Trust Board (Open)

Meeting held on Wednesday 5th January 2022 at 9.30 am to 11.45 am via Microsoft Teams

AGENDA

Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
09:30	**PROCEDURAL ITEMS**					
20 mins	1.	Patient Story	Information	Mrs AM Riley	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 8th December 2021	Approval	Mr D Wakefield	Enclosure	
	5.	Matters Arising via the Post Meeting Action Log	Assurance	Mr D Wakefield	Enclosure	
20 mins	6.	Chief Executive's Report – December 2021	Information	Mrs T Bullock	Enclosure	
10:15	**STRATEGY**					
10 mins	7.	Digital Strategy Progress Update	Assurance	Mrs A Freeman	Enclosure	**BAF 7**
10:25	**PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES**					
5 mins	8.	Quality Governance Committee Assurance Report (16-12-21)	Assurance	Ms S Belfield	Enclosure	**BAF 1**
5 mins	9.	IPC Board Assurance Framework - December 2021	Assurance	Mrs AM Riley	Enclosure	**BAF 1**
10:35	**ENSURE EFFICIENT USE OF RESOURCES**					
5 mins	10.	Performance & Finance Committee Assurance Report (14-12-21)	Assurance	Mr P Akid	Enclosure	**BAF 6, 7, 8 & 9**
10:40	**ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT AND RESEARCH**					
5 mins	11.	Transformation and People Committee Assurance Report (15-12-21)	Assurance	Prof G Crowe	Enclosure	**BAF 1, 2, 3, 4 5**
10:45 – 11:00: COMFORT BREAK						
11:00	**ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS**					
40 mins	12.	Integrated Performance Report – Month 8	Assurance	Mrs AM Riley Mr P Bytheway Mrs R Vaughan Mr M Oldham	Enclosure	**BAF 1, 2, 3, 6 & 9**
11:40	**CLOSING MATTERS**					
5 mins	13.	Review of Meeting Effectiveness and Business Cycle Forward Look	Information	Mr D Wakefield	Enclosure	
	14.	Questions from the Public **Please submit questions in relation to the agenda, by 9.00 am 4th January to nicola.hassall@uhnm.nhs.uk**	Discussion	Mr D Wakefield	Verbal	
11:45	**DATE AND TIME OF NEXT MEETING**					
	15.	**Wednesday 9th February 2022, 9.30 am via Microsoft Teams**				

PROUD TO CARE

Trust Board (Open)

Meeting held on Wednesday 8th December 2021, 9.30 am to 12.30 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												
Mrs T Bowen	TBo	Non-Executive Director												
Mr P Bytheway	PB	Chief Operating Officer												
Mrs T Bullock	TB	Chief Executive												
Prof G Crowe	GC	Non-Executive Director						Chair						
Dr L Griffin	LG	Non-Executive Director												
Mr M Oldham	MO	Chief Financial Officer	JT											
Mr M Lewis	ML	Medical Director	JO	AW	JO	JO	JO	JO						
Dr K Maddock	KM	Non-Executive Director												
Mrs AM Riley	AR	Chief Nurse	SP	MR	SP	SP								
Mrs R Vaughan	RV	Director of Human Resources					JH							

Non-Voting Members:			**A**	**M**	**J**	**J**	**J**	**A**	**O**	**N**	**D**	**J**	**F**	**M**
Ms H Ashley	HA	Director of Strategy												
Mrs S Gohir	SG	Associate Non-Executive Director												
Prof A Hassell	AH	Associate Non-Executive Director												
Mrs A Freeman	AF	Director of IM&T	HP	MB	MB	MB	HP	HP			HP			
Mrs L Thomson	LT	Director of Communications												
Miss C Rylands	CR	Associate Director of Corporate Governance				NH								
Mrs L Whitehead	LW	Director of Estates, Facilities & PFI					BD							

In Attendance:	
Mrs G Grimes	(item 1)
Mrs N Hassall	Deputy Associate Director of Corporate Governance (minutes)
Mrs C Lees	(item 1)

Members of Staff and Public via MS Teams: 3

No.	Agenda Item	Action
1.	**Staff Story**	
170/2021	Mrs Vaughan highlighted that as it was Disability History Month and Mrs Grimes had been asked to attend to share stories in relation to her role as Chair of the Disability and Long Term Conditions Staff Network. Mrs Grimes highlighted that she had become Chair of the Staff Network and explained that she had long term condition and disability and had been supported well by her line manager, in the way in which adjustments had been put in place and her vision was for all staff to feel as supported as she felt. She recalled some positive staff stories from the network, where line managers had supported staff with long term conditions by agreeing to flexible working, support for staff with hearing impairments and support for staff with ADHD and ASD. She also	

highlighted some stories in which staff had not been appropriately supported by their line managers and identified how the network had tried to support those members as well as continuing to raise awareness with line managers and improving communication between managers and staff. Mrs Grimes referred to the introduction of the Tailored Adjustment Plan which was used for staff with a long term condition or disability to support them in their role and added that a disability toolkit was to be launched for line managers to enable them to compassionately support employees.

It was noted that the meetings were held on a quarterly basis with a wide range of membership and Mr Wakefield queried the proportion of staff with disabilities compared to those who had joined or were involved with the group. Mrs Grimes stated that the membership was approximately 40 although not all join the meetings. She added that there was wider engagement via social media.

Dr Griffin referred to the fact that some disabilities were not always visual or obvious which could cause difficulties, as well as there being some reluctance of staff highlighting their disabilities in order to avoid being labelled as disabled, therefore this required consideration so that staff were encouraged to have conversations with their line manager so that adjustments could be made. He queried if the network had the support it required and Mrs Grimes confirmed that the group was well supported by communications and time to attend the meetings had been granted.

Ms Bowen welcomed the insightful stories provided and queried the uptake of using the Tailored Adjustment Plan. Mrs Grimes stated that this was unknown as it was used in individual areas and not captured corporately, although promotion of the document continued to be taken forward.

Mrs Bullock queried if other national networks were utilised in order to obtain information and guidance on long term conditions and disabilities for staff and Mrs Grimes stated that these were highlighted to members and were also signposted within the disability toolkit. She added that Access to Work were also utilised in order to undertake workplace assessments.

Dr Lewis referred to the recent Workforce Disability Equality Standard (WDES) data which identified staff were not keen to declare they were disabled and commented that work was required to address this. Mrs Grimes agreed and stated that by not making colleagues aware, it resulted in members of staff not being very well supported.

Ms Gohir queried if there were any gaps in training or any themes identified where managers were not being supportive. Mrs Grimes stated that statutory and mandatory training was in place, and an additional module was available for staff to complete in relation to disability. She stated that one of the main challenges was that some managers felt that it was not equitable to make adjustments for some staff and not others, rather than recognising the importance of treating people individually based on their needs.

Professor Hassell referred to the role of line managers in providing staff members with adequate support and queried whether there were any 'hot spots'. Mrs Grimes confirmed that this was sporadic and were no specifics area which required focussed support.

Mr Oldham referred to the ongoing work with the line managers and the need for leaders to set the right example and culture. He queried how hotspot areas would be escalated and Mrs Grimes stated that this would be raised with the relevant

	HR Business Partner. Mr Wakefield welcomed the stories, apologised for the negative experiences of some staff and thanked Mrs Grimes for the support being provided. He welcomed the vision identified and stated that the negative stories demonstrated a lack of understanding which was being addressed by the ongoing communications, introduction of the disability toolkit and Tailored Adjustment Plan. He recognised the importance of raising this within the leadership training and noted the importance of treating staff individually based on their needs rather than equitably. It was queried how the themes identified would be monitored and it was noted that this would be via the WDES report as well as the staff network communicating with staff on the actions being taken. **The Trust Board noted the staff story.**	
2.	**Chair's Welcome, Apologies & Confirmation of Quoracy**	
171/2021	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 on the work undertaken in the West Building to address the CPE outbreak and he thanked Mr Bytheway for providing a separate briefing on the winter plan to the Non-Executive Directors. He recognised the continued pressures and challenges being faced by staff and the importance of ensuring staff continued to feel supported.	
3.	**Declarations of Interest**	
172/2021	The standing declarations were noted. Dr Griffin highlighted that he was to join the Nottingham Independent Maternity Review and this was noted.	
4.	**Minutes of the Previous Meeting held 3rd November 2021**	
173/2021	The minutes of the meeting from 3rd November 2021 were approved as an accurate record.	
5.	**Matters Arising from the Post Meeting Action Log**	
174/2021	PTB/465 – Mrs Riley explained that the action could not be completed until the report was received at the end of March 2022. Mr Wakefield stated reflected on the recent meeting with the Chief Maternity Officer whereby assurance was provided in relation to the ongoing work being undertaken by the maternity team and it was agreed to devolve the action back to the Quality Governance Committee as part of the business cycle.	
6.	**Chief Executive's Report – November 2021**	
175/2021	Mrs Bullock highlighted a number of areas from her report. Professor Crowe formally recorded his thanks to the Denise Coates Foundation for the funding which had been provided.	

	Professor Crowe referred to the change in guidance requiring front line staff to be vaccinated against Covid, as a condition of their employment and queried how progress in respect of this was to be monitored. Mrs Vaughan stated that the Trust was waiting for the guidance to pass through the legal processes but in the meantime had commenced planning and scoping, with a task and finish group set up which would in turn report into the Transformation and People Committee. Professor Crowe queried how specific groups of staff would be supported and Mrs Vaughan stated that staff with medical exemptions would be supported and engaged with, and one of the main areas of work was identifying those in scope. Professor Hassell congratulated the staff involved in the new series of Critical Condition. **The Trust Board received and noted the report and approved EREAFs 8392, 8325 and 8064.**	
PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES		
7.	**Quality Governance Committee Assurance Report (25-11-21)**	
176/2021	Ms Belfield highlighted the following from the report: • The Committee noted the ongoing actions being taken to replace the CPAP machines which was challenging given the number of machines being utilised • The Committee noted an increase in lapses of care in relation to pressure ulcers and had requested further assurance in respect of the actions being taken • The Committee welcomed the positive work being undertaken in relation to palliative care, in particular the ways in which staff were increasing their knowledge and understanding of end of life care • The Committee requested further information to be provided in relation to research studies to inform further discussions • A further update from the sepsis team was requested, so that assurance could be sought on the work being undertaken Dr Chan provided a presentation on caesarean section rates and highlighted that the current targets provided crude figures which did not focus on appropriateness. She stated that going forwards it had been recognised that this could be improved by focussing on the Robson 10 classification and highlighted the actions being taken to improve data entry and accuracy in relation to reporting of the Robson 10 classifications. Mr Wakefield welcomed the presentation and the assurance provided. Ms Gohir referred to ethnicity data and how it was reported and monitored given the differences in outcomes and queried whether any trends had been reported, reflecting the national trends. Dr Chan confirmed that ethnicity data was recorded and reviewed and differences in outcomes were compared. It was agreed to consider ethnicity and maternity outcomes to a future Quality Governance Committee. **The Trust Board received and noted the assurance report.** Dr Chan left the meeting.	**AMR**
8.	**IPC Board Assurance Framework (BAF) – November 2021**	

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177/2021	Mrs Riley highlighted the following: • Risk scores had been amended following the discussion at the previous meeting • Work had been undertaken in the West Building following the CPE outbreak and a further NHSI visit was to take place on 10th December where it was anticipated that there would be a reduction in the risk • Work on taking forward a cleaning collaborative was underway • The Portacount business case has been approved Mr Wakefield queried how the learning in respect of cleaning mechanical beds had been taken forward nationally and Mrs Riley stated that no response had been received to date, but this continued to be taken forward nationally and in the meantime the Trust would continue to periodically disassemble beds to review any build-up of debris, which would over time give a frequency to how often this should be undertaken. Professor Maddock referred to the actions being taken in the West Building and queried the timescales and associated disruption expected in relation to the sink replacement programme. Mrs Riley agreed to obtain this information. Dr Griffin queried whether the initial risk score was correct given the consequence of the CPE outbreak. Mrs Riley commented that she felt the score reflected reality when it was determined. Mr Wakefield queried the lessons learned from the CPE outbreak and how these were being shared with others. Mrs Riley stated that this was being taken forward through the Infection Prevention Committee and added that the IPC BAF would reflect the learning identified. **The Trust Board received and noted the report.**	**AMR**
ENSURE EFFICIENT USE OF RESOURCES		
9.	**Performance & Finance Committee Assurance Report (23-11-21)**	
178/2021	Dr Griffin highlighted the following from the report: • Significant discussion held with regards to consideration of business cases • Delays in the completion of business case reviews were highlighted and the Committee noted the actions being taken to ensure more timely completion • The Committee noted the actions being taken to improve data security and protection training compliance • The nature of operational challenges were noted in particular workforce availability, resilience of staff, challenges for service recovery, winter challenges and demand **The Trust Board received and noted the assurance report.**	
10.	**H2 Plan**	
179/2021	Ms Ashley highlighted the following from the presentation: • The plan had been submitted on 18th November following the discussion at the Board during the time Out in November • The Trust was expecting to receive the planning guidance for 2022/23 before Christmas	

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	• The main focus of the plan was on broad requirements such as elective recovery, health and wellbeing of staff, ability to respond to non-elective pressures over winter and the ability to deliver against the winter plan • In addition the other area of focus was on reducing the number of long waiters Dr Griffin referred to elective recovery, validation of long waiters and utilisation of external validators and queried if individuals refused to be treated in the Independent Sector, how that would be tackled. He also queried the harm reviews for long waiters and how they were progressing and queried how many 104 week wait patients were young/old with significant comorbidities. Mr Bytheway stated that only 6 patients waiting over 104 weeks were under 18 and approximately 50 were over the age of 80. He stated that in terms of patient choice if a patient was to refuse treatment in the Independent Sector they would remain on the list and be seen in date order, but engagement with patients continued to try to increase the uptake so that patients were seen sooner. Mr Bytheway referred to the validation being undertaken and the previously agreed business case to increase validators given the significant requirement to validate the now very large number of long waiters. Mr Bytheway highlighted that harm reviews continued to be undertaken and escalations taken forwards as required. Ms Ashley referred to those patients with long term conditions, this was being taken into account in terms of the determining the clinical priority. Ms Bowen queried what was being done to measure inclusivity of the winter plan and equitable management of the waiting list. Mr Bytheway referred to the way in which decisions were made to prioritise and treat patients based on the length of time they had been waiting as well as the clinical urgency, with the biggest focus on cancer and clinically urgent patients (P2) who were categorised to have their operation in 4 weeks. Ms Bowen referred to the number of 104 and 52 week waits and queried whether the actions being taken to improve theatre staffing were being realised. Mr Bytheway stated that there had been some improvements in theatre staffing resulting in increased operating at County Hospital. Ms Bowen referred to the colorectal cancer backlog and queried the actions being taking to take forward FIT testing. Mr Bytheway stated that as the colorectal cancer pathway was significantly challenged, with a significant number of increasing referrals and challenges with workforce, a number of changes to improve the pathway were being made, and approximately 60% of referrals were having FIT testing. Mr Wakefield referred to the underlying deficit which seemed higher and requested a further discussion on this at the Performance and Finance Committee. Mr Oldham stated that it was due to the assumptions made on allocations. **The Trust Board received and noted the H2 Plan.**	**MO**
ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT & RESEARCH		
11.	**Transformation and People Committee Assurance Report (24-11-21)**	
180/2021	Professor Crowe highlighted the following from the report: • A positive update was provided by the Guardian of Safe Working who was	

	taking action to address the exception reports • A quarterly update was provided by Organisational Development which demonstrated continuing activities including civility and respect and implementation of the health and wellbeing plan • The Committee received and commented on the first draft of the clinical strategy • Strategic workforce planning updates would be provided at future meetings • Absence and sickness rates were continuing to be a challenge • In terms of Improving Together, activities were continuing to be embedded although current workforce challenges were resulting in a risk to the momentum of the programme Mr Wakefield referred to the bid on nursing apprenticeships and queried how this was being taken forward and Mrs Riley confirmed that this was progressing through the usual governance process. Professor Hassell referred to the challenges identified in obstetrics and gynaecology and queried whether these were internal issues and Dr Lewis stated were the issues were being addressed internally. **The Trust Board received and noted the assurance report.**	
ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS		
12.	**Integrated Performance Report – Month 7**	
181/2021	Mrs Riley highlighted the following in relation to quality and safety: • Significant work continued to be undertaken to understand the whole pathway associated with pressure ulcers and lapses in care, in order to identify improvements which would be reported to Quality Governance Committee • Falls were continuing to see an improvement in reducing falls with harm, although AMU remained the area with the highest number of falls due to staffing, which was hoping to be mitigated as part of the business case • 1 covid death had been identified which was being reviewed Mr Wakefield referred to the challenges associated with pressure ulcers and lapses in care and queried how this was being raised with staff. Mrs Riley stated that the reasons for the lapses in care needed to be determined so that learning could be shared and agreed that the reason for the rises would be provided to the Quality Governance Committee. Ms Gohir referred to sepsis awareness and queried how quickly new starters were trained in sepsis. Mrs Riley stated that this should form part of ward induction but agreed to confirm the timing. Professor Crowe referred to Covid related deaths in the organisation and queried the progress being made in reviewing these and learning from the cases. Dr Lewis confirmed that the deaths were being reviewed as part of the Structured Judgement Review process and added that Medical Examiners were also involved. He stated that an update would be provided to the Quality Governance Committee in February/March 2022 with regards to nosocomial infections and the reviews undertaken and added that the death rate from covid was in line with other Trusts with a similar population prevalence of covid, and nosocomial rates were also in line with other comparable Trusts. Mr Bytheway referred to the national Covid enquiry and highlighted that the	**AMR** **AMR** **ML**

Terms of Reference were awaited, but planning had commenced in relation to retention of documents. He added that all silver and gold meetings were recorded and an administrative audit of discussions at gold/silver had previously been undertaken which demonstrated that the appropriate process had been followed.

Professor Hassell referred to covid mortality and added that this was also scrutinised by the Mortality Review Group which reported to the Quality Governance Committee.

Mr Bytheway highlighted the following in terms of urgent care performance:
- Occupancy in October had been affected by the CPE outbreak, whereby 50 to 60 beds had been closed, contributing to a deterioration in performance and an increase in ambulance holds
- During November ambulance handovers within 15 minutes had improved, and time to initial assessment had also improved as well as slight improvements in flow
- The number of medically fit for discharge (MFFD) patients had increased in October
- Winter wards had opened on time and the worst case scenario for MFFD patients was being tracked
- In terms of workforce, the business case for the Emergency Department had been agreed and a formal report was to be provided to the Performance and Finance Committee on the progress against this business case. He added that the recruitment campaign for Junior Doctors/SHO's had been very successful with the majority of staff anticipated to commence in January 2022
- CRIS category 3 and 4 diversion with the ambulance service had commenced and two test of changes had gone well
- A further test of change regarding navigation to the urgent care centre had commenced

Professor Maddock queried the main reason for the continued drop in 4 hour performance and Mr Bytheway stated that the main issue related to flow although the improvements in ED workforce was expected to improve performance due to the number of patients which could be seen in the 4 hour target.

Dr Griffin welcomed the system investment in social care and queried whether a positive impact had started to be experienced. Mr Bytheway commented that there had been an associated time lag and therefore the impact was not expected to be seen until the end of December, which was a recognised risk.

Mr Bytheway continued to summarise cancer performance:
- There continued to be challenges in the skin, breast and colorectal pathways
- A colorectal summit had been held with clinicians and an action plan was in place looking at system working and internal processes
- Breast cancer was challenged due to workforce and skin referrals continued to be high and work was being undertaken to establish whether this was normal variance
- The number of 2 week wait referrals were significantly higher and further impacted by the challenges in outpatients, workforce and theatre staffing
- The cancer team continued to take forward additional treatments and the Trust was starting to see an increase in the number of treatments per week

Mr Bytheway continued to summarise planned care performance:
- The main challenges related to the ability to access theatres although a commitment had been made in relation to no non-admitted 104 breaches by

	March 2022 • Validation continued on the planned care waiting list, with planning underway to take account of wave 4 of covid and associated increase in numbers within critical care which would affect the ability to operate • Divisional leaders had been met with, looking at what could be done to enable operating to continue during winter whilst at the same time considering what could be stood down at times of surge Mr Wakefield referred to wave 4 and the consequences on the waiting list queried whether the Trust was working with Public Health England in the messages being provided to the public, in order to manage expectations. Mr Bytheway stated that messages had been focussed on what was happening in the community and Ms Ashley stated that the Trust was part of a national pilot which looked to share waiting list size and times so that people could access the necessary information and manage expectations. Ms Ashley agreed to confirm the timeline associated with the pilot. Mrs Bullock agreed that the Trust needed to continue to be transparent and open in explaining the challenges being faced and the impact on planned care activity. Mr Bytheway referred to diagnostics performance and stated that the main challenges continued to be in relation to non obstetric ultrasound which was not expected to improve until February 2022. Mrs Vaughan highlighted the following in relation to workforce performance: • Sickness absence remained a concern, with an increase in month to 5.66% and stress related absence one of the main causes of absence as well as respiratory reasons • There had been an increase in the number of staff accessing counselling and wellbeing services • Work was being undertaken divisionally to understand the reasons for stress related absence with some noted as being due to the pandemic, fatigue as well as personal reasons for stress • Staff continued to be supported on health and wellbeing with sessions provided on self-care, self-help and staff resilience • Deep dives had been undertaken to ensure staff absence was being managed as per policy • Covid related absences was approximately 20% of overall absences • There had been a deterioration in PDR compliance and work was continuing with divisional teams to better support them in taking forward improvements • Mandatory training remained at a static position • The vacancy rate had slightly increase to 9.7%, due to changes in establishment to support the winter plan Mr Wakefield queried if the vacancy rate was covered by bank and agency and Mrs Vaughan stated that this was the case but not for all areas. Ms Bowen queried the vacancy rate compared to other Trust and Mrs Vaughan agreed to obtain this information. Mr Oldham highlighted the following in relation to financial performance: • The H2 budget aimed at achieving a breakeven position for the full year but a slight change was anticipated due to some changes in activity, resulting in additional income being received by the elective recovery fund and a further surplus • The Trust delivered a £2.2 m surplus in month and overall year to date	HA RV

	surplus and there had been some movement in month regarding delays to the managed equipment service resulting in savings. Additional income from Health Education England had been received and some slippage on non-recurrent investment was noted • There had been a slight increase in covid costs which stood at £1.2 m in month, but remained within the cost allocation • £14.3 m of capital had been spent year to date and the Trust was behind plan due to some delays in schemes, although this continued to be monitored closely Mr Wakefield referred to pay costs which were £2.7 m above plan and queried if this was due to activity. Mr Oldham stated that this was due to the wage awards and income had been adjusted accordingly. Ms Bowen referred to the slippage on the digital pathology project and queried if it was anticipated that the new timelines would be achieved. Mr Oldham stated that project plans were in place and Ms Ashley agreed to obtain a further update. **The Trust Board received and noted the performance report.**	**HA**
GOVERNANCE		
13.	**Speaking Up Report – Quarter 2**	
182/2021	Mrs Vaughan highlighted the following from the report: • The Trust continued to review the actions arising from national reports as well as implementing recommendations where appropriate • The Freedom to Speak Up index was no longer being published and the new national process had not been confirmed, although it was expected this would be linked to the responses in the staff survey • Training packages had been revised which reflected national packages and the Trust continued to utilise other means of obtaining feedback via national and internal surveys • Recruitment to the lead Freedom to Speak Up Guardian was due to take place and the role was to be aligned to the Corporate Governance portfolio • The concerns raised in the quarter were consistent with previous themes with the majority relating to issues regarding attitudes and behaviours Professor Hassell referred to recruitment to the Freedom to Speak Up Guardian and queried if the number of hours for the role were to change. Mrs Vaughan stated that benchmarking had been undertaken and it had subsequently been agreed to increase the role to full time. Ms Bowen referred to the NHSIE hotline which staff could report into and queried if any data for the organisation would be provided. Mrs Vaughan stated that if the Trust was made aware of a concern it would be included within the report. Ms Bowen referred the reference within the report to the safe storage of confidential records and queried if that was a one off incident or a wider issue. Mrs Vaughan agreed to obtain an update into the investigation of that case to provide assurance of any wider learning. Professor Crowe acknowledged the work which had continued to be undertaken by Mrs Lees and recorded his thanks. Mrs Vaughan stated that Mrs Lees would continue in the role until the new appointment had been made.	**RV**

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	The Trust Board noted the speaking up data and themes raised during Quarter 2 2021-22 and the actions proposed to further encourage and promote a culture of speaking up at UHNM.	
CLOSING MATTERS		
14.	**Review of Meeting Effectiveness and Business Cycle Forward Look**	
183/2021	No further comments were raised.	
15.	**Questions from the Public**	
184/2021	Mr Syme queried how the Trust could demonstrate it was being a good corporate citizen within the new Placed Based Partnerships (PBP) - System Based NHS. Mrs Bullock commented on the way in which the Trust was involved in increasing diversity such as involvement in the stepping up programmes, promoting inclusivity, and involvement with Project SEARCH. In addition, she stated that a system sustainability plan was in place which UHNM had contributed to. She added that the Trust was an active member of the 2 PBPs and their associated work programmes. Mrs Ashley provided further information in respect of the PBPs. Mr Syme referred to the intention to use Independent Sector capacity to help alleviate the backlog of elective work which included transferring cancer work, and queried if the Trust had managed to negotiate this with the Independent Sector. Mr Syme queried the type of cancer work being transferred to the Independent Sector and queried what checks and balances were in place to ensure safe and quality outcomes for patients being transferred under this arrangement. Mr Bytheway confirmed that the Trust had not been able to negotiate transfers of cancer work to the Independent Sector, but rather focussed on general surgery and orthopaedic work, with cancer cases continuing to be treated at UHNM. Mr Syme referred to the number of ambulance handover delays of over 60 minutes which had increased by 60% in October 2021. He queried if the entire 'Care System' 'normalised' extended Ambulance Handover Delays for the short to medium term and if not what the Trust and partners were implementing that is new to considerably reduce such delays. Mr Bytheway stated that the Trust recognised the challenging position for the ambulance service and impact on patients and staff. He stated that in October a number of beds had been closed which exacerbated the problem and a number of actions had been put in place to reduce the high number of ambulance conveyances, which included working with the community to divert patients to the most appropriate area. He stated that challenges remained with occupancy which was higher than any national benchmark and staffing in AMU was being increased as this was one of the biggest challenges in transferring patients. He concluded by stating that neither the Trust nor the 'care system' had normalised the position, but agreed it was challenging for all parties.	
DATE AND TIME OF NEXT MEETING		
16.	Wednesday 5th January 2022, 9.30 am, via MS Teams	

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Trust Board (Open)

Post meeting action log as at 17 December 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/465	07/04/2021	Midwifery Continuity of Carer Action Plan	To discuss the document further at QGC, in terms of the specific actions to be taken and anticipated dates of delivery for the revised trajectories. In addition, to provide information on peer group comparisons.	Lynn Dudley	26/08/2021	07/12/2021	Update provided at December's meeting and agreed to devolve the action to QGC given that this would not be able to be completed until the report was received in March 2022.	B
PTB/488	06/10/2021	Patient Story	To take an update to QGC on the actions taken as a result of the patient story regarding sickle cell.	Ann Marie Riley	27/01/2022		Action not yet due.	GB
PTB/489	03/11/2021	Patient Story	To liaise with Mrs Luyt in respect of planning for future admissions	Matthew Lewis	05/01/2022		**Update to be provided in January.**	GB
PTB/490	03/11/2021	Research Strategy	To provide a session on the Research Strategy at a future Board Seminar	Matthew Lewis Kam Karunanithi	12/01/2022		Agreed to schedule at the Board Seminar in January.	GA
PTB/491	03/11/2021	IPC BAF	To update the BAF risk in relation to infrastructure, reflecting the CPE outbreak and associated learning/actions.	Lorraine Whitehead	31/01/2022	16/12/2021	Complete - IPC BAF updated.	B
PTB/495	03/11/2021	BAF - Q2	To discuss the approach to revising the BAF with Mr Wakefield	Claire Rylands	05/01/2022		Meeting to be held with Mr Wakefield.	GA
PTB/496	03/11/2021	Workforce Disability Equality Standard Report	To prioritise the actions identified in terms of possible impact	Ro Vaughan	05/01/2022		**Update to be provided in January.**	GB
PTB/497	07/12/2021	Quality Governance Committee Assurance Report (25-11-21)	To take an update to QGC in relation to maternity outcomes and ethnicity.	Ann Marie Riley	27/01/2022		Action not yet due.	GB
PTB/498	07/12/2021	IPC Board Assurance Framework – November 2021	To obtain the information in relation to timescales and impact of the sink replacement programme	Ann Marie Riley	09/02/2022		Action not yet due.	GB
PTB/499	07/12/2021	H2 Plan	To further discuss the change in the underlying deficit at PAF.	Mark Oldham	25/01/2022		Action not yet due.	GB
PTB/500	07/12/2021	Integrated Performance Report - Month 7	To take an update to the Quality Governance Committee on the reasons for the increase in pressure ulcers and lapses in care, lessons learned and actions being taken	Ann Marie Riley	25/01/2022		Action not yet due.	GB
PTB/501	07/12/2021	Integrated Performance Report - Month 7	To confirm the timescales expected to be adhered to in terms of training new staff in sepsis awareness	Ann Marie Riley	05/01/2022		**Update to be provided in January.**	GB
PTB/502	07/12/2021	Integrated Performance Report - Month 7	To take an update to the QGC in terms of covid / nosocomial death reviews	Matthew Lewis	24/03/2022		Action not yet due.	GB
PTB/503	07/12/2021	Integrated Performance Report - Month 7	To confirm the timescale associated with the planned care national pilot	Helen Ashley	09/02/2022		Action not yet due.	GB
PTB/504	07/12/2021	Integrated Performance Report - Month 7	To provide benchmarking information in relation to vacancy rates.	Ro Vaughan	09/02/2022		Action not yet due.	GB
PTB/505	07/12/2021	Integrated Performance Report - Month 7	To obtain an update in relation to the timescales associated with completion of the Digital Pathology programme.	Helen Ashley	09/02/2022		Action not yet due.	GB
PTB/506	07/12/2021	Raising Concerns Report – Quarter 2	To obtain further information in relation to learning associated with the case referring to storage of confidential records.	Ro Vaughan	09/02/2022		Action not yet due.	GB

Chief Executive's Report to the Trust Board

FOR INFORMATION

Part 1: Chief Executive's Highlight Report

1. Contract Awards and Approvals

Department of Health Procurement Transparency Guidance states that contract awards over £25,000 should be published in order that they are accessible to the public. Since 13th November to 9th December, 2 contract awards, which met this criteria, were made, as follows:

- **Supply of Sutures** supplied by J&J at a total cost of £558,700.44, for the period 24/11/21 – 30/11/22, approved on 23/11/21
- **Home Delivered Haemodialysis** supplied by various at a total cost of £720,000.00, providing savings of £2,387.00 for the period 01/12/21 - 30/11/23, approved on 23/11/21

In addition, the following eREAFs were approved by the Performance and Finance (PAF) Committee in December and requires Board approval due to their value:

Installation of 2nd VIE plant and medical gas infrastructure works - (eREAF 8497)

Contract Value £1,042,992.41 incl. VAT
Duration Capital Purchase
Supplier IHP Vinci Construction

Staff Shuttle Bus Service Royal Stoke - (eREAF 8481) - Extension

Contract Value £1,066,927.00 incl. VAT
Duration 01/02/22 - 31/01/24
Supplier ABC Supreme 2002 Ltd

Link Bus Service between Royal Stoke and County Hospital - (eREAF 8480) - Extension

Contract Value £1,071,628.00 incl. VAT
Duration 01/02/22 - 31/01/24
Supplier ABC Supreme 2002 Ltd

The Trust Board are asked to approve the above eREAFs.

2. Consultant Appointments

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

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Locum Consultant Intensivist	Vacancy	TBC	TBC
Specialist Doctor in Clinical Haematology x 5	Vacancy	Yes	TBC
Locum Consultant Spinal Surgeon x2	Vacancy	Vacancy	17/01/2022
Locum Consultant Cardiac Surgeon	Vacancy	Yes	17/01/2022
Medical Examiner x 8	New	Yes	TBC

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

Post Title	Reason for advertising	Start Date
Clinical Director – NMCPS	Extension	01/12/2021
Locum Consultant Radiologist GI & Uroradiology	New	07/12/2021
Specialist Doctor in Clinical Haematology	Vacancy	28/12/2021
Locum Consultant Neurosurgeon	Extension	28/12/2021
Locum Consultant Neurologist	Extension	30/12/2021
Consultant Histopathologist	Retire & Return	01/12/2021
Senior Appraiser	Vacancy	01/12/2021
Senior Appraiser	Vacancy	01/12/2021
Clinical Lead for Emergency Surgery	Vacancy	01/12/2021
Clinical Lead for Colorectal Surgery	Vacancy	01/12/2021
Consultant Ophthalmologist	Retire & Return	16/12/2021
Clinical Lead - Cellular Pathology	Vacancy	13/12/2021

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

Post Title	Closing Date	Note
Glaucoma Consultant Ophthalmology	05/12/2021	No applications
Consultant Gastroenterologist	12/12/2021	No Applications
Locum Consultant Breast Radiology	05/12/2021	Candidate withdrew
Clinical Lead for Haematology	22/11/2021	Candidate withdrew

3. Covid 19 and Trust Pressures

The pressure on our services is continuing, with the Prime Ministers announcement in relation to Omicron and 'turbo charging' the vaccination programme. We all recognise the potential increasing numbers of people affected and ultimate pressure this will have on the NHS. Locally there are growing numbers cases of the new Omicron variant community and we are seeing cases in our hospitals.

Therefore we are now planning for a fourth wave of patients with Covid-19 needing hospital care. We recognise how difficult this news is for our staff who have worked tirelessly throughout and where possible and how much this has taken a toll on staff wellbeing. As far as possible, we would wish to maintain all of our services as we know there are too many patients who have been waiting far longer than they should for the treatment they need. This will be a difficult balance which will require our workforce to be flexible and to work together to make some very difficult decisions.

Our system has worked together collectively to try to create capacity to manage this fourth surge but we have to recognise that our 'normal' winter plan had a deficit of 100 beds that had not been resolved. Therefore, that gap required closure before we could begin to impact on the additional beds required for the 4th surge. Additional community beds are available and there are staffing plans for most of these however, we know that the infectious nature of Omicron will have an impact on staffing. As a result, workforce remains our single biggest risk during this surge.

4. CQC Inspection Report

On 22nd December we received our inspection report from the Care Quality Commission and were delighted to be rated as 'Outstanding' for caring. The CQC has now published its official report confirming our rating following two focused inspections of two core services at our Royal Stoke University Hospital and County Hospital sites during August and October 2021. Outstanding is the CQC's highest rating and has been achieved for caring during what has been the toughest time for the NHS. The Trust also saw its rating for being well-led improve and is now rated as 'Good'.

We were rated as Requires Improvement overall as well as for whether our services are safe, effective and responsive.

The inspection team noted that there has been an improvement since its last inspection and while managing considerable challenges during the significant impact from the Covid-19 pandemic, we had continued with our important change and improvement programme, Improving Together.

I am delighted that the hard work and commitment of our staff has been recognised. To be rated outstanding for caring, whilst managing the changes and pressures during the Covid-19 pandemic, is a fantastic achievement and a true testimony to their dedication and compassion.

We have made some significant improvements since the CQC's last inspection and we are pleased the inspectors found many areas of outstanding practice.

We recognise there is still much to do and have already started work to address the areas the inspectors have highlighted for improvement. We are committed to providing the best possible care for our patients and have approved and begun a programme to recruit more than 30 new doctors to work in our Emergency Departments. We will continue to develop all of our services as we aim to achieve an overall rating of outstanding for both our hospitals.

Our Quality Governance Committee will be reviewing the report in detail at their meeting in January before we bring this to the Board in February; work is already underway with our action plan.

5. Staffordshire and Stoke on Trent Quarterly System Review Meeting (QSRM)

Our QSRM took place on 8th December involving system partners and our regulators and we have received feedback which noted considerable progress in the Stoke-on-Trent system with regard to:

- Robust governance and programme management to manage the transition to ICB establishment
- The process that has worked well to collectively build a set of H2 plans
- System approach to workforce planning and promoting the health and wellbeing of staff
- Preliminary CQC report which signals improvement in a number of areas for Caring and Well Led
- Ability of UHNM to flex up critical care capacity in response to growing UEC pressures and to offer mutual aid to others
- Comprehensive approach to RSV capacity planning which has been showcased at a regional event
- Overall performance in mental health, with trajectories for improvement in place

We collectively agreed the key areas of concern and our regulators welcomed an honest exchange regarding plans and support needed for:

- Sustained urgent and emergency pressures across the system which are resulting in an unacceptable level of ambulance handover delays and poor flow out of hospital
- The plans for addressing elective long waiters, cancer backlogs and the growing risk to elective work
- Delivery of the vaccination programme, particularly in respect of 12-15 year olds and boosters

We will continue to focus on these areas as a system and will be providing feedback on progress at our next review scheduled for 22nd February 2022.

6. Integrated Care System (ICS) Board Partner Briefing (16th December 2021)

The ICS Board met on 16th December in public. There were a number of items discussed, which included:

- **Step on Individual Placement and Support (IPS):** Board members heard a resident story about their experience of the Step On service which enables individuals who have or have had a mental health diagnosis to gain and retain the type of work they choose to have.

- ICS Chair and Interim ICB Chief Executive's Report: Covering a range of key system issues including national Level 4 incident and actions required, vaccination programme progress and risks, pressures in Urgent and Emergency Care, funding for tackling winter pressures, establishment of a Primary Care Collaborative as part of the General Practice Development Programme, the 'Together Against Abuse' campaign, Peter Axon commencing his role as Interim Chief Executive Officer and a development session on Population Health Management.

ICS Transition Timeline: showing the significant steps to be taken towards being formally established including adoption of the national guidance on Readiness to Operate, requirement for a local model of distributed clinical and professional leadership and work of the Health and Care Senate. Since the meeting, there has been a national delay to the implementation of ICS's from April to July.

- System Wide Strategy: Under development, establishing a core set of principles for engaging people and communities.
- General Practice Access Plan: Describes the initiatives in place to increase capacity over the winter period.
- ICS Quality Strategy: Under development through the system Quality & Safety Committee.
- System People Hub: Recognised as a national exemplar by regulators.
- Urgent and Emergency Board: overseen the development and delivery of an improvement plan to tackle the challenges and issues impacting on delivery of responsive and effective care.

7. Winter Planning

Our winter plan has many elements to it, from helping people choose the right place to receive the care they need to increasing the numbers of staff at our hospitals. To date our plan has included:

- Recruitment of 93 additional international nurses
- A month long campaign encouraging more people to join the nurse bank for registered nurses, midwives and Operational Department Practitioners
- Recruitment of 100 nursing assistants through an agency
- Ensuring that there is a free and accessible water supply to all on site
- Reviewing our food provision to ensure that there is affordable, accessible and nutritious hot and cold options to our staff across both sites, 24/7 with a click and delivery system service being trailed in Critical Care
- NHS 111 kiosks in both Accident & Emergency Departments

The Trusts internal winter plan is designed and aligned to the system winter plan which brings together all system partners contributions to winter planning, whether as a single organisation or through working in partnership with each other and below are some of the areas focussed on:

- System level investment of £2m in a new facility at Chesford Grange for additional community beds
- a further £1m invested in domiciliary care staffing
- Additional GP slots to significantly increase the number of appointments
- Opening of additional care home beds
- Development of Virtual Wards
- Increasing the Community Rapid Intervention Service (CRIS) to prevent conveyance to hospital or expedite discharge

8. Maternity Services

Along with our Chairman, and Non-Executive Director and board champion for maternity services, members of the Executive Team and the maternity leadership team met with NHS England regional and national teams to discuss maternity services. The national team took the opportunity to raise awareness on what they are seeing in maternity services across England. Our maternity team were asked to continue

the great work they are doing and I know from discussing their plans they will continue with the excellent work to develop and further improve services.

9. CPE Outbreak – Follow Up Inspection

We had a further follow up external inspection of the West Building at Royal Stoke by representatives from NHS Improvement Midlands Region. This follows a significant amount of work last month by the estates, cleaning and nursing teams to not just meet but exceed cleaning standards in all areas of the accommodation following a CPE outbreak. The visit was a success with only minor improvements noted and whilst I recognise that there is more to do, my thanks go out to all involved.

10. Royal Stoke & UHNM win GOLD in 2021 RITA Awards

Over the last 12 months UHNM Charity has funded a number of RITAs (Reminiscence Interactive Therapy Activities). This is an innovative, evidence-based, state-of-the-art digital therapy system which allows patients to use apps, games and other leisure activities as part of their hospital recovery. The work to support our patients and use RITA with our elderly patients with cognitive impairments, such as dementia has been recognised in the inaugural RITA Awards, with the highest Gold Award.

11. Christmas Tree Competition

Despite our challenges, it was fantastic to see our staff getting into the Christmas spirit as I joined other members of the executive team to judge the wonderful array of Christmas trees in our annual Charity Christmas Tree competition. Also, a record number of requests were made this year for charity funding to decorate areas, with 186 requests for new decorations for our many wards and departments.

12. Critical Condition

The film crew responsible for filing the latest series of our Channel 5 documentary 999: Critical Condition have confirmed that the programme will be aired from Thursday 6th January and will run for eight weeks. I will be looking forward to seeing our staff and services showcased in all their shining glory.

Executive Summary

Meeting:	Trust Board	Date:	5th January 2022
Report Title:	Digital Strategy Update	Agenda Item:	7
Author:	Amy Freeman, Director of Digital Transformation		
Executive Lead:	Amy Freeman, Director of Digital Transformation		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

n/a	n/a	n/a

Executive Summary

Situation

- *Trust Board update on the progress of the Digital Strategy.*

Background

- *A number of actions have been taken since August 2021 to inform the development of the Digital Strategy.*

Assessment

- *Progress has been made and plans are in place for completion in March 2022.*

Key Recommendations

The Trust Board is asked to receive and note the report.

Digital Strategy Update

20th December 2021

1. Introduction

This paper details the actions undertaken in 2021 to support the development of the Trusts Digital Strategy and actions planned for 2022.

2. Background

The current Digital Transformation Strategy comes to an end in 2023, however, after 2 years of living with Covid-19 and with the acceleration of digital during that period it is fitting that a new strategy is authored to reflect the changing times.

Our vision is to deliver exceptional care with exceptional people and it has never been more important to enable this vision with supportive digital and data insight services. The delivery of digital technology and data driven insights can make a significant impact on patient outcomes through supporting service and pathway redesign, clinical decision support, enabling patient self-management and self-service, and increased productivity.

The new digital strategy aims to set out how UHNM will use digital and data insights to enable the delivery of exceptional care including how we develop our exceptional people to be digitally confident.

