM care has seen a decrease during June 2022
- Nutrition Ambition approved and will be launched imminently; Safe Mobility Ambition and Continence Ambition in development
- Collaborating with John Hopkins Hospital (Baltimore USA) to introduce patient mobility goals and

capture of this data alongside qualitative and qualitative research

Areas to note where the set standards were not met:

- Friend & Family Test for A&E 63.8% and below 85% target.
- Falls rate was 6.1 per 1000 bed days
- There were 15 Pressure ulcers including Deep Tissue Injury identified with lapses in care during June 2022.
- 89% verbal Duty of Candour compliance recorded in Datix (32 out of 36 cases)
- 50% (18 out of 36 cases) Duty of Candour 10 working day letter performance following formal verbal notification. During May and June 2022 there continued reduced capacity within the DQSM team and across clinical services which has impacted on the recording/uploading of letters/information to Datix within the 10 working day target.
- 1 Never Event reported
- C Diff YTD figures above trajectory with 14 against a target of 8.
- Emergency Portals and Children's Sepsis Screening compliance has improved but remains below the 90% target; Emergency Portals Sepsis IVAB in 1 hour 52% and is below the 90% target for audited patients

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

- 56 reported incidents relating to staffing shortages and lack of appropriate staff on wards/departments during June 2022.
- Medication related incidents rate per 1000 bed days is 4.5 and patient related 3.8 which are lower to previous month and mean rates.
- 34 Definite Hospital Onset / Nosocomial COVID-19 cases reported in June 2022.

Operational Performance

Emergency Care

- June saw a challenging month for the non-elective pathway with increasing numbers of COVID positive patients and COVID related staff absences. The IPC restrictions associated with this rise caused delays throughout the month and impacted performance and capacity to drive transformational change while responding to operational pressures. Following a positive improvement in performance in May from April, focus shifted towards the maintenance of this improved position and protecting capacity wherever possible for improvement work to drive long term performance.
- There were slight deteriorations in performance against most metrics in June, with notable exceptions been a significant worsening of the number of 60 minute ambulance handover delays and the continued improvement of SDEC utilisation. It is important to note that while 60 minute ambulance handover delay performance saw a disappointing return to the performance of previous months, ambulance arrival triage within 15 minutes rose to above 70%, the highest performance this year. Escalation System and Regional calls held throughout the month have highlighted similar delays throughout the Midlands consistent with rising COVID cases.
- Despite these challenges multiple key objectives have been met throughout the month in line with the Non-Elective Improvement Plan. This has significant progress against ED recruitment (supported by the Tiered Medical Rota going live), the rolling out of Phase 2 & 3 of the Discharge Step Change Project (including the introduction of a new TOC template), and user testing and sign off of both a ED to Ward dashboard and a multi-specialty electronic referral form.
- Finally, two key senior individuals were confirmed in June to be commencing in post in July that will provide vital support to the Non-Elective Improvement Programme; the NEL Programme PMO Lead and the Deputy Chief Medical Officer – Performance. Both of these will be welcome additions and will provide valuable input, capacity, and insight to the programme.

Cancer

- Most recent submitted Cancer Waiting Times position is May 22. The June 22 position is a performance prediction which will be has been impacted by histology results confirm a cancer or non-cancer diagnosis for patients treated. June 62 day targets, while are estimated to be improved on May although not where they need to be. Additional resource within histology has supported this and this is expected to continue in a phased approach as additional members of staff join.
- Both Skin and Breast have a recovery plan for 2ww first appointment. The Breast plan came to fruition and saw significant improvement against the standard for that pathway – currently booking at day 14,

which will be reflected in July performance.

- Colorectal and Skin pathways have seen a dramatic spike in referrals – both receiving nearly 250 per week towards the end of June. WLI's are being secured where possible. A Colorectal plan is in place, overseen by the COO and Clinical Director to meet demand but is being further worked up to also reduce backlogs.
- The 28 Day Faster Diagnosis position is currently at 55% in June, with the majority of breaches currently recorded in Colorectal and Skin. This standard will be a focus of an Improving Together project covering all pathways.

Planned Care

- Theatre plan for Q1 2022/23 gives 104% of 19/20 capacity. County theatre re-opened 11th April – all 7 theatres now online. As reported last month County theatres have exceeded the 104% target and activity has continued to grow despite continued staffing challenges between both sites driven by trauma and Covid sickness rates.
- The focus has moved to 78 week waiters with an Annual Plan to reduce them to below 300 patients by March 2023. The major change will be managing the non-admitted (Outpatient) patients to ensure they get a decision to treat or discharge well before March so any treatment can be carried out to meet the 78 week standard.

RTT

- The overall Referral To Treatment (RTT) Waiting has increased again in June after May's reduction. (76,920) up from 75,858 in May. This is the first decrease since summer 2020.
- The number of patients > 18 weeks has continued to decrease to 34,753 from 34,928 in April. This indicates the rise in total waiting list is due to increased additions to the waiting list rather than reduced throughput.
- At the end of June the numbers of > 104 weeks was 60. The Trust almost achieved the national standard of all eliminating 104 week waits end of June, with the allowed exception of those patients who have chosen not to be treated in June or are too complex to have their treatment arranged during June. A small number of patients were cancelled in the last few days of June who could not be rebooked in time.

Diagnostics

- Activity across in the DM01 increased by 9% (1,771 patients), and overall DM01 performance improved by 3% to 70% compliance
- Within DM01, the greatest proportions of > 6 week waits are within Non-obstetric ultrasound and endoscopy. Both ultrasound and endoscopies positions are related to an increase in demand alongside workforce shortfalls
- Non-obstetric Ultrasound performance increased by 0.9% to 51.4%. Endoscopy performance also increased by 1.2% to 64%. There is a clear short and long term Endoscopy expansion plan in place and work continues with Ultrasound to deal with staff shortages.
- If Ultrasound & Endoscopy were removed from DM01 performance, the Trust would have overall DM01 compliance of 93%
- Plain film is an area with a high volume of waiters, predominantly due to staffing shortages; P/F walk in centres for all patients will start in August, and will recover the position quickly by inviting patients to attend a number of locations for their x-ray (RS / County / Leek / Longton / Haywood
- Histology turnaround times remain a high risk

Workforce

Key messages

- Our two main areas of focus continue to be on addressing staff availability in relation to both increased covid related absence during month 3 and also increased turnover. Work on management of sickness absence continues along with support for staff wellbeing.
- Recruitment activity is high as teams work to support additional recruitment requirements both as a result of increased staff turnover and additional recruitment linked to business cases. In addition planning for winter is now in place to support wards and departments with additional staffing and workforce resilience.
- There has been an upturn in appraisal rate compliance which is encouraging and we continue to see a

stable picture in terms of core compliance with statutory and mandatory training.
- Work on our cultural improvement programme has now commenced at pace following approval of the plans through our Culture Committee. Progress will be monitored by the Transformation and People Committee.

Finance

Key messages

- The final plan submission is for a breakeven position with the improvement relating to income for additional non-pay inflationary pressures and an assumption that there will be no claw back of ERF funding; both of these assumptions have been required by NHSI/E.
- For the year to date the Trust has delivered an actual deficit of £0.3m against a planned surplus of £2.3m; this position is after a number of one off items totalling £2.4m have been accounted for resulting in a normalised deficit of £2.7m.
- The Trust incurred £0.9m of costs relating to COVID-19 in month which is lower than the prior month figure with £0.4m being chargeable on top of this allocation for COVID-19 testing costs.
- To date the trust has validated £2.5m CIP savings in year; these schemes have a full year impact of £4.4m, which presents a considerable variance to the Trust's recurrent target of £13.6m which was identified as a key risk in the Trust's financial plan submission.
- Capital expenditure in Month 3 is £1.9m which is £0.1m behind the plan of £2.0m. The majority of the expenditure to date is the pre-committed repayment of the PFI and IFRS16 lease liabilities.
- The cash balance at Month 3 is £83.9m, which is £6.7m higher than plan. Cash received is generally in line with plan with payments £5.1m behind plan.

Key Recommendations

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

NHS
University Hospitals of North Midlands
NHS Trust

Integrated Performance Report

Month 3 2022/23

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Contents

A note on **SPC**

University Hospitals of North Midlands NHS Trust

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

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

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

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

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

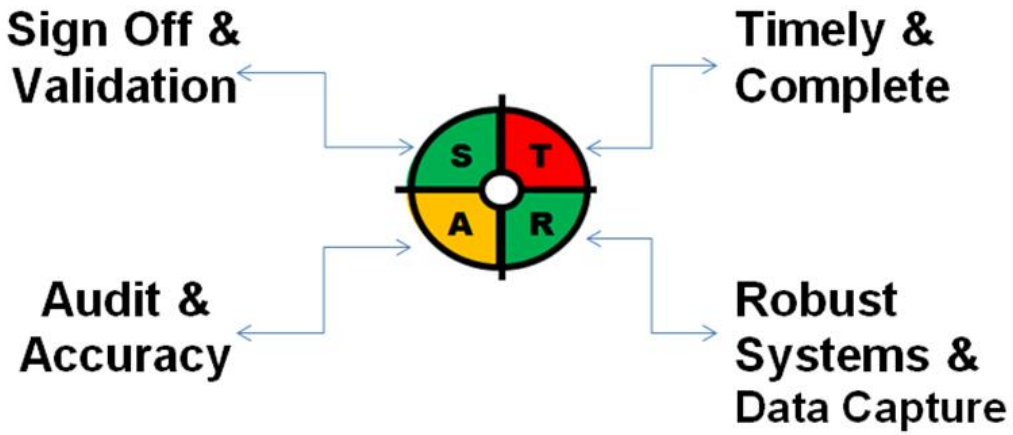
Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

A note on **Data Quality**

NHS
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

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Quality Dashboard

University Hospitals of North Midlands NHS Trust

Metric	Target	Latest	Variation	Assurance
Patient Safety Incidents	N/A	1557		
Patient Safety Incidents per 1000 bed days	N/A	41.15		
Patient Safety Incidents per 1000 bed days with no harm	N/A	26.80		
Patient Safety Incidents per 1000 bed days with low harm	N/A	12.11		
Patient Safety Incidents per 1000 bed days reported as Near Miss	N/A	1.48		
Patient Safety Incidents with moderate harm +	N/A	28		
Patient Safety Incidents with moderate harm + per 1000 bed days	N/A	0.74		
Harm Free Care (New Harms)	95%	96.7%		
Patient Falls per 1000 bed days	5.6	6.1		
Patient Falls with harm per 1000 bed days	1.5	1.3		
Medication Incidents per 1000 bed days	6	4.5		
Medication Incidents % with moderate harm or above	0.50%	1.18%		
Patient Medication Incidents per 1000 bed days	6	3.8		
Patient Medication Incidents % with moderate harm or above	0.50%	1.41%		

Metric	Target	Latest	Variation	Assurance
Serious Incidents reported per month	0	15		
Serious Incidents Rate per 1000 bed days	0	0.40		
Never Events reported per month	0	1		
Duty of Candour - Verbal/Formal Notification	100%	89%		
Duty of Candour - Written	100%	50.0%		
All Pressure ulcers developed under UHNM Care	TBC	52		
All Pressure ulcers developed under UHNM Care per 1000 bed days	N/A	1.37		
All Pressure ulcers developed under UHNM Care lapses in care	12	15		
All Pressure ulcers developed under UHNM Care lapses in care per 1000 bed days	0.5	0.40		
Category 2 Pressure Ulcers with lapses in Care	8	8		
Category 3 Pressure Ulcers with lapse in care	4	0		
Deep Tissue Injury with lapses in care	0	6		
Unstageable Pressure Ulcers with lapses in care	0	1		

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Quality Dashboard

NHS University Hospitals of North Midlands NHS Trust

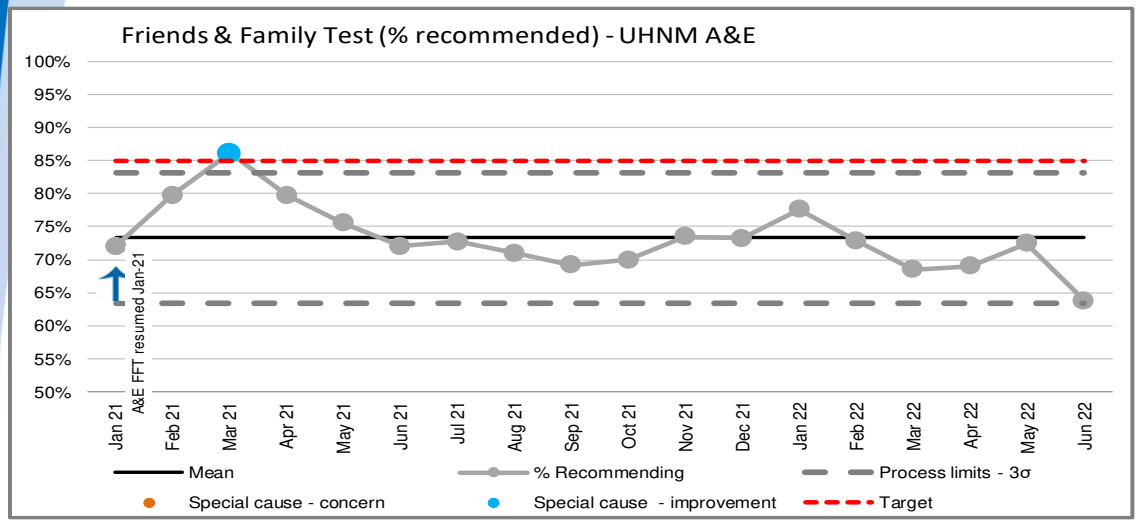
Metric	Target	Latest	Variation	Assurance
Friends & Family Test - A&E	85%	63.8%		
Friends & Family Test - Inpatient	95%	98.9%		
Friends & Family Test - Maternity	95%	100.0%		
Written Complaints per 10,000 spells	21.11	19.10		
Rolling 12 Month HSMR (3 month time lag)	100	94.77		
Rolling 12 Month SHMI (4 month time lag)	100	105.20		
Nosocomial COVID-19 Deaths (Positive Sample 15+ days after admission)	N/A	3		
VTE Risk Assessment Compliance	95%	99.6%		
Reported C Diff Cases per month	8	14		
Avoidable MRSA Bacteraemia Cases per month	0	0		
HAI E. Coli Bacteraemia Cases per month	8	13		
Nosocomial "Definite" HAI COVID Cases - UHNM	0	34		

Metric	Target	Latest	Variation	Assurance
Inpatient Sepsis Screening Compliance (Contracted)	90%	90.3%		
Inpatient IVAB within 1hr (Contracted)	90%	95.7%		
Children Sepsis Screening Compliance (All)	90%	85.2%		
Children IVAB within 1hr (All)	90%	N/A		
Emergency Portals Sepsis Screening Compliance (Contracted)	90%	80.0%		
Emergency Portals IVAB within 1 hr (Contracted)	90%	52.0%		
Maternity Sepsis Screening (All)	90%	100.0%		
Maternity IVAB within 1 hr (All)	90%	100.0%		

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Friends & Family Test (FFT) – A&E



Variation	Assurance

Target	Apr 22	May 22	Jun 22
85%	69.1%	72.4%	63.8%

Background

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

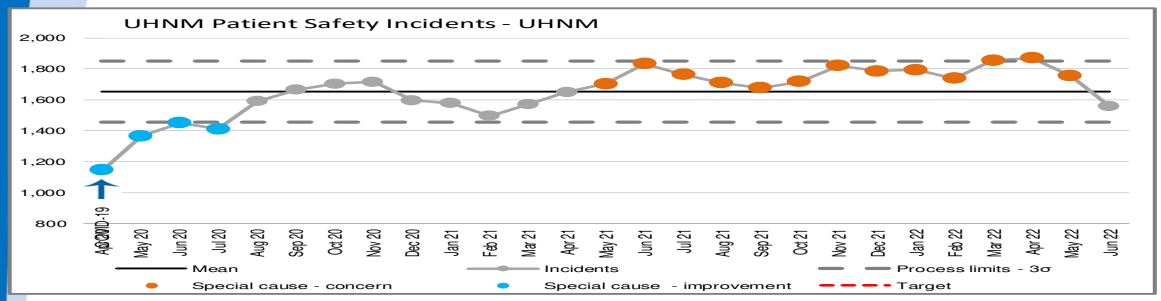
What do the results tell us?

- Although the satisfaction rate for ED remains below our internal target at 64% for June 22, the Trust received 970 responses which is a significant drop compared to previous months and will impact on the overall satisfaction score. Netcall are investigating the cause of the reduction in numbers. The Trust overall satisfaction rate is lower than the national average of 75% (NHS England).
- Feedback from patient experience of using 111First and the kiosks is being monitored. 25% of respondents used 111First prior to attending ED, which remains static. Satisfaction score of patients using 111First was 54% which is a decrease but is also likely to be impacted by the reduction in the number of responses

Actions :

- Themes from patient feedback remain the same and are around wait times, staff attitude and access to pain relief.
- Patient Experience team have been liaising with ED Matron with regards to re-establishing the departmental patient experience meeting to discuss themes and plans for improvement and requests for new membership within the department have been sent. Invitation to the monthly Patient Experience Group meetings have also been extended to the ED management team so progress against any improvements can be monitored.
- Senior AHP for Patient Experience is working with Volunteer Coordinator to look at a specific role around gathering feedback to try and support improvements in accessibility to alternative formats of the FFT survey (other than just text messaging); and increasing both the response rate and satisfaction rates.

Reported Patient Safety Incidents

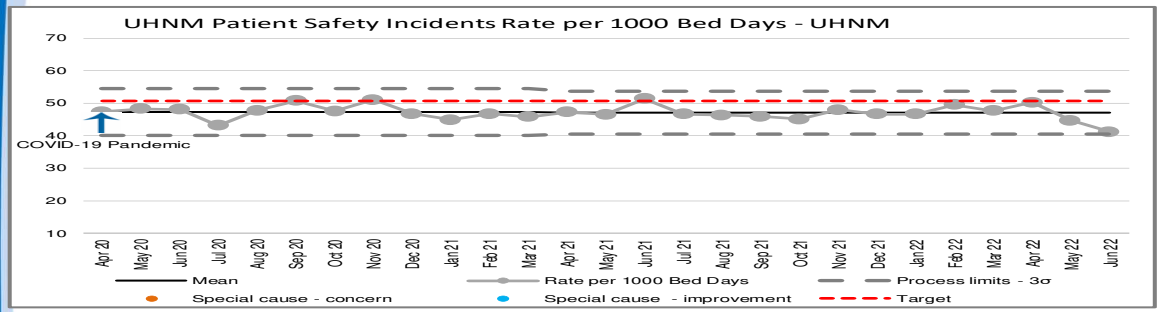


Variation	Assurance
	

Target	Apr 22	May 22	Jun 22
N/A	1870	1755	1557

Background

Total Reported patient safety incidents



Variation	Assurance
	

NRLS Mean	Apr 22	May 22	Jun 22
50.70	50.28	44.67	41.15

What is the data telling us:

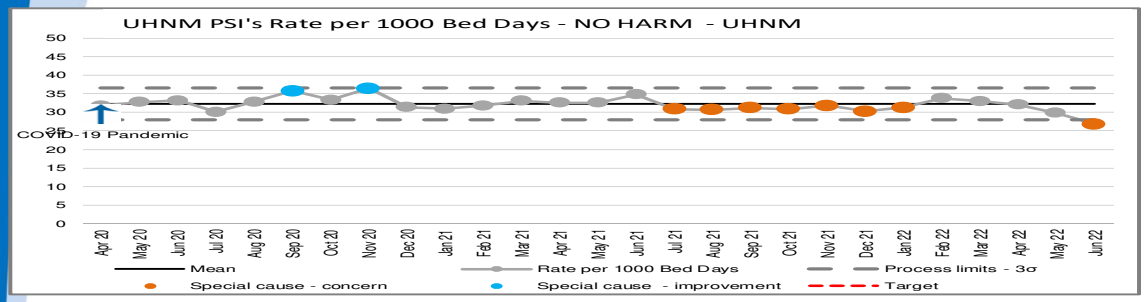
The above data relates to **all** reported Patient Safety Incidents (PSIs) across the Trust. The May 2022 total remains above the mean total since COVID-19 started. However, the reporting of incidents and near misses should continue to be encouraged and promoted and increasing rates and numbers of total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

The largest categories for reported PSIs excluding Non Hospital Acquired Pressure Ulcers are Patient Falls, Medication, Patient Flow and Clinical assessment related incidents. There has been no significant changes in these categories during June compared to previous months.

There has been an in month increase in the number of total staffing related incidents submitted during June 2022 with 56.

The rate of reported PSIs per 1000 bed days has decreased below long term mean rate but remains in normal variation

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

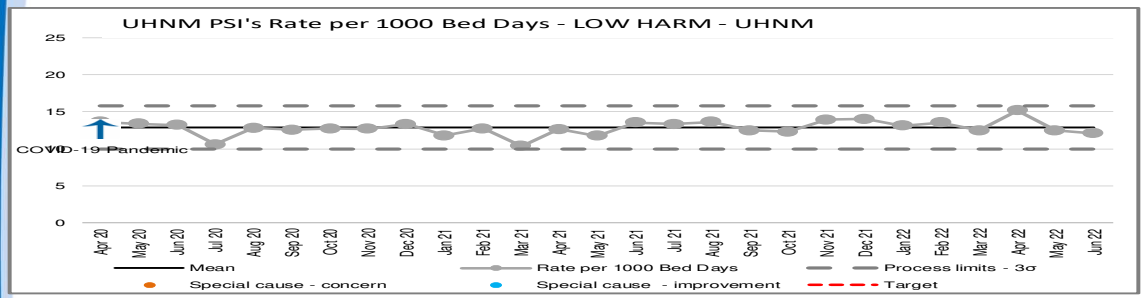


Variation	Assurance

Target	Apr 22	May 22	Jun 22
N/A	32.10	29.83	26.80

Background

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

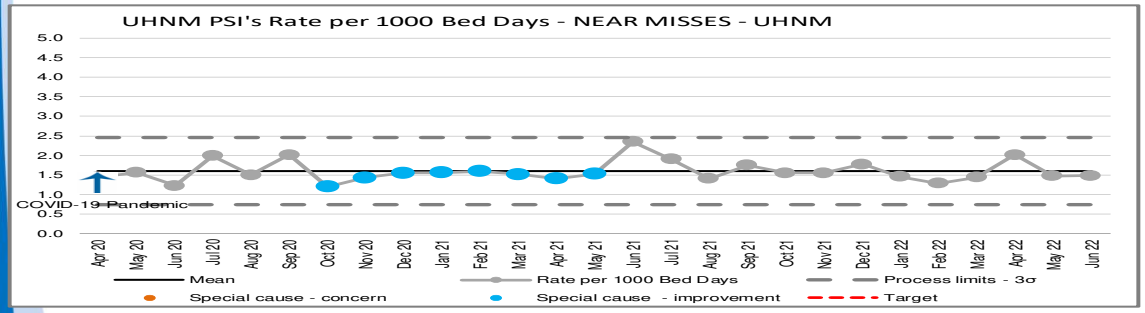


Variation	Assurance

Target	Apr 22	May 22	Jun 22
N/A	15.16	12.50	12.11

Background

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



Variation	Assurance

Target	Apr 22	May 22	Jun 22
N/A	2.02	1.48	1.48

Background

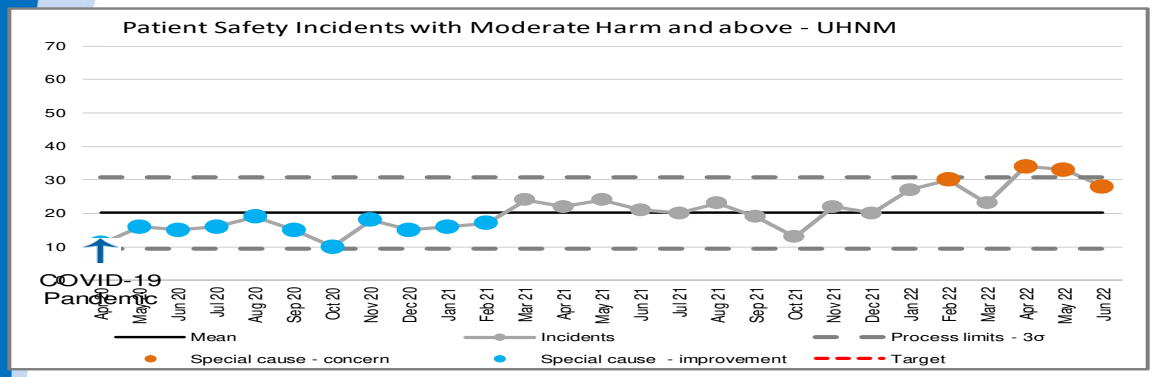
The rate of Patient safety Incidents per 1000 bed days that are reported as NEAR MISS

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 and within normal variation.

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

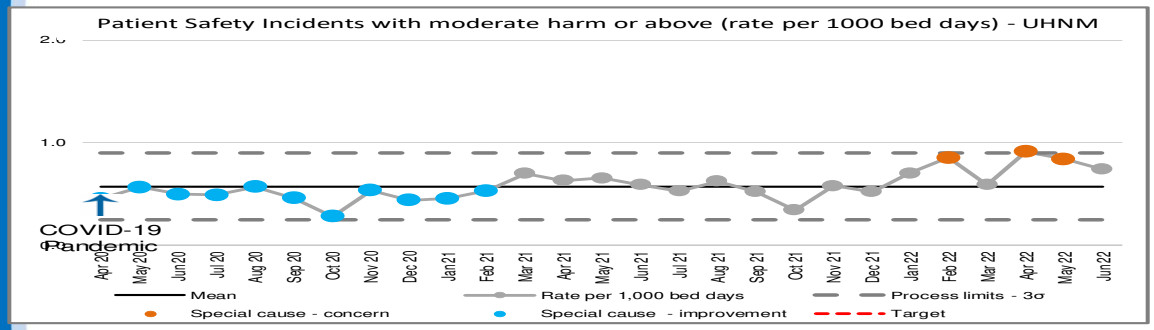


Variation	Assurance

Target	Apr 22	May 22	Jun 22
N/A	34	33	28

Background

Patient safety incidents with reported moderate harm and above



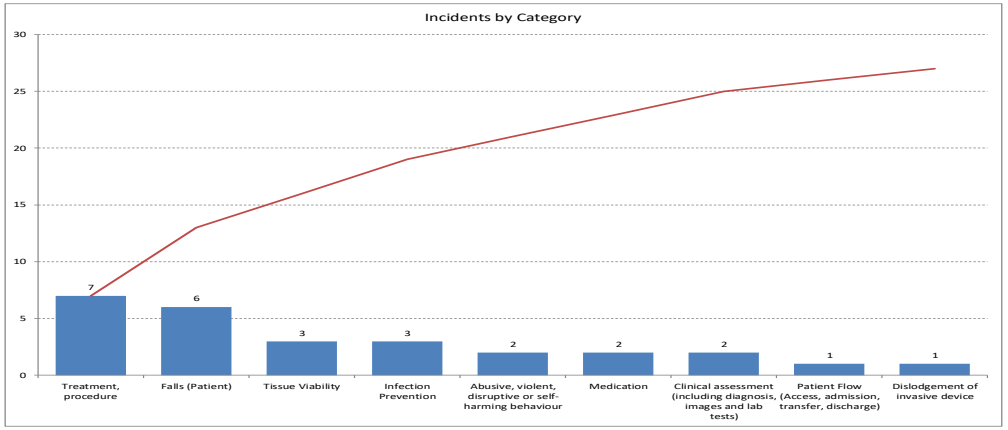
Variation	Assurance

Target	Apr 22	May 22	Jun 22
N/A	0.91	0.84	0.74

What is the data telling us:

The variation noted in charts above for moderate harm or above total and rate per 1000 bed days is at the upper process control and the past 6 months is above the mean rate hence the higher variation indicator. The monthly total may be amended following investigation of the incidents and level of harm reviewed and confirmed.

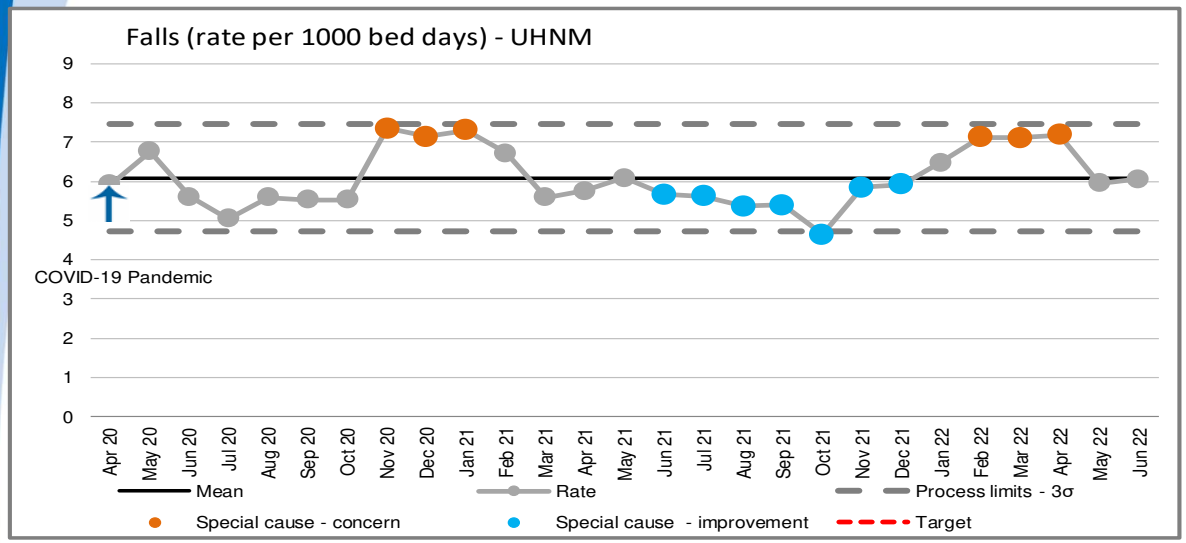
The top category of incidents resulting in moderate harm reflect the largest reporting categories with 7 Treatment/procedure, 6 Falls, 3 Tissue Viability related, 3 Infection prevention being top 4 categories with 3 or more incidents.



Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Patient Falls Rate per 1000 bed days



Variation	Assurance

Target	Apr 22	May 22	Jun 22
N/A	7.2	6.0	6.1

Background

The number of falls per 1000 occupied bed days

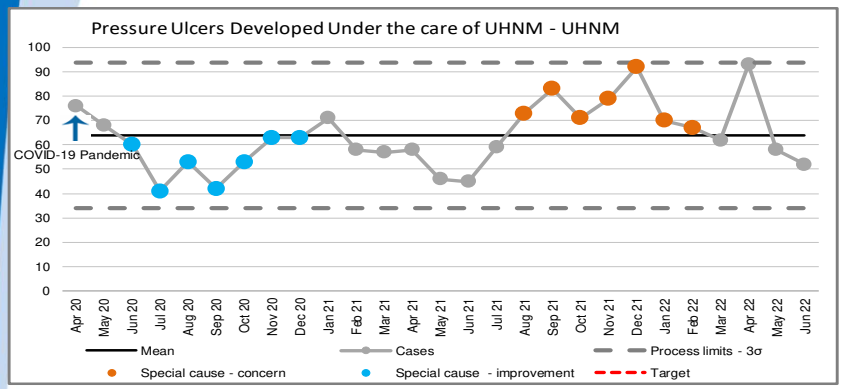
What is the data telling us:

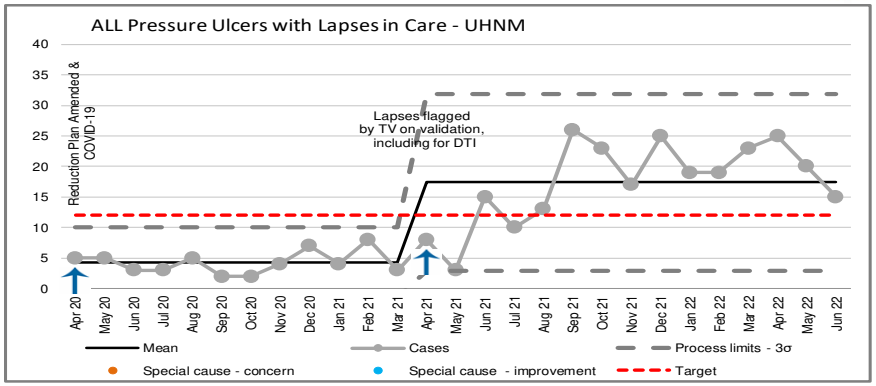
The Trust's rate of reported patient falls per 1000 bed days was within the normal range in June.

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

- A further falls champion refresher day and new falls champion training dates have been advertised.
- There is an ongoing audit process to identify areas for continual improvement.
- Wards to continue to promote the "Call don't fall" posters.

Total Pressure Ulcers developed under care of UHNM





Variation	Assurance

Target	Apr 22	May 22	Jun 22
N/A	93	58	52

Background

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

Variation	Assurance

Target	Apr 22	May 22	Jun 22
12	25	20	15

Background

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

The number of pressure ulcers reported as developed under UHNM care was within normal range in June. The tables below show breakdowns of the pressure ulcers reported last month.

Category	Total (Jun 2022)
DTI	21
Category 2	25
Category 3	2
Category 4	0
Unstageable	4
Total	**52**

Top Body Locations	Total (Jun 2022)
Heel	18
Buttock	10
Nose	5
Sacrum	5
Gluteal Cleft	5

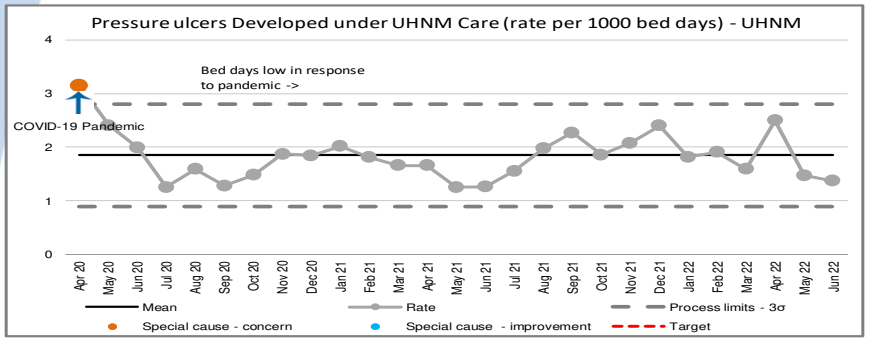
The number of pressure ulcers reported as developing under the care of UHNM, where lapses in care have been identified, has been significantly higher than in previous years, but there does not currently appear to be a further increasing trend.

