University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 7th April 2021 at 9.30 am to 12.25 pm via Microsoft Teams

AGENDA

Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
09:30	**PROCEDURAL ITEMS**					
20 mins	1.	Patient Story	Information	Mr S Purser	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 10th March 2021	Approval	Mr D Wakefield	Enclosure	
5 mins	5.	Matters Arising via the Post Meeting Action Log	Assurance	Mr D Wakefield	Enclosure	
20 mins	6.	Chief Executive's Report – March 2021	Information	Mrs T Bullock	Enclosure	**BAF 6**
10:20	**PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES**					
5 mins	7.	Quality Governance Committee Assurance Report (24-03-21)	Assurance	Prof A Hassell	Enclosure	**BAF 1**
10 mins	8.	Midwifery Continuity of Care Action Plan	Assurance	Mrs S Wallis	Enclosure	
10 mins	9.	Midwifery Workforce Review	Assurance	Mrs S Wallis	Enclosure	
10 mins	10.	Maternity New Serious Incident Report Summary Quarter 4 2021	Assurance	Mrs S Wallis	Enclosure	
10 mins	11.	IPC Board Assurance Framework	Information	Dr J Oxtoby	Enclosure	**BAF 1**
11:05	**ENSURE EFFICIENT USE OF RESOURCES**					
5 mins	12.	Performance & Finance Committee Assurance Report (23-03-21)	Assurance	Dr L Griffin	Enclosure	**BAF 9**
11:10 – 11:25 : BREAK						
11:25	**ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT AND RESEARCH**					
5 mins	13.	Transformation and People Committee Assurance Report (25-03-21)	Assurance	Prof G Crowe	Enclosure	**BAF 2 & 3**
10 mins	14.	2020 NHS Annual Staff Survey	Assurance	Mrs R Vaughan	Enclosure	
11:40	**ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS**					
40 mins	15.	Integrated Performance Report – Month 11	Assurance	Mr S Purser/Dr J Oxtoby Mr P Bytheway Mrs R Vaughan Mr M Oldham	Enclosure	
12:20	**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 5.00 pm 5th April to nicola.hassall@uhnm.nhs.uk**	Discussion	Mr D Wakefield	Verbal	
12:25	**DATE AND TIME OF NEXT MEETING**					
	18.	**Wednesday 5th May 2021, 9.30 am via Microsoft Teams**				

University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 10th March 2021, 9.30 am to 12.15 pm
Via Microsoft Teams

MINUTES OF MEETING

Attended	Apologies / Deputy Sent	Apologies

Voting Members:			A	M	J	J	J	A	O	N	D	J	F	M
Mr D Wakefield	DW	Chairman (Chair)												
Mr P Akid	PA	Non-Executive Director												
Ms S Belfield	SB	Non-Executive Director												
Mr P Bytheway	PB	Chief Operating Officer												
Mrs T Bullock	TB	Chief Executive												
Prof G Crowe	GC	Non-Executive Director												
Dr L Griffin	LG	Non-Executive Director												
Mr M Oldham	MO	Chief Financial Officer												
Dr J Oxtoby	JO	Medical Director							AW					
Dr K Maddock	KM	Non-Executive Director						PO	PO	PO	PO	PO	PO	
Mrs M Rhodes	MR	Chief Nurse												
Mr I Smith	IS	Non-Executive Director												
Mrs R Vaughan	RV	Director of Human Resources												

Non-Voting Members:			A	M	J	J	J	A	O	N	D	J	F	M
Ms H Ashley	HA	Director of Strategy & Transformation												
Mr M Bostock	MB	Director of IM&T			HP									
Prof A Hassell	AH	Associate Non-Executive Director												
Mrs L Thomson	LT	Director of Communications												
Miss C Rylands	CR	Associate Director of Corporate Governance						Item 7 & 8					NH	NH
Mrs F Taylor	FT	NeXT Non-Executive Director												
Mrs L Whitehead	LW	Director of Estates, Facilities & PFI												

In Attendance:		
Mrs N Hassall	NH	Deputy Associate Director of Corporate Governance (minutes)
Mrs G Hatton	GH	Associate Chief Nurse – Medicine
Mrs S Hughes	SH	Ward Manager
Mrs N Opiniano	NO	Matron
Mr S Summerfield	SS	Advanced Nurse Practitioner

Members of Staff and Public via MS Teams: 10

No.	Agenda Item	Action
1.	**Staff Story**	
035/2021	Mrs Rhodes introduced Mr Summerfield and the Ward 79 team to Board members, to highlight their story and the way in which they compassionately cared for a married couple during the pandemic. Mrs Hughes, Ward Manager, explained that two patients were admitted to Ward 79 in January, a husband and wife, both had multiple comorbidities and initially one was being cared for in a side room and one in a bay. The team had enabled the wife to see her husband by visiting the side room after which a decision was	

PROUD TO CARE

	made to move some of the beds around to make a space where they both could be in the same bay, this included putting two beds together and pillows in between so that they could hold hands. She explained that the team also provided some music for them and gave them the privacy they required. She explained that the couple had 10 hours together before the wife died and the husband died 24 hours later. It was highlighted that the family were thankful for the compassion shown to the couple. Mr Summerfield added that he anonymously shared the story on Twitter to show the care and compassion provided by the team and felt it was a positive way to demonstrate compassion and by doing so, the story had inspired change in other organisations. Mrs Rhodes stated that she visited the ward after the event, to provide the team with the Chief Nurse Award for Compassion, where an initial concern was discussed in terms of mixing genders, but agreed that on this occasion it was the right thing to do. She stated that whilst it was a mixed sex breach, it was done for all the right reasons and she welcomed the sharing of the story. Mr Wakefield thanked the team for the story and queried if the action had set a precedent for further requests to keep patients together. Mrs Hughes stated that if the situation occurred again she would take the same action, although in an ideal situation, larger two bedded side rooms would be available. Mr Wakefield queried the reaction and the recognition from other staff and Mrs Hughes stated that others were astounded and the team did not appreciate how much recognition they would get by sharing the story. She added that the positivity received following the story gave staff a boost. Dr Griffin welcomed the story and the action taken which he felt demonstrated the contagious power of kindness in that it could spread so widely and he thanked the team for doing the right thing. Mr Wakefield thanked the team for the actions taken and agreed it was the right thing to do which staff should always aim to do. **The Trust Board noted the staff story.** Mrs Hughes, Mrs Opiniano, Mrs Hatton and Mr Summerfield left the meeting.	
2.	**Chair's Welcome, Apologies & Confirmation of Quoracy**	
036/2021	Mr Wakefield welcomed members of the Board and observers to the meeting and the above apologies were received. It was confirmed that the meeting was quorate. Mr Wakefield reflected that it had been a year since the start of the pandemic, due to which so much had changed and he offered his sympathies to all those affected by the disease. He thanked all the staff at UHNM for their continued efforts and mentioned the passing of Mark Elliot, whose funeral procession was to pass through the Trust in the afternoon. Mr Wakefield welcomed Dr Maddock to the Board, taking over from Professor Owen and added that it was the final meeting for Mr Smith, whose term was to end on 31st March, and he thanked him for his time at the Trust.	

3.	**Declarations of Interest**	
037/2021	The standing declarations were noted. Mr Oldham highlighted that his son was due to join the Trust in the IT Department in April and agreed to update his declaration of interest form.	
4.	**Minutes of the Previous Meeting held 3rd February 2021**	
038/2021	The minutes of the meeting from 3rd February 2021 were approved as an accurate record.	
5.	**Matters Arising from the Post Meeting Action Log**	
039/2021	PTB/459 – it was noted that internal audit were working with the Trust to review the action plan associated with the Ockenden report.	
6.	**Chief Executive's Report – February 2021**	
040/2021	Mrs Bullock highlighted a number of areas from her report. Mr Wakefield referred to the staff vaccinations and how we get to a position of understanding which staff have been vaccinated by their GPs, Vaccination Centres, Pharmacists etc and if this was linked to their GP record. He queried if this information could be shared with the Trust in order to obtain a more accurate position in terms of number of staff vaccinated. Mrs Bullock explained that individual members of staff could confirm, as part of the conversations held with their line managers, although due to data protection it was difficult to obtain further information externally due to GDPR issues. Mrs Bullock went on to describe two pieces of work she had requested from system Chief Executives to overcome the incomplete picture; an urgent review of what information can / should be shared and the development of a system wide information system. Dr Maddock queried the take up of second doses and whether there had been any resistance to having the second dose due to side effects with the first. Mrs Bullock stated that the Trust did not sense any hesitancy from staff in having the second dose, and rather staff were anxious about not having had the date for their second vaccine and noted that most staff reported no or minimal side effects, with a small number having moderate side effects and very few having more severe side effects. Mr Smith queried what action could be taken for staff refusing to have the vaccine and Mrs Bullock stated that as this was not mandated, the Trust needed to continue to highlight the benefits of the vaccine as well as the risks of not having it, to ensure any decisions were fully informed. Professor Crowe referred to the success in receiving the digital aspirant funding which was a positive move forwards towards digital transformation and added that he would be keen to support further activities associated with this. Mr Wakefield queried the practical implications from moving from a level 4 to level 3 incident level and queried if this impacted on patients waiting for an operation. Mr Bytheway stated that the reduction in incident levels signalled the commencement of the recovery phase, going from significant incident mode to	

	preparing the organisation to recommence theatre operating, moving teams back into normal areas, and stepping forward with business as usual. Mr Wakefield provided the Boards thanks to the volunteers from Stoke on Trent City Council and the military, for the support they provided to colleagues in recent months. **The Trust Board received and noted the report and approved EREAFs 7311, 5162 and 7308.**	
PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES		
7.	**Quality Governance Committee Assurance Report (24-02-21)**	
041/2021	Professor Hassall highlighted the following from his report: • In terms of patient falls, a lot of work had been undertaken, including a deep dive and key challenges were associated with staffing levels and moving of staff to different areas. The Committee were assured of the actions being taken but this remained an area under scrutiny • The Committee noted a low reporting rate of medication incidents when compared with peers therefore the numbers reported were being highlighted at Trust and Divisional level to encourage additional reporting • The Committee reviewed the mortality summary report looking at incidence of Covid related deaths in comparison to other Trusts and whereas crude mortality was above the peer average, the Trust had higher rates of comorbidity than average, therefore the HSMR for Covid mortality was lower • Report authors were considering how to improve the timelines of performance reporting going forwards Mrs Rhodes stated that in terms of medication errors, this area was one of the first priorities to be covered by the Delivering Exceptional Care programme, in order to increase reporting and decrease the number of incidents resulting in harm. **The Trust Board received and noted the assurance report.**	
8.	**Infection Prevention and Control Board Assurance Framework (BAF)**	
042/2021	Mrs Rhodes highlighted that there had been little change since the document was presented in February, although additional key lines of enquiry had been included. She stated that the document was being updated to reflect additional controls and assurances and the document would continue to be brought on a monthly basis, although there may be more change in some months than others. Mrs Rhodes added that for some of the measures it would be difficult to obtain assurance, so this would be discussed at Quality Governance Committee (QGC). Mr Smith referred to the learning following the pandemic in terms of infection prevention measures and queried what things would continue as a result of the pandemic, which were not in place prior to Covid. Mrs Rhodes stated that following investigation of outbreaks, lessons learnt had been identified which had resulted in making changes to documentation, social distancing between beds, changes to cleaning regimes and increased touch point cleaning. She added that there was a lot of learning to be considered nationally, given that there had been fewer cases of flu and norovirus as a result of social distancing and wearing	

	masks. Mr Wakefield commented that the clear communications regarding infection prevention had been welcomed. Mrs Bullock referred to macro learning following the pandemic, and that Emergency Department staff had agreed to change how to care for flu patients going forwards as a result. Mr Wakefield queried if it was possible to have flu and Covid at the same time and whether this would be identified. Mrs Rhodes confirmed that testing was undertaken for both so this could be identified. Dr Oxtoby agreed that it was important to learn lessons locally, and nationally, and added that because there had not been many cases of flu, it could become more prevalent next winter. **The Trust Board noted the document and noted ongoing work was being undertaken to strengthen the assurance framework going forwards, which would be reported to the Board in April 2021.**	
ENSURE EFFICIENT USE OF RESOURCES		
9.	**Performance & Finance Committee Assurance Report (23-02-21)**	
043/2021	Dr Griffin highlighted the following from the report: • Continued impact of the pandemic affecting less critically urgent elective work • Some incremental improvements in urgent care performance were being made, including improvements to patient flow • The Committee reviewed the revised urgent care standards • Continued strong financial performance anticipating break-even position • Further guidance for 2021/22 was awaited, and it was likely that 2021/22 would be more challenging • There had been some slippage in the capital programme although work was being undertaken to catch up and close the gap **The Trust Board received and noted the assurance report.**	
ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT AND RESEARCH		
10.	**Transformation and People Committee Assurance Report (26-02-21)**	
044/2021	Professor Crowe highlighted the following: • The two highest risks related to the people aspects, including sustainable workforce • A number of positive assurances were provided across a number of areas • The Committee received an excellent presentation in terms of nurse recruitment, which outlined a broad range of activities for both overseas recruitment, retention and development of staff • It was noted that some reports had not been provided by subgroups and this would be addressed going forwards Mrs Rhodes referred to the work being undertaken on nurse recruitment and added that further updates would be brought to the Transformation and People Committee in due course.	

	The Trust Board received and noted the assurance report.	
11.	**Gender Pay Gap Report**	
045/2021	Mrs Vaughan highlighted the following: • 78% of the workforce was female and it was noted that women were over represented in all quartiles, other than the upper pay quartile • Over the past 12 months a number of changes had been made, in particular looking at greater degrees of flexible and agile working, which had made significant inroads due to the pandemic • Additional work was required in terms of understanding any barriers within the medical workforce for flexible working and actions to make senior roles more attractive • A number of actions had been identified in terms of addressing some of the issues raised within the report • Some benchmarking information had been included and the Trust performed positively when compared with peers Mr Wakefield referred to representation on the High Potential Scheme of which 50% were women, and queried whether this should have been higher given that 78% of the workforce were female. Mrs Vaughan explained that the programme was a system leadership development scheme and added that in addition to the scheme, internal leadership programmes were also in place which had a broader representation. Professor Hassell welcomed the transparency within the report and referred to the bonus pay gap and queried what made the numbers so different in 2018. Mrs Vaughan explained that this had been previously reviewed and nothing in particular had been highlighted and the same processes were in place. She added that there had been a change in the past 12 months whereby the system was open to everyone therefore some differences were to be expected in the 2021 analysis. Dr Oxtoby referred to the number of applications for local awards from female colleagues and stated that their applications had the same likelihood of success as male applications, therefore the main challenge was ensuring more female staff applied. Professor Hassell queried if any additional support had been put in place to encourage female Consultants to apply for the Clinical Excellence Awards (CEA) and Mrs Vaughan stated that this had been an area of focus previously, and work had also been undertaken with the British Medical Association to encourage staff to apply, which included help with producing applications and presenting the information. Professor Hassell referred to the proportion of male / female workforce in each pay quartile and suggested that the number of staff applying for a CEA should be listed as percentage of eligible employees. Mrs Vaughan agreed to include this breakdown. Mr Wakefield noted the actions being taken to close the gap and queried how female members of staff felt about the actions being taken. Mrs Vaughan stated that a survey of female medical staff was to be undertaken in order to establish their views of flexible working given the challenges around those roles. **The Trust Board approved the report and the recommended actions to further**	RV

	reduce the Gender Pay Gap at UHNM.	
ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS		
12.	**Integrated Performance Report – Month 10**	
046/2021	Mrs Rhodes highlighted the following: • There had been an increase in falls across the organisation, in particular due to the challenges associated with staffing and ward moves as well as patients being cared for in side rooms with the doors closed as part of infection prevention measure. Actions are being taken in terms of how visibility could be enhanced into side rooms. Staff had also reported issues of needing to put on full Personal Protective Equipment prior to assisting patients and a further deep dive has been undertaken • The falls educator/coordinator had been seconded into critical care over the past few months but has returned to their substantive role • In terms of duty of candour, surgery had initiated a process which was enabling the Division to sustain 100% compliance for both verbal and written duty of candour. This process was being shared with other Divisions • Additional work was undertaken in order to understand the reasons for 50% sepsis screening within maternity, and issues highlighted in terms of differences in indicators which had been discussed with the teams and work undertaken in order for staff to complete the documentation accurately, resulting in 100% compliance for February • It was proposed to include peer benchmarking information on a quarterly basis, once this had been updated • Numbers of nosocomial infections had started to reduce as the number of Covid-19 cases in hospital reduced and going forwards the numbers would be tracked against community prevalence Mr Wakefield referred to the peaks in nosocomial infections in previous months and welcomed the reduction in cases. He queried if the Trust was confident that it was doing as much as possible to reduce transmission and Mrs Rhodes stated that she was confident of the actions being taken, although operational flow was the main challenge, particularly adhering to the guidance in respect of patients having two negative swabs prior to being moved, as the risk of this needed to be balanced against the wider risk and impact on flow across the organisation. She added that there were also occasions when the Trust was not able to consistently comply, although individual audits were being undertaken, and any outbreaks were reviewed as part of a Root Cause Analysis. Mr Wakefield referred to his visit to Ward 117 and the equipment in place to filter the air, and queried if this could be implemented in other areas. Mrs Rhodes stated that the equipment in place was required as part of a national recommendation due to Ward 117 being a dedicated infectious diseases unit. She stated that this would have implications in other areas as larger spaces would be required and there would need to be a reduction in beds. Mr Smith referred to the reference of the pathology network within the finance report, and the changes not having an effect on the bottom line and requested clarification. Mr Oldham stated that in year, the Trust had taken on staff who had previously been employed by Mid Cheshire Hospitals NHS Foundation Trust and East Cheshire Hospital NHS Trust to provide the network service, therefore pay costs increased which reflected a variance but the associated income had increased, netting the each other off and not having an overall impact.	

Mr Smith queried whether routine typing of samples for c-difficile were being undertaken and whether the typing demonstrated any significant issues. Mrs Rhodes explained that results were being provided and no particular cases had been linked. In addition a deep dive had been undertaken and information had also been provided to the Care Quality Commission.

Professor Hassell referred to the senior review panel in place to review Covid related deaths and queried where the panel would report to. Mrs Rhodes explained that some regional guidance had been received in respect of this, and it was the intention to review nosocomial deaths through the Structured Judgement Review process which would report to the mortality review group through to the Quality Governance Committee.

Mr Wakefield referred to the narrative and the reference to the use of Reminiscence Interactive Therapy Activities (RITA) and requested additional information. Mrs Rhodes stated that the system was a computer on wheels which had a TV screen and iPad and included information which was preloaded, linked to reminiscence, with things such as the coronation, old films and music. She explained that this was utilised for dementia patients in that it particularly helped to calm down aggressive patients. It was noted that the system had been provided by the charity.

Mr Bytheway highlighted the following:

- In January there had been severe pressure within the first couple of weeks although the Trust had progressed to a better position in terms of flow, ambulance holds and the number of patients waiting over 12 hours
- In February work commenced to transform and manage urgent care, which saw an increase in the number of discharges prior to 12.00 pm and a reduction in stranded and super stranded patients. An increase in medically fit for discharge (MFFD) patients had been identified, which was being addressed with the system
- When comparing Emergency Department performance nationally, the Trust had improved during February, despite this being at a time when there were high attendances.
- Teams continued to be committed to ensuring further improvements in urgent care performance

Mr Wakefield queried the reason for the conversation rate in the Emergency Department being high and Mr Bytheway stated that the acuity of patients was higher due to minor injuries going elsewhere.

Dr Griffin queried the reasons for delays in stranded and super stranded patients and the number of MFFD patients and Mr Bytheway explained that in terms of MFFD patients, these had increased due to patients requiring bed based facilities because of the severity of their illness, which had an impact in the ability to discharge the patients in a timely manner.

Mr Bytheway explained that the work in relation to reducing the number of stranded and super stranded patients, was a key element of the non-elective improvement programme and sustained weekly oversight was being provided by teams in order to continue to reduce the numbers of these patients.

Mr Wakefield referred to the level of discharges before midday and the improvements made and queried what was impacting upon the emergency readmission rate. Mr Bytheway stated that some Covid patients were representing, but with other symptoms and not with the same issue.

Mr Bytheway continued to highlight cancer performance:

- A deterioration in performance was expected in January and February
- 1 standard was achieved in January; the radiotherapy standard and in February the Trust had achieved 4 of the standards and was close to achieving the two week wait standard.
- In terms of referrals, there had been a reduction in February following high demand in December and January and the Trust was holding its position in terms of 2 week wait patients
- The 104 day position had stabilised and the size of the patient tracking list had stabilised and had not increased, therefore it was expected that performance would deliver in February and further improvements in March

Mr Wakefield referred to the capacity and demand review for two week wait patients and the progress made to date. Mr Bytheway stated that referral rates had been re-profiled and Divisions were identifying the capacity available, with a particular focus on colorectal and urology. It was noted that work was expected to conclude in March prior to setting the required benchmark.

Mr Wakefield referred to the capacity issues and whether in the next two to three months the Trust would be in a position to tackle the backlogs. Mr Bytheway stated that diagnostics performance had held when compared with the first wave, therefore it was expected to fully open from 29th March and he was confident that performance would return and reduce the backlog. He stated that for endoscopy, this was more problematic due to challenges within medicine but an additional 10 sessions a week were being put in place so that the number of long wait patients reduced by the end of March. He added that theatres had been operating on 10 to 12 theatres a week therefore by 29th March the aim was to have 25 / 34 theatres running at full capacity, with the plan for quarter 1 was to ensure that there was a clear plan for all P2 patients i.e. those with cancer, requiring critical care or clinically urgent, and ensuring these patients were operated on, before moving towards treating P3 and P4 patients from quarter 2 onwards.

Dr Griffin referred to the health and wellbeing of staff and queried how these were to be supported before moving ahead with the recovery of services. He referred to the NHSEI funding to support the treatment pathway of patients before the year end and queried if this had been received. Mr Bytheway stated that during March, efforts were being targeted to treat patients on waiting lists which did not require a theatre i.e. ophthalmology and dermatology therefore the aim was to maximize that element of work. He also confirmed that the funding had been received.

Mr Bytheway added that diagnostics performance had been maintained and it was in a positive place to recover in a timely manner. He stated that staff were being supported over the next 2 weeks to reflect, recover and engage with appropriate well being services as part of a phased return to business as usual.

Mrs Vaughan highlighted the following in relation to workforce performance:

- There had been some improvements in sickness absence and since month 10 further improvements had been made. The in-month sickness rate was noted to be 5.71% and Covid related absence was 36% of all absences
- The Trust continued to promote the vaccination programme, although this was not without its challenges and conversations were being encouraged with managers in terms of addressing any reasons for hesitancy in having the vaccination
- Criteria had been updated in terms of shielding which affected some members of staff and these arrangements expected to be in place until the

end of March

- A period of rest and recovery was being planned as part of the Trust's wellbeing programme, which would be different for different areas and although two weeks had been identified, some areas may choose to reflect during a different period. It was recognised that some staff would require different initiatives and support throughout the course of the year
- PDR performance was at 74.65% and from April the Trust aimed to get appraisals back on track and in a simplified form
- Statutory and mandatory training performance remained constant although there had been a slight dip in performance since December

Professor Crowe referred to Covid related staff absences, and whether there was a sense of what the baseline should be, in terms of reductions. Mrs Vaughan referred to the ongoing validation of data which needed to be undertaken before considering any baseline information and added that no specific benchmark data was available. She stated that she expected absences to continue to reduce as the programme moved forwards with the second doses of the vaccine, although the impact from the return of schools needed to be considered, in addition to a possible rise in short term absence as a result of side effects following the second dose of the vaccine.

Professor Crowe referred to job planning for medical staff and queried how this was to be managed in the coming year. Mrs Vaughan stated that conversations were ongoing as to what job planning should look like going forwards which needed to consider the flexibility required. Dr Oxtoby added that job planning had been a significant challenge in the past year as it was difficult to do in a meaningful way due to the instability. He stated that the Trust had been constrained in moving forwards with 2021/22 job planning and there had been some delay although the timescale for completion was anticipated to be the end of June.

Mr Wakefield thanked the Human Resources team for the initiatives which were continuing to be undertaken in terms of testing and wellbeing support.

Mr Oldham highlighted the following:

- Continued positive performance in month, similar to previous months
- The Trust delivered a surplus in month of £1.9 m and a cumulative surplus of £4 m
- The forecast position was £5.4 m and the Trust was £1.3 m ahead of that in month, therefore a surplus was anticipated, although the annual leave accrual needed to be factored into the position which could equate to £10 m. In addition there was uncertainty as to whether part of the accrual would be funded.
- The Trust had received funds of £2 m additional costs associated with Covid and £1.9 m had been spent in month 10, with other costs funded separately regarding testing and the vaccination programme
- In terms of the capital programme, the Trust had a £60 m programme in 2020/21 which included £31 m of additional public dividend capital. All allocations had been provided for and the Trust had started to receive cash in March. There were some risks associated with capacity for pathology testing and some Covid costs to be reimbursed which was yet to be confirmed
- The Trust was £4.6 m behind profile for capital as at month 10 although this was expected to catch up
- Cash was better than planned but this would deteriorate in March due to previously having had two payments at once

	Mr Wakefield welcomed the positive financial discussion for the year end and thanked the team for getting to such a position. Dr Griffin referred to the capital programme and delivering the allocation which was an achievement given the restrictions of the pandemic. He queried whether the benefits accrued from the investments could be provided and it was agreed to consider this in due course as well as highlighting within the annual report. **The Trust Board received and noted the performance report.**	**LW** **NH**
CLOSING MATTERS		
13.	**Review of Meeting Effectiveness and Business Cycle Forward Look**	
047/2021	No further questions were raised.	
14.	**Questions from the Public**	
048/2021	Mr Syme raised a question in relation to post Covid complications following hospitalisation, and referred to the 3300 patients who had been discharged home. He referenced the SAGE paper from February 2021 which referred to over 30% readmission rates and 12% death rates post discharge and data which demonstrated significant differences of readmission and death rates when factoring in ethnicity, in that non-white patients were found to have a greater risk of readmission and a higher risk of death post hospitalisation. He queried if the Trust was aware of this data and if so what the Trust, working with its health and care partners, was doing to mitigate the discrepancy in death rates and readmission rates. Mrs Bullock confirmed that the Trust was aware of the data and Dr Oxtoby added that the local position was different to that reported by SAGE. He stated that the Trust's readmission rate was approximately 8% which demonstrated that patients were not developing severe problems post discharge. In terms of ethnicity, the figures for overall mortality for the Trust for black and minority ethnic (BAME) populations demonstrated that mortality rates were significantly lower and the BAME in hospital death rate was 3.5%. He stated that the issues in terms of poor outcomes for BAME patients were known, therefore the Trust continued to be involved in taking actions to address this in terms of completing risk assessments for BAME staff, prioritising BAME staff for vaccination in line with their risk assessment and encouraging senior BAME staff to act as a champion for vaccinations for both staff and those in the community. In addition, wider efforts were being taken in the system to access BAME communities and provide them with information on Covid and the benefits of vaccination. Mr Syme referred to the Ockenden Report and the stipulation of "all maternity Serious Incidents (SIs) being shared with Trust Boards at least monthly and confirmation that funding allocated for maternity staff training was ring fenced and any CNST Maternity Incentive Scheme (MIS) refund was used exclusively for improving maternity safety. He requested clarification as to how SIs or zero SIs within maternity services would be reported and queried if the Trust had been in receipt of the maternity incentive scheme refund and whether this had been used exclusively for improving maternity services. Mrs Rhodes stated that all Serious Incidents were reported through the Quality Governance Committee and since the publication of the Ockenden report, this	

	had been reviewed and from April, maternity SIs would be reported through the Trust Board as requested. Mrs Rhodes stated that the Trust had a refund from CNST although this was not exclusively used for maternity, but £400,000 funding had been invested into maternity services. She stated that in terms of the funding for training, this was ring-fenced for maternity staff. Mr Oldham added that the CNST refund was not additional money provided to the Trust. Mr Syme requested the Board to comment on the position that the Trust Board had not appointed a non-white Executive or Non-Executive Director to the Trust Board for over 20 years. Mr Wakefield stated that the issue of there being a disproportionately low level of BAME members on Boards had been recognised at a national level and agreed this needed to be addressed. He stated that within the Trust, there was a clear commitment to address this and as such recruitment processes had been previously reviewed and the Trust's approach had been revised to increase the reach into BAME communities. He added that the Trust also actively sought opportunities to talk to and encourage BAME candidates to apply for roles and that final recruitment panels would include BAME representatives. In addition, BAME stakeholders were being invited to join various stakeholder panels. Mr Wakefield stated that despite best efforts, the Trust had previously failed to address this issue and was committed to resolve this within the current recruitment campaigns.	
DATE AND TIME OF NEXT MEETING		
15.	Wednesday 7th April 2021, 9.30 am, via MS Teams	

Trust Board (Open)

Post meeting action log as at **31 March 2021**

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

Ref	Meeting Date	Agenda Item	Action	Assigned to	Due Date	Done Date	Progress Report	RAG Status
PTB/457	03/02/2021	Chief Executive's Update	To invite representatives from the Community Rapid Intervention Service (CRIS) to a future meeting, to provide a staff story.	Tracy Bullock	06/05/2021		Invited to May's meeting.	GB
PTB/459	03/02/2021	Ockenden Report: Assessment and Assurance Framework and Action Plan	To consider whether the internal auditors could assist in providing independent assurance on the action plan	Michelle Rhodes	31/03/2021	11/03/2021	Complete. Internal audit undertaking a review.	B
PTB/463	10/03/2021	Gender Pay Gap Report	To include expand on the breakdowns of staff in each pay quartile, by identifying the number of staff applying for a CEA as a percentage of those eligible to apply.	Ro Vaughan	31/03/2021	31/03/2021	Complete - information provided to Professor Hassell.	B
PTB/464	10/03/2021	Integrated Performance Report - M10	To outline the benefits accrued from the capital investments made during 2020/21 and highlight this within the annual report.	Lorraine Whitehead Nicola Hassall	30/04/2021		Action not yet due.	GB

University Hospitals of North Midlands NHS Trust

Chief Executive's Report to the Trust Board

FOR INFORMATION

Part 1: Trust Executive Committee

The Trust Executive Committee met on 31st March 2021. The meeting was held virtually using Microsoft Teams; there was no agenda or papers as the general purpose of the meeting was to provide an opportunity to discuss the latest position with regard to Covid-19, key priorities and to hear from Divisions in terms of areas of focus / challenges:

Key highlights from the Executive Team were as follows:

- Anticipated visit from the Care Quality Commission
- Number of Covid patients in hospital, which have now reduced significantly and hospital admissions / deaths which are reducing across the country at a significant rate
- Focussing on job planning given the time of the year; Divisions / Directorates now need to complete as we move into the new financial year
- ED performance and flow a key area of focus both corporately and at divisional level
- Focus on operational delivery as we move into 2021; structure for Restoration and Recovery has been established focussing on a number of key work streams
- Continued focus within HR on reducing sickness absence, ensuring staff wellbeing, returning shielding staff to work and risk assessments
- Staff survey findings have been received and it is pleasing to see that some of the scores have seen improvement although UHNM remains below average
- UHNM has now acquired Grindley Hill Court which allows for the progression of Project STAR
- Rest Facilities Programme has now been completed at Royal Stoke and progress continues to be made on the County Site

Key highlights from the Divisions were as follows:

- Staff wellbeing with some very positive initiatives held during the rest period which were well received
- Ongoing management of adverse incidents and preventative management
- Management of waiting list and utilisation of the independent sector although some challenges with patients not wanting to be treated
- Developments in digital technology
- Focus on operational delivery and performance
- Demand and capacity for 21/22
- Recovery and Restoration
- Divisional Chair for Surgery will be leaving soon – recruitment process underway

Part 2: Chief Executive's Highlight Report

1. Contract Awards and Approvals

Department of Health Procurement Transparency Guidance states that contract awards over £25,000 should be published in order that they are accessible to the public. Since 12th February to 11th March, 4 contract awards, which met this criteria, were made, as follows:

- **Internal Audit and Counter Fraud Service (REAF 7410)** supplied by RSM Risk Assurance Services LLP at a total cost of £620,160.00, for the period 01/04/21 – 31/03/25, approved on 01/03/21
- **Non-Emergency and High Dependency Patient Transport Service UHNM (REAF 7361)** supplied by ERS Transition Ltd at a total cost of £9,485,297.73, for the period 01/04/21 – 31/03/25, approved on 03/02/21
- **Trust wide Annual Expenditure (REAF 7311)** supplied by SCCL at a total cost of £14,300,000.00, for the period 01/04/21 – 31/03/22, approved on 23/02/21
- **Salary Sacrifice Vehicle Leasing (REAF 7308)** supplied by NHS Fleet Solutions at a total cost of £2,700,605.10, for the period 01/04/21 – 31/03/25, approved on 23/02/21

In addition, the following REAF was approved by the Performance and Finance (PAF) Committee in March and requires Board approval due to its value:

Endoscopy Consumables (eREAF 7336)

Contract Value	£2,376,000.00
Duration	01/05/21 – 30/04/23
Supplier	Various
Savings	£27,153.00 incl.VAT

This eREAF has been raised to cover the supply of all consumables used within the Endoscopy service based at Royal Stoke and County. The Endoscopy service cares for patients throughout Staffordshire and the surrounding areas and the consumables purchased are used across the full range of diagnostic and therapeutic procedures provided across both sites.

The Trust will be using the NHS Supply Chain 'National Framework Agreement for the Supply of Cardiac Surgery, Cardiac Rhythm Management, and Diagnostic & Interventional Consumables & Associated Products'. NHS terms will apply.

The Trust Board are asked to approve the above REAF.

2. Consultant Appointments

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

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Locum Vascular Surgeon	Vacancy	Yes	19/04/2021

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

Post Title	Reason for advertising	Start Date
Consultant Obstetrician with an Interest in Fetal Medicine	Vacancy	01/03/2021
Consultant Vascular Interventional Radiologist with Thrombectomy	Vacancy	01/03/2021
Clinical Lead - Quality Improvement	New	01/03/2021
Clinical Lead - Quality Improvement	New	01/03/2021

Post Title	Reason for advertising	Start Date
Child Health Clinical Lead for General Paediatrics	Vacancy	01/03/2021
Locum Consultant Plastic Surgeon	Extension	01/03/2021
Locum Restorative Consultant	Extension	02/03/2021
Consultant Gastroenterologist	Extension	02/03/2021
Locum Consultant - General Paediatrician	Extension	04/03/2021
Paediatric Anaesthetist	Vacancy	08/03/2021
Locum Consultant - General Paediatrician	Extension	16/03/2021
Consultant Geriatrician with an interest in Ortho Geriatrics	Retire & Return	22/03/2021
Locum Consultant - General Paediatrician	Vacancy	29/03/2021

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

Post Title	Closing Date	Note
Locum Consultant Paediatrician with an interest in Gastroenterology	08/03/2021	No applications
Locum Consultant - General Paediatrician	08/03/2021	No applications
Intensive Care	21/03/2021	No applications

3. Covid-19

We have recently joined together to reflect and remember everything we have been through over the past year and the National Day of Reflection marked a milestone in our history and start of the country's first lockdown. We held two very moving and poignant live events of remembrance through the UHNM Facebook page and took time to remember staff and patients lost to the virus and looked ahead to the future with hope.

Over the past two weeks, we have also encouraged staff to find time to reflect, remember and check in and support each other and I have been impressed and inspired by the wide range of activities staff embraced in order to do this.

There has been a positive reduction in the number of new admissions we are seeing due to Covid-19 and we have reached single figures of Covid patients in our Critical Care Unit. We are now looking ahead to increasing our planned and elective work in a safe and controlled way, and will be prioritising our urgent and cancer patients.

4. HSJ Award 'Driving Efficiency Through Innovation'

I am thrilled to announce that UHNM in partnership with MPFT were successful in the recent Health Service Journal Awards. The Team won the Driving Efficiency Through Innovation Award, for the Smart with your Heart project, which personalised patient care by:

- Telemonitoring patient's self-assessed overall health with interactive texts in language understandable to patients
- Providing bespoke digital library content with enhanced content driven by patient request.
- Providing timely, responsive patient contact to facilitate health care options activated by appropriate alert texts

This approach reduced all cause readmissions by 50%, reduced cost and improved patent experience. The judges commented that "This was a great example of a truly patient-centric project, looking at holistic needs and delivered by a passionate team. The judges said it was refreshing to see a project that is deliberately seeking to combine the use of simple technologies with non-clinical coaching to enable widespread uptake and ease of access. The winners provided clear evidence of efficiencies that had been delivered and had a very clear focus on system-wide working and engaged actively across its ICS".

Well done to those involved!

5. Urgent Care Improvements

In order to continue to make improvements in urgent care performance, a number of actions have been taken by the teams. These have included monthly meetings between the Emergency Department and Acute Medicine to improve relations and discuss innovations and solutions to issues raised, reviewing the electronic referral process from the Emergency Department to Acute Medicine, reviewing medical rota patterns to provide greater coverage across sites at peak periods, a continued focus on triage time and decision making and sustained focus and delivery on pre noon discharges since January.

In respect of the latter, Medicine are routinely delivering 20% to 25% pre noon discharges most days including weekends and there has been a reduction in stranded and super stranded patients as a result of the established multi agency meetings (3 sessions per week) in delivering faster escalation and enhanced acute medical flow. Earlier discharges have also delivered the acute portal capacity to mitigate 4 hour performance breaches for medical bed capacity, and is contributing to the overall improvement in performance.

6. Plans for Elective Recovery in Quarter 1

As part of the Trust's plan to restore services to pre-Covid levels P2 (Priority level 2 Surgery that can be deferred for up to 4 weeks) waiting list analysis has been completed, identifying circa 4,000 patients on the list for diagnostic or surgical intervention procedures requiring theatre access; of these 3,000 do not have a booked admission date. Theatre Capacity at Royal Stoke and County is being scaled up from 29th March 2021 where teams will start to allocate treatment dates.

The Increasing Capacity Framework Contract (ICF) has been confirmed for quarter 1 with circa 1,300 patients per month eligible to transfer to the Independent Sector via the CCG Choice and Referral Centre. This will reduce the Day Case / P3 (Priority level 3 Surgery that can be delayed for up to 3 months) and P4 (Priority level 4 Surgery that can be delayed for more than 3 months) list and some of our long wait patients and is in addition to the 700 patients already transferred for treatment in Q4.

Non ICF contracts are being drafted with the Independent Sector for other non-framework activity to support other time critical surgery identified on our waiting lists that we wish to expedite and discussions are on-going with regards to additional support for high volume activity treatments which could be enacted at Royal Stoke or County out of hours. In addition, modelling of timescales to reduce the waiting list demand down to reference numbers by P category is underway using the new National Planning Guidance (March 2021).

7. Hospital Hub Vaccination Campaign

UHNM has played a significant part in getting the vaccine to thousands of staff and local people; over 13,500 of our staff have been vaccinated including Sodexo, e-zec, some staff from NHS partners and other contractors. As we finished our role at the end of March, I would like to thank all the staff that have been involved many of whom have given up their own time to vaccinate colleagues and patients.

As an update to the Board, as of the 1st April 2021 the numbers vaccinated through the UHNM hub are as follows:

Total vaccines given:	
Total as of 1st April	41,539
1st dose	21,201
2nd dose	20,243
Unable to vaccinate	95

	First dose	Second dose	% of first dose of total vaccinated
Numbers and % Patients > 80s vaccinated	434	427	2%
Numbers and % Patients <80	1,198	1,172	6%
Numbers and % UHNM (incl Sodexo and Ezec)	11,290	10,965	53%
Numbers and % Care Home staff vaccinated	1,525	1,437	7%
Numbers and % WMAS staff vaccinated	406	399	2%
Numbers and % MPFT staff vaccinated	255	250	1%
Numbers and % NSC staff vaccinated	932	899	4%
Numbers and % LHA/other NHS staff vaccinated	5,161	4,694	24%

We know that nationally the rate of vaccination for BAME staff is generally much lower and given the impact of Covid-19 on our BAME colleagues it was important that we vaccinated as many as possible.

Unfortunately the true vaccination rate for any groups of our staff can never be fully understood as vaccinations have also been given through other routes such as system vaccination hubs, vaccination centres, GPs and Pharmacies. As a result of Information Governance regulations this information cannot be shared although we have requested information on raw numbers for each staff group.

However, we can assure the Board that all of our staff have been offered a vaccine. To date the UHNM hub has vaccinated 76% of its staff in total and 63% of its BAME staff which is excellent in comparison to the regional/national uptake. We also know that many more of our staff have been vaccinated to date through the other portals.

8. Overseas Nurses

During the month we have taken time to prepare for new colleagues to join us. I April I am delighted to say we will be welcoming 77 overseas nurses to the UHNM family. Along with our Chief Nurse, Michelle Rhodes and staff who had already joined us from overseas, we have developed a welcome video and package to support them in their imminent arrival and we will be everything we can to ensure that they receive a very warm welcome.

9. Joint Advisory Group on Gastrointestinal Endoscopy

I received a letter from Dr Chris Healey JAG (Joint Advisory Group on Gastrointestinal Endoscopy) accreditation chair which confirmed that following an inspection, both County and Royal Stoke University hospitals have met all the required JAG accreditation standards.

JAG accreditation is awarded to high-quality gastrointestinal endoscopy services and in his letter he congratulated the team for 'the high standard of achievement and for their hard work during the accreditation process'. Well done team, I know a great deal of work went into achieving this high standard and it recognises the amazing service they provide to our patients.