3. 2021 Actions

During 2021 a number of actions were undertaken to inform and shape the new digital strategy.

- NHS Providers Digital Board Development Session
  This session helped the Board understand what a good digital strategy looks like and the types of questions they may want to use when evaluating a new strategy.

- Clinical Strategy Review
  The clinical strategy has been reviewed to understand any digital elements of the clinical strategy that will need to be enabled by the digital strategy.

- Stakeholder Map
  A stakeholder map has been developed to ensure good and relevant engagement.
- Information Management & Technology (IM&T) senior management team away day
  This session allowed the departments senior managers to explore the vision, values, principals and priorities for the strategy based on the clinical strategy and the quality improvement priorities.

- The HIMSS Analytics Electronic Medical Record Adoption Model (EMRAM) Assessment
  The HIMSS EMRAM assessment incorporates methodology and algorithms to automatically score hospitals around the world relative to their Electronic Medical Records (EMR) capabilities. This eight-stage (0-7) model measures the adoption and utilisation of electronic medical record (EMR) functions. Moving organisations closer to achieving a near paperless environment that harnesses technology to support optimised patient care by completing each stage. UHNM score 2 out of 7. The gap analysis from this review will be used to help prioritise effort and investment.

- NHSX What Good Looks Like (WGLL) Framework
  An assessment of UHNM against the NHSX WGLL framework has been undertaken the Trust is 1.6 out of 5. This gap analysis will be used to help prioritise effort and investment.

- Go Look Learn Visits
  Every go look learn visit I have undertaken has involved questions about digital and ideas for improvement of innovation. The feedback from these visits will be incorporated into the strategy.

- Review of NHS Strategies
  Digital strategies from 4 Trusts have been reviewed to help inform the UHNM strategy.

- Digital Strategy Workshop
  A digital strategy workshop has taken place to seek input from the CCIO.

- Governance Structure
  The governance structure has been redeveloped to ensure the strategy will be enabled by a fit for purpose governance structure. The first of the new meetings commence in January 2022.

4. Planned 2022 Actions

It is hoped that the digital strategy will be ready in March 2022 the remaining actions include:-

- Digital Staff Survey - January
  A survey to seek the opinion of our users on the innovations that will make the biggest difference to them and their work.
- All Staff IM&T Away Day - February
  I will present the digital strategy and seek feedback from the team. The team will also agree the vision from the following options
  - Embracing technology and insights to support the delivery of exceptional care with exceptional people
  - Embracing digital and insights to support the delivery of exceptional care with exceptional people
  - Delivering digital innovation and insights to support the delivery of exceptional care with exceptional people
- Integrated Care System Engagement
  I will circulate the strategy to the ICS digital stakeholders for feedback and to ensure they agree it is aligned with the ICS direction of travel.

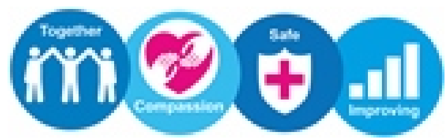
- Executive Digital and Data Protection and Security Group Approval

- Performance and Finance Committee Approval

- Trust Board Approval

5. Conclusion

In the past 5 months significant work has been put into developing a digital strategy that is fit for the future and plans are in place for the strategy to be ready for March 2022.



Quality Governance Committee Chair's Highlight Report to Board

16th December 2021

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Section 29A warning notice issued by the Care Quality Commission; actions have been identified, the majority delivered and have been signed off by the Care Quality Commission. A decision is awaited on the outcome of this process. • Executive Health and Safety Group have identified a number of risks which included risks relating to staffing levels, needlestick injuries, completion of risk assessments and some security matters. All of which will be overseen by the Committee including a deep dive into needlestick in juries. • Backlog of Root Cause Analysis incidents has been identified and is being reviewed in more detail and will be monitored through the Quality and Safety Oversight Group • Volume of work required by the maternity department, a substantial amount coming to the Quality Committee which is labour intensive • Escalation of the Medical Examiner Report to the Audit Committee as means of positive assurance	• Maternity Services Self-Assessment has been undertaken against a number of key requirements; this has allowed the team to priorities key areas for improvement in 2022 • Triangulation of incidents, claims and complaints associated with maternity services to be included in a future report to the Committee • Birth rate plus midwifery establishment review to be conducted, with a reported expected to be available by March 2022 • Ethnicity to be included in Mortality Reports in the future • Progress is underway with delivering the Clinical Audit Programme; 68% projects have been commenced and all projects are planned to be completed in the planned timeframes • Review of VTE performance data underway which is underway
Positive Assurances to Provide	**Decisions Made**
• Royal Stoke were one of the early adopters of the Medical Examiner's Office and good progress has been made to date; the service has been used as a regional exemplar of service • Compliance with 10 NHS Resolution CNST Maternity Incentive Scheme (1-3 years) and 90% assurance compliance from the national submission of evidence for Ockenden, with an action plan in place to address gaps in evidence • Standardised Mortality Ratio for Covid related patients is below the peer group average • HSMR is for the 12 month period July 2020 to June 2021 is 93.66 and is noted as being lower than expected and slightly lower than the corresponding 12 months in 2019/20 • QIA assessment has been undertaken for 5 schemes	There were no items requiring a decision.

Comments on the Effectiveness of the Meeting

- Important to ensure that the Maternity Team have sufficient agenda time at future meetings
- Feedback to be provided on the mortality papers in terms of the way in which it is presented to the Committee
- Positive that the balance of time is now on discussions rather than spending the time presenting the paper
- Committee members preference is for specialist leads to continue to attend and present items, providing that they are sufficiently briefed and prepared

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Medical Examiner Annual Report	Assurance	9.	Month 8 Quality and Safety Report	Assurance
2.	Covid-19 Mortality Benchmarking Report	Assurance	10.	Update on CQC Section 29A Warning Notice	Assurance
3.	Mortality Summary Report	Assurance	11.	Clinical Audit Progress Report	Assurance
4.	Maternity Services Self-Assessment Board Assurance Framework Q2 21/22	Assurance	12.	Executive Health & Safety Group Assurance Report	Assurance
5.	CNST Maternity Incentive Scheme Year Four	Assurance	13.	Quality and Safety Oversight Group Assurance Report	Assurance
6.	Maternity Family Experience Report Q1 2021/22	Assurance	14.	Quality Impact Assessment Report	Information
7.	Midwifery Continuity of Care Update and Action Plan	Assurance	15.	Review of Meeting Effectiveness and Attendance	Verbal
8.	Midwifery Continuity of Care Update and Action Plan	Assurance	16.	Review of Business Cycle and Matters for Escalation	Verbal

3. 2021 / 22 Attendance Matrix

Attended | Deputy Sent | Apologies Received

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

Executive Summary

Meeting:	Trust Board	Date:	5th January 2022
Report Title:	Infection Prevention Board Assurance Framework	Agenda Item:	9
Author:	Helen Bucior, Infection Prevention Lead Nurse Emyr Philips , Associate Chief Nurse Infection Prevention/Deputy DIPC		
Executive Lead:	Mrs Ann-Marie Riley, 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/risks

- Not moving patients until 2 negative COVID screens achieved. For asymptomatic patients this is not always possible and therefore remains on the action plan. COVID themes paper on IPCC agenda
- Recording mask fit testing is in place for area that use Health rostering system. Compliance and mask fit failure rate to be monitored by the Divisions - this remains on the action plan
- None conformities for decontamination of bed that are returned for repair remains and difficulty with dismantling of electronic beds at ward level remains an actions and will be included in the cleaning collaborative work
- West building estates/building long standing issues including number of non -compliant hand wash sinks

Progress

- Following NHSEi 10th December – Trust moved back to AMBER. Internal risk rating for both criteria 1 and 2 reduced to reflect this
- External company continues to assist with mask fit testing
- Ward are currently receiving reminder calls to prompt COVID screening
- Cleaning Collaborative work stream (multi-disciplinary representation) established and using Improving Together tools and methodologies to work through the actions needed to respond to the cleaning issues in West Building highlighted during the CPE Outbreak

Key Recommendations:

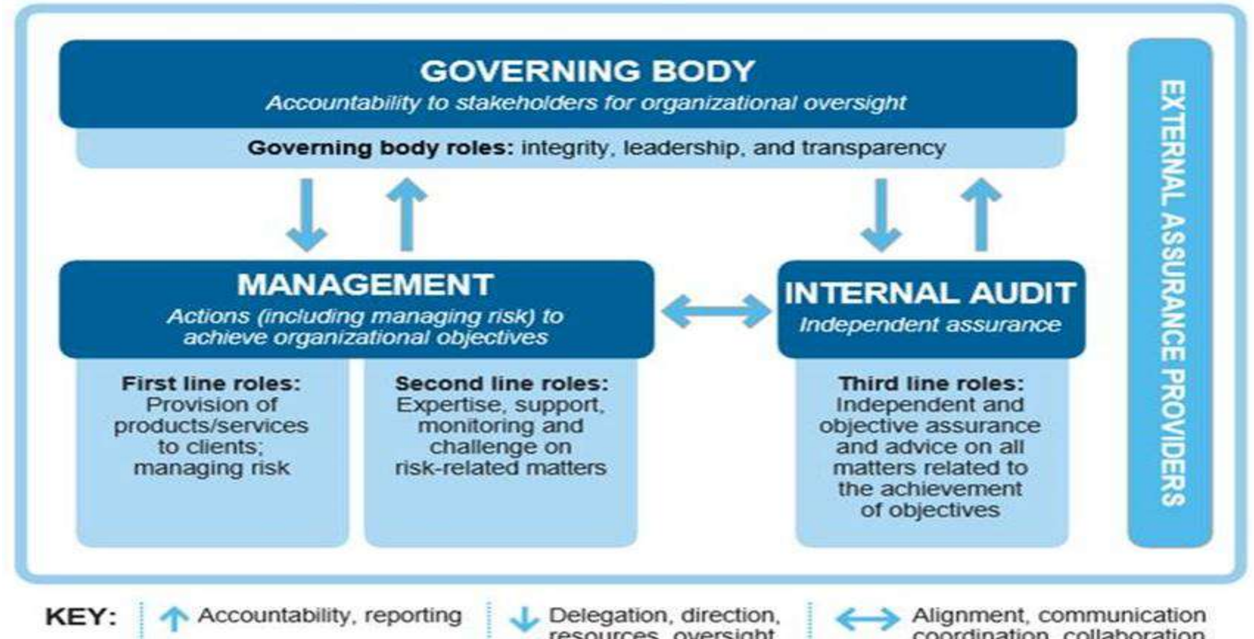
Trust Board are asked to note the document for information, and note the ongoing work to strengthen the assurance framework going forward.

Infection Prevention and Control Board Assurance Framework

December 2021

Summary Board Assurance Framework as at Quarter 1 2020/21

Ref / Page	Requirement / Objective	Risk Score				
		Q4	Q1	Q2	Q3	Change
BAF 1 Page 3	Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users.	Mod 6	Mod 6	Mod 6	Mod 6	↓(end of Q3)
BAF 2 Page 15	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	Mod 6	Low 3	Low 3	Mod 6	↓(end of quarter 3)
BAF 3 Page 24	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	High 9	Mod 6	Mod 6	Mod 6	→
BAF 4 Page 27	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care, in a timely fashion.	Low 3	Low 3	Low 3	Low 3	→
BAF 5 Page 30	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	Low 3	Low 3	Low 3	Low 3	→
BAF 6 Page 33	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	Mod 6	Mod 6	Low 3	Low 3	→
BAF 7 Page 40	Provide or secure adequate isolation facilities.	Low 3	Low 3	Low 3	Low 3	→
BAF 8 Page 42	Secure adequate access to laboratory support as appropriate.	Low 3	Low 3	Low 3	Low 3	→
BAF 9 Page 47	Have and adhere to policies designed for the individuals and provide organisations that will help prevent and control infections.	Low 3	Low 3	Low 3	Low 3	→
BAF 10 Page 50	Have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	Low 3	Low 3	Low 3	Low 3	→



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

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

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

Risk Scoring

Quarter	Q4	Q1	Q2	Q3	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2	2	2	2	There are a number of controls in place, however evidence of assurance monitoring has demonstrated some gaps which will be addressed through the action plan CPE colonisation OB/ NHSEi visited rated Trust as RED on the NHSEI matrix from mid- September to Mid- December and therefore we increased the risk rate to 16, this risk has now reduced and NHSEi and has moved the Trust back to AMBER. End of quarter 3 position risk reduced to 6	Likelihood:	1	End of Quarter 3
Consequence:	3	3	3	3		Consequence:	3	
Risk Level:	6	6	6	6		Risk Level:	3	

Control and Assurance Framework

	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
1.1	Systems and processes are in place ensure: • Local risk assessments are based on the measure as prioritised in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff • The documented risk assessment includes: • A review of the effectiveness of the ventilation in the area • Operational capacity • Prevalence of infections/variants concern in the local area	• Trust has a nominated ventilation lead • Work with LRF to obtain community rates • Risk assessment follow Hierarchy of controls • IP attends the weekly Staffordshire and Stoke on Trent , Test, Trace and Outbreak Management Group • Daily Tactical meetings	• From June 2020 IP team to review patients that are found COVID positive and nursed in bay to ascertain compliance with pathway and IP control measures are in place Review pathways and identify theme • Theme report to IPCC • Pre AMS check COVID -19 screening results, if patient arrives in green area with no COVID screen a Datix is raised.	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
• Triaging and SARS-CoV-2 testing is undertaken for all patients either at the pointe of admission or soon as possible/practical following admission across all pathways;	• 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 was revised in September 2020 to 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 • 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		

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
		Areas. • All children, symptomatic or asymptomatic are swabbed in child health. This is recorded within their medical records, placed onto the nursing and medical handover so that we are made of the results and whether we need to chase if not received within a timely manner. The patient flow reports to the Child Health tactical meeting every morning how many children have been swabbed result and any outstanding • All children swabbed are placed into a sideward upon receiving their result are either kept within a side ward or moved to a bay if the swab is negative. • Screening for patients on systematic anticancer treatment and radiotherapy • Out patient flow chart in place • Thermal imaging cameras in some areas of the hospital • Iportal alert in place for COVID positive patients • Extremely vulnerable patient placement added into new COVID ward round guidelines (October 2020) 8th-march-2021-covid-ward-round-guidan • Doors fitted to resus areas in both ED's		

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 an unacceptable risk of transmission remains following the risk assessment, consideration to the extended use of respiratory RPE for patient care in specific situations should be given	• Discussed at Clinical group. Paper prepared by Deputy Medical Director which received exec approval w/c 26 July 2021 • August 2021 Introduction of FFP3 masks for all contact/ within 2 metres of COVID positive patients. The use of FFP3 masks for aerosol generating procedures remains in place		
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 that test negative are rescreened on days 4, 6, 14 and weekly • 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 covid-19-faq-v6-10-6-2021.docx	• Unannounced visits for clinical areas with clusters or HAI cases of COVID-19 • Review of HCAI COVID cases by IP Team/RCA • 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	• 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**
		contacts of positives are advised to complete self –isolation if discharged or transferred within that time frame Patient Information Lealfet - Contact 202 Testing and lifting IP precautions.pdf • All patients are screened 48 hours prior to transfer to care homes • New UHNM ward round guidance October 2020. This also included placement of the extremely vulnerable patient 4th-february-2021-covid-ward-round-gui guidance-on-screening-and-testing-for-co		
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	

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 • Patients, visitors and staff are able to maintain 2 metre social and physical distancing in all patient care areas, unless staff are providing clinical/personal care and wearing appropriate PPE • 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 The role of PPE guardians/safety champions to embed and encourage best practice has been considered	• 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 • Lessons learnt poster Lessons learnt - Non Clinical June 2021.pdf Lessons learnt - Clinical June 2021.pdf unannounced-ip-visit-template-2020-11.pdf non-clinical-assurance-visit-checklist-2020-	• Donning and Doffing training also held locally in clinical areas • Cascade training records held locally by Divisions • Sodexo and Domestic service training records • IP unannounced 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**
	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	• QIA process for occasions when we risk assess that the 2 metres can be breached SOP bed removal due to social distancir •		
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. • The clinical group initially weekly , now stepped down to Bi weekly • Tactical group – The tactical Group held daily. April 2021 now stepped down. The Group decide and agreed tactical actions Makes recommendations to Gold command • Chief nurse updates • Changes/update to staff are included in	• 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
		weekly Facebook live sessions • COVID -19 intranet page • COVID -19 daily bulletin with updates • IP provide daily support calls to the clinical areas		
1.6	Changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted.	• Incidence Control Centre (ICC) Governance • Clinical Group, Divisional cells, Workforce Bureau, Recovery cells subgroup feed in to tactical group. • COVID Gold command , decisions /Assurance reported to Trust Board Via CEO Report/COO	• Meeting Action log held by emergency planning • Trust Executive Group Gold command – Overall decision making and escalation • Tactical, Operational Delivery Group - The delivery of the objectives and benefits, and programme communications COVID 19 response and R&R. Co -ordination of resources. Escalation forum for linked Groups and Cells ensuring that the interdependencies are effectively managed, including system. Makes recommendations to Gold Command for key decisions. • Clinical steering Group – Coordinate clinical decision – making to underpin continual service delivery and COVID 19 related care • Workforce Group – Lead	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
			the plan and priorities for our people recovery. Health and Wellbeing. Agree significant pipeline changes in working practices. Agree the impact if change made during COVID and priorities to support recovery • Divisional Groups – Agree infection Prevention measures COVID19RRGOVERNANCE NOV20v1.pptx	
1.7	Risks are reflected in risk registers and the Board Assurance Framework where appropriate. • Linked NHSIE Key Action 5: Daily data submissions have been signed off by the Chief Executive, the Medical Director or the Chief Nurse and the Board Assurance Framework is reviewed and evidence of reviews is available. • 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	• 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 • RCA process for all probable and definite COVID 19	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	prevention and control interventions are optimal, the Board Assurance Framework is complete and agreed action plans are being delivered. • There are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas	• Visiting /walk round of areas by executive/senor leadership team SOP bed removal due to social distancir		
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	CPE colonisation outbreak West Building

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

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 3 Progress Report**	**BRAG**
1.	1.1	Up- to- date COVID -19 Divisional pathways	ACN's	30/09/2020	Associate Chief Nurse contacted and request made for COVID -19 pathways 28th July 2020. ED pathways in place and also County to Royal transfer of COVID positive patients. Divisional restoration plans in progress	Complete
2	1.1	Revised pathways to include actions for extremely vulnerable patients who are admitted into the Trust	ACN's	31/10/2020	4th September Chief Nurse DIPC request at senior meeting that extremely vulnerable patients are included in revised pathways. October 2020 Extremely vulnerable patient recommendations included into the COVID ward round guidance document. November 2020 – Confirmation from ED County highly vulnerable patients are admitted into single cubicle. Consultant ED Royal confirms the same process. Children's – highly vulnerable have direct access to ward	Complete
3	1.2	NHSI key point 4 : Patients are not moved until at least two negative test results are obtained, unless clinically justified	Microbiologist/ ACN's	31/05/2020 31/08/2021 29/10/2021 31/12/2021 28/02/2021	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 after admission. Implementation of the new guidance is in place and a manual prompt is provided to the clinical areas. (Days 4 and 6 admission day counted as day 1). Waiting for 2 negatives swabs before moving for patients that are not COVID suspected does not always occur. April 2021 Chief Nurse reminded ACN's of testing guidance June 2021 – Day 14 and weekly COVID testing for patients who test negative and remain an inpatient - in place	Action under surveillance

					September 2021 A COVID themes review paper is presented at IPCC bi monthly and is an agenda item. Investigation of themes and discussions at COVID outbreak meetings provide an opportunity to review not always achieving this standard and whether this has an impact on potential transmission or outbreak. A number of specialised ward strive to isolate admissions into a single room until COVID results are known. November 2021 actions continues to remain under surveillance December 2021 action continues to remain under surveillance	
4	1.3	Patient COVID -19 discharge information letter for patient who are discharged but contact of a positive case	IP Team	31/11/2020	Action at COVID weekly meeting was to create an information leaflet for patients and household members on discharge, with information on isolating, symptoms and useful information for informing the local authorities and the test and trace system. 6th November leaflet sent out for comments 22/12/2020 to Clinical Group for approval. Progressed to Outbreak Group and Tactical Group , minor changes made 12th December 2020 Submitted to Gold	Complete
5	1.4	Improving staff FFP3 mask fit staff training data recording and retention of records.	Health and Safety	31/08/2021	Proposed Fit Testing compliance improvement Task and Finish Group. Inaugural meeting took place 29th July 2020. ESR will be up and running for the purpose of recording fit test records as soon as the Trust gives the go ahead to procure Portacount fit test systems, this is a project lead by Health and Safety As at 03/02/2021 People O&D have created FFP3 mask "classes" on ESR. Health and Safety are in the process of collating fit test records which were requested at Exec Health and Safety Groups from Divisional H&S Leads. Portacount Business case : Health and Safety Head continues with Business case with target date for completed revised for end of August 2021 10/03/2020 Portacount machine obtained (on loan) by Infection Prevention Team via Midlands Coordinator for the FFP3 Mask	Complete

					Project. Plus mask fit tester will be available to test staff using the portacount machine. The portacount is a quantitative test and uses specialised equipment to measure exactly how much air is leaking through the seal of a mask. ACN'S informed and response requested to aid in identifying testing priority. Midlands Coordinator is meeting IP next week to work through plan. Mask fit testing also continues using hood and bitrex (qualitative, relies on taste) Mask fit testing option also added to e rostering to enable areas to identify staff member that have been tested and record mask model. A report can also be produced with compliance using this system. The mask fit testing certificate must also continue to be completed and filed in the staff member personal folder. Updated mask fit strategy to March which includes mask fit re test frequency. May 2021 FFP3 cascade mask fit refresher in progress. This refresher includes checking that fitters are aware of e rostering and the need to file test certificate in staff members personal folder June 2021 Portacount Business case - Awaiting decision from Exec Health and Safety Group July 2021 Portacount Business case withdrawn at Health and Safety July 2021 update Infection Prevention, those staff that failed on the Bitrex method referred to the Portacount machine, gave us an extra 75% pass rate on the original failures. This is a valuable additional tool for us to get as many staff trained as possible. Action complete FFP3 testing records can now be added as a skill	

					to Health roster. The portacount machine action will be added as criteria 6 and 10 as business case re-instated	
6.	1.4	Divisions to retain current mask fit training records and compliance score for their areas whilst central recording and retention of records process is agreed	ACN'S	30/09/2020	Associate Chief Nurse contacted and request made for assurance with staff mask fit compliance. Compliance also added to Divisional papers for infection Prevention and Control Committee (IPCC). Current process that clinical areas hold their own training records and can also enter basic details on Health Rostering including model of mask staff fitted with. A number of clinical areas have also forwarded training records to the IP Team. IP Team. IP have a list of mask fit testers, this is also available on the Trust COVID intranet page.	Complete
7.	1.8	Re instate admission proud to care documentation, currently emergency admission document in place	Deputy Director of Quality and Safety	30/09/2020	Original proud to care booklet reinstated now	Complete
8.	1.8	To complete an analysis (Advantages and disadvantages) to reinstating MRSA screening as per UHNM policy	Deputy Director Infection Prevention	14/06/2021	MRSA screening had reduced temporarily due to the COVID pandemic but UHNM are still following PHE 2014 guidance. This was an agreed temporary change in UHNM practice. Previously the Trust were screening over and above the 2014 guidance. Due to the COVID pandemic less elective work is taking place therefore less elective screening. High risk areas all still screen on admission. Risk based screening is for lower risk areas. Prior to the 2014 guidance the DIPC at the time (supported by the CCGs) did not want to reduce the screening policy the Trust already had in place. The CCG requested screening policy have to be approved by the CCGs. Discussed at IPCC. DIPC requested a pro's and con's exercise re screening changes due to the COVID pandemic. The Trust has not dropped below national guidance. October 2020 MRSA screening is around 50% of pre COVID screening, laboratory does not have the capacity to process COVID work and level of MRSA screens pre COVID. Paper to November IPCC. This continues to be under review during COVID Pandemic.	complete

					March 2021 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. 20/04/2021 Due to wave 2 COVID 19 , paper deferred to May IPCC 2021 May 2020 Screening recommenced a pre COVID 19 pandemic. DIPC advised action complete	
9.	1.8	To explore an alternative laboratory for Clostridium difficile ribotying	Kerry Rawlin Laboratory	31/08/2020	Leeds Hospital has agreed to help with ribotyping Clostridium difficile specimens. Await first batch of results to gain assurance that process is working 04/09/2020 we are experiencing problems in receiving ribotyping results back from Leeds. Usually they would arrive electronically. UHNM have contacted Leeds and are awaiting a resolution with their IT team and the PHE reference electronic reporting system. Ribotype now being received from Leeds and added to ICNET patient case	Complete
10	1.8	To Investigate, agree implement and follow-up measures. CPE colonisation outbreak in west building.	DIPC/IP team	31/10/2021 30/11/2021	October 2021 Infection prevention review on –going Multi- disciplinary /agency approach Out Break Team/Meetings Environmental and water testing undertaken External support and visits NHSEi and UK HSA Terminal cleans using HPV in progress CPE screening continues Action plan in place including estates action plan November 2021 03/11/2021 Terminal clean including stream and HPV completed for West Building FEAU/ward 122Wards have reopened Screening of patients continues Outbreak meetings continue	Complete

					05/11/2021 revisit by NHSEi and only minor areas for improvement noted, further visit planned for December Action plan in place Typing continues for positive cases Awaiting further typing from environmental samples FEAU Work in progress with ambulance service ESR Estates action plan in place 09/11/2021 Non-compliant hand wash sinks identified - waiting decision re replacements and funding Cleaning collaborative improvement project now underway 30/11/2021 Estates works, small designated team identified project manager assigned. Funding approved from finance point of view, awaiting formal approval from execs Action plan and meetings remain in place. 14/12/2021 CPE colonisation outbreak team closed the outbreak on 14th December 2021 where the group agreed a criteria when to reconvene • If we see any infections rather than colonisation. • If we see an increase in colonisations over a time period of a number of weeks or if they continue.	
11	1.8	NHSEi visit 21/10/21 – In line with internal escalation matrix , given the extent of the outbreak and general concerns identified NHSEi are escalating the Trust from amber to RED on the matrix	DIPC/Divisions	30/11/2021 31/12/2021	October 2021 Action plan in place Risk level raised 05/11/2021 revisit by NHSEi with only minor areas for improvement noted, further visit planned for December Action plan in place 10/12/2021 10th December revisit by NHSEi with only minor points picked up at the inspection .The Trust was moved back to AMBER	Completed

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

Risk Scoring

Quarter	Q4	Q1	Q2	Q3	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2	1	1	2	Whilst cleaning procedures are in place to ensure the appropriate management of premises further work is required around cleaning responsibilities and revision of assurance processes in relation to cleanliness. The risk for this criteria was raised to 12 from Mid -September to Mid-December. Due to enhanced surveillance around the cleaning process and more assurance the risk has been reduced to 6.	Likelihood:	1	End of Quarter 1 2022
Consequence:	3	3	3	3		Consequence:	3	
Risk Level:	6	3	3	6		Risk Level:	3	

Control and Assurance Framework

Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
2.1	Designated nursing/medical 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	• 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
		timely		
2.2	Designated cleaning teams with appropriate training in required techniques and use of PPE are assigned to Covid-19 isolation or cohort areas. Assurance processes are in place for monitoring and sign off terminal cleans as part of outbreak management	• SOP and cleaning method statements for cleaning teams • PPE education for cleaning teams • 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 cleaning supervisors/managers during COVID • Cleanliness complaints or concerns are addressed by completing cleanliness audit walkabouts with clinical teams, and CPM / domestic supervisors • PPE and FFP3 mask fit training records with are held by cleaning 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	• Learning from CPE outbreak. We have recognised areas we can strengthen our assurance process on standards of cleanliness
2.3	Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line	• SOP for terminal and barrier cleans in place and was reviewed in	• C4C audits reinstated July 2020 these results are fed	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	with PHE and other national guidance.	February 21. • 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.	into IPCC • Completion of random 10% rooms each week by cleaning supervisors/managers 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/EFP 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	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
			completed during IP spot checks • Additional ad-hoc cleaning requests can be requested by clinical teams 24/7 should the environment become contaminated between scheduled cleans. • November 2021 Implementation of IPS audit	
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 • Barrier cleans also requested for other infections /period of increased incidence /outbreaks e.g C.diff , Norovirus	• 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	Manufacturer's guidance and recommended product	• Contact times detailed in SOP and	• Monthly on-going training 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
	'contact time' must be followed for all cleaning / disinfectant solutions / products.	cleaning methods statements • Included in mandatory training • Included in IP Q+A • Disinfectant used routinely	completed with all domestic staff to ensure that core competencies such as cleaning effectively with chemicals is trained out on a frequent basis. • Where outbreaks are identified, regular staff who clean in this area have competency checks to 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).	• 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,	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	Linked NHSIE Key Action 1: All high touch surfaces and items are decontaminated multiple times every day – once or twice a day is insufficient.		and if additional cleans are required between scheduled cleaning, these can be requested via the helpdesk.	
2.9	Linen from possible and confirmed Covid-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken.	• Included in IP questions and answers manual • Linen posters depicting correct linen bag displayed in clinical areas and linen waste holds • Red alginate bags available for infected linen in the clinical areas • Infected linen route	• IP quarterly audits , undertaken by own areas, audits held locally by divisions and requested to also send to harmfreecare email • Datix reports/adverse incidents • IPS audits undertaken by the IP Team	
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 and requested to also send to harmfreecare email •	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
2.11	Reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance. Resuable non –invasive care equipment is decontaminated: ○ Between each use ○ After blood and/or body fluid contamination ○ At regular predefined interval as part of an equipment cleaning protocol ○ Before inspection, service or repair equipment	• 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/ GVS 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 • Bed Storage Group looking at non conformities for beds that require repair	• IP audits held locally by divisions • Datix reports/adverse incident reports	• Decontamination of beds returned for repair process non conformities • Electronic beds – difficult dismantle the bed base mechanism to allow for effective cleaning –this issue has been raised regionally by NHSI
2.12	Review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission. Ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air Where possible ventilation is maximised by opening	• HTM hospital ventilation • UHNM has established a Ventilation Safety Group as recommended by the Specialised Ventilation for Healthcare Society in order to provide assurance to the Trust Board on the safe operation and reduction in risk of infection transmission through ventilation	• Estates have planned programme of maintenance • The Authorising Engineer Ventilation will provide external independent specialist advice and support as well as carrying out an annual audit for system compliance.	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	windows where possible to assist the dilution of air.	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. • Lessons learnt poster which encourage regular opening of windows to allow fresh air PDF ventilation-air-changes-per-hour-2021-06 • IP and estates have worked with areas know to be undertaking aerosol generating procedures and completed the fallow times		
2.13	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	• 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	• Reports produced after each visit, and re-audits completed if disciplines fail to achieve agreed %.	Cleanliness assurance processes around

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
shared equipment	to review environmental standards – 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 3 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.	Complete
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 cleaning teams and action plan devised Action Plan Following NHS England NHS Im NHSI action plan June 21.docx C4C audit programme in place Ward to complete quarterly environment audits	Complete

					IP environment audits	
3	2.4	To address dirty nursing equipment and commodes, plus computer on wheels	ACN'S / IP/ Deputy Head of IM&T	31/05/2021 – re: Computers on Wheels	Dirty nursing equipment and commodes found during NHSI Visit. These were addressed at the time. Action for IM&T re computer. Terminal clean check list to be revisited to set out roles and responsibilities for cleaning. Full ward terminal clean check list agreed by IP , Sodexo /retained and County. IT have reviewed a number of computers on wheels and confirmed high level of dust. The computer is housed is a box and would require to be unlocked and vacuum, IT have identified that there is a danger that the cables can be disturbed during this process. The two companies used by UHNM Ergotron and Parity do not offer a cleaning service IT have contacted clinical technology to see if they can provide cleaning service For the air intakes that have dust collection this would require a wipe over Visible parts of COW such as external casing, screen, and keyboard mouse to be cleaned by clinical staff. 18/02/2021 – Feedback from IM&T. They are chasing cost associated with cleaning of COW's 03/03/2021 – Feedback from IM&T cost still awaiting. They are chasing. Outside of COW and parts that can be seen are cleaned by the clinical staff 15/03/2021 Cleaning of internal parts of COW IM&T have raised this to a COW provider and they are providing a cost to clean the devices. In addition reached out to an internal UHNMM cleaning team to gain a cost 16/03/2021 – Costing back from external company for cleaning internal parts of COW, next stage to be agreed 22/04/2021 – 2 costings back for comparison, next stage to be agreed 27/04/2021 Paper/presentation prepared for Chief nurse to present to execs May 2021 Further information send , awaiting decision	Complete

					May 2021 Raised at Local Meeting with other IP Teams , feedback - only outside/touch points of Computer cleaned June 2021 Discussed at the Execs meeting 08/06/2021 it was agreed that the risk would appear low ,however a risk assessment to be completed , if the outcome of risk assessment is low then the risk will held by the organisation and replace with new style replacement COW over time. June risk assessment completed = low To review risk in 6 months' time	
4	2.8	All high touch surfaces and items are decontaminated multiple times every day – once or twice a day is insufficient. • Electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily. • Cleaning of communal toilets after each use inpatient areas – Letter -CEM/CMO /2020/043 24TH December 2020	Head of CPM Estates, Facilities & PFI Division IP Team	30/04/2021	To revisit high touch points protocol to check frequency of clean for area that area not on barrier cleans – computers , mobile phones, keyboards Cleaning of communal toilets after each use inpatient areas – Letter -CEM/CMO /2020/043 24TH December 2020. This letter was raised at IPCC 25/01/2021. 16th February Meeting with IP & Facilities colleagues to discuss the NHS/NHSE/PHE facilities cleaning requests in line with COVID 19 – letter CEM/CMO 24th December 2020 Hefma network Responses/Scoping exercise completed Trust position work in progress. Paper to next March IPCC Additional cleaning resource in place for ED Royal Stoke and overnight at County this requirement has been extended for a further 3 months Wheelchair cleaning stations also installed across both sites Clinical areas aware of the need to decontaminate high touch points such as desk top phones and keyboards April 2020 Lessons learnt poster uploaded into the Trust intranet, including clinical and non- clinical cleaning high touch points	Complete
5	2.11	None conformities for decontamination of bed that are beds returned for repair	Divisions Facilities and	30/09/2021 29/10/2021	Group in place and meetings held to work through the none conformity issue	Complete

		Highlighted from Recent CPE outbreak West building, electronic beds bases are difficult to dismantle to allow effective cleaning	Estates	30/11/2021 31/12/2021 End of quarter 4	November 2021 Datix continue to be submitted October 2021 UKHSA and NHSEI are also taking the action away which includes escalating this issue to the national IP and procurement teams to flag as a concern. Also to share learning across the region and nationally To aid effective cleaning of bed frames the electronic beds in West Building/FEAU Ward 122 have been dismantled by Estates due to lack of support from the company and decontaminated using steam and HPV December 2021 Advice from NHSEi re electronic beds, follow hospital process for bed decontamination routinely . Dismantling of beds only as part of ward closure/ maintenance plan This action will now be closed as included in the collaborative work Part of collaborative work point 2.13	
6	2.4	West Building long standing Estates issues. Reactive work	Divisions Facilities and Estates	05/11/2021 30/11/2021 End of quarter 1 2022	On going review of CPE colonisation in West Building. Long standing estates issues in West Building including a number of non- compliant hand wash sinks. Reactive estates works list identified. Long term plan to be agreed. November 2021 Capital funding agreed and allocated c £150k for the replacement of 75 non-compliant wash hand basins including associated IPS panels within the West Building Wards and FEAU.	In progress
7	2.13	Cleaning issues both nursing and cleaning responsibilities highlighted during CPE outbreak west Buildings. Strengthen assurance process on standards of cleanliness	Divisions Facilities/ACN	12/11/2021 31/12/2021 End of quarter 1 2022	October 2021 Terminal cleans in progress Review sign off process November 2021 03/11/2021 terminal clean west building completed Terminal clean briefing sheet designed Terminal clean of all West using steam and HPV Terminal Clean of FEAU and ward 122 using steam and HPV completed 06/11/2021 Cleaning Collaborative work stream (multi-disciplinary representation) established and using Improving Together tools	In progress

					and methodologies to work through the actions needed to respond to the cleaning issues in West Building highlighted during the CPE Outbreak.	

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

Risk Scoring

Quarter	Q4	Q1	Q2	Q3	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	2	2	2	Whilst there are controls and assurances place some of the finding of the antimicrobial audits demonstrate area of non-compliance therefore further control are to be identified and implemented in order to reduce the level of risk	Likelihood:	2	End of Quarter 1 2021
Consequence:	3	3	3	3		Consequence:	3	
Risk Level:	9	6	6	6		Risk Level:	6	

Control and Assurance Framework

Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
3.1	Arrangements around antimicrobial stewardship are maintained.	• 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	• Same day escalation to microbiologist, if concerns. Outcome recorded on I portal • Metric available around the number of times App accessed by UHNM staff • Compliance with guidelines and other AMS metrics reported to Infection prevention and control Committee (IPCC) • Meeting minutes reviewed and	

Control and Assurance Framework					
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		ensure AMS activities are optimal • Formal regional meetings and informal national network activities • AMS CQUIN further mandates key AMS principles to be adhered to • All national CQUINS currently suspended by NHSE / PHE • Monthly review of antimicrobial consumption undertaken by AMS team. Available online at UHNM	actions followed up • Real time discussions / requests for support / advice enabled via regional and national social media accounts. National (incl. PHE) thought leaders members • Trust and commissioners require timely reporting on compliance with AMS CQUIN targets. • Wards showing deviation from targets are followed up by targeted AMS team ward reviews generating action plans for ward teams. On hold during COVID19 due to redeployment of duties	
3.2	Mandatory reporting requirements are adhered to and boards continue to maintain oversight. Linked NHSIE Key Action 5: Daily data submissions have been signed off by the Chief Executive, the Medical Director and the Chief Nurse and the Board Assurance Framework is reviewed and evidence of reviews is available. 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.	• 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	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	Currently suspended.	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 3 Progress Report	BRAG
1.	3.1	Further controls are required to improve compliance	ACN'S	30/04/2021	Antimicrobial audits results discussed at IPCC 27th July 2020. Separate meeting with chief nurse/IP and ACN's to be arranged during August to discussed results and any corrective actions. Feedback meeting completed 4th September 2020. – Senior meeting. To review escalation of areas that are not compliant with antimicrobial guidelines. New point prevalence audits undertaken by AMS pharmacists during December 2020 to provide updated snapshot for ACNs. Results will be discussed at March IPCC meeting 31/03/2021 Following discussion of these results at March 2021 IPCC a meeting has been arranged between Chief Nurse, deputy DIPC, lead AMS pharmacist and lead AMS microbiologist to discuss ways in which divisions can be supported to improve their stewardship performance. Individual clinical areas can be identified from Pharmacy audit data. Meeting date 15.4.21 April 2021 Meeting held between ASG leads, CD Pharmacy, Deputy DIPC and DIPC on 15th April 2022. Action plan in place	Complete
2.	3.1	To review current escalation of areas that are not compliant with antimicrobial guidelines	DIPC	30/04/2021	Raised at September Antimicrobial Pharmacist Group and IPCC. Escalation process to be agreed. Meeting between Antimicrobial Pharmacist and Deputy DIPC undertaken. Escalation process to be discussed at November Antimicrobial Stewardship Group. January 2021 discussed at Trust Board to be discussed at ASG, then to IPCC Following discussions between DIPC and AMS Pharmacist a draft escalation protocol has been produced and was presented at January ASG as the November meeting cancelled (clinical	Complete

Control and Assurance Framework						
Key Lines of Enquiry (KLOE)			Controls in Place		Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
					pressures) the group have 2 weeks to review. Will thereafter to be forwards to IPCC for discussion and ratification at the March IPCC meeting. 31/03/2021 The draft escalation protocol was approved at March ASG. It will be shared with Chief Nurse and Deputy DIPC at meeting above (15.4.21) and target wards will be identified. Protocol approved at March 2021 ASG. August 2021 Ward to be audited during September and if any wards are non-compliant this will be taken back to ASG for escalation as per the protocol October 2021 Audit to be undertaken during November. Subsequent analysis of data will determine if any areas are non-compliant	

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

Risk Scoring								
Quarter	Q4	Q1	Q2	Q3	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	1	1	1	1	There is a substantial amount of information available to provide to patients this requires continuous update as national guidelines change	Likelihood:	1	End of Q3 – Achieved in Q4
Consequence:	3	3	3	3		Consequence:	3	
Risk Level:	3	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:				
4.1	Implementation of national guidance on visiting patients in a care setting. There is clearly displayed , written information available to prompt patients, visitor and staff to comply with hands, face and space advice	• 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	• 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
		instructed to wear face masks and 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 carer 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 partners are able to attend all scans and antenatal appointments induction of labour and post natal appointments • 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 • Guidance to accommodate visitor if appropriate and necessary to assist a patients communication and/or to meet their health, emotional , religious or spiritual need • A familiar care/parent or guardian/support/personal assistant		

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		• Children both parents /guardian where the family bubble can be maintained • March 2021 Visiting guidance inpatient during COVID 19 pandemic: principles discussed at Clinical Group and tactical • Visiting COVID-19 information available on UHNM internet page • August 2021 Input from Matron for Mental Health & Learning Disability re leaflets. Minor changes required.		
4.2	Areas in which suspected or confirmed Covid-19 patients are being treated are clearly marked with appropriate signage and have restricted access.	• ED colour coded areas are identified by signs • Navigator manned ED entrance • Hospital zoning in place	• Daily Site report for county details COVID and NON COVID capacity	
4.3	Information and guidance on Covid-19 is available on all trust websites with easy read versions.	• COVID 19 section on intranet with information including posters and videos	• COVID-19 page updated on a regular basis	
4.4	Infection status is communicated to the receiving organisation or department when a possible or confirmed Covid-19 patient needs to be moved.	• Transfer policy C24 in place , expires November 2020 • IP COVID step down process in place	• Datix process	
4.5	Implementation of the Supporting excellence in infection prevention and control behaviours toolkit has been considered	• UHNM developed material, posters • Hierarchy of controls video use on COVID 19 intranet page • UHNM wellbeing support and information		

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 3 Progress Report**	**BRAG**
1.	4.4	To include COVID-19 in transfer policy	Deputy Director of Quality and Safety	31/12/2020	3rd August 2020 Meeting arranged between IP and Quality and Safety to commence review of transfer policy to include COVID -19. Policy for the Handover, Transfer and Escort Arrangements of Adults patients between wards and Departments which Expires November 2020. October IP have now submitted IP/COVID information for incorporation in to this Policy.	Complete

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive

timely and appropriate treatment to reduce the risk of transmitting infection to other people.

