University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 3rd November 2021 at 9.30 am to 12.45 pm via Microsoft Teams

AGENDA

Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
09:30	**PROCEDURAL ITEMS**					
20 mins	1.	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 6th October 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 – October 2021	Information	Mrs T Bullock	Enclosure	**BAF 6**
10:15	**STRATEGY**					
10 mins	7.	Research Strategy	Approval	Ms H Ashley / Dr K Karunanithi	Enclosure	
10:25	**PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES**					
5 mins	8.	Quality Governance Committee Assurance Report (21-10-211)	Assurance	Prof A Hassell	Enclosure	**BAF 1**
10 mins	9.	Maternity Serious Incident Report – Q2	Assurance	Mrs AM Riley	Enclosure	
5 mins	10.	IPC Board Assurance Framework - October 2021	Assurance	Mrs AM Riley	Enclosure	**BAF 1**
15 mins	11.	Winter Plan	Assurance	Mr P Bytheway	Enclosure	
11:00 – 11:10: COMFORT BREAK						
11:10	**ENSURE EFFICIENT USE OF RESOURCES**					
5 mins	12.	Performance & Finance Committee Assurance Report (19-10-21)	Assurance	Mr P Akid	Enclosure	**BAF 9**
11:15	**ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT AND RESEARCH**					
5 mins	13.	Transformation and People Committee Assurance Report (20-10-21)	Assurance	Prof G Crowe	Enclosure	**BAF 2 & 3**
11:20	**ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS**					
40 mins	14.	Integrated Performance Report – Month 6 • Ambulance Handover Letter	Assurance	Mrs AM Riley Mr P Bytheway Mrs R Vaughan Mr J Tringham	Enclosure	
12:00	**GOVERNANCE**					
5 mins	15.	Audit Committee Assurance Report (21-10-21)	Assurance	Prof G Crowe	Enclosure	
10 mins	16.	Board Assurance Framework – Q2	Assurance	Miss C Rylands	Enclosure	
10 mins	17.	Workforce Disability Equality Standard Report	Assurance	Mrs R Vaughan	Enclosure	
5 mins	18.	EPRR Assurance Statement	Approval	Mr P Bytheway	Enclosure	
5 mins	19.	Calendar of Business 2022/23	Approval	Miss C Rylands	Enclosure	
5 mins	20.	Update on Board Development 2021/22	Assurance	Miss C Rylands	Enclosure	
12:40	**CLOSING MATTERS**					
5 mins	21.	Review of Meeting Effectiveness and Business Cycle Forward Look	Information	Mr D Wakefield	Enclosure	
	22.	Questions from the Public **Please submit questions in relation to the agenda, by 9.00 am 1st November to nicola.hassall@uhnm.nhs.uk**	Discussion	Mr D Wakefield	Verbal	
12:45	**DATE AND TIME OF NEXT MEETING**					
	23.	**Wednesday 8th December 2021, 9.30 am via Microsoft Teams**				

University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 6th October 2021, 9.30 am to 12.00 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 & Transformation												
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						
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:	
Mr A Bailey	Patient (item 1)
Mrs C Burt	Patient Representative (item 1)
Mrs A Grocott	Head of Patient Experience (item 1)

Members of Staff and Public via MS Teams: 4

No.	Agenda Item	Action
1.	**Patient Story**	
135/2021	Mrs Burt thanked Board members for the opportunity to provide Mr Bailey's story to the Trust Board, and welcomed the timing, given that it was Black History Month. Mr Bailey referred to his experiences in hospital due to being treated for sickle cell thalassemia and Mrs Burt provided some background to sickle cell. Mrs Burt explained that whilst Mr Bailey's condition was usually managed at home, he sometimes required hospital admissions at times of crisis. Mr Bailey highlighted the following in relation to his hospital admissions:	

PROUD TO CARE

- Upon contacting the haematology department, if a bed is available on Ward 201 Mr Bailey would normally be admitted directly to the Ward from home to be provided with pain relief, fluids and oxygen, and within 48 hours the pain is usually under control and symptoms managed
- However, if a bed is not available on Ward 201 Mr Bailey would need to attend A&E whereby a lot of staff do not have knowledge of sickle cell resulting in feeling like a burden due to staff having a particular lack of understanding of the level of pain relief required.
- There was a lack of awareness from staff and despite having a care plan in place setting out what pain relief and medication is required, he had on occasion been made to feel as though he was a drug addict due to the pain relief he required, and he often felt he was not in the best environment for his condition
- Mr Bailey commented that many aspects of his care was positive whilst noting the improvements that could be made

Mrs Burt commented that she felt improvements could be made if efforts were focussed on education and training as well as research and innovation in terms of looking at staff attitudes and outcomes of those with sickle cell with prioritised pathways.

Mr Bailey thanked Dr Graham for support, Angela Salmon, and the staff on Ward 201 for the support, care and attention given to her son.

Mr Wakefield apologised for the shortcomings in the experience provided.

Ms Gohir queried if Mr Bailey felt the prejudice regarding pain relief was due to his race, or lack of knowledge. Mr Bailey stated that he felt it was due to lack of knowledge and possibly some prejudice but usually was due to lack of education and understanding.

Dr Lewis apologised for the aspects of care which fell short and stated that he recognised the issues described, from his previous experience of treating those with sickle cell and agreed education was required for staff in terms of treatment required for sickle cell and in particular the unusual characteristics of requiring high levels of pain relief. He also agreed to consider the way in which the Trust could look at providing the newly announced treatment for sickle cell.

Professor Hassell thanked Mrs Burt and Mr Bailey for the story and queried how many times Mr Bailey had been able to go straight to Ward 201. Mrs Burt stated that over the past 2 years the majority of times had been via A&E.

Mrs Riley agreed that a lot of work was to be done to improve the patient experience for those with sickle cell and she agreed to work with Mrs Burt and Mr Bailey to get the right solution in place.

Mr Wakefield summarised the points raised in terms of when patients cannot be directly admitted to the ward, there is a lack of staff knowledge despite having a care plan in place and that needs to be actioned. He apologised for the attitudes which made Mr Bailey feel like a burden and drug addict and stated that the delay in providing pain relief was also something which needed to be addressed going forwards. He also agreed that there was an opportunity to work with system partners to improve equality and diversity. It was agreed that an update on the actions taken following the story would be provided to a future Quality Governance Committee (QGC) meeting.

AMR

	Mrs Burt, Mr Bailey and Mrs Grocott left the meeting. **The Trust Board noted the patient story.**	
2.	**Chair's Welcome, Apologies & Confirmation of Quoracy**	
136/2021	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 apologised from the outset that due to the CQC Well Led inspection which was underway, some Executives and Non-Executive Directors would need to leave parts of the meeting to attend interviews	
3.	**Declarations of Interest**	
137/2021	The standing declarations were noted.	
4.	**Minutes of the Previous Meeting held 4th August 2021**	
138/2021	The minutes of the meeting from 4th August 2021 were approved as an accurate record.	
5.	**Matters Arising from the Post Meeting Action Log**	
139/2021	PTB/484 – Mrs Riley stated that the results from the ribotyping for August were awaited and once received the information would be included within future performance reports. PTB/485 - Mrs Vaughan confirmed that information had been provided to Professor Hassel although it was noted that the level of detail required was not available via the speaking up index.	
6.	**Chief Executive's Report – September 2021**	
140/2021	Mrs Bullock highlighted a number of areas from her report. Mr Wakefield referred to his recent visit to AMU and commented on how impressed he was in terms of the Improving Together Boards and huddles and how these were continuing to be taken forward, despite current pressures. Mr Wakefield referred to the vacancies for consultants and senior clinicians and queried if there were any long-standing vacancies which had not been able to be filled causing a negative impact on patients. Mrs Bullock stated that mitigation was in place by using locums and agency staff and if any adverse outcomes were realised, these would be reported via Datix and any deaths would be considered via the mortality reviews. Mrs Bullock was not aware of any harms directly related to long-standing vacancies Ms Gohir referred to cancer performance and queried the plan for prioritisation given current pressures. Mrs Bullock stated that throughout Covid there remained a strong focus on cancer and Mr Bytheway added that cancer patients had been prioritised throughout the pandemic and efforts were continuing to operate on	

	cancer and clinically urgent patients. It was noted that the main two areas of challenge were urology and colorectal, but the focus would remain on treating those clinically urgent and cancer patients. Ms Bowen referred to workforce challenges and queried what workforce planning was being undertaken in a wider capacity within the Trust to address the current challenges. Mrs Bullock stated that clinical service line reviews considered whether the necessary workforce was in place to deliver services now and in the future. Mrs Vaughan added that a system wide workforce plan was in place, but this was driven financially, therefore UHNM workforce plans were in place at a Divisional and specialty level. She stated that these were being refined, but the work was based on supply and demand, forecasting, potential retirements, turnover, planning through known and forecasted information. Professor Crowe acknowledged and welcomed the work on overseas recruitment and the number of nurses recruited. **The Trust Board received and noted the report and approved EREAFs 8122 and 8017.**	
PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES		
7.	**Quality Governance Committee Assurance Report (23-09-21)**	
141/2021	Ms Belfield highlighted the following from the report: • Current workforce challenges were having an impact on health and safety and quality safety oversight attendance • A positive presentation was provided on the Perfect Ward looking at how the Trust could improve working with Divisional staff in a digitalised way and in future the Committee would monitor the outcomes from the programme • A positive report was provided in terms of mental health and learning disability • Positive general trend in respect of quality indicators Mr Wakefield referred to request from the Committee to obtain the breakdown on emergency caesarean section rates and ethnicity breakdown and welcomed this being provided at a future meeting. **The Trust Board received and noted the assurance report.**	
8.	**Infection Prevention and Control Board Assurance Framework (BAF)**	
142/2021	Mrs Riley highlighted the following: • Several changes had been made to the document as a result of the internal audit • The portacount business case had been developed and would go through the relevant approval process Professor Maddock requested further information in relation to the non-conformities of decontamination of beds following repair and Mrs Riley stated that this related to beds being sent for repair and ensuring the right systems were in place to ensure these were decontaminated beforehand. Mr Wakefield referred to BAF 1 and the high rates of Covid across the Midlands and queried whether this had resulted in visitor restrictions. Mrs Riley stated that at the peak the Trust considered a proposal to restrict visiting but this continued	

	to be monitored with no particular issues having been raised. She stated that for any hot spot areas, visiting was restricted. Mr Wakefield referred to the action on page 14 of the document, related to patients not being moved until at least 2 negative tests and queried the reason this was problematic with a revised due date. Mrs Riley agreed to obtain additional information in relation to this and confirm with Mr Wakefield. **The Trust Board received and noted the report.**	**AMR**
ENSURE EFFICIENT USE OF RESOURCES		
9.	**Performance & Finance Committee Assurance Report (21-09-21)**	
143/2021	Mr Wakefield highlighted the following from the report: • Data Security and Protection training stood at 89%, with some staff having been identified as being 24 months overdue, therefore actions were being taken to ensure these staff undertook the training as soon as possible • There had been a breach of individual sensitive information which had been reported to the Information Commissioners Office, but no further action was to be taken and the issues raised were to be addressed via completion of the Root Cause Analysis • Concerns were raised regarding cancer challenges and the Committee noted the plan which was being developed for planned care with a number of short-term actions being considered • System partners continued to be made aware of the current pressures, the full hospital protocol had been signed off and sickness absence continued to be a major challenge • The Committee approved the Emergency Department business case and a number of milestones were to be realised before funding was released • The Committee also approved the business case in relation to CT7 Mr Oldham joined the meeting. **The Trust Board received and noted the assurance report.**	
ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS		
10.	**Integrated Performance Report – Month 5**	
144/2021	Mr Bytheway highlighted the following in terms of urgent care performance: • A number of actions had been taken in August with regards to ambulatory attendances and ambulance attendances and during September the use of the CRIS service had significantly increased resulting in reduced conveyances to hospital • Work was ongoing in respect of navigating patients direct to ambulatory care and to the urgent care centre through work with Vocare • Good progress had been made with Consultant Connect allowing GPs to refer patients direct into portals but the main challenge was GP engagement and call response times • In the main challenges related to occupancy and there had been an increase in Covid numbers during August/September as well as an increase in Medically Fit for Discharge patients (MFFDs), resulting in the Trust moving into internal incident levels on 3 occasions • Additional beds were being opened with the aim of reducing occupancy as	

part of the winter plan and the Trust also continued to work with the system to reduce MFFDs
- Workforce challenges were also being experienced within the system, particularly in domiciliary care which was having an impact on their assistance in reducing the number of MFFD patients
- A winter readiness programme was underway to increase discharges before noon up to 25-30% and each Division was working to a plan to do so but main challenge was the amount of work required to facilitate this
- ED workforce in terms of the number of doctors and nurse vacancies in the department continued to pose a challenge and the lack of available agency and bank staff. A number of actions were being taken in respect of recruitment as well as looking to further increase bank and agency rates and seconding fixed term doctors into the department for a 6 month period
- Actions continued to be taken to reduce the number of 60 minute waits in the Department and a number of rapid events were commencing to look at taking a consistent approach to ambulance offloads throughout the region

Mr Wakefield referred to ambulance handovers in 15 minutes which had continued to deteriorate and initial assessment in 15 minutes and queried how performance in these areas would be improved in the next 2 months. Mr Bytheway stated that there had been an improvement in initial assessment in 15 minutes due to the nursing workforce in the department being stabilised, but the main issue was in respect of the high number of ambulatory patients. He stated that work was being completed to ensure there was enough nurse resource in the department to enable timely triage to be provided. In addition, the system winter plan had not yet been approved and was being reviewed to consider the ongoing workforce challenges, looking at collaboration with the ambulance service, increasing triage ability at the front door and increasing medical staff, although improvements relied on a reduction in occupancy to allow the department to flow.

Ms Bowen queried whether the red GP was having an impact and Mr Bytheway stated that this was part of the primary care package in ED and was having an impact and the majority of patients seen were discharged, but the main challenge was those patients on the admitted pathway.

Mr Bytheway continued to summarise cancer performance:
- A trajectory was in place which outlined the direction of travel based on an agreed set of referrals and treatments, which was unlikely to be met in the next few months due to the numbers in the backlog but as theatres opened more patients who had breached will be seen as well as patients being sent to the Independent Sector
- The number of treatments provided would continue to be monitored to ensure these were being undertaken in line with plan
- Referrals in August were high, but activity was lower particularly in those challenged specialties
- Efforts had been refocussed on 62 day operative procedures and a number of business cases had been agreed to treat patients and as some of the non-inpatient treatments come online this should result in an improvement in the cancer 62 day target

Mr Bytheway added that a trajectory had been agreed for diagnostics and monies provided to support ultrasound which was the main issue and performance was expected to be back online by the end of November.

Mr Bytheway left the meeting.

Ms Riley highlighted the following in relation to quality and safety:

- Pressure ulcers had slightly increased, and a deep dive had been undertaken which demonstrated the increase related to surgery and in particular those patients in critical care who had been proned
- Falls were reducing and as part of Improving Together, AMU which historically had high numbers of falls, had reduced the number of falls for the third month running, reducing from 15-20 a month to 5, which as particularly positive
- There had been an increase in the number of incidents reported due to staffing, which was positive, in terms of making staff aware of where concerns were being raised these incidents were a fair representation of the pressures being experienced
- The learning from the lapses in care identified for pressure ulcers would be built into ongoing monitoring via the Perfect Ward system

Mr Wakefield referred to the increases in pressure sores due to patients being proned but queried why the levels were higher than the first and second waves. Mrs Riley stated that this was due to improving the robustness of checking pressure ulcers and reporting, which changed at the end of June whereby every pressure ulcer was now checked and assessed by the Tissue Viability team, rather than this being undertaken at a departmental level.

Professor Maddock queried if there was a plan in place to prevent ulcers in the first place for those patients being proned and Mrs Riley stated that reviews are being undertaken to ensure the Trust was adhering to best practice as well as assessing whether there were further interventions available to reduce pressure ulcers and this would be reported to QGC.

Mr Wakefield referred to the escalation of staffing issues and mitigating actions and queried the process for escalation. Mrs Riley stated in the first instance, the ward would contact their matron who would assess whether any movements could be made within the Division. If not, work would be undertaken with other Divisions as well as identifying any possible corporate support. She stated that the key was understanding the problem in terms of the cause and length of time as the action required may be different. In addition, the Matron of the day oversees staffing and coordinates mitigation across the Divisions. Mrs Riley stated that when assessing the mitigation, decisions were made to make each area as safe as possible.

Mr Oldham highlighted the following in relation to financial performance:

- Month 5 position demonstrated a surplus of £13.5 m and the Trust had continued a similar trajectory to previous months, forecasting £6 m better than plan for the first 6 months, and the Trust aimed to utilise some of the surplus within the second half of the year to support restoration and recovery
- The run rate remained consistent, pay was underspent primarily due to nursing and corporate services and non-pay remained underspent due to the level of activity being delivered
- £9.8 m of capital had been spent to date, and the Trust was £2.3 m behind plan due to an underspend related to the Lower Trent Ward scheme, although discussions were ongoing with NHSIE on reprofiling the Trust's Public Dividend Capital to support this. In addition, some unallocated capital remained to be worked through of £1.7 m
- The cash position remained positive with a forecast at the end of month 6 of £66 m compared with a year-end balance of £55.8 m

Mr Wakefield referred to the issue of the backlog, the winter plan and utilisation of

the Independent Sector and queried whether this was modelled into the outturn position. Mr Oldham stated that this was being worked through and as plans across the system were being developed, to help support winter pressures and escalate recovery by improving use of Independent Sector, these would be factored into the forecast.

Ms Bowen referred to the Integrated Care System which reported the lowest proportion of Covid monies having been spent in the region and queried how this had impacted on the Trust. Mr Oldham referred to two schemes for Covid monies, the first in relation to operational costs and the operational groups had not reported any issues whereby investments required to support additional measures to respond to Covid had not been funded. He stated that the statement referred to the spend against the Elective Recovery Fund, which related to activity being undertaken to recover activity, which had been generated in the first 6 months and aimed to be utilised for the latter part of year but the challenge in the system was due to the additionality being provided by the activity which needed to be demonstrated.

Mrs Vaughan highlighted the following in relation to workforce performance:

- Staff sickness stood at 5.30% which had decreased on the previous month but this was anticipated to increase in September due to the impact of schools returning and isolation measures linked to Covid
- Covid related absence stood at 29% which had been the case for a number of weeks
- The Trust was continuing to apply all relevant guidance and acting in accordance with measures for NHS staff and had commenced the Covid booster vaccinations as well as flu vaccinations, as well as continuing with risk assessments and regular testing of staff
- Divisional teams were reporting an increase in stress related absence, although not all work related, and provisions continued to be in place for staff support via counselling and system wide psychological wellbeing hub
- PDR performance had reduced slightly in August and Divisions had acknowledged this was due to clinical pressures and annual leave
- Statutory and mandatory training stood at 96% for the core for all training which was positive given current pressures and essential to role training also continued to be monitored
- Efforts continued to be made to recruit to workforce vacancies

Mr Wakefield referred to the demand for hospital services and ongoing pressures on staff and the need to ensure the Trust helped to support staff wellbeing. He stated that as staff absences due to Covid and stress formed half of all absences that a robust plan to deal with this was required and suggested that this remained a focus for the Transformation and People Committee (TAP) going forwards.

Professor Crowe referred to wellbeing programmes in place and wellbeing conversations being held by line managers and queried how well embedded the conversations were, and whether there was anything else which could be done to help support staff. In addition, he queried the actions being taken to improve basic hygiene factors such as food and rest areas and provision of 24 hour facilities.

Mrs Vaughan stated that wellbeing conversation continued to be promoted to line managers and staff continued to be trained on utilising the RESPOND model to support wellbeing conversations as well as reminding staff to undertake risk assessments. In addition, specific plans for wellbeing provision over winter were being considered, looking at basic hygiene factors in terms of provision of food

	and drink, hydration stations as well as speaking to staff about what wellbeing means to them. **The Trust Board received and noted the performance report.**	
GOVERNANCE		
11.	**Workforce Race Equality Standard (WRES) Report 2021**	
145/2021	Mrs Vaughan highlighted the following: • The majority of information utilised for the report had been taken from the 2020 staff survey • An analysis of key metrics had been provided which included trends to assess the direction of travel • 5 metrics had improved, 3 had deteriorated and 1 with no change • The pace of change had been impacted by Covid but actions continued to be taken to reinforce messages regarding race equality and equality, diversity and inclusion more broadly • Further work in relation to bullying and harassment continued to be undertaken and actions required due to the outcomes of the ongoing review would be considered once the review has reported its findings. • The Trust's strategy for equality and diversity continued to be refined and this would be discussed with stakeholders in due course Mr Wakefield queried how confident the Trust was that the actions being taken would address the findings. Mrs Vaughan stated that the Trust needed an opportunity to drive forward some changes in particular the work regarding civility and respect and middle manager training. She referred to the importance of empowering staff to raise any issues and providing the mandate for staff to undertake the developmental work and specific programmes so that they were able to respond appropriately when concerns were raised as well as addressing concerns before they became issues. Professor Crowe requested assurance on how the priorities were mapped into the Connects programme and progress with the behaviour compact. Mrs Vaughan stated that during the past 12 months some progress had been made, particularly in relation to the Connects programme which incorporated an inclusivity masterclass. In addition, Board members had undertaken a cultural awareness programme across the system and inclusion schools had also been put in place by the system. She stated that the initiatives put in place were expected to grow in the next 12 months. In relation to the behavioural compact, the national leadership development behavioural compact was awaited but the Trust had continued with the programme regarding civility and respect which would be included in a middle management development programme. Ms Bowen referred to the numbers of staff experiencing discrimination which seemed to be a large percentage and queried the reasons behind this and Mrs Vaughan stated that as the information was taken from the staff survey, it was difficult to obtain further data on this, therefore feedback is requested through staff networks and try to understand the issues being raised although she felt the actions being taken for training middle managers in particular and the way in which they handle issues was important in order to improve the metric. Mr Wakefield referred to the 15.2% of staff who felt they had experienced discrimination or bullying compared with the average of 16.8% and queried what lessons the Trust had learned from others. Mrs Vaughan stated that detailed	

	benchmarking had been lacking over the past 18 months but actions being taken were similar to other Trusts. **The Trust Board received and noted the report and noted the actions being taken to close the gaps in career and workplace experience between BAME staff and the overall workforce at UHNM during 2021/22.**	
ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT AND RESEARCH		
12.	**Transformation and People Committee Assurance Report (22-09-21)**	
146/2021	Professor Crowe highlighted the following: • In terms of major actions, the Committee had requested action to be taken in respect of a short-term heat map summary highlighting key issues associated with workforce and a more detailed report had been requested on longer term workforce planning • The Committee held a deep dive discussion on Improving Together whereby detailed examples of tools and practices being used were welcomed, as well as considering reporting on metrics going forwards **The Trust Board received and noted the assurance report.**	
CLOSING MATTERS		
13.	**Review of Meeting Effectiveness and Business Cycle Forward Look**	
147/2021	Mr Wakefield welcomed the patient story, and the fact that a story was provided by a patient currently in hospital. Mrs Bullock noted it was a happy chance that this story was delivered during Black Awareness Months and also that the patient was currently in hospital, as patient stories take time to bring to Board and this had been underway for some time based on previous admissions although she was pleased with how well it worked.	
14.	**Questions from the Public**	
148/2021	It was noted that Mr Bytheway had prepared to respond to Mr Syme's questions but was not available due to his interview with the CQC. Mr Wakefield therefore noted that the responses would be added to the minutes after the meeting and suggested that Mr Syme speak to Mr Bytheway separately, if required. Mr Syme referred to the NHS constitutional standard for 2 week waits for breast cancer and queried whether the funding bid for the provision of a nurse led community breast pain clinic had been successful and if it was successful when the clinic would be fully operational. It was noted that the bid was funded via the West Midlands Cancer Alliance and it was anticipated to commence in November 2021, subject to recruitment. Mr Syme referred to the 2 week suspension of electives in September 2021 and queried whether the individuals affected had been contacted and provided with a new treatment date. In addition, he queried whether the P2 patients affected had been given new treatment dates and he queried the number of individuals affected by the elective suspension and how many patients were contacted to explain the reason for the delay.	

	It was noted that patients had been delayed in being called for their procedures rather than being cancelled and rebooked and treatment dates were being offered in line with clinical urgency, prioritisation and waiting time against the available capacity. It was noted that the Trust continued to operate on all P1 /P2 patients as required during the 2 week suspension. In terms of P2 patients being given new dates, it was noted that all patients would be treated within their agreed clinical urgency assessment and the number of individuals affected by the suspension were difficult to determine, although urgent P1 and P2 cases had continued during that time. Mr Syme referred to ambulance handover delays and queried any learning from 60 minute breaches in the local system as well as querying what actions had been taken by the local care system to reduce or mitigate the 60 minute handover delays. Mrs Bullock provided a partial answer the question based on Mr Bytheway's update from the performance report and noted the main intervention was the CRIS which had been extended to allow for P3 and P4 calls from the West Midlands Ambulance Service (WMAS) to be managed without a conveyance to hospital, in addition to introducing the Red GP. In addition, it was noted that the Trust continued to work with the West Midlands Ambulance Service (WMAS) and the system to look at alternate pathways to support.	
DATE AND TIME OF NEXT MEETING		
15.	Wednesday 3rd November 2021, 9.30 am, via MS Teams	

Trust Board (Open)

Post meeting action log as at 25 October 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		Action delayed - due to be taken to November's QGC meeting	R
PTB/484	04/08/2021	Integrated Performance Report - Month 3	For future reports to highlight whether c-difficile cases were isolated or linked	Ann Marie Riley	06/10/2021	06/10/2021	Once the results from the ribotyping were avaialble, this information would be reported within future performaance reports.	B
PTB/485	04/08/2021	Speaking Up Report – Q1	To request detailed analysis on the UHNM speaking up index and provide to Professor Hassell.	Ro Vaughan	06/10/2021	06/10/2021	Information provided to Professor Hassell but detailed information not avaialble via speaking up index.	B
PTB/486	04/08/2021	Board Assurance Framework (BAF) – Q1	To include actual deadlines and due dates for actions, in the Q2 version.	Claire Rylands	03/11/2021	25/10/2021	Q2 BAF on November's agenda.	B
PTB/487	06/10/2021	Infection Prevention and Control Board Assurance Framework	To obtain the additional information in respect of the action regarding patients not moving until 2 negative tests, to Mr Wakefield.	Ann Marie Riley	03/11/2021		**Update to be provided**	GB
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	31/12/2021		Action not yet due.	GB

University Hospitals of North Midlands NHS Trust

Chief Executive's Report to the Trust Board

FOR INFORMATION

Part 1: Trust Executive Committee

The Trust Executive Committee met on 27th October 2021. The meeting was held virtually using Microsoft Teams; there was no agenda although we did take the opportunity to discuss feedback around the future format and function of the Committee, in order to maximise the opportunity we have coming together as a senior management team. We also took the opportunity to discuss the Clinical Strategy and to gain vital feedback from our senior clinicians and managers in terms of the next steps in developing the strategy. The following provides a brief overview of the discussion:

Clinical Strategy

- Clinical strategy has been developed following the service line review process
- Important to be clear around how the strategy aligns with system wide priorities although it was recognised that system strategy is continuing to be developed
- Recognition that as the system strategy matures, our corporate strategy will need to be refreshed to ensure alignment
- Further consideration to be given to patient care co-ordination and how this links to other strategies such as the Patient Experience / Quality Strategies
- Need to be clear about the broader strategic framework, interdependencies with enabling strategies and clarity on links to other supporting strategies
- Keen to ensure wider engagement with clinical teams

Trust Executive Committee

- Format and function of the Committee changed with Covid and has been used as a forum for updates on operational matters, initially related to Covid
- Keen to focus on more strategic matters in particular those that have cross organisational impact
- Business cases to be taken to future meetings to ensure broader discussion around interdependencies – this will ensure wider engagement and an understanding of key developments across the organisation
- Keen to have a wider understanding of ICS developments
- Decision making around investments
- Divisional updates to focus on the most acute pressures
- Executive updates to focus on regional / national updates
- Divisions to put forward suggestions on future strategic discussions

Part 2: Chief Executive's Highlight Report

1. Contract Awards and Approvals

Department of Health Procurement Transparency Guidance states that contract awards over £25,000 should be published in order that they are accessible to the public. Since 13th September to 12th October, 4 contract awards, which met this criteria, were made, as follows:

- **Trauma, CMF and Orthopaedic External and Internal Fixation Consumables (REAF 8122)** supplied by various at a total cost of £6,353,916.14, with savings of £198,451.92, for the period 01/09/21 - 31/08/25, approved on 08/10/21
- **Contract Renewal - Recombinant Factors (REAF 8050)** supplied by various at a total cost of £723,597.60, for the period 01/09/21 - 30/06/25, approved on 22/09/21
- **Contract Renewal Human Albumin/Albutein (REAF 8049)** supplied by Grifols UK Ltd at a total cost of £988,680.00, for the period 01/09/21 - 30/04/25, approved on 10/09/21
- **Services of Junior Doctors via Health Education England (REAF 8017)** supplied by Health Education England at a total cost of £2,263,333.34, for the period 01/09/21 - 31/03/22, approved on 08/10/21

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

Supply of Ports, Trocars, Stapling and Energy Devices - Extension (eREAF 8275)

Contract Value £2,469,565.93 incl. VAT
Duration 10/11/21 – 09/11/22
Supplier Various

Total Negated Inflation - £10,216.56 incl. VAT

The Trust Board are asked to approve the above eREAF.

2. Consultant Appointments

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

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Consultant Chemical Pathologist	Vacancy	Yes	TBC
Clinical Lead – Imaging x 4	Vacancy	Yes	01/22/2021
Locum Consultant in Emergency Medicine	Maternity	Yes	TBC
Locum Consultant in Emergency Medicine	Maternity	Yes	TBC
Respiratory Consultant	Vacancy	Yes	TBC
Locum Consultant Radiologist - Body Radiology	Vacancy	Yes	01/12/2021
Locum Consultant Paediatrician - PICU	Vacancy	Yes	06/03/2022
Locum Consultant Paediatrician - PICU	Vacancy	Yes	18/10/2021

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

Post Title	Reason for advertising	Start Date
Clinical Lead - MSK Radiology	Vacancy	01/10/2021
Executive Medical Director	Vacancy	01/10/2021
Locum Stroke Consultant	Extension	01/10/2021
Medical Support Worker - O&G	Extension	01/10/2021
Locum Consultant Spinal Surgeon	Extension	04/10/2021
Locum Consultant Spinal Surgeon	Extension	03/10/2021
General Paediatric Consultant	Vacancy	04/10/2021
Consultant Radiologist	Extension	05/10/2021

Lead Appraiser	Vacancy	06/10/2021
Locum Consultant Imaging - Breast Radiologist	Extension	15/10/2021
Locum Consultant Thoracic Surgeon	Vacancy	18/10/2021
Locum Consultant Orthopaedic Surgeon	Extension	15/10/2021
Consultant Gastroenterologist	Retire & Return	20/10/2021
ENT Head & Neck Consultant Surgeon	Vacancy	01/10/2021
Locum Consultant Paediatrician - PICU	Vacancy	01/10/2021

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

Post Title	Closing Date	Note
Consultant Intensivist	Vacancy	No Applicants
Glaucoma Consultant Ophthalmology	Vacancy	No Applicants

3. Covid 19 and Trust Pressures

We remain under significant pressure and as well as working hard to recover our elective services, we are seeing a high level of demand and are starting to see an increase in the number of patients in our organisation with Covid. We continue to work closely with our system partners to ensure that we can discharge those patients who no longer need to receive acute care, as well as redirecting those patients who do not need to be seen within our Emergency Department. However, I am very aware of the impact working under such continued pressure is having on our staff and we are continuously seeking to improve our Wellbeing offerings to provide support where it is needed.

4. Care Quality Commission Well Led Inspection

Last month I was able to share some of the preliminary feedback we received from the first part of our Core Standards Inspection and mentioned that we were looking forward to welcoming the CQC again on 5th and 6th October for the Well Led part of our Inspection. Whilst as I write, the remainder of our Core Standards Inspection is yet to conclude, we were delighted to receive some further initial feedback in relation to their Well Led Inspection. Their letter can be found at appendix 1 of this report.

5. Engaging with our Medical Workforce

Throughout the year I regularly speak to senior doctors in training at Keele University as part of the Clinical Leaders Programme. It is a great way of connecting with our future medical leaders and this month I was also pleased to attend the Grand Round at both the Royal Stoke and County Hospital sites also. This provides me with a great opportunity to speak to medical staff and to provide them with an insight into the priorities nationally and locally, such as the direction of the NHS and our Staffordshire system, as well as hearing their own views.

6. Staffordshire System

Our Staffordshire system is currently at a critical stage of establishing the NHS Board, Integrated Care Partnerships and Place-based partnerships which will support collaborative working between hospitals, community services, social care and primary care to ensure that we are delivering what our local population needs. A key milestone to this locally is the recruitment of the ICS Chief Executive and I was delighted to play a part in the process although we await for the outcome to be agreed nationally.

7. Allied Health Practitioners (AHP) Day

Thursday 14th October was AHP day where we took the opportunity to thank all of our AHP's and to recognise the contribution they make to our patients, day in, day out. AHP's are the third largest healthcare workforce with significant opportunities to support the delivery of the NHS Long Term Plan. Nationally, the day gives an opportunity to showcase to others the impact they make to the delivery of high quality care and to improve awareness of the fourteen AHP professions.

8. Advanced Care Practitioners (ACP) Conference

I was delighted to be able to open our ACP Conference this month. This is the first time I have been able to meet and thank personally a large number of staff face to face. It was great to see staff there from a

range of professional backgrounds and given the current pressures, I was so pleased to see staff taking the time to reflect, develop and network.

9. Vaccination Programme

Our Vaccination Hub is up and running at both Ward 75 at the Royal Stoke and County Hospital and I'm really pleased that hundreds of staff have already now received both the Covid-19 vaccine booster alongside their flu vaccination. There has been lots of national publicity this month from national leading experts on the anticipated rise in flu and the dangers this presents and so it is positive to see our staff taking this seriously for the protection of our patients, colleagues and loved ones.

10. Staff Awards

Our Staff Awards programme is a celebration of outstanding contributions made by staff over the past year across nine award categories. Due to Covid, we will be holding the event virtually again this year although to make it even more special for our very deserving staff, we are really pleased to be able to award some wellbeing based prizes. The shortlist has now been announced and we look forward to announcing the winners very soon!

11. World Kindness Day

Looking forward to November, on World Kindness Day we will be asking our staff what a good day looks like working here and what makes a bad day. From this we will be able to work together to build a culture which makes it a great place to work for everyone. Valuing each other, being kind and recognising other's achievements is something we can all do without any cost.

12. National Health System Forum

On Thursday, 30th September 2021 representatives from Estates, Facilities and PFI and Sodexo were invited by the DHSC to present at a National Health System Forum established to share good practice and knowledge across the NHS. The presentation focussed on the benefits derived from our Strategic Partnership and our joint participation in the Cabinet Office Strategic Supplier Relationship Management Programme (SSRM). The presentation was received very positively with knowledge shard in respect of performance improvement, reduction of costs, mitigating of risks and harnessing of innovation, all of which feature strongly in the Government's commitment to continue to improve relationships between Government and key strategic suppliers to the NHS.

Care Quality Commission
Citygate
Gallowgate
Newcastle Upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

www.cqc.org.uk

By email

Our reference: INS2-10959393161
Tracey Bullock
Chief Executive
University Hospitals of North Midlands NHS Trust
Newcastle Road
Stoke on Trent
Staffordshire
ST4 6QG

7 October 2021

CQC Reference Number: INS2-10959393161

Dear Mrs Bullock,

Re: CQC inspection of University Hospitals of North Midlands NHS Trust

Following your feedback meeting with Sarah Dunnett, Karen Richardson, Rhian Williams and Tyson Hepple on 6 October 2021, I thought it would be helpful to give you written feedback as highlighted at the inspection and given to you and your colleagues Paul Bytheway, Anne-Marie Riley, Claire Rylands, Scott Malton, Amy Freeman, Lorraine Whitehead, Ro Vaughan, Matthew Lewis, Mark Oldham and Helen Ashley at the feedback meeting.

This letter does not replace the draft report we will send to you, but simply confirms what we fed-back on 6 October 2021 and provides you with a basis to start considering what action is needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report and evidence appendix, this correspondence should be used to inform discussions with the board. When scheduling a discussion of this letter, or the draft report, please inform your CQC Regional Communications Manager, who is copied into this letter.

An overview of our feedback

The feedback to you was:

- It is clear that the trust has done an enormous amount of work since our last inspection.
- The governance processes in place identify issues which enables the board to know where the risks/ gaps are and take actions to make improvements which should deliver sustainable change.
- We heard examples of excellent practice and processes in safeguarding across the organisation.
- There are processes in place to identify learning from incidents and complaints but further work is required to ensure timely review, response and a consistency to drive improvement and outcomes for patients.
- Financial governance is good via established committees and oversight completed rigorously.
- There is a cohesive board which has complementary skills who work well together. Board members understand their roles and are able to challenge appropriately.
- Staff views are sought and we've seen evidence of how patients and public views are considered, but further work is needed. There are plans in place to increase the voice of patients.
- We have heard good examples of how quality improvement is being used across the trust and look forward to hearing how this work leads to improvements in patient care.
- The work on the digital strategy and engagement staff and plans to engage with patients is impressive.
- We can see that you understand the need to address the bullying and harassment issues that have been raised and have made good progress in addressing this, however further work is required.

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to Dale Bywater at NHS Improvement

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

Telephone: 03000 616161

Write to: CQC
Citygate
Gallowgate
Newcastle upon Tyne

NE1 4PA

If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Yours sincerely

Sarah Dunnett

Sarah Dunnett
Head of Hospitals Inspection

c.c. David Wakefield Chair of Trust
Dale Bywater
Jonathan Davies CQC regional communications manager

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board	**Date:**	3rd November 2021
Report Title:	Research Strategy	**Agenda Item:**	7
Author:	Dr Kamaraj Karunanithi Director of Research and Innovation		
Executive Lead:	*Helen Ashley, Director of Strategy*		

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:

The Research Strategy has been updated and is presented to the Board for approval. The strategy has been reviewed by internal and external stakeholders, principal investigators and staff; the strategy has also been discussed at the Executive R&I Group and Transformation and People Committee.

Key Recommendations:

The Strategy is submitted for approval.

NHS
University Hospitals of North Midlands
NHS Trust

Research Strategy 2021-2026

Executive Summary

A successful Research and Innovation agenda is of huge strategic importance to University Hospitals of North Midlands (UHNM) NHS Trust. A trust that values research inspires curiosity, high clinical standards and innovation; it also offers patients the chance to take part in ground-breaking studies; it allows staff to fulfil their academic careers in the same organisation; it facilitates better recruitment and retention of highly performing clinicians.

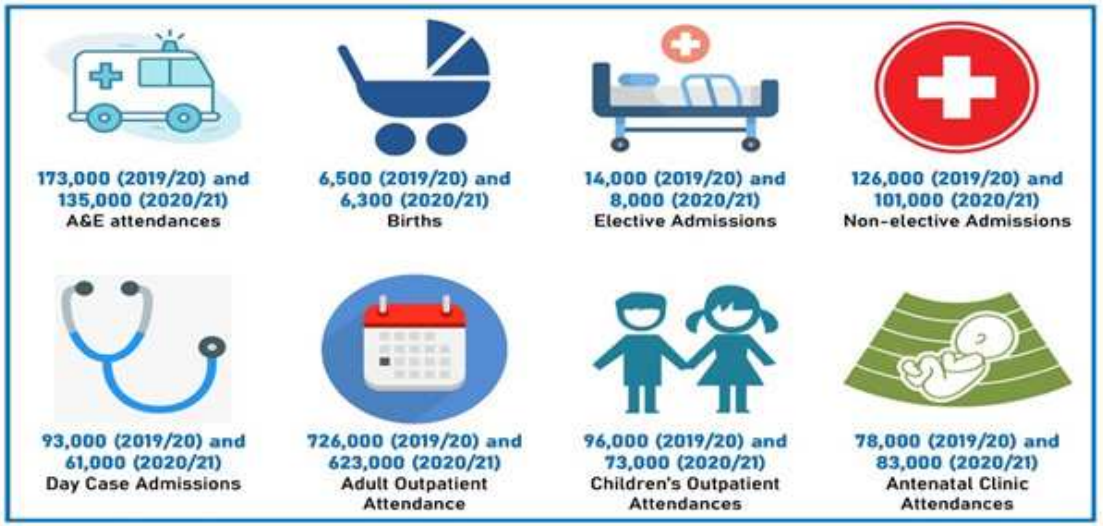
It creates an environment for change and quality improvement, adds a level dynamism that attracts and retains the best staff and brings state-of-the-art advances to the diverse population of around 1,000,000 that UHNM serves. UHNM already enjoys a robust reputation for success in Trust-led academic research. UHNM also hosts a large portfolio of externally-led clinical studies and clinical trials. This clinical Research and Innovation Strategy outlines the commitment and direction required over the next 5 years for UHNM to fulfil its clinical research obligations to its patients, staff, the NHS and the wider economy.

The Research and Innovation Strategy is fully aligned with the Trust's 2025 Vision and national NHS agenda as set out in the NHS Long Term Plan (Jan 2019) and Care Quality Commission (CQC) drive to include research as part of their programme. Recognising the value of clinical research is therefore of greater significance to the Trust than ever as it navigates challenging times.

The strategy has been informed through consultation with key internal and external stakeholders and by surveying the opinions of Trust principal investigators, patients and staff.

The local context

University Hospitals of North Midlands (UHNM) NHS Trust is a centre of clinical and research excellence, providing care for a catchment area of approximately 1,000,000 individuals. UHNM participates in clinical trials from across the healthcare sector from novel interventions and drugs to device innovations which aim to improve quality of life and outcomes for our patients. These cutting-edge developments are then translated and implemented into our day-to-day clinical practice.



Research and innovation is an integral part of our core values as a University Hospital, enabling us to constantly learn in order to be able to offer better care to the population that we serve, leading to improvements in clinical outcomes. We see research and innovation as fundamental to what we do as healthcare providers.

The response of the healthcare research community in 2020/21 in response to the COVID 19 pandemic has been transformational. UHNM has participated in Urgent Public Health COVID 19 research that has been a national priority for all clinical research networks; recruiting over 5000 patients to COVID research trials. This has impacted on our usual research activities and also our finances, as the pandemic has pulled staff away from research to carry out frontline clinical roles and diverted attention from our funded non-UPH studies.

The way that the research community has pulled together to deliver these complex interventional and non-interventional COVID 19 trials has demonstrated the ability to work in partnership and to deliver research at scale. The pandemic has highlighted the importance and capability of research to impact on health outcomes. The pandemic has shown the value of widespread participation in clinical studies to identify, test and refine novel tests and treatments. It has also brought research to the forefront of people's attention both locally and nationally and this is something to capitalise on going forward.

Our immediate challenge will be how we continue to deliver against the urgent public health research alongside our restoration and reactivation plans to enable the restart of our usual non-COVID research activities.

Background

Drivers and Duty of Care

NHS England has a legal duty to promote research and the use of research evidence in the NHS. The NHS Constitution (2009) promotes the conduct and use of research as a core part of the NHS to improve the current and future health and care of the population.

Research remains a continuing national priority; the UK Government's January 2017 green paper on a modern industrial strategy for better living standards and productivity identifies ten pillars of growth, the first of which is science, research and innovation. The importance of research was further emphasized in the 2019 NHS Long Term Plan, which stated that 'Research active hospitals have lower mortality rates, with benefits not limited to those patients who participate in research'.

There is good evidence that trusts who participate in research have improved health outcomes and healthcare processes (1,2,3). Being research active also makes the organisation a more attractive employer and increases its prestige as well as bringing in additional income and generating cost savings for patient care.
In addition, patients and carers, appreciate the opportunity to take part in research and having access to novel treatments.

1. Ozdemir et al Research activity and the association with mortality. PLoS ONE 2015;10:e0118253
2. Hanney S et al. Engagement in research: an innovative three stage review of the benefits for health-care performance. Health Services and Delivery Research; 2013 1(8).
3. Boaz A, et al. Does engagement of clinicians and organisations in research improve healthcare performance: a three-stage review. BMJ Open 2015; 5:e009415

National research agenda & funding

UK clinical research activity is led by the National Institute for Health Research (NIHR). Created in 2006, as part of the strategy for the UK to become a global leader in health research, the NIHR is now a major part of the health research landscape and the UK's largest public funder of health research.

The NIHR's stated vision is 'to improve the health and wealth of the nation through research.'
The NIHR's mission is 'to provide a health research system in which the NHS supports outstanding individuals working in world-class facilities, conducting leading-edge research focused on the needs of patients and the public.'

The NIHR has radically transformed the funding mechanisms for health research in NHS Trusts, moving from historical block funding towards directed and commissioned research programmes and infrastructure initiatives. The NIHR established 15 Clinical Research Networks (CRNs) that provide comprehensive coverage of the whole of England. To support the implementation of proven good practice and innovation and to facilitate the effective working with industry 15 Academic Health Science Networks (AHSNs) were established in 2013.
The aim was to bring together local NHS, University and industry partners to accelerate the spread of innovation and improve quality of care.

The changes in funding have encouraged and facilitated academics and NHS researchers to work closely together, this is something we aim to further strengthen as part of our Research strategy.

Patient Experience

Studies have shown that patient satisfaction is higher in those who participate in research studies than those who do not. Indeed, our own data illustrate this with friends and family survey results for research patients being significantly higher than the Trust average. As participants in clinical trials, patients receive 1:1 care via the named, consistent research practitioner contact and therefore feel that they have more attentive care, leading to better satisfaction scores, even though the trial itself might not bring direct benefits to them.

Health outcomes

Recent evidence suggests that hospitals that support high quality patient-centred research can show better healthcare outcomes. This has led to a partnership between the NIHR, the Health Research Authority (HRA) and the Medicines and Healthcare products Regulatory Agency (MHRA), together with the Care Quality Commission (CQC), to develop new research indicators for use as part of CQC's monitoring and inspection programme.

The CQC is increasingly recognising the value of research and it has recently been identified that research active organisations fare better in CQC inspections. A key development has been the recent agreement by the CQC to include, for the first time, a question about research opportunities offered to patients in the CQC Annual Survey of Inpatient Experience.

This follows the decision to include key research related questions in its inspection framework for the Trust-wide 'Well-led' domain, a process that UHNM has already participated in with very positive results.

The additional research questions aim to determine how well an NHS Trust integrates research into its corporate strategy and planning, and how well research opportunities are communicated to patients. Together, this emphasis will drive the agenda to integrate research into patient care.

> ***Research is so important because without this we are not able to move forward to help diagnose patients and to improve their quality of life after an illness***

Ensuring patient and public involvement in the UHNM's research vision:

Research is only possible if patients and members of the public are willing to take part, and is only useful if it is directed at issues which are of concern to sufferers and those who care for them.

It is widely accepted that Research that reflects patient and public concern is more likely to attract funding and will enhance public and patient awareness of research, which helps build public confidence in the hospital.

A separate PPIE plan has been developed that outlines our aspirations and intentions for patient and public involvement and also covers research in BAME and hard to reach (under-served) groups such as those with learning difficulties, dementia and those who are non-English speaking. This aims to ensure the research we do reflects the needs of our local population and is inclusive and ensures equality. See Appendix 2.

Research Performance at UHNM

Ensuring patient and public involvement in the UHNM's research vision:

The table below outlines the research activity at UHNM over the last 3 years. The data for 2020/21 is skewed due to the COVID pandemic and the trial recruitment into Urgent Public Health trials. For this reason we plan to benchmark ourselves against the 2019/20 data, this will be the baseline data from which to monitor growth in research activity in the organisation. We aim for 10% growth year on year from 2019/20. Our long term goal is to compete with other University Hospitals within the region such as University Hospitals Coventry and Warwick (UHCW) and University Hospitals Birmingham (UHB), our current aim is to be the second most research active trust in the West Midlands within 3 years.

As of August 2021 we have 112 active PIs working on trials at UHNM.

There are more than 50 studies currently in pipe line open for 2021-22

Financial Year	Number of studies open to recruitment	Number of studies in follow up	Non-commercial portfolio (open/in follow up)	Commercial portfolio (open/in follow up)	Non-commercial-Non portfolio (open/in follow up)	Total Number of studies
2019/20	55	71	(38/45)	(14/20)	(3/6)	126
2020/21	25	39	(20/30)	(3/6)	(2/3)	64
2021/22	14	11	(9/7)	(5/4)	(0/0)	25

Achieving our mission

The UHNM Vision and Strategic intent

Mission

To improve clinical outcomes and experience through access to clinical research for our staff and patients that will be applicable across the wider NHS.

Research and Innovation Vision

To undertake world-class applied health services research and innovation in collaboration with regional partners that generate significant improvements to the delivery of our clinical services and the enhanced care of our patients. The vision will also see a significant increase in the participation of patients and staff in research activities.

Strategic aims

In line with UHNMs strategic objectives (appendix 1) – which includes achieving excellence in employment, education, development and research. R&I propose four broad strategic aims which underpin the delivery of our mission:

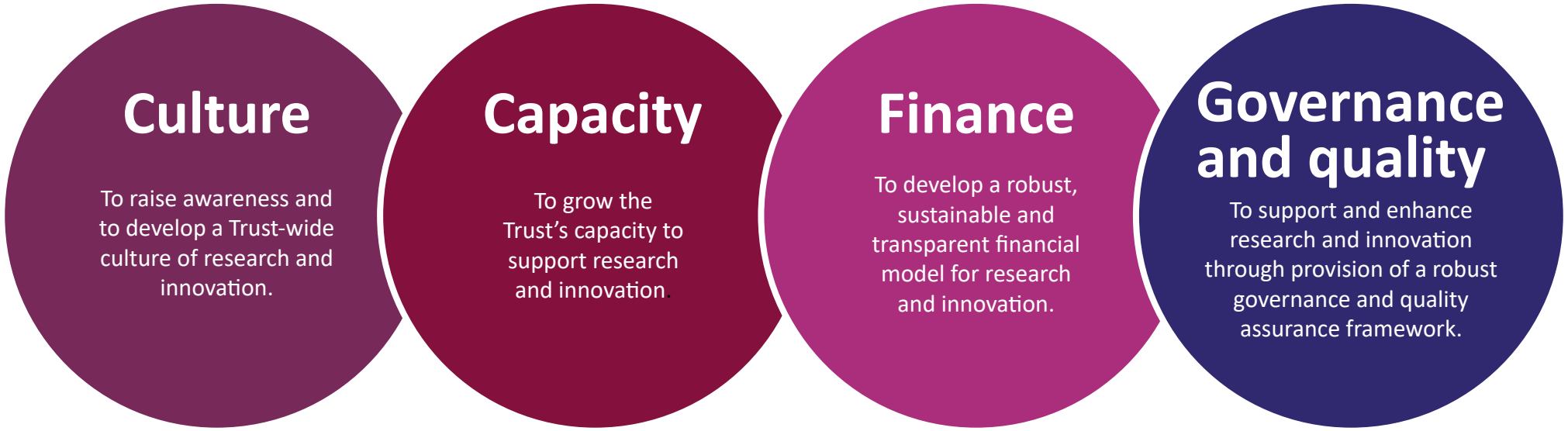
1. Culture: To develop a Trust-wide culture of research and innovation.

2. Capacity: To grow the Trust's capacity for research.

3. Finance: To develop a robust, sustainable and transparent financial model for research and innovation.

4. Governance: To support and enhance research and innovation through provision of a robust governance framework.

Trust priorities for research



These priorities are underpinned by ensuring:

- Provision of time, resources and facilities to deliver high quality research
- Skilled support to develop grant applications, and to navigate the regulatory and approval processes for the delivery of research
- Effective local partnerships to ensure we maximise potential to deliver high quality health research
- Identification and support for emerging talent and provision of research mentorship (supporting clinicians, nurses, AHPS to meet their potential)
- Embedding of research across the organisation ensure divisional understanding of the role of research
- Ensuring the patients have a voice
- Improving access to information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Strategic Aim 1: To raise awareness and to develop a Trust-wide culture of research and innovation.

What will we achieve?	How we will achieve it?	Success factor and time lines
Internal interactions		
Raising awareness of research in all teams	Research regularly on the agenda of multi-disciplinary meetings Research included in relevant staff supervision discussions/appraisals Look at inclusion of research in mandatory training sessions Increase visibility of research to patients/ visitors/staff. (i.e. set up research hubs where people can ask about studies, posters, radio adverts, communications programmes).	Recruitment of patients into NIHR portfolio studies forms part of the core job descriptions for all staff. R&I input into appraisals of all staff with PA time funded from the R&I budget or with research in their job plans The value of research recognised by rewarding activities through Chief Exec Awards, staff awards, CRN awards.
Celebrate successes	Encourage all staff to share successes with other staff and at appropriate meetings. Engage with employee/team nominations within the trust as well as external CRN awards etc. Foster a culture that thanks staff and showcases achievements (wellbeing newsletter, communications)	Reintroduce annual research and innovation event to showcase R&I and its impact on services and patient care Regular interaction with Trust communicationss to showcase research successes in Trust wide communications Showcase research impact stories on the R&I website
Ensure ability/readiness to open studies in all service areas	Identify research leads to drive the research agenda in all departments and are able to troubleshoot operational issues that are barriers to research	Research lead in place within departments Forum in place for research leads to meet and share best practice

Improving access to information

Ensure staff are able to access training and information relating to research on the intranet.

Ensure patients have access to research information and how to volunteer on the UHNM website.

Updated intranet and internet pages with up to date information relating the R&I, its processes, including up to date news and impact stories.

Set up a programme of training to support staff to develop as research leaders (i.e. PI master-classes, protocol workshops, stats clinics).

External interactions and partnerships

Work closely with local HEI (Keele University and Staffordshire University) to develop a collaborative research culture	Identify areas of strength between local partners. Maximise the use of honorary academic titles, in collaboration with local Higher Education Institutions (HEIs), which will lead to improved collaboration between existing groups. Work with regional partners to ensure sufficient methodological input into the development, submission, running and dissemination of clinical research	Increased number of individuals with honorary academic titles across research active specialities in the organisation. Improved links with RDS, CTU and methodological researchers. Dedicated resources ringfenced, or joint posts identified to facilitate research such as statistician or health economics support. Create a joint research strategy with local partners including Keele University, Staffordshire University and MPFT. To include high profile academic appointments, with dedicated time set aside for research.
Establish joint working opportunities with regional partners including Midlands Partnership Foundation Trust (MPFT)	Identify opportunities for joint working across organisations	Work with MPFT to develop evaluation plans for research in the region
Improve engagement with patients to increase visibility of research	Identify patient research champions to help drive the research agenda at UHNM Set up patient user groups within specialities	Co production of research involving patients at all stages of the research process Create a research PPI strategy

Strategic Aim 2: To grow the Trust's capacity for research.

What will we achieve?	How we will achieve it?	Success factor and time lines
Capacity of researchers to deliver research		
Workforce with capacity and capability for research	Clinician contribution to R&I will be appropriately reflected in the job planning process.	Studies open in clinical specialities who have not previously participated in research or where activity has been minimal.
Train, mentor and support research active staff to deliver high quality applied health research that is of benefit to our patients and services	Research learning events for staff Protected time for researchers to allow for research training and developing research grant applications Ensure UHNM has trained Good Clinical Practice (GCP) trainers to deliver in-house GCP training to departments	Create a network of research mentors and research champions across the trust Increased number of PIs and CIs at the organisation in both medical and non-medical professions.
Pump prime and support new researchers and nascent/emerging specialities and research programmes	Look at options to develop charitable funds, divisional accounts to support early stage research and dissemination. Provide a system for mentorship and development of individuals to enable them to become PIs ans CIs of the future	Increase locally funded Pilot projects. Increase in publications from new researchers/ specialities. Increased number of applications for fellowships and new researcher funding streams
Increase the visibility of under-represented professions such as AHPs, midwives and nursing by strengthening their research capacity and capability	Ensure that nursing/AHPs are identified and supported alongside medical staff as appropriate	Increased number of applications from nurses/ midwives/AHPs for academic scholarships, Fellowships and grant applications.