Quality and Governance Chair's Highlight Report to Board

24th March 2021

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• A risk was highlighted in relation to infusion pump giving sets in terms of a national issue. In adult critical care, it was noted that the team had moved over to a new pump, but the main issue related to NICU and PICU due to only using one type of pump, therefore the risk was being balanced between switching pumps and retraining staff to use new pumps. • An update was provided in terms of getting it right first time and some delays were noted due to Covid, although the programmes were recommencing following receipt of a number of national reports	• To bring an update in relation to the deep dive into C-Difficile cases at the next meeting • To provide an update in respect of the independent assessment of ligature points within the Trust, at a future meeting • To provide an update at the next meeting regarding the changes to visiting • To further consider any additional learning from the RCA, in terms of treating and caring for trans patients and assessing whether this impacted upon the treatment provided. It was agreed to make the patient aware of the further actions being taken
Positive Assurances to Provide	**Decisions Made**
• A verbal update was provided in respect of Covid and the reduction in the number of inpatients across both sites, including a reduction in critical care which was positive. The number of nosocomial infections had also reduced in addition to reductions in sickness absence. • A verbal update was provided in terms of the maternity compliance assessment and the Trust had been scored green for 37 elements. One area rated as red was maternity SI reporting to the Board and 10 amber areas which were being addressed. • In terms of quality and safety performance, a number of positive improvements were noted • It was noted that national audits had been paused due to Covid although in terms of compliance and effectiveness for quarter 3, 99% of patient safety alerts had been closed and 91% of NICE guidance closed. • Members discussed the actions taken to remove ligature points within the Trust and the actions being taken to obtain independent assurance • In terms of the CQC Insight report, a number of outlier alerts had been discussed with the local CQC Inspector and a positive meeting was held regarding the progress made • Updates were provided in terms of the patient experience activities undertaken during quarter 3 and it was highlighted that the hospital user group had continued to meet virtually with improved attendance. It was noted that recent visiting guidance had been received which was in the process of being reviewed prior to implementation • The Committee received the full Root Cause Analysis which had been undertaken following the serious incident which was highlighted as part of the Patient Story reported to the Trust Board in August whereby 4 recommendations had been identified and actions were being taken to share the learning from the incident • No additional escalations were provided by the Quality and Safety Oversight Group and it was noted that membership of the group was being considered	• The Committee approved the midwifery continuity of carer action plan which had been put in place

• A verbal update was provided in respect of health and safety. There were no matters for escalation and the group virtually approved Terms of Reference for the Central Functions Group as well as approving a number of fire safety protocols.	

Comments on the Effectiveness of the Meeting

- Committee members present were happy with the effectiveness of the meeting

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Executive Directors Update including Covid-19	Information	7.	CQC Insight Report Update (March 2021)	Assurance
2.	Midwifery Continuity of Carer Action Plan	Approval	8.	August Patient Story RCA	Assurance
3.	Maternity Compliance Assessment Update	Information	9.	Q3 Patient Experience Report 2020/21	Assurance
4.	Month 10 Quality & Safety Report	Assurance	10.	Quality & Safety Oversight Group Highlight Report	Assurance
5.	Get It Right First Time Update	Assurance	11.	Executive Health & Safety Group Highlight Report	Assurance
6.	Q3 Compliance and Effectiveness Report	Assurance	12.		

3. 2020 / 21 Attendance Matrix

Attended | Apologies & Deputy Sent | Apologies

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

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	7th April 2021
Report Title:	Midwifery Continuity of Care action plan	**Agenda Item:**	8.
Author:	Sharon Wallis, Head of Midwifery		
Executive Lead:	Michelle Rhodes – Chief Nurse		

Purpose of Report:

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

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

Executive Summary:

This report and action plan provides an update on progress of midwifery continuity of carer (C of C) against the expectations of NHS England on maternity providers to ensure that

- *Plans should reflect how the Trust will continue or resume continuity of carer models so that at least 35% of women booking for maternity care are being placed onto continuity of carer pathways. In light of the increased risk facing, women from Black, Asian and minority ethnic backgrounds and women from the most deprived areas, local systems should consider bringing forward enhanced continuity of carer models primarily that 51% of women by March 2021 are delivered on a continuity of carer pathway.*

It is a requirement of CNST Maternity safety incentive scheme year 3 that progress in meeting the revised C of C action plan is overseen by the board on a minimum of a quarterly basis commencing January 2021.

Due to the COVID-19 pandemic, the maternity transformation programme was paused and resumed again in August 2020. Trajectories have been amended slightly however the national ambition remains the same.

An action plan has been developed in collaboration with Staffordshire Local Maternity System to support C of C and achieving the aim with the first C of C team who started in January 2021 focusing on vulnerable women including teenage parents and substance misuse. A second home birth team is forming and will be functioning in the spring.

Key Recommendations:

The Trust Board is asked to approve this action plan

STAFFORDSHIRE AND STOKE-ON-TRENT CONTINUITY OF CARER ACTION PLAN

UHNM plan to increase the number of women receiving continuity of carer across the whole maternity pathway

Background:

There is current, strong, high quality evidence for the positive impact that midwifery continuity of carer (MCOC) has on a range of outcomes for women and babies. The evidence is derived from the large number of randomised controlled trials (15) with more than 17,000 women, gathered together in a Cochrane Review (Sandall et al 2016). This review found the following outcomes for women who received the intervention of midwife-led continuity models, compared to standard care:

More Likely
- To know the midwife that cares for them in labour
- Feel satisfied with their experience of maternity care
- To have a normal birth

Less Likely
- To experience a fetal loss
- To have a premature birth
- To have an instrumental birth
- To have an epidural, amniotomy or episiotomy

The evidence from randomised controlled trials is that MCOC is of benefit to women both at 'low' and 'higher' risk of complications. There is emerging evidence that MCOC can have very significant benefits for vulnerable women living with a range of social and psychosocial complexity (Rayment-Jones, 2015; Homer et al 2017).

No adverse outcomes for mother or baby were found in any of the trials.

Evidence suggests that, if implemented correctly, MCOC models of care have the potential to improve job satisfaction and flexibility of working lives for midwives (Fleming 2006, Collins et al 2010, Newton et al 2014, Gilkison 2015, Dixon et al 2017, Fenwick et al 2017).

What are Local Maternity and Neonatal Systems being asked to deliver?

Each LMNS should ensure that by March 2021, 35% of women booked for maternity care are placed on to continuity of carer pathways, and that "the proportion of Black and Asian women and those from the most deprived neighbourhoods on continuity of carer pathways should meet or exceed the proportion in the population as a whole". Being 'placed' on a continuity of carer pathway means that a woman has received care from a midwife/team who aims to provide all her antenatal, intrapartum and postnatal care, as set out above. A woman should be 'placed' on a continuity of carer pathway as early as possible – to give the woman maximum opportunity to build a trusting relationship with their midwife, and realise the benefits set out in evidence – and certainly by the 28 weeks antenatal appointment at the very latest, to be counted nationally.

Therefore by March 2021, the following women should be placed on continuity of carer pathways:
- At least 35% of all women booked;
- At least 35% of all Black and Asian women booked;
- At least 35% of all women booked from the most deprived 10% of areas.

This is in line with the Long Term Plan commitment that 75% of women from these groups should receive continuity of carer by 2024, and has been made more urgent in light of the increased risk facing Black and Asian women of both poor maternity outcomes and outcomes from COVID-19.

How will delivery be measured?

Delivery of this milestone will be measured using data submitted by provider Maternity Information Systems to the Maternity Services Data Set (MSDS). The metric will measure all women who reach 29 weeks gestation in March 2021, and will count how many by this point have been placed onto a continuity of carer pathway and assigned a named lead midwife and team, as indicated on their maternity care plans. Within this, two measures will look specifically at women who are recorded as Black and Asian, and as living in the most deprived 10% of areas.

Current position

Since January 2020 UHNM, with the support of Staffordshire and Stoke LMNS, has employed a lead midwife for continuity of carer. The purpose of the role is to work alongside existing maternity teams and co-produce the changes and improvements required in order to deliver a continuity of carer model in a safe and sustainable way. This is through:

- Engagement with staff
- Engagement with women
- Co-designing midwifery continuity teams
- Leadership
- Clinical expertise

In March 2020 UHNM submitted data to NHSE/I confirming that 12.5% of women pregnant below 28 weeks gestation had been placed onto a continuity pathway, The 12.5 % was achieved through the implementation of a geographical mixed risk continuity team which consisted of 6.3 WTE midwives and a specialist diabetic midwife working flexibly to provide continuity to the diabetic ladies throughout their maternity journey. The geographical mixed risk team was very much in its infancy with only 3 out of the 7 midwives working with the chosen caseload. However, the midwives had commenced placing the women onto the pathway in anticipation for when the other 4 midwives were released from the current area of work. The caseload was approximately 210 women and in March, the total number of women who had been placed on the pathway was 113.The 12.5 % was based on a denominator of 519 (number of women who reach 29 weeks gestation in March)

Also in March the board received a staffing paper detailing the uplift required to the budgeted midwifery establishment in order to implement continuity of carer for the majority of women accessing UHNM maternity services. This uplift was agreed and supported with additional funding for 6 WTE midwives utilising transformation monies from the LMNS.

Between March and July 2020 the Covid-19 pandemic impacted on the ability for UHNM to proactively progress these plans as the midwifery workforce was centralised and re-deployed to maintain safety on the consultant maternity unit.

- Since August, the lead midwife for continuity has been able to fulfil her role with a number of achievements in a short period:
- The implementation of a vulnerable team for the teenagers and substance misuse ladies. This is a team approach to continuity including 7.9 WTE midwives and 1.9 WTE MSW.
- An expression of interest for a continuity team specifically for the BAME population was written and circulated to relevant staff members which generated limited interest. However through the engagement week this has improved. To enable the swift introduction of continuity for the BAME population a task and finish group has also been created and regular weekly meetings take place. There has been continued input from the outpatient matron, external support from nurse specialist for refugees and asylum seekers and also MVP representation.
- The implementation of a TWINS service which includes 1.0 WTE midwives working alongside an obstetric consultant who will be working flexibly to provide continuity to women with a twin pregnancy throughout their maternity journey
- Monthly newsletters have been sent out
-

- Regular team meetings with the midwives working in models of continuity have been undertaken to assist introduction of the different way of working. Team meetings also support team building and provides an opportunity for feedback of positives and negatives experiences which enables improved ways of working
- Networking meetings with other lead midwives for continuity from other trusts have taken place
- Attendance at steering group meetings to support the implementation of continuity
- Engagement with staff via 1-2-1 sessions and roadshow sessions. Also w/c 19/10/20 UHNM provided a Continuity of Carer week which promoted implementation of continuity models, face to face sessions were provided and virtual sessions via Microsoft teams. Sessions included benefits to women and their families and also to staff by means of improved work life balance and greater job satisfaction. All sessions were well attended giving staff the opportunity to ask relevant questions and further their own knowledge. It is important to note that attendance was had from a wide variety of staff grades including MSWs band 5s, band 6s, Labour ward Co-ordinators and Ward managers
- Regular communications shared via relevant social media platforms e.g. UHNM maternity forum
- Maintained weekly meetings with HOM to provide updates on progress
- Worked alongside the Trusts Communications team to support the promotional work undertaken in relation to continuity
- Communicated weekly with community team leads via Microsoft teams to provide updates on Continuity

Next steps

A steering group for the service change has been established. Chaired by the lead midwife for the maternity transformation programme (MTP) it reports through the Maternity Reconfiguration group to the MTP board (see appendix A)

The steering group will monitor the action plan and escalate when off track

Primary Action	Secondary Actions	Additional information/comments e.g. financial cost, name of training provider etc	Specific Action Owner (s)	Target date	Action completed	Update	Interdependencies	Risks
Creation of a steering group to provide a detailed focus on Continuity of Carer and identify the drivers for change	Setup a continuity of carer steering group to implement the vision of CofC for the majority of women and setup governance process/arrangements to monitor progress and outcomes	Continuity of Carer Steering Group to be created and directly report into the service reconfiguration meeting, MTP Board, Trust Quality and Safety Committee and CCG Quality and Safety Committee. LMNS Dashboard to monitor outcomes for women. Continuously audit outcomes and experience from existing teams and women. Share findings from audits with relevant stakeholders and audiences, to increase interest and showcase success. Undertake an evaluation of Continuity of Carer via the following routes: Staff Students Women and families Stakeholders Universities RCM Triangulation with Quality outcomes via the LMNS dashboard	Lead Midwife for Maternity Transformation	**October 2020** **On-going**		**Update:** January 2021 Continued monthly steering group meetings ongoing Progress delayed due to Covid pandemic.		

	Terms of Reference to be produced for the steering Group and agree representation/members of the group	Terms of reference drafted and adequate representation agreed.	Lead Midwife for Maternity Transformation and Project Assistant	**October 2020**				
	Ensure engagement of UHNM senior midwives/managers so to enable input into the CofC proposals and how to develop it on a larger scale, via the steering group, team meetings and 1:1 sessions	These individual are now members of the CofC steering group. Attendance at Senior team meetings and further engagement at teams meetings or 1:1 as required.	Lead Midwife for Continuity of Carer LMNS Midwife	**October 2020** **On-going**				
	Assess risks relating to failure to achieve the 35% of women booked onto a CofC pathway by March 2021	The risk has been included with failure to achieve all objectives for the programme, due to the pausing of the programme, covid – current risk score is 16. The risk has been recorded on the MTP risk register.	Is this going to be risk assessed by the MTP/LMNS or the Trust? MTP Senior Programme Manager	November 2020				
	Produce paper to be presented at UHNM Trust Board, with the inclusion of an action plan which meets the requirements of CNST	Paper and Action Plan to be produced via the CofC planning group by November 2020.	Lead Midwife for Maternity Transformation	November 2020				Trust's response to Covid may delay the paper going through their internal governance process.
	Obtain sign up from UHNM's Trust Board Safety Champion	Paper to be presented at UHNM Trust Board, with the inclusion of an action plan which meets the requirements of CNST	Head of Midwifery (UHNM)					Obtaining time with the Trust Board Safety Champion, due to Covid-19
	18/2/21 Monitor and validate K2 data quality in relation to CofC figures in line with national measurable parameters	Monitor caseload data monthly and validate against MSDS submission	Lead midwife CofC LMNS Data Analyst	Monthly				

Work towards implementation of further future continuity teams in order to work towards the targets set by NHSE/I of 35% of women to be a Continuity of Carer pathway by March 2021 • At least 35% of all women booked; • At least 35% of all Black and Asian women booked; • At least 35% of all women booked from the most deprived 10% of areas.	Further development of the existing CofC teams to address inequalities, disproportionately and deprivation as outlined in the objectives set by NHSE/I	Embed the different way of working in a continuity model to all team members	Lead Midwife for Continuity of Carer	Review Feb 2021 May 2021 August 2021		**Update: January 2021:** Due to continued pressures of Covid19 pandemic further progression of additional CofC teams has been delayed. This is being monitored by monthly CofC steering group **Update February 2021:** In January 2021 594 women in total booked and of those 45 were placed on a CofC pathway which equates to 7.57% At UHNM there are currently 3157 pregnant women (not including Out of Area), of that number 237 are currently on a CofC pathway which equate to 7.50% Team Alton have delivered 7 continuity babies since 25/1/21.		
		Assess effectiveness of the different way of working and make necessary adaptions to policies and working processes in response to findings	Lead Midwife for Continuity of Carer			Review Feb 2021 May2021 August 2021 **Update January 2021:** Proposed plan to review via audit in April 2021 Adaptations to policy to made if required.		
		The team to commence providing intrapartum care for women who have been assigned to CofC pathway	Continuity of Carer midwives	To be commenced January 2021		**Update January 2021:** On-calls commenced 25/1/21		

		Promotion of good team working and effective working relationships through the introduction of insights discovery model	Lead Midwife for Continuity of Carer	Awaiting confirmation of dates		**Update January 2021:** Due to Trusts pressures OD Team unable to provide training review March 2021		
		Design and roll out rota/ on call rota.	Lead Midwife for Continuity of Carer	Sept 2020 Review March 2021				
		Review effectiveness and make necessary changes as required	Lead Midwife for Continuity of Carer	Review Feb 2021				
	Implementation of a continuity team which predominantly serves the BAME communities which aligns to the national target in line with the Long Term Plan commitment that 75% of women from these groups should receive continuity of carer by 20241, and has been made more urgent in light of the increased risk facing Black and Asian women of both poor maternity outcomes and outcomes from COVID-19.	Expression of interest to be circulated to all relevant staff members	Lead Midwife for continuity of carer	Oct 2020				
		Confirm members of first BAME team	Lead Midwife for Continuity of Carer	December 2020				
		Plans for 2nd and 3rd wave of implementation of teams specific for BAME	LMNS Midwife	January 2021		**Update January 2021:** Recruitment to BAME CofC team currently on hold due to difficulties releasing staff members from inpatient areas. Also limited interest in joining the team		
		To work alongside other service providers and charities to improve standards of care for the BAME communities	Lead Midwife for Continuity of Carer	Review Jan 2021		**Update January 2021**: Recruitment to BAME CofC team currently on hold due to difficulties releasing staff members from inpatient areas. Also limited interest in joining the team		
		Define equipment required for team/s	LMNS Midwife	November 2020		Update January 2021: Bid for equipment successful, order to be placed by UHNM		
		Confirm venue for first BAME team	BAME task and finish group	October 2020				

		To advertise for a bilingual maternity support worker to work within the team.	Outpatient Matron	February 2021				
		Create and complete an operational policy in relation to the care of BAME women for maternity services	LMNS Midwife	December 2020		**Update January 2021:** Draft to be circulated for next LMNS board for comments		
		Review existing JD's to ensure compliance with HR and relevant regulations	Matrons	December 2020		**Update January 2021:** Email to be sent to inpatient and outpatient Matron to confirm if actioned.		
	Implementation of a low risk case loading team	Define members of team	Lead Midwife for Continuity of Carer	November 2020 Ongoing		**Update January 2021:** Work towards implementing team has been paused due to UHNM HOM unable to facilitate releasing of staff to support the project. Further discussion to be had a next CofC steering group meeting.		
		Define caseload for the team considering recommended ratio	Lead Midwife for Continuity of Carer	Jan 2021		**Update January 2021:** Work towards implementing team has been paused due to UHNM HOM unable to facilitate releasing of staff to support the project. Further discussion to be had a next CofC steering group meeting.		
		Identify parameters for the case loading midwives to work within to avoid burnout	Lead Midwife for Continuity of Carer	December 2020		**Update January 2021:** Work towards implementing team has been paused due to UHNM HOM unable to facilitate releasing of staff to support the project. Further discussion to be had a next CofC steering group meeting.		

		Identify venues to be utilised	Lead Midwife for Continuity of Carer	December 2020		**Update January 2021:** Work towards implementing team has been paused due to UHNM HOM unable to facilitate releasing of staff to support the project. Further discussion to be had a next CofC steering group meeting.		
		Meeting to take place with current Newcastle team leader to discuss the introduction of a case loading model within the Newcastle area.	Lead Midwife for Continuity of Carer	December 2020		**Update January 2021:** Work towards implementing team has been paused due to UHNM HOM unable to facilitate releasing of staff to support the project. Further discussion to be had a next CofC steering group meeting.		
		Inform the GPs of change of practice	Lead Midwife for Continuity of Carer	December 2020 UPDATE Jan 21- as above		**Update January 2021** – as above.		
		Define equipment required for the team	Lead Midwife for Continuity of Carer	December 2020 UPDATE Jan 21- as above		**Update January 2021** – as above.		
		Design rota and once implemented continually assess effectiveness, making appropriate changes as required.	Continuity of Carer Midwives	January 2021		**Update January 2021** – as above.		
	Implementation of a continuity team for women who are pregnant subsequent to perinatal loss	Expression of interest to be circulated to all relevant staff members	Lead Midwife for Continuity of Carer	December 2020		**Update January 2021** – as above.		
		Define members of the team	Lead Midwife for Continuity of Carer	December 2020		**Update January 2021** – as above.		
		Meeting to take place with Bereavement Midwives to discuss implementation	Lead Midwife for Continuity of Carer	December 2020		**Update January 2021** – as above.		
		Design rota to cover the service 24/7 Define equipment for team	Continuity of Carer Midwives	January 2021		**Update January 2021** – as above.		

		Identify venues to be utilised for antenatal care	Lead Midwife for Continuity of Carer	January 2021		**Update January 2021** – as above.		
Consider the Implementation of an organisational change which will enable UHNM to further increase the number of midwives that will support the CofC model and consequently achieve the future desired trajectories.	Develop a business case to support the large scale change	Draft business case to include benefits of change process	Lead Midwife for Maternity Transformation Programme and Senior Programme Manager for the MTP	**April 2021**				
	Existing workforce organisational change proposal and consultation to support CofC Models	Draft materials to enable consultation to commence	Head of Midwifery (UHNM) Human Resources(UHNM) RCM	**April – July 2021**				
		Union involvement within the process						
		Agree plan with UHNM HR Team and SMT						
		Consultation to take place						
		1:1 and team meetings						
		Gather feedback from staff						
		Act on feedback						
		End of Consultation						
	Engage with unions throughout the MOC process.	Engagement of unions through the steering group meeting						
Develop a future workforce that is competent and skilled to work within a CofC model	Provide the opportunity for student midwives to work within a CofC team. Liaise with universities to ensure placement meets curriculum standards	Meeting to take place with course tutors to ensure placements include exposure to CofC model COC lessons to be included in curriculum	Lead Midwife for Continuity of Carer	April 2021				
	Midwifery Job description change for new starters to include CofC model	Liaise with Matrons	Lead Midwife for Continuity of Carer	December 2020		**Update January 2021:** To discuss with inpatient and outpatient Matron to confirm if this change has been made.		

	Ensure the new workforce understand CofC and how they will be well placed to work within the CofC models after completing the preceptorship programme	CofC objectives included within current preceptorship booklet.	Lead Midwife for CofC	October 2020				
	Recruit Student Midwives to the Continuity of Carer Steering group	Offer students who have previously expressed interest in CofC the opportunity to attend the steering group meetings	Lead Midwife for CofC	October 2020				
	Engagement with preceptorship midwives who are about to complete the programme and new starters by attending study days	Set up meeting with Midwifery Lecturers at local Universities	Lead Midwife for CofC	February 2021		**Update January 2021:** Delay in progression due to Lead Midwife for CofC returning to work clinically to support the wider team due to Covid Pandemic.		
		Discuss with universities the need to have CofC assessment tools included in sign off documentation	Lead Midwife for Continuity of Carer UPDATE- see above	March 2021				
		Liaise with lead preceptorship Midwife/Nurse to ensure CofC is embedded into Trust Preceptorship programme for midwives	Lead Midwife for Continuity of Carer UPDATE – See above	October 2020 Review March 2021				
	Feedback and experience of student midwives	To agenda the suggestion that a student feedback and experience form is created and completed at the end of a COC placement.	LMNS Midwife UPDATE –see above	April 2021				
Support the movement of midwives across the service Io empower and enable CofC team members to develop their team	CofC team bespoke sessions led by University of Birmingham - HEE funded Attendance of midwives working in continuity to the National HEE funded training programme (IPIP)	To create a training needs analysis for members of staff working within CofC	Lead Midwife for Continuity of Carer/ Continuity of Carer steering group	April 2021				
		Identify staff who are required to attend CofC specific training						

		Arrange dates and times of training						
	UHNM practice development training package to be developed and implemented	To work together with the Trusts training and development team to design a training package to include all elements of CofC creating a more fluid approach to across the service working. Additionally bi-annual updates to be included in mandatory training.	Development in Education midwives / Lead Midwife for Continuity of Carer	June 2021				
Promotion of continuity of carer across the LMNS, STP and ICS whilst utilising various methods of communications and engagement. Targeting various different groups including * service users * women and families * local population * staff * students * Universities * stakeholders RCM	CofC awareness events to take place at UHNM to increase awareness and engagement with staff	These events to take place on a quarterly basis and to be promoted via the LMNS,STP and MVP	Lead Midwife for Continuity of Carer	January 2021, April 2021				
	MCOC week to support dissemination of information and delivery of National CofC ambition	To undertake face to face and Microsoft teams presentations and workshops in order to increase knowledge and promote working in a model of continuity	Lead Midwife for Continuity of Carer	October 2020				
	1-2-1 sessions	Meet with staff members to discuss all aspects of continuity of carer, including benefits for both women and staff	Lead Midwife for Continuity of Carer	Review Jan 21 Apr 21				
	Drop in sessions and roadshow sessions	To provide optimum opportunity for staff members wishing to find out more about CofC in order to further raise the profile of CofC	Lead Midwife for Continuity of Carer	Review Jan 21 Apr 21				
	Production of Newsletters	To distribute a monthly newsletter in order to communicate updates in relation to CofC to all relevant staff members	Lead Midwife for Continuity of Carer	On-going quarterly				
	Social Media Engagement Regular UHNM Communications involvement Use of social media platforms such as UHNM Maternity Facebook Forum to showcase positive findings from continuity teams. Videos of midwives and women's experience of continuity	To utilise every positive finding from the outcomes in the most productive way possible	Lead Midwife for Continuity of Carer	Review Jan 21 April 21				

	Increase awareness of CofC model through LMNS workstreams and the Maternity Transformation Board	Communicate updates on work being carried out within the Trust in relation to CofC with The MTP board meeting	Lead Midwife for Continuity of Carer	Review Jan 21 Apr 21				
	Promotion of CofC work/progress, new teams and information via the MVP, service users, women and families	To undertake roadshow sessions in antenatal clinic To utilise promotional material in visiting areas within the acute setting and other community settings e.g. children's centre Engagement with local press utilise social media platforms to showcase current teams success and future plan Team sessions with MVP champions	MVP Lead / Lead Midwife for Continuity of Carer	Jan 21 Review April 21		**Update January 2021**: Due to pause inappropriate timing. To be reviewed when further progression with future teams has been achieved		
	Production of infographics portraying benefits for both staff and women	To work alongside data analyst to abstract the positive outcomes of CofC from the data in order to present information quickly and clearly	Lead Midwife for Continuity of Carer/ LMNS Data Analyst	June 2021				
	Involvement with wider stakeholders (HV/DCPP/Family Visitors/Children's Centres	To invite relevant stakeholders to continuity steering group meetings	Lead Midwife for MTP	December 2021				
		To provide regular updates to relevant stakeholders	Continuity Steering group	November 20 Review Jan 21 April 21				
		Maintain links with other CofC lead Midwives and network to share learning	Lead Midwife for Continuity of Carer	November 20 Review Jan 21 Update Jan 21- continue to attend networking meetings.				

Evaluation of Continuity of Carer outcomes and experience	Undertake an evaluation of Continuity of Carer via the following routes: Staff Students Women and families Stakeholders Universities RCM Triangulation with Quality outcomes LMNS dashboard	Monitoring of outcomes via audit of preterm births, episiotomies, preterm birth, emergency LSCS's Use of analgesia Homebirths both prior to and post implementation Survey monkey to be distributed to both staff and student midwives to establish work life balance/ job satisfaction/ experience/ monitor retention figures of staff Monitoring of LMNS dashboard data for outcomes.	Continuity of Carer steering group	December 2020 Review March 2021 Review Jun 2021		**Update January 2021:** Due to pause and delay due to Covid pandemic audit to be undertaken when appropriate data available.		

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	7th April 2021
Report Title:	Midwifery Workforce Review	**Agenda Item:**	9.
Author:	Sharon Wallis, Head of Midwifery		
Executive Lead:	Michelle Rhodes – Chief Nurse		

Purpose of Report:

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

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

Executive Summary:

This paper identifies issues within the current midwifery workforce establishment reflecting recommendations from Birthrate+ review in light of actions from the Ockenden report and meeting compliance with CNST standard five of Maternity Incentive Scheme year 3.

In summary

- Due to a fall in the birth rate, the budgeted establishment is 1:26 against Birthrate + recommendations of 1:25 in 2019
- Specialist roles have increased with new consultant midwife role appointed
- Ward acuity and staff shortfalls have been challenging due to COVID -19 related absence rates
- Compliance with one to one care in labour and supernumerary status of the delivery Suite coordinator is 100%
- Positive impact of temporary suspension of services at FMBU on senior midwifery staffing
- Recommended uplift in establishment with support workers to provide a career structure and support midwifery staff in ward areas
- Consideration to over recruit into midwifery posts due to increasing requirements on midwifery training to meet competence/ compliance and perpetual number of midwives on maternity leave
- Next staffing report due October 2021

Key Recommendations:

The Trust Board is asked to note the paper which will be presented for further discussion and consideration at the next Transformation and People Committee.

Midwifery Workforce Review

January 2021

Midwifery staffing

Safe midwifery staffing has featured as a standard within the CNST maternity incentive scheme for the last three years with requirement that the Trust board are cited on any midwifery workforce challenges. The Head of Midwifery is responsible for reporting and escalating staffing issues to the Chief Nurse. The recent publication of the Ockenden report on maternity services at Shrewsbury and Telford hospital has also identified safe staffing as a key action for all trusts. Heads of Midwifery have also been tasked to review senior leadership in accordance with Royal College of Midwives 2019 publication "Strengthening midwifery leadership: a manifesto for better maternity care". A timeframe is required to meet the recommendations of both Birthrate + and the RCM report which is to be agreed by the trust board.

Safe Maternity Staffing is recognised in the following documents;

- Birth-rate Plus (the only calculating tool endorsed by NICE)
- Nice Safe Staffing (2016)
- NHS England NQB Safe Staffing documents (2017).
- Strengthening midwifery leadership: a manifesto for better maternity care (2019)

In the 1990'S and early 2000's, when Birthrate + was in development, the midwife to birth ratio used by most trusts was 1:28. This is a crude but still quoted figure which is calculated on a monthly basis according to the staff either by budgeted establishment or available staff (excludes maternity leave and staff in half or no pay unless backfilled). The issue with calculating and reporting workforce by this method is;

- Retrospective
- Fluctuates by the number of births per month
- Does not account for acuity / complexity of women
- Includes all clinical midwives regardless of where they provide care
- Wide variation across trusts in reporting e.g births per month or running total, clinical midwives only or including support workers

Band 3 Maternity support Workers are also included in the figure as they are funded from midwifery establishment although they cannot provide any intrapartum care. Birthrate Plus (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units for a significant number of years. It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The recommendations from the report are based on activity and acuity of women in every part of the service, not just the birthing episode.

With the publication of Ockenden and CNST standards, it is clear that trusts have to acknowledge and work towards meeting their own Birthrate + recommendations. As Birthrate+ should be repeated every three years, UHNM is due to be reassessed from autumn 2021 for a spring 2022 report.

The BR+ review conducted between November 2018 and February 2019 for UHNM recommended that Trust should aim toward a **midwife to birth ratio of 1:25** to account for the complexity and acuity of the women in the service. The shortfall was 24WTE midwives at the time. Based on the birth rate for 2020, the **midwife to birth ratio is 1:26.1** based on budgeted staff. This is due to a slight reduction in the birth rate however if recalculated on actual staff, the midwife to birth ratio is **1:26.7**. This is predominantly due to the number of staff on maternity leave as vacancies are very low. An additional 6 WTE midwives would achieve the Birthrate + recommendations of a ratio of 1:25 however there are difficulties in recruiting to midwifery

posts. Consideration to review the skill mix and take it slightly over 90:10 midwife to support staff may be a more appropriate and viable option. There is no definitive research into the optimum midwife to maternity support worker ratio, but current data and the consensus of expert midwifery opinion is that a 90%/10% split between midwives and maternity support workers allows for flexible and sustainable services. (Ball J, Washbrook M, RCM 2013)

The staffing charts based on acuity below, show significant gaps in staff, on occasions up to 4 staff short. There may be scope to introduce a nurse associate role to support the midwives particularly on the post-natal areas. The role would provide nursing care particularly post-operative to women, support drug rounds and wound care and advice which would not impinge on the statutory role of the midwife. In addition this would provide;

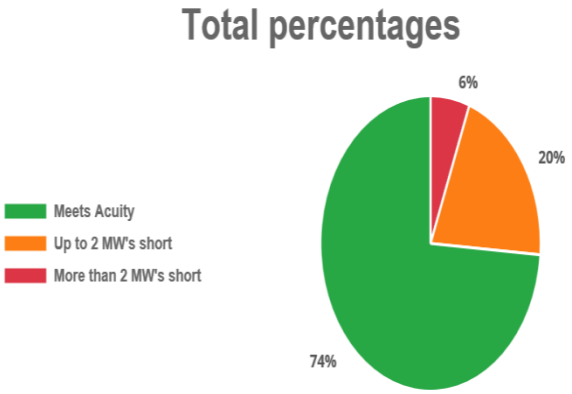
- Appropriate trained staff undertaking appropriate non midwifery skills
- Greater career / development opportunities for band 3 to band 4 where there are none currently
- Not draw on the meagre pool of midwifery for recruitment

There would be significant interest from current staff to undertake training to achieve an accredited qualification such as Nursing Associate especially with a band 4 on completion. The cost for six mid point band 3 MSWs would be £155,958

Birthrate + acuity tool

The LMS has funded access to the Birthrate + website acuity tool for delivery suite from June 2019 and for the wards from February 2020. This provides information on the level of acuity within the area versus the staffing and includes impact on activity for example delays in induction and relevant actions taken. The accuracy of the data is dependent on the coordinating midwife inputting into the tool four times in a 24 hour period. The chart below shows the percentage of times where staffing has been appropriate for the acuity of the women or not.

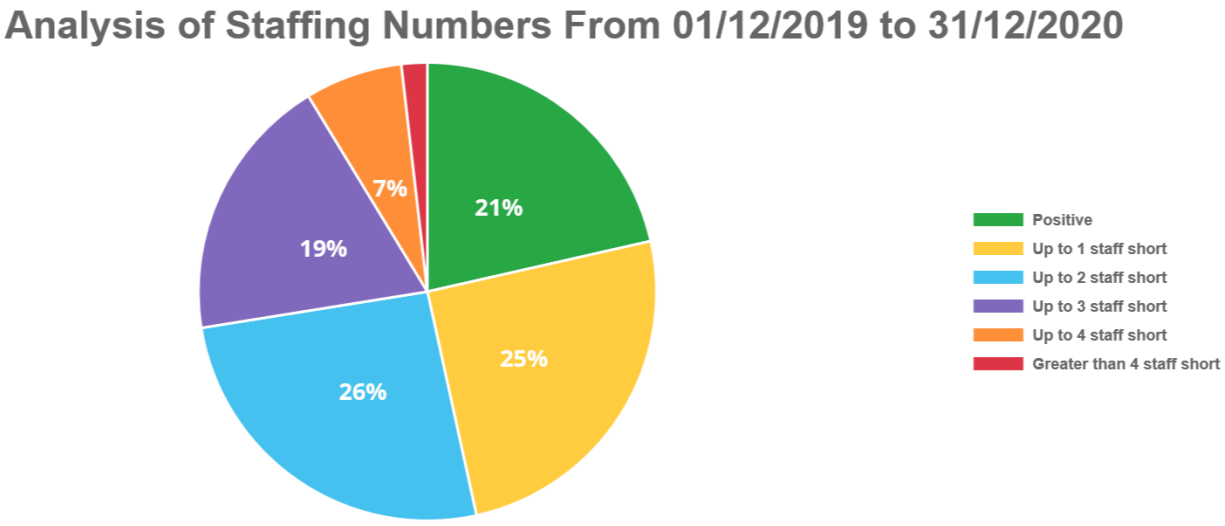
December 2020 safe staffing – delivery suite



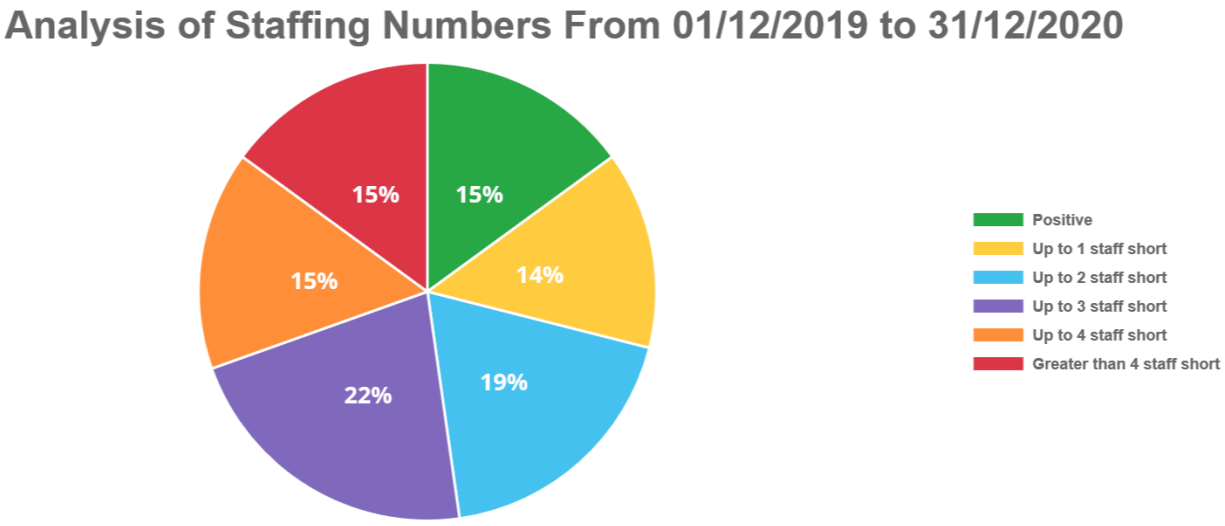
December 2020 safe staffing – 205/ 206

The data below shows the staffing shortfalls on ward 205/206 for the same period. A note of caution as the submission compliance was 41.56% on 205 and 50.63% on 206 however this is improving with more staff able to input into the tool. While Delivery Suite is the highest immediate risk area where one to one care is maintained at 100%, it is often to the detriment of the ward areas. Most concerning is the shortfall of more than four staff on 15% of occasions on 206. This is partially due to additional caesarean section lists increasing the acuity however work is on-going to ensure the robustness of the data and reduce variation e.g. extra care babies should not be recorded on 205 acuity tool as Transitional Care is already counted and staffed.

205



206



This is a visual depiction of the complexities and variance of midwifery staffing which is variable and unpredictable. The service is responsive to peaks in activity with staffing moving from one area to another, supported by an escalation process to call in community midwives for support however escalation to cover acute services requires the temporary suspension of the home birth service. This is to ensure that 100% of women in active labour receive one to one care in labour above all other demands. The diagram also supports the introduction of enhanced support roles such as nursing associates so that midwives can be allocated where their skill are most needed. The diagrams also demonstrate the impact that absence has on staffing due to Covid-19 and long term illness plus maternity leave.

Temporary suspension of services at FMBU County hospital

Staff were relocated at the start of the pandemic to support and maintain safe staffing at RSUH site. The band 7s have been invaluable ensuring senior leadership is available 24 hours a day. This has also provided an opportunity to review the role of the band 7 due to a number of retirements and a reduction in band 7 cover on the Midwife Birth Centre. Following the publication of a national safety report from HSIB on decision making and safety factors in intrapartum care, the role of Flow coordinator is being developed, this will ensure:

- Delivery suite coordinator has sole responsibility for that area only, not the whole unit out of hours
- Additional senior support for both maternity and neonatal unit including transfers
- Oversight of safe staffing across the unit
- Staff are moved appropriately with the activity
- Support at a senior level for Maternity Assessment Unit
- Additional senior leadership out of hours
- Support for all areas as required
- Maintenance of flow throughout the unit

This can be achieved using the current cohort of band 7 co coordinators and does not require additional resource

Strengthening midwifery leadership: a manifesto for better maternity care (2019)

In response to this report, funding has been moved from deputy Head of Midwifery post to a consultant midwife as there were no applicants for the deputy role. This is currently out to advert.

In the past year, additional specialist midwife posts have been created including;

- 1 WTE additional Professional Midwifery Advocate for quality
- 0.6WTE digital midwife
- 0.4 WTE OASI midwife for perineal care

These posts have been created using band 7 vacancies from within current establishment. All band 7 management posts have been filled, including additional support for delivery suite.

Continuity of carer

In August 2019, the Local Maternity System successfully bid for money from NHS England to support delivery of Continuity of Carer. This consisted of one WTE band 7 lead midwife plus six WTE band 6 midwives on 12-18 month fixed term contracts. This was added to the vacancy and recruitment of newly qualified staff in October 2019. These posts have been difficult to fill as they are fixed term so the trust agreed to make the band 6 posts substantive. It has been a challenge to recruit into band 6 posts due to a lack of movement within the workforce generally and all trusts having vacancies.

Due to the pandemic, maternity transformation including continuity of carer was suspended from March 2020 to August 2020 however there is an expectation that C of C models will continue although the initial expectation of 35% booked by March 2021 has been retracted. The current message from the national team is that C of C is not going away.

UHNM has been building a team to support teenage pregnancy, drug & alcohol misuse and learning disabilities based around services already in existence. Midwives have joined the team from the acute setting and community based staff have been supported to update their intrapartum care within the unit. There are currently eight midwives within the team who are fully up and running from mid-January 2021. A second team to support home births is planned for later in the year.

There is also a midwife for care of diabetes who offers C of C and two midwives who share a fulltime role supporting women with multiples who also provide some C of C.

The challenge is to upscale it while maintaining safe services which cannot be achieved currently. While there are continued staffing issues due to the pandemic, it is not feasible to release staff to a C of C team. Other issues for consideration are;

- There are consistently a minimum of 10 WTE midwives on maternity leave at any given time; currently 12.74 WTE in December 2020
- Current sickness rates are above the Trust target at 9%
- The increasing training requirements for midwives adding up to over 37 hours per year to maintain compliance. To implement a 24% uplift in midwifery establishment to achieve this, an additional 7 WTE midwives would be required in addition to the recommended BR+ figure
- Flexible and part time working and compressed hours for full time staff reduces flexibility and reluctance to work in C of C models especially if enhancements are impacted negatively.
- Challenge of recruiting to fixed term posts and back fill for secondments affects the establishment.

CNST standards for midwifery staffing

Midwifery safe staffing has always been a standard within the CNST Maternity Incentive Scheme. Trust boards should be sighted on maternity services and compliant with;

- Meeting Birthrate + recommendations for midwifery staffing
- Ensuring one to one care in labour for 100% of women
- Confirming that the Delivery Suite coordinator is supernumerary for every shift i.e. does not have any patients allocated to them. This is to maintain a helicopter view of the unit and ensure safety

UHNM is consistently compliant with one to one care and supernumerary status for the coordinator

Midwifery red flags

NICE safe midwifery staffing for maternity settings (2015) suggested a number of red flags that trusts could use as a means to escalate staffing concerns. These include;

- Redeployment of staff to other services/sites/wards based on acuity or
- Staff absences due to illness/isolation/shielding/symptoms
- Delayed or cancelled time critical activity.
- Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing).
- Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication).
- Delay of more than 30 minutes in providing pain relief.
- Delay of 30 minutes or more between presentation and triage.
- Full clinical examination not carried out when presenting in labour.
- Delay of two hours or more between admission for induction and beginning of process.
- Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output).
- Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

These red flags have been included in the Datix reporting system and are reviewed on a weekly basis as a standard item on the obstetric risk meeting agenda. They are also included in the monthly maternity dashboard. Between June and December 2020, there were 8 datix regarding staffing due to;

- Escalation to community for support within the unit and suspension of home birth (6)
- Delay in triage on MAU > 2hours
- Lack of suitably trained staff

Seven of the eight incidents have been submitted in the period between October and December 2020 when there were high levels of staff absence due to COVID -19 either infection or isolating.