Risk Scoring								
Quarter	**Q4**	**Q1**	**Q2**	**Q3**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	1	1	1	1	Whilst arrangements are in place ensure the screening of all patients. To continue to reinforce COVID screening protocol and monitor compliance. Surveillance of omicron cases within UHNM is in place.	**Likelihood:**	1	End of Q4 – achieved
Consequence:	3	3	3	3		**Consequence:**	3	
Risk Level:	3	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 Staff are aware of agreed template for triage questions to ask	• 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 • Work completed to install doors to resus areas in both ED's • December 2021 – review of green resus now doors are in place	• 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
	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 coverings are used by all outpatients and visitors Face masks are available for all patients and they are always advised to wear them Individuals who are clinically extremely vulnerable form COVID 19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room 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 Patients are encouraged to wear face masks Monitoring of Inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so) and is not detrimental to their physical or mental	• Use of mask for patients included in IP COVID -19 • question and answers manual • All staff and visitors to wear masks from Monday15th June2020 • 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 • Patient who are clinically extremely vulnerable should remain in a single room for the duration of their hospital stay • Patient are encourage to wear mask – leaflet in place 8th-march-2021-covid-ward-round-guidan	• Hospital entrances Mask dispensers and hand gel available • Datix /incidents • COVID-19 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**
	needs			
5.3	Ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff. Linked NHSIE Key Action 6: Where bays with high numbers of beds are in use, these must be risk assessed, and where 2m can't be achieved, physical segregation of patients must be considered and wards are effectively ventilated.	• Colour coded areas in ED to separate patients, barriers in place. • Screens in place at main ED receptions • Colour coded routes identified in ED • Social distancing risk assessment in place • Perspex screens agreed through R+R process for other reception area • Social distance barriers in place at main reception areas • Chief Nurse/DIPC visited clinical areas to review social distancing within bays. A number of beds have been removed throughout the Trust.	• Division/area social distancing risk assessments	
5.4	For patients with new-onset symptoms, it is important to achieve isolation and instigation of contact tracing as soon as possible.	• Process for isolation symptom patient in place • Process for cohorting of contacts • Contacting patients who have been discharged from hospital then later found to be a close contact of a COVID-19 positive case , patient to be informed by the clinical area and self- isolation advice provided as per national guidance • https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance/stay-at-home-guidance-for-households-with-possible-coronavirus-covid-19-infection	• If patient found to be positive in the bay and exposing other patient. IP liaise with clinical are, apply bay restrictions. • Patient who tested negative on admission and remain an inpatient are retested for COVID days 4 and 6, day 14 then weekly • Spot check audits	
5.5	Patients with suspected Covid-19 are tested promptly. There is evidence of compliance with routine testing protocols in line with key actions	• All patients who require overnight stay are screened on admission and patients who develop symptoms – UHNM screening guidance in place	• Adverse incident monitor /Datix	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		• December 2021 – surveillance of Omicron cases in place to monitor number of inpatients with the variant		
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 in place which includes rescreening /re testing. Pathways in place for positive COVID 19 patients • Iportal alert and April 2021 contact alert in place iportal/medway • The IP team have been applying a Covid-19 contact alert within the ICNET system since November 2020 and this continues. • Inpatient contacts are cohorted • COVID 19 positive patients are cared for on blue wards or single rooms or COVID 19 cohort areas on critical care unit	• Datix process • IP reviews	
5.7	Patients who attend for routine appointments and who display symptoms of Covid-19 are managed appropriately.	• Restoration and Recovery plans • Thermal temperature checks in imaging, plan to extent to other hospital entrances • Mask or face coverings for patients attending appointments from Monday 15th June 2020	• 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.	Complete
2.	5.4	Process for contacting patients who have been discharged home and have then been found to	Deputy of Director	31/08/2020	IP guide liaise with clinical areas to identify closed contacts, close contact are isolated for remainder of hospital stay for 14	Complete

		in close contact with a COVID -19 positive patient during their stay	Infection		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	Complete
4.	5.2	Face masks are available for all patients and they are always advised to wear them	IP/ACN's	31/03/2021 Revised target date 16th April	Face mask leaflet produced to be submitted for ratification on 14th April 2021. To be submitted to tactical /clinical group week beginning 15th March. Can be used prior to ratification as trial April 2021 Ratified by patient Group and available for use	Complete
5	5.4	Monitoring of Inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so)	ACN's/Matrons	31/03/2021	Assurance for monitoring of inpatient compliance with wearing face masks. Matrons daily walk round	Complete

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

Risk Scoring

Quarter	Q4	Q1	Q2	Q3	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2	2	1	1	Whilst information and communication/controls are in place to ensure staff are aware of their responsibilities spot audits continue. Work in progress to further improve retention of FFP3 mask fit training records	Likelihood:	1	End of Quarter 2 2021
Consequence:	3	3	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:				
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. Patient pathways and staff flow are separated to minimise contact between pathways. E.g. this could include provisions of spate entrances/exits or use of one way system , clear signage and restricted access to communal areas,	• 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 • One way systems in place • One way signs in place along corridors	• Tactical group action log • Divisional training records • Mandatory training records	
6.2	All staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation, and on how to safely don and doff it.	• PPE and standard precautions part of the infection prevention Questions and Answers manual. • FFP3 train the trainer programme in place • Trust mask fit strategy	• 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**
		• 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	• Training records originally held locally by the Clinical areas • Records held on L drive for those trained by the infection prevention team • April 2021,Option now available to enter FFP3 training onto Health Rostering this captures the model of mask and date trained • Test certificate must continue to be filed in personal folder and this is reiterated to mask fit tester. November 2021 wider spot checks commenced IP • Health and Safety leading on portacount mask fit business case which has the potential to enhance mask fit training records further as this system is capable of collected data which can be uploaded •	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
6.4	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 (Sundstrom))	• SOP 's available on Trust intranet • Training logs held divisionally for air powered systems • IP training log for air powered systems key trainers and distribution of reusable FFP3 masks (Sundstrum)	
6.5	Any incidents relating to the re-use of PPE are monitored and appropriate action taken.	• PPE standard agenda at COVID Tactical meeting • Datix process • Midlands Region Incident Coordination Centre PPE Supply Cell	• Tactical group action log • Datix process • Incidents reported by procurement to centre PPE supply Cell	
6.6	Adherence to the PHE national guidance on the use of PPE is regularly audited with actions 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	• Hand washing technique depicted on soap dispensers • Social distance posters	• 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**
	• Good respiratory hygiene measures • Staff maintain physical distancing of 2 metres wherever possible in the workplace unless wearing PPE as part of direct care • Staff maintain social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace • Frequent decontamination of equipment and environment in both clinical and non-clinical areas • clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas • Staff regularly undertake hand hygiene and observe standard infection prevention precautions • Guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas	displayed throughout the Trust • IP assurance visits • Matrons visits to clinical areas • Car sharing question forms part of OB investigation process • Communications reminding staff re car sharing • IP Q+A decontamination 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 • Hand hygiene audits	
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	• Paper Towels are available for hand drying in the Clinical areas	• IP audits to check availability	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	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			
6.9	Staff understand the requirements for uniform laundering where this is not provided on site.	• Instruction for staff laundering available on the Trust COVID - 19 section of intranet • Dissolvable bags to transport uniforms home available for staff • Communications /daily bulletin to remind staff not to travel to and from work in uniforms	• Clinical areas to monitor • Reports of member of public reporting sighting of staff in uniform	
6.10	All staff understand the symptoms of Covid-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household displays any of the symptoms.	• For any new absences employee should open and close their usual absence via Empactis system • Symptom Advice available on Trust intranet • Communications updated to reflect changing national guidance	• 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 • Communications updated to reflect changing national guidance	• Cluster /outbreak investigations	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
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 • RCA's are required for all Probable and Definite HAI Covid-19 cases	• Theme report IPCC • RCA review	
6.15	Robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of outbreak meetings.	• ICNet surveillance system • Daily COVID reports of cases	• Outbreak investigation • Outbreak minutes	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 4 Progress Report	BRAG
1.	6.3	Improving staff FFP3 mask fit staff training data recording and retention of records	Health and Safety	31/08/2021	Proposed Fit Testing compliance improvement Task and Finish Group. Inaugural meeting planned for 29th July 2020. ESR will be up and running for the purpose of recording fit test records as soon as the Trust gives the go ahead to procure Portacount fit test system as this is part of the project lead by Health and Safety. December 2020 Health and Safety have 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.	complete

					Business case : Head of Health and Safety's continues with business case with a revised due date end of August 2021 10/03/2020 Portacount machine obtained (on loan) by Infection Prevention Team via Midlands Coordinator for the FFP3 Mask Project. Plus mask fit tester will be available to test staff using the portacount machine. The portacount is a quantitative test and uses specialised equipment to measure exactly how much air is leaking through the seal of a mask. ACN'S informed and response requested to aid in identifying testing priority. Midlands Coordinator is meeting IP next week to work through plan. In additional Mask fit testing also continues using hood and bitrex (qualitative, relies on taste) Mask fit testing option also added to e rostering to enable areas to identify staff member that have been tested. A report can also be produced with compliance using this system. The mask fit testing certificate must also continue to be completed and filed in the staff member personal folder. Updated mask fit strategy to March IPCC which includes re test frequency May 2021 FFP3 cascade mask fit refresher in progress. This refresher includes checking that fitters are aware of e rostering and the need to file test certificate in staff members personal folder June 2021 Portacount Business case - Awaiting decision from Exec Health and Safety Group July 2021 Portacount Business case withdrawn at Health and Safety July 2021 update	

					Infection Prevention, those staff that failed on the Bitrex method referred to the Portacount machine, gave us an extra 75% pass rate on the original failures. This is a valuable additional tool for us to get as many staff trained as possible. Action complete as FFP3 testing records can now be added as a skill to Health roster. The portacount machine action will be added as separate action	
2	6.3	Monitoring FFP3 mask fit compliance %	Divisions	31/09/2021	To monitor the mask fit compliance % for own division using available records – Health Roster	On- going
3	6.2	To improve FFP3 mask fit failure levels by using the portacount machine. Portacount method allows testing of individuals who are unable or unsure if they can taste the Bitrex solution	Health and Safety	31/11/2021	Health and Safety progressing portacount machine business case	Complete
4	6.2	Spot audits of PPE on wards and Departments	Quality and Safety Team IP	30/04/2021	Audits are required on a weekly basis – ongoing action	Complete

7. Provide or secure adequate isolation facilities

Risk Scoring								
Quarter	**Q4**	**Q1**	**Q2**	**Q3**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	1	1	1	1	Isolation facilities are available and hospital zoning in place.	**Likelihood:**	1	Q4 20/21– achieved
Consequence:	3	3	3	3		**Consequence:**	3	
Risk Level:	3	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:				
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 Areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas	• Hospital zoning in place • Recovery and Restoration plans for the Trust – • December 2020 –another increased wave of COVID 19 • COVID prevalence considered when zones identified • Purple wards • Blue COVID wards identified at both sites created during second wave • Green wards for planned screened elective patients • Recovery and Restoration plans • Ward round guidance available on COVID 19 intranet page	• June 2020 IP team to review patients that are found COVID positive and nursed in bay to ascertain compliance with pathway and IP control measures are in place Review pathways and identify themes which are presented at IPCC . • Themes report to IPCC	
7.2	Patients with suspected or confirmed COVID -19 are isolated in appropriate facilities or designated areas where appropriate;	• Areas agreed at COVID-19 tactical Group • Restoration and Recovery plans	• Action log and papers submitted to COVID-19 tactical and Clinical Group	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	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.			
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 • Patients received from London to critical care unit – screening policy for resistant organisms in place	• RCA process for Clostridium *difficile* • CDI report for January Quality and Safety Committee and IPCC • Outbreak investigations • MRSA bacteramia investigations • Datix reports	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 4 Progress Report	BRAG
1.	7.1	ED to align with inpatient zoning model	ED leads	18/09/2020	Both sites have remodel ED areas. Corridor ED Royal review planned	Complete
2.	7.1	Strict adherence to policy re patient isolation and cohorting	Site teams/ward teams	18/09/2020 process	inappropriate patient moves reported via Datix. Daily process Discuss at outbreak meetings as necessary	Complete
3.	7.3	Clostridium *difficile* report to Quality and Safety Committee and IPCC	IP	31/01/2021	Report prepared with antimicrobial analysis included and presented at both committee's Jan 2021, Regular item at IPCC	Complete

Secure adequate access to laboratory support as appropriate.

Risk Scoring

Quarter	Q4	Q1	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	1	1	1	1	Laboratory services for UHNM are located in the purpose built Pathology Laboratory on-site at RSUH. The Laboratory is United Kingdom Accreditation Service (UKAS) accredited. Work continues to improve COVID-19 screening compliance as per screening protocol.	Likelihood:	1	Q4 20/21– target achieved
Consequence:	3	3	3	3		Consequence:	3	
Risk Level:	3	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:				
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	
8.2	Patient and staff Covid-19 testing is undertaken promptly and in line with PHE and other national guidance. Linked NHSIE Key Action 7: Staff Testing: a) Twice weekly lateral flow antigen testing for NHS patient facing staff is implemented. Whilst lateral flow	• All patients that require an overnight stay are screened for COVID-19 on admission or pre admission if planned/elective surgery • 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
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. Letter 6th April NHS October 2020 the region implemented requirement for screening on day 13 d) All patients must be tested 48 hours prior to discharge directly to a care home and must only be discharged when the test result is available. Care home patients testing positive can only be discharged to CQC designated facilities. Care homes must not accept discharged patients unless they have that persons test result and can safely care for them.	endoscopy • Process in place for staff screening via empactis system and Team Prevent • Patients who test negative are retested 4, day 6 and day 14 and weekly • 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**
	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.	• 11th May 2021 introduction of day 14 screen and also weekly screen for negative patients • From 29th April 2021 a team from HR are supporting the IP Team by contacting the clinical area to advise when screens are due • In addition to the above from 11th May 2021 inpatients who have not tested covid 19 positive within the previous 90 days are to be rescreened on day 14 and then weekly • 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	• MRSA screening compliance • Prompt to Protect 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
		Prevention Questions and Answers Manual	completed by IP • Spot check for CPE screening	

No.	KLOE	Action Required	Lead	Due Date	Quarter 2 Progress Report	BRAG
1.	8.1	Champions COVID-19 swabbing technique in clinical areas	Deputy Director if infection Prevention	31/12/2020	Training package and recording system to be devised. Work to commence. 1st September swabbing video recorded, minor changes to be completed week commencing 14th September then video will be circulated to key people for preview and comments. Child positioning included in video Screening video now complete and uploaded on to Trust intranet November 2020. A number of areas have identified swabbing Champions, request sent to ACN's. Implementation of champions in progress.	Complete
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 - process in place 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. This is in place and prompt is provided to clinical areas September 2021 Areas continue to receive a prompt call for COVID screening Review of the data calls confirms that we are still achieving over 90% contact levels on the daily inpatients that require day 3,6 or 14 swabbing compared to 45% when we first started this process The daily percentages of swabbing for those that were required is currently running at over 75% for those patients who were remaining in hospital overnight following the day they were on the swabbing calls list – this compares to 55% when we first started the calls process	Complete

3	8.2	Those who test negative upon admission must have a second test 3 days after admission and a third test 5 days post admission	Deputy Chief Nurse	07/12/2020	Report received by Deputy Chief Nurse on a daily basis with list of patients that are due for re screen. Clinical areas then contacted and prompt to re screen. Day 14 and weekly screening in place.	Complete
4.	8.3	To complete an analysis (Advantages and disadvantages) to reinstating pre COVID 19 UHNM screening policy	Deputy Director if infection Prevention	14/06/2021	MRSA screening had reduced temporarily due to the COVID pandemic but UHNM are still following PHE 2014 guidance. This was an agreed temporary change in UHNM practice. Previously the Trust were screening over and above the 2014 guidance. Due to the COVID pandemic less elective work is taking place therefore less elective screening. High risk areas all still screen on admission. Risk based screening is for lower risk areas. Prior to the 2014 guidance the DIPC at the time (supported by the CCGs) did not want to reduce the screening policy the Trust already had in place. The CCG requested screening policy have to be approved by the CCGs. Discussed at IPCC. DIPC requested a pro's and con's exercise re screening changes due to the COVID pandemic. The Trust has not dropped below national guidance. October MRSA screening is around 50% of pre COVID screening; laboratory does not have the capacity to process COVID work and level of MRSA screens pre COVID. Paper to November IPCC. This continues to be under review during COVID Pandemic. Feb 2020 This continues to be under review during COVID pandemic March 2020 Elective screening for high risk surgery and overnight surgery to resume MRSA bacteraemia surveillance continues 20/04/2021 Due to wave 2 COVID 19 , paper deferred to May IPCC 2021 May 2020 Screening recommenced a pre COVID 19 pandemic. DIPC advised action complete	Complete

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

Risk Scoring								
Quarter	**Q4**	**Q1**	**Q2**	**Q3**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	1	1	1	1	There is a range of information, procedures, and pathways available along with mechanism to monitor.	**Likelihood:**	1	Q4 20/21 – target achieved
Consequence:	3	3	3	3		**Consequence:**	3	
Risk Level:	3	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:				
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	
9.2	Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff.	• Notifications from NHS to Chief nurse/CEO • IP team COVID lead checks Public Health England webpage daily (Monday-Friday) for updates • Changes raised at COVID clinical group which is held twice weekly • Daily tactical group • Incident control room established where changes are reported through • Chief nurse updates	• Clinical Group meeting action log held by emergency planning	

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

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

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 2 Progress Report	BRAG
1.	9.1	CEF Audits to recommence	Deputy Director of Quality and Safety	30/09/2020	Review of tool kit with Chief Nurse planned, aiming to trial during August and reinstate audits fully during September 2020. CEF audits reinstated.	Complete
2.	9.1	Proud to care booklet audits paused. Plan for recommencing	Deputy Director of Quality and Safety	30/09/2020	Original proud to care booklets reinstated	Complete
3.	9.1	Compliance with correct mask wearing and Doctors complaint with Bare Below the Elbow	Deputy DICP/Medical Director/ ACN's	Revised 31/03/2021	NHSI Action plan devised. Senior walk rounds of clinical areas in place.	Complete

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

Risk Scoring

Quarter	Q4	Q1	Q2	Q3	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	1	1	1	1	There are clear control in place for management of occupational needs of staff through team prevent to date Monitoring of adhere to social distancing and PPE continues. Work in progress to further improve retention of FFP3 mask fit training records	Likelihood:	1	End of quarter 2 2021
Consequence:	3	3	3	3		Consequence:	3	
Risk Level:	3	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:				
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 repeated each time a different model is used 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-	• 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 • Divisions hold records • Option now available on Health roster to capture mask fit testing • SOP for reusable face masks and respiratory hoods in place	• Training records for reusable masks • Training records held locally • Mask fit option now available on Health Rostering to record mask type and date	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	usable FFP3, staff who are unable to pass a fit 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	• For staff groups that use Heather roster FFP3 mask fit testing details can be added as a skill to this system.		
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. Health and care settings are COVID 19 secure workplaces as far as practical, that is that any work place risks are mitigated maximally for everyone 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 – Car sharing	• 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
		instructions added to COVID 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	31/08/2021	Proposed fit testing compliance improvement task and finish group Inaugural meeting planned for 29th July 2020. ESR will be up and running for the purpose of recording fit test records as soon as the Trust gives the go ahead to procure Portacount mas k fit systems as this is part of the project lead by Health and Safety case As at 03/02/2021 People O&D have created FFP3 mask "classes" on ESR. Health and Safety are in the process of collating fit test records which were requested at Exec Health and Safety Groups from Divisional H&S Leads. Portacount Business case : Health and Safety Head continues with Business case with target date for completed revised for end of August 2021 10/03/2020 Portacount machine obtained (on loan) by Infection Prevention Team via Midlands Coordinator for the FFP3 Mask Project. Plus external mask fit tester will be available to test staff using the portacount machine. The portacount is a quantitative test and uses specialised equipment to measure exactly how much air is leaking through the seal of a mask. ACN'S informed and response requested to aid in identifying testing priority. Midlands Coordinator is meeting IP next week to work through plan. In additional m ask fit testing also continues using hood and bitrex (qualitative, relies on taste) Mask fit testing option also added to e rostering to enable areas to identify staff member that have been tested. A report can also be produced with compliance using this system. The mask fit testing certificate must continue to be completed and filed in the staff member personal folder.	Complete

					Updated mask fit strategy to March IPCC with include update on re fit frequency <u>May 2021</u> FFP3 cascade mask fit refresher in progress. This refresher includes checking that fitters are aware of e rostering and the need to file test certificate in staff members personal folder <u>June 2021</u> Portacount Business case - Awaiting decision from Exec Health and Safety Group <u>July 2021</u> Infection Prevention, those staff that failed on the Bitrex method referred to the Portacount machine, gave us an extra 75% pass rate on the original failures. This is a valuable additional tool for us to get as many staff trained as possible. <u>Action complete</u> FFP3 testing records can now be added as a skill to Health roster. The portacount machine action will be added as action below	
1	10.2	To improve FFP3 mask fit failure levels by using the portacount machine. Portacount method allows testing of individuals who are unable or unsure if they can taste the Bitrex solution	Health and Safety	November 2021	<u>July 2021</u> The portacount is based on the calculation of particulates external and internal to the mask rather than reliance on staff judgement. Health and Safety to progress with portacount business case. Work to start September2021 <u>October 2021</u> Business case circulated for comments by Health and Safety <u>November 2021</u> Business case progressed by Health and Safety	Complete

2	10.2	Monitoring FFP3 mask fit compliance %	Divisions	31/09/2021 29/10/2021	To monitor the mask fit compliance % for own division using available records / Health Roster	Complete

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

14th December 2021

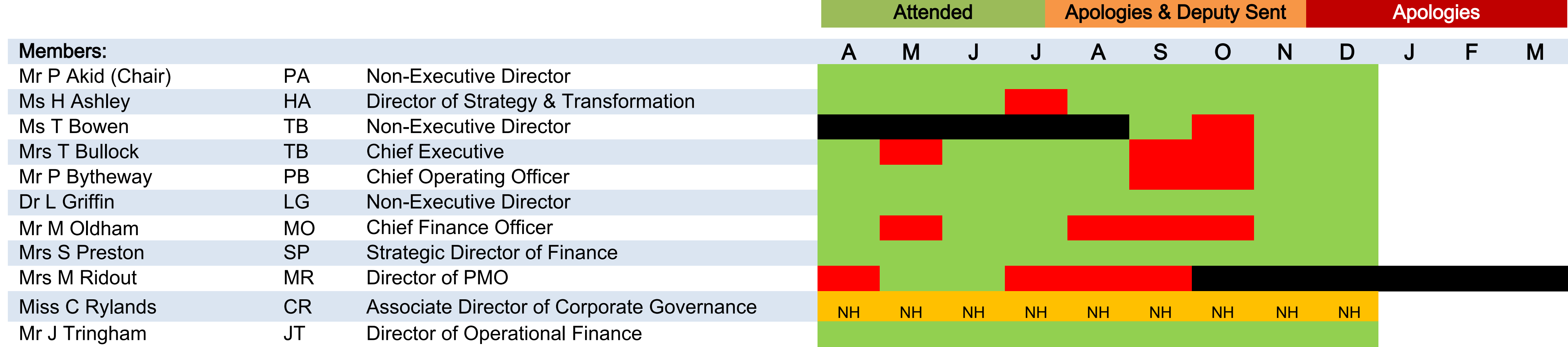
1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• An update was provided in respect of the actions being taken in light of the global IT vulnerability in order to secure UHNM systems • An update was provided by the Executive Business Intelligence Group with a number of areas escalated to the Committee including challenges associated with histology reporting, recruitment to Divisional Business Advisors, lack of consistency in capacity and demand modelling and completion of discharge letters resulting in an increase in uncoded spells • The Committee received an update from the Executive Infrastructure Group whereby the delays in the capital programme were highlighted in addition to an additional burden in obtaining data security and protection information for new medical equipment. The Committee also noted the ongoing actions being taken in respect of replacement of CPAP machines • In terms of operational performance, urgent care performance continued to be challenged, there had been significant handover delays in relation to medically fit for discharge patients and ongoing challenges associated with bed occupancy and workforce. Challenges with 2 week cancer waits were highlighted for colorectal, breast and skin specialties	• To confirm the reasons for the delays with the capital / IM&T programme highlighted to the Executive Infrastructure Group • To expand the next IPR report to highlight the way in which actions being taken had impacted and improved performance • To provide further detail at the next meeting in relation to the actions being taken in relation to the neurophysiology challenges
Positive Assurances to Provide	**Decisions Made**
• An update was provided in respect of implementing EPMA whereby there had been a change in scope of the project and the Committee were assured that appropriate due diligence had been undertaken on the new product The update from the data security and protection group highlighted that a post incident action had been undertaken as part of a previous network outage. The Committee requested further assurance in respect of ensuring improvements in data security training compliance and noted the work undertaken with Divisions to highlight staff whose training was out of date although workforce pressures were resulting in difficulties with completion of all statutory and mandatory training • Month 8 financial performance demonstrated a surplus of £0.8 m and it was noted that the Trust was expecting to achieve a surplus above plan with system mitigations being explored. The slippage to some of the capital schemes was highlighted. • The Committee welcomed the positive results of the audit undertaken in respect of compliance with the overseas visitors policy • The Committed noted that a positive operational delivery group meeting had been held, with the main challenges affecting diagnostics and non-obstetric ultrasound. Elective operating had increased and bed modelling was being re-run in relation to the winter plan. The Committee noted the ongoing actions being focussed in outpatients to reduce the number of patients waiting over 18 weeks and noted the ongoing challenges with utilisation of the independent sector	• The Committee approved BC-0401 Sustainability of Spinal Services, BC-0428 NIVCCU-Ward 222 Nursing Establishment and Business Case BC-0444 Electronic Anaesthetic Medical Records System • The Committee approved the change in scope of the EPMA project and noted the changes in project implementation timescales • The Committee approved the following eREAFs; Installation of 2nd VIE plant and medical gas infrastructure works (eREAF 8497). Staff Shuttle Bus Service- Royal Stoke (eREAF 8481) – Extension, Link Bus Service between Royal Stoke and County Hospital. (eREAF 8480) – Extension, Clinical Key Resource Library (eREAF 8383) and Anaesthetic Medical Records (eREAF 8544)
Comments on the Effectiveness of the Meeting	
• The Committee welcomed the discussion held and the flow of the meeting.	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Business Case BC-0401 Sustainability of Spinal Services	Approval	8.	Executive Infrastructure Group Assurance Report (December 2021)	Assurance
2.	Business Case BC-0428 NIVCCU-Ward 222 Nursing Establishment	Approval	9.	Overseas Visitors Policy Annual Audit	Assurance
3.	Business Case BC-0444 Electronic Anaesthetic Medical Records System	Approval	10.	Operational Delivery Group Assurance Report (December 2021)	Assurance
4.	Electronic Prescribing & Medicines Administration (EPMA) Project Update and Next Steps	Approval	11.	Month 8 Performance Report – 2021/22	Assurance
5.	Executive Data Security & Protection Group Assurance Report (November 2021)	Assurance	12.	Month 8 Finance Report - 2021/22	Assurance
6.	Authorisation of New Contract Awards and Contract Extensions	Approval	13.	Non-Elective Improvement Group Minutes	Information
7.	Executive Business Intelligence Group Assurance Report (December 2021)	Assurance			

3. 2021 / 22 Attendance Matrix



Attended | Apologies & Deputy Sent | Apologies

Members:			A	M	J	J	A	S	O	N	D	J	F	M
Mr P Akid (Chair)	PA	Non-Executive Director												
Ms H Ashley	HA	Director of Strategy & Transformation												
Ms T Bowen	TB	Non-Executive Director												
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	NH			
Mr J Tringham	JT	Director of Operational Finance												

In addition, Matthew Lewis, Medical Director and Amy Freeman, Director of Digital Transformation were in attendance.

Transformation and People Committee Chair’s Highlight Report to Board

15th December 2021

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Risk of deterioration in training position associated with the Improving Together Programme highlighted as a result of Covid and increasing Trust pressures • Risk associated current workforce challenges and the impact on research activity • Scheduling and recording of follow up of patients in research trials, with some inconsistencies across specialities; this had been reviewed and actions identified to address gaps • Workforce / staffing risks identified by all Divisions, including some ‘hot spots’ via the Executive Workforce Assurance Group; nursing and midwifery fill rates are reduced overall which is reflective of the vacancy / sickness rate across the organisation • Stress related absence is the highest proportion of sickness absence at present; staff moves have been identified as a key factor in contributing to stress. Supportive measures continue to be delivered as part of the wellbeing agenda. • Response to the national Staff Survey is below the national average although the formal report is awaited. 3500 staff had responded to the BRAP survey. Therefore it might be necessary to triangulate the surveys in order to gain a broader overview. • Potential for misuse of the Equality Act in relation to the ‘vaccines as a condition of deployment’ programme; advice has been sought which has confirmed that religious beliefs are not an exemption.	• Two corporate projects now underway aligned with Improving Together Programme and through the Transformation Team; County Hospital Theatre Recovery Programme and Complex Discharge Improvement Projects • Transformation ‘strategy’ to be brought back to the Transformation and People Committee at the end of January after which it will be shared with the Board • Additional monitoring of wards where staffing levels have been identified as a concern continues to be undertaken • Profile of divisional absence relating to long covid has been requested in order that an organisation wide picture can be developed; national discussions are taking place around the management of long covid • ‘Vaccines as a condition of deployment’ has been passed by parliament and there are a number of key milestones which have to be met. Work is underway to validate the vaccination status of our staff and it is a significant piece of work in terms of understanding the type of roles which are in scope. Board Assurance Framework will be updated accordingly. • Consideration to be given around including workforce management / planning on the Internal Audit Programme – to be considered by the Audit Committee
Positive Assurances to Provide	**Decisions Made**
• To date, implementation of the Improving Together Programme is on plan within the original budget as outlined in the approved business case; whilst the approach has been adapted to circumstances • Virtual Staff Awards was regarded as a very successful and valuable events • Work is progressing well with leadership development and in particular the Middle Managers Programme • Following a review of the role and focus of the Executive Workforce Assurance Group, it was recognised that the Group was now functioning well with good engagement • Fill rates for midwifery and ED are consistently above the minimum required	• Approval of the minutes of the previous meeting • Approval of the approach proposed for the Outline Content of the Strategic Workforce Plan; this will involve a set of workforce demographics which will shape a high level assurance report for the Committee

Comments on the Effectiveness of the Meeting

- Business Cycle continues to be delivered
- Useful meeting with some excellent quality papers, helpful reports received in relation to Improving Together, Nurse and Midwifery Staffing and Workforce Planning Outline

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Business Case Review: BC-0349 Operational Excellence – Improving Together	Assurance	7.	Outline Content of Strategic Workforce Plan	Discussion
2.	Improving Together Highlight Report	Assurance	8.	Review of Meeting Effectiveness and Attendance	Information
3.	Executive Research and Innovation Group Assurance Group (December 21)	Assurance	9.	Review of Business Cycle	Information
4.	Executive Workforce Assurance Group Assurance Report (December 21)	Assurance	10.	Summary of Actions and Items for Escalation to Trust Board	Approval
5.	Nursing and Midwifery Staffing and Quality Report: Quarter 1 and 2 2021/22	Assurance	11.	Issues Associated with Process, Procedures and Compliance for Escalation to Audit Committee	Approval
6.	Month 8 Workforce Report	Assurance	12.		

3. 2021 / 22 Attendance Matrix

Attended | Apologies & Deputy Sent | Apologies

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

Executive Summary

Meeting:	Trust Board	Date:	5th January 2022
Report Title:	Integrated Performance Report, Month 8 2021/22	Agenda Item:	12
Author:	Quality & Safety: Jamie Maxwell, Head of Quality & safety; Operational Performance: Warren Shaw, Associate Director of Performance & Information; Matt Hadfield, Deputy Associate Director of Performance & Information. Workforce: Claire Soper, Assistant Director of Human Resources; Finance: Jonathan Tringham, Director of Operational Finance		
Executive Lead:	Anne-Marie Riley: Chief Nurse Paul Bytheway: Chief Operating Officer Ro Vaughan: Director of Workforce Mark Oldham: Director of Finance		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Improving Together

Risk Register Mapping

Executive Summary

Situation

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

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

Assessment

Quality & Safety

The Trust achieved the following standards in November 2021:

- Friend & Family (Inpatients) 98.6% and exceeds 95% target.
- Friends & Family Test for Maternity returned 100%.
- Harm Free Care continues to be above the national 95% target with 96.6%
- Trust rolling 12 month HSMR continues to be below expected range.
- C Diff YTD figures below trajectory with 5 against a target of 8.
- VTE Risk Assessment completed during admission continues to exceed 95% target with 99.0% (point prevalence audit via Safety Thermometer).
- Zero avoidable MRSA Bacteraemia cases reported.

- There have been no Category 4 Pressure Ulcers attributable to lapses in care during November 2021.
- Sepsis Screening compliance in Emergency Portals exceeded the target 90% with 93.0%.
- Inpatient Sepsis IVAB within 1 hour achieved 97.8% and exceeded 90% target rate
- Maternity Sepsis Screening compliance 91.7% against 90% target
- Zero Never Events.

The Trust did not achieve the set standards for:
- Friend & Family Test for A&E 69.2% and below 85% target.
- Falls rate was 5.8 per 1000 bed days but is below the average rate per 1000 bed days during COVID-19 pandemic
- There were 20 Pressure ulcers including Deep Tissue Injury identified with lapses in care during November 2021.
- 81.3% Duty of Candour 10 working day letter performance following formal verbal notification.
- Inpatients Sepsis Screening 88.6% below 90% target rate
- Emergency Portals IVAB in 1 hour improved to 86% but is below the 90% target for audited patients
- Children's Sepsis Screening compliance 85.7% and below the 90% target.
- Maternity Sepsis IVAB in 1 hour compliance at 50% and below the targets
- Emergency C Section rate is above 15% target at 19.51%.

During November 2021, the following quality highlights are to be noted:
- The rate of complaints per 10,000 spells is 24.90 and is below (positive) the target of 35 and within normal variation. Majority of complaints in October 2021 relate to clinical treatment.
- Total number of Patient Safety Incidents increased (1752) and the rate per 1000 bed days has also increased slightly at 46.14 and both measures are within normal variation.
- Total incidents with moderate harm or above and the rate of these incidents have increased but is normal monthly variation. November 2021 has seen increase compared to previous months reductions.
- Slight decrease in total reported incidents relating to staffing shortages and lack of appropriate staff on wards/departments. However there are still extreme workforce pressures noted by Divisions and support measures continue across the Trust and system wide.
- Rate of falls reported that have resulted in harm to patients had reduced during recent months and currently at 1.6 in November 2021. The rate of patient falls with harm continues to be within the control limits and normal variation and is around the mean rate which may indicate there may be improvement in reducing harm from falls.
- Medication related incidents rate per 1000 bed days is 5.5 and patient related 4.5 which are increases compared to previous months. The monthly variation is within the normal expected variation and consistent with Trust mean rates. However whilst it is below the previously published NRLS national mean rate of 6.0 the arte is nearer to the national mean rate. Reporting of incidents is continually promoted to aid learning and improvement.
- Pressure Ulcers developed under UHNM care has seen an increase during previous 4 months but during November 2021 there has been decrease in rate with lapses in care.
- 4 Hospital Onset / Nosocomial COVID cases reported in November 2021.
- 1 COVID-19 death falling in to the 'Definite' category (according to the National definition of Nosocomial deaths).
- 13 Serious Incidents reported in November 2021. All the serious incidents were reported on STEIS within the 2 working date target following confirmation of SI criteria.

Operational Performance

Emergency Care
- The number of attendances at Royal Stoke ED has slightly decreased over the last month with an average of 335 per day (reduced from 345) but has peaked to over 408 on odd days throughout November. The number of ambulance arrivals remained fairly static with a daily average of 140 and the self-presenting ambulatory demand remained at c200/day.
- Daily average admissions slightly reduced from 117 to 114 with the conversion rate remaining around 34%.
- Ambulance handover delays for 30-60mins have increased and peaked at the beginning of November, reducing slightly since and the > 60 mins also rose in November. However the percentage of handovers within 15 minutes increased from 63% to 64%. With improvement seen over the last 3 weeks.
- Time to initial assessment improved by over 3% against previous month.
- System-wide performance increased slightly by 0.8% to 38.9%. Non admitted performance in ED

improved to 49% with a slight increase also seen in non-admitted. Acuity slightly increased for the month from 224 to 227 averages per day requiring assessment in Majors.

Cancer

- The Trust is provisionally predicted to achieve the Subsequent Radiotherapy standard for November 21.
- The overall 2WW position for November is predicted to achieve in the region of 47%. Specialties with the most 14 day breaches are Breast, Skin, Colorectal and Upper GI. Performance against the 62 day standard is currently at 50% for November 21. This is an un-validated position that is expected to change as histology confirms a cancer or non cancer diagnostic for patients treated.
- Theatre, Oncology, Diagnostic and Surgical workforces have been impacted, resulting in breaches. The position is being managed through the reinstated daily clinical prioritisation meetings and a robust planned care assurance framework. 2WW and 62 day position is significantly challenged, and will be validated prior to upload.
- In November, UHNM hosted an Integrated Care System Cancer Summit, in order to gain system commitment and support that will help drive pathway improvements, and aid recovery of cancer performance.

Planned Care

- Day Case and Elective Activity delivered 84.4% for November 21 against the national ask of 95%. This is lower in Inpatients than Day case (70% IP, 87% DC).
- In month Planned Care Cell focuses on elective recovery based on 10 high impact changes in accordance with the elective plan.
- Modelling of Q4 theatre capacity required to enable validation of H2 plan delivery offset against covid surge demand planning.
- CCG Commissioned Deloitte review is ongoing and UHNM are sense checking any outputs that will improve treatment capacity in the IS.
- CCG have an interim commissioning manager who is supporting elective opportunities in Tier 2 sector/regionally around mutual aid.
- Referral Hub – awaiting specification from 18 week source group and reviewing use of electronic ERS to manage referrals.
- Some work has already taken place at specialty level with respect to patient contact. This is being coordinated and consolidated to inform corporate next step and avoid duplication. Quotes now received for additional support to this project.

RTT

- The indicative performance for November 21: the total number of Referral to Treatment pathways grew to 68,054 (September 67,714). There has been a slight increase in the number of > 52 weeks from 3,563 to 3,870. This rise is expected to continue over winter due to the usual NEL surge/winter pressures including any covid/IPC impact.
- RTT performance in October was 58.5% (September is 59.8%).
- Work plans around long wait patient validation and treatment tracking are in progress.

Diagnostics

- For DM01 (15 nationally identified Dx tests) the un-validated position for total waiting list has increased in November from 20,134 to 20,874. The Non-obstetric ultrasound waiting list reduced slightly from 10,569 to 9,935. Due to the challenges in Non-Obstetric Ultrasound this has adversely affected performance. The current DM01 diagnostic performance for November 21 is at 69% (October 68 %).
- The greatest proportion of > 6 week waits is within Non-obstetric ultrasound and endoscopy. The ultrasound position is related to an increase in demand alongside workforce shortfalls. The waiting list is growing significantly by c250 per week against a limited workforce that is at full capacity. The independent sector has now been commissioned to provide additional capacity. For endoscopy (colonoscopy and gastroscopy). This is related to an on-going increase in demand. Improvement actions are being developed and implemented.

Workforce

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

Sickness

- The in-month sickness rate was 5.57% (5.66% reported at 31/10/21). The 12 month cumulative rate decreased to 5.27% (5.33% at 31/10/21)
- The Wellbeing Plan is being reviewed as per NHSE&I requirements in their Planning for Winter letter dated 13/12/21. The letter has asked Trusts to ensure Wellbeing Plans have kept pace with the changing nature of the pandemic, with a continued focus on on-going health and wellbeing conversations.
- Divisions are taking action to address sickness absence via the Improving Together Programme.
- The daily sitreps show that the number of open absences has been increasing steadily from 6th December and, as of 17th December 2021, covid-related open absences* numbered 279 which was 29% of all open absences (compared to 166 covid-related absences on 6th December) [**includes absences resulting from adhering to isolation requirements*]
- In line with Government policy we are now working with colleagues across to the Trust to implement the mandated vaccination programme for all staff who work in clinical areas

Appraisals

- The Non-Medical PDR compliance rate was 75.80% at 30th November 2021, which is a slight improvement from the position at 31st October 2021 (75.21%).
- Surgical, Specialised and CWD Divisions have PDRs as one of their driver metrics and are pulling plans together to improve
- Corporately, we continue to consider ways to streamline the process and ensure that managers have reasonable spans of control

Statutory and Mandatory Training

- The Statutory and Mandatory training rate at 30th November 2021 was 95.47% (95.38% at 31 October 2021. This compliance rate is for the 6 'Core for All' subjects only.
- At 30th November 2021, 91.39% of staff had completed all 6 Core for All modules (91.24% at 31/10/21)

Vacancies

- The overall Trust vacancy rate was 10.5% as a result of a small uplift in budgeted establishment to account for Winter planning.
- In accordance with the requirements et out in the NHSEI letter 'Planning for Winter', dated 13/12/21, the Trust will be looking at how to accelerate recruitment plans where possible, including for healthcare support workers
- A business case is being progressed for the International Recruitment of a further 100 registered nurses for 2022/23

Finance

Key messages

- The Trust set a plan at the start of the year with a H1 surplus of £8.3m and a full year deficit of £8.8m. The guidance for H2 was reviewed and the Trust set a revised breakeven plan for the financial year ending 31 March 2022. At both a National and System level an agreement was reached that the Trust was to carry forward the surplus of £14.5m delivered in H1 and therefore the planned position for H2 was a £14.5m deficit to achieve a breakeven plan for the year. Since then, the Trust has worked through the submitted activity plans and calculated an expected income of £5.1m against the Elective Recovery Fund. Therefore in November 2021, the Trust formally submitted a revised annual plan of a £5.1m surplus for the financial year ending 31 March 2022.
- The Trust has delivered an actual surplus of £0.4m in month and a year to date surplus of £16.3m resulting in a favourable variance of £6.8m against the year to date plan. The positive position in month is primarily driven by underspends against non-recurrent investment funds for both System Elective Recovery and workforce.
- The Trust incurred £1m of costs relating to COVID-19 in month which is a decrease of £0.2m compared with Month 7's figure. This remains within the Trust's fixed allocation with £0.6m being chargeable on top of this allocation for COVID-19 testing costs.
- Capital expenditure for the year to date stands at £15.9m which is £2.3m behind the plan mainly due to an underspend relating to digital pathology and estates infrastructure.
- The cash balance at Month 8 is £80.3m which is £1m higher than plan, the main reason being lower

than forecast capital payments which reflects the overall slippage against the capital plan.

- An updated plan for H2 has been presented in November and at Month 9 and in line with NHSIE guidelines, a full year forecast position will be presented to the Committee.