Actions:

Following an increase in lapses with heel offloading a heel offloading campaign was held in May 2022.

Further analysis is under way to determine whether there is any links identified between the lapses in care and staff absences.

Pressure Ulcers developed under care of UHNM per 1000 bed days

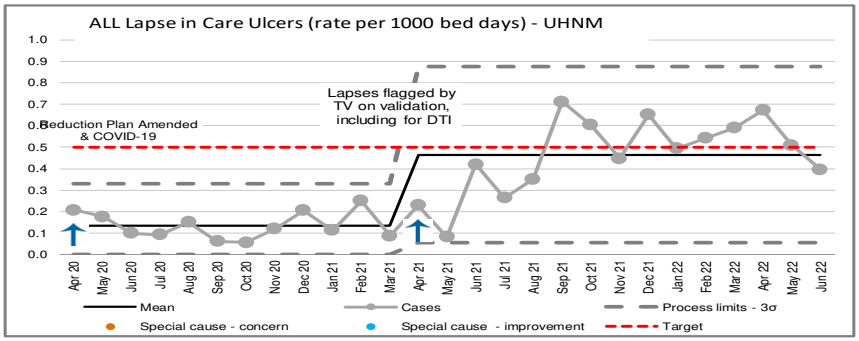


Variation	Assurance

Target	Apr 22	May 22	Jun 22
N/A	2.50	1.48	1.37

Background

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



Variation	Assurance

Target	Apr 22	May 22	Jun 22
0.5	0.67	0.51	0.40

Background

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

What the data is telling us

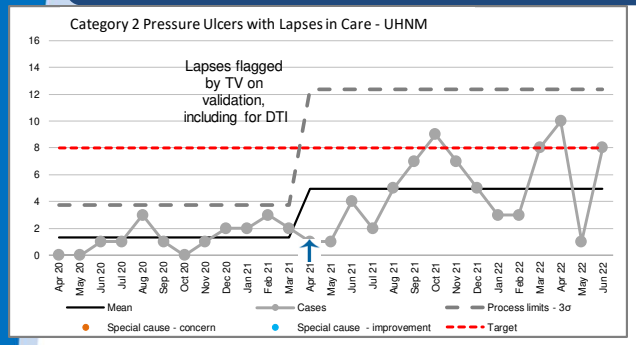
The rate of pressures ulcers reported as developed under UHNM care appears stable, showing only expected variation.

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

Actions

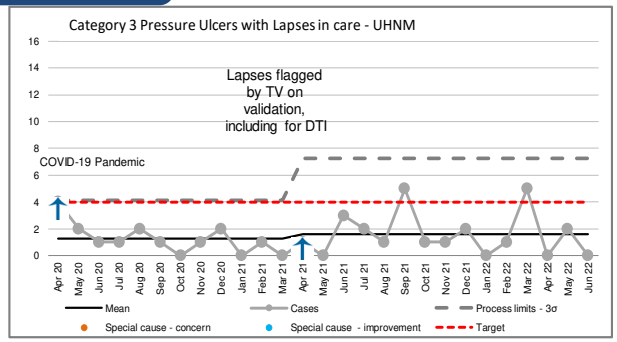
- Pressure Ulcer Prevention (PUP) education is now delivered on multiple platforms including the Nursing Assistant, adaptation nurse and Preceptorship induction programme , new starters in ED and child health. Mandatory ED training and ward PUP champions has been re-launched to cascade information. Education and support can also be requested as required.
- Summer Conference took place on 6th July 2022
- Wards are invited to RCA panels to focus on improvements and learning

Pressure Ulcers with lapses in care



Variation	Assurance

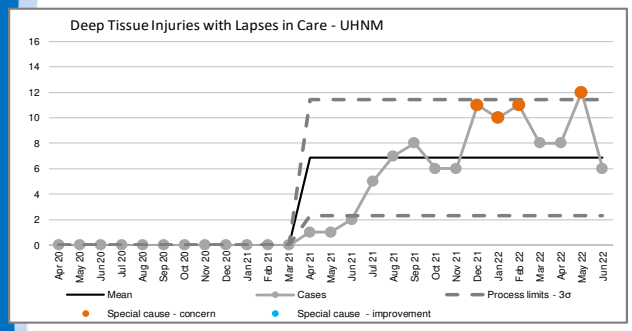
Target	Apr 22	May 22	Jun 22
8	10	1	8
Background			



Variation	Assurance

Target	Apr 22	May 22	Jun 22
4	0	2	0
Background			

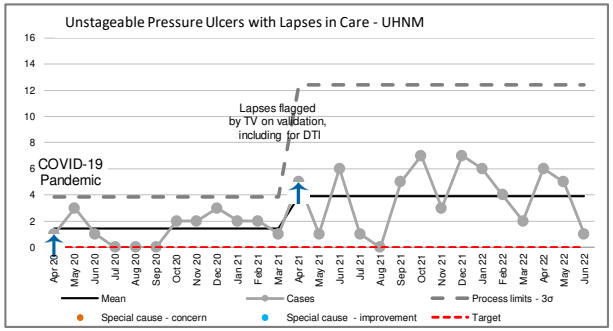
Category 3 pressure ulcers which developed under the care of UHNM with lapses in care associated



Variation	Assurance

Target	Apr 22	May 22	Jun 22
N/A	8	12	6
Background			

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



Variation	Assurance

Target	Apr 22	May 22	Jun 22
0	6	5	1
Background			

unstageable ulcers which developed under the care of UHNM with Lapses in care associated

What is the data telling us:

The number of pressure ulcers reported as developing under UHNM care with identified lapses in care is showing only normal variation in each of the categories .

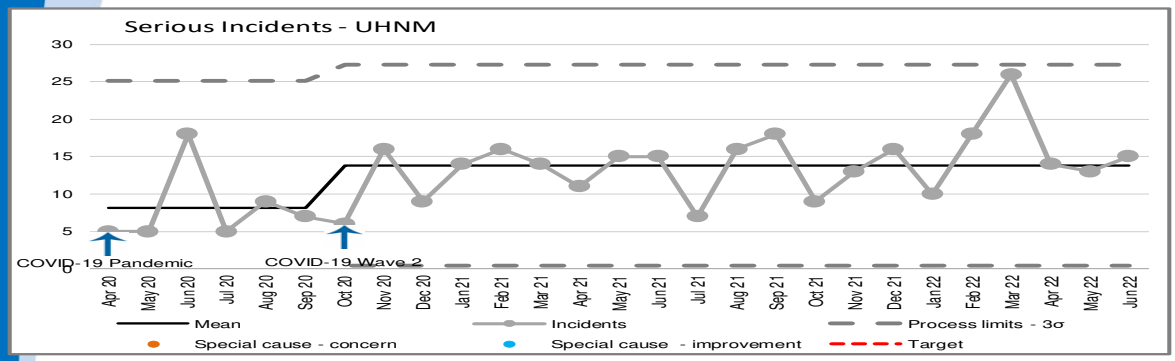
As shown in the table below, the most common lapses identified was management of repositioning.

Root Cause(s) of damage - Lapses - Jun 2022	Total
Management of heel offloading	9
Management of repositioning	8
Management of continence	1

Actions:

- High reporting wards will be sent notification, with Hot Debriefs taking place on the wards, with audits and action plans to be implemented along this.
- Communication is provided by SSR for Q&S to multiple reporting wards to highlight learning needs and support formulation of the action panel ahead of RCA panel.
- To plan a focus for lapses of repositioning
- Pressure Ulcer Prevention (PUP) Champions training dates have commenced, along with other training from the TV team
- Tendable audit questions completed which will support with RCA learning and 5 key questions which link into common RCA themes will be added to CEF

Serious Incidents per month

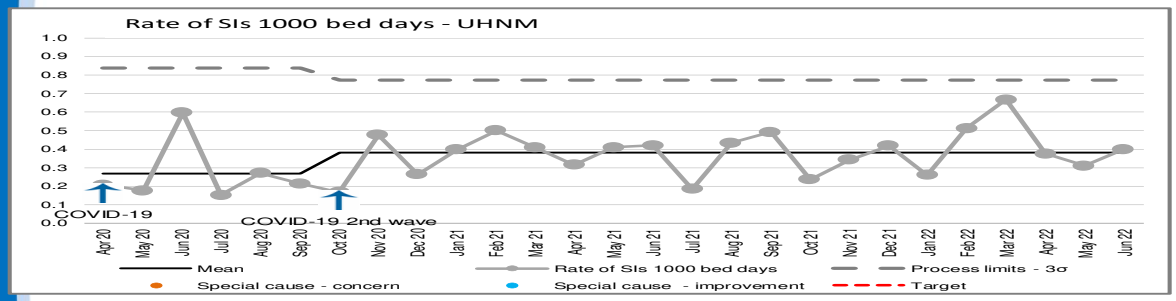


Variation	Assurance
	F

Threshold	Apr 22	May 22	Jun 22
0	14	13	15

Background

The number of reported Serious Incidents per month



Variation	Assurance
	?

Target	Apr 22	May 22	Jun 22
0	0.38	0.31	0.40

Background

The rate of Serious Incidents Reported per 1000 bed days

What is the data telling us:

Monthly variation is within normal limits. Target has been set at 0 for serious incidents but this is under review to develop trajectory for reducing serious incidents across UHNM. June 2022* saw 15 incidents reported:

7 Falls related incidents

3 Maternity/Obstetric incidents

1 Surgical/invasive procedure related

2 Diagnostic related

1 Treatment related

1 Blood product/transfusion related

The rate of SIs per 1000 bed days has varied consistently within confidence limits indicating normal variation and there has not been any significant trends. The current rate of SIs per 1000 bed days for June 2022 is 0.4 and is same as the long term mean of 0.4 since COVID-19 started in December 2020.

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

Serious Incidents Summary

University Hospitals of North Midlands NHS Trust

Summary of new Maternity Serious Incidents

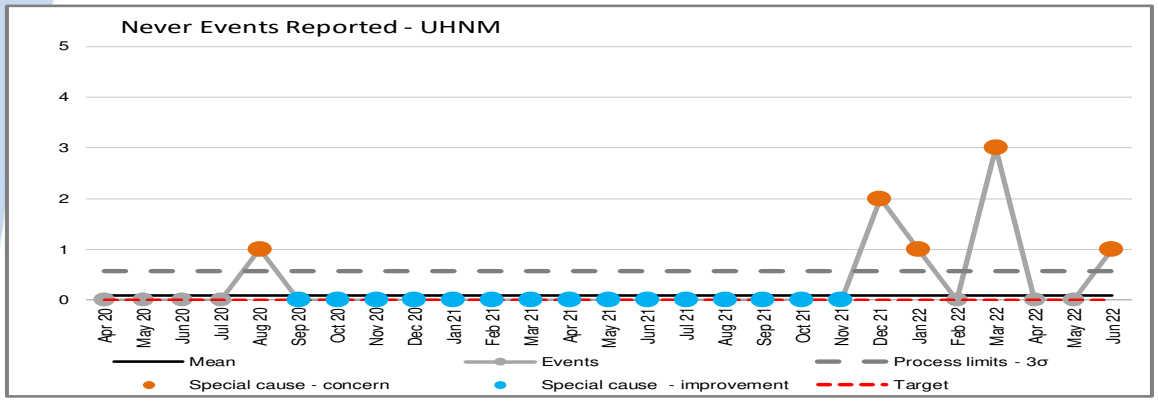
Following the formal recommendations in the Ockenden Report, below is an outline of the Maternity related serious incidents reported during May 2022. The new recommendation requires the Trust Board to receive summary on the new Maternity related Serious Incidents along with previously reported summary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

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

There were 3 Maternity related Serious Incidents reported on STEIS during June 2022

Log No	Patient Ethnic Group:	Type of Incident	Target Completion date	Description of what happened:
2022/12317	White - British	Maternity/Obstetric incident meeting SI criteria: mother and baby (this include foetus. neonate and infant)	09/09/2022	A Stillbirth reported
2022/12612	White - British	Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus. neonate and infant)	13/09/2022	Neonatal Death
2022/14402	White - Other	Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus. neonate and infant	30/09/2022	Neonatal Death

Never Events



Variation	Assurance

Target	Apr 22	May 22	Jun 22
0	0	0	1

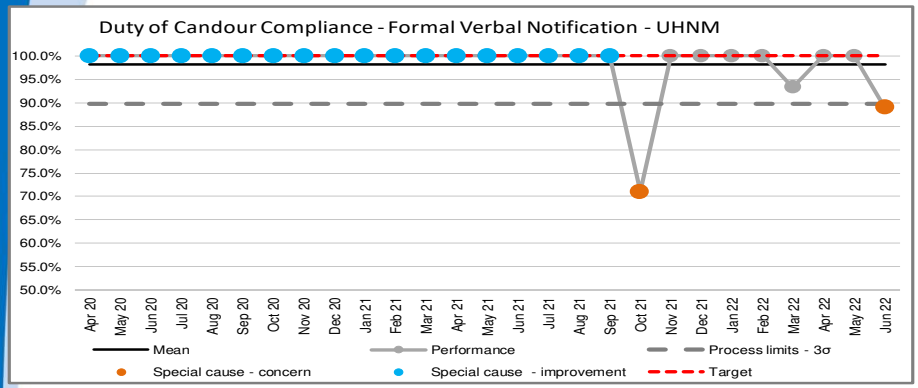
Background

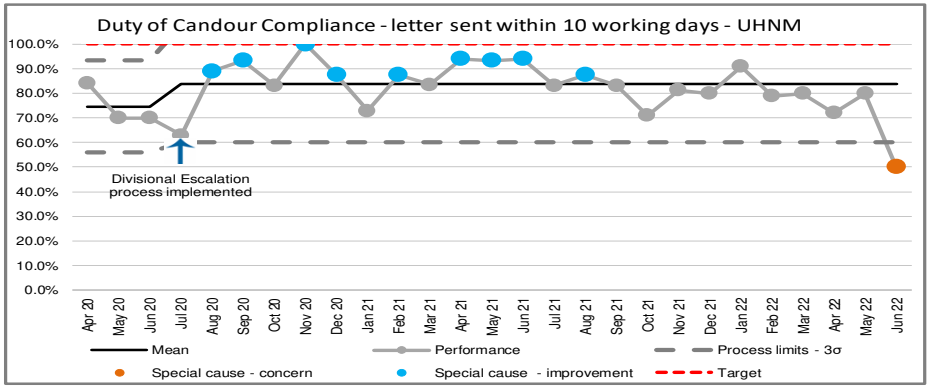
Defined as Serious Incidents that are wholly preventable, as strong systemic protective barriers should be in place

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

Log No.	STEIS Category	Never Event Category	Description	Target Completion date
2022/13571	Surgical invasive procedure incident meeting SI criteria	Retained foreign object post procedure	Missing swab was identified and checked prior to completion of procedure. Retained swab confirmed following x ray at clinic follow up. Policy was followed in terms of utilising X ray to try and find the swab. Investigation is underway. The investigation is ongoing and learning will be shared following its completion.	22/09/2022

Duty of Candour Compliance





Variation	Assurance
L	?

Target	Apr 22	May 22	Jun 22
100%	100.0%	100.0%	89.0%

Background

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

Variation	Assurance
L	?

Target	Apr 22	May 22	Jun 22
100%	72.0%	80.0%	50.0%

Background

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

What is the data telling us:

During June there were 32 incidents reported and identified that have formally triggered the Duty of Candour. 32 of these cases (89%) have recorded that the patient/relatives been formally notified of the incident in Datix.

Confirmed Follow up Written Duty of Candour compliance (i.e. receiving the letter within 10 working days of verbal notification) during June 2022 is 50% as at 11th July 2022 with delays in compliance noted within Non emergency Medicine and Specialised. Delays are result of clinician signatures and updating letters

During May and June 2022 there was reduced capacity within the DQSM team and across clinical services which has impacted on the recording/uploading of letters/information to Datix within the 10 working day target.

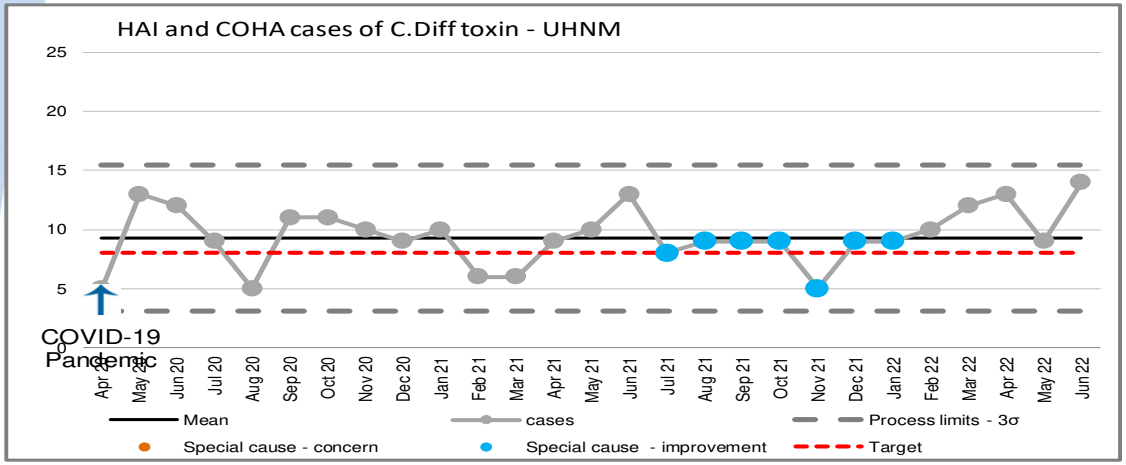
Actions taken:

New staff have been appointed to vacant DQSM posts and are commencing during July 2022 which will again support the Divisional teams in following up with completion of the Duty of Candour letters.

Escalations on outstanding letters are provided to relevant directorates and divisions via the Divisional Quality & Safety Managers and these are provided once identified and Duty of Candour required and where there has been no response prior to the deadline date.

Compliance is included in Divisional reports for discussion and action. Outstanding letters / information uploaded to Datix has been escalated with individual wards/departments and via Directorate/Divisional structures.

Reported C Diff Cases per month



Variation	Assurance

Target	Apr 22	May 22	Jun 22
8	13	9	14

Background

Number of HAI + COHA cases reported by month

What do these results tell us?

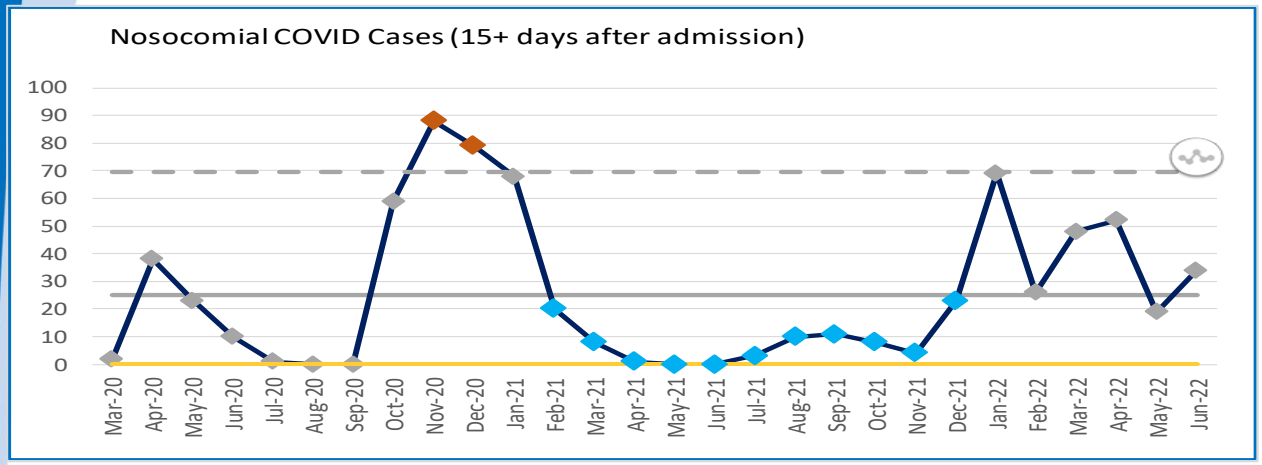
Number of C Diff cases are within SPC limits and normal variation .

HAI: cases that are detected in the hospital three or more days after admission (day 1 is the day of admission)
COHA: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks
There has been one clinical area that has had more than one Clostridium difficile case in a 28 day period. Ribotyping results have been reported however in one of the specimens CDiff was not grown by the testing centre so it is not possible to determine whether patient to patient transmission has occurred.

Actions:

- Continue surveillance for HAI C diff with continued immediate implementation of control measures to prevent transmission
- In all cases control measures are instigated immediately
- Each in-patient is reviewed by the C *difficile* nurse 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



What do these results tell us?

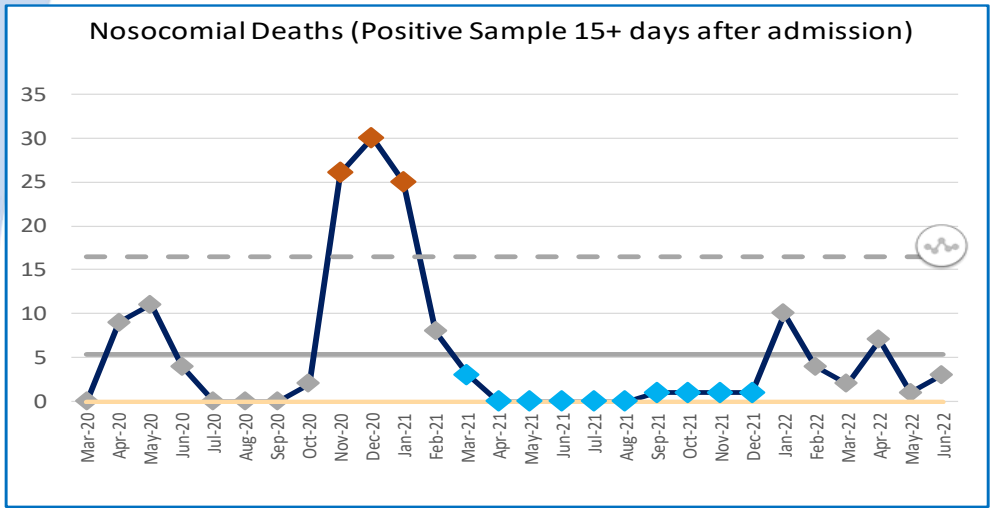
- Increase in cases throughout June 2022 with 34 definite Healthcare Acquired COVID -19 cases.
- June has seen increase in Probable and definite Hospital Onset COVID
- Monthly total is within normal variation

Actions :

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

	UHNM		
	Total Admissions	COVID cases	
		Prob	Def
Oct 20	17006	63	59
Nov 20	14956	109	88
Dec 20	14701	107	79
Jan 21	14255	128	68
Feb 21	14101	31	20
Mar 21	17105	12	8
Apr 21	16554	3	1
May-21	17273	0	0
Jun-21	18527	0	0
Jul-21	18168	4	3
Aug-21	17160	14	10
Sep-21	17327	11	10
Oct-21	17055	8	8
Nov-21	17700	4	4
Dec-21	16688	13	23
Jan-22	16109	67	69
Feb-22	16278	39	26
Mar-22	18518	71	48
Apr-22	16538	72	52
May-22		14	19
Jun-22	18416	34	34

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



What do these results tell us?

Increase in monthly total but within normal variation limits

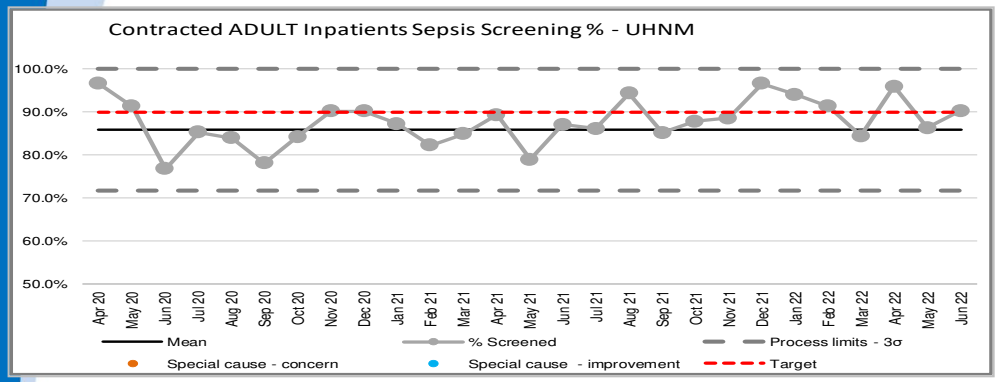
The criteria for the Definite Hospital acquired/Nosocomial COVID-19 is that the patient had **first positive** COVID-19 swab result 15 days or more following admission to UHNM.

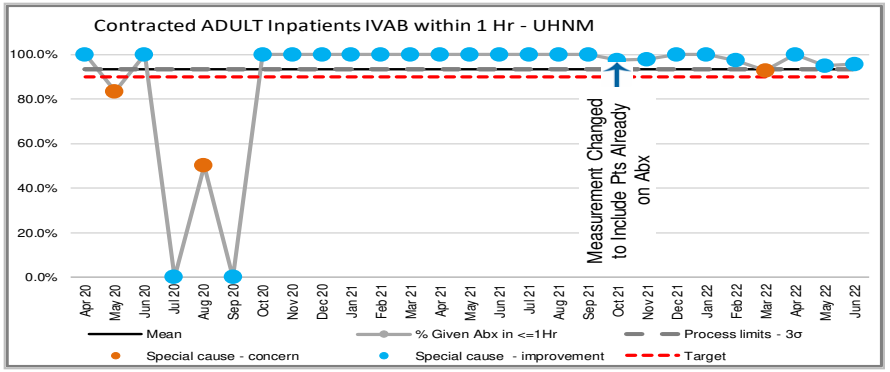
- 3 recorded definite hospital onset COVID-19 deaths in June 2022
- Total 147 hospital acquired COVID-19 deaths with 1st positive results 15 days or more following admission recorded since 1st March 2020 up to 30th June 2022
- 11 Definite Hospital acquired COVID-19 deaths during 2022/23 YTD
- The mean number of deaths per month since March 2020 is 5.

Actions :

All definite Nosocomial COVID-19 deaths up to March 2022 have been reviewed and report has been submitted to the Mortality Review Group identifying the outcome of the case reviews assessing the aspects of COVID-19 management of the patients. Reviews for any further deaths will be undertaken and outcomes compared to the reviews already completed.

Sepsis Screening Compliance (Inpatients Contract)





Variation	Assurance

Target	Apr 22	May 22	Jun 22
90%	96.0%	86.3%	90.3%

Background

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

Variation	Assurance

Target	Apr 22	May 22	Jun 22
90%	100.0%	95.0%	95.7%

Background

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

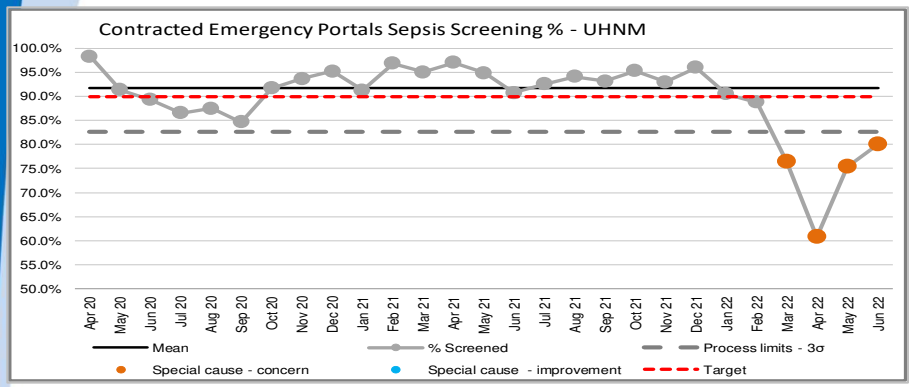
What is the data telling us:

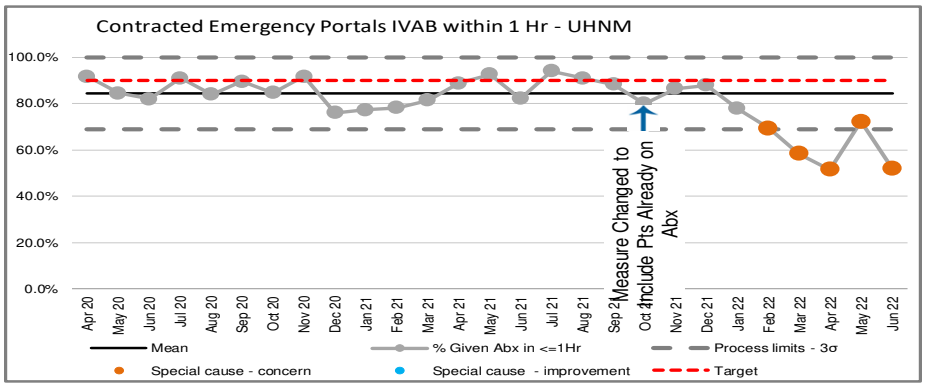
Inpatient areas achieved the screening target in June 2022. There were 58 cases audited with 6 missed screening.
IVAB within 60 minutes was above target rate with consistently high results.

Actions:

- The Sepsis Team have an agreed programme of work underway to support ongoing continual improvement for this metric

Sepsis Screening Compliance (Emergency Portals Contract)





Variation	Assurance
L	?

Target	Apr 22	May 22	Jun 22
90%	61%	75%	80%

Background

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

Variation	Assurance
L	?

Target	Apr 22	May 22	Jun 22
90%	51%	72%	52%

Background

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

What is the data telling us:

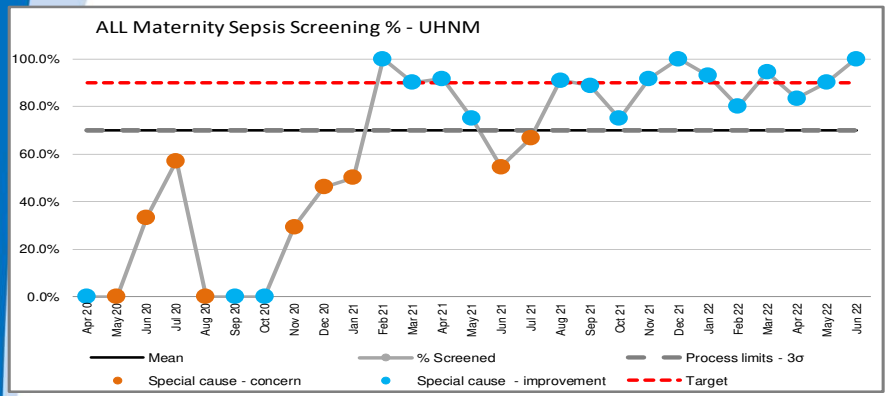
Adult Emergency Portals screening below target for June 2022 but has improved compared to April and May 2022. There were 45 cases audited with 9 missed screening in total from 1 of the emergency portal.

The performance for IVAB within 1hr below target rate in June 2022 at 52%. Out of 45 cases, there were 40 red flags sepsis in which 8 cases already on IVAB, 17 cases were newly identified sepsis and 15 cases have alternative diagnosis. There were 12 delayed IVAB with 6 cases delayed within 2 hours and 6 cases above 2 hours.

Actions:

- PGD under development with ED team to allow the sepsis bundle to be commenced at point of admission.
- Sepsis Team to provide sepsis session when staffing and acuity allows: on-going
- The Sepsis team is working collaboratively with the A&E Quality nurses, sepsis champions, senior team and A&E sepsis clinical lead to provide support with late IVAB incidents. The screening documentation and late IVAB have been addressed through escalation however, on-going plan to resolve issue with holding ambulances remain the challenge .
- Face to face A&E sepsis induction for new nursing staff, nursing assistant and medical staff will recommence once capacity pressure/flow improve in the department
- Regular meeting with A&E senior team reinstated to review current robust actions in place

Sepsis Screening Compliance ALL Maternity

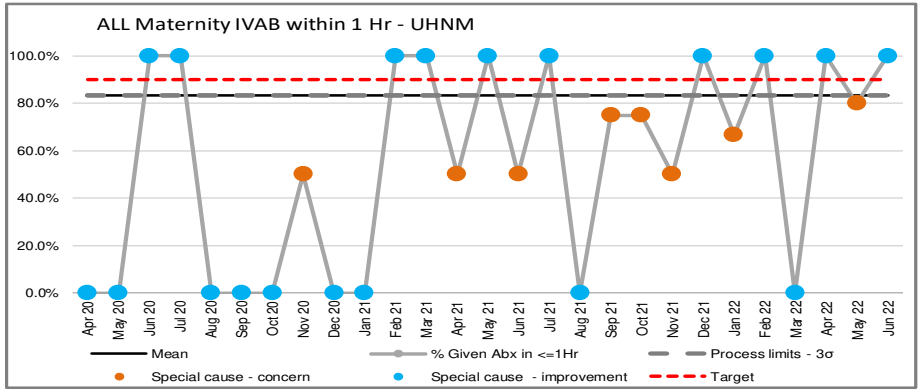


Variation	Assurance
H	F

Target	Apr 22	May 22	Jun 22
90%	83.3%	90.0%	100.0%

Background

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



Variation	Assurance
H	F

Target	Apr 22	May 22	Jun 22
90%	100%	80%	100%

Background

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

What is the data telling us:

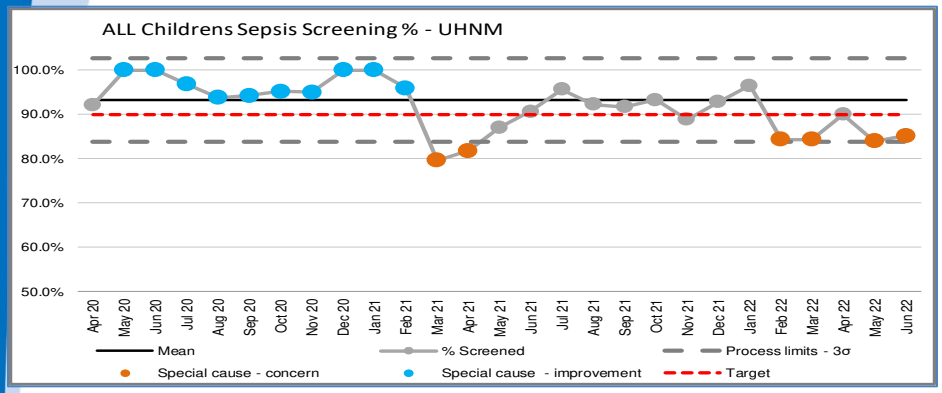
Maternity Inpatients and Emergency portal (MAU) audits show significant improvement in screening compliance above the mean rate with meeting the target performance with 100% in June 2022. There were 8 cases audited from both Emergency portal and Inpatients areas with no missed screening.