Capacity of the R&I team to deliver research

Review delivery team workforce and the capacity to deliver	Recruit to vacancies Match workforce to the complexity of studies Review the possibility of integrating research into clinical areas through using specialist nurses such as the Stroke Early Assessment Team (SEAT) nurses. This will increase exposure to research and facilitates recruitment into trials.	Clinical Research matron appointed to support strategic leadership of the delivery team. Specialist nurses engaged with research and appropriately trained Appointment of a senior Assistant Director of Nursing post for R&I in collaboration with Keele University to support strategic leadership
Ensure succession planning and support development of staff	Training and mentorship in place appropriate to roles	
Match capacity to deliver sponsored trials in line with pipeline of work	Review trial coordination capacity and offset costs with trial income	Named trial coordinator /data manger time on grants to allow growth of the team
Improve links with academic institutions and clinical trials units	Formalise a strategic vision between UHNM and Keele CTU	Collaborative working with CTU, with costing mechanisms that maximises research potential and benefits to both organisations
Support services engagement	Formalise research objectives and priorities with support services (Pharmacy, Imaging and Pathology).	Improved engagement with support services with clear priorities and objectives outlined and linked to funding

Strategic Aim 3: Develop a robust, sustainable and transparent financial model for research and innovation

What will we achieve?	How we will achieve it?	Success factor and time lines
Core financial aims		
Ensure R&I works with divisions to ensure appropriate spend of research monies	Make explicit and transparent the allocation of research funding to each division based on activity and strategic priorities	Funding allocated to divisions ringfenced for research activities (including training, dissemination through publications/conferences, and pump priming research within specialities)
Work with divisions and commissioners to identify Excess Treatment Costs (ETC) associated with research and how these can be met.	Identify a mechanism to enable ETC to be met Share best practice with local NHS organisations and CRN to facilitate the process	ETC no longer a barrier to the delivery of important UHNM led research
Commercially funded trials		
Increase the percentage of commercial trials within the UHNM research portfolio	More strategic selection of trials Increasing the spread of commercially active specialities – e.g. Dermatology was historically very research active Development of PIs or delivery staff who specialise in commercial activities Facilitating the use of remote SIV, SQV, monitoring follow ups Improve response times to sponsor querieS	Increased proportion of commercially funded research (currently 20% aim for 50%) Delivery of high quality research for commercial trials ensuring that UHNM is a site of choice for future studies

Academic Grants

Increase the pipeline and success of academic grants	Improved training for new CIs including protocol workshops and access to statistical support Supporting new researchers by working on Fellowships, clinical research scholars applications	Increased number of grant applications Funding secured from a variety of funders UHNM sponsored trials delivered to a high standard ensuring funders will look favourably at applications led by UHNM

Academic Grants

Increase in hosted trials that have income attached and provide good recruitment opportunities to support meeting recruitment targets set by the CRN	More strategic selection of projects (reduce number of unfunded studies unless there is a strategic reason to undertake them) Supporting development of new PIs- including the delivery of PI master classes Mentorship of PIs	Strong portfolio of hosted trials across a broad spectrum of specialities Increased the proportion of trials open which have funding to cover costs Recruitment targets met due to strategic selection of trials

Strategic Aim 4: To support and enhance research and innovation through provision of a robust governance and quality assurance framework. **

What will we achieve?	How we will achieve it?	Success factoR
UHNM Sponsored Trials		
Sponsorship of Clinical Trial of Investigational Medicinal Products (CTIMP) trials at UHNM	Test the Quality Management System (QMS) on a low risk CTIMP Undergo MHRA inspection to review progress	Ensure that UHNM have sponsored CTIMPs open and the studies can demonstrate robust oversight as measured by successful MHRA inspection within next 2 years
Upgrade our Quality management System to enable UHNM to sponsor medical device trials including apps	Look at what would be needed to deliver medical device trial sponsorship (ensure adequate training). Engaged with regulatory specialist to develop expertise	SOPS written and adopted into QMS to allow medical device sponsorship with next 3 years Identify medical device studies to test processes. Become the preferred Trust in the West Midlands for Medical Device companies wanting to undertake research
Robust sponsor trial oversight and efficient delivery and response to funders	Adopt redcap to support sponsored trial delivery Monitoring and audit plans in place for all sponsored studies All sponsorship decisions made by the clinical oversight group and decisions documented Appropriate training of the Quality Assurance team to ensure robust oversight of all trust sponsored studies	Redcap tested and adopted into practice Robust sponsorship processes ensure oversight for all UHNM led trials

Capability for rapid approval of projects and research prioritisation	Rapid approval process in place to support UHNM PI/CI to navigate approval process Engaged Clinical Oversight Group and peer review panel who are able to review and provide timely, critical feedback to the study team.	Fast track process in place for high priority UHNM led trials Increased membership of the peer review and Clinical Oversight Group panels

UHNM hosted trial performance

Ensure processes for remote monitoring and SIVs are in place to assist with hosted trial oversight by sponsors	Ensure processes and resources needed to allow remote monitoring are in place	Remote monitoring SOP in place regularly used Best practice shared with other local organisations
Transparent performance monitoring of all Research activity	Quarterly performance reports presented to the Executive R&I Steering Group Annual performance reports that can be shared at Trust board level and with partner organisations	Robust performance reports produced quarterly and used to feedback at appropriate meetings Annual performance reports shared both internally and externally

Quality assurance & regulatory compliance

UHNM-sponsored Clinical Trials of Investigational Medicinal Products (CTIMPs) are required to meet the Good Clinical Practice (GCP) standards as inspected by the Medicines and Healthcare products Regulatory Agency (MHRA). This focuses on all aspects of patient safety and data integrity and includes: a robust Quality Management System (QMS) to manage all systems and processes, relevant staff training and competencies, clear sponsor oversight, pharmacovigilance and secure data management. Outside this subset of studies, UHNM-sponsored non-CTIMPs, while not regulated by the MHRA, require robust oversight and management to fulfil requirements such as those required by research governance, research ethics, information governance and Health Research Authority (HRA). Hosted studies, while not sponsored by the Trust, do have some exposure to the MHRA as sponsors are required to ensure that sites recruiting patients to their studies are following the necessary standards. This is reflected in monitoring visit requests to provide assurance by external sponsors.

Aims for 2024

Recruitment

- Top 5 sites in research recruitment, Excellent metrics (NIHR)
- Top 10 sites in recruitment , Commercial studies
- Reputation as “Centre of Excellence” with increase in the number of home grown studies, increase in successful grant applications increase by 25%.

Engagement and Capacity

- Increase the number of Principal and Chief Investigators by 50% and 20%, respectively by 2022
- Incentivising Directorates, A research recognition scheme which rewards and incentivises our staff (to attract and retain our staff)
- Development of Academic unit status in at least 3 directorates

Partnership

- Well established partnerships with Keele and Staffordshire University : Joint academic/clinical posts
- Establish three new strategic partnerships with the industry and charity sectors by 2022
- deliver at least 5 CRN portfolio studies requiring cross system working in partnership with local NHS organisations and the CRN

Staff retention

- Develop a rigorous staff support and appraisal and development process within the Clinical research office
- Supportive training pathways achieved
- Enhancements in core infrastructure proportional to increase activity

Finance

- Increase the combined annual research income by 30%.
- Achieve a 50% increase income from commercial research
- Deliver 10 new SME research and innovation collaborations by 2022.

Developing research areas of strength/Focus on key areas in research

Across UHNM, there are a number of individuals, across a diverse array of clinical departments, who are “shining lights” within their respective fields of research and innovation, many of whom have international profiles. Our aim is to support these individuals and to develop more research leaders within the organisation. Specifically, we plan to offer dedicated PAs for a fixed time period and consider creating senior lecturer or professor posts with our Academic partners for individuals who demonstrate consistent research outputs.

R&I have been working with individual specialities to identify opportunities and develop plans to improve their academic research profiles. To date we have been developing links with Cardiology and Renal medicine and our aim is to expand this to other aspiring departments such Cancer, Stroke, Respiratory medicine, Obstetrics and Gynaecology and Radiology. With that in mind R&I have been supporting the stroke team in their application to reapply for Hyper acute Stroke Research Centre status and we are committed to supporting this on a long term basis. Similarly, a Cancer Clinical Research Facility has been established to oversee and lead the development of cancer studies across the trust.

Cancer Clinical Research Facility

The Cancer Clinical Research Facility was established in 2020 with a view to enhance both academic (UHNM sponsored) and hosted research trials within the broader cancer research area. This presents a massive opportunity for UHNM to become established as a leader in cancer research.

UHNM has a long established track record in academic as well as commercial cancer clinical trials particularly in breast cancer, lung cancer, myeloma and acute leukaemia. We need to replicate similar success and improve research in all cancers through a strategy of focussing on all modalities of interventions such as systemic anti-cancer therapies, radiotherapy, early detection/screening and genomics.

Active participation in clinical trials is integral to provide excellent patient care particularly in cancers. Our vision is to have an excellent cancer clinical research programme, well supported by clinical research infrastructure, to enable optimal cancer care comparable to international standards.

CCRF Aims

1. Patients in North Midlands to have access to cancer clinical trials comparable to leading institutions in the UK. All patients across all cancer sites to have the opportunity to participate in clinical trials

2. To open clinical trials for most of the cancers relevant to UHNM and provide access for patients to participate

3. At least 10-15% of newly diagnosed patients are recruited to clinical trials

4. Establish a balanced portfolio of clinically relevant and patient centred trials comprising academic as well as commercial trials. The portfolio is likely to be dominated by academic trials comprising 60 to 70% of the portfolio and commercial trials 30 to 40%

5. Facilitate rapid incorporation of genomics in cancer care and ultimately to deliver precision medicine

6. Facilitate wider engagement of clinical teams in cancer research and enhance training in clinical research

7. Establish streamlined pathways to assess feasibility and open clinical trials at UHNM without time delays in interactions between departments

8. Work in collaboration with regional and national clinical research networks to optimise clinical research at UHNM.

9. Attract and establish researchers with a good academic track record, develop collaborative links with local HEI partners to support their progress with the aim of developing future generations of researcher leaders at UHNM.

Hyper Acute Stroke Facility

The presence of the Hyperacute Stroke facility builds on an established track record of accrual to stroke clinical trials and academic strengths at UHNM. This facility will form the foundation for further growth of our research portfolio in the stroke arena and we are looking at innovative ways to support this such as training and supporting the stroke early assessment team nurses to support recruitment into hyperacute stroke trials, this will also boost engagement with the clinical teams and provides support in addition to the R&I delivery team out of hours to recruit to these clinically important studies.

Staffordshire Children's Hospital at Royal Stoke

Children's Hospital R&I strategy can broadly be outlined as:

1. To involve children and young people and their families in the co-creation and delivery of research studies. No research about me, without me.

2. Build on existing relationships with Keele University to support and develop independent research, funded in partnership with major funding bodies (NIHR, RfPB and MRC) and industry. Stronger together.

3. Work with UHNM R&I teams to allow Children and Young People to participate in world-leading research studies e.g. NIHR, RfPB and commercially funded research studies. Building and maintaining research capacity.

The current independent research focus of SCH@RS is predominantly within Paediatric Respiratory Medicine, with active research in children with bronchiolitis, asthma, cystic fibrosis and protracted bacterial bronchitis.

Pharmacy

There is a well-established pharmacy Clinical Trials Team supporting CTIMP studies both in CRN funded research and commercial studies at UHNM. Future planning of pharmacy services will need to take account of both existing clinical networks such as cancer collaboratives and future arrangements in ICSs and provider collaboratives.

The R and I Strategy for Pharmacy includes:

1. Build capacity in the pharmacy team to support the expanding portfolio of clinical trials undertaken at UHNM.

2. Build capability of the team to support personalised genomic medicines including cellular, gene therapy and ATMPs requiring training and accreditation.

3. Ensure sufficient aseptic capacity available to support the delivery of studies

4. Ensure quality management systems are robust to support the Trust ambition to sponsor CTIMP studies

5. Work with local HEI partners to provide expert knowledge and support to sponsored studies

6. Develop existing relationships with other NHS Trusts to provide pharmacy services to support their research ambitions

7. The Pharmacy will expand its practice based research through links with clinical specialities and HEI partners

8. Support the credentialising of Consultant Pharmacists with regard to the Research and Evaluation element to deliver effective practice in line with the Royal Pharmaceutical Society Advanced Pharmacy Framework

9. Continue to work with existing clinical networks such as cancer collaboratives and future arrangements in ICSs and provider collaboratives to ensure access to clinical trials from a pharmacy perspective.

Summary and concluding comments

It is clear that participation in R&I activity is not only a national requirement, but that it also brings major benefits to the Trust, its staff and the population it serves. This strategy seeks to maximise these benefits by focusing on empowering patients as partners in high quality research, increases visibility internally and externally to UHNM and aims to support and nurture a sustainable workforce with the skills to deliver world class research. The strategic aims outlined will enable us to work with partners to strategically and operationally align our research to the clinical services and needs of the local community.

We believe that the four strategic aims encompass the elements necessary to facilitate this. Indeed, if we are able to develop an R&I culture underpinned by robust governance, we believe that increased capacity and financial stability will become part of a virtuous circle that will enable R&I activity to grow and develop further.

Appendix 1

Appendix 1 – UHNM Strategic Objectives

Appendix 2

Appendix 2: R&I Patient and Public Involvement and Engagement Plan outline

Mission
To improve clinical outcomes and experience through access to clinical research for our staff and patients that will be applicable across the wider NHS.

Research and Innovation Vision
To undertake world-class applied health services research and innovation in collaboration with regional partners that generate significant improvements to the delivery of our clinical services and the enhanced care of our patients. The vision will also see a significant increase in the participation of patients and staff in research activities.

Our PPI Strategic aims align to the UK Standards for Public Involvement in Research:
1). Inclusive Opportunities
Offer Public Involvement opportunities that are accessible and that reach people and groups according to research needs

2) Working together
Work together in a way that values all contributions, and that builds and sustains mutually respectful and productive relationships

3) Support and learning
Offer and promote support and learning opportunities that build confidence and skills for public involvement in research

4) Communications
Use plain language for well-timed and relevant communications, as part of involvement plans and activities

5) Impact
Seek improvement by identifying and sharing the difference that public involvement makes to research

6) Governance
Involve the public in research management, regulation, leadership and decision making

Quality Governance Committee Chair's Highlight Report to Board

21st October 2021

1. Highlight Report

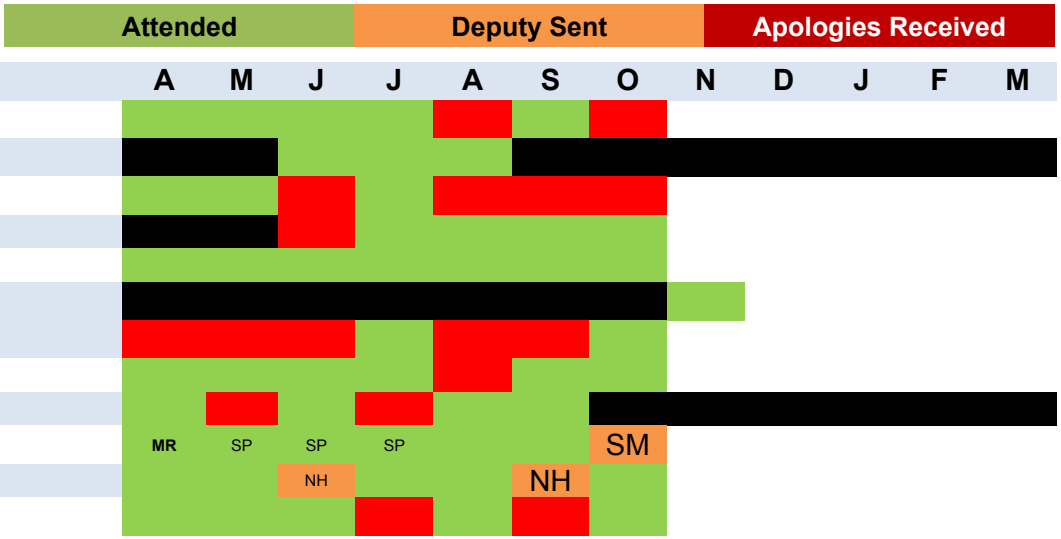
Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• During Q2 there were 5 new serious incidents reported in Maternity, one of which is being investigated as a Healthcare Safety Investigation Bureau Investigation although de-escalation has been requested, the remainder are being investigated internally and the findings will be reported once concluded • Changes in CNST requirements for Maternity Services mean that compliance cannot be attained if 80% of standards within the Saving Babies Lives Care Bundle are not achieved – there are some challenges associated with these standards which are being worked through • 1 MRSA Bacteraemia was reported in Quarter 2 and C Difficile cases are above trajectory with 58 cases versus 48 trajectory • An outbreak of Carbapenemase producing Enterbacteriaceae (CPE) has occurred within the West Building which has been identified through routine screening; a number of actions have been identified and are in the process of being implemented including a full terminal clean • The impact of eliminating corridor waits in line with national guidance has resulted in patients remaining on the ambulance and this has created new challenges for the system • Ligature risk has been identified across the organisation due to environmental / building factors, this is mitigated through increased monitoring arrangements • There has been a 4 month increase in Pressure Ulcers which coincide with a lapse in care; focus on this forms part of our Improving Together priorities • Section 29a Warning Notice received by the CQC in relation to Mental Health Assessment and medical workforce within Emergency Department; actions underway for completion by the end of November • Pharmacy workforce challenges are the top risk on their Directorate Risk Register	• Continued work to be undertaken within the Maternity Department and the wider organisation around identification of lessons learned, changes in practice as a result and the monitoring of implementation • Business case under development for Portacount machine as set out within the Infection Prevention and Control Board Assurance Framework • Multidisciplinary Group within the Emergency Department which has a specific focus on time to initial assessment; an action plan with associated KPIs are in place to support this workstream • Work is underway to embed implementation of the NHS 111 Kiosks • Implementation of a number of recommendations associated with improving Sepsis Screening compliance – ongoing audits of compliance will continue • Deeper Dive into learning arising from an incident which occurred in February 2021 to be presented at the next meeting • New guidance from NHS Resolution in relation to GIRFT has led to a significant piece of work within legal services where high value / high volume claims are being focussed upon with a review of over 300 claims across 21 specialties being undertaken in order to identify learning • Work ongoing in response to a request from NHSIE in relation to the mortuary; Board assurance is required and will be escalated to the Board
Positive Assurances to Provide	**Decisions Made**
• Maternity Services have submitted all of the evidence required to the national online Ockenden portal and are currently awaiting further feedback • No harms in the last 6 months with regard to triage or waiting within the Emergency Department, there have been two external peer reviews of the services by the CCG and NHSIE and they have acknowledged that the ongoing improvements are having a positive impact resulting in improved patient safety • Health and Safety Executive have revoked a previously reported RIDDOR reportable death associated with Covid-19 and have confirmed they are satisfied with the actions taken • Patient Safety Incidents with moderate harm or above have continued to show a reducing trend for 6 months • First Trust using the monoclonal antibodies in the UK and a successful upgrade has occurred within the Pharmacy Department which has mitigated cyber risk previously highlighted	• Approval of Ligature Risk Assessment Tool based on a corporate approach which will be monitored via the Mental Health Steering Group – it was agreed to discuss this with the Care Quality Commission as part of the ongoing dialogue around Mental Health Assessment

Comments on the Effectiveness of the Meeting
• Very busy agenda; going forward we need to see better Executive Summaries in some areas and a meeting etiquette setting out expectations is to be developed and circulated

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Q2 Maternity Serious Incident Report	Assurance	13.	Legal Services Annual Litigation Report	Assurance
2.	Saving Babies Lives Care Bundle: UHNM Compliance September 2021	Assurance	14.	Section 29A Warning Notice	Assurance
3.	Ockenden Update and Action Plan	Assurance	15.	Q2 Board Assurance Framework	Approval
4.	Q2 Infection Prevention HAI Report	Assurance	16.	Executive Health & Safety Group Assurance Report (October 2021)	Assurance
5.	Infection Prevention & Control BAF	Assurance	17.	Quality & Safety Oversight Group Highlight Report (October 2021)	Assurance
6.	Health and Safety Executive - Letter of Contravention to the Trust	Assurance	18.	Briefing paper & QIA for the temporary suspension of home birth services.	Information
7.	Trust Ligature Assessment	Assurance	19.	Temporary Reconfiguration of Midwife Birth Centre Briefing	Information
8.	ED BAF	Assurance	20.	FMBU Update	Information
9.	Sepsis Review	Assurance	21.	Review of Meeting Effectiveness	Information
10.	M6 Quality & Safety Report	Assurance	22.	Review of Business Cycle	Information
11.	Get It Right First Time Update	Assurance	23.	Summary of Actions and Items for Escalation to the Trust Board	Approval
12.	Medicines Optimisation Report Q1 / Q2	Assurance	24.	Issues Associated with Process, Procedures and Compliance for escalation to Audit Committee	Approval

3. 2020 / 21 Attendance Matrix



Executive Summary

Meeting:	Trust Board (Open)	**Date:**	3rd November 2021
Report Title:	Maternity New Serious Incident (SI) Report Summary Quarter 2 2021	**Agenda Item:**	9.
Author:	Donna Brayford, Quality & Risk Manager; Sharon Bailey, Lead Midwife for Education and Development; Claire Hill, Lead Midwife for Education and Development		
Executive Lead:	Ann-Marie Riley, Chief Nurse		

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

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

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

Situation:

Following the publication of the Ockenden review, Trust Boards are to have specific sight of Maternity Serious Incidents on a quarterly basis. This report provides a summary of the numbers and types of Serious Incidents formally logged on STEIS (national reporting system) by Maternity during Quarter 2 (2021). A Serious Incident report is presented to the Directorate and CWD Division monthly.

Assessment:

In Q2 - 5 new serious incidents were reported:

July 2021	1 serious incident
August 2021	1 serious incident
September 2021	3 serious incidents

Category of Incidents:

- 1 Healthcare Safety Investigation Branch (HSIB) investigation.
- 0 Retrospective incidents following completion of investigation.
- 2 new incidents to be investigated by local Root Cause Analysis (RCA).
- 2 new incidents to be investigated by the Perinatal Mortality Review Tool (PMRT).

Immediate Actions:

- A Memo has been distributed advising all medical and midwifery staff that women receiving ondansetron in the first trimester of pregnancy for hyperemesis should be informed of the small risk of cleft lip /and or cleft palate.

Areas of concern/escalation:

- The Risk Register score for maternity triage has been increased to 15. Maternity services are now planning to introduce 24/7 triage cover by a band 7/senior band 6 Midwife to answer triage telephone calls. Maternity are currently identifying how this service can be supported within our establishment. The plan has been included in a workforce paper that is currently in draft which will be presented throughout UHNM and to the executive teams.

Maternity New Serious Incident Reporting Process – for information (Quarter 2 2021)

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

HSIB Investigations and SI Reporting.

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

Key Recommendations:

The Trust Board accepts and is assured by the report.

1. Definitions

Antepartum haemorrhage - defined as bleeding from the genital tract during pregnancy.

Cardiotocograph (CTG) - is used during pregnancy to monitor fetal heart rate and uterine contractions.

Cooling Therapies are described as:

Passive – turning off heating equipment and removing covering from the baby.

Active – placing the baby on a temperature controlled cooling mattress or using a temperature controlled cooling cap.

Therapeutic - is a procedure where the infant is cooled to between 33 and 34 degrees Celsius, with the aim of preventing further brain injury following a hypoxic (lack of oxygen) injury. Hypothermia is usually induced by cooling the whole body with a blanket or mattress.

Hypoxic ischaemic encephalopathy (HIE) - is a type of newborn brain damage caused by oxygen deprivation and limited blood flow.

Low cord pH – may indicate a baby has suffered a significant hypoxic incident before birth.

Perinatal Mortality Review Tool (PMRT) - Systematic, multidisciplinary review of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care.

2. New Serious Incidents

Maternity have reported 5 Serious Incidents during Q2 (2021), July (n=1), August (n= 1) and September (=3). Table 1 gives a brief description of the incident and immediate actions taken. It has been agreed by the Directorate, Division and Trust Board that all HSIB investigations will be reported as Serious Incidents and then de-escalated if required.

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

SI ID/ Date on STEIS	Datix ID/ Incident Date	Incident description	Immediate Actions	Outcome
2021/16483 July 2021	248229 June 2021	• Inappropriate induction at 34 and 6 days. • Mother received a caesarean section and spinal anaesthesia. • Baby delivered at 35 weeks and required admission to the neonatal unit. • Potential impact upon subsequent labour for the mother.	• Individual practitioner met with educational supervisor. • Verbal and written Duty of Candour completed. • Local Root Cause Analysis in progress.	• Mother and Baby well. • Awaiting outcome of investigation.
2021/16264 August 2021	250418 July 2021 HSIB	• Early Neonatal Death. • Cord Prolapse at home. • Deteriorating maternal condition on admission to Maternity, transferred to intensive care.	• HSIB referral completed. • Verbal and written Duty of Candour completed • Immediate staff de-brief performed. Staff support arranged. • Staff de-brief offered to ambulance crew. • No further immediate safety actions identified.	• Mum well, discharged home. • HSIB investigation in progress, awaiting report.
2021/19485 September 2021	251596 Sept 2020	• Term baby born with Cleft Lip and Palate. • Unable to locate record of discussion of risk of Ondansetron when administered to mother at less than 12 weeks gestation. • Medicines and Healthcare products Regulatory Agency (MHRA) update states 'Ondansetron: small increased risk of oral clefts following use in the first	• Memo sent to all medical staff to remind medical staff to counsel women appropriately. • To perform spot case audit on women who have received ondansetron. • Verbal and written Duty of Candour completed. • Local Root Cause in progress. Joint RCA with pharmacy.	• Baby and family continue to receive support from Birmingham Cleft Lip and Palate team and UHNM paediatric gastroenterology.

SI ID/ Date on STEIS	Datix ID/ Incident Date	Incident description	Immediate Actions	Outcome
		12 weeks of pregnancy'. Recommendation: if the clinical decision is to offer Ondansetron in pregnancy, women must be counselled on the potential benefits and risk of use, both to her and to her unborn baby and the final decision should be made jointly.	• Delay in reporting as incident report triggered by GP complaint during the post-natal period. • Adverse drug reaction reported to MHRA.	
2021/19478 September 2021	252148 August 2021	• Ante partum Stillbirth at 31 weeks and 4 days gestation. • Delay in triage on admission to Maternity Assessment Unit (MAU).	• Plan to implement 2nd triage midwife to assist in performing triage as per UHNM guidelines. • Head of Midwifery considering a new staffing model to enable 24 hour phone triage by a senior midwife. • Due to the frequency of inability to triage risk register score increased to 15. • Datix completed for every triage breach. • PMRT Multi–disciplinary review will be completed. Verbal and written DOC completed.	• Mother and family continue to be supported by the bereavement team.
2021/19762 September 2021	254486 September 2021	• Neonatal Death at 30 weeks and 6 days gestation. • Parents have requested a coroner's inquest due to their concerns around care provided on the antenatal ward prior to baby's delivery. • Local media reporting.	• Staff support arranged from the Professional Midwifery Advocate. • Coroner's inquest to be held. • To consider requesting an external Trust to be lead reviewer to give parents assurance of openness and transparency. • Verbal and written DOC completed.	• Mother and family continue to be supported by the bereavement team.

3. Current Serious Incidents in progress

Maternity have 12 ongoing serious incidents (including new incidents).

Investigation in progress: 8 serious incidents (4 local RCA, 2 HSIB, 2 PMRT).

Investigations completed/awaiting to be presented and closed by Risk Management Panel and CCG SI Group: 4 incidents.

SI ID & date	Datix ID & date	Incident description	Immediate Actions	Outcome
2021/685 Investigation completed	235087 December 2020	• A category 2 emergency caesarean section (CS) (Category 2 CS is maternal or fetal compromise which is not immediately life threatening) for failure to progress in labour. • Impacted fetal head (fetal head is stuck in the pelvis). • Baby required transfer to the neonatal unit for passive cooling.	• This was an obstetric emergency which was managed in accordance with guidance from the maternity team. No immediate omissions in care noted that would have contributed towards the outcome. • Delay in reporting due to waiting for confirmation of HSIB referral. In future, the risk team will proceed with the 72 hour brief. • HSIB referral rejected as baby was passively cooled not actively cooled. Team initially informed baby was actively cooled. • No immediate actions. • Local RCA completed. For presentation at division. De-escalation has been requested.	• Baby recovered quickly, required very minimal intensive care support. • Baby is well, feeding as expected, good reflexes, no concerns with vision or hearing. • To be followed up in 4-6 months then discharged by neonatology if all remains well.
2021/684 Investigation completed	235002 December 2020	• A category 1 emergency caesarean section (Category 1 CS immediate threat to life of woman or fetus) at 36+6 weeks for antepartum haemorrhage; a placental abruption (placenta separates from the uterus) was confirmed at CS. • Baby needed transferring to the neonatal unit and required therapeutic cooling.	• This is an obstetric emergency which was managed in accordance with guidance from the maternity team. No immediate omissions in care noted that would have contributed towards the outcome. • The incident does not fulfil reporting criteria for referral to the HSIB. • No immediate actions. • Local RCA completed. For presentation at Division, then request de-escalation.	• MRI showed no evidence of newborn brain damage (HIE). • Baby is progressing very well, feeding as expected, good reflexes, no concerns with vision or hearing. • To be followed up in 3 months, then to be discharged by

SI ID & date	Datix ID & date	Incident description	Immediate Actions	Outcome
				neonatology if all remains well.
2021/2331 Investigation completed	236483 HSIB January 2021	• A category 2 emergency caesarean section at 37 weeks for suspicious cardiotocograph (CTG). • Baby needed transfer to the neonatal unit and required active cooling. The cooling was discontinued on day 3. The baby continued to be ventilated and experienced seizures.	• The care provided appears to have been managed in accordance to maternity and neonatal guidelines. • Delay in reporting due to waiting for confirmation of HSIB referral. In future, the risk team will proceed with the 72 hour brief. • No immediate actions. • HSIB investigation completed, triangulation meeting family completed. • Presented at Directorate and division. To be presented at RMP – to continue de-escalation.	• Baby sadly passed away.
2021/3124 Investigation in progress	218366 March 2020	• A category 1 caesarean section at 37 weeks and 6 days for a pathological cardiotocograph (CTG); a pathological CTG is a CTG with 1 abnormal feature or 2 non reassuring features. • Baby needed transferring to the neonatal unit and required active cooling. • Retrospective Incident.	• This is an obstetric emergency which was managed in accordance with guidance from the maternity team. • Retrospective Serious Incident, a brief overview took place at the time of the incident but it was not formally investigated. COVID-19 escalations were being discussed apace at the time and the Directorate also experienced a maternal death in the unit at a similar time point which could account for why the incident was overlooked at the time. Recognised through failsafe audit that an RCA required. Sincere apologies given to parents for delay. • Parents given option to request a HSIB investigation in view of late formal investigation, declined. • No immediate actions. • Local RCA ongoing.	• Baby continues to be care of the paediatric team. • Some motor reflex delay noted, parents report abnormal jerky movements. • Baby currently waiting for a further MRI and follow up.

SI ID & date	Datix ID & date	Incident description	Immediate Actions	Outcome
2021/3974 Investigation completed	237628 January 2021	• Sudden unexpected post-natal neonatal collapse at 25 minutes of age. • Baby was intubated and transferred to the neonatal unit. • Active cooling was commenced on admission to the neonatal unit.	• HSIB referral rejected as MRI reported to be normal, local RCA ongoing. • Immediate action - the neonatal team were not crash bleeped following the neonatal collapse. MDT decision that clinical staff should crash bleep the neonatal team for any sudden unexpected postnatal collapse of a newborn baby. Memo sent to all areas. • Local RCA completed –waiting to be presented at directorate.	• Baby is well, feeding on demand, with normal reflexes on her last examination. • To be reviewed again in 3 months then if remains well will be discharged by the neonatology team.
2021/6701 Investigation in progress	239973 February 2021	• Acute collapse following major maternal haemorrhage. • 17+4 weeks pregnant with twins, Findings of a ruptured rudimentary horn of the uterus (a uterine abnormality). Both fetus's in the abdomen. • Ultrasound scans did not diagnose that the pregnancy had implanted in a rudimentary uterine horn.	• Potentially two opportunities to identify issue and instigate different management plan • Local RCA ongoing.	• Mum remains under the care of the midwifery team • Seen at 6 weeks post – operatively, and mum is recovering well. Debrief given.
2021/9749 Investigation in progress	243402 Aug 2021	• Baby required transfer to the neonatal unit and required active cooling. • Forceps delivery following a prolonged fetal bradycardia possibly due to placental abruption.	• Case reported to HSIB for investigation • Support provided to the family. • Draft HSIB report received by the trust to be reviewed for factual accuracy and shared with staff for approval.	• MRI report revealed no convincing abnormality to suggest HIE or structural changes to explain seizures. • Baby was discharged home with mum at 24 days of age. Baby continues to receive anti convulsants. Plan to repeat MRI if seizures persist.

4. Serious Incidents closed during Q2 – Learning and Actions

2021/4461

Datix ID: 223201 Incident Date: 21.06.20

- **Actively Cooled Baby and Neonatal Death.**
- **Retrospective SI following receipt of HSIB report.**
- **The HSIB clinical panel consider that an urgent neonatal review was indicated following the neonatal collapse and there was a delay in calling for the neonatal team.**
- **Ongoing support provided to the family by the bereavement team.**

LEARNING AND ACTIONS

What has now changed?

1. **Every secondary neonatal post-natal collapse will now trigger an emergency neonatal crash call.**
2. **Secondary neonatal post-natal collapse is now included in the annual mandatory training sessions and incorporated into live drills.**
3. **Audit completed to evaluate use of interpreter services for women and families who do not speak English. This audit will be repeated quarterly to assess effective improvements in services.**

5. Current HSIB Cases

2 Current HSIB cases ongoing

Executive Summary

Meeting:	Trust Board	**Date:**	3rd November 2021
Report Title:	Infection Prevention Board Assurance Framework	**Agenda Item:**	10
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
- Business case for the portacount machine remains on the action plan
- 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 on the action plan
- CPE colonisation outbreak west building and subsequent 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
- West building estates/building long standing issues
- Difficulty with dismantling of electronic beds for decontamination at ward level
- Cleaning issues in West Building both Domestic and Nursing – review of cleaning assurance processes underway

Progress

- External company continues to assist with mask fit testing
- Ward are currently receiving reminder calls to prompt COVID screening
- Portacount business case in progress
- CPE colonisation outbreak in West Buildings review in progress. Deep clean in process
- Estates dismantled beds to aid with decontamination in the short term

Key Recommendations:

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

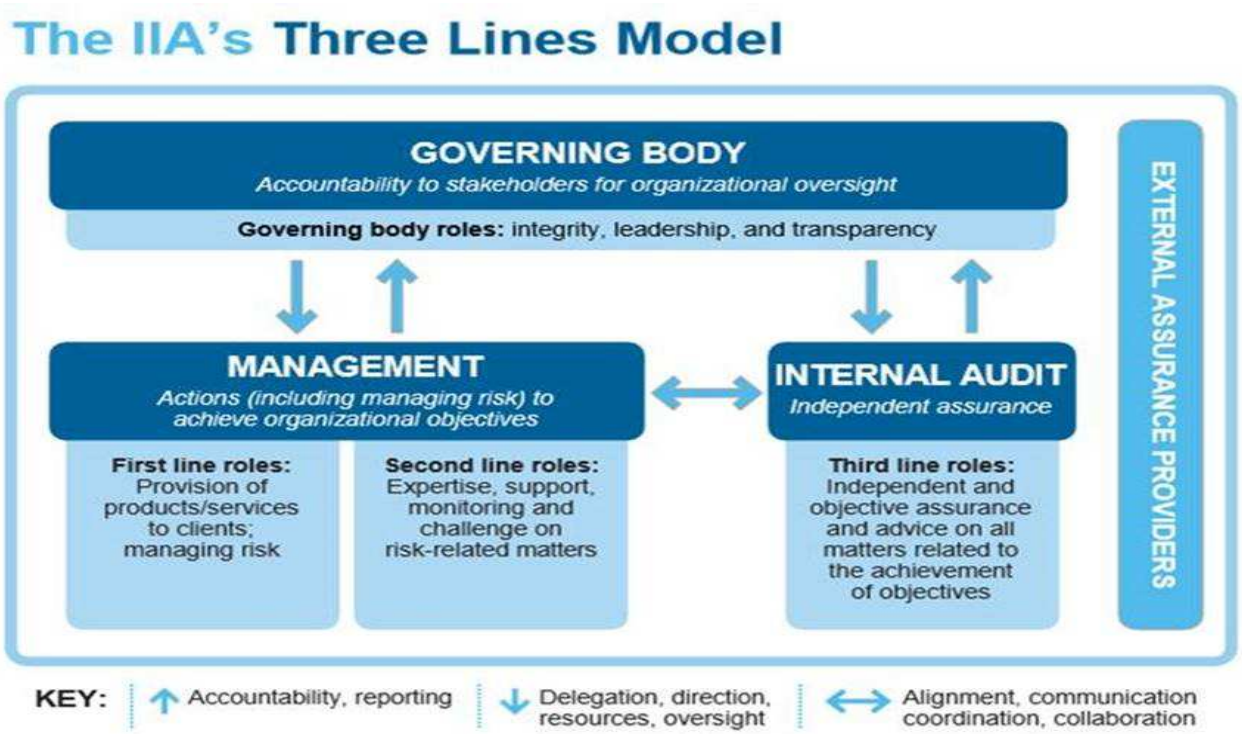
University Hospitals of North Midlands NHS

Infection Prevention and Control Board Assurance Framework

October 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	High 12	↑
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	High 12	↑
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	4	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	Likelihood:	1	End of Quarter 2
Consequence:	3	3	3	4		Consequence:	3	
Risk Level:	6	6	6	12		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 • Triaging and SARS-CoV-2 testing is	• 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**
	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 Areas.		

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		• 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-c ovid-ward-round-guicng-and-testing-for-co  guidance-on-screeni		
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	• FFP3 Training records further improvement part of health and safety portacount business case

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	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	On-going 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 4 Progress Report	BRAG
1.	1.1	Up- to- date COVID -19 Divisional pathways	ACN's	30/09/2020	Associate Chief Nurse contacted and request made for COVID -19 pathways 28th July 2020. ED pathways in place and also County to Royal transfer of COVID positive patients. Divisional restoration plans in progress	Complete
2	1.1	Revised pathways to include actions for extremely vulnerable patients who are admitted into the Trust	ACN's	31/10/2020	4th September Chief Nurse DIPC request at senior meeting that extremely vulnerable patients are included in revised pathways. October 2020 Extremely vulnerable patient recommendations included into the COVID ward round guidance document. November 2020 – Confirmation from ED County highly vulnerable patients are admitted into single cubicle. Consultant ED Royal confirms the same process. Children's – highly vulnerable have direct access to ward	Complete
3	1.2	NHSI key point 4 : Patients are not moved until at least two negative test results are obtained, unless clinically justified	Microbiologist/ ACN's	31/05/2020 31/08/2021 29/10/2021 31/12/2021	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.	
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 Project. Plus mask fit tester will be available to test staff using the portacount machine. The portacount is a quantitative test and	Complete

					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. <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> Portacount Business case withdrawn at Health and Safety <u>July 2021 update</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 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. <u>March 2021</u> Screening for elective high risk surgery to resume This action continues to be under review during COVID Pandemic	complete

					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	On- going CPE colonisation outbreak in west building.	DIPC/IP team	31/10/2021	October 2021 Infection prevention review on –going Multi- disciplinary /agency approach Out Break Team/Meetings External support and visits NHSEi and UK HSA Terminal cleans using HPV in progress CPE screening continues Action plan in place	On-going
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		October 2021 Action plan in place Risk level raised	On-going

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	4	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	Likelihood:	1	End of Quarter 2 2021
Consequence:	3	3	3	4		Consequence:	3	
Risk Level:	6	3	3	12		Risk Level:	3	

Control and Assurance Framework

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
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 timely	• Clinical Group action log • PPE training records which are held locally	
2.2	Designated cleaning teams with appropriate training in required techniques and use of PPE are assigned to Covid-19 isolation or cohort areas. Assurance processes are in place for monitoring and sign off terminal cleans as part of outbreak management	• SOP and cleaning method statements for domestic teams/Sodexo • PPE education for Domestic /Sodexo staff • Initial meetings held with facilities/estates to discuss and plan COVID-19 requirements IP agenda item • Representatives from the division are attending the daily tactical meetings, and an E,F & PFI daily	• Clinical teams sign off any terminal cleans requested to say that clean has been completed to the agreed standard. • Spot check assurance audits completed by Sodexo and retained during COVID period • Cleanliness complaints or concerns are addressed by completing cleanliness audit	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		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	walkabouts with clinical teams, and CPM / Sodexo. • PPE and FFP3 mask fit training records with are held by Sodexo /retained services • GREAT training record cards are held centrally by Sodexo for all individual domestics • Key trainers record • Notes from Sodexo Performance Monthly meeting , Sodexo Operational meeting , Divisional IP Meeting and facilities/estates meeting	
2.3	Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance.	• SOP for terminal and barrier cleans in place and was reviewed in February 21. • 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.	• C4C audits reinstated July 2020 these results are fed into IPCC • Completion of random 10% rooms each week by Sodexo to ensure that all rooms are cleaned to the agreed cleaning standards – Any rooms that are found to be below standard are rectified immediately. • Terminal clean electronic request log • Patient survey feedback is reviewed by joint CPM /	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
			Sodexo group and action plan completed if needed.	
2.4	Increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance.	• Increased cleaning process (barrier clean) included in Infection Prevention Questions and Answers manual • Process in place for clinical areas with clusters and HAI cases of COVID -19 requiring increased cleaning and /or terminal cleans	• Barrier clean request electronic log held by Sodexo and circulated following any updates / removal of barrier cleans to Sodexo and Trust staff including IP Team. • IP spot checks for clinical areas with clusters of COVID -19 or HAI cases of COVID -19 • Disinfectant check completed during IP spot checks • Additional ad-hoc cleaning requests can be requested by clinical teams 24/7 should the environment become contaminated between scheduled cleans.	
2.5	Attention to the cleaning of toilets / bathrooms, as Covid-19 has frequently been found to contaminate surface in these areas.	• Cleaning schedules in place • Barrier cleans (increased cleaning frequency) process in place which includes sanitary ware and other frequent touch points	• Cleaning schedules are displayed on each ward • Additional ad-hoc cleaning requests can be requested by clinical teams 24/7 should the environment become contaminated between scheduled cleans.	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
2.6	Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses.	• Virusolve and Tristel disinfectant used • Virusolve wipes also used during height of pandemic	• Evidence from manufacture that these disinfectants are effective against COVID -19 • Evidence of Virusolve weekly strength checks , held locally at ward /department level • IP checks that disinfectant is available during spot checks	
2.7	Manufacturers guidance and recommended product 'contact time' must be followed for all cleaning / disinfectant solutions / products.	• Contact times detailed in SOP and cleaning methods statements • Included in mandatory training • Included in IP Q+A • Disinfectant used routinely	• Monthly on-going training is completed with all domestic staff to ensure that core competencies such as cleaning effectively with chemicals is trained out on a frequent basis. • Where outbreaks are identified, regular staff who clean in this area have competency checks to 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	• Cleaning of frequently touch points included in Barrier clean process • Offices and back offices also supplied with disinfectant wipes to	• IP checks • Barrier clean request log • Terminal clean request log • Additional ad-hoc cleaning	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	twice daily and when known to be contaminated with secretions, excretions and bodily fluid. • Electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily. • Rooms / areas where PPE is removed must be decontaminated, timed to coincide with periods immediate after PPE removal by groups of staff (at least twice a day). Linked NHSIE Key Action 1: All high touch surfaces and items are decontaminated multiple times every day – once or twice a day is insufficient.	keep work stations clean. • Non- invasive medical equipment must be decontaminated after each use. IP Q+A manual	requests can be requested by clinical teams 24/7 should the environment become contaminated between scheduled / barrier cleans. • Non-clinical areas are cleaned at regular frequencies through the day especially sanitary ware, and if additional cleans are required between scheduled cleaning, these can be requested via the helpdesk.	
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 audits held locally by divisions • Datix reports/adverse incidents	
2.10	Single use items are used where possible and according to single use policy.	• IP question and answers manual • Medical device policy • SOP for Visor decontamination in time of shortage	• IP audits held locally by divisions	

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 none conformities Electronic beds – difficult dismantle the bed base mechanism to allow for effective cleaning
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 windows where possible to assist the dilution of air.	• HTM hospital ventilation • UHNM has established a Ventilation Safety Group as recommended by the Specialised Ventilation for Healthcare Society in order to provide assurance to the Trust Board on the safe operation and reduction in risk of infection transmission through ventilation systems. TOR written • The Trust also appointed external	• 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**
		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  ventilation-air-changes-per-hour-2021-06 •		
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 shared equipment	• Regular walkabouts of all non-clinical areas are completed, and any actions found are either emailed through to helpdesk to be logged as jobs to be completed or are noted by Sodexo at time of audit – follow-up visits are completed to ensure all jobs have been completed • Quarterly Environmental Audits are completed of all clinical areas by an independent auditor plus input from nursing, cleaning and estates to review environmental standards – reports produced after each visit, and re-audits completed if disciplines fail to achieve agreed %.	• Reports produced after each visit, and re-audits completed if disciplines fail to achieve agreed %.	West building Estates issues West Building Cleaning issues

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	**KLOE**	**Action Required**	**Lead**	**Due Date**	**Quarter 4 Progress Report**	**BRAG**
1.	2.3	To re instate C4C cleanliness audits and patients survey	Head of CPM Estates, Facilities & PFI Division	30/09/2020	Soft FM cleaning services and Sodexo recovery plan in place which includes the process for reinstating the monitoring process and patient surveys which have commenced 6th July 2020. 04/09/2020 The C4C audits programme are now covering all areas but are not fully multi-disciplinary audit team e.g. only CPM on them due to social distancing. (yet to invite Sodexo, Nurse)We are likely to expand this out during October 2020 December 2020 – email confirmation from Sodexo and retained that C4C audits are in place 01/10/20 – Fully disciplinary team are now invited to C4C audits with strict social distancing in place at all times. Audits remain fluid to allow maximum access during the 3rd wave of Covid.	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 Sodexo 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 IP environment audits	Complete
3	2.4	To address dirty nursing equipment and commodes, plus computer on wheels	ACN'S / IP/ Deputy Head of IM&T	31/05/2021 – re: Computers on Wheels	Dirty nursing equipment and commodes found during NHSI Visit. These were address at time. Action for IM&T re computer. Terminal clean check list to be revisited to set out roles and responsibilities for cleaning. Full ward terminal clean check list agreed by IP , Sodexo /retained and County. IT have reviewed a number of computers on wheels and confirmed high level of dust. The computer is housed is a box and would require to be unlocked and vacuum, IT have	Complete

					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 May 2021 Raised at Local Meeting with other IP Teams , feedback - only outside/touch points of Computer cleaned June 2021 Discussed at the Excecs 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 <u>April 2020</u> 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 High lighted from Recent CPE outbreak West building, electronic beds bases are difficult to dismantle to allow effective cleaning	Divisions Facilities and Estates	30/09/2021 29/10/2021 30/11/2021	Group in place and meetings held to work through the none conformity issue <u>October 2021</u> 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	In progress

					West Building have been dismantled by Estates due to lack of support from the company.	
6	2.4	West Building long standing Estates issues. Reactive work	Divisions Facilities and Estates	05/11/2021	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 work list identified. Long term plan to be agreed. Business case to be developed for compliant hand hygiene sinks.	In progress
7	2.13	Cleaning issues both nursing and cleaning responsibilities highlighted during CPE outbreak west Buildings	Divisions Facilities/ACN	12/11/2021	October 2021 Terminal cleans in progress Review sign off process	In progress

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 ensure AMS activities are optimal • Formal regional meetings and informal national network activities • AMS CQUIN further mandates key AMS principles to be adhered to • All national CQUINS currently suspended by NHSE / PHE • Monthly review of antimicrobial	• Same day escalation to microbiologist, if concerns. Outcome recorded on I portal • Metric available around the number of times App accessed by UHNM staff • Compliance with guidelines and other AMS metrics reported to Infection prevention and control Committee (IPCC) • Meeting minutes reviewed and actions followed up • Real time discussions / requests for support / advice enabled via regional and national social media accounts. National (incl. PHE) thought leaders members • Trust and commissioners require timely reporting on compliance	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		consumption undertaken by AMS team. Available online at UHNM	with AMS CQUIN targets. • Wards showing deviation from targets are followed up by targeted AMS team ward reviews generating action plans for ward teams. On hold during COVID19 due to redeployment of duties	
3.2	Mandatory reporting requirements are adhered to and boards continue to maintain oversight. Linked NHSIE Key Action 5: Daily data submissions have been signed off by the Chief Executive, the Medical Director 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. Currently suspended.	• Whilst only a snap-shot audit the Trust value the output from these audits. Work is underway Q1 and Q2 20/21 to review potential change in data collection to optimise impact. • IPCC scrutinise results. Divisions held to account for areas of poor performance. Audit outputs will be used as basis of feedback on performance to individual clinical areas going forward. • Trust CQUIN contracts manager holds regular track and update meetings to challenge progress vs AMS CQUINS, Currently suspended.	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	**KLOE**	**Action Required**	**Lead**	**Due Date**	**Quarter 4 Progress Report**	**BRAG**
1.	3.1	Further controls are required to improve compliance	ACN'S	30/04/2021	Antimicrobial audits results discussed at IPCC 27th July 2020. Separate meeting with chief nurse/IP and ACN's to be arranged during August to discussed results and any corrective actions. Feedback meeting completed 4th September 2020. – Senior 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 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	Complete

					at meeting above (15.4.21) and target wards will be identified. Protocol approved at March 2021 ASG. <u>August 2021</u> 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 <u>October 2021</u> To gain update/progress report from pharmacy	

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 instructed to wear face masks and other PPE if they are providing	• Monitored by clinical areas • PALS complaints/feedback from service users	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
		bedside care. We will continue to monitor prevalence and changes in visiting restrictions will be reinstated with immediate effect should it be necessary • The only exceptional circumstances where on visitor , an immediate family member or 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 • Children both parents /guardian where the family bubble can be		

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
		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 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	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	• ED navigator records patient temperature and asked screening questions. Patient then directed to colour coded area • All patients who are admitted are now screened for COVID 19	• June 2020 IP team review patients that are found COVID positive and nursed in bay to ascertain compliance with pathway and IP control measures are in place Review pathways and identify theme . COVID 19 -Themes report to IPCC • ED pathways including transfer of COVID positive patient from County to Royal Hospital	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	questions to ask Triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible			
5.2	Mask usage is emphasized for suspected individuals. Face 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	• 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**
	around the ward (if clinically ok to do so) and is not detrimental to their physical or mental 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.	• All patients who require overnight stay are screened on admission and patients who	• 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**
	There is evidence of compliance with routine testing protocols in line with key actions	develop symptoms – UHNM screening guidance in place		
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 in close contact with a COVID -19 positive	Deputy of Director Infection	31/08/2020	IP guide liaise with clinical areas to identify closed contacts, close contact are isolated for remainder of hospital stay for 14 day or if discharged home continue isolation at home. Clinical	Complete

		patient during their stay			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	2		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 • 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	Monitoring FFP3 mask fit compliance using Health roster
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 's available on Trust intranet • Training logs held divisionally for air powered systems	

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 in place for the care of reusable FFP3 masks (Sundstrom))	• 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 • Good respiratory hygiene measures • Staff maintain physical distancing of 2 metres	• Hand washing technique depicted on soap dispensers • Social distance posters displayed throughout the Trust • IP assurance visits • Matrons visits to clinical areas	• 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**
	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	• 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 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	• 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**
	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	• Cluster /outbreak investigations	
6.11	All staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE and other national guidance if they or a member of their household display any of the symptoms	• Communication /documents • Reminders on COVID bulletins Trust intranet • Staff Lateral flow testing	• Cluster /outbreak investigations	
6.12	A rapid and continued response through on- going surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patient/individuals)	• ICNET surveillance system • Reports • Trust wide daily COVID Dashboard/report • COVID -19 Tactical daily	• COVID Dashboard • COVID -19 Tactical daily briefing • COVID 19 Gold update slides	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		• briefing		
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. 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	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. 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 <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> Portacount Business case withdrawn at Health and Safety <u>July 2021 update</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> 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	31/10/2021	Health and Safety to progress portacount machine business case	On- going
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

8. Secure adequate access to laboratory support as appropriate.

Risk Scoring								
Quarter	Q4	Q1	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	1	1	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	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 2 Progress Report	BRAG
1.	8.1	Champions COVID-19 swabbing technique in clinical areas	Deputy Director if infection Prevention	31/12/2020	Training package and recording system to be devised. Work to commence. 1st September swabbing video recorded, minor changes to be completed week commencing 14th September then video will be circulated to key people for preview and comments. Child positioning included in video Screening video now complete and uploaded on to Trust intranet November 2020. A number of areas have identified swabbing Champions, request sent to ACN's. Implementation of champions in progress.	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 <u>September 2021</u> 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.		• Monitoring of FFP3 compliance using Health roster
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	• 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	• 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**
	remind staff to follow public health guidance outside of the workplace.	process in place • November 2020 – Car sharing 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	• Via emapactis • Staff queries' through workforce bureau or team prevent	

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

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)	Complete

					Mask fit testing option also added to e rostering to enable areas to identify staff member that have been tested. A report can also be produced with compliance using this system. The mask fit testing certificate must continue to be completed and filed in the staff member personal folder. Updated mask fit strategy to March IPCC 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	October 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.	On-going

					Health and Safety to progress with portacount business case. Work to start September2021	
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	On-going

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.

University Hospitals of North Midlands NHS Trust

UHNM Winter Surge & Resilience Plan October 2021 to March 2022

October 2021

UHNM WINTER SURGE & RESILIENCE PLAN 2021/22

UHNM commenced Winter Surge & Resilience Planning in June 2021.

Winter Surge & Resilience Planning Group Convened with Trust Stakeholders.
Mandate from NHSEI – 'plan for the worst case scenario' for winter based on:

- Unmet non elective demand in the community due to legacy Covid impact
- Low influenza demand in winter 20/21 with risk of surge
- Uncertainty around Covid19 and emergent strains impact
- A commitment to protecting elective pathways during Q3 and Q4.

Winter Surge & Resilience Group Outputs:

- UHNM Winter finance plan drafted and approved in July 21.
- UHNM Winter Bed Model drafted against 3 scenarios in accordance with the
- UHNM Workforce recruitment against winter plans commenced July 21.
- UHNM alignment with system Scenario 1 Modelling for Covid-19 Sept/Oct 21.
- UHNM influenza admissions remain below threshold but expected to rise from mid December 21.
- UHNM paediatric RSV are 15% above 18/19 activity in Oct 21 - Scenario 3 Modelling.
- UHNM Ward escalation capacity open from October 21 as modelled against demand.

The next set of slides provide detail of the System Modelling of winter demand by modality and the impact for UHNM

COVID Modelling: How the Scenarios have been Created

The scenarios have been created by aligning actual hospital beds occupied to the model up to end of August 21.
R_0 values are inputted into the model from Sept 21.

Scenario 1 (Best Case):
Assumes that the R_0 value will remain constant, throughout the surge period, from what is currently observed.

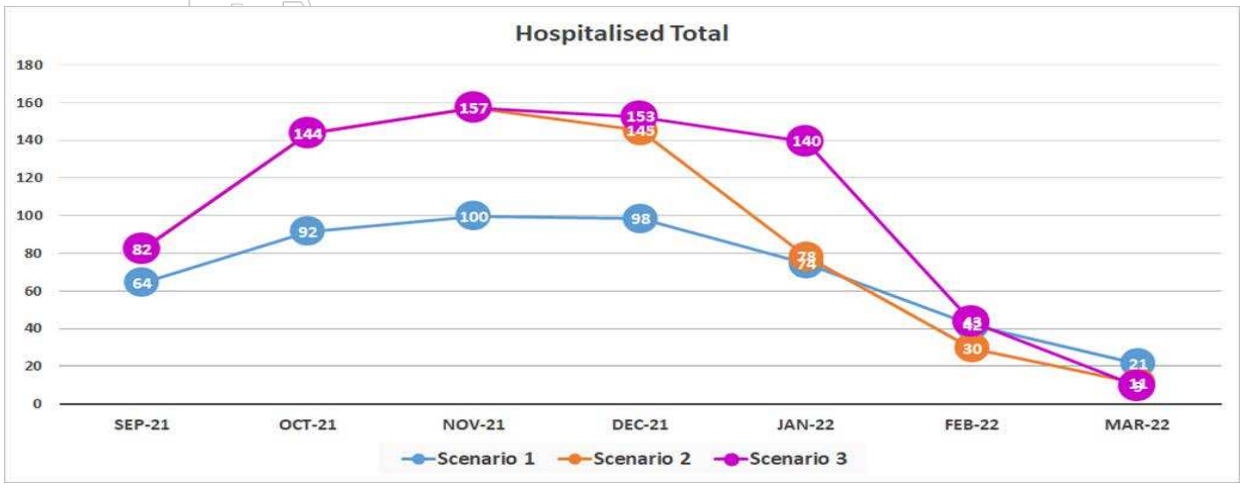
Scenario 2 (Average Case):
Assumes that from September the currently observed R_0 value will increase slightly and remain at that level.

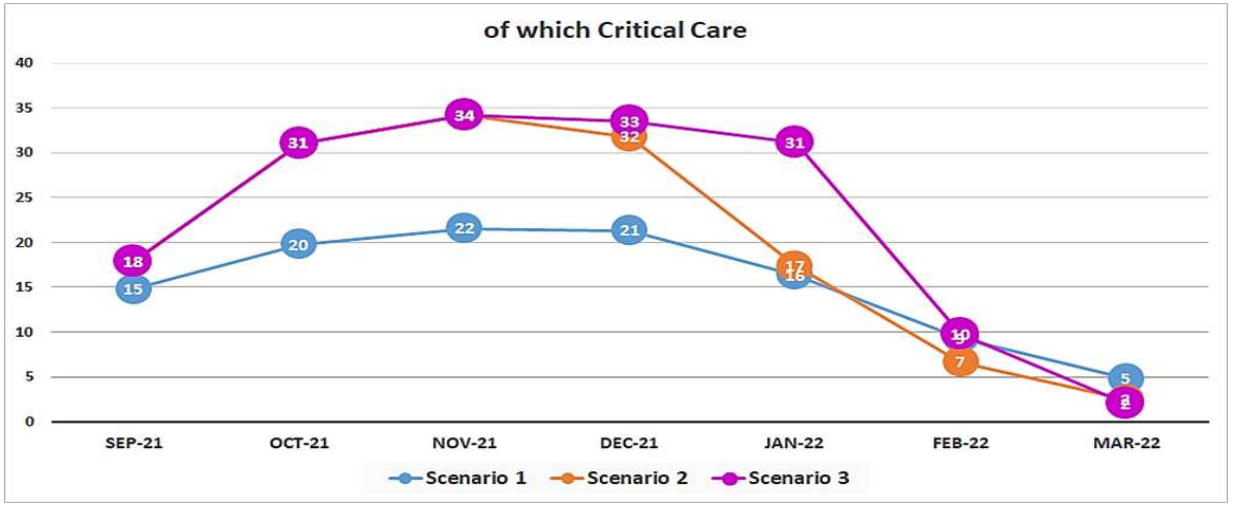
Scenario 3 (Worst Case):
Assumes that there will be incremental increases in the R_0 value in September, November & December, with an R_0=3.0 during the Xmas & New Year period.