Key Recommendations

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

Integrated Performance Report

Month 8 2021/22

Quality | Operational | Workforce | Finance

Contents

Section		Page
1	Introduction to SPC and DQAI	3
2	Quality	5
3	Operational Performance	17
4	Workforce	52
5	Finance	58

A note on SPC

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

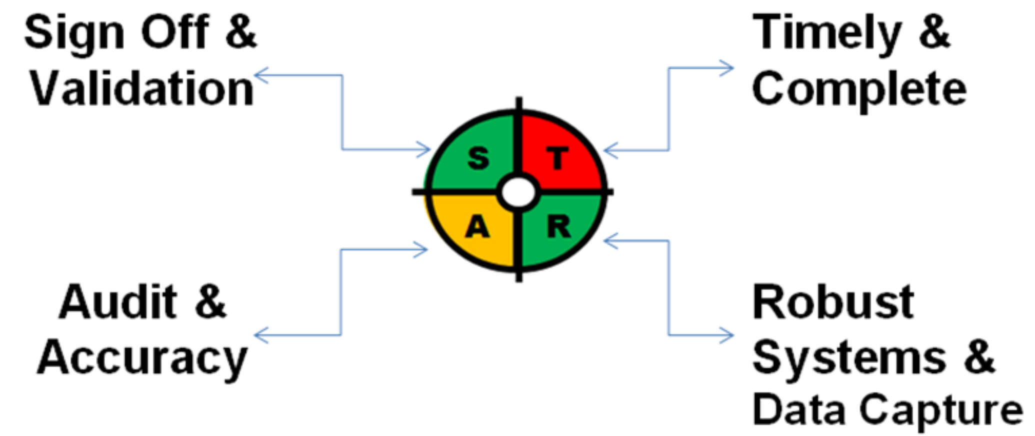
Assurance - how assured of consistently meeting the target can we be?

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

A note on **Data Quality**

- 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 | Operational | Workforce | Finance

Quality Spotlight Report

Key messages

The Trust achieved the following standards in November 2021:

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- Zero avoidable MRSA Bacteraemia cases reported.
- There have been no Category 4 Pressure Ulcers attributable to lapses in care during November 2021.
- Sepsis Screening compliance in Emergency Portals exceeded the target 90% with 93.0%.
- Inpatient Sepsis IVAB within 1 hour achieved 97.8% and exceeded 90% target rate
- Maternity Sepsis Screening compliance 91.7% against 90% target
- Zero Never Events.

The Trust did not achieve the set standards for:

- Friend & Family Test for A&E 69.2% and below 85% target.
- Falls rate was 5.8 per 1000 bed days but is below the average rate per 1000 bed days during COVID-19 pandemic
- There were 20 Pressure ulcers including Deep Tissue Injury identified with lapses in care during November 2021.
- 81% Duty of Candour 10 working day letter performance following formal verbal notification.
- Inpatients Sepsis Screening 88.6% below 90% target rate
- Emergency Portals Sepsis IVAB in 1 hour improved to 86% but is below the 90% target for audited patients
- Children's Sepsis Screening compliance 85.7% and below the 90% target.
- Maternity Sepsis IVAB in 1 hour compliance at 50% and below the targets
- Emergency C Section rate is above 15% target at 19.51%.

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

- The rate of complaints per 10,000 spells is 24.90 and is below (positive) the target of 35 and within normal variation. Majority of complaints in October 2021 relate to clinical treatment.
- Total number of Patient Safety Incidents increased (1752) and the rate per 1000 bed days has also increased slightly at 46.14 and both measures are within normal variation.
- Total incidents with moderate harm or above and the rate of these incidents have increased but is normal monthly variation. November 2021 has seen increase compared to previous months reductions.
- Slight decrease in total reported incidents relating to staffing shortages and lack of appropriate staff on wards/departments.
- Rate of falls reported that have resulted in harm to patients had reduced during recent months and currently at 1.6 per 1000 bed days in November 2021. The rate of patient falls with harm continues to be within the control limits and normal variation and is around the mean rate which indicates there may be improvement in reducing harm from falls.
- Medication related incidents rate per 1000 bed days is 5.5 and patient related 4.5 which are increases compared to previous months. The monthly variation is within the normal expected variation and consistent with Trust mean rates. However whilst it is below the previously published NRLS national mean rate of 6.0 the arte is nearer to the this national mean rate. Reporting of incidents is continually promoted to aid learning and improvement.
- Pressure Ulcers developed under UHNM care has seen an increase during previous 4 months but during November 2021 there has been decrease in number with lapses in care.
- 4 Hospital Onset / Nosocomial COVID-19 cases reported in November 2021.
- 1 COVID-19 death falling in to the 'Definite' category (according to the National definition of Nosocomial deaths of first positive result 15 days or more after admission to hospital).
- 13 Serious Incidents reported in November 2021. All the serious incidents were reported on STEIS within the 2 working date target following confirmation of SI criteria.

Quality Dashboard

Metric	Target	Latest	Variation	Assurance
Patient Safety Incidents	N/A	1648		
Patient Safety Incidents per 1000 bed days	N/A	43.25		
Patient Safety Incidents per 1000 bed days with no harm	N/A	29.52		
Patient Safety Incidents per 1000 bed days with low harm	N/A	12.02		
Patient Safety Incidents per 1000 bed days reported as Near Miss	N/A	1.34		
Patient Safety Incidents with moderate harm +	N/A	12		
Patient Safety Incidents with moderate harm + per 1000 bed days	N/A	0.31		
Harm Free Care (New Harms)	95%	96.6%		
Patient Falls per 1000 bed days	5.6	4.7		
Patient Falls with harm per 1000 bed days	1.5	1.0		
Medication Incidents per 1000 bed days	N/A	3.9		
Medication Incidents % with moderate harm or above	TBC	0.67%		
Patient Medication Incidents per 1000 bed days	N/A	3.2		
Patient Medication Incidents % with moderate harm or above	TBC	0.83%		

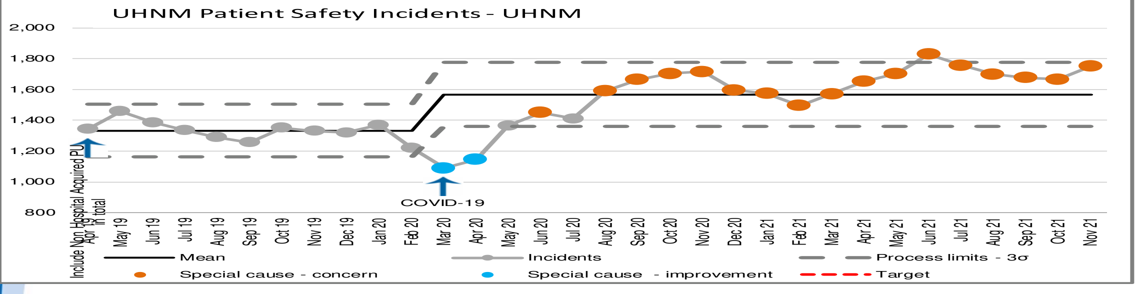
Metric	Target	Latest	Variation	Assurance
Serious Incidents reported per month	N/A	9		
Serious Incidents Rate per 1000 bed days	N/A	0.24		
Never Events reported per month	0	0		
Duty of Candour - Verbal/Formal Notification	100%	100%		
Duty of Candour - Written	100%	81.3%		
All Pressure ulcers developed under UHNM Care	TBC	88		
All Pressure ulcers developed under UHNM Care per 1000 bed days	N/A	2.16		
All Pressure ulcers developed under UHNM Care lapses in care	12	20		
All Pressure ulcers developed under UHNM Care lapses in care per 1000 bed days	0.5	0.84		
Category 2 Pressure Ulcers with lapses in Care	8	10		
Category 3 Pressure Ulcers with lapse in care	4	2		
Deep Tissue Injury with lapses in care	0	4		
Unstageable Pressure Ulcers with lapses in care	0	4		

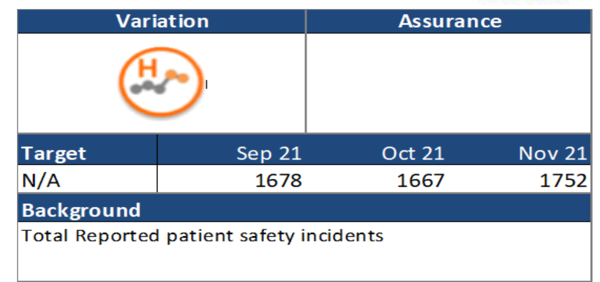
Quality Dashboard

Metric	Target	Latest	Variation	Assurance
Friends & Family Test - A&E	85%	70.0%		
Friends & Family Test - Inpatient	95%	98.6%		
Friends & Family Test - Maternity	95%	100.0%		
Written Complaints per 10,000 spells	35	27.55		
Rolling 12 Month HSMR (3 month time lag)	100	93.66		
Rolling 12 Month SHMI (4 month time lag)	100	102.48		
Nosocomial COVID-19 Deaths (Positive Sample 15+ days after admission)	N/A	1		
VTE Risk Assessment Compliance	95%	99.2%		
Emergency C Section rate % of total births	15%	19.51%		
Reported C Diff Cases per month	8	5		
Avoidable MRSA Bacteraemia Cases per month	0	0		
HAI E. Coli Bacteraemia Cases per month	N/A	5		
Nosocomial "Definite" HAI COVID Cases - UHNM	0	4		

Metric	Target	Latest	Variation	Assurance
Inpatient Sepsis Screening Compliance (Contracted)	90%	88.6%		
Inpatient IVAB within 1hr (Contracted)	90%	97.8%		
Children Sepsis Screening Compliance (All)	90%	85.7%		
Children IVAB within 1hr (All)	90%	N/A		
Emergency Portals Sepsis Screening Compliance (Contracted)	90%	93.0%		
Emergency Portals IVAB within 1 hr (Contracted)	90%	86.5%		
Maternity Sepsis Screening (All)	90%	91.7%		
Maternity IVAB within 1 hr (All)	90%	50.0%		

Reported Patient Safety Incidents

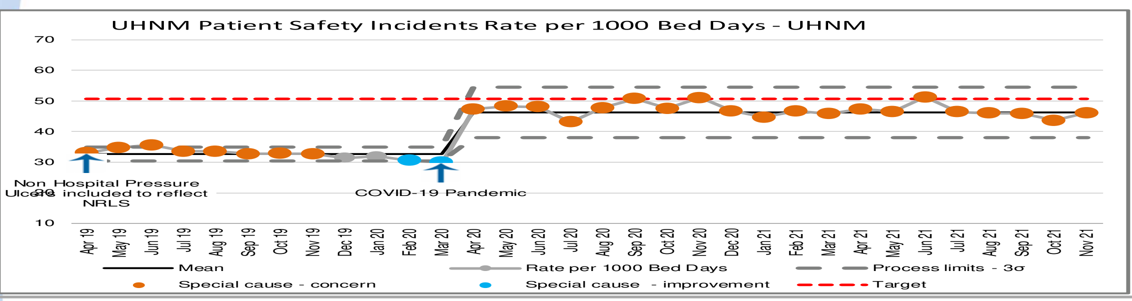




Variation	Assurance		
Target	Sep 21	Oct 21	Nov 21
N/A	1678	1667	1752

Background

Total Reported patient safety incidents



Variation	Assurance		
NRLS Mean	Sep 21	Oct 21	Nov 21
50.70	45.91	43.71	46.14

What is the data telling us:

T The above data relates to **all** reported Patient Safety Incidents (PSIs) across the Trust. The November 2021 total remains above the mean total since COVID-19 started. However, the reporting of incidents and near misses should continue to be encouraged and promoted and increasing rates and numbers of total incidents is not necessarily to be viewed as concern. It is important to review the different levels of harm within the overall totals.

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

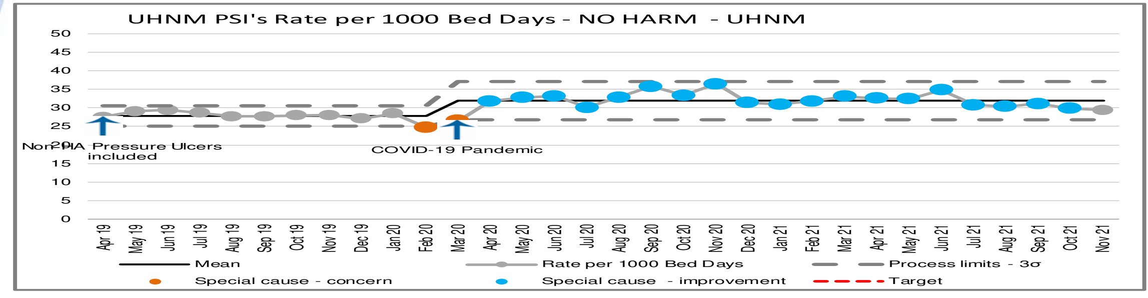
- Patient related Slip/Trip/Fall - 222 (178)
- Clinical assessment (Including diagnosis, images and lab tests) – 90 (80)
- Patient flow incl. access, discharge & transfer - 100 (97)
- Documentation – 49 (50)
- Pressure Ulcers (Hospital acquired) – 81 (79)

Treatment/Procedure - 79 (62)
Medication incidents - 173 (122)
Infection Prevention – 32 (73) (69)
Staffing – 30 (33)

There has been same number of staffing related incidents submitted during November with 60 (61 in October) incidents reported. 30 (33 in October) of these were under patient related and the remaining 30 were reported as staff related. However, these incidents do have potential impact on patient care and experience if wards/departments are experiencing staff shortages.
The Directorates reporting most PSIs are Emergency Medicine, General Medicine, Obstetrics & Gynaecology, Anaesthetics, Critical Care & Theatres, Specialised Medicine, General Surgery & Urology , Trauma and Clinical Support Services. 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 remained relatively stable following the change at the start of COVID-19 pandemic but is currently below the NRLS mean

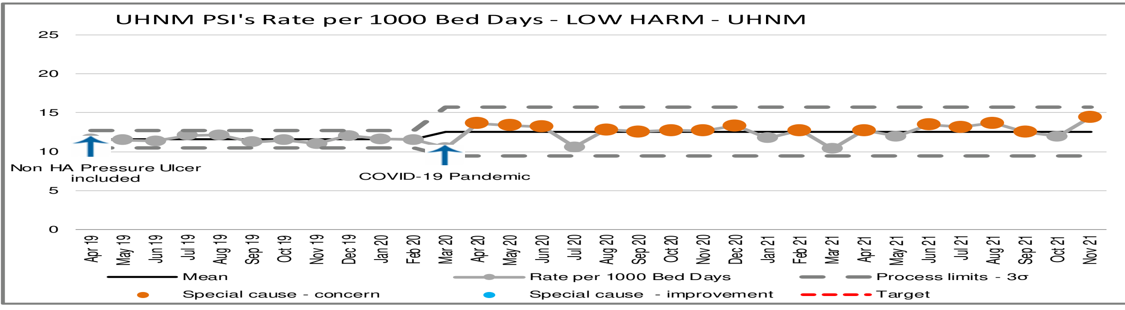
Reported Patient Safety Incidents with No / Low Harm or Near Misses per 1000 bed days



Variation			Assurance
Target	**Sep 21**	**Oct 21**	**Nov 21**
N/A	31.14	29.89	29.44

Background

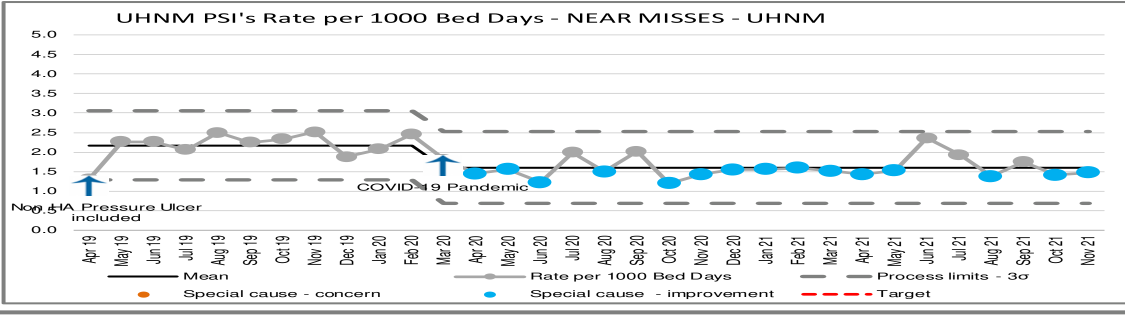
The rate of Patient safety Incidents per 1000 bed days that are reported as resulting in No Harm to the affected patient.



Variation			Assurance
Target	**Sep 21**	**Oct 21**	**Nov 21**
N/A	12.50	11.98	14.40

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	**Sep 21**	**Oct 21**	**Nov 21**
N/A	1.75	1.42	1.47

Background

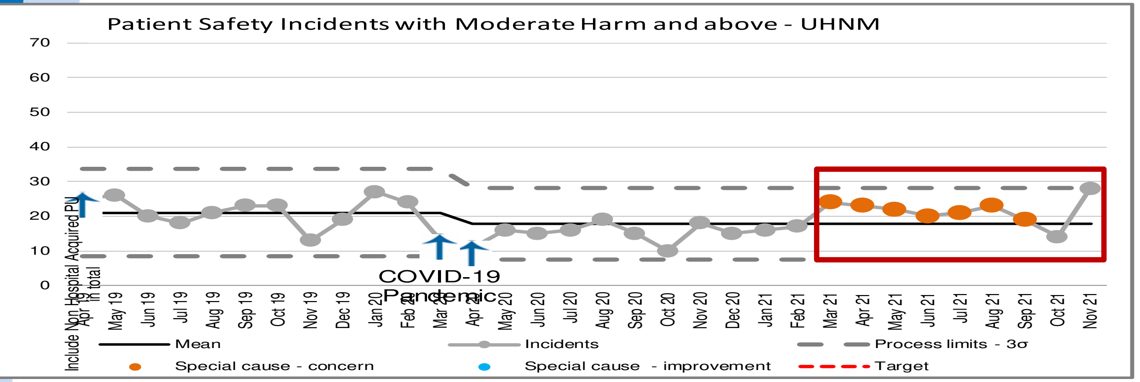
The rate of Patient safety Incidents per 1000 bed days that are reported as NEAR MISS

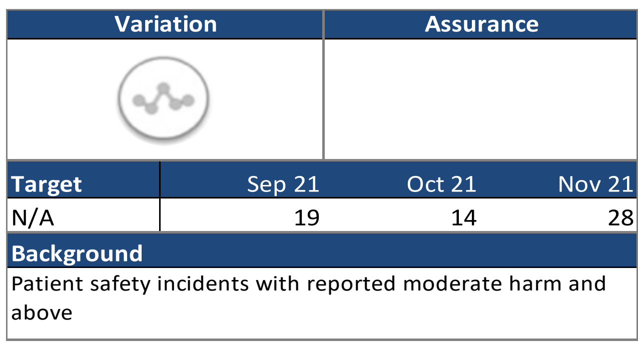
What is the data telling us:

The Rate of Patient Safety Incidents per 1000 bed days with no harm or low harm are showing consistent trends. Although Low harm has seen increase in month November but still within normal variations. 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 remained relatively stable 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	Sep 21	Oct 21	Nov 21
N/A	19	14	28

Background

Patient safety incidents with reported moderate harm and above

Patient Safety Incidents with harm (rate per 1000 bed days) - UHNM

Non Hospital Pressure Ulcers included to reflect NRLS

COVID-19 Pandemic

Mean | Rate per 1,000 bed days | Process limits - 3σ | Special cause - concern | Special cause - improvement | Target

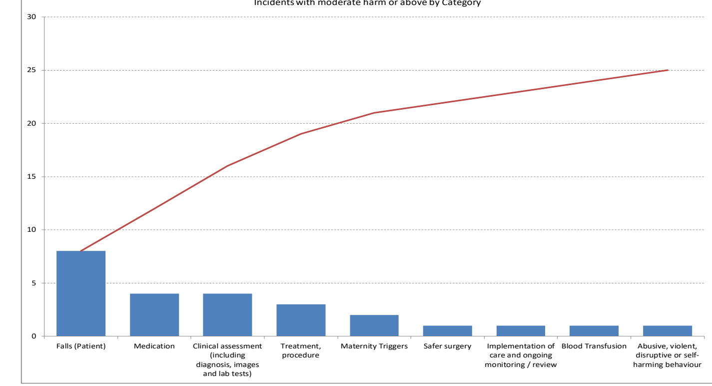
Variation		Assurance	
Target	Sep 21	Oct 21	Nov 21
N/A	0.52	0.37	0.74

What is the data telling us:

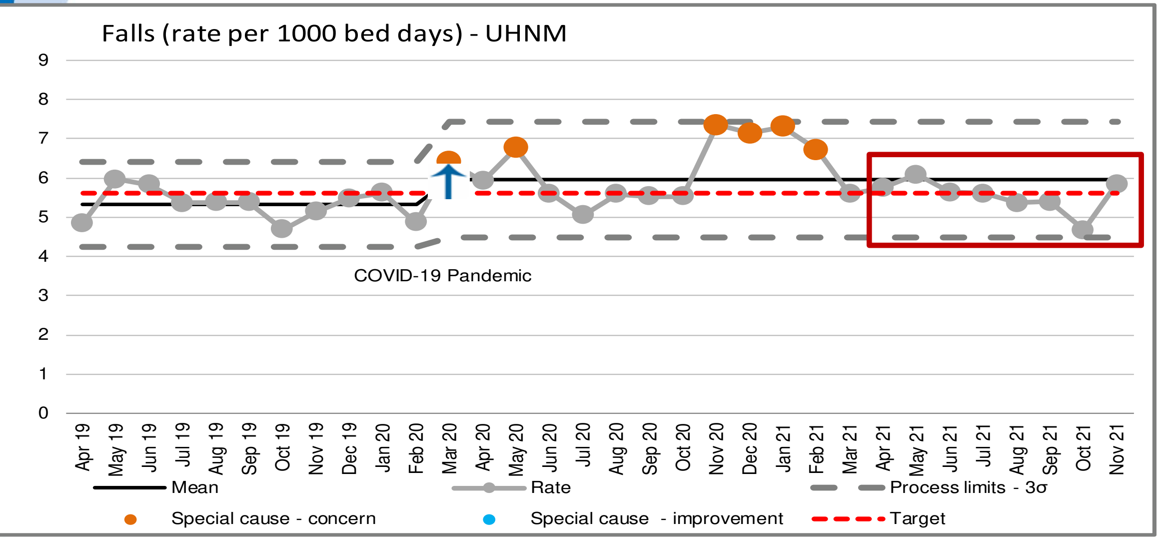
The variation noted in charts above for moderate harm or above total and rate per 1000 bed days is within normal variation and no special cause noted. Whilst noted that not statistically significant yet the previous months were showing reductions in the number and rate of incidents with moderate harm or above. November has however seen an increase but still remains in normal variation.

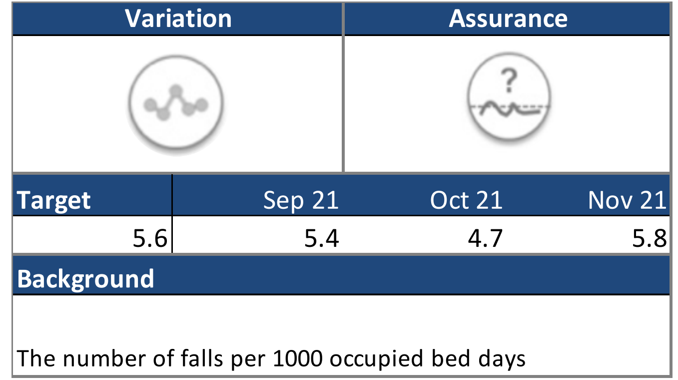
The top category of incidents resulting in moderate harm reflect the largest reporting categories with 8 Falls, 4 medication, 4 Clinical Assessment and 3 Treatment related being top 4 categories.

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% .



Patient Falls Rate per 1000 bed days





Variation	Assurance

Target	Sep 21	Oct 21	Nov 21
5.6	5.4	4.7	5.8

Background

The number of falls per 1000 occupied bed days

What is the data telling us:

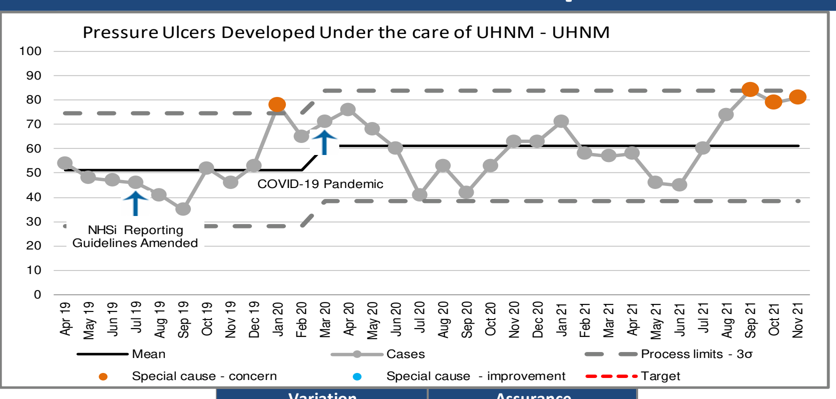
The chart shows the Trust's rate of reported patient falls per 1000 bed days is currently not showing any significant change. The Trust adopted the average rate of 5.6 patient falls per 1000 bed days from the Royal College of Physicians National Falls Audit report (2015) as a target rate.

The areas reporting the highest numbers of falls in November 2021 were:
Royal Stoke AMU, Royal ED, Ward 201, Ward 230 and Ward 228.

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

- A Falls champion study day has taken place which will support the wards to reduce inpatient falls.
- After the falls RCA has taken place, the consultant is now included in the outcome letter and therefore providing information regarding the contents that will be provided on the duty of candour letter.
- Changes to the capturing of delirium on datix have been made to enable us to look at the relationship between delirium and falls in more detail.
- The falls risk alert symbol for use in ED for transfers to AMU is still in use. The team are revising the way in which they identify the risk on transfer

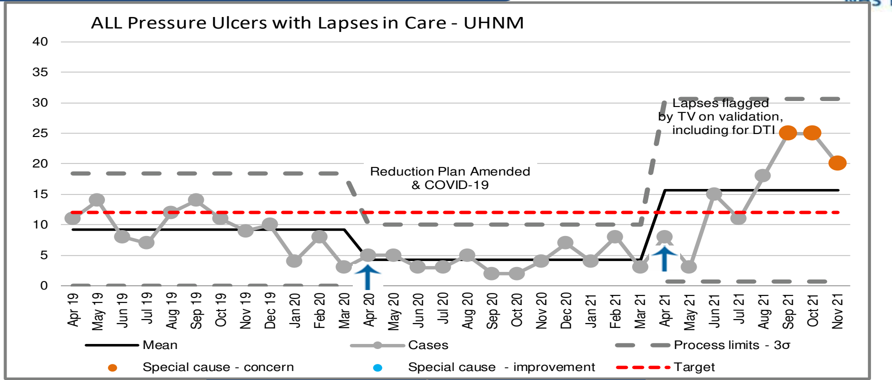
Total Pressure Ulcers developed under care of UHNM



Variation	Assurance		
Target	Sep 21	Oct 21	Nov 21
N/A	84	79	81

Background

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



Variation	Assurance		
Target	Sep 21	Oct 21	Nov 21
12	25	25	20

Background

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

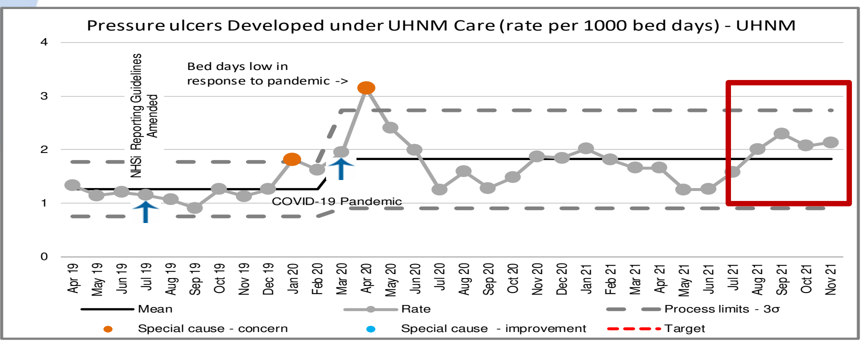
The tables below show breakdowns of the pressure ulcers reported in November 2021.

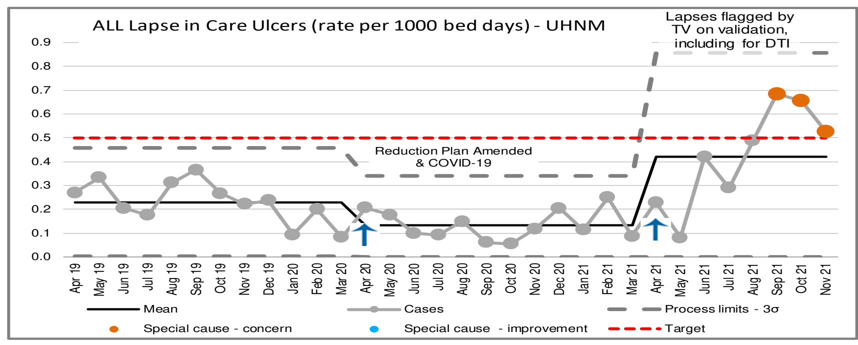
Category	Total (Nov 2021)
DTI	22
Category 2	40
Category 3	8
Category 4	0
Unstageable	11
Total	**81**

Top Body Locations	Total (Nov 2021)
Heel	17
Sacrum	16
Buttock	10

The number of pressure ulcers reported as developing under the care of UHNM in November is significantly above average. This is primarily due to numbers of Category 2 ulcers (40), compared to a 2-year monthly average of 23. Number within all other categories are stable.

Pressure Ulcers developed under care of UHNM per 1000 bed days

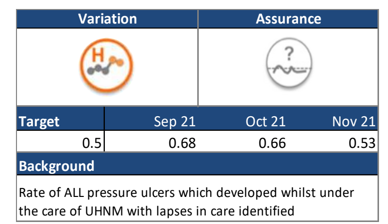




Variation	Assurance		
Target	Sep 21	Oct 21	Nov 21
N/A	2.30	2.07	2.13

Background

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



Variation	Assurance		
Target	Sep 21	Oct 21	Nov 21
0.5	0.68	0.66	0.53

Background

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

What the data is telling us

The chart above left shows no significant change in the rate of pressure ulcers reported as developing under the care of UHNM since early 2020.

The chart above right shows the rate of pressure ulcers with lapses in care identified was significantly higher between September – November than in previous months (see detail on previous slide). All lapses in care are fully investigated and an action plan with evidence of actions completed or in progress are presented at MDT panel. Spot audits are also presented at this panel to provide assurance that actions and learning from RCAs have resulted in actual improvements in preventative practice.

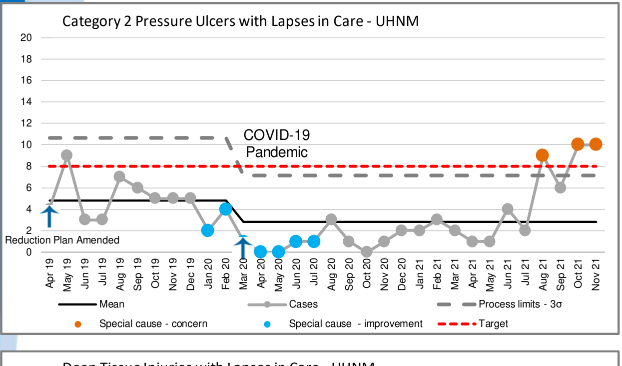
High reporting areas will be presenting all incidents at bespoke RCA panels, to allow identification of ward trends, to identify the need for focussed improvement and education supported by the Tissue Viability and Corporate Nursing Quality & Safety Teams.

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

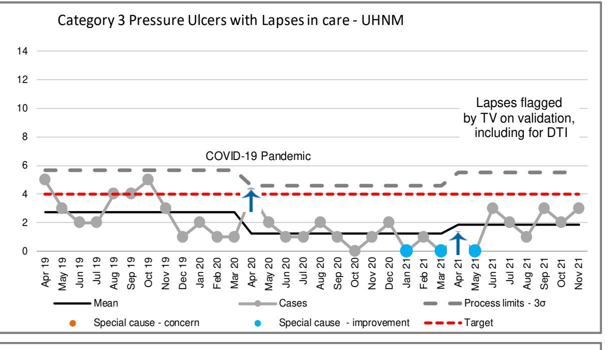
Actions

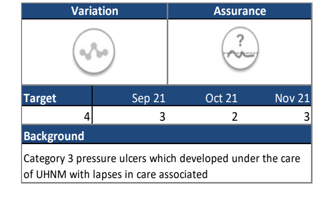
- Themes and incidents are under constant review by the Quality & Safety team to identify and discuss any emerging themes.
- The aSSKINg bundle has been amended to promote a focus on Air Mattress pump checking. This is in response to a number of incidents where the Air Mattress pump was found to be faulty or switched off
- A Trust wide audit of chairs is underway following the identification of a number of chairs that have lost their pressure relieving qualities due to wear and tear.
- Pressure Ulcer Prevention (PUP) education is now delivered on a multiple platform including Nursing Assistant and Preceptorship induction programme as well as for new starters in ED and child health. Education and support can be requested on ad hoc basis.
- Harm Free Care alerts are now circulated Trust wide in response to incidents and the themes identified during the rise in incidents in June and July will feature in the next alert.
- The Quality & Safety team are engaged in supporting clinical areas who are focusing on pressure ulcers as a driver or watch metric . Surgery Division have identified Pressure Ulcers reduction as a driver metric.
- Review of surfaces in ED to enhance Pressure ulcer prevention, now awaiting delivery of new mattresses

Pressure Ulcers with lapses in care

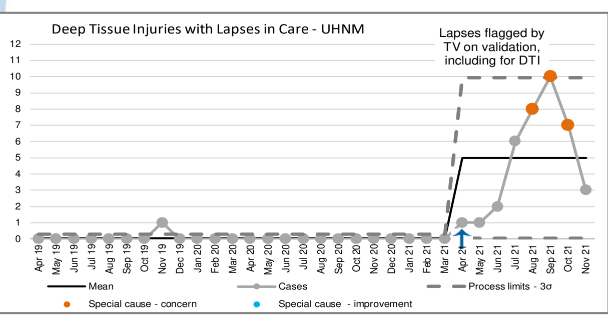


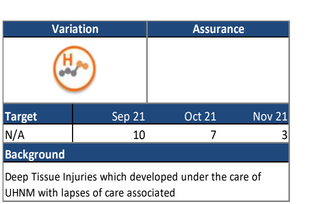
Variation	Assurance		
Target	**Sep 21**	**Oct 21**	**Nov 21**
8	6	10	10
Background			



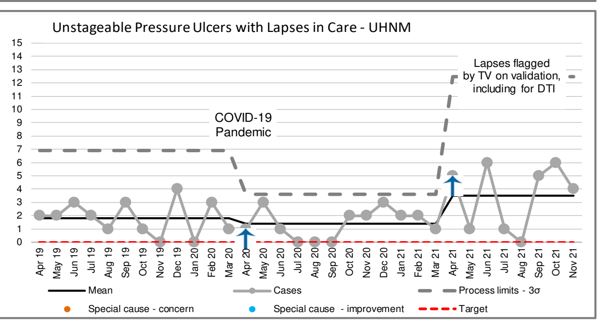


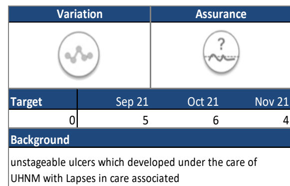
Variation	Assurance		
Target	**Sep 21**	**Oct 21**	**Nov 21**
4	3	2	3
Background			
Category 3 pressure ulcers which developed under the care of UHNM with lapses in care associated			





Variation	Assurance		
Target	**Sep 21**	**Oct 21**	**Nov 21**
N/A	10	7	3
Background			
Deep Tissue Injuries which developed under the care of UHNM with lapses of care associated			





Variation	Assurance		
Target	**Sep 21**	**Oct 21**	**Nov 21**
0	5	6	4
Background			
unstageable ulcers which developed under the care of UHNM with Lapses in care associated			

What is the data telling us:

The charts above show that the Pressure Ulcers with lapses in care reported in November 2021 included a range of categories. Numbers with lapses may change as incidents are reviewed/validated. The higher number of Pressure Ulcers with lapses in care identified in recent months may be partly due to the new process introduced in April 2021 capturing lapses more effectively. Under this process lapses are flagged by the Tissue Viability Team when they review the patient, rather than waiting for review at Panel. Numbers may change once the cases are reviewed at Tissues Viability Panel.

As shown in the table below, common lapses identified are management of repositioning and heel offloading . Additionally, deep tissue injuries will appear to have increased due to the recent decision to investigate upon identification instead of waiting for evolution into an established category. This decision was made to capture learning and ensure all pressure ulcers that develop under our care are investigated.

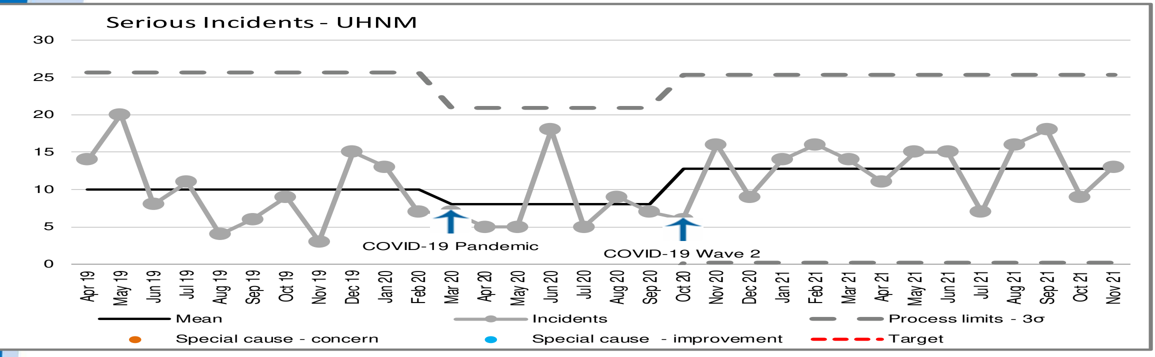
The only location with more than 1 lapse in November was: Emergency Care Centre (4)

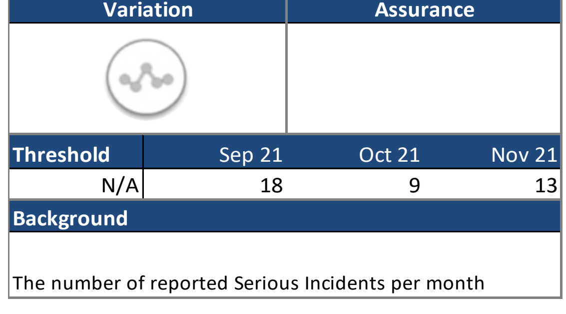
Root Cause(s) of damage - Lapses - Nov 2021	Total
Management of repositioning	12
Management of heel offloading	5
Clinical condition	3
Management of device	1

Actions:

- Education continues on high reporting areas from TV Team and Corporate team
- The Tissue Viability Team and Corporate Nursing Team are supporting high reporting areas following panel
- presentation, to gain assurance around actions. Feedback is then provided to the ward managers.
- Pressure Ulcer Prevention (PUP) Champions training is in process planning for next year and focuses on learning from incidents.
- A 6 monthly review of the process to attribute and validate the lapses in care is currently being undertaken.

Serious Incidents per month





Variation		Assurance	
Threshold	Sep 21	Oct 21	Nov 21
N/A	18	9	13

Background

The number of reported Serious Incidents per month

Rate of SIs 1000 bed days - UHNM

1.00 0.90 0.80 0.70 0.60 0.50 0.40 0.30 0.20 0.10 0.00

COVID-19 COVID-19 2nd wave

Apr 19 May 19 Jun 19 Jul 19 Aug 19 Sep 19 Oct 19 Nov 19 Dec 19 Jan 20 Feb 20 Mar 20 Apr 20 May 20 Jun 20 Jul 20 Aug 20 Sep 20 Oct 20 Nov 20 Dec 20 Jan 21 Feb 21 Mar 21 Apr 21 May 21 Jun 21 Jul 21 Aug 21 Sep 21 Oct 21 Nov 21

Mean — Rate of SIs 1000 bed days — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Variation		Assurance	
Target	Sep 21	Oct 21	Nov 21
N/A	0.49	0.24	0.34

Background

The rate of Serious Incidents Reported per 1000 bed days

What is the data telling us:

November 2021* saw 13 incidents reported with 12 at RSUH and 1 at County Hospital:

- 9 Falls related incidents
- 1 Medication related incidents
- 1 Treatment delay
- 1 Maternity/Obstetric (mother only)
- 1 Maternity/Obstetric (baby only)

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

There are currently 66 incidents open on STEIS for UHNM as at 30th November 2021.

28 RCAs are awaited which is increase from previous report, 6 RCAs have been submitted to the CCG and are under going review process prior to closure and 32 RCAs are within timescale

**Reported on STEIS as SI in November 2021, the date of the identified incident may not be November 2021.*

Serious Incidents Summary

Summary of new Maternity Serious Incidents

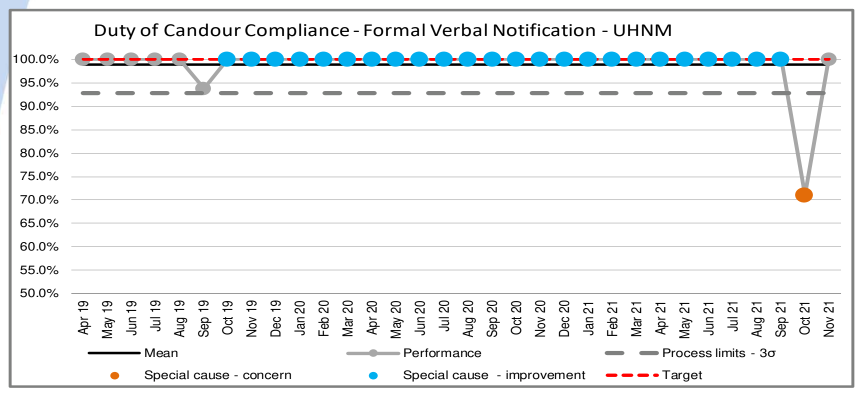
Following the formal recommendations in the Ockenden Report, below is an outline of the Maternity related serious incidents reported during June 2021. The new recommendation requires the Trust Board to receive summary on the new Maternity related Serious Incidents along with previously reported summary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

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

There were 2 Maternity related Serious Incidents reported on STEIS during November 2021

Log No	Patient Ethnic Group:	Type of Incident	Target Completion date	Description of what happened:
2021/23088	White- British	Obstetric/Maternity related (Mother only)	08/02/2022	Healthcare Safety Investigation Branch (HSIB) Referral. Maternal Death, 24 days post-partum following an emergency caesarean section at 40 weeks and 2 days gestation. Covid positive. Coroner's Inquest. It has been agreed all HSIB investigations will be reported as a Serious Incident. Third Pregnancy (1 x normal vaginal delivery of live male infant at 40 weeks gestation, 2007 and 1 x emergency caesarean section of live male infant at 31 weeks and 5 days gestation, 2019) Hypothyroidism Raised Body Mass Index (BMI) at booking (BMI = 42) Anxiety, depression White, British Non-smoker History of Pneumonia Not received Covid vaccination
2021/23613	Asian or asian British Pakistani	Obstetric/Maternity related (baby only)	15/02/2022	The Serious Incident report is based on the grading of care following a PMRT review which was completed as per MBRRACE guidance. Extreme Preterm Death. Comfort care given and memory making with family. Grading of care of the mother and baby up to the point of birth of the baby: C - The review group identified care issues which they considered may have made a difference to the outcome of the baby. Grading of care of the birth of the baby from birth up to the death of the baby: C – The review group identified care issues which they considered may have made a difference to the outcome of the baby. Grading of care of care of the mother following the death of her baby: A – The review group concluded that there were no issues with care identified for the mother following the death of her baby.