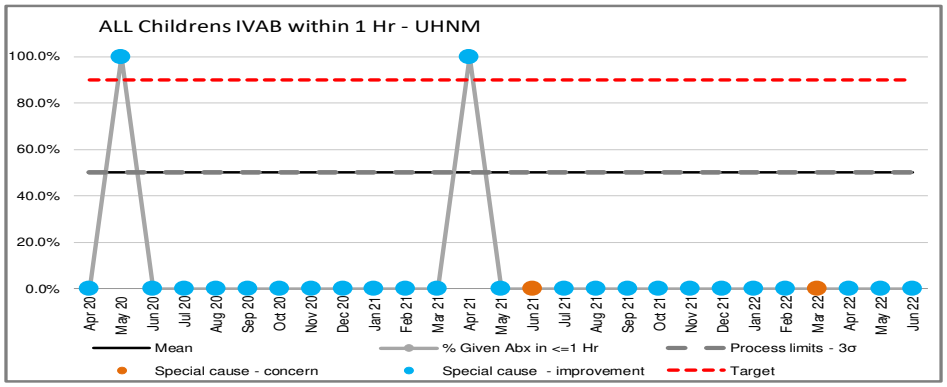
100% of the red flag sepsis patients identified in the June 2022 audits achieved IV antibiotics within an hour.

Actions:

- The Maternity Senior team and clinical staff have continued to work collaboratively with the sepsis team to ensure patient safety: on-going
- The Sepsis team will continue to audit comprehensively to ensure maintenance of high standard of sepsis practice and compliance: on-going
- Maternity educator is supporting the sepsis team by conducting independent sepsis audits in the whole Maternity department with good effect: on-going
- PGD for sepsis led by Maternity educator/team is underway and this will be supported by the sepsis team, micro consultant, pharmacist and sepsis clinical lead
- Future plan for Maternity 5 hour sepsis CPD champion training remain in the pipeline however, has been temporarily put on-hold due to current operational pressures

Sepsis Screening Compliance ALL Children





Variation	Assurance
L	?

Target	Apr 22	May 22	Jun 22
90%	90.0%	84.0%	85.2%

Background

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

Variation	Assurance
H	F

Target	Apr 22	May 22	Jun 22
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:

Children's Services show variation at lower process limit with 4 out of the last 5 points at lower process limit for Sepsis Screening and below the target rate of 90% indicating that there is need for improvement.

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

There were a total of 27 cases audited for both emergency and inpatients areas with 4 missed screening. IVAB within 60 minutes was not applicable as no red flags sepsis identified from the 27 cases.

Actions:

- The Sepsis Team will continue to deliver re-enforcement and kiosks to specific areas when falls in compliance are identified: on-going
- The Sepsis Team has continued to adjust the audit process in emergency portals to take smaller samples over a wider range of dates to give a more comprehensive perspective; on-going
- Plan of collaborative work with Children education lead and aiming to deliver 3-5 hour Sepsis CPD champion training and ward based sessions: on- hold but plan to reinstate in the next few months

Operational Performance

2025 Vision "Achieve NHS Constitutional patient access standards"

Spotlight Report from Chief Operating Officer

NHS University Hospitals of North Midlands NHS Trust

Emergency Care

- June saw a slight decline in Type 1 attendances to 13500. While this is a reduction from May, it is still higher than seen in previous months.
- 4 hour performance remained static to 62.5% in line with the previous month.
- 12 hour delays in the department grew again in June up to 550 (although this is lower than four out of the five previous months despite sustained high attendances). This has likely been impacted by flow out of the ED reducing due to infections across the bed base against increasing prevalence of COVID, ultimately causing a rise in occupancy, a key determining factor of performance.
- WTBS remained relatively static month on month although this is a maintenance of a poor position and is expected to improve as the ED workforce embeds.
- Ambulance handovers remain a challenge and delays over 60 minutes increased significantly to 1069.
- SDEC utilisation continued to improve reaching a new record high of above 35%. This in conjunction with a YTD record for ambulance triage within 15 minutes demonstrates the continued efforts of the ED to manage and stream demand in a safe and effective manner.
- The percentage of discharge occurring before noon also rose to six month high. This is likely as a result of the increased drive for early flow in response to operational pressures and the need to generate early flow through the ED.
- Refreshes of all workstreams continue to develop and be positively received with an overarching drive to ensure a consistent, data driven, and targeted approach to operational improvements and transformational change management.
- June was a challenging month as COVID driven IPC restrictions, workforce absences, and occupancy began to rise to third COVID wave levels. Following a positive May it was disappointing to be unable to maintain momentum as efforts were focussed on mitigating negative performance impact.

Cancer

- Most recent submitted Cancer Waiting Times position is May 22. The June 22 position is a performance prediction which will be impacted as histology results confirm a cancer or non cancer diagnosis for patients treated.
- Both Skin and Breast have a recovery plan for 14 day first appointment. Breast have significantly improved against the standard – currently booking at day 14, which will be reflected in July performance.
- Colorectal and Skin pathways have seen a dramatic spike in referrals – both receiving nearly 250 per week towards the end of June. WLI's are being secured where possible. A Colorectal plan is in place, overseen by the COO and Clinical Director to meet demand but is being further worked up to also reduce backlogs.
- The 104+ backlog has decreased this month to 153. within the cohort, 29 patients are on a Colorectal pathway – 19% and 38 are on a Skin pathway – 25%. Divisions have been asked to focus on this cohort and discharge patients where appropriate – e.g. where there are patients waiting over 104 days with an outstanding clinical review. In June 22, the proportion of patients waiting over the key standard, 62 days to treatment, was 11.9% which is an improved position since last month.
- The 14 day position for June 22 is predicted to achieve in the region of 44%. However the trust saw around 200 more patients than the previous.
- The 28 Day Faster Diagnosis position is currently at 55% in June, with the majority of breaches currently recorded in Colorectal and Skin.
- There are currently 670 patients in the 2WW backlog. Of the 2WW patients who have breached, 189 patients are in Colorectal and 242 are in Skin. – combined they equate to 64% of the backlog.

Spotlight Report from Chief Operating Officer

NHS University Hospitals of North Midlands NHS Trust

Planned Care

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

- Day Case has shown a small deteriorated in June, down to 90% from 92% in May. Elective Activity increased to 97% from 96% BAU in May up. This is still some way from the national ask of 110%/108%.
- Theatre plan for Q1 2022/23 gives 104% of 19/20 capacity. County theatre re-opened 11th April – all 7 theatres now online. As reported last month County theatres have exceeded the 104% target and activity has continued to grow despite continued staffing challenges between both sites driven by trauma and Covid sickness rates.
- The focus has moved to 78 week waiters with an Annual Plan to reduce them to below 300 patients by March 2023. The major change will be managing the non-admitted (Outpatient) patients to ensure they get a decision to treat or discharge well before March so any treatment can be carried out to meet the 78 week standard.

RTT

- The overall Referral To Treatment (RTT) Waiting has increased again in June after May's reduction. (76,920) up from 75,858 in May. This is the first decrease since Summer 2020.
- The number of patients > 18 weeks has continued to decrease to 34,753 from 34,928 in April. This indicates the rise in total waiting list is due to increased additions to the waiting list rather than reduced throughput.
- At the end of June the numbers of > 104 weeks was 60. The Trust almost achieved the national standard of all eliminating 104 week waits end of June, with the allowed exception of those patients who have chosen not to be treated in June or are too complex to have their treatment arranged during June. A small number of patients were cancelled in the last few days of June who could not be rebooked in time.

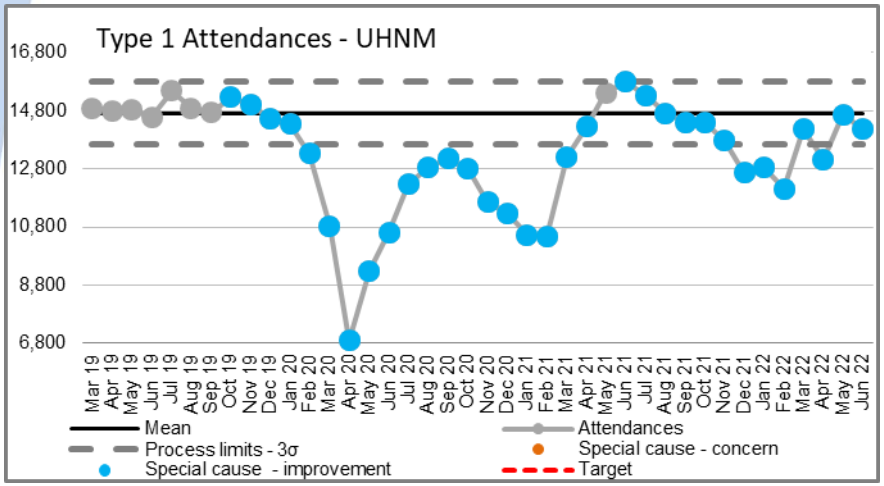
Diagnostics

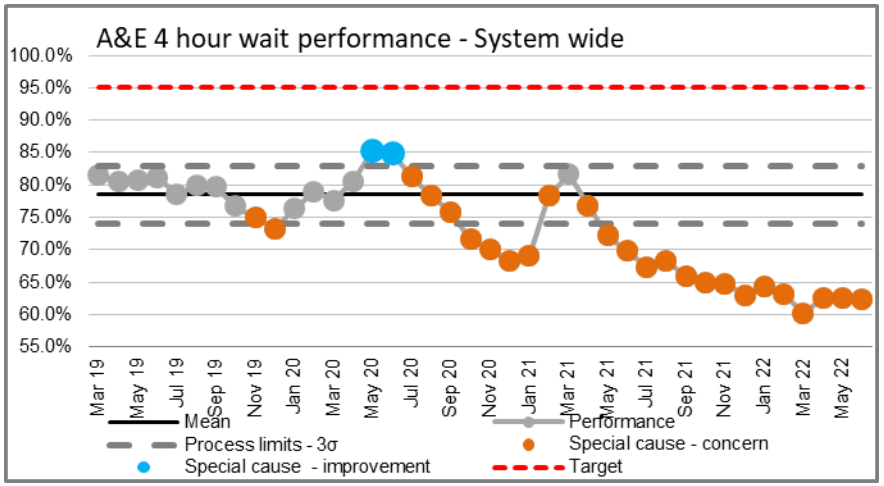
- Activity across in the DM01 increased by 9% (1,771 patients), and overall DM01 performance improved by 3% to 70% compliance
- Within DM01, the greatest proportion of > 6 week waits are within Non-obstetric ultrasound and endoscopy. Both ultrasound and endoscopies positions are related to an increase in demand alongside workforce shortfalls
- Non-obstetric Ultrasound performance increased by 0.9% to 51.4%. Endoscopy performance also increased by 1.2% to 64%. There is a clear short and long term Endoscopy expansion plan in place and work continues with Ultrasound to deal with staff shortages.
- If Ultrasound & Endoscopy were removed from DM01 performance, the Trust would have overall DM01 compliance of 93%
- Plain film is an area with a high volume of waiters, predominantly due to staffing shortages; P/F walk in centres for all patients will start in August, and will recover the position quickly by inviting patients to attend a number of locations for their x-ray (RS / County / Leek / Longton / Haywood
- Histology turnaround times remain a high risk

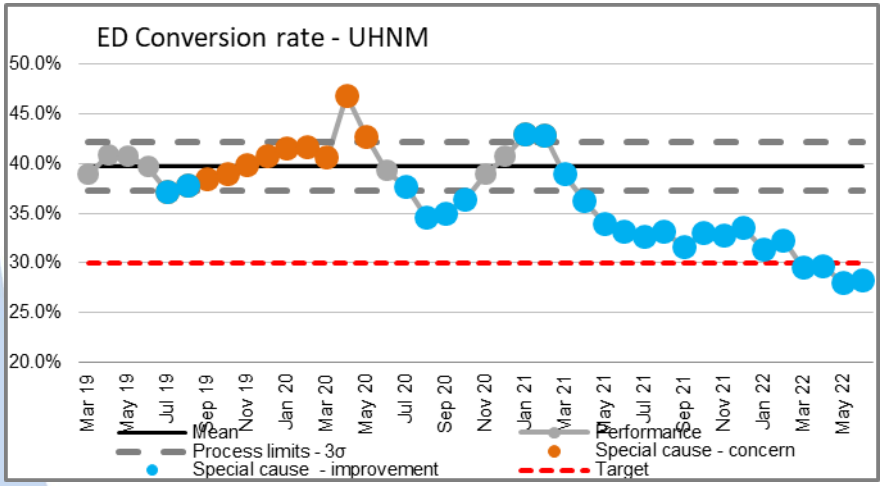
Section 1: Urgent Care

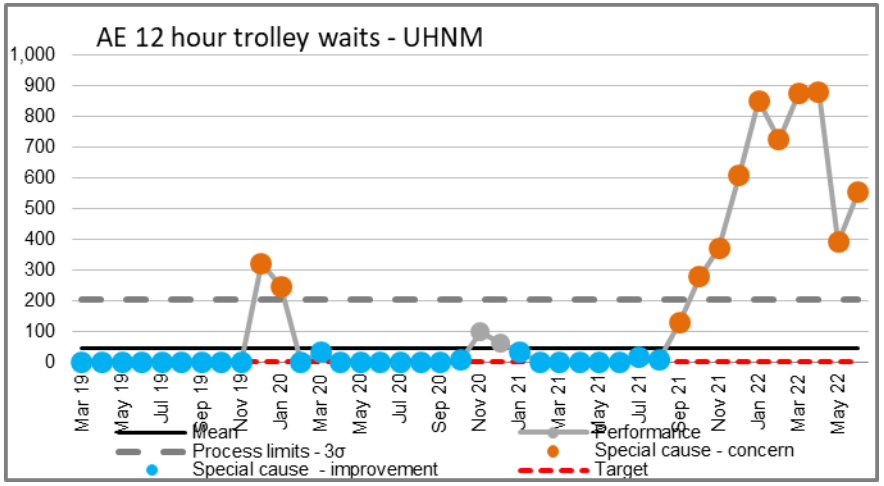
Headline Metrics

Urgent Care – monthly *(context)*



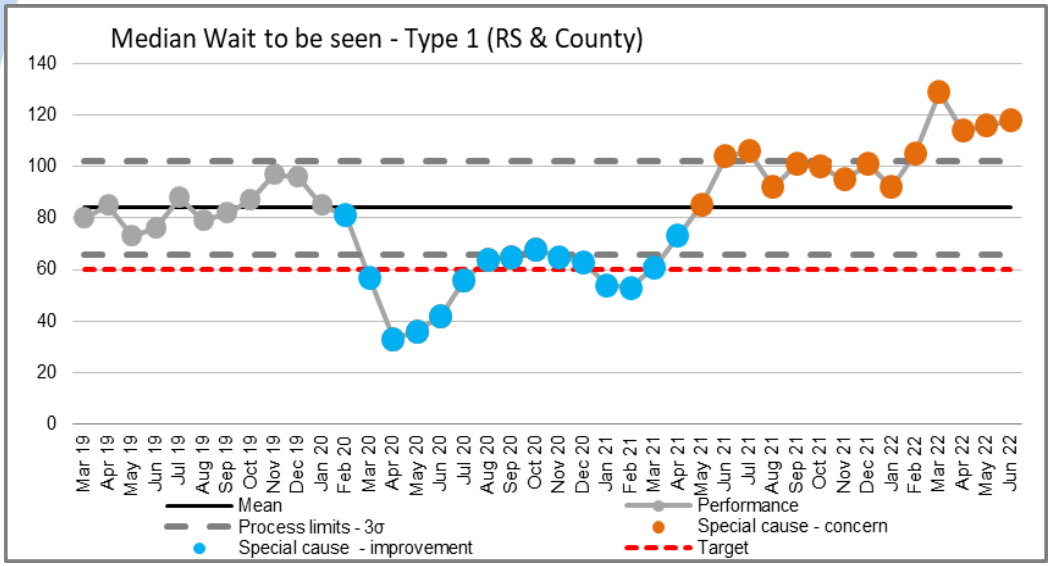






Quality | Operational | Workforce | Finance

WTBS & 12 Hour in department



Variation	Assurance
H	F

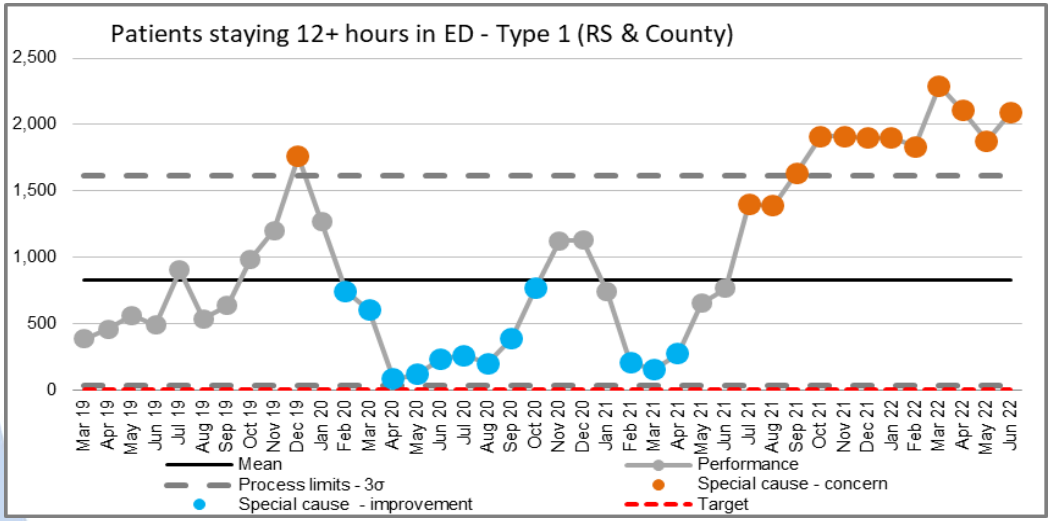
Target	Apr 22	May 22	Jun 22
60	114	116	118

Background

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

What is the data telling us?

Performance for the previous 3 months has fallen between the control limits with the month below the lower control limit.



Variation	Assurance
H	F

Target	Apr 22	May 22	Jun 22
0	2106	1877	2086

Background

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

What is the data telling us?

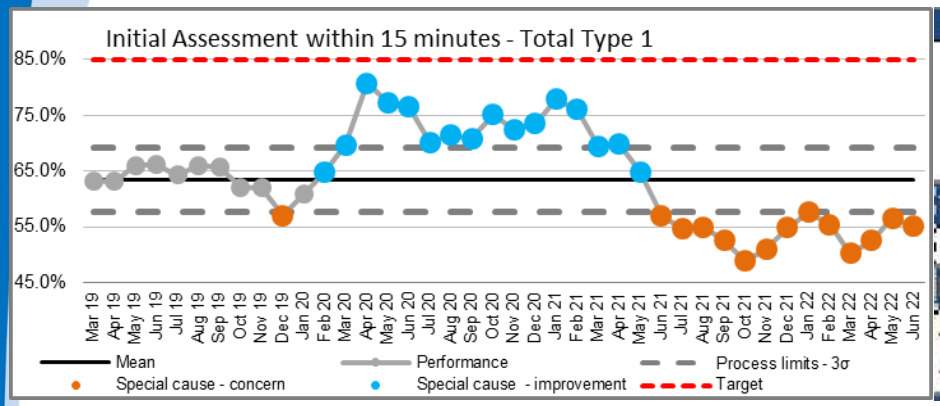
Performance for the previous 2 months had improved however in June we saw an increase of 209 patients waiting over 12hr in the department

Section 1: Urgent Care

Workstream 1; Acute Front Door

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

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
L	F

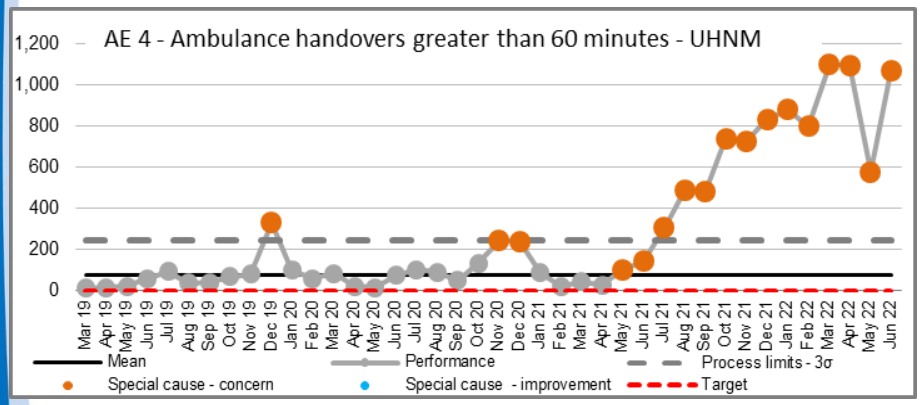
Target	Apr 22	May 22	Jun 22
85%	52.5%	56.5%	55.1%

Background

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

What is the Data telling us?

Performance remains below the 1920 lower control limit at 55.1% in June. This is back at the level seen at the beginning of last summer.



Variation	Assurance
H	?

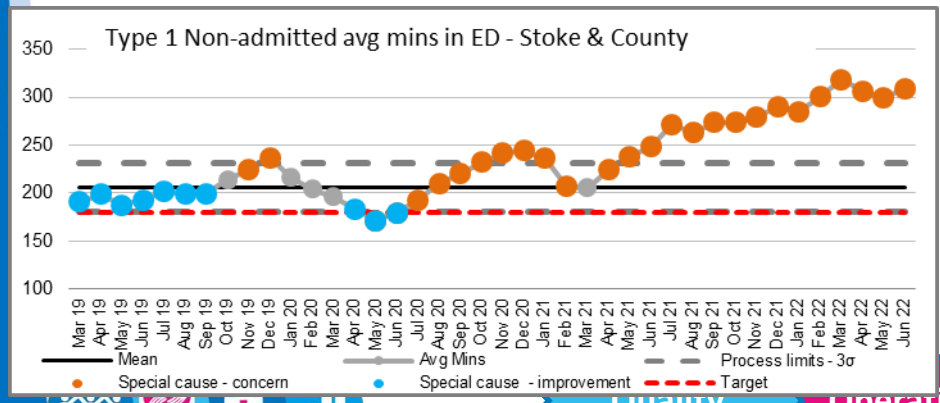
Target	Apr 22	May 22	Jun 22
0	1097	577	1069

Background

The number of ambulance handovers greater than 60 mins

What is the Data telling us?

Handover delays over 1 hour have risen dramatically over the last 12 months with significant improvement shown in May 2022 and a return to previous performance in June 2022.



Variation	Assurance
H	?

Target	Apr 22	May 22	Jun 22
180	307	299	309

Background

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

What is the Data telling us?

Mean time in department has been increasing since March 2021 with improvements seen from March 2022 to May 2022 and a slightly deterioration in June 2022.

Time To Triage, Ambulance Handover, & Treatment

University Hospitals of North Midlands NHS Trust

Summary

- Time to initial assessment has declined slightly when compared to last month from 56.5% to 55.1% for Type 1 attendances. Three final triage posts are out for advert with interview dates set. Sickness amongst the triage staff also increased in month due to COVID absences.
- Ambulance handovers remain a significant challenge and delays over 60 minutes rose again up to 1069.
- Despite ongoing ambulance handover delays the triage of patients arriving via ambulance within the 15 minute standard is at 71% in June and is the highest performance seen in recent months.
- The average time in department for non-admitted patients has stabilised in recent months after a prolonged period of deterioration, a slight rise was seen in June to July from 385 to 409 minutes.

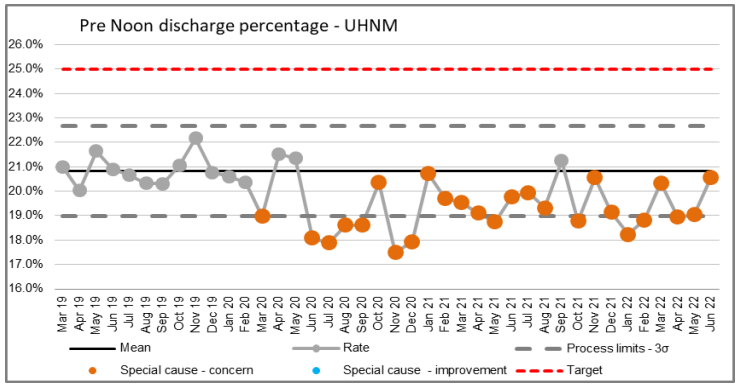
Actions

- Progress ED recruitment with agreement for one Consultant in Paediatric Emergency Medicine (to replace a consulting exiting), two NHS Locum Consultants (to backfill military deployments) and the skill mix adjustment of two unfilled Junior CESR posts into three ANP posts going through sign off now as the next posts.
- Fortnightly meetings continue with UHNM Deputy Associate Director – UEC and WMAS Head of Patient Flow for to improve working relationships. HALO support and competency is now under formal review.
- ED Tiered Medical Rota has been developed and is now live. This provides a clear and accessible picture of medical and Senior Decision Maker coverage in the ED. There is further development required to enable the rota to show proportional fill rate of medical staffing on shift.

Section 1: Urgent Care

Workstream 2; Acute Patient Flow

Pre-Noon, Simple & Timely, & Occupancy



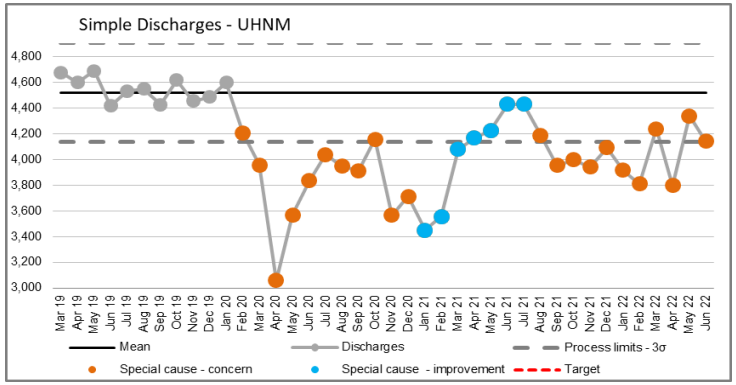
Variation	Assurance
L	F

Target	Apr 22	May 22	Jun 22
25%	18.9%	19.0%	20.6%

Background

The percentage of discharges complete before 12 noon.

Pre noon discharges have been below the 1920 mean for the last 8 months triggering the cause for concern SPC rule. June has seen an increase to 20.6%



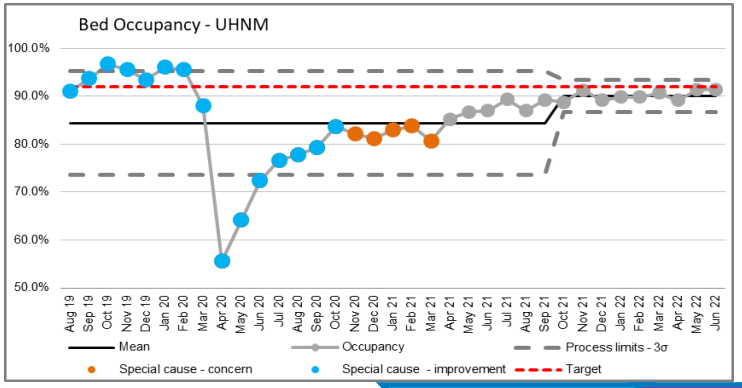
Variation	Assurance
L	

Target	Apr 22	May 22	Jun 22
N/A	3795	4337	4142

Background

Patients discharged without complex needs

Simple & timely discharges are below pre pandemic levels and have moved in line with bed demand



Variation	Assurance
~	?

Target	Apr 22	May 22	Jun 22
92%	89.2%	91.4%	91.5%

Background

The percentage of general and acute beds occupied overnight at UHNM

COVID had a significant impact on bed occupancy however the last 7 months have been fairly consistent averaging 89%.

Pre-Noon, Simple & Timely, & Occupancy

University Hospitals of North Midlands NHS Trust

Summary

- Pre noon discharges rose to 20.6% in June. This is the highest level recorded this year and reflects recent focus to drive early flow through the ED.
- The number of Simple & Timely discharges reduced on previous months with a dip to 4142 (although this is still higher than seven out of the eight most recent months).
- Overall bed occupancy continues to remain at a relatively static level and will need to be sustainably reduced in order to improve organisational patient flow.

Actions

- Refresh of the Workstream 2 Improvement Plan has been agreed with the supporting outline peer analysis completed. Deep dives will now be completed to ensure identified opportunities are appropriately weighted and prioritised.
- New TOC forms have been implemented as part of the Step Change Project across the Division of Medicine on 9th June to positive feedback.
- Following previous successes the Step Change Project is now planned to commence across two further wards starting 4th July for Phase 3 and four additional wards starting 18th July for Phase 4.
- The newly appointed Deputy Chief Medical Officer has agreed to join Workstream 2 to ensure appropriate medical engagement and challenge across the Divisions.

Together Compassion Safe Improving

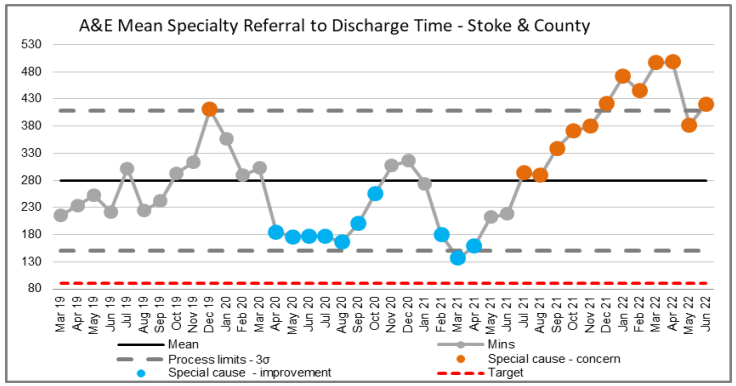
Quality | Operational | Workforce | Finance

Section 1: Urgent Care

Workstream 3; Delivering UEC Standards

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

NHS University Hospitals of North Midlands NHS Trust



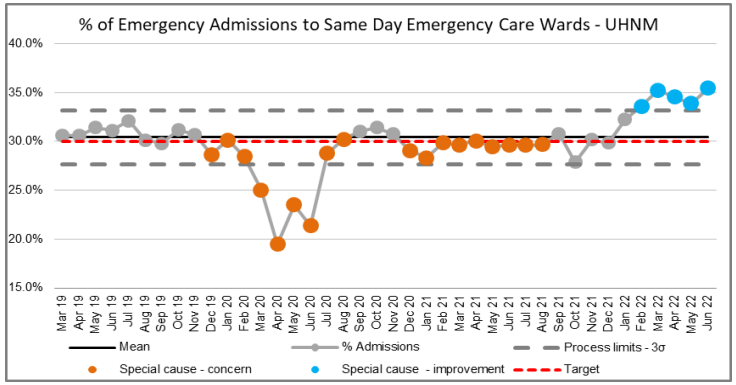
Variation	Assurance
H	F

Target	Apr 22	May 22	Jun 22
90	498	382	420

Background

The average time from the ED referral to a specialty to discharge from the ED

The average time from referral to discharge has increased since March 2021. June 2022 has seen an increase of 50 mins vs May.



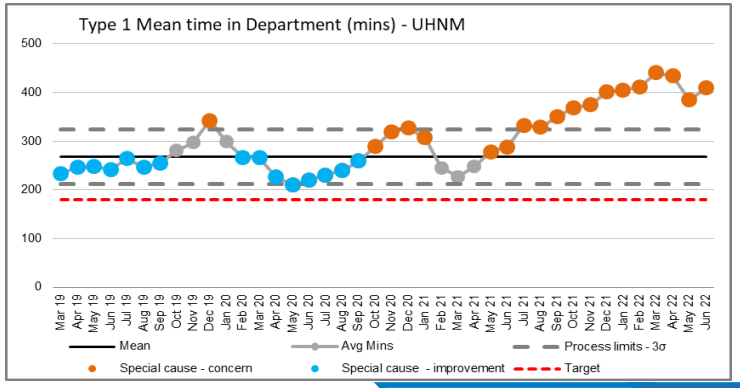
Variation	Assurance
H	?

Target	Apr 22	May 22	Jun 22
30%	34.5%	33.9%	35.4%

Background

% of emergency admissions that are admitted to the Trust's SDEC wards, and discharged within 24 hours

The Trust has been consistently in line with pre pandemic proportions of patients going through SDEC with the last 4 months seeing a significant increase up to 35% in June.



Variation	Assurance
H	F

Target	Apr 22	May 22	Jun 22
180	435	385	409

Background

The mean time (in minutes) spent in the A&E department

Total time in department has been increasing since March 2021 with the last 8 data points sitting above the control limits. June 2022 has seen a slight increase from May.