Below shows maximum monthly R_0 values input in to the model for each month for Natural Immunity Days of 275 (9 Months)

R0 Value Used							
Scenario Name / Description	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Scenario 1							
Sep-21: R0=1.6; Immunity Days=275 (Central)	1.6	1.6	1.6	1.6	1.6	1.6	1.6
Scenario 2							
Sep-21: R0=1.8; Immunity Days=275 (Central)	1.8	1.8	1.8	1.8	1.8	1.8	1.8
Scenario 3							
Sep-21: R0=1.8; Winter Plateau; Immunity Days=275 (Central)	1.8	1.8	2.1	3	1.8	1.8	1.8

COVID19 SYSTEM MODELLING - UHNM





Beds Occupied by COVID patients

Assumes UHNM is 56% of Total.

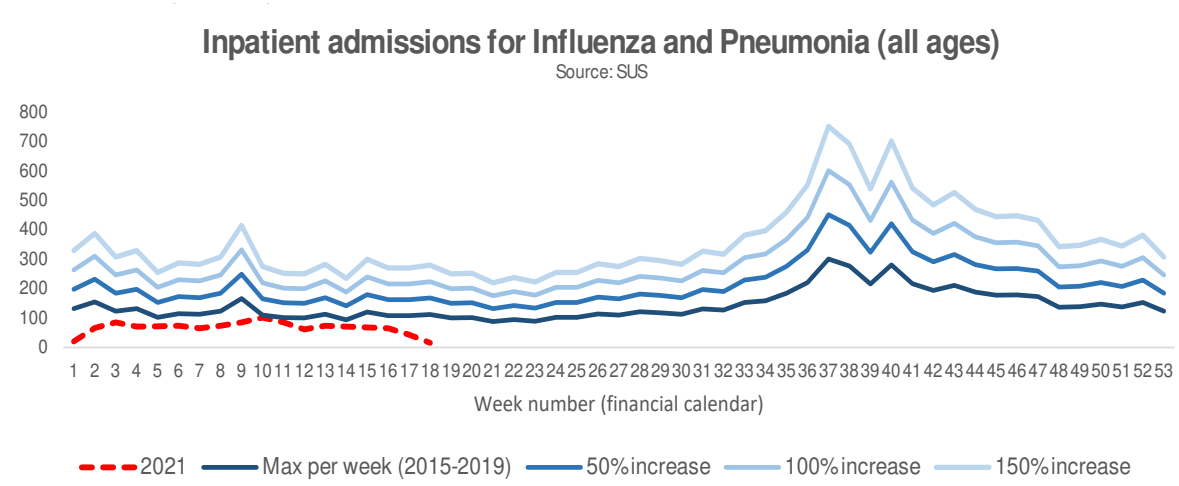
Out of Area activity was not included in the totals for Staffs & S-o-T so this % may be too low.

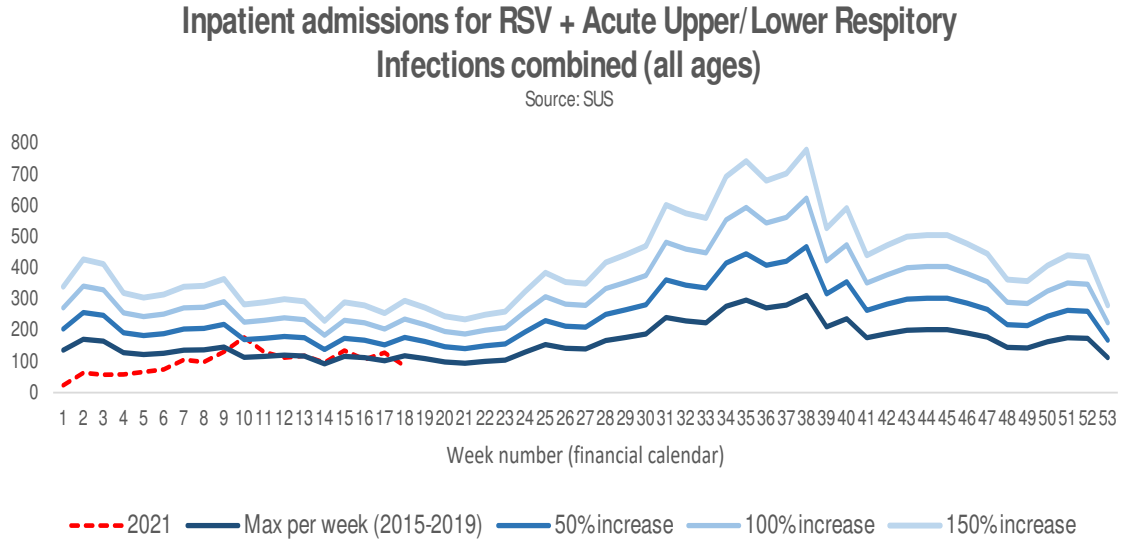
Scenario 1: Sep-21: R0=1.6; Immunity Days=275 (Central)

Scenario 2: Sep-21: R0=1.8; Immunity Days=275 (Central)

Scenario 3: Sep-21: R0=(1.8, 2.1, 3.0); Immunity Days=275 (Central)

INFLUENZA & RSV - SYSTEM MODELLING





- Data is for patients registered in Staffordshire and Stoke CCG, and who were admitted to the 6 main trusts, sourced from SUS inpatient admissions
- Data until for 2021 (until the end of July) is shown in red
- Incremental increases of 50%, 100% and 150% are calculated against the highest weekly number observed between 2015 and 2019
- Flu admissions peak during Weeks 37 to 40 (December to January)
- **Flu admissions for 2021 so far have been lower than previous years**
- Admissions for respiratory admissions (combined) show a peak during Week 38 (typically occurring between 11th to 23rd December)
- Combined **respiratory admissions during 2021 have been up to 50% higher than previous years** during Weeks 9 and 17

Influenza, pneumonia and respiratory infections (all ages): Number of patients in hospital by month

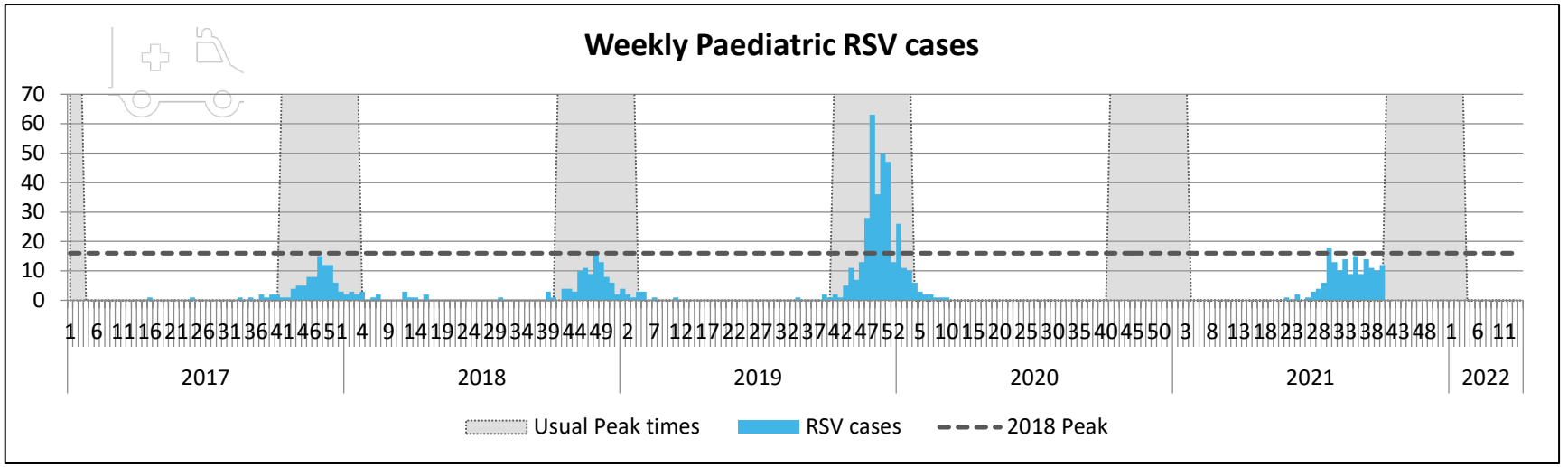
Influenza and pneumonia - number in hospital:

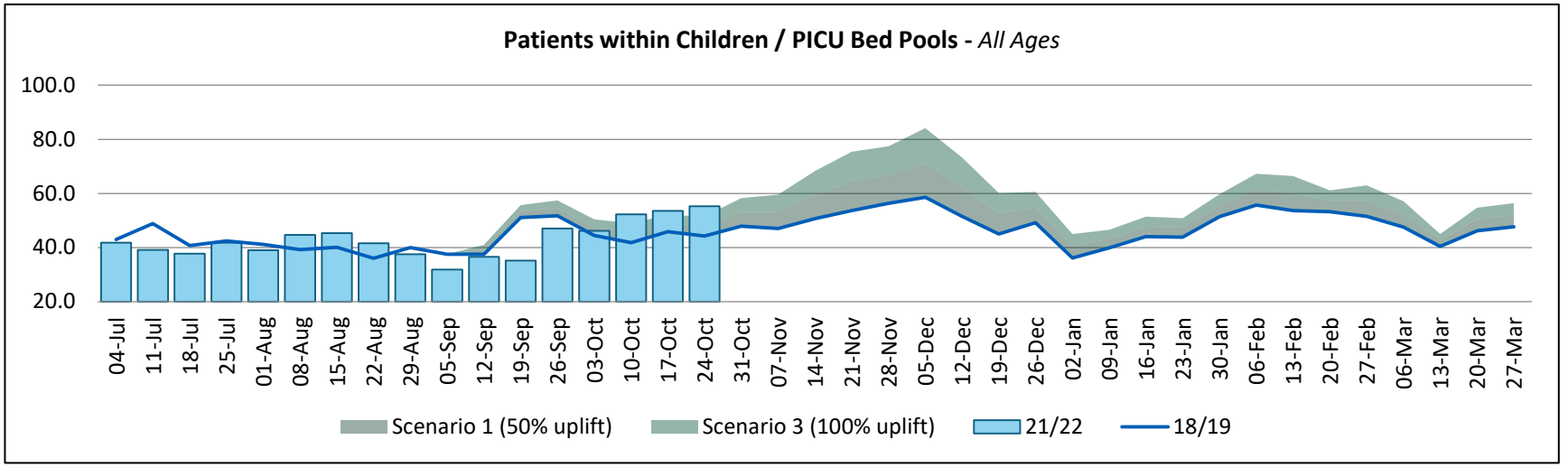
	April	May	June	July	August	September	October	November	December	January	February	March
2021 (actual)	59	64	67	53								
Upper baseline (max. per month 2015-2019)	160	135	130	119	108	108	112	130	191	262	246	215
50% increase	240	203	195	179	162	162	168	195	287	393	369	323
100% increase	320	270	260	238	216	216	224	260	382	524	492	430
150% increase	400	338	325	298	270	270	280	325	478	655	615	538

RSV and acute upper/ lower repiratory infections (combined)- number of in hospital

	April	May	June	July	August	September	October	November	December	January	February	March
2021 (actual)	27	37	36	42								
Upper baseline (max. per month 2015-2019)	50	44	40	36	38	40	53	75	87	80	56	57
50% increase	75	66	60	54	57	60	80	113	131	120	84	86
100% increase	100	88	80	72	76	80	106	150	174	160	112	114
150% increase	125	110	100	90	95	100	133	188	218	200	140	143

PAEDIATRIC RSV – SYSTEM MODELLING PROJECTIONS





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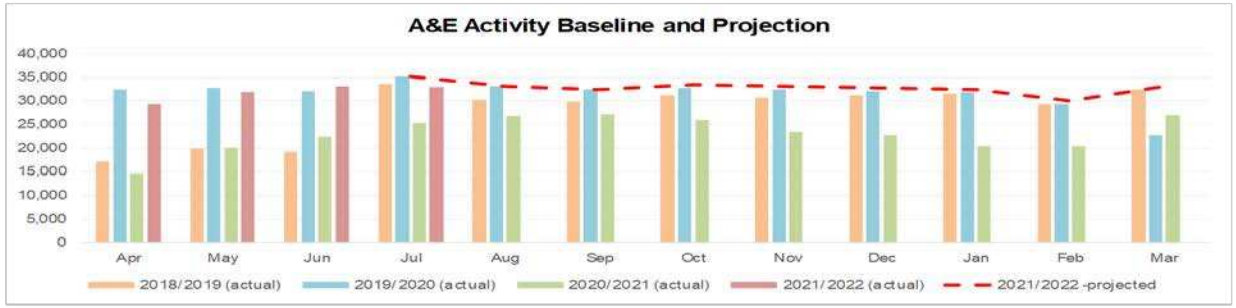
URGENT CARE DEMAND ED – SYSTEM MODELLING PROJECTIONS

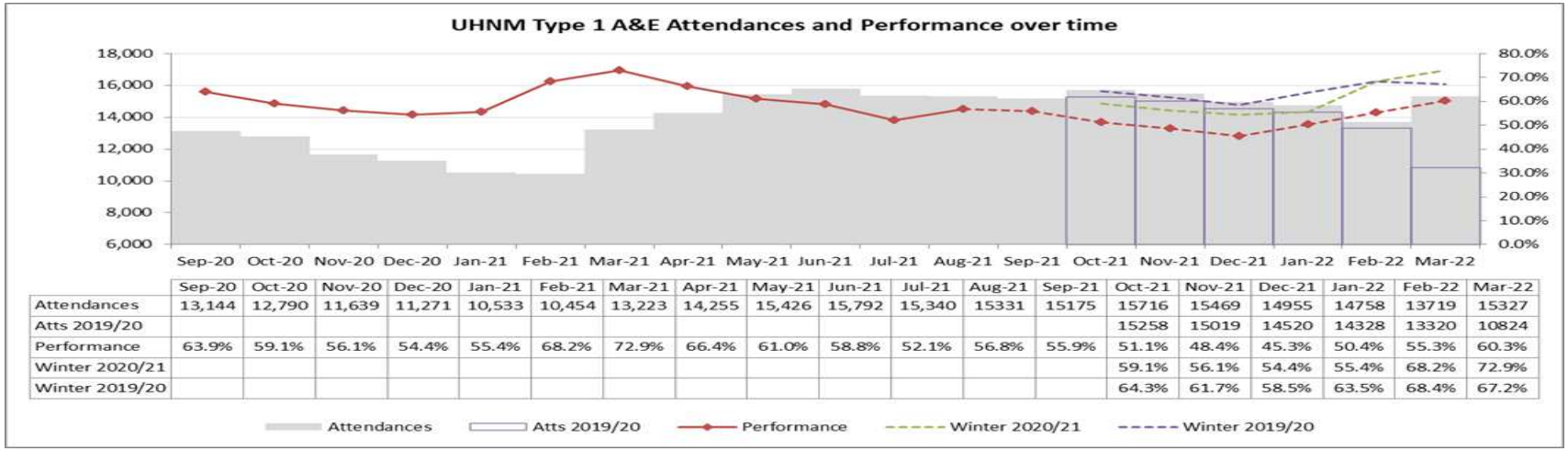
A&E Attendances

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/2019 (actual)	17,156	19,859	19,257	33,660	30,201	29,823	31,207	30,660	31,140	31,475	29,216	32,389
2019/2020 (actual)	32,348	32,802	31,986	35,165	33,045	32,387	32,741	32,444	32,035	31,849	29,374	22,662
2020/2021 (actual)	14,553	20,062	22,354	25,250	26,835	27,131	25,974	23,341	22,634	20,411	20,482	27,060
2021/2022 (actual)	29,223	31,968	33,098	32,850								
2021/2022 -projected				**35,165**	**33,045**	**32,387**	**33,396**	**33,093**	**32,676**	**32,486**	**29,961**	**33,037**



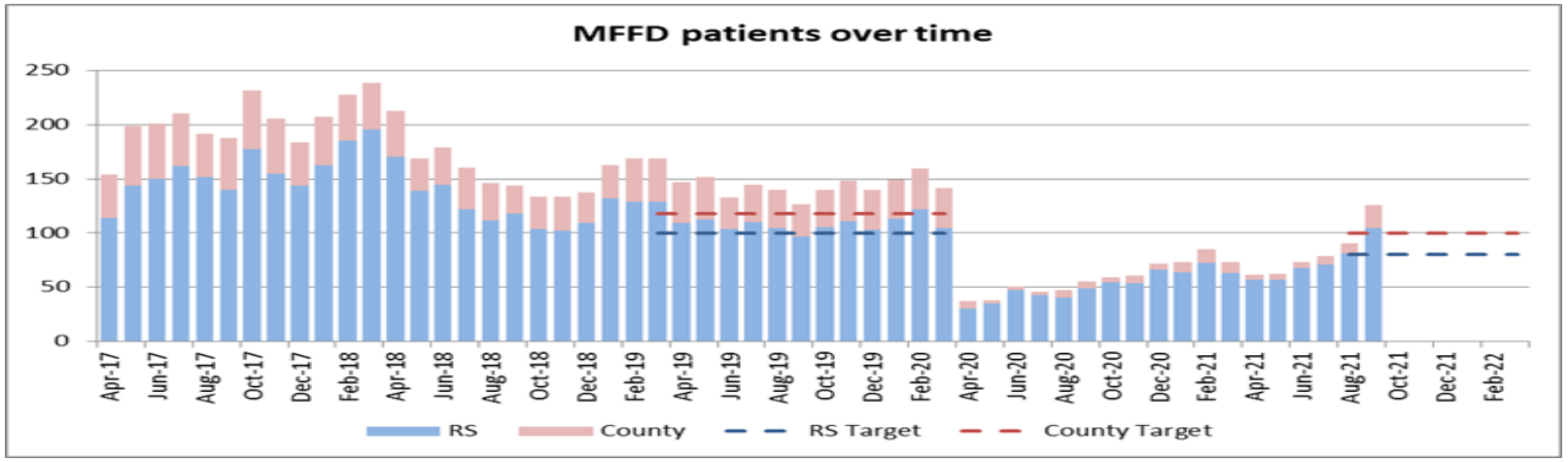
Data Source: SUS AE
Included: All Staffordshire CCGs and the following Proivders;
- UHNM
- UHDB (including small element of Derby Acute)
- Royal Wolverhampton

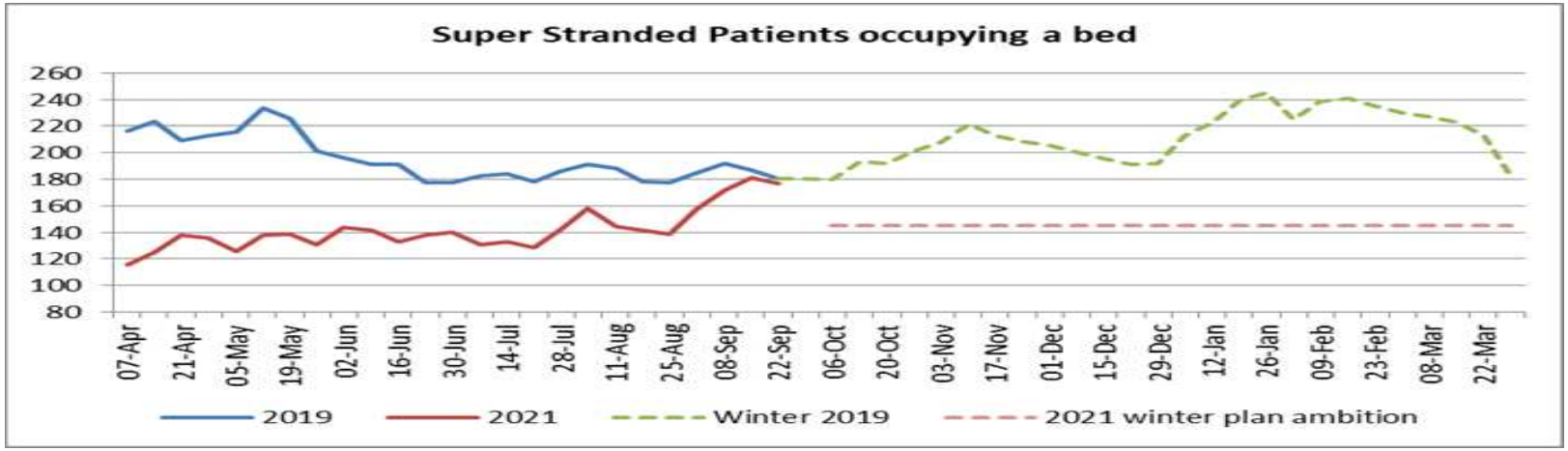
Projection Criteria:
Jul to Sep based on 2019/20
Oct to Feb based on 2019/20 + 2%
Mar based on 2018/19 + 2% (due to COVID inpact in Mar 2020)



	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	Dec-21	Jan-22	Feb-22	Mar-22
Attendances	13,144	12,790	11,639	11,271	10,533	10,454	13,223	14,255	15,426	15,792	15,340	15331	15175	15716	15469	14955	14758	13719	15327
Atts 2019/20														15258	15019	14520	14328	13320	10824
Performance	63.9%	59.1%	56.1%	54.4%	55.4%	68.2%	72.9%	66.4%	61.0%	58.8%	52.1%	56.8%	55.9%	51.1%	48.4%	45.3%	50.4%	55.3%	60.3%
Winter 2020/21														59.1%	56.1%	54.4%	55.4%	68.2%	72.9%
Winter 2019/20														64.3%	61.7%	58.5%	63.5%	68.4%	67.2%

UHNM LONG STAY PATIENTS & MFFD - MODELLING PROJECTIONS





- **Medically Fit For Discharge patients have been increasing over the agreed 80/ day since June 21.**
- **Super stranded metrics show a rising trend in occupied beds exceeding 2021/22 planning assumptions.**
- **Weight of evidence led the system to conclude the worst case scenario of bed modelling based on**
- **103 MFFD most likely scenario to deploy for bed modelling in spite of enabler schemes planned.**

SYSTEM WINTER/ SURGE PLANNING ASSUMPTIONS 2021/22

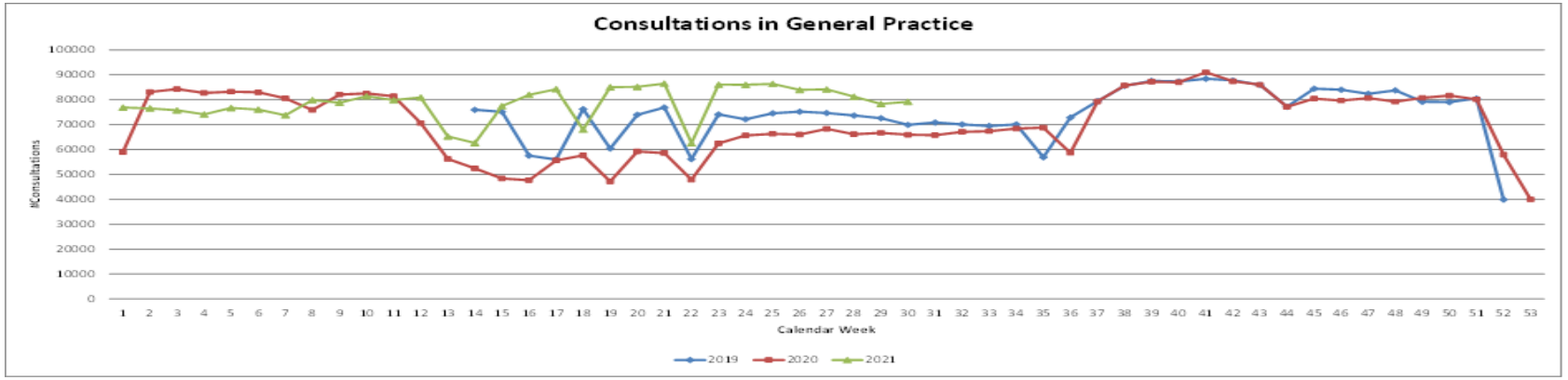
Health and social care partners have worked together during 2021 to ensure a system-wide approach is in place to respond to surges in healthcare demand resulting from both the COVID-19 pandemic and seasonal pressures.

The System and UHNM plan is predicated on the following assumptions:

- No increase in underlying demand when compared to the winter of 2019/2020 for the Acute NHS Trusts.
- Increased flu based on 2019/20 – UHNM from mid December 2021.
- Bed occupancy at 85% and consistent MFFD of around 130 (worst case scenario) across the UHNM footprint given current surge position and average MFFD volumes of circa 120-130 during August/September 21.
- Infection control measures remaining across all sites as is currently the position (including triple cohorting – COVID, Flu etc)
- No decrease in elective and planned care demand / activity as per elective recovery plans.
- System capacity to offset the UHNM bed gap to support sustainable elective activity.

The following slides outline the Primary and Social Care & Mental Health Schemes supporting UHNM urgent care demand and onward discharge.

SYSTEM WINTER/ SURGE PLANNING – Primary Care 2021/22



		per week			
		Mins		£130.00	
QUARTER	01/04/2021	60		per week	26
Row Labels	RAW PRACTICE LIST SIZE	Total Additional mins (based on Raw list size)	Number of additional hours per week	cost based on £130 GP hourly rate/running costs	Number of weeks (above)
NHS Cannock Chase CCG	135428	8126	135.4	£ 17,605.64	£ 457,746.64
NHS East Staffordshire CCG	146327	8780	146.3	£ 19,022.51	£ 494,585.26
NHS North Staffordshire CCG	217141	13028	217.1	£ 28,228.33	£ 733,936.58
NHS South East Staffordshire And Seisdon Peninsula CCG	216055	12963	216.1	£ 28,087.15	£ 730,265.90
NHS Stafford And Surrounds CCG	150817	9049	150.8	£ 19,606.21	£ 509,761.46
NHS Stoke On Trent CCG	296340	17780	296.3	£ 38,524.20	£1,001,629.20
Grand Total	1162108.0	69726.5	1162.1	£ 151,074.04	£3,927,925.04
		Additional appoinments per week	4648		

GP practices 8.00 am to 6.30 pm Monday to Friday. Extended offered outside these times. Consultations currently higher since April 2021 when compared to the previous two years. Proposal to deliver an additional 4648 GP appointments per week (based on 15 minute appointment) across Staffordshire and Stoke on Trent at a cost of £151,074 per week. NB: This will be subject to General Practice having the resilience and workforce available to deliver this.

UHNM WINTER SURGE/RESILIENCE BED PLAN - 2021/22

Baseline Modelling Assumptions
60% BAU for Electives (baseline 19/20)
100% BAU for Non Electives (baseline 19/20) - note 3% now added to this (from 19/20 baseline)
MFFD maintains the position of 130 or less (June 2021) throughout winter 21/22. 130 is the total MFFD across the 2 sites (SD updated 03/09/21)
19/20 baseline flu replaced with 17/18 level - but brought forward 1 month to Nov
Represents how many beds needed 85% of the time (within the month, within the day)
Escalation Ward 8 at County is subject to IPC confirmation as fit to use. Estimated estates work will be complete by end December 2021
Escalation ward 75 will be available from December 2021. Being used as a vaccination hub to December 2021
MFFD specialty pathway- daily transfer to County to be discussed with System Partners as a way to manage the RSUH bed gap
Assumption No Covid in patients at County
Elective Bed base and theatre/ward workforce ring fenced to protect elective capacity
Covid & Flu & IPC patients have to be cohorted separately - PODs investment required to increase isolation capacity
IPC impact NV/Cdiff other not yet modelled - awaiting pathology data on profiling.
Strategy of increasing SDEC and Portal workforce capacity to meet ED demand and manage in patient conversion with winter investment
CRIS & Virtual Ward enablers will manage alternative conveyance pathways
Primary Care Reponse; capacity, 111, Vocare, SIFT GP support 'Hot' pathways
Includes 'additional beds needed due to covid, flu, noro = including cross contamination (10 beds Oct - March 22)
Patients within A&E with a decision to admit, ARE being reflected within the above demand
Ward 210 - 14 beds medicine.
v4.3 Medicine core bed base increased by 20 beds Ward 112 (specialised core beds reduced by 20)

- **UHNM bed model for winter was drafted against the system request of having 3 Scenario Plans (Best, Most Likely and**
- **Worst Case scenarios) using the system modelling and Sit Rep measures going into winter.**
- **The UEC Board approved The 'Worst Case Scenario'.**
- **This model which has the largest profiled bed deficit uses MFFD at 130 based on the evidence in September 21 and takes into account the Covid19 surge from September 2021.**
- **The Adult and Paediatric acute and critical care capacity have been over subscribed.**

UHNM WINTER SURGE/RESILIENCE BED PLAN - 2021/22

Trust/System Name: UHNM v4.3: 130 MFFD

	UHNM					
Bed Base	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Feb-22**	**Mar-22**
Core Bed Base (excluding Maternity, Paediatric or Critical Care Beds)	**1,245**	**1,245**	**1,245**	**1,245**	**1,245**	**1,245**
RSUH	1,060	1,060	1,060	1,060	1,060	1,060
Medicine	467	467	467	467	467	467
Surgery	262	262	262	262	262	262
Specialised	291	291	291	291	291	291
CWD	40	40	40	40	40	40
County	185	185	185	185	185	185
County	185	185	185	185	185	185
Demand	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Feb-22**	**Mar-22**
Anticipated Bed Demand	**1,270**	**1,314**	**1,374**	**1,403**	**1,369**	**1,339**
Royal Stoke	1,122	1,155	1,198	1,212	1,185	1,164
Covid-19 for information only	105	63	26	26	26	26
Medicine	520	565	626	650	616	596
Surgery	258	260	236	239	241	241
Specialised	299	284	291	276	283	282
CWD	45	46	46	46	44	44
County	148	160	176	191	184	175
County	148	160	176	191	184	175
Core Bed Gap	**-25**	**-69**	**-129**	**-158**	**-124**	**-94**
Mitigated by:						
Escalation Capacity	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Feb-22**	**Mar-22**
County AAU (7 beds)	7	7	7	7	7	7
County Ward 7 (14 beds) - subject to remedial estates works and IPC endorsement	-	-	-	14	14	14
Beds Lost to Social Distancing	-32	-32	-32	-32	-32	-32
RSUH Ward 218 (22 beds)	22	22	22	22	22	22
RSUH Ward 75 (19 beds) - available from December 2021	-	-	19	19	19	19
RSUH Ward 104/105 (5 beds)	5	5	5	5	5	5
RSUH Ward 210 (7 beds)	7	7	7	7	7	7
Total Escalation Capacity	**9**	**9**	**28**	**42**	**42**	**42**
Core Bed Gap After Escalation Capacity applied	**-16**	**-60**	**-101**	**-116**	**-82**	**-52**
ASSUMPTIONS						
Key Assumptions - MFFD's maintain the position of 130 (June 2021) throughout winter 2021/22 across the 2 sites						
RSUH MFFDs adjusted - system mitigation plans include aspirational stretch target of 100	112	112	112	112	112	112
County MFFDs adjusted - syste mitigation plans include aspirational stretch target of 100	18	18	18	18	18	18
Total MFFDs	**130**	**130**	**130**	**130**	**130**	**130**
Key Assumptions - 2019/20 baseline flu replaced with 2017/18 levels from November 2021						
RSUH FLU	-	16	72	67	55	27
County FLU	-	13	29	25	22	11
Total FLU	**-**	**29**	**101**	**93**	**77**	**38**

The acute bed gap is shown for October 2021 to March 2022 of between -16 and -116 once UHNM escalation capacity is enacted. This is to be mitigated by increasing capacity in other providers, mainly community beds via Midlands Partnership NHS Foundation Trust.

UHNM WINTER SURGE/RESILIENCE PLAN ENABLERS TO COVER OFF THE BED DEFICIT - 2021/22

Additional Community Bed Capacity

In addition to the above, Cheadle Hospital will open in December 2021 to provide additional capacity in Community Beds to the effect of 26 beds. This will be through to March 2022 inclusive. Their opening does not change the outcome of the 'The Future of Local Health Services' consultation and subsequent decision of the governing bodies of the clinical commissioning groups.

Additional UCC/CRIS Services

UCCC - Current capacity for up to 85 patient referrals/calls to be triaged per day (currently have 4 Triage nurses and 4 Admin staff on duty covering 8am – 10pm),

CRIS - with an average of 35 patient visits (currently have 7 ACP's on duty between 8am – 12N with an average of 5 visits per practitioner). This figure has been achieved for last 2/3 weeks with the current workforce of 17.4WTE

These referrals are split between visits and virtual, and include signposting to appropriate Community Service response, Clinical support and advise with decision making, and also up to 5 days reviews for patients admitted to the CRIS Virtual Ward.

The UCCC also manages a further Virtual Ward for Oximetry @ Home with an average of 5-8 patients per week. This involves both a telephony and technology text messaging system offer for up to 14 days monitoring.

Increase this capacity to maximise slots – an increase in workforce would equate to approx. 5-7 visits per day with 1 additional practitioner on a 10.5 hour shift – needing 2 per day to cover 8am – 12MN = 8am – 6.30pm & 1.30pm – 12 MN. Total increase to workforce = 3.2WTE. In total over 7 days would = 84 additional patient visits per week, 12 per day

UHNM WINTER SURGE/RESILIENCE PLAN ENABLERS TO COVER OFF THE BED DEFICIT - 2021/22

Increase the number of call handlers and time of operation in the day – currently reviewing the need for UCCC to receive referral after 8pm – definite need especially requested by WMAS as no accessible alternate pathways available OOHS. UCCC will become Pan-Staffordshire wide access point for Urgent/Emergent AA covering North, South, SW and East Staffs (UHNM, RWT, UHDB)

Build in social care assessor and MH resource to CRIS team for rapid response – MH currently excluded from CRIS criteria. Clinical team rule out any organic causes for increased confusion or delirium – possibility of utilising MH crisis response within team to undertake joint visits. Minimal need for Social Care input if patients kept at home in first instance as care packages remain in place, not the increased risk of needing 24 hour care assessment. Benefit to having SCA within UCCC would be for ongoing needs identified at point of sub-acute crisis assessment.

CRIS staff at front-door at ED to screen ambulance arrivals – currently undergoing TOC to determine if needed permanently, or is it to educate and support Paramedics to understand what can be cared for within the Community. Once education and shared learning has cascaded through WMAS and they begin to "Think UCCC First" will there still be the need?

Continue to promote with WMAS but also focus on 111, GP, community and care homes accessing to drive up utilisation – comms work here? **Launch "Think UCCC First"** in similar way to 111 programme. Whereby **mandate that ALL Cat 3 & 4 WMAS calls** come via UCCC before allowing conveyance,

ALL Care Home 999 calls (unless evident life threatening requiring immediate emergency response) have to come via UCCC before ambulance dispatched, any **GP referrals for HDU vehicles** for ED transfer are reviewed by UCCC for alternative pathway, continue to engage with 111 providers re what alternatives are in the Community.

More focus on 111 – definite scope to increase both CRIS as SDEC option and wider Community service referrals

UHNM WINTER SURGE/RESILIENCE PLAN ENABLERS - 2021/22

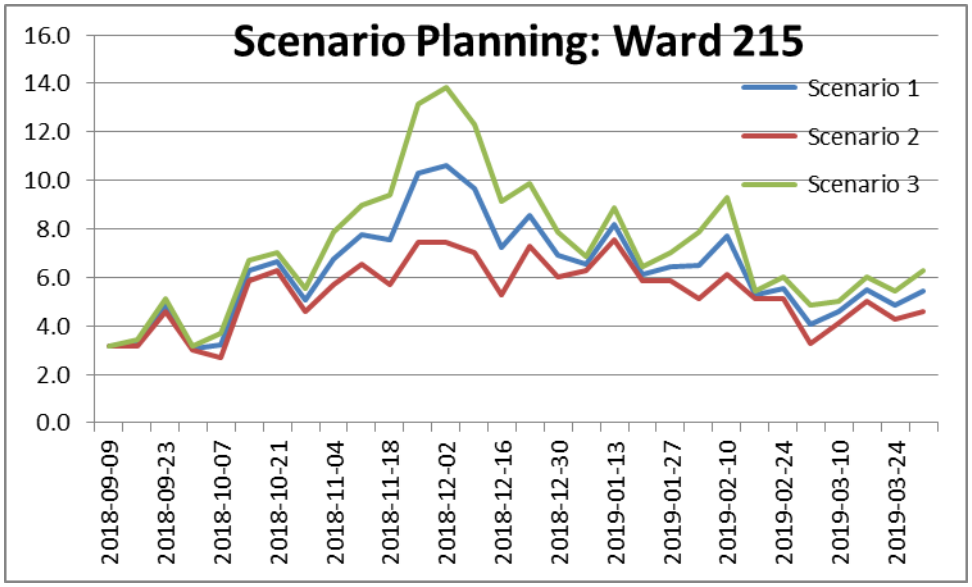
Royal Stoke:

- Investment to support cubicle resus capacity to support IPC isolation and enable reconfiguration of the Emergency Department pathways.
- Investment in Specialised Decision Unit adjacent to the Emergency Department Footprint (8 assessment trolleys) to improve immediate specialised interventions out of the Emergency Department.
- Additional Critical Care Capacity (2 escalation beds on the RSUH site with +4 beds based on other theatre reconfiguration, in sever pressure, subject to Covid19 19 surge and workforce recruitment)
- The purchase of PODS to convert our identified Covid19/Flu wards to support IPC isolation capacity – Medicine and Specialised.
- Maintenance of the Covid19 ED to Ward pathway with Medicine portal and acute ward capacity into a single zone on the top floor PFI build to support improved pull and flow of patients from the Emergency Department and ensure Covid19 suspected patient isolation from the main hospital flow.
- Emergency Access Unit for our Haematology and Oncology Patients to be able to pass through the Emergency Department and receive treatments which may support discharge rather than admission to an acute bed base.
- Investment in staffing with overseas nurses within the Trust from October 21.
- Investment in Agency Nursing staff in and out of hours to supplement Ward/Portal capacity as a contingency to any workforce attrition during Covid19/winter non elective demand impact.
- System partners to support diversion of appropriate pathways to Haywood WiC.
- Investment in pathology workforce and equipment to deliver 24/ Covid19/flu test reporting during winter.
- Investment in Pharmacy and Imaging resources to expedite medication administration and diagnostics interventions with rapid reporting to support no delays pathways through the Emergency Department.
- Investment in additional PTS /Paramedic ambulance provision to support the safe and timely transfers of our patients between sites or out of county repatriations.
- Investment in GP expert resource for Covid19 Paediatrics, and Ambulatory Red & Green pathways in ED to source alternative triage pathways.

County Hospital:

- Additional 14 beds - Ward 8 estate configuration from December 2021.
- Equipment provision to maintain an elective orthopaedic service on EOU and extend elective bed and theatre capacity at County.
- Ambulance provision to support expedited transfers of patient between County and Royal Stoke.
- Investment in GP resource for Ambulatory pathways to support admission avoidance/see and treat.
- NACU on County Site to protect elective sessions.
- Discharge Lounge configured with MRU to support early pull from wards /returners to site .

UHNM WINTER SURGE/RESILIENCE – PICU - 2021/22



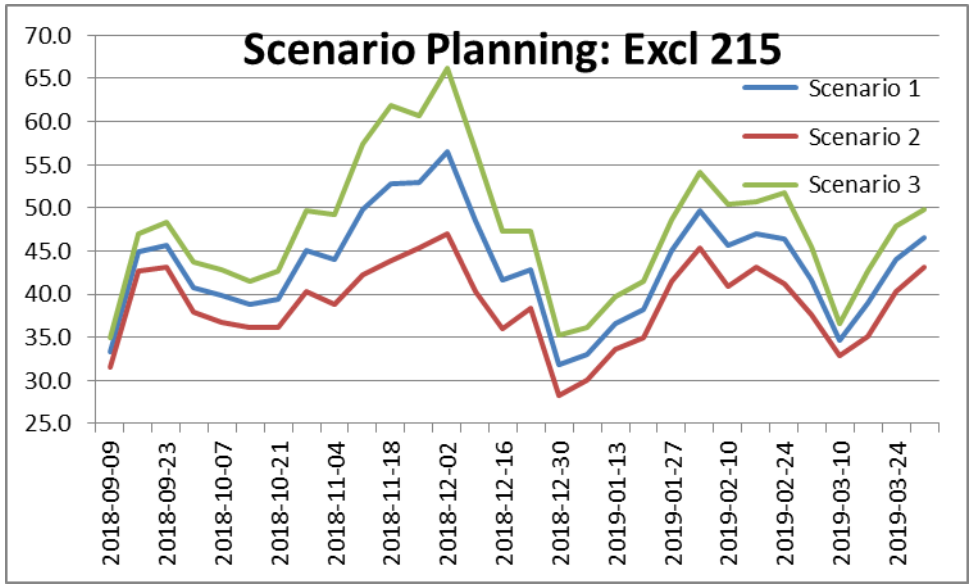
Scenario 1: As scenario 1, but with a 50% uplift within the subset of patients Age 0/1 with respiratory conditions.
Scenario 2: Actual volume of patients in beds as an average (regardless of age)
Scenario 3: As scenario 1, but with a 100% uplift within the subset of patients Age 0/1 with respiratory conditions

Most Likely: Scenario 1: UHNM can support activity using existing PICU beds (8) plus additional PICU beds created (up to 10 level 3 beds). Additional beds sourced from HDU bed stock. If HDU bed demand is high, ward level beds will be converted to HDU.

Possible: Scenario 2: UHNM can support activity using PICU.

Least Likely: Scenario 3: Require regional support.

UHNM WINTER SURGE/RESILIENCE – CWD CHILD HEALTH DEMAND - 2021/22



Scenario 1: As scenario 1, but with a 50% uplift within the subset of patients Age 0/1 with respiratory conditions.
Scenario 2: Actual volume of patients in beds as an average (regardless of age)
Scenario 3: As scenario 1, but with a 100% uplift within the subset of patients Age 0/1 with respiratory conditions

Most Likely: Scenario 1: UHNM can support activity but will need to cancel sleep study and overnight elective surgical activity. Use of additional beds on ward 218 (adult medicine) to keep paediatric elective activity going as much as possible

Possible: Scenario 2: UHNM can support activity

Least Likely: Scenario 3: UHNM can support activity but will need to cancel all routine elective surgical capacity and day cases

UHNM & System aligned Paediatric RSV Plans have been endorsed by NHSEI

UHNM WINTER SURGE/RESILIENCE – CWD CHILD HEALTH DEMAND & IMPACT - 2021/22

Scenarios		Elective Impact
Scenario 1	50% RSV increase	Cancellation of elective sleep study activity and elective overnight surgical activity
Scenario 2	Normal RSV	No cancellation of elective surgery/sleep study/day case activity
Scenario 3	100% RSV increase	Cancellation of elective surgery/sleep study/daycase activity

Considerations

- Should demand exceed capacity consideration will need to be given to utilising additional beds on ward 218 (significant risk to adult occupancy). This will prevent cancellation of elective surgical activity.
- Adult Critical Care to support with taking patients more than 12 years old and over 50 kgs should surge exceed expectations.

UHNM WINTER SURGE/RESILIENCE – CRITICAL CARE SURGE PLAN - 2021/22

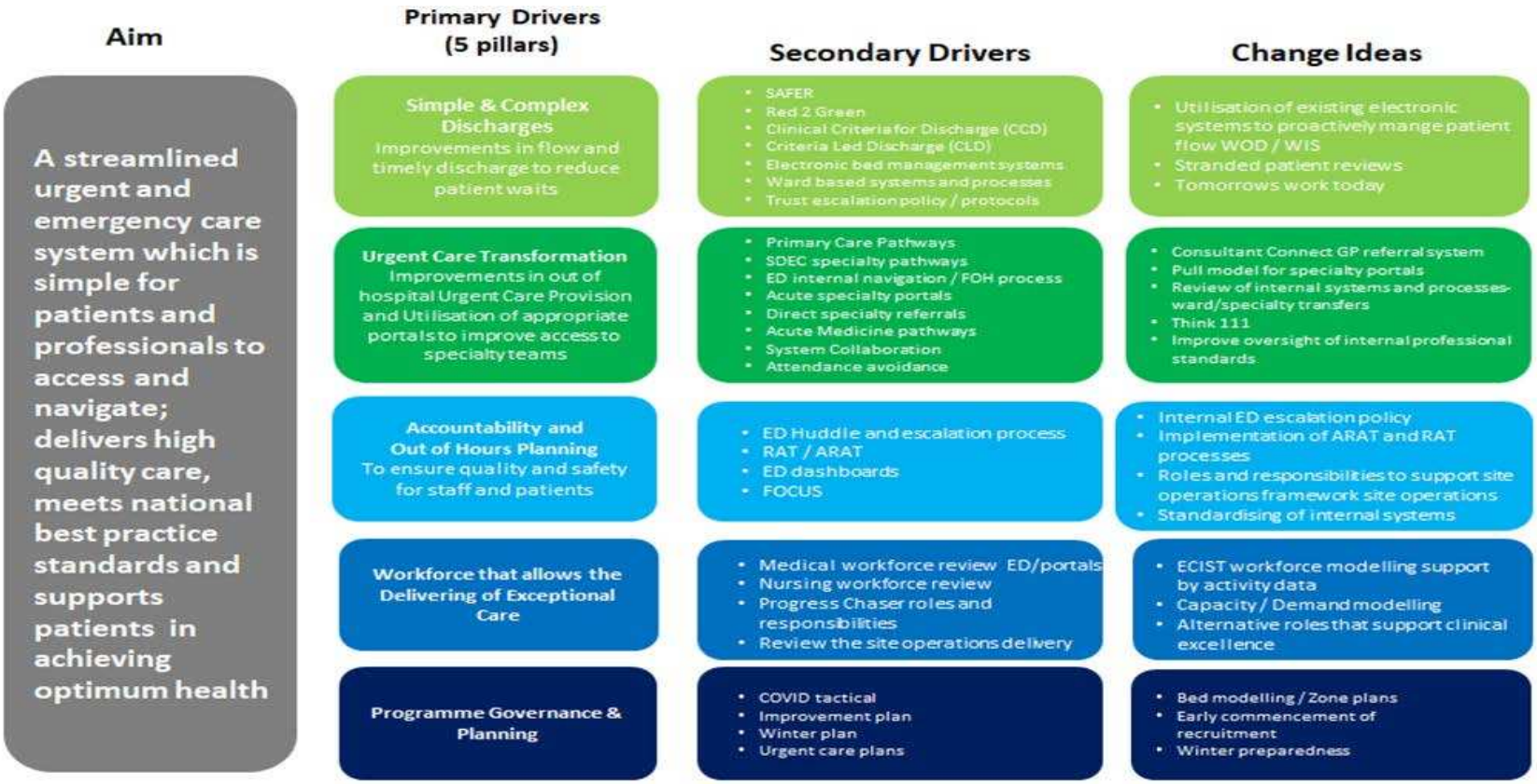
CRITICAL CARE CAPACITY AND DEMAND MODEL & THEATRE SUSTAINABILITY PLAN

Scenario plan based on assumptions that ACCU currently staffed to Dependency of 32. Current unavailability rates are equivalent to 2 beds. Recruitment proposals drafted to address this but do determine a pre-existing recruitment challenge.

Scenario	COVID	*Non-COVID	Total Pts	Mitigation	Impact on Elective
10 % (current)	7 (dep 7)	30 (dep 25)	37 (dep 32)	Use POD 2 – Theoretically able to staff as long as dependency <32	Minimal – some restriction on Cardiac Capacity
20 %	13 (dep 13)	30 (dep 25)	43 (dep 38)	Use POD 1 & 2– would require additional staff for 6 Pts (33 RN's) provided by CTU Pod 1	Would require cessation of elective Cardiac work unless over recruitment for ACC capacity work
45% of Jan 21	30 (dep 30)	30 (dep 25)	60 (dep 55)	Use POD 2 & 1 & SSCU, would require additional staff for 17 Pts (94 RN's) provided by CTU, Theatres, Recovery and wards. Flexing of Nurse : Pt ratios required	Would require cessation of elective theatre activity and reversion to Jan 2021 timetable with provision of Cat A & B nurses from theatres
55% of Jan 21	36 (dep 36)	30 (dep 25)	66 (dep 61)	Use POD 2 & 1 & SSCU & PACU would require further staff for additional 6 Pts (33 RN's) provided by CTU, Theatres, Recovery and wards	Would require cessation of elective theatre activity and reversion to Jan 2021 timetable with provision of Cat A & B nurses from theatres

All CWD schemes operational by November 2021.
CWD Incident Response Model confirmed for winter surge/escalation response.

UHNM NON ELECTIVE IMPROVEMENT PLAN - 2021/22



Non Elective Improvement Plan delivery enacted through a CE Chaired programme Group Convened twice a month to review actions and agree urgent care mitigations tracked against the Urgent Care Dashboard.

UHNM WINTER/SURGE RESILIENCE – FINANCIAL PLAN 2021/22

		Profiled Cost (£)							Approved	under consideration	Rejected
		Oct	Nov	Dec	Jan	Feb	Mar	Total Cost	£	£	£
Sub Total Medicine		**78,848**	**275,502**	**833,328**	**942,164**	**909,191**	**957,680**	**3,996,713**	**2,648,701**	**150,000**	**1,488,012**
Sub Total Surgery		**55,288**	**115,977**	**115,977**	**115,977**	**115,977**	**115,977**	**635,174**	**635,174**		
Sub Total Specialised		**148,713**	**148,713**	**148,713**	**148,713**	**148,713**	**148,713**	**892,278**	**892,278**	**0**	**0**
Sub Total CWD		**49,856**	**157,088**	**181,051**	**181,051**	**181,051**	**175,871**	**925,968**	**829,182**	**0**	**96,786**
Access Coordinator	PAY		**11,762**	11,762	11,762	11,762	11,762	**58,810**	**58,810**		
Medical Staffing Weekend Rota Co-Ord support	Pay		1,000	1,000	1,000	1,000	1,000	5,000	5,000		
Transport	NON PAY		**19,453**	20,102	20,102	15,563	20,102	**95,322**	**95,322**		
Communication	PAY		700	700	700	700	700	**3,500**	**3,500**		
Grand Total		**332,705**	**730,196**	**1,312,633**	**1,421,469**	**1,383,957**	**1,431,805**	**6,612,765**	**5,167,967**	**150,000**	**1,584,798**
Cumulative variance to approved plan											6,902,765

- **The UHNM financial plan was drafted and approved by the UHNM Operational Delivery Group in July 2021**
- **Divisions enacted recruitment plans from August 2021 for assurance workforce resources in place from October 2021.**
- **Additional bids to support Winter surge plans have been drafted and submitted to the ICS for consideration.**

Divisional Schemes Funded for 2021/22 Q3 & Q4

Medicine & Urgent Care

- Discharge Lounge extended hours
- Matron to cover winter escalation
- Operational Manager - Escalation
- Extended working hours AEC = 1hr
- Uplift Infectious Diseases Consultant
- Additional ED Resources 5 SHO
- ED Acute Med Medics and Nurses
- Weekend Elderly Care ENP
- physiotherapy urgent care
- Weekend Consultant Cover
- Additional weekend discharge facilitators (surge bid)

Surgery & Critical Care

- Critical Care (2 beds)
- Critical Care Discharge Facilitator
- Lyme Building Pharmacist
- SAU (6 trollies)

CWD

- EAU scheme to support improved ambulatory pathways through Oncology and Haematology in order to optimise acute bed capacity and avoid back flow into medicine.
- Pharmacy – ward pharmacist, dispensing hubs and ED support to TTO management.
- Extended times for imaging and reporting.
- Additional paediatric consultant ward rounds

Specialised

Specialised Decisions Unit (SDU)

Weekend & Unsocial working for ANP's across Trauma

Ortho/ Spine SPR based in SDU (8am-12 midnight)

SALT Therapists (Weekend working to facilitate discharge)

Extension of SPR based in ED for Neurology & Hot Clinic provision for admission avoidance

Extension of SHO based in ED for Neurology & Hot Clinic provision for admission avoidance

Extension of Community Support Discharge (ESD) for Neurology & NoF

The above schemes have been funded to support Winter Surge and Resilience Plans within UHNM

SYSTEM FUNDED WINTER/SURGE RESILIENCE PLANS 2021/22

SRO	No.	Title	Brief Description	Cost	October	November	December	January	February	March
Paul B	1	UHNM Core Escalation Capacity	County AAU (7 beds)	£2.640m	✓	✓	✓	✓	✓	✓
			County Ward 7 (14 beds)					✓	✓	✓
			RSUH Ward 218 (22 beds)		✓	✓	✓	✓	✓	✓
			RSUH Ward 75 (19 beds)				✓	✓	✓	✓
			RSUH Ward 104/105 (5 beds)		✓	✓	✓	✓	✓	✓
			RSUH Ward 201 (14 beds)		✓	✓	✓	✓	✓	✓
Paul B	2	UHNM Surgical Capacity	Additional CC / SAU Capacity	£0.635m	✓	✓	✓	✓	✓	✓
Paul B	3	UHNM Specialist Capacity	Additional Specialist Capacity	£0.892m	✓	✓	✓	✓	✓	✓
Paul B	4	UHNM CWD Capacity	Additional CWD Capacity	£0.925m	✓	✓	✓	✓	✓	✓
Paul B	5	UHNM Corporate	Transport, Comms, Access Roles	£0.147m	✓	✓	✓	✓	✓	✓
Jennie C	5	Community Beds	Cheadle Hospital (26 beds)	£1.239m			✓	✓	✓	✓
Jennie C	6	Additional D2A Beds	27 x D2A Care Home Beds	£1.783m			✓	✓	✓	✓
Jennie C	7	Additional Home First	1000hrs/week	£3.787m	✓	✓	✓	✓	✓	✓
Jennie C	8	Additional Discharge Team Resource	Complex Assessment & Rehab working across T&T and D2A	£0.078m	✓	✓	✓	✓	✓	✓
Cheryl H	9	Acute GP	Extension of Red Zone GP	£0.240m	✓	✓	✓	✓	✓	✓
Jon O'B	10	Physical Health / MH Wards	GP & Physician Associate working across OP MH Wards	£0.109m	✓	✓	✓	✓	✓	✓
Jon O'B	11	Facilitated Discharge MH	Social Worker based at Harplands covering 3 x Acute Wards	£0.123m	✓	✓	✓	✓	✓	✓
Jon O'B	12	HABIT Model	Improved Flow Ward 1 Mixed Sex	£0.035m	✓	✓	✓	✓	✓	✓

System Finance and Performance endorsement of schemes to support surge capacity at UHNM System Partner schemes designed to reduce the acute bed deficit detailed above.

UHNM WINTER/SURGE RESILIENCE – HEALTH & WELL BEING 2021/22

The System aim is to meet the Health and Wellbeing Needs of our Diverse System Workforce and to ensure we have a sustainable HWB offer in place for the future.

Health and Wellbeing Governance Infrastructure
Revised formal HWB Steering Group established by the ICS having strategic oversight of system HWB support in place.
ICS Staff Psychological Wellbeing Hub
Hub is receiving calls from a diverse background accessing the Hub.
Enhanced Health & Wellbeing Evaluation Programme Bid
Staffordshire and Stoke on Trent ICS have been successful in their £1.6million bid to measure the impact and outcome success of the funding already received for health and wellbeing initiatives
Critical Care Support
Psychologists diverted to specifically support critical care
Staff counselling and support team working with critical care staff
System-wide staff psychological wellbeing hub
#Take21in21
Social movement campaign through social media channels raising the profile of self-care
Pre-cursor to System-wide wellbeing event

UHNM
Well Being initiatives are published on the Internet together with in reach sessions.
Workforce Cell coordinating mutual aid activities and taking escalations to provide targeted well being & psychological counselling.
Comfort rounds are commissioned for departmental support during periods of escalation – approved at Covid19 Tactical.

UHNM WINTER/SURGE RESILIENCE – RISK PROFILE 2021/22

UHNM Winter Plan Risk Evaluation: The following denote a high level risk evaluation based on factors that impact the Trust plans but for which the Trust cannot solely deliver solutions as they are subject to external impacts and enablers.

Workforce: availability to open and maintain UHNM escalation areas in the event of a winter super surge or other winter viruses should planned mitigations be insufficient to manage the demand. UHNM has experienced high volumes of staff attrition over the summer and autumn consistent with other organisations and this the single highest risk and issue of concern in spite of mitigation plans proposed round market equivalent rates of pay and aligned well being packages of support.

System Resilience:
Primary care ability to maintain admission/attendance avoidance and Community/Social Care to support medically fit / sub-acute patients from the hospital footprint against agreed standards if faced with similar oversubscribed workforce/ patient demand and winter virus/Covid19 and urgent care challenges.

Critical Care & Other Tertiary Network capacity: capacity to decant Adult and Paediatric Critical Care patients in the network, should UHNM capacity become compromised due to Covid19 or Major Trauma impact. RSV and Escalation plans offered in mitigation.

Acute Bed Base Capacity: the confidence of the system response to the bed capacity against demand in light of documented workforce and system resilience challenges; especially within the medical bed base if the Covid19/RSV/IPC winter viruses all align and require triple cohorting.

EU Exit: impact on specialist workforce availability, and availability of equipment/medicines sourced from outside of the United Kingdom once all contingency supply chains have been accessed.

Winter Communications Campaign

- The aim of the campaign will to try to reduce attendances or to divert the public to other NHS services.
- The approach will make users aware of the existing demand, reinforce what preparation UHNM has taken for winter and seek to change public behaviour through the public a social marketing.
- In 2020 /2021 a budget of £1,500 was allocated to target audiences across Stoke –on-Trent and Staffordshire on Facebook and Twitter only.
- The campaign reached 600,000 people in Staffordshire and Stoke-on-Trent - a 6,664% increase in reach compared to previous years.
- Essentially an external social marketing campaign, it aims to target general public, specifically women aged 24 to 55-years-old who have been identified as key decision makers in households and family groups and are the most likely to influence health choices made by younger and older generations.
- This year the campaign will again incorporate paid-for advertising but will also include targeted Google adverts.
- The UHNM Where for Care campaign has been refreshed for 2020/21 and will be adopted by partners in Staffordshire and Stoke-on-Trent to become system wide.
- The campaign “Where for Care?” will strongly align to the national winter campaigns of Help Us Help You, 111 First and promote the ED Kiosks.
- Additional adverts and signage will also be developed for key billboard locations in and around Royal Stoke and supported by regional 111 radio advertising.