Summary

This paper has identified the workforce challenges within midwifery including;

- The current midwife to birth ratio is approaching the Birthrate + recommendation of 1:25 due to a reduction in the birthrate

- There is an opportunity, with investment, to supplement the midwifery workforce with trained maternity support workers to achieve the recommendations of Birthrate +
- One to one care in labour and supernumerary status of the coordinator is 100%
- There has been an increase in midwifery red flags due to the impact of COVID -19 on attendance rates
- The temporary suspension of services at the FMBU has had a positive impact on senior presence in the unit and provided an opportunity to further improve safety within the unit 24 hours a day within the existing establishment
- There has been an increase in specialist roles within maternity using vacancies in a different way
- Continuity of Carer remains a challenge however there has been small steps made with the first team now established and individuals supporting CofC when possible
- Maternity leave is a significant issue which is not recruited to due to difficulties attracting midwives
- Increasing training requirements for midwives is not reflected in the current uplift and needs to be reviewed.

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	7th April 2021
Report Title:	Maternity New Serious Incident Report Summary Quarter 4 2021	**Agenda Item:**	10.
Author:	Donna Brayford, Quality & Risk Midwife; Sharon Wallis, Head of Midwifery		
Executive Lead:	Michelle Rhodes, Chief Nurse		

Purpose of Report:

Assurance	✓	Approval		Information	

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

Executive Summary:

Situation:

Following the publication of the Ockenden review, Trust boards are to have specific sight of Maternity Serious Incidents on a monthly basis. The report provides a summary of the numbers and types of Serious Incidents formally logged on STEIS (national reporting system) by Maternity during Quarter 4 (2021). Ongoing, this report will be provided monthly.

Assessment:

Q4 saw 10 new serious incidents reported

- 3 Healthcare Safety Investigation Branch (HSIB) investigations
- 3 Retrospective incidents following completion of investigation
- 4 new incidents to be investigated by local Root Cause Analysis (RCA)

Immediate Actions:

- Maternity clinicians instructed to crash call the neonatal team for any sudden unexpected postnatal collapse

Areas of concern/escalation:

- In future, reporting of a retrospective SI will include an explanation for delay in the 72 hour brief
- CCG SI group to be made aware of a potential increase in reporting of SIs due to the decision to report all HSIB investigations as SIs
- The Quality and Risk Team will strive to a more timely completion of the 72 hour brief

Key Recommendations:

The Trust Board is asked to note the contents of the report.

Maternity New Serious Incident Reporting Process – for information (Quarter 4 2021)

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

HSIB Investigations and SI Reporting

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

1. NEW SERIOUS INCIDENTS

Maternity have reported 10 Serious Incidents (SIs) during Q4 (2021), January (n=4),February (n= 5) and March (=1). Table 1 gives a brief description of the incident and immediate actions taken. It has been agreed by the Directorate, Division and Trust Board all HSIB investigations will be reported as Serious Incidents, and then de-escalated if required

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

SI ID	Datix ID	Incident description	Immediate Actions
2021/685 (72 hr brief sent to Divisional team 05/01/21)	235087	• A category 2 emergency caesarean section (CS)(Category 2 CS is maternal or fetal compromise which is not immediately life threatening) for failure to progress in labour • Impacted fetal head. • Baby required transfer to the neonatal unit for passive cooling.	• This was an obstetric emergency which was managed in accordance with guidance from the maternity team. No immediate omissions in care noted that would have contributed towards the outcome. • Delay in reporting due to waiting for confirmation of HSIB referral. In future, the risk team will proceed with the 72 hour brief. • HSIB referral rejected as baby was passively cooled not actively cooled. Team initially informed baby was activiely cooled. • No immediate actions • Local RCA ongoing
2021/684 (72 hr brief sent to Divisional team)	235002	• A category 1 emergency caesarean section (Category 1 CS immediate threat to life of woman or fetus) at 36+6 weeks for antepartum haemorrhage; a placental abruption (placenta separates from the uterus) was confirmed at CS. • Baby needed transferring to the neonatal unit and required active cooling.	• This is an obstetric emergency which was managed in accordance with guidance from the maternity team. No immediate omissions in care noted that would have contributed towards the outcome. • The incident does not fulfil reporting criteria for referral to the HSIB • No immediate actions. • Local RCA ongoing
2021/2331 (72 hr brief sent to Divisional team 21/1/21)	236483 HSIB	• A category 2 emergency caesarean section at 37 weeks for suspicious cardiotocograph (CTG) • Baby needed transferred to the neonatal unit and required active cooling. The cooling was discontinued. The baby continued to be ventilated and experienced seizures.	• The care provided appears to have been managed in accordance to maternity and neonatal guidelines • Delay in reporting due to waiting for confirmation of HSIB referral. In future, the risk team will proceed with the 72 hour brief. • No immediate actions • HSIB investigation ongoing

SI ID	Datix ID	Incident description	Immediate Actions
2021/3124	218366	• A category 1 caesarean section at 37 weeks and 6 days for a pathological cardiotocograph (CTG); a pathological CTG is a CTG with 1 abnormal feature or 2 non reassuring features. • Baby needed transferring to the neonatal unit and required active cooling. • Retrospective SI	• This is an obstetric emergency which was managed in accordance with guidance from the maternity team. • Retrospective SI, a brief overview took place at the time of the incident but it was not formally investigated. COVID-19 escalations were being discussed apace at the time and the Directorate also experienced a maternal death in the unit at a similar time point which could account for why it was overlooked at the time. Recognised through failsafe audit that an RCA required. Sincere apologies given to parents for delay. • Parents given option to request a HSIB investigation in view of late formal investiagtion, declined • No immediate actions • Local RCA ongoing
2021/1244	225370	• A category 1 caesarean section for prolonged fetal braycardia • Low cord gases at delivery • Misinterpretation of Ante-natal CTGs • Retrospective SI following completion of RCA	• Local RCA completed. Action plan developed and implementation ongoing – actions focus on use of SBAR tool and Ante – natal CTG interpretation training. • Retrospective SI, COVID 19 has contributed to the delay in the completion of the investigation due to the clinical priorities. A written apology for the delay in the investigation has been sent to the mother.
2021/1236	215762	• A category 1 caesaraen section for pathological CTG • Lack of recognition of suspected uterine rupture • Retrospective SI following completion of RCA.	• Local RCA completed. Action plan developed and implementation ongoing – actions focus on theatre listing prioritisation and documentation of pain relief and its effects. • Retrospective SI, RCA initiated following appointment where the mother raised concerns around her care. COVID 19 has contributed to the delay in the completion of the investigation due to the clinical priorities. A written apology for the delay in the investigation has been sent to the mother.
2021/3974	237628	• Sudden unexpected post-natal neonatal collapse at 25 minutes of age. • Baby was intubated and transferred to the	• HSIB referral rejected as MRI reported to be normal, local RCA ongoing • Immediate action - the neonatal team were not crash

SI ID	Datix ID	Incident description	Immediate Actions
		neonatal unit. • Active cooling was commenced on admission to the neonatal unit	bleeped following the neonatal collapse. MDT decision that clinical staff should crash bleep the neonatal team for any sudden unexpected postnatal collapse of a newborn baby. Memo sent to all areas • Local RCA ongoing
2021/4461	223201 HSIB	• Passively Cooled Baby and Neonatal Death • Retrospective SI following receipt of HSIB report • Safety Recommendation - The HSIB clinical panel consider that an urgent neonatal review was indicated and there was a delay in calling for the neonatal team. It is not known if this had an impact on the outcome for the Baby.	• HSIB Investigation completed. Action plan developed and ongoing – focus on neonatal crash call escalation following unexpected neonatal collapse. • HSIB Safety recommendation challenged by the maternity team, but report upheld by HSIB
2021/4474	225710 HSIB	• A category 1 emergency caesarean section, placental abruption • Baby needed transferring to the neonatal unit and required active cooling. • Retrospective SI following receipt of HSIB report • Safety Recommendation – had the baby been delivered within the category 1 timescale , this may have made a difference to the outcome of the baby. Missed opportunity to transfer to theatre at an earlier time point as anaesthetic team available. Several emergencies simultaneously impacted on communication prioritisation between delivery suite and theatre teams.	• HSIB Investigation completed. Action plan developed and ongoing – focus on development of a new role to assist in management of high activity and escalation across maternity areas where required. Role commenced February 2020.
2021/6701 (72 hr brief sent to Divisional team)	239973	• Acute collapse and risk of hypovolaemic cardiac arrest secondary to major maternal haemorrhage. • Ultrasound scans did not diagnose that the pregnancy had implanted in a rudimentary uterine horn	• Potentially two opportunities to identify issue and instigate different management plan • Immediate actions – Independent practioner temporarily suspended from undertaking the procedure • Local RCA ongoing.

2. Current Serious Incidents in progress

Maternity have 10 ongoing serious incidents.

Investigation in progress: 6 incidents (5 local RCA, 1 HSIB)
Investigation completed, awaiting to be presented and closed by CCG SI Group: 4 incidents

3. Current HSIB Cases

2 HSIB cases were referred in January (n=1) and February (n=1) 2021
1 was rejected and 1 is ongoing.

Ongoing HSIB investigation
Criteria HIE damage.

- HSIB contact with parents -Verbal consent from parents to continue investigation- baby remains unwell- Mum wishes to delay HSIB discussion until baby is more stable
- Delay in uploading notes due to new HSIB computer system – notes uploaded to EGRESS
- Chronology started

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	7th April 2021
Report Title:	Infection Prevention Board Assurance Framework Q4 2020/21	**Agenda Item:**	11
Author:	Helen Bucior, Infection Prevention Lead Nurse Emyr Philips , Associate Chief Nurse Infection Prevention/Deputy DIPC Claire Rylands, Associate Director of Corporate Governance		
Executive Lead:	Michelle Rhodes, Chief Nurse/DIPC		

Purpose of Report:

Assurance		Approval		Information	✓

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

Executive Summary:

Situation

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

Background

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

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

Assessment

- There continue to be a number of systems, processes and controls in place; however evidence of assurance monitoring has demonstrated some gaps which will be addressed through the action plans.

Progress

- Portacount fit test systems; Portacount machine and mask fit tester (on loan for 3 months) obtained by Infection Prevention Team via DHSC National test support team. The portacount is a quantitative test and uses specialised equipment to measure exactly how much air is leaking through the seal of a FFP3 mask
- Mask fit testing skill now available on Health Roster. This will enable areas to record fit testing electronically and also compile compliance data using this system. The mask fit testing certificate must continue to be completed and filed in the staff member personal folder

Key Recommendations:

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

University Hospitals of North Midlands NHS Trust

Infection Prevention and Control Board Assurance Framework

Quarter 4 – March 2021
2020/21

Summary Board Assurance Framework as at Quarter 1 2020/21

Ref / Page	Requirement / Objective	Risk Score				
		Q1	Q2	Q3	Q4	Change
BAF 1 Page 3	Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users.	High 9	High 9	High 9	Mod 6	↓
BAF 2 Page 13	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	Mod 6	Low 3	Mod 6	Mod 6	→
BAF 3 Page 19	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	High 9	High 9	High 9	High 9	→
BAF 4 Page 22	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care, in a timely fashion.	Mod 6	Mod 6	Mod 6	Low 3	↓
BAF 5 Page 25	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	High 9	Low 3	Low 3	Low 3	→
BAF 6 Page 28	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	High 9	High 9	High 9	Mod 6	↓
BAF 7 Page 32	Provide or secure adequate isolation facilities.	Mod 6	Low 3	Mod 6	Low 3	↓
BAF 8 Page 34	Secure adequate access to laboratory support as appropriate.	Mod 6	Mod 6	Low 3	Low 3	→
BAF 9 Page 38	Have and adhere to policies designed for the individuals and provide organisations that will help prevent and control infections.	Mod 6	Low 3	Mod 6	Low 3	↓
BAF 10 Page 41	Have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	Mod 6	Mod 6	Mod 6	Low 3	↓

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

Risk Scoring								
Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3	3	2	There are a number of controls in place, however evidence of evidence of assurance monitoring has demonstrated some gaps which will be addressed through the action plan	Likelihood:	1	End of Quarter 4
Consequence:	3	3	3	3		Consequence:	3	
Risk Level:	9	9	9	6		Risk Level:	3	

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

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

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
		• Out patient flow chart in place • Thermal imaging cameras in some areas of the hospital • Iportal alert in place for COVID positive patients • Extremely vulnerable patient placement added into new COVID ward round guidelines (October 2020)		
1.2	Patients with possible or confirmed Covid-19 are not moved unless this is essential to their care or reduces the risk of transmission. There are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically imperative That on occasions when it is necessary to cohort COVID or non-COVID patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per guidance.	• All patients admitted to the Trust are screened for COVID -19 • All patients are rescreened on days 4-6 • Critical care plan with step down decision tree • COVID-19 Divisional pathways • Step down guidance available on COVID 19 intranet page • Barrier and Terminal clean process in place • IP PHE guidance • COVID Q+A available on Trust intranet	• Unannounced visits for clinical areas with clusters or HAI cases of COVID-19 • Review of HCAI COVID cases by IP Team • Datix /adverse incidence reports for inappropriate transfers	• NHSI key point 4 : Patients are not moved until at least two negative test results are obtained, unless clinically justified
1.3	Compliance with the national guidance around discharge or transfer of Covid-19 positive patients.	• Infection prevention step down guidance available on Trust intranet • All patients who are either positive or s	• Datix/adverse incidence reports	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
		are positives are advised to complete self –isolation if discharged or transferred within that time frame Patient Information Lealfet - Contact 202 uhnm-guidance-on-testing-and-re-testing- • All patients are screened 48 hours prior to transfer to care homes • New UHNM ward round guidance October 2020. This also included placement of the extremely vulnerable patient 4th-february-2021-covid-ward-round-guic		
1.4	**All staff (clinical and non-clinical)** are trained in putting on and removing PPE, know what PPE they should wear for each setting and context and have access to the PPE that protects them for the appropriate setting and context as per national guidance. Linked NHSIE Key Action 3: Staff wear the right level of PPE when in clinical settings, including use of face masks in non-clinical settings. Linked Key Infection Prevention points – COVID 19 vaccination sites	• Key FFP3 mask fit trainers in place in clinical areas • PPE posters and information available on the Trust COVID -19 page. This provides the what, where and when guide for PPE • Infection Prevention Questions and Answers Manual include donning and doffing information. • Areas that require high level PPE are agreed at clinical and tactical • Aerosol generating procedures (AGP's) which require high level PPE agreed at clinical and tactical group	• Daily stock level of PPE distributed via email and agenda item for discussion at COVID-19 tactical group • IP complete spot check of PPE use if cluster/OB trigger • Records of Donning and Doffing training for staff trained by IP • A number of Clinical areas have submitted PPE donning an doffing records to the IP team	• Training completed in areas - records are held locally by clinical areas, these include Divisional donning and doffing training records and Divisional FFP3 mask fit training records • FFP3 Training records require central holding/recording

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	Monitoring of IP practices, ensuring resources are in place to enable compliance with IP practice of staff adherence to hand hygiene? • Staff adherence to hand hygiene • Staff social distancing across the workplace • Staff adherence to wearing of fluid resistant surgical face masks • a) clinical • b) non clinical setting Monitoring of staff compliance with wearing appropriate PPE, within the clinical setting Consider implementing the role of PPE guardians/safety champions to embed and encourage best practice There are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace	• COVID -19 Clinical Group reviews any proposed changes in PPE from the clinical areas • Link to Public Health England donning and doffing posters and videos available on Trust intranet • Chief Nurse PPE video • Extended opening hours supplies Department • Risk assessment for work process or task analysis completed by Health and Safety • PHE announced from 11th June 2020 all staff to wear mask in both clinical and non-clinical health care setting • Matrons walk rounds • Specialised division summarised BAF and circulated to matrons • ACN's to discuss peer review of areas • Poster displayed in entrances and along corridors reinforcing the use of masks social distancing and one way systems • Catch it , bin in, kill it posters in ED waiting rooms	• Donning and Doffing training also held locally in clinical areas • Cascade training records held locally by Divisions • Sodexo and Domestic service training records • IP assurance visits • Review of UHNM vaccination areas against key infection prevention points COVID -19 • Hand hygiene audits	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
1.5	National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way.	• Notifications from NHS to Chief nurse/CEO • IP team COVID lead checks Public Health England webpage daily (Monday-Friday) for updates • Changes raised at -19 clinical groups which was held originally twice weekly, reduced to weekly and now increased back to twice weekly due to surge of COVID. • Purpose of the Clinical Group - The Group receive clinical guidance and society guidance which is reviewed and if agreed used to advise clinical teams after approval at Exec COVID -19 meeting which is held twice monthly. • Tactical group – The tactical Group held daily. The Group made decided and agreed tactical actions into the incident. • Chief nurse updates • Changes/update to staff are included in weekly Facebook live sessions • COVID -19 intranet page • COVID -19 daily bulletin with updates • IP provide daily support calls to the clinical areas	• Clinical Group meeting action log held by emergency planning	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
1.6	Changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted.	• Incidence Control Centre (ICC) Governance • Clinical Group , Divisional cells, Workforce Bureau , Recovery cells subgroup feed in to tactical group. • COVID Gold command , decisions /Assurance reported to Trust Board Via CEO Report/COO	• Meeting Action log held by emergency planning • Trust Executive Group Gold command – Overall decision making and escalation • Tactical, Operational Delivery Group - The delivery of the objectives and benefits, and programme communications COVID 19 response and R&R. Co - ordination of resources. Escalation forum for linked Groups and Cells ensuring that the interdependencies are effectively managed, including system. Makes recommendations to Gold Command for key decisions. • Clinical steering Group – Coordinate clinical decision – making to underpin continual service delivery and COVID 19 related care • Workforce Group – Lead the plan and priorities for our people recovery . Health and Wellbeing. Agree significant pipeline changes in working	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
			practices. Agree the impact if change made during COVID and priorities to support recovery • Divisional Groups – Agree infection Prevention measures  COVID19RRGOVERNANCE NOV20v1.pptx	
1.7	Risks are reflected in risk registers and the Board Assurance Framework where appropriate. • Linked NHSIE Key Action 5: Daily data submissions have been signed off by the Chief Executive, the Medical Director or the Chief Nurse and the Board Assurance Framework is reviewed and evidence of reviews is available. • Trust Board has oversight of on going outbreaks and actions plans • Linked NHSIE Key Action 9: Local Systems must assure themselves, with commissioners that a Trust's infection prevention and control interventions are optimal, the Board Assurance Framework is complete and agreed action plans are being delivered.	• Risk register and governance process • Datix incidents • Board assurance document standing agenda item Trust board and IPCC. • TOR • Outbreak IImarch submissions are copied to Chief Nurse/DIPC and exec Team • Outbreak areas are included in daily tactical meeting • Outbreak areas included in Gold update slides • Outbreak meetings attended by CCG and PHE • Definite Nosocomial COVID 19 case numbers are in included in Quality Performance Report • Nosocomial death review process	• IP risks are agenda item at Infection Prevention and Control committee (IPCC) • Definite Nosocomial COVID 19 case numbers are in included in Quality Performance Report • Nosocomial death review process – paper to Quality and Governance Committee 20th January 2021 • COVID themes report to IPCC	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	• There are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas	• Visiting /walk round of areas by executive/senor leadership team		
1.8	Robust IPC risk assessment processes and practices are in place for non Covid-19 infections and pathogens.	• IP questions and answers manual • Section in IP questions and answer manual 2.1 priority of isolation for different infections and organisms • Sepsis pathway in place • Infection Risk assessment in proud to care booklets and admission documentation • C.diff care pathway • IP included in mandatory training • Pre Amms IP Screening • Birmingham paused ribotyping service for C.DIFF due to COVID-19. During periods of increased incidence ribotyping is useful to establish person to person transmission, Leeds Hospital are now undertaking this service • Proud to care booklets revised an reinstated August/September 2020	• MRSA screening compliance • Monthly Sepsis Compliance audits. Screening compliance for sepsis and time to antibiotics for Red flag patients • IP audits • Infection Prevention Health care associated infection report, including submitted to monthly to Quality and Safety. • Submission of Infection figures to Public Health England. Clostridium difficile, MRSA blood stream infections (bacteraemia) and Gram Negative blood stream infections • Seasonal influenza reporting • Audit programme for proud to care booklets	• Universal MRSA Screening of all emergency admission in emergency portals paused due to COVID -19. Only MRSA weekly screening continued on critical care/HDU both adult and paediatric, haematology/oncology wards and renal ward, this is under review.

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

					22/12/2020 to Clinical Group for approval. Progressed to Outbreak Group and Tactical Group , minor changes made 12th December 2020 Submitted to Gold	
4	1.4	Improving staff FFP3 mask fit staff training data recording and retention of records.	Health and Safety	31/12/2020 – revised date 31/03/2021	Proposed Fit Testing compliance improvement Task and Finish Group. Inaugural meeting took place 29th July 2020. ESR will be up and running for the purpose of recording fit test records as soon as the Trust gives the go ahead to procure Portacount fit test systems, this is a project lead by Health and Safety As at 03/02/2021 People O&D have created FFP3 mask "classes" on ESR. Health and Safety are in the process of collating fit test records which were requested at Exec Health and Safety Groups from Divisional H&S Leads. Portacount Business case : Waiting Head of Health and Safety's go-ahead <u>10/03/2020</u> Portacount machine obtained (on loan) by Infection Prevention Team via Midlands Coordinator for the FFP3 Mask Project. Plus mask fit tester will be available to test staff using the portacount machine. The portacount is a quantitative test and uses specialised equipment to measure exactly how much air is leaking through the seal of a mask. ACN'S informed and response requested to aid in identifying testing priority. Midlands Coordinator is meeting IP next week to work through plan. Mask fit testing also continues using hood and bitrex (qualitative, relies on taste) Mask fit testing option also added to e rostering to enable areas to identify staff member that have been tested. A report can also be produced with compliance using this system. The mask fit	

					testing certificate must also continue to be completed and filed in the staff member personal folder. Updated mask fit strategy to March IPCC	
5.	1.4	Divisions to retain current mask fit training records and compliance score for their areas whilst central recording and retention of records process is agreed	ACN'S	30/09/2020	Associate Chief Nurse contacted and request made for assurance with staff mask fit compliance. Compliance also added to Divisional papers for infection Prevention and Control Committee (IPCC). Current process that clinical areas hold their own training records and can also enter basic details on OLM. A number of clinical areas have also forwarded training records to the IP Team. IP Team. IP have a list of mask fit testers.	
6.	1.8	Re instate admission proud to care documentation, currently emergency admission document in place	Deputy Director of Quality and Safety	30/09/2020	Original proud to care booklet reinstated now	
7.	1.8	To complete an analysis (Advantages and disadvantages) to reinstating MRSA screening as per UHNM policy	Deputy Director Infection Prevention	31/12/2020 – revised target date 31/03/2021	MRSA screening had reduced temporarily due to the COVID pandemic but UHNM are still following PHE 2014 guidance. This was an agreed temporary change in UHNM practice. Previously the Trust were screening over and above the 2014 guidance. Due to the COVID pandemic less elective work is taking place therefore less elective screening. High risk areas all still screen on admission. Risk based screening is for lower risk areas. Prior to the 2014 guidance the DIPC at the time (supported by the CCGs) did not want to reduce the screening policy the Trust already had in place. The CCG requested screening policy have to be approved by the CCGs. Discussed at IPCC. DIPC requested a pro's and con's exercise re screening changes due to the COVID pandemic. The Trust has not dropped below national guidance. October 2020 MRSA screening is around 50% of pre COVID screening, laboratory does not have the capacity to process COVID work and level of MRSA screens pre COVID. Paper to November IPCC. This continues to be under review during COVID Pandemic. <u>March 2021</u>	

					Screening for elective high risk surgery to resume This action continues to be under review during COVID Pandemic and surveillance of MRSA bacteraemia cases is on-going.	
6.	1.8	To explore an alternative laboratory for Clostridium difficile ribotying	Kerry Rawlin Laboratory	31/08/2020	Leeds Hospital has agreed to help with ribotyping Clostridium difficile specimens. Await first batch of results to gain assurance that process is working 04/09/2020 we are experiencing problems in receiving ribotyping results back from Leeds. Usually they would arrive electronically. UHNM have contacted Leeds and are awaiting a resolution with their IT team and the PHE reference electronic reporting system. Ribotype now being received from Leeds and added to ICNET patient case	

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

Risk Scoring								
Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	**2**	1	2	2	Whilst cleaning procedures are in place to ensure the appropriate management of premises further evidence to confirm compliance e.g. c4c audits to be reinstated	Likelihood:	**1**	End of quarter 4
Consequence:	**3**	3	3	3		Consequence:	**3**	
Risk Level:	**6**	3	6	6		Risk Level:	**3**	

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
2.2	Designated cleaning teams with appropriate training in required techniques and use of PPE are assigned to Covid-19 isolation or cohort areas. Assurance processes are in place for monitoring and sign off terminal cleans as part of outbreak management	• SOP and cleaning method statements for domestic teams/Sodexo • PPE education for Domestic /Sodexo staff • Initial meetings held with facilities/estates to discuss and plan COVID-19 requirements IP agenda item • Representatives from the division are attending the daily tactical meetings, and an E,F & PFI daily meeting is taking place which includes our partners • Discussed at March Matrons meeting. To ensure terminal cleans are signed off by the Nurse in Charge	• Clinical teams sign off any terminal cleans requested to say that clean has been completed to the agreed standard. • Spot check assurance audits completed by Sodexo and retained during COVID period • Cleanliness complaints or concerns are addressed by completing cleanliness audit walkabouts with clinical teams, and CPM / Sodexo. • PPE and FFP3 mask fit training records with are held by Sodexo /retained services • GREAT training record cards are held centrally by Sodexo for all individual domestics • Key trainers record • Notes from Sodexo Performance Monthly meeting , Sodexo Operational meeting , Divisional IP Meeting and facilities/estates meeting	
2.3	Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance.	• SOP for terminal and barrier cleans in place and was reviewed in February 21.	• C4C audits reinstated July 2020 these results are fed into IPCC	

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
			should the environment become contaminated between scheduled cleans.	
2.5	Attention to the cleaning of toilets / bathrooms, as Covid-19 has frequently been found to contaminate surface in these areas.	• Cleaning schedules in place • Barrier cleans (increased cleaning frequency) process in place which includes sanitary ware and other frequent touch points	• Cleaning schedules are displayed on each ward • Additional ad-hoc cleaning requests can be requested by clinical teams 24/7 should the environment become contaminated between scheduled cleans.	
2.6	Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses.	• Virusolve and Tristel disinfectant used • Virusolve wipes also used during height of pandemic	• Evidence from manufacture that these disinfectants are effective against COVID -19 • Evidence of Virusolve weekly strength checks , held locally at ward /department level • IP checks that disinfectant is available during spot checks	
2.7	Manufacturers guidance and recommended product 'contact time' must be followed for all cleaning / disinfectant solutions / products.	• Contact times detailed in SOP and cleaning methods statements • Included in mandatory training • Included in IP Q+A • Disinfectant used routinely	• Monthly on-going training is completed with all domestic staff to ensure that core competencies such as cleaning effectively with chemicals is trained out on a frequent basis. • Where outbreaks are identified, regular staff who	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
			clean in this area have competency checks to ensure that they are following GREAT card training • Spot checks completed by CPM includes observation of cleaning techniques by the domestic staff.	
2.8	As per national guidance: • 'Frequently touched' surfaces, e.g. door / toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated more than twice daily and when known to be contaminated with secretions, excretions and bodily fluid. • Electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily. • Rooms / areas where PPE is removed must be decontaminated, timed to coincide with periods immediate after PPE removal by groups of staff (at least twice a day). Linked NHSIE Key Action 1: All high touch surfaces and items are decontaminated multiple times every day – once or twice a day is insufficient.	• Cleaning of frequently touch points included in Barrier clean process • Offices and back offices also supplied with disinfectant wipes to keep work stations clean. • Non- invasive medical equipment must be decontaminated after each use. IP Q+A manual	• IP checks • Barrier clean request log • Terminal clean request log • Additional ad-hoc cleaning requests can be requested by clinical teams 24/7 should the environment become contaminated between scheduled / barrier cleans. • Non-clinical areas are cleaned at regular frequencies through the day especially sanitary ware, and if additional cleans are required between scheduled cleaning, these can be requested via the helpdesk.	• To check protocol for none barrier clean areas and also electronic equipment
2.9	Linen from possible and confirmed Covid-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken.	• Included in IP questions and answers manual • Linen posters depicting correct	• IP audits held locally by divisions • Datix reports/adverse	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		linen bag displayed in clinical areas and linen waste holds • Red alginate bags available for infected linen in the clinical areas • Infected linen route	incidents	
2.10	Single use items are used where possible and according to single use policy.	• IP question and answers manual • Medical device policy • SOP for Visor decontamination in time of shortage	• IP audits held locally by divisions	
2.11	Reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance.	• IP question and answers manual covers decontamination • Air powered hoods – SOP in place which includes decontamination process for the device • Re usable FFP3 Masks – Sundstrom/Elipse. SOP's in place which includes the decontamination process • Medical device policy • Availability of high level disinfectant in clinical areas • Sterile services process • Datix process	• IP audits held locally by divisions • Datix reports/adverse incident reports	
2.12	Review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission. Ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to	• HTM hospital ventilation • UHNM has established a Ventilation Safety Group as recommended by the Specialised Ventilation for Healthcare Society in order to provide assurance to the Trust Board on the safe operation and	• Estates have planned programme of maintenance • The Authorising Engineer Ventilation will provide external independent specialist advice and support as well as carrying	

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

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	**KLOE**	**Action Required**	**Lead**	**Due Date**	**Quarter 4 Progress Report**	**BRAG**
1.	2.3	To re instate C4C cleanliness audits and patients survey	Head of CPM Estates, Facilities & PFI Division	30/09/2020	Soft FM cleaning services and Sodexo recovery plan in place which includes the process for reinstating the monitoring process and patient surveys which have commenced 6th July 2020. 04/09/2020 The C4C audits programme are now covering all areas but are not fully multi-disciplinary audit team e.g. only CPM on them due to social distancing. (yet to invite Sodexo, Nurse)We are likely to expand this out during October 2020 December 2020 – email confirmation from Sodexo and retained that C4C audits are in place 01/10/20 – Fully disciplinary team are now invited to C4C audits with strict social distancing in place at all times. Audits remain fluid to allow maximum access during the 3rd wave of Covid.	
2	2.4	To address cleaning issues and environmental damage highlighted during NHSI visit	Head of CPM Estates, Facilities & PFI Division	14/12/2020	Feedback from NHSI provided to Sodexo and action plan devised  Action Plan Following NHS England NHS Im  NHSI action plan Feb 2021.docx	
3	2.4	To address dirty nursing equipment and commodes, plus computer on wheels	ACN'S / IP/ Deputy Head of IM&T	30/12/2020 – revised target date for Computers on Wheels 31/04/2021	Dirty nursing equipment and commodes found during NHSI Visit. These were address at time. Action for IM&T re computer. Terminal clean check list to be revisited to set out roles and responsibilities for cleaning. Full ward terminal clean check list agreed by IP , Sodexo /retained and County. IT have reviewed a number of computers on wheels and confirmed high level of dust. The computer is housed is a box and would require to be unlocked and vacuum, IT have identified that there is a danger that the cables can be disturbed during this process. The two companies used by UHNM Ergotron and Parity do not offer a cleaning service	

					IT have contacted clinical technology to see if they can provide cleaning service For the air intakes that have dust collection this would require a wipe over 18/02/2021 – Feedback from IM&T. They are chasing cost associated with cleaning of COW's 03/03/2021 – Feedback from IM&T cost still awaiting. They are chasing. Outside of COW and parts that can be seen are cleaned by the clinical staff 15/03/2021 Cleaning of internal parts of COW IM&T have raised this to a COW provider and they are providing a cost to clean the devices. In addition reached out to an internal UHNMM cleaning team to gain a cost 16/03/2021 – Costing back from external company for cleaning internal parts of COW, next stage to be agreed	
4	2.8	All high touch surfaces and items are decontaminated multiple times every day – once or twice a day is insufficient. • Electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily. • Cleaning of communal toilets after each use inpatient areas – Letter -CEM/CMO /2020/043 24TH December 2020	Head of CPM Estates, Facilities & PFI Division IP Team	31/03/2021 revised 30/04/2021	To revisit high touch points protocol to check frequency of clean for area that area not on barrier cleans – computers , mobile phones, keyboards Cleaning of communal toilets after each use inpatient areas – Letter -CEM/CMO /2020/043 24TH December 2020. This letter was raised at IPCC 25/01/2021. 16th February Meeting with IP & Facilities colleagues to discuss the NHS/NHSE/PHE facilities cleaning requests in line with COVID 19 – letter CEM/CMO 24th December 2020 Hefma network Responses/Scoping exercise completed Trust position work in progress. Paper to next IPCC Additional cleaning resource in place for ED Royal Stoke and overnight at County this requirement has been extended for a further 3 months Wheelchair cleaning stations also installed across both sites Clinical areas aware of the need to decontaminate high touch points such as desk top phones and keyboards	

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

Risk Scoring								
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	**3**	**3**	**3**	**3**	Whilst there are controls and assurances place some of the finding of the antimicrobial audits demonstrate area of non-compliance therefore further control are to be identified and implemented in order to reduce the level of risk	**Likelihood:**	**2**	End of quarter 4 (revised date Q1 2021)
Consequence:	**3**	**3**	**3**	**3**		**Consequence:**	**3**	
Risk Level:	**9**	**9**	**9**	**9**		**Risk Level:**	**6**	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
Systems and processes are in place to ensure:				
3.1	Arrangements around antimicrobial stewardship are maintained.	• Regular, planned Antimicrobial stewardship (AMS) ward rounds • Trust antimicrobial guidelines available 24/7 via intranet and mobile device App • Clostridium *difficile* Period of increased incidence and outbreaks are reviewed by member of AMS team and actions generated cascaded to ward teams • Regional and National networking to ensure AMS activities are optimal • Formal regional meetings and informal national network activities • AMS CQUIN further mandates key AMS principles to be adhered to • All national CQUINS currently	• Same day escalation to microbiologist, if concerns. Outcome recorded on I portal • Metric available around the number of times App accessed by UHNM staff • Compliance with guidelines and other AMS metrics reported to Infection prevention and control Committee (IPCC) • Meeting minutes reviewed and actions followed up • Real time discussions / requests for support / advice enabled via regional and national social media accounts. National (incl. PHE) thought leaders members	• Further controls required due to elements of non - compliance with audits • Gap in control identified as there is no current escalation of areas not complying with antimicrobial guidelines. • New escalation process being formulated. Currently under review by ASG

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

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	**KLOE**	**Action Required**	**Lead**	**Due Date**	**Quarter 4 Progress Report**	**BRAG**
1.	3.1	Further controls are required to improve compliance	ACN'S	31/12/2020 - revised target date 30/04/2021	Antimicrobial audits results discussed at IPCC 27th July 2020. Separate meeting with chief nurse/IP and ACN's to be arranged during August to discussed results and any corrective actions. Feedback meeting completed 4th September 2020. – Senior meeting. To review escalation of areas that are not compliant with antimicrobial guidelines. New point prevalence audits undertaken by AMS pharmacists during December 2020 to provide updated snapshot for ACNs. Results will be discussed at March IPCC meeting 31/03/2021 Following discussion of these results at March 2021 IPCC a meeting has been arranged between Chief Nurse, deputy DIPC, lead AMS pharmacist and lead AMS microbiologist to discuss ways in which divisions can be supported to improve their stewardship performance. Individual clinical areas can be identified from Pharmacy audit data. Meeting date 15.4.21	
2.	3.1	To review current escalation of areas that are not compliant with antimicrobial guidelines	DIPC	31/10/2020 - revised target date 30/04/2021	Raised at September Antimicrobial Pharmacist Group and IPCC. Escalation process to be agreed. Meeting between Antimicrobial Pharmacist and Deputy DIPC undertaken. Escalation process to be discussed at November Antimicrobial Stewardship Group. January 2021 discussed at Trust Board to be discussed at ASG, then to IPCC Following discussions between DIPC and AMS Pharmacist a draft escalation protocol has been produced and was presented at January ASG as the November meeting cancelled (clinical pressures) the group have 2 weeks to review. Will thereafter to be forwards to IPCC for discussion and ratification at the March IPCC meeting. 31/03/2021 The draft escalation protocol was approved at March ASG. It will be shared with Chief Nurse and Deputy DIPC at meeting above (15.4.21) and target wards will be identified.	

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

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

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

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
		other PPE if they are providing bedside care. We will continue to monitor prevalence and changes in visiting restrictions will be reinstated with immediate effect should it be necessary • The only exceptional circumstances where on visitor , an immediate family member or care will be permitted to visited are listed below- • The patient is in last days of life- palliative care guidance available on Trust intranet • The birthing partner accompany a women in established labour • The parent or appropriate adult visiting their child • Other ways of keeping in touch with loved ones e.g. phone calls , video calls are available • EOL visiting guidance in place • March 2021 Visiting guidance inpatient during COVID 19 pandemic: principles discussed at Clinical Group and tactical • COVID-19 information available on UHNM internet page		
4.2	Areas in which suspected or confirmed Covid-19 patients are being treated are clearly marked with appropriate signage and have restricted access.	• ED colour coded areas are identified by signs • Navigator manned ED entrance • Hospital zoning in place	• Daily Site report for county details COVID and NON COVID capacity	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		• Isolation signs for doors		
4.3	Information and guidance on Covid-19 is available on all trust websites with easy read versions.	• COVID 19 section on intranet with information including posters and videos	• COVID-19 page updated on a regular basis	
4.4	Infection status is communicated to the receiving organisation or department when a possible or confirmed Covid-19 patient needs to be moved.	• Transfer policy C24 in place , expires November 2020 • IP COVID step down process in place	• Datix process	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter Progress Report	BRAG
1.	4.4	To include COVID-19 in transfer policy	Deputy Director of Quality and Safety	31/12/2020	3rd August Meeting arranged between IP and Quality and Safety to commence review of transfer policy to include COVID -19. Policy for the Handover, Transfer and Escort Arrangements of Adults patients between wards and Departments which Expires November 2020. October IP have now submitted IP/COVID information for incorporation in to this Policy.	