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

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

NHS University Hospitals of North Midlands NHS Trust

Summary

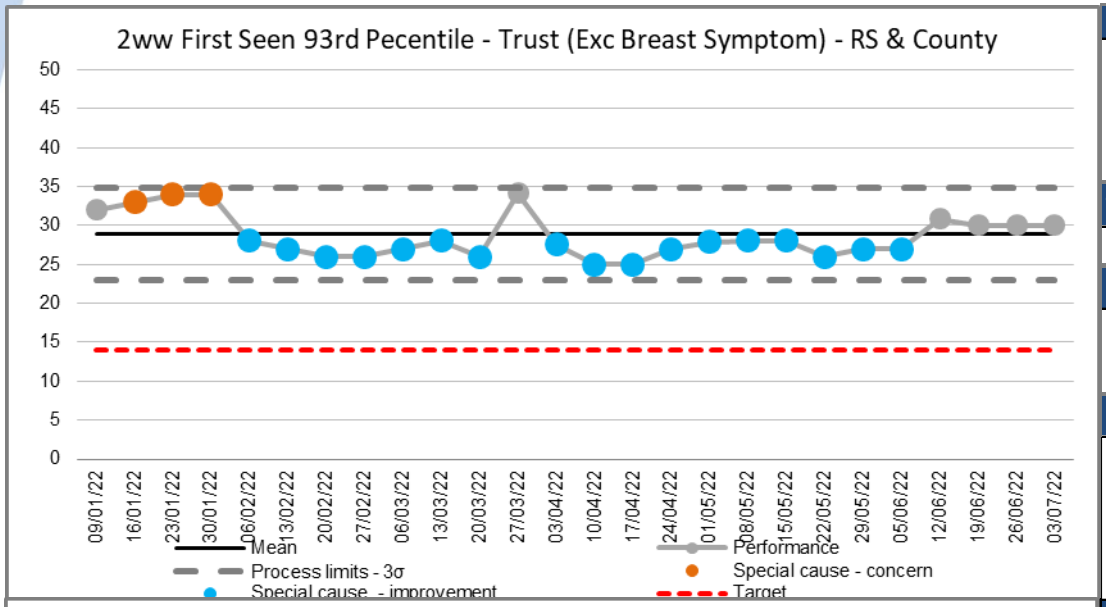
- SDEC utilisation continues to rise further with June reaching another record at 35%. This continued increase is as a result of improvements in ED navigation and direct GP referrals embedded and becoming more widely known.
- The average time from specialty referral to discharge grew in month up from 382 to 420 minutes reflecting restricted flow throughout the organisation.
- Mean time in department for all patients raised slightly to 409 from 385 minutes in June. This is largely in line with the overall slight deterioration (with the exception of ambulance handovers) from June to July as a result of increased staff absences and IPC restrictions impacting flow.

Actions

- The Workstream 3 structure has been redesigned in line with the development of the corporate projects and A3 development. Finalised A3 are now scheduled to go to the Trust Boardroom in early July.
- User testing of the AE to Ward dashboard with acute clinical and ward colleagues took place with further adjustments identified. Final version to be reviewed in late July with a target go live date of 1st August.
- SAU multi specialty electronic referral meeting held with agreement gained from Vascular to review referral form and starting to build order communication form for their requirements.

Section 2: ELECTIVE CARE

Cancer – Headline metrics



Variation	Assurance
	F

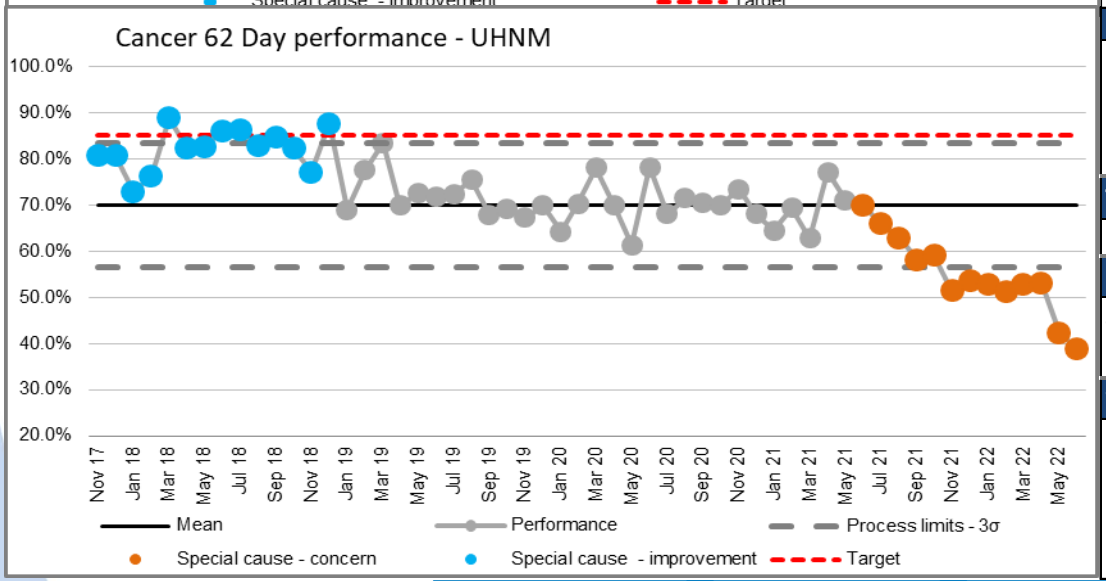
Target	Jun 22	Jun 22	Jul 22
14	30	30	30

Background

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

What is the data telling us?

Trust wide – all suspected cancer 2WW referrals. Excluding Breast symptomatic referrals where cancer is not suspected.
93 % of patients first seen for week ending 03/07 had a 14 day clock stop within day 30 of the pathway.



Variation	Assurance
L	F

Target	Apr 22	May 22	Jun 22
85%	53.2%	42.3%	38.8%

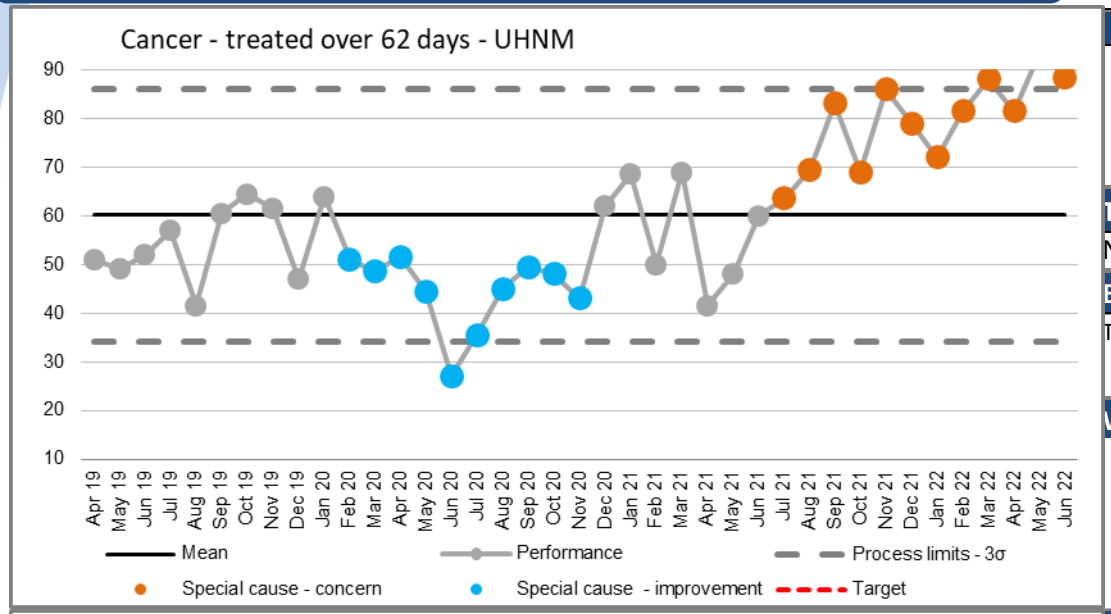
Background

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

What is the data telling us?

Performance significantly challenged and below standard for the past 12 months with a steep decline in May and predicted at 38 % for June – position still to be validated

Cancer - Headline metrics



Variation	Assurance
H	

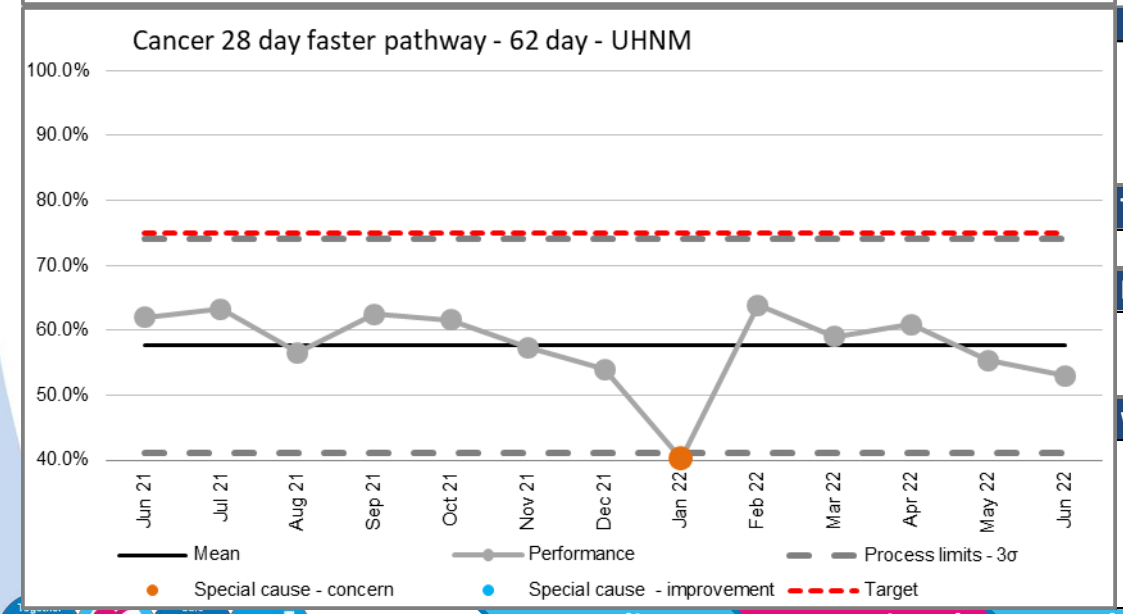
Target	Apr 22	May 22	Jun 22
N/A	81.5	93.5	88.5

Background

The number of patients treated over 62 days

What is the data telling us?

Demonstrates total volume of patients who have been treated beyond day 62 is a cause for concern and has been rising over the past 12 months.



Variation	Assurance
	F

Target	Apr 22	May 22	Jun 22
75%	60.9%	55.4%	53.0%

Background

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

What is the data telling us?

Final May position landed worse than predicted at 54%
A further decline is expected for June 22 – currently at 52% which is expected to change as more pathways are recorded.

Cancer Trajectories

NHS University Hospitals of North Midlands NHS Trust

Provider Level					April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022	December 2022	January 2023	February 2023	March 2023
RJE	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	E.B.32	Count	The number of cancer 62-day pathways (patients with and without a decision to treat, but yet to be treated or removed from the PTL) waiting 63 days or more after an urgent suspected cancer referral excluding non-site specific symptoms	462	440	420	400	380	360	340	320	300	280	250	191
				UHNM snap-shot PTL position	579	632	639									

National planning guidance 22/ 23 set out the ambition to return the number of patients waiting over 62 days on the live PTL to the levels seen pre-pandemic. The PTL Backlog trajectory for UHNM is set out above; the actuals shown above are a snap shot in time of the PTL position. This is for the week ending last full week of the month per PAF report
For the month of June 2022, the backlog position was 639 - this includes patients with a decision to treat and a future treatment date scheduled, however this is still 219 patients larger than the required trajectory to return to pre-pandemic waits.

Patients awaiting a 2WW are currently awaiting 30 days to be seen and there are 670 patients in the 2WW backlog. Of the 2WW patients who have breached, 189 patients are in Colorectal and 242 are in Skin.
The number of patients waiting over 104 days is 153. Of these, 29 are on a Colorectal pathway – 19%, 38 are on a Skin pathway – 25%.
There are 52 patients waiting over 104 days with a diagnosis of cancer. Of those, 25 are in Urology, 6 are in Breast and 7 in Colorectal.

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

All Divisions are focusing on the backlog and discharge patients where appropriate. Pathway plans are detailed overleaf – there is a concentration on the first appointments and diagnostics and including Oncology. All diagnostic modalities have submitted plans for a reduction in waiting times which includes additional staffing, insourcing and outsourcing and building additional capacity through CDC's.

Cancer

Summary

- Pathology and Oncology have recovery plans in place to support on-going pressures.
- Skin and Colorectal receiving high volume of referrals – putting on additional capacity to accommodate the demand.
- Breast have recovered 2ww position to booking within 14 days for suspected cancer – breakdown within percentile graphs on following slides.

Actions

Pathology:

Creation of a dashboard to allow tracking of patients to be timed and those requiring an expedited test to be on an accelerated pathway.

Appointment of additional staffing to support the histology turn around times, due to be in place on a phased timeline by Autumn.

Skin:

The transformational delivery unit (TDU) of the ICS are supporting a system wide meeting looking at delivery of GP initiated Teledermatology. Internally, funds have been secured for 12 month Plastic Locum – to be advertised. Minor Ops treatment rooms required to accommodate the increasing volume of lesions referred – Long term plans for current Dermatology department to expand – feasibility study for Phase 1 completed.

Breast:

Additional 2WW capacity for 60 patients has cleared the backlog of patients waiting, and have added regular increased capacity. This has reduced the wait currently to 15 days.

Colorectal:

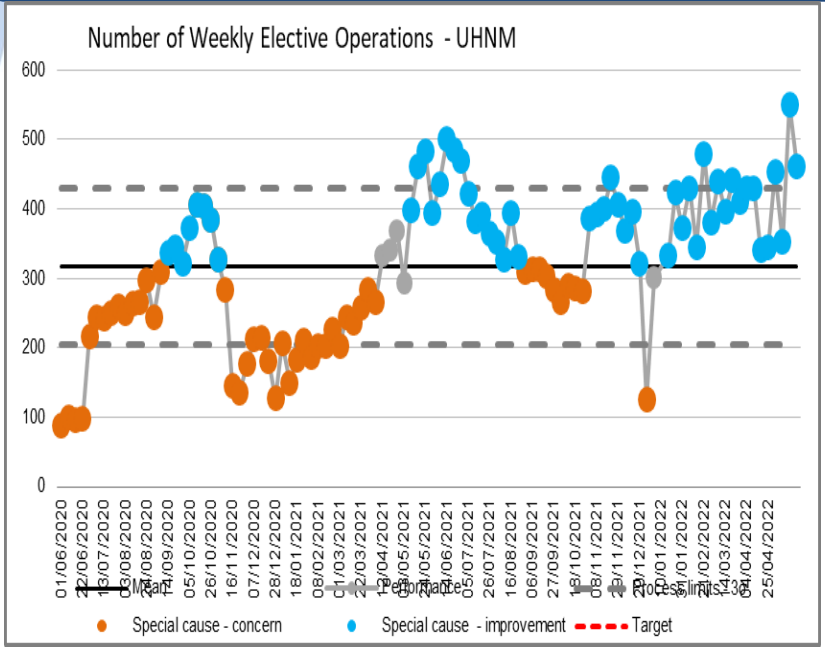
Receiving high volumes of almost 250 patients per week. Additional triage sessions are being be picked up by Consultants, Speciality Doctors and GPSI – however there is limited uptake due to pension issue. Outsourcing options being explored to clear the backlog of patients waiting to be triaged including results management; subject to funding approval. The team are risk stratifying the current backlog of patients by FIT score 200>, 100> and 50> to ensure those with the highest risk of cancer are seen sooner . Despite increasing referrals the 14 day 93rd percentile remains around 30 days.

Oncology:

Recent capacity and staffing review, additional locum staff have been found to support on-going delivery.

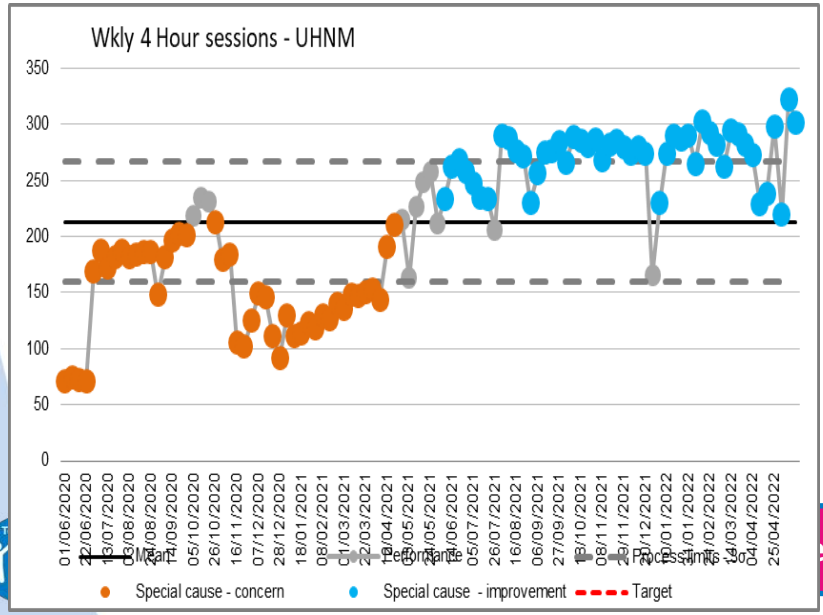
Business case in process for investment in the Clinical Oncology workforce over a 3 year phased implementation focusing on medical workforce and SACT nursing resource in year 1 to go to CWD Board 14.7.22 for onward approval.

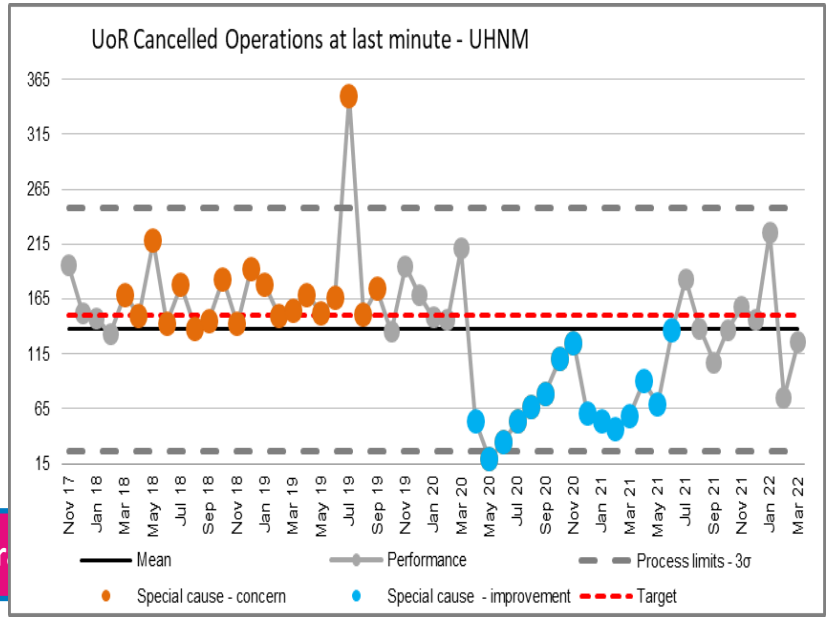
Planned care – *Inpatient Activity*



The number of weekly elective operations has been on an upward trajectory. This has coincided with the increases in the number of weekly 4 hour sessions increasing.
The number of patients cancelled on the day had also been taking a downward turn- the has levelled.

There is currently a fire break in the system due to covid numbers and staff absence, this is predicted until August and will negatively affect the improvements in this area for a short period.





Planned care - *Inpatients*

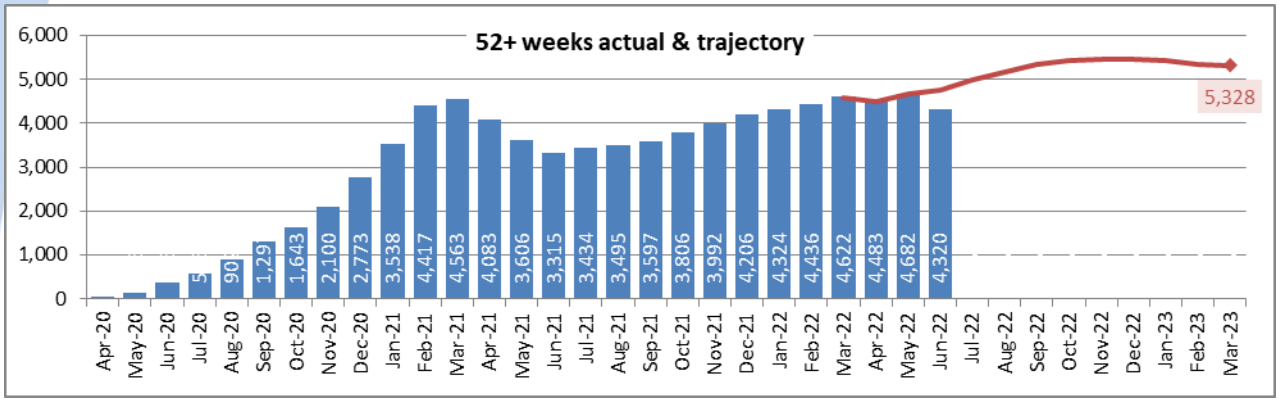
Elective inpatients Summary

- Day Case and Elective Activity delivered 90% and 97% respectively for May 22 against the national ask of 110%/108%, an deterioration for Day Case, but improvement on May's position for Day Case (92%) and Electives (96%).
- There is a real focus on 104w cases, many of whom were complex and required whole/half lists.
- At the end of June the numbers of > 104 weeks was 60 - a decrease of more than 50% from 314 in April. The Trust almost achieved the national standard of all eliminating 104 week waits end of June, with the allowed exception of those patients who have chosen not to be treated in June or are too complex to have their treatment arranged during June. A small number of patients were cancelled in the last few days of June who could not be rebooked in time.
- Insourcing arrangements at weekends continue and have been bolstered to provide more weekend capacity in T&O this started in Feb.
- Contracting arrangements for 2022/23 have been confirmed with extension of existing IPT contracts for Ramsay & Nuffield.
- County and Royal Stoke Theatres have re-implented a "6-5-4" weekly operational meeting to ensure a higher proportion of available lists are fully used and to move capacity to the specialties most needing it. This also tracks and ensures bookings so that patients and staff are given more notice so cancellations and non-attendances can be driven down

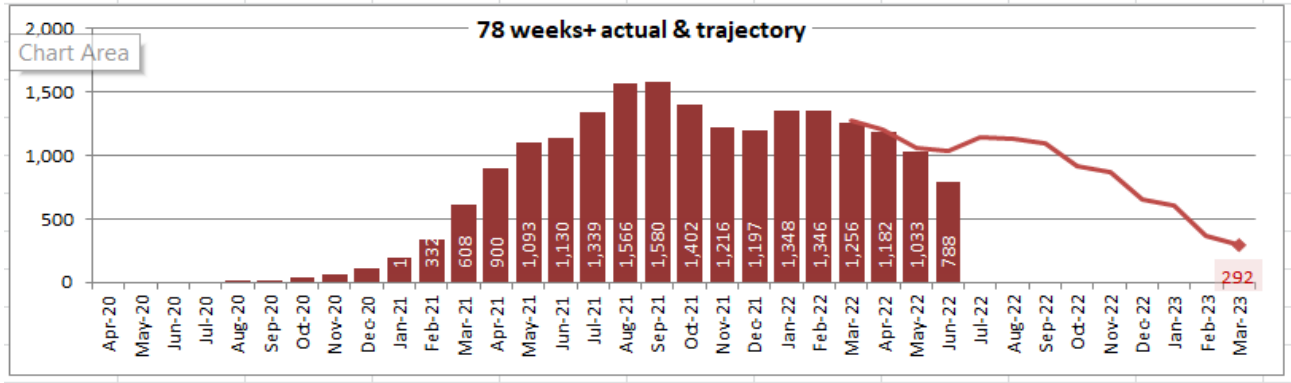
Actions

- External validation support commenced 21st March, focusing on long waiters, themes and trends. Report expected end of 8th July.
- Demand scoping for 22/23 IS complete & shared with CCGs. Final numbers for capacity agreed.
- New electronic process for managing patients transfers to IS live and working.
- Trust wide revamp of validation & training underway, focusing on tracking long waiters, exposing and addressing bottlenecks in pathways. Phase 1 to deep dive training needs analysis. RTT Trainer now in post to commence work on Phase 1.
- Active reporting focus on ensuring the right patients (urgent and longest waiters) are the patients booked into all available capacity so that the limited resource available continues to be used for the right patients by clinical need
- Patient by patient monitoring by each specialty and by the corporate team on the small number of patients at risk of the end-July deadline for 104 weeks combined with forecasting for August and onwards
- Long wait focus moved to patients due to breach 104 weeks in Q2, with plans to eliminate 78 weeks by end of March 2023. Key enables are ring fencing of beds for Orthopaedics as RSUH, modular theatre at County and improvement in theatre utilisation and booking.
- Increased focus on non-admitted patients and increasing outpatient & diagnostic capacity, improving utilisation and business processes to move patients to a decision to admit.

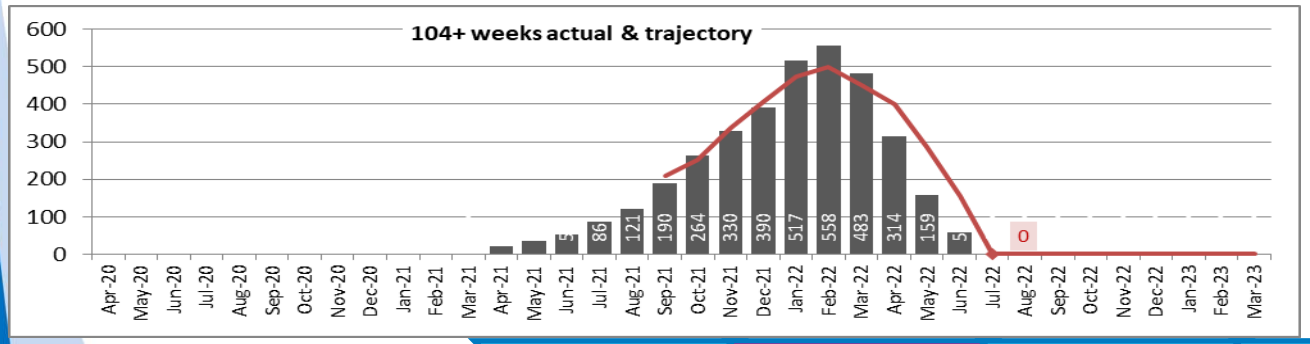
Planned care – *RTT Trajectories*



In June 22 there has been a positive reduction >300 to the 52 week position which had been gradually increasing since June 21.



78 Week Waits has seen reductions for the last 4 months.



104 Week Waits have been continually decreasing since Early March. Reduction now exceeding the trajectory set. Most challenged specialties are T&O and Spinal. There is consideration for 104 patients to be held based on complexity and patient choice.

Planned care

NHS University Hospitals of North Midlands NHS Trust

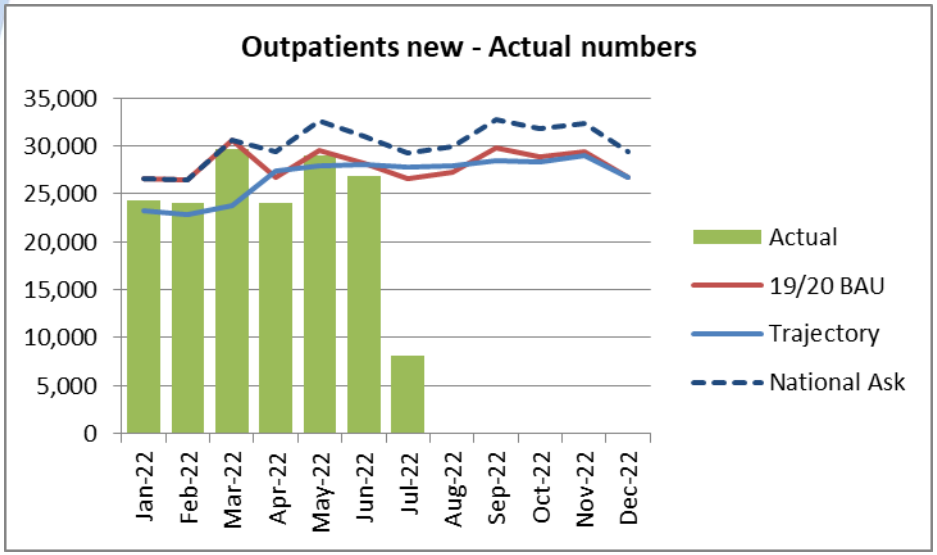
Summary

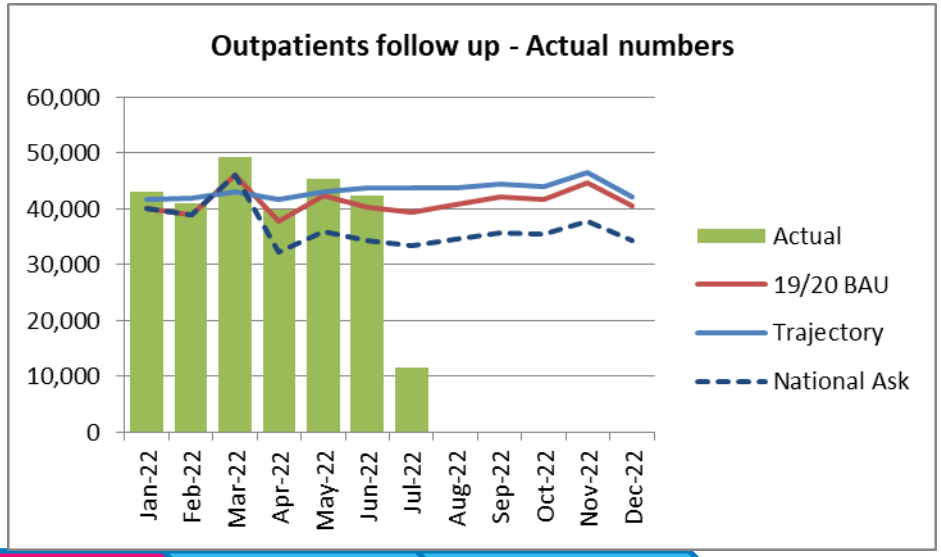
- 52+ week patients; Reduction for the first time sine June 21.
- 78+ patients have been gradually reducing
- Positive 104+ week position at month end with plan for 0 end July other than those complex patients where this is not possible or if patients have chosen to wait.
- The overall Referral To Treatment (RTT) Waiting list has increased. April was 76,023, May 75,858. Indicative number for June is 76,920.

RTT

- Validation has increased with extra resource. This will provide an accurate picture of the resource required in the medium term to reduce the list. On 1st March, there were 28,375 patients due to breach 78 weeks by end of 2022/23, with 17,410 un-validated. By 1st July, this had reduced to 11,007, with only 8 un-validated.
- The number of patients > 18 weeks has decreased slightly to a level of 34,753 (May 34,928).
- The increase in total waiting list size is due to increased referrals/clock starts.
- At the end of May the numbers of > 104 weeks was 60 - a decrease from 314 in April. The Planned Care group is monitoring progress against treatment plans for these patients.
- Performance has slightly decreased throughout June at provisional 54.82% (May 55.29%).
- Work plans around long wait patient validation and treatment tracking are in progress to support the Data Quality Strategy & Audit requirements.

Planned care – *Outpatient activity & RTT*





Planned care - *Outpatients*

NHS University Hospitals of North Midlands NHS Trust

Actions

- OP Cell Programme Structure & TOR updated for 22/23 to reflect Elective Recovery Planning Guidance.
- **Work stream 1 Outpatient Service Delivery & Performance**
  - Partial Booking Rollout, Netcall Rollout, CAF Issues Action Plan, and OP Clinic Process vs. Maturity model. Review Date training prioritised; DQ Alert circulated & Quick Reference Guides created. Wider training plan being developed with on-going input into Trust training considerations (systems & processes), and links to DQ group. Utilisation focus including bookings %, DNAs & cancellations.
- **Work stream 2 Outpatient Transformation**
  - **Enhanced Advice & Guidance**

    ICS Referral Optimisation Steering Group set up, A3 drafted to define the programme of work. Task & Finish Groups remain for Urology, Neurology, Respiratory and Gastro. Validating post referral A&G data with view to include this in submission & to update the projected plan. Full review of UHNM Consultant to Consultant Referrals taking place as NHSE/I state UHNM an outlier.
  - **PIFU** divisional % PIFU Targets for 22/23 agreed with Divisions. PIFU Divisional Challenge with COO July 11th.

    Specialty Rollout Ahead of plan on rollout volume. Extending rollout in existing specialties, for example Sleep, IBD, T&O. On track for rollout for ENT, Sleep, Gynaecology & Child Health in July. Actively linking with divisions & specialties to identify PIFU opportunities.

    Infrastructure; Revision of terminology; 'Discharge SOS' & Add to PIFU Framework to support wider rollout and communication. Outcomes updated from 5th July. PIFU Intranet section live, including Clinician & Admin Focus, shared widely. Broader comms plan for GPs & patients.
  - **Virtual Care 25%;** SUS submission 'fix' implemented from Nov 2021 (with BI); longer term, alignment of clinic booking and media type outcomes.
  - **Patient Portal**; support provided to identify potential OP benefits, following demos from suppliers to a wide UHNM audience & patients.
- **Work stream 3 Outpatient Waiting List Management & Reporting**
  - Focused actions on Outpatient Reviews
  - Waiting List Validation plan being pulled together, to be shared for Divisional signoff.
  - 1m+ plans approved (March '22) from risk assessments, supports FTF activity increase where required; CAFs to be submitted to ensure managed.
  - SMS via Netcall targeting follow up backlog patients trialled successfully in derm & plastics. Netcall Partial Booking module purchased to facilitate similar approach for other specialties; urology & gastro first. Specialty/Outpatient process described, Rollout Plan being drafted, Netcall training to be scheduled July.