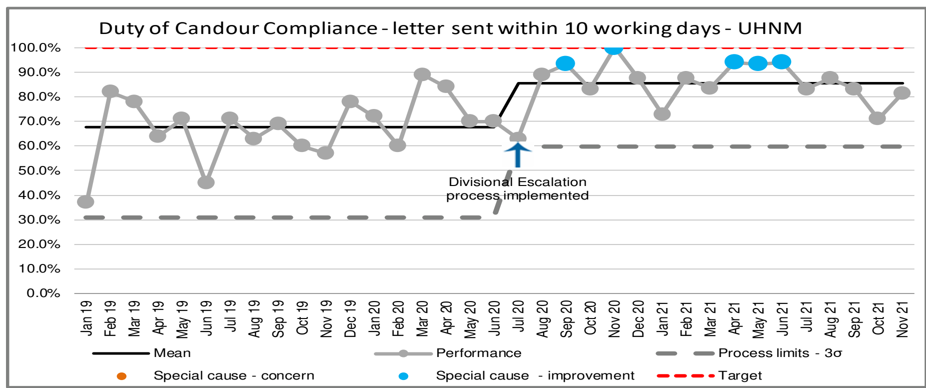
Duty of Candour Compliance



Variation	Assurance		
Target	Sep 21	Oct 21	Nov 21
100%	100.0%	71.0%	100.0%

Background

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



Variation	Assurance		
Target	Sep 21	Oct 21	Nov 21
100%	83.3%	71.0%	81.3%

Background

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

What is the data telling us:

During November there were 16 incidents reported and identified that have formally triggered the Duty of Candour. All 16 of these cases (100%) have recorded that the patient/relatives been formally notified of the incident in Datix.

Confirmed Follow up Written Duty of Candour compliance (i.e. receiving the letter within 10 working days of verbal notification) during November 2021 is 81.3%.

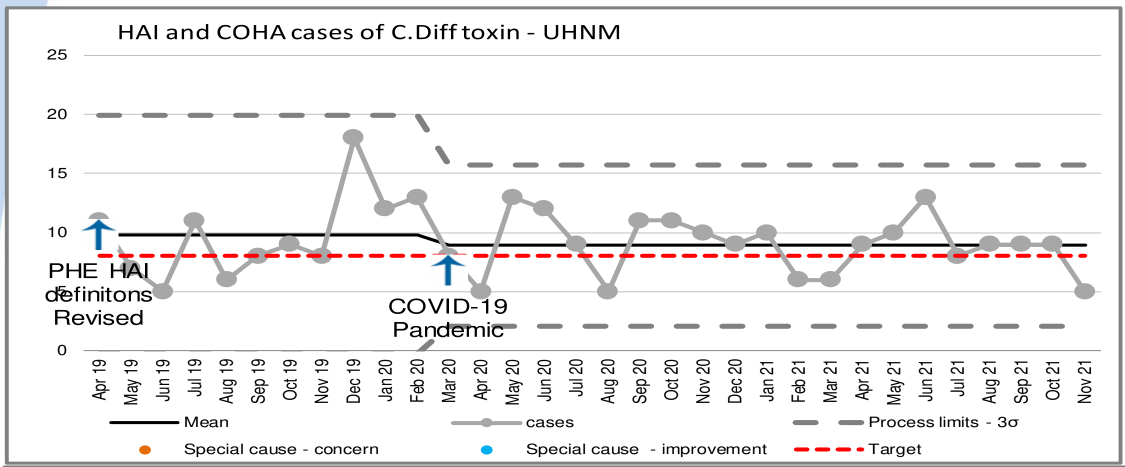
There were 3 cases that had not received the letter within 10 days.

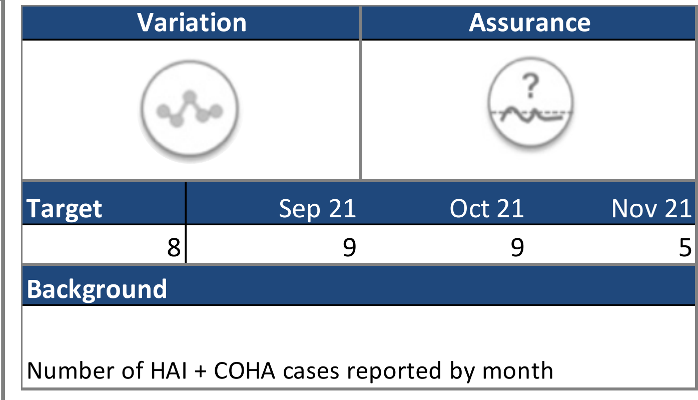
Actions taken:

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

Compliance is included in Divisional reports for discussion and action.

Reported C Diff Cases per month





Variation	Assurance

Target	Sep 21	Oct 21	Nov 21
8	9	9	5

Background

Number of HAI + COHA cases reported by month

What do these results tell us?

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

There have been 5 reported C diff cases in November of these with all 5 being Hospital Associated Infection (HAI) cases.

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

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

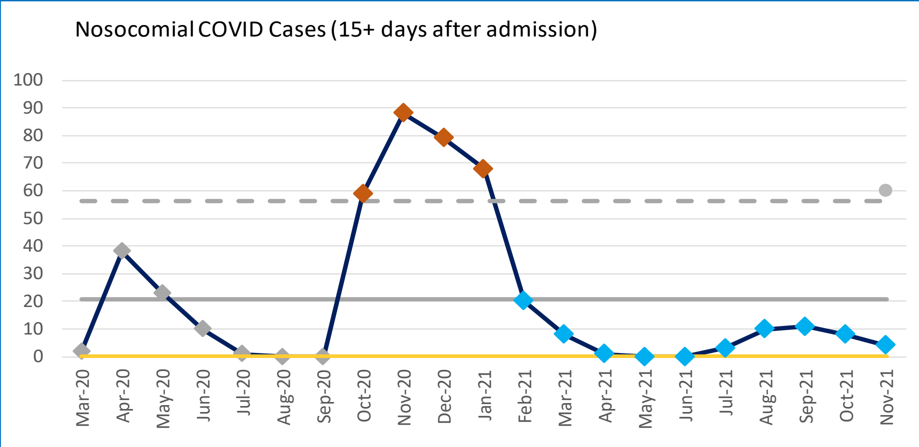
There has been one clinical area that has had more than one Clostridium *difficile* case in a 28 day period.

- Ward 76a, Royal Stoke Hospital 2x HAI toxin. Ribotypes are still outstanding so it is not possible to say whether person to person transmission has occurred.
- IP measures in place

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 have been paused due to COVID 19 but are due to recommence
- 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	109	88
Dec 20	526.0	404.1	370.2	318.7	14701	107	79
Jan 21	283.0	328.0	296.0	239.5	14255	128	68
Feb 21	86.60	113.2	104.6	125.2	14101	31	20
Mar 21	56.0	61.6	56.2	76.8	17105	12	8
Apr 21	24.1	23.6	17.7	35.1	16554	3	1
May-21	49.0	36	27.9	18.3	17273	0	0
Jun-21	100.4	76.9	62.4	93.6	18527	0	0
Jul-21	290.1	273.5	242.9	223.3	18168	4	3
Aug-21	310.8	321.7	360.5	375.6	17160	14	10
Sep-21	355.3	414.0	512.2	423.3	17327	11	10
Oct-21	484.9	468.8	569.7	532.7	17055	8	8
Nov-21	476.1	400.2	455.2	492.2	17700	4	4

What do these results tell us?

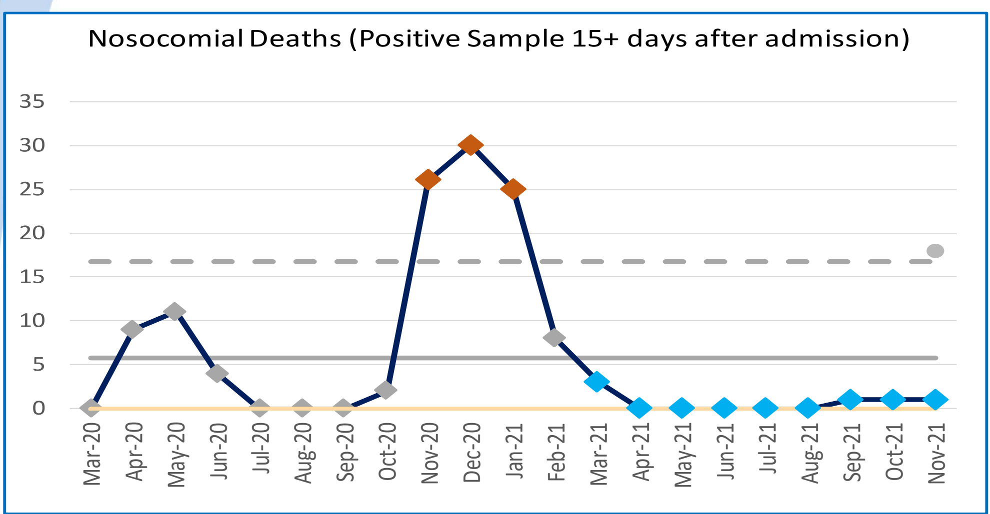
- The data shows an in month decrease in definite Healthcare Acquired COVID -19 cases with 5 in November 2021 (these patients were within CWD)
- Local, Regional and National community COVID-19 rates decreased in November 2021 (see table opposite) compared to October 2021 but the rates are reported as much higher than November 2020
- November has seen decrease in Probable and definite Hospital Onset COVID and is below Wave 2 figures and November 2020 figures.

Actions :

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

Quality | Operational | Workforce | Finance

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.

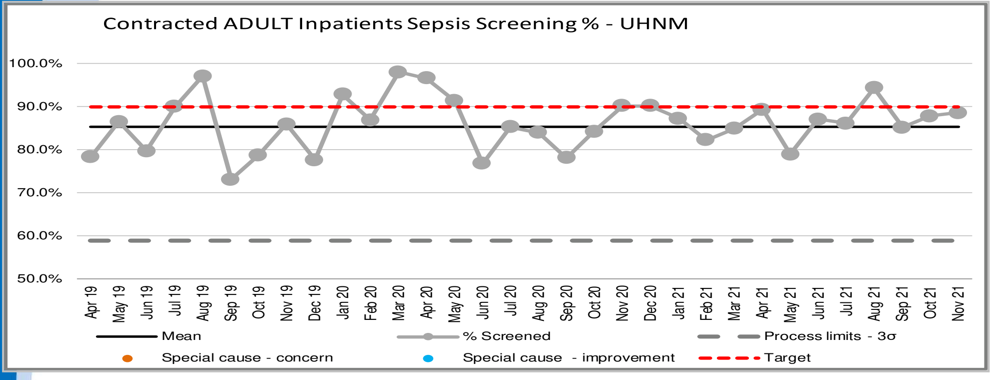
- There have been 1 recorded definite hospital onset COVID-19 deaths during November 2021
- Total 119 hospital acquired COVID-19 deaths with 1st positive results 15 days or more following admission recorded since March 2020.
- The mean number of deaths per month since March 2020 is 6

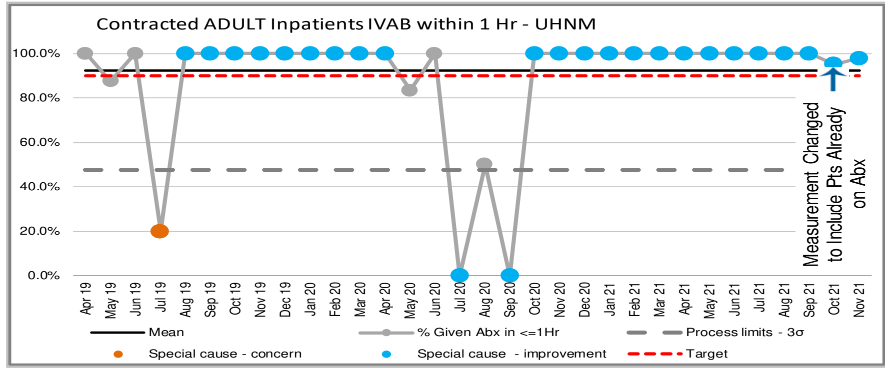
Actions :

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

COVID-19 mortality review panel underway and the outcomes will be reported via the Trust Mortality Review Group and learning will be shared.

Sepsis Screening Compliance (Inpatients Contract)





Contracted ADULT Inpatients Sepsis Screening

Variation		Assurance	
Target	**Sep 21**	**Oct 21**	**Nov 21**
90%	85.2%	87.9%	88.6%

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

Contracted ADULT Inpatients IVAB within 1 Hr

Variation		Assurance	
Target	**Sep 21**	**Oct 21**	**Nov 21**
90%	100.0%	95.1%	97.8%

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

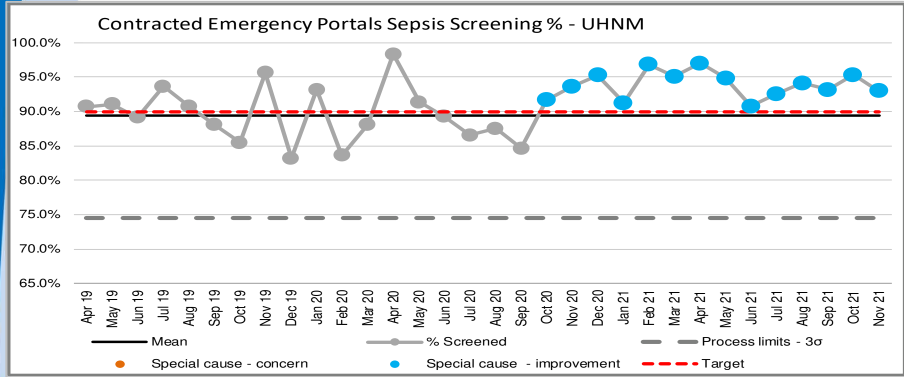
What is the data telling us:

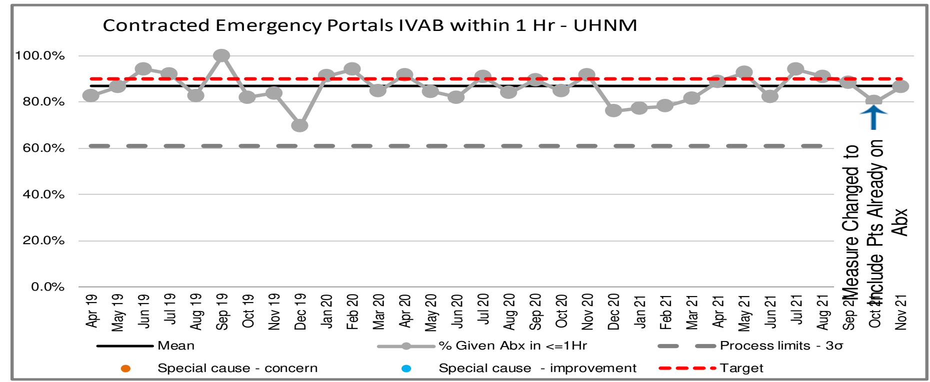
November 2021 Inpatients results show improvement in screening compliance to 88.6%. Compliance for IVAB within an hour achieved 97.8%.
Of the 132 Inpatients that triggered a sepsis screen in the audit, 92 had sepsis red flags present, 4 of these patients were given IVAB within hour and the 1 delayed IVAB was given within two hours. For the remaining 92 patients, 47 had alternative diagnosis that were deemed as not sepsis related . The remaining 40 patients were already receiving IVAB prior to the identified red flag trigger. Screening compliance from the four division did not achieve >90% this month however reinforcement and robust actions remain in place.

Actions:

- The sepsis team have continued to provide sepsis re-enforcement, kiosks, visiting ward areas to update clinical staff and promote awareness around sepsis: on-going
- The Sepsis team regularly identify areas of poor compliance and prioritise those areas for more focused re-enforcement and sepsis kiosks each month; on-going
- The Sepsis team continued to work closely with the VitalPac team in order to address issues around staff access and sepsis vitals reporting; on-going
- Task & Finish Group is being convened with the ACNs involvement to improve compliance: on-going
- The Sepsis team offered both delivering out of hours training (7 am) to capture late & night staff as well as early shift staff: on-going
- Continued focus and support provided to all divisions to maintain and sustain compliance: plan of providing additional training sessions is being arranged
- The Sepsis Team will continue to create awareness by being involved for HCA and Students induction programmes, this will also include new nursing staff.
- Involvement in the development of the Sepsis Dashboard report by supporting and working closely with the Business Intelligence team (testing & reviewing)

Sepsis Screening Compliance (Emergency Portals Contract)





Variation	Assurance		
Target	**Sep 21**	**Oct 21**	**Nov 21**
90%	93%	95%	93%
Background			
The percentage of audited Emergency Portal patients receiving sepsis screening for Sepsis Contract purposes			

Variation	Assurance		
Target	**Sep 21**	**Oct 21**	**Nov 21**
90%	88%	80%	86%
Background			
The percentage of Emergency Portals patients from sepsis audit receiving IVAB within 1 hour for Sepsis Contract purposes			

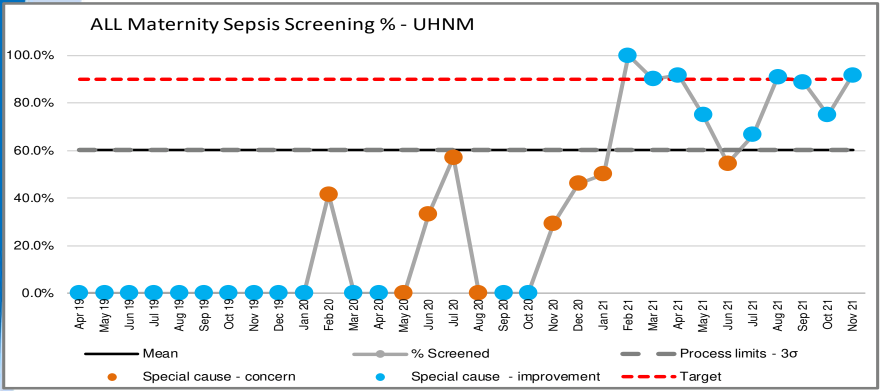
What is the data telling us:

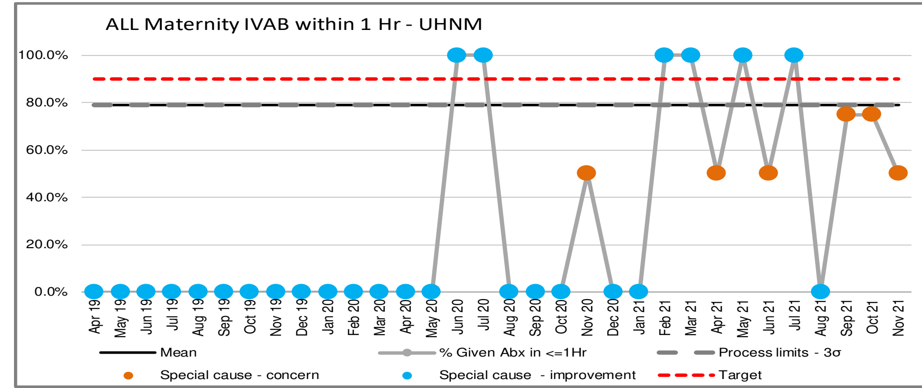
Adult Emergency Portals screening in November 2021 achieved 93% for the 114 patients audited.
The performance for IVAB within 1hr has improved to 86% in November. There were 97 red flag sepsis patients identified from the 114 patients audited in the screening sample. Out of the 97 red flag patients, 35 received IVAB within an hour whilst 29 were already on IVAB and 23 had an alternative diagnosis.
There was 10 delayed IVAB , nine from A&E Royal Stoke site and one from A&E County which 9 were administered within 2 hours and 1 administered > 2 hours. This has been escalated to both A&E Royal & County senior teams.

Actions:

- The Sepsis team continue to closely monitor the compliance by visiting the A&E regularly and offering department based sepsis reinforcement when staffing and acuity allows; on-going
- 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 and robust actions put in place. The late IVAB have been addressed through escalation and training for individual staff involved.
- To continue with sepsis awareness to all levels of clinical/ medical staff by providing sepsis kiosks when necessary, this will give staff opportunity to discuss and ask questions about sepsis and management; on-going

Sepsis Screening Compliance ALL Maternity



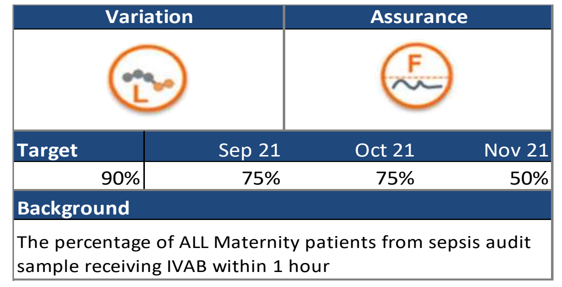


Variation	Assurance
H	F

Target	Sep 21	Oct 21	Nov 21
90%	88.9%	75.0%	91.7%

Background

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



Variation	Assurance
L	F

Target	Sep 21	Oct 21	Nov 21
90%	75%	75%	50%

Background

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

What is the data telling us:

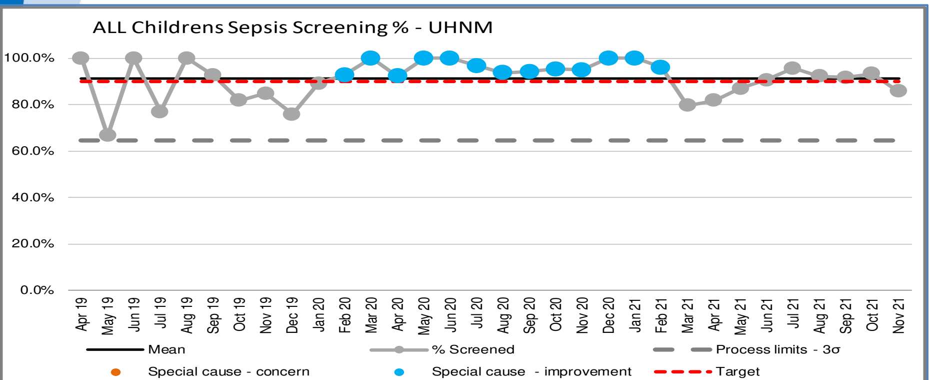
Maternity Inpatients and Emergency portal (MAU) audits show improvement in screening compliance with 91.7%, from the 12 patients that triggered with MEOWS >4. From the 12 patients audited, only 1 missed screening identified from one of the inpatient wards.

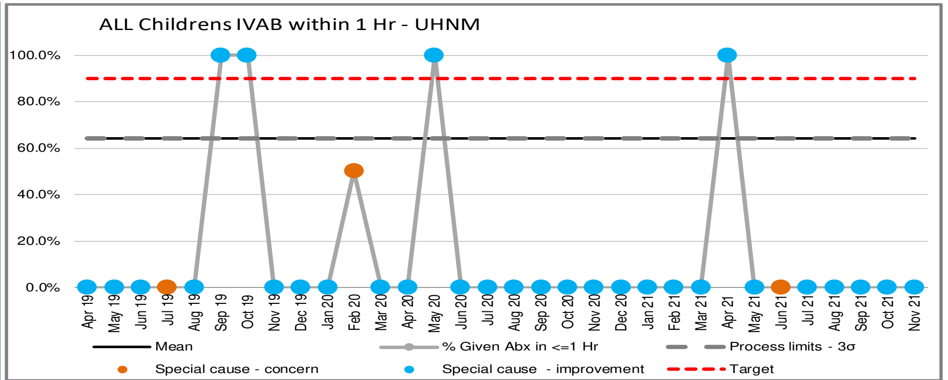
IVAB within an hour dropped to 50% with only 1 delayed IVAB administered within 2 hours from one of the inpatient wards. Overall, considering the small size samples for November, the Maternity sepsis screening compliance has only missed 1 screening and 1 delayed IVAB in inpatient ward.

Actions:

- The Maternity Senior team and clinical staff have continued to work collaboratively with the sepsis team to ensure patient safety; on-going
- The Sepsis team will continue to audit Maternity comprehensively to ensure maintenance of high standard of sepsis practice and compliance: on-going
- Missed screening has been escalated and communicated to the Maternity senior team for learning.
- Maternity educator is supporting the sepsis team by conducting independent sepsis audits in the whole Maternity department with good effect: on-going
- The plan of delivering Maternity 5 hour sepsis CPD champion training remain in the pipeline for future collaborative work has been temporarily put on-hold

Sepsis Screening Compliance ALL Children

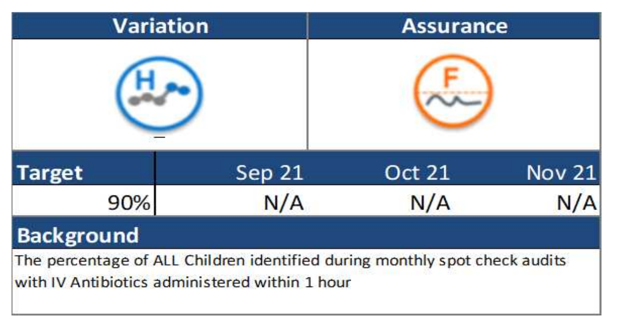




Variation	Assurance		
Target	**Sep 21**	**Oct 21**	**Nov 21**
90%	91.7%	93.3%	85.7%

Background

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



Variation	Assurance		
Target	**Sep 21**	**Oct 21**	**Nov 21**
90%	N/A	N/A	N/A

Background

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

What is the data telling us:

The charts above show decline in sepsis compliance compared to September and October 2021, with a result of 85.7%, below the target rate.
CAU screening compliance has dropped by achieving 89% (with only 1 missed screening) and Children A&E has also achieved 89% (with 2 missed screening). IVAB within hour compliance for CAU & Children A&E are not applicable or no red flags trigger. Children Inpatients ward 216 and ward 217 have no PEWS 5> triggers during randomised audits. Most inpatients Paediatrics are already on oral antibiotics or IV antibiotics prior to trigger of PEWS >5 (this is both of moderate and high risks).

Actions:

- The Sepsis Team will continue to deliver re-enforcement and kiosks to specific areas when falls in compliance are identified. Ward managers and seniors teams are encouraged to forward concerns and ad hoc training is offered to all areas when required; on-going
- The Sepsis Team has continued to adjust the audit process in emergency portals to take smaller samples over a wider range of dates to give a more comprehensive perspective
- Plan of collaborative work with Children education lead and aiming to deliver 3-5 hour Sepsis CPD champion training and ward based sessions: on-going

Operational Performance

2025 Vision "Achieve NHS Constitutional patient access standards"

Quality | Operational | Workforce | Finance

Spotlight Report from Chief Operating Officer

Emergency Care

- The number of attendances at Royal Stoke ED has slightly decreased over the last month with an average of 335 per day (reduced from 345) but has peaked to over 408 on odd days throughout November. The number of ambulance arrivals remained fairly static with a daily average of 140 and the self presenting ambulatory demand remained at c200/day.
- Daily average admissions slightly reduced from 117 to 114 with the conversion rate remaining around 34%.
- Ambulance handover delays for 30-60mins have increased and peaked at the beginning of November, reducing slightly since and the > 60 mins also rose in November. However the percentage of handovers within 15 minutes increased from 63% to 64%. With improvement seen over the last 3 weeks.
- Time to initial assessment improved by over 3% against previous month.
- System-wide performance increased slightly by 0.8% to 38.9%. Non admitted performance in ED improved to 49% with a slight increase also seen in non admitted. Acuity slightly increased for the month from 224 to 227 average per day requiring assessment in Majors.

Cancer

- The Trust is provisionally predicted to achieve the Subsequent Radiotherapy standard for November 21.
- The overall 2WW position for November is predicted to achieve in the region of 47%. Specialties with the most 14 day breaches are Breast, Skin, Colorectal and Upper GI. Performance against the 62 day standard is currently at 50% for November 21. This is an un-validated position that is expected to change as histology confirms a cancer or non cancer diagnostic for patients treated.
- Theatre, Oncology, Diagnostic and Surgical workforces have been impacted, resulting in breaches. The position is being managed through the reinstated daily clinical prioritisation meetings and a robust planned care assurance framework. 2WW and 62 day position is significantly challenged, and will be validated prior to upload.
- In November, UHNM hosted an Integrated Care System Cancer Summit, in order to gain system commitment and support that will help drive pathway improvements, and aid recovery of cancer performance.

Spotlight Report from Chief Operating Officer

Planned Care

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

- Day Case and Elective Activity delivered 84.4% for November 21 against the national ask of 95%. This is lower in Inpatients than Day case (70% IP, 87% DC).
- In month Planned Care Cell focus on elective recovery based on 10 high impact changes in accordance with the elective plan.
- Modelling of Q4 theatre capacity required to enable validation of H2 plan delivery offset against covid surge demand planning.
- CCG Commissioned Deloitte review is ongoing and UHNM are sense checking any outputs that will improve treatment capacity in the IS.
- CCG have an interim commissioning manager who is supporting elective opportunities in Tier 2 sector/regionally around mutual aid.
- Referral Hub – awaiting specification from 18 week source group and reviewing use of electronic ERS to manage referrals.
- Some work has already taken place at specialty level with respect to patient contact. This is being coordinated and consolidated to inform corporate next step and avoid duplication. Quotes now received for additional support to this project.

RTT

- The indicative performance for November 21: the total number of Referral To Treatment pathways grew to 68,054 (September 67,714). There has been a slight increase in the number of > 52 weeks from 3,563 to 3,870. This rise is expected to continue over winter due to the usual NEL surge/winter pressures including any covid/IPC impact.
- RTT performance in October was 58.5% (September is 59.8%).
- Work plans around long wait patient validation and treatment tracking are in progress.

Diagnostics

- For DM01 (15 nationally identified Dx tests) the unvalidated position for total waiting list has increased in November from 20,134 to 20,874. The Non-obstetric ultrasound waiting list reduced slightly from 10,569 to 9,935. Due to the challenges in Non-Obstetric Ultrasound this has adversely affected performance. The current DM01 diagnostic performance for November 21 is at 69% (October 68 %).
- The greatest proportion of > 6 week waits are within Non-obstetric ultrasound and endoscopy. The ultrasound position is related to an increase in demand alongside workforce shortfalls. The waiting list is growing significantly by c250 per week against a limited workforce that is at full capacity. The independent sector have now been commissioned to provide additional capacity. For endoscopy (colonoscopy and gastroscopy). This is related to an on-going increase in demand. Improvement actions are being developed and implemented.

Section 1: NON ELECTIVE IMPROVEMENT

Urgent Care – Attendances and 4 hour performance

Type 1 Attendances - UHNM

16,800
14,800
12,800
10,800
8,800
6,800

Nov 17, Jan 18, Mar 18, May 18, Jul 18, Sep 18, Nov 18, Jan 19, Mar 19, May 19, Jul 19, Sep 19, Nov 19, Jan 20, Mar 20, May 20, Jul 20, Sep 20, Nov 20, Jan 21, Mar 21, May 21, Jul 21, Sep 21, Nov 21

Mean | Attendances | Process limits - 3σ
Special cause - concern | Special cause - improvement | Target

Type 1 performance (RS & County) - UHNM

95.0%
85.0%
75.0%
65.0%
55.0%
45.0%

Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21, Nov 21

Mean | Performance | Process limits - 3σ
Special cause - concern | Special cause - improvement | Target

Urgent Care – In Month Performance Summary

SUMMARY

Attendances; Total type 1 attendances slightly decreased in November from October. At the RS site, the daily average attendances were 335 day. Children's attendances remained at an average of 75 per day.

Triage; Initial assessment within 15 minutes increased slightly in November 50% by 3%. Performance is influenced most where there are surges of over 30 attendances within the hour, particularly in the evening. This can be where staff shortages, particularly decision makers has been a challenge. The department are aiming to stop the decline in triage time with re-deployment of staff in the department at the time and are looking at tiered rotas in line with RCEM guidance. A business case addressing workforce challenges was approved in early October and staff are being recruited to as per the planning timescale in that case, with staff starting to come on line from December 2021.

Ambulance; The percentage of ambulance handovers within 15mins at RSUH site rose to 65% for the month . Ambulance handover delays for 30-60mins increased and the > 60 mins also rose in November. Longer delays occurred during peak ambulance arrival times in early evening, when multiple Crews arrive on site in succession. Improvement seen the last 3 weeks running.

Long waits; The number of patients in the department for > 12 hours is of significance again in November although slightly lower than seen in October, there was a continuation of the high numbers seen in previous months with a spike mid month of 504 in one week. There were 368 validated, 12 hour trolley waits, a significant rise on previous months.

Admissions; The number of patients attending and admitted with Covid-19 began to increase again with admissions to wards and critical care proving challenging (up to 15 new hospitalisations a day mid October). The total number of admissions decreased slightly from 117 to 114 per day average. 1+ LoS spell are at around 97% of 1920 BAU. The average LoS for patients admitted in October was c 1 day longer than that in 1920. The high number of patients waiting to be admitted at 9am remained and grew to over 200 on average per week. Discharges pre-noon remained much the same as previous months and remains above the 12 month average.

Performance; With the increase in spells over 1 day LoS the number of stranded, and long stay patients rose. The time from referral to admission increased from 339 to 371 causing admitted performance to reduce, achieving 19% (reduction of 1%). Non-admitted performance also fell from 50.3% to 48.9%

Improvement Overview and Focus

- **Patient safety and delivering quality care are of the utmost importance to UHNM.**
- **The most valuable possession for the patient is their time.**
- **UHNM will improve quality and performance by reducing ED waiting times for assessment, treatment, home or onward admission to portal/bed base.**

Acute Front Door

STREAMING & DEFLECTION REDESIGN:

- UHNM Enhanced Primary Care Model
- Clinical Navigation / 111 First / Kiosk Deflection
- Rapid Assessment & Treatment (RATs) Stream
- SIFT / Ambulatory Majors management model

COMPLEX TRIAGE:

- 15 min triage standard review
- Ambulance handover processes SOP review

MEASURED BY

- Numbers streamed to primary care / UCC
- KIOSK Activity
- Number of patients navigated direct to Portal
- Ambulance Handover times ★
- Proportion of patients triaged in 15mins ★

Acute Front Door

WORKFORCE REVIEW & RECRUITMENT:

- Tier structured workforce 24/7
- Shift Skill Mix management – training rqs
- Specialty E-referral & CRTP
- CDU feasibility study

MEASURED BY

- Proportion of Pts seen in 1hr ★
- Overnight WTBS
- Non admitted breaches
- CRTP ★

Ward based Principles

REDUCING CONGESTION:

- Right sizing and maintaining Portal Capacity
- EDD led flow management in Medicine
- LOS reviews and stranded reduction

MEASURED BY

- 12Hr Breaches ★
- Total time in department ★
- SDEC
- Spells >1 day LOS

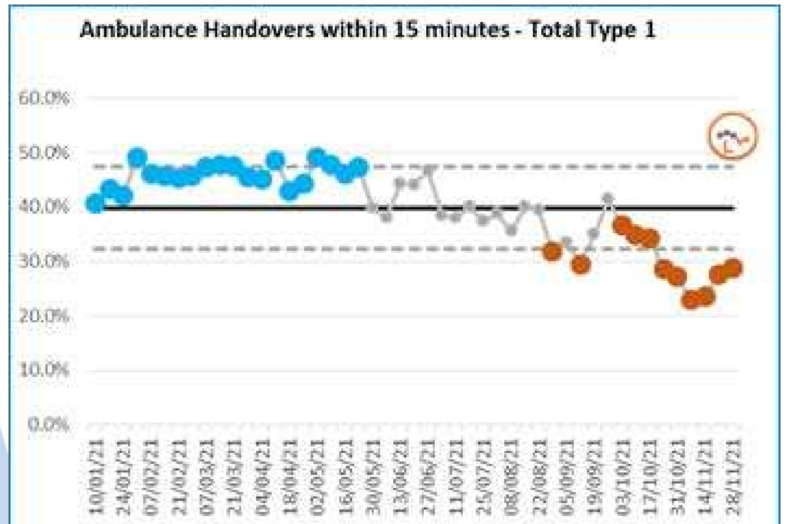
Quality | Operational | Workforce | Finance

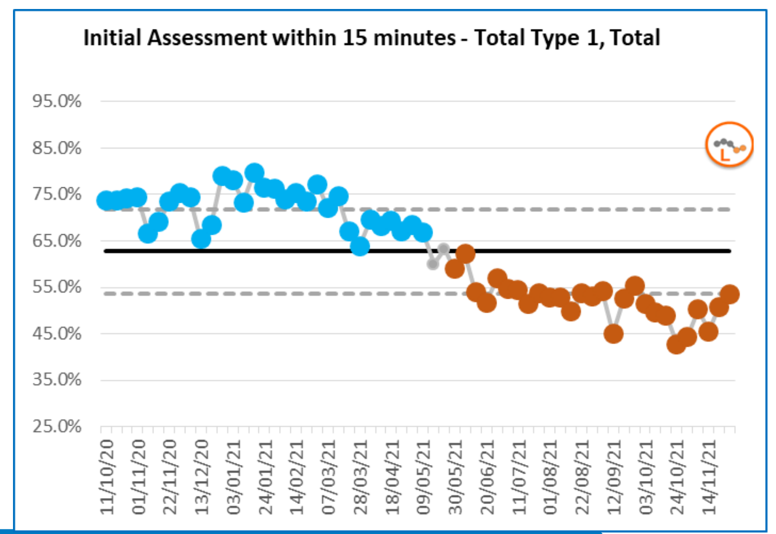
TIME FOCUSED METRICS / UEC Standard

Front Door - Attendance Management

RECENT AND IMMINENT ACTIONS

- **Test of change commenced for Navigator at the front door to support redirection to alternative places of care including portals (if attending with GP letter) and primary care services from December**
- **Internal UHNM – UCC model group commenced reporting to COO with a view of delivering 'UCC like' model from April 1st**
- **Working closely with WMAS to effect earlier handover against 'rapid handover' policy should it be implemented by WMAS**
- 'RED' GP reinstated and capacity increased - daily monitoring of referrals demonstrates that Vocare are currently seeing on average 23 Children (increase from 17) and 31 adults per day (decrease from 38).
- Use of GP referral hub and consultant connect to prevent GP walk in directed to ED
- Regular social media campaigns to highlight alternative services on offer in the community and use of 111First
- 111 Kiosks - early review of the data available indicates that only 4% of patients are being redirected to alternative pathways
- Separate hot and cold ambulance arrival areas to segregate COVID and non COVID ambulance arrivals in continued use; for review for 2022

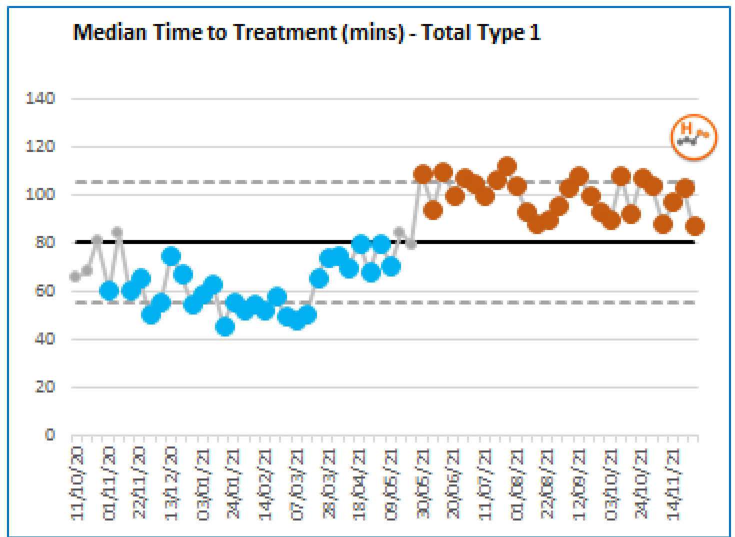


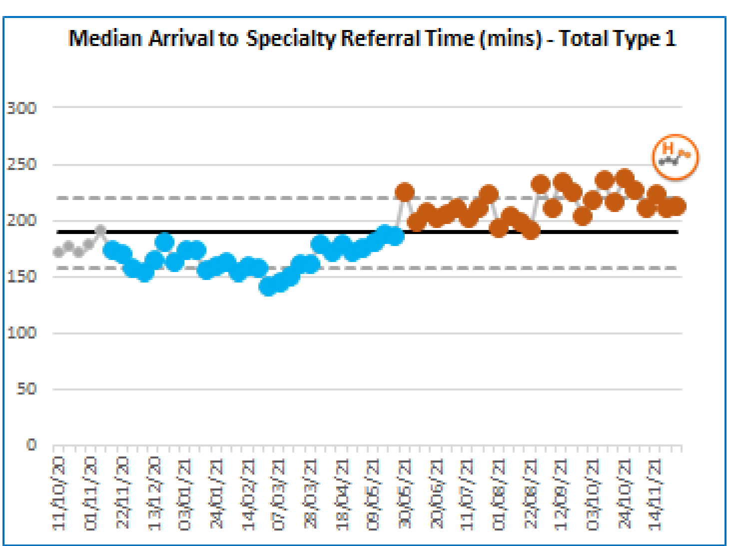


Front Door - Prompt Decisions

RECENT AND IMMINENT ACTIONS

- ED medical workforce business case to address workforce issues with clear key metrics to measure improvements approved by Trust Board in October. Initial interviews have recruited 9 SHO's with 2 commencing as early as December 21.
- Engage senior clinicians. Re-set department structures and revise rotas, commenced Nov 21
- Medical rota alignment to the new Tier's recommended by RCEM is underway
- A&E internal improvements including roles and responsibilities, huddles and rounding to improve grip, supported by visible improvement and escalation dashboards





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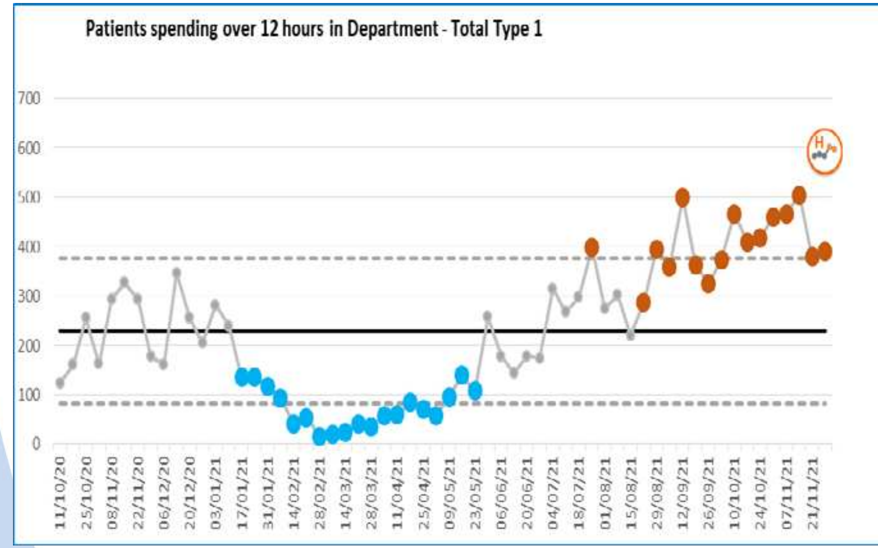
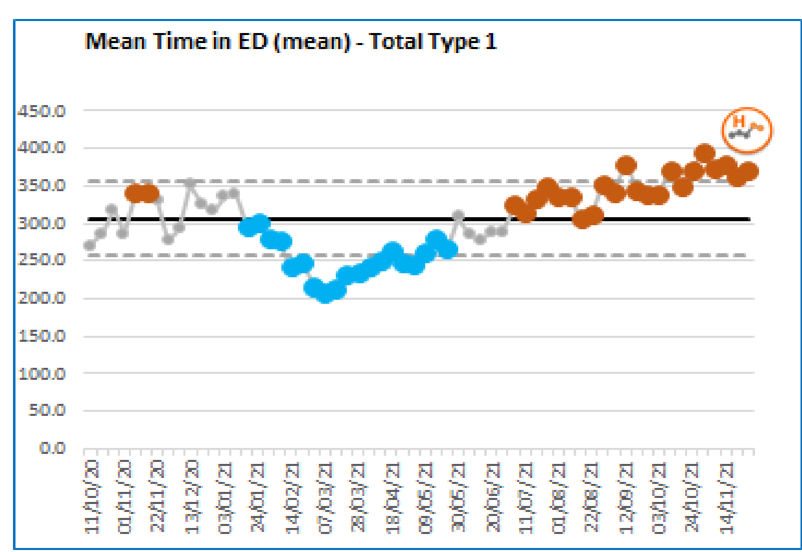
Ward based Principles - Early Egress for Admissions

RECENT AND IMMINENT ACTIONS

- **Medicine division piloting new approach to EDD management to define true capacity/demand at start of the day and to drive behaviours at ward level**
- **From mid December, discharges earlier in the day to be supported through the Transitional Discharge Lounge proposal to Tactical ops group.**
- **Later in December will be use of discharge lounge space in the West to facilitate early movement from FEAU/AMU and support the 10/10 and 11/11 Medicine mantra.**
- Application of MFFD and possible transition to Medically Optimised for Transfer (MOFT) to be reviewed and wards instructed on use
- Continued LOS work on stranded patients – great success seen in 21+ day waits.