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

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
5.1	Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed Covid-19 symptoms and to segregate them from non Covid-19 cases to minimise the risk of cross-infection as per national guidance. Screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases. Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from Non Covid-19	• ED navigator records patient temperature and asked screening questions. Patient then directed to colour coded area • All patients who are admitted are now screened for COVID 19	• June 2020 IP team review patients that are found COVID positive and nursed in bay to ascertain compliance with pathway and IP control measures are in place Review pathways and identify theme . COVID 19 -Themes report to IPCC • ED pathways including transfer of COVID positive patient from County to Royal Hospital	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	Staff are aware of agreed template for triage questions to ask Triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible			
5.2	Mask usage is emphasized for suspected individuals. Face masks are available for all patients and they are always advised to wear them Provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients (particularly when moving around the ward) if this can be tolerated and does not compromise their clinical care Monitoring of Inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so)	• Use of mask for patients included in IP COVID -19 • question and answers manual • All staff and visitors to wear masks from Monday15th June • ED navigator provide masks to individual in ED • Mask stations at hospital entrances • Covid-19 bulletin dated 12th June 2020 • 28th August updated guidance from PHE recommends in patients to also wear surgical masks if tolerated and does not compromise care • IP Assurance visits • Senior walk rounds of clinical areas • Matrons daily visits	• Hospital entrances Mask dispensers and hand gel available	• Face mask leaflet produced for patients, awaiting approval • CAN/Matrons to monitor/process to monitor
5.3	Ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff. Linked NHSIE Key Action 6: Where bays with	• Colour coded areas in ED to separate patients, barriers in place. • Screens in place at main ED receptions • Colour coded routes identified in ED • Social distancing risk assessment in place	• Division/area social distancing risk assessments	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	high numbers of beds are in use, these must be risk assessed, and where 2m can't be achieved, physical segregation of patients must be considered and wards are effectively ventilated.	• Perspex screens agreed through R+R process for other reception area • Social distance barriers in place at main reception areas • Chief Nurse/DIPC visited clinical areas to review social distancing within bays. A number of beds have been removed throughout the Trust.		
5.4	For patients with new-onset symptoms, it is important to achieve isolation and instigation of contact tracing as soon as possible.	• Process for isolation symptom patient in place • Process for cohorting of contacts • Contacting patients who have been discharged from hospital then later found to be a close contact of a COVID-19 positive case , patient to be informed by the clinical area and self- isolation advice provided as per national guidance • https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance/stay-at-home-guidance-for-households-with-possible-coronavirus-covid-19-infection	• If patient found to be positive in the bay and exposing other patient. IP liaise with clinical are, apply bay restrictions. • Patient who tested negative on admission and remain an inpatient are retested for COVID days 4 and 6	
5.5	Patients with suspected Covid-19 are tested promptly.	• All patients who require overnight stay are screened on admission. All patients that test negative for COVID 19 are retested on day 4 and 6	• Adverse incident monitor /Datix	
5.6	Patients who test negative but display or go on to develop symptoms of Covid-19 are segregated and promptly re-tested and contacts traced.	• Screening protocol discussed at Clinical group which includes re testing • Inpatient contacts are cohorted • COVID 19 positive patients are cared for on blue wards or single rooms or COVID 19 cohort areas on critical care unit	• Datix process • IP reviews	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
5.7	Patients who attend for routine appointments and who display symptoms of Covid-19 are managed appropriately.	• Restoration and Recovery plans • Thermal temperature checks in imaging, plan to extent to other hospital entrances • Patient temperature checks in outpatient department • Mask or face coverings for patients attending appointments from Monday 15th June	• Datix process	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	**KLOE**	**Action Required**	**Lead**	**Due Date**	**Quarter 4 Progress Report**	**BRAG**
1.	5.1	Up- to- date COVID -19 Divisional pathways	ACN's	30/09/2020	Associate Chief Nurse contacted and request made for COVID -19 pathways 28th July 2020. ED pathways in place and also County to Royal transfer of COVID positive patients. Divisional recovery plans and identification of COVID wards due to second wave continues.	
2.	5.4	Process for contacting patients who have been discharged home and have then been found to in close contact with a COVID -19 positive patient during their stay	Deputy of Director Infection	31/08/2020	IP guide liaise with clinical areas to identify closed contacts, close contact are isolated for remainder of hospital stay for 14 day or if discharged home continue isolation at home. Clinical team inform patient who have already been discharged COVID intranet page. October COVID -19 ward round guidance	
3.	5.7	Process to monitor patients who attend routine appointments who display symptoms of COVID-19 are managed appropriately	ACN'S	31/07/2020	Thermal camera located in a number outpatient areas – with SOP if patient triggers. Script in place for scheduling outpatient/ investigations	
4.	5.2	Face masks are available for all patients and they are always advised to wear them	IP/ACN's	31/03/2021 Revised target date 16th April	Face mask leaflet produced to be submitted for ratification on 14th April 2021. To be submitted to tactical /clinical group week beginning 15th March. Can be used prior to ratification as trial	
5	5.4	Monitoring of Inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so)	ACN's/Matrons	on-going	Assurance for monitoring of inpatient compliance with wearing face masks. Matrons daily walk round	

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

Risk Scoring								
Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3	3	2	Whilst information and communication/controls are in place to ensure staff are aware of their responsibilities spot audits undertaken have demonstrated some gaps in compliance	Likelihood:	1	End of Q4
Consequence:	3	3	3	3		Consequence:	3	
Risk Level:	9	9	9	6		Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
	Separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas	• To be confirmed	• To be confirmed	
6.1	All staff (clinical and non-clinical) have appropriate training, in line with the latest PHE and other guidance, to ensure their personal safety and working environment is safe.	• PPE discussed at tactical group • Training videos available • FFP3 mask fit key trainers • Donning and Doffing posters, videos and PHE available on Covid-19 section of Trust intranet	• Tactical group action log • Divisional training records • Mandatory training records	
6.2	All staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation, and on how to safely don and doff it.	• PPE and standard precautions part of the infection prevention Questions and Answers manual. • FFP3 train the trainer	• Training records • IP spot checks	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		programme in place • Trust mask fit strategy • SOP and training for reusable FFP3 masks • SOP and training for use of air powered hoods • Critical care - Elipse FFP3 reusable introduced • PPE posters are available in the COVID -19 section of trust intranet page		
6.3	A record of staff training is maintained.	Mask fit strategy in place	• FFP3 training records entered onto OLM and held on L drive for those trained by the infection prevention team • Training records held locally by the Clinical areas	• FFP3 Mask Training records held locally by divisions for training completed by key trainers in the clinical areas • OLM captures that staff member attended IP training session but not the outcome e.g. passed or failed mask fit training
6.4	Appropriate arrangements are in place so that any reuse of PPE is in line with the CAS Alert is properly monitored and managed.	• SOP in place for reuse of visors • SOP in place for use of air powered filters systems plus key trainers • SOP in place for the care of reusable FFP3 masks (Sundstrum))	• SOP 's available on Trust intranet • Training logs held divisionally for air powered systems • IP training log for air powered systems key trainers and distribution of reusable FFP3 masks (Sundstrum)	
6.5	Any incidents relating to the re-use of PPE are monitored and appropriate action taken.	• PPE standard agenda at COVID Tactical meeting • Datix process • Midlands Region Incident	• Tactical group action log • Datix process • Incidents reported by procurement to centre PPE	

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace • Frequent decontamination of equipment and environment in both clinical and non-clinical areas • clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas • Guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas	part of OB investigation process • Communications reminding staff re car sharing • IP Q+A decontamination section • COVID Q+A • Wearing of mask posters displayed throughout the Trust • Advise and videos' on the Trust internet page • Hand hygiene posters /stickers on dispenser display in public toilets	• Cleanliness audits • IP environmental audits • Quarterly audits conducted and held by the clinical areas	
6.8	The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance Guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas	• Paper Towels are available for hand drying in the Clinical areas	• IP audits to check availability	
6.9	Staff understand the requirements for uniform laundering where this is not provided on site.	• Instruction for staff laundering available on the Trust COVID - 19 section of intranet • Dissolvable bags to transport	• Clinical areas to monitor • Reports of member of public reporting sighting of staff in uniform	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		uniforms home available for staff • Communications /daily bulletin to remind staff not to travel to and from work in uniforms		
6.10	All staff understand the symptoms of Covid-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household displays any of the symptoms.	• For any new absences employee should open and close their usual absence via Empactis system • Symptom Advice available on Trust intranet	• Cluster /outbreak investigations	
6.11	All staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE and other national guidance if they or a member of their household display any of the symptoms	• Communication /documents • Reminders on COVID bulletins Trust intranet • Staff Lateral flow testing	• Cluster /outbreak investigations	
6.12	A rapid and continued response through on- going surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patient/individuals)	• ICNET surveillance system • Reports • Trust wide daily COVID Dashboard/report • COVID -19 Tactical daily briefing	• COVID Dashboard • COVID -19 Tactical daily briefing • COVID 19 Gold update slides	
6.13	Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	• ICNet surveillance system • Reports	• Theme report IPCC • RCA review on selected cases	
6.15	Robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of outbreak meetings.	• ICNet surveillance system • Daily COVID reports of cases	• Outbreak investigation • Outbreak minutes	

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 4 Progress Report	BRAG
1.	6.3	Improving staff FFP3 mask fit staff training data recording and retention of records	Health and Safety	31/12/2020 - revised target date 31/03/2021	Proposed Fit Testing compliance improvement Task and Finish Group. Inaugural meeting planned for 29th July 2020. ESR will be up and running for the purpose of recording fit test records as soon as the Trust gives the go ahead to procure Portacount fit test system as this is part of the project lead by Health and Safety. December 2020 Health and Safety have agreement to proceed to Business case As at 03/02/2021 People O&D have created FFP3 mask "classes" on ESR. Health and Safety are in the process of collating fit test records which were requested at Exec Health and Safety Groups from Divisional H&S Leads. Business case : Waiting Head of Health and Safety's go-ahead 10/03/2020 Portacount machine obtained (on loan) by Infection Prevention Team via Midlands Coordinator for the FFP3 Mask Project. Plus mask fit tester will be available to test staff using the portacount machine. The portacount is a quantitative test and uses specialised equipment to measure exactly how much air is leaking through the seal of a mask. ACN'S informed and response requested to aid in identifying testing priority. Midlands Coordinator is meeting IP next week to work through plan.	

					In additional Mask fit testing also continues using hood and bitrex (qualitative, relies on taste) Mask fit testing option also added to e rostering to enable areas to identify staff member that have been tested. A report can also be produced with compliance using this system. The mask fit testing certificate must also continue to be completed and filed in the staff member personal folder. Updated mask fit strategy to March IPCC	
2	6.2	Spot audits of PPE on wards and Departments	Quality and Safety Team IP	ongoing	Audits are required on a weekly basis	

7. Provide or secure adequate isolation facilities.

Risk Scoring								
Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2	1	2	1	Isolation facilities are available and hospital zoning in place. Further work is currently being undertaken during next wave of COVID to identify next blue ward	Likelihood:	1	Quarter 4
Consequence:	3	3	3	3		Consequence:	3	
Risk Level:	6	3	6	3		Risk Level:	3	

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

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		available on COVID 19 intranet page		
7.2	Areas used to cohort patients with possible or confirmed Covid-19 are compliant with the environmental requirements set out in the current PPE national guidance.	• Areas agreed at COVID-19 tactical Group • Restoration and Recovery plans	• Action log and papers submitted to COVID-19 tactical and Clinical Group	
7.3	Patients with resistant / alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement.	• Infection Prevention Questions and Answers Manual includes alert organisms/resistant organism • Support to Clinical areas via Infection Prevention triage desk • Site team processes • Clostridium *difficile* report C diff report 2021.docx • Patients received from London to critical care unit – screening policy for resistant organisms in place	• RCA process for Clostridium *difficile* • CDI report for January Quality and Safety Committee and IPCC • Outbreak investigations • MRSA bacteramia investigations • Datix reports	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 4 Progress Report	BRAG
1.	7.1	ED to align with inpatient zoning model	ED leads	18/09/2020	Both sites have remodel ED areas. Corridor ED Royal review planned	
2.	7.1	Strict adherence to policy re patient isolation	Site	Daily	inappropriate patient moves reported via Datix. Discuss at	

		and cohorting	teams/ward teams	process	outbreak meetings as necessary	
3.	7.3	Clostridium *difficile* report to Quality and Safety Committee and IPCC	IP	31/01/2021	Report prepared with antimicrobial analysis included and presented at both committee's Jan 2021	

8. Secure adequate access to laboratory support as appropriate.

Risk Scoring								
Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2	2	1	1	Laboratory services for UHNM are located in the purpose built Pathology Laboratory on-site at RSUH. The Laboratory is United Kingdom Accreditation Service (UKAS) accredited. Work is currently in progress to improve COVID-19 swab screening for clinical staff to improve the risk of false COVID-19 negative results.	Likelihood:	1	End of Q4
Consequence:	3	3	3	3		Consequence:	3	
Risk Level:	6	6	3	3		Risk Level:	3	

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

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 NHS patient facing staff is implemented. Whilst lateral flow technology is the main mechanism for staff testing, this can continue to be used alongside PCR and LAMP testing. b) If your Trust has a high nosocomial infection rate you should undertake additional targeted testing of all NHS Staff, as recommended by your local and regional infection prevention and control team. Such cases must be appropriately recorded, managed and reported back. Linked to NHSIE Key Action 8: Patient Testing: a) All patients must be tested at emergency admission, whether or not they have symptoms. b) Those with symptoms of Covid-19 must be retested at the point symptoms arise after admission. c) Those who test negative upon admission must have a second test 3 days after admission and a third test 5 – 7 days post admission. d) All patients must be tested 48 hours prior to discharge directly to a care home and must only be discharged when the test result is available. Care home patients testing positive can only be discharged to CQC designated facilities. Care homes must not accept discharged patients unless they have that persons test result	endoscopy • Process in place for staff screening via empactis system and Team Prevent • Patients who test negative are retested after 5 days. • Patient who develop COVID symptoms are tested • Staff screening instigated in outbreak areas • November 2020 - Lateral flow device staff screening to be implemented to allow twice weekly. Staff are asked to submit results via text. Jan 2021 Recent communications on COVID bulletin to remind staff to submit results • Questions and answers available on the COVID 19 page Trust intranet re lateral flow including actions to take for reporting both a negative or positive result • All patient discharged to care setting as screened 48 hours prior to transfer/discharge • Designated care setting in place for positive patients requiring care facilities on discharge – Trentham Park		

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	and can safely care for them. **e)** Elective patient testing must happen within 3 days before admission and patients must be asked to self-isolate from the day of the test until the day of admission. There is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control and testing document • That sites with high nosocomial rates should consider testing COVID negative patients daily. • That those being discharged to a care facility within their 14 day isolation period should be discharged to a designated care setting, where they should complete their remaining isolation.	• Reviewed as part of outbreak investigation • Matrons and ACN'S aware of retesting requirement • Not required currently but kept under review • Patients are tested as part or outbreak investigation • Designated home identified- Trentham Park		
8.3	Screening for other potential infections takes place.	• Screening policy in place, included in the Infection Prevention Questions and Answers Manual	• MRSA screening compliance • Prompt to Protect audits completed by IP • Spot check for CPE screening	• Blanket screening for MRS A paused due to COVID -19

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	**KLOE**	**Action Required**	**Lead**	**Due Date**	**Quarter 2 Progress Report**	**BRAG**
1.	8.1	Champions COVID-19 swabbing technique in clinical areas	Deputy Director if infection Prevention	on-going	Training package and recording system to be devised. Work to commence. 1st September swabbing video recorded, minor changes to be completed week commencing 14th September then video will be circulated to key people for preview and comments. Child positioning included in video Screening video now complete and uploaded on to Trust intranet November 2020. A number of areas have identified swabbing Champions, request sent to ACN's. Implementation of champions in progress.	
2	8.2	NHSIE Key Action - Those who test negative upon admission must have a second test 3 days after admission and a third test 5-7 days post admission	Microbiologist/IP Team	07/12/2020	Following NHSI new guidance Those who test negative for COVID on admission are to be retested on day 4 and day 6, with admission day counted as day one. Implementation of this is underway and prompt is provided to clinical areas	
3	8.2	Those who test negative upon admission must have a second test 3 days after admission and a third test 5 days post admission	Deputy Chief Nurse	07/12/2020	Report received by Deputy Chief Nurse on a daily basis with list of patients that are due for re screen. Clinical areas then contacted and prompt to re screen.	
4.	8.3	To complete an analysis (Advantages and disadvantages) to reinstating pre COVID 19 UHNM screening policy	Deputy Director if infection Prevention	31/12/2020 -revised target date 31/04/2021	MRSA screening had reduced temporarily due to the COVID pandemic but UHNM are still following PHE 2014 guidance. This was an agreed temporary change in UHNM practice. Previously the Trust were screening over and above the 2014 guidance. Due to the COVID pandemic less elective work is taking place therefore less elective screening. High risk areas all still screen on admission. Risk based screening is for lower risk areas. Prior to the 2014 guidance the DIPC at the time (supported by the CCGs) did not want to reduce the screening policy the Trust already had in place. The CCG requested screening policy have to be approved by the CCGs. Discussed at IPCC. DIPC requested a pro's and con's exercise re screening changes due to the COVID pandemic. The Trust has not dropped below national guidance. October MRSA screening is around 50% of pre COVID screening; laboratory does not have the capacity to process COVID work	

					and level of MRSA screens pre COVID. Paper to November IPCC. This continues to be under review during COVID Pandemic. Feb 2020 This continues to be under review during COVID pandemic <u>March 2020</u> Elective screening for high risk surgery and overnight surgery to resume MRSA bacteraemia surveillance continues	

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

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

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
9.1	Staff are supported in adhering to all IPC policies, including those for other alert organisms.	• IP included in mandatory update • Infection Prevention Questions and Answers manual with ICON on every desk top for ease of use • Infection Prevention triage desk which provides advice and support to clinical areas	• IP audit programme • Audits undertaken by clinical areas • CEF audits • Proud to care booklet audits	• NHSI visit highlighted a number of staff none compliant to wearing of masks , and Doctor non compliant with Bare below the elbow
9.2	Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff.	• Notifications from NHS to Chief nurse/CEO • IP team COVID lead checks Public Health England webpage daily (Monday-Friday) for updates • Changes raised at COVID clinical group which is held twice weekly • Daily tactical group • Incident control room established where changes are reported through • Chief nurse updates	• Clinical Group meeting action log held by emergency planning	

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

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

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 2 Progress Report	BRAG
1.	9.1	CEF Audits to recommence	Deputy Director of Quality and Safety	30/09/2020	Review of tool kit with Chief Nurse planned, aiming to trial during August and reinstate audits fully during September 2020. CEF audits reinstated.	
2.	9.1	Proud to care booklet audits paused. Plan for recommencing	Deputy Director of Quality and Safety	30/9/2020	Original proud to care booklets reinstated	
3.	9.1	Compliance with correct mask wearing and Doctors complaint with Bare Below the Elbow	Deputy DICP/Medical Director/ ACN's	on-going	NHSI Action plan devised. Senior walk rounds of clinical areas in place.	

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

Risk Scoring								
Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2	2	2	1	There are clear control in place for management of occupational needs of staff through team prevent to date	Likelihood:	1	End of Quarter 4
Consequence:	3	3	3	3		Consequence:	3	
Risk Level:	6	6	6	3	Adhere to social distancing gaps in adherence	Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
10.1	Staff in 'at risk' groups are identified and managed appropriately, including ensuring their physical and psychological wellbeing is supported. That risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic and pregnant staff	• All managers carry our risk assessment • Process available on the COVID 19 Trust intranet page • BAME risk assessment • Young persons risk assessment • Pregnant workers risk assessment • Risk assessment to identify vulnerable workers	• Risk assessment and temporary risk mitigation will be reported to the workforce bureau. To protect confidentiality individual risk assessments will not be requested as these should be kept in the employees personal file • Managers required to complete , review and update risk assessments for vulnerable persons	

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board			
10.3	Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the crossover of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance.	• Restore and Restorations plans	• Incidence process/Datix	
10.4	All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas. Linked NHSIE Key Action 2: Staff maintain social distancing in the workplace, when travelling to work (including avoiding car sharing) and to remind staff to follow public health guidance outside of the workplace.	• Social distancing tool kit available on COVID 19 intranet page • Site circulation maps • Keep your distance posters • COVID-19 secure declaration • Social distancing risk assessment guidance for managers presentation 5th June2020 • Meeting room rules • Face masks for all staff commenced 15th June • Visitor face covering • COVID secure risk assessment process in place • November 2020 – Care sharing instructions added to COVID	• Social distance monitor walk round introduced Friday 5th June • Social distance department risk assessments • COVID-19 secure declarations	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		Bulletin		
10.5	Consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas.	• Social distancing tool kit • Staff encouraged to keep to 2 metre rule during breaks • Purpose build rooms for staff breaks in progress	• Social distance monitor walk rounds • Social distance posters identify how many people allowed at one time in each room	
10.6	Staff absence and wellbeing are monitored and staff who are self-isolating are supported and able to access testing.	• Team Prevent available to offer guidance and treatment to staff presenting with onset of symptoms.	• Team prevent monitoring process • Work force bureau	
10.7	Staff who test positive have adequate information and support to aid their recovery and return to work.	• Team Prevent available to offer guidance and treatment to staff presenting with onset of symptoms. • Empactis line will first ask – is the absence related to coronavirus. To which the employee must say yes or no • Once the absence is reported to the employees manger via email, the manager will categorise the absence type specified in the flow chart. • Team prevent complete COVID 19 staff screening • Areas where transmission has occurred are discussed at clinical group and relevant staff screening under an ILOG number is agreed. • Flow charts or staff returning to work available on COVID 19 section of intranet	• Via emapactis • Staff queries' through workforce bureau or team prevent	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	**KLOE**	**Action Required**	**Lead**	**Due Date**	**Quarter 4 Progress Report**	**BRAG**
1.	10.2	Improving Staff FFP3 mask fit recording and retention of records	Health and Safety	31/12/2020 – revised target date 31/03/2021	Proposed fit testing compliance improvement task and finish group Inaugural meeting planned for 29th July 2020. ESR will be up and running for the purpose of recording fit test records as soon as the Trust gives the go ahead to procure Portacount mas k fit systems as this is part of the project lead by Health and Safety case As at 03/02/2021 People O&D have created FFP3 mask "classes" on ESR. Health and Safety are in the process of collating fit test records which were requested at Exec Health and Safety Groups from Divisional H&S Leads. Business case : Waiting Head of Health and Safety's go-ahead <u>10/03/2020</u> Portacount machine obtained (on loan) by Infection Prevention Team via Midlands Coordinator for the FFP3 Mask Project. Plus mask fit tester will be available to test staff using the portacount machine. The portacount is a quantitative test and uses specialised equipment to measure exactly how much air is leaking through the seal of a mask. ACN'S informed and response requested to aid in identifying testing priority. Midlands Coordinator is meeting IP next week to work through plan. In additional m ask fit testing also continues using hood and bitrex (qualitative, relies on taste) Mask fit testing option also added to e rostering to enable areas to identify staff member that have been tested. A report can also be produced with compliance using this system. The mask fit testing certificate must also continue to be completed and filed in the staff member personal folder.	

					Updated mask fit strategy to March IPCC	

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

Performance and Finance Chair's Highlight Report to Board

23rd March 2021

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Committee members expressed their disappointment that business case reviews had not been undertaken as planned, for as long as indicated in the report, given the scale of investment made • A verbal update was provided by the Executive Infrastructure Group and a risk was highlighted in terms of an issue with infusion pump consumables which would be reported to the Quality Governance Committee. In addition an update in terms of the timeline for presenting the Medical Equipment Strategy to the Committee was provided.	• To circulate the NHSIE funding assumptions to members of the Committee • To confirm the approach and rationale in deciding which business cases would be reviewed • To provide the cancer assurance document to the Committee in due course • To continue to provide the update in respect of the proposed emergency care standards within the Integrated Performance Report and to consider whether median length of time in the Department could also be reported • To provide a reconciliation of the cash position and year end forecast • To provide an update of the Galcanezumab business case, 6 months from commencement of the service and include on the business cycle going forwards • To provide the Business Intelligence Strategy to the Committee in April
Positive Assurances to Provide	**Decisions Made**
• There continued to be a significant reduction in the Covid footprint within the organisation and critical care had reduced to 80% occupancy • An update was provided in terms of commencing with restoration of services; the Committee questioned the ability to treat all P2 patients by the end of quarter 1 although it was expected that normal operating (as seen in September 2020) would fully resume by May • The progress made in delivering the IM&T Strategy was highlighted, the Committee referred to a number of risks in relation to some of the projects being undertaken and assurance was provided in terms of the planned, phased approach to implementing the various changes whilst at the same time protecting the Trust • The Committee received a positive update in terms of the changes being made across the urgent care portals to make sustained, improved urgent care performance • In terms of month 11 cancer performance, it was noted that the backlog had increased slightly but improved performance was expected in April and trajectories were being developed • Progress towards the proposed urgent emergency care standards was highlighted with some improvements noted • Financial performance for month 11 finance achieved a surplus in month. The Trust had been notified that it would receive monies for the annual leave accrual and a further accrual, which would result in the Trust delivering a surplus at year end. • An update was provided by the Executive Data Security and Protection Group in terms of the progress made by the group • An update was provided by the Executive Business Intelligence Group, and attention was drawn to the approval of the Business Intelligence Strategy	• The Committee agreed to review the schedule of business cases and confirm which business cases would be reviewed by the individual authors and reported back to the Committee • The Committee approved the business case in relation to Galcanezumab which would be taken forward for Trust Board approval • The Committee approved EREAF 7336 Endoscopy Consumables • The Committee agreed to consider the expenditure associated with payroll partnership agreement to the Trust Board, following approval of the case at the previous meeting

Comments on the Effectiveness of the Meeting
• The Committee welcomed the presentation by the Medical Division on improvements in urgent care performance, and particularly welcomed the quality of the analytics and the evidence of real improvements

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Executive Directors Update including Covid-19	Information	7.	Month 11 Finance Report	Assurance
2.	IM&T Strategy Update	Assurance	8.	Business Case Approvals: • BC-0400 NICE Guidance - Migraine - Galcanezumab	Approval
3.	Business Case Reviews	Approval	9.	Authorisation of New Contract Awards and Contract Extensions	Approval
4.	Month 11 Performance Report	Assurance	10.	Executive Data Security & Protection Group Highlight Report	Assurance
5.	Proposed Urgent Emergency Care Standards	Assurance	11.	Executive Infrastructure Group Highlight Report	Assurance
6.	Emergency Department Improvement	Assurance	12.	Executive Business Intelligence Group Highlight Report	Assurance

3. 2020 / 21 Attendance Matrix

Attended	Apologies & Deputy Sent	Apologies

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

Transformation and People Committee Chair's Highlight Report to Board

25th March 2021

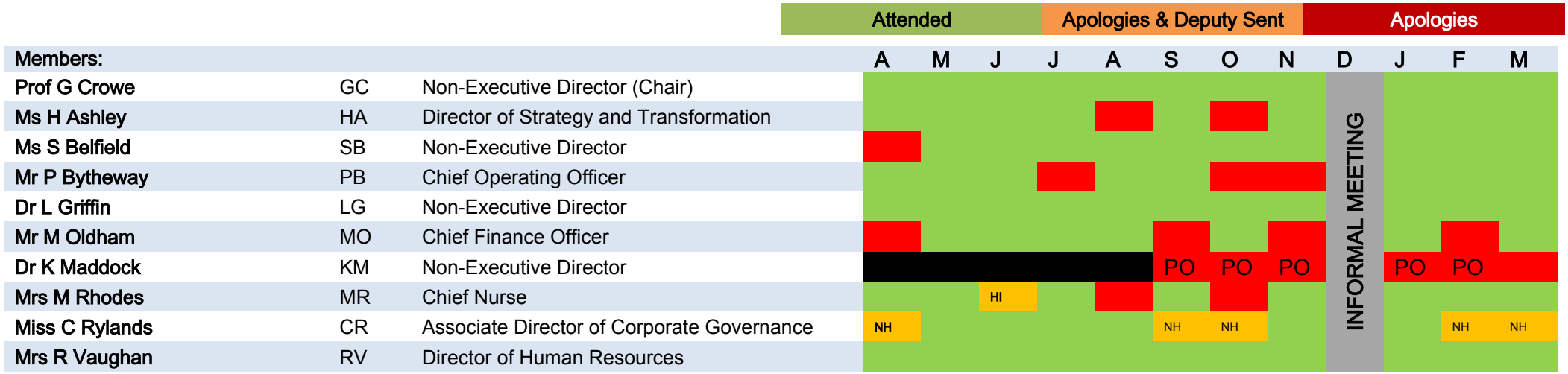
1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• There were no matters of concern or key risks raised.	• To provide the Committee with assurance of the completion of divisional and directorate workforce action plans • To provide an update in terms of the 2021/22 HR Delivery Plan at a future meeting • To clarify which questions make up the scores for staff engagement
Positive Assurances to Provide	**Decisions Made**
• The Trust had approached the end of the rest and recovery fortnight which had been well received by staff • Staff survey results for 2020 had seen an improvement in health and wellbeing and safety environment- bullying and harassment and this was consistent with national trends. In respect of other areas, there were no statistically significant changes. The Committee welcomed some of the encouraging responses, although recognised that significant improvements were required for a number of indicators • The Committee welcomed the 'deep dive' into the Delivering Exceptional Care Programme and understanding the various initiatives and programmes as well as providing greater clarity of the alignment of the programmes. The Committee recognised the further work to be done regarding communication to staff of the programme as well as the need to consider what updates were to be provided to the Trust Board.	• The Committee agreed that it would be helpful for a further session to be provided to members, on transformation initiatives and their alignment with the Delivering Exceptional Care Programme
Comments on the Effectiveness of the Meeting	
• The Committee welcomed the change in format of the meeting, so that elements of the Delivering Exceptional Care Programme could be considered in more detail	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Executive Directors Update including Covid-19	Information	3.	M11 Workforce Report	Information
2.	2020 NHS Annual Staff Survey	Assurance	4.	Delivering Exceptional Care	Assurance

3. 2020 / 21 Attendance Matrix



University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	7th April 2021
Report Title:	2020 NHS Annual Staff Survey	**Agenda Item:**	14.
Author:	Claire Soper, Head of HR Governance and Workforce Information		
Executive Lead:	Ro Vaughan, Director of Human Resources		

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

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

Executive Summary:

Situation - Each year NHS staff are invited to take part in the NHS Staff Survey, which gathers views on staff experience at work around key areas, and including staff engagement and involvement, health and wellbeing, and safety culture.

Background - The 2020 NHS Staff Survey was carried out between September and December 2020 and the Trust response rate was 44%.

The report has been presented to the Transformation and People Committee

Assessment – There were two statistically significant improvements in the 2020 scores when compared to the previous year's data concerning Health and Wellbeing and Safe Environment – Bullying and Harassment. There was no statistically significant change in the remaining 8 themes.

Staff Morale is highlighted as an area of concern, although this is in the context of the global pandemic. Staff say they have unrealistic time pressures, that they are not involved in decisions on changes affecting their work areas and that they do not receive the respect they deserve from colleagues at work. They have less choice in deciding how to do their work, relationships are strained and their immediate manager does not encourage them. However, the percentage of staff who said they are thinking of leaving the Trust did reduce.

There was a small increase in staff saying they experienced physical violence from patients, relative or other members of the public (16.5% up to 16.6%). Experience of physical violence from other colleagues also increased from 1.4% to 1.7%.

Importantly, we have seen improvements in staff recommending the Trust as a place to work (from 60.4% to 64.3%) and in recommending the organisation as place to receive care (from 73.8% to 76.2%)

There are variations in the staff survey results across each Division and separate Divisional plans are put in place to tailor actions to address staff survey findings as appropriate to each area. These plans will reflect not only delivery of the Trust's People Strategy objectives, but actions to improve staff engagement and motivation within each Division

Key Recommendations

The Trust Board is asked to note the progress made to date and to approve the corporate priorities planned for 2021/22, aimed at continuing the improvements in organisational culture and maximising the potential of our people to improve patient outcomes

NHS Annual Staff Survey Findings 2020

1. Introduction

Nationally the Staff Survey scores for both the health and wellbeing and safety culture themes are the highest for five years. There have been encouraging signs of improvement in some areas of staff motivation and engagement. Of the other themes, compared to 2019, safe environment – bullying and harassment and violence also show improvement, two remain consistent (equality, diversity and inclusion, and staff engagement), and two remain at a relatively similar level (quality of care and safe environment). There has been a negative trend in the opportunity for staff to show initiatives in their role and to make suggestions to improve the work of their team and department, and a mixed picture in terms of support and feedback from immediate managers.

Results from UHNM largely mirror these national trends and the following table presents an overview of the 10 themes, comparing this Trust's results to the national average for acute trusts, and indicating the scores of the best and worst performing acute trusts.

	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	6.9	7.3	6.9	8.1	8.7	9.8	7.4	7.6	7.1
Your org	9.1	5.9	6.5	6.0	7.5	8.0	9.4	6.7	6.9	6.1
Average	9.1	6.1	6.8	6.2	7.5	8.1	9.5	6.8	7.0	6.5
Worst	8.1	5.5	6.2	5.6	7.0	7.2	9.1	6.1	6.4	6.0
Responses	4,529	4,552	4,559	4,496	4,046	4,421	4,525	4,515	4,612	4,577

The chart shows that the main themes where this Trust scores lower than national average are:

1. **Health and wellbeing** – all aspects of this theme improved. Positively, staff perceptions on opportunities for flexible working improved from 48.1% to 51.6% and the organisation taking positive action on health and wellbeing improved from 24.5% to 27.9%.

   Fewer staff said they had experienced Musculoskeletal problems (reduced from 27% to 26.4%) and fewer staff said they had come to work despite not feeling well enough (reduced from 59.1% to 49.4%)

   However, there was an increase in the percentage of staff saying they had felt unwell as a result of work related stress.

2. **Immediate Managers** –There was an improvement in staff saying their immediate manager took a positive interest in their health and safety (from 65.3% to 65.6%, but fewer staff said their immediate manager valued their work (reduced from 68.9% to 67.3%). Staff perceptions were also reduced as regards:

   - The support they get from their immediate manager (from 66.4% to 64.9%)
   - Their manager gives clear feedback (from 57.0% to 55.6%)
   - Their immediate manager asks for staff opinion before making decisions affecting their work (from 49.9% to 48.7%)

   Encouragingly, there has been a slight improvement in staff feeling that communication with senior management is effective and that senior managers act on staff feedback.

3. **Morale** – Staff say they have unrealistic time pressures, that they are not involved in decisions on changes affecting their work areas and that they do not receive the respect they deserve from colleagues at work. The have less choice in deciding how to do their work, relationships are strained and their immediate manager does not encourage them. This is of course in the context of the Trust operational pressures in managing the impact of the covid pandemic, where staff have worked in different environments, with different teams and under challenging conditions.

   Although the percentage of staff who said they are thinking of leaving reduced, the percentage of staff looking for other jobs, and who say they would leave as soon as they got another job, increased.

4. **Safe Environment – Violence** – There was a small increase in staff saying they experienced physical violence from patients, relatives or other members of the public (16.5% up to 16.6%). Experience of physical violence from other colleagues also increased from 1.4% to 1.7%. Both of these aspects are above the national average.

   Staff experience of violence at work from a manager reduced from 0.7% to 0.6%.

5. **Safety Culture** – Continuing the improvement seen on 2019, and reflecting the implementation of Just and Learning Culture, there were further improvements in every aspect of this theme:

   - The percentage of staff saying those involved in an error, near miss or incident are treated fairly improved from 57.4% to 58.7%
   - That the organisation takes action to ensure errors or incidents don't happen again improved from 69.9% to 73.1%
   - Staff saying they receive feedback staff in response to reported incidents improved from 58.9% to 60%
   - Staff feeling secure about raising unsafe clinical practice improved from 67.8% to 69.8
   - Staff confidence that the organisation would address their concerns increased from 56.1% to 56.7%, and
   - Staff saying the Trust acts on concerns raised improved from 71.4% to 72.8%

6. **Team Working** – Perhaps reflecting operational pressures over the last 12 months, fewer staff said their teams have shared objectives (down from 69.1% to 68.3%) and teams have been meeting less to discuss effectiveness (from 50.9% to 48.7%)

7. **Staff engagement –** At 6.9, the staff engagement score remains just below the acute trust average of 7.0. This is unchanged from the previous year.

   Staff morale was impacted in 2020, with fewer staff saying they looked forward to coming to work and staff saying they were less enthusiastic about their job. There was also a reduction in staff saying time passed quickly for them at work.

   Staff also said they felt less able to contribute to improvements in 2020, which is probably a reflection of the operational changes implemented to manage the covid-19 pandemic

   There were significant improvements in staff perceptions that care of patients was the organisation's top priority, recommendation of the Trust as a place to work and as a place to receive treatment

Staff were also asked four questions relating to their experience during the Covid-19 pandemic. However, there was little distinction between the results of those staff whose method of working has been impacted most by covid-19 and the 'All Staff' results.

The main areas of distinction were that staff working on covid wards and those redeployed had greater concerns for their health and wellbeing and staff shielding for a household member report lower morale. Also, staff required to work from home/remotely reported a greater perception of bullying and harassment and staff working on covid wards reported a greater instance of violence

Overall, staff provided more positive feedback in 2020 with the exception of perceptions around Immediate Managers, and Team Working. These two issues were also raised via the Listening events which have taken place over the last year and programmes are in place towards addressing these:

- The overarching OD programme, *Delivering Exceptional Care*, is designed to increase staff engagement, empower staff to contribute to improvements and enable a quality view of the organisation.
- The leadership and management development work is underway towards improving organisational culture and leadership.

2. Improvement Activities

The overall vision is that we want to be a Trust that is seen positively by our staff in all aspects of staff engagement, with the goal of being above average as a Trust overall by the next survey (2021) and in the top 20% of Trusts by 2023

The improvement activities set out below follow on from the 2019 Staff Survey, when we set out our key areas of corporate focus planned for 2020/21. A detailed action plan has been shared with the Transformation and People Committee and this is a summary of the key areas:

1 **To improve and evidence the positive action taken on health and wellbeing,**

Our goal is to provide our people with a safe and healthy work place that is compassionate and inclusive for all. Towards achieving this, we will embed and sustain the wellbeing work that we have introduced during 2020 to date, supported by a refreshed Wellbeing Plan and an emphasis on the basic needs of our staff, supporting individuals to stay safe, healthy and well. This will be physically, psychologically, socially, and financially.

We will continuously review where improvements are needed and plan initiatives to support health and wellbeing in conjunction with our occupational health provider, counselling services, system partners and with oversight from our Trust Wellbeing Guardian

2 **Towards improving equality and diversity, staff morale and a culture of safety, we will maintain the focus on:**

We are committed to building an inclusive workforce which is valued and whose diversity reflects the community it serves, enabling us to deliver the best possible healthcare service to our patients, carers and communities. Our Equality, Diversity and Inclusion Strategy (EDI) is underpinned by a detailed EDI Delivery Plan, which sets out the actions we will implement to deliver including the following key actions:

- Adopt the toolkit on civility and respect to enable the Trust to create positive workplace cultures
- Introduce cultural intelligence training as part of our Connects Development Programme
- Launch the Work in Confidence System
- Implement the second cohort of reverse mentoring

3 **Leadership and Management Development and Visibility**

Taking forward the findings from the Trust Culture and Leadership Diagnostic Programme, and building on the experiences of staff during covid, we will develop a Trust wide OD programme linked to “Delivering Exceptional Care” where management development and the leadership diagnostic will feed staff engagement activities.

We will also put further development in place for middle management and first line management

4 **Improving Staff Engagement**

The aim of enhancing staff engagement via the Delivering Exceptional Care programme (DEC) is to improve staff engagement to above average by the next Staff Survey, and ensure the Trust is placed in the top 20% of Acute Trusts by 2023. Work on DEC will commence at pace during 2021/2022.

A staff ‘morale checker’ is to be introduced in 2021/22, replacing the staff friends and family test.

The Staff Survey findings are shared with the Divisions who will review the information as it impacts on their areas so that tailored interventions can be implemented that are appropriate and are aligned to the corporate priorities for staff engagement and the wider corporate agenda under the *Delivering Exceptional Care* programme.

3 Recommendations

The Trust Board is asked to approve the activities planned for 2021/22, aimed at continuing the improvements in organisational culture and maximising the potential of our people to improve patient outcomes

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	Date:	7th April 2021
Report Title:	Integrated Performance Report, month 11 2020/21	Agenda Item:	15.
Author:	Performance Team		
Executive Lead:	Helen Ashley: Director of Strategy and Transformation /Deputy Chief Executive		

Purpose of Report:

Assurance	✓	Approval		Information	

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

Executive Summary:

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

February began with some encouraging signs as regional and local reports show that the numbers of people testing positive with Covid-19 had begun to decrease. Although the pressure in the hospitals remained high, particularly in the critical care unit, a gradual decline in the number of patients being admitted with Covid-19 and remaining as inpatients was seen in February. The number of inpatients reduced by half (from a peak of 349 in Jan to 139 in Feb, with daily new cases reducing to around 11/day, with a total of 3368 patients having been discharged in total.

In addition the number of beds restricted due to infection prevention also fell to half of what the Trust was experiencing in January to less than 20 beds.

The Trust internal incident remained on level 4.

Quality & Safety:

The Trust achieved the following standards in February 2021:

- Harm Free Care improved to 96.4% and continues to be above the national 95% target
- Trust rolling 12 month HSMR and SHMI continue to be below and within expected ranges respectively
- 100% of patients/family informed verbally of incidents that are reported as meeting duty of candour

threshold
- VTE Risk Assessment continues to exceed 95% target with 99.1% (via Safety Express audit)
- Zero avoidable MRSA Bacteraemia cases reported
- C Diff target below trajectory target of 8 during February 2021 with 6 cases reported
- There have been no Category 2, 3 or 4 Pressure Ulcers attributable to lapses in care. However, there are a number of incidents awaiting investigation, and, as such, this figure may change.
- Sepsis Screening compliance in Emergency Portals improved to 96.8% and remains above the target 90%
- Children's Sepsis Screening compliance 96.8% and above 90% target
- Inpatients IVAB within 1 hour achieved 100% for audited patients
- Maternity Sepsis Screening recorded 100% and IVAB within an hour was also 100%
- Zero Never Events

The Trust did not achieve the set standards for:
- Patient Falls rate per 1000 bed days higher than target in February 2021 at 6.7 falls per 1000 bed days
- 87.5% Duty of Candour 10 day letter performance following formal verbal notification. 1 case not sent letter within 10 working days.
- Inpatient Sepsis Screening compliance (adult Inpatients) decreased to 82.7% and below the target of 90%
- C Diff YTD figures are above trajectory with 105 against a target of 86
- Emergency Portals IVAB in 1 hour improved to 78.3% but still below the 90% target

During February 2021, the following quality highlights are to be noted:
- The rate of complaints per 10,000 spells has increased to 33.96 but is below (positive) the target of 35 but is within normal variation.
- Total number of Patient Safety Incidents decreased in February but the rate per 1000 bed days increased
- Patient Safety Incidents with moderate harm or above and rate of incidents with moderate harm or above per 1000 bed days has remained low and around the long term average. National comparison taken from latest CQC Insight Report is that 26.1% of reported patient safety incidents to NRLS resulted in harm. UHNM latest results are 22.8%. UHNM is lower that national average (September 2019 – August 2020)
- Rate of falls reported that have resulted in harm to patients has remained relatively stable at 1.6 compared to 1.5 in previous month. The rate of patient falls with harm continues to be within the control limits and normal variation
- Medication related incidents rate per 1000 bed days has increased slightly to 4.8. Current national NRLS published mean rate in 6 (April 2019 –March 2020)
- Nosocomial COVID Infections have reported decrease during February 2021 with 20 compared to 68 in January 2021, December 2020 with 79 reported cases and 88 in November 2020
- COVID-19 deaths falling in to the 'Definite' category (according to the National definition of Nosocomial deaths) decreased to 8 in February
- Serious Incidents have increased since start of COVID-19 Wave 2 in October 2021 with 16 reported in February 2021.

Operational Performance:
Although the pressure in the hospitals, due to Covid-19 remained high, particularly in the critical care unit, a gradual decline in the number of patients being admitted with Covid-19 and remaining as inpatients was seen in February. The number of inpatients reduced by half (from a peak of 349 in Jan to 139 in Feb, with daily new cases reducing to around 11/day. Attendances started to show an increase with an average of 277/day at Royal Stoke., an increase of c20/day. Whilst overall NEL admissions remained around the same.

The number of patients who had had covid-19 and were discharged reached 3368. The number of bed restrictions/ closures continued, however numbers reduced and from mid-Feb the number of closures across the month was less than 20.

Operational performance improved and Royal Stoke hit the 4hour performance of > 80% on several

occasions, not achieved since Aug-20. The Trust system wide 4hour performance achieved 78.2%, a significant increase from January (69%) and for UHNM Type 1 this was 68.1% (January 55.5%). There were zero 12 hour trolley waits.

In February improvements were seen across most of the cancer standards. The trust is predicted to achieve five of the standards: 31 day first treatment, 31 day anti-cancer drugs, 31 day surgery, 31 day radiotherapy, and the 28 day standard. The total PTL remains steady although the backlog has risen slightly. The 104+ day backlog remains steady at 54 for February 21.

The 2ww PTL rose following the second phase of the pandemic, however from early January the PTL reduced and has levelled out during February although the size of the waiting list is still higher than that seen pre-covid. Performance against the 2ww standard has improved and is currently at 91.62% compared to January 88.16% even with, on average, seeing the same number of patients. Demand appears to have levelled off although numbers are slightly higher than the same time last year.

31 Day subsequent treatment (surgery) has seen a significant improvement in February, currently achieving 98.4% compared to 78.13% in January. Cancer surgery continues being prioritised within the Trust and independent sector.

The latest data on 62 day performance is achieving 66.2%. The 62 day PTL and backlog and has shown a steady reduction through February with levels almost at the numbers seen pre- 2nd phase of pandemic. Similarly the number of patients in the 63-103 days is also reducing. The corporate cancer team has completed a high level specialty comparator analysis of referrals and treatments 2020 compared to 2021 with an in depth clinical review of pathways over the next month to contextualise our cancer assurance/risk evaluation for the second covid19 surge response.