• Winter PR Campaign

PR Plan

- A proactive winter PR plan will run alongside the campaign, highlighting the positive steps being taken by UHNM to improve flow; schemes to support discharges and initiatives to avoid admission.
  - ❑ CRIS – developments and latest stats
  - ❑ Falls Response Service – latest stats
  - ❑ Emergency Department improvements
  - Introduction of an electronic referral process out of ED to speed up the patient's journey.
  - Rota redesign to maximise the impact of the current staffing levels by improving the match to demand
  - Introducing a range of clinicians across the department to reduce the reliance on traditional medical staffing.
  - Design and Implementation of a transformed Navigation model to significantly reduce unnecessary ED Footfall
  - Implementation of a transformed Triage model to significantly reduce the waiting times for initial assessment
  - Introduction of the Senior in Front Triage (SiFT) model to improve non-admitted pathway and patient experience.
  - Think 111 First / Kiosks to improve non-admitted pathway and patient experience; getting the patient to the right place at the right time.
  - Approval of ED Business Case to recruit to medical and nursing posts within the department business case and recruitment
  - ❑ Get Up, Get Dressed, Keep Moving

Internal

- A large focus of internal communications will run alongside the communications plan to improve steps being taken to improve flow within the hospital and between UHNM and the community.
- Internal communications will focus on:
  - ❑ Red 2 Green
  - ❑ Discharge processes
  - ❑ ReSPECT
  - ❑ Get Up, Get Dressed, Keep Moving
  - ❑ Emergency Department improvements
  - ❑ New UEC Standards

REGIONAL/SYSTEM PLANS & EXPECTATIONS FROM NOVEMBER 2021/22

What the region will be doing/asking?

Cell Structure - The region will be standing back up a number of support cells (which worked to good effect during COVID) to help measure and monitor all activity and performance, reporting exceptions to enable insight from the clinical and operational Subject Matter Experts to provide a good level of oversight on the Operational/ Clinical issues impacting over the Winter period.

Continuous data insight using existing data flows but there maybe requirements to establish additional data flows e.g. Community Bed Capacity. This data will be also be shared with ICS's each day in the form of regional winter overview

Winter Assurance meetings with ICS's (where required) to discuss winter plans and to gain further assurance on those plans (Late Oct/ Early Nov - dates to be confirmed) based on the responses from KLOEs issued to each ICS which have been aligned to the UEC Recovery National 10-point plan and H2 Planning Priorities. These will be due back to the region at 12noon 22nd October 2021

Clinical Support - Within the regional Cell Structure the Clinical Directorate will be establishing a Clinical Support & Oversight model with a Clinical Reference Group over the winter period

UEC Improvement Support – will be undertaking a number of pre-winter support measures including:

- On-site improvement work across regions most challenged acute providers and systems to support improving flow and maximising attendance and admission avoidance.
- Comprehensive list of pre-hospital, front door and flow interventions produced and tailored to each systems needs.
- Improvement approach will be adopted to winter 2021/22 through all systems being provided with a tool kit to support rapid decompression and flow, tools to include:
- Missed Opportunity Audit
- NEWS2 Audit (Acute and System)
- Long Stay Wednesday Process/ MADE event guidance

What we expect of Systems?

SENIOR ICS LEVEL SIGN-OFF - Expectation that all Winter Plans for ICS & Providers – have received System Oversight & Assurance with a set of aligned actions and have been fully signed off at ICS Senior Levels which includes Social Care.

ICS's & Providers Single Point's of Contact (SPOC) Established – As outlined previously there will be a requirement for all ICS's and Providers to establish SPOCs to be ready to stand up from 1st November 2021 ready to run 5-7days per week. Covering the core business hours + extended hours when required.

ICS's have robust escalation protocols in place to manage expected winter pressures with robust data flows to ensure there is good level of oversight on all areas of Capacity (Acute (Elective & NEL) / Community/ Ambulance / Primary Care and Mental Health/ Maternity/ Social Care).

PATIENT SAFETY, STRONG IPC & CLEANING - ICS's leaders to ensure there are robust processes with Clinical Oversight & Leadership is in place to ensure Patient Safety & IPC-Cleaning is maintained and any escalation requirements are in place. Throughout Winter the region will be seeking assurance from the ICS leadership on all aspects of Patient Safety/ IPC & Cleaning.

Staff Health & Wellbeing – Region will be seeking assurance that there are processes in place for continually assessing the Health & Wellbeing of Staff and that there are robust interventions in place.

ICS Winter Directors – Linking to the establishment of ICS SPOC. There will be a requirement for ICS's to nominate a Winter Director in order the regional Winter Director to link directly during the period required.

ICS Winter Room Plans aligned to UHNM Winter Surge & Resilience Plans.

UHNM WINTER SURGE/RESILIENCE – UHNM ICC - 2021/22

The role of the UHNM Incident Control Centre (ICC) is to manage and coordinate the Trusts response to all levels of emerging incidents outside of the parameters of the Trusts normal working function

The Core Staffing for the ICC is x1 Head of Resilience and EPRR, x1 EPRR Manager, x1 PA, with additional support from the Transformation / PMO office over 5 days

The UHNM ICC is manned 5 days a week on core hours with +/- week end reporting as directed.
In a Level 4 Incident Response this will go to x7 days a week from 08:00 – 20:00

The ICC administers and supports the Daily TAC meetings Currently daily 10.30 am Divisional Stakeholder meetings.

The ICC is responsible for reviewing and forwarding all information requests that come from NHSE

The ICC collates and submits daily returns for RS Daily Capacity, CH Daily Capacity, Trust Discharges, Mortuary Return, Lateral Flow Return, Vaccinations, Critcon levels,

Weekly returns are: Weekly Activity Return, Paediatric Shielding, ITU Consumables

The Level 4 Corporate Oversight Structure is show on the next slide: Gold, Silver and Bronze Controls once the service triggers have been enacted. GOLD meetings, twice weekly clinical meetings , attendance on NHSE Webinars with regards to Covid issues once a Level 4 incident is declared the details on the following slides will be initiated.

UHNM WINTER SURGE/RESILIENCE – INCIDENT RESPONSE STRUCTURE - 2021/22

- **Function** Strategic Oversite
- **Location** Via Teams
- **Members:** Executive Team
- Gold Command
- Medical Director or Deputy
- Chief Operating Officer or Deputy
- Chief Nurse
- Director of Finance/IT/Estates
- Director of Human Resources or Deputy
- Director of Corporate Services or Deputy
- Press Officer / Communications Lead
- EPRR

Strategic Responsibilities

Meet twice weekly

- Returning to Business as Usual
- Obtaining Resources
- Authorising Service Closures
- Authorising Diverts
- Overseeing Covid Response for the trust
- High level External Communications

- **Function** Tactical Response and conduet to Gold & Bronze
- **Location** ICC Springfield and VIA Teams
- **Members;**
- Silver Commander
- Assistant Director of Operation(s)
- EPRR (Tactical Advisor)
- Senior Nurse
- HR Manager
- Finance
- Estates Management

Tactical Responsibilities

- Provide a leadership of the response and guidance to divisional staff
- Coordinate the Trust's response in their areas
- Facilitate the flow of information to Bronze and TAC
- Maintain reponse plans

- **Function** Divisional Leads
- **Location** Divisional Operational Bases
- **Members:**
- Divisional Management Teams
- Divisional Staffing
- Administrative Support
- Specialist Advisors as required

Operational Responsibilities

- Manage Local Operational Response
- Attend daily meetings to report to TAC
- Ensure situation reports are submitted
- Support Operational areas as required

UHNM WINTER SURGE/RESILIENCE – OPERATIONAL OVERSIGHT MODEL 2021/22

Time	Meeting / intention
0800 – 0830	Divisional Beds
0830 – 0900	Site Beds
0900 – 0930	Divisional Command – Check in, EPPR updates, Cell Updates, Priorities
0930 – 1100	Cell Focus & Delivery – Agreed workstreams, actions and delivery
1030 – 1130	***Trust EPPR Tactical***
11.30 – 1200	Divisional Beds
12.00 – 12.30	Site Beds
13.00 – 13.30	Division Covid / Winter Briefing – update & check-in for broader divisional team
13.30 – 14.00	Divisional Command – reconvene decisions / support / progress
1430 - 1500	Divisional Beds
1500 – 1530	Site Beds
1600 - 1630	Refresh tomorrows plans – all directorates updates received
1730 – 1800	Site Beds
19:30 – 20:00	Night Plan Site Meeting – review of 17.30 actions and Divisional Plans for overnight
21.30	Site Escalation Call – subject to Escalation status – SOC & GOC participation

UHNM WINTER SURGE/RESILIENCE – INCIDENT RESPONSE STRUCTURE BY ROLE - 2021/22

	Mon – Fri Out of Hours	Weekend	Lv 4 on-site requirement
GOC	Join 17:30 Site Capacity call. Make decision if 19:30 or 21.30 meeting required based on advice from SOC and Site Matron. GOLD commander for Major Incident with on site presence subject to escalation position against Level 4 triggers.	Join 08:30 Site Capacity call. Make decision if Div reps required on site & TAC to be convened. Make decision if 19.30 and 21.30 meeting to be convened. GOLD commander for Major Incident	WMAS offload at 2hrs with no plan to de-escalate in following 30mins No portal capacity identified for the following 2hours with risk of 12hr DTA breeches Critical Capacity at 120% with no step-downs identified or capacity to step-down into Approaching full hospital triggers relevant to the Division –e.g. no discharges identified next 4-6 hours.
SOC	To be onsite in the Site office for 17:30 Capacity Meeting. To update GOC on site position and take escalation calls from WMAS / other system SOCs. To be the point of escalation till 09:00 next day for all site related issues.	Join Site Capacity calls throughout day. Escalate to GOC keeping them updated on site position.	At GOC/GOC Oversight request or Level 4 triggers as above.
OPS Oversight	To be on site 12:00 – 20:00 to support site oversight and assist with mitigation plans for de-escalation, flow management and other external flow actions.	Chair TAC meetings and provide update report to CCG system call and continue to update UHNM ICC and GOC/SOC on any feedback actions.	At GOC request.
Divisional Reps	Divisional Leadership and oversight for capacity plans. Working with Flow Teams to ensure pull from ED and PACE on discharges. Join Site Capacity Calls to articulate plans and support with mitigating actions.	Join 8.30 Site Capacity Calls to articulate plans and support with mitigating actions. Divisional Leadership and oversight for capacity plans. Working with Flow Teams to ensure pull from ED and PACE on discharges.	At GOC/GOC oversight request or Level 4 triggers as above or any emergent Divisional specific escalation risks.

Performance and Finance Chair's Highlight Report to Board

19th October 2021

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Escalations from the Executive Business Intelligence Group were noted in terms of the actions being taken to improve histology turnaround time reporting as well as addressing the challenges in taking forward an appropriate demand and capacity model • Escalations from the Executive Infrastructure Group were noted in relation to the additional costs incurred for Project STAR for asbestos removal, postponement of the testing of the maternity systems and major incident planning due to operational pressures, Thermometers which were not fit for purpose with alternatives being identified and the ongoing actions being taken in respect of the required replacement of CPAP machines as part of a national recall • Operational performance challenges including the outstanding system surge plan and ongoing challenges and worsening position in relation to urgent care. Further assurance was requested in relation to ambulance waits and triage procedures. • Urgent care resilience as the Trust moves into winter and the need for sight and approval of the Winter Plan • The Committee received a revised Investment paper which provided an update on the recurrent investment decisions approved to date which were affordable but noted the value of potential investments and the way in which these were considered and assessed in terms of potential impact on patient safety. The Committee considered the impact of future investment decisions and how non-recurrent decisions could be made in future years to provide realistic assumptions for 22/23 spending and members agreed that further consideration was required as to how to balance the financial versus patient safety risks.	• To establish a view from NHS X in relation to the N365 business case regarding the limitations of the national tenant and whether they would be supportive of a local approach • To discuss the improvement plan for IM&T and associated timescales with the Chairman • To confirm the reasons for obtaining an extension to the contract associated with the eREAF, in particular why this did not go to tender prior to the end of the current contract • To identify the number of contracts which had been rolled forward or extended • To highlight the risk in relation to system failure to reduce the number of patients attending at emergency portals, within the BAF as well as strengthening the current narrative within the current risks • To clarify the impact of the postponement of the EPRR testing within maternity • To consider the H2 plan at November's meeting • To hold a broader discussion regarding future investment cases at the Closed Board in November in terms of current pressures, and rationale regarding the balance of risk
Positive Assurances to Provide	**Decisions Made**
• The Committee considered the suggested changes to the business case for Microsoft Office N365 in terms of not adopting the national tenant and instead migrating services to a UHNM tenant, noting the particular opportunities this would provide, although noting the additional costs which would be incurred • The Committee received initial findings for 15 areas identified by the Director of Digital Transformation which would be used to inform the revised IM&T Strategy going forwards • The Committee noted the revisions and improvements made to the Board Assurance Framework as at Quarter 2, and noted the most significant risks. The Committee challenged whether the cyber security risk should not have reduced in risk score, given some of the limitations noted in relation to IM&T, but concluded that the problems identified would not significantly impact on the achievement of the strategic objectives. • The Committee noted the update in relation to the EPRR annual statement which demonstrated that the Trust was compliant with the requirements and where limitations were noted, plans were in place to address these • An update was provided in relation to Data Security and Protection, whereby training had decreased to 87% and actions continued to be taken with directorate teams, providing trajectories for improvement as well as focussing on those staff whose training had been out of date for some time. Outputs from the review by NHS X were noted and the actions taken as a result in addition to other key pieces of work in relation to data security and protection. • Month 6 performance saw a surplus of £0.2 m, with an overall surplus of £13.7 m for H1, and the Committee noted the requirement for break-even at the year end. It was noted that the pay award was provided to staff in September and income had been received to match the costs, and capital funding for the 4th Linac had also been agreed. The Committee noted the ongoing discussions in relation to the Trent project, for the capital to be re-phased	• The Committee approved the revised business case for Microsoft N365 and obtain information from NHS X prior to being brought to the Closed Trust Board in November • The Committee approved eREAF 8275 - Supply of Ports, Trocars, Stapling and Energy Devices – Extension • The Committee approved the Quarter 2 Board Assurance Framework which would be considered by respective Committees prior to being discussed by the Trust Board • The Committee approved the EPRR Annual Assurance Statement

Comments on the Effectiveness of the Meeting
• Committee members welcomed the discussion held

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Microsoft Office N365 Business Case Review	Approval	8.	Operational Delivery Group Assurance Report (October 2021)	Assurance
2.	IM&T Strategy Progress Report	Assurance	9.	Month 6 Performance Report	Assurance
3.	Authorisation of New Contract Awards and Contract Extensions	Approval	10.	Data Security & Protection Update Q2	Assurance
4.	Q2 Board Assurance Framework	Approval	11.	Investment Assurance Report	Assurance
5.	Executive Business Intelligence Group Assurance Report (October 2021)	Assurance	12.	Month 6 Finance Report - 2021/22	Assurance
6.	EPRR Annual Statement / Assurance	Approval	13.	Non-Elective Improvement Group Minutes	Information
7.	Executive Infrastructure Group Assurance Report (October 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					
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

20th October 2021

1. Highlight Report

Matters of Concern or Key Risks to Escalate

- Concerns highlighted through the **WDES Report** around the percentage of disabled staff experiencing harassment, bullying or abuse from patients / service users or others; the national report has also been issued and this will be shared with the Board.
- Lower numbers of the medical workforce have declared their **disability status** when compared to Agenda for Change.
- 26 **formal conduct cases** were active during quarter 2, an increase has been seen with regard to cases associated with medication
- Concerns expressed around the **timescales for completion of some disciplinary investigations**, whilst it was acknowledged that the 28 day timescale is challenging, work is ongoing to improve timescales for conclusion – further details to be included in the next report around these actions
- Performance against **workforce KPIs** demonstrates under performance in relation to PDR
- **Stress related sickness** remains the top reason for absence (25.13% of all absences) at 8th September
- Covid is having significant implications on the roll out of **Improving Together** training although an average of 120 individuals per month are being trained – therefore a 'stepped' training programme is being delivered, according to role
- **Audit Committee** to consider a review workforce related planning and management matters as part of the Internal Audit Programme

Major Actions Commissioned / Work Underway

- Implementation of the **WDES Plan** will be monitored on a regular basis through the Equality and Diversity Group
- **Civility and Respect** Task and Finish Group is meeting on a fortnightly basis; a programme has begun within Estates and Facilities entitled 'Holding their Mirror Up' which is proving successful
- **Equality, Diversity and Inclusion Strategy** is currently under development and is soon to be presented for approval
- Further consideration of assurance to be provided around the size and scale of the bank, management of absences, understanding the establishment versus reality, recruitment processes
- Revised **Performance Management Review** process has commenced as part of the Improving Together Programme
- Further consideration to be given around the development of KPI's / RAG rating to provide assurance against progress with the **Improving Together programme metrics**, further consideration to also be given to an 'accreditation' approach rather than 'recognition'
- A further review of the structure of some elements of the **Board Assurance Framework** is underway with a view to enacting at Q3
- Development of **Clinical Strategy** well underway, due to be presented to the Committee for approval in November

Positive Assurances to Provide

- Within Agenda for Change pay bands we have seen **improvements in disability disclosure**, year on year improvements have been seen with disability staff having equal opportunities
- Q2 **Workforce Equality, Diversity and Inclusion** (EDI) report demonstrated positive progress being made around the EDI agenda – further discussion planned for the Board Time Out
- Statutory and Mandatory training has exceeded the target of 95% as at 30th September at 95.5%
- NED Champion for **Wellbeing** noted positive work being undertaken in relation to the development and delivery of the Wellbeing Plan

Decisions Made

- Approval of the **Board Assurance Framework at Q2**
- Agreed for a report on **Rostering / Impact of Staffing** to be included in the business cycle for meetings going forward

Comments on the Effectiveness of the Meeting

- Richness on conversation relating to EDI aspects was extremely helpful
- Useful to receive further assurance on workforce planning
- Positive to see the momentum being built in relation to the Improving Together Programme
- Agreed that the meeting has been effective

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Workforce Disability Equality Standard	Assurance	6.	Q2 Board Assurance Framework	Approval
2.	Progress Report on Workforce Equality, Diversity and Inclusion – Quarter 2	Assurance	7.	Executive Research & Innovation Group Assurance Report (Oct-21)	Assurance
3.	Q2 Formal Disciplinary Activity	Assurance	8.	Executive Strategy & Transformation Group Assurance Report (Oct-21)	Assurance
4.	M6 Workforce Report	Assurance	9.	Executive Workforce Assurance Group Assurance Report (Oct-21)	Assurance
5.	Improving Together Highlight Report	Assurance			

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									
Mrs R Vaughan	RV	Director of Human Resources						JH						

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board	**Date:**	3rd November 2021
Report Title:	Integrated Performance Report, month 6 2021/22	**Agenda Item:**	14.
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:

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

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

Executive Summary:

Situation

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

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

Assessment

Quality & Safety

The Trust achieved the following standards in September 2021:

- Friend & Family (Inpatients) 99.0% and an improvement from previous months and exceeds 95% target.
- Friends & Family Test for Maternity returned 100%.
- Harm Free Care continues to be above the national 95% target with 96.8%

- Falls rate was 5.4 per 1000 bed days and is below the average rate per 1000 bed days during COVID-19 pandemic
- Trust rolling 12 month HSMR continues to be below expected range.
- 100% of patients/family was informed verbally of incidents that are reported as meeting duty of candour threshold.
- VTE Risk Assessment continues to exceed 95% target with 99.7% (via Safety Thermometer).
- Zero avoidable MRSA Bacteraemia cases reported.
- There have been no Category 4 Pressure Ulcers attributable to lapses in care during September 2021.
- Inpatient IVAB within 1 hour achieved 100% and exceeded 90% target rate
- Sepsis Screening compliance in Emergency Portals exceeded the target 90% with 91%.
- Emergency Portals Sepsis screening 93% against 90% target
- Children's Sepsis Screening compliance 91.7% and above the 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.
- There were 13 Pressure ulcers identified with lapses in care during September 2021 and 9 Deep Tissue Injuries.
- 83% Duty of Candour 10 working day letter performance following formal verbal notification.
- C Diff YTD figures above trajectory with 9 against a target of 8.
- Inpatients Sepsis Screening 85.2% below 90% target rate
- Emergency Portals IVAB in 1 hour 88% against the 90% target for audited patients
- Maternity Sepsis Screening 88.9% and IVAB in 1 hour compliance at 75% and below the targets
- Emergency C Section rate is above 15% target at 23.19%.

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

- The rate of complaints per 10,000 spells is 20.20 and is below (positive) the target of 35 and within normal variation. Majority of complaints in September 2021 relate to clinical treatment. This is the lowest monthly rate recorded since April 2019.
- Total number of Patient Safety Incidents decreased (1615) and the rate per 1000 bed days has also decreased at 44.27 and both measures are within normal variation.
- Total incidents with moderate harm or above and the rate of these incidents have decreased but is normal monthly variation. Whilst noted that not statistically significant yet but the previous 6 months are showing reductions in the number and rate of incidents with moderate harm or above.
- Decrease in reported incident 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 has reduced during recent months and currently at 1.3 in September 2021. The rate of patient falls with harm continues to be within the control limits and normal variation but last 3 months are below the mean rate.
- Medication related incidents rate per 1000 bed days is 4.9 and patient related 3.8. The monthly variation is within the normal expected variation and consistent with Trust mean rates. However it is below the previously published NRLS national mean rate of 6.0. There is noted reduction and below mean rate especially for patient related medication incidents. 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 and increase in rate with lapses in care.
- 10 Hospital Onset / Nosocomial COVID cases reported in September.
- 1 COVID-19 deaths falling in to the 'Definite' category (according to the National definition of Nosocomial deaths).
- 18 Serious Incidents reported in September 2021. All the serious incidents were reported on STEIS within the 2 working date target.

Operational Performance

Since earlier this year the Trust continued the difficult task of recovering services whilst also managing the demands that Covid-19 has brought with it: reduced bed capacity due to social distancing and infection prevention measures; the constraints of wearing PPE.

However, in September the Trust faced continued and increasing extreme pressure which caused challenges in providing high quality care and patient flow due to the increasing numbers of Covid-19 positive patients being cared for. This added to with the number of staff who are off work for Covid-19 related issues seriously impacted on the delivery of our services. Both hospital sites faced unprecedented times.

The demand for Critical care beds increased and at times through the month there was very limited or zero capacity.

For these reasons and in order to continue to keep staff and the patients safe the Trust, together with NHS partners across Staffordshire and Stoke-on-Trent, made the decision to move to a *system-wide incident Level 4 on 10th September.*

The Trust made a decision to temporarily postpone all non-urgent operations and this continued into the third week of September. With these actions the Trust started to see an ease of the pressures towards the end of the month.

Emergency Department

- Whist the number of attendances at Royal Stoke ED remained the same as August with a daily average of 345 the case-mix changed. The number of ambulance arrivals fell slightly from a daily average of 156 to 147 and the self-presenting ambulatory was c200/day.
- The daily average number of admissions and conversion rate fell slightly. Daily average admissions were 112 and the conversion rate 32.6%.
- Ambulance handover delays for 30-60mins rose slightly static and the > 60 mins remained static in September after a sharp rise seen in August. The percentage of handovers within 15 minutes fell to 30% or below, due to the periods of ambulance surges often late afternoon that require processing time to clear.
- System-wide performance was 66% (August 68%), with total type 1 at 51.1%. At Royal Stoke the non-admitted performance fell to 50.4% (August 54.3%) and the admitted performance fell from 24% to 20% indicating the key issues for August were related to extended timescales to securing a admitted placement. MFFDs rose to their highest numbers year to date as have the number of patients with > 21 days stay in September.
- The department had continued days with sub 60% performance with most of the front door metrics challenged.

Cancer

- 2WW Referral volumes remain very high, although are still under the NHSEI predictions that modelled demand based on the 2020 referral deficit due to covid. Pre-validation position shows that UHNM have appointed a record number of 2WW patients in September (around 3400)
- The 2WW standard has improved since last month and is predicted to land at 69% in September. The majority of 14 day breaches are within Skin and Colorectal.
- Breast has recovered 14 day performance in September and is predicted to achieve both suspected cancer and symptomatic 2WW targets.
- Performance against the 62 day standard for September is currently at 54% however this is an un-validated position which is expected to change as histology confirms a cancer or non-cancer diagnosis for patients who have been treated in month.
- Clinical prioritisation of patients into available theatre capacity is continuing through September. This presents a challenge to performance - until the surgical backlog is reduced patients are not being dated by target but according to clinical need. Specialties have been asked to explore cases suitable for the IS through the Elective Recovery fund.

PTL Updates:

- The number of patients waiting over 104 days has decreased this month to 75. Of these 33 are on a Colorectal pathway.
- Consultant and ANP capacity in Colorectal along with missing FIT results is the main factor impacting the backlog. Other contributing factors include delays to Urology surgery due to capacity, complex pathways. Clinical prioritisation of patients into available theatre capacity is continuing through September. This presents a challenge to performance - until the surgical backlog is reduced patients are not being dated in target but according to clinical need. Specialties have been asked to explore cases suitable for the IS through the Elective Recovery fund.

Planned Care

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

- Day Case and Elective Activity delivered 83.6% for August 21 against the national ask of 95%. This is lower in Inpatients than Day case (76.3% IP, 84.7% DC).
- Over a thousand patients sent as IPT to independent sector, with a further 700 clinically reviewed as suitable to be sent. 900 of the original 2.5k have been identified as not suitable for IS treatment.
- New plan in development to identify and track patients suitable for transfer patients to the IS as they are added to the waiting list.
- Next Planned Care Cell focus on theatre capacity and productivity given the emergent covid risks and staff isolation rate of attrition.
- Scoping of schemes to support management of referred demand (Referral Hub) and waiting list management (Patient Contact Initiative)
- Patients are to be contacted via text message to confirm they still wish to have their procedure, with longest waiting patients prioritised for contact by phone.

RTT

- The indicative performance for September 21: the total number of Referral To Treatment pathways grew to 69,127 (Aug = 67,784, July = 65, 574).
- There has been a slight increase in the number of > 52 weeks to 3,597. This rise is expected to continue over winter due to the usual pressures and wave of covid.
- RTT performance in September is 59.8% (August 59.9%)
- Work plans around long wait patient validation and treatment tracking are in progress.

Diagnostics

- For DM01 (15 nationally identified Dx tests) the total waiting list has increased in September from 19,580 to 20,314.
- The current DM01 diagnostic performance for September 21 has improved to 68.14% (August 66.19%) of which non-obs ultrasound contributes 5,606 of the 6,472 breaches.
- 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 has now been commissioned to provide additional capacity. An improvement is expected by the end of November 2021. For endoscopy (colonoscopy and gastroscopy). This is related to an on-going increase in demand. Improvement actions are being developed and implemented.
- Histology remains a high risk with laboratory and reporting capacity extremely challenged. Actions are in place to improve the situation however the consultant histology workforce has significant gaps due to retirements.

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 5.36% (5.30% reported at 31/08/21). The 12 month cumulative rate increased to 5.25% (5.18% at 31/08/21)

- Stress-related sickness absence remains the top reason for absence, although this does include both work-related and personal/domestic life stress. In the 12 months ending 30 Sept 2021, 28.6% of sickness absence was stress-related.
- Three of the clinical divisions have identified sickness as a driver metric under the Improving Together programme and have been asked to undertake a deep dive into reasons for stress related absence to see if we can better target our actions to support
- The Trust has a comprehensive Wellbeing Plan in place to support staff with a focus on ensuring staff psychological wellbeing. Wellbeing focus groups are being held and a specific 'Winter Wellbeing Plan' has been agreed and is being put into place
- As of 20th October 2021, covid-related open absences* numbered 255, which was 28.81% of all open absences (25.13% at 8th September 2021) [**includes absences resulting from adhering to isolation requirements*]

Appraisals
The Non-Medical PDR compliance rate was 76.18% at 30 September 2021 (78.21% at 31st August 2021). Performance in completing PDRs continues to deteriorate, with clinical pressures being cited as the main reason. Managers continue to be reminded that holding PDR conversations with staff remains especially important for discussions around the impacts of covid-19 on individuals as well as being a means of facilitating support mechanisms. PDR is a means of managers providing clarity around objectives, as well as discussing career aspirations.

Statutory and Mandatory Training
The Statutory and Mandatory training rate at 30 September 2021 was 95.50% (96.0% at 31 August 2021). This compliance rate is for the 6 'Core for All' subjects only. At 30 September 2021, 91.80% of staff had completed all 6 Core for All modules (92.28% at 31/08/21)

Vacancies
The overall Trust vacancy rate was 9.11%. Although this remains consistent with previous months, there is a trend of an increasing vacancy rate emerging slowly. In mitigation, there is a recruitment pipeline in place. Other mitigations 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

The Trust has delivered a surplus of £0.2m in month against a planned surplus of £1.4m and therefore a final H1 surplus of £13.7m. The adverse position in month is primarily driven by ERF underperformance against plan.

ERF income recognised for the year to date is £8.3m against a revised planned figure of £8.8m. Based on activity plans, the plan originally assumed £8.8m of income for H1 with additional costs approved of £0.6m to support the delivery of the activity plans. Revised thresholds for receiving ERF funding have been announced for Q2 which have reduced the forecast income earned by the Trust and there has also been a significant underspend against the £0.6m anticipated spend in H1.

The Trust incurred £1m of costs relating to COVID-19 in month which is a decrease of £0.3m compared with Month 5's figure. This remains within the Trust's fixed allocation with £0.4m being chargeable on top of this allocation for COVID-19 testing costs.

The backdated pay award was processed in month totalling £6.3m for which the Trust has accrued additional income (as per National guidance) to offset; budgets have also been adjusted to reflect the pay award.

Capital expenditure for the year to date stands at £12.4m which is £3.1m behind the plan mainly due to an underspend relating to the lower Trent wards scheme and digital pathology (MES).

The cash balance at Month 6 is £59.8m which is £6.6m lower than plan, the main reason being that the Q2 invoice to Health Education England was raised in late September and the cash is now expected to be received in Month 7.

Key Recommendations:

To note performance and actions being taken to make improvements where required

NHS
University Hospitals of North Midlands
NHS Trust

Integrated Performance Report

Month 6 2021/22

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Contents

A note on **SPC**

University Hospitals of North Midlands NHS Trust

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

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

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

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

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

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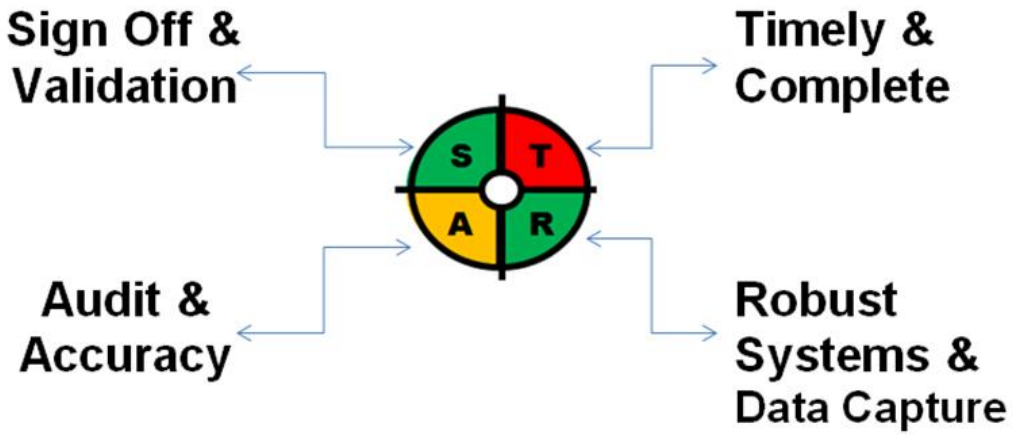
A note on **Data Quality**

University Hospitals of North Midlands NHS Trust

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



Explaining each domain

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

RAG rating key

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

Quality

Caring and Safety

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

Quality Spotlight Report

NHS
University Hospitals of North Midlands
NHS Trust

Key messages

The Trust achieved the following standards in September 2021:

- Friend & Family (Inpatients) 99.0% and an improvement from previous months and exceeds 95% target.
- Friends & Family Test for Maternity returned 100%.
- Harm Free Care continues to be above the national 95% target with 96.8%
- Falls rate was 5.4 per 1000 bed days and is below the average rate per 1000 bed days during COVID-19 pandemic
- Trust rolling 12 month HSMR continue to be below expected range.
- 100% of patients/family were informed verbally of incidents that are reported as meeting duty of candour threshold.
- VTE Risk Assessment continues to exceed 95% target with 99.7% (via Safety Thermometer).
- Zero avoidable MRSA Bacteraemia cases reported.
- There have been no Category 4 Pressure Ulcers attributable to lapses in care during September 2021.
- Inpatient IVAB within 1 hour achieved 100% and exceeded 90% target rate
- Sepsis Screening compliance in Emergency Portals exceeded the target 90% with 91%.
- Emergency Portals Sepsis screening 93% against 90% target
- Children's Sepsis Screening compliance 91.7% and above the 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.
- There were 13 Pressure ulcers identified with lapses in care during September 2021 and 9 Deep Tissue Injuries.
- 83% Duty of Candour 10 working day letter performance following formal verbal notification.
- C Diff YTD figures above trajectory with 9 against a target of 8.
- Inpatients Sepsis Screening 85.2% below 90% target rate
- Emergency Portals IVAB in 1 hour 88% against the 90% target for audited patients
- Maternity Sepsis Screening 88.9% and IVAB in 1 hour compliance at 75% and below the targets
- Emergency C Section rate is above 15% target at 23.19%.

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

- The rate of complaints per 10,000 spells is 20.20 and is below (positive) the target of 35 and within normal variation. Majority of complaints in September 2021 relate to clinical treatment. This is the lowest monthly rate recorded since April 2019.
- Total number of Patient Safety Incidents decreased (1615) and the rate per 1000 bed days has also decreased at 44.27 and both measures are within normal variation.
- Total incidents with moderate harm or above and the rate of these incidents have decreased but is normal monthly variation. Whilst noted that not statistically significant yet but the previous 6 months are showing reductions in the number and rate of incidents with moderate harm or above.
- Decrease in reported incident 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 has reduced during recent months and currently at 1.3 in September 2021. The rate of patient falls with harm continues to be within the control limits and normal variation but last 3 months are below the mean rate.
- Medication related incidents rate per 1000 bed days is 4.9 and patient related 3.8. The monthly variation is within the normal expected variation and consistent with Trust mean rates. However it is below the previously published NRLS national mean rate of 6.0. There is noted reduction and below mean rate especially for patient related medication incidents. 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 and increase in rate with lapses in care.
- 10 Hospital Onset / Nosocomial COVID cases reported in September.
- 1 COVID-19 deaths falling in to the 'Definite' category (according to the National definition of Nosocomial deaths).
- 18 Serious Incidents reported in September 2021. All the serious incidents were reported on STEIS within the 2 working date target.

Quality Dashboard

NHS University Hospitals of North Midlands NHS Trust

Metric	Target	Latest	Variation	Assurance
Patient Safety Incidents	N/A	1677		
Patient Safety Incidents per 1000 bed days	N/A	45.50		
Patient Safety Incidents per 1000 bed days with no harm	N/A	29.84		
Patient Safety Incidents per 1000 bed days with low harm	N/A	13.27		
Patient Safety Incidents per 1000 bed days reported as Near Miss	N/A	1.68		
Patient Safety Incidents with moderate harm +	N/A	23		
Patient Safety Incidents with moderate harm + per 1000 bed days	N/A	0.62		
Harm Free Care (New Harms)	95%	96.8%		
Patient Falls per 1000 bed days	5.6	6.0		
Patient Falls with harm per 1000 bed days	1.5	1.8		
Medication Incidents per 1000 bed days	N/A	4.9		
Medication Incidents % with moderate harm or above	TBC	0.00%		
Patient Medication Incidents per 1000 bed days	N/A	3.8		
Patient Medication Incidents % with moderate harm or above	TBC	1.46%		

Metric	Target	Latest	Variation	Assurance
Serious Incidents reported per month	N/A	16		
Serious Incidents Rate per 1000 bed days	N/A	0.18		
Never Events reported per month	0	0		
Duty of Candour - Verbal/Formal Notification	100%	100%		
Duty of Candour - Written	100%	83.3%		
All Pressure ulcers developed under UHNM Care	TBC	88		
All Pressure ulcers developed under UHNM Care per 1000 bed days	N/A	2.41		
All Pressure ulcers developed under UHNM Care lapses in care	12	22		
All Pressure ulcers developed under UHNM Care lapses in care per 1000 bed days	0.5	0.60		
Category 2 Pressure Ulcers with lapses in Care	8	2		
Category 3 Pressure Ulcers with lapse in care	4	3		
Category 4 Pressure Ulcers with lapses in care	0	0		
Unstageable Pressure Ulcers with lapses in care	0	7		

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Quality Dashboard

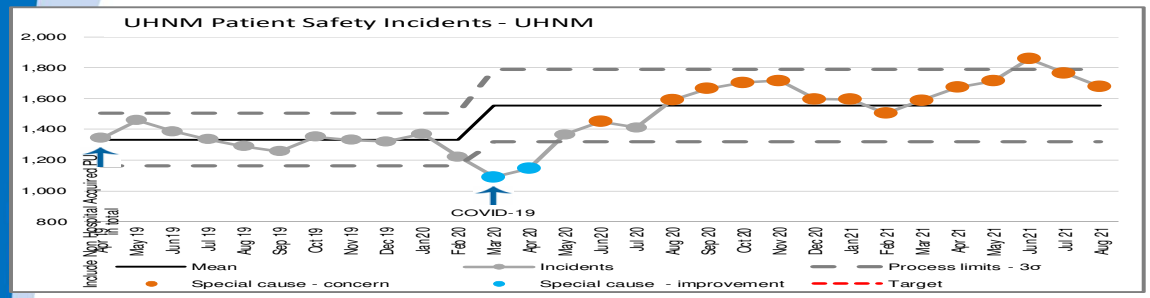
Metric	Target	Latest	Variation	Assurance
Friends & Family Test - A&E	N/A	71.0%		
Friends & Family Test - Inpatient	N/A	98.9%		
Friends & Family Test - Maternity	N/A	100.0%		
Written Complaints per 10,000 spells	35	16.89		
Rolling 12 Month HSMR (3 month time lag)	100	93.66		
Rolling 12 Month SHMI (4 month time lag)	100	102.48		
Nosocomial COVID-19 Deaths (Positive Sample 15+ days after admission)	N/A	1		
VTE Risk Assessment Compliance	95%	99.5%		
Emergency C Section rate % of total births	15%	23.19%		
Reported C Diff Cases per month	8	9		
Avoidable MRSA Bacteraemia Cases per month	0	0		
HAI E. Coli Bacteraemia Cases per month	N/A	12		
Nosocomial "Definite" HAI COVID Cases - UHNM	0	11		

Metric	Target	Latest	Variation	Assurance
Inpatient Sepsis Screening Compliance (Contracted)	90%	85.2%		
Inpatient IVAB within 1hr (Contracted)	90%	100.0%		
Children Sepsis Screening Compliance (All)	90%	91.7%		
Children IVAB within 1hr (All)	90%	N/A		
Emergency Portals Sepsis Screening Compliance (Contracted)	90%	93.2%		
Emergency Portals IVAB within 1 hr (Contracted)	90%	88.2%		
Maternity Sepsis Screening (All)	90%	88.9%		
Maternity IVAB within 1 hr (All)	90%	75.0%		

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Reported Patient Safety Incidents

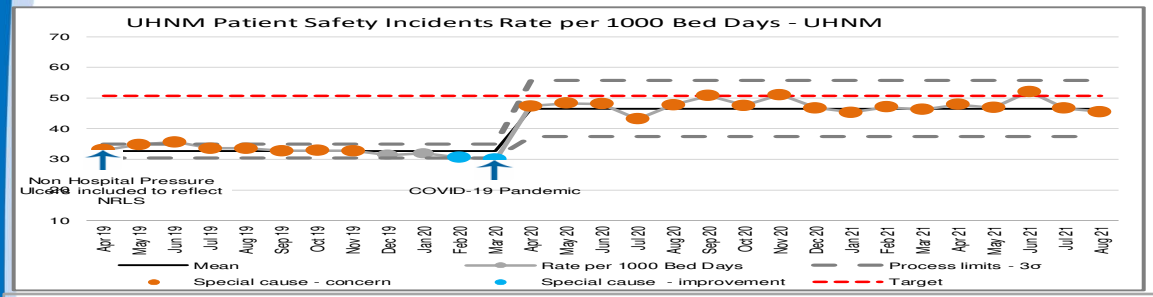


Variation	Assurance
	

Target	Jul 21	Aug 21	Sep 21
N/A	1758	1682	1615

Background

Total Reported patient safety incidents



Variation	Assurance
	

NRLS Mean	Jun 21	Jul 21	Aug 21
50.70	52.08	46.68	45.50

What is the data telling us:

The above data relates to **all** reported Patient Safety Incidents (PSIs) across the Trust. The September 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 - 196 (198)
- Clinical assessment (Including diagnosis, images and lab tests) – 83 (88)
- Patient flow incl. access, discharge & transfer - 106 (107)
- Documentation – 46 (34)
- Pressure Ulcers (Hospital acquired - 88
- Treatment/Procedure - 59 (71)
- Medication incidents - 151 (156)
- Infection Prevention – 69 (82)
- Staffing – 49 (74)

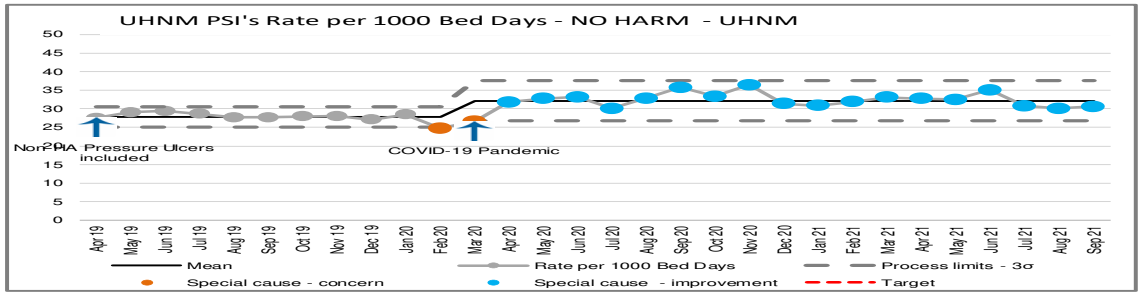
There has been a reduction during September in the total number of incident reporting relating to staffing with 74 incidents reported. 22 of these were under patient related and the remaining 27 were reported as staff related. However, these incidents do have potential impact on patient care and experience if wards/departments are experiencing staff shortages.

The Directorates reporting most PSIs are Emergency Medicine, General Medicine, Obstetrics & Gynaecology, Clinical Support Services, General Surgery & Urology and Trauma. 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 rate

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

University Hospitals of North Midlands NHS Trust

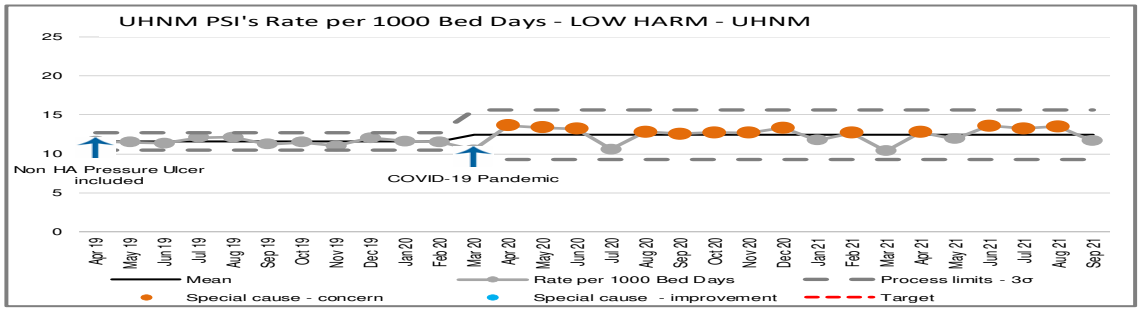


Variation	Assurance
H	

Target	Jul 21	Aug 21	Sep 21
N/A	30.77	30.06	30.62

Background

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

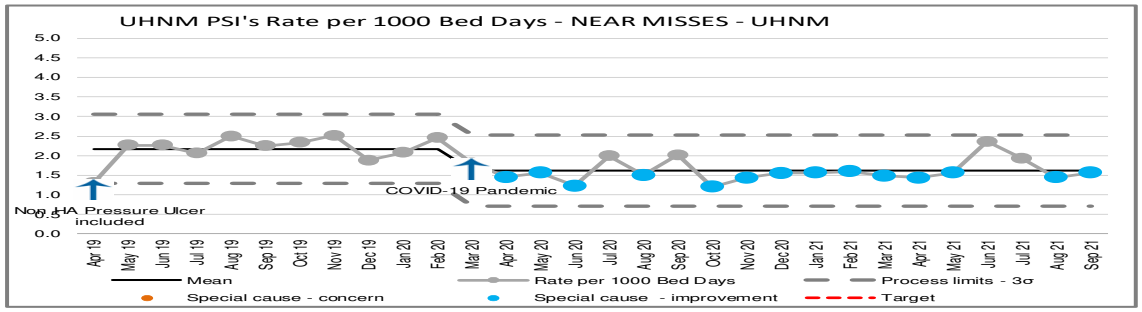


Variation	Assurance

Target	Jul 21	Aug 21	Sep 21
N/A	13.27	13.53	11.65

Background

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



Variation	Assurance
L	

Target	Jul 21	Aug 21	Sep 21
N/A	1.93	1.44	1.56

Background

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

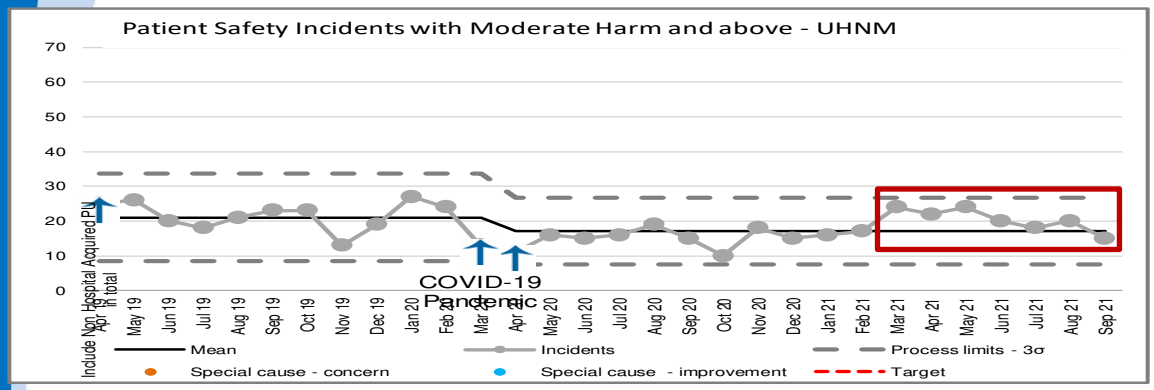
What is the data telling us:

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

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

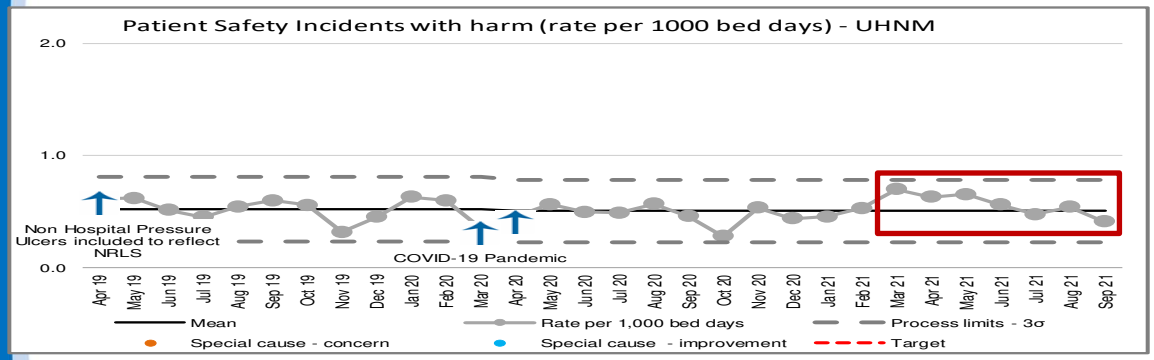


Variation	Assurance

Target	Jul 21	Aug 21	Sep 21
N/A	18	20	15

Background

Patient safety incidents with reported moderate harm and above



Variation	Assurance

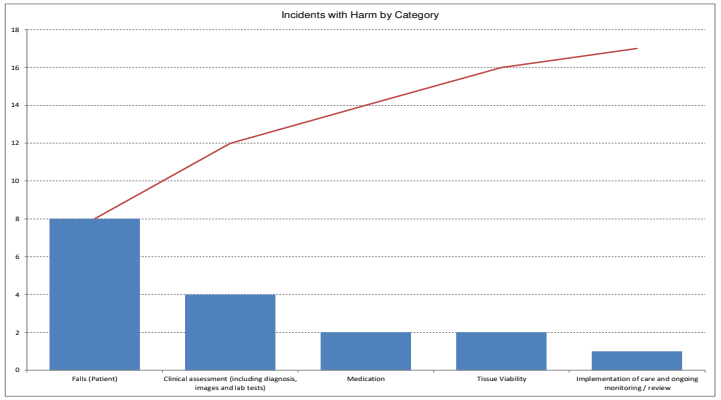
Target	Jul 21	Aug 21	Sep 21
N/A	0.48	0.54	0.41

What is the data telling us:

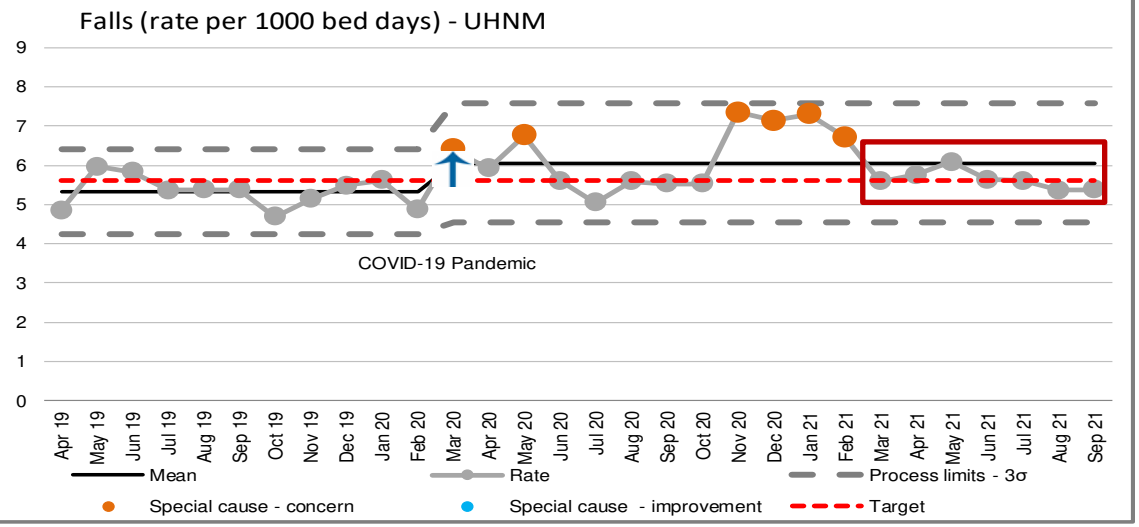
The variation noted in charts above for moderate harm or above total and rate per 1000 bed days is within normal variation and no special cause noted. Whilst noted that not statistically significant yet the previous 6 months are showing reductions in the number and rate of incidents with moderate harm or above

The top category of incidents resulting in moderate harm reflect the largest reporting categories with Slips/Trips/Falls being the largest category with 8.
The second largest category is Clinical assessment related reported 4

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



Patient Falls Rate per 1000 bed days



Variation	Assurance

Target	Jul 21	Aug 21	Sep 21
5.6	5.6	5.4	5.4

Background

The number of falls per 1000 occupied bed days

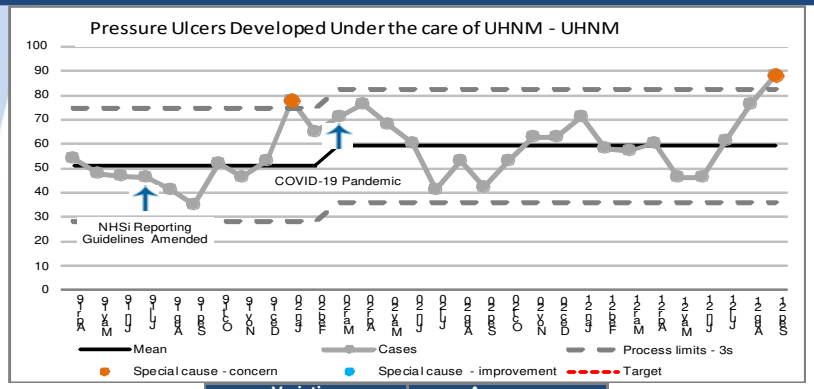
What is the data telling us:

The data shows the Trust's rate of reported patient falls per 1000 bed days. Using the rate makes allowance for changes in activity/increased patient numbers. The Trust set a target rate, based on the Royal College of Physicians National Falls Audit published rate for acute hospitals, of 5.6 patient falls per 1000 bed days. September 2021 shows 5.4 and remains below the current Trust mean rate.
The Top areas for total falls in September 2021 were:
Ward 233 Short Stay Unit, Royal Stoke AMU, Royal ED, Ward 112 – Orthopaedics, Ward 127

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

- Data for Ward 233 (Short Stay Unit)'s falls has been shared with the ward to increase awareness.
- Royal Stoke AMU and ED remain in the top falling areas but on going falls reduction projects continue and both areas are sustaining an improvement in falls numbers.
- The monthly falls audit has been adapted following the annual bed rail audit to help focus attention on safe use of bed rails. As well as increasing awareness through self assessment during this audit the Quality and Safety team are carrying out spot checks to help provide assurance of safe use of bed rails.
- Following a successful Falls conference in September that included discussions on prevention of deconditioning, plans are being made to look at safer mobilisation and positive risk taking. Wards are being asked to focus on decreasing the number of unwitnessed falls and to ensure harm from deconditioning is minimised by encouraging mobilisation and independence with appropriate support. Changes to the risk assessment book have been proposed to support this.
- Both Medicine and Specialised Divisions have identified the reduction of the rate falls per 1000 bed days as a driver metric.

Total Pressure Ulcers developed under care of UHNM

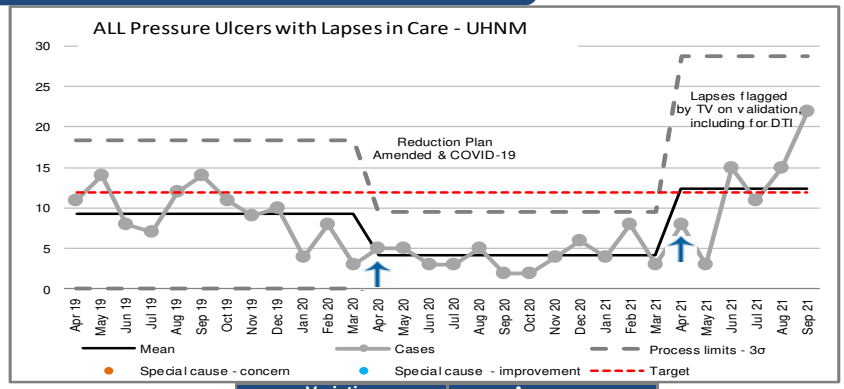


Variation	Assurance
H	

Target	Jul 21	Aug 21	Sep 21
N/A	61	76	88

Background

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



Variation	Assurance
	?

Target	Jul 21	Aug 21	Sep 21
12	11	15	22

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 September 2021.

Category	Total (Sept 2021)
DTI	32
Category 2	35
Category 3	8
Category 4	0
Unstageable	13
Total	**88**

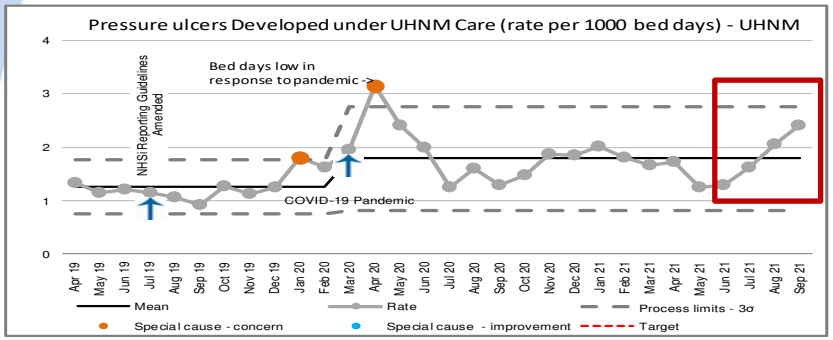
Top Body Locations	Total (Sept 2021)
Heel	23
Sacrum	15
Buttock	14
Coccyx	8

The number of pressure ulcers reported as developing under the care of UHNM in September is significantly above average. This is primarily due to numbers of Category 2 ulcers (35, compared to a 2-year monthly average of 24). Number within all other categories are stable.

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 as notes are reviewed retrospectively, for example where patients were discharged before TV could review.