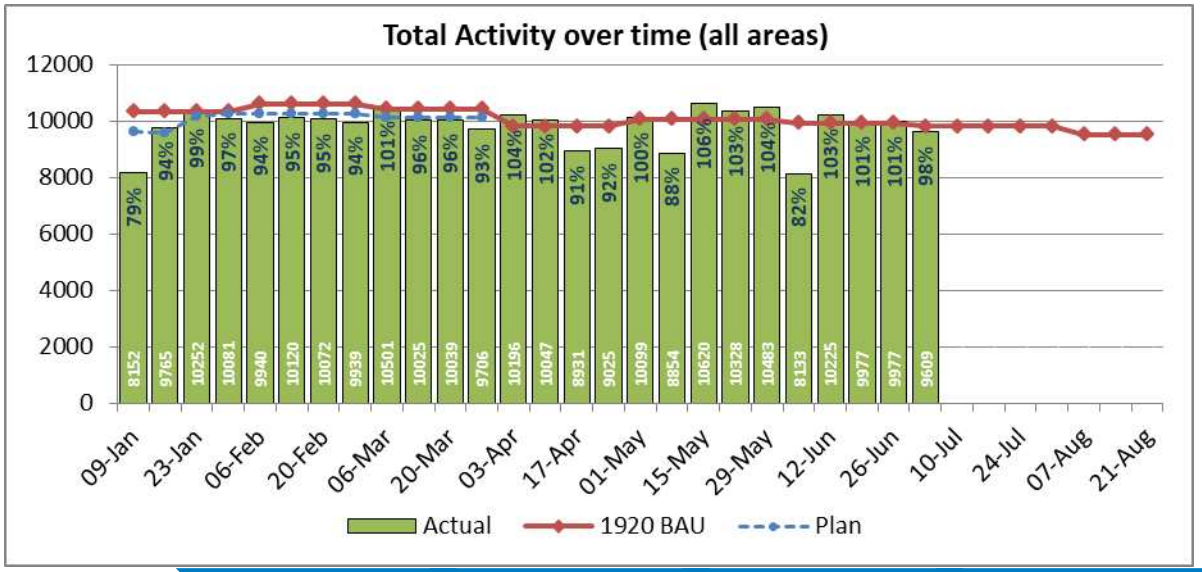
Risks

- Deteriorated waiting list position vs pre-covid; volume of patients requiring DQ and clinical validation very challenging, on Divisional Risk Registers.
- Clinical Validation requirement; risk of achieving vs resources available.

Diagnostic Activity

NHS
University Hospitals of North Midlands
NHS Trust

		Apr-22				May-22				Jun-22			
Area	DM01 Test	Total WL	6+	%	Activity	Total WL	6+	%	Activity	Total WL	6+	%	Activity
Imaging	Magnetic Resonance Imaging	5,060	1,429	71.8%	3,231	5,277	1,153	78.2%	3,512	5,400	1,230	77.2%	3,467
	Computed Tomography	3,449	31	99.1%	7,655	3,403	21	99.4%	7,949	3,661	26	99.3%	7,787
	Non-obstetric ultrasound	9,631	4,770	50.5%	4,354	10,035	4,873	51.4%	4,799	10,621	5,364	49.5%	4,465
	Barium Enema	0	0		0	0	0		0				
	DEXA Scan												
Physiological Measurement	Audiology - Audiology Assessments	301	2	99.3%	359	354	0	100.0%	374	303	3	99.0%	424
	Cardiology - echocardiography	1,953	424	78.3%	1,331	2,061	321	84.4%	1,435	2,153	454	78.9%	1,273
	Cardiology - electrophysiology	1	1	0.0%	5	1	1	0.0%	3	0	0		4
	Neurophysiology - peripheral neuroph	297	0	100.0%	215	295	0	100.0%	290	317	0	100.0%	242
	Respiratory physiology - sleep studies	384	12	96.9%	185	447	20	95.5%	238	545	55	89.9%	220
	Urodynamics - pressures & flows	1	0	100.0%	0	0	0		0	0	0		0
Endoscopy	Colonoscopy	706	286	59.5%	315	632	247	60.9%	478	668	241	63.9%	301
	Flexi sigmoidoscopy	473	241	49.0%	82	389	201	48.3%	126	377	155	58.9%	71
	Cystoscopy	132	6	95.5%	167	125	8	93.6%	215	123	5	95.9%	212
	Gastroscopy	1,114	586	47.4%	812	954	446	53.2%	1,063	698	270	61.3%	844
	Totals	23,502	7,788	67%	18,711	23,973	7,291	70%	20,482	24,866	7,803	69%	19,310



Planned care - *Diagnostics*

University Hospitals of North Midlands NHS Trust

Diagnostics Summary

- Activity across all DM01 increased, and overall performance improved by 3% to 70% compliance
- Within DM01, the greatest proportion of > 6 week waits are within Non-obstetric ultrasound and endoscopy. Both ultrasound and endoscopies positions are related to an increase in demand alongside workforce shortfalls
- Non-obstetric Ultrasound performance increased by 0.9% to 51.4%. Endoscopy performance also increased by 1.2% to 64%
- If you removed Ultrasound & Endoscopy from DM01 performance, the Trust would have overall DM01 compliance of 93%
- Plain film is an area with a high volume of waiters, predominantly due to staffing shortages
- Histology turnaround times remain a high risk

Actions

- Non obstetric ultrasound performance remains a Driver Metric for CWD and has specific focus for improvement, and has a recovery plan for being within DM01 by January 2023
- Walk in centres for Plain Film MSK started in July. Walk in centres for all other Plain Film will start in August, which will give capacity for immediate imaging from referral and will allow decisive recovery for P/F waits.
- Endoscopy remains a high risk areas, with a recovery plan in place using internal and external resources and a business case has been prepared to reduce unnecessary endoscopies by using a CQC accredited triage and clinical prioritisation service. National Access has been updated for Endoscopy patients with a high DNA rate, and is being implemented within the UHNM Access Policy, which will support in managing the waiting list
- The Diagnostic Cell is progressing solutions for ensuring that anniversary / planned patients are reflected correctly against their RTT pathway; there are a number of patients over 26 weeks that are reflected as past anniversary / planned date which shows an incorrect position
- For Histology there is an action plan in place and the position is improving. Cancer related histology is being treated urgently and all cancer related escalations are being prioritised. Increased staff are now in place for the blocks delay and the cancer team now have direct patient level access to reduce the time spent escalating delays and awaiting a response.
- Capacity and Demand work has been completed within Imaging relating directly to Consultant Radiologist and SpR capacity

Inpatient and Outpatient Decile & Ethnicity

"In line with NHS Planning Guidance the Trust must ensure board papers are published that include an analysis of waiting times disaggregated by ethnicity and deprivation" The Trust has only recently had the capability to analyse this information and will therefore spend the coming months seeking to understand what the data and take action to positively impact upon unwarranted variation

Inpatient IMD Decile	1	2	3	4	5	6	7	8	9	10	Unknown
Weeks Waited- >104	9.99%	8.97%	8.50%	7.72%	7.62%	11.96%	12.63%	10.59%	13.53%	7.95%	0.55%
Weeks Waited- 78-104	13.91%	10.70%	9.96%	8.72%	7.65%	10.29%	11.60%	7.57%	13.33%	5.35%	0.91%
Weeks Waited- 52-77	14.83%	12.44%	10.12%	8.63%	6.81%	11.84%	9.77%	7.74%	11.87%	4.46%	1.50%
Weeks Waited- Under 52	13.07%	11.57%	9.75%	8.78%	7.67%	10.83%	10.79%	9.26%	11.60%	5.63%	1.05%

Outpatient IMD Decile	1	2	3	4	5	6	7	8	9	10	Unknown
Weeks Waited- >104	11.15%	10.65%	8.95%	9.05%	7.92%	11.33%	11.23%	10.01%	12.81%	6.04%	0.87%
Weeks Waited- 78-104	12.63%	9.62%	9.63%	9.45%	7.22%	11.52%	11.83%	9.72%	11.16%	5.99%	1.24%
Weeks Waited- 52-77	13.33%	11.20%	9.92%	8.81%	7.53%	10.88%	10.68%	9.17%	11.74%	5.89%	0.85%
Weeks Waited- Under 52	13.56%	11.52%	10.10%	9.01%	7.51%	10.53%	10.49%	8.92%	11.30%	6.01%	1.05%

Inpatient Ethnicity	African	Any Other Asian Background	Any Other Black Background	Any other ethnic group	Any Other Mixed Background	Any other White background	Bangladeshi	Caribbean	Chinese	Indian	Pakistani	White & Asian	White & Black African	White & Black Caribbean	White British	White Irish	Not Specified	Not Stated	Unknown
Weeks Waited- >104	0.20%	0.32%	0.07%	0.22%	0.40%	0.52%	0.05%	0.05%	0.20%	0.42%	0.40%	0.20%	0.05%	0.02%	93.77%	0.37%	0.72%	1.82%	0.22%
Weeks Waited- 78-104	0.58%	0.74%	0.16%	0.82%	0.25%	1.15%	0.16%	0.25%	0.16%	0.49%	1.07%	0.66%	0.08%	0.16%	88.31%	0.08%	1.48%	1.23%	2.14%
Weeks Waited- 52-77	0.25%	0.86%	0.21%	0.71%	0.57%	1.82%	0.11%	0.25%	0.11%	0.32%	1.18%	0.18%	0.04%	0.18%	86.60%	0.07%	2.07%	1.82%	2.67%
Weeks Waited- Under 52	0.39%	0.55%	0.14%	0.62%	0.54%	1.08%	0.08%	0.16%	0.13%	0.49%	1.39%	0.20%	0.15%	0.19%	85.37%	0.28%	2.68%	2.71%	2.84%

Outpatient Ethnicity	African	Any Other Asian Background	Any Other Black Background	Any other ethnic group	Any Other Mixed Background	Any other White background	Bangladeshi	Caribbean	Chinese	Indian	Pakistani	White & Asian	White & Black African	White & Black Caribbean	White British	White Irish	Not Specified	Not Stated	Unknown
Weeks Waited- >104	0.28%	0.50%	0.17%	0.50%	0.43%	0.76%	0.13%	0.20%	0.12%	0.52%	1.16%	0.31%	0.13%	0.12%	87.88%	0.30%	3.07%	2.30%	1.15%
Weeks Waited- 78-104	0.34%	0.51%	0.15%	0.54%	0.43%	1.26%	0.20%	0.15%	0.12%	0.27%	1.50%	0.27%	0.12%	0.14%	87.22%	0.36%	2.47%	1.92%	2.03%
Weeks Waited- 52-77	0.32%	0.67%	0.18%	0.61%	0.52%	1.06%	0.09%	0.20%	0.15%	0.45%	1.95%	0.37%	0.17%	0.17%	85.80%	0.21%	2.52%	2.27%	2.29%
Weeks Waited- Under 52	0.42%	0.63%	0.19%	0.64%	0.57%	1.20%	0.14%	0.17%	0.16%	0.58%	1.80%	0.32%	0.15%	0.24%	83.19%	0.29%	3.23%	2.75%	3.33%

APPENDIX 1

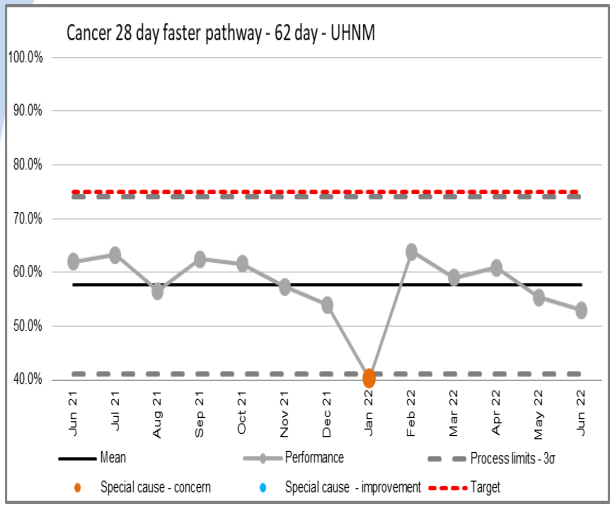
Operational Performance

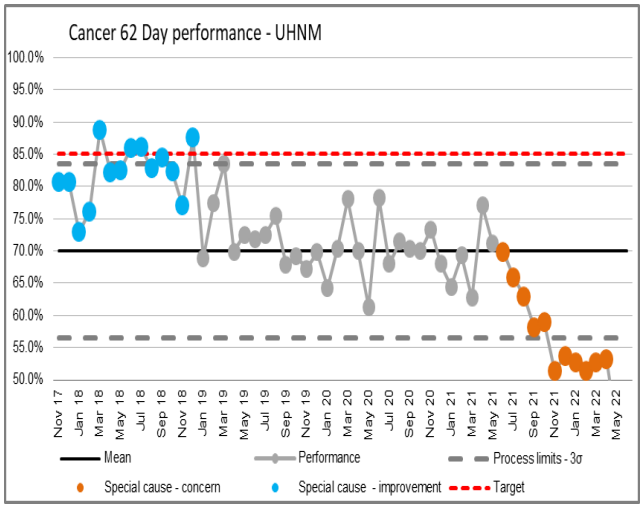
Constitutional standards

	Metric	Target	Latest	Variation	Assurance	DQAI
A&E	A&E 4 hour wait Performance	95%	62.50%	L	F	
	12 Hour Trolley waits	0	390	H	?	
Cancer Care	Cancer Rapid Access (2 week wait)	93%	41.77%	L	?	
	Cancer 62 GP ref	85%	38.75%	L	F	
	Cancer 62 day Screening	90%	57.14%	L	?	
	31 day First Treatment	96%	84.29%	L	?	
Elective waits	RTT incomplete performance	92%	53.97%	L	F	
	RTT 52+ week waits	0	4682	H	F	
	Diagnostics	99%	66.86%	L	F	

	Metric	Target	Latest	Variation	Assurance	DQAI
Use of Resources	DNA rate	7%	7.3%		?	
	Cancelled Ops	150	126		?	
	Theatre Utilisation	85%	76.0%			
Inpatient / Discharge	Same Day Emergency Care	30%	30.1%	H	F	
	Super Stranded	183	182	H	?	
	DToC	3.5%	4.40%		?	
	Discharges before Midday	25%	19.1%	L	F	
	Emergency Readmission rate	8%	11.8%	L	F	
	Ambulance Handover delays in excess of 60 minutes	0	577	H	?	

Cancer – 62 Day





Variation	Assurance
L	F

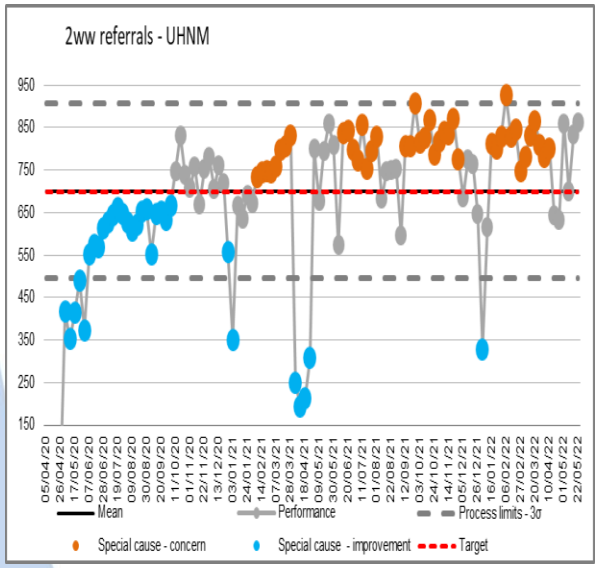
Target	Apr 22	May 22	Jun 22
85%	53.2%	42.3%	38.8%

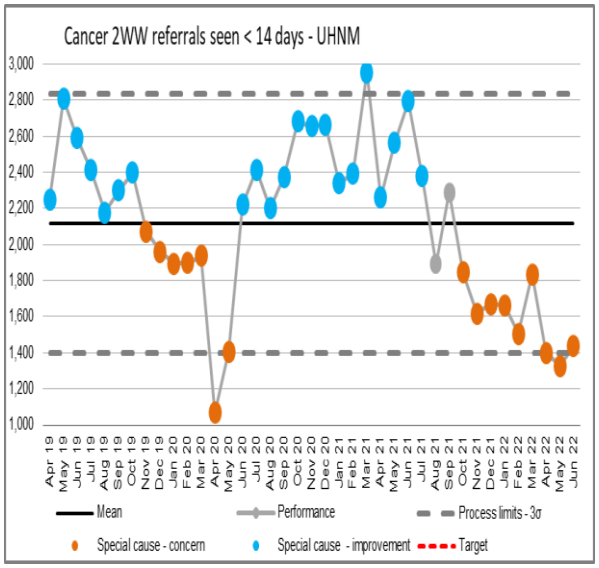
Background

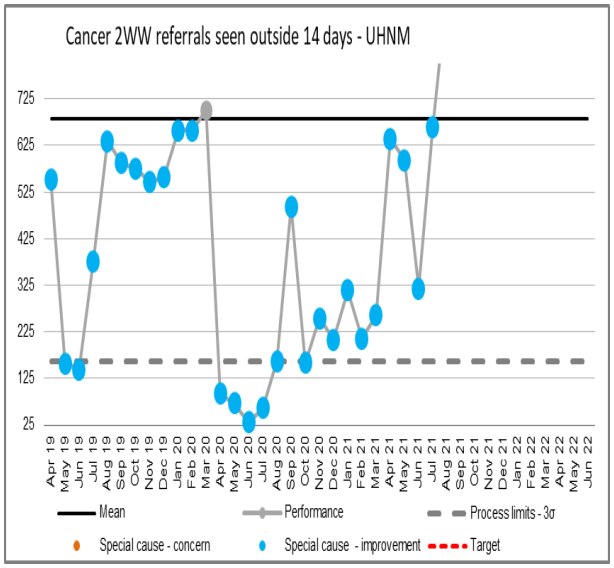
% patients beginning their treatment for cancer within 62 days following an urgent GP referral for suspected cancer

What is the data telling us?

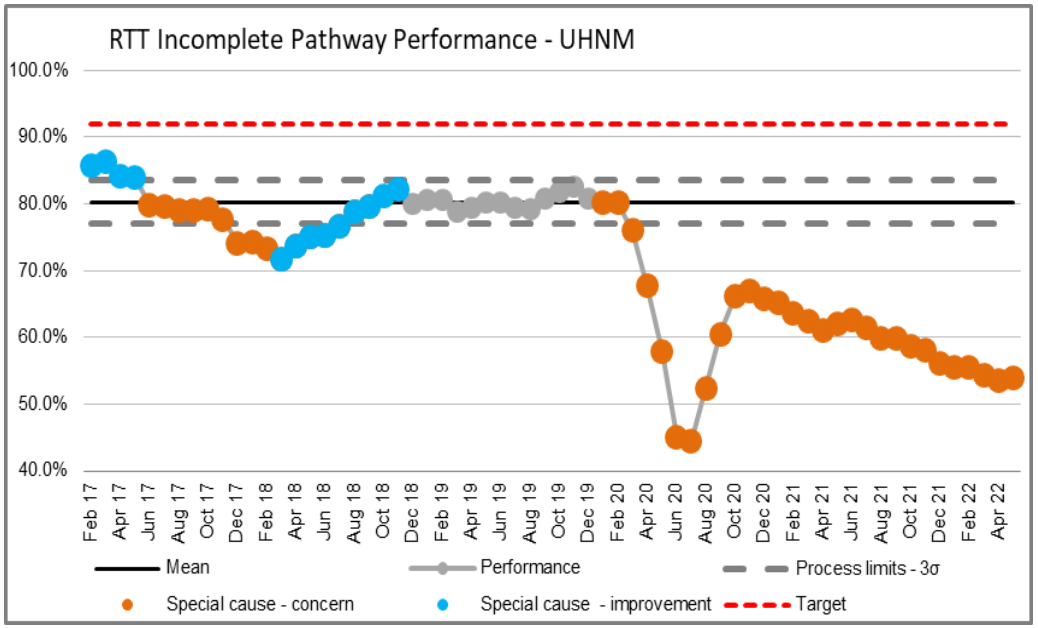
Apart from three occasions the standard has been below the mean since Sept-19.







Referral To Treatment



Variation	Assurance
	

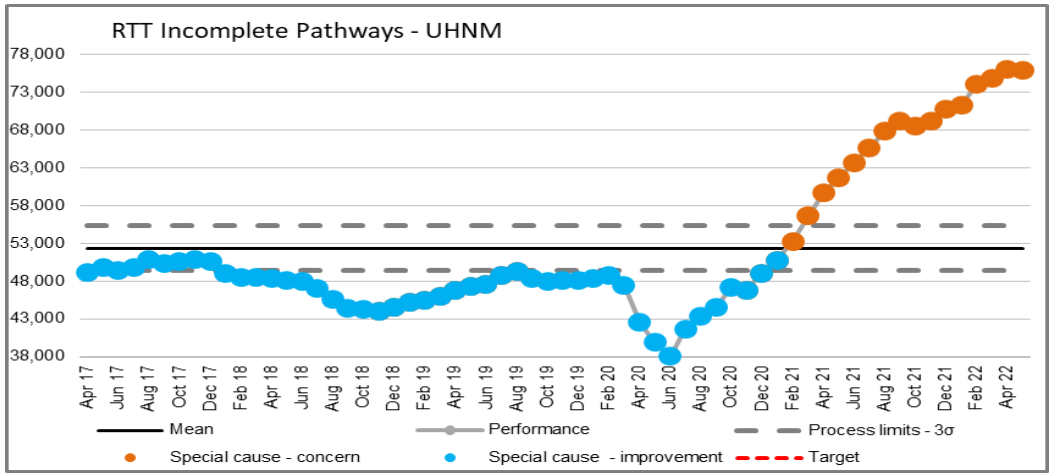
Target	Mar 22	Apr 22	May 22
92%	54.3%	53.5%	54.0%

Background

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

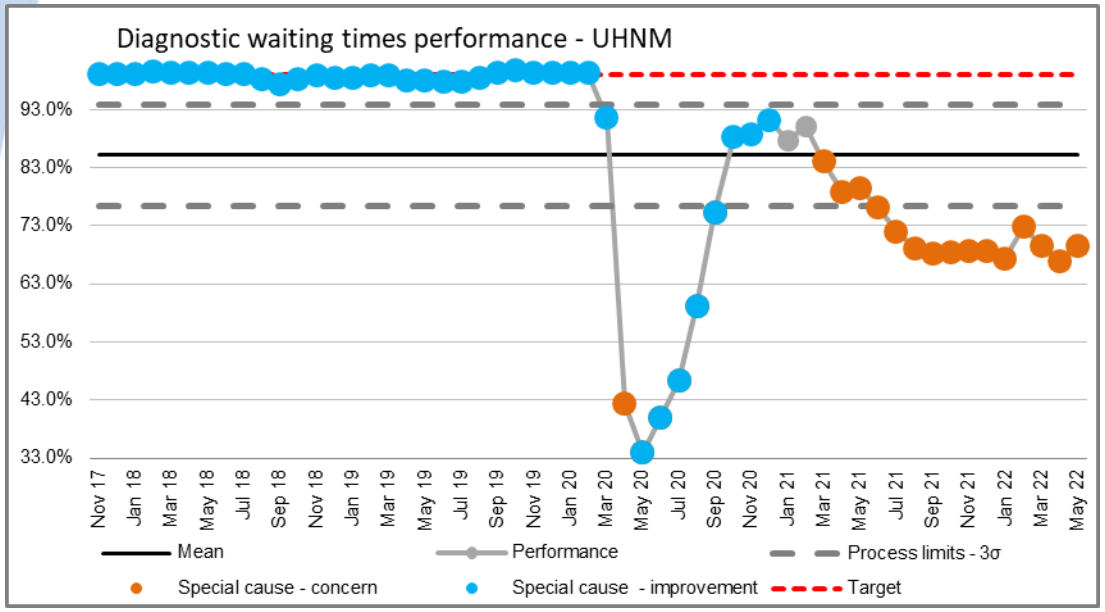
What is the data telling us?

Steady decline in performance since the pandemic began.



Quality | Operational | Workforce | Finance

Diagnostic Standards



Variation	Assurance
L	F

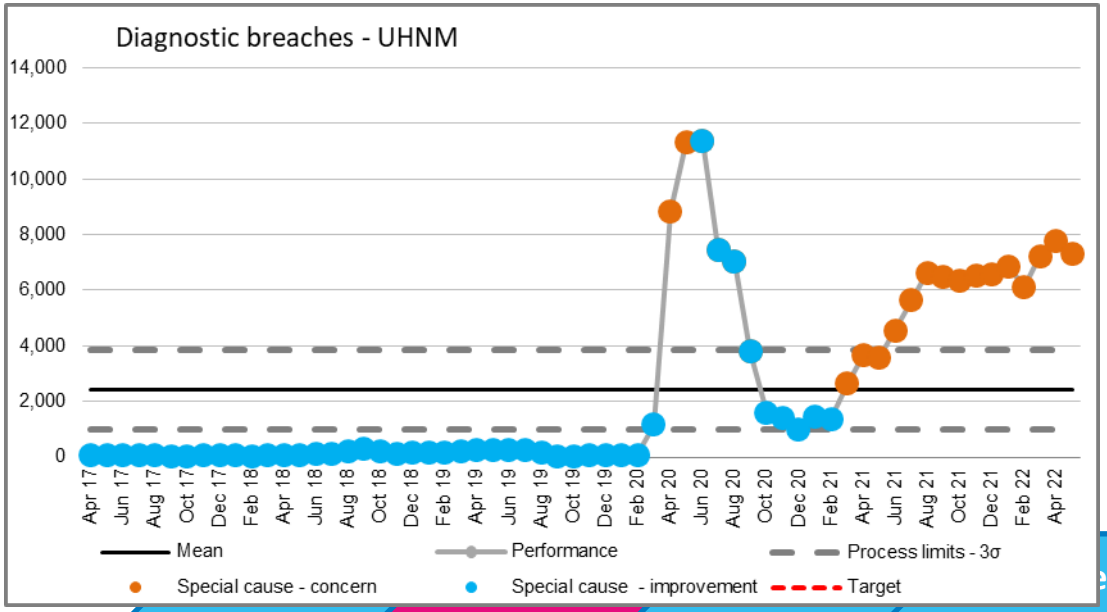
Target	Mar 22	Apr 22	May 22
99%	69.5%	66.9%	69.6%

Background

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

What is the data telling us?

The diagnostic performance has shown normal variation up until March 2020. Special cause variation occurred from March (COVID-19). Recovery has been evident until the second wave of the pandemic



Workforce

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

Workforce Spotlight Report

University Hospitals of North Midlands NHS Trust

Key messages

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

Overall, the level of workforce risk remains at ext16 due to the cultural issues highlighted by the brap report, and the impact of increased covid-related absences on sickness levels and workforce availability. There are measures in place to mitigate risks including a recruitment pipeline.

The Cultural Improvement Programme is being finalised following completion of the final session for staff to have their say on the BRAP/Kline report. Detailed actions and target dates are to be agreed by Trust Executives as part of the Culture Review implementation programme. Updates on the Cultural Review improvement actions are being communicated out on a monthly basis and, over the past two months listening events have taken place and specific areas for improvement have been worked on including:

- Launching the ENABLE programme for managers, focused on giving staff the skills and tools to be an outstanding manager
- Development of an Inclusivity Master Class as part of the Connects Leadership Programme which centres on building an inclusive culture.
- Development of a Medical Leaders Fundamentals Programme for all new clinical leaders which launched in June for Clinical Directors and Clinical Leads.
- The Equality, Diversity and Inclusion Strategy will be launched in the coming weeks and the Resolution Policy has now been approved. A behaviours document has been drafted, which describes the behaviours we want to see and what we do not want to see. Additionally, a meeting and email etiquette will be published this month.
- A 'Civility Saves Lives' programme has been designed and launched in Imaging in June. A second session with the Emergency Department will take place on 29th July.

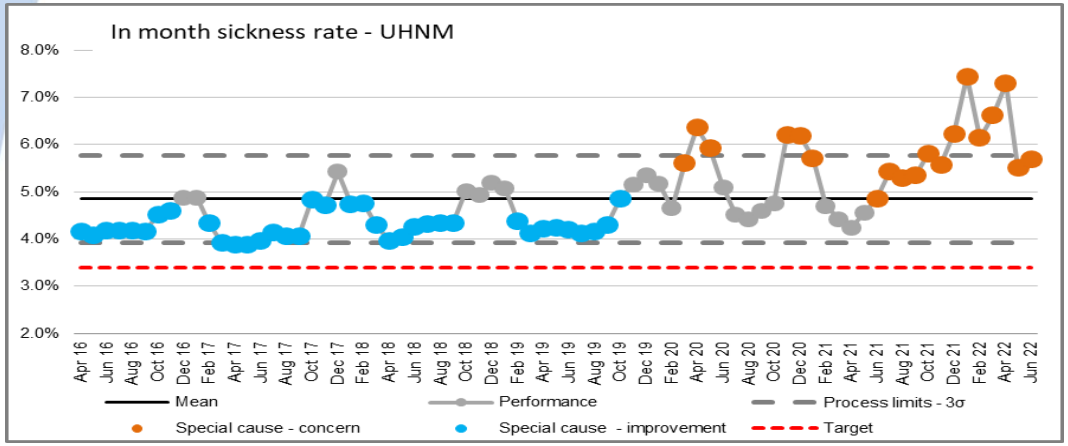
Sickness levels remain high and above target. Covid-related absence increased during June. Sickness levels continue to be monitored on a daily basis. Covid communication bulletins have recommenced to advise staff on the process for reporting absences, covid testing and infection prevention and control measures etc.

All Divisions have been asked to produce workforce plans detailing their requirements for Winter 22/23 and covering the mix of recruitment, overtime, bank and agency. As well as the recruitment aspects of winter planning, plans to provide support for our staff throughout winter are being developed. This includes the usual offerings of flu/covid vaccination, support via counselling services including opportunities and webinars for stress/resilience as well as specific offerings via the System Wellbeing Hub. We will continue to signpost financial wellbeing support offerings and we are working with the Wellbeing Champions to look at developing a "winter wellbeing kit" to provide support to all wards and departments.

Workforce Dashboard

Metric	Target	Latest	Variation	Assurance
Staff Sickness	3.4%	5.68%		
Staff Turnover	11%	11.50%		
Statutory and Mandatory Training rate	95%	94.29%		
Appraisal rate	95%	75.41%		
Agency Cost	N/A	3.75%		

Sickness Absence



Variation	Assurance
H	F

Target	Apr 22	May 22	Jun 22
3.4%	7.3%	5.5%	5.7%

Background

Percentage of days lost to staff sickness

What is the data telling us?

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

Summary

The **M3** in-month sickness rate was 5.68% (5.50% in May 22). The 12 month cumulative rate increased to 6.17% (6.10% 31/05/22).

Covid-related absence increased during June 2022 and as at 15 June, this had increased to 306 covid-related open absences*, which was 34% of all absences[**includes absences resulting from adhering to isolation requirements*]

The increase in covid-related absences is impacting on the Divisional trajectories for achieving a reduction in Sickness Absence. Performance at M3 was as follows

(12m cumulative Absence FTE %)

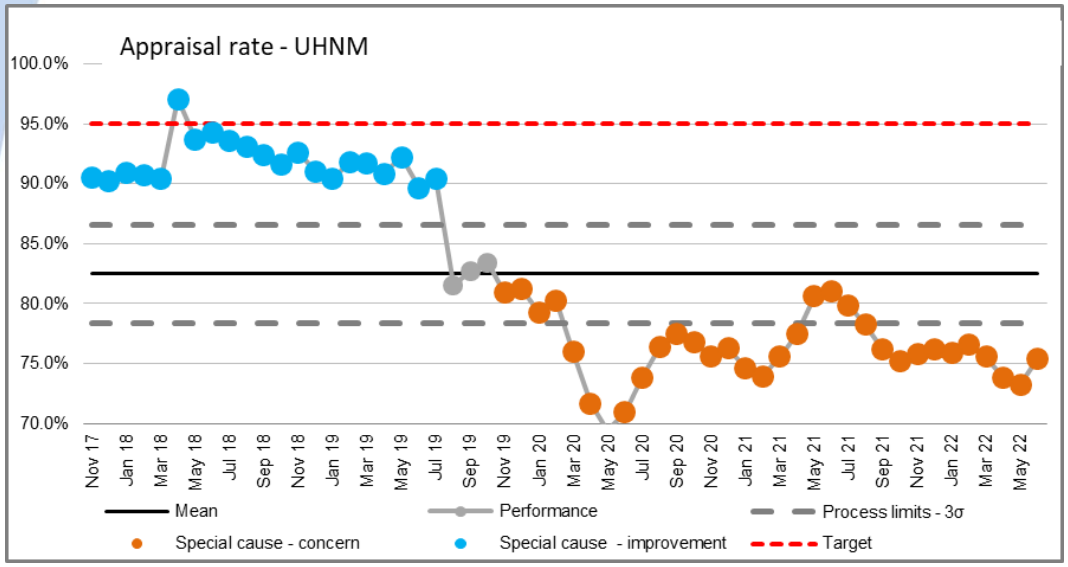
Org L2	Divisional Trajectory - by March 2023	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Change on previous month
205 Central Functions	3.39%	3.80%	3.83%	3.89%	4.13%	4.13%	4.11%	↓
205 Children's, Women's & Diagnostics	5.25%	5.20%	5.29%	5.53%	5.88%	5.94%	5.97%	↑
205 Estates, Facilities and PFI Division	5.25%	5.13%	5.26%	5.56%	5.81%	5.75%	5.76%	↑
205 Medicine Division	5.25%	6.01%	6.14%	6.33%	6.56%	6.64%	6.67%	↑
205 Specialised Division	5.25%	4.64%	4.78%	4.96%	5.32%	5.47%	5.69%	↑
205 Surgical Division	4.50%	6.46%	6.57%	6.75%	7.02%	7.18%	7.30%	↑

Actions

The focus remains on managing areas of high sickness, and continued daily monitoring of sickness absence rates, including COVID related absence

Covid communication bulletins have recommenced to advise staff on the process for reporting absences, covid testing and infection prevention and control measures etc.

Appraisal (PDR)



Variation	Assurance
L	F

Target	Apr 22	May 22	Jun 22
95.0%	73.8%	73.3%	75.4%

Background

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

What is the data telling us?

The appraisal rate is consistently below the target of 95%.

Note: Completion of PDRs was suspended during covid-19 unless there was capacity to complete them.