The National ask for February-21 was for total Outpatients to be at 100% of last year's business as usual and for Inpatients 90%. The trajectories for February were set 92.7% (Outpatients) and 84.6% (Inpatients) of BAU for last year. The actuals for February, against BAU, was outpatients 90.6% and inpatients 67.1%. This demonstrates the efforts to maintain out-patient capacity even if the in-patient work has fallen due to the requirement for workforce staffing to support the 200% critical care mutual aid support to London. Q1 – theatre and diagnostic capacity plans being drafted against time critical surgery patients (P2) and those eligible to be offered to the Independent Sector as Choice Referrals (P3/4) as part of the scaling up of planned care activity, in concert with CCG colleagues. Additional capacity has been sourced at county and the IS for ad hoc lists during March with major surgery cases being booked as the critical care dependency bed base is released from the covid surge.

The indicative performance for February 21: the total number of Referral To Treatment pathways grew to 53,269 (January 50,735, December 49,054). This is above the forecast 46,100. The Trust has 4,392 over 52 week breaches (January 3538, December 2,773) as a consequence of standing down elective work. This was over the forecasted position. Recovery plans for recovery of the long waiting patients are being reviewed. RTT performance in February 63.57% (January is 65.20%, December 65.73%).

February saw a rise in performance (DM01) with the indicative position at 90.1%, compared to 85.7% in January. The waiting list size has risen sharply to 13,858 from 11, 841. The Diagnostic cell recommenced in February to oversee recovery.

Workforce:

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

The Workforce Bureau has stepped down in part and will be reinstated fully if the need arises.

Sickness and covid-related absences continue to be monitored daily. Staff showing symptoms, or with household members showing symptoms, are tested and results returned within 24-48 hours. From 31st March 2020 – 12th March 2021 we have carried out 8,808 tests, excluding staff outbreak screening.

Risk assessment processes remain in place and all BAME and Category C risk assessments will continue to be reviewed and updated if necessary. The Empactis system is used to provide managers with health risk assessment reminders and work with Occupational Health continues to embed risk assessments into the pre-employment health assessment process. The Risk Assessment form continues to be updated as new guidance is received. As at 12th March, over 95% of all permanent and fixed term staff have completed a covid-related risk assessment with their manager

Roll out of the second dose of the vaccination commenced from 25th February for those staff and workers who received their first vaccination in the Trust. The roll out plan aims to deliver all second dose vaccinations by 1st April

The key performance issues are that the sickness rate remains above target and compliance with PDR requirements. The Executive decision taken to suspend PDR's unless there is capacity to continue to undertake them remains in place.

Sickness
The in-month sickness rate was 4.70% (5.71% reported at 31/01/21). The 12 month cumulative rate increased to 5.43% (5.42% at 31/01/21). The wellbeing plan is being developed to support and signpost staff to a range of wellbeing offers depending on staff needs at this time, including psychological support.

Appraisals
The Non-Medical PDR compliance rate was 73.94% (74,65% at 31st January 2021).

Statutory and Mandatory Training
The Statutory and Mandatory training rate at 28th February 2021 was 93.76% (93.41% at 31st January 2021). At 28 February 2021, 89.89% of staff had completed all 6 Core for All modules (89.17% at 31/01/21)

For Finance, the key messages are:

- The Trust has received confirmation that it will receive £12.4m additional funding for M7-12 relating to the TSA agreement, NHSI have factored £7.4m of this into the plan which remains at a £7.2m deficit however the remaining £5m is factored into an expected forecast of £2.2m; the Trust is forecasting to be £2.2m better than this and achieve a breakeven position for the year.
- The Trust has delivered a surplus of £4.4m in Month 11 against a planned deficit of £0.7m which is driven by DHSC funding relating to the TSA agreement, underspends against the COVID-19 allocation, continued slippage against growth funding and the winter plan, additional HEE income and a VAT credit adjustment relating to 2019/20; all of these items are non-recurrent.
- The Trust is forecasting to breakeven for the year; this is after accruing for untaken annual leave, absorbing reductions in Non NHS income and providing for the impact of the Flowers tribunal. It is expected that funding will be allocated for these issues; any received will improve the Trust's position.
- The Pathology Network went live on 1 December with the financial impact included in the financial position and whilst there is a negligible impact on the bottom line, this is causing variances between the reporting categories (i.e. other income, pay and non-pay)
- The Trust incurred £2m of costs relating to COVID-19 which is a reduction in comparison with Month 10 (£2.4m) primarily in non-pay due to reduced demands on decontamination and testing. This remains within the Trust's allocation with £0.4m being chargeable on top of this allocation.
- Capital expenditure for the year to date stands at £45.3m which is £5.1m behind plan with the main driver being slippage on the PDC funded RI site demolition and phasing of the Linac and IR2 bi-plane.
- The month end cash balance is £110.6m which is £33.8m more than plan.

Key Recommendations:

To note performance.

NHS
University Hospitals of North Midlands
NHS Trust

Integrated Performance Report

Month 11 2020/21

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Contents

A note on **SPC**

University Hospitals of North Midlands NHS Trust

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

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

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

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

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

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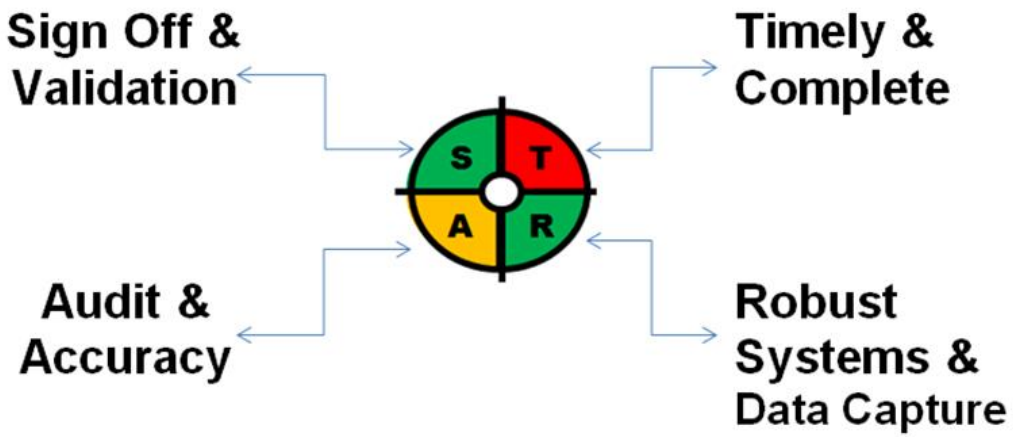
A note on **Data Quality**

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

Key messages

The Trust achieved the following standards in February 2021:

- Harm Free Care improved to 96.4% and continues to be above the national 95% target
- Trust rolling 12 month HSMR and SHMI continue to be below and within expected ranges respectively
- 100% of patients/family informed verbally of incidents that are reported as meeting duty of candour threshold
- VTE Risk Assessment continues to exceed 95% target with 99.1% (via Safety Express audit)
- Zero avoidable MRSA Bacteraemia cases reported
- C Diff target below trajectory target of 8 during February 2021 with 6 cases reported
- There have been no Category 2, 3 or 4 Pressure Ulcers attributable to lapses in care. However, there are a number of incidents awaiting investigation, and, as such, this figure may change.
- Sepsis Screening compliance in Emergency Portals improved to 96.8% and remains above the target 90%
- Children's Sepsis Screening compliance 96.8% and above 90% target
- Inpatients IVAB within 1 hour achieved 100% for audited patients
- Maternity Sepsis Screening recorded 100% and IVAB within an hour was also 100%
- Zero Never Events

The Trust did not achieve the set standards for:

- Patient Falls rate per 1000 bed days higher than target in February 2021 at 6.7 falls per 1000 bed days
- 87.5% Duty of Candour 10 day letter performance following formal verbal notification. 1 case not sent letter within 10 working days.
- Inpatient Sepsis Screening compliance (adult Inpatients) decreased to 82.7% and below the target of 90%
- C Diff YTD figures are above trajectory with 105 against a target of 86
- Emergency Portals IVAB in 1 hour improved to 78.3% but still below the 90% target

During February 2021, the following quality highlights are to be noted:

- The rate of complaints per 10,000 spells has increased to 33.96 but is below (positive) the target of 35 but is within normal variation.
- Total number of Patient Safety Incidents decreased in February but the rate per 1000 bed days increased
- Patient Safety Incidents with moderate harm or above and rate of incidents with moderate harm or above per 1000 bed days has remained low and around the long term average. National comparison taken from latest CQC Insight Report is that 26.1% of reported patient safety incidents to NRLS resulted in harm. UHNM latest results are 22.8%. UHNM is lower that national average (September 2019 – August 2020)
- Rate of falls reported that have resulted in harm to patients has remained relatively stable at 1.6 compared to 1.5 in previous month. The rate of patient falls with harm continues to be within the control limits and normal variation
- Medication related incidents rate per 1000 bed days has increased slightly to 4.8. Current national NRLS published mean rate in 6 (April 2019 –March 2020)
- Nosocomial COVID Infections have reported decrease during February 2021 with 20 compared to 68 in January 2021, December 2020 with 79 reported cases and 88 in November 2020
- COVID-19 deaths falling in to the 'Definite' category (according to the National definition of Nosocomial deaths) decreased to 8 in February
- Serious Incidents have increased since start of COVID-19 Wave 2 in October 2021 with 16 reported in February 2021.

Quality Dashboard

NHS University Hospitals of North Midlands NHS Trust

Metric	Target	Latest	Variation	Assurance
Patient Safety Incidents	N/A	1463		
Patient Safety Incidents per 1000 bed days	N/A	45.77		
Patient Safety Incidents per 1000 bed days with no harm	N/A	30.57		
Patient Safety Incidents per 1000 bed days with low harm	N/A	12.70		
Patient Safety Incidents per 1000 bed days reported as Near Miss	N/A	1.81		
Patient Safety Incidents with moderate harm +	N/A	20		
Patient Safety Incidents with moderate harm + per 1000 bed days	N/A	0.63		
Harm Free Care (New Harms)	95%	96%		
Patient Falls per 1000 bed days	5.6	6.7		
Patient Falls with harm per 1000 bed days	1.5	1.6		
Medication Incidents per 1000 bed days	N/A	5		
Medication Incidents % with moderate harm or above	TBC	0.0%		
Patient Medication Incidents per 1000 bed days	N/A	3.9		
Patient Medication Incidents % with moderate harm or above	TBC	0.0%		

Metric	Target	Latest	Variation	Assurance
Serious Incidents reported per month	N/A	16		
Serious Incidents Rate per 1000 bed days	N/A	0.50		
Never Events reported per month	0	0		
Duty of Candour - Verbal/Formal Notification	100%	100%		
Duty of Candour - Written	100%	87.5%		
All Pressure ulcers developed under UHNM Care	TBC	51		
All Pressure ulcers developed under UHNM Care per 1000 bed days	N/A	1.60		
All Pressure ulcers developed under UHNM Care lapses in care	12	1		
All Pressure ulcers developed under UHNM Care lapses in care per 1000 bed days	0.5	0.03		
Category 2 Pressure Ulcers with lapses in Care	8	1		
Category 3 Pressure Ulcers with lapse in care	4	0		
Category 4 Pressure Ulcers with lapses in care	0	0		
Unstageable Pressure Ulcers with lapses in care	0	0		

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Quality Dashboard

NHS
University Hospitals of North Midlands
NHS Trust

Metric	Target	Latest	Variation	Assurance
Friends & Family Test - A&E	N/A	N/A	H	?
Friends & Family Test - Inpatient	N/A	97.6%		P
Friends & Family Test - Maternity	N/A	N/A	H	?
Written Complaints per 10,000 spells	35	33.96		?
Rolling 12 Month HSMR (3 month time lag)	100	94.64	L	P
Rolling 12 Month SHMI (4 month time lag)	100	102.91	H	P
Nosocomial COVID-19 Deaths (Positive Sample 15+ days after admission)	N/A	8	H	
VTE Risk Assessment Compliance	95%	99.1%	H	?
Emergency C Section rate % of total births	15%	15.5%	H	?
Reported C Diff Cases per month	8	6		?
Avoidable MRSA Bacteraemia Cases per month	0	0		P
HAI E. Coli Bacteraemia Cases per month	N/A	10		
Nosocomial "Definite" HAI COVID Cases - UHNM	0	20		

Metric	Target	Latest	Variation	Assurance
Inpatient Sepsis Screening Compliance (Contracted)	90%	82.2%		?
Inpatient IVAB within 1hr (Contracted)	90%	100.0%		?
Children Sepsis Screening Compliance (All)	90%	96.0%	H	P
Children IVAB within 1hr (All)	90%	N/A	H	F
Emergency Portals Sepsis Screening Compliance (Cor	90%	96.8%		?
Emergency Portals IVAB within 1 hr (Contracted)	90%	78.3%		?
Maternity Sepsis Screening (All)	90%	100.0%	H	F
Maternity IVAB within 1 hr (All)	90%	100.0%	H	P

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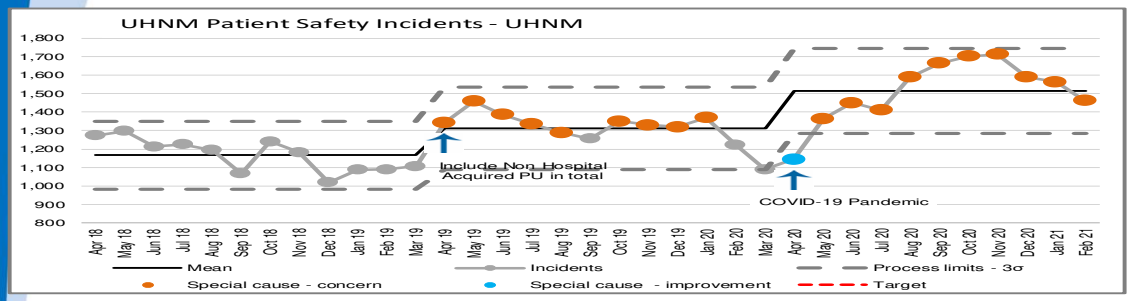
Reported Patient Safety Incidents

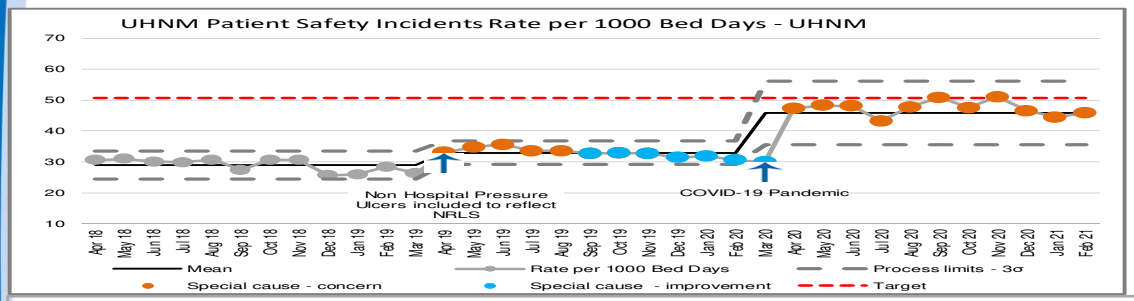


Variation	Assurance
	

Target	Dec 20	Jan 21	Feb 21
N/A	1589	1564	1463

Background

Total Reported patient safety incidents



Variation	Assurance
	

NRLS Mean	Dec 20	Jan 21	Feb 21
50.70	46.55	44.51	45.77

What is the data telling us:

The above data relates to **all** reported Patient Safety Incidents (PSIs) across the Trust. February 2021 has seen a decrease in total number of reported PSIs and is within variation limits. The reporting of incidents and near misses should continue to be encouraged and promoted.

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

- Patient related Slip/Trip/Fall - 215 (257)
- Clinical assessment (Including diagnosis, images and lab tests) – 68 (93)
- Patient flow incl. access, discharge & transfer - 77 (69)
- Documentation – 46 (36)
- Treatment/Procedure - 55 (64)
- Medication incidents - 128 (106)
- Infection Prevention – 52 (52)

There have been increases in Medication, Patient Flow and Documentation related incidents compared to January 2021 totals (in brackets).

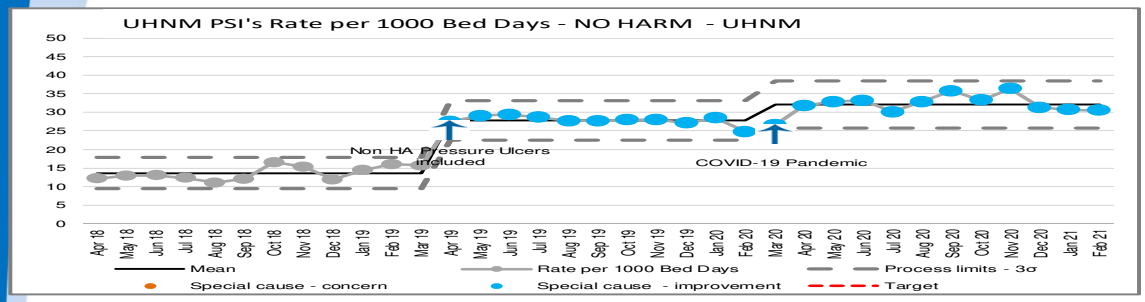
PSIs are reviewed and analysis undertaken on locations and themes.

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

The rate of reported PSIs per 1000 bed days has increased compared to January 2021. UHNM have seen increases in the rate of PSIs from the start of the COVID-19 pandemic as result of increased reported PSI numbers and reduced activity.

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

University Hospitals of North Midlands NHS Trust

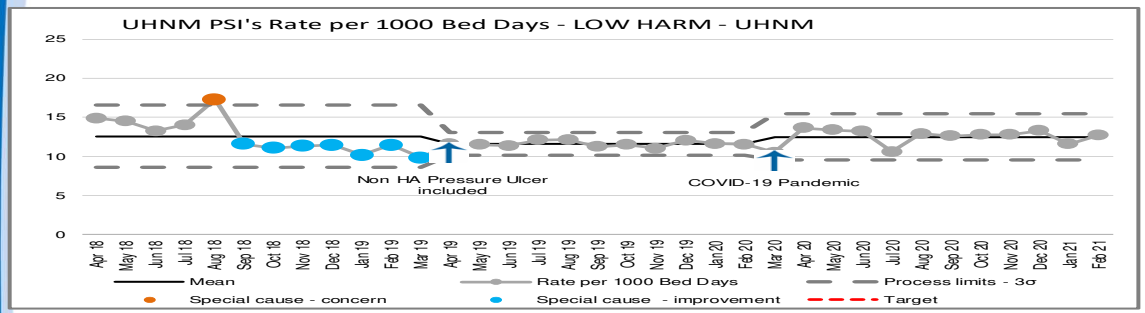


Variation	Assurance

Target	Dec 20	Jan 21	Feb 21
N/A	31.29	30.68	30.57

Background

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

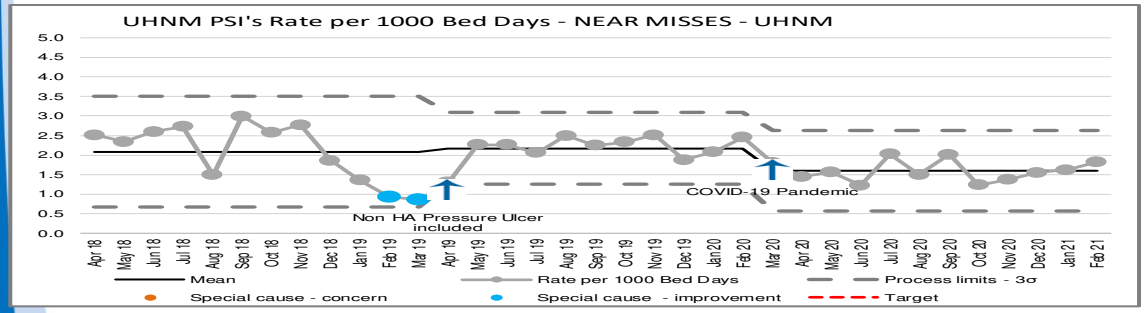


Variation	Assurance

Target	Dec 20	Jan 21	Feb 21
N/A	13.30	11.58	12.70

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	Dec 20	Jan 21	Feb 21
N/A	1.55	1.62	1.81

Background

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

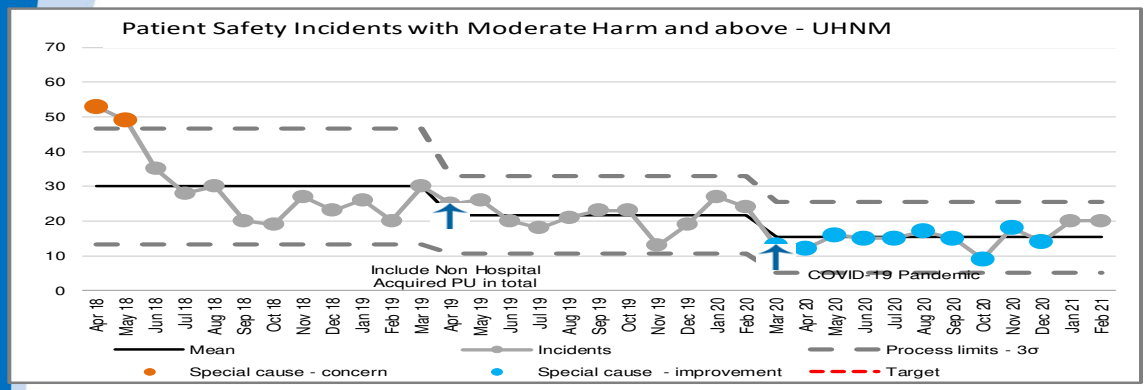
What is the data telling us:

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

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

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

Reported Patient Safety Incidents with Moderate Harm or above

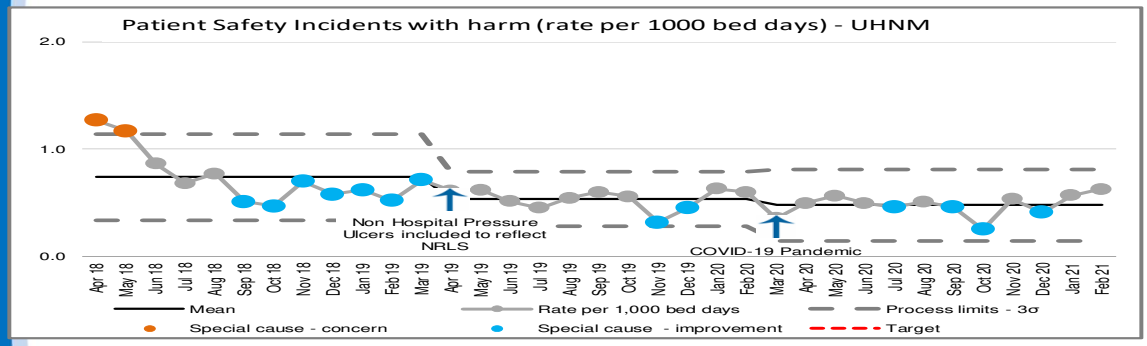


Variation	Assurance

Target	Dec 20	Jan 21	Feb 21
N/A	14	20	20

Background

Patient safety incidents with reported moderate harm and above



Variation	Assurance

Target	Dec 20	Jan 21	Feb 21
N/A	0.41	0.57	0.63

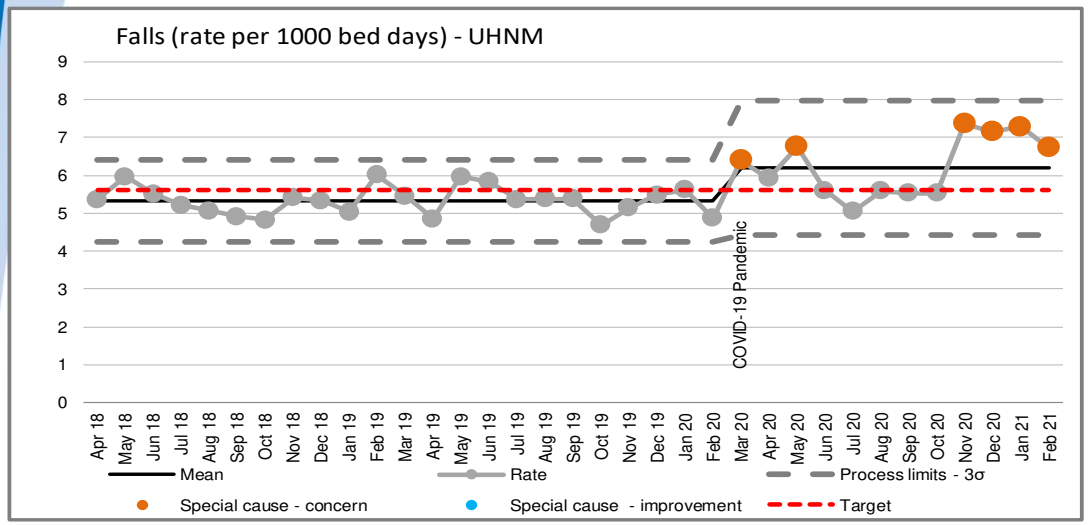
What is the data telling us:

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

The top category of incidents resulting in moderate harm reflect the largest reporting categories with Slips/Trips/Falls being the largest category.
The second largest category is Treatment/Procedure (3 of these are unintended injury during procedure (bleeding), 1 treatment delay, 1 complication of treatment, 1 delay in recognising complication, 1 delay in monitoring and 1 extravasation injury)

National Comparison taken from latest CQC Insight Report is that 26.1% of reported patient safety incidents to NRLS resulted in harm. UHNM latest results are 22.8% . UHNM is lower than national average.

Patient Falls Rate per 1000 bed days



Variation	Assurance
	

Target	Dec 20	Jan 21	Feb 21
5.6	7.1	7.3	6.7

Background

The number of falls per 1000 occupied bed days

What is the date telling us:

The data shows the Trust's rate of reported patient falls per 1000 bed days. Using the rate makes allowance for changes in activity/increased patient numbers. The Trust set a target rate, based on the Royal College of Physicians National Falls Audit published rate for acute hospitals, of 5.6 patient falls per 1000 bed days. Since the start of COVID-19, the average rate has been above the target rate with a rise from October 2020. The chart shows the rate in February has reduced from 7.3 in Jan to 6.7.

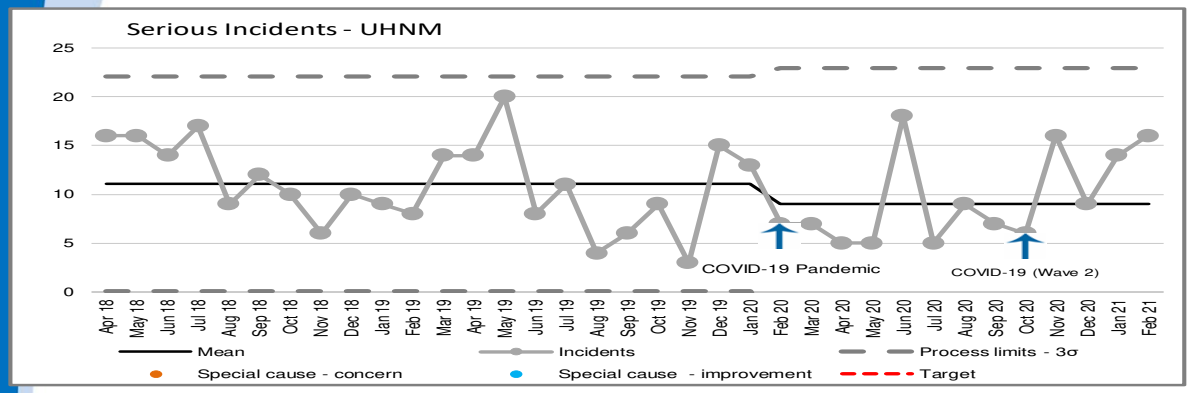
The wards and departments reporting the largest number of falls in February were:

Royal Stoke AMU FEAU (W232) Royal ED Ward 218 (Blue Winter Escalation) Ward 225 - Fractured NoF

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

- A falls prevention/awareness presentation has been shared with the nurse bank to be sent out to all bank staff.
- Volunteers are supporting several areas across medicine to help with 1:1's, training on RITA has been provided to assist them with distraction activities.
- Although AMU (RSUH) and FEAU remain in the top wards for patient falls their numbers are reducing following the support offered. AMU now have two RITA devices to support with distraction and as pressures settle staff have been encouraged to complete the monthly falls audit to help identify areas needing further actions. FEAU have identified a further falls champion to support with training and ED are currently looking at visibility and data has been provided on falls pre/post COVID-19 and witnessed / unwitnessed falls to support this.
- A meeting is set up with Medicine ACN to discuss actions within medicine.
- We continue to encourage the use of the STOP 5 hot debrief tool.
- Support has been set up with Matron and Charge Nurse for Ward 225 to discuss issues and to make a further action plan to reduce falls.

Serious Incidents per month

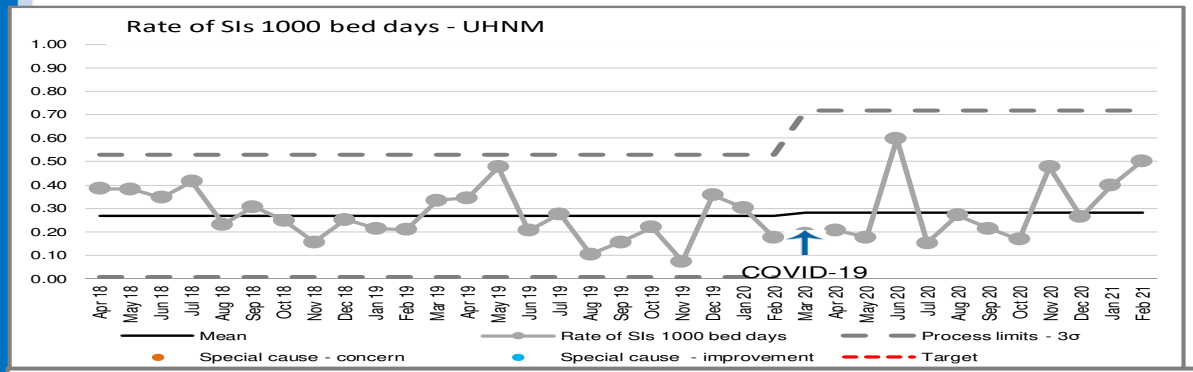


Variation	Assurance

Threshold	Dec 20	Jan 21	Feb 21
N/A	9	14	16

Background

The number of reported Serious Incidents per month



Variation	Assurance

Target	Dec 20	Jan 21	Feb 21
N/A	0.26	0.40	0.50

Background

The rate of Serious Incidents Reported per 1000 bed days

What is the data telling us:

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

February 2021 saw 16 incidents reported with 12 at RSUH and 4 at County Hospital:

- 7 Falls related incidents
- 6 Maternity (baby only)
- 1 Diagnostic related
- 1 Pressure Ulcer
- 1 Aggressive / Abusive Behaviour - Patient to Patient

100% of the reported Serious Incidents during February 2021 were reported on STEIS within the agreed 2 working timeframe from identification/confirmation the incident met the serious incident reporting criteria

The rate of SIs per 1000 bed days for February 2021 is 0.47 which compares to organisational average rate of 0.29. The current 2020/21 YTD average rate is 0.31.

Serious Incidents Summary

NHS University Hospitals of North Midlands NHS Trust

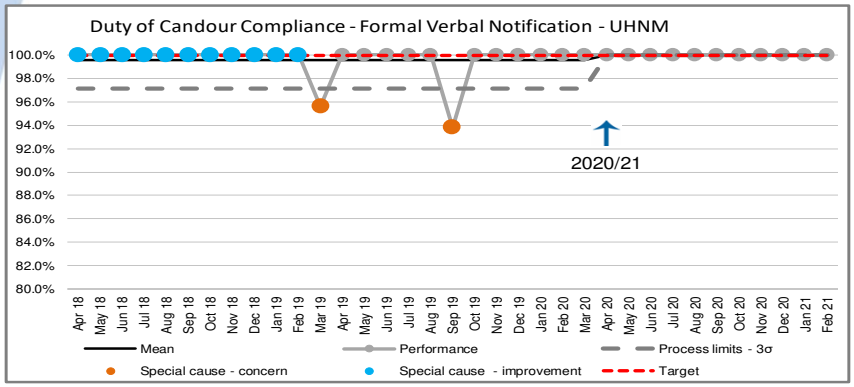
Summary of new Maternity Serious Incidents

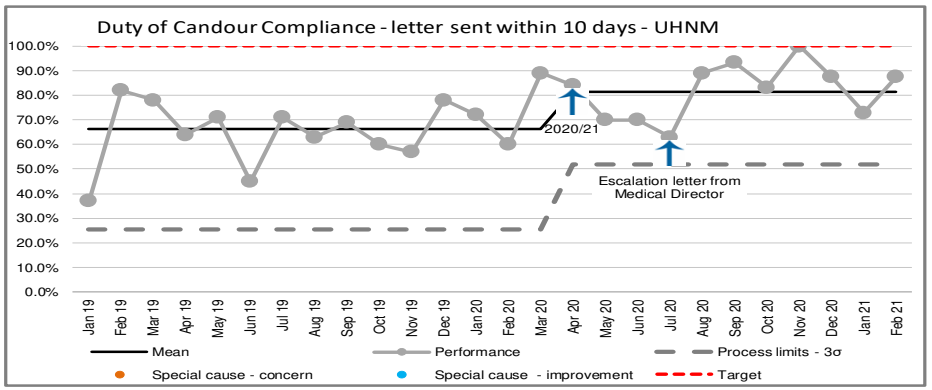
Following the formal recommendations in the Ockenden Report, below is an outline of the Maternity related serious incidents reported during February 2021. The new recommendation requires the Trust Board to receive summary on the new Maternity related Serious Incidents along with previously reported summary of numbers and categories. It should be noted that all incidences of a Cooled Baby are reported to HSIB are now logged as serious incident whilst the outcome of the investigation is awaited. If no areas for improvement identified and all appropriate care provided then these incidents will be de escalated as serious incident. 4 of the incidents below relate to Cooled Babies.

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

STEIS Ref. No.	Target Completion Date	SI Category	Incident Synopsis
2021/2331	28/04/2021	Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant)	Agreed reporting as potential SI as case reported to HSIB under NHSR early notification scheme for cooled babies. Attended MAU with Spontaneous Rupture of Membranes for previous 3 days. Known history of severe polyhydramnios. Induction labour had been planned for 13/01/2021. Sub optimal CTG and arranged Cat 2 EMCS. Baby born and normal appearance. Baby required 50% oxygen and therefore CPAP commenced and transferred to Neo Natal Unit to initiate therapeutic cooling.
2021/3124	070/05/2021	Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant	Category 1 Caesarean Section (Category 1 CS immediate threat to life of woman or fetus) at 37 weeks and 6 days for a pathological cardiotocograph (CTG). Baby needed transferring to the neonatal unit and required therapeutic hypothermia – cooling
2021/3688	14/05/2021	Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant)	Reported following investigation. Accidental dislodgement of ET Tube in pre term baby (25 weeks) and required reintubation. 2 failed reintubation attempts without drugs and 1 failed attempt with drugs. Baby became hypoxic with poor heart rate and needed extensive resuscitation including ongoing CPR for >60 min in total, 6 doses of adrenaline, several dose bicarbonate, glucose. Developed a Right pneumothora and needed a chest drain to be inserted. Also large pulmonary haemorrhage (acute haemorrhage protocol activated)
2021/3974	19/05/2021	Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant)	Baby dusky floppy emergency buzzer active paediatrician asked to attend. Resuscitation required and baby transferred to NNU with neonatal team. Baby needed transferring to the neonatal unit and required therapeutic hypothermia – cooling.
2021/4461	26/05/2021	Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant)	Baby born in good condition, APGARS 9 + 9 + 10. At 20 mins of age, became dusky, taken to resus, colour worsening, sats low, commenced in 100% O_2 and sats remains low, paeds called once present - Intubated sats remain at 63% on 100% O_2. Transferred to NNU baby to be cooled.
2021/4474	26/05/2021	Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant)	Patient attended MAU with APH/? placental abruption at 41+4 gestation Primip MBC booked low risk Active bleed on MAU - 200mls placenta post. clear of os transferred to Delivery Suite - reviewed by medical staff - CTG suspicious, vaginal examination performed - decision for EMCS cat 1

Duty of Candour Compliance





Variation	Assurance
	P

Target	Dec 20	Jan 21	Feb 21
100%	100.0%	100.0%	100.0%

Background

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

Variation	Assurance
	?

Target	Dec 20	Jan 21	Feb 21
100%	87.5%	73.0%	87.5%

Background

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

What is the data telling us:

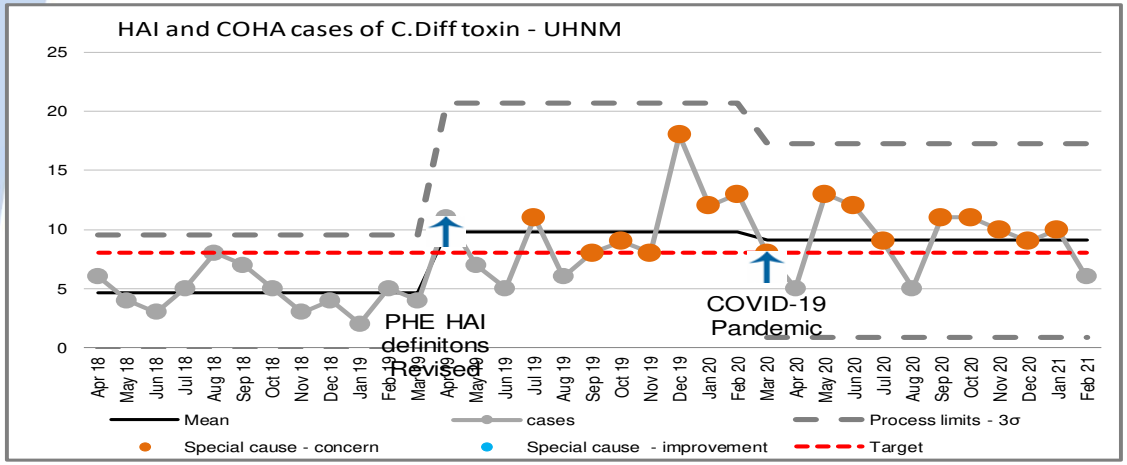
During February there were 8 incidents reported that formally triggered the Duty of Candour. All with 8 in the Medicine Division and all have been formally notified of the incident.

Follow up Written Duty of Candour Compliance for receiving the letter within 10 working days of verbal notification during February 2021 was 87.5% with 7 cases receiving their letter within 10 working days of the initial formal verbal notification.

Actions being taken to sustain the improved compliance:

- Escalations on outstanding letters are provided to relevant directorates and divisions via the Divisional Governance & Quality Managers.
- Support is being provided with the drafting of the 10 day notification letters for clinicians by the Divisional Governance & Quality team.
- Directorate Teams are receiving updates on new incidents where duty of candour is formally required
- Compliance being included in Divisional reports for discussion and action.

Reported C Diff Cases per month



Variation	Assurance

Target	Dec 20	Jan 21	Feb 21
8	9	10	6

Background

Number of HAI + COHA cases reported by month

What do these results tell us?

Chart shows the number of reported C diff cases per month at UHNM.
There have been 6 reported C diff cases in February which is below monthly trajectory.
4 of these were Hospital Associated Infection (HAI) cases and 2 Community Onset Hospital Associated (COHA) cases.

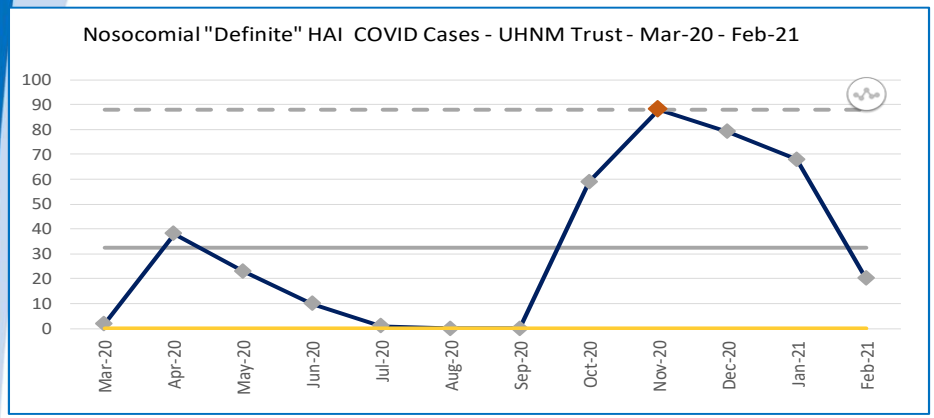
HAI: cases that are detected in the hospital two or more after admission
COHA: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks

One clinical area has reported 2 cases Clostridium *difficile* toxin cases within a 28 day period (1 HAI and 1 COHA), awaiting ribotype results
For February 2021, UHNM is above trajectory for the year to date 2020/21 , 101 cases versus a year to date target of 85

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
- RCA reviews with the CCG are paused due to COVID 19.
- Each in-patient is reviewed by the C *difficile* nurse at least 3 times a week, and forms part of a multi-disciplinary review.
- Routine ribotyping of samples is now being undertaken at Leeds hospital. This will help determine if cases can be linked
- A Clostridium *difficile* task and finish Group in progress

HAI Nosocomial COVID Cases per Month



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

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

What do these results tell us?

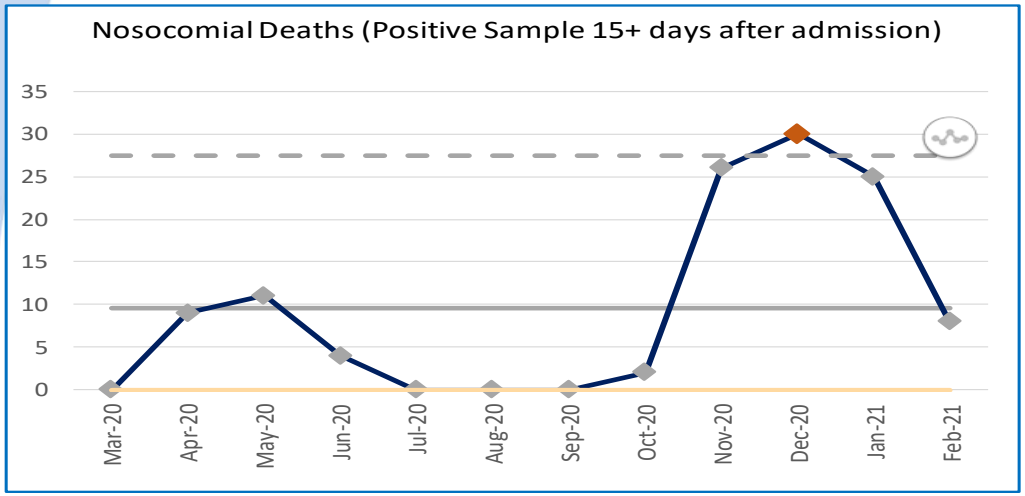
- The data shows an in month decrease in definite Healthcare Acquired COVID - 19 cases. The UHNM case numbers reflect the changes in community rates on national, regional and local levels. October and November saw higher community rates in Staffordshire and Stoke than West Midlands and national average.
- COVID ward outbreaks were reported during February 2021 on:
  - Wards 227, 222, 76b , 120, 100/101
- All the outbreaks have now been closed and restrictions removed.