Locations with more than 1 lapse in September were: Emergency Care Centre (3), Ward 227 ARTU (2), W 230 Gastro (2), County Ward 12 (2), FEAU (2)

Pressure Ulcers developed under care of UHNM per 1000 bed days

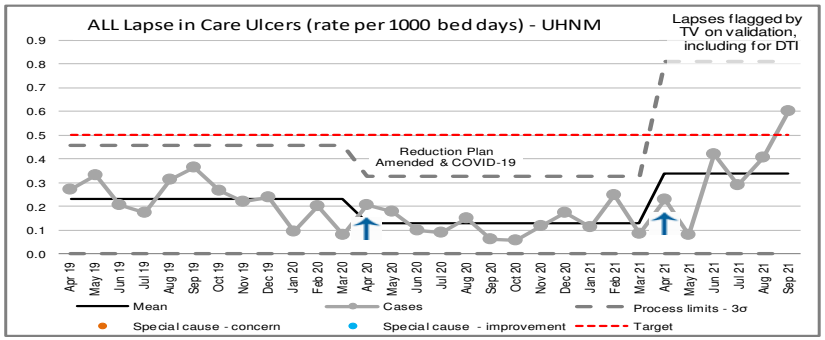


Variation	Assurance
	

Target	Jul 21	Aug 21	Sep 21
N/A	1.61	2.06	2.41

Background

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



Variation	Assurance
	

Target	Jul 21	Aug 21	Sep 21
0.5	0.29	0.41	0.60

Background

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

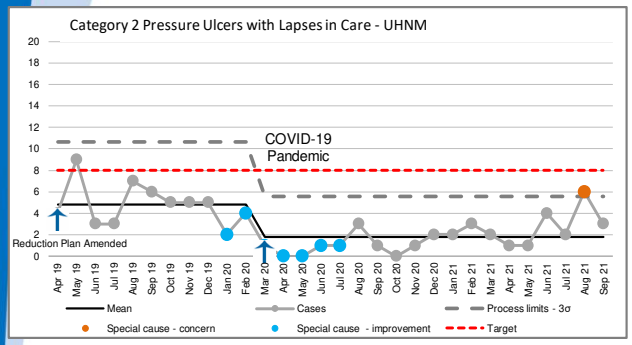
What the data is telling us

The chart above left shows that the rate of pressure ulcers reported as developing under the care of UHNM is increasing but at present not statistically significant.
The chart above right shows the rate of pressure ulcers with lapses in care identified was significantly higher in September 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.
- A Trustwide audit of chairs is underway following the identification of a number of chairs that have lost their pressure reliving qualities due to wear and tear.
- Pressure Ulcer Prevention (PUP) education is now a feature on the trust NA and Preceptorship induction programme as well as for new starters in ED and child health.
- Harm Free Care alerts are now circulated Trustwide 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.

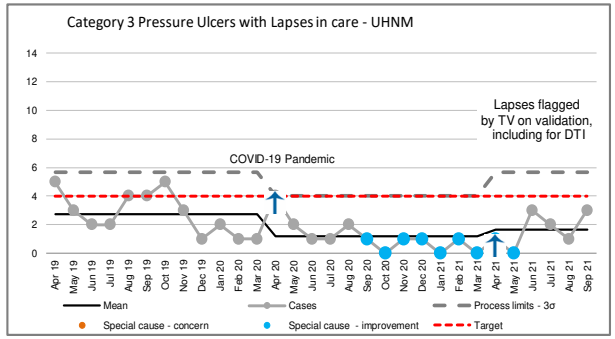
Pressure Ulcers with lapses in care



Variation	Assurance

Target	Jul 21	Aug 21	Sep 21
8	2	6	3

Background

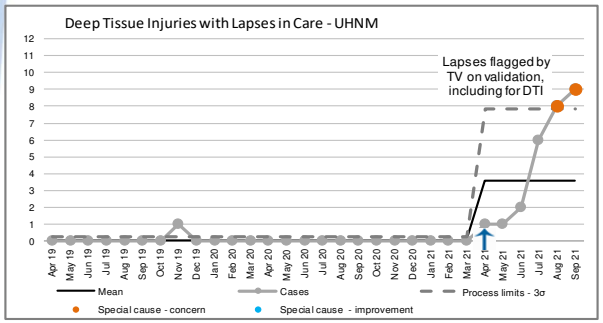


Variation	Assurance

Target	Jul 21	Aug 21	Sep 21
4	2	1	3

Background

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

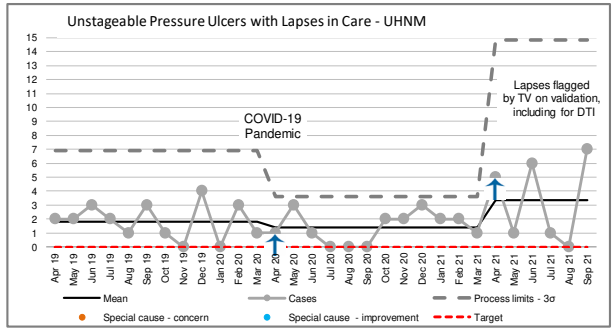


Variation	Assurance

Target	Jul 21	Aug 21	Sep 21
N/A	6	8	9

Background

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



Variation	Assurance

Target	Jul 21	Aug 21	Sep 21
0	1	0	7

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 September 2021 included a range of categories. No Category 4 pressure ulcers with lapses in care have been reported since February 2021. Numbers may change as incidents are reviewed/validated.

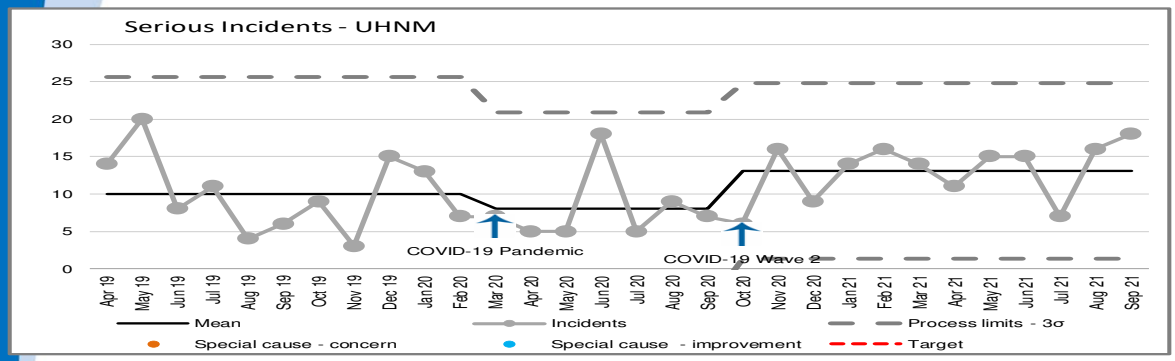
As described on slide 21, this may be down to the new validation process identifying lapses on the initial assessment by Tissue Viability , but also reflective of trust pressures in relation to staffing. Common lapses identified are management of repositioning and heel offloading which will be the focus for "stop the pressure day" on the 18th November. 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.

Actions:

- Education continues around bed profiling on high reporting areas.
- 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 due to re-commence in October 2021 and focuses on learning from incidents.

Root Cause of damage - Lapses - Sept 2021	Total
Management of repositioning	11
Management of heel offloading	6
Management of device	2
Clinical condition, Management of repositioning	1
Clinical condition	1
TBC	1
Total	**22**

Serious Incidents per month

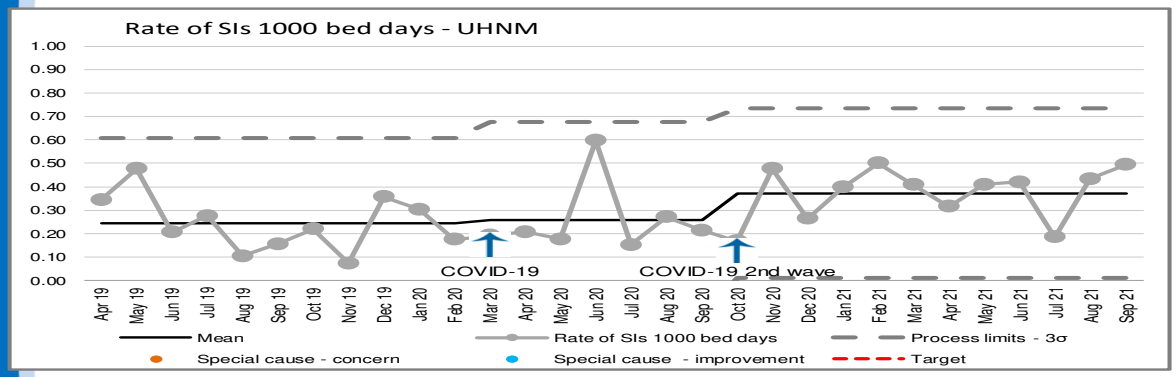


Variation	Assurance

Threshold	Jul 21	Aug 21	Sep 21
N/A	7	16	18

Background

The number of reported Serious Incidents per month



Variation	Assurance

Target	Jul 21	Aug 21	Sep 21
N/A	0.19	0.43	0.49

Background

The rate of Serious Incidents Reported per 1000 bed days

What is the data telling us:

September 2021* saw 18 incidents reported:

- 10 Falls related incidents
- 4 Diagnostic related
- 1 surgical procedure related
- 3 Maternity related (Baby Only)

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

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

Serious Incidents Summary

University Hospitals of North Midlands NHS Trust

Summary of new Maternity Serious Incidents

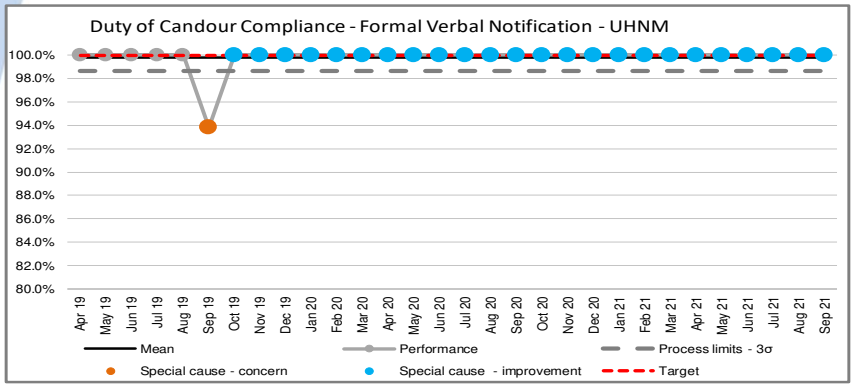
Following the formal recommendations in the Ockenden Report, below is an outline of the Maternity related serious incidents reported during June 2021. The new recommendation requires the Trust Board to receive summary on the new Maternity related Serious Incidents along with previously reported summary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

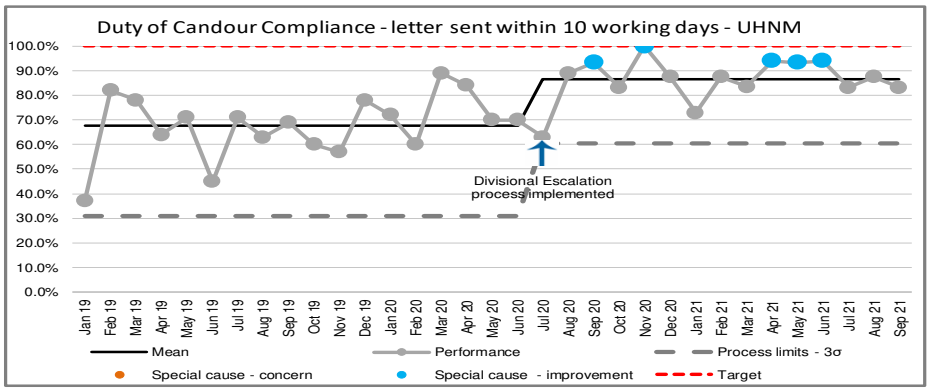
All Serious Incidents will continue to be are reported and investigated and the final Root Cause Analysis presented at Divisional meetings and Risk Management Panel for review and agreement prior to sharing with CCGs for closure.

There were 3 Maternity related Serious Incidents reported on STEIS during September 2021

Log No	Patient Ethnic Group:	Type of Incident	Target Completion date	Description of what happened:
2021/19478	White - British	Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant)	15-Dec-21	Delay in triaging mother following reports of no fetal movements, baby stillborn. G1 P0 @ 31+3/40 weeks gestation. Attended MAU with lower abdominal pain 17/08/2021, unsure of fetal movements. Cervix closed. Unable to locate fetal heart. IUD confirmed. Known SGA on 1st centile from the 10th.
2021/19485	White - British	Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant)	15-Dec-21	Term baby born with cleft lip and palate. Unable to locate record of discussion of risk of ondansetron when administered to mother at less than 12 weeks gestation.
2021/19762	White - British	Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant)	17-Dec-21	Death of Neonate at 30+5 weeks gestation following full resuscitation.

Duty of Candour Compliance





Variation	Assurance
H	?

Target	Jul 21	Aug 21	Sep 21
100%	100.0%	100.0%	100.0%

Background

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

Variation	Assurance
	?

Target	Jul 21	Aug 21	Sep 21
100%	83.3%	87.5%	83.3%

Background

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

What is the data telling us:

During September there were 18 incidents reported and identified that have formally triggered the Duty of Candour. All of these cases (100%) have been formally notified of the incident.

Confirmed Follow up Written Duty of Candour compliance (i.e. receiving the letter within 10 working days of verbal notification) during September 2021 is 83.3%.

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

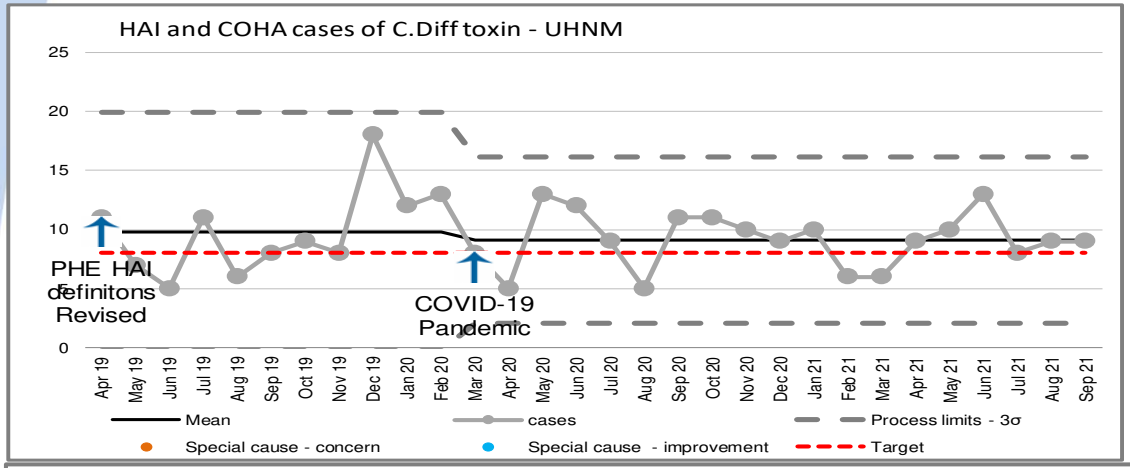
However all of the cases have received formal notification letter but after the 10 working day target. Since the new escalation process was introduced within the Divisions there has been an improvements in performance with smaller confidence intervals and better performance.

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	Jul 21	Aug 21	Sep 21
8	8	9	9

Background

Number of HAI + COHA cases reported by month

What do these results tell us?

Chart shows the number of reported C diff cases per month at UHNM. Previous 12 months are 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 9 reported C diff cases in September of these 5 were Hospital Associated Infection (HAI) cases and 4 Community Onset Healthcare Associated (COHA) cases.

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

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

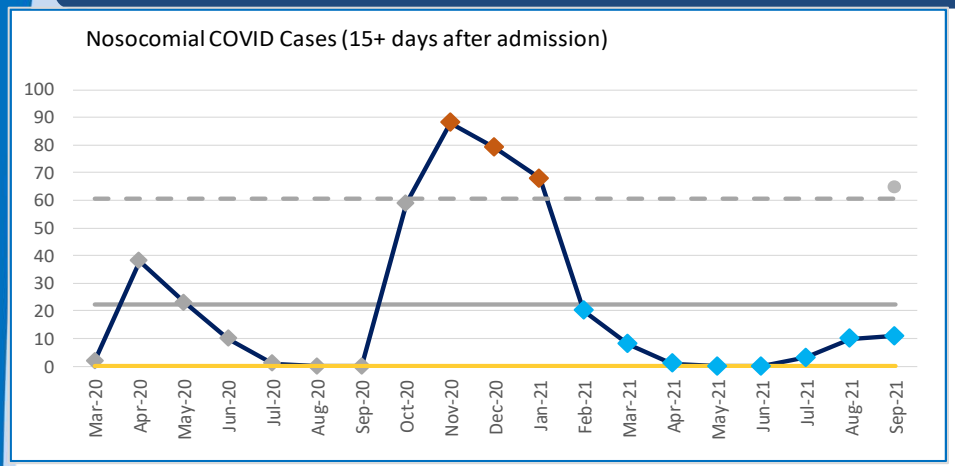
There has been two clinical areas that have had more than one Clostridium *difficile* case in a 28 day period.

- Ward 12, County Hospital 2x HAI toxin. Ribotypes are different which means no person to person transmission
- Ward 201, Royal Hospital 2 x toxin COHA toxin one ribotype is 050, we are awaiting the ribotype of the second Case
- 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

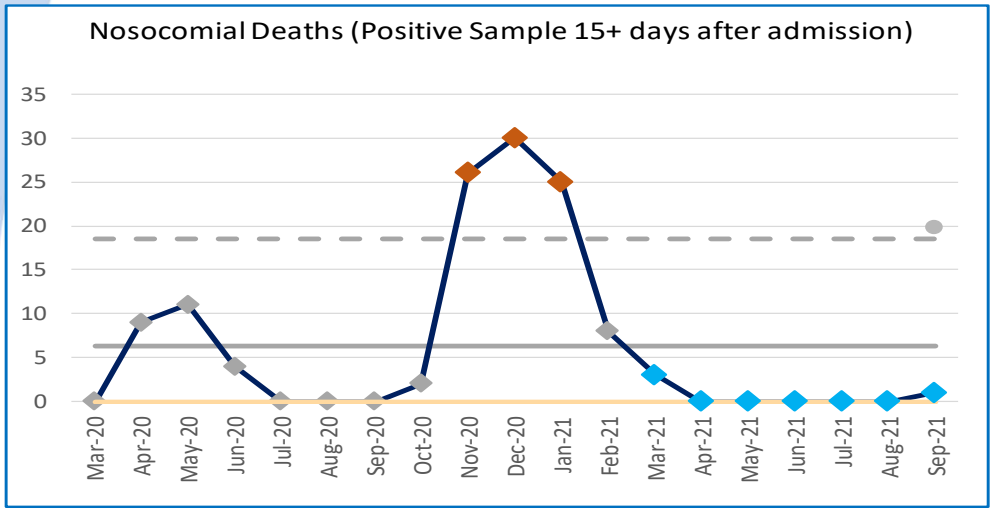
What do these results tell us?

- The data shows an in month decrease in definite Healthcare Acquired COVID - 19 cases with 10 in August 2021 (these patients were within CWD)
- Local, Regional and National community COVID-19 rates have increased in August 2021 (see table opposite)
- August has seen slight increase in Probable and definite Hospital Onset COVID but is below Wave 2 figures during October and March.

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

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 September 2021 on Ward 227 (Positive swab 25 days post admission)
- 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 7

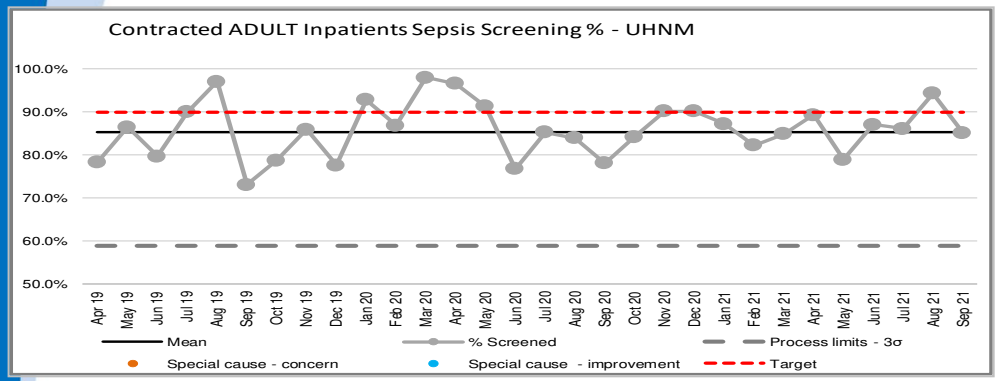
Actions :

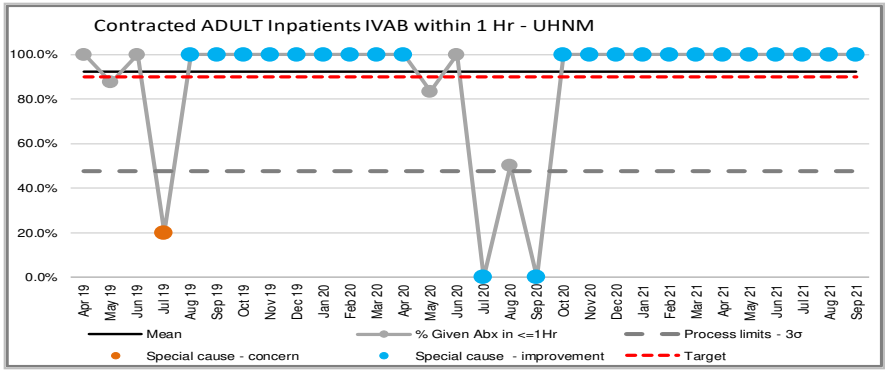
The online SJR form has been adapted to include specific COVID related questions following pilot review by Deputy Medical Director.

Initial reviews are underway with notes requested for review. Outcomes will be reported via the Trust Mortality review Group.

Sepsis Screening Compliance (Inpatients Contract)

University Hospitals of North Midlands NHS Trust





Variation	Assurance

Target	Jul 21	Aug 21	Sep 21
90%	86.1%	94.4%	85.2%

Background

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

Variation	Assurance

Target	Jul 21	Aug 21	Sep 21
90%	100.0%	100.0%	100.0%

Background

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

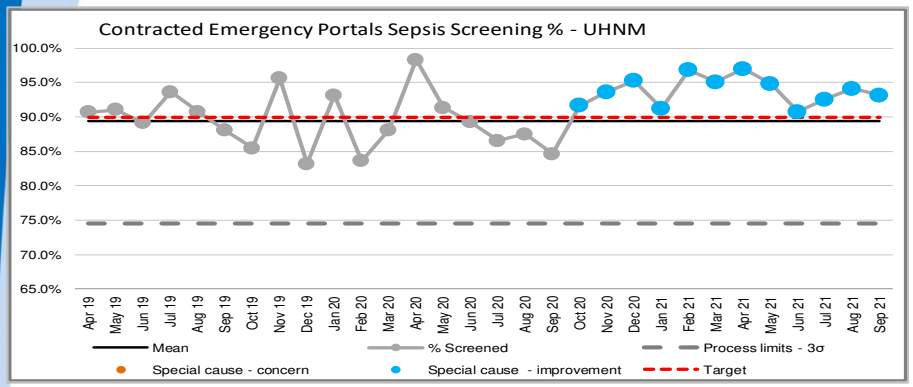
What is the data telling us:

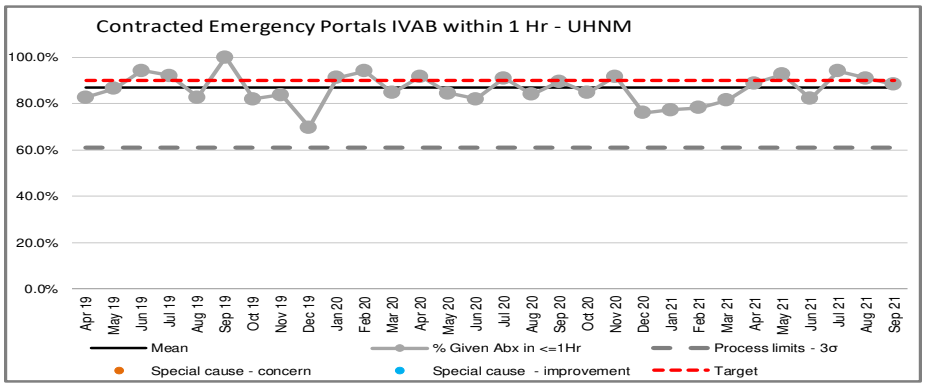
Inpatients September results show drop in screening compliance to 85.2% and continues to maintain 100% compliance for IVAB within an hour. Of the 128 Inpatients that triggered a sepsis screen, 90 had sepsis red flags present, 2 of these patients were given IVAB within hour and of the remaining 88 patients, 48 had alternative diagnosis that were deemed as not sepsis related and IVAB were not indicated. The remaining 40 patients were already receiving IVAB prior to the identified red flag trigger. Screening compliance from the four division did not achieve >90% this month however reinforcement and 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
H	?

Target	Jul 21	Aug 21	Sep 21
90%	93%	94%	93%

Background

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

Variation	Assurance
	?

Target	Jul 21	Aug 21	Sep 21
90%	94%	91%	88%

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 September 2021 achieved 93% for the 88 patients audited.

The performance for IVAB within 1hr has dropped to 88% in September. There were 79 red flag sepsis patients identified from the 88 patients audited in the screening sample. Out of the 79 red flag patients, 30 received IVAB within an hour whilst 26 were already on IVAB and 19 had an alternative diagnosis.

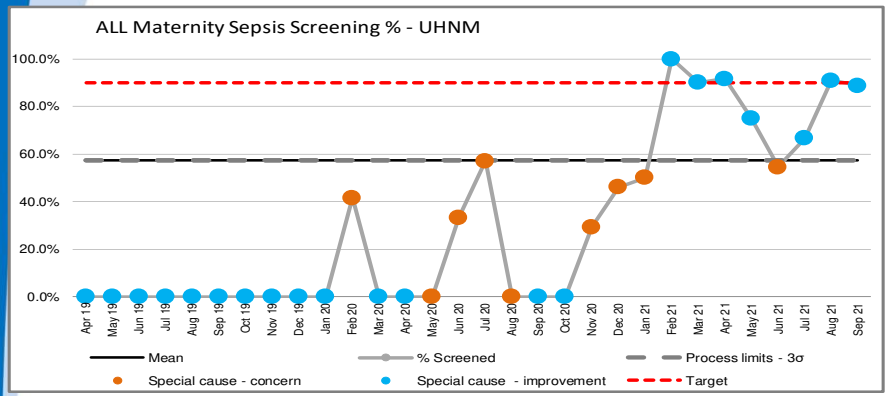
There was 4 late IVAB within an hour, three from A&E Royal Stoke site and one from AMU Royal Stoke which were all administered within 2 hours. This has been escalated to the A&E and AMU senior teams for learning.

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.
- The Sepsis Team will continue issuing certificates in recognition of individual staff who demonstrate a high standard for sepsis compliance and practice.

Sepsis Screening Compliance ALL Maternity

University Hospitals of North Midlands NHS Trust

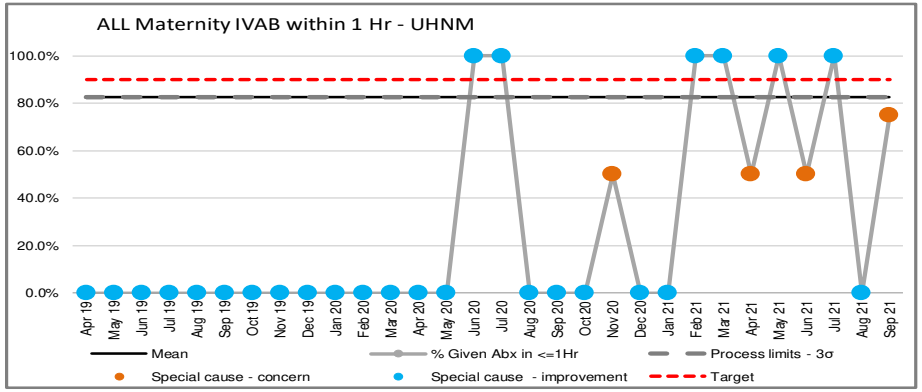


Variation	Assurance
H	F

Target	Jul 21	Aug 21	Sep 21
90%	66.7%	90.9%	88.9%

Background

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



Variation	Assurance
L	F

Target	Jul 21	Aug 21	Sep 21
90%	100%	N/A	75%

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 shows slight decline in September. Screening compliance achieved 88.9%, from the 9 patients that trigger with MEOWS >4 audited in K2 electronic system. From the 9 patients audited, only 1 missed screening identified from one of the inpatient wards.

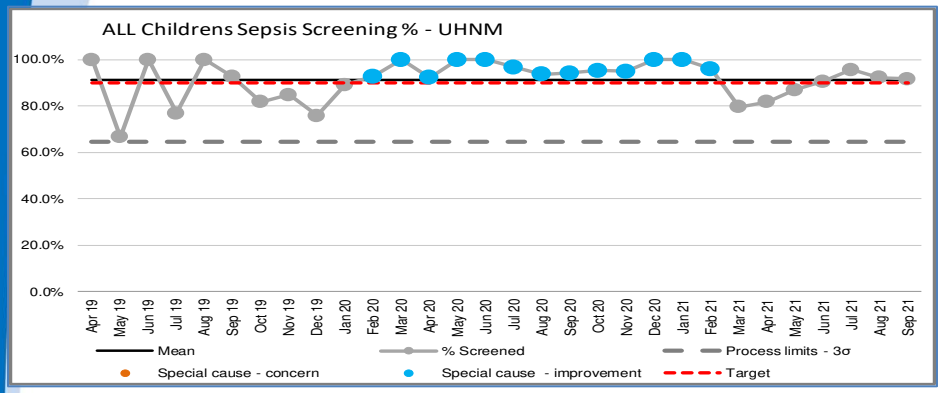
IVAB within an hour achieved 75% with only 1 delayed IVAB (5 minutes late or given within 65 minutes) from the emergency portal (MAU) and inpatient wards achieved 100%. Overall, considering the small size samples for September audit, the Maternity sepsis screening compliance has continued to maintain good improvement from the previous months.

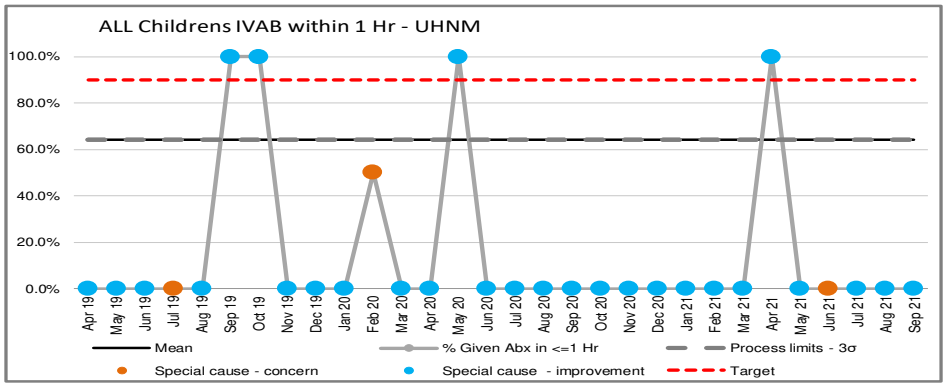
Actions:

- The Maternity Senior team and clinical staff have continued to work collaboratively with the sepsis team to ensure patient safety.
- 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. Their previous action plan developed to achieve > 90% compliance has a positive effect and will be continuously supported by the sepsis team: on-going
- 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: on-going

Sepsis Screening Compliance ALL Children

NHS University Hospitals of North Midlands NHS Trust





Variation	Assurance
	?

Target	Jul 21	Aug 21	Sep 21
90%	95.7%	92.3%	91.7%

Background

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

Variation	Assurance
H	F

Target	Jul 21	Aug 21	Sep 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 slight decline in sepsis compliance compare to July & August 2021, with a result of 91.7%.and above the target rate.
CAU screening compliance has dropped to below 90% and excellent improvement for Children A&E from June, August & September by achieving >90% for screening compliance, IVAB within hour compliance for CAU & Children A&E are not applicable or no red flags trigger. Children Inpatients ward 216 has missed 1 screen while ward 217 have no PEWS 5> triggers during randomised audits. 1 missed screens has been escalated to the senior team. 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

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Operational Performance

2025 Vision "Achieve NHS Constitutional patient access standards"

Spotlight Report from Chief Operating Officer

NHS
University Hospitals of North Midlands
NHS Trust

Since earlier this year the Trust continued the difficult task of recovering services whilst also managing the demands that Covid-19 has brought with it: reduced bed capacity due to social distancing and infection prevention measures; the constraints of wearing PPE.

However, in September the Trust faced continued and increasing extreme pressure which caused challenges in providing high quality care and patient flow due to the increasing numbers of Covid-19 positive patients being cared for. This added to with the number of staff who are off work for Covid-19 related issues seriously impacted on the delivery of our services. Both hospital sites faced unprecedented times.

The demand for Critical care beds increased and at times through the month there was very limited or zero capacity.

For these reasons and in order to continue to keep staff and the patients safe the Trust, together with NHS partners across Staffordshire and Stoke-on-Trent, made the decision to move to a *system-wide incident Level 4 on 10th September.*

The Trust made a decision to temporarily postpone all non-urgent operations and this continued into the third week of September. With these actions the Trust started to see an ease of the pressures towards the end of the month.

Spotlight Report from Chief Operating Officer

NHS University Hospitals of North Midlands NHS Trust

Emergency Care

- Whist the number of attendances at Royal Stoke ED remained the same as August with a daily average of 345 the case-mix changed. The number of ambulance arrivals fell slightly from a daily average of 156 to 147 and the self presenting ambulatory was c200/day.
- The daily average number of admissions and conversion rate fell slightly. Daily average admissions were 112 and the conversion rate 32.6%.
- Ambulance handover delays for 30-60mins rose slightly static and the > 60 mins remained static in September after a sharp rise seen in August. The percentage of handovers within 15 minutes fell to 30% or below, due to the periods of ambulance surges often late afternoon that require processing time to clear.
- System-wide performance was 66% (August 68%), with total type 1 at 51.1%. At Royal Stoke the non-admitted performance fell to 50.4% (August 54.3%) and the admitted performance fell from 24% to 20% indicating the key issues for August were related to extended timescales to securing a admitted placement. MFFDs rose to their highest numbers year to date as have the number of patients with > 21 days stay in September.
- The department had continued days with sub 60% performance with most of the front door metrics challenged.

Cancer

- 2WW Referral volumes remain very high, although are still under the NHSEI predictions that modelled demand based on the 2020 referral deficit due to covid. Pre-validation position shows that UHNM have appointed a record number of 2WW patients in September (around 3400)
- The 2WW standard has improved since last month and is predicted to land at 69% in September. The majority of 14 day breaches are within Skin and Colorectal.
- Breast have recovered 14 day performance in September and are predicted to achieve both suspected cancer and symptomatic 2WW targets.
- Performance against the 62 day standard for September is currently at 54% however this is an un-validated position which is expected to change as histology confirms a cancer or non cancer diagnosis for patients who have been treated in month.
- Clinical prioritisation of patients into available theatre capacity is continuing through September. This presents a challenge to performance - until the surgical backlog is reduced patients are not being dated by target but according to clinical need. Specialties have been asked to explore cases suitable for the IS through the Elective Recovery fund.
- PTL Updates:

  The number of patients waiting over 104 days has decreased this month to 75. Of these 33 are on a Colorectal pathway.
  Consultant and ANP capacity in Colorectal along with missing FIT results is the main factor impacting the backlog. Other contributing factors include delays to Urology surgery due to capacity, complex pathways. Clinical prioritisation of patients into available theatre capacity is continuing through September. This presents a challenge to performance - until the surgical backlog is reduced patients are not being dated in target but according to clinical need. Specialties have been asked to explore cases suitable for the IS through the Elective Recovery fund.

Spotlight Report from Chief Operating Officer

NHS University Hospitals of North Midlands NHS Trust

Planned Care

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

- Day Case and Elective Activity delivered 83.6% for August 21 against the national ask of 95%. This is lower in Inpatients than Day case (76.3% IP, 84.7% DC).
- Over a thousand patients sent as IPT to independent sector, with a further 700 clinically reviewed as suitable to be sent. 900 of the original 2.5k have been identified as not suitable for IS treatment.
- New plan in development to identify and track patients suitable for transfer patients to the IS as they are added to the waiting list.
- Next Planned Care Cell focus on theatre capacity and productivity given the emergent covid risks and staff isolation rate of attrition.
- Scoping of schemes to support management of referred demand (Referral Hub) and waiting list management (Patient Contact Initiative)
- Patients are to be contacted via text message to confirm they still wish to have their procedure, with longest waiting patients prioritised for contact by phone.

RTT

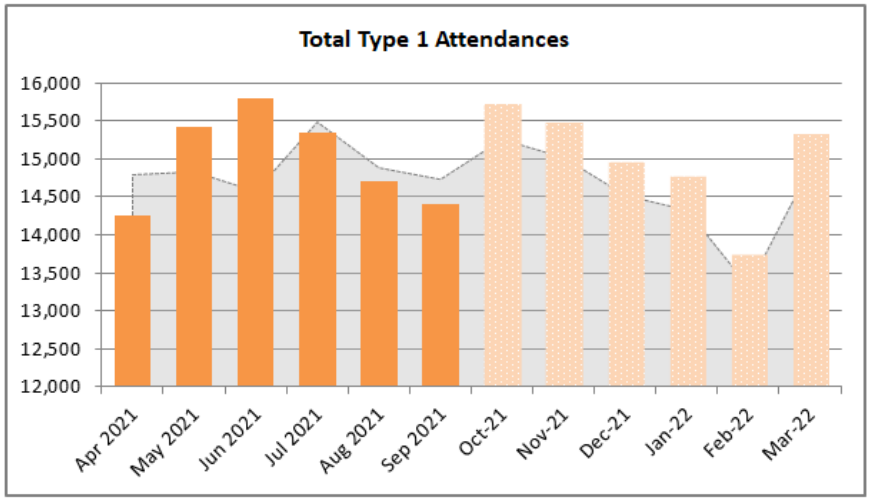
- The indicative performance for September 21: the total number of Referral To Treatment pathways grew to 69,127 (Aug = 67,784 , July = 65, 574).
- There has been a slight increase in the number of > 52 weeks to 3,597. This rise is expected to continue over winter due to the usual pressures and wave of covid.
- RTT performance in September is 59.8% (August 59.9%)
- Work plans around long wait patient validation and treatment tracking are in progress.

Diagnostics

- For DM01 (15 nationally identified Dx tests) the total waiting list has increased in September from 19,580 to 20,314.
- The current DM01 diagnostic performance for September 21 has improved to 68.14% (August 66.19%) of which non-obs ultrasound contributes 5,606 of the 6.472 breaches.
- 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. An improvement is expected by the end of November 2021. For endoscopy (colonoscopy and gastroscopy). This is related to an on-going increase in demand. Improvement actions are being developed and implemented.
- Histology remains a high risk with laboratory and reporting capacity extremely challenged. Actions are in place to improve the situation however the consultant histology workforce has significant gaps due to retirements.

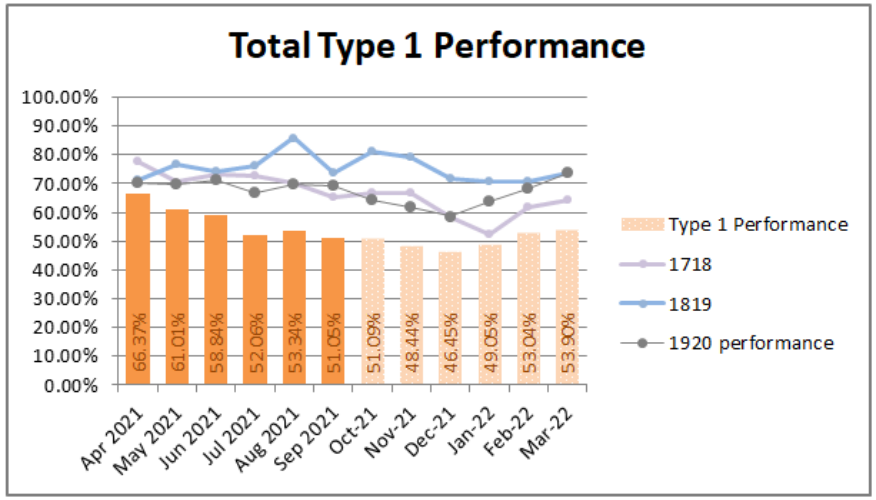
Section 1: NON ELECTIVE IMPROVEMENT

Urgent Care – Trajectory

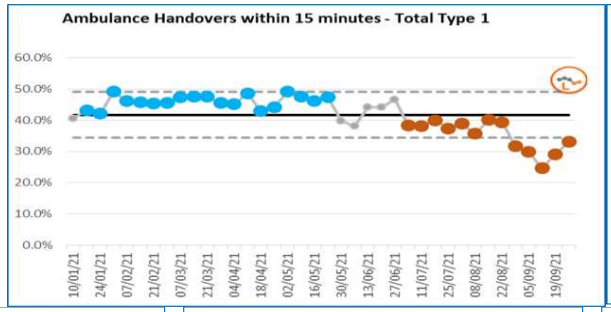


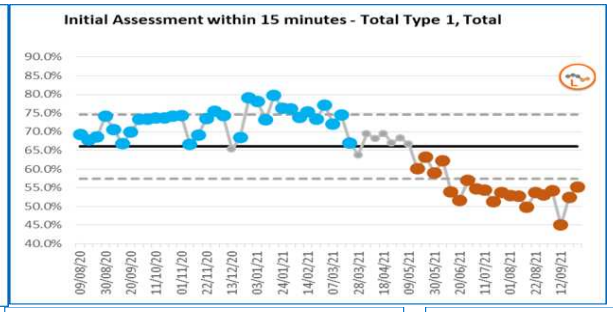
3% growth on 1920 BAU modelled for Type 1 attendance numbers.

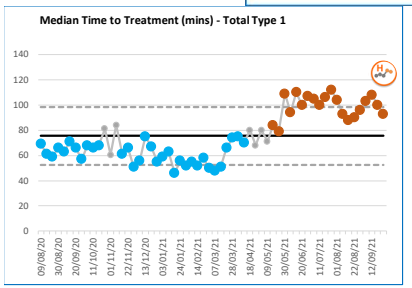
this is based on Q1 actual (2.6% increase) however July 21 saw fewer patients than in July 19 indicating the growth may have been temporary unmet demand.

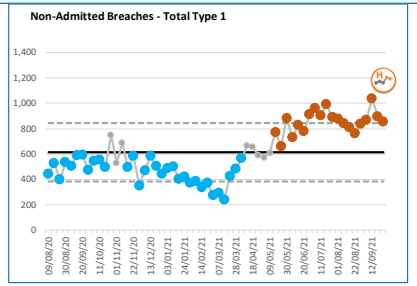


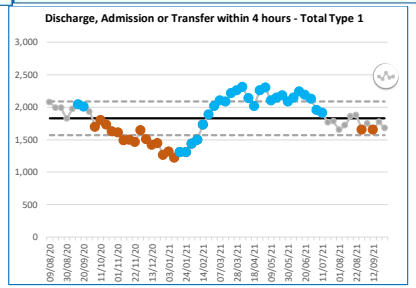
With demand in line with 1920 numbers - 4 hour performance has been set to track 1920 BAU going into Winter, but starting at July's lower performing starting point. a more conservative performance improvement out of winter has been taken more in line with other years.

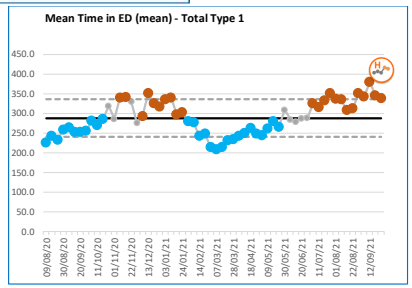

Ambulance Handovers within 15 minutes - Total Type 1

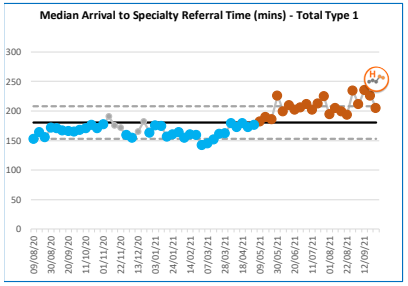

Initial Assessment within 15 minutes - Total Type 1, Total

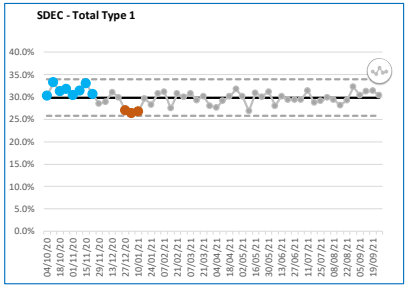

Median Time to Treatment (mins) - Total Type 1

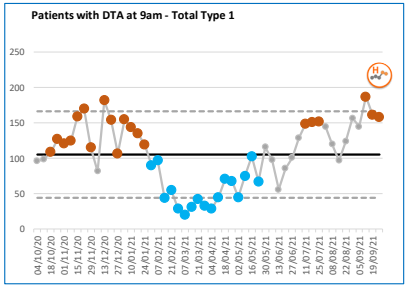

Non-Admitted Breaches - Total Type 1

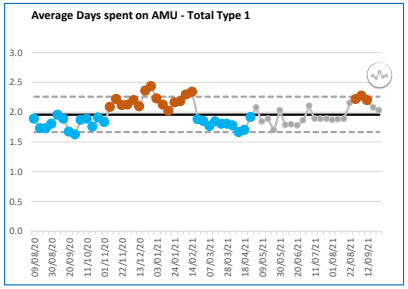

Discharge, Admission or Transfer within 4 hours - Total Type 1

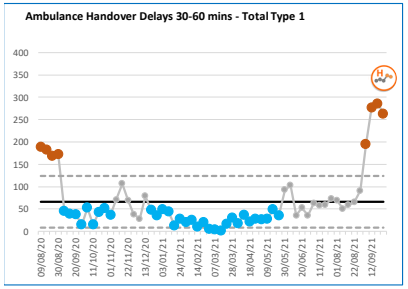

Mean Time in ED (mean) - Total Type 1

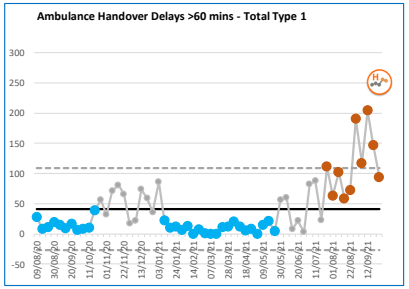

Median Arrival to Specialty Referral Time (mins) - Total Type 1

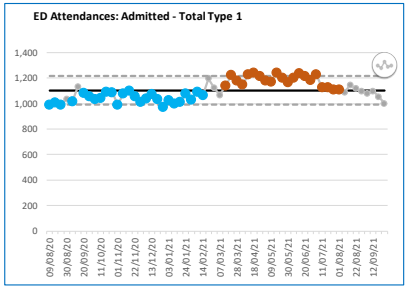

SDEC - Total Type 1

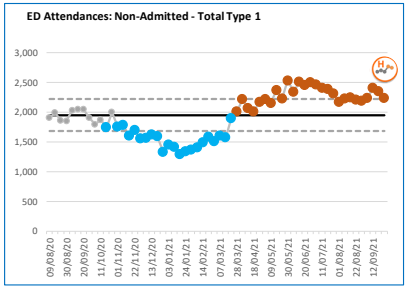

Patients with DTA at 9am - Total Type 1


Average Days spent on AMU - Total Type 1


Ambulance Handover Delays 30-60 mins - Total Type 1


Ambulance Handover Delays >60 mins - Total Type 1


ED Attendances: Admitted - Total Type 1


ED Attendances: Non-Admitted - Total Type 1

Urgent Care – Work stream 1: Front Door

SUMMARY

Total type 1 attendances reduced slightly in September. At the RS site, the daily average attendances were 345/ day (compared to August 348/ day). Children's attendances rose slightly from a daily average of 66 to 75/day. Whilst the adult attendances fell slightly by c5/day. Notably the number of patients attending and admitted with suspected Covid began to increase again with admissions to wards and critical care proving challenging. The 7-day rolling average of covid positive admitted patients reached 82compared to the 55 seen in August. Beds were also restricted for infection prevention and the numbers continued through from August to September only reducing towards the end of September.

The percentage of ambulance handovers within 15mins that had fallen in August deteriorated further in September and is below 30%. This was notable at the Royal Stoke site. The number of handovers 30-60mins remained static whilst the > 60 mins rose. Initial time to triage remained, in the main, similar to that of August at c52%, although there were two episodes where performance fell to 45%. This was significantly worse for the non-admitted. A key issue is the allocation of staff at the front door. Staffing levels were a concern throughout the month with bank and agency uptake low. Key staffing issues related to covid, self isolating with RN vacancies also increasing .

The number of patients in the department for > 12 hours is of significance in that UHNM is reported to have the highest numbers. September saw a continuation of the high numbers seen in August with a spike at the end of the month to around 499 in one week, the highest number seen so far. There were 127 validated, 12 hour trolley waits, a significant rise from August.

The total number of admissions fell from 120/day in August to a daily average of 110/day in September. The NEL demand for stays requiring an overnight bed are at 96% of BAU 2019/20. The number of patients referred to all specialties fell slightly to an average of 119/day in compared to 124 in August with an average referral to discharge time of 366 minutes (August 313mins). The high number of patients waiting to be admitted at 9am seen in August continued to rise through September.

The admitted performance did not improve from the position in August and overall achieved 20.2%. Non-admitted performance also fell to 50.3%.

Downstream indications were that patients were staying longer. The daily average Nos. of beds occupied in Medicine rose again in September from 438 to 447. The number of Long stay patients is now in line with pre-pandemic numbers. Long stay of 21+ days rose significantly in September as did the number of MFFDs. Discharges pre-noon remained much the same as August but remains above the 12 month average.

Urgent Care – Work stream 1: Front Door

National bundle

- The percentage of ambulance handovers in 15mins has continued to show signs of deterioration. However, there is a robust process for patients who are held on ambulances with a navigator at the front door and clinicians who review and check the patients.
- The percentage of patients whose Time to initial Assessment maintained an overall position of c52%-54%, however there was a week where this fell to 45%.
- The rises that impact on performance the most are where there are surges of over 30 attendances within the hour particularly in the evening where staff shortages, particularly decision makers has been a challenge. The department are aiming to maintain the triage time with re-deployment of staff in the department at the time. A business case addressing workforce challenges has been completed and is pending Trust Board approval expected in October 21.
- Targeting of SIFT and RAT has seen WTBS reduce from a median of 120 minutes in July to 100 minutes in August.
- The MEAN time in the department has also risen for both admitted and non-admitted patients
- The number of patients spending over 12 hours in the department has remained above the mean.
- The number of patients referred to all specialties fell slightly to an average of 119/day in compared to 124 in August with an average referral to discharge time of 366 minutes (August 313mins).

Performance

- System-wide performance is down to 65.6% (August 68.2%), with total type 1 at 50.6%. At Royal Stoke the non-admitted performance fell to 50.3% and the admitted performance fell to 20.2%.
- The community based CRIS team and WMAS are targeting interventions at C3 and C4 non life threatening ambulance calls. This is in its early days, the average number of ambulance conveyance for the relevant age range has remained steady at 78 per day for July and August.
- 111 Kiosks went live in both emergency departments in September – It is early days but it is anticipated to support the future primary care stream / ambulatory care developments that are in review and transition.

Urgent Care – Work stream 1: Front Door

NHS University Hospitals of North Midlands NHS Trust

ACTIONS

Attendances:

Improvement and system wide actions which include;

- 'RED' GP reinstated and capacity increased - daily monitoring of referrals demonstrates that Vocare are currently seeing on average 17 Children and 38 Adults per day. ED are still experiencing Children's attendance with 66 per day on average. From the manual collection of numbers we have for Red GP they are seeing 18 patients per day, split by 10 Children and 8 Adults:
- WIC increase in staff to support ambulatory demand
- Use of GP referral hub and consultant connect to prevent GP admissions
- Enhanced access for NHS 111 to support admissions to SDEC / AEC. First NHS 111 Patient Redirection Tool kiosk in place at County ED and RSUH
- Continue to attempt to Increase staff within ED to support attendance surges (SIFT and RAT) however fill rate remains low.

National bundle:

- Review of Test of Change data for new triage pilot at RSUH completed, Plan has been reached and is under review with the CCG and Vocare on how to sustain triage nurse numbers
- The electronic referral system introduced has shown some real benefits with a reduction in time spent on the telephone. -Continue to develop plan to expand the roll-out across Specialised and Surgery
- Visible trigger boards are now in place within ED
- Maintaining a focus on initial time to triage – re-deploying staff in the department when required.
- Specific focus of patients that are 12 hour in ED via RCAs being undertaken
- Main resuscitation area now has doors to all eight cubicles increasing the flexibility around infection control

Workforce:

- ED medical workforce business case to address workforce issues with clear key metrics to measure improvements approved by Paf in September to trust Board October.
- Engage senior clinicians. Re-set department structures and r
- Medical rota alignment to the new Tier's recommended by RCEM is underway
- Working on A&E internal improvements including roles and responsibilities, huddles and rounding to improve grip, supported by visible improvement and escalation dashboards

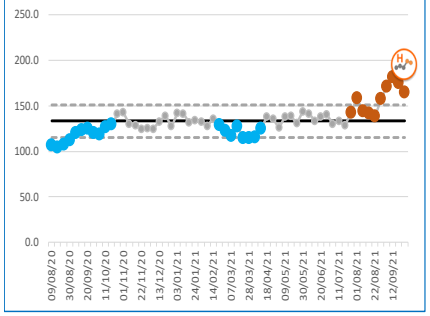
Urgent Care – Work stream 1: Front Door

University Hospitals of North Midlands NHS Trust

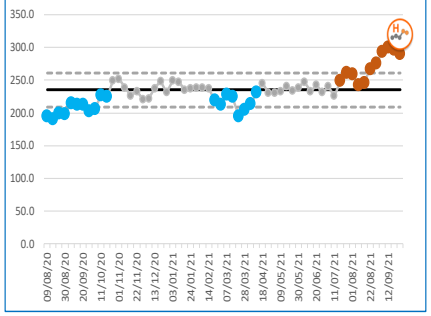
Acute Front Door priorities and action plans have been reset to focus on the non admitted pathways and interfaces with key servcies / pathways internally and externally ;

- Admitted and non admitted themes to be retained – some items transfer to BAU
- Re prioritisation of self presenting pathway to include;
  - Digital solutions, implementation of NHS 111 patient redirection tool
  - Development of directory of service to support patient redirection tool
  - Navigation and triage, patient contact time, trusted assessment and direct referral to portals
  - Interface with SIFT clinician
  - UCC medium and Longer recommendations / solutions

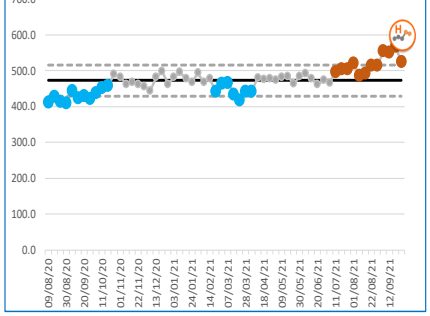
Avg. number of Beds occupied by Long-Stay Patients 21+ days - All POD's: Trust - All Divisions



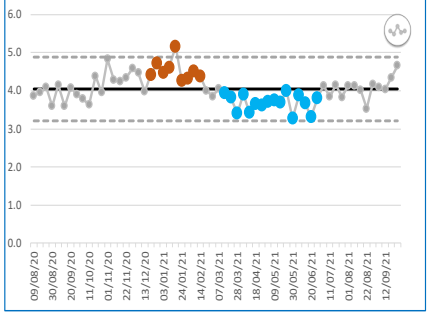
Avg. number of Beds occupied by Long-Stay Patients 14+ days - All POD's: Trust - All Divisions



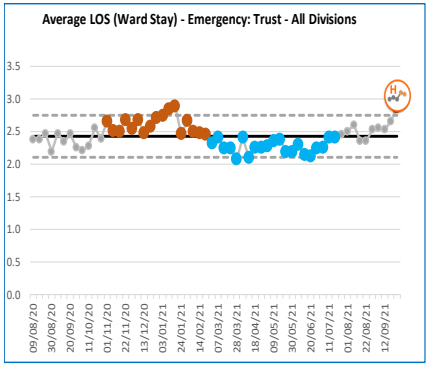
Avg. number of Beds occupied by Long-Stay Patients 7+ days - All POD's: Trust - All Divisions



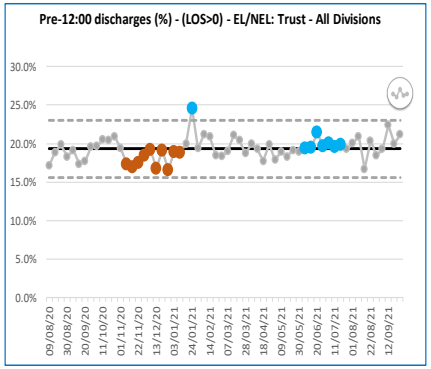
Average LOS (Spell) - Emergency: Trust - All Divisions



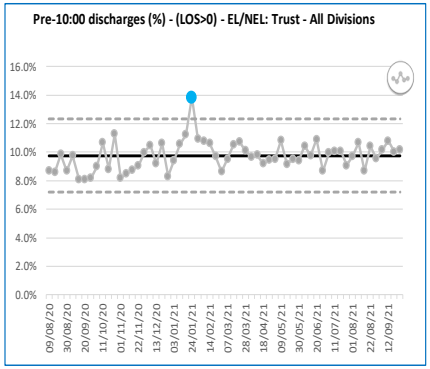
Average LOS (Ward Stay) - Emergency: Trust - All Divisions



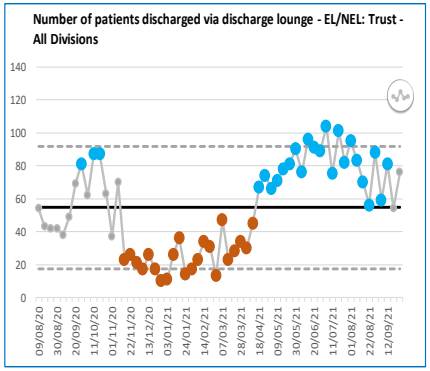
Pre-12:00 discharges (%) - (LOS>0) - EL/NEL: Trust - All Divisions



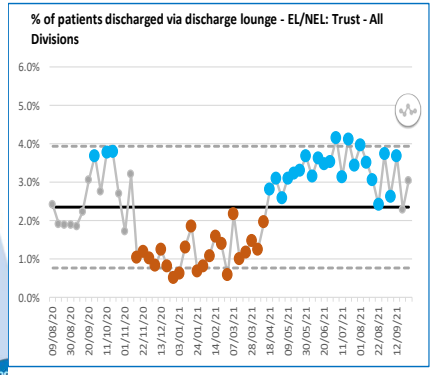
Pre-10:00 discharges (%) - (LOS>0) - EL/NEL: Trust - All Divisions



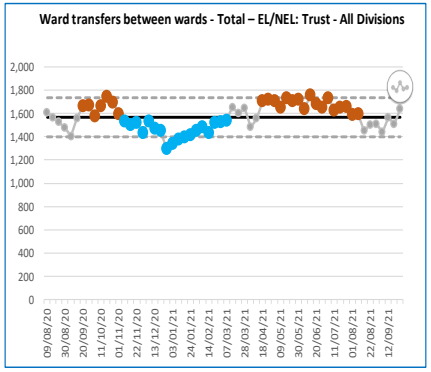
Number of patients discharged via discharge lounge - EL/NEL: Trust - All Divisions



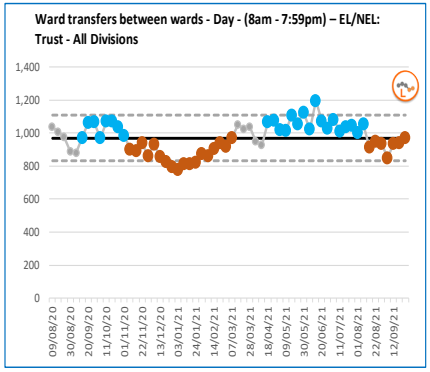
% of patients discharged via discharge lounge - EL/NEL: Trust - All Divisions



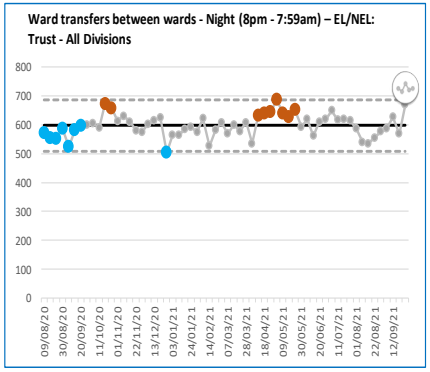
Ward transfers between wards - Total – EL/NEL: Trust - All Divisions



Ward transfers between wards - Day - (8am - 7:59pm) – EL/NEL: Trust - All Divisions



Ward transfers between wards - Night (8pm - 7:59am) – EL/NEL: Trust - All Divisions



Urgent Care – Work stream 2: Flow

SUMMARY

- The Trust reached pre-pandemic levels of long stay patients (14 & 21 days or more. Stays of 21+ days rose significantly in September. The daily average rose from 150 – 165/ day. The rise is not solely due to MFFDs. The average number of beds used remained high for all groups of patients. Rises were more notable in Medicine and Specialised Divisions. The average LOS (ward stay) for emergency admissions remained above the mean at c2.5 days on average with a week when this rose to 3days.