Summary

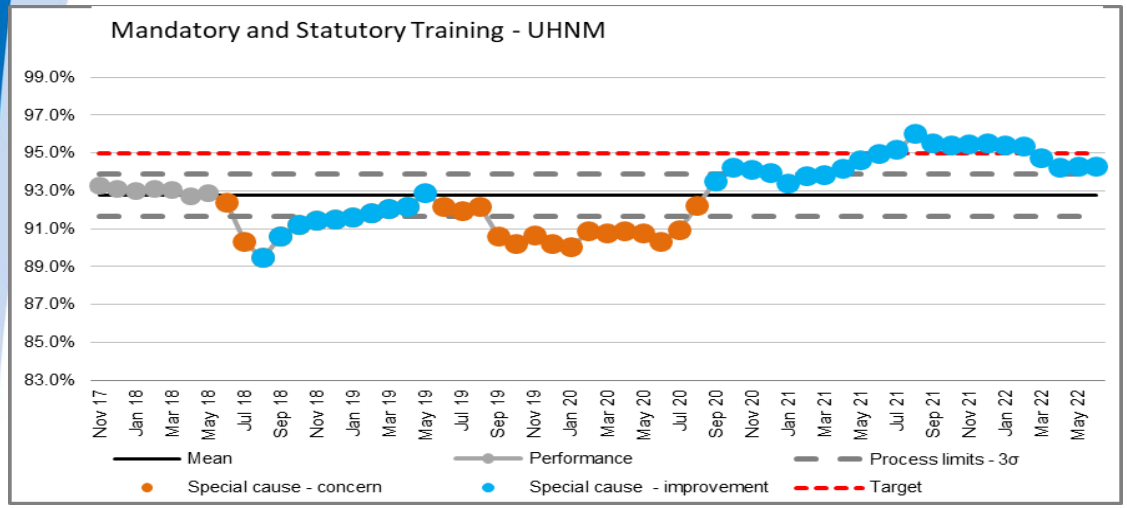
At 30 June 2022, the PDR Rate had improved to 75.41% (73.26% at 31st May 22)

Actions

The renewed focus with the Divisions is continuing, with:

- Weekly update reports detailing compliance and outstanding PDR's being circulated
- Focused discussions to improve performance.
- Management time being reinstated

Statutory and Mandatory Training



Variation	Assurance
H	F

Target	Apr 22	May 22	Jun 22
95.0%	94.3%	94.3%	94.3%

Background

Training compliance

What is the data telling us?

At 94.3%, the Statutory and Mandatory Training rate just below the Trust target for the core training modules

Summary

The Statutory and Mandatory training rate at 30 June 22 remained at 94.3% (94.3% at 31 May 22). This compliance rate is for the 6 'Core for All' subjects only

Competence Name	Assignment Count	Required	Achieved	Compliance %
205|MAND|Security Awareness - 3 Years|	10600	10600	9998	94.32%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	10600	10600	10030	94.62%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	10600	10600	10055	94.86%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	10600	10600	10005	94.39%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	10600	10600	10025	94.58%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	10600	10600	9853	92.95%

Compliance rates for the Annual competence requirements were as follows:

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 1 Year|	10600	10600	9085	85.71%
NHS|CSTF|Information Governance and Data Security - 1 Year|	10600	10600	9251	87.27%

Actions

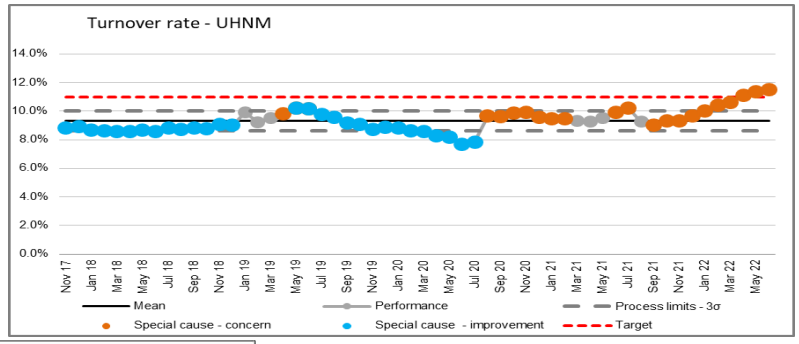
We continue to raise the issue of compliance with Divisions and communicate to staff the need to complete statutory and mandatory training.

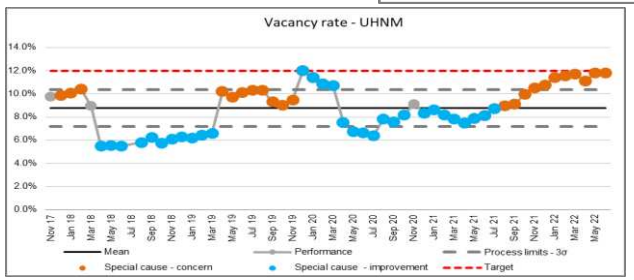
Compliance is monitored and raised via the Divisional performance review process.

Workforce Turnover

NHS University Hospitals of North Midlands NHS Trust

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





The overall Trust vacancy rate calculated as Budgeted Establishment less staff in post, increased to 11.82% (from 11.78%)
The vacancy rate is influenced by changes to budgeted establishment for Winter Workforce Plan and approved business cases, as well as changes to staff in post.

Variation	Assurance
H	P

Target	Apr 22	May 22	Jun 22
11.0%	11.1%	11.4%	11.5%

Background

Turnover rate

What is the data telling us?

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

Summary

The 12m Turnover rate was 11.5% (11.38% at 31/05/22).

Vacancies at 30-06-22	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous month %
Medical and Dental	1,477.19	1,301.08	176.11	11.92%	12.34%
Registered Nursing	3,351.01	2,903.83	447.18	13.34%	12.86%
All other Staff Groups	6,415.59	5,710.25	705.34	10.99%	11.12%
Total	11,243.79	9,915.16	1,328.63	11.82%	11.79%

Although staff in post increased in June 2022 by 12.57 fte, budgeted establishment also increased by 17.18 fte, which increased the vacancy rate by 4.61 overall [*Note: the Staff in Post fte is a snapshot at a point in time, so may not be the final figure for 30/06/22]
In month, Bank and Agency fte was 813.98, which covered 61.3% of this vacancy position.
There was 1304.4 FTE in the recruitment pipeline.
Other mitigations against the vacancy position include offering Additional PA's; extended / increased hours; On call payments and overtime.

Overall the target average time to hire (from vacancy creation to complete of employment checks) is 60 days. For June 2022, the time taken averaged at 71 days overall.

Actions

The Recruitment service is working through a full review to identify process improvements using the Improving Together methodology.

All Divisions have been asked to produce workforce plans detailing their requirements for Winter 22/23 and covering the mix of recruitment, overtime, bank and agency. In terms of assurance on the resilience of the plans, the ward based staff requirement for the 3 escalation wards will be placed out to advert for 2 weeks and an assessment will be completed at that point

Finance

2025 Vision "Ensure efficient use of resources"

Finance Spotlight Report

NHS University Hospitals of North Midlands NHS Trust

This report presents the financial performance of the Trust for June (Month 3). Key elements of the financial performance are:

- The final plan submission is for a breakeven position with the improvement relating to income for additional non-pay inflationary pressures and an assumption that there will be no claw back of ERF funding; both of these assumption have been required by NHSI/E.
- For the year to date the Trust has delivered an actual deficit of £0.3m against a planned surplus of £2.3m; this position is after a number of one off items totalling £2.4m have been accounted for resulting in a normalised deficit of £2.7m.
- The Trust incurred £0.9m of costs relating to COVID-19 in month which is lower than the prior month figure with £0.4m being chargeable on top of this allocation for COVID-19 testing costs.
- To date the trust has validated £2.5m CIP savings in year; these schemes have a full year impact of £4.4m, which presents a considerable variance to the Trust's recurrent target of £13.6m which was identified as a key risk in the Trust's financial plan submission.
- Capital expenditure in Month 3 is £1.9m which is £0.1m behind the plan of £2.0m. The majority of the expenditure to date is the pre-committed repayment of the PFI and IFRS16 lease liabilities.
- The cash balance at Month 3 is £83.9m, which is £6.7m higher than plan. Cash received is generally in line with plan with payments £5.1m behind plan.

Finance Dashboard

	Metric	Target	Latest	Variation	Assurance
I&E	TOTAL Income	variable	80.1		
	Expenditure - Pay	variable	67.7		
	Expenditure - Non Pay	variable	33.0		
Activity	Daycase/Elective Activity	variable	7,184		
	Non Elective Activity	variable	8,921		
	Outpatients 1st	variable	22,954		
	Outpatients Follow Up	variable	37,569		

Income & Expenditure

Income & Expenditure Summary Month 03 2022/23	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Income From Patient Activities	888.3	75.0	73.8	(1.3)	222.1	222.1	0.1
Other Operating Income	85.2	7.1	7.9	0.8	21.3	21.4	0.0
Total Income	973.5	82.2	81.7	(0.5)	243.4	243.5	0.1
Pay Expenditure	(582.4)	(47.5)	(44.1)	3.3	(143.3)	(139.1)	4.2
Non Pay Expenditure	(331.8)	(28.3)	(30.1)	(1.8)	(82.6)	(90.3)	(7.7)
Total Operational Costs	(914.2)	(75.8)	(74.3)	1.5	(225.9)	(229.4)	(3.5)
EBITDA	59.4	6.4	7.4	1.1	17.5	14.1	(3.4)
Depreciation & Amortisation	(33.6)	(2.8)	(2.8)	0.0	(8.4)	(8.5)	(0.1)
Interest Receivable	0.3	0.0	0.1	0.0	0.1	0.2	0.1
PDC	(8.9)	(0.7)	(0.7)	(0.0)	(2.2)	(2.2)	(0.0)
Finance Cost	(17.1)	(1.4)	(1.4)	0.0	(4.3)	(4.3)	0.0
Other Gains or Losses	0.0	0.0	0.0	0.0	0.0	0.1	0.1
Surplus / (Deficit)	0.0	1.4	2.6	1.2	2.6	(0.6)	(3.2)
DHSC PPE adjustment	0.0	0.0	0.3	0.3	0.0	0.3	0.3
Total	0.0	1.4	2.9	1.5	2.6	(0.3)	(2.9)

- Income from patient activities has underperformed in month primarily due to the continued NHSE contract gap and an adjustment in month against Devices income due to a rebate which has been received and needs to be passed back to NHSE; for which a corresponding benefit is reflected in the non-pay position.
- Other operating income has over performed in month and this is primarily driven by a prior year income accrual in respect of the Pathology Network. The remaining variances are driven by an increase in education income after receipt of an updated education contract from HEE; this is offset by the continued under performance on car parking income.
- Pay is underspent in month by £3.3m which is primarily driven a £3.1m release of the premium element of the annual leave accrual. The remaining variance is driven by underspends across registered nursing and NHS Infrastructure. The pay award (2%) continues to be accrued inline with funding received for the remainder of the staff groups where the award has yet to be announced.
- Non-pay is overspent in month by £1.8m; primarily driven by an increase in provisions in month in respect of a tribunal and potential CQC fine. This is offset by a PFI insurance gain share credit note which has been received in month of £0.7m.

Capital Spend

Capital Expenditure as at Month 3 2022/23 £m	2022/23 Revised Plan June PAF	In Month			Year to Date		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance
PFI lease liability repayment	(10.5)	(0.9)	(0.9)	-	(2.6)	(2.6)	-
Repayment of IFRS16 leases	(3.7)	(0.3)	(0.3)	-	(0.9)	(0.9)	-
Pre-committed items	(14.3)	(1.2)	(1.2)	-	(3.6)	(3.6)	-
PFI lifecycle and equipment replacement	(3.5)	(0.2)	(0.2)	-	(0.5)	(0.5)	-
PFI enabling cost	(0.3)	-	-	-	-	-	-
PFI related costs	(3.8)	(0.2)	(0.2)	-	(0.5)	(0.5)	
Wave 4b Funding - Lower Trent Wards	(5.2)	-	(0.0)	(0.0)	(0.1)	(0.1)	(0.0)
Project STAR multi-storey car park	(6.8)	-	-	-	-	-	-
TIF 2 PDC (CTS Phase 1)	(3.9)	-	-	-	-	-	-
TIF 2 PDC (Inpatient Wards)	(0.4)	-	-	-	-	-	-
TIF 2 PDC ('FM' Build)	(0.6)	-	-	-	-	-	-
TIF 2 PDC (CTS Phase 2)	(0.1)	-	-	-	-	-	-
Emergency Department (restatement costs)	-	-	-	-	-	-	-
Schemes funded by PDC and Trust funding	(17.0)	-	(0.0)	(0.0)	(0.1)	(0.1)	(0.0)
LIMS (Laboratory Information Management System)	(0.3)	(0.1)	-	0.1	(0.1)	(0.1)	0.0
EPMA (Electronic Prescribing)	(0.6)	(0.0)	(0.0)	0.0	(0.1)	(0.1)	0.0
CT7 enabling works (BC 415)	(1.1)	-	-	-	(0.0)	(0.0)	0.0
Patient Portal roll out costs (BC 462)	(0.5)	-	-	-	-	-	-
Pharmacy Dispensary	(0.3)	(0.1)	(0.1)	-	(0.3)	(0.3)	-
Anaesthetic medical records (Nasstar) (BC 444)	(0.1)	-	-	-	-	-	-
Home reporting implementation costs (BC 453)	(0.1)	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0
Market testing refresh - CRIS/PACS/MRI	(0.5)	-	-	-	-	-	-
Schemes with costs in more than 1 financial year	(3.6)	(0.2)	(0.1)	0.1	(0.6)	(0.5)	0.1
2022/23 schemes	(13.3)	(0.5)	(0.4)	0.1	(0.8)	(0.8)	(0.0)
IFRS 16 New Vehicles lease	(0.1)	-	-	-	-	-	-
IFRS 16 County Theatres TIF1 (IFRS16)	(2.1)	-	-	-	-	-	-
Lease liability re-measurement	(0.1)	-	-	-	-	-	-
IFRS16 funded schemes	(2.3)	-	-	-	-	-	-
Donated/Charitable funds expenditure	(4.7)	-	-	-	(0.0)	(0.0)	-
Charity funded expenditure	(4.7)	-	-	-	(0.0)	(0.0)	-
Overall capital expenditure	(59.0)	(2.0)	(1.9)	0.1	(5.5)	(5.5)	(0.0)

Total capital financing in 2022/23 is £59m of which £14.3m is allocated to the repayment of PFI and IFRS16 lease liabilities.

Other significant areas of expenditure are the completion of the scheme to increase the area of the pharmacy dispensary and progression against those items committed in 2021/22. Work will continue to ensure that schemes with pre-commitments from 2021/22 are completed as soon as possible in 2022/23.

The Estates sub-group is slightly behind plan at Month 3 due to underspends against a number of schemes but no significant issues have been identified.

The medical devices sub-group is ahead of plan due to the earlier than forecast delivery of EEG equipment for neurophysiology.

Balance sheet

Balance sheet as at Month 3	31/03/2022	30/06/2022			
	Actual £m	Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment	576.4	568.7	568.3	(0.4)	
Right of Use Assets	-	18.8	18.6	(0.2)	
Intangible Assets	20.7	19.4	19.5	0.0	
Trade and other Receivables	1.4	1.4	1.4	-	
Total Non Current Assets	598.6	608.4	607.8	(0.6)	
Inventories	16.3	16.3	16.3	(0.0)	
Trade and other Receivables	41.6	39.2	39.6	0.4	
Cash and Cash Equivalents	87.6	77.3	83.9	6.7	Note 1
Total Current Assets	145.5	132.8	139.8	7.0	
Trade and other payables	(116.6)	(98.8)	(106.0)	(7.2)	Note 2
Borrowings	(10.7)	(13.9)	(13.5)	0.4	
Provisions	(2.5)	(2.5)	(5.2)	(2.7)	Note 3
Total Current Liabilities	(129.8)	(115.2)	(124.7)	(9.5)	
Borrowings	(257.8)	(265.5)	(265.6)	(0.0)	
Provisions	(3.9)	(3.9)	(3.8)	0.1	
Total Non Current Liabilities	(261.6)	(269.4)	(269.4)	0.0	
Total Assets Employed	352.6	356.6	353.6	(3.1)	
Financed By:				-	
Public Dividend Capital	648.2	648.2	648.2	-	
Retained Earnings	(437.0)	(432.9)	(436.0)	(3.1)	Note 4
Revaluation Reserve	141.4	141.4	141.4	-	
Total Taxpayers Equity	352.6	356.6	353.6	(3.1)	

Note 1 - Cash is £6.7m higher than plan. The variance is due to higher than planned cash receipts of £1.6m with payments are £5.1m lower than plan year to date. General and capital payments are lower than plan as detailed in note 2 for payables.

Note 2 - Payables are £7.2m higher than plan. General payables are £4.7m higher than plan and reflects a significant value of invoices outstanding (circa £3.3m) with NHS Supply Chain at the end of Month 3. The Trust receives weekly invoices from NHS Supply Chain including for high cost devices which need to be verified prior to payment, queries on a number of the weekly invoices had not been resolved with NHS Supply Chain to enable payment by the month end. The remaining variance to plan also reflects the revenue position to Month 3.

Capital payables are £2.5m higher than plan and this reflects where invoices have not yet been received or approved for 2021/22 capital expenditure. This position will be reviewed in quarter 2.

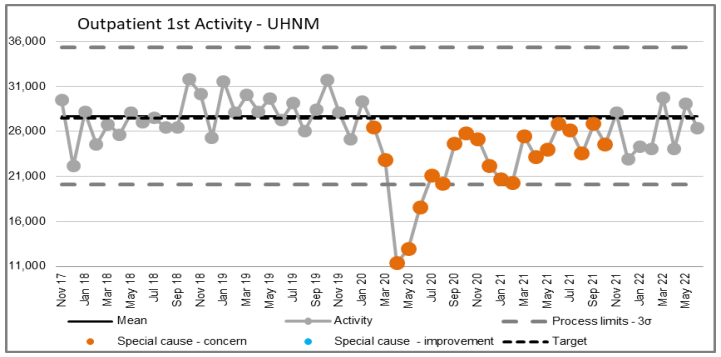
Note 3 - Provisions are £2.7m higher than plan and have increased in month in relation to two new provisions. A case has arisen which relates to a staffing issue and which has a total potential cost to the Trust of £2m. A £0.6m provision is also required for a potential fine from the Care Quality Commission (CQC) relating to an on-going investigation.

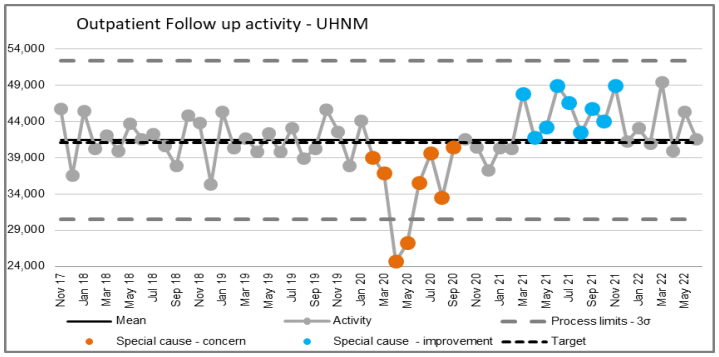
Note 4 - Retained earnings show a £3.1m variance from plan and reflect the revenue position at Month 3.

Activity

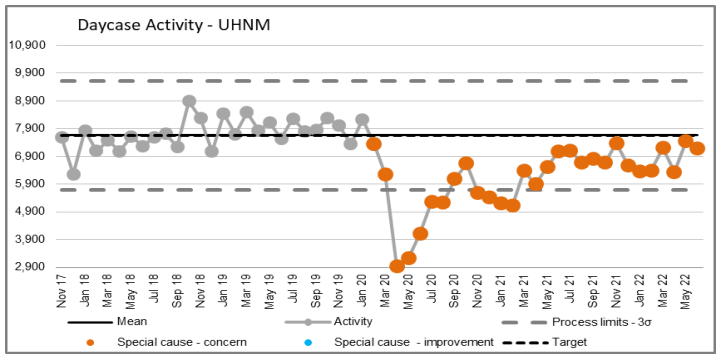
NHS University Hospitals of North Midlands NHS Trust

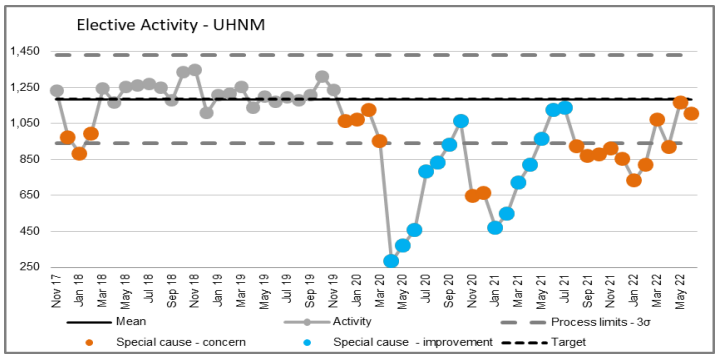
Planned care Outpatient



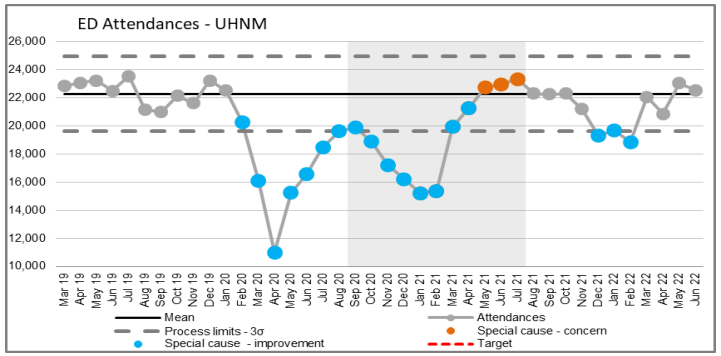


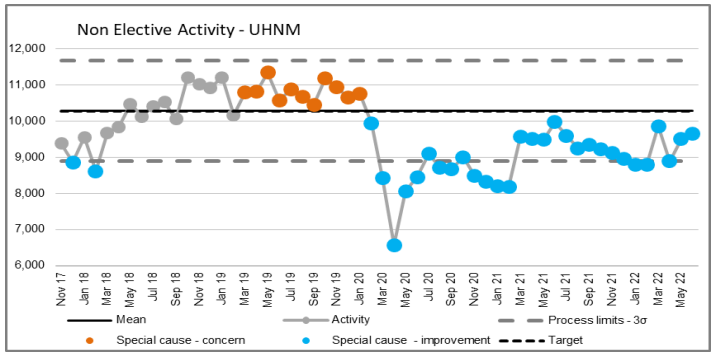
Planned care Inpatient





Urgent Care





Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Audit Committee Chair's Highlight Report to Trust Board

28th June 2022

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Concern expressed around assurance on bed and discharge arrangements in view of the proposal to defer the audit of this into the following year's programme – further consideration of this needed between executives • Concern expressed around the number of internal audit actions where timeframes have been revised; Executive Leads to be invited to the next Audit Committee to provide an explanation if not completed by that point • Concern expressed that there remain a number of policies which require review in a timely manner • Concern expressed around the Transformation and People Committee being responsible for a high number of risks on the BAF and their capacity to do this • The External Auditor Judgement of Governance for 2020/21 was that there were no significant weaknesses in arrangements, but set out an improvement recommendation in relation to embedding the Cultural Improvement Programme • There have been 3 referrals received in 2022/23 to Counter Fraud to date • Total losses and special payments made during quarter 1 are £131, 537	• Internal Audits of Bank and Agency and Workforce Planning are currently underway aligned with the approved programme of work • A system wide piece of work is underway to support bed modelling in relation to the winter plan; this will look at what is needed to close the gap between capacity and demand • Options being explore for the introduction of an electronic • Target date to be added to the Summary Board Assurance Framework; further work to be undertaken on ensuring the Summary can be taken as 'standalone' at the Board and also inclusion of predicted impact of actions to enable a forward view as to whether the target date is achievable • National project underway in relation to mandate fraud which has increased in risk
Positive Assurances to Provide	**Decisions Made**
• Positive feedback given by Internal Audit around the process for publication of declarations of interests publicly in line with national policy • The External Auditor Judgement of Financial Sustainability and Improving Economy, Efficiency and Effectiveness for 2020/21 was that there were no significant weaknesses in arrangement identified ('green' rating) • The External Auditor Judgement of Governance for 2020/21 identified that the governance arrangements associated with the Cultural Improvement Programme were robust and effective • Proactive work on Fraud Prevention remains ongoing • Assurance was provided that management recommendations in relation to ELFS have been enacted and completed by the due dates	• Approval of Clinical Audit Programme for 2022/23 • Approval of an addition to the Internal Audit Programme to undertake an audit of financial sustainability • Policy G19 Standing Orders approved by the Committee subject to an addition of reference to holding of meetings virtually taking into account national requirements and local need
Comments on the Effectiveness of the Meeting	
• Meeting was managed well online, very useful discussion of reports presented • Feeling of openness and frankness in the discussions taking place although some of the Executive Summaries are not Executive Summaries; intervention needed • Consideration to be given in the future around the timing of the July meeting given the clash with school holidays	

2. Summary Agenda

No.	Agenda Item	BAF Mapping		Purpose	No.	Agenda Item	BAF Mapping		Purpose
		BAF No.	Risk				BAF No.	Risk	
1.	2022 / 2023 Clinical Audit Programme	**BAF 1**		Approval	8.	Auditor's Annual Report	**BAF 8**		Assurance
2.	Internal Audit Progress Report	-		Assurance	9.	LCFS Progress Report	-		Approval
3.	Internal Audit Recommendation Tracker	-		Assurance	10.	Losses and Special Payments Q1 2022/23	**BAF 8**		Assurance
4.	Corporate Governance Report	-		Assurance	11.	SFI Breaches and Single Tender Waivers Q1 2022/23	**BAF 8**		Assurance
5.	Board Assurance Framework Q1 2022/23	-		Approval	12.	ELFS ISAE3402 Type II Report 2021-22	**BAF 8**		Assurance
6.	Issues for Escalation from Committees	-		Assurance	13.				
7.	G19 Standing Orders Policy	-		Approval	14.				

3. 2022 / 23 Attendance Matrix

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

Members:		A	J	J	A	S	O	N	D	J	F	M
Prof G Crowe	Non-Executive Director (Chair)											
Dr L Griffin	Non-Executive Director	PA										
Ms S Belfield	Non-Executive Director	SB										
Mrs T Bowen	Non-Executive Director											
Other Attendees:												
Ms N Coombe	External Audit – Grant Thornton											
Mr G Patterson	External Audit – Grant Thornton											
Mr M Gennard	Internal Audit - RSM											
Mr A Hussain	Internal Audit - RSM											
Ms S Coster	LCFS - RSM			AD								
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											

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	3rd August 2022
Report Title:	Board Assurance Framework (BAF) Q1 22/23	**Agenda Item:**	14
Author:	Claire Rylands, Associate Director of Corporate Governance		
Executive Lead:	Executive Directors (as assigned to individual risk assessments)		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

n/a	*Please refer to Appendix 3*	

Executive Summary

Situation

The enclosed report provides the refreshed Board Assurance Framework for 2022/23 at Quarter 1. This has been presented to Committees for scrutiny and assurance.

Background

Trust Policy RM01 sets out our Risk Management Framework, including the Board Assurance Framework. The purpose of the Board Assurance Framework is to identify the key strategic risks which threaten the achievement of our Strategic Priorities. Each risk is assigned to an Executive Lead/s and Committee. The Board Assurance Framework was presented to Committees during July.

Assessment

At Quarter 1, there are 3 risks which have been scored at Extreme 16:

- Delivering positive patient outcomes
- Sustainable workforce
- Delivering responsive patient care

'High Quality' is the most threatened of our Strategic Priorities, with 8 out of 9 strategic risks posing a threat to it. 'Responsive' is the second most threatened, with 7 out of 9 risks posing a threat to it and 'Resources' is our third most threatened, with 6 out of 9 risks posing a threat to it.

Key Recommendations

The Trust Board is asked to consider the Quarter 1 BAF and confirm whether it is satisfied that the risk scores are an accurate representation of our current position, and whether there is sufficient action being taken to mitigate these risks.

The Trust Board is asked to approve the Q1 BAF

University Hospitals of North Midlands NHS Trust

Board Assurance Framework (BAF)

Quarter 1 2022/23

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 2022/23 BAF were agreed initially by the Executive Team and then endorsed by the Board at a development session in March 2022. These strategic risks were a refinement of those agreed for the 2021/22 BAF, and are summarised below.

Assessment

Significant work has been undertaken to improve the format and function of BAF and our risk management processes over recent years and this has resulted in four consecutive annual reviews undertaken by our Internal Auditors concluding with a rating of 'Significant Assurance with Minor Improvement Opportunities'. These findings have contributed to the positive and improved overall Head of Internal Audit Opinion for 2021/22 of 'Substantial Assurance'. A programme of risk management improvement remains an ongoing focus for the organisation and this will continue throughout the course of 2021/23. However, we continue to improve the format and function of the BAF and will do this on an ongoing basis in order to optimise its effectiveness.

Key Changes to the BAF at Quarter 1

For 2021/23, all risks have been refreshed in line with the discussion held at our Trust Board Development Session in Mach 2022.

Key to 'BRAG' Ratings

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

3. Summary Board Assurance Framework

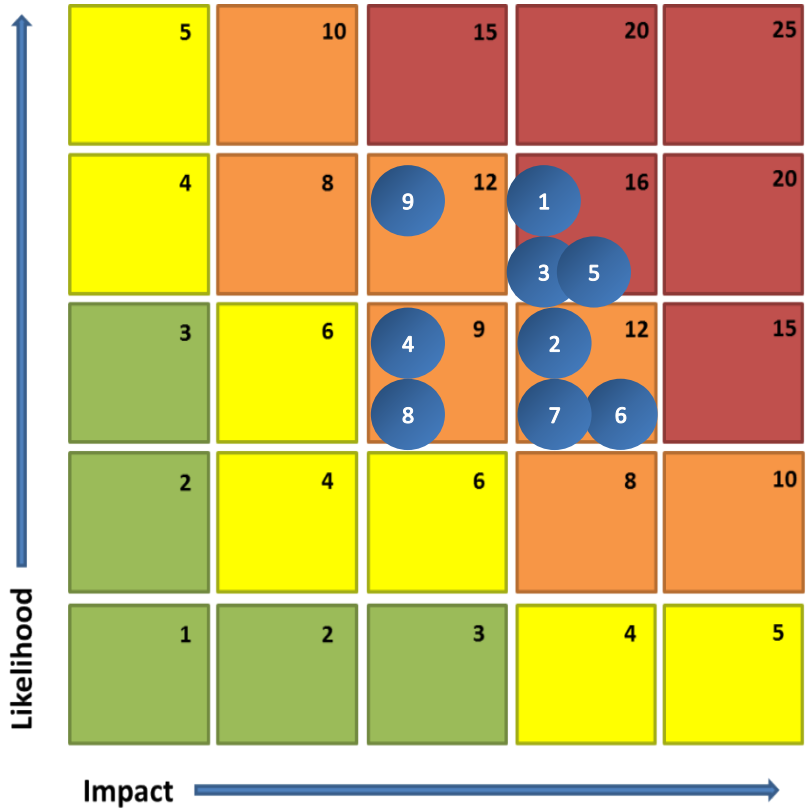
BAF	Summary Risk Title	Strategic Priorities	Q1			Q2			Q3			Q4			Target			Change
			L	C	S	L	C	S	L	C	S	L	C	S	L	C	S	
BAF 1	Delivering Positive Patient Outcomes		4	4	Ext 16										3	2	Mod 6	n/a
BAF 2	Leadership, Culture & Delivery of Values / Aspirations		3	4	High 12										3	2	Mod 6	n/a
BAF 3	Sustainable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

L Likelihood C Consequence S Score

Strategic Priorities

High Quality | Responsive | People | Improving & Innovating | System & Partners | Resources

4. Strategic Risk Heat Map



BAF 1	●●●●	Positive Patient Outcomes
BAF 2	●●	Leadership, Culture and Delivery of Values
BAF 3	●●●●	Sustainable Workforce
BAF 4	●●●	System Working
BAF 5	●●●●	Responsive Patient Care
BAF 6	●●●●	IM&T Infrastructure
BAF 7	●●●●	Compliant Estate
BAF 8	●●	Financial Performance
BAF 9	●●●●●	Research & Innovation

What does the Strategic Risk Heat Map tell us?

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

Threat to Strategic Priorities		BAF								
		1	2	3	4	5	6	7	8	9
	'High Quality' is the most threatened of our strategic priorities, with 8 out of 9 strategic risks posing a threat to it, 3 of which are scored at **Extreme**.	Ext 16	High 12	Ext 16	High 9	Ext 16	High 12	High 12	n/a	High 12
	'Responsive' is the second most threatened of our strategic priorities, with 7 out of 9 strategic risks posing a threat to it, again 3 of which are scored at **Extreme**.	Ext 16	n/a	Ext 16	High 9	Ext 16	High 12	High 12	n/a	High 12
	'Resources' is the third most threatened of our strategic priorities, with 6 out of 9 strategic risks posing a threat to it, 2 of which are scored at **Extreme**.	n/a	n/a	Ext 16	n/a	Ext 16	High 12	High 12	High 9	High 12

5. Board Assurance Framework 2021 / 22

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

Risk Description

Cause	Event	Effect
If pressures on our staff lead to them being unable to deliver high quality, timely and safe patient care and treatment	**Then** we may not be able to provide harm free care including the inability to reduce the number of nosocomial infections, pressure ulcers, falls and venous thromboembolism (VTE)	**Resulting in** avoidable patient harm, higher than expected mortality and poor patient experience and satisfaction.

Lead Director / s:	Chief Nurse and Medical Director	**Supported by:**	Chief Operating Officer
Lead Committee/s:	Quality Governance Committee / Transformation & People Committee	**Executive Group:**	Quality and Safety Oversight Group

Strategic Objectives and Risk Register

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

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	4				**Likelihood:**	3	31/12/2022
Consequence:	4				**Consequence:**	2	
Risk Level:	**Ext 16**				**Risk Level:**	**Mod 6**	
Rationale for Risk Level:	In Q1 we saw improvements in COVID related sickness across the organisation for all staff groups. However, new variants of COVID remain a real and probable risk.						

Links to Risk Register > 12 (Appendix 3):	Ext 20	Ext 16	Ext 15	High 12	High 10	High 9	High 8
	5 risks	**9 risks**	**3 risks**	**22 risks**	**-**	**-**	**-**

Position Statement

What progress has been made during the last quarter?

Continued with daily escalation staffing meetings, led by senior nursing staff, which have been successful in mitigating workforce risk where possible. Overseas nursing recruitment processes continue with further recruitment being seen during the quarter. Management of Covid-19 transmission risk has been a challenge to minimise the number of Nosocomial outbreaks. Patient falls have remained one of the highest reported patient safety incidents, particularly in admission portals, resulting in a focus by the Corporate Nursing Quality & Safety Team. Urgent work has been commissioned to remove a number of cubicle doors in ED at Royal Stoke to improve patient visibility.