Actions :

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

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

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



What do these results tell us?

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

- The data shows a decrease in definite Healthcare Acquired COVID -19 deaths during February 2021 compared to November, December 2020 and January 2021.
- Total recorded definite hospital onset COVID-19 deaths is 8 during February 2021
- 8 recorded at RSUH and 0 at County Hospital
- Total 115 hospital acquired COVID-19 deaths with 1st positive results 15 days or more following admission recorded since March 2020.
- The mean number of deaths per month since March 2020 is 9.4, however following the in month reduction in February 2021 the monthly total is below the overall mean.

Actions :

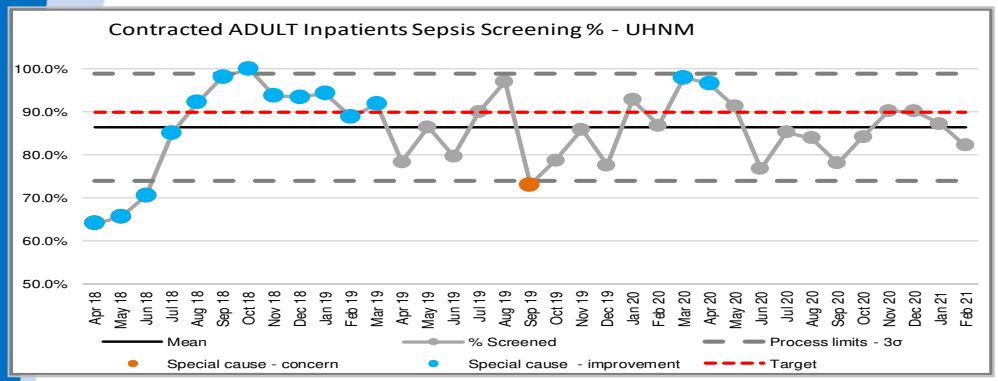
Review Panel comprising of the Deputy Medical Director and senior clinicians from Clinical Divisions will commence reviewing these deaths during end of Quarter 4 2020/21.

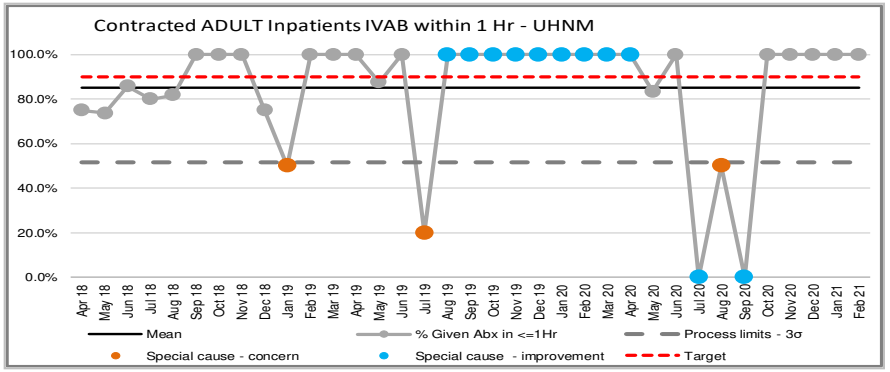
The Senior Clinicians have been identified by Divisional Chairs and Clinical Directors

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

Sepsis Screening Compliance (Inpatients Contract)

NHS
University Hospitals of North Midlands
NHS Trust





Variation	Assurance
	

Target	Dec 20	Jan 21	Feb 21
90%	90.2%	87.2%	82.2%

Background

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

Variation	Assurance
	

Target	Dec 20	Jan 21	Feb 21
90%	100.0%	100.0%	100.0%

Background

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

What is the data telling us:

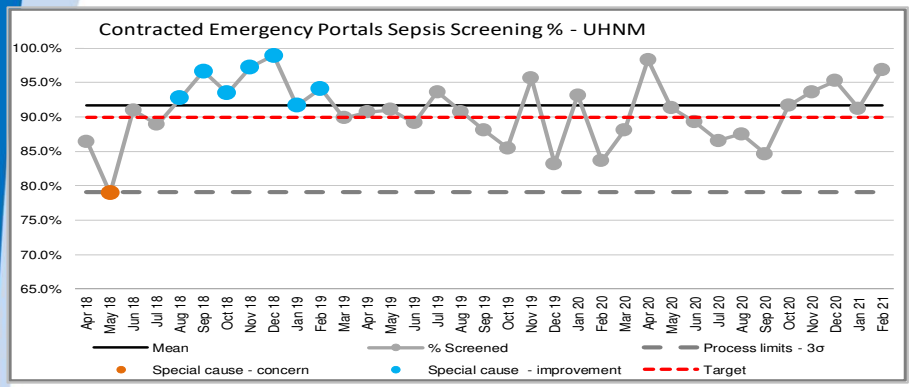
February results now at 82.2% which shows drop from the previous 2 months. Inpatient areas did achieve 100% for IVAB within an hour. Of the 107 Inpatients that triggered a sepsis screen, 28 were not red flags sepsis and 79 patients with red flags, 4 of these patients were given IVAB within hour and of the remaining 75 patients, 36 had alternative diagnosis that were deemed as not sepsis related and IVAB were not indicated. The remaining 39 patients were already receiving IVAB prior to the identified red flag trigger.

Actions:

- In the absence of formal practical training due to COVID-19 restrictions, the sepsis team have continued to provide sepsis re-enforcement which consists of visiting ward areas to update clinical staff and promote awareness around sepsis whilst answering any queries they may have as well as sepsis kiosks and 15-20 minutes drop in session (commenced already in prioritised areas, like older adults wards & other medicine areas and Surgery Division.
- The Sepsis Team now input data fortnightly rather than monthly in order to identify Inpatient areas with poor compliance and prioritise those areas for sepsis re-enforcement.
- The Sepsis Team continue to work closely with the VitalPacs team in order to address issues such as staff access levels, sepsis alerts not showing and training needs.
- The missed screens for this month were due to, lack of communication between HCA's and qualified staff, Student Nurses not communicating observations in a timely manner and night shifts having higher occurrences. Therefore, the sepsis team continue to provide unannounced ward visits out of hours to deliver reinforcement to those staff who work regular nights. We also plan to arrange training for students and have delivered sepsis re-enforcement for those involved with missed screens.
- The Sepsis Clinical Lead and Sepsis Team have continued to deliver yearly sepsis training to all level of clinicians via Microsoft Teams.
- Specialised Division & Renal Department already arranged training during March 2021.

Sepsis Screening Compliance (Emergency Portals Contract)

University Hospitals of North Midlands NHS Trust

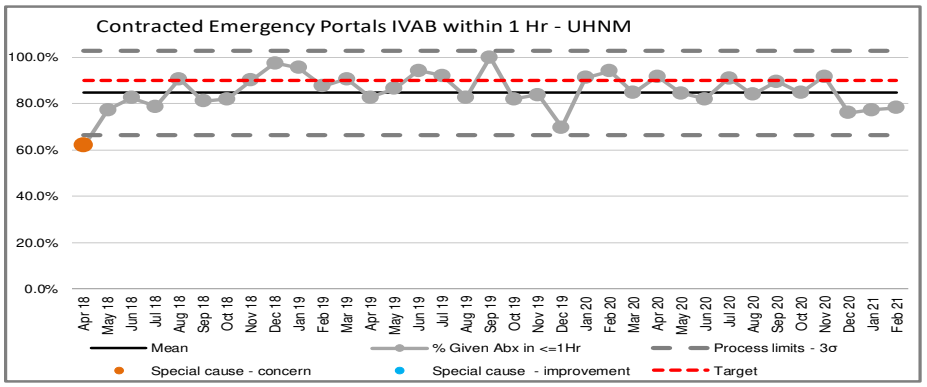


Variation	Assurance

Target	Dec 20	Jan 21	Feb 21
90%	95%	91%	97%

Background

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



Variation	Assurance

Target	Dec 20	Jan 21	Feb 21
90%	76%	77%	78%

Background

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

What is the data telling us:

Adult Emergency Portals screening in February 2021 achieved 97% for the 63 patients audited.

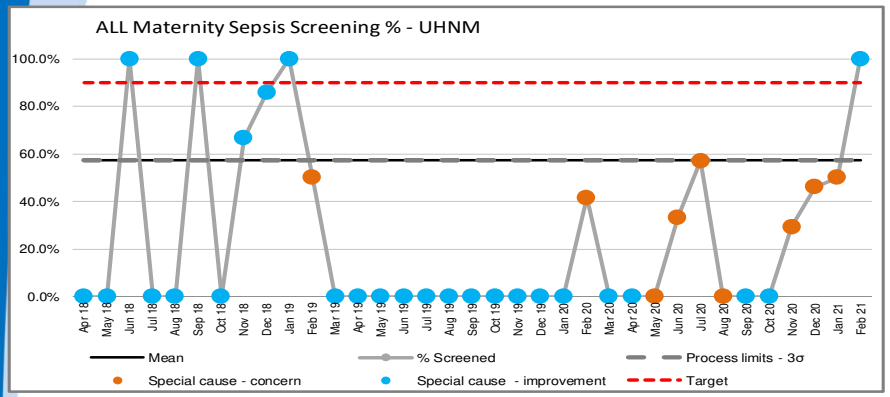
The subsequent IVAB within 1 hour performance increased to 78%. There were 50 red flag sepsis patients identified from the 63 patients audited in the screening sample. Out of the 50 red flag patients, only 22 required IVAB within an hour (16 were already on IVAB and 12 had an alternative diagnosis).

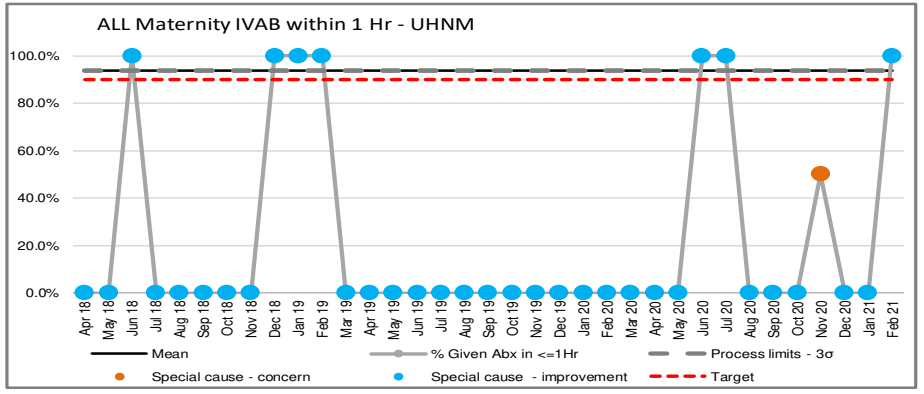
Of the 22 requiring IVAB, 17 were administered within 1hr and a further 3 were within 2 hours. The remaining 2 were significantly late and have been escalated to the respective areas' senior teams.

Actions:

- The Sepsis Team continued to closely monitor the compliance by visiting the A&E regularly and provided immediate sepsis reinforcement when staffing and acuity allows
- The A&E Education Team and A&E Sepsis doctor will continue to provided sepsis virtual education for both A&E sites as required. Sepsis talk via Microsoft teams will also commence from the 3rd week of March 2021, this will be available trust wide and will be advertised via comms
- The Sepsis Team is working collaboratively with the A&E Quality nurses, senior staff and A&E Sepsis clinical lead for providing solutions to late IVAB incidents
- As winter pressures ease we anticipate smaller incident of late IVAB given within 2hrs. The late IVAB >2hrs have been addressed through training for individual staff involved

Sepsis Screening Compliance ALL Maternity





Variation	Assurance
H	F

Target	Dec 20	Jan 21	Feb 21
90%	46.2%	50.0%	100.0%

Background

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

Variation	Assurance
H	P

Target	Dec 20	Jan 21	Feb 21
90%	N/A	N/A	100%

Background

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

What is the data telling us:

Maternity Inpatients and Emergency portal (MAU) audited by the Sepsis Team in February 2021. All patients that trigger with MEOWS >4 were audited via the Maternity K2 system. The Inpatient wards and MAU screening compliance scored 100% for the 12 patients audited.

IVAB within an hour also achieved 100% for the 2 red flag sepsis patients identified.

Actions:

- The Maternity Senior Team have been working collaboratively with the sepsis team and following the creation an action plan, which was presented in the last IPCC meeting, great improvements have been seen. The Sepsis Team provided training to all maternity staff in February and had an excellent uptake. The issue of attaching completed screening tools to the K2 system has been addressed internally and this is now standard practice.
- The new electronic version of maternity sepsis screening tool will be ready for trialling very soon, and hopefully become available in their K2 Athena system. The sepsis team will monitor this situation and provide training on this aspect of screening when it is available.
- The sepsis team will continue to audit Maternity comprehensively to ensure the maintenance of this newly achieved high standard of sepsis compliance.

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

Although the pressure in the hospitals, due to Covid-19 remained high, particularly in the critical care unit, a gradual decline in the number of patients being admitted with Covid-19 and remaining as inpatients was seen in February. The number of inpatients reduced by half (from a peak of 349 in Jan to 139 in Feb, with daily new cases reducing to around 11/day. Attendances started to show an increase with an average of 277/day at Royal Stoke., an increase of c20/day. Whilst overall NEL admissions remained around the same .

The number of patients who had had covid-19 and were discharged reached 3368. The number of bed restrictions/ closures continued, however numbers reduced and from mid-Feb the number of closures across the month was less than 20.

Operational performance improved and Royal Stoke hit the 4hour performance of > 80% on several occasions, not achieved since Aug-20.. The Trust system wide 4hour performance achieved 78.2%, a significant increase from January (69%) and for UHNM Type 1 this was 68.1% (January 55.5%). There were zero 12 hour trolley waits.

Cancer

In February improvements were seen across most of the cancer standards. The trust is predicted to achieve five of the standards: 31 day first treatment, 31 day anti cancer drugs, 31 day surgery, 31 day radiotherapy, and the 28 day standard. The total PTL remains steady although the backlog has risen slightly. The 104+ day backlog remains steady at 54 for February 21 .

The 2ww PTL rose following the second phase of the pandemic , however from early January the PTL reduced and has levelled out during February although the size of the waiting list is still higher than that seen pre-covid. Performance against the 2ww standard has improved and is currently at 91.62% compared to January 88.16% even with, on average, seeing the same number of patients. Demand appears to have levelled off although numbers are slightly higher than the same time last year.

31 Day subsequent treatment (surgery) has seen a significant improvement in February, currently achieving 98.4% compared to 78.13% in January. Cancer surgery continues being prioritised within the Trust and independent sector.

The latest data on 62 day performance is achieving 66.2%. The 62 day PTL and backlog and has shown a steady reduction through February with levels almost at the numbers seen pre- 2nd phase of pandemic. Similarly the number of patients in the 63-103 days is also reducing. The corporate cancer team has completed a high level specialty comparator analysis of referrals and treatments 2020 compared to 2021 with an in depth clinical review of pathways over the next month to contextualise our cancer assurance/risk evaluation for the second covid19 surge response.

Planned Care

The National ask for February-21 was for total Outpatients to be at 100% of last years business as usual and for Inpatients 90%. The trajectories for February were set 92.7% (Outpatients) and 84.6% (Inpatients) of BAU for last year. The actuals for February, against BAU, was outpatients 90.6% and inpatients 67.1%. This demonstrates the efforts to maintain out patient capacity even if the in patient work has fallen due to the requirement for workforce staffing to support the 200% critical care mutual aid support to London. Q1 – theatre and diagnostic capacity plans being drafted against time critical surgery patients (P2) and those eligible to be offered to the Independent Sector as Choice Referrals (P3/4) as part of the scaling up of planned care activity, in concert with CCG colleagues. Additional capacity has been sourced at county and the IS for ad hoc lists during March with major surgery cases being booked as the critical care dependency bed base is released from the covid surge.

RTT

The indicative performance for February 21: the total number of Referral To Treatment pathways grew to 53,269 (January 50,735, December 49,054). This is above the forecast 46,100. The Trust has 4,392 over 52 week breaches (January 3538, December 2,773) as a consequence of standing down elective work. This was over the forecasted position. Recovery plans for recovery of the long waiting patients are being reviewed. RTT performance in February 63.57% (January is 65.20% ,December 65.73%).

Diagnostics

February saw a rise in performance (DM01) with the indicative position at 90.1%, compared to 85.7% in January. The waiting list size has risen sharply to 13,858 from 11, 841. The Diagnostic cell recommenced in February to oversee recovery.

Urgent Care - Summary

NHS University Hospitals of North Midlands NHS Trust

- The 4hr performance in ED improved in February. System-wide the 4hr performance increased to 78.3% (January 70.1%), with Royal Stoke increasing to 63.8% from 47.5%. There were days in the latter half of February where RS performance was > 80%, not recorded since August-20.
- Attendances , which had fallen, showed an increase by 20/day on average. Ambulances remained steady with a n average of 150/day. Ambulances accounted for 54% of attendances at Royal Stoke. Less surges were noted.
- Zero 12 hour trolley waits.
- The Trust internal incident remained on level 4.

- The Urgent Care Programme metrics have shown an improvement in performance:
  - At the front door, time to triage, median time to treatment and mean time in ED all improved (slide 7)
  - Flow improved particularly referral to discharge time. MFFD and super stranded patients are still seeing the effects of the high number of covid positive inpatients (slide 8 & 9) with numbers remaining high, however discharges in Medicine started to see an increase.
  - NEL admissions remained around the same although Site management has shown an increase in the number of patients discharged pre-noon. SDEC has not quite recovered receiving 30% of admissions, however AMU and AEC have admitted and discharged patients in < 24 hrs. The 1+ Los for emergency admissions has continued to rise to an average of 8.4 days (this rise is in line with the previous year).
  - NHS-111 continued and numbers have risen to a daily average of 35.

- The overall improved flow contributed to the improved performance, clinical care and experience for the patient. However, pressures within the hospital remained high in February, particularly in critical care, however for the first time since mid-Nov there was a significant fall in the numbers of covid-positive patients in the hospital. At the end of February the number had reduced to less than half at 138 compared to the maximum of 349 patients in January. At the end of February the daily new numbers of covid patients averaged 11/ day with nosocomial cases also reducing.
- Within the Medical bed pool, numbers showed a reduction for the first time with a daily average of 441 patients, 28 patients less per day. 91 escalation beds were opened through February.
- The bed restrictions for Infection Prevention have continued but again a significant reduction was seen in February to under 25/ day

- After a period of where consistently 50% of staff absences were due to covid, the proportion is decreasing.

Urgent Care Improvement Programme

NHS University Hospitals of North Midlands NHS Trust

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

Work stream 1 - Acute Front Door

- Embed and sustain the changes seen in January through engagement with the team
- Complete business case for ED workforce to support the flow through the Department
- Implement streamlined referral process and review flow from ED to Acute Medicine and to wards
- Establish task and finish group to support quality improvement and the implementation of the new Urgent Care standards.

1. Weekly Urgent Care Meetings within ED and Acute Medicine consolidated to reinvigorate the urgent care actions and support sustained improvement in a context of reducing covid capacity and de-escalation of winter capacity
2. CQC Triage times paper submitted to Urgent Care Board for approval in order to protect the nursing staff within ED to support this process.
3. Electronic Referral from ED to Acute Medicine, AMRA and AEC.

Work stream 2 - Patient Flow

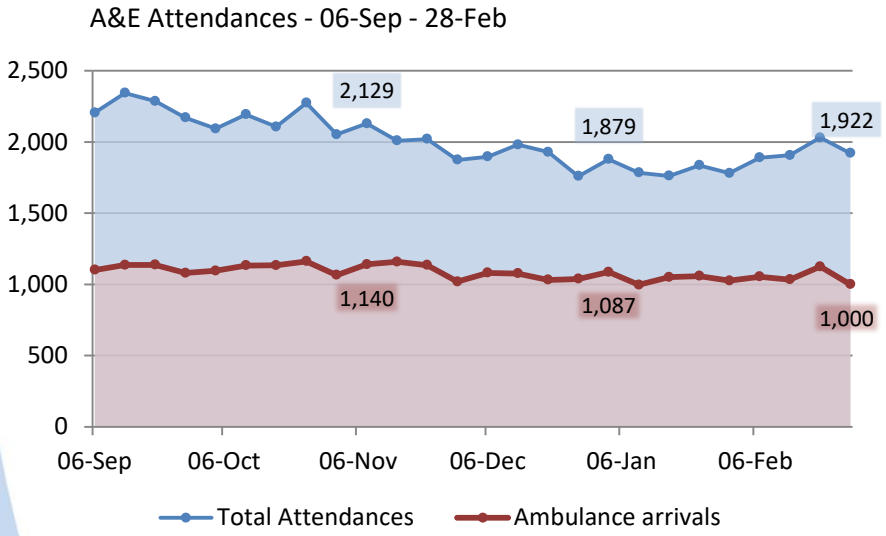
- Maintain focus of discharges before midday through improvement workshops
- Support length of stay by using directorate Teams – support improvements seen
- Review need for COVID discharge lounge to support earlier flow
- Importance of young persons rehab Unit working with MPFT
- Confirm In reach model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

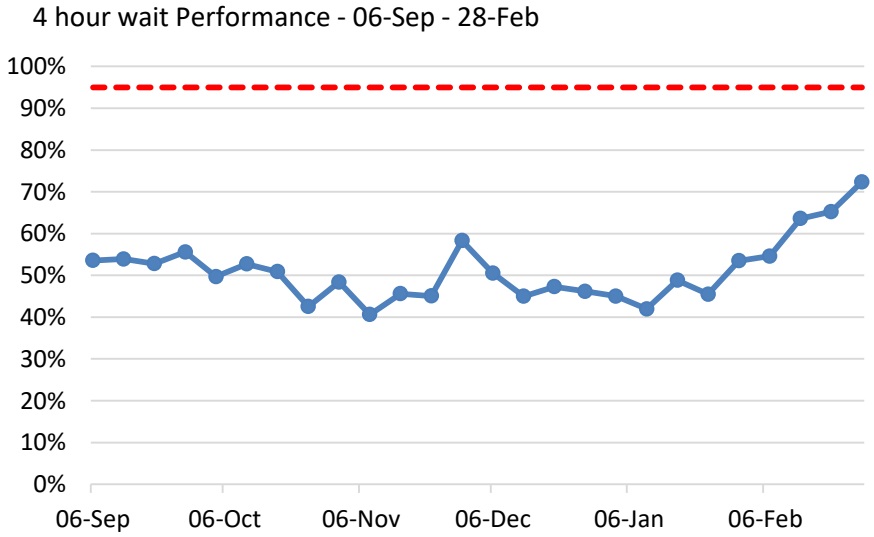
Work stream 3 -Clinical Site Management

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

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

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





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

University Hospitals of North Midlands NHS Trust

Work stream 1: Front Door – timing metrics

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

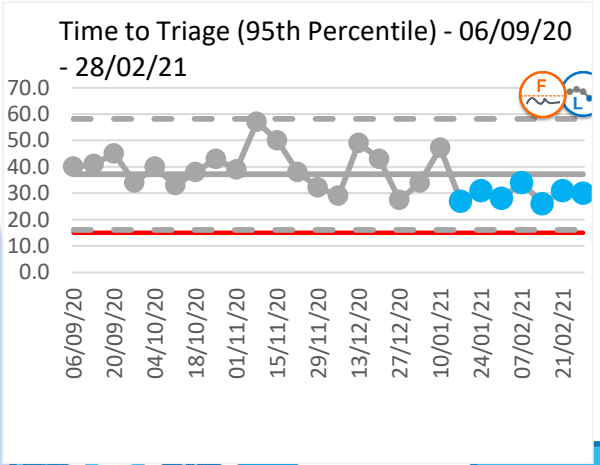
Whilst the triage time is below the target of 15 minutes, February saw considerable sustained improvements (blue dots).

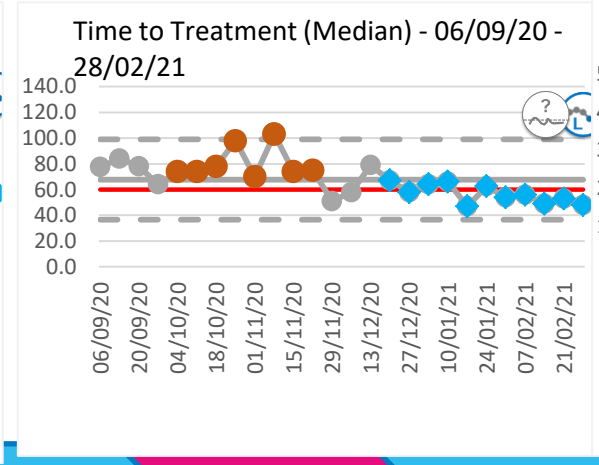
The median time to treatment - set at 60 minutes to ensure patients treated quickly and for those requiring referrals to other specialties are done so in optimum time.

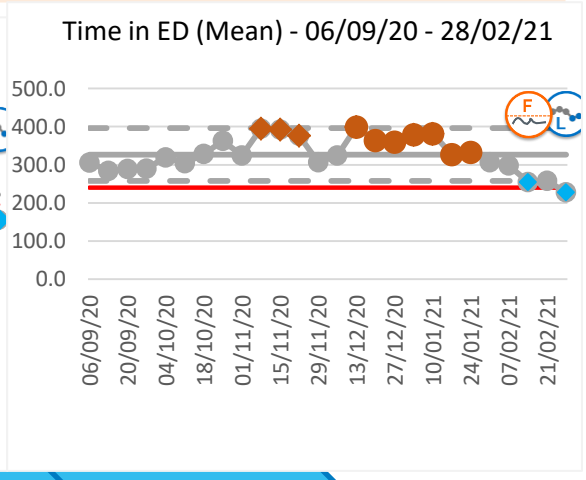
Since the end of December the median time to treatment has shown sustained improvement, with the latest data showing a median time at 48 minutes. All four weeks in February were below the 60 minute target.

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

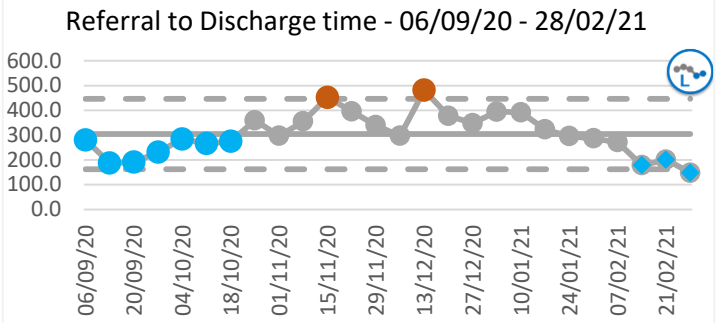
The mean time in the ED has dramatically reduced through January and continued through February. With the average now exceeding the 240 minute target.





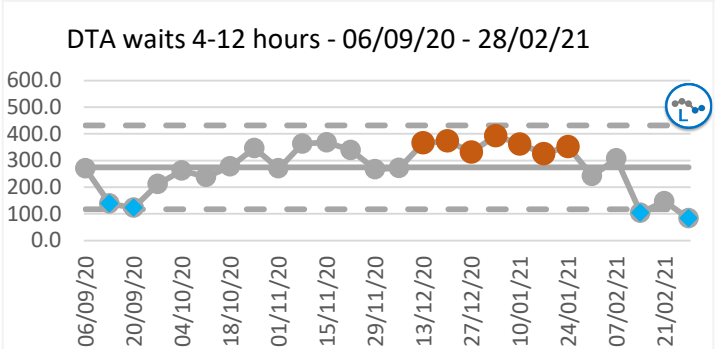


Work stream 2: Flow



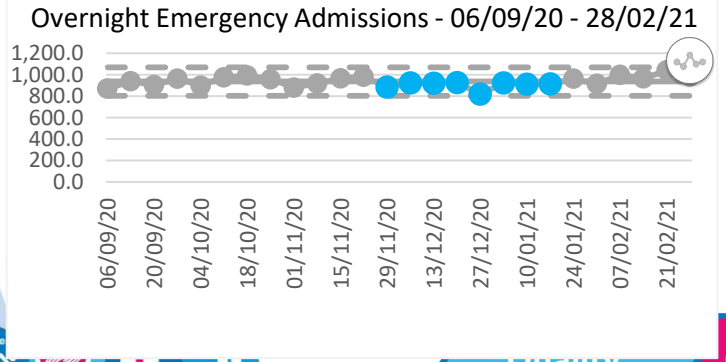
Referral to Discharge Time – improve the time taken from referral to specialties to discharge from ED either as admission or discharge home.

The referral to discharge time increased through Nov and Dec, following the second phase of the covid pandemic, however since mid-January a reduction in time is evidenced. This reduction is the main driver for the improvement in performance seen. And with three of the last four weeks below the control limit, this is a statistically significant improvement in spite of demand not decreasing



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

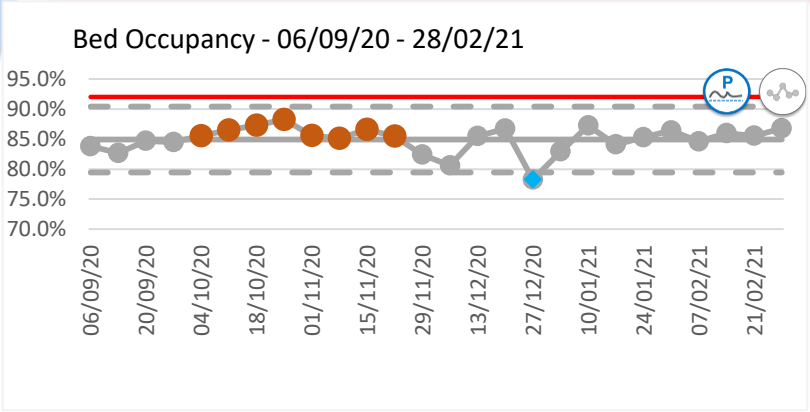
The number of patients through the second phase of the pandemic was consistently > 300. This has reduced significantly with the latest data showing below 100.



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

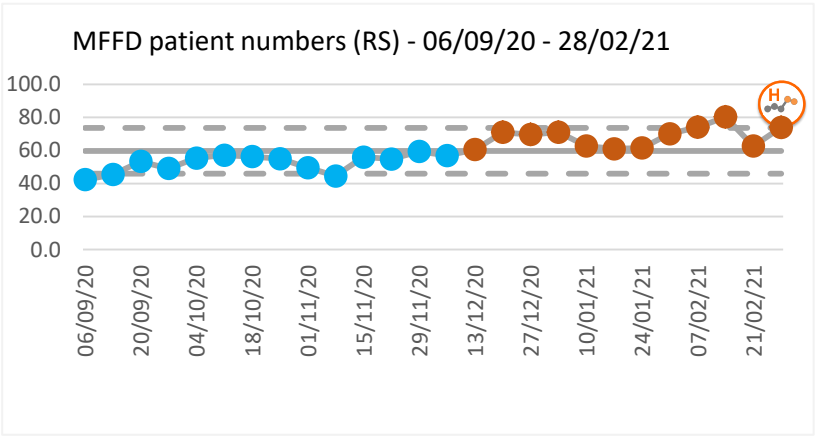
The number of NEL admissions has remained fairly static in February.

Work stream 2: Flow cont.



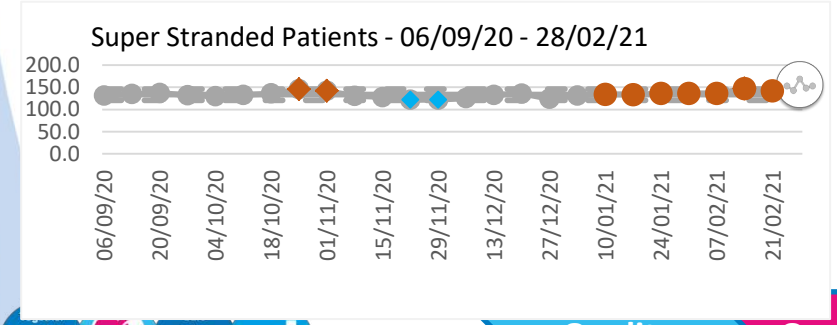
Bed occupancy:

With 1+ day LoS admissions remaining static so too has the overall bed occupancy at the Trust.



MFFD.

After a period of very low Medically Fit For Discharge numbers through the summer and into November, the number of patients in an acute bed medically fit is rising. The increase is slow but fairly consistent.



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

The number of patients in beds with a length of stay over over 21 days has followed a similar pattern to the MFFD numbers. A slow but sure increase over time. However it is important to know the number is just over 100 patients fewer than the same point last year.

Work stream 3: Clinical Site Management

University Hospitals of North Midlands NHS Trust

Pre-noon discharges.

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

The percentage of pre-noon discharges has seen a slight increase but is someway off the target of 33%

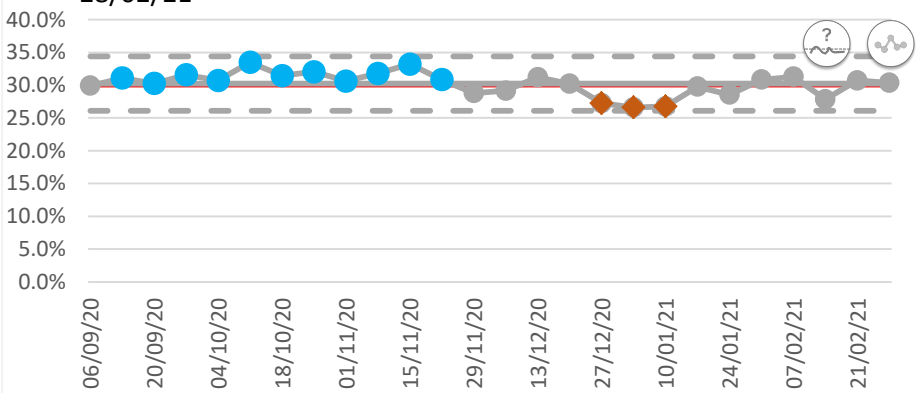
Same Day Emergency Care (SDEC)

Improve allocation of patients to most clinically appropriate clinical areas and clinical pathways.
The target is for 30% of patients treated on ambulatory care pathways.

The SDEC percentage of patients as a proportion of NEL admissions has remained stable at 30%.

Pre Noon discharges - 06/09/20 - 28/02/21

Same Day Emergency Care proportion of NEL admissions - 06/09/20 - 28/02/21



Compassion Improving

Quality Operational Workforce Finance

Cancer

University Hospitals of North Midlands NHS Trust

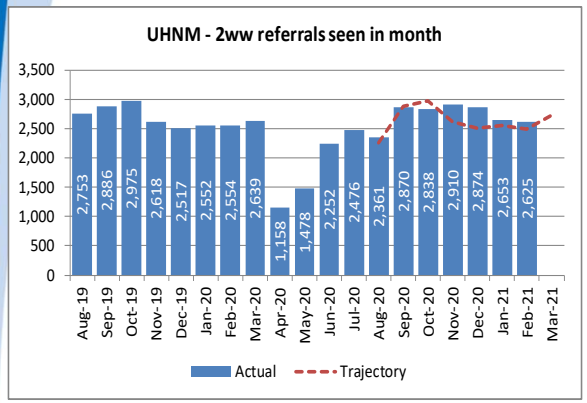
Summary:

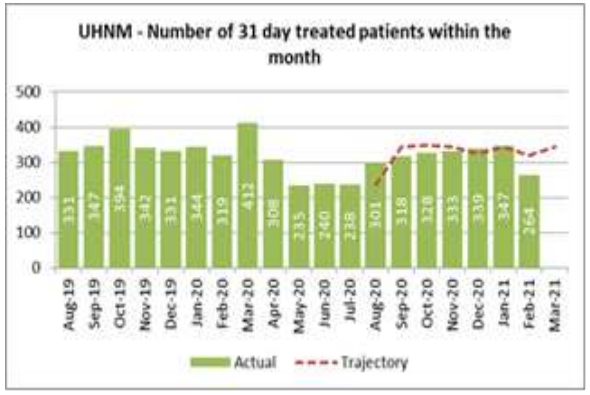
- In February improvements were seen across most of the cancer standards. The trust is predicted to achieve five of the standards: 31 day first treatment, 31 day anti cancer drugs, 31 day surgery, 31 day radiotherapy, and the 28 day standard. The total PTL remains steady although the backlog has risen slightly. The 104+ day backlog remains steady at 54 for February 21
- The 2ww PTL rose following the second phase of the pandemic , however from early January the PTL reduced and has levelled out during February although the size of the waiting list is still higher than that seen pre-covid.
- Performance against the 2ww standard has improved and is currently at 91.62% compared to January 88.16% with on average as many patients seen.
- Demand appears to have levelled off although numbers are slightly higher than the same time last year.
- 31 Day subsequent treatment (surgery) has seen a significant improvement in February, currently achieving 98.4% compared to 78.13% in January. Cancer surgery continues being prioritised within the Trust and independent sector.
- The latest data on 62 day performance is achieving 63.8%. The 62 day PTL and backlog and has shown a steady reduction through February with levels almost at the numbers seen pre- 2nd phase of pandemic. Similarly the number of patients in the 63-103 days is also reducing.
- Delays are multifaceted including capacity in Endoscopy, Pathology and reduced theatre capacity. The new assurance framework highlights surgical category timeframes and ensures that patients are dated according to clinical priority.
- Despite trust pressures the 104+ day backlog remains steady at 48. This cohort is still being monitored daily and escalated for clinical validation and mitigating actions where necessary.

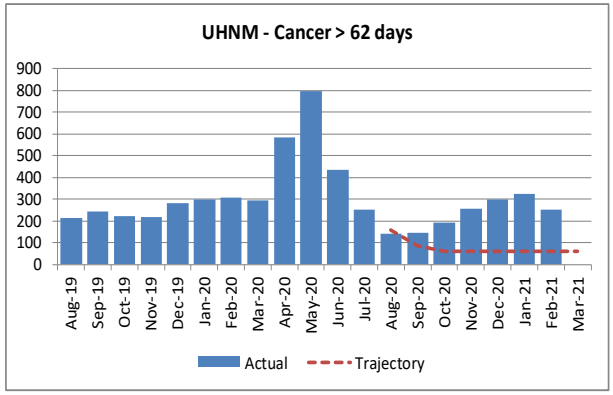
Actions:

- Vague symptoms pathway group convened with excellent clinical engagement and follow on actions confirmed.
- 2ww demand against bookings kept under review with escalations to teams for additional capacity to ensure pathway improvements are sustained.
- Action plans to address bottlenecks in Endoscopy and Pathology have been drafted as part of the Q1 capacity and demand plans. Cancer endoscopy has been prioritised now with 57 patients '@ 3 week wait.
- Capacity plans being drafted to support the 24 theatres coming on line at the acute together with the new contract with the IS from 1st April to start to treat patients to pathway and continue to improve performance.
- Specialty comparator analysis completed to evaluate quality indicators and activity between 2020 and 2021 Further deep dive with clinical input being conducted over the next 4 weeks to frame the cancer assurance/risk position statement with regard to the covid second surge management of patients.