- MFFD numbers have risen to a Trust total of 119, a gradual but there has been a constant rise from has seen the numbers seen in May.

- The pre-noon discharge percentage of 30% was not reached and the overall steady rate of c20% across all areas dipped to below 20% in two weeks. Pre-noon discharges need to be seen jointly with LoS as areas have brought forward discharges to the previous afternoon/evening. Average Los (spell) for emergency admissions was maintained at around the Mean at 4 days.

- The significant increased numbers of patients discharged via the discharge lounge fell slightly. There was one week when performance fell and this as notable in Medicine.

ACTIONS

- Maintain focus of discharges before midday through improvement workshops. Teams aim to deliver 25% plus pre noon discharges. Surgery have increased their pre-noon discharges to 20% with a new action to identify two early discharge 'golden' patients in helping to achieve the 25% required

- Maintain focus on the use and future opportunities for the UHNM discharge Lounge as part of surge plans and winter.

- Support length of stay by using directorate Teams – support improvements seen.

- Importance of young persons rehab Unit working with MPFT.

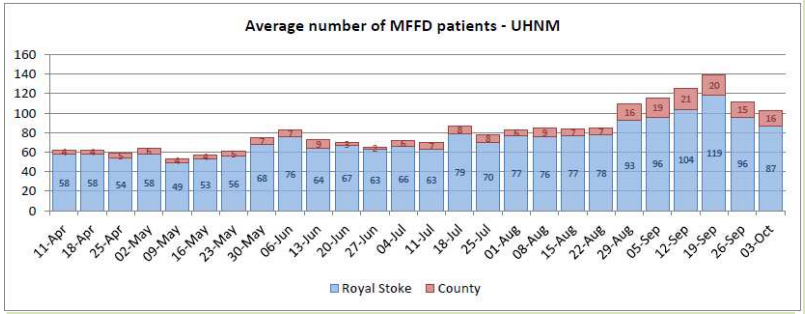
- Set up Task and Finish Groups with each division to support sustained improvements and prepare more focused plan on improvements ahead of winter.

Work stream 3: Clinical Site Management

University Hospitals of North Midlands NHS Trust

Summary

- UHNM has continued to see a high number of patients in the department with a DTA at 9am.
- The percentage of patients allocated to SDEC rose to 31% in September and AEC and AMRA portals over subscribed most days with ambulatory patients. The commissioning of the primary care pod in September is said to support ambulatory pathway diversion.
- MFFD numbers have risen to well above 100 on some days (intra reporting) which equates to the winter threshold standard due to MPFT going into Level 3/4 escalation. Numbers have come down towards the end of September



Actions

- The IPS standards for all portals has been agreed and compliance monitored by the site team - these metrics have been challenged during September due to the acuity of patients admitted and the workforce attrition rate.
- New Corporate Sit Rep Slide Set endorsed and implemented that details front door and ward occupancy status together with risks and mitigating actions required to support improved flow. Further enhancements are being made with Divisional consultation.
- One Team Model 90 day orientation complete.
- Adverts out for 3 Clinical Site Managers, Band 7 x 4 recruited, Band 6 structure being consolidated. All panel meetings have been agreed with Task Lists and KPS now circulated. The new rosters are being drafted to support phasing and embedding of the new structures from 1st October 2021 which includes commissioning of the new control room at RSUH and a winter control room to support escalation actions.

Section 2: ELECTIVE CARE

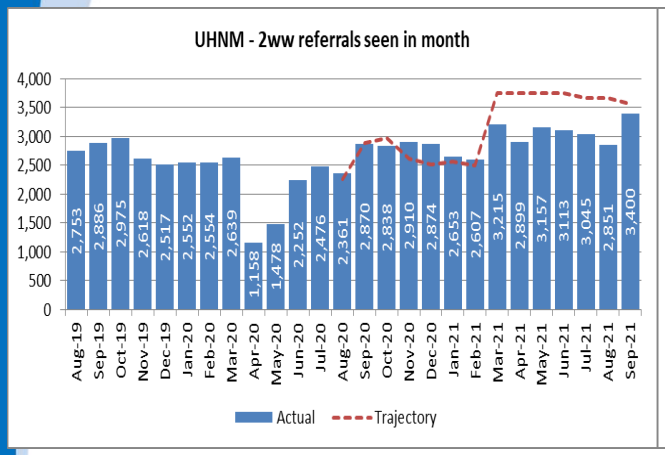
Cancer

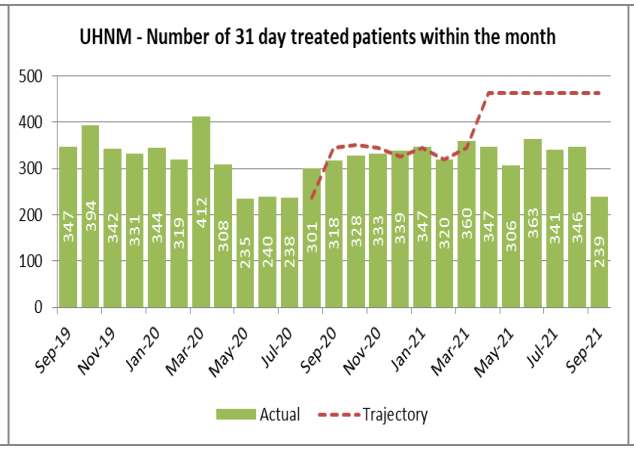
- The PTL has reduced for the fifth week in a row although volumes are still very high.
- PTL meetings have been revamped, a new timetable with extended times has been implemented and specialties continue to positively engage. Breast planning and forecasting discussions have been amalgamated with PTL meetings, providing a more efficient PTL / performance overview, and escalations are proving effective with good response from diagnostic services. E.g Radiology have been able to expedite appointments and reports where identified through PTL meetings, which has directly impacted suspected cancer patient pathways.
- The WMCA have funded a scheme to implement community based 'Spot clinics' to help tackle the increasing demand of 2ww referrals to UHNM of which approx. 30% are discharged following first appointment. The team have piloted the first spot clinic located internally to prove concept, with expected discharge from 1st OPA rates achieved. Awaiting community location confirmation before running 1st community based clinic by Q3.
- The new Vague Symptoms Pathway went live on 20/09 – this is a new Rapid Diagnostic service at UHNM led by the WMCA regional RDC Lead clinician, a nurse practitioner and supported by a cancer navigator. The service provides speedy access to investigations for patients who present with non specific symptoms that don't fit a 2WW pathway, but where there is a GP gut feeling of cancer. This new service has been proven in other areas to prevent emergency admissions and repeat GP visits, and aims to facilitate faster and earlier diagnosis. This pathway will be monitored through a minimum dataset, tracked by the cancer services team, and evaluated by the West Midlands Cancer Alliance.
- The WMCA have also funded breast pain clinics that will alleviate pressure on 2WW Breast services by creating capacity in the community, releasing specialist time in secondary care to see patients with suspected cancer. The project group has worked up the detailed proposal to include clinic days, times and to describe the pathway. Clinic locations are being sought by commissioners.
- The Endoscopy department have recruited to positions that enhance capabilities of the capsule endoscopy service. The investment from WMCA will support rapid diagnostic pathways and most challenged areas, such as LGI.
- FIT take up on the LGI pathway has improved following escalation to the Cancer STP Board meeting, although still more than half of patients referred on the LGI pathway have FIT requested at point of referral. Investment in pathology has been agreed to support with sending the kits out– a FIT Kit administrator will be funded through the RDC investment from WMCA. UHNM have also proposed 1 x FIT co-ordinator per place based partnership (3 per ICS) to track FIT requests, compliance and results, to give practices more confidence that FIT can be used to guide 2WW referrals. This will be an added safety net and tracking mechanism that could releases capacity on the 2WW LGI pathway to recover performance, reduce turn around times and improve faster diagnosis.

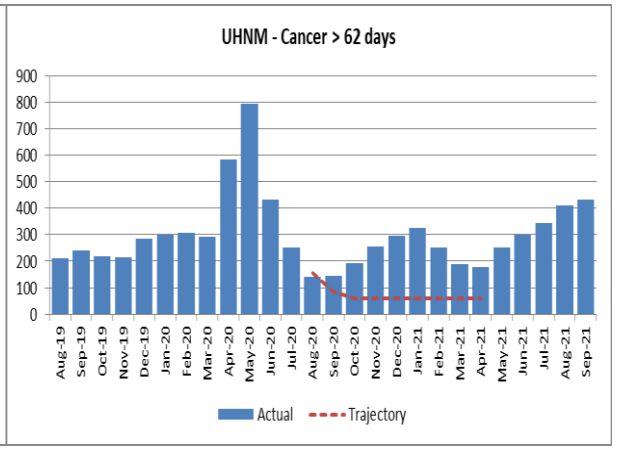
Cancer

- Trajectories have been agreed and are being tracked against the actual positions. Most recent published data is for July:
  - 14 Day Trajectory July: 73.7 %. Actual 78.1%. Actual Seen. 3045. Actual Breaches 665. The trust is currently performing better than the set trajectory on this standard.
  - 31 Day Trajectory July: 91.7%. Actual 93.5%. Actual Treated 341. Actual Breaches 22. The trust is currently performing better than the set trajectory on this standard.
  - 62 Day Trajectory July: 74.5%. Actual 65.6%. Actual Treated 186.5. Actual Breaches 64. The trust is below the set trajectory on this standard.

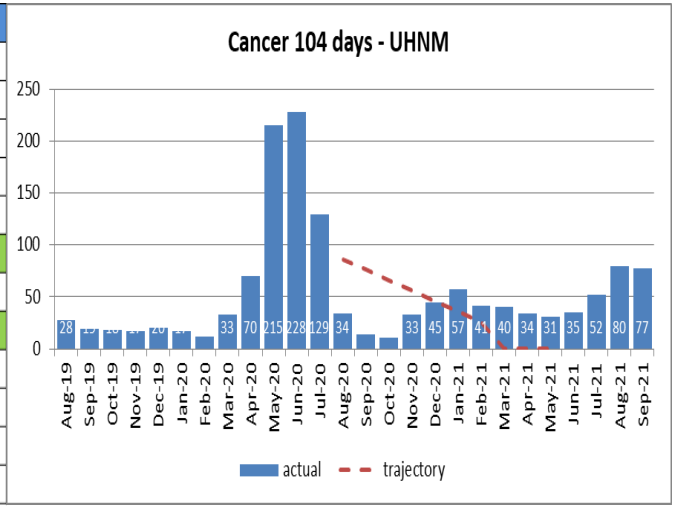
Cancer







Aug Provisional	Target	Trust Actual	Clock Stops	Breaches	Breaches Over	Needed Treatments
TWW Standard	93%	65.6%	2917	1002	798	11398
TWW Breast Symptomatic	93%	86.2%	87	12	6	85
31 Day First	96%	90.0%	201	20	12	300
31 Day Subsequent Anti Cancer Drugs (inc Chemo)	98%	96.0%	25	1	1	26
31 Day Subsequent Surgery	94%	88.9%	27	3	2	24
31 Day Subsequent Radiotherapy	94%	96.1%	102	4	Achieved!	Achieved!
62 Day Standard	85%	49.5%	104	52.5	37	247
Rare Cancers - 31 Day RTT pathway	85%	100.0%	1	0	Achieved!	Achieved!
62 Day Screening	90%	80.8%	26	5	3	25
28 Day FDS Standard	75%	67.4%	1600	522	123	489
62 Day Consultant Upgrade	93%	77.8%	54	12	9	118
Closed Pathways > 104 Day			18.5			



Planned care - *Inpatients*

University Hospitals of North Midlands NHS Trust

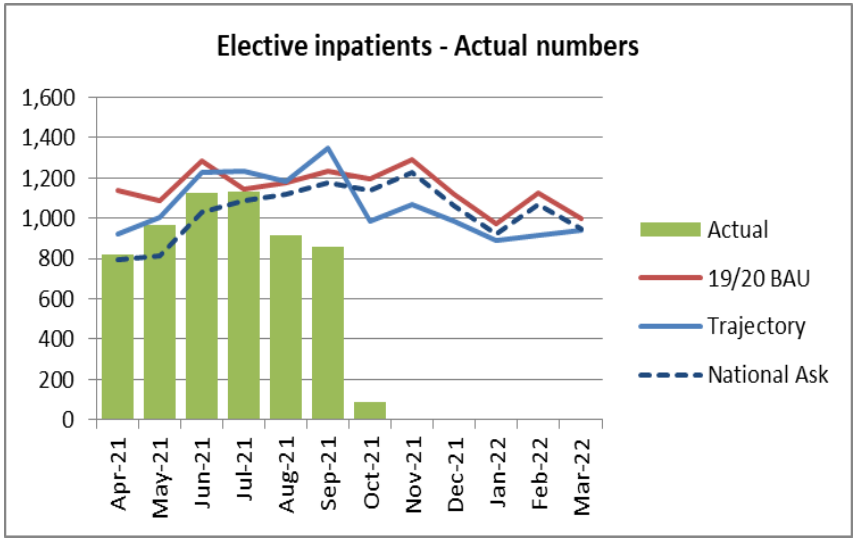
Elective inpatients Summary

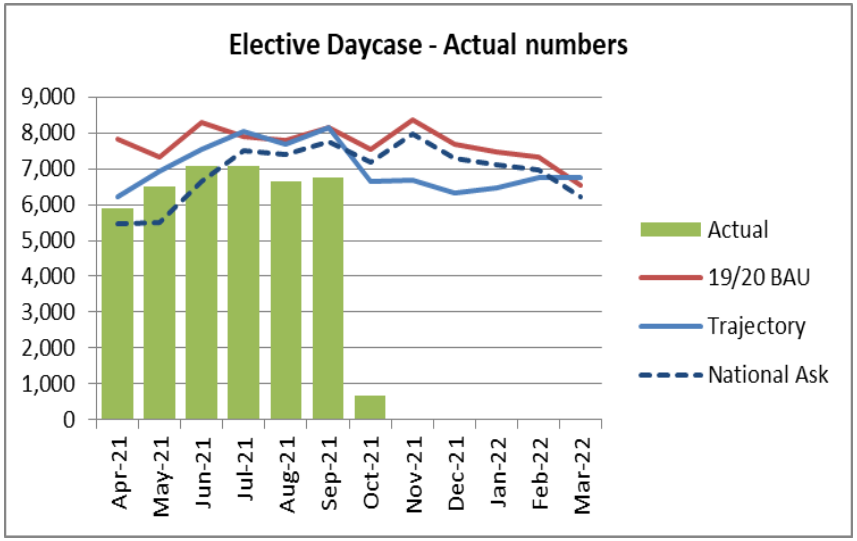
- For August the total inpatient actuals against BAU has risen to 83.6%. This is lower in Inpatients than Day case (76.3% IP, 84.7% DC).
- Cases continue to be treated at the Independent Sector and some electives at County.
- 2,500 Planned Transfer of T&O & Spine Cases to the Nuffield for treatment to the year end under an adjusted contract.
- 1,780 patients to be transferred to Ramsay for treatment under adjusted contract
- P2 breaches plateau except for Medicine who have seen most significant rise. (Endoscopy/Respiratory electives impact due to medicine surge response/staff attrition).
- P3 seen a marginal reduction over the last few weeks as these cases have been filtered into surgery according to case mix of surgical team available.
- P2 Re-Audit August 2021 for oversight of Clinical Triage/Risk. Sampling informs CareFlow field in use for documenting clinical oversight.

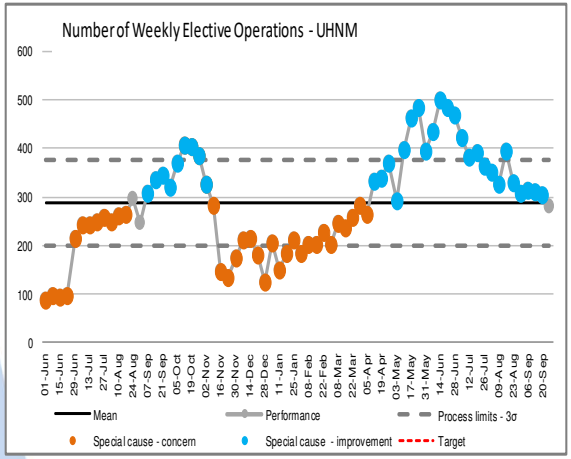
Actions

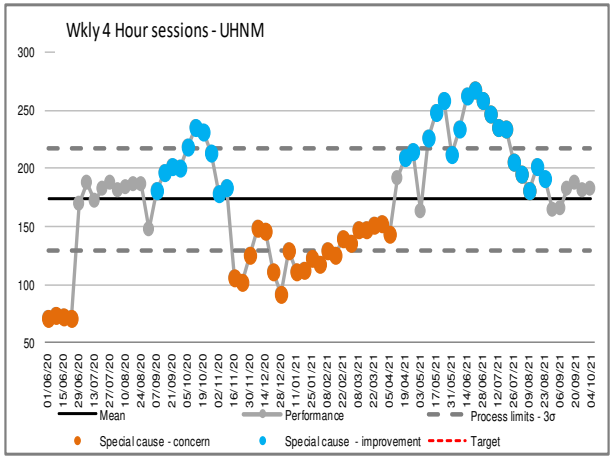
- **Patient contact initiative:** Text message 'chatbot' to be used to contact patients to validate waiting list, with an option for call centre for patients not comfortable with SMS. Corporate validation team focus will be on validation of 104 week patients to determine how many are true TCIs.
- **Elective referral hub:** CCG Led initiative to support triage of OPD referrals to protect acute capacity for high threshold referrals. Progress update received from CCG who are exploring specialty demand in order to optimise the impact of any pilot. UHNM are exploring the opportunity of scoping a fire break referral hub for cancer referrals to triage out high volume and low threshold referrals to protect 2ww cancer capacity.
- **Theatres:** Surgical division have amended trajectory for returning to 100% of 19/20 activity due to continued staffing issues (sickness & redeployment). "New normal" theatre plan set to enable a sustainable timetable and reduction in cancellations. Plan is in two phases but is reliant on theatre workforce restoration from mutual aid support to critical care and return to work of staff currently isolating/sick as the Division has been under significant challenge with regard to ODP staffing.
- **IS subcontracting:** as well as 4280 patients to be transferred to IS as an IPT, £600k has been approved to continue to send patients under a subtracting arrangement o Nuffield & Ramsay. Divisional teams are reviewing which patients can be sent as a subcontract over winter to release capacity to concentrate on cancers at UHNM

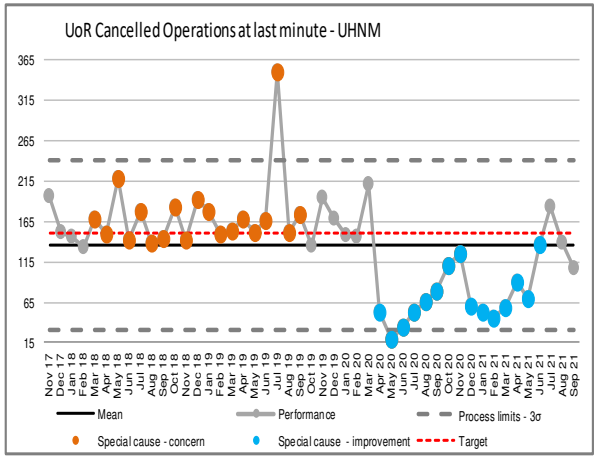
Planned care – *Inpatient Activity*











Planned care - *Outpatients*

NHS University Hospitals of North Midlands NHS Trust

Summary

- For September the total outpatient actuals against BAU for outpatients was was 98%. This is higher in Follow ups than new (88% New, 105% follow up).
- September 21 numbers recorded to date were 70,532. However this may increase further as the outstanding outcomes are completed.

Outpatients

- For outpatient appointments (appointment type) the Trust delivered **72.7%** F2F and **27.3%** non F2F(Telephone & Video). For new appointment types F2F was **74.7%** & non F2F **25.3%** & follow ups F2F **71.7%** & non F2f **28.3%**.
- August's performance for ASIs position decreased by 1.9% to 85.8% within 3 days (from 87.7% in June).
- 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).
- 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). Increase to 9,544 as at 5th October.

RTT

- The overall Referral To Treatment (RTT) Waiting list continues to rise. For September the indicative number of Incomplete pathways has risen to 69,127 (August 67,784).
- The number of patients > 18 weeks has risen to a level of 27,784 (August 27,160).
- The numbers of 52 week waits in September has increased slightly with a reported 3597 (August 3495).
- At the end of September the numbers of > 104 weeks reported were 203. The Planned Care group is monitoring progress against treatment plans for these patients.
- Performance however, was similar to that of the previous month at 59.8% (August 59.9%).
- Follow up backlog increased to 70,501 (August 70,388).

Planned care - *Outpatients*

NHS University Hospitals of North Midlands NHS Trust

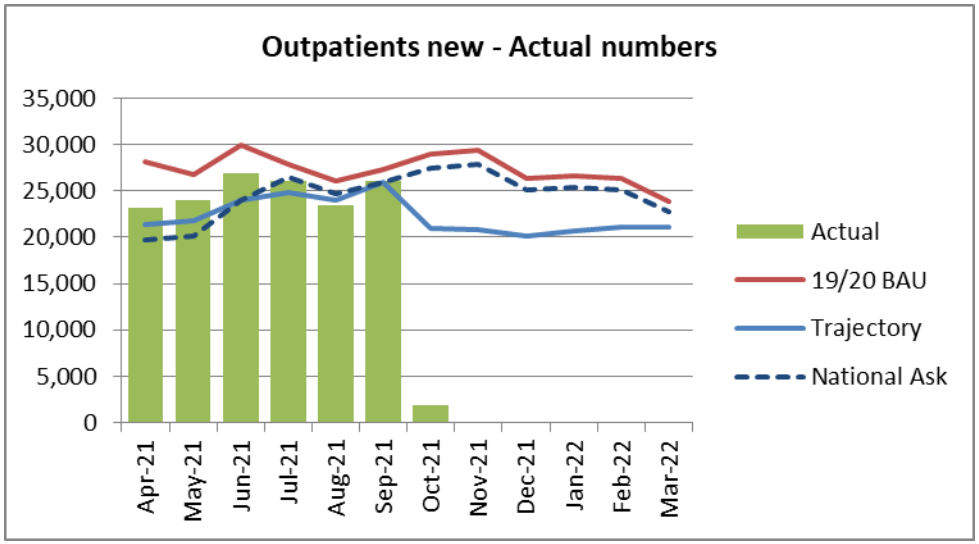
Actions

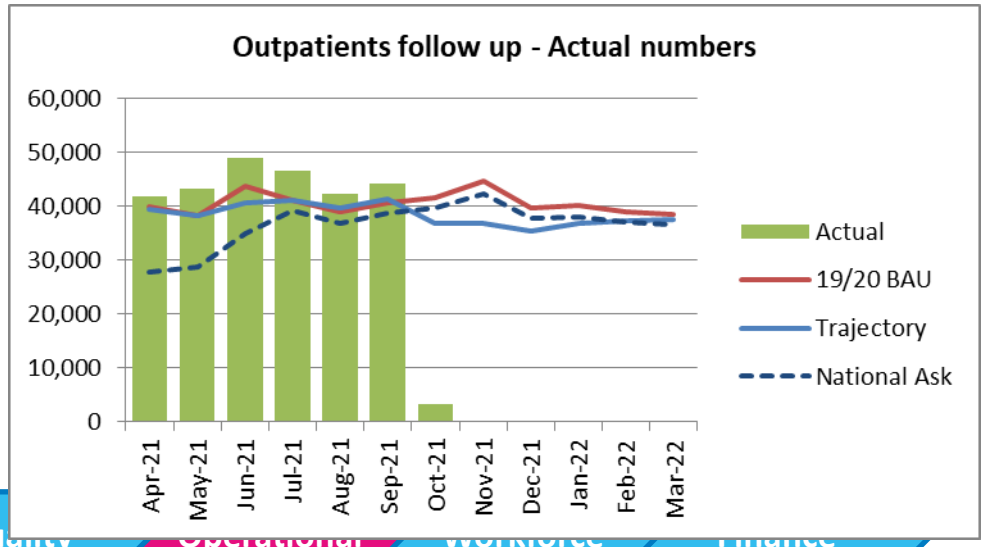
- Key actions identified around Divisional Waiting List Management with a focus on validation, data quality and >52 weeks patients. Clear reporting now in place to support this approach.
- ASI performance / unoutcomed activity monitoring in place; assurances around triage processes and clinical prioritisation 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.
- Submissions to Elective Recovery Fund in place for A&G & PIFU. Work continues to ensure we are able to capture all the A&G data outside of eRS. 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 similar workaround, alongside plan to test measures for established self-managed cancer pathways to see if possible in principle.
- 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 are being established following initial meetings. Summary will be presented to the work stream for clarification of themes and next steps on 8th October
- 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.
- PIFU System Progress Meeting held with NHSE, positive feedback for current status, presented at regional Midlands PIFU Meeting at request of NHSE, to share approach.
- Virtual Care 25%; SUS submission 'fix' sought (with BI) whilst alignment of clinic booking and media type outcome progressed.

Risks:

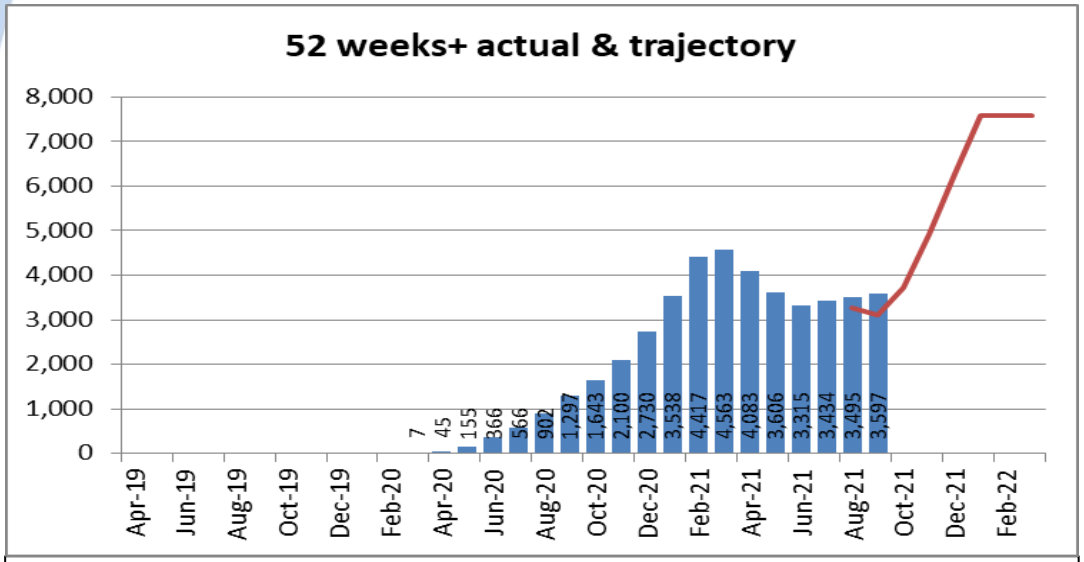
- Deteriorated waiting list position vs pre-covid; volume of patients requiring DQ and clinical validation very challenging, raised on Divisional Risk Registers.
- FTF activity limitations for ENT, Oral & Eyes in non-shared OP areas; need to increase but restricted by social distancing.
- Elective Care 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).
- PIFU H2 end target of 3% of all outpatient activity moved or discharged to PIFU. Whilst achieving rollout to additional specialties in low volumes and continuing to progress to other specialties, definition not yet available and current position vs target therefore unclear.
- Awaiting final confirmation that the target will be 15% A&G requests when compared to new referrals. As a system currently at 10.1%. Target likely to be 'stretched' as counting activity not currently captured may achieve the proposed target; need to ensure we can report eRS referral data when we send referrals back to GPs with advice and guidance. Work to continue to ensure we are able to capture all the A&G data outside of eRS, including Consultant Connect, Health Harmony (primary care) and GP telephone discussions not currently captured/reported on e.g. Heart Failure (HF) Line
- Challenge of level 4 pressures at organisation & system level during September.

Planned care – *Outpatient activity & RTT*

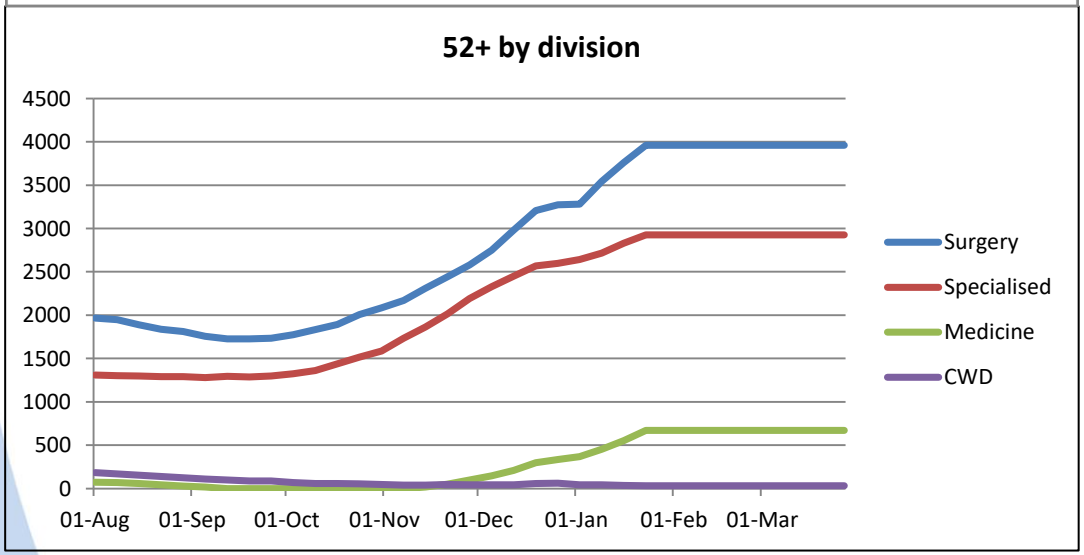




Planned care – *RTT Trajectories*

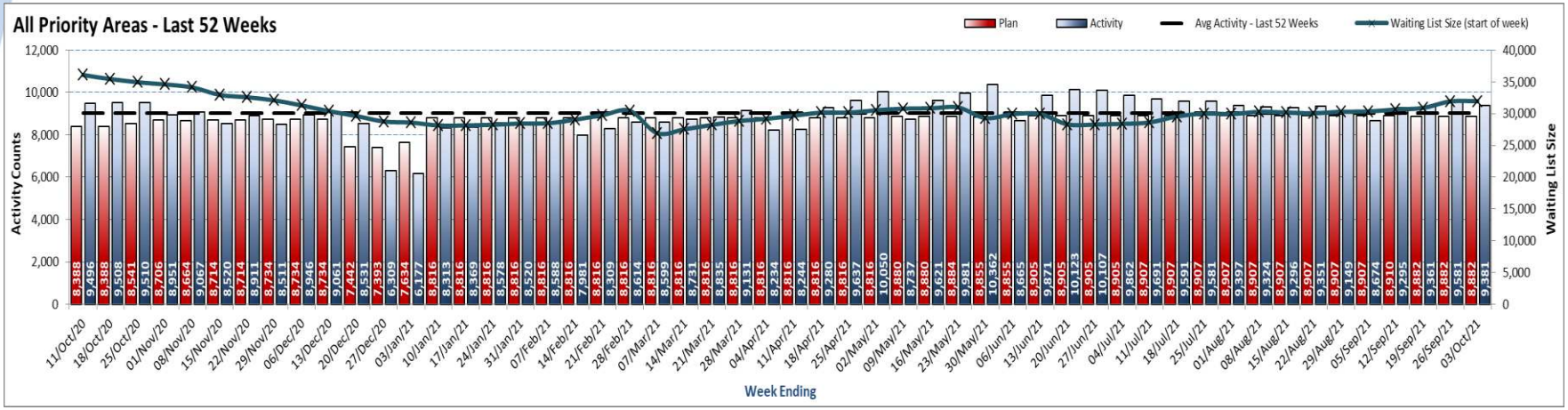


52 Week Waits are expected to increase over the next 6 months with a total of 7,590 at the end of March.



52 Week Waits are expected to increase across all divisions except CWD.

Diagnostic Activity



Summary

- For DM01 (15 nationally identified Dx tests) the total waiting list has increased in September from 19,580 to 20,314.
- The current DM01 diagnostic performance for September 21 has improved to 68.14% (August 66.19%) of which non-obs ultrasound contributes 5,606 of the 6.472 breaches.
- The greatest proportion of > 6 week waits are within Non-obstetric ultrasound, which has doubled to 10,318 since Mar-21 and is related to the significant increase in demand. The waiting list is growing significantly by c250 per week against a workforce that is at full capacity. A request for additional investment in workforce has been completed but no approval has yet been given to outsource activity.
- Capacity and Demand work is being planned in the next quarter and is reliant on transformation and corporate support
- A working group is set up comprising of imaging, breast surgery and the cancer to team to review the increase in breast referral s and total capacity required. There also seems to be more referrals from Primary care for patients under the age 35. Cancer team are engaging with the PCN/CCG regarding referrals, and within radiology effort is being made to put on additional capacity out of hours to clear the backlog with more joint working with surgery.
- Imaging – average demand over last 6mths was 9,000 patient requests per week.

Diagnostic Activity

University Hospitals of North Midlands NHS Trust

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 Network partners. A trajectory for improvement is being finalised, improvements planned by end Sept 21

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

Mitigation:

Paper for approval for additional staffing resource to July ODG.

Attempting to source locum sonographers

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.

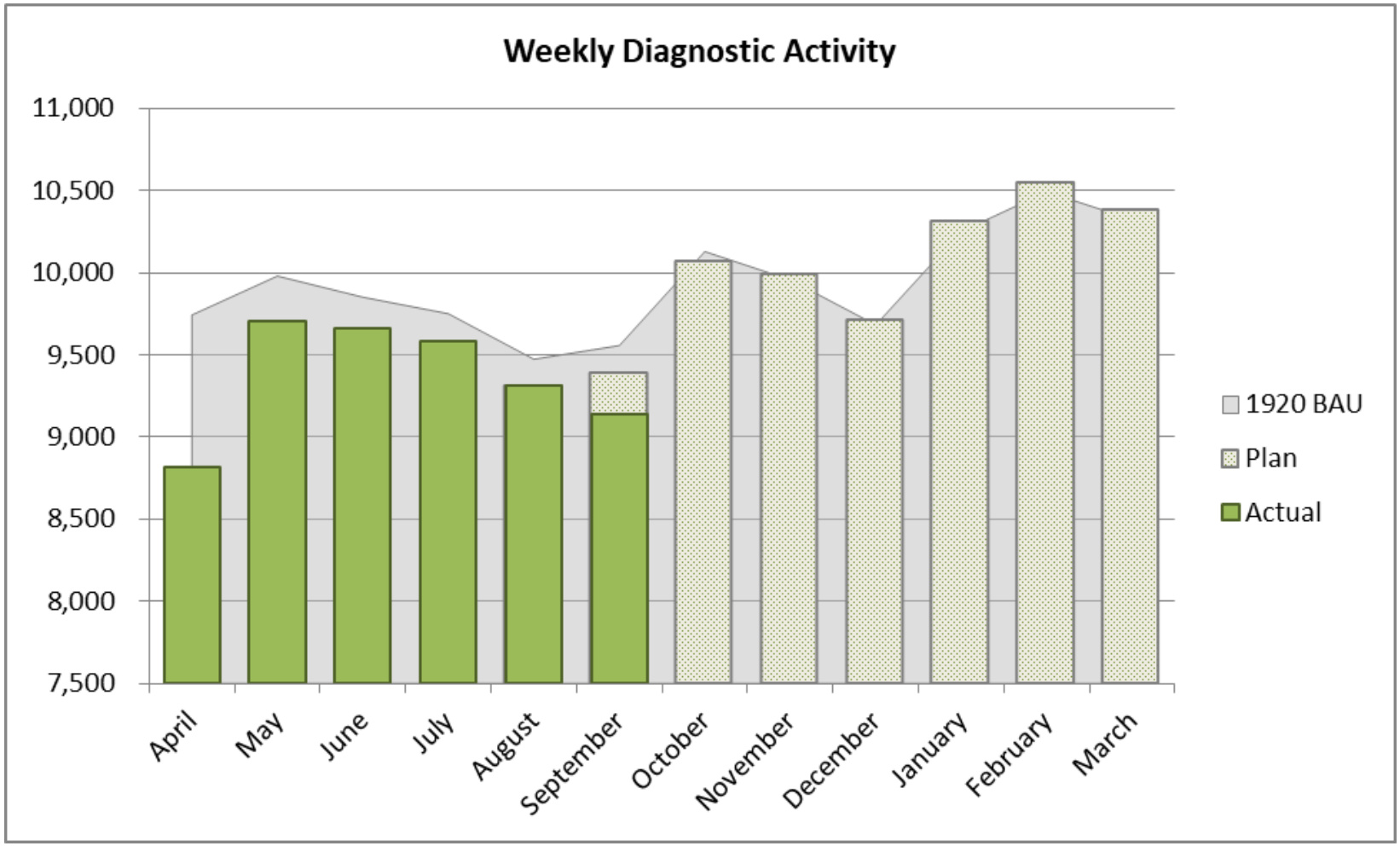
Impact:

- 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



APPENDIX 1

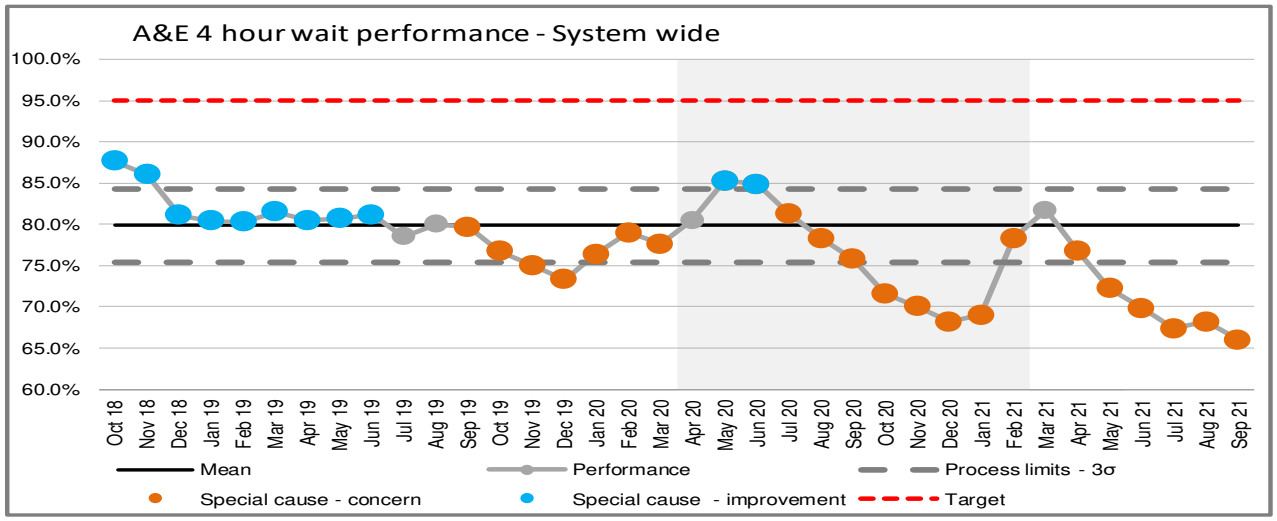
Operational Performance

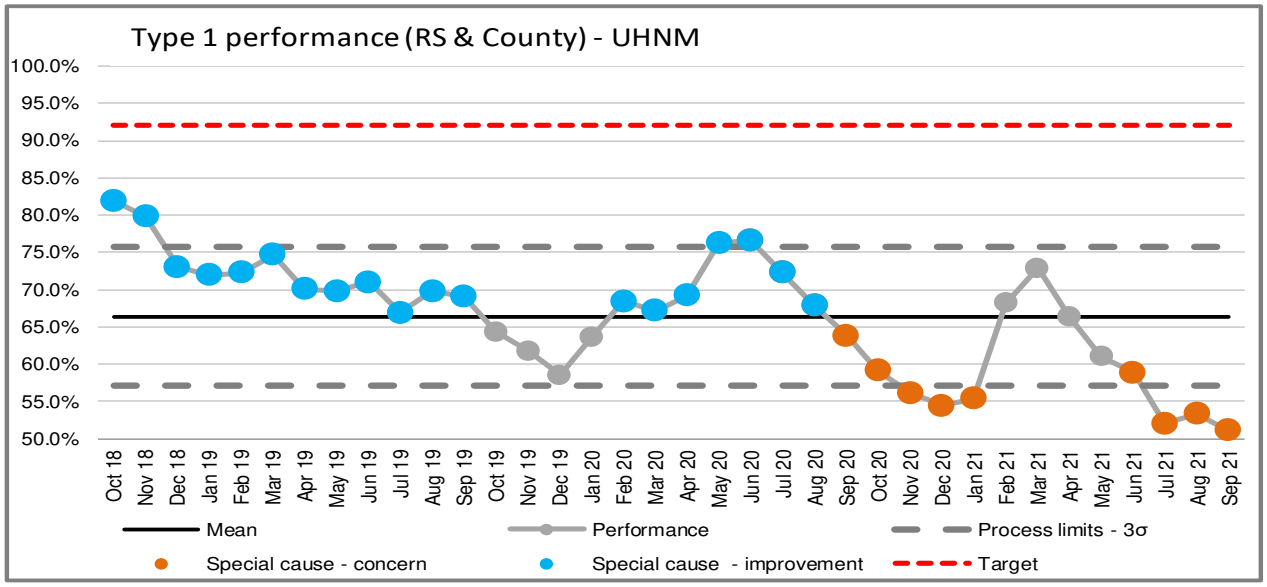
Constitutional standards

	Metric	Target	Latest	Variation	Assurance	DQAI
A&E	A&E 4 hour wait Performance	95%	66.00%	L	F	
	12 Hour Trolley waits	0	7	L	?	
Cancer Care	Cancer Rapid Access (2 week wait)	93%	65.85%	L	?	
	Cancer 62 GP ref	85%	52.60%	L	?	
	Cancer 62 day Screening	90%	83.33%		?	
	31 day First Treatment	96%	90.57%	L	?	
Elective waits	RTT incomplete performance	92%	59.80%	L	F	
	RTT 52+ week waits	0	3550	H	F	
	Diagnostics	99%	71.95%	L	F	

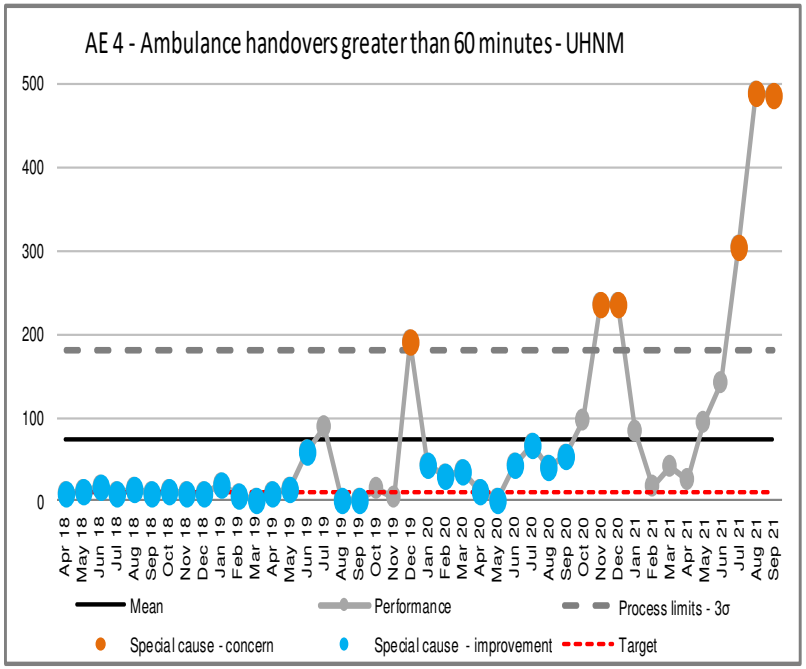
	Metric	Target	Latest	Variation	Assurance	DQAI
Use of Resources	DNA rate	7%	7.3%		?	
	Cancelled Ops	150	138		?	
	Theatre Utilisation	85%	76.0%			
Inpatient / Discharge	Same Day Emergency Care	30%	30.1%	H	?	
	Super Stranded	183	174	H	P	
	DToC	3.5%	2.10%	L	?	
	Discharges before Midday	30%	19.0%	L	F	
	Emergency Readmission rate	8%	11.7%	L	F	
	Ambulance Handover delays in excess of 60 minutes	10	485	H	?	

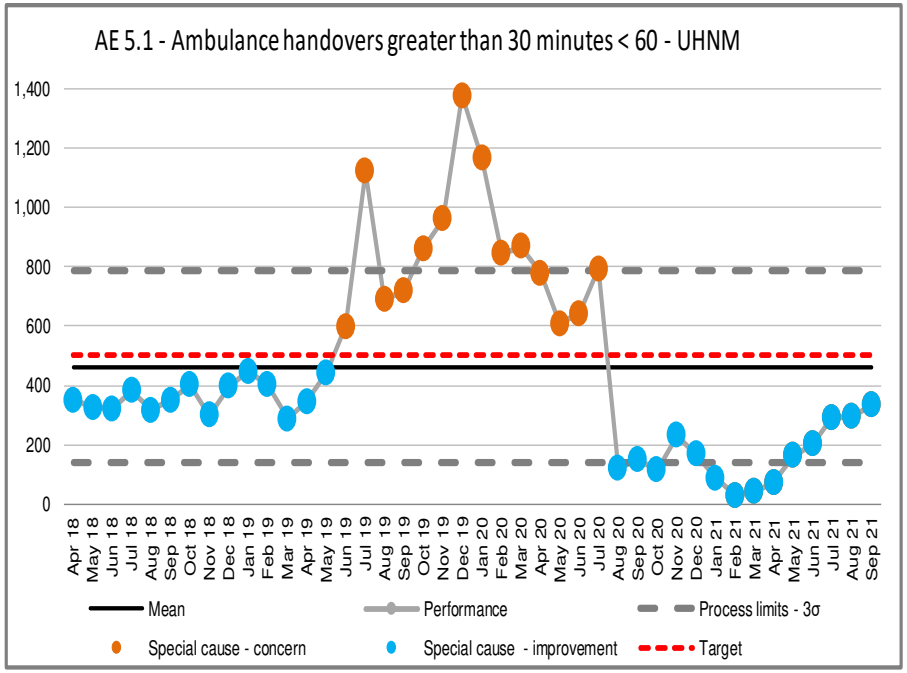
URGENT CARE – 4 hour access performance





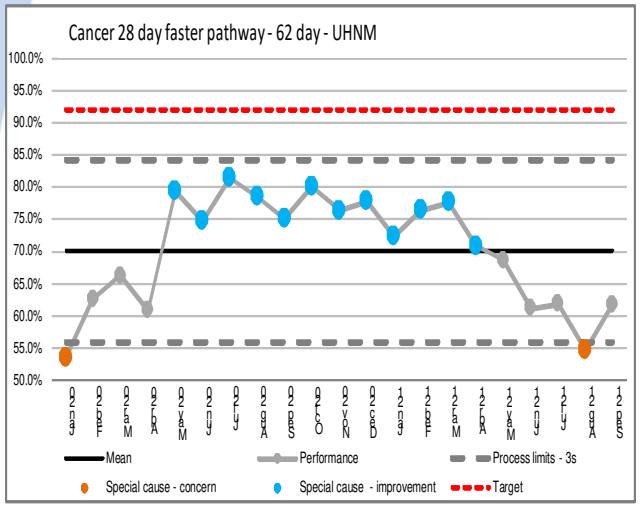
URGENT CARE – 4 hour access – ambulance handovers

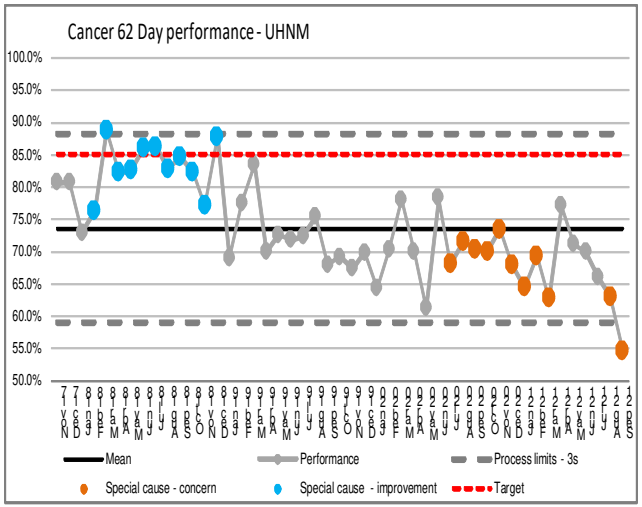




From August – internal validation of > 30 minutes

Cancer – 62 Day





Variation	Assurance
	

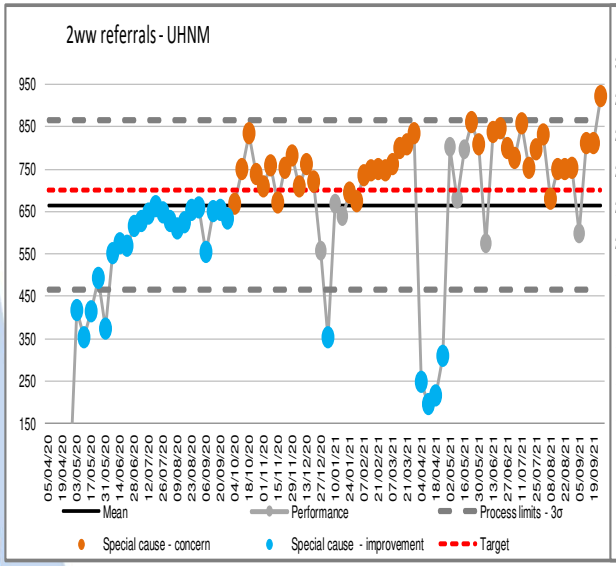
Target	Jul 21	Aug 21	Sep 21
85%	66.0%	62.9%	54.6%

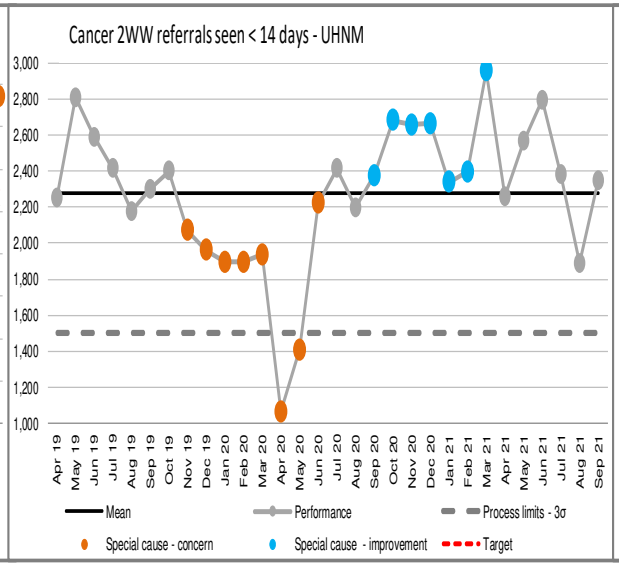
Background

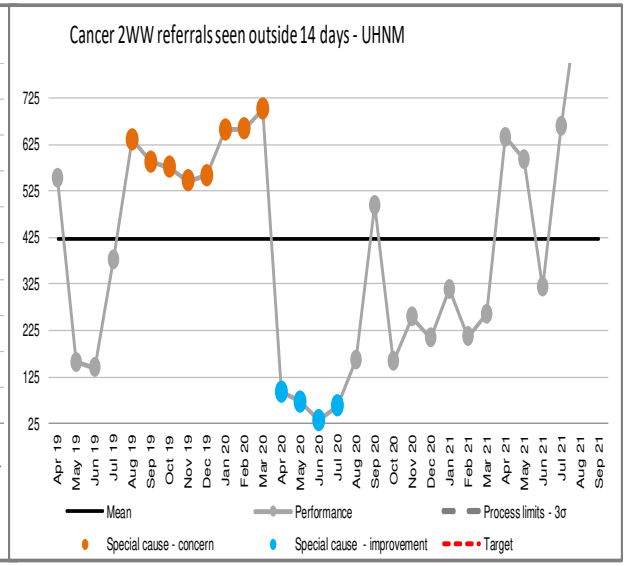
% patients beginning their treatment for cancer within 62 days following an urgent GP referral for suspected cancer

What is the data telling us?