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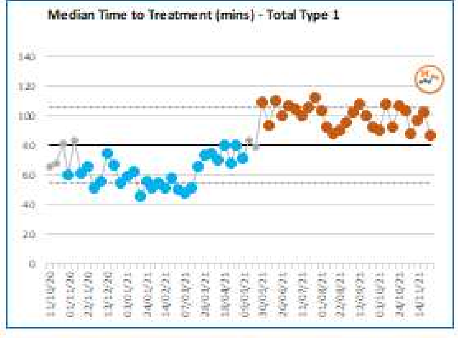
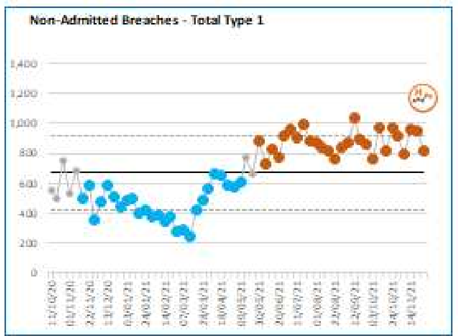
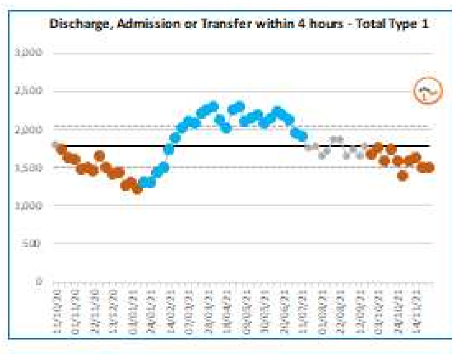
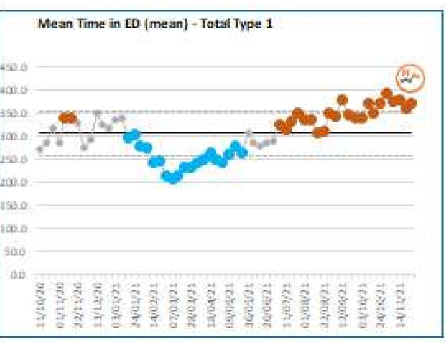
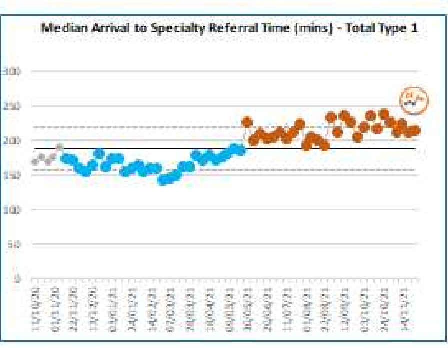
Front door

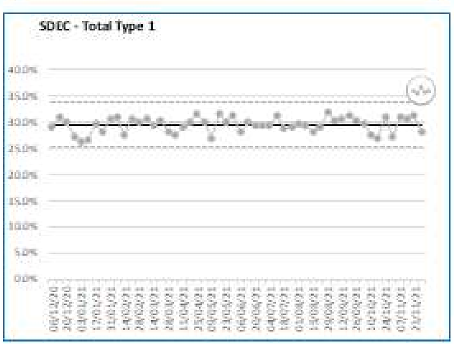


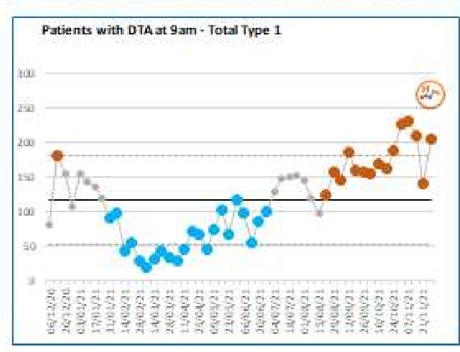


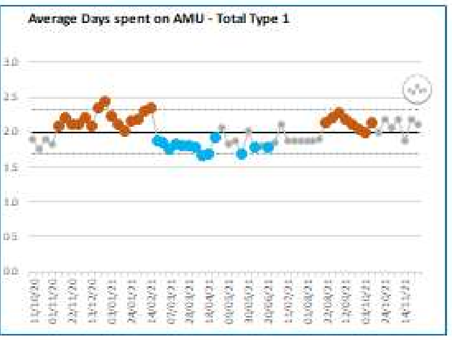


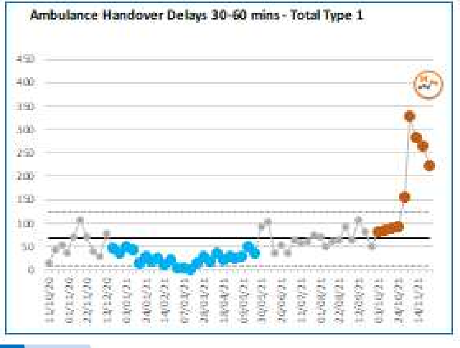


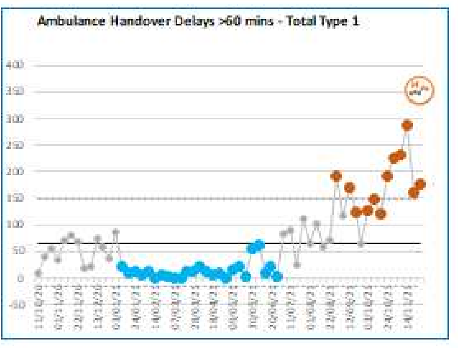


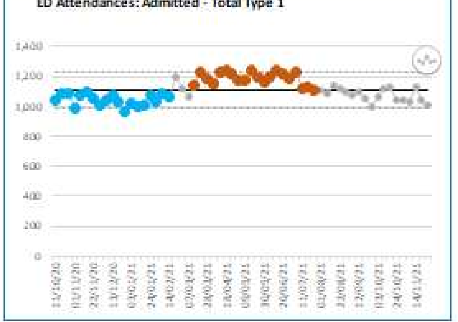


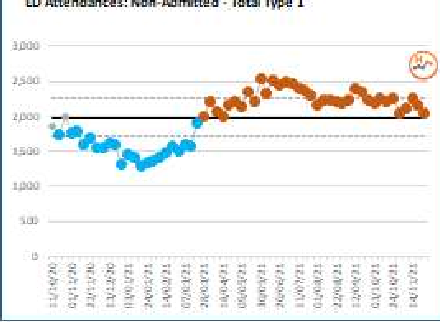




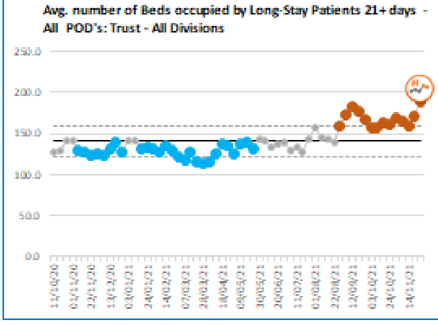


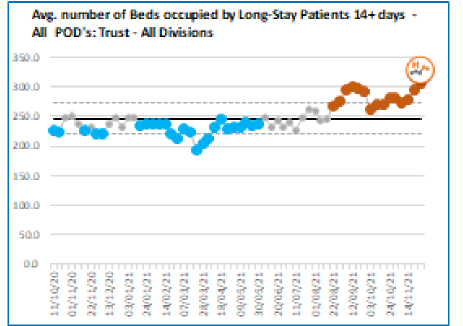


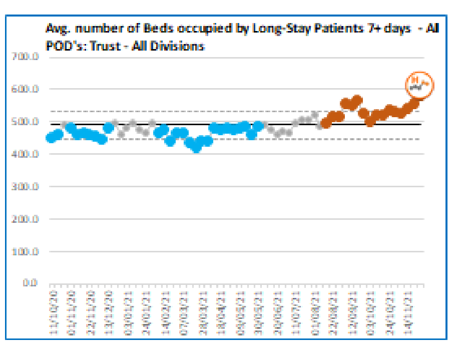


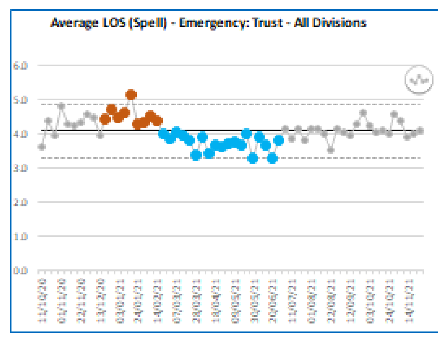


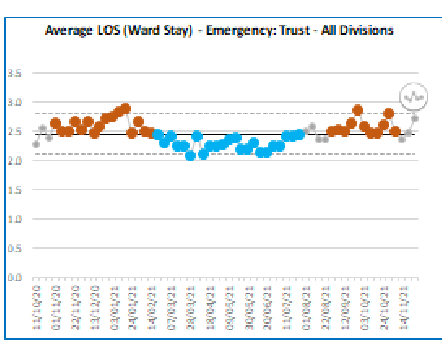
Flow

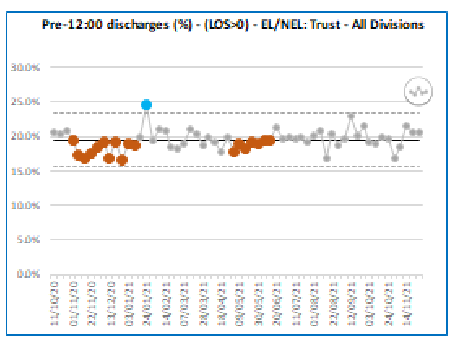


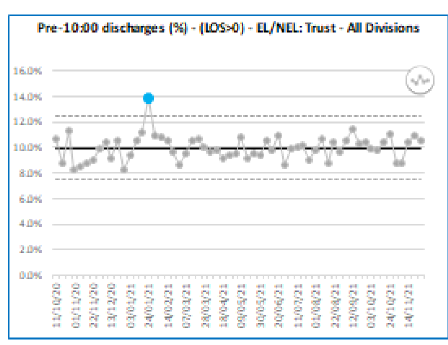


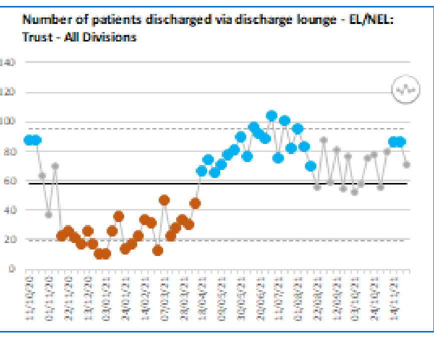


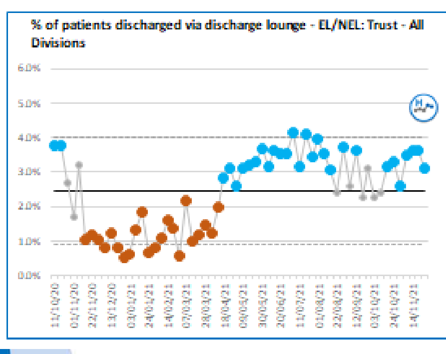


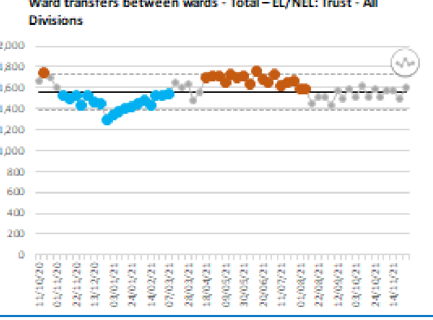


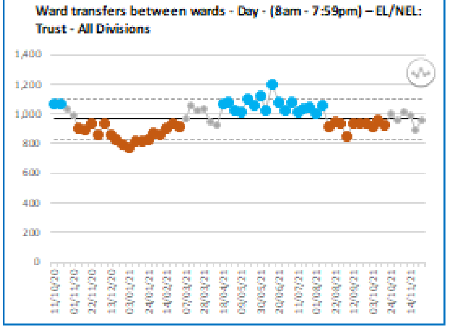


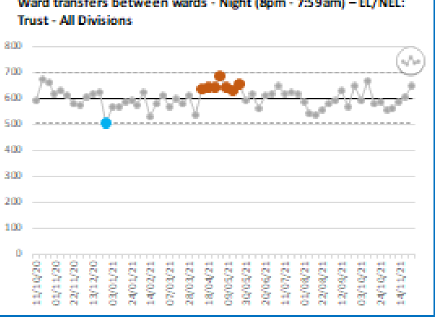












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Section 2: ELECTIVE CARE

Cancer

Challenges:

- High number of patients waiting on ERS in the RAS to be appointed: 1084 as of 01.12.21. Of these, 450 are on a skin cancer pathway, some of whom have been waiting over 4 weeks to be appointed.
- 2WW performance also significantly challenged in Breast, Skin, Colorectal – trust overall 2WW predicted performance at under 50% for November which will significantly impact future months for 28 day, 62 day performance. Skin 2WW performance is predicted to land at 16% in November.
- Increased uptake of Telederm solutions and locations for community spot clinics could help alleviate pressures – both schemes being explored with the CCG.
- The Trust is improving completeness against the 28 Day FDS dataset which is at 90% for October. Performance against the operational standard for 28 Day FDS in November is provisionally at 55%. This position will fluctuate as more pathways are recorded before the publication deadline.

Actions:

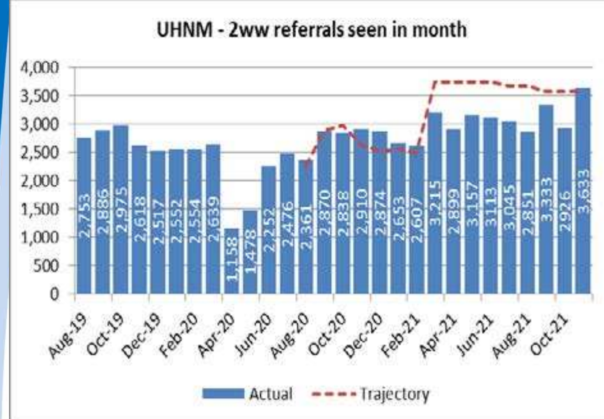
- Cancer Services hosted an ICS Cancer Summit in order to reaffirm a joint commitment to system wide cancer recovery, and to describe a structure of working groups that could feed into the ICS Cancer Board, to help drive pathway improvements and aid recovery of cancer performance. The session outlined 10 high impact actions that could facilitate cancer recovery, and described 5 working groups that would be accountable to the ICS Cancer Board to increase pace of funded cancer recovery schemes delivery.
- The Breast Pain the Community paper was presented at the Northern ICP Clinical Assembly on Thursday 2nd December. The Breast Pain clinic facilities required to deliver the service have been agreed. The breast ANP has visited 2 GP practices Furlong Medical Practice Tunstall and Brindsley Avenue Practice at their Barlaston site. The band 4 admin/co-ord post will be advertised shortly, and the pilot was endorsed by GPs and commissioners at the Northern Clinical Assembly.
- There is a new RDC lead in Radiology dedicated to expediting cancer appointments, who has met with Cancer Services Manager to learn more about cancer pathways and how the two departments can work together better to improve performance.
- Cancer pathway improvement activities from across the directorates will be monitored through a new monthly highlight report, based on intelligence from the Cancer Performance meeting, chaired by the Cancer Services Manager.
- On-going talks between cancer services and 18 Weeks to implement 2WW referral triage hub, piloted with Colorectal. Director of cancer and clinical lead from 18 week are also exploring the opportunity of further support at the front end of the pathway.

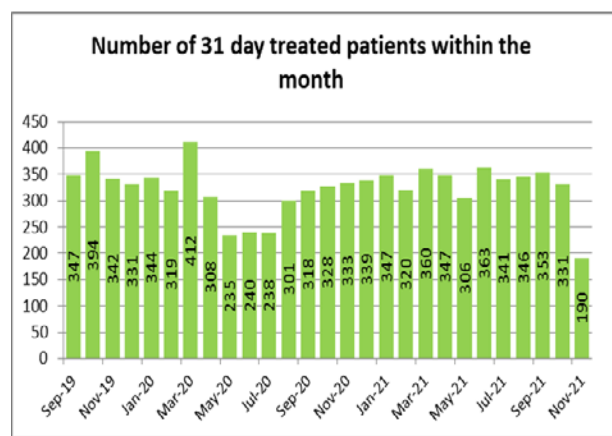
Cancer

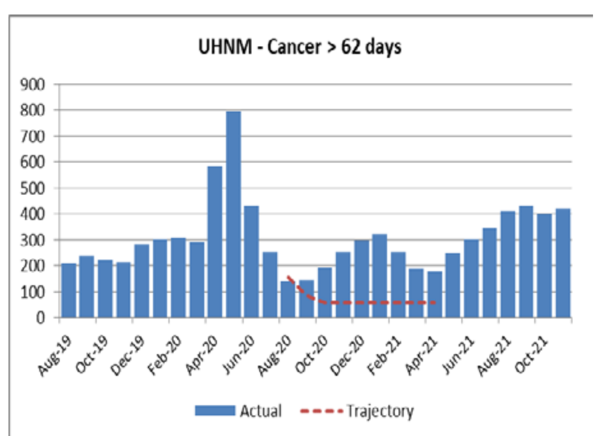
- Trajectories have been agreed and are being tracked against the actual positions. Most recent published data is for September:
  - 14 Day Trajectory September: 82.0%. Actual 68.7%. Actual Seen. 3333. Actual Breaches 1042. The trust is below the set trajectory on this standard.
  - 31 Day Trajectory September: 93.7%. Actual 86.9%. Actual Treated 353. Actual Breaches 46. The trust is below the set trajectory on this standard.
  - 62 Day Trajectory September: 76.6%. Actual 57.7%. Actual Treated 199.0. Actual Breaches 84.0. The trust is below the set trajectory on this standard.

Trust			Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
14 Day Standard 93% *(suspected cancer, excluding breast symptom)*	TRAJECTORY	First Seen	3745	3745	3745	3666	3666	3566	3566	3566	3566	3566	3566	3566
		Breaches	809	769	699	961	901	641	481	366	306	246	186	166
		Performance	78.3%	79.4%	81.3%	73.7%	75.4%	82.0%	86.5%	89.7%	91.4%	93.1%	94.7%	95.3%
	ACTUALS	First Seen	2899	3157	3113	3045	2851	3333	2865	3633	504	0	0	0
		Breaches	640	593	318	665	961	1042	1019	1919	291	0	0	0
		Performance	77.9%	81.2%	89.7%	78.1%	66.2%	68.7%	64.4%	47.1%	42.2%			
		Variation	-0.4%	1.8%	8.4%	4.4%	-9.2%	-13.3%	-22.1%	-42.6%	-49.2%			
		Regional (Midlands)	81.7%	85.0%	81.1%	83.4%	84.0%	81.4%						
		National	85.4%	87.5%	84.9%	85.6%	84.7%	84.1%						
31 Day First Treatment Standard 96%	TRAJECTORY	Treatment	463	463	463	463	463	463	463	463	463	463	463	463
		Breaches	49	46	43	38	34	29	25	23	22	20	19	18
		Performance	89.4%	90.0%	90.7%	91.7%	92.6%	93.7%	94.6%	95.0%	95.2%	95.6%	95.8%	96.1%
	ACTUALS	Treatment	347	306	363	341	346	353	331	190	2	0	0	0
		Breaches	23	19	22	22	29	46	42	28	0	0	0	0
		Performance	93.3%	93.7%	93.9%	93.5%	91.6%	86.9%	87.3%	85.2%	100.0%			
		Variation	3.9%	3.7%	3.2%	1.8%	-1.0%	-6.9%	-7.4%	-9.9%	4.7%			
		Regional (Midlands)	91.9%	92.5%	91.9%	91.9%	90.2%	88.7%						
		National	94.2%	95.1%	94.6%	94.7%	93.7%	92.6%						
62 Day (2ww) Standard 85%	TRAJECTORY	Treatment	246.0	246.0	246.0	246.0	246.0	246.0	246.0	246.0	246.0	246.0	246.0	246.0
		Breaches	75.5	71.5	67.5	62.5	59.5	57.5	50.0	44.0	38.0	32.0	32.0	32.0
		Performance	69.3%	70.9%	72.5%	74.5%	75.8%	76.6%	79.6%	82.1%	84.5%	86.9%	86.9%	86.9%
	ACTUALS	Treatment	181.0	166.5	198.0	186.5	187.5	199.0	168.0	118.5	0.0	0.0	0.0	0.0
		Breaches	42.0	48.5	59.0	64.0	69.5	84.0	70.0	58.5	0.0	0.0	0.0	0.0
		Performance	76.7%	70.8%	70.2%	65.6%	62.9%	57.7%	58.3%	50.6%				
		Variation	7.4%	-0.1%	-2.3%	-8.9%	-12.9%	-18.9%	-21.3%	-31.5%				
		Regional (Midlands)	69.9%	66.4%	66.4%	63.3%	61.6%	58.3%						
		National	75.4%	73.0%	73.3%	72.1%	70.7%	68.0%						

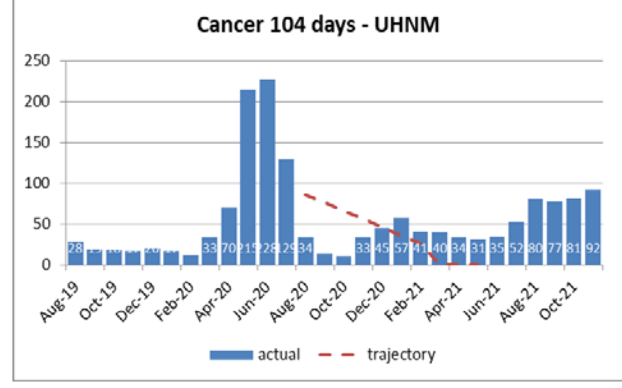
Cancer







November Provisional	Target	Trust Actual	Clock Stops	Breaches	Breaches Over	Needed Treatments
TWW Standard	93%	47.2%	3633	1919	1665	23782
TWW Breast Symptomatic	93%	11.5%	26	23	22	303
31 Day First	96%	85.3%	190	28	21	510
31 Day Subsequent Anti Cancer Drugs (in	98%	95.8%	24	1	1	27
31 Day Subsequent Surgery	94%	80.6%	31	6	5	69
31 Day Subsequent Radiotherapy	94%	95.1%	82	4	Achieved!	Achieved!
62 Day Standard	85%	50.6%	118.5	58.5	41	272.5
Rare Cancers - 31 Day RTT pathway	85%	75.0%	4	1	1	3
62 Day Screening	90%	61.9%	21	8	6	60
28 Day FDS Standard	75%	66.4%	2108	708	182	725
62 Day Consultant Upgrade	93%	79.1%	43	9	6	86
Closed Pathways > 104 Day			20			



Planned care - *Inpatients*

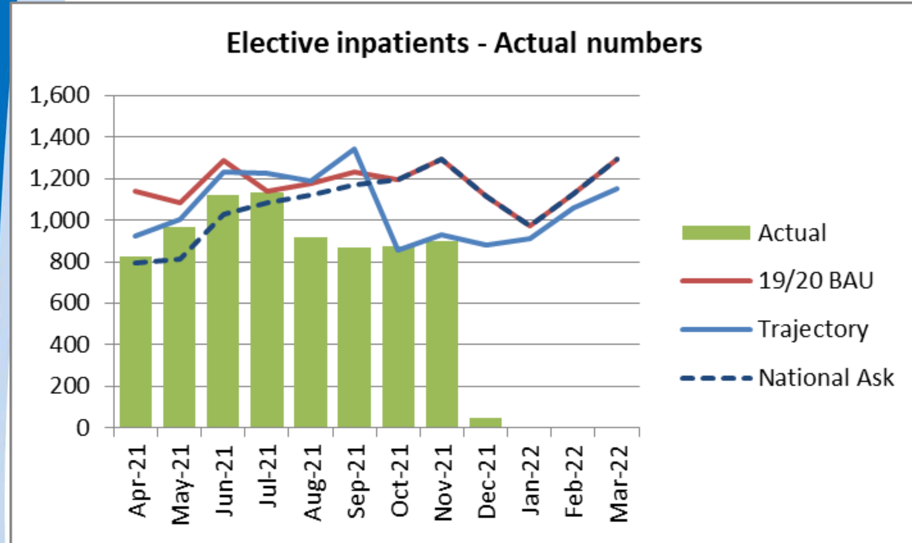
Elective inpatients Summary

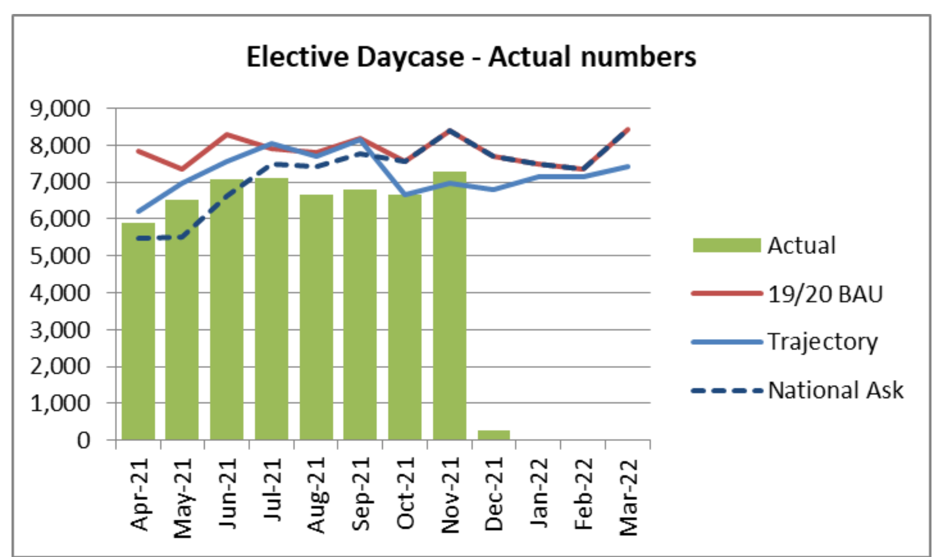
- For November the total inpatient actuals against BAU was 84%. This is lower in Inpatients than Day case (70% IP, 87% DC).
- In sourcing arrangements at week ends continue to keep patient treatment volumes buoyant.
- CCG offer of Spire for additional capacity being reviewed and patients going via CCG Choose and Book Service.
- Nuffield continue to treat but outcomes slow which impacts on our in month activity volumes (particularly impactful on T&O)
- Ramsay continue to treat patients to contact but again their admin processes are impacting on our numbers reported.
- Ramsay endoscopy pathways have slowed in terms of treatments and the service has been challenged about capacity and likely outputs as some of our long waiters are not being treated. CCG are supporting with challenging conversations.
- Referral Hub being scoped and offer expected from the in sourcing company within the next 2 weeks.
- UHNM working with the Deloitte team to understand capacity across the region and how best to optimise.

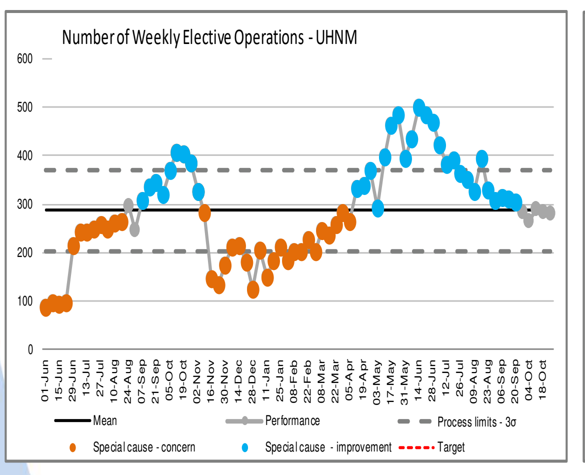
Actions

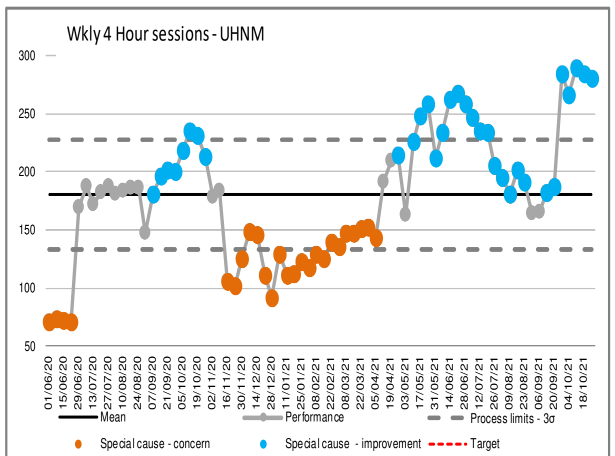
- Progressing resource plan to support increased validation and contacting patients for Q4.
- Progressing with transferring additional patients to the IS on the back of Deloitte or own internal reviews of capacity.
- Elective Storyboard and Slide set being finalised that covers off internal and external performance measures for assurance of a consistent approach to tracking activity linked to performance.
- Theatres drafting their Q4 capacity plans for Divisions to be able to book patients into – this is to be balance against NHSEI request to prepare for a further covid surge.
- Training continues on RTT for new staff and where post validation has found incorrect actioning of pathway for staff to be retrained.

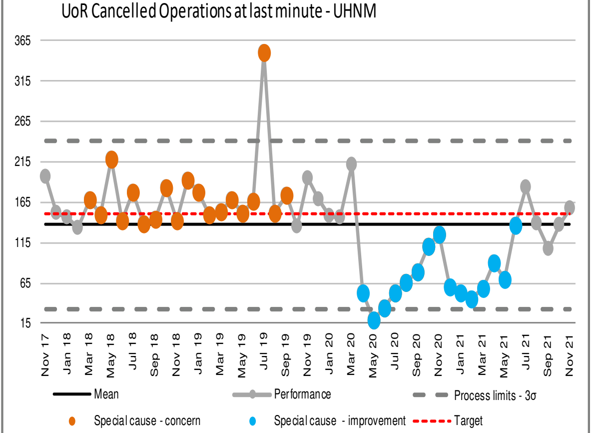
Planned care – *Inpatient Activity*











Planned care - *Outpatients*

Summary

- For November (as at 29/11) , the total outpatient actuals against BAU for outpatients was 97%. This is higher in follow ups than new (89% New, 102% follow up).
- Nov update - For outpatient appointments (appointment type) the Trust delivered **71.5%** F2F and **28.5%** non F2F(Telephone & Video). For new appointment types F2F was **73.3%** & non F2F **26.7%** & follow ups F2F **70.5%** & non F2f **29.5%**
- OP Cell A3 work has helped to define current overall waiting list position by category; vs pre covid increase of 15,000 (6.5%) to 250,000, and increase in those >52 weeks (vs Review Date) by 7,800 (200%) to c.12,000 (half of increase attributable to use of Review Date). As at 28/11/2021, total WL has increased further to 260,000. Recent increases in waiting list attributed to 2 categories; New & Follow Up Non-18 weeks. Specialty breakdown shared.
- Reduction from 11,631 (end of June) to 10,010 (25th July) in >52 week patients (14%). Further reduction to 9,184 as at 5th September (21% vs end of June). Up to 9,669 as at 28th Nov; has been at a similar level for several weeks.

RTT

- The overall Referral To Treatment (RTT) Waiting list continues to rise. For November the indicative number of Incomplete pathways has risen to 69204 (October 68,054).
- The number of patients > 18 weeks has risen to a level of 29,072 (October 28,252).
- The numbers of 52 week waits in November has increased with a reported 4,046 (October 3,870) this figure is below trajectory.
- At the end of November the numbers of > 104 weeks reported were 337. The Planned Care group is monitoring progress against treatment plans for these patients.
- Performance however, was similar to that of the previous month at 58.0% (October 58.5%).

Planned care - *Outpatients*

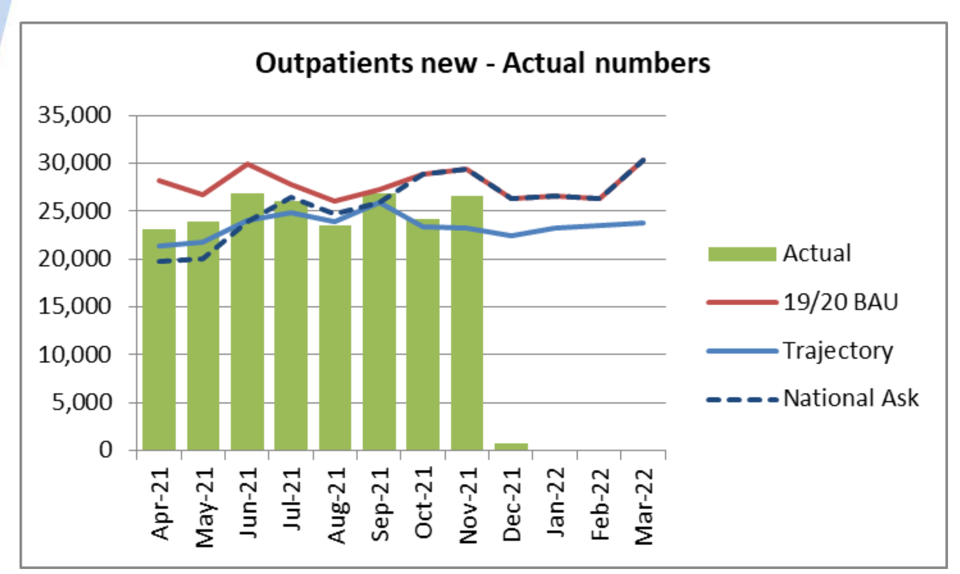
Actions

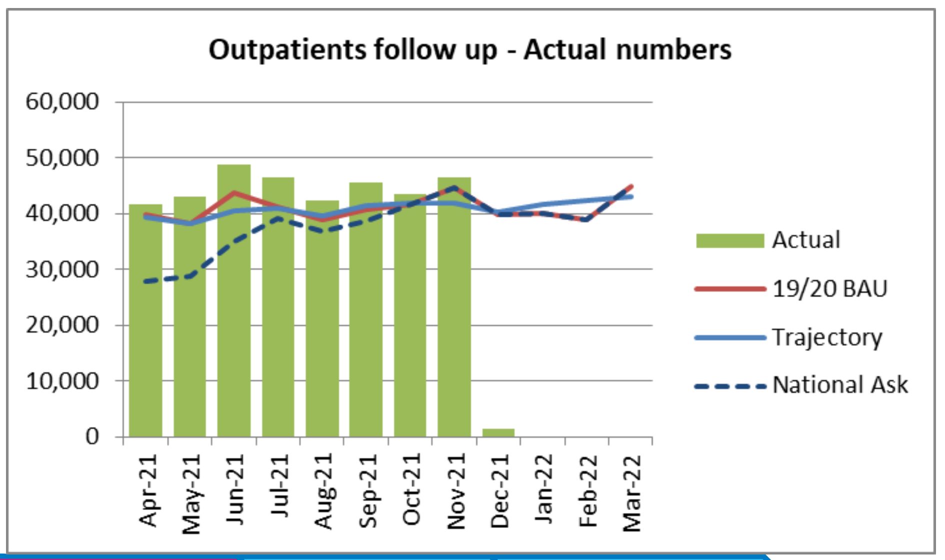
- Key actions identified around Divisional Waiting List Management with a focus on validation, data quality and >52 weeks patients. Clear reporting now in place to support this approach. Neurology, Cardiology & Ophthalmology have fed back from their Divisional A3s relating to follow up backlog plans. Divisions have fed back details of their plans relating to OP New Waits >16 weeks & >52 week patients.
- ASI performance reports actively monitored (with live reporting now available); assurances around triage processes and clinical prioritisation of new patients provided from Divisions.
- Outpatient Service Delivery & Performance workstream delivering vs. plans for Partial Booking Rollout, Netcall Rollout, CAF Issues Action Plan, and OP Clinic Process vs. Maturity model. Real time Room utilisation feedback being trialled. Session flags updated to support utilisation monitoring. Review Date training prioritised; Review Date DQ Alert circulated & Quick Reference Guides created, plus floor walking support. Wider training plan being developed including e-learning plans and embedded SME. Ongoing input into Trust training considerations (systems & processes), with links to DQ group.
- Enhanced Advice & Guidance sub workstream (linking with system). Meetings held with specialties (with clinical & managerial representation) discussing associated specialty data packs, to confirm the initial 6 specialties. Task & Finish Groups now underway for Urology, Neurology, Respiratory and Gastroenterology to take actions forward to increase A&G, develop pathways FAQs etc. GP/Practice data re variation of the use of A&G shared. CCG meeting with Teams relating to targeted specialties, to encourage use of A&G
- PIFU sub-workstream rolling out vs plan. Patients now added to pain, respiratory and cardiology pathways, plus established self-managed cancer pathways. Interest from other specialties incl. T&O, gastro, haem, neurology, derm, plastics. Fortnightly PIFU Implementation Group supporting a rapid initial rollout to 4 specialties, remit now extended to incorporate additional specialties, plus weekly project catchup. Specialty meetings held/scheduled to extend usage. Meeting arranged with UHDB to understand approach. PIFU System Progress Meeting held with NHSE, positive feedback for approach, presented at regional Midlands PIFU Meeting at request of NHSE. Links maintained with NHSE.
- Submissions to Elective Recovery Fund in place for A&G & PIFU. Consultant Connect data is included and confirmed, community RAS data now included and backdated. Method of recording of PIFU removals/conversions still to be determined; meeting held with Sherwood Forest (who use Medway) to understand their approach. Exploring options of PIFU flag, alongside plan to test measures for established self-managed cancer pathways to see if possible in principle.
- Virtual Care 25%; SUS submission 'fix' implemented from Nov 2021 (with BI) whilst longer term alignment of clinic booking and media type outcome continues.

Risks:

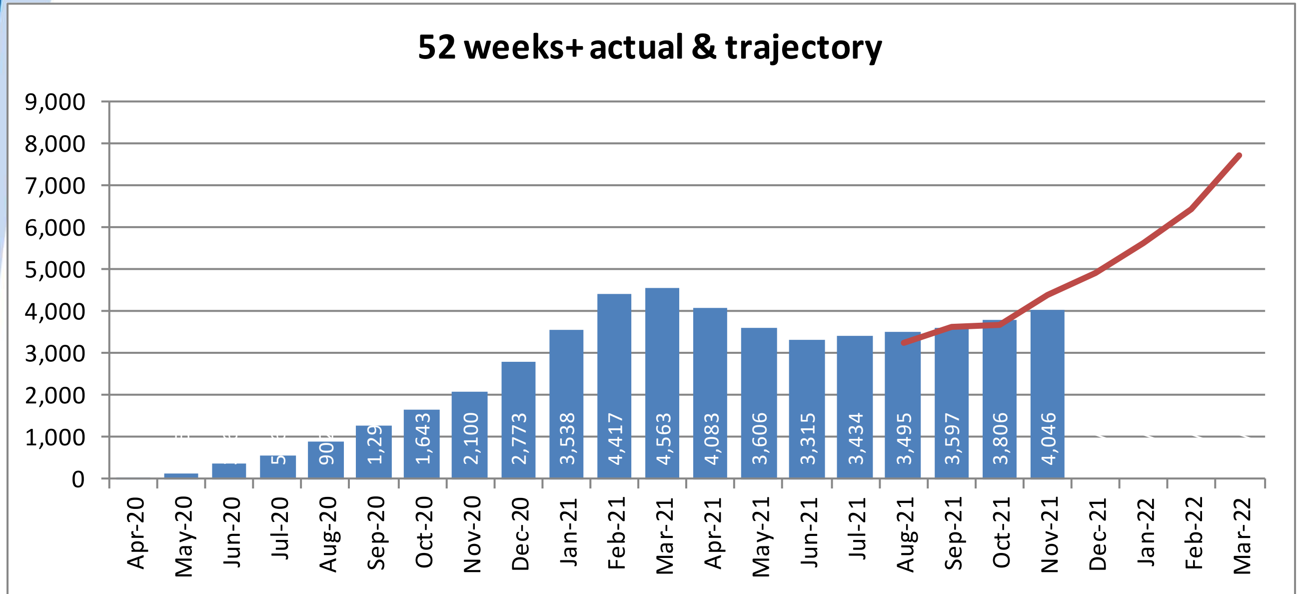
- Deteriorated waiting list position vs pre-covid; volume of patients requiring DQ and clinical validation very challenging, raised on Divisional Risk Registers.
- Need to increase FTF activity in some OP areas, restricted by social distancing, 1m+ plans discussed, subject to approval.
- Elective Care Fund Gateway 3 met; however virtual care flagged as not achieving 25% NFTF using SUS data, whilst achieving consistently using media type outcome (used by Model Health System & other NHSE benchmarking). BI fix applied from November.
- PIFU H2 end target of 2% of all outpatient activity moved or discharged to PIFU (1.5% by December). Whilst achieving rollout to initial specialties in low volumes, shortfall projected currently against this target (nationally an issue); but actions identified to extend rollout and close the gap as outlined above.
- H2 planning guidance has confirmed a target of <u>at least</u> 12% A&G requests when compared to new referrals by March 2022. For November the latest position is 16.2% (subject to validation)
- Challenge of level 4 pressures during September & October at organisation & system level.