Cancer

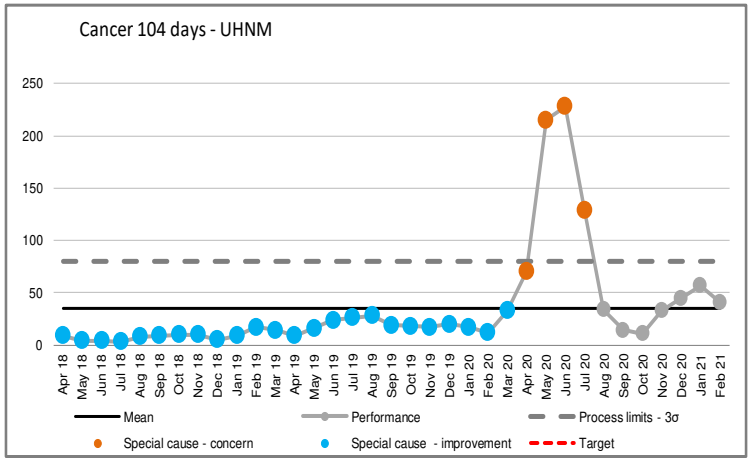






Summary draft achievement position for **Feb-21**

	Target	Trust Actual	Clock Stops	Breaches	Breaches Over	Needed Treatments
TWW Standard	93%	91.6%	2654	220	35	489
TWW Breast Symptomatic	93%	83.3%	24	4	3	34
31 Day First	96%	98.5%	384	18	3	67
31 Day Subsequent Chemotherapy	98%	100.0%	13	0	Achieved!	Achieved!
31 Day Subsequent Surgery	94%		0	0	1	1
31 Day Subsequent Radiotherapy	94%	95.2%	84	4	Achieved!	Achieved!
62 Day Standard	85%	66.2%	157	51	28	184
Rare Cancers - 31 Day RTT pathway	85%	100.0%	1	0	Achieved!	Achieved!
62 Day Screening	90%	75.0%	20	5	4	31
28 Day FDS Standard	75%	77.4%	1943	440	Achieved!	Achieved!
62 Day Consultant Upgrade	86%	63.7%	89.5	32.5	20	143.5
Closed Pathways > 104 Day			14			



Planned care - *Inpatients*

University Hospitals of North Midlands NHS Trust

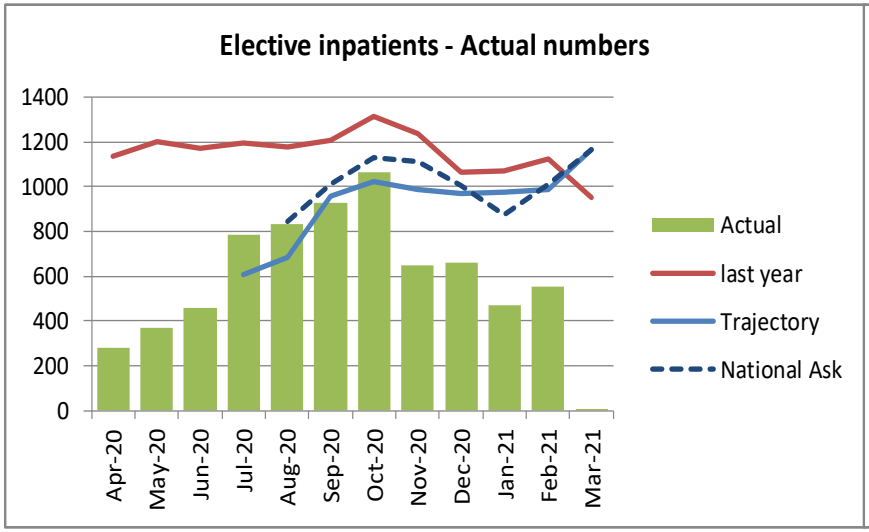
Elective inpatients Summary

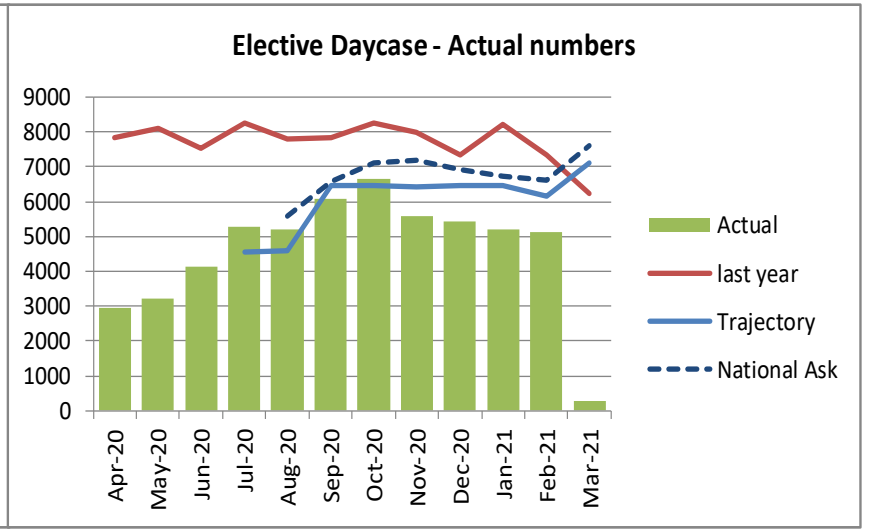
- Elective/Daycase activity combined had seen a steady rise since April 20 in line with restoration plans until November when special cause occurred (second wave Covid-19). Following the initial fall in November, activity has remained at around 67% - 69% of BAU..
- The number of elective operations for UHNM are below the numbers seen pre-covid, although since mid-Jan the numbers have shown a steady weekly rise. For RS & County, Elective operations were 818 (compared to January 751). Cancellations on the day continued to show low numbers. These are being driven by a number of factors but can all relate back to the second surge in COVID cases i.e. patients testing positive, no SSCU/critical care beds, patients changing their minds about surgery. Backfilling short notice cancellations is very difficult due to the COVID secure pathways (patients requiring swabs and isolation).
- Insourcing contracts in discussion for Q1 in respect to 60+ week long waiters. Business case deadlines have been advised to all DMs considering insourcing for Q1.
- The reduction in beds in the surgical bed base due to COVID outbreaks in Medicine resulting in further zoning of capacity and of course the growing dependency in CC meaning that staff deployment from other specialities and disciples are now caring for critical care patients.
- NHSEI have advised that there will be some funding release to support treatment pathways for patient to the year end.
- NHSEI have funded Independent sector transfers for Q4, UHNM have outsourced c. 1000 patients so far which have included some cancers, cat p1/p2 and long waiters. Transfer will continue until end of March and we expect to see a decrease in long waiters at UHNM.
- From April the IS contract is based on local negotiation with the main contract being P3/4 against the framework offers by Site (this means continuing to identify and send patients to the C&RC to transfer into the IS). Stratification by post code means we can try and mitigate some of the choice rejects we have endured in the first round (circa 30%) and to ensure the offer is credible.

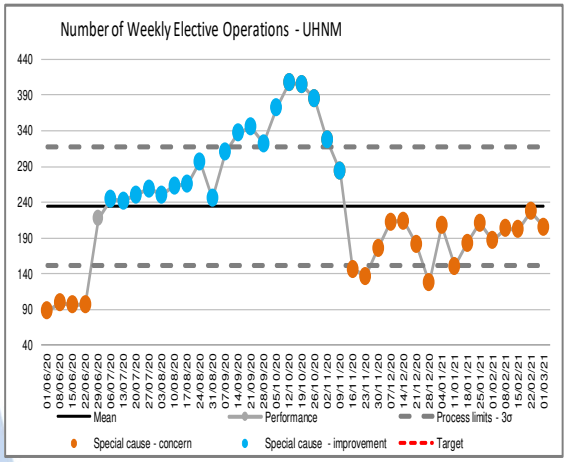
Actions

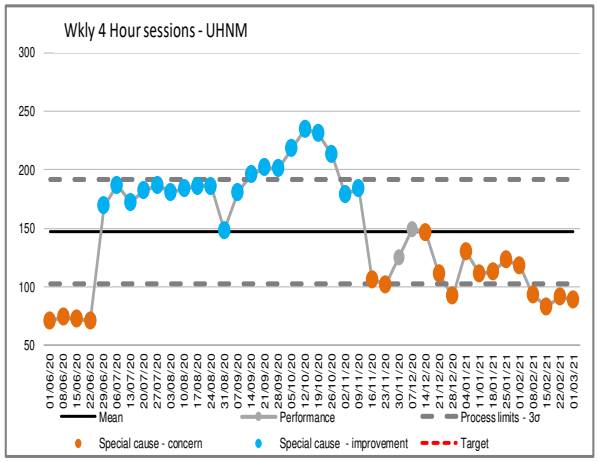
- Categories P5 for covid related delays and P6 for non covid related delays introduced. Surgery have linked with information services to develop a report to support the identification & prioritisation of urgent electives, and will keep Outpatient Cell informed of potential impact on OP activity.
- Long waiters governance assurance paper now complete. Weekly RCA/Clinical harm review meetings have been set up and have taken place from mid-January and will continue.
- Weekly assurance meeting to monitor long waits and specialty plans for the over 52 week patients have now taken place from mid-January and will continue. This is also supported by a clinical harm review process.
- The Surgical Division have been asked to review patient lists for County with a view to relaxing P2 criteria in an effort to optimise all capacity.
- From end of March surgery are planning to have 24 theatres operational to book time critical P2 patients for which the specialties are being asked to validate and identify those patients who need a TCI (i.e. are not diagnostics/other pathways) with a view to modelling a timeline for treatment against theatre capacity coming on line.

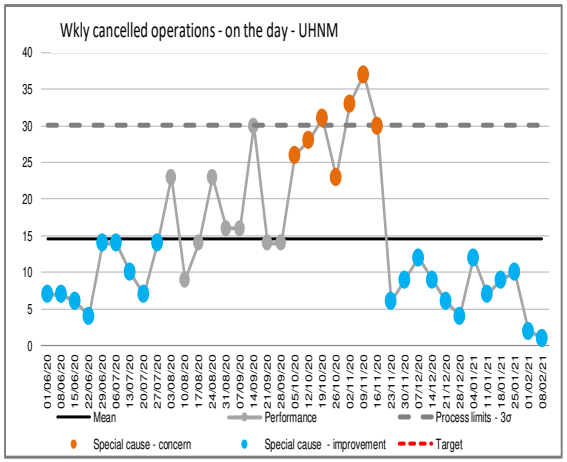
Planned care – *Inpatient Activity*











Planned care - *Outpatients*

University Hospitals of North Midlands NHS Trust

Summary

- Activity for outpatients in February 21, the Trust delivered 90.6% vs. BAU and the trajectory set at 92.7%.
- February 21 numbers recorded were 59,225, however this may increase as the outstanding outcomes are completed.
- The overall Referral To Treatment (RTT) Waiting list continues to rise. For February the number of Incomplete pathways has risen to 53, 269 (January 50,735). The Trust trajectory has been developed based on the assumption that referrals will return to 100% of last year demand (Phase 3 ask). The numbers of RTT pathways has exceeded the trajectory for the last 4 months suggesting more demand from General Practitioners/ clock starts following outpatient attendance, however it is too early to say if this is a trend likely to continue. We are however, significantly above the levels seen pre-covid.
- The RTT waiting list shape has changed with the number of patients > 18 weeks remaining at a high level of 19,404 (January 17,656).
- The numbers of 52 week waits in February has risen to 4,392 (January 3,538: December is 2,773: November were 2,100). These are expected to grow further through the year and the Trust trajectory of 2756 for March 2021 has already been exceeded. Further reviews are to be undertaken to support the reduction.
- For outpatient appointments (appointment type) the Trust delivered 54.1% F2F and 32.1% non F2F(Telephone & Video). There were 13.8% of appointments not set which is a 1% improvement which helped to increase the F2F element against January (for new appointment types F2F was 58.6% & non F2F 27.1% & follow ups F2F 52.0% & non F2f 34.5%). Work is underway to make the Media Type field in Medway mandatory which will eliminate 'Not Set'.
- February's performance for ASIs improved position to 88.1% within 3 days (from 87.3% in January) despite COVID pressures.

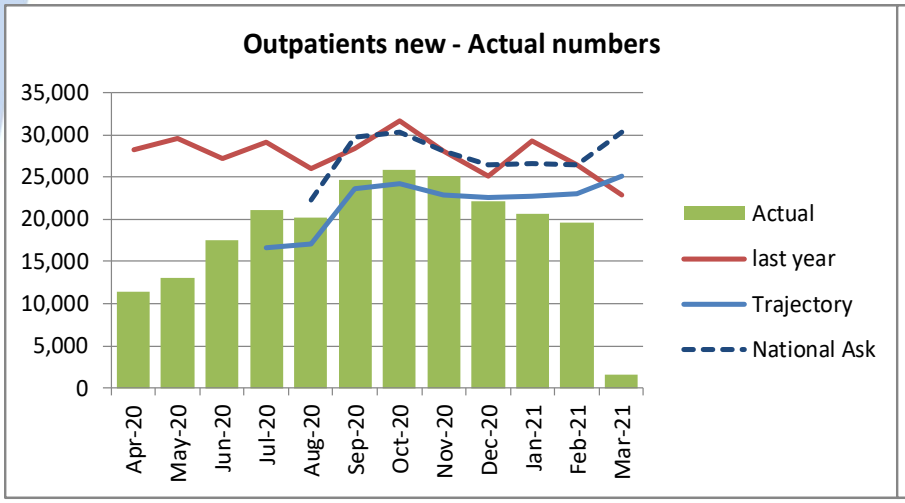
Actions

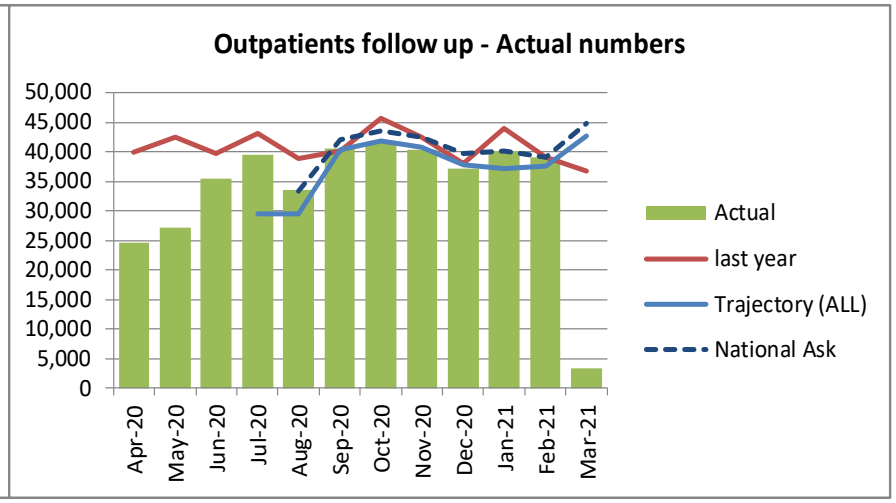
- Work is required on template reconfiguration based on Divisional assumptions - this needs to be aligned to the in patient and diagnostics plans for the purpose of substantive job planning.
- Revised 52 ww trajectory to be drafted once all cell plans confirmed to reduce the end of March 2021 delivery.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

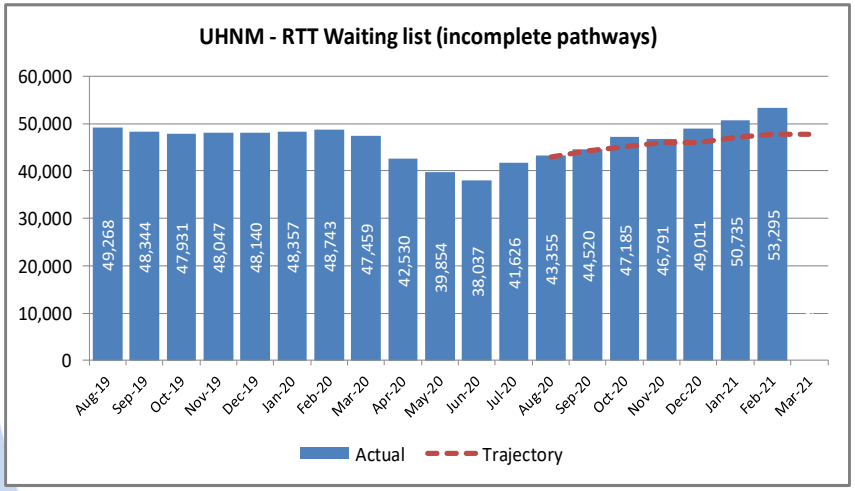
Risks:

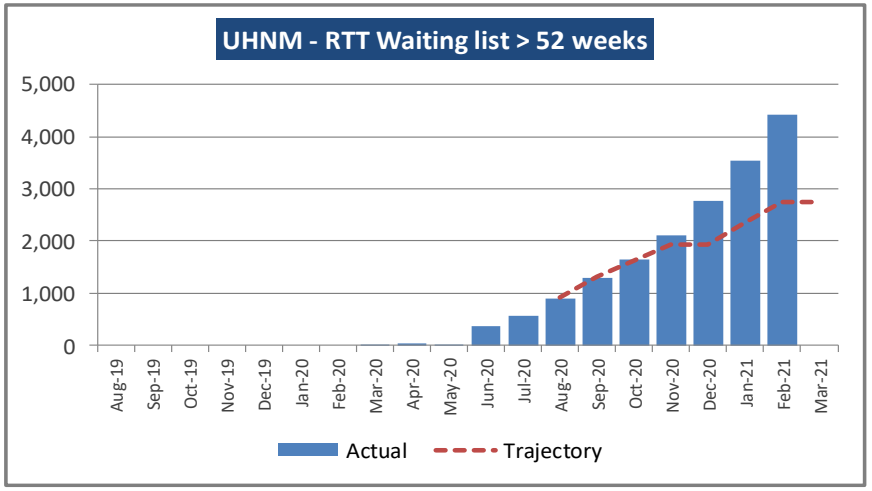
- Impact of stopping FTF activity in some areas to release staff to support frontline being monitored.

Planned care – *Outpatient activity & RTT*

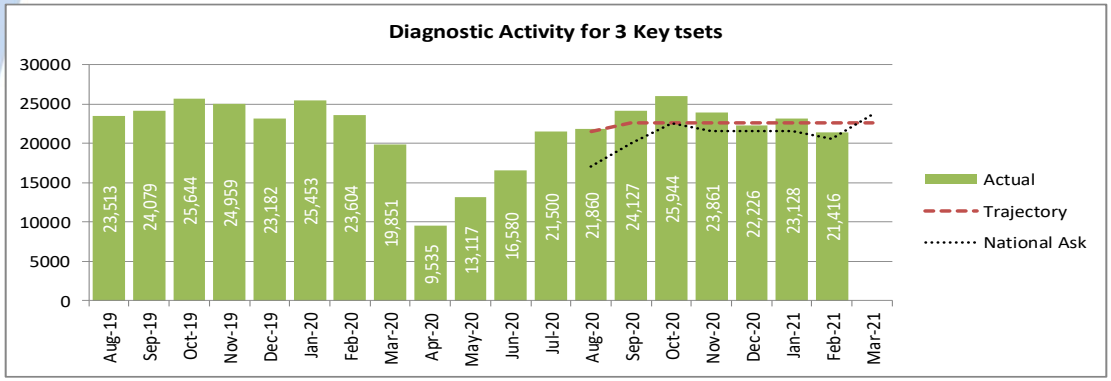








Diagnostic Activity



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

Background
Activity for the 6 key DM01 tests

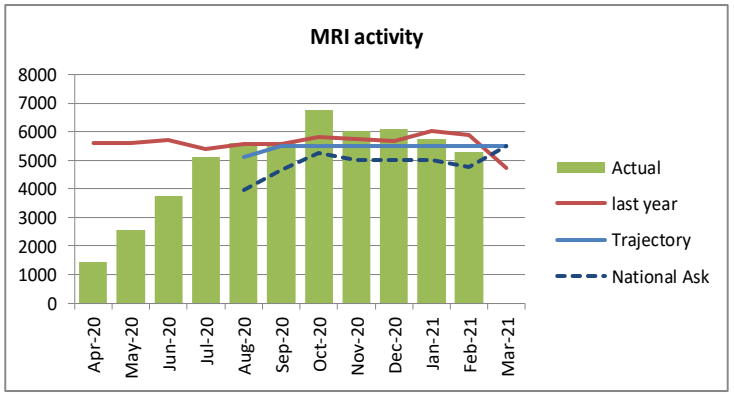
Summary

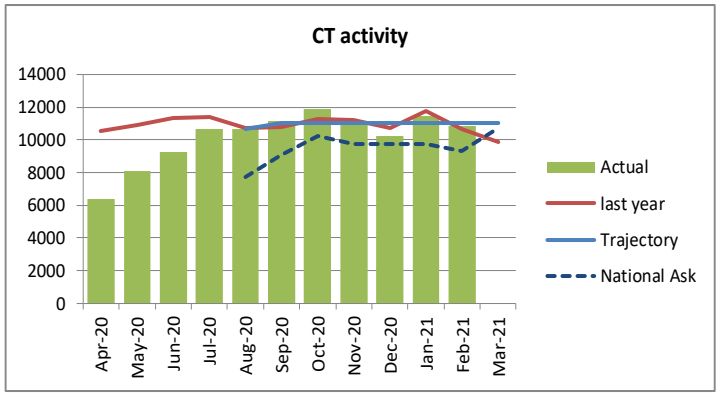
- For the 6 key diagnostic tests in phase 3, February saw a slight decrease in activity which appears to be normal variation (as is for all the DM01 tests) and is in line with expected activity in a shorter working month. The trust trajectory for activity has consistently met the national ask and would be on trajectory to deliver to the year end. This was before the impact the new variant of Covid-19, the easing of restrictions over the Christmas period and the usual winter pressures which has shown some early indications of having an impact on performance and the size of the waiting list. The indicative diagnostic DM01 performance for February 21 was 90.1% a rise from January of 85.7%. The waiting list size is 13,858 (January 11, 841). Recovery plans are now being transacted and monitored via the Diagnostic Cell to end of March 2021, with investment requests approved for DMO1 modalities to support this recovery timescale.

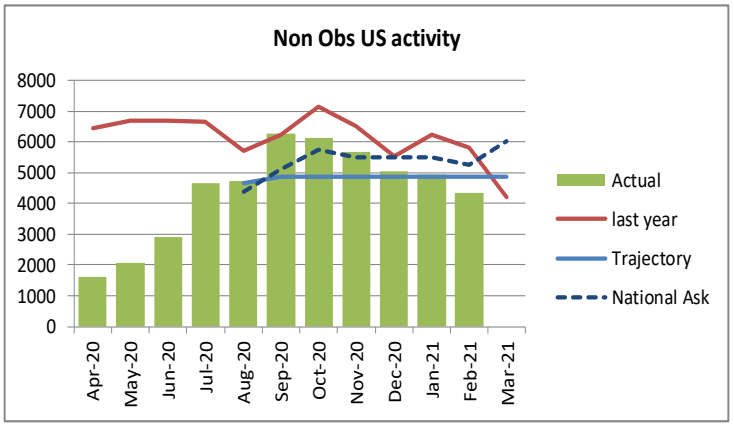
Actions

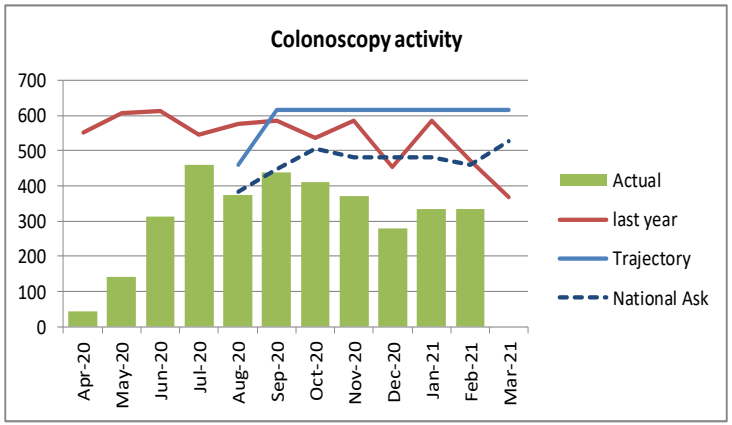
- The diagnostic work streams have made significant improvements and are working towards more initiatives to improve systems and processes.
    - Patient Connect is fully operational for pathology services and a scoping exercise underway to see if this can be transferred to other areas
    - Robotic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

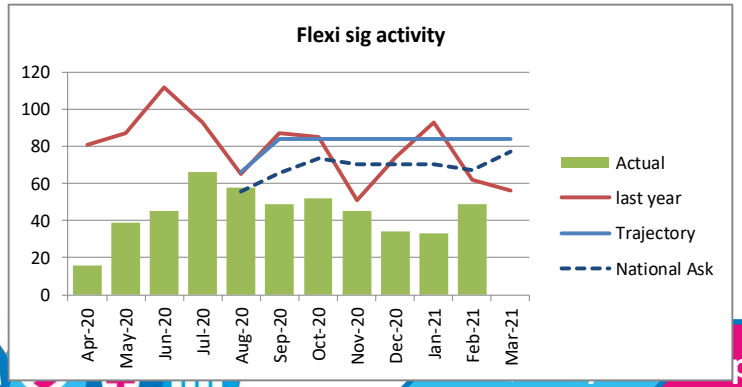
Diagnostics

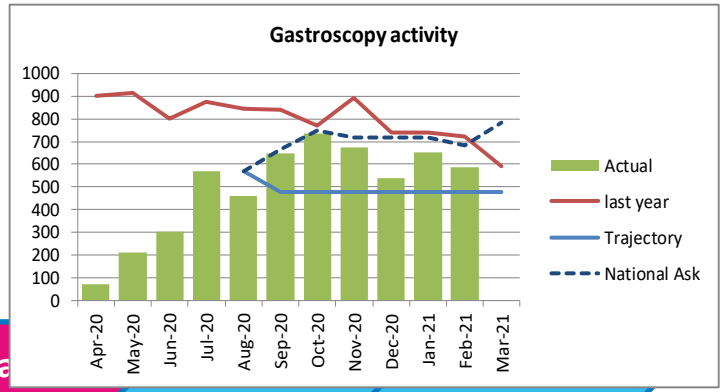












APPENDIX 1

Operational Performance

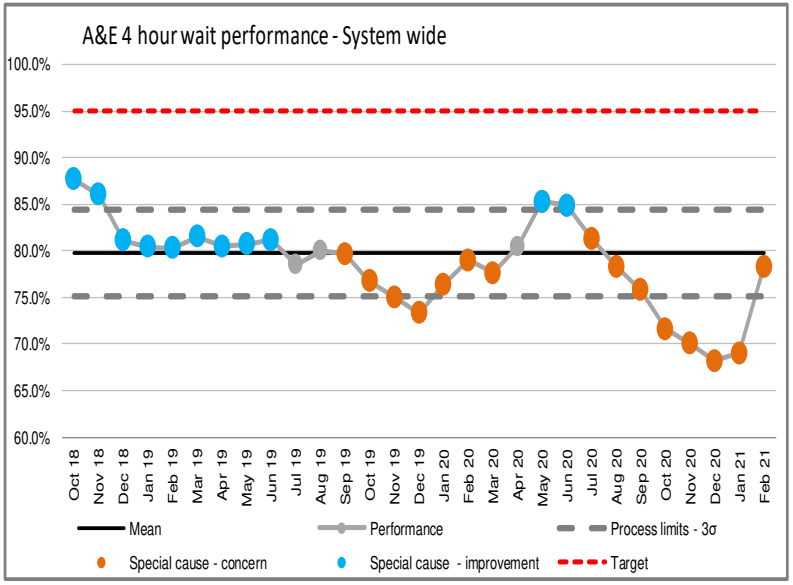
Constitutional standards

	Metric	Target	Latest	Variation	Assurance	DQAI
A&E	A&E 4 hour wait Performance	95%	78.30%	L	F	
	12 Hour Trolley waits	0	1		?	
Cancer Care	Cancer Rapid Access (2 week wait)	93%	91.62%		?	
	Cancer 62 GP ref	85%	66.21%	L	?	
	Cancer 62 day Screening	90%	70.83%		?	
	31 day First Treatment	96%	98.48%		?	
Elective waits	RTT incomplete performance	92%	63.54%	L	F	
	RTT 52+ week waits	0	4417	H	F	
	Diagnostics	99%	88.00%		?	

	Metric	Target	Latest	Variation	Assurance	DQAI
Use of Resources	DNA rate	7%	8.2%		?	
	Cancelled Ops	150	46	L	?	
	Theatre Utilisation	85%	76.0%			
Inpatient / Discharge	Same Day Emergency Care	30%	28.5%		?	
	Super Stranded	183	139	L	?	
	DToC	3.5%	2.00%	L	?	
	Discharges before Midday	30%	19.4%		F	
	Emergency Readmission rate	8%	11.7%	L	F	
	Ambulance Handover delays in excess of 60 minutes	10	18		?	

URGENT CARE – 4 hour access performance

University Hospitals of North Midlands NHS Trust



Variation	Assurance
L	F

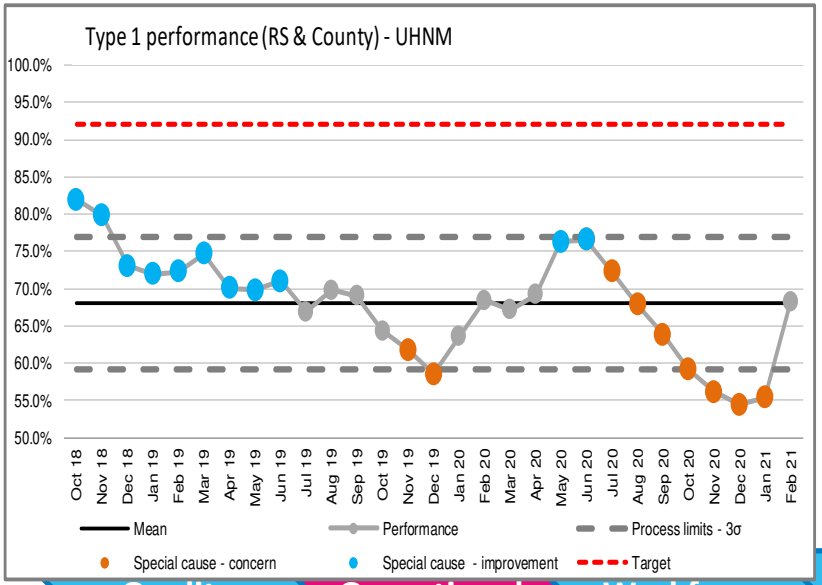
Target	Dec 20	Jan 21	Feb 21
95%	68.2%	69.0%	78.3%

Background

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

What is the data telling us?

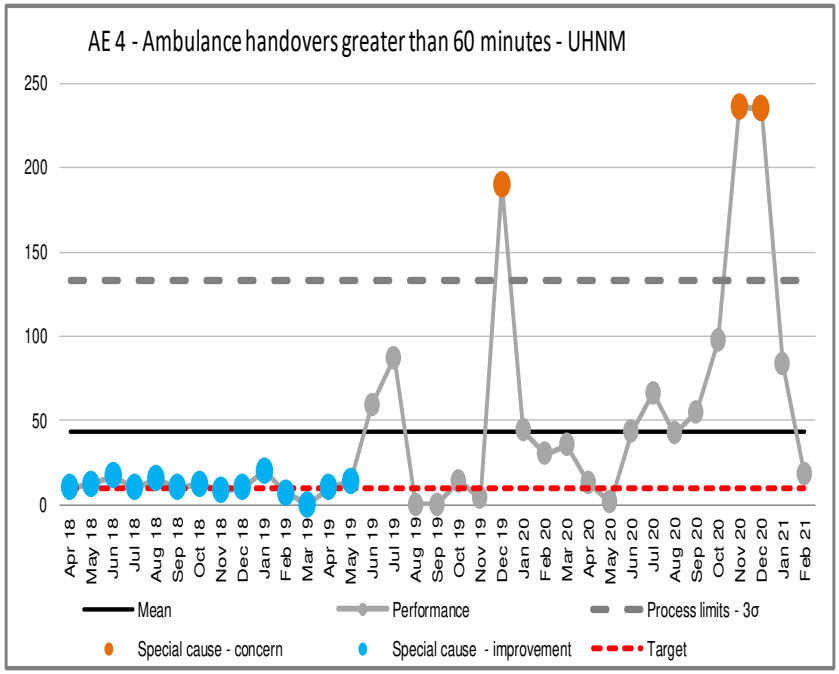
The improvemnets seen in May and June have not been sustained and performance is showing special cause concern. Performance has been below the lower control limit for 4 months.

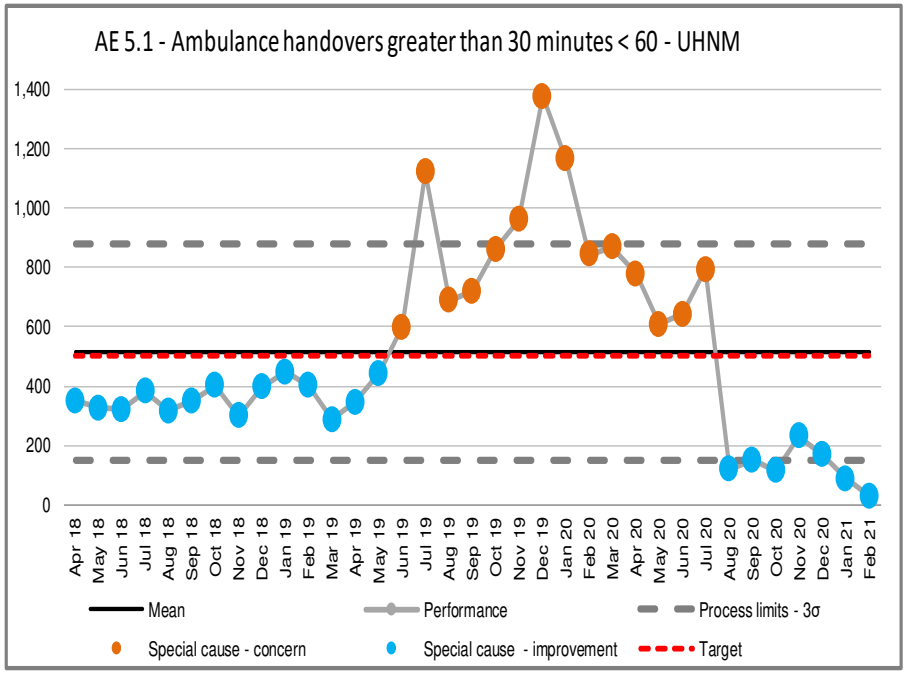


Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

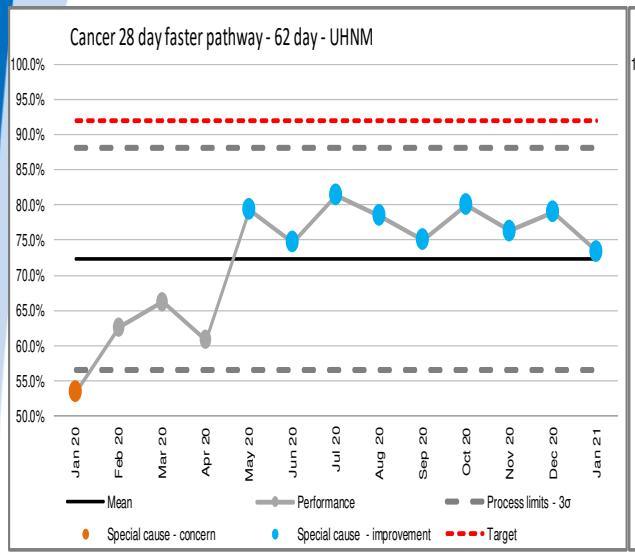
URGENT CARE – 4 hour access – ambulance handovers

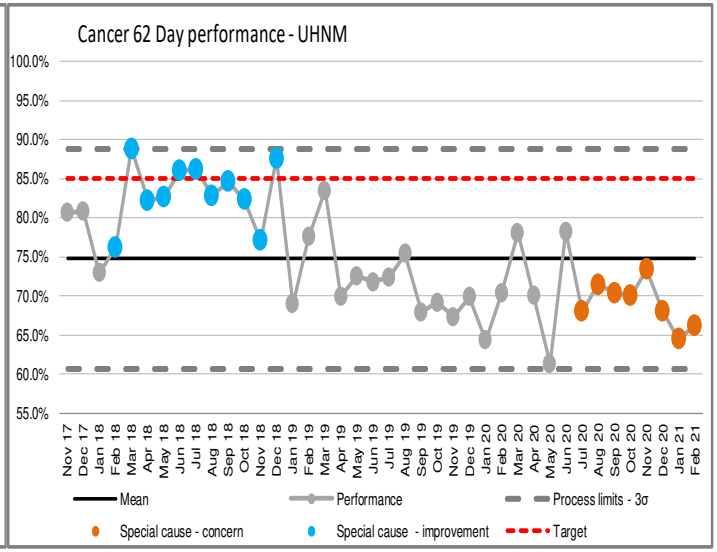




From August – internal validation of > 30 minutes

Cancer – 62 Day





Variation	Assurance
	

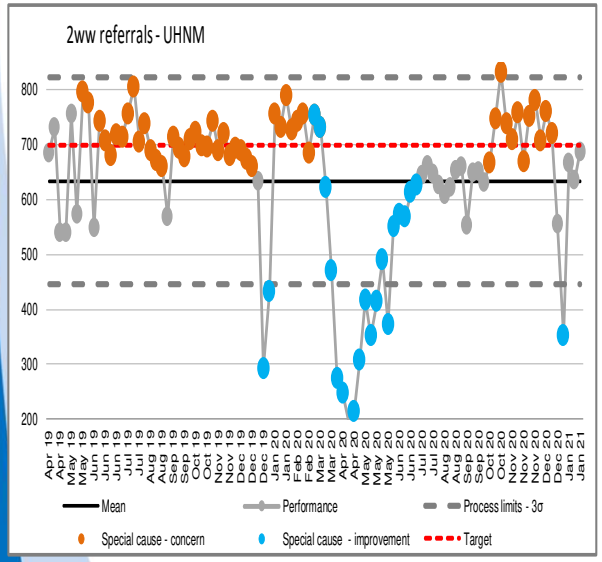
Target	Dec 20	Jan 21	Feb 21
85%	68.0%	64.4%	66.2%

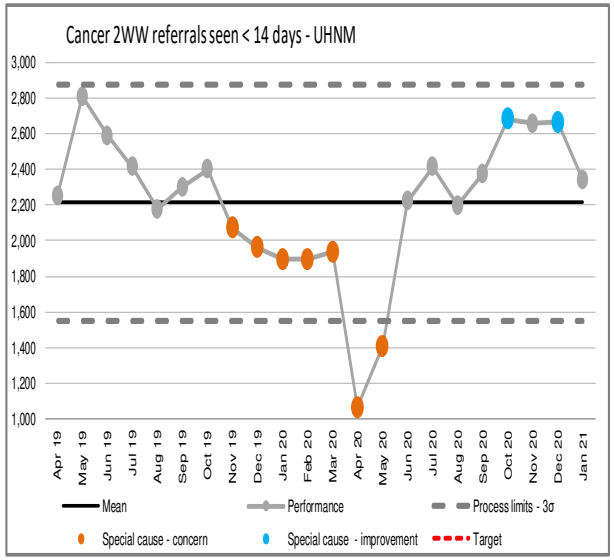
Background

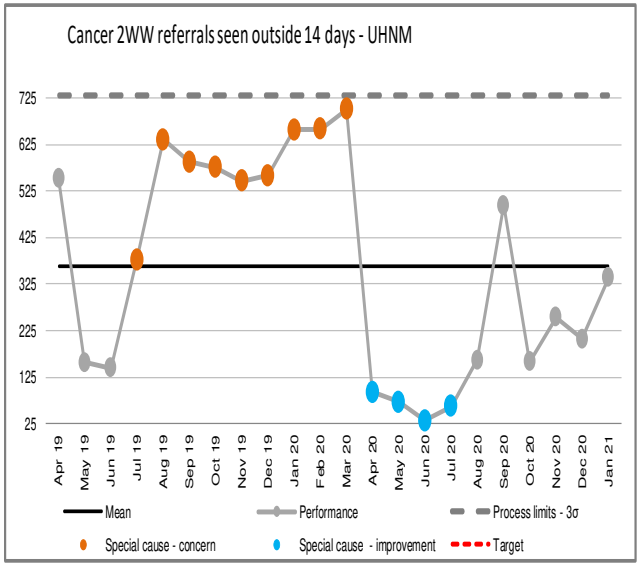
% patients beginning their treatment for cancer within 62 days following an urgent GP referral for suspected cancer

What is the data telling us?

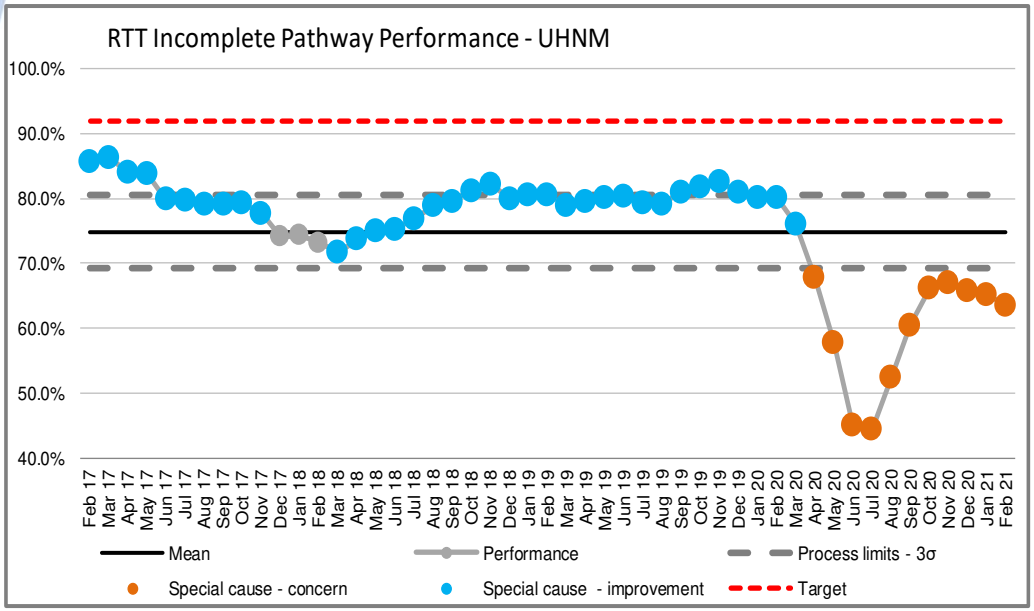
Performance shows normal common cause variation. However this has been consistently below the mean since July-20. This indicates that the target is unlikely to be met.







Referral To Treatment



Variation	Assurance
	

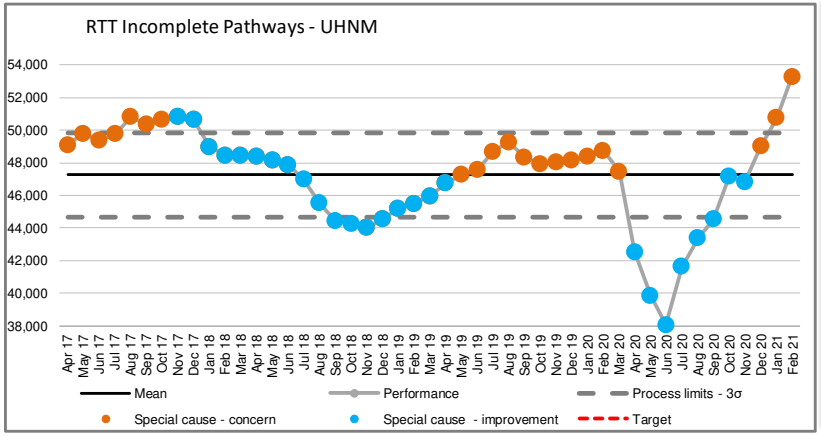
Target	Dec 20	Jan 21	Feb 21
92%	65.8%	65.2%	63.6%

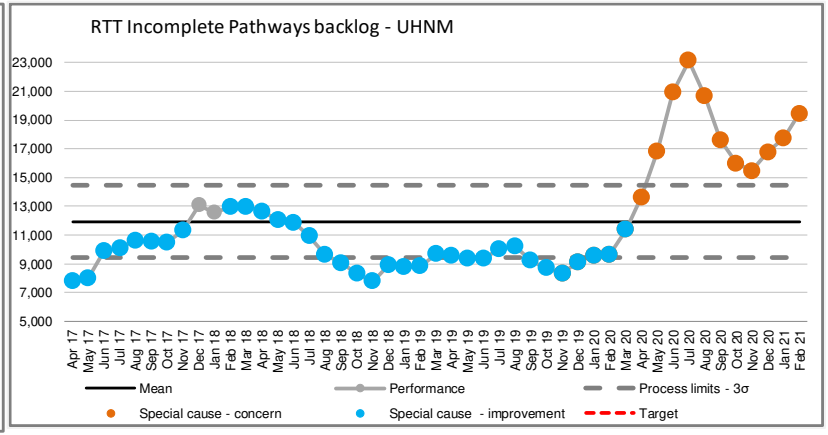
Background

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

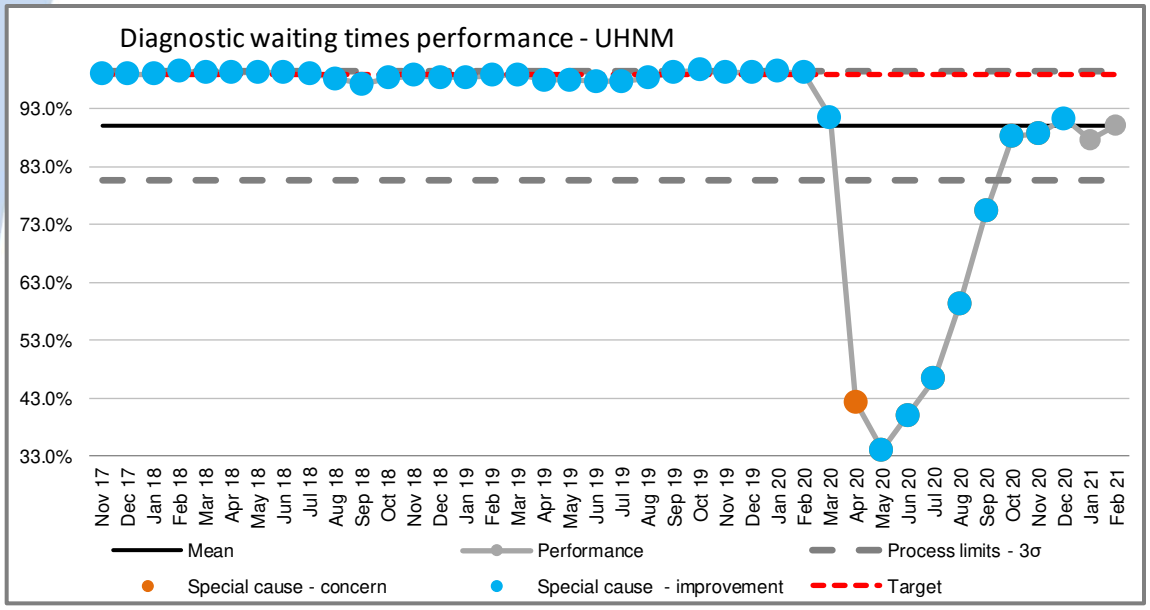
What is the data telling us?