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







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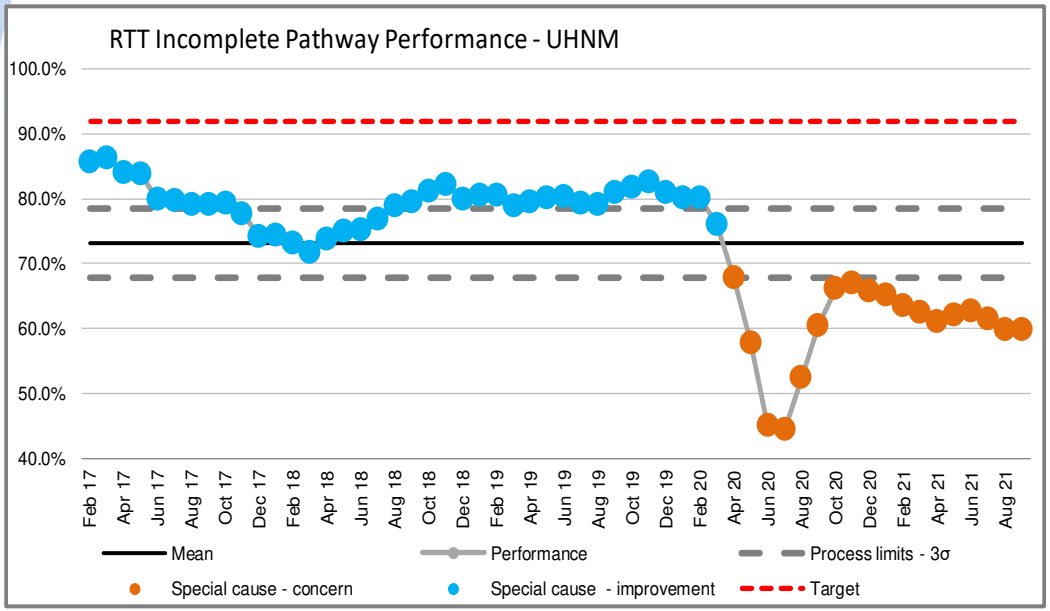
Referral To Treatment



Variation	Assurance
	

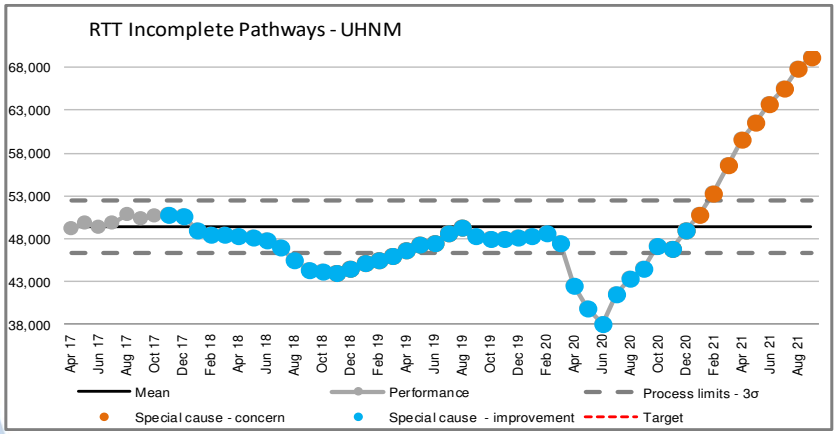
Target	Jul 21	Aug 21	Sep 21
92%	61.4%	59.9%	59.8%

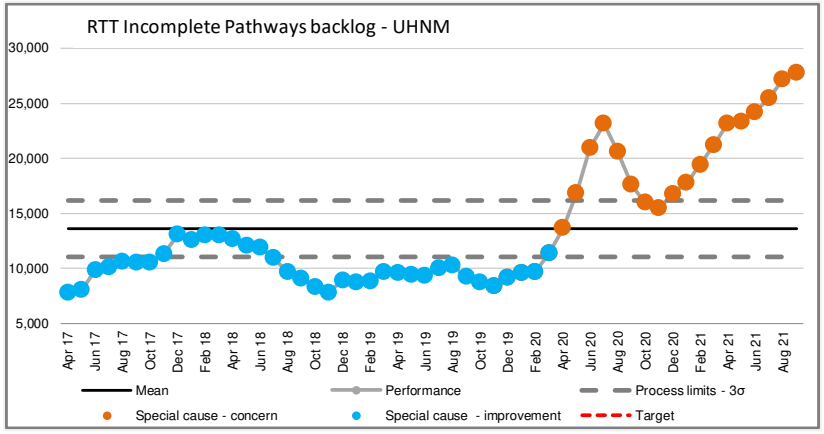
Background

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

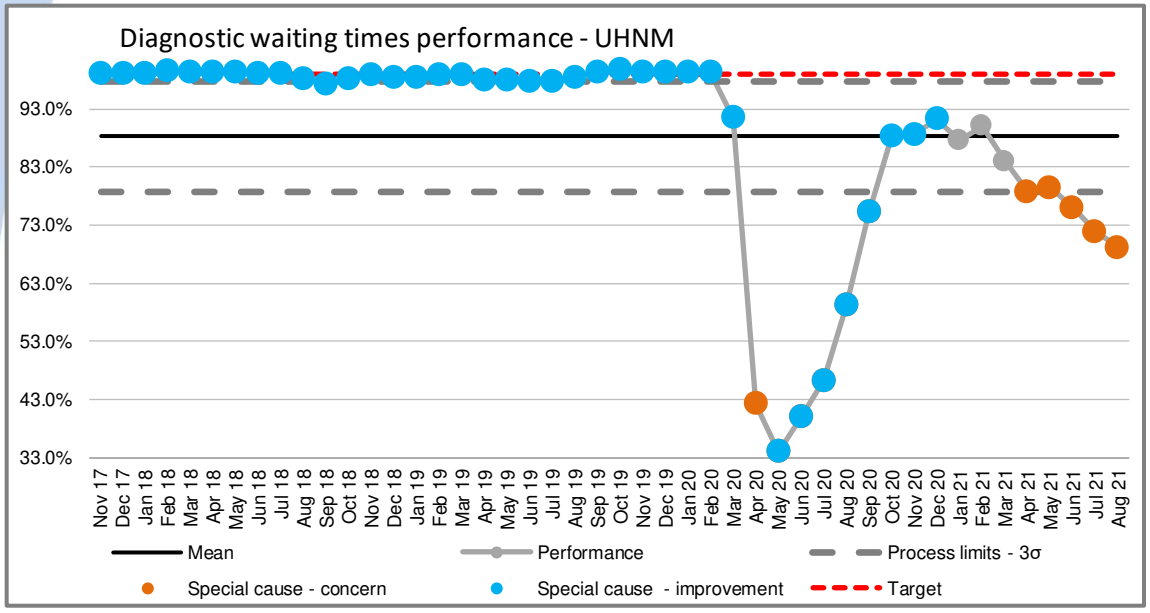
What is the data telling us?

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



Variation	Assurance
	

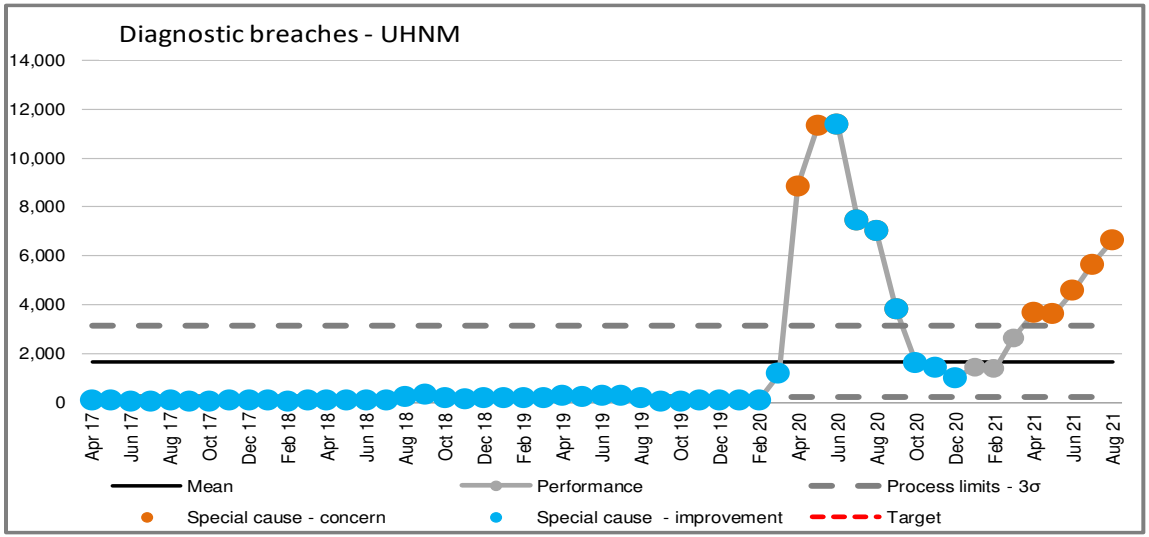
Target	Jun 21	Jul 21	Aug 21
99%	76.1%	72.0%	69.2%

Background

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

What is the data telling us?

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



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APPENDIX 2

UEC Standards - National proposal
March 2021

Introduction

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

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

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

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

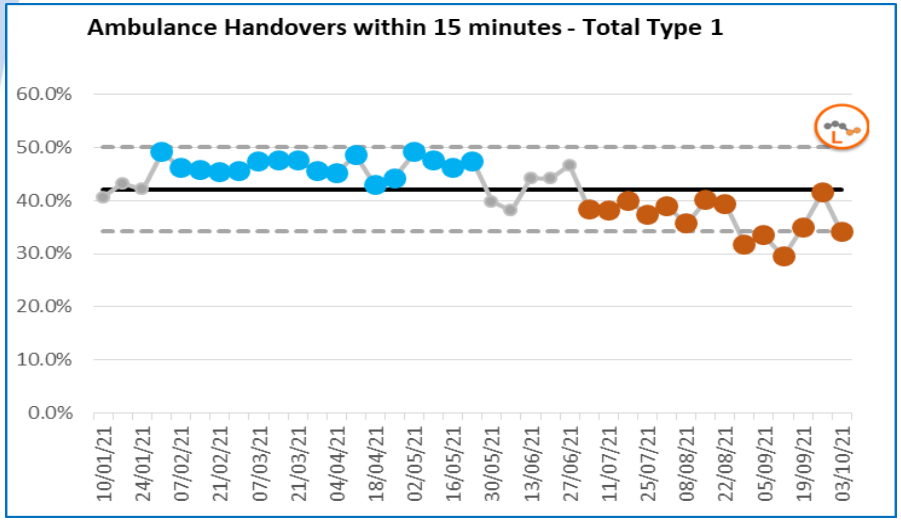
Governance

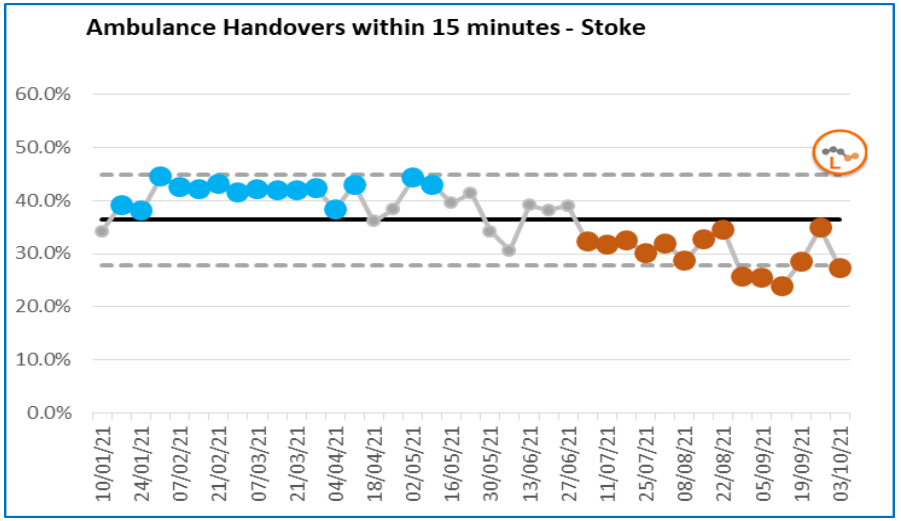
The newly proposed UEC standards will be monitored through both ED performance review and Medicine Divisional board meetings. Organisationally oversight will be through the Urgent Care Programme Board in addition to relevant trust committees

Assessment

Ambulance Handover Times	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

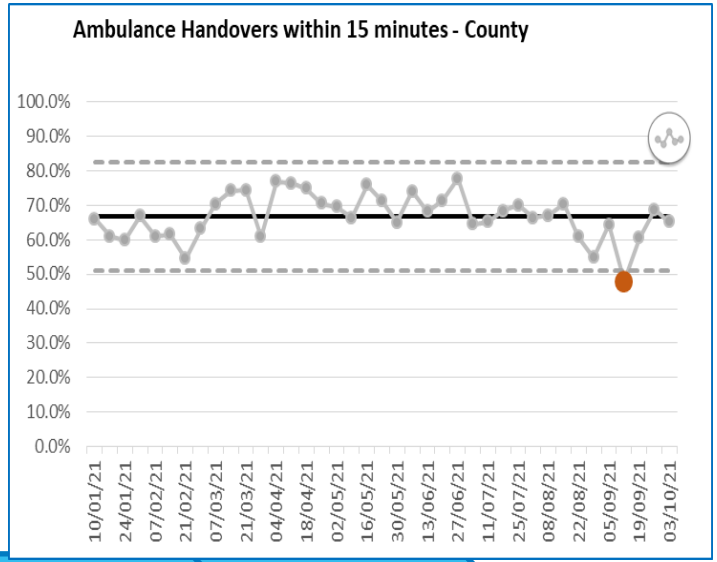




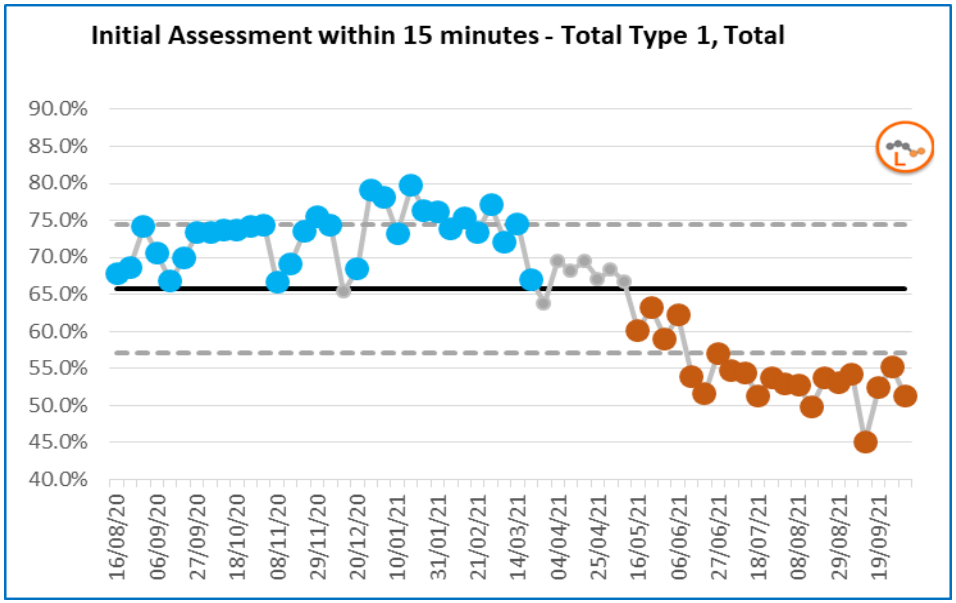
Internal collection of data for Ambulance handovers within 15 minutes began at the beginning of January 21. This is the time taken for the ambulance service to hand over the care to the ED.
N.B. this is un-validated performance and also includes handover time related to direct ambulance conveyance to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

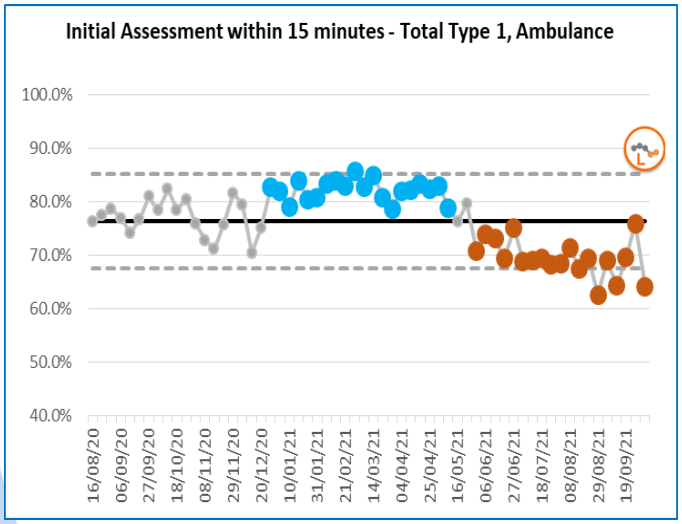
For total ambulance handovers at UHNM in September, the percentage within 15 minutes remained around the lower control limit of 34% and one week at below 30%. A local UHNM target of 48% has been set as the goal to improve to as part of the NEL Improvement programme.

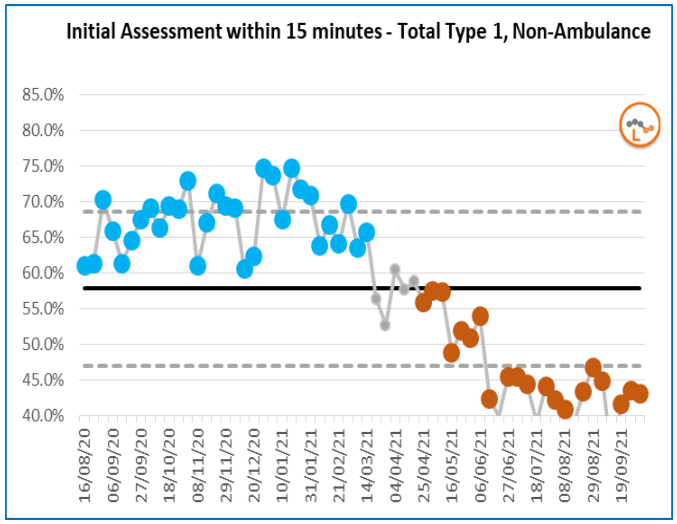
County have maintained a much higher percentage than Royal Stoke albeit with much smaller numbers.



3. Time To Initial Assessment – percentage within 15 minutes





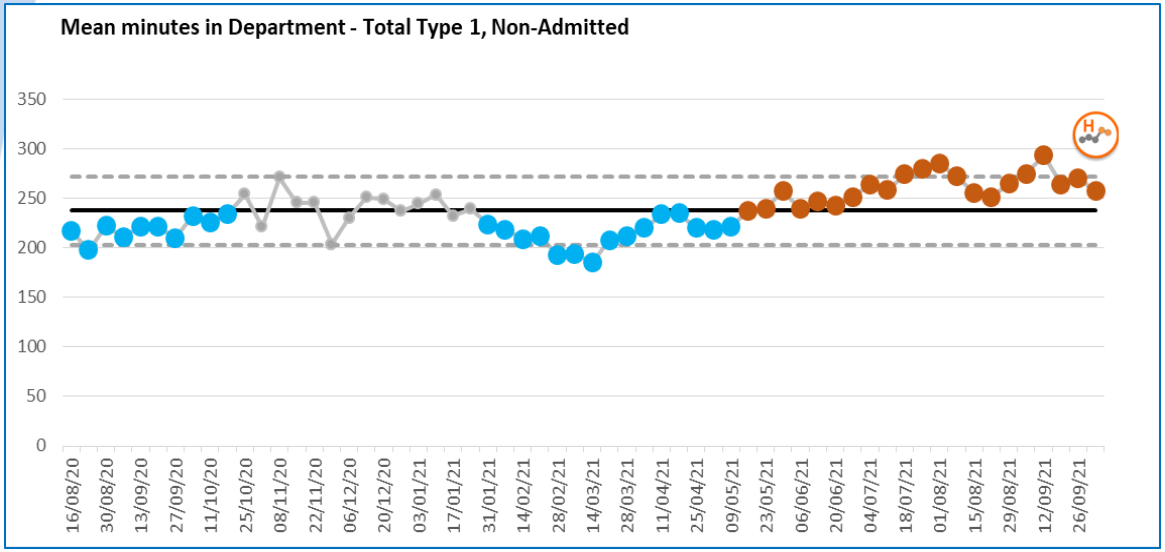


Time to Initial assessment is the time from arrival to when the patient is first triaged.

The total proportion of patients waiting under 15 minutes for their initial assessment maintained a performance of under **55 or under %.**

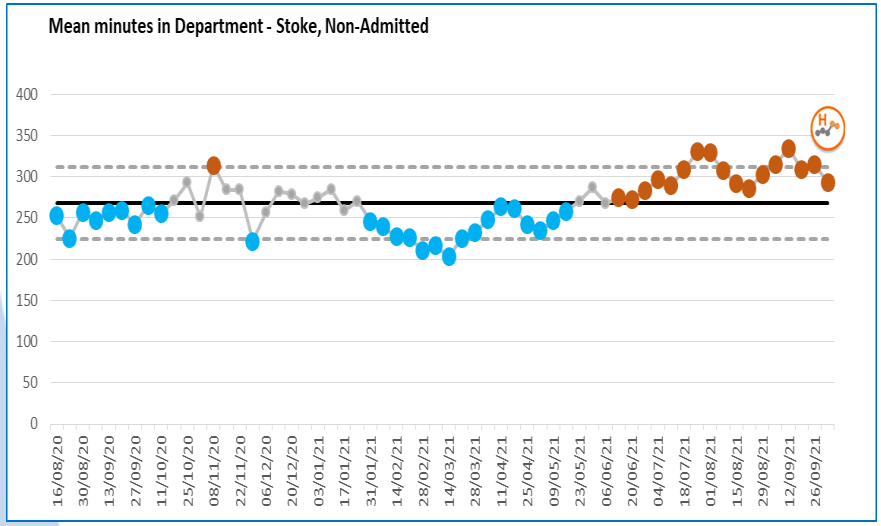
A local UHNM improvement target of 85% has been set.

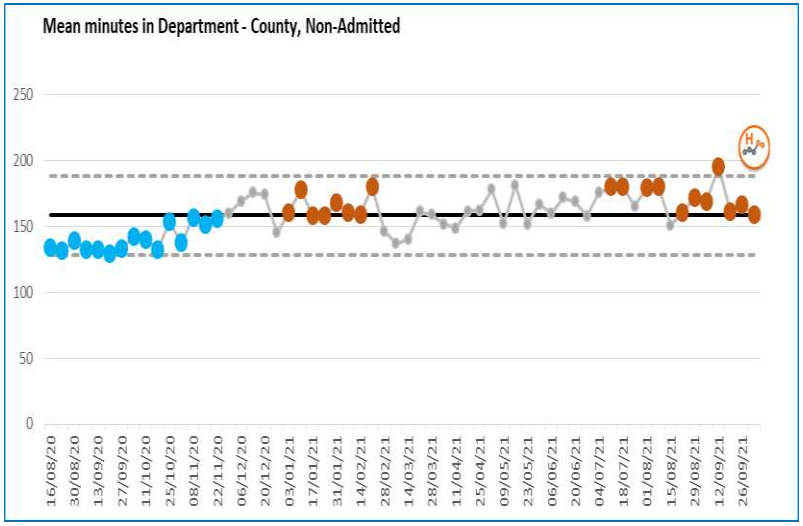
4. Average (mean) time in Department – non admitted patients



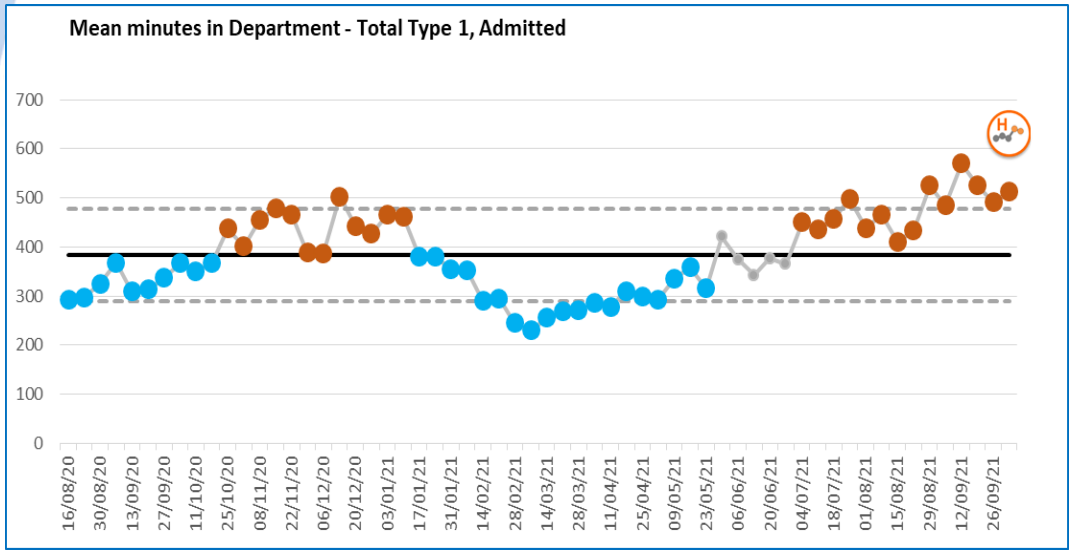
The mean time in the department through September remained above the mean and was for one week the highest seen. On average over the month this was 270mins (August 260mins).
The rise was more notable at Royal Stoke.

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





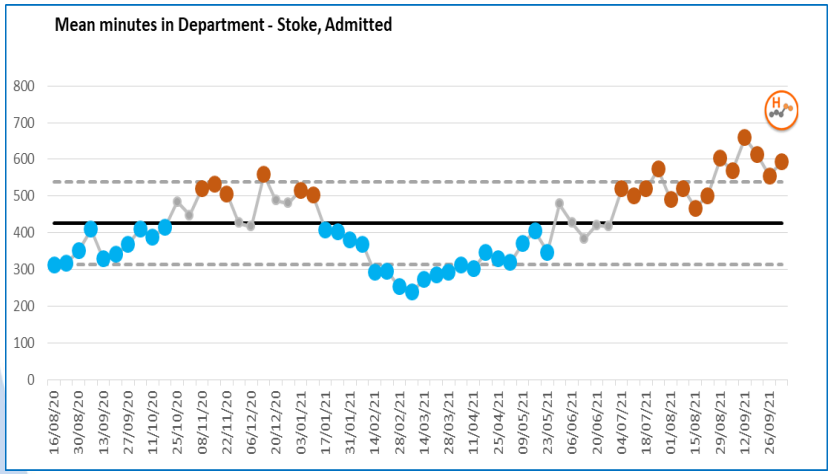
5. Average (mean) time in Department – admitted patients

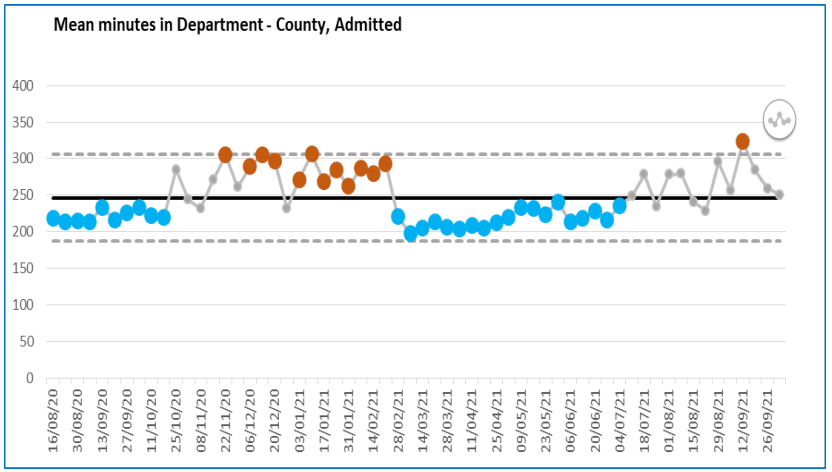


The mean time in the department for admitted patients rose to 570 mins in September. Higher than seen in August.

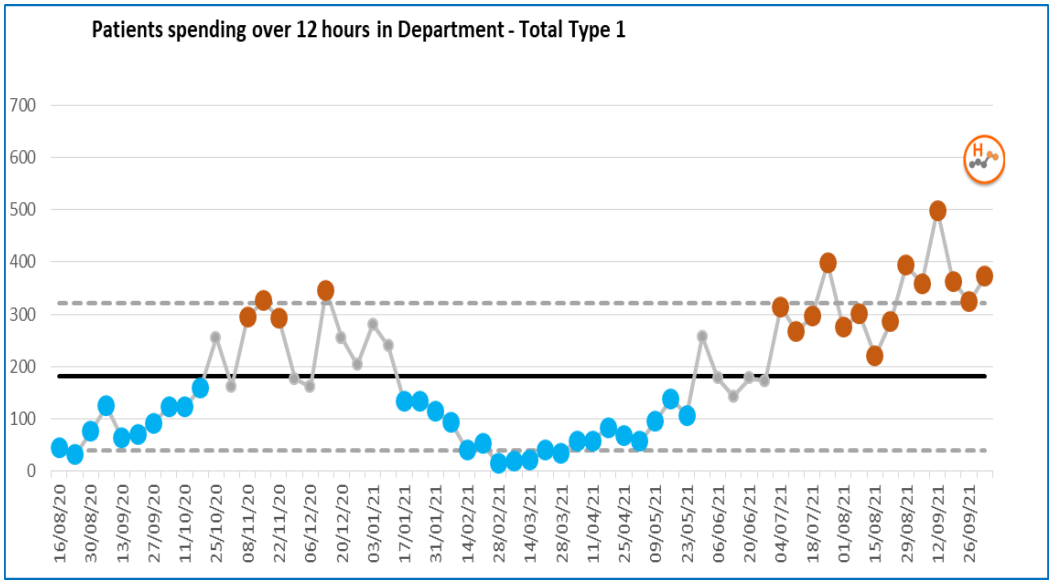
This was notable at both Royal Stoke and County.

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

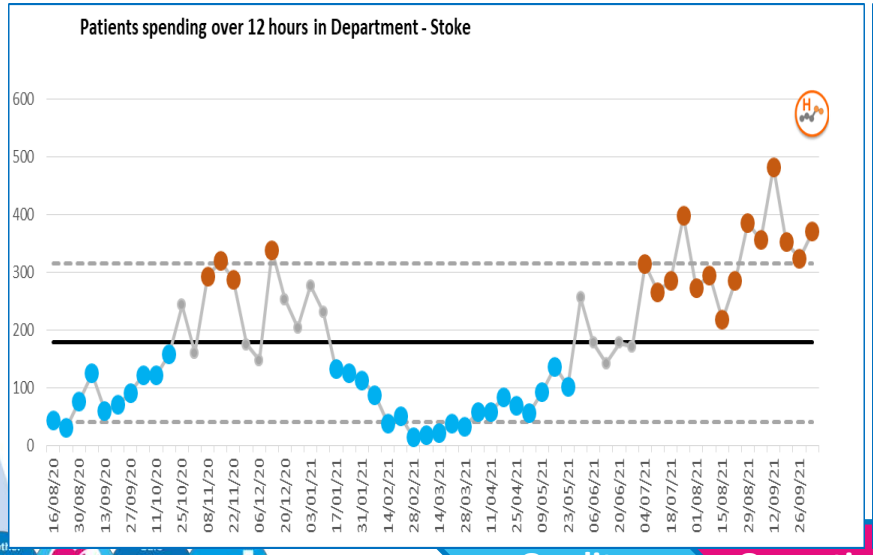


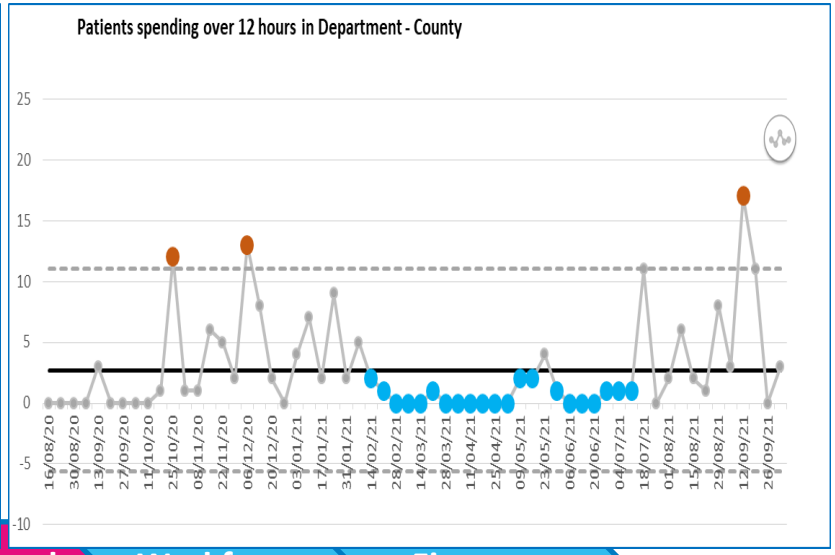


6. Patients spending more than 12 hours in the department



The number of patients spending over 12 hours in the department remained high in September with a spike up to 500. This was notable at Royal Stoke, although there was a spike at County.





Workforce

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

Workforce Spotlight Report

University Hospitals of North Midlands NHS Trust

Key messages

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

Sickness

The in-month sickness rate was 5.36% (5.30% reported at 31/08/21). The 12 month cumulative rate increased to 5.25% (5.18% at 31/08/21)

Stress-related sickness absence remains the top reason for absence, although this does include both work-related and personal/domestic life stress. In the 12 months ending 30 Sept 2021, 28.6% of sickness absence was stress-related.

Three of the clinical divisions have identified sickness as a driver metric under the Improving Together programme and have been asked to undertake a deep dive into reasons for stress related absence to see if we can better target our actions to support

The Trust has a comprehensive Wellbeing Plan in place to support staff with a focus on ensuring staff psychological wellbeing. Wellbeing focus groups are being held and a specific 'Winter Wellbeing Plan' has been agreed and is being put into place

As of 20th October 2021, covid-related open absences* numbered 255, which was 28.81% of all open absences (25.13% at 8th September 2021) [**includes absences resulting from adhering to isolation requirements*]

Appraisals

The Non-Medical PDR compliance rate was 76.18% at 30 September 2021 (78.21% at 31st August 2021).

Performance in completing PDRs continues to deteriorate, with clinical pressures being cited as the main reason. Managers continue to be reminded that holding PDR conversations with staff remains especially important for discussions around the impacts of covid-19 on individuals as well as being a means of facilitating support mechanisms. PDR is a means of managers providing clarity around objectives, as well as discussing career aspirations.

Statutory and Mandatory Training

The Statutory and Mandatory training rate at 30 September 2021 was 95.50% (96.0% at 31 August 2021). This compliance rate is for the 6 'Core for All' subjects only. At 30 September 2021, 91.80% of staff had completed all 6 Core for All modules (92.28% at 31/08/21)

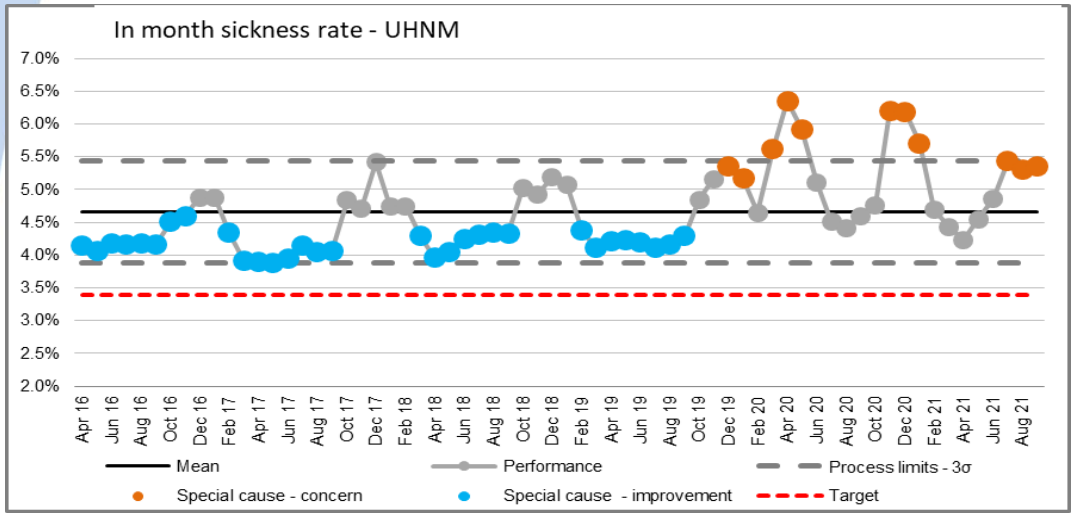
Vacancies

The overall Trust vacancy rate was 9.11%. Although this remains consistent with previous months, there is an trend of an increasing vacancy rate emerging slowly. In mitigation, there is a recruitment pipeline in place. Other mitigations 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.

Workforce Dashboard

Metric	Target	Latest	Variation	Assurance
Staff Sickness	3.4%	5.36%		
Staff Turnover	11%	9.02%		
Statutory and Mandatory Training rate	95%	95.50%		
Appraisal rate	95%	76.18%		
Agency Cost	N/A	3.25%		

Sickness Absence



Variation	Assurance
H	F

Target	Jul 21	Aug 21	Sep 21
3.4%	5.4%	5.3%	5.4%

Background

Percentage of days lost to staff sickness

What is the data telling us?

Sickness rate is consistently above the target of 3.4%.

Although there has been no significant change to the cumulative rate over the last few months, the in-month sickness rate is increasing in part due to covid-related absence

Summary

The in-month sickness rate was 5.36% (5.30% reported at 31/08/21). The 12 month cumulative rate increased to 5.25% (5.18% at 31/08/21)

Stress-related sickness absence remains the top reason for absence, although this does include both work-related and personal/domestic life stress. In the 12 months ending 30 Sept 2021, 28.6% of sickness absence was stress-related.

Actions towards improving sickness rates are being developed through the Improving Together Programme and A3 process.

- The Trust has a comprehensive Wellbeing Plan in place to support staff with a focus on ensuring staff psychological wellbeing and wellbeing courses available from now until December 2021 have been promoted.
- Wellbeing focus groups are being held and
- The Winter Wellbeing Plan has been agreed

As of 20th October 2021, covid-related open absences* numbered 255, which was 28.81% of all open absences (25.13% at 8th September 2021) [**includes absences resulting from adhering to isolation requirements*]

Actions

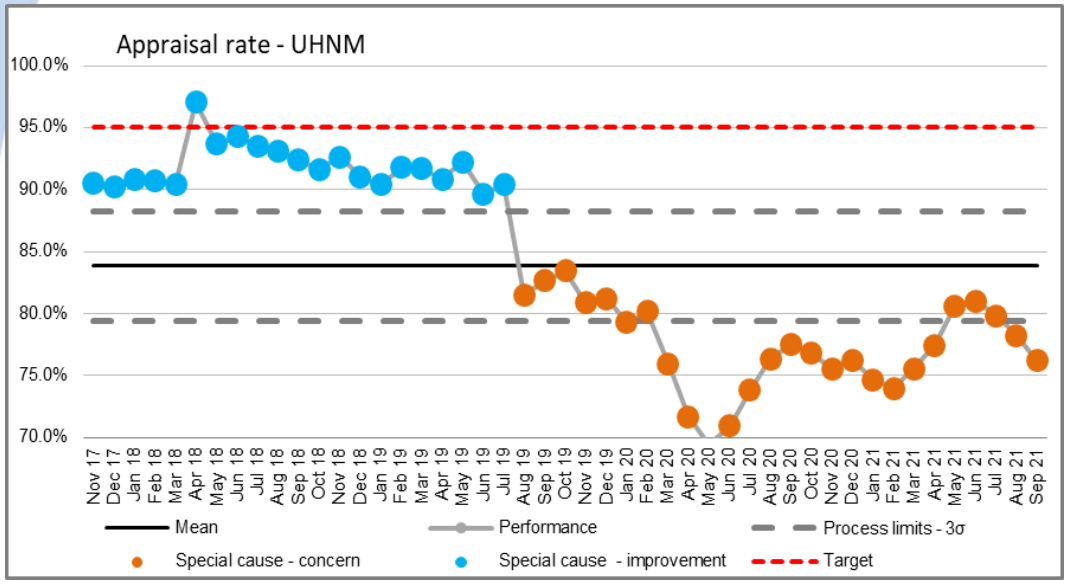
The focus over the next 6 months will be on training managers on the importance of call backs and return to work interviews via the Empactis System

Measures to support the Trust in reducing covid infections continue to be offered and regular communications continue to be issued to update staff on any changes to government guidance

The winter Flu vaccination programme has commenced and the Covid-19 Booster is being offered alongside this.

Three of the clinical divisions have identified sickness as a driver metric under the Improving Together programme and have been asked to undertake a deep dive into reasons for stress related absence to see if we can better target our actions to support

Appraisal (PDR)



Variation	Assurance
L	F

Target	Jul 21	Aug 21	Sep 21
95.0%	79.8%	78.2%	76.2%

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 76.18% at 30 September 2021 (78.21% at 31st August 2021).

Clinical pressures due to covid have been cited as the main reason for the drop in performance.

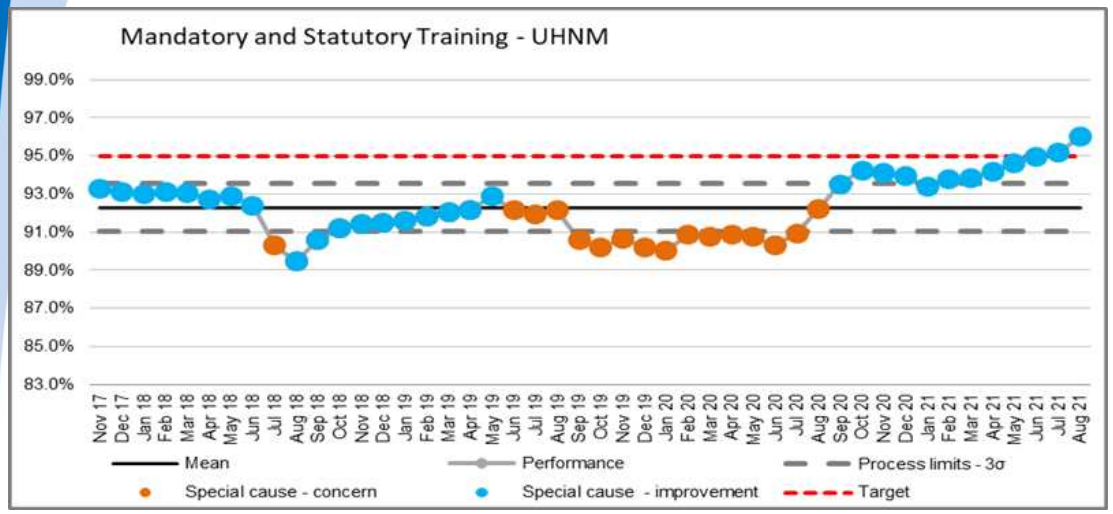
Actions

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

Divisions have been asked to revise their trajectories to reflect a realistic position of what they are able to achieve

Divisions have also been asked to continue to undertake PDR's wherever possible as opportunity to discuss wellbeing and support.

Statutory and Mandatory Training



Variation	Assurance
H	F

Target	Jul 21	Aug 21	Sep 21
95.0%	95.2%	96.0%	95.5%

Background

Training compliance

What is the data telling us?

At 95.50%, the Statutory and Mandatory Training rate has achieved the Trust target for the core training modules

Summary

The Statutory and Mandatory training rate at 30 September 2021 was 95.50% (96.0% at 31 August 2021). This compliance rate is for the 6 'Core for All' subjects only. At 30 September 2021, 91.80% of staff had completed all 6 Core for All modules (92.28% at 31/08/21)

Competence Name	Assignment Count	Required	Achieved	Compliance %
205|MAND|Security Awareness - 3 Years|	10548	10548	10036	95.15%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	10548	10548	10088	95.64%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	10548	10548	10023	95.02%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	10548	10548	10057	95.35%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	10548	10548	10069	95.46%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	10548	10548	10164	96.36%

Compliance rates for the Annual competence requirements were as follows:

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 1 Year|	10548	10548	8977	85.11%
NHS|CSTF|Information Governance and Data Security - 1 Year|	10548	10548	9284	88.02%

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

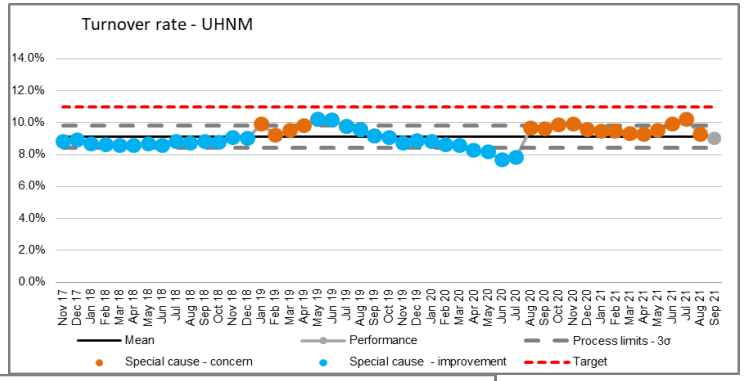
Actions

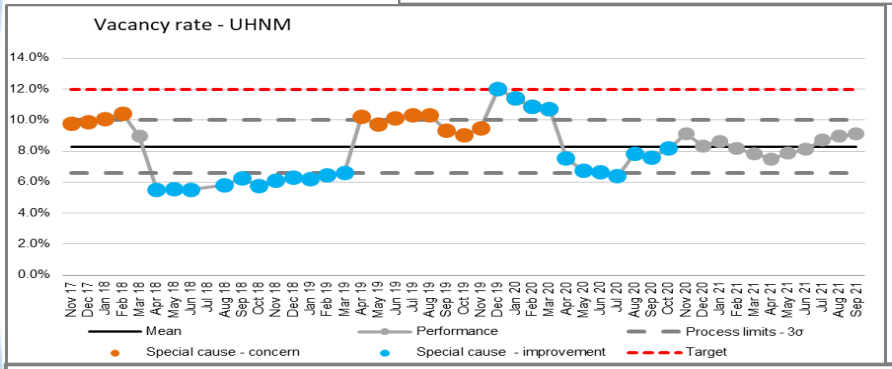
We continue to raise the issue of compliance with Divisions and communicate to staff the need to complete statutory and mandatory training.

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

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.

Variation	Assurance

Target	Jul 21	Aug 21	Sep 21
11.0%	10.2%	9.3%	9.0%

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%

Summary

The overall Trust vacancy rate was 9.11%. Although this remains consistent with previous months, there is an trend of Increasing vacancy rate emerging.

Vacancies at 30 Sept 2021	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous month %
Medical and Dental	1,427.29	1,247.15	180.14	12.62%	13.31%
Registered Nursing	3280.39	2861.05	419.34	12.78%	12.26%
All other Staff Groups	6277.26	5875.73	401.53	6.40%	6.27%
Total	10,984.94	9,983.93	1,001.01	9.11%	8.97%

There was a 15.77FTE increase in vacancies between August and September
- Medical & Dental (10.03) fewer vacancies
- Registered Nursing + 18.33 increase in vacancies and
- An increase of 7.47 vacancies across all other staff group vacancies

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

Actions

- By December 2020 we will have 93 international nurses joining us.
- We are running a campaign with Indeed for nursing assistants – 50 to be recruited w/c 18 October with further tranche on interviews planed on w/c 8 November numbers dependent on remaining vacancies but potential for a further 50 to be recruited
- Registered nurses, midwives, ODP's and registrants are being recruited to the Nurse Bank
- An action plan is in place to support the deployment of staff should the need arise

Finance

2025 Vision "Ensure efficient use of resources"

Finance Spotlight Report

NHS University Hospitals of North Midlands NHS Trust

Key messages

- The Trust has delivered a surplus of £0.2m in month against a planned surplus of £1.4m and therefore a final H1 surplus of £13.7m. The adverse position in month is primarily driven by ERF underperformance against plan.
- ERF income recognised for the year to date is £8.3m against a revised planned figure of £8.8m. Based on activity plans, the plan originally assumed £8.8m of income for H1 with additional costs approved of £0.6m to support the delivery of the activity plans. Revised thresholds for receiving ERF funding have been announced for Q2 which have reduced the forecast income earned by the Trust and there has also been a significant underspend against the £0.6m anticipated spend in H1.
- The Trust incurred £1m of costs relating to COVID-19 in month which is a decrease of £0.3m compared with Month 5's figure. This remains within the Trust's fixed allocation with £0.4m being chargeable on top of this allocation for COVID-19 testing costs.
- The backdated pay award was processed in month totalling £6.3m for which the Trust has accrued additional income (as per National guidance) to offset; budgets have also been adjusted to reflect the pay award.
- Capital expenditure for the year to date stands at £12.4m which is £3.1m behind the plan mainly due to an underspend relating to the lower Trent wards scheme and digital pathology (MES).
- The cash balance at Month 6 is £59.8m which is £6.6m lower than plan, the main reason being that the Q2 invoice to Health Education England was raised in late September and the cash is now expected to be received in Month 7.

Finance Dashboard

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

Income & Expenditure

Income & Expenditure Summary Month 06 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	822.9	79.2	77.9	(1.3)	441.7	438.3	(3.4)
Other Operating Income	94.6	7.2	6.7	(0.5)	43.2	41.6	(1.5)
Total Income	917.5	86.5	84.7	(1.8)	484.9	479.9	(5.0)
Pay Expenditure	(547.8)	(51.6)	(50.8)	0.7	(277.3)	(271.1)	6.2
Non Pay Expenditure	(330.2)	(29.1)	(29.0)	0.1	(172.5)	(168.2)	4.4
Total Operational Costs	(878.0)	(80.7)	(79.8)	0.8	(449.9)	(439.3)	10.6
EBITDA	39.5	5.8	4.8	(1.0)	35.0	40.6	5.6
Depreciation & Amortisation	(29.9)	(2.5)	(2.7)	(0.2)	(15.0)	(15.0)	(0.0)
Interest Receivable	0.3	0.0	0.0	(0.0)	0.1	0.0	(0.1)
PDC	(7.6)	(0.6)	(0.7)	(0.1)	(3.8)	(3.9)	(0.1)
Finance Cost	(16.1)	(1.3)	(1.3)	0.0	(8.1)	(8.0)	0.0
Other Gains or Losses	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Surplus / (Deficit)	(13.8)	1.4	0.2	(1.2)	8.3	13.7	5.4
Financial Recovery Fund	5.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	(8.8)	1.4	0.2	(1.2)	8.3	13.7	5.4

The Trust delivered a £0.2m surplus for Month 6 against a planned surplus of £1.4m and a year to date surplus position of £13.7m against a planned surplus position of £8.3m; this surplus is measured against the Trust's financial plan which was re-submitted in June 2021 to take into account the full impact of the ERF. The main variances in month are:

- Income from patient activities has underperformed in month due to underperformance in respect of ERF (£1.2m). The trust has received £0.4m of ERF income in month all of which relates to prior periods (see additional table below). Additional pass-through device income has been received in month in excess of plan (£0.3m). This over performance is offset by Independent Sector (IS) under performance of £0.7m (both of which are offset by corresponding movements in non-pay).
- The primary drivers for the underperformance of other operating income in month are education and training income (£0.2m), COVID-19 Outside of Envelope funding (£0.1m) and car parking income (£0.1m).
- Pay is underspent in month by £0.7m which is primarily driven by underspends across registered nursing and COVID-19 funding underutilised in month. The pay award was processed in Month 6 which amounted to £6.3m and budgets have also been uplifted for this.
- Non-pay is underspent against plan in month by £0.1m due to the continuing reduced spend on the Independent Sector contract which is offset by pass-through device non pay which has continued to overspend against plan.

Capital Spend

Capital Expenditure as at Month 6 2021/22 £m	Total approved scheme cost - schemes > 1 yr (excl PFI)	Revised 2021/22 Plan	In Month			Year to Date		
	Plan	Plan	Budget	Actual	Variance	Budget	Actual	Variance
PFI & finance lease liability repayment	-	(9.2)	(0.8)	(0.8)	-	(4.6)	(4.6)	-
Pre-committed items	-	(9.2)	(0.8)	(0.8)	-	(4.6)	(4.6)	-
PFI lifecycle and equipment replacement	-	(5.3)	(0.2)	(0.2)	-	(1.0)	(1.0)	-
PFI enabling cost	-	(0.8)	-	-	-	-	-	-
PFI related costs	-	(6.1)	(0.2)	(0.2)	-	(1.0)	(1.0)	
RI demolition	(7.4)	(0.9)	(0.3)	(0.3)	0.0	(0.8)	(0.8)	0.0
Project STAR multi-storey car park	(1.5)	(1.2)	-	(0.1)	(0.1)	(0.2)	(0.3)	(0.1)
Thornburrow decant office accommodation	(2.4)	(1.9)	(0.0)	(0.3)	(0.3)	(1.9)	(1.8)	0.1
Wave 4b Funding - Lower Trent Wards	(9.5)	(7.1)	(0.6)	(0.3)	0.3	(2.6)	(0.7)	1.9
CT7 scanner enabling cost	-	(1.1)	-	-	-	-	-	-
STP diagnostic Funding and Cancer funding CT7	-	(1.0)	-	-	-	-	-	-
Schemes funded by PDC and Trust funding	(20.8)	(13.1)	(0.9)	(1.0)	(0.1)	(5.4)	(3.5)	1.9
LIMS (Laboratory Information Management System)	(2.7)	(0.6)	(0.1)	(0.0)	0.0	(0.4)	(0.4)	0.0
EPMA (Electronic Prescribing)	(4.7)	(0.5)	(0.0)	(0.1)	(0.0)	(0.2)	(0.2)	(0.0)
Completion of RSUH ED doors	(0.4)	(0.2)	-	(0.2)	(0.2)	(0.2)	(0.2)	0.0
Pathology integration	(0.2)	(0.1)	-	-	-	-	-	-
Medical devices fleet replacement	(4.9)	(0.7)	-	-	-	-	-	-
Schemes with costs in more than 1 financial year	(12.9)	(2.2)	(0.1)	(0.3)	(0.1)	(0.8)	(0.8)	(0.0)
ICT Infrastructure	-	(0.6)	(0.1)	(0.1)	0.1	(0.3)	(0.1)	0.2
Estates Infrastructure	-	(4.4)	(0.2)	(0.2)	0.0	(0.6)	(0.5)	0.0
Medical Equipment Replacement	-	(2.5)	(0.1)	(0.0)	0.1	(1.4)	(1.2)	0.1
Health & Safety Compliance	-	(0.2)	-	-	-	(0.0)	(0.0)	0.0
Beds, mattresses and hoists	-	(0.1)	(0.0)	-	0.0	(0.1)	(0.1)	0.0
Critical Risk Infrastructure	-	(0.3)	(0.1)	(0.0)	0.0	(0.2)	(0.1)	0.1
4th Linear Accelerator Replacement	-	(2.5)	-	-	-	-	(0.0)	(0.0)
West building doctors accommodation	-	(0.1)	-	-	-	(0.1)	(0.1)	-
Commitments b/f from 2020/21	-	(0.3)	-	(0.0)	(0.0)	(0.3)	(0.3)	0.0
Lloyds dispensary footprint	-	(0.7)	(0.1)	(0.0)	0.1	(0.1)	(0.0)	0.1
Digital Pathology (MES)	-	(0.7)	(0.7)	-	0.7	(0.7)	-	0.7
Isolation PODs ward 127 - BC approved	-	(0.1)	-	-	-	-	-	-
County ward 7 - Winter Plan	-	(0.1)	-	-	-	-	-	-
Potential embedded leases from approved cases	-	(0.1)	-	-	-	-	-	-
2021/22 schemes	-	(12.8)	(1.4)	(0.4)	1.0	(3.8)	(2.5)	1.3
Balance to be allocated in updated Plan	-	(1.7)	-	-	-	-	-	-
Funds to be allocated to schemes	-	(1.7)	-	-	-	-	-	-
Donated/Charitable funds expenditure	-	(0.4)	(0.1)	(0.1)	-	(0.4)	(0.4)	-
Charity funded expenditure	-	(0.4)	(0.1)	(0.1)	-	(0.4)	(0.4)	-
Overall capital expenditure	(33.7)	(45.0)	(3.3)	(2.5)	0.8	(15.5)	(12.4)	3.1

The Lower Trent scheme is £1.9m behind plan. The scheme, including the options for the decant of administrative staff has been reviewed and agreed by the Executive Team. A further report was presented to Executive Team in October setting out the phasing of expenditure within this plan and the PDC funding required in each year. This represents a change to the funding profile previously agreed with NHSIE and once this change has been agreed with NHSIE the impact will be reflected in the capital plan.

ICT sub-group expenditure is £0.2m behind plan due to changes in the allocation of funds within the sub-group allocation with funding for the data centre reduced and re-allocated to new ICT schemes.

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. The requirements and documentation are currently being finalised within the managed equipment scheme.

Balance sheet

Balance sheet as at Month 6	31/03/2021	30/09/2021				
	Actual £m	Original Plan £m	Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment	531.2	499.0	529.9	527.0	(2.9)	Note 1
Intangible Assets	22.8	21.8	19.8	19.7	(0.2)	
Other Non Current Assets	-	-	-	-	-	
Trade and other Receivables	0.5	-	0.5	0.5	-	
Total Non Current Assets	554.5	520.7	550.2	547.1	(3.1)	
Inventories	15.0	12.3	15.0	16.2	1.2	Note 2
Trade and other Receivables	47.4	50.8	42.3	49.1	6.8	Note 3
Cash and Cash Equivalents	55.8	9.1	66.4	59.8	(6.6)	Note 4
Total Current Assets	118.2	72.1	123.7	125.2	1.5	
Trade and other payables	(98.5)	(59.7)	(96.0)	(89.2)	6.8	Note 5
Borrowings	(8.3)	(9.0)	(8.3)	(8.3)	0.0	
Provisions	(3.6)	(2.4)	(3.6)	(3.6)	0.0	
Total Current Liabilities	(110.4)	(71.1)	(107.9)	(101.1)	6.9	
Borrowings	(268.5)	(277.6)	(264.0)	(264.0)	(0.0)	
Provisions	(2.2)	(0.9)	(2.2)	(2.1)	0.1	
Total Non Current Liabilities	(270.7)	(278.4)	(266.2)	(266.2)	0.0	
Total Assets Employed	291.5	243.3	299.8	305.1	5.3	
Financed By:					-	
Public Dividend Capital	637.9	610.6	637.9	637.9	0.0	
Retained Earnings	(465.3)	(466.1)	(457.0)	(451.9)	5.1	Note 6
Revaluation Reserve	118.9	98.9	118.9	119.1	0.2	
Total Taxpayers Equity	291.5	243.3	299.8	305.1	5.3	

The balance sheet plan reflects the impact on the balance sheet of the 2021/22 revenue plan submitted to NHSIE in June 2021. Variances to the plan at Month 6 are explained below:

1. Property, Plant and Equipment is £2.9m lower than plan and reflects the underspend in the capital plan to Month. 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. The inventory balance at Month 6 reflects the value of high cost devices held mainly in relation to the pace makers inventory count, a £1.8m increase to 31 March 2021. The increase is partly offset by reductions in the balance of £0.8m DHSC donated consumables that was held at 31 March 2021.
3. The receivables balance reflects the £5.3m invoice raised in late September to Health Education England for Q2 training funding which is normally received within the quarter. Accruals include £3.3m in relation to the Elective Recovery Fund, this is a reduction compared to previous months as £5m cash was received in September relating to Q1. 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.
4. Cash is £6.6m lower than plan at Month 6, mainly a result of a delay in receiving training income.
5. Trade and other payables are £6.8m lower than plan which reflects the impact of the revenue and capital underspends year to date and the reduction in capital creditors from the 31 March 2021.
6. Retained earnings shows a variance of £5.1m from plan which reflects the year to date revenue underspend at Month 6.

Expenditure - Pay and Non Pay

Pay Summary Month 06 2021/22	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Medical	(162.7)	(14.9)	(15.2)	(0.3)	(82.1)	(83.3)	(1.3)
Registered Nursing	(162.2)	(15.4)	(14.5)	0.9	(81.9)	(77.2)	4.7
Scientific Therapeutic & Technical	(67.3)	(6.4)	(6.3)	0.1	(34.1)	(32.9)	1.1
Support to Clinical	(71.9)	(6.9)	(7.1)	(0.3)	(36.8)	(37.5)	(0.7)
Nhs Infrastructure Support	(83.6)	(8.0)	(7.7)	0.2	(42.5)	(40.2)	2.3
Total Pay	(547.8)	(51.6)	(50.8)	0.7	(277.3)	(271.1)	6.2

Pay –Key variances:

The pay award was processed in Month 6 which amounted to £6.3m of which offsetting income was accrued as per NHSIE guidance.

- 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 6 budget there is £0.2m of underutilised budget in reserves (part of the £0.7m noted below) and this is offset against £0.3m of vacancy factor budget. Within the Month 6 actual were total premium costs (bank and agency) of £1.2m covering existing workforce vacancies and absences.
- Within the above budget for Month 6 is £0.7m of reserves which have not been spent (split across numerous expenditure headings) with the main elements being £0.4m on the COVID-19 reserve and £0.2m on the contingency reserve.

Non Pay Summary Month 06 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	(78.2)	(6.8)	(7.0)	(0.1)	(39.2)	(40.8)	(1.6)
Other Drugs	(22.5)	(1.9)	(2.2)	(0.3)	(11.2)	(11.6)	(0.3)
Supplies & Services - Clinical	(89.9)	(8.4)	(8.6)	(0.2)	(44.8)	(44.0)	0.7
Supplies & Services - General	(7.5)	(0.6)	(0.7)	(0.1)	(3.7)	(3.3)	0.4
Purchase of Healthcare from other Bodies	(24.8)	(2.1)	(1.1)	1.0	(16.9)	(11.8)	5.0
Consultancy Costs	(1.5)	(0.1)	(0.2)	(0.1)	(0.8)	(1.2)	(0.4)
Clinical Negligence	(25.4)	(2.2)	(2.2)	0.0	(13.2)	(13.2)	0.0
Premises	(33.9)	(2.7)	(2.9)	(0.2)	(17.3)	(17.9)	(0.5)
PFI Operating Costs	(35.5)	(2.9)	(3.0)	(0.0)	(17.7)	(17.7)	(0.0)
Other	(11.1)	(1.3)	(1.1)	0.1	(7.7)	(6.7)	1.1
Total Non Pay	(330.2)	(29.1)	(29.0)	0.1	(172.5)	(168.2)	4.4

Non Pay key variances:

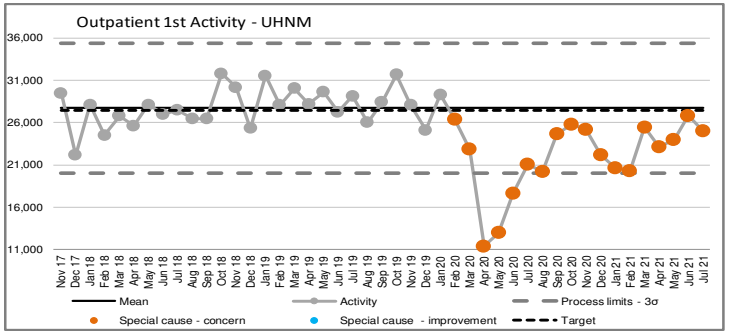
Supplies and services - clinical is slightly overspent in month in part due to over performance against the planned figure for pass through devices (£0.3m). There has also been a stock adjustment in month for theatres which has caused an adverse movement to the position of £0.2m as the stock takes are carried out on a quarterly basis. These overspends are offset by reduced activity and spend due to the planned 2 week elective shut down because of operational pressures.

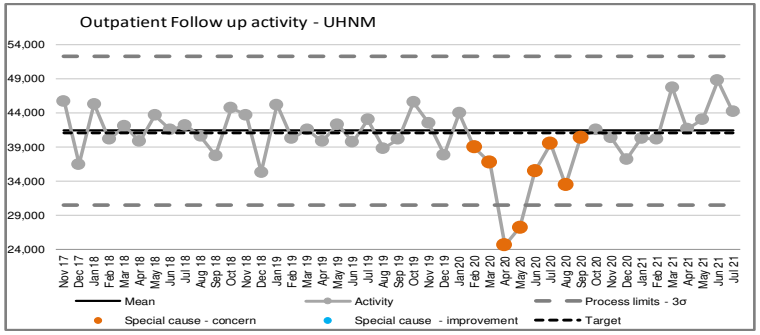
Purchase of healthcare from other bodies is underspent in month largely as a result of the IS contract as the Trust had planned a £1.4m cost in month against an actual cost of £0.7m (year to date variance of £4m).

Activity

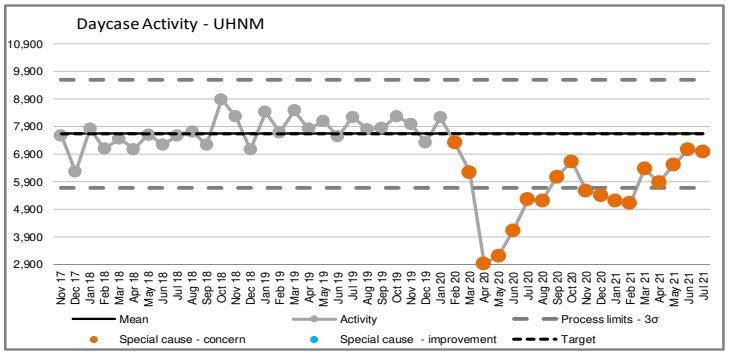
NHS University Hospitals of North Midlands NHS Trust

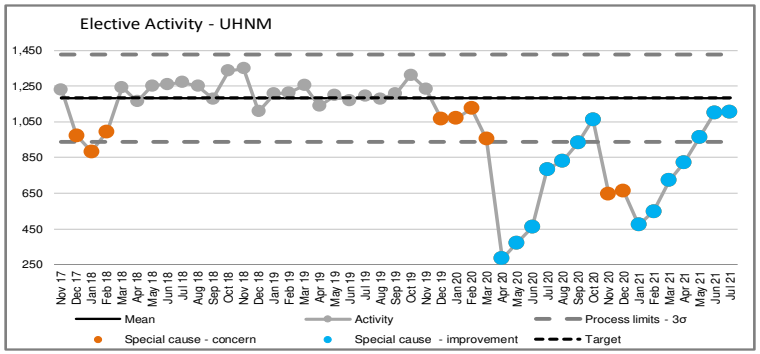
Planned care Outpatient



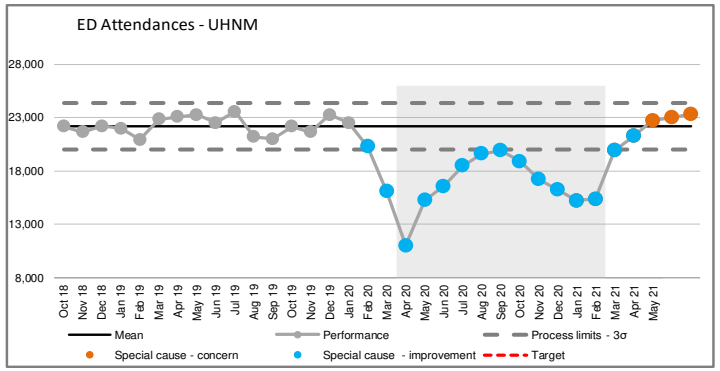


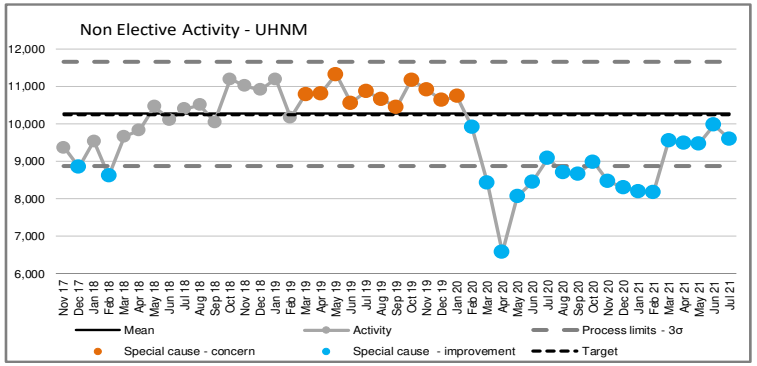
Planned care Inpatient





Urgent Care





Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

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To: Tracy Bullock
CEO
University Hospitals of North Midlands NHS Trust

CC: ICS Lead
Ambulance Service Chief Executive
Trust Chair
CCG Accountable Officer

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

26 October 2021

Dear Tracy

For action – Addressing ambulance handover delays

We are writing to all Trusts and ICSs regarding delays in handing over responsibility for the care of patients from ambulances to Emergency Departments, recognising that these delays can only be addressed through good system working and cross-organisational cooperation.

In the UEC Recovery 10 Point Action Plan we asked that ICSs "make sure there are robust steps in place to avoid handover delays". We know, and are grateful, that staff within your system are already working incredibly hard to resolve this problem. Given the impact on patients, we must however press to identify further solutions to eliminate all handover delays.

Handover delays

National policy has set out that handovers should take no more than 15 minutes, ensuring patients receive necessary emergency care and allowing ambulances to get back on the road responding to patients in the community.

You will be keenly aware of the risks associated with hospital handover delays.

Acute trusts should take responsibility for patients from when the ambulance arrives and ED staff are informed of arrival, regardless of the patient's exact location. In practice, there is a need for close cooperation and risk sharing between services.

Taking action to eliminate delays

All systems must take action to ensure that ambulances are not used as additional ED cubicles, and that crews are able to safely offload their patient to the care of the ED. It is important that patient safety is prioritised and as a result we emphasise that corridor care is unacceptable as a solution.

We are now asking you to work together as a system and agree what actions you would need to take to immediately stop all delays. We appreciate that this may involve some difficult choices, and that we will need to discuss and involve colleagues, including the CQC, where helpful. For ease of reference we are attaching a list of

measures which we know that some of you have implemented which have demonstrated clear benefits.

Today we also are asking Trusts, and their Systems, to report the actions that they have put in place to ensure delays have been eliminated in all Board Meetings, taking time to discuss the challenges with data to support the issue. You may find it helpful to invite clinical staff from the relevant areas to join these discussions.

In addition to the above, because of the significant problems being experienced on the Royal Stoke University Hospital *s*ite, we need to ask that you urgently have a conversation with your Regional Director to review the actions you may need to take to eliminate these delays. We appreciate that this is not an easy ask, as referred to above some of these actions may have implications and we may need to have a dialogue in order to find the best way forward. We anticipate that these conversations should take place w/c 1 November, and will result in an agreed plan for the system.

This should not deter you from continuing to taking action to address immediate delays prior to this date.

Initiatives being used in systems

The following is not exhaustive, and a combination of initiatives is likely to be most effective:

- Establish surge capacity / priority admission unit to care for patients out with ED following a decision to admit; this may require conversion of existing space, or temporary accommodation, within the acute trust to accommodate patients prior to admission to the appropriate ward
- Wherever practical implement “fit-to-sit” for patients that do not require a trolley
- Ensure early access to clinical decision-makers to enable prompt admission / discharge
- Establish additional community capacity to enable earlier discharge for patients no longer requiring acute medical care
- Increase capacity of discharge lounge to free beds earlier in the day, accompanied by rapid support from non-emergency patient transport services
- Maximise discharge through following principles within the hospital discharge and community support: policy and operating model
- Increase direct access to GP streaming, SDEC, acute frailty services and medical / surgical assessment units from ambulance crews to reduce direct ED conveyance
- Match community and mental health service capacity and demand to enable reduced conveyance to ED for appropriate patients
- Work with two hour community crisis response teams to offer appropriate alternative pathways to an ambulance response
- Local agreement of staffing models e.g. using acute trust, ambulance service and community service staff in partnership to support surge capacity

- Making use of HALO staff to support handover of care, or working with ambulance services to explore whether Community First Responders are available to take on additional roles to support care for patients
- Work with Provider Collaboratives and ambulance services to support boundary changes and diverts, where this will help to decompress a site

We thank you for taking this necessary rapid action to address the risks associated with handover delays.

Yours sincerely,

Pauline Philip DBE
National Director for Emergency and Elective Care

Professor Steve Powis
National Medical Director

Dale Bywater
Regional Director Midlands

Audit Committee Chair's Highlight Report to Board

October 2021

1. Highlight Report

Matters of Concern or Key Risks to Escalate

- Review of Divisional Governance has concluded with Partial Assurance; a restructure of the Divisions is underway and expectations are going to be reset as part of that process
- There were a number of actions identified within the Audit Tracker Report where delays to implementation had been identified; explanations for any delays were provided
- Some concern around slippage in the review of some Trust Policies although the Committee were assured that actions are in place to improve the position
- The Transformation and People Committee escalated Workforce Planning to the Committee with a view to Internal Audit review being undertaken; this was agreed for commencement in December
- Performance and Finance Committee raised concerns with regard to non-elective performance which it was noted would be part of the discussion at Board through the Integrated Performance Report and the Highlight Report
- Fraud associated with working from home has been identified as a key risk (3/4 referrals) – work is being undertaken to improve communication and awareness, along with systems associated with Return to Work discussions
- Losses and special payments made during the period July to September 2021 is £145, 518 and £287, 324 year to date – work is ongoing with Divisions to improve this position, in particular with the Interventional Radiology Department where a significant loss of stock was reported

Major Actions Commissioned / Work Underway

- Information on the amount of income generated as a result of improved processes for recovering income for the treatment of overseas patients
- Further support to be given to the Divisions in oversight and implementation of the issues arising from the Internal Audit Report, this includes some quicker wins in terms of review of Terms of Reference along with some medium term improvements
- Job Planning Policy under review and will be presented to the LNC for approval in December
- Work has commenced on the refresh of the Quality Strategy, between the Medical Director and the Chief Nurse
- Declarations of Interest received year to date are at 70% response rate and so we have reached our escalation process which is currently underway
- Improvements to the format and function of the BAF continue to be made and a plan is in place to make further changes for the Q3 BAF, with assurances linking directly back to the Committee agendas. Further focus will be through Board Development on targets and Risk Appetite.
- 21/22 External Audit cycle has now commenced in terms of the planning cycle
- A report will be taken to the Executive Team with regard to Single Tender Waivers and SFI breaches which covers those that sit within Central Functions and are not picked up via Divisional Performance Reviews

Positive Assurances to Provide

- Internal Audit reports for Overseas Patient Process follow up and Consultant Job Planning have concluded with Reasonable Assurance; the Medical Director provided an overview of his plans to address this which included a review of the Trust Policy
- The Quality Governance Committee escalated positive assurance in relation to Research & Innovation and the improvements made.
- Very positive levels of engagement with the Trust highlighted by the Counter Fraud Team
- A review of pre-employment compliance checks has concluded that there are proportionate procedures in place to mitigate pre-employment fraud

Decisions Made

- Some minor changes to the Internal Audit plan were agreed
- Approval of Trust Policy G01 for the Development and Review of Trust Policies
- Approval of the Board Assurance Framework for Q2

Comments on the Effectiveness of the Meeting

- Meetings will continue to be held online although this will remain under review.
- All participants agreed they felt able to contribute to the meeting
- Pleased with the reports provided by RSM Tenon

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Internal Audit Progress Report • Overseas Patient Process • Consultant Job Planning • Divisional Governance	Assurance	6.	G01 Development and Control of Policies and Procedures	Assurance
2.	Internal Audit Recommendation Tracker	Assurance	7.	External Audit Progress Report and Sector Update	Assurance
3.	Corporate Governance Report	Assurance	8.	LCFS Progress Report	Assurance
4.	Board Assurance Framework Q2	Approval	9.	Losses and Special Payments Q2 21/22	Assurance
5.	Issues for Escalation from Committees	Assurance	10.	SFI Breaches and Single Tender Waivers Q2 21/22	Assurance

3. 2021 / 22 Attendance Matrix

			Attended	Apologies & Deputy Sent	Apologies
Members:			Apr	Jun	Jul	Oct	Jan
Prof G Crowe	GC	Non-Executive Director (Chair)					
Mr P Akid	PA	Non-Executive Director					
Ms S Belfield	SB	Non-Executive Director					
Attendees:							
Ms N Coombe	NC	External Audit					
Mr G Patterson	GP	External Audit					
Mr A Bostock	AB	Internal Audit - KPMG					
Ms A Khela	AK	Internal Audit - KPMG					
Mr S Stanyer	SS	LCFS - KPMG					
Mr M Gennard	MG	Internal Audit - RSM					
Mr A Hussain	AH	Internal Audit - RSM					
Ms A Deegan	AD	LCFS - RSM					
Mr J Dutton	JD	Corporate Governance Officer (Minutes)					
Mrs N Hassall	NH	Deputy Associate Director of Corporate Governance					
Mr M Oldham	MO	Chief Finance Officer					
Mrs S Preston	SP	Strategic Director of Finance					
Miss C Rylands	CR	Associate Director of Corporate Governance					

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	3rd November 2021
Report Title:	Quarter 2 Board Assurance Framework	**Agenda Item:**	16.
Author:	Claire Rylands, Associate Director of Corporate Governance		
Executive Lead:	*Chief Executive, Chief Nurse, Chief Operating Officer, Chief Finance Officer, Director of HR*		

Purpose of Report:

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

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

Executive Summary:

Situation

The Board Assurance Framework (BAF) provides a structure and process to enable the Board to focus on the key risks might compromise the achievement of our Strategic Priorities. The BAF has been updated for Quarter 2 21/22 and was presented to the Committees of the Board during October for scrutiny and approval.

Background

The Strategic Risks identified within the BAF were refreshed by the Executive Team and endorsed by the Board at the start of 21/22. As part of our Risk Management Improvement Programme, the BAF is continuously refined in order to ensure that it meets the needs of the Board. This is tested by our Internal Auditors on an annual basis and the findings of their review form the basis of our ongoing improvement programme.

Assessment

There are a number of changes to the format BAF for Q2 and these are detailed within the report; to summarise:

- Addition of a section to capture gaps to be addressed in order to meet the target risk scores
- Updates to the BAF are identified in blue text for ease of identification
- Refreshed links to the Risk Register and inclusion of a summary Risk Register at appendix 3
- A revised approach to the Strategic Risk Heat map with supporting narrative

Key Conclusions:

- A review of risk scores at Quarter 2 has demonstrated an increase in some risk scores, which are reflective of current operational and workforce challenges. The 3 most significant risks are in relation to 1) Delivering Positive Patient Outcomes, 2) Sustainable Workforce and 3) Delivering Responsive Patient Care – all of which are now scored as Extreme 16.
- The Strategic Risk Heat Map identifies our Strategic Priorities for 'High Quality' and 'Responsive' are currently under the most significant threat to achievement.

Key Recommendations:

- Consider the Quarter 2 BAF and confirm whether it is satisfied that the risk scores are an accurate representation of our current position, and whether there is sufficient action being taken to mitigate these risks.
- Approve the Q2 BAF

NHS
University Hospitals of North Midlands
NHS Trust

Board Assurance Framework (BAF)

Quarter 2 2021/22

1. Introduction

Situation

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

Background

The Strategic Risks contained within the 2021/22 BAF were agreed initially by the Executive Team and then endorsed by the Board at a development session ahead of the start of the new financial year. These strategic risks were a refinement of those agreed for the 2020/21 BAF, given the significant overhaul undertaken in early 2020 just ahead of the Covid-19 pandemic.

Assessment

Significant work has been undertaken to improve the format and function of BAF and our risk management processes over recent years and this has resulted in three consecutive annual reviews undertaken by our Internal Auditors concluding with a rating of 'Significant Assurance with Minor Improvement Opportunities'. These findings have contributed to the positive and improved overall Head of Internal Audit Opinion for 2020/21 of 'Significant Assurance with Minor Improvement Opportunities'. A programme of risk management improvement remains an ongoing focus for the organisation and this will continue throughout the course of 2021/22. However, we continue to improve the format and function of the BAF and will do this on an ongoing basis in order to optimise its effectiveness.

At Quarter 1, we took into account recommendations made by our most recent Internal Audit Review, including an indicators of whether the risks identified are 'internally or externally driven'. We also included the Risk Appetite Matrix (appendix 2) as a reference point; this is used to determine the target levels of risk.

Key Changes to the BAF at Quarter 2

1) When updating the BAF for Quarter 2, further consideration has been given to the **scoring of risk**. This has resulted in some key changes to levels of risk identified, placing our 3 most significant risks as follows:

   - BAF 1 – Delivering Positive Patient Outcomes (Extreme 16)
   - BAF 3 – Sustainable Workforce (Extreme 16)
   - BAF 6 – Delivering Responsive Patient Care (Extreme 16)

   This is to reflect the operational pressures being faced by the organisation and is captured within the BAF in the 'rationale for risk score' sections. The target risk score for BAF 6 'Delivering Responsive Patient Care' has also been revised from Moderate 6 to High 12 as this is deemed to be a more realistic target for this year based upon the current position.

2) Following discussion at the Audit Committee, a new section has been added to each section of the BAF, '**Gaps in Control or Assurance**'. Within this section, Executive Leads have identified the key gaps which need to be addressed in order to meet the target risk score.

3) To assist in the **identification of key changes** since the Quarter 1 BAF was presented; any new information is displayed in blue text. This includes changes to the risk rationale, controls, assurances, gaps to be addressed and action plan.

4) A refresh of **links to the Risk Register** has also been undertaken. This now includes risks which have been reported to Executive Groups, scoring 12 or above which have been escalated by Divisions. This is following the development of a new style summary report for Executive Groups, which has been further refined for consideration by Committees of the Board (appendix 3). Whilst the content of this information is limited (due to them being operational risks rather than strategic), the aim is to provide Committees of a high level overview of risks being managed at an operational level. It should be noted that the full risk assessments are considered through divisional governance arrangements and at the Executive Groups. Risks also form part of the Performance Management Review process.

5) A revised approach to the **Strategic Risk Heat Map,** with supporting narrative to describe the level of threat posed to our Strategic Priorities. If deemed to be of benefit, further analysis could be included within future reports which looks more specifically into the levels of likelihood and consequence of threat to our Strategic Priorities.

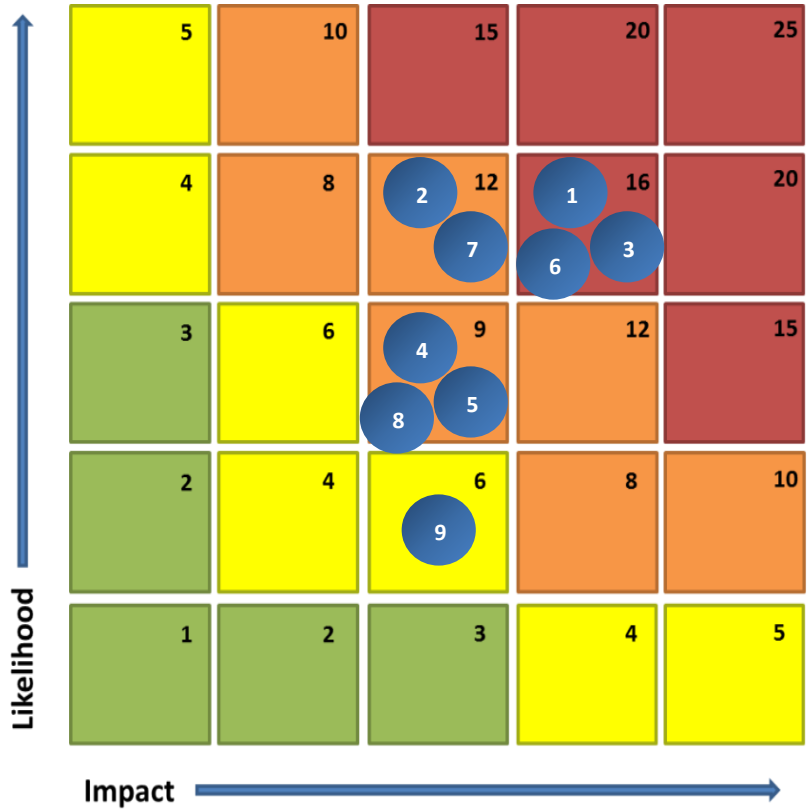
Key to 'BRAG' Ratings

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

2. Summary Board Assurance Framework 21/22

BAF	Summary Risk Title	Strategic Priorities	Q1			Q2			Q3			Q4			Target			Change
			L	C	S	L	C	S	L	C	S	L	C	S	L	C	S	
BAF 1	Delivering Positive Patient Outcomes	Quality ●	3	3	High 9	4	4	Ext 16							2	2	Mod 4	↑
		Responsive ●																
		People																
		Improving ●																
		System																
		Resources																
BAF 2	Leadership, Culture & Delivery of Trust Values & Aspirations	Quality ●	3	4	High 12	3	4	High 12							2	3	Mod 6	→
		Responsive																
		People ●																
		Improving																
		System																
		Resources																
BAF 3	Sustainable Workforce	Quality ●	3	4	High 12	4	4	Ext 16							3	3	High 9	↑
		Responsive ●																
		People ●																
		Improving																
		System																
		Resources ●																
BAF 4	System Working – Vertical	Quality ●	3	3	High 9	3	3	High 9							2	3	Mod 6	→
		Responsive ●																
		People																
		Improving																
		System ●																
		Resources																
BAF 5	System Working – Horizontal	Quality ●	3	3	High 9	3	3	High 9							2	3	Mod 6	→
		Responsive ●																
		People																
		Improving																
		System ●																
		Resources ●																
BAF 6	Delivering Responsive Patient Care	Quality ●	4	3	High 12	4	4	Ext 16							4	3	High 12	↑
		Responsive ●																
		People ●																
		Improving																
		System ●																
		Resources ●																
BAF 7	Delivery of IM&T Infrastructure	Quality ●	3	5	Ext 15	3	4	High 12							1	5	Mod 5	↓
		Responsive ●																
		People																
		Improving																
		System																
		Resources ●																
BAF 8	Infrastructure to Deliver Compliant Estate Services	Quality ●	3	4	High 12	3	3	High 9							2	4	High 8	↓
		Responsive ●																
		People																
		Improving																
		System ●																
		Resources																
BAF 9	Financial Performance	Quality	2	3	Mod 6	2	3	Mod 6							1	3	Low 3	→
		Responsive																
		People																
		Improving																
		System ●																
		Resources ●																

3. Strategic Risk Heat Map



No.	Risk Title	Strategic Priorities
BAF 1	Delivering Positive Patient Outcomes	
BAF 2	Leadership, Culture and Delivery of Trust Values	
BAF 3	Sustainable Workforce	
BAF 4	System Working – Vertical	
BAF 5	System Working – Horizontal	
BAF 6	Delivering Responsive Patient Care	
BAF 7	Delivery of IM&T Infrastructure	
BAF 8	Infrastructure to Deliver Compliant Estates Services	
BAF 9	Financial Performance	

What does the Strategic Risk Heat Map tell us?

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

- **'High Quality'** is the most threatened of our strategic priorities, with 8 out of 9 strategic risks posing a threat to it and 3 of those risks are scored at Extreme 16.
- **'Responsive'** is the second most threatened of our strategic priorities, with 7 out of 9 strategic risks posing a threat to it, again 3 of those risks are scored at Extreme 16.
- **'System and Partners'** is the third most threatened of our strategic priorities in terms of the number of risks which pose a threat to it, which is 5 out of 9, however only one of those risks (BAF 6), is classed as Extreme.
- For **'People'**, whilst only 3 strategic risks have been identified as posing a threat to it, 2 of those 3 have been classed as Extreme.

4. Board Assurance Framework 2021 / 22

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

Risk Description

Cause	Event	Effect
If unable to achieve agreed safe staffing requirements for nursing, medical and AHPs	**Then** we may not be able to provide harm free care including the inability to reduce the number of nosocomial infections, pressure ulcers, falls and VTE	**Resulting in** avoidable patient harm, higher than expected mortality and poor patient experience and satisfaction.

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

Strategic Objectives and Risk Register

Impact on Strategic Objectives:	High Quality	✓	Improving and Innovating	✓	
	Responsive	✓	Systems and Partners		
	People		Resources		
Links to Risk Register	ID 8877: Avoidable Hospital Acquired Infections			High 12	
	ID 13419: Midwifery Safe Staffing			Ext 15	
	ID 21706: Safer Care Nursing Resource in SDU			High 12	

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	4			**Likelihood:**	3	31/03/2022
Consequence:	3	4			**Consequence:**	2	
Risk Level:	**High 9**	**Ext 16**			**Risk Level:**	**Mod 6**	
Rationale for Risk Level:	The risk remains above target due to acknowledged national and regional staff shortages in key professions as a result of historical vacancies and the continuing pressures from the COVID-19 pandemic. The target date and target risk level have been amended as the Trust is expected to continue to face ongoing staffing challenges throughout the winter 2021/2022.						

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Daily nurse staffing meetings to identify requirements and appropriate escalation of gaps and required support • Safer Staffing Tool completion twice daily by Ward staff • Local processes in place for medical and AHP staff to assess requirements and establishments • International Recruitment commenced and approval for c.70 nurses. • Senior leadership team in place for each ward and	• 6th monthly nurse staffing establishment reviews to ensure established nursing numbers match acuity • Validation of pressure ulcers undertaken by Corporate Tissue Viability Team • Validation of infections undertaken by Infection Prevention/Microbiology Teams • Datix and Root Cause Analysis (RCA) training available to ensure accurate reporting and investigation of patient harm. Bespoke sessions arranged within	• Annual External Audit of Quality Account • Registered and regulated by CQC • CQC Inspection Programme • Process in place with Commissioners to undertake Clinical Quality Review Meetings (CQRM) • NHSEI scrutiny of COVID-19 cases/Nosocomial infections/Trust implementation of Social distancing, Patient/Staff screening and PPE Guidance • 6 nominated Patient Safety Specialists participating with

	department, with overarching accountability for delivering quality and minimising hospital acquired harm • Falls Champion role in each Ward/Department. • Tissue Viability Link Nurses in each Ward/Department • Corporate Quality & Safety Team co-ordinate Improvement Programmes for Pressure Ulcers, Falls and VTE • Specific governance arrangements in place for Maternity Services, including compliance with CNST requirements. • Infection Prevention Team co-ordinate Improvement Programmes for infections, including Sepsis and Nosocomial COVID-19 infections • Training Programmes in place for all key harms • Patient experience team in place • Crude Mortality rates - monitoring and notification from Medical Examiner • Monthly Directorate Mortality and Morbidity meetings (M&M) are held to review deaths and discuss cases. • Agreed policies and procedures for the management of patients with mental health conditions and / or Mental Health Act	Divisions. • Root Cause Analysis (RCA) Scrutiny Panels in place for Serious Incidents, Pressure Ulcers, Patient Falls, Venous Thromboembolism (VTE) and Infections • Agreed reduction trajectories in place for each patient harm • Collaborative working in place with CCG representatives regarding harm reduction • Care Excellence Framework in place, with an identified schedule of annual visits to each Ward/Department, or more frequently if indicated • COVID-19 deaths have been included in the Trust's SJR process to allow for review of care provided to patients and identify any potential areas for improvement/learning • Mortality Review Panel for Definite Nosocomial COVID-19 deaths established by Deputy Medical Director to identify learning and good practice. Review commenced to identify ward status for inclusion in mortality reviews. • Nosocomial COVID-19 Infections will be subject to RCA and reported to the Infection Prevention Committee • A strengthened clinical governance framework including revised Terms of Reference for the Quality and Safety Oversight Group (QSOG) and Quality Governance Committee (QGC) remains in place • 'High Quality' identified as a Key Priority Domain for the UHNM Improving Together Programme • 52 week / 104 day Harm Review Panel process in place with CCG representation	development programme by NHSI as part of national NHS Patient Safety Strategy. Induction / Training • Full compliance for years 1 & 2 against CNST 10 Standards
Assurances:	• Safer Staffing Tool is live record of staff numbers against activity and acuity for individual ward • Quality dashboard available on Intranet • Quality dashboard and Patient Experience dashboard in place and included nosocomial infections during Q2 • Monthly Patient Safety Reports from Ward to Board • Serious incidents report provided to QSOG monthly including maternity related incidents • Improved timeliness of reporting monthly data agreed during June 2021 • Training Records available	• Red Flags and Datix Incident reports are monitored in relation to staffing shortages to allow for local action / escalation. • Scrutiny of staffing reports at Transformation & People Committee • National SitRep submitted for Nursing Fill Rate • Scrutiny of level of Patient Harm and Patient Experience within Executive-Led Divisional Performance Reviews on a monthly basis • Outcome letters as a result of Falls and Pressure Ulcer RCA Panels sent to Senior Sisters/Charge Nurses, Matrons and Associate Chief Nurses	• Internal Audit undertaken to review Trust's Incident Reporting and investigation processes. Final report received in Q4 with significant assurance and minor improvement opportunities

	at Ward and Corporate level • Care Excellence Framework Visit Reports shared with Ward and Divisional Teams • Mortality report to Mortality Review Group includes analysis of rates and outcomes from mortality reviews. • Monthly highlight reports from Trust Risk Management Panel to Patient Safety Group and QSOG • Presentation of annual M&M activity by Directorate Mortality leads at Mortality Review Group • Infection Prevention Board Assurance Framework – COVID-19 developed with regular reports to QSOG and QGC provided • Updated COVID-19 Mortality report to Mortality Review Group and QSOG • Quarter 2 update to be provided to Mortality review Group in July 2021 • Quality Performance Report enhanced to include peer benchmarking where possible for quality indicators including nosocomial COVID-19 reporting	• Audit programme to monitor compliance with relevant Trust policies • UHNM Quality Account developed and published according to NHSEI Guidance on 30th June 2021 • Patient stories reported to the Trust Board on a monthly basis • Friends and family test results are reported and monitored on a regular basis • Maternity Services Board Assurance Framework in place.	

Gaps in Control or Assurance
What are the gaps to be addressed in order to achieve the target risk score?
• CQC Regulatory Actions to be addressed • UHNM Policies and Procedures for management of patients under Mental Health Act require review following CQC inspection • Further work required to seek assurance from the 52 week / 104 day Harm Review process

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

No.	Action Required	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	To develop Trust Patient Safety Incident Review Plan (PSIRP) and engagement of Patient Safety Partners to support review and patient involvement in Trust quality meetings.	Chief Nurse & Medical Director	30/06/2022	National PSIRF guidance has been updated following COVID-19 with amended dates and learning from early adopters. This is under review and inclusion in UHNM PSIRP. National timescale is to implement in 2023	
2.	To complete the recruitment of 70 international nurses	Chief Nurse	31/03/2022	On schedule to recruit 70 nurses with plans for between 10 and 15 per month to start. 3rd cohort to arrive November 2021. 17 newly recruited international nurses from this programme have commenced in practice	
3.	To implement Perfect Ward audit system and app	Chief Nurse	31/03/2021	Perfect Ward project has been approved and shared with Executives and NEDs. Project Plan under development.	
4.	To respond and action: • Section 29a received via CQC	Chief Nurse	30/11/2021	Reviewing evidence to confirm factual accuracy and response to	

	during inspection commenced via 23/08/21 • Existing Section 31			CQC by 14/10/21. Weekly updates on Section 31 to CQC. Triage times not at required times.	
5.	Policies and Procedures for the Management and care of patients with mental health conditions and / or under the Mental Health Act to be reviewed and updated.	Chief Nurse	30/11/2021	Review commenced and policies to be agreed via appropriate governance forums.	

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

Risk Description

Cause	Event	Effect
If we are unable to ensure the leadership culture reflects our values and aspirations	**Then** a negative cultural environment could be established	**Resulting in** an adverse impact on patient care, staff disengagement and ineffective performance.

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

Strategic Objectives and Risk Register

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

Links to Risk Register	ID 9151 Mismatch between Trust culture and values	**High 9**
	ID 9149 If staff don't feel supported, listened to and valued	**Mod 6**

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3			**Likelihood:**	2	March 2022
Consequence:	4	4			**Consequence:**	3	
Risk Level:	**High 12**	**High 12**			**Risk Level:**	**Mod 6**	

Rationale for Risk Level:

- Covid-19 pandemic meant that a significant portion of development & talent activities were postponed. The impact of socially distanced training and suitably sized training space has been challenging in the delivery of both leadership development training
- There continues to be a significant uplift in Divisions requesting OD support. Plans have been created for each Division with limited capacity for direct OD consultant support
- Although there was no improvement in the staff engagement rate, there were two statistically significant improvements in the 2020 staff survey scores concerning Health and Wellbeing and Safe Environment – Bullying and Harassment. There was no statistically significant change in the remaining 8 themes.
- Staff sickness rates remain high, but stable. Turnover and vacancy rates remain steady
- **The independent review commissioned to investigate the concerns raised by medical staff regarding bullying and harassment is underway. The risk score may be revised once the outcome of this review is known.**

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Staff Voice pulse check survey implemented from June 2021 • Divisional Staff Engagement Plans set out the tailored actions to improve staff experience • Improving Together programme – Staff engagement A3 is developed	• People Strategy and supporting HR Delivery Plan, with performance reported to Transformation and People Committee. The HR Delivery Plan has been updated to take account of the actions required to support the NHS People Plan and ensure alignment of objectives • Partnership working with the STP is in place to introduce a range of Recruitment and	• National Quarterly Pulse Survey implemented from July 2021 The 2020 Staff Survey results showed there were two statistically significant improvements in the 2020 scores when compared to the previous year's data concerning Health and Wellbeing and Safe Environment – Bullying and Harassment. There was no

		Retention initiatives • The Trust has set targets for staff engagement rates; sickness and turnover. Actual performance is monitored on against target.	statistically significant change in the remaining 8 themes. • At 6.9, the staff engagement score remains just below the acute trust average of 7.0. This is unchanged from the previous year • There was improvement in staff recommending the Trust as a place to work (from 60.4% to 64.3%) and in recommending the organisation as place to receive care (from 73.8% to 76.2%).
Assurances:	• Annual NHS Staff Survey – At 6.9, the 2020 staff engagement score remained just below the acute trust average of 7.0. • The Trust staff engagement rate from the 2020 NHS Staff Survey shows a higher level of engagement from BAME staff: **Ethnicity** / **Staff Engagement Score** BME 7.4 White 6.9 Blank 6.8 UHNM Overall 6.9 Acute trust Average 7.0 • HRBP's report actual performance to Divisional Boards and Divisions are held to account via Performance Reviews • The diagnostic phase of the NHSi Culture and Leadership Programme commenced in 2019/20 and will provide an additional indicator of staff engagement. This programme was suspended during Covid and has now been reinstated • Feedback from staff is received via listening events, Facebook live comments. senior leadership team walkabouts, and the Chief Executive's 'Time to Talk' sessions	• The Trust monitors how effectively we address any gaps in the treatment and experience of our Black, Asian and Minority Ethnic (BAME) workforce through the Workforce Race Equality Standard (WRES), and our Disabled workforce through the Workforce Disability Equality Standard (WDES). • We have three active Staff Networks, the Black, Asian and Minority Ethnic (BAME) Staff Network, the LGBT+ Staff Network and the Disability Staff Network. Our Staff Networks each have an Executive Sponsor. • Monthly reports are provided to Transformation and People Committee detailing hard to recruit posts and long term agency. Agency costs are reported in the monthly Finance Report to Performance and Finance Committee • The Executive Workforce Assurance Group is in place Analysis of data and historic trends, reported in monthly performance reports to TAP and Trust Board show that, as at 31 May 21, • The in-month sickness rate was 4.55% (4.23% reported at 30/04/21). The 12 month cumulative rate reduced to 5.05% (5.21% at 30/04/21). Sickness and covid-related absences continue to be monitored daily. Staff showing symptoms, or with household members showing symptoms, are tested and results returned within 24-48 hours. As of 9th June 2021, covid-related open absences numbered 81, which was 13.46% of all absences (8.32% at 11th May 2021) Actions towards improving sickness rates are being developed through the Improving Together Programme and A3 process. Divisional Teams are developing their own A3's with their specific actions to address sickness and improve compliance with completing call backs and return to work interviews via the Empactis System. • The turnover rate was 9.50% and the overall Trust vacancy rate, calculated as Budgeted Establishment less staff in post, was 7.86%, both of which	To address the findings of the Staff Survey, corporate priorities planned for 2021/22 are aimed at continuing the improvements in organisational culture and maximising the potential of our people to improve patient outcomes, the Trust wellbeing plan has been refreshed and updated • The wellbeing offer is updated weekly and includes Listen and Learn events • The Trust has commissioned 5 x 6-week Covid rehabilitation courses from our Occupational Health provider, TP Health. The course includes education and psycho-education, followed by pulmonary rehabilitation exercises and mindfulness based relaxation • The Staff Psychological and Wellbeing Hub opened on 14th May. As at 25th June, there had been 21 UHNM staff referrals, of which 15 had received assessments, 2 had planned assessments and 4 were awaiting responses. • The results of a medical staffing survey, sent out from the Local Negotiation Committee (LNC) to all UHNM doctors, raised a number of concerns regarding bullying or harassment. Staff have been urged to speak up using the Freedom to Speak Up Guardian confidential service or formal HR route. Additionally, the Trust has commissioned a review to gain an understanding of the issues raised by the LNC Survey - this involves a full review of all staff groups to understand the extent of bullying and harassment and importantly action that can be take • Our Gender Pay Gap report shows the difference in the average earnings between

		remain consistent with previous months	all men and women employed at UHNM and the actions we are taking to further reduce the gender pay gap. We also participate in the Stonewall Workplace Equality Index as measure of our commitment to LGBTQ+ equality. • The system has submitted a bid to take part in a pilot programme called 'Scope for Growth – Career Conversations'. The aim is to create a framework for a structured career development conversation between an individual and their line manager. This will be supported by the Trust should the bid be successful. • The Trust has signed up to the National People Pulse Survey from July 2021.

Gaps in Control or Assurance
What are the gaps to be addressed in order to achieve the target risk score?
• Rates of staff engagement based on our staff survey and outcomes are now 12 months out of date, although ongoing staff perceptions are measured through the Staff Voice Survey and staff focus groups / staff feedback • The 2021 survey is underway and a communications campaign is underway to encourage an improved response rate, which will provide more accurate survey outcomes , the updated results will be available in March 2022 • To provide a current measure, consideration should be given to updating the Staff Voice Survey to include a staff engagement indicator • Through Improving Together, there is a process to improve sickness absence although performance in this area is yet to be reported • The independent review commissioned to investigate the concerns raised by medical staff regarding bullying and harassment is underway – the risk score may be revised once the outcome of this review is known

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

No.	Action Required	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	Resume the Trust-wide cultural analysis	Director of Human Resources	31/03/22	***The programme was suspended during the Covid-19 pandemic*** The first stage of the programme was completed, with feedback shared with the Executive Team in January 21. This will inform the OD plans going forwards. The programme has now recommenced	
2.	Implement a UHNM plan relating to the launch of the "Leadership Compact" document within the NHS People Plan	Director of Human Resources	TBC once the national Leadership Compact is released	Development of the Leadership Compact will commence on completion of the Culture analysis, which was ***suspended during the Covid-19 pandemic*** The Leadership Compact has not yet been released nationally	
3.	Leadership and Management Development offer: Internal and External offer focus on managers across the Trust to ensure a competency level is embedded	Director of Human Resources	31/03/2022	Leadership and Management Development is in progress and will be on-going throughout 2021/22 • Plans include for all new managers into the Trust to complete GTM/GTL within 3 months of commencing. • Following the staff survey results regarding middle manager competencies, a business case has been developed to provide for resources to ensure existing managers are developed and is awaiting approval.	
4.	Work with members of the Quality Improvement Academy to deliver "Improving Together to	Director of Human Resources	31/03/23	Coaching sessions continue with the Executive Team and an External coach has been confirmed for next session on 28th June. The **Positive & Inclusive Culture A3** continues	

	Deliver Exceptional Care" and lead on those aspects linked to leadership behaviours and cultural change			through the development process, where the drive metric will be the staff engagement rate	

BAF 3: Sustainable Workforce

Internally Driven	✓
Externally Driven	✓

Risk Description

Cause	Event	Effect
If we are unable to sustain our workforce at the required levels, taking into account the impact of Covid on staff resilience and retention,	**then** we may not have staff with the right skills in the right place at the right time,	**resulting in** adverse impact on patient outcomes, increase in premium costs, staff disengagement and inability to take forward continuous improvement and innovation.

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

Strategic Objectives and Risk Register

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

Links to Risk Register		
	ID 8580: Medical staffing for the Emergency Department (both sites)	**Ext 20**
	ID17977: Reduced staffing in Cancer Centre Pharmacy	**Ext 16**
	ID 10868: T&O Junior Doctor Staffing Gaps	**High12**
	ID 13419: Midwifery Safe Staffing	**Ext 16**
	ID 20809: NMCPS Histology Admin Capacity	**Ext 16**
	ID 8451: Trauma Directorate Nursing Workforce	**High 12**
	ID 18039: Consultant Rota Children's ICU	**High 12**
	ID 18093: Nurse Staffing within the NNU	**High 12**

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	4			**Likelihood:**	3	March 2022
Consequence:	4	4			**Consequence:**	3	
Risk Level:	**High 12**	**Ext 16**			**Risk Level:**	**High 9**	

Rationale for Risk Level:

- The increase in the level of risk (likelihood) is based on some of the workforce and staffing challenges the Trust is now experiencing
- Although there are good plans in place to mitigate risks, with additional recruitment taking place, the need to open additional capacity through winter and the ongoing staffing pressures, due to sickness levels and vacancies, is currently playing against the plans

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Workforce planning process ensures alignment with activity and financial plans • Actions to improve staff experience are detailed in Divisional Staff Engagement Plans • Ongoing recruitment processes • Rotas and rota coordinators management of roster processes	• The Trust's People Strategy is supported by an HR Delivery Plan, with improvement activities cascaded via Divisional People Plans. With the release of the NHS People Plan in July 2020, the HR Delivery Plan has been reviewed and updated to ensure alignment of objectives. The HR Delivery Plan sets out what we aim to deliver to support the national 'People	• The workforce planning process ensures alignment of workforce with activity and financial plans. A Phase 3 Restoration and Recovery Workforce Plan has been produced in line with NHSi requirements. The Plan was amalgamated with

	• Directorate and divisional management teams monitor staffing levels • Chief Nurse staffing reviews • Annual NHS Staff Survey • The first UHNM Staff Voice has been released. This is a monthly staff survey designed to help understand key issues important to staff about wellbeing, making improvements to where they work and the way they provide patient care • National Quarterly Pulse Survey implemented from July 2021 **Digital Agenda:** The draft People Digital Strategy for the NHS was released in September 2021 and sets out draft commitments for the next 3 years. The Digital Agenda is a system-led work programme initially covering the roll out of a Digital Staff Passport to hold staff 'verified employment and training credentials'.	Plan' 4 pillars of activity, which outlines what people can expect from the NHS, from their leaders and each other. • The system led workforce demand and supply process remains in place and will continue to manage redeployment of staff where required, as well as system wide recruitment initiatives. The Trust continues to progress its own recruitment plans as well. • The Workforce Bureau has been reconstituted to manage the upsurge in workforce risks and issues. • The Winter is plan out to advert and / or in process of being recruited to • We have an Established Bank – including Nursing, Medics and other staff groups • Business cases are progressing to address staffing in ED, Anaesthetics and Critical Care and other hotspots • Medical rotas are reviewed, vacant shifts covered where possible from doctor bank and agency, adverts out for Trust grades where applicable. Locums are used / recruited to fill gaps where necessary • Weekly meetings take place with Medical Staffing to review rotas, gaps and progress against recruitment • Processes are in place to request mutual aid from across the System • General recruitment drives are on-going and there is an element of head hunting via informal networks • Golden Handshakes and handcuffs can be used for new starters **Digital Agenda:** The Trust has volunteered to participated in a trial of the digital staff passport. This will involve identifying doctors training who are due to rotate in the Spring/Summer of 2022. As confirmation of acceptance on to the pilot has not yet been received, no actions are arising at this time.	those of other system partners and submitted to NHSi as a system plan. For UHNM, this incorporates the resource required for the Winter Plan. • The *COVID-19 Staff Shortage Contingency Arrangements*, a sub-plan to the Trust's Business Continuity Plan, is in place. This specific Business Continuity plan details the processes that will be put in place within the operational settings of each Division to manage a disruption of service delivery as a result of staff shortages and is supplemented by the *Disruptive Incident Staffing Plan and Operational Workforce Plan*. The plan has been noted as a specific source of assurance on the Board Assurance Framework • Internal redeployment and volunteer process are place to offer support to areas of need and partnership working with the STP continues with system-wide processes for mutual aid and redeployment of staff where possible. • The 2020 Staff Survey results showed there were two statistically significant improvements in the 2020 scores when compared to the previous year's data concerning Health and Wellbeing and Safe Environment – Bullying and Harassment. There was no statistically significant change in the remaining 8 themes. ○ At 6.9, the staff engagement score remains just below the acute trust average of 7.0. This is unchanged from the previous year ○ There was improvement in staff recommending the Trust as a place to work (from 60.4% to 64.3%) and in recommending the organisation as place to receive care (from 73.8% to 76.2%). To address the findings
Assurances :	• HRBPs report actual performance to Divisional Boards and Divisions are held to account via Performance Reviews • Chief Nurse regular reports on Staffing Levels and use of the safe staffing tools	**Staffing Levels and Recruitment** • Monthly reports to Transformation and People Committee cover hard to recruit posts and long term agency and Agency costs are reported in the monthly Finance Report to Performance and Finance Committee • 95 overseas nurses accepted under the International nurse recruitment programme and are joining the Trust in cohorts. They work as Nursing Assistants until they qualify for their PIN • Recruitment continues to reduce Healthcare Support Worker vacancies to zero and we have now commenced a month long campaign to recruit registrants on to the Nurse Bank with support from Indeed – with separate adverts for nurses, midwives and ODPs • Analysis of data and historic trends,	

		reported in monthly performance reports to TAP and Trust Board show that, as at 31 August 2021 • We have implemented a ***Just & Learning Culture*** approach promoting a culture of fairness openness and learning where staff feel confident to speak up supporting staff when things go wrong so errors can be prevented from being repeated • We work closely with our education partners and continue to implement our Apprenticeship Strategy and Widening Participation initiatives in recognition of the need for clear educational pathways from schools and colleges into the NHS for clinical support, healthcare scientists, administration and nursing assistant roles. • We have well-established Banks for Medical Staffing, Nursing, Nursing support and Admin and Clerical staff • The Trust is supporting 30 of our Assistant Practitioners through a 2 year apprenticeship to become Registered Nurses and a further 10 nursing assistants on a 4 year apprenticeship to become Registered Nurses. • At 31st August 2021, the turnover rate was 9.26% and the overall Trust vacancy rate, calculated as Budgeted Establishment less staff in post, was 8.97%, both of which remain consistent with previous months. • 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 **Sickness levels and staff wellbeing** • The wellbeing governance structure is led by an Executive Director who oversees delivery of the wellbeing plan at corporate and local level. The Wellbeing Plan has been refreshed and updated. • The Empactis Absence Management System supports the delivery of a consistent approach to managing the key processes associated with health, absence and engagement. • Sickness and covid-related absences continue to be monitored daily. Staff showing symptoms, or with household members showing symptoms, are tested and results returned within 24-48 hours • Risk assessment processes remain in place and all ethnically diverse staff and Category C risk assessments will continue to be reviewed and updated if necessary. • The daily sickness sitrep highlights wards and areas with high numbers of	of the Staff Survey, corporate priorities planned for 2021/22 are aimed at continuing the improvements in organisational culture and maximising the potential of our people to improve patient outcomes • A new National quarterly 'People Pulse survey has been implemented from July 2021 • Workforce risks are reported via Datix and are monitored to ensure Divisional action and review. Divisions have recently reported increased staffing challenges due to operational pressures and the opening of additional capacity, combined with high sickness rates and vacancy levels.

		staff calling in as absent. This can then trigger the mitigating actions set out in the *COVID-19 Staff Shortage Contingency Arrangements*, and the *Disruptive Incident Staffing Plan and Operational Workforce Plan.* E-rostering systems are also used to identify areas where workforce capacity is a risk. • The in-month sickness rate was 5.30% at 31/08/21 and the 12 month cumulative rate was 5.18%. Sickness and covid-related absences continue to be monitored daily. Staff showing symptoms, or with household members showing symptoms, are tested and results returned within 24-48 hours. • Stress-related sickness absence remains the top reason for absence, although this does include both work-related and personal/domestic life stress. In the 12 months ending 31 August 2021, 28.4% of sickness absence was stress-related. The Trust has a comprehensive Wellbeing Plan in place to support staff with a focus on ensuring staff psychological wellbeing and wellbeing courses available from now until December 2021 have been promoted. • Covid related absences have increased slowly throughout August and into September and, as of 8th September 2021, covid-related open absences* numbered 187, which was 25.13% of all absences (21.52% at 11th August 2021) [*includes absences resulting from adhering to isolation requirements] • Actions towards improving sickness rates are being developed through the Improving Together Programme and A3 process. Divisional Teams are developing their own A3's with their specific actions to address sickness and improve compliance with completing call backs and return to work interviews via the Empactis System.	

Gaps in Control or Assurance
What are the gaps to be addressed in order to achieve the target risk score?
• Rates of staff engagement based on our staff survey outcomes are now 12m out of date, although ongoing staff perceptions are measured through the Staff Voice Survey and staff focus groups/staff feedback. • The 2021 staff survey is underway and a communications campaign is underway to encourage an improved response rate, which will provide more accurate survey outcomes. The updated results will be available in March 2022. • To provide a current measure, consideration should be given to updating the Staff Voice Survey to include a staff engagement indicator • To improve visibility of workforce demand, vacancy levels and workforce supply pipeline, additional information has been incorporated into the monthly workforce report to the Transformation and People Committee (from month 6) • A piece of work is to be carried out with the Divisions to obtain a clear overview of their operational workforce demand and supply concerns, together with details on how they are proposing to close the gap

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

No.	Action Required	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	Provide support and development to line	Director of Human	31/03/22	To support the Staff Survey improvement activity:	GA

	managers to enable them to develop their approach to management which includes leading agile workers.	Resources		Improving Leadership and Management Development and Visibility • The Leadership and Management Development programme has recommenced and will be on-going throughout 2021/22 • Management development sessions have been offered around managing/leading agile teams • An Agile Working Policy has been put in place The UHNM Staff Voice has been released. This is a monthly staff survey designed to help management understand key issues important to staff about wellbeing, making improvements to where they work and the way they provide patient care	
2.	Re-establish the Workforce Bureau to co-ordinate the response to current workforce issues.	Director of Human Resources	**Complete**	Workforce Bureau is meeting 3 times per week, with links into the Tactical Group, vaccination group and the System's Deployment and Resourcing Group, which meets twice weekly	**B**

BAF 4: System Working - Vertical

Internally Driven	
Externally Driven	✓

Risk Description

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

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

Strategic Objectives and Risk Register

Impact on Strategic Objectives:	High Quality	✓	Improving and Innovating		
	Responsive	✓	Systems and Partners	✓	
	People		Resources		
Links to Risk Register	n/a				
	n/a				

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3			**Likelihood:**	2	31 March 2022
Consequence:	3	3			**Consequence:**	3	
Risk Level:	**High 9**	**High 9**			**Risk Level:**	**Mod 6**	
Rationale for Risk Level:	• Work in progress to further extend our hugely successful procurement collaboration with a further acute Trust • Strategic direction with MCHFT now clear – need to formalise strategic approach with SaTH although Executive meetings now in place • UHNM Strategy has been delayed due to Covid • System strategy delayed due to Covid, recruitment to substantive CEO and considerable NHS reorganisation underway						

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• ICS Shadow Board in place • ICS Development Plan in place, approved by NHSE/I, with workstream and leads in place • ICS Director in post • System wide Executive Forum, • System Performance, Finance & Strategy Group • System workforce group • System quality group being re-established • Three system Place Based Partnerships • Provider Collaborative Workstream now on line,	• Transformation and Delivery Unit • ICS Workstreams • ICS Development Plan in place and approved by NHSE/I • Three Places developed with OD programme in place • CCG merger approved	• ICS designation plan approved by NHSIE • System Quarterly Performance Review Meetings (outcome shared with the Board, most recent October 2021)

	• Self-Assessment completed • Back Office Workstream in place		
Assurances:	• UHNM Chair, Chief Executive and Director of Strategy are members of relevant system groups / meetings • CFO/COO & DoS are members of Finance, Strategy & Operations system group • MD member of system wide Clinical Senate • System working regular UHNM Board and Executive Director meeting agendas	• Regular reports from TDU to Exec Forum in place but to be reviewed • UHNM internal reporting of system working in place but under review • Provider Collaborative workstream being led by UHNM CEO	• Assessments by NHS E/I

Gaps in Control or Assurance
What are the gaps to be addressed in order to achieve the target risk score?
• No substantive ICS Chief Executive • Revised governance and infrastructure note yet complete for transition into system wide ICP and NHS Board • Absence of system wide strategy • Consideration reorganisation of the NHS infrastructure underway

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

No.	Action Required	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	Appoint ICS Executive Lead.	NSC Director of Human Resources	01/10/21	Interviews will conclude on 15th October but successful candidates require ratification by the CEO of