Key Controls Framework – 3 Lines of Defence

1st Line of Defence

- Daily nurse staffing meetings to identify requirements and appropriate escalation of gaps and required support
- Safer Staffing Tool completion twice daily by Ward staff
- Local processes in place for medical and AHP staff to assess requirements and establishments
- International Recruitment commenced and approval for c.70 nurses.
- Development of Site Safety Dashboard
- Quality Impact Assessments undertaken for change in services regarding additional capacity areas and changes in establishments
- Senior leadership team in place for each ward and department, with overarching accountability for delivering quality and minimising hospital acquired harm
- Falls Champion role in each Ward/Department.
- Tissue Viability Link Nurses in each Ward/Department
- Corporate Quality & Safety Team co-ordinate Improvement Programmes for Pressure Ulcers, Falls and VTE
- Specific governance arrangements in place for Maternity Services, including compliance with CNST requirements.
- Infection Prevention Team co-ordinate Improvement Programmes for infections, including Sepsis and

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

Assurance Map

Committee Assurances (assurances received by the Committee/s during this quarter)

1st Line (Divisional)		2nd Line (Corporate)		3rd Line (External)	
Ockenden Final Report	✓	Q4 Infection Prevention Report	!		
Pressure Ulcer Review	!	Q4 Infection Prevention BAF	!		
52 Week Breach Assurance Report	✓	Mortality Summary Report	!		
BC-0436 Specialised Decisions Unit Business Case	✓	M12, M1, M2 Quality & Safety Report	!		
Nursing Vacancies	!	M12, M1, M2 Performance Report	!		
Q4 Maternity New Serious Incident Report	!	M12, M1, M2 Workforce Performance Report	!		
Q4 Perinatal Mortality Report	! ✓	Executive Workforce Assurance Group Report	✓		
Q4 Maternity Dashboard	✓	Executive Quality and Safety Oversight Assurance Reports	✓		
Q4 Guardian of Safe Working Report	!	Quality Strategy	✓		
Medical Examiner Update	✓	Q4 Serious Incident Report	!		
Emergency Department Medical Workforce Update	!	Never Events Review	✓		
BC-0477 NICU Nurse Staffing Establishment RSUH	✓	Annual Plan 2022/23	✓		
Expansion in Foundation Posts Business Case	✓	Q4 Nursing and Midwifery Staffing and Quality Report	✓		
		Q4 Patient Experience Report	✓		
		Quality Impact Assessment Report	✓		

Other Assurances (assurances received by the Committee annually / bi-annually / ad hoc)

Gaps in Control or Assurance

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

- Establishment review to be completed which will align acuity with workforce
- Business case agreed for Maternity, recruitment underway
- Recruitment against Emergency Department Business Case to be completed
- 52 week / 104 day harm review process being reviewed

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

No.	Action Required	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	To implement Perfect Ward audit system and app	Chief Nurse	30/09/2022	Timeframe extended due to technical compatibility issue which is being worked through with IM&T. Monthly clinical excellence audit developed and in testing phase	GA
2.	To develop Trust Patient Safety Incident Review Plan (PSIRP) and engagement of Patient Safety Partners to support review and patient involvement in Trust quality meetings.	Chief Nurse & Medical Director	30/04/2023	National PSIRF guidance has been updated following COVID-19 with amended dates and learning from early adopters. This is under review and inclusion in UHNM PSIRP. UHNM steering group up and running, National timescale is to implement in 2023	GA
3.	Establishment Review to be completed to align acuity with workforce.	Chief Nurse	31/08/2022	Establishment review underway.	GA
4.	Recruitment of midwives in line with Business Case and Birth Rate Plus.	Chief Nurse	30/09/2022	Trust Board Seminar discussed current gap and action to be taken. Agreement in principle to proceed with recruitment pending completion and approval of business case.	GA
5.	Recruitment against Emergency Department Business Case to be completed.	Chief Nurse	30/07/2022	Consultant posts appointed to, awaiting visas / recruitment checks to conclude. Nursing recruitment ongoing, monitored monthly through Division.	GA

	BAF 2:	Leadership, Culture and Delivery of Values / Aspirations	Internally Driven	✓
			Externally Driven	

Risk Description

Cause	Event	Effect
If we are unable to live our values and improve the culture of the organisation to make UHNM a place where all staff are treated with respect and have the opportunity to build a fulfilling career	**Then** staff may experience unacceptable behaviours and a climate of bullying, harassment and inequality	**Resulting** in an adverse impact on staff wellbeing, recruitment, retention and performance, ultimately reducing the quality of care experienced by patients.

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

Strategic Objectives and Risk Register

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

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3				**Likelihood:**	3	Will be agreed once the Cultural Improvement Programme is finalised
Consequence:	4				**Consequence:**	2	
Risk Level:	**High 12**				**Risk Level:**	**Mod 6**	

Rationale for Risk Level:

- The National view of the 2021 Staff Survey presents a picture that NHS Staff perception is of increasing workloads with less resource available and increasing time pressures. More staff report experiencing burnout and nationally, 46.8% of staff experienced stress – 8% higher than in 2017. There was an overall decline in staff perceptions that care of patients/service users is a top priority and in standards of care. There was also an overall decline in staff willing to recommend organisations as places to work and in diversity and equality indicators. Locally, the Trust scored lower than national average against all 7 themes, as well as staff engagement and morale.
- The results of the BRAP/Kline work are also linked to the Staff Survey outcomes as regards issues raised and actions planned. Both reports indicate a number of issues need to be addressed and the key focus for action will be to address behaviours, generally across the Trust and specifically in staff groups and hotspot areas. This is because adverse staff behaviours increase the risk to the Trust's culture, values and aspirations, impacting on patient care, increasing staff disengagement and affecting performance as well as having an adverse effect on our ability to recruit and retain staff.
- Based on the National Staff Survey, a methodology to calculate a more frequent staff engagement rate has been implemented using the results of the Staff Voice Survey. The June 2022 staff voice results indicate the local staff engagement rate, at 6.34, was improved compared to the previous 3 months previous months
- Leadership and management development offers continue to be promoted.
- Sickness levels remain high and above target. Covid-related absences continue to fluctuate, Wellbeing Plans are in place with our Occupational Health and Staff Support and Counselling Providers contributing to the range of offers
- The key risk and challenge likely to prevent successful delivery of activities, aimed at improving organisational culture and behaviours and maximising the potential of our people to improve patient outcomes, is that operational pressures, the impact of covid and other winter pressures, prevent staff from being released to undertake the necessary training and development.

Links to Risk Register > 12 (Appendix 3):	Ext 20	Ext 16	Ext 15	High 12	High 10	High 9	High 8
	-	-	-	1 risk	-	-	-

Position Statement

What progress has been made during the last quarter?

Staff Engagement

- A number of open sessions have taken place across the Trust to enable staff to discuss the recent findings of the Culture Review and to encourage teams to discuss the report's findings and help to develop an action plan for improvement. Following feedback from these sessions with staff, the Cultural Improvement Programme is being finalised.

Staff Experience

- The Equality, Diversity and Inclusion Strategy is in final draft stage
- A Resolution Policy is under consultation to streamline the Dignity at Work process
- A Behaviours Framework is being developed to support early resolution of issues
- The development and design of 'Civility Saves Live' programme commenced in June
- We have asked for staff volunteers to become Staff Experience Champions to promote and encourage employee engagement and be a point of contact in their local area of work; act as the link to help connect people who have the ideas with people who can help turn them into reality, and to be actively involved in a variety staff engagement activities across all divisions,
- The new Freedom to Speak Up Guardian has promoted drop in sessions for staff who may wish to raise a concern and feel that they have nowhere else to go as well as a full programme of events to be held during June 2022

Staff Wellbeing

- Divisions have set trajectories for achieving a reduction in Sickness Absence (subject to Covid Pandemic spikes, Winter Pressures and staffing deficiencies) with a year-end target of around 5.5%, which will is monitored via the Improving Together Programme (Staff Availability Objective). The focus remains on managing areas of high sickness, with specific deep dives in to stress/anxiety, MSK and Covid-related absences, with assurance meetings having taken place in the Divisions and continued daily monitoring of sickness absence rates, including COVID related absence
- Several Health & Wellbeing Webinars have been promoted for June 2022

Leadership Development

- The ENABLE Programme for Managers has commenced and an inclusivity Master Class has been built into our Connects Leadership Programme. A Clinical Leaders Programme was launched in June 2022

Key Controls Framework – 3 Lines of Defence

1st Line of Defence	• Divisional Staff Engagement Plans set out the tailored actions to improve staff experience • Improving Together programme – Staff engagement A3 is developed
2nd Line of Defence	• Staff Voice pulse check survey implemented from June 2021 • People Strategy and supporting HR Delivery Plan, with performance reported to Transformation and People Committee. The HR Delivery Plan is aligned to the NHS People Plan and updated for 2022/23 actions and objectives • Partnership working with the STP is in place to introduce a range of Recruitment and Retention initiatives • The Trust has set targets for staff engagement rates; sickness and turnover. Actual performance is monitored against target.
3rd Line of Defence	• National Quarterly Pulse Survey was implemented from July 2021 • The 2021 National Staff Survey results have been analysed and corporate improvement activities set out and reported to Board. Divisions have reviewed Staff Survey information so that they can implement tailored interventions, communications and action plans to address the issues their staff say are important to them. Performance monitoring is carried out via the Executive Workforce Assurance Group, • The Trust wellbeing plan and wellbeing offer is refreshed and updated periodically. • The Culture Review has been completed and the results were reported to Board in April 2021. A number of open sessions have taken place for staff to discuss the findings of the Culture Review. Following feedback from these sessions with staff, the Cultural Improvement Programme is being finalised • Our Gender Pay Gap report shows the difference in the average earnings between all men and women employed at UHNM and the actions we are taking to further reduce the gender pay gap. • The Stonewall Equality Index is a benchmarking tool for employers to measure their progress on LGBT+ inclusion in the workplace. We last took part in 2019 and scored in 325th place. • Leadership Development offerings are in place

Assurance Map

Committee Assurances (assurances received by the Committee/s during this quarter)

1st Line (Divisional)		2nd Line (Corporate)		3rd Line (External)	
		Q4 Workforce Equality, Diversity and Inclusion Report	!		
		Q4 Speaking Up Report	✓		
		Q4 Disciplinary Activity	!		
		M12, M1, M2 Workforce Performance Report	!		
		People Plan 2022/23	✓		
		BRAP Report & National Staff Survey – Corporate Actions	✓		
		Executive Workforce Assurance Group Report	✓		
		Annual Plan 2022/23	✓		
		People Plan Annual Report 2021/22	✓		
		Organisational Development and Culture Update	! ✓		
		Health & Wellbeing Plan Progress Report	✓		
		Creating a Great Place to Work: Improving our Organisational Culture	! ✓		

Other Assurances (assurances received by the Committee annually / bi-annually / ad hoc)

Gaps in Control or Assurance

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

- Up-skill managers to adopt a motivational and inspiring leadership style (Enable Programme)
- Improve and evidence the positive action taken on health and wellbeing (Staff Survey)
- Improve equality and diversity, staff morale and a culture of safety (Staff Survey)
- Improve Leadership and Management Development and Visibility (Staff Survey)
- Improve Staff Engagement (Staff Survey)
- Implement the Culture Review Improvement Plan and ensure there are processes in place to monitor and report progress

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

No.	Action Required	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	Take forward the findings from the Trust Culture and Leadership Diagnostic Programme, and the Culture Review by formulating and embedding plans which reflects the themes identified including: a) Putting structures in place to help staff challenge and report inappropriate and bullying behaviours in the workplace b) Launch a programme of staff development underpinned by NHSI/E's "Kindness into Action" programme	Chief People Officer	Improvement Plan is yet to be agreed	The Cultural Improvement Programme is being finalised following completion of the final session for staff to have their say on the BRAP/Kline report Detailed actions and target dates are to be agreed by Trust Executives as part of the Culture Review implementation programme	GA
2.	Develop and promote the Trust's leadership and behaviour compact as outlined in the national People Plan	Chief People Officer	Improvement Plan is yet to be agreed	The leadership behavioural framework which will be co-created with our leaders as part of the Middle Management Programme development process. We are supporting the Improving Together Programme and Quality Academy with those aspects linked to leadership behaviours and cultural change	GA
3.	Promote the Civility and Respect agenda and a) Introduce a Resolution Policy. b) Deliver the National Civility and Respect Toolkit and c) implement a Civility and Respect training programme with a focus on race	Chief People Officer	Improvement Plan is yet to be agreed	Detailed actions and target dates are to be agreed by Trust Executives as part of the Culture Review implementation programme • The Draft Resolution Policy will go to TJNCC in July 2022 • The National Civility and Respect Toolkit was completed in June 2022	GA
4.	Roll out our Medical Leadership programme	Chief People Officer	This is an on-going programme	Roll out commenced in June 2022 A 2nd cohort is planned from Oct 2022 and the programme will be repeated with 2 cohorts annually going forward	B
5.	Deliver "Enable" our Middle Management programme to support leaders in maintaining positive, compassionate and inclusive behaviours.	Chief People Officer	This is an on-going programme	Communications promoting the 'Enable Middle Management' programme have been issued. The programme will be delivered to 616 managers in 2022/2023	B

BAF 3: Sustainable Workforce

Internally Driven	✓
Externally Driven	✓

Risk Description

Cause	Event	Effect
If we are unable to achieve a sustainable workforce	**Then** we may not have staff with the right skills in the right place at the right time	**Resulting** an adverse impact on staff wellbeing, recruitment and retention, increasing premium costs and potentially compromising the quality of care for our patients

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

Strategic Objectives and Risk Register

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

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	4				Likelihood:	3	30/04/23
Consequence:	4				Consequence:	3	
Risk Level:	Ext 16				Risk Level:	High 9	

Rationale for Risk Level:

The level of workforce risk remains at Ext16 due to the cultural issues highlighted by the Culture Review. Although there are good plans in place to mitigate risks and additional recruitment is taking place, there is still an impact of covid surges on sickness levels and workforce availability.

- Divisions report increased staffing challenges due to operational pressures and the opening of additional capacity, combined with high sickness rates and vacancy levels
- Sickness levels remain high and above target. Absence continues to be monitored on a daily basis, with operational contingency plans in place.
- Processes are in place for the redeployment of staff and to escalate requests for support to the wider System should the need arise.
- The UK Visas and Immigration (UKVI) are processing the high number of emergency visas related to the humanitarian crisis as a result of the war in Ukraine as a priority. This has resulted in a significant delay in processing work, study and family visa applications, which may cause delays in the recruitment process for sponsored candidates and employees

To mitigate these risks and challenges further, the process for assuring workforce availability is being reviewed through the Improving Together programme in 2022/23. This will cover sickness absence, vacancies and retention in particular. Additionally:

- There are extensive programmes of work to develop and sustain workforce supply routes. Updates on these in key areas are provided to both the Executive Workforce Assurance Group and the Transformation and People Committee
- The medical workforce and nursing workforce groups are in place to assess and assure on workforce supply.
- The Trust is represented on regional workforce groups lead by head of professions including nursing, AHPs and pharmacists.
- The Trust is represented on regional service groups such as diagnostics, cancer, urgent and emergency care. These are led by heads of professions to bring about improvements and workforce supply is a key factor for these groups.
- There is a Diagnostic Steering Group which has workforce as a key strategic driver,
- Turnover and vacancy rates are reported in the Board Integrated Performance Report and the Trust Workforce Report which is reviewed by the Transformation and People Committee.
- The Trust's People Strategy is supported by a HR Delivery Plan which sets out the programmes of work to address workforce retention and enabling workforce supply. This is reviewed by the Executive Workforce Assurance Group and the Transformation and People Committee.
- The Transformation and People Committee also receives regular updates on workforce numbers, vacancies and staff absences.

Links to Risk Register > 12 (Appendix 3):	Ext 20	Ext 16	Ext 15	High 12	High 10	High 9	High 8
	4 risks	11 risks	2 risks	16 risks	-	-	-

Position Statement

What progress has been made during the last quarter?

- The Trust workforce plan for 2022/23 has been triangulated with Finance and Activity Plans and submitted to the System as part of the annual Operational Planning round
- The review of the process for assuring workforce availability has commenced with the development of an A3 covering sickness absence, vacancies and retention.
- Work with Divisional teams has commenced to support the development of their people plans Delivery Plans are being developed and progress will be tracked through EWAG
- As part of plans for addressing workforce supply a business case for International recruitment of nurses during 2022/23 has been approved
- The Recruitment service is currently working through a full review to identify process improvements using the Improving Together methodology and the development of a Step Change project. Activities have been process mapped and standard operating procedures revised
- There has been a renewed focus on support and management of sickness absence

Key Controls Framework – 3 Lines of Defence

1st Line of Defence	• Workforce Plan reported to Transformation & People Committee • Workforce planning process ensures alignment with activity and financial plans. The Trust workforce plan for 2022/23 has been triangulated with Finance and Activity Plans and submitted to the System as part of the annual Operational Planning round • Actions to improve staff experience are detailed in Divisional Staff Engagement Plans • Ongoing recruitment processes • Rotas and rota coordinators management of roster processes • Medical rotas are reviewed, vacant shifts covered where possible from doctor bank and agency, adverts out for Trust grades where applicable. Locums are used / recruited to fill gaps where necessary • Directorate and divisional management teams monitor staffing levels • Chief Nurse staffing reviews • The UHNM Staff Voice is a monthly staff survey designed to help understand key issues important to staff about wellbeing, making improvements to where they work and the way they provide patient care. This survey also provides a local measure of staff engagement. **Digital Agenda:** The draft People Digital Strategy for the NHS was released in September 2021 and sets out draft commitments for the next 3 years. The Digital Agenda is a system-led work programme initially covering the roll out of a Digital Staff Passport to hold staff 'verified employment and training credentials'.
2nd Line of Defence	• The Trust's People Strategy is supported by an HR Delivery Plan, with improvement activities cascaded via Divisional People Plans. The HR Delivery Plan has been updated for 2022/23 priorities and actions. • The system led workforce demand and supply process remains in place and will continue to manage redeployment of staff where required, as well as system wide recruitment initiatives. The Trust continues to progress its own recruitment plans as well. • Processes are in place to request mutual aid from across the System if required • The Workforce Bureau is now operating as a virtual bureau. • Established Banks are in place – including Nursing, Medics and other staff groups • Business cases have been approved to address staffing in ED, Anaesthetics and Critical Care and other hotspots and are being recruited to • Weekly meetings take place with Medical Staffing to review rotas, gaps and progress against recruitment • General recruitment drives are on-going and there is an element of head hunting via informal networks • Golden Handshakes and handcuffs can be used for new starters **Digital Agenda:** The Trust has volunteered to participate in a trial of the digital staff passport. This will involve identifying doctors training who are due to rotate in the Summer of 2022. It has been confirmed that the Trust has not been successful in taking part in the first tranche of the pilot but this will continue to be pursued.

3rd Line of Defence	• The Trust workforce plan for 2022/23 has been triangulated with Finance and Activity Plans and submitted to the System as part of the annual Operational Planning round
	• Plans remain in place to ensure the workforce issues associated with any surge in Covid-related absences remain in place, including:
	  ○ The *COVID-19 Staff Shortage Contingency Arrangements*, supplemented by the *Disruptive Incident Staffing Plan and Operational Workforce Plan*.
	  ○ Internal redeployment and volunteer process established to offer support to areas of need
	  ○ Partnership working with the STP, with system-wide processes for mutual aid and redeployment of staff where possible.
	• The 2021 National Staff Survey results have been analysed and corporate improvement activities set out and reported to Board. Divisions have reviewed Staff Survey information so that they can implement tailored interventions, communications and action plans to address the issues their staff say are important to them. Performance monitoring is carried out via the Executive Workforce Assurance Group
	• The National quarterly 'People Pulse survey was implemented from July 2021
	• Workforce risks are reported via Datix and are monitored to ensure Divisional action and review.
	• Divisions report increased staffing challenges due to operational pressures and the opening of additional capacity, combined with high sickness rates and vacancy levels
	• Quarterly vacancy benchmarking data is available via NHS Digital
	• UHNM was named Employer of the Year for Higher Apprenticeships by Staffordshire University in May 2022

Assurance Map

Committee Assurances (assurances received by the Committee/s during this quarter)

1st Line (Divisional)		2nd Line (Corporate)		3rd Line (External)	
BC-0436 Specialised Decisions Unit Business Case	✓	M12, M1, M2 Workforce Performance Report	!		
Nursing Vacancies	!	People Plan 2022/23	✓		
Q4 Guardian of Safe Working Report	!	Executive Workforce Assurance Group Report	✓		
Emergency Department Medical Workforce Update	!	Annual Plan 2022/23	✓		
BC-0477 NICU Nurse Staffing Establishment RSUH	✓	People Plan Annual Report 2021/22	✓		
Expansion in Foundation Posts Business Case	✓	Q4 Nursing and Midwifery Staffing and Quality Report	✓		

Other Assurances (assurances received by the Committee annually / bi-annually / ad hoc)

Gaps in Control or Assurance

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

- Development of Divisional People Plans and Workforce Plans for 2022/23, aligned to the corporate agenda
- Review of processes to assess workforce availability, covering sickness absence, vacancies and retention (Improving Together programme)
- On-going development of workforce supply and recruitment processes to address future workforce supply issues

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

No.	Action Required	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	Develop an A3 under the Improving Together programme for 2022/23 covering sickness absence, vacancies and retention.	Chief People Officer	Completed	The A3 template has been developed	**BA**
2.	Work with Divisional teams to support the development of their people plans	Chief People Officer	30/09/22	Delivery Plans are being developed with Divisions. Progress will be tracked through EWAG	**GA**
3.	Align the Trust's workforce plan with capacity plans developing a local toolkit for use by management teams	Chief People Officer	31/12/22	Trust workforce plan for 2022/23 has been triangulated with Finance and Activity Plans and submitted to the System	**GA**
4.	Work with clinical leaders and managers to improve workforce supply, to reduce vacancy levels, by promoting UHNM as a great place to work and by using social media, international recruitment and other promotional campaigns	Chief People Officer	This is an on-going programme of work	Business case for International recruitment of nurses has been approved Medical workforce and nursing workforce groups are in place to assess and assure on workforce supply. The Trust is represented on regional workforce groups lead by head of professions including nursing, AHPs and pharmacists, and on regional service groups such as diagnostics, cancer, urgent and emergency care. These are led by heads of professions to bring about improvements and workforce supply is a key factor for these groups. Following recent bids, HEE has confirmed that new medical training posts are being allocated to UHNM. This expansion of training posts recognises the need for more consultants in future.	**BA**
5.	Engage activities with community groups, voluntary sectors, Armed Forces to promote careers at UHNM	Chief People Officer	30/09/22	The first "Step into Medicine" virtual session was held in June, for School and College students who want to start a career in medicine. The session provided students with an opportunity to listen to our qualified doctors and their journey o becoming a doctor	**BA**

Further Actions (to reduce Likelihood / Consequence of risk to achieve 'Target Risk Level') in line with Risk Appetite					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarterly Progress Report**	**BRAG**
				The Hospital Virtual Work Experience programme is being developed for delivery from September 2022. Aimed at local students, aged 14–19, the programme will provide insight on the range of clinical careers available in an acute hospital setting.	
6.	Support education leads and work with education teams and providers across the system to enhance opportunities for learning and the education experience for our trainees	Chief People Officer	30/09/22	A number of learning activities were sourced and delivered during Learning at Work Week in May 2022. Activities were open to all staff and included the "Art of Brilliance" – focussing on wellbeing, personal impact, and being your best self and "Rising Stronger" – taking staff on a journey from mental health to mental wealth, based on the science of positive psychology	**GA**

BAF 4: System Working

Internally Driven	
Externally Driven	✓

Risk Description

Cause	Event	Effect
If we are unable to effectively collaborate, engage and influence key stakeholders as part of the Integrated Care system	**Then** we may not be able to provide health services which meet the wider needs of the system population	**Resulting in** fragmented, poor quality, inefficient and ineffective services

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

Strategic Objectives and Risk Register

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

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3				Likelihood:	2	31/03/2023
Consequence:	3				Consequence:	3	
Risk Level:	High 9				Risk Level:	Mod 6	
Rationale for Risk Level:	Whilst the new ICS legal framework and governance arrangements are now in place these need to be operationalised which will be the focus over the coming quarters.						

Links to Risk Register > 12 (Appendix 3):	Ext 20	Ext 16	Ext 15	High 12	High 10	High 9	High 8
	-	-	-	-	-	-	-

Position Statement

What progress has been made during the last quarter?

The formal transition to the ICS has taken place, which includes the development of the ICP and the NHS ICB. UHNM Chief Executive is a nominated member of the NHS ICB for physical health and is also chair of the Provider Collaborative which was formally established on 1st April 2022.

Key Controls Framework – 3 Lines of Defence

1st Line of Defence	• Regular updates from the Executive Strategy and Transformation Group
2nd Line of Defence	• Regular discussions at Executive Team meeting each week • Regular update on ICS transformation programme to Transformation and People Committee • Regular updates in closed session of Trust Board and through Chief Executive's update to Public Board • Board Seminars with a specific focus on partnership working and collaboration • Adoption of a number of UHNM approaches to risk management and governance at system level through governance and risk system network
3rd Line of Defence	• Representation in the formal governance structure of the ICB • Members of the Executive Team play a key role in relevant system led forum / workstreams. • Medical Director has established a new Deputy Medical Director role with a specific focus on system working.

Assurance Map

Committee Assurances (assurances received by the Committee/s during this quarter)

1st Line (Divisional)		2nd Line (Corporate)		3rd Line (External)	
		Executive Strategy & Transformation Group Assurance Report	✓	Integrated Care System Board Partner Briefing – April 2022	✓
		Annual Plan 2022/23	✓	Staffordshire and Stoke on Trent ICS Development Plan / Newsletter	✓

Other Assurances (assurances received by the Committee annually / bi-annually / ad hoc)

				Quarterly System Performance	

				Review Meeting	

Gaps in Control or Assurance

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

- Development of stakeholder feedback on UHNM as a partner, including adoption of revised Code of Governance in relation to system working
- Future CQC inspections on Well Led will incorporate the legal duty to collaborate through a focus on system working / engagement and partnership working
- Provider Collaborative to develop its work plan or road map to January 2023
- Progress against wider clinical partnerships / networks beyond the ICS to be provided through the system Provider Collaborative and UHNM internal governance structure

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

No.	Action Required	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	Development of stakeholder feedback on UHNM as a partner, including adoption of revised Code of Governance in relation to system working.	Director of Strategy & Transformation	30/9/2022	To be developed during July / August with a view to having a first completed stakeholder feedback review by the end of September.	
2.	Development of work plan or road map to January 2023 in relation to provider collaboration.	Chief Executive	31/1/2023	Underway at system level with a view to having a draft in place by August 2022.	
3.	Progress against wider clinical partnerships / networks beyond the ICS to be provided through our governance structure.	Director of Strategy & Transformation / Chief Executive	30/9/2022	Arrangements to be made for reporting into Executive Strategy and Transformation Group and Transformation and People Committee although content / format to be ageed.	

	BAF 5:	Delivering Responsive Patient Care	Internally Driven	✓
			Externally Driven	✓

Risk Description

Cause	Event	Effect
If we are unable to create sufficient capacity to deal with service demand	**Then** we may be unable to treat patients in a timely manner	**Resulting in** high hospital occupancy, delays to patient care and potential patient harm

Lead Director / s:	Chief Operating Officer	**Supported by:**	Chief Nurse and Medical Director
Lead Committee:	Performance and Finance Committee	**Executive Group:**	Operational Delivery Group

Strategic Objectives and Risk Register

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

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	4				Likelihood:	3	31/08/2023
Consequence:	4				Consequence:	3	
Risk Level:	Ext 16				Risk Level:	High 9	
Rationale for Risk Level:	Ongoing patient delays and wait to treatment on both non elective and elective pathways						

Links to Risk Register > 12 (Appendix 3):	Ext 20	Ext 16	Ext 15	High 12	High 10	High 9	High 8
	4 risks	-	1 risk	9 risks	-	-	-

Position Statement

What progress has been made during the last quarter?

Refresh of the non-elective improvement programme, utilisation of significant investment in Emergency Department medical workforce, operational focus on hospital occupancy and discharge and the progression of transformational projects across all 3 non-elective improvement workstreams. This has been supported by ongoing and integrated work with system partners across the newly formed Integrated Care System.

Key Controls Framework – 3 Lines of Defence

1st Line of Defence	• 4 x daily capacity calls with Head of Operations, Deputy Chief Operating Officer (COO) / COO attendance • Fortnightly improvement meetings tracking the actions / milestones across the 3 the NEL improvement work streams supported by the Deputy COO with exec oversight • Weekly weekend planning meetings to provide assurance of the safe delivery of services and to identify and mitigate risks throughout the weekend period • Weekly meetings with system partners including West Midlands Ambulance Service to identify opportunities for collaboration and to appropriately share risk across the system - to support the admission avoidance actions within Programme 1of the NEL improvement programme • Divisional accountable officers rota'd on a daily basis to provide a visible and accessible point of contact for operational management and risk mitigation
2nd Line of Defence	• Monthly internal performance review meetings between Executive and Divisional Leadership Teams to ensure appropriate improvements, management of risk and accountability • Executive led Non-Elective and Elective Improvement Programme Groups to ensure ongoing performance improvement • Standing up of executive led daily tactical response meetings when significant risks are identified and require corporate support
3rd Line of Defence	• 3x weekly COO call chaired by ICB with representation from all system partners • System Urgent Emergency Care Board to support system-wide non-elective improvements and provide opportunities for collaboration and management of risk across the system

Assurance Map

Committee Assurances (assurances received by the Committee/s during this quarter)

1st Line (Divisional)		2nd Line (Corporate)		3rd Line (External)	
52 Week Breach Assurance Report	✓	M12, M1, M2 Performance Report	!		
Emergency Department Medical Workforce Update	!	Operational Delivery Group Highlight Report	! ✓		
Business Case: BC-0470 Extension of Respiratory Post Covid Follow Up Service	✓	Planned Care Cell Highlight Report	!		
Review of Urgent Care	✓	Non Elective Improvement Board Minutes	✓		
BC-0479 Expansion of County Elective Capacity	✓				
Request for Funding – MRI Mobile Scanner	✓				
Planned Care Improvement Deep Dive	✓				

Other Assurances (assurances received by the Committee annually / bi-annually / ad hoc)

Gaps in Control or Assurance

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

- **High occupancy** – unable to reduce our occupancy to facilitate planned and urgent care pathways
- Unreliable simple discharge delivery that supports flow through the organisation
- High MFFD as a % of bed occupancy

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

No.	Action Required	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	Fully execute business cases that support non-elective programme of work	Chief Operating Officer	30 Nov 2022		GA
2.	Develop and implement robust winter planning, integrated with wider system provisions	Chief Operating Officer	5 Oct 2022		GA
3.	Deliver objectives as described in non-elective improvement programme	Chief Operating Officer	31 Mar 2023		GA
4.	Develop comprehensive capacity, demand, organisational and system bed model to ensure data driven approach to improvement	Chief Operating Officer	31 Oct 2022		GA
5.	Increase capacity of UHNM footprint through the development of County Hospital as an elective care centre	Chief Operating Officer	30 November 2022		GA
6.	Ensure full exploration and development of opportunities to utilise data and technology to support the delivery of clinical services	Chief Operating Officer	31 Mar 2023		GA

BAF 6: Delivery of IM&T Services

Internally Driven	✓
Externally Driven	

Risk Description

Cause	Event	Effect
If our infrastructure and clinical systems are not sufficient or adequately governed or protected	**Then** this could compromise connectivity and access to key critical patient information **services such as clinical decision support**	**Resulting in** compromised patient care (including patient delays, cancellation of services, **clinical harm**), staff inefficiencies and breaches of confidentiality, reputational damage and potential fines.

Lead Director / s:	Director of Digital Transformation	**Supported by:**	Medical Director and Chief Finance Officer
Lead Committee:	Transformation and People Committee	**Executive Group:**	Executive Data Security & Protection Group

Strategic Objectives and Risk Register

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

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3				**Likelihood:**	1	31/03/2024
Consequence:	4				**Consequence:**	4	
Risk Level:	**High 12**				**Risk Level:**	**Mod 4**	
Rationale for Risk Level:	Digital Health Technology, if effectively deployed and highly available is able to improve patient safety through clinical decision support, alerts and monitoring. Failure to adopt this technology could result in harm that would have been avoidable. Likewise when the technology is adopted if it is unavailable for a sustained period of time our patients could be impacted by harm that would otherwise been avoidable.						

Links to Risk Register > 12 (Appendix 3):	Ext 20	Ext 16	Ext 15	High 12	High 10	High 9	High 8
	-	-	-	**7 risks**	-	-	-

Position Statement

What progress has been made during the last quarter?

The Digital Strategy has been approved by Trust Board.
The network and communication requirements specification has been produced ready for market testing.
Demonstrations of electronic patient record solutions have been undertaken ready for us to start producing the requirements specification.
The System C contract renewal has been drafted and has been circulated to procurement legal advisors for review prior to signature.
The Patients Know Best patient portal project has commenced.
A replacement video consultation solution based on Microsoft Teams has demonstrated and will now be piloted in 3 areas.

Key Controls Framework – 3 Lines of Defence

1st Line of Defence	Known Log4J vulnerabilities mitigated Forced computer reboot policies approved and live ensuring equipment receives updates Recruitment of Cyber Security Team Digital A3 completed and presented to Execs, Digital and Data Security and Protection Executive Group and Executive Infrastructure Group
2nd Line of Defence	Cyber security action plan in place Cyber security services contracted from I3Secure Third party commissioned to undertake SQL 2012 upgrades Network and Communication services strategic outline case approved.
3rd Line of Defence	Internal audit of data security and protection Internal audit of asset management HIMMS INFRAM assessment completed HIMSS 2 HIMSS EMRAM assessment completed HIMSS 2 Annual Data Security and Protection Toolkit submitted.