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





Diagnostic Standards



Variation	Assurance

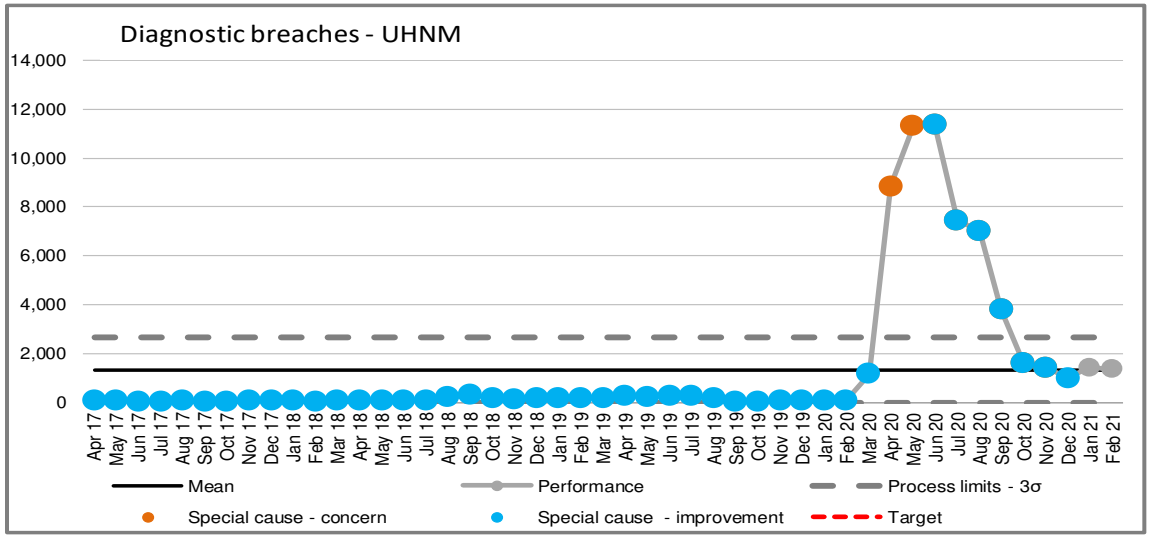
Target	Dec 20	Jan 21	Feb 21
99%	91.2%	87.6%	90.1%

Background

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

What is the data telling us?

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



Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

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, workforce deployment, staff wellbeing, absence management and staff testing.

The Workforce Bureau has stepped down in part and will be reinstated fully if the need arises.

- Sickness and covid-related absences continue to be monitored daily. Staff showing symptoms, or with household members showing symptoms, are tested and results returned within 24-48 hours. From 31st March 2020 – 12th March 2021 we have carried out 8,808 tests, excluding staff outbreak screening.
- Risk assessment processes remain in place and all BAME and Category C risk assessments will continue to be reviewed and updated if necessary. The Empactis system is used to provide managers with health risk assessment reminders and work with Occupational Health continues to embed risk assessments into the pre-employment health assessment process. The Risk Assessment form continues to be updated as new guidance is received. As at 12th March, over 95% of all permanent and fixed term staff have completed a covid-related risk assessment with their manager
- Roll out of the second dose of the vaccination commenced from 25th February for those staff and workers who received their first vaccination in the Trust. The roll out plan aims to deliver all second dose vaccinations by 1st April

The key performance issues are that the sickness rate remains above target and compliance with PDR requirements. The Executive decision taken to suspend PDR's unless there is capacity to continue to undertake them remains in place.

Sickness

The in-month sickness rate was 4.70% (5.71% reported at 31/01/21). The 12 month cumulative rate increased to 5.43% (5.42% at 31/01/21). The wellbeing plan is being developed to support and signpost staff to a range of wellbeing offers depending on staff needs at this time, including psychological support

Appraisals

The Non-Medical PDR compliance rate was 73.94% (74,65% at 31st January 2021).

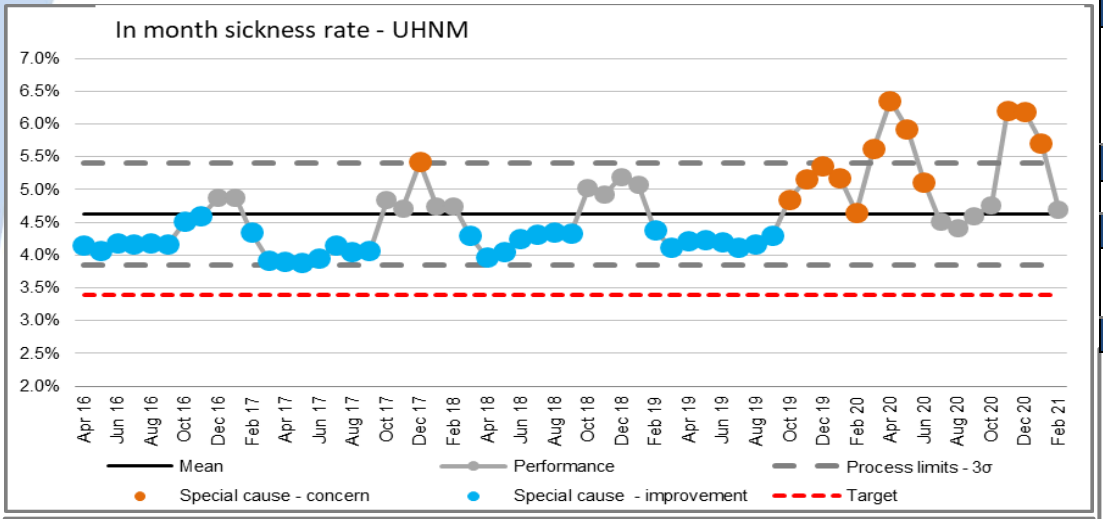
Statutory and Mandatory Training

The Statutory and Mandatory training rate at 28th February 2021 was 93.76% (93.41% at 31st January 2021). At 28 February 2021, 89.89% of staff had completed all 6 Core for All modules (89.17% at 31/01/21)

Workforce Dashboard

Metric	Target	Latest	Variation	Assurance
Staff Sickness	3.4%	4.70%		F
Staff Turnover	11%	9.48%	H	P
Statutory and Mandatory Training rate	95%	93.76%	H	F
Appraisal rate	95%	73.94%	L	F
Agency Cost	N/A	3.27%		P

Sickness Absence



Variation	Assurance

Target	Dec 20	Jan 21	Feb 21
3.4%	6.2%	5.7%	4.7%

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 seen from March through to July was a result of covid-19. Covid related absences reduced in January following the rollout of the lateral flow tests and vaccinations

Summary

The in-month sickness rate was 4.70% (5.71% reported at 31/01/21). The 12 month cumulative rate increased to 5.43% (5.42% at 31/1/21)

Absence episodes continued to reduce throughout February, although have plateaued since 1st March 2021.

As of 9th March 2021, covid-related open absences numbered 258, which was 36.7% of all absences (39.3% at 13th February 2021)

Roll out of the second dose of the vaccination commenced from 25th February for those staff and workers who received their first vaccination in the Trust. The roll out plan aims to deliver all second dose vaccinations by 1st April

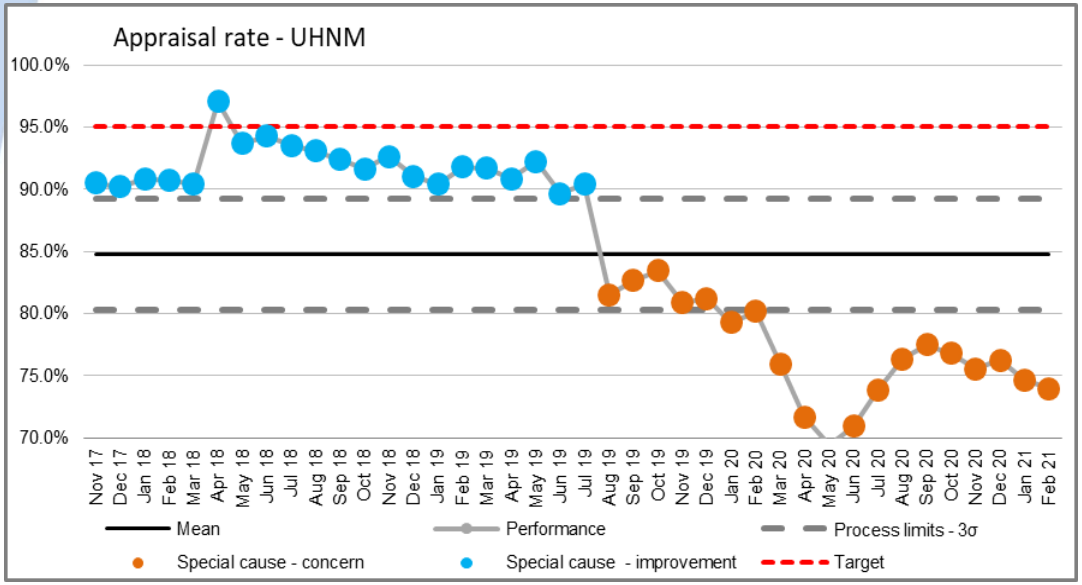
Actions

Leader Listening Spaces were provided in February to support leaders on topics/challenges that are current during the pandemic; "Rainbow" Team listening support sessions are to continue until June , and a "Tea and Empathy" listening service launched in February 2021 with over 38 members of staff coming forward to deliver peer to peer support and signposting available 24/7 for staff seeking listening support

A two week period has been designated in March for staff to rest and reflect

The wellbeing plan is being developed to support and signpost staff to a range of wellbeing offers depending on staff needs at this time, including psychological support.

Appraisal (PDR)



Variation	Assurance
	

Target	Dec 20	Jan 21	Feb 21
95.0%	76.3%	74.7%	73.9%

Background

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

What is the data telling us?

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

Summary

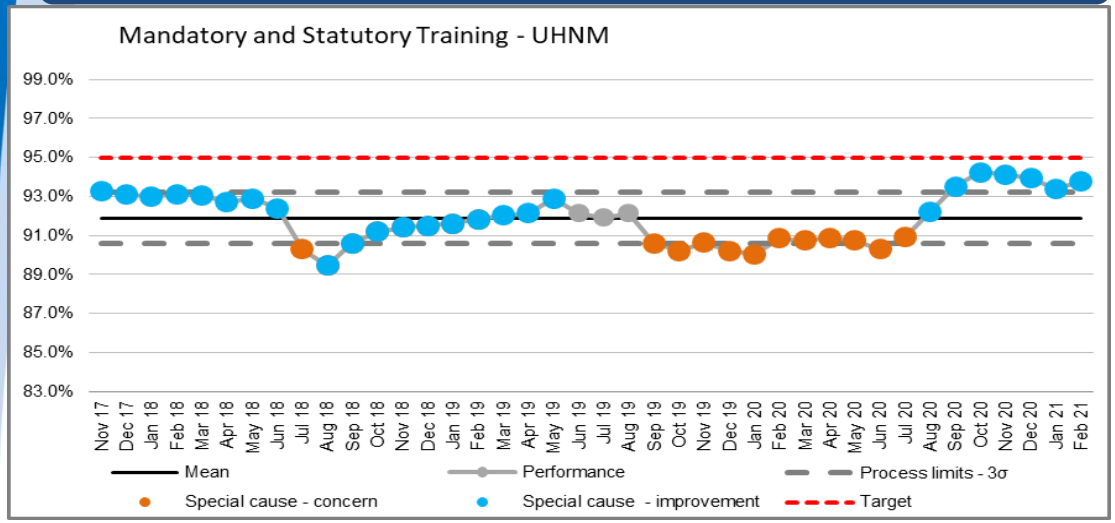
The Non-Medical PDR compliance rate was 73.94% (74,65% at 31st January 2021).

Actions

Due to the surge in covid, an Executive decision was taken to suspend PDR's unless there is capacity to continue to undertake them. This suspension remains in place.

Performance against the workforce kpi's is managed via the performance review meetings, which have recently recommenced (March 2021). As well as COVID patients numbers and nosocomial infections , these performance reviews will also focus on workforce challenges .

Statutory and Mandatory Training



Variation	Assurance
H	F

Target	Dec 20	Jan 21	Feb 21
95.0%	93.9%	93.4%	93.8%

Background

Training compliance

What is the data telling us?

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

Summary

The Statutory and Mandatory training rate at 28th February 2021 was 93.76% (93.41% at 31st January 2021). At 28 February 2021, 89.89% of staff had completed all 6 Core for All modules (89.17% at 31/01/21)

Competence Name	Assignment Count	Required	Achieved	Compliance %
205|MAND|Security Awareness - 3 Years|	10834	10834	10184	94.00%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	10834	10834	10182	93.98%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	10834	10834	10058	92.84%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	10834	10834	10123	93.44%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	10834	10834	10160	93.78%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	10834	10834	10239	94.51%

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

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 1 Year|	10913	10913	9041	82.85%
NHS|CSTF|Information Governance and Data Security - 1 Year|	10913	10913	9372	85.88%

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

Actions

We continue to raise the issue of compliance with Divisions and communicate to staff the need to complete statutory and mandatory training. Compliance is monitored and raised via the Divisional performance review process

Finance

2025 Vision "Ensure efficient use of resources"

Finance Spotlight Report

NHS University Hospitals of North Midlands NHS Trust

Key messages

- The Trust has received confirmation that it will receive £12.4m additional funding for M7-12 relating to the TSA agreement, NHSI have factored £7.4m of this into the plan which remains at a £7.2m deficit however the remaining £5m is factored into an expected forecast of £2.2m; the Trust is forecasting to be £2.2m better than this and achieve a breakeven position for the year.
- The Trust has delivered a surplus of £4.4m in Month 11 against a planned deficit of £0.7m which is driven by DHSC funding relating to the TSA agreement, underspends against the COVID-19 allocation, continued slippage against growth funding and the winter plan, additional HEE income and a VAT credit adjustment relating to 2019/20; all of these items are non-recurrent.
- The Trust is forecasting to breakeven for the year; this is after accruing for untaken annual leave, absorbing reductions in Non NHS income and providing for the impact of the Flowers tribunal. It is expected that funding will be allocated for these issues; any received will improve the Trust's position.
- The Pathology Network went live on 1 December with the financial impact included in the financial position and whilst there is a negligible impact on the bottom line, this is causing variances between the reporting categories (i.e. other income, pay and non-pay)
- The Trust incurred £2m of costs relating to COVID-19 which is a reduction in comparison with Month 10 (£2.4m) primarily in non-pay due to reduced demands on decontamination and testing. This remains within the Trust's allocation with £0.4m being chargeable on top of this allocation.
- Capital expenditure for the year to date stands at £45.3m which is £5.1m behind plan with the main driver being slippage on the PDC funded RI site demolition and phasing of the Linac and IR2 bi-plane.
- The month end cash balance is £110.6m which is £33.8m more than plan.

Finance Dashboard

	Metric	Target	Latest	Variation	Assurance
I&E	TOTAL Income	variable	74.2		
	Expenditure - Pay	variable	44.8		
	Expenditure - Non Pay	variable	23.4		
Activity	Daycase/Elective Activity	variable	5,684		
	Non Elective Activity	variable	8,190		
	Outpatients 1st	variable	20,013		
	Outpatients Follow Up	variable	38,955		

Income & Expenditure

Income & Expenditure Summary Month 11 2020/21	Annual Plan £m	In Month			Year to Date		
		Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Income From Patient Activities	777.6	65.1	26.6	(38.5)	712.4	678.4	(34.0)
Other Operating Income	55.8	5.3	47.8	42.6	50.6	100.5	50.0
Total Income	833.3	70.4	74.5	4.1	762.9	779.0	16.0
Pay Expenditure	(522.0)	(44.9)	(44.7)	0.2	(477.0)	(473.2)	3.8
Non Pay Expenditure	(266.7)	(22.0)	(21.3)	0.8	(243.5)	(249.9)	(6.4)
Total Operational Costs	(788.7)	(67.0)	(66.0)	1.0	(720.5)	(723.1)	(2.6)
EBITDA	44.6	3.4	8.5	5.1	42.4	55.8	13.4
Depreciation & Amortisation	(29.2)	(2.4)	(2.4)	(0.0)	(26.5)	(26.6)	(0.0)
Interest Receivable	0.1	0.0	0.0	0.0	0.1	0.1	0.0
PDC	(5.7)	(0.3)	(0.3)	0.0	(5.4)	(5.3)	0.0
Finance Cost	(17.1)	(1.4)	(1.4)	(0.0)	(15.7)	(15.7)	(0.0)
Other Gains or Losses	0.0	0.0	0.0	0.0	0.0	0.1	0.0
Surplus / (Deficit)	(7.2)	(0.7)	4.4	5.1	(5.1)	8.4	13.4
MRET central funding	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Financial Recovery Fund	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	(7.2)	(0.7)	4.4	5.1	(5.1)	8.4	13.4

At Month 11 the Trust has reviewed its performance against its revised plan and is £5.1m better than plan in month and £13.4m better than plan for the year to date; key points to note are:

- The actual Month 11 position includes £2.0m of income relating to the TSA agreement; £1.2m received from Stafford and Surrounds CCG and £0.8m directly from the DHSC; this is accounted for as other operating income. Only £0.8m of this is being reported as a variance as the revised plan figure has been adjusted for the funding received via the CCG (i.e. the planned deficit of £14.6m has been improved by £7.4m to reach the revised plan of a £7.2m deficit) with the Trust expected to better this plan by the £5m.
- The impact of the Pathology Network in month is additional operating income of £1.2m, additional pay expenditure of £0.8m and additional non pay expenditure of £0.1m.
- The underspend against pay expenditure mainly relates to the additional investment to support winter where the Trust has not been able to recruit to all of the posts (£0.5m) and the underspend against the COVID-19 pay expenditure plan (£0.9m), offset against the additional Pathology Network pay costs noted above.
- The underspend within non pay is largely related to education and training fees due to a lack of expected spend on courses as a result of COVID-19.

Capital Spend

Capital Expenditure as at Month 11 2020/21 £m	Revised Annual	In Month			Year to Date		
	Plan	Revised Budget	Actual	Variance	Revised Budget	Actual	Variance
PFI & finance lease liability repayment	(11.6)	(1.0)	(1.0)	-	(10.6)	(10.6)	-
Pre-ccommitted items	(11.6)	(1.0)	(1.0)	-	(10.6)	(10.6)	-
ICT Infrastructure	(2.9)	(0.5)	(0.1)	0.4	(2.2)	(2.2)	-
Estates Infrastructure	(1.9)	0.0	0.5	0.5	(2.1)	(1.8)	0.3
Medical Equipment	(2.3)	-	(0.1)	(0.1)	(1.4)	(1.4)	(0.1)
PFI lifecycle and equipment	(2.0)	(0.2)	(0.2)	-	(1.9)	(1.8)	0.1
Health & Safety Compliance	(0.2)	-	(0.0)	(0.0)	(0.1)	(0.1)	(0.1)
Project Star	(0.9)	-	(0.0)	(0.0)	(0.9)	(0.8)	0.1
Investment schemes	(0.1)	-	-	-	-	(0.1)	(0.1)
COVID-19 Trust funded	(0.9)	-	-	-	(0.9)	(0.9)	-
Linac	(2.2)	(0.3)	(0.1)	0.2	(2.2)	(0.2)	2.1
IR2 Bi Plane	(1.4)	-	(0.1)	(0.1)	(1.0)	(0.1)	0.9
LIMS	(0.8)	(0.1)	(0.0)	0.0	(0.7)	(0.4)	0.3
EPMA	(0.8)	(0.2)	(0.1)	0.1	(0.6)	(0.5)	0.1
IM&T additional projects	(0.3)	-	-	-	-	-	-
Medical devices fleet replacement	(0.9)	-	-	-	-	-	-
Pathology schemes	(0.6)	-	(0.2)	(0.2)	(0.3)	(0.4)	(0.1)
Trust funded capital programme	(18.2)	(1.3)	(0.4)	0.8	(14.4)	(10.8)	3.6
Royal Infirmary Site demolition	(5.2)	(0.7)	(0.6)	0.1	(4.8)	(3.9)	0.9
ED & RI Decant Accomodation Medical Records	(0.6)	-	(0.2)	(0.2)	(0.3)	(0.3)	-
COVID-19 PDC (approved)	(1.3)	(0.0)	(0.0)	(0.0)	(1.3)	(1.3)	(0.0)
PDC award for HSLI	(1.2)	-	(0.0)	(0.0)	(1.2)	(1.1)	0.0
Wave 4b funding - modular wards	(9.1)	-	-	-	(9.1)	(9.1)	-
Critical Risk Infrastructure	(3.2)	(0.8)	(0.9)	(0.1)	(1.5)	(1.8)	(0.3)
Emergency Department Schemes	(2.8)	-	(0.3)	(0.3)	(2.8)	(2.5)	0.2
ED Decant accomodation - Russell building	(0.7)	-	(0.1)	(0.1)	(0.7)	(0.3)	0.4
ED Decant accomodation - Trent scheme	(0.5)	-	-	-	(0.3)	-	0.3
Adapt & Adopt	(0.4)	-		-	-	-	-
Critical Care Resilience	(0.4)	-	-	-	-	-	-
Purchase of Grindley Hill Court	(5.4)	-	-	-	-	-	-
Pathology expansion	(0.5)	-	(0.1)	(0.1)	(0.5)	(0.5)	-
Rapid testing	(0.2)	-	-	-	-	-	-
Diagnostic equipment	(0.4)	-	-	-	(0.4)	(0.4)	(0.0)
Other PDC funding	(0.2)	-	-	-	-	(0.1)	(0.1)
PDC funded capital schemes	(32.0)	(1.5)	(2.2)	(0.7)	(22.8)	(21.3)	1.5
Charitable funds expenditure	-	(2.4)	(2.4)	-	(2.7)	(2.7)	-
Charity funded expenditure	-	(2.4)	(2.4)	-	(2.7)	(2.7)	-
Overall capital expenditure	(61.8)	(6.1)	(6.0)	0.2	(50.4)	(45.3)	5.1

Trust Funded Schemes

The Linac and IR2 bi-plane schemes are £2.1m and £0.9m behind plan; it is anticipated that the expenditure for both schemes will take place in Month 12.

PDC funded Schemes

The RI demolition scheme £0.9m underspend is due to initial contractor delays due to COVID-19 restrictions and delays caused by the removal of additional asbestos.

The Trust was awarded £4.3m for works on the ED Priority Assessment Unit and Paediatric ED Modular Assessment Unit. The assessment unit element of the scheme was completed in line with the MOU. The decant solution element for the assessment unit has been achieved by staff moving to the CEC rather than to new accommodation. As a result £1.5m of the funding is being utilised by the Trust in 2020/21 to progress the decant solutions required for the Trent business case and Estates management team.

The forecast is that expenditure will be incurred by the year end on all schemes.

Cash flow

Cash Summary at Month 11 2020/21		In Month			Year to date		
	Revised Budget £m	Revised Plan £m	Actual £m	Variance £m	Revised Plan £m	Actual £m	Variance £m
Opening balance	26.7	85.4	90.2	4.8	26.7	26.7	-
Block mandate payments	760.0	63.3	67.9	4.6	760.0	772.1	12.0
Contract income 2019/20	(7.4)	-	-	-	(7.4)	(7.4)	-
Other Income (including other NHS)	63.3	3.6	6.0	2.3	71.1	70.3	(0.8)
Health Education England Training Income	22.5	5.0	4.6	(0.4)	22.5	23.6	1.1
PSF/FRF - 2019/20 Q4	9.7	-	-	-	9.7	9.7	-
Capital funding (PDC capital)	26.4	7.2	13.6	6.4	20.9	22.6	1.8
Total Receipts	874.5	79.1	92.0	12.9	876.8	890.9	14.1
Payroll (excluding agency)	(492.5)	(43.7)	(43.6)	0.1	(451.3)	(452.0)	(0.6)
Accounts payable	(347.7)	(32.0)	(24.6)	7.4	(324.7)	(319.3)	5.5
PDC Dividend	(5.0)	-	-	-	(3.2)	(3.2)	-
Capital payments	(42.4)	(12.1)	(3.4)	8.7	(47.5)	(32.5)	14.9
Total Payments	(887.5)	(87.8)	(71.7)	16.1	(826.7)	(807.0)	19.7
Closing Balance	13.7	76.8	110.6	33.8	76.8	110.6	33.8

- The revised cash flow budget above reflects the plan submission for the second half of the financial year on 22 October. The year-end forecast cash balance of £13.7m reflected the year end revenue deficit forecast of £14.7m in this plan. This revised plan does not include additional cash expected to be received from NHSI/E and DHSC in relation to Mid Staffs transitional funding, based on this the forecast cash balance at the year-end is expected to be £26m.
- At the end of February the cash balance of £110.6m is £33.8m higher than plan. Cash received for Block mandates is £12m higher than plan year to date. This is due to the receipt in advance of the top up COVID-19 funding for Month 12 in addition to the block being received in advance. In addition £7.4m was received from Stafford and Surrounds CCG in month 9 relating to the transitional funding for the period Month 7-12. These items were not included in the plan values.
- Accounts payable in month and year to date are lower than plan. This reflects the cash impact of the current surplus revenue position and the impact of CPVID-19 on non-pay expenditure. The Trust is continuing to comply with Treasury guidance for the prompt payment of suppliers and is paying invoices as they are approved.
- Capital payments are significantly lower than plan. While capital funding has been drawn down in line with the requirements of national deadlines the lower than planned cash spend is partly due to under spends on Project Star/RI demolition, pathology LIMS and COVID-19 related capital to Month 11. Capital cash payments are also behind plan due to a significant level of accruals where projects are on-going rather than finalised and fully invoiced. The forecast is for capital expenditure to be in line with plan at the year end.

Balance sheet

NHS University Hospitals of North Midlands NHS Trust

Balance sheet as at Month 11	31/03/2020	28/02/2021			
	Actual £m	Revised Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment	483.0	491.8	491.1	(0.7)	
Intangible Assets	24.5	19.7	19.9	0.2	
Other Non Current Assets	-	-	-	-	
Trade and other Receivables	0.4	0.4	0.4	-	
Total Non Current Assets	507.9	511.8	511.4	(0.5)	
Inventories	13.3	13.1	13.7	0.6	
Trade and other Receivables	49.6	34.3	47.1	12.9	Note 1
Cash and Cash Equivalents	26.7	76.8	110.6	33.8	Note 2
Total Current Assets	89.6	124.2	171.4	47.2	
Trade and other payables	(74.8)	(130.7)	(143.5)	(12.9)	Note 3
Borrowings	(208.0)	(10.6)	(10.7)	(0.0)	
Provisions	(6.7)	(6.7)	(6.7)	(0.0)	
Total Current Liabilities	(289.5)	(148.0)	(160.9)	(12.9)	
Borrowings	(276.6)	(265.9)	(266.0)	(0.1)	
Provisions	(1.2)	(1.2)	(1.1)	0.1	
Total Non Current Liabilities	(277.7)	(267.1)	(267.1)	(0.1)	
Total Assets Employed	30.3	221.0	254.7	33.8	
Financed By:				-	
Public Dividend Capital	409.7	614.9	627.7	12.7	Note 4
Retained Earnings	(476.2)	(490.8)	(469.8)	21.0	Note 5
Revaluation Reserve	96.9	96.9	96.9	-	
Total Taxpayers Equity	30.3	221.0	254.7	33.8	

The revised balance sheet plan reflects the plan submitted to NHSI/E on 22 October which is based on the Month 6 balance sheet and expected movements for the remainder of the financial year. Variances to the revised plan at Month 11 are explained below:

- Note 1 – The receivables figure includes £4.9m transitional funding in relation to the Mid Staffs integration, where an invoice has been raised to DHSC for Months 7-12. The variance is also due to receivables including a £5m accrual in relation to specialised commissioners pass through funded drugs. The remaining variance is due to invoices raised but where cash has not been received relating to Mid and East Cheshire Trusts totalling £2.4m in relation to the Pathology Network. The aged debt figure also includes outstanding invoices totalling £2m with Stoke CCG, Stafford and Surrounds CCG and Royal Wolverhampton.
- Note 2 – variance mainly due to the £7.4m cash received from Stafford and Surrounds CCG relating to the Month 7-12 transitional funding and the receipt in advance of COVID-19 top up payments relating to Month 11. Cash payments relating to capital schemes are lower than planned due to a number of capital schemes being behind plan and a significant level of capital accruals. Lower than planned non-pay cash payments reflect the current revenue position.
- Note 3 - The payables balance reflects the receipt in advance for March block income received on the 15th February as part of the national COVID-19 response, of this £7.5m is higher than the plan figure due to additional COVID-19 funding also being received a month in advance. The remaining variance to plan is due to an increase in the level of accruals and capital creditors of £7m reflecting the level of capital work carried out but not invoiced.
- Note 4 - Public Dividend Capital is £12.7m higher than plan and reflects additional capital funding that the Trust has received in year for Project STAR, the Emergency Department and Critical Risk Infrastructure.
- Note 5 - Retained earnings show a £21m variance compared to plan and reflects the better than plan revenue position compared to the original plan(*) prior to confirmation of the transitional funding and a £1m difference between the cash received for Donated Assets and the amount of depreciation charged for Donated Assets.

- *The balance sheet plan has not been updated by NHSI to reflect the additional TSA funding of £7.4m and therefore shows an I&E deficit position of £11.2m at Month 11 rather than the £8.3m year to date I&E surplus.

Expenditure - Pay and Non Pay

NHS University Hospitals of North Midlands NHS Trust

Pay Summary (£m)	Annual Plan	In Month			YTD		
		Plan	Actual	Variance	Plan	Actual	Variance
Medical	(160.5)	(13.9)	(13.6)	0.3	(146.5)	(145.9)	0.6
Registered Nursing	(155.3)	(13.5)	(12.9)	0.6	(141.7)	(138.1)	3.7
Scientific Therapeutic & Technical	(58.4)	(5.0)	(5.3)	(0.4)	(53.4)	(54.0)	(0.6)
Support to Clinical	(71.1)	(6.0)	(6.1)	(0.1)	(65.1)	(64.6)	0.4
Nhs Infrastructure Support	(76.8)	(6.5)	(6.8)	(0.3)	(70.3)	(70.6)	(0.3)
Total Pay	(522.0)	(44.9)	(44.7)	0.2	(477.0)	(473.2)	3.8

Pay - As in the prior month the Trust is now reporting pay spend for the staff who have TUPE'd as part of the Pathology Network arrangements which in month amounted to £0.8m. However, the pay still remains underspent in month and YTD primarily as a result of the winter slippage referenced above which was £0.5m in month. Whilst the COVID-19 spend has remained material in month (see section 2.3) the pay element of the COVID-19 plan was underspent in month by £0.9m.

Non Pay Summary (£m)	Annual Plan	In Month			YTD		
		Plan	Actual	Variance	Plan	Actual	Variance
Tariff Excluded Drugs Expenditure	(67.5)	(5.4)	(5.8)	(0.4)	(61.5)	(66.6)	(5.0)
Other Drugs	(19.8)	(1.7)	(1.4)	0.2	(18.1)	(18.7)	(0.7)
Supplies & Services - Clinical	(55.8)	(4.6)	(5.1)	(0.5)	(51.0)	(55.1)	(4.2)
Supplies & Services - General	(6.9)	(0.5)	(0.6)	(0.0)	(6.3)	(6.6)	(0.2)
Purchase of Healthcare from other Bodies	(16.3)	(1.7)	(1.2)	0.5	(14.4)	(11.3)	3.1
Consultancy Costs	(1.4)	(0.0)	(0.0)	(0.0)	(1.1)	(1.0)	0.0
Clinical Negligence	(22.3)	(1.9)	(1.9)	0.0	(21.1)	(21.1)	0.0
Premises	(29.4)	(2.0)	(2.1)	(0.1)	(26.9)	(27.4)	(0.5)
PFI Operating Costs	(34.7)	(2.9)	(2.9)	(0.0)	(31.8)	(32.0)	(0.1)
Other	(12.6)	(1.2)	(0.2)	1.1	(11.3)	(10.2)	1.1
Total Non Pay	(266.7)	(22.0)	(21.3)	0.8	(243.5)	(249.9)	(6.4)

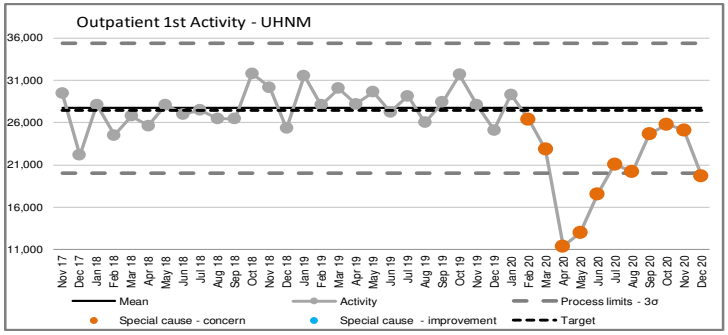
Non-pay – the Non-pay is driven by:

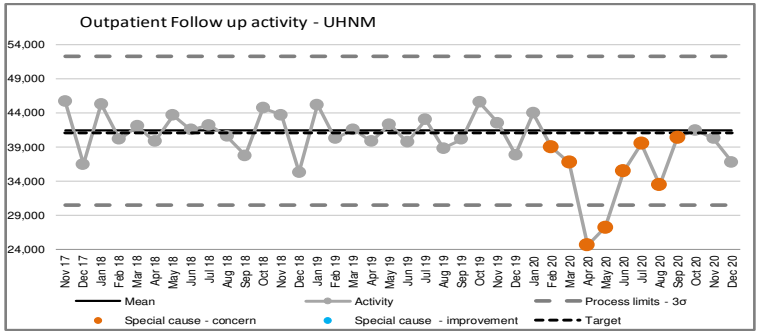
- An overspend on pass through drug expenditure (£0.4m) largely in CWD which is a reduction on prior month overspends.
- An overspend on supplies and services – clinical (£0.5m) driven by increased COVID-19 testing costs and the Pathology Network costs (which is recovered through the Pathology Network) offset by reduced spend against elective procedure costs.
- An underspend on purchased healthcare (£0.5m) due to no spend on the Independent Sector contract as the contract has continued to be held centrally for the second half of the year.
- Underspend within other (£1.1m) relating to education and training fees due to a lack of expected spend on courses as a result of COVID-19.
- Within premises costs there is a refund from HMRC due to a VAT ruling relating to IT software of £0.9m which is offset by an additional accrual of £0.7m in relation to the provision for market testing for the PFI.

Activity

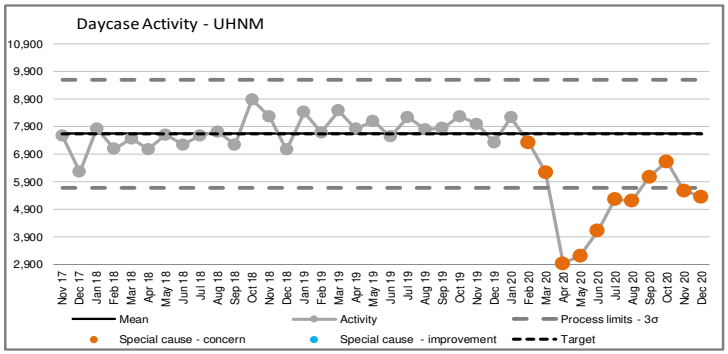
NHS University Hospitals of North Midlands NHS Trust

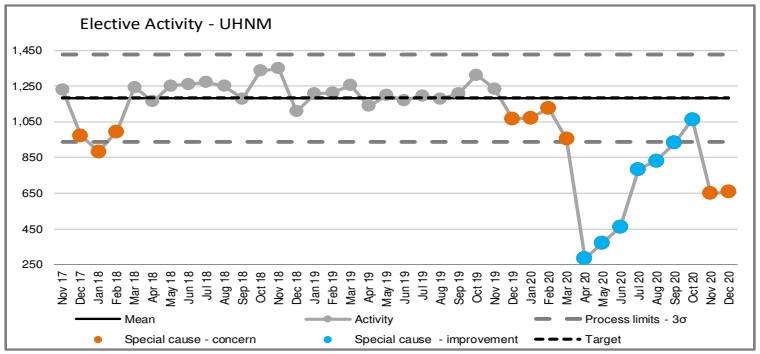
Planned care Outpatient



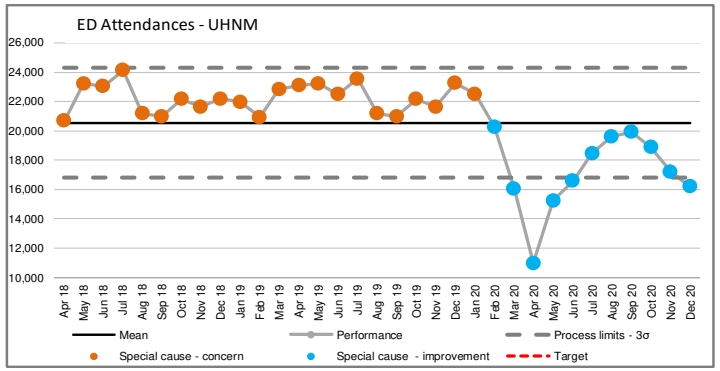


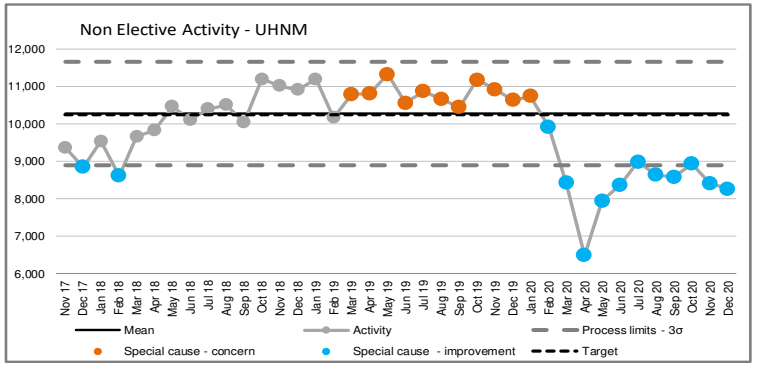
Planned care Inpatient





Urgent Care





Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Trust Board

2021/22 BUSINESS CYCLE

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

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Notes
		7	5	9	7	4	8	6	3	8	5	9	9	
PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES														
Chief Executives Report	Chief Executive													
Patient Story	Chief Nurse													
Quality Governance Committee Assurance Report	Associate Director of Corporate Governance													
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer													
Care Quality Commission Action Plan	Chief Nurse													
Bi Annual Nurse Staffing Assurance Report	Chief Nurse													
Quality Account	Chief Nurse													
7 Day Services Board Assurance Report	Medical Director													Timing TBC
NHS Resolution Maternity Incentive Scheme	Chief Nurse													Timing TBC
Saving Babies Lives Care Bundle	Chief Nurse													
Continuity of Care Action Plan	Chief Nurse													
Midwifery Staffing	Chief Nurse													
Maternity Family Experience Report	Chief Nurse													
Winter Plan	Chief Operating Officer													
PLACE Inspection Findings and Action Plan	Director of Estates, Facilities & PFI													Timing TBC
Infection Prevention Board Assurance Framework	Chief Nurse													
ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS STANDARDS														
Integrated Performance Report	Various													
ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT & RESEARCH														
Transformation and People Committee Assurance Report	Associate Director of Corporate Governance													
Gender Pay Gap Report	Director of Human Resources													
People Strategy Progress Report	Director of Human Resources													
Revalidation	Medical Director													
Workforce Disability Equality Report	Director of Human Resources													
Workforce Race Equality Standards Report	Director of Human Resources													
Staff Survey Report	Director of Human Resources													
LEAD STRATEGIC CHANGE WITHIN STAFFORDSHIRE AND BEYOND														
System Working Update	Chief Executive / Director of Strategy													
ENSURE EFFICIENT USE OF RESOURCES														
Performance and Finance Committee Assurance Report	Associate Director of Corporate Governance													
Revenue Business Cases / Capital Investment / Non-Pay Expenditure £1,000,001 and above	Director of Strategy													
IM&T Strategy Progress Report	Director of IM&T													Deferred to May due to annual leave
Going Concern	Chief Finance Officer													
Estates Strategy Progress Report	Director of Estates, Facilities & PFI													
Annual Plan 2020/21	Director of Strategy													
Financial Plan 2021/22	Chief Finance Officer													
Capital Programme 2021/22	Chief Finance Officer													
GOVERNANCE														
Nomination and Remuneration Committee Assurance Report	Associate Director of Corporate Governance													
Audit Committee Assurance Report	Associate Director of Corporate Governance													

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