Planned care – *Outpatient activity & RTT*

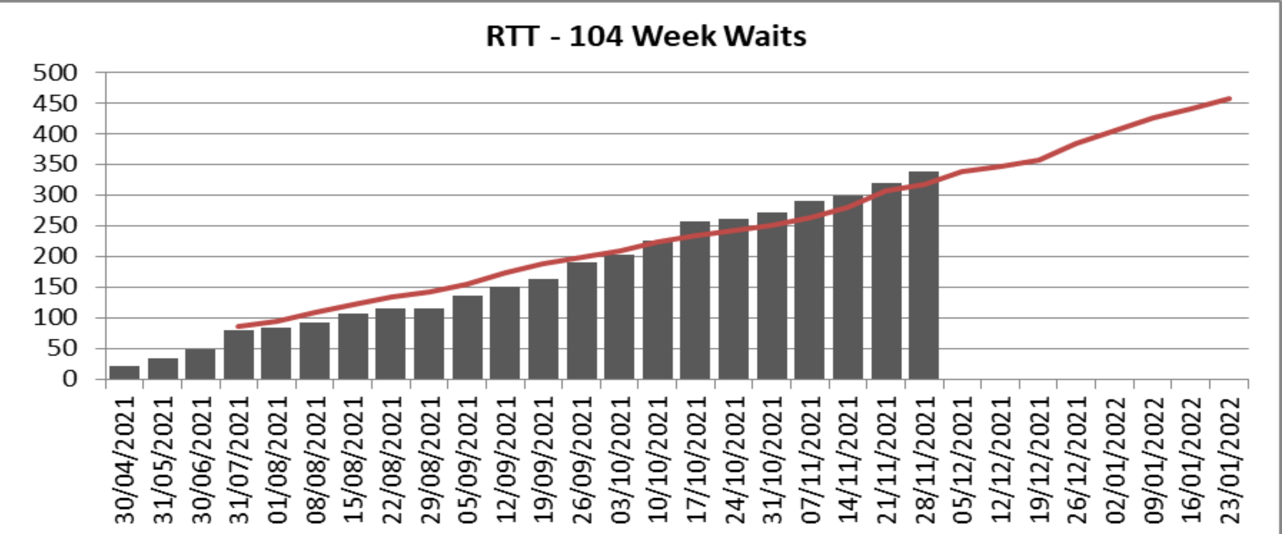




Planned care – *RTT Trajectories*

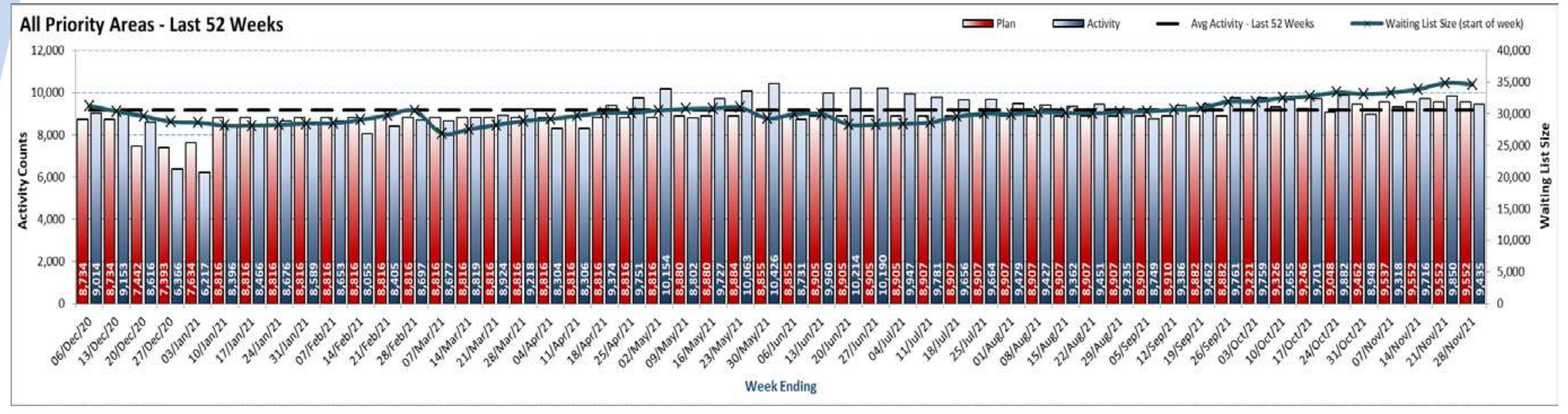


52 Week Waits are expected to increase over the next 6 months with a total of 7,721 at the end of March.



104 Week Waits are also expected to increase. Rising to a total of 452 end of March.

Diagnostic Activity



Summary

- For DM01 (15 nationally identified Dx tests) the unvalidated position for total waiting list has increased in November from 20,134 to 20,874. The Non-obstetric ultrasound waiting list reduced slightly from 10,569 to 9,935. Due to the challenges in Non-Obstetric Ultrasound this has adversely affected performance. The current DM01 diagnostic performance for November 21 is at 69% (October 68 %).
- The greatest proportion of > 6 week waits are within Non-obstetric ultrasound and endoscopy. The ultrasound position is related to an increase in demand alongside workforce shortfalls, a number of actions are in place and Non obstetric ultrasound performance is a Driver Metric for CWD and has specific focus for improvement.
- DM01 performance excluding non obs ultrasound would be c90%.
- Capacity and Demand work is being planned in the next quarter and is reliant on Information services capacity.
- Histology and Endoscopy remain high risk areas both have plans for improvement. Histology turnaround times are showing some initial signs of improvement.
- Neurophysiology service will experience a deterioration in DM01 performance in late Dec / early January due the unexpected sickness in the team and planned annual leave (with a team of only 2 consultants). This has so far resulted in 98 breaches. Skill mix is being utilised where safe to do so and locum agencies and outsourcing companies have been contacted but this has not so far been successful. Risk management is being undertaken, an update on impact will be provided next month.

Areas of Concern:

Histology turnaround times remain a concern due to the increase in demand and the deficits in consultant workforce, challenges in the laboratory and shortage in administrative staff directly related to an increase in outsourcing non urgent specimens.

Impact :

Turnaround times not to required standard for some specialties for Cancer and non-cancer

Delays in results available for MDT and / or patient treatment – delayed treatment risk.

Increase in outsourcing and locum costs

Increasing staff sickness due to workplace pressures

Mitigation:

- A remedial plan has been developed with Transformation team and Network partners. Improvements are evident – work in progress
- There are 6 Histology trainees who will qualify in the next 12 months (3 in Spring / 3 in Autumn) – recruitment timelines are being progressed

Non obstetric ultrasound increase in demand - capacity is insufficient to reduce the waiting list backlog any further

Impact:

Increase in waiting times and backlog for non urgent scans

Inability to meet DM0-1 standards

Increased stress for current staff, Poor patient experience

Delays in the scanning and return of patient reports from the Independent Sector provider

Mitigation:

Approval of funding for temporary Independent Sector Capacity – now in place – scanning c 900 patients per month

Continuing to try to source locum sonographers

Reviewing workforce plans and AFC banding in line with other Trusts

Endoscopy backlog - This is reducing and the teams have deployed capacity to significantly reduce backlogs and support urgent/cancer pathways and stabilise the elective pathways.

Impact:

- Delayed diagnosis / Treatment
- DM01 performance standard not met
- Outpatient Waiting list growth

Mitigation:

- Use of the Independent sector has been prioritised for P3 classification patients where suitable (DM01) to date 680 pts have been transferred to beacon park but remain on UHNM list as TCI dates not yet known.
- Session Utilisation at RSH and County to maximise throughput to support DM01 movement and day case lists at the week ends continue to deliver circa 165 cases each week.

Diagnostic Trajectory

DM01 Modality	Nov	Dec	Jan	Feb	Mar
Gastroscopy (Endoscopy)	60%	65%	75%	80%	85%
Respiratory Physiology (Sleep)	100%	100%	100%	100%	100%
401 Clinical Neurophysiology	100%	100%	100%	100%	100%
Urodynamics	100%	100%	100%	100%	100%
Magnetic Resonance Imaging	97%	97%	97%	97%	97%
Computed Tomography	99%	99%	99%	99%	99%
Non-obstetric ultrasound	60%	75%	85%	95%	97%
Cardiology – Echocardiography	To be confirmed by mid Dec				
Cardiology – Electrophysiology	To be confirmed by mid Dec				
Flexible sigmoidoscopy	To be confirmed by mid Dec				
Cystoscopy	To be confirmed by mid Dec				

- DM01 trajectory based on modality

APPENDIX 1

Operational Performance

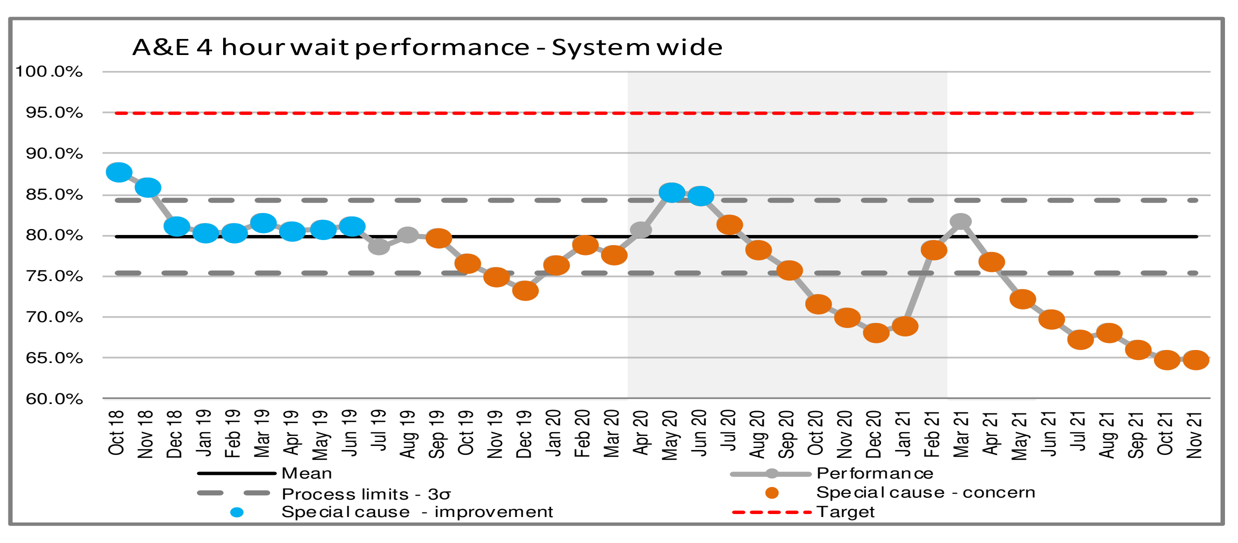
Quality Operati

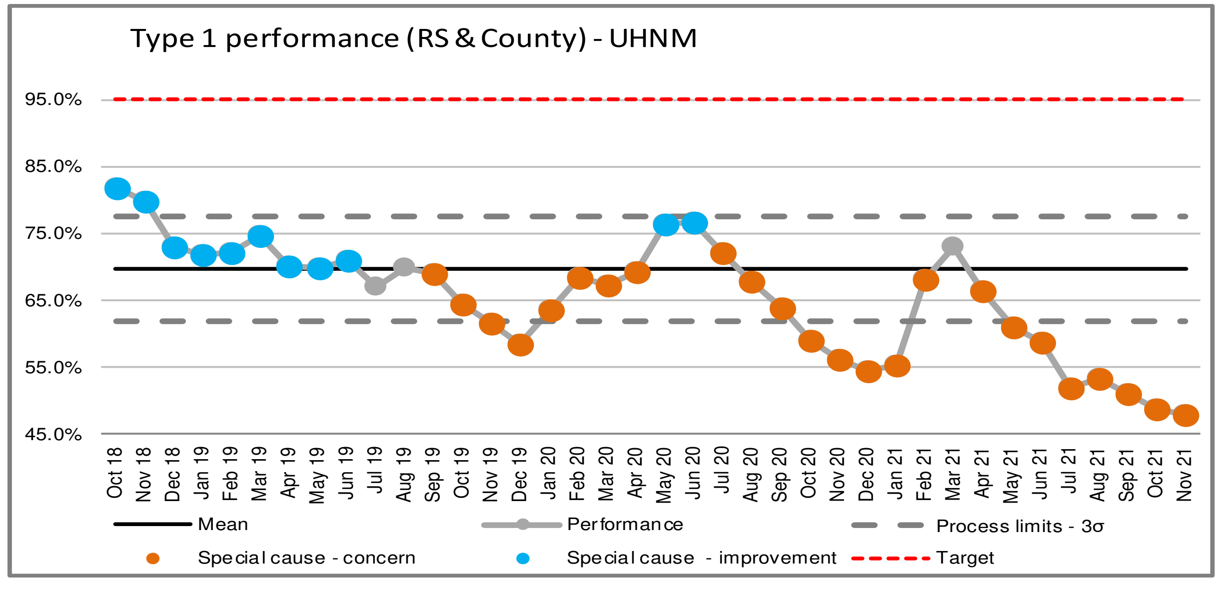
Constitutional standards

	Metric	Target	Latest	Variation	Assurance	DQAI
A&E	A&E 4 hour wait Performance	95%	64.80%	L	F	
	12 Hour Trolley waits	0	372	H	?	
Cancer Care	Cancer Rapid Access (2 week wait)	93%	47.18%	L	?	
	Cancer 62 GP ref	85%	50.63%	L	?	
	Cancer 62 day Screening	90%	61.90%		?	
	31 day First Treatment	96%	85.26%	L	?	
Elective waits	RTT incomplete performance	92%	57.99%	L	F	
	RTT 52+ week waits	0	4046	H	F	
	Diagnostics	99%	68.14%	L	F	

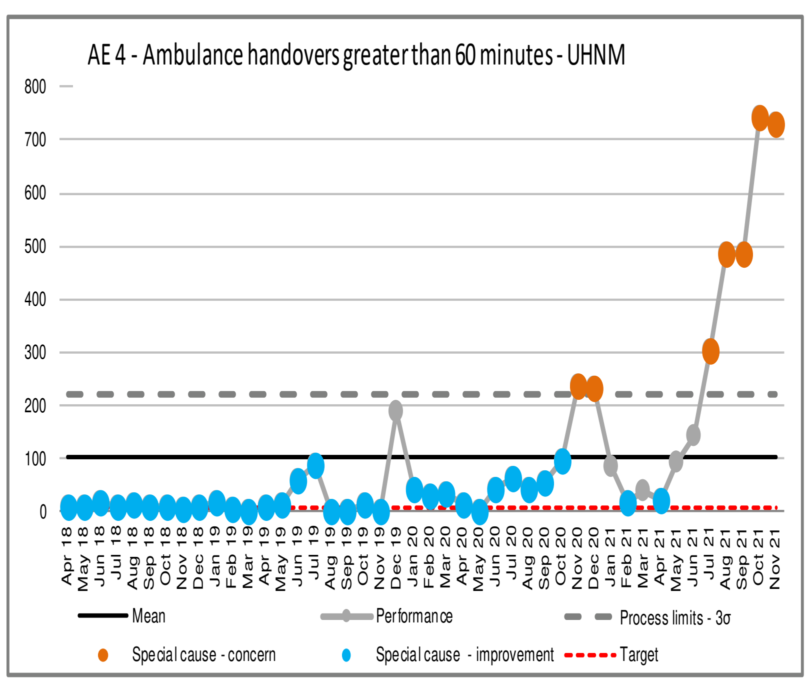
	Metric	Target	Latest	Variation	Assurance	DQAI
Use of Resources	DNA rate	7%	7.3%		?	
	Cancelled Ops	150	158		?	
	Theatre Utilisation	85%	76.0%			
Inpatient / Discharge	Same Day Emergency Care	30%	30.1%	H	?	
	Super Stranded	183	205	H	P	
	DToC	3.5%	3.40%		?	
	Discharges before Midday	30%	20.2%		F	
	Emergency Readmission rate	8%	11.8%	L	F	
	Ambulance Handover delays in excess of 60 minutes	10	729	H	?	

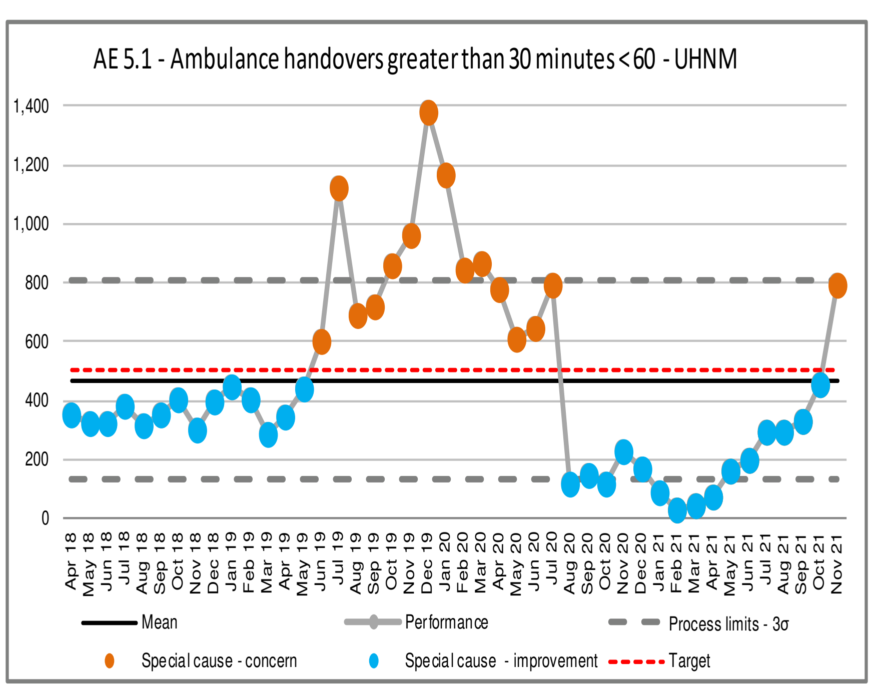
URGENT CARE – 4 hour access performance





URGENT CARE – 4 hour access – ambulance handovers

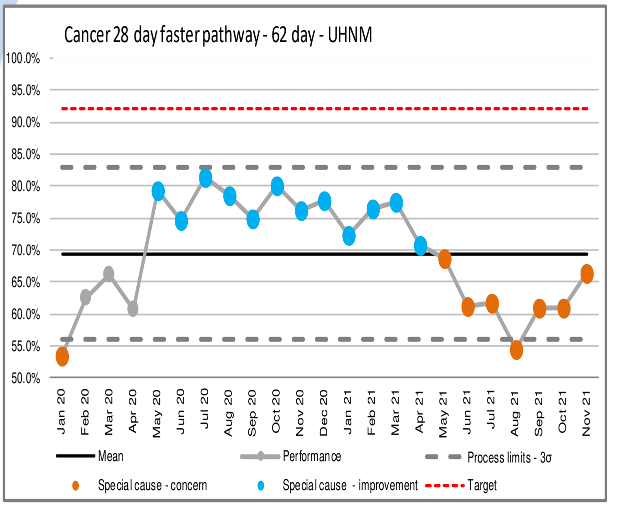


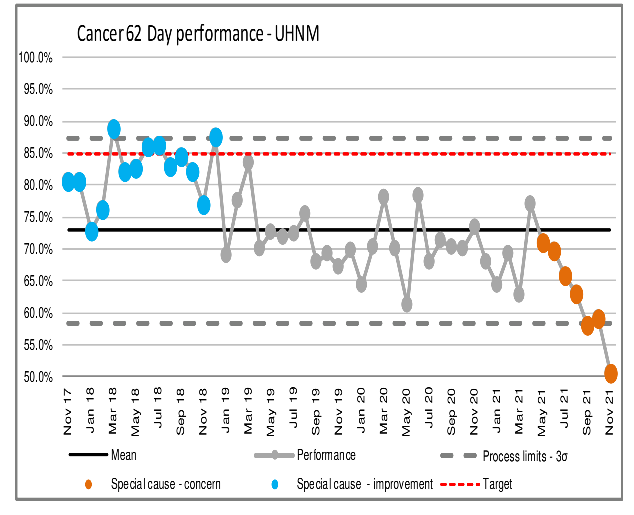


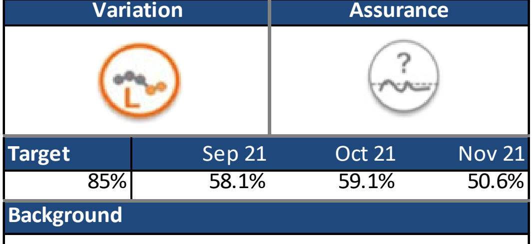
From August – internal validation of > 30 minutes

Quality | Operational | Workforce | Finance

Cancer – 62 Day







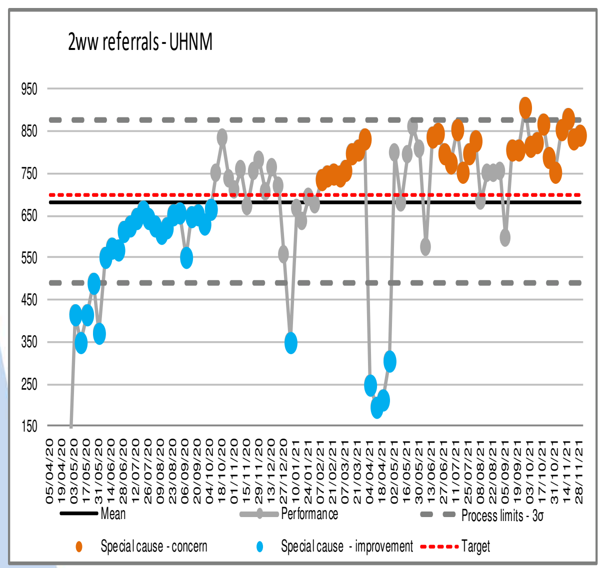
Target	Sep 21	Oct 21	Nov 21
85%	58.1%	59.1%	50.6%

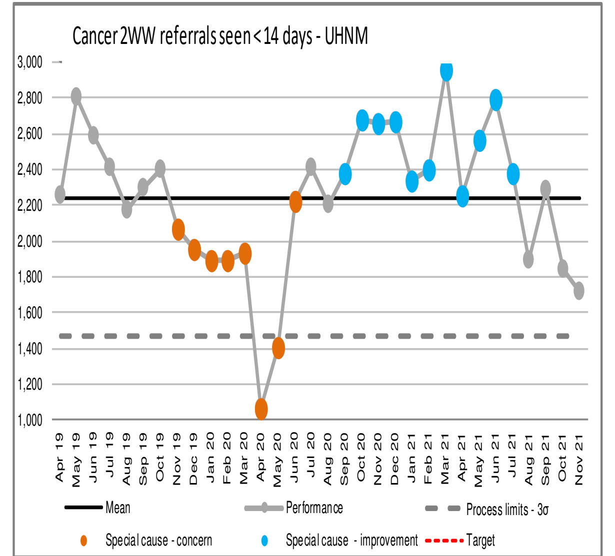
Background

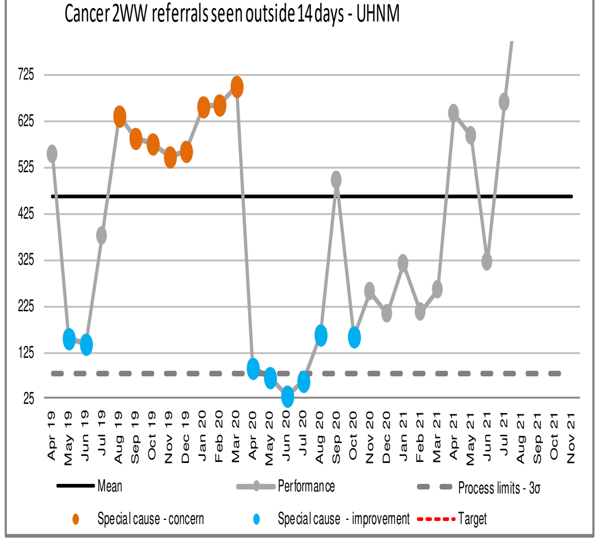
% patients beginning their treatment for cancer within 62 days following an urgent GP referral for suspected cancer

What is the data telling us?

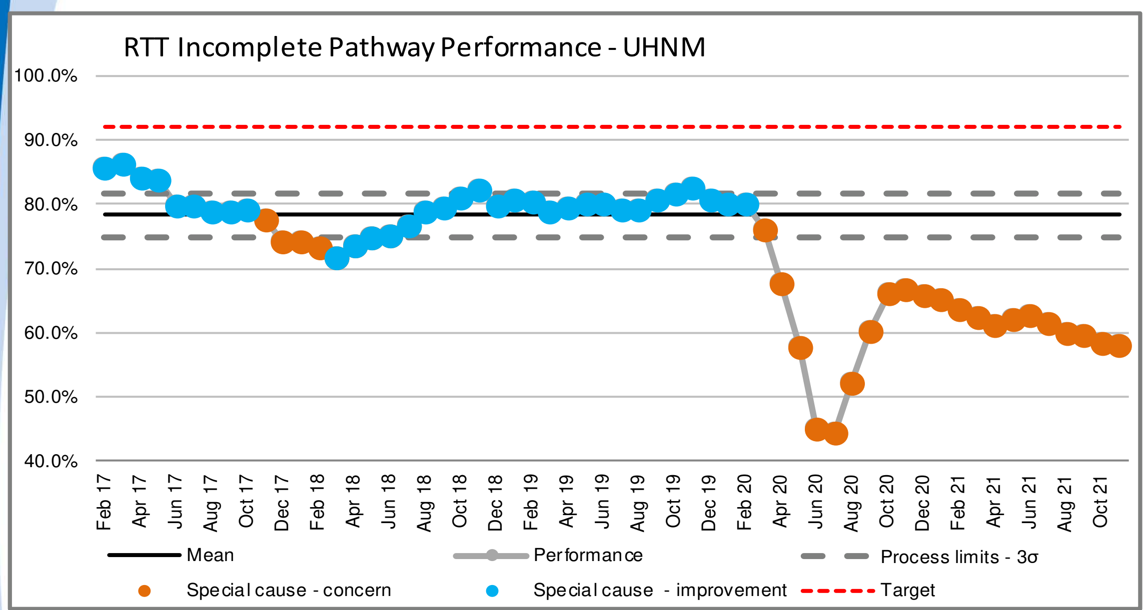
Apart from three occasions the standard has been below the mean since Sept-19.







Referral To Treatment



Variation	Assurance

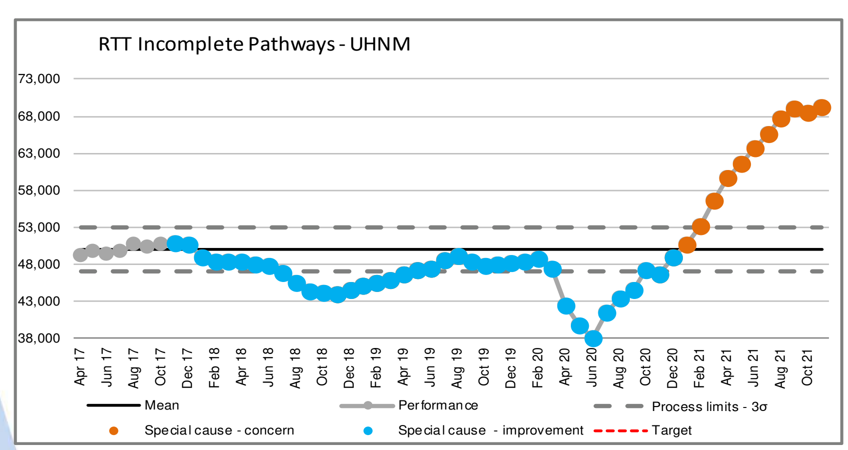
Target	Sep 21	Oct 21	Nov 21
92%	59.8%	58.6%	58.0%

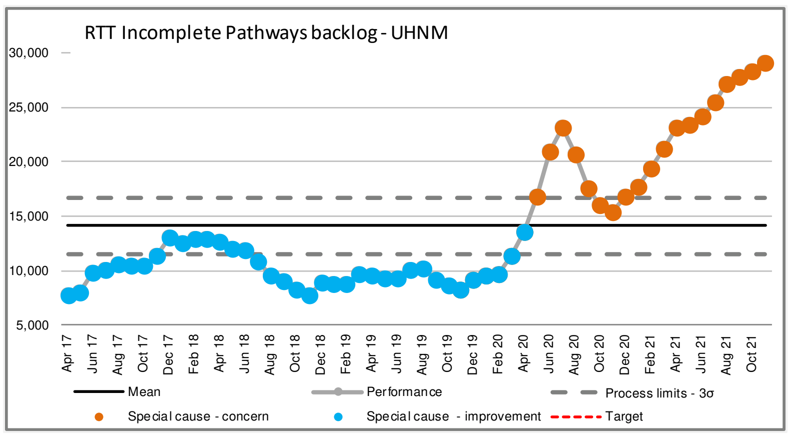
Background

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

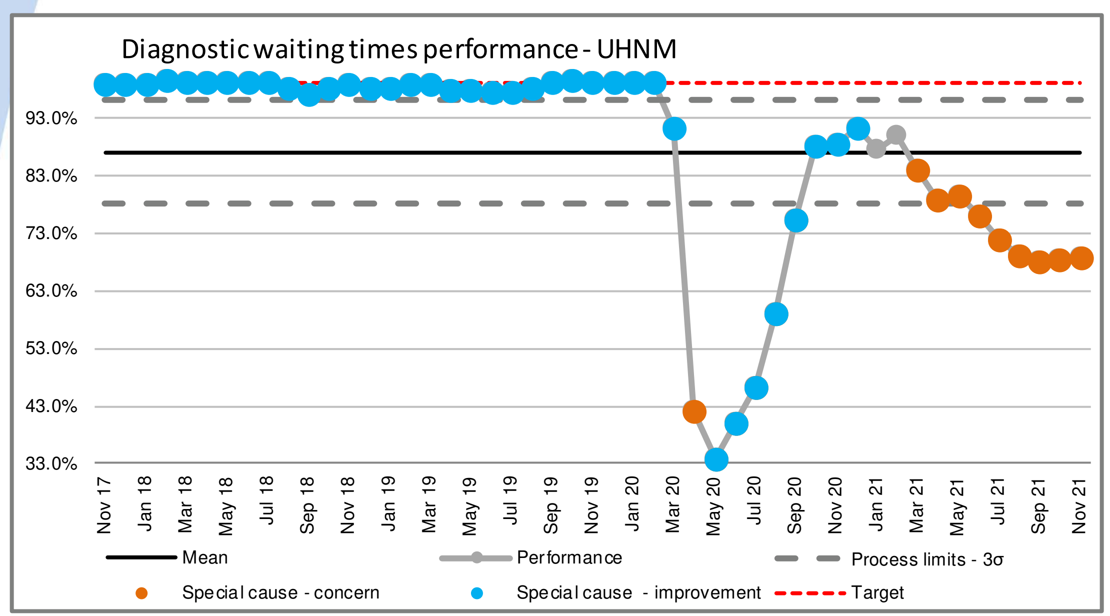
What is the data telling us?

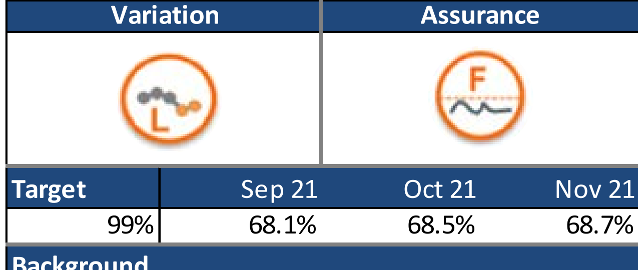
Recovery of RTT performance was seen from July until a steady deterioration was seen with the second wave of the pandemic. This apears to have plateaued.





Diagnostic Standards





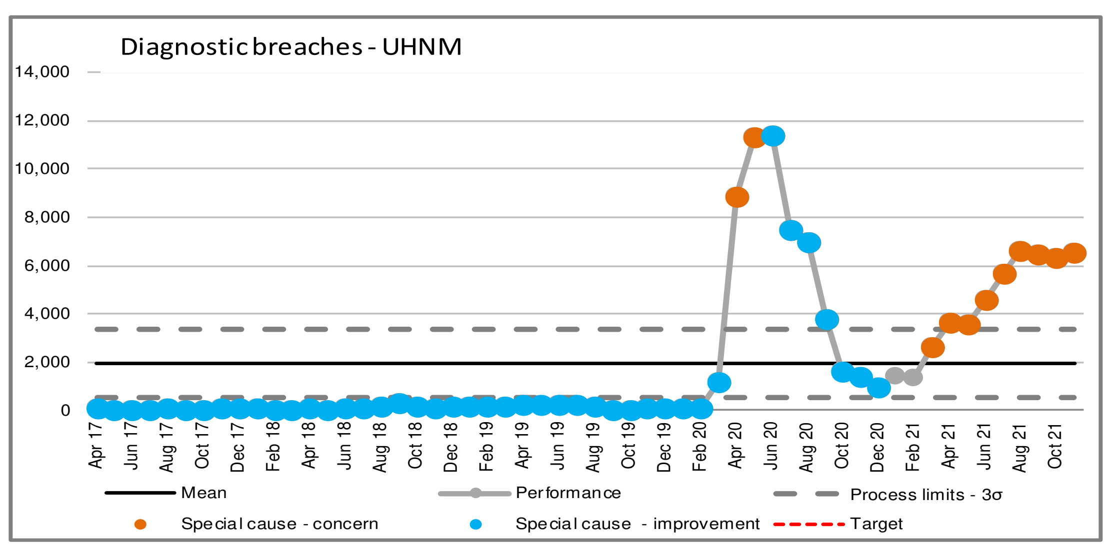
Target	Sep 21	Oct 21	Nov 21
99%	68.1%	68.5%	68.7%

Background

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

What is the data telling us?

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



APPENDIX 2

UEC Standards - National proposal

Quality Operati

Introduction

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

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

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

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

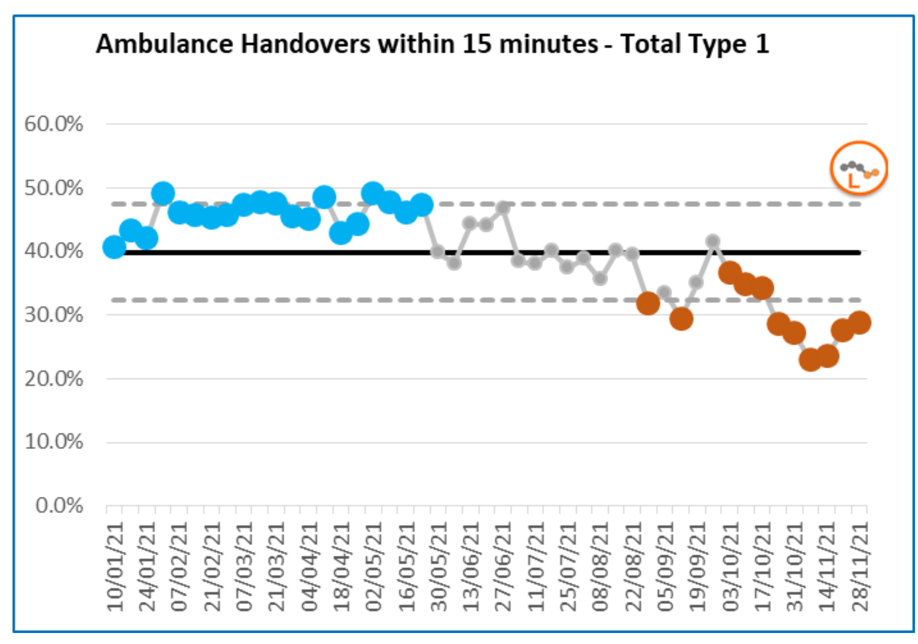
Governance

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

Assessment

Ambulance Handover Times	Ambulance handovers have steady deteriorated since the beginning of June.
Initial Assessment within 15 minutes	The proportion of patients waiting under 15 minutes for their initial assessment has continued to fall from the end of April. This was consistently below the lower control limit This was more notable in the non-ambulance assessments.
Mean time in the department	Both Admitted and non admitted mean times in department increased through September
Patients spending more than 12 hours in department	The number of patients spending over 12 hours in the department rose in September.

2. Percentage of Ambulance Handovers within 15 minutes



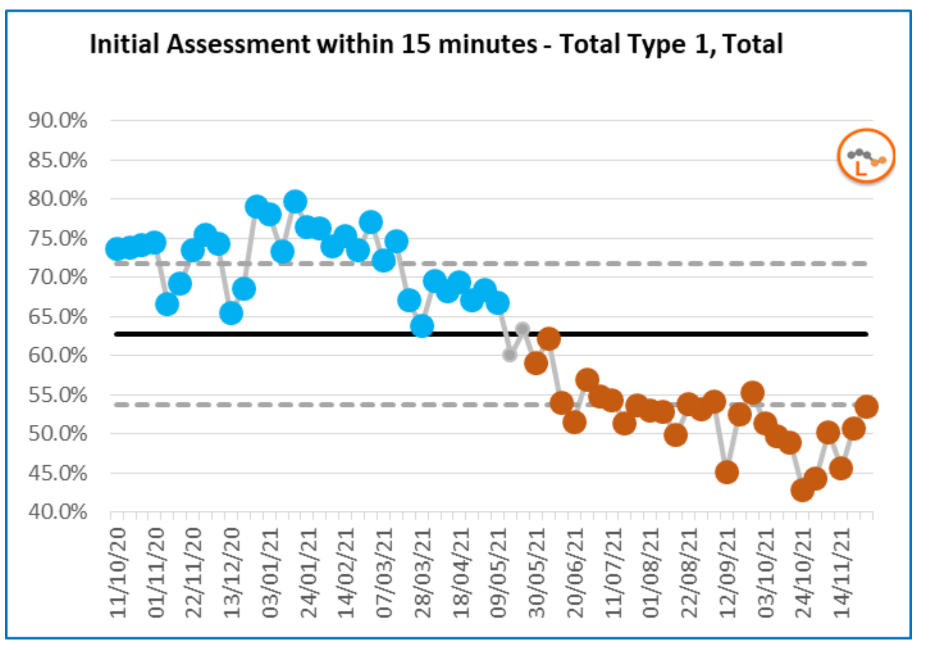
Internal collection of data for Ambulance handovers within 15 minutes began at the beginning of January 21. This is the time taken for the ambulance service to hand over the care to the ED.
N.B. this is un-validated performance and also includes handover time related to direct ambulance conveyance to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

For total ambulance handovers at UHNM in November, the percentage within 15 minutes remained below the lower control limit of 34%. A local UHNM target of 48% has been set as the goal to improve to as part of the NEL Improvement programme.

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

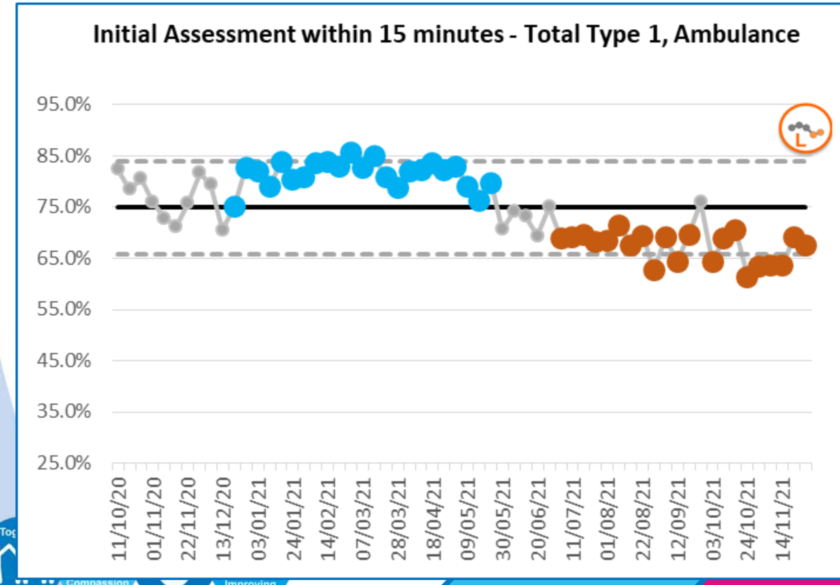
Quality | Operational | Workforce | Finance

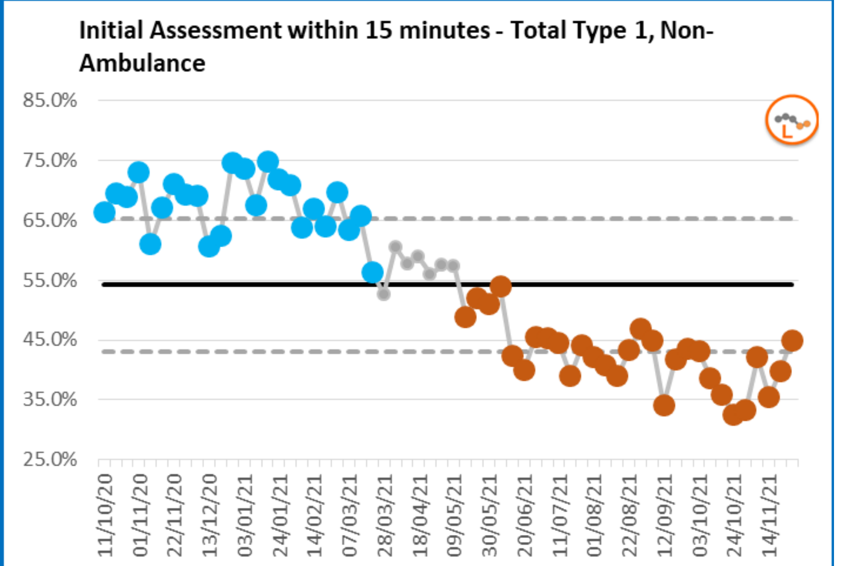
3. Time To Initial Assessment – percentage within 15 minutes



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

The total proportion of patients waiting under 15 minutes for their initial assessment continues to remain below the lower control limit but early signs of improvement emerging.
A local UHNM improvement target of 85% has been set.