Assurance Map

Committee Assurances (assurances received by the Committee/s during this quarter)

1st Line (Divisional)		2nd Line (Corporate)		3rd Line (External)	
Log4j progress update	✓	Executive Digital and Data Security & Protection Group Assurance Report	!	IT Cyber Security Governance and Risk Management Framework Internal Audit	✓
BC-0397 Network and Communications Strategic Outline Case	✓	Digital Strategy	✓	IT Asset Management Internal Audit Review	✓
		Executive Infrastructure Group Assurance Report	!	Data Security and Protection Toolkit Internal Audit	✓
		NASSTAR Network Incident Debrief	✓		

Other Assurances (assurances received by the Committee annually / bi-annually / ad hoc)

Gaps in Control or Assurance

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

- Office 365 migration
- Electronic prescribing and medicines administration solution
- Electronic patient record strategic outline case
- Network services outline business case
- Backup and firewall implementation
- iPortal rewrite into a supported platform
- Ward Information system rewrite onto a supported platform
- Recruit to the Commercial Manager post
- Recruit to the Technical Architect post
- Approval to recruit to the Chief Nurse Information Officer post
- Implement laboratory management information system
- Commission a 24 x 7 security operations centre
- Trust wide phishing exercise to improve cyber security awareness
- Establish the Digital Advocate network

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

No.	Action Required	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	Office 365 Implementation	Director of Digital Transformation	31/03/2023	High level design agreed Due diligence completed Communications and engagement organisation commissioned	
2.	Network and Communication Market Testing	Director of Digital Transformation	28/09/2022	Strategic Outline Case approved Requirements specification completed Procurement legal advice sought	
3.	iPortal and WIS rewrite	Director of Digital Transformation	31/03/2023	WIS in test iPortal in development	
4.	Commission 24 x 7 SOC service	Director of Digital Transformation	01/11/2022	Specification agree with ICB	
5.	Backup solution implementation	Director of Digital Transformation	31/03/2023	Project manager assigned	
6.	Firewall solution implementation	Director of Digital Transformation	01/11/2022	Project manager assigned	
7.	Resources business case	Director of Digital Transformation	01/10/2022	Case in draft awaiting review through operational groups.	

BAF 7: Infrastructure to Deliver Compliant Estate Services

Internally Driven	✓
Externally Driven	

Risk Description

Cause	Event	Effect
If we are unable to sufficiently invest and develop our retained clinical and non-clinical estate	**Then** we may be unable to provide services in a fit for purpose healthcare environment	**Resulting in** the inability to provide high quality services in a safe, secure and compliant environment

Lead Director / s:	Director of Estates, Facilities and PFI	**Supported by:**	Director of Digital Transformation and Chief Finance Officer
Lead Committee:	Performance and Finance Committee	**Executive Group:**	Infrastructure Group

Strategic Objectives and Risk Register

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

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3				Likelihood:	3	31/03/2023
Consequence:	4				Consequence:	3	
Risk Level:	High 12				Risk Level:	High 9	

Rationale for Risk Level:

- **Sustainability / Net Zero Carbon (NZC)** – UHNM Green Plan 2022-25 complete and fully aligned to the Greener NHS Programme/NZC agenda. Significant capital investment required to ensure target delivery.
- **Estate condition –** targeted capital backlog maintenance; statutory maintenance programme and progression of capital schemes (including Lower Trent) to reduce estate condition risks.
- **Estate Strategy / Clinical Strategy –** independent review of estate at County by ARCHUS complete and Royal Stoke is underway to inform refreshed Estates Strategy in line with updated Clinical Strategy.
- **West Building –** identified physical estates works completed to improve compliance, alongside refresh of service standards and monitoring arrangements to ensure cleaning standards improved and sustained.
- **Estates Workforce** - vacancies in workforce with retention and recruitment issues, aging workforce, risk to service in short/medium term.
- **PFI Market Testing Opportunities** – Approvals secured for Sodexo Business Case, focus now on other PFI opportunities within Network and Communications (Nasstar) and MES & PACS (Siemens).

Links to Risk Register > 12 (Appendix 3):	Ext 20	Ext 16	Ext 15	High 12	High 10	High 9	High 8
	-	-	1 risk	3 risks	-	-	-

Position Statement

What progress has been made during the last quarter?

- **Project STAR –** consultation complete; majority demolition complete. Grindley Hill Court residents relocated and site under IHP`s control for multi-story car park scheme. Secured planning application approval for new car park on 8th June 2022.
- **Estate condition –** backlog maintenance items prioritised for targeted capital schemes; statutory maintenance and progression of capital schemes (including Lower Trent) to reduce estate condition risks.
- **Estate Strategy/Clinical Strategy –** independent review of estate at County completed and similar review almost complete at Royal Stoke. Both reviews being used to help inform the refreshed Estates Strategy and site development control plans.
- **PFI Market Testing Opportunities –** Sodexo Business Case approval secured and now concluding legals/commercials. Focus now on exploring other PFI opportunities and investment led/VfM solutions for N&C and MES and PACS services.
- **Sustainability / NZC** – UHNM Green Plan 2022-25 complete and well received at EIG (10th June); 5-year capital requirement submitted and considered on potential investment scheme lists. Schemes progressing towards targets, including decarbonisation plan and backlog maintenance enhancements, flow modelling and LED lighting and developing clinical NZC leads to support the delivery of clinical areas of the Green Plan and targets.

Key Controls Framework – 3 Lines of Defence

1st Line of Defence

- Project STAR **–** Approved Business Case and planning for multi-story car park approved.
- Estate Condition**:** Planned Preventive Maintenance programme; competent estates staff/ Authorised Persons; KPI's monitored through CEF/ Environmental Audits**.** Maintenance Operational Board; Operational policies; Service Specifications PFI, 7 Facet Survey.
- Fire Safety/ Security Policies; Protocols; Guidelines; patrolling; CCTV; FRA's in place
- Sustainability / NZC – Sustainable Development Steering Group (biannual), Sustainability Working

	Groups (monthly) and NZC Trust Board Lead (Director EFP).
2nd Line of Defence	• Estate Condition - Capital bids prioritised against Estate 7 Facet Findings and approved at CIG. • Estate Strategy – Clinical Strategy and independent review used to inform refreshed Estate Strategy. Fire/Security: 'On the spot' fire improvement notices, Fire Safety KPIs & ad-hoc audits/inspection • LSMS close working with local Police and visibility on site • Sustainability / NZC – External funding applications (Low Carbon Skills Fund and Public Sector Decarbonisation Fund). Also working with external partners regarding zero-capital solutions (EV Strategy) • Capital team / Capital programme Audit – RSM UK LLP.
3rd Line of Defence	• Statutory maintenance programme – Maintenance Operational Board • Regulatory inspection/validation programmes including: CQC, PLACE, PAM and ERIC • External audits including Fire and Police Service and external audit i.e. KPMG • Authorising Engineers Audits of building services and associated maintenance regimes. • Participation in National Programme (SSRM) hosted by Cabinet Office & HM Treasury • Sustainability National Audits – ¼ Greener NHS Data Collections, Annual Fleet Data Collection; upcoming National Waste and Food Data Collections

Assurance Map

Committee Assurances (assurances received by the Committee/s during this quarter)

1st Line (Divisional)		2nd Line (Corporate)		3rd Line (External)	
		Capital Plan 2022/23	✓	Capital Programme Internal Audit	✓
		Executive Infrastructure Group Assurance Report	!		
		Capital Programme Inflation Pressures	!		
		Executive Health and Safety Assurance Report	!		
		Revised Capital Plan 2022/23	✓		
		Health and Safety Annual Report 2021/22	✓		
		Fire Annual Report 2021/22	✓		

Other Assurances (assurances received by the Committee annually / bi-annually / ad hoc)

Gaps in Control or Assurance

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

Project STAR; capital schemes, Wards -Trent W122 refurbishment and the additional Lower Trent, 2021/22 statutory maintenance programme – continue to progress consistent with agreed programmes.

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

No.	Action Required	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	Forecast likely energy cost increases (from April 2024)	Director EF&P	30/04/2024	Production of a paper which outlines the likely cost pressures for gas and electricity from April 2024. Mitigation strategy is to make energy efficiency investments (as outlined in the Green Plan).	GB
2.	RI Site demolition	Director of E,F & PFI	31/03/2023	Phases 1-5 completed, Final building demolition reliant on ward 80/81 becoming vacant.	GA
3.	Car parking solution	Director of E, F&PFI	31/03/2023	Secured planning approval and vacant possession of site to now allow construction to commence.	GA
4.	RI/COPD - Release land for land sale	Director of E,F& PFI	2024/2025	Will be released upon completion of construction and new car park at GHC.	GA
5.	Lower Trent Business Case	Director of E,F&PFI	31/01/2023	Conclude decant and complete refurbishment consistent with revised ward programme.	GA
6.	PFI Market Testing Opportunities	Director of E,F&PFI	31/12/2022	Formalise Sodexo Business Case and progress other investment led/VfM opportunities associated with N&C and MES/PACS.	GA
7.	Estate condition	Director of E,F&PFI	31/03/2023	Delivery statutory maintenance & capital schemes in accordance with approved programmes.	GA
8.	Strategic Supplier Programme	Director of E,F & PFI	31/03/2023	Refresh current programme and identify additional schemes for delivery 22/23. Workshop completed.	GA
9.	Estates Workforce Reviews	Director of E,F & PFI	31/08/2022	Focus now on Estates Operations skill mix and Recruitment / Retention review completed. Business case being completed.	GA
10.	Cleaning Collaborative	Director of E,F & PFI	31/03/2023	Sustain improvements seen in West Building and progress all agreed activities to plan.	GA

BAF 8: Financial Performance

Internally Driven	✓
Externally Driven	✓

Risk Description

Cause	Event	Effect
If we, or system partners, are unable to operate within available resources	**Then** the system financial plan for 2022/23 may not be delivered	**Resulting in** increasing Cost Improvement Programmes, and a lack of ability to invest in the development of future services

Lead Director / s:	Chief Finance Officer	**Supported by:**	Chief Operating Officer
Lead Committee:	Performance and Finance Committee	**Executive Group:**	Infrastructure Group

Strategic Objectives and Risk Register

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

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3				**Likelihood:**	2	30/09/2022
Consequence:	3				**Consequence:**	2	
Risk Level:	**High 9**				**Risk Level:**	**Mod 4**	
Rationale for Risk Level:	At Month 2 the Trust is £4.4m behind plan so unlikely to meet target for Q1, mitigating actions and forecasts will be identified at M3 when a clearer view of performance for the year will be known.						

Links to Risk Register > 12 (Appendix 3):	Ext 20	Ext 16	Ext 15	High 12	High 10	High 9	High 8
	-	-	-	**3 risks**	-	-	-

Position Statement

What progress has been made during the last quarter?

- A final financial plan has been agreed and submitted that delivers a breakeven position for the year.
- The in-year gap on the Specialised Commissioning contract has been reduced significantly.
- A list of potential mitigations and pressures has been prepared to inform the forecast for the year being carried out at Month 3.
- Investment assurance paper presented to Performance and Finance Committee outlining affordability of investments to date and framing funds available for further recurrent investment

Key Controls Framework – 3 Lines of Defence

1st Line of Defence	• Performance Management meetings in place with Divisions • SFIs and scheme of delegation • Planned care board approving and monitoring spend against ERF • Exec Team approval of additional investment up to £250k
2nd Line of Defence	• Finance report in place to performance and Finance Committee with associated scrutiny; enhanced to include run rate performance and analysis of additional COVID related expenditure • ICS CFO meeting to review system position
3rd Line of Defence	• Consideration of Internal audit programme to reflect changing risks in financial plan • Varying the pace of investment to provide additional mitigation • External audit programme in place

Assurance Map

Committee Assurances (assurances received by the Committee/s during this quarter)

1st Line (Divisional)		2nd Line (Corporate)		3rd Line (External)	
		Financial Plan 2022/23	✓	System Plan 2022/23	!
		Investment Assurance	!	Capital Programme Internal Audit	✓
		M12, M1, M2 Finance Report	✓		
		Annual Plan 2022/23	✓		

Other Assurances (assurances received by the Committee annually / bi-annually / ad hoc)

Gaps in Control or Assurance

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

The system has submitted a breakeven plan for 2022/23 but has an underlying deficit of £133m of which UHNM represents £30m. UHNM plans include recurrent CIPs of £13.6m which have not all been identified. It is unclear what level of inflation the Trust will experience during 2022/23 with no allowance made for costs in excess of 2.7% for non-pay and 2% for pay (these assumptions agreed by NHSI/E). In year non-recurrent flexibility is available to support in-year but the underlying position will need addressing going forward into 2023/24.

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

No.	Action Required	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	Confirm level of Non-recurrent mitigations	Chief Finance Officer	30 June 2022	n/a	GA
2.	Identification of recurrent CIP	Deputy CEO	30 June 2022	Work underway.	GA
3.	Quantification of Non Pay inflation in 2022/23.	Chief Finance Officer	On-going	Procurement are reviewing top 20 contracts to assess likely cost increase in 2022/23	GA

BAF 9: Research & Innovation

Internally Driven	✓
Externally Driven	✓

Risk Description

Cause	Event	Effect
If we are unable to secure sufficient capacity, resource and skills needed	**Then** we may be unable to deliver the Research and Innovation Strategy	**Resulting in** a failure to maintain our reputation as successful researching university hospital, offering patients the opportunity to participate in research and to provide high quality innovative care and our ability to attract and retain highly skilled staff due to our research profile

Lead Director / s:	Medical Director	**Supported by:**	Chief Nurse
Lead Committee:	Transformation & People Committee	**Executive Group:**	Research & Innovation Group

Strategic Objectives and Risk Register

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

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	4				Likelihood:	2	31/03/2023
Consequence:	3				Consequence:	2	
Risk Level:	High 12				Risk Level:	Mod 4	
Rationale for Risk Level:	At present there is a risk regarding our Good Clinical Practice (GCP) compliance and there are gaps in our assurance arrangements in ensuring that all training is up to date.						

Links to Risk Register > 12 (Appendix 3):	Ext 20	Ext 16	Ext 15	High 12	High 10	High 9	High 8
	-	-	-	-	-	-	-

Position Statement

What progress has been made during the last quarter?

During the last quarter, the Board has approved our refreshed Research Strategy, which is aligned to our broader Strategic Priorities. There has been an improvement in the number of open research studies and recruitment during the last quarter. A number of Steering Groups have been established with key speciality areas, i.e. Stroke, Cancer, Cardiology, Neurology, Renal and Paediatrics. The Centre for NMAHP Research, Education and Excellence CeNREE has also been established.

Key Controls Framework – 3 Lines of Defence

1st Line of Defence	• Steering Groups established at Speciality level to increase engagement with the central department
2nd Line of Defence	• Research Strategy developed with key objectives and key performance metrics defined • Departmental leadership team meeting structure in place to oversee delivery of research strategy and priorities • Executive Research and Innovation Group in place • A3 developed on participation in clinical trials which has been identified as a Strategic Initiative as part of our Improving Together Strategy Deployment Room • Financial return review with Divisional Business Advisors on a monthly basis
3rd Line of Defence	• Partnership Group with West Midlands Clinical Research Network (WMCRN) • Engagement with higher education – i.e. Keele / Staffordshire Universities • Annual review of academic grants with NIHR (Finance Committee)

Assurance Map

Committee Assurances (assurances received by the Committee/s during this quarter)

1st Line (Divisional)		2nd Line (Corporate)		3rd Line (External)	
		Research Strategy	✓		
		Executive Research & Innovation Group Assurance Report	✓		

Other Assurances (assurances received by the Committee annually / bi-annually / ad hoc)

Gaps in Control or Assurance

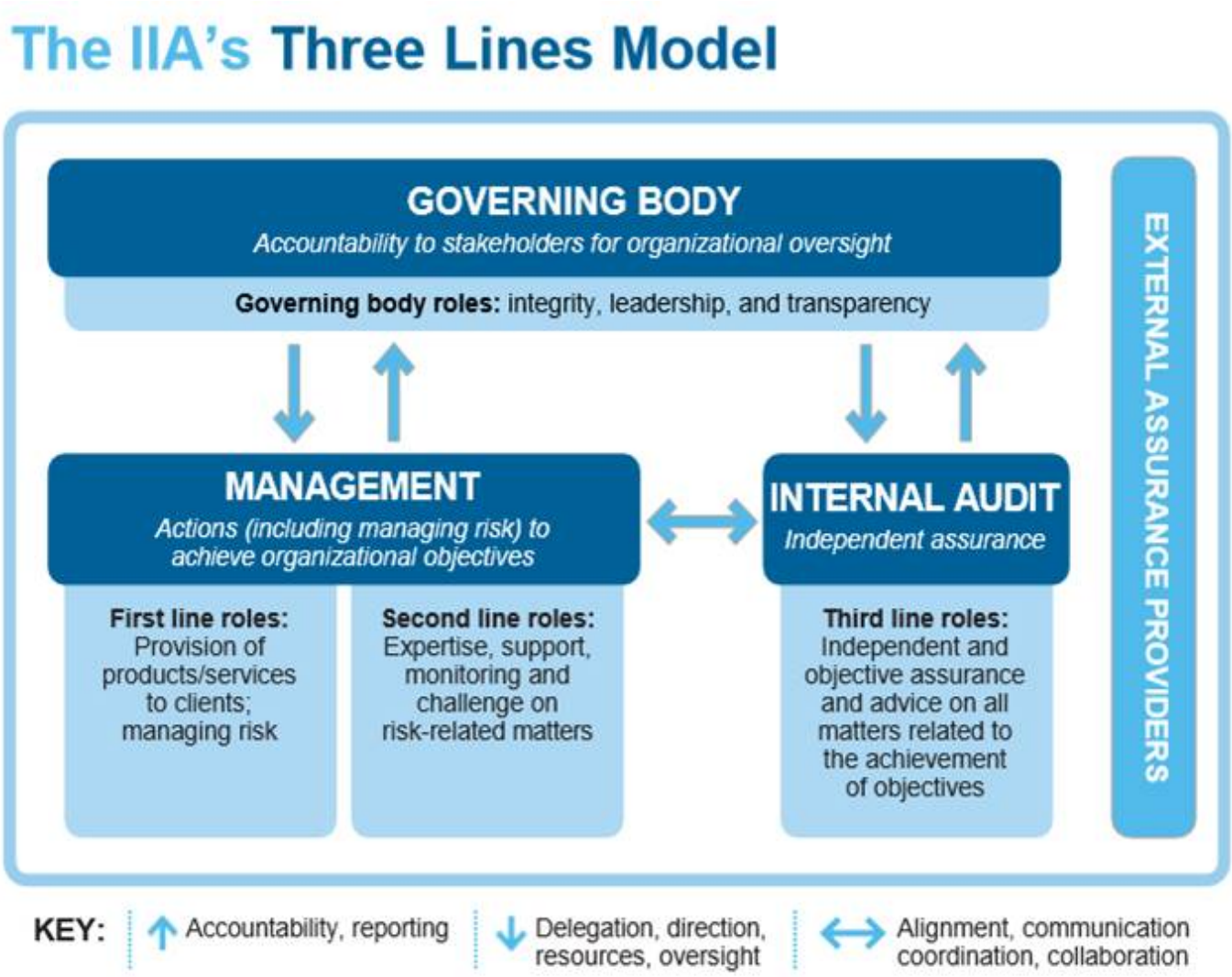
What are the gaps to be addressed in order to achieve the target risk score?

- Review of governance arrangements and membership of Executive Research and Innovation Group to ensure that the agendas are aligned to the new objectives of the strategy with clear Terms of Reference and accountability arrangements
- Desktop review of R&I structure being undertaken
- Develop a report which provides assurance against key performance metrics
- A review needs to be undertaken to determine levels of compliance with GCP training requirements

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

No.	Action Required	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	Review of governance arrangements and membership of Executive Research and Innovation Group to ensure that the agendas are aligned to the new objectives of the strategy with clear Terms of Reference and accountability arrangements.	Medical Director	30/9/2022	Director of Research and Innovation to work with the Associate Director of Corporate Governance to review the existing structures	**GA**
2.	Desktop review of R&I structure being undertaken.	Medical Director	30/9/2022	Review is currently underway.	**GA**
3.	Develop a report which provides assurance against key performance metrics set out within the Research Strategy.	Medical Director	30/9/2022	Director of Research to develop refreshed report on delivery of the strategy.	**GA**
4.	A review needs to be undertaken to determine levels of compliance with GCP training requirements.	Medical Director	30/9/2022	Review to be undertaken by the Director of Research.	**GA**

Appendix 1: Three Lines of Defence



Appendix 2: Risk Appetite Matrix

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

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

Appendix 3: Links to Risk Register

ID	EIG	DDSP	QSOG	H&S	EWAG	Risk Description	Division	Apr	May	Jun	Target Risk Score	BAF Link
24135			✓		✓	CTG Training	CWD	20	20	20	2	1
20926			✓			Falls/deteriorating patients within the Emergency Department (Royal)	Medical	15	15	15	4	1
8877			✓			Hospital Acquired Infections	Central Functions	12	12	12	8	1
21315			✓			Inability to achieve triage times within CED	CWD	12	12	12	6	1
21634			✓		✓	Staff absences relating to COVID-19 at RSUH and County	Medical	12	12	12	6	1
21640			✓			Lack of pressure relief from patient chairs	Specialised	12	12	12	4	1
24464			✓			EPU Service/capacity/Management	CWD			12	4	1
16652					✓	Staff Wellbeing and Welfare	Medical	12	12	12	2	2
20616			✓		✓	Insufficient Biomedical Scientific Staff Resource - Haematology & Blood Transfusion Service at Macclesfield Hospital	CWD			16	4	3
21591			✓			Insufficient Clinical Staff to Support the NMCPS Microbiology Service	CWD			16	6	3
11002			✓		✓	Consultant Medical Staff Recruitment	CWD	12	12	12	6	3
21719			✓			Medicine Safety Officer Vacancy	CWD	12	12	12	4	3
23569					✓	Lack of pharmacy staff to meet demand due to increased bed base	Medical	12	12	12	2	3
23597			✓			Low staffing for Anticoagulation Department at Cheshire Sites	CWD	12	12	12	8	3
23787					✓	Gaps in Junior Doctor workforce	CWD	12	12	12	6	3
24281			✓			Cardiothoracic Theatre Staffing Establishment	Surgical		12	12	4	3
21433			✓		✓	Adult Critical Care Consultant Workforce	Surgical	20	20	20	6	1, 3
23834			✓		✓	Delayed Induction of Labour	CWD			20	4	1, 3
23843			✓		✓	Respiratory Consultant workforce (County)	Medicine	20	20	20	4	1, 3
23868			✓		✓	Review of Renal workforce and activity levels	Medical	12	12	20	6	1, 3
8822					✓	Medical Workforce Staffing Oncology	CWD	16	16	16	6	1, 3
13419			✓		✓	Midwifery safe staffing	CWD	16	16	16	4	1, 3
18093			✓		✓	Nurse Staffing within the NNU	CWD	16	16	16	12	1, 3
18842					✓	Gaps within the Junior Medical Rota	CWD	25	16	16	6	1, 3
21157			✓		✓	Haematology Service at MCHT Leighton	CWD	16	16	16	6	1, 3
21595			✓		✓	Insufficient technical staff in Microbiology	CWD	16	16	16	6	1, 3
22514			✓		✓	Nurse Staffing in the Emergency Department	Medical	16	16	16	6	1, 3
23024			✓		✓	Gaps in B5 radiographer rosters to provide 24/7 x-ray service	CWD	16	16	16	12	1, 3
23842			✓		✓	Delivery of RTT - Outpatient capacity/wait times	Medical	16	16	16	4	1, 3
11518			✓			Midwifery Continuity of Carer (MCoC) model	CWD	15	15	15	4	1, 3
16432			✓		✓	Covid 19 & Compliance with CNST Maternity Safety Actions	CWD	15	15	15	5	1, 3
8615			✓		✓	Radiotherapy Radiographer Staffing Levels	CWD	12	12	12	4	1, 3
10868			✓		✓	T&O Junior Doctor Staffing gaps	Specialised			12	2	1, 3
11294			✓		✓	NMCPS Pathology Histology Medical Reporting Capacity (achieving TAT)	CWD	16	16	12	6	1, 3
13899					✓	recruitment of staff to meet capacity and demand on ward 202	CWD	12	12	12	6	1, 3

ID	EIG	DDSP	QSOG	H&S	EWAG	Risk Description	Division	Apr	May	Jun	Target Risk Score	BAF Link
17977			✓		✓	Reduced staffing in Cancer Centre Pharmacy	CWD	16	16	12	6	1, 3
21481			✓			Reduced Breast service (Imaging), due to vacancy within Breast Radiologist workforce	CWD	20	20	12	12	1, 3
21503			✓		✓	General Paediatric Consultant Rota	CWD	12	12	12	4	1, 3
21867			✓		✓	None-compliance with contractual requirements of antenatal ultrasound	CWD	12	12	12	9	1, 3
24032			✓		✓	Respiratory Physiology - risk to service delivery/wait times	Medical	12	12	12	2	1, 3
24990			✓		✓	Lack of oncology support for UGI cancer	Surgical			12	4	1, 3
10333			✓			Increasing waiting list size and patients waiting greater than 18 weeks for treatment	Surgical	20	20	20	6	5
10342			✓			Delivery of constitutional cancer quality standards	Surgical	20	20	20	6	5
22570			✓			Colorectal 2 week wait delays	Surgical	20	20	20	4	5
24028			✓			Lack of flow across the Trust leading to congestion of ED (both sites) and UEC standards unable to be met	Medicine	20	20	20	6	5
17873			✓			Inability to Off-load Patients from Ambulances (both sites)	Medical	15	15	15	4	5
15066			✓			Spines 52 week breach	Specialised	12	12	12	4	5
15697			✓			Attainment of the Cancer 28 day target GI	Medical	12	12	12	6	5
15788			✓			Delivery of RTT Performance - Diagnostic Capacity	Medical	12	12	12	9	5
17637			✓			Decline in cancer performance	Surgical	12	12	12	6	5
18664			✓			Gynaecology 52 Week Wait Patient Numbers	CWD	12	12	12	9	5
20134			✓			Specialised Surgery Follow Up Backlog	Surgical	12	12	12	4	5
20739			✓			Endoscopy planned patients waiting list	Medical	12	12	12	6	5
22449			✓			Obstetric Ultrasound Demand versus capacity	CWD	16	12	12	9	5
23568	✓		✓			Size of the AEC footprint	Medical			12	2	5
8849		✓				Staff using unsecured and unlicensed personal phones for work email	Central Functions	12	12	12	4	6
9897		✓				Insecure Information on Desktop PCs	Central Functions	12	12	12	4	6
17542		✓				Restoration & Recovery - IT remote working, support and vulnerabilities	Central Functions	12	12	12	4	6
21784		✓				Confidentiality, Integrity and Availability of Trust Information	Central Functions	12	12	12	4	6
22094		✓				Lack of devices for windows 7 replacement project	Central Functions	12	12	12	3	6
23753		✓				Network failure due to multiple service providers	Central Functions	12	12	12	4	6
23755		✓				System failure due to lack of Information Technology Infrastructure Library (ITIL)	Central Functions	12	12	12	4	6
23331	✓			✓		MCHT Ceiling RAAC planks	CWD	15	15	15	4	7
15959				✓		Surgical Plume Smoke evacuation - carcinogenic	Surgery	12	12	12	2	7
20315	✓					Interventional Room 5 does not meet Ventilation Building Regulations	CWD	12	12	12	6	7
21742			✓			Lack of a clean utility room to dispense medications safely within CED	CWD	12	12	12	2	7
21697	✓					Recurrent CIP requirements for 22/23 and beyond not met in Trust due to recovery pressures	Central Functions	12	12	12	8	8

ID	EIG	DDSP	QSOG	H&S	EWAG	Risk Description	Division	Apr	May	Jun	Target Risk Score	BAF Link
21699	✓					VAT recovery on Car park business case - in relation to all workers not charged	Central Functions	12	12	12	8	8
21700	✓					Valuation of RI and COPD sites in relation to funding of Project Star MSCP Business Case	Central Functions	12	12	12	2	8

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	3rd August 2022
Report Title:	Update on Board Development Programme	**Agenda Item:**	15.
Author:	Deputy Associate Director of Corporate Governance		
Executive Lead:	Tracy Bullock, Chief Executive		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Executive Summary:

Situation

This paper is to provide the Board with an overview on progress against the topics identified to be delivered within the 2022/23 Board Seminar Programme.

Background

The Board Development Programme was approved by the Board in May 2022. This comprised variety of business and developmental topics including 'must dos', emerging developments and operational/strategic challenges, aligned to our Strategic Priorities.

Assessment

A review of the Board Development Programme has been undertaken and the attached demonstrates the topics which have been covered as planned, deferred or added. The main changes to the programme are as follows:

- Estates and County Hospital updates brought forward from September to July
- Addition of Safeguarding session at the Closed Board in August
- Freedom to Speak Up brought forward from January to October
- Well Led Assessment deferred from October to November
- The addition of a session on Clinical Research Network proposed for January 2023

Key Recommendations:

The Board is asked to note the updated Board Development Programme and to consider the timing of future sessions, highlighting where any changes are required and whether any additional items should be included.

Board Development Programme

2022 / 2023 Timetable

University Hospitals of North Midlands NHS Trust

Strategic Priority	Topic	Development (D) or Business (B)	Purpose / Outcome	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
				1st	11th		13th	3rd	14th	11th/ 12th	9th		11th		15th
High Quality	Ockenden Update	B	Understanding of current progress with Ockenden recommendations, areas of challenge and variation												
Improving & Innovating	Research Strategy	D & B	Understanding progress of implementation of the Strategy and future opportunities for research and innovation												
High Quality Responsive Resources	Operational Delivery, Elective Waits & 22/23 Financial Landscape	B	Consideration of the challenges associated with use of the Independent Sector, changes to infection prevention guidance and impact of covid related costs.												
Systems & Partners	System Plan & Delivery 2022/23	B	Understanding and agreement of the core elements of the System Plan submission, including key risks			NEDS Mtg									
Resources	Estates Strategy	B	Refresh of the Estates Strategy, Archus review and Development Control Plan												
Systems & Partners	County Hospital Strategy	B	Overview of the strategy for transformation of the County Hospital site												
High Quality	Safeguarding	B	'New agency approach' to Safeguarding – Adult and Children's Safeguarding					Closed Board							
People	People Strategy – Culture	D	Consideration of expected behaviours, dealing with conflict and managing bias												
Improving & Innovating	Improving Together	D	Understanding of programme progress to date, key risks, Board / Committee assurance and next steps.												
Systems & Partners	'Integration' White Paper & Place	D & B	Understanding the progress to date and any key issues/implications												
Resources	Estates Strategy – Sustainability	B	Progress with net carbon zero and implementing the estates strategy												
Resources	Digital Strategy – EPR	D & B	Consideration of the electronic patient record and implementing the digital strategy												

Together Compassion Safe Improving

PROUD TO CARE

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				1st	11th		13th	3rd	14th	11th/ 12th	9th		11th		15th
People	Freedom to Speak Up	D & B	Self-assessment and Trust Board training												
Improving & Innovating	Well Led Assessment	B	To self-assess against the Well Led Framework, identifying any gaps to be addressed								Closed Board				
Improving & Innovating	Clinical Research Network	B	Purpose and scope to be defined												
Improving & Innovating	Strategic Risks – BAF	B	Agreement of the Strategic Risks for the Board Assurance Framework (BAF) for 2022/23.												
Systems & Partners	System / Provider Collaborative Joint Meetings	D & B	Purpose and scope and date to be defined												

Key:

	Complete
	Planned
	Delayed

Trust Board

2022/23 BUSINESS CYCLE

KEY TO RAG STATUS	
Paper rescheduled for future meeting	
Paper rescheduled for next meeting	
Paper taken to meeting as scheduled	

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Notes
		6	4	8	6	3	7	5	9	7	11	8	8	
HIGH QUALITY														
Chief Executives Report	Chief Executive													
Patient Story	Chief Nurse					Staff								
Quality Governance Committee Assurance Report	Associate Director of Corporate Governance													
Quality Strategy Update	Chief Nurse													
Clinical Strategy	Director of Strategy													
Care Quality Commission Action Plan	Chief Nurse													
Bi Annual Nurse Staffing Assurance Report	Chief Nurse													
Quality Account	Chief Nurse													
7 Day Services Board Assurance Report	Medical Director													TBC
NHS Resolution Maternity Incentive Scheme	Chief Nurse													
Maternity Serious Incident Report	Chief Nurse													
Winter Plan	Chief Operating Officer													
PLACE Inspection Findings and Action Plan	Director of Estates, Facilities & PFI													TBC
Infection Prevention Board Assurance Framework	Chief Nurse													
RESPONSIVE														
Integrated Performance Report	Various	M11	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer													
PEOPLE														
Transformation and People Committee Assurance Report	Associate Director of Corporate Governance													
Gender Pay Gap Report	Chief People Officer													
People Strategy Update	Chief People Officer													
Revalidation	Medical Director													
Workforce Disability Equality Report	Chief People Officer													
Workforce Race Equality Standards Report	Chief People Officer													
Staff Survey Report	Chief People Officer													
Raising Concerns Report	Associate Director of Corporate Governance		Q4			Q1			Q2			Q3		
IMPROVING AND INNOVATING														
Research Strategy	Medical Director													Taken to TAP in April. Final version to be presented to Board in September (due to annual leave during August)
SYSTEM AND PARTNERS														
System Working Update	Chief Executive / Director of Strategy													
RESOURCES														
Performance and Finance Committee Assurance Report	Associate Director of Corporate Governance													
Revenue Business Cases / Capital Investment / Non-Pay Expenditure £1,000,001 and above	Director of Strategy		N/A											
Digital Strategy Update	Director of Digital Transformation													
Going Concern	Chief Finance Officer													Taken to Audit Committee
Estates Strategy Update	Director of Estates, Facilities & PFI													Date to be confirmed
Annual Plan	Chief Finance Officer													
Capital Programme 2022/23	Chief Finance Officer													Taken to PAF

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Notes
		6	4	8	6	3	7	5	9	7	11	8	8	
GOVERNANCE														
Nomination and Remuneration Committee Assurance Report	Associate Director of Corporate Governance													
Audit Committee Assurance Report	Associate Director of Corporate Governance													
Board Assurance Framework	Associate Director of Corporate Governance		Q4			Q1			Q2			Q3		
Accountability Framework	Associate Director of Corporate Governance													TBC
Annual Evaluation of the Board and its Committees	Associate Director of Corporate Governance													
Annual Review of the Rules of Procedure	Associate Director of Corporate Governance													
G6 Self-Certification	Chief Executive													
FT4 Self-Certification	Chief Executive													
Board Development Programme	Associate Director of Corporate Governance													