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

Mean minutes in Department - Total Type 1, Non-Admitted

350
300
250
200
150
100
50
0

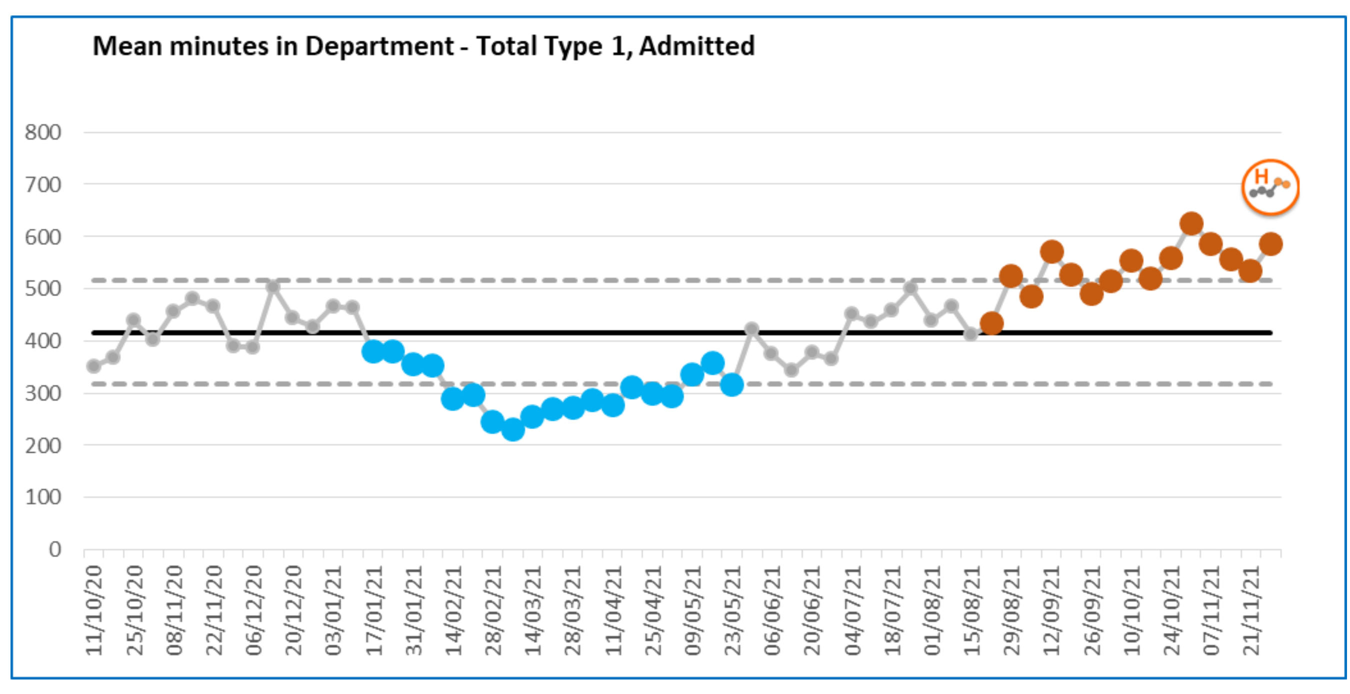
11/10/20 25/10/20 08/11/20 22/11/20 06/12/20 20/12/20 03/01/21 17/01/21 31/01/21 14/02/21 28/02/21 14/03/21 28/03/21 11/04/21 25/04/21 09/05/21 23/05/21 06/06/21 20/06/21 04/07/21 18/07/21 01/08/21 15/08/21 29/08/21 12/09/21 26/09/21 10/10/21 24/10/21 07/11/21 21/11/21

H

The mean time in the department through November remained above the mean and was for one week the highest seen. On average over the month this was 260mins.

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

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



The mean time in the department for admitted patients continued to be above the control limit of 514 minutes

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

6. Patients spending more than 12 hours in the department

Patients spending over 12 hours in Department - Total Type 1

The number of patients spending over 12 hours in the department remained high all weeks remaining above the upper control limit of 378.

Quality | Operational | Workforce | Finance

Workforce

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

Workforce Spotlight Report

Key messages

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

Sickness

The in-month sickness rate was 5.57% (5.66% reported at 31/10/21). The 12 month cumulative rate decreased to 5.27% (5.33% at 31/10/21)

The Wellbeing Plan is being reviewed as per NHSE&I requirements in their Planning for Winter letter dated 13/12/21. The letter has asked Trusts to ensure Wellbeing Plans have kept pace with the changing nature of the pandemic, with a continued focus on on-going health and wellbeing conversations.

Divisions are taking action to address sickness absence via the Improving Together Programme.

The daily sitreps show that the number of open absences has been increasing steadily from 6th December and, as of 17th December 2021, covid-related open absences* numbered 279 which was 29% of all open absences (compared to 166 covid-related absences on 6th December) [**includes absences resulting from adhering to isolation requirements*]

In line with Government policy we are now working with colleagues across to the Trust to implement the mandated vaccination programme for all staff who work in clinical areas

Appraisals

The Non-Medical PDR compliance rate was 75.80% at 30th November 2021, which is a slight improvement from the position at 31st October 2021 (75.21%).

Surgical, Specialised and CWD Divisions have PDRs as one of their driver metrics and are pulling plans together to improve

Corporately, we continue to consider ways to streamline the process and ensure that managers have reasonable spans of control

Statutory and Mandatory Training

The Statutory and Mandatory training rate at 30th November 2021 was 95.47% (95.38% at 31 October 2021. This compliance rate is for the 6 'Core for All' subjects only. At 30th November 2021, 91.39% of staff had completed all 6 Core for All modules (91.24% at 31/10/21)

Vacancies

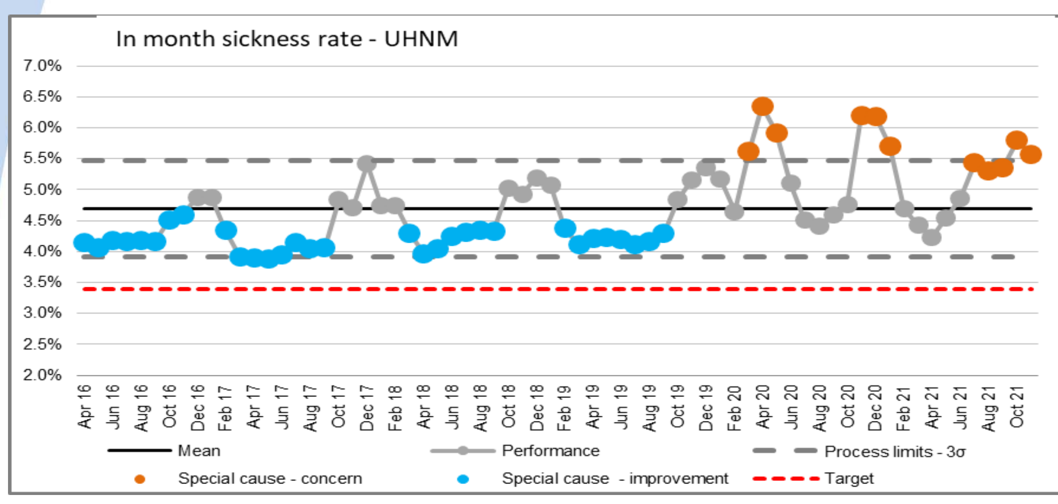
The overall Trust vacancy rate was 10.5% as a result of a small uplift in budgeted establishment to account for Winter planning.

- In accordance with the requirements et out in the NHSEI letter 'Planning for Winter', dated 13/12/21, the Trust will be looking at how to accelerate recruitment plans where possible, including for healthcare support workers
- A business case is being progressed for the International Recruitment of a further 100 registered nurses for 2022/23

Workforce Dashboard

Metric	Target	Latest	Variation	Assurance
Staff Sickness	3.4%	5.57%	H	F
Staff Turnover	11%	9.33%		P
Statutory and Mandatory Training rate	95%	95.47%	H	F
Appraisal rate	95%	75.80%	L	F
Agency Cost	N/A	3.74%		P

Sickness Absence



Variation		Assurance	
H		F	
Target	**Sep 21**	**Oct 21**	**Nov 21**
3.4%	5.4%	5.8%	5.6%

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 in-month sickness rate decreased in November 2021

Summary

The in-month sickness rate was 5.57% (5.66% reported at 31/10/21). The 12 month cumulative rate decreased to 5.27% (5.33% at 31/10/21).
However, the daily sickness sitreps indicate that sickness rates will increase during December 2021.

- The daily sickness sitreps show that the number of open absences has been increasing steadily from 6th December 2021.
- As of 17th December 2021, covid-related open absences* numbered 279 which was 29% of all open absences (compared to 166 covid-related absences on 6th December)

[**includes absences resulting from adhering to isolation requirements*]

In line with Government policy we are now working with colleagues across to the Trust to implement the mandated vaccination programme for all staff who work in clinical areas

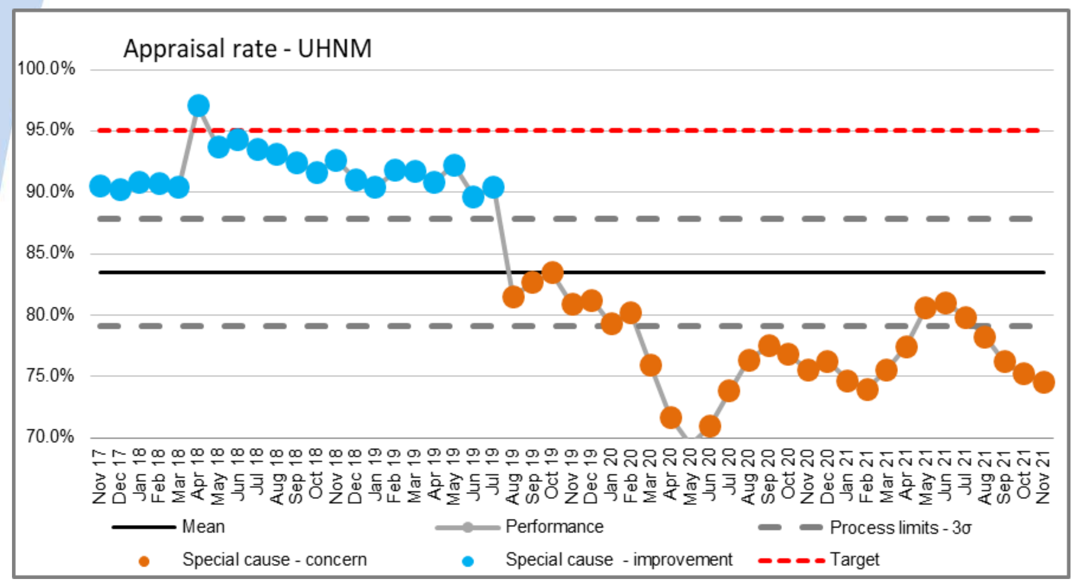
Actions

The Wellbeing Plan is being reviewed as per NHSE&I requirements in their Planning for Winter letter dated 13/12/21. The letter has asked Trusts to ensure Wellbeing Plans have kept pace with the changing nature of the pandemic, with a continued focus on on-going health and wellbeing conversations.

Actions being taken by the Divisions to address sickness absence include:

- Absence management assurance meetings continue to taking place with Directorates to obtain assurance on the management of long term and frequent absences.
- Specific interventions and focused work with line managers in the areas of concern and with further training in the use of Empactis provided as necessary

Appraisal (PDR)



Variation	Assurance
L	F

Target	Sep 21	Oct 21	Nov 21
95.0%	76.2%	75.2%	75.8%

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%.

The PDR rate has deteriorated since July 2019.

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

Summary

The Non-Medical PDR compliance rate was 75.80% at 30th November 2021, which is a slight improvement on the position at 31st October 2021 (75.21%) although performance remains below target.

Surgical, Specialised and CWD Divisions have PDRs as one of their driver metrics and are pulling plans together to improve.

Both Specialised and Surgical Divisions saw an improvement between 30 October and 31st November. CWD and Medicine Divisions position deteriorated.

Actions

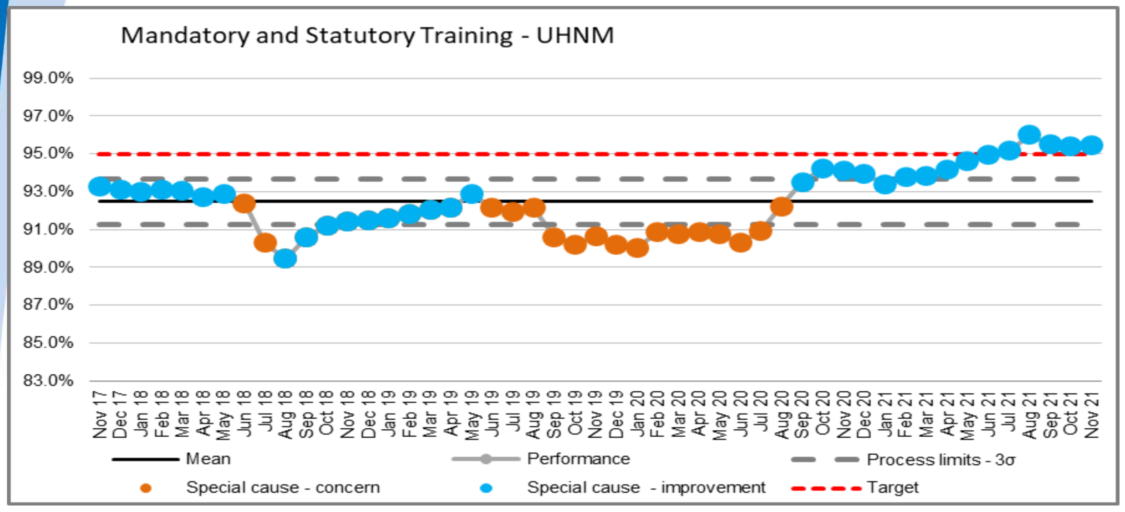
Performance against the workforce kpi's is managed via the performance review meetings.

Surgical, Specialised and CWD Divisions have PDRs as a driver metrics and are pulling plans together to improve. The Divisions are looking at

- Setting and monitoring trajectories
- Setting group goals and objectives for some teams where there is the same role and a shared common aim, whilst ensuring that individual development needs are captured
- Ensuring quality within the PDR process by having Wellbeing as the first subject of conversation

Corporately, we continue to consider ways to streamline the process and ensure that managers have reasonable spans of control

Statutory and Mandatory Training



Variation	Assurance
H	F

Target	Sep 21	Oct 21	Nov 21
95.0%	95.5%	95.4%	95.5%

Background

Training compliance

What is the data telling us?

At 95.47%, the Statutory and Mandatory Training rate is better than the Trust target for the core training modules

Summary

The Statutory and Mandatory training rate at 30th November 2021 was 95.47% (95.38% at 31 October 2021. This compliance rate is for the 6 'Core for All' subjects only.

At 30th November 2021, 91.39% of staff had completed all 6 Core for All modules (91.24% at 31/10/21)

Competence Name	Assignment Count	Required	Achieved	Compliance %
205|MAND|Security Awareness - 3 Years|	10622	10622	10090	94.99%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	10622	10622	10156	95.61%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	10622	10622	10105	95.13%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	10622	10622	10142	95.48%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	10622	10622	10139	95.45%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	10622	10622	10211	96.13%

Compliance rates for the Annual competence requirements were as follows:

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 1 Year|	10622	10622	9120	85.86%
NHS|CSTF|Information Governance and Data Security - 1 Year|	10622	10622	9423	88.71%

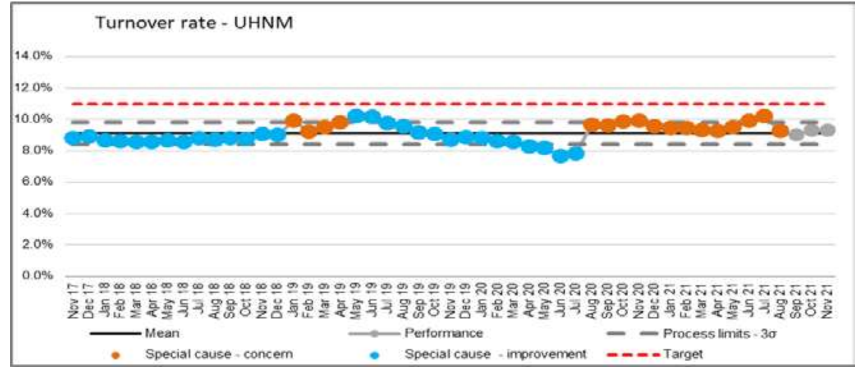
Actions

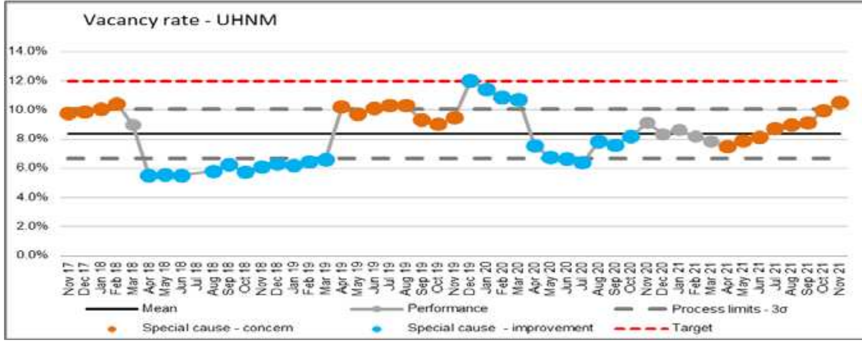
We continue to raise the issue of compliance with Divisions and communicate to staff the need to complete statutory and mandatory training.

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

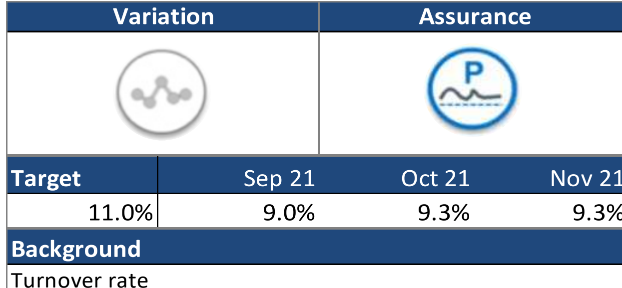
Workforce Turnover

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





The overall Trust vacancy rate is calculated as Budgeted Establishment less staff in post.



Target	Sep 21	Oct 21	Nov 21
11.0%	9.0%	9.3%	9.3%

Background

Turnover rate

What is the data telling us?

The special cause variation in the Turnover rate from August 2020 was a result of the B3 Student Nurses, who had supported the Trust throughout the first wave of covid-19, returning to University. The 12m rolling turnover rate remains below the target 11%

Actions

In accordance with the requirements et out in the NHSEI letter 'Planning for Winter', dated 13/12/21, the Trust will be looking at how to accelerate recruitment plans where possible, including for healthcare support workers.

A business case is being progressed to recruit a further 100 internationally recruited nurses, in 2022/23

Summary

The 12m Turnover rate was 9.33% at 30 November and the overall Trust vacancy rate was 10.5% as a result of an uplift in budgeted establishment, not a reduction in staffing.

Vacancies at 30 Nov 2021	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous month %
Medical and Dental	1,451.60	1,250.25	201.35	13.87%	13.79%
Registered Nursing	3334.01	2909.25	424.76	12.74%	13.15%
All other Staff Groups	6370.30	5824.48	545.82	8.57%	7.43%
Total	11,155.91	9,983.98	1,171.93	10.50%	9.97%

The change in the vacancy rate was a result of an increase in budgeted establishment (+69.78FTE) whereas staff in post increased by 3.46FTE, giving a net increase in vacancies of 66.32FTE

***Note 1** - the Medical and Dental staff figure in post excludes circa 75wte GPVTS staff who are employed by St Helens and Knowsley meaning the vacancy rate is over-stated and should be around 9.83%

In addition to the Recruitment pipeline, mitigations against the vacancy position include offering Additional PA's; extended / increased hours; On call payments and overtime. The Trust also uses Bank & Agency to cover gaps in staffing and, when necessary, will redeploy staff internally . Staff are also supported by our student cohorts and volunteer groups

Finance

2025 Vision “Ensure efficient use of resources”

Quality | Operational | Workforce | Finance

Finance Spotlight Report

Key messages

- The Trust set a plan at the start of the year with a H1 surplus of £8.3m and a full year deficit of £8.8m. The guidance for H2 was reviewed and the Trust set a revised breakeven plan for the financial year ending 31 March 2022. At both a National and System level an agreement was reached that the Trust was to carry forward the surplus of £14.5m delivered in H1 and therefore the planned position for H2 was a £14.5m deficit to achieve a breakeven plan for the year. Since then, the Trust has worked through the submitted activity plans and calculated an expected income of £5.1m against the Elective Recovery Fund. Therefore in November 2021, the Trust formally submitted a revised annual plan of a £5.1m surplus for the financial year ending 31 March 2022.
- The Trust has delivered an actual surplus of £0.4m in month and a year to date surplus of £16.3m resulting in a favourable variance of £6.8m against the year to date plan. The positive position in month is primarily driven by underspends against non-recurrent investment funds for both System Elective Recovery and workforce.
- The Trust incurred £1m of costs relating to COVID-19 in month which is a decrease of £0.2m compared with Month 7's figure. This remains within the Trust's fixed allocation with £0.6m being chargeable on top of this allocation for COVID-19 testing costs.
- Capital expenditure for the year to date stands at £15.9m which is £2.3m behind the plan mainly due to an underspend relating to digital pathology and estates infrastructure.
- The cash balance at Month 8 is £80.3m which is £1m higher than plan, the main reason being lower than forecast capital payments which reflects the overall slippage against the capital plan.
- An updated plan for H2 has been presented in November and at Month 9 and in line with NHSIE guidelines, a full year forecast position will be presented to the Committee.

Finance Dashboard

	Metric	Target	Latest	Variation	Assurance
I&E	TOTAL Income	variable	80.1		
	Expenditure - Pay	variable	44.0	H	?
	Expenditure - Non Pay	variable	28.5		P
Activity	Daycase/Elective Activity	variable	7,469	L	?
	Non Elective Activity	variable	9,323	L	?
	Outpatients 1st	variable	22,911	L	?
	Outpatients Follow Up	variable	41,262		?

Income & Expenditure

Income & Expenditure Summary Month 08 2021/22	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Income From Patient Activities	868.6	71.6	71.6	(0.0)	580.5	580.5	(0.1)
Other Operating Income	88.5	7.6	7.6	0.0	58.2	57.8	(0.3)
Total Income	957.1	79.2	79.2	0.0	638.7	638.3	(0.4)
Pay Expenditure	(561.4)	(47.9)	(46.0)	1.9	(368.4)	(363.0)	5.4
Non Pay Expenditure	(337.1)	(28.9)	(28.3)	0.6	(224.9)	(223.0)	1.8
Total Operational Costs	(898.5)	(76.8)	(74.3)	2.4	(593.3)	(586.1)	7.2
EBITDA	58.7	2.4	4.9	2.5	45.4	52.2	6.8
Depreciation & Amortisation	(29.9)	(2.5)	(2.5)	(0.0)	(20.0)	(20.0)	(0.0)
Interest Receivable	0.1	0.0	0.0	(0.0)	0.0	0.0	(0.0)
PDC	(7.6)	(0.6)	(0.6)	0.0	(5.1)	(5.1)	0.0
Finance Cost	(16.1)	(1.3)	(1.3)	0.0	(10.7)	(10.7)	0.0
Other Gains or Losses	0.0	0.0	0.0	0.0	0.0	0.0	(0.0)
Surplus / (Deficit)	5.1	(2.0)	0.4	2.4	9.6	16.3	6.8
Financial Recovery Fund	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	5.1	(2.0)	0.4	2.4	9.6	16.3	6.8

The Trust delivered a £0.4m surplus for Month 8 against a planned deficit of £2m and a year to date surplus position of £16.3m against a planned surplus position of £9.6m; this surplus is measured against the Trust's financial plan was submitted in November 2021 to take into account the adjustments required for H2. The main variances in month are:

- In Month 8 £0.4m was recognised in respect of ERF from previous periods; no income has been assumed in respect of ERF for Month 8 nor is there a planned figure for Month 8 as the £5.1m expected income is included within the plan in Q4. This additional income in month is offset by underperformance against the Independent Sector contract.
- Pay is underspent in month by £1.9m which is primarily driven by underspends across registered nursing and NHS infrastructure and non-recurrent funding underutilised in month for the System Elective Recovery fund and COVID-19.
- Non-pay is underspent against plan in month by £0.6m primarily due to the non-recurrent funding underutilised in month and as a result of a budget adjustment made in month for the Independent Sector contract as noted above.

Capital Spend

Capital Expenditure as at Month 8 2021/22 £m	Revised 2021/22 Plan	2021/22 year end forecast	In Month			Year to Date		
	Plan	Actual	Budget	Actual	Variance	Budget	Actual	Variance
PFI & finance lease liability repayment	(9.2)	(9.2)	(0.8)	(0.8)	-	(6.1)	(6.1)	-
Pre-committed items	(9.2)	(9.2)	(0.8)	(0.8)	-	(6.1)	(6.1)	-
PFI lifecycle and equipment replacement	(5.3)	(5.3)	(0.2)	(0.2)	-	(1.3)	(1.3)	-
PFI enabling cost	(0.8)	(0.2)	-	-	-	-	-	-
PFI related costs	(6.1)	(5.6)	(0.2)	(0.2)	-	(1.3)	(1.3)	
RI demolition	(0.9)	(1.2)	(0.2)	0.2	0.3	(1.1)	(0.7)	0.4
Project STAR multi-storey car park	(1.2)	(1.2)	-	(0.1)	(0.1)	(0.2)	(0.6)	(0.4)
Thornburrow decant office accommodation	(1.9)	(2.0)	(0.0)	(0.0)	0.0	(1.9)	(1.9)	(0.0)
Wave 4b Funding - Lower Trent Wards	(2.2)	(2.2)	(0.4)	(0.2)	0.3	(1.2)	(1.1)	0.2
CT7 scanner enabling cost	(1.2)	(0.1)	-	-	-	-	-	-
STP diagnostic Funding and Cancer funding CT7	(1.0)	(1.0)	-	-	-	-	-	-
PDC funding - elective recovery (critical care) TIF	(0.3)	(0.3)	-	-	-	-	-	-
PDC funding - elective recovery (CTS/theatre) TIF	(1.5)	(1.5)	-	-	-	-	-	-
PDC funding Cyber Security/Home working TIF	(0.3)	(0.3)	-	-	-	-	-	-
Schemes funded by PDC and Trust funding	(10.4)	(9.9)	(0.6)	(0.1)	0.4	(4.4)	(4.2)	0.2
LIMS (Laboratory Information Management System)	(0.6)	(0.6)	(0.0)	(0.0)	0.0	(0.5)	(0.3)	0.2
EPMA (Electronic Prescribing)	(0.5)	(0.5)	(0.0)	(0.0)	0.0	(0.3)	(0.3)	(0.0)
Completion of RSUH ED doors	(0.2)	(0.2)	-	-	-	(0.2)	(0.2)	0.0
Pathology integration	(0.3)	(0.3)	-	(0.1)	(0.1)	-	(0.1)	(0.1)
Medical devices fleet replacement	(0.7)	(0.7)	-	-	-	-	-	-
Schemes with costs in more than 1 financial year	(2.3)	(2.4)	(0.1)	(0.1)	(0.1)	(1.0)	(0.9)	0.1
2021/22 schemes	(14.1)	(14.8)	(0.6)	(0.4)	0.2	(5.4)	(3.3)	2.1
Balance to be allocated in updated Plan	(1.3)	(1.7)	-	-	-	-	-	-
Funds to be allocated to schemes	(1.3)	(1.7)	-	-	-	-	-	-
Donated/Charitable funds expenditure	(0.4)	(0.4)	(0.0)	(0.0)	-	(0.4)	(0.4)	-
Charity funded expenditure	(0.4)	(0.4)	(0.0)	(0.0)	-	(0.4)	(0.4)	-
Overall capital expenditure	(43.4)	(43.4)	(2.2)	(1.7)	0.6	(18.2)	(15.9)	2.3

The main variances against the Capital plan are explained below.

Works on the demolition of the RI site are £0.4m behind plan due to the identification of additional asbestos; as a result the demolition will be completed slightly later than planned and with an increase to the original budget.

Project Star multi storey car park costs are £0.4m higher than plan due to expenditure relating to additional budget being incurred earlier than expected.

Within 2021/22 schemes the main variances relate to

- Estates infrastructure expenditure which is £0.5m behind plan mainly due to delays in the Lyme building chiller replacement project, ward 122 refurbishment and the theatre lighting scheme
- Medical devices replacement which is £0.4m behind plan due to delays in the delivery of the bronchoscope and of the flow cytometer, both are due to be delivered by the end of the calendar year and the replacement programme remains on schedule however a risk has been identified in the procurement of equipment due to delays in internal information governance requirements by divisions.
- The Digital Pathology scheme is £0.7m behind plan; this scheme is a finance lease asset as part of the managed equipment scheme and will be brought on when the relevant equipment is provided to the Trust.

Balance sheet

Balance sheet as at Month 8	31/03/2021 Actual £m	30/11/2021 Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment	531.2	526.3	524.8	(1.5)	Note 1
Intangible Assets	22.8	18.9	18.6	(0.2)	
Other Non Current Assets	-	-	-	-	
Trade and other Receivables	0.5	0.5	0.5	-	
Total Non Current Assets	554.5	545.6	543.9	(1.7)	
Inventories	15.0	16.0	16.1	0.1	
Trade and other Receivables	47.4	43.0	45.8	2.8	Note 2
Cash and Cash Equivalents	55.8	79.3	80.3	1.0	Note 3
Total Current Assets	118.2	138.3	142.3	4.0	
Trade and other payables	(98.5)	(106.2)	(102.2)	4.1	Note 4
Borrowings	(8.3)	(8.3)	(8.3)	0.1	
Provisions	(3.6)	(3.6)	(3.6)	0.0	
Total Current Liabilities	(110.4)	(118.2)	(114.0)	4.1	
Borrowings	(268.5)	(262.5)	(262.6)	(0.1)	
Provisions	(2.2)	(2.2)	(2.1)	0.1	
Total Non Current Liabilities	(270.7)	(264.7)	(264.7)	(0.0)	
Total Assets Employed	291.5	301.1	307.5	6.4	
Financed By:				-	
Public Dividend Capital	637.9	637.9	637.9	0.0	
Retained Earnings	(465.3)	(455.7)	(449.1)	6.6	Note 5
Revaluation Reserve	118.9	118.9	118.7	(0.2)	
Total Taxpayers Equity	291.5	301.1	307.5	6.4	

Variances to the plan at Month 8 are explained below:

1. Property, Plant and Equipment is £1.5m lower than plan and reflects the underspend in the capital plan to Month 8. The main areas of underspend are the Digital pathology scheme £0.7m, medical equipment replacements, estates infrastructure and the expansion of the pharmacy dispensary area. This is partly offset by lower than forecast depreciation and upward revaluations to Wilfred Place and the crèche at County to reflect the sale of the land.
2. Trade and other receivables are £2.8m higher than plan. The main reasons for the variance are accrued income balances in respect of:
   - Annual leave provision at 31 March 2021
   - DHSC transitional support income for 2021/22
   - Out of envelope costs for Months 7 and 8.

   The increases are partly offset by a credit note provision for the Specialised Services block payments in relation to high cost devices where activity has not matched the income received.
3. Cash is £1.0m higher than plan at Month 8, this is mainly due to lower than planned capital payments due to slippage in the capital programme.
4. Trade and other payables are £4.1m higher than plan mainly due to higher than plan levels of deferred income. This relates to cancer funding received for cancer transformation from NHS Stoke on Trent CCG and Q3 funding received from Health Education England.
5. Retained earnings show a variance of £5.6m from plan which reflects the revenue surplus year to date.

Expenditure - Pay and Non Pay

Pay Summary Month 08 2021/22	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Medical	(170.1)	(14.2)	(14.2)	(0.1)	(112.5)	(111.6)	0.9
Registered Nursing	(163.5)	(14.2)	(13.2)	1.0	(106.0)	(103.6)	2.3
Scientific Therapeutic & Technical	(68.2)	(5.9)	(5.5)	0.4	(44.7)	(44.0)	0.8
Support to Clinical	(75.2)	(6.3)	(6.3)	(0.0)	(50.2)	(50.1)	0.1
Nhs Infrastructure Support	(84.4)	(7.3)	(6.8)	0.5	(55.0)	(53.7)	1.3
Total Pay	(561.4)	(47.9)	(46.0)	1.9	(368.4)	(363.0)	5.4

Pay –Key variances

- Within the above budget for Month 8 is £1.6m of reserves which have not been spent (split across numerous expenditure headings) with the main elements being £0.5m for the non-recurrent investment reserve primarily relating to System Elective recovery, £0.4m in respect of Specialised Commissioners and £0.3m against COVID-19.
- The underspend on registered nursing remains in line with the prior year trend as a result of the number of vacancies across the trust. Within the Month 8 budget there is £0.6m of underutilised budget in reserves (part of the £2.5m noted above) and within the Month 8 actual were total premium costs (bank and agency) of £1.4m covering existing workforce vacancies and absences.

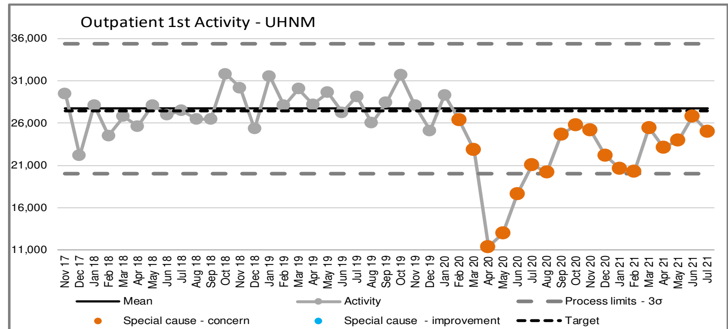
Non Pay Summary Month 08 2021/22	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Tariff Excluded Drugs Expenditure	(79.8)	(6.8)	(7.3)	(0.4)	(54.2)	(55.2)	(1.0)
Other Drugs	(23.3)	(2.1)	(2.1)	(0.0)	(15.6)	(15.4)	0.2
Supplies & Services - Clinical	(89.6)	(7.7)	(7.7)	(0.1)	(58.8)	(59.0)	(0.2)
Supplies & Services - General	(7.1)	(0.7)	(0.6)	0.1	(4.6)	(4.8)	(0.2)
Purchase of Healthcare from other Bodies	(24.6)	(2.2)	(1.7)	0.5	(16.2)	(15.3)	1.0
Consultancy Costs	(2.0)	(0.1)	(0.1)	(0.0)	(1.5)	(1.5)	(0.0)
Clinical Negligence	(25.4)	(2.2)	(2.2)	0.0	(17.6)	(17.6)	0.0
Premises	(32.0)	(2.5)	(2.5)	(0.1)	(21.7)	(21.9)	(0.2)
PFI Operating Costs	(35.5)	(2.9)	(3.0)	(0.0)	(23.6)	(23.6)	(0.0)
Other	(17.8)	(1.6)	(1.0)	0.6	(11.1)	(8.8)	2.3
Total Non Pay	(337.1)	(28.9)	(28.3)	0.6	(224.9)	(223.0)	1.8

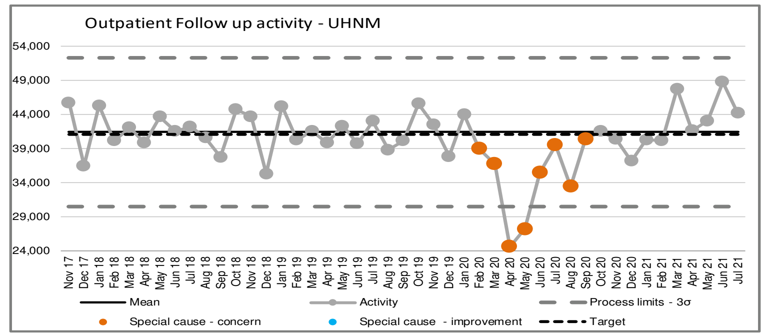
Non Pay key variances:

- Purchase of Healthcare is underspent primarily as a result of a budget adjustment relating to the Independent Sector spend in month of £0.7m of which £0.3m relates to the prior period, therefore the true underspend on the Independent Sector in month is £0.1m. An equal and opposite position is reflected within income.
- Other expenditure shows an underspend in month of £0.6m which is driven by underspends against non-recurrent reserves of which £0.2m is against the H2 workforce reserve, £0.2m is against the COVID reserve and the balance is against the inflation reserve.

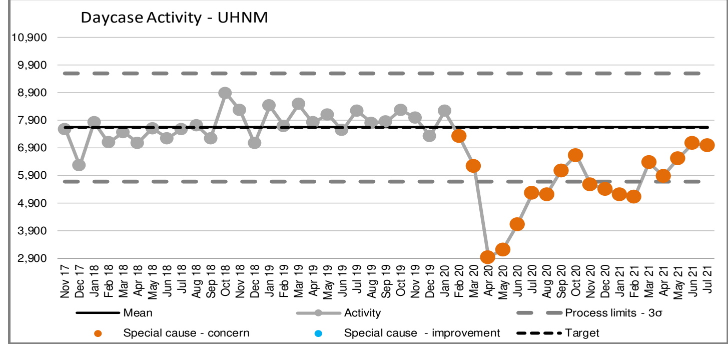
Activity

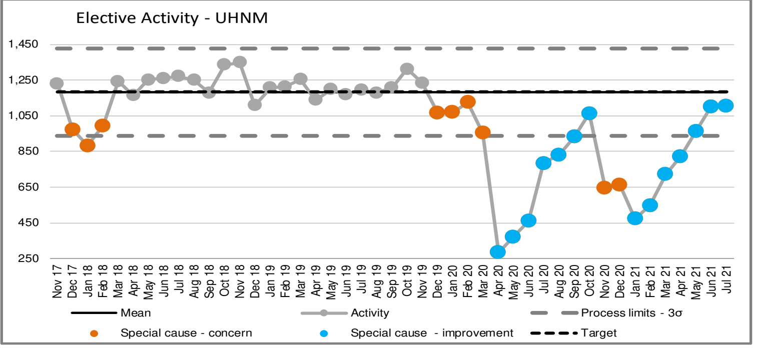
Planned care Outpatient



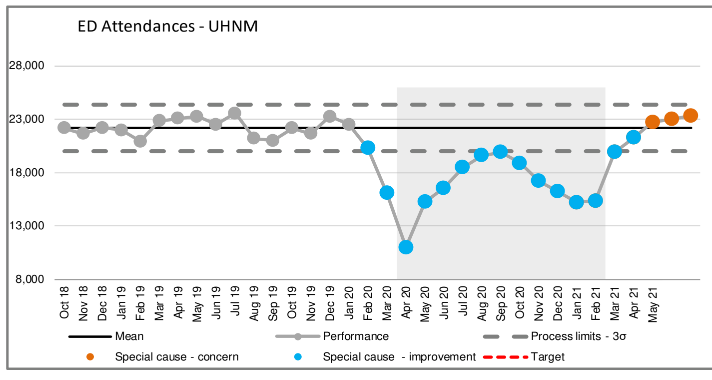


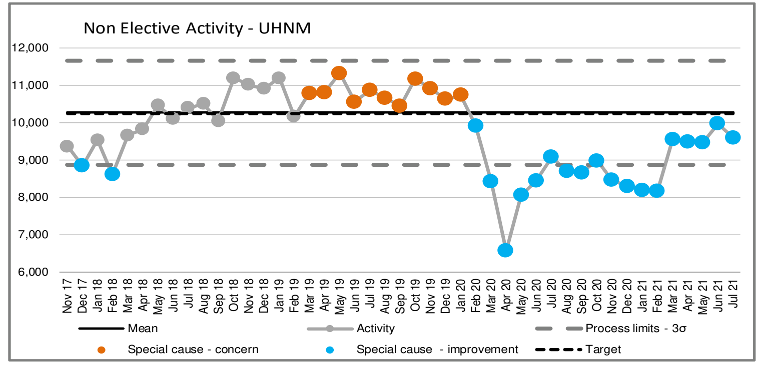
Planned care Inpatient





Urgent Care

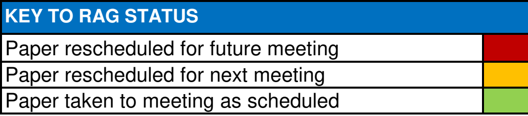




Quality | Operational | Workforce | Finance

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 7	May 5	Jun 9	Jul 7	Aug 4	Sep 8	Oct 6	Nov 3	Dec 8	Jan 5	Feb 9	Mar 9	Notes
PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES														
Chief Executives Report	Chief Executive													
Patient Story	Chief Nurse													
Quality Governance Committee Assurance Report	Associate Director of Corporate Governance													
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer													
Care Quality Commission Action Plan	Chief Nurse													Highlighted as part of QGC Assurance Summary. Not provided to December as awaiting finalised CQC Inspection report and updated action plan for 2021.
Bi Annual Nurse Staffing Assurance Report	Chief Nurse													Deferred - awaiting presentation at TAP prior to bringing to Board.
Quality Account	Chief Nurse													
7 Day Services Board Assurance Report	Medical Director													Timing TBC
NHS Resolution Maternity Incentive Scheme	Chief Nurse													
Maternity Serious Incident Report	Chief Nurse													
Winter Plan	Chief Operating Officer													
PLACE Inspection Findings and Action Plan	Director of Estates, Facilities & PFI													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													
Research Strategy	Medical Director													
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													Timing TBC - waiting to refresh once the clinical strategy has been determined
H2 Plan	Chief Finance Officer													

Title of Paper	Executive Lead	Apr 7	May 5	Jun 9	Jul 7	Aug 4	Sep 8	Oct 6	Nov 3	Dec 8	Jan 5	Feb 9	Mar 9	Notes
Annual Plan	Chief Finance Officer													
Capital Programme 2021/22	Chief Finance Officer													
GOVERNANCE														
Nomination and Remuneration Committee Assurance Report	Associate Director of Corporate Governance													
Audit Committee Assurance Report	Associate Director of Corporate Governance													
Board Assurance Framework	Associate Director of Corporate Governance		Q4			Q1			Q2			Q3		
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													Deferred to July's meeting to allow discussion with Executive Team prior to being presented to the Trust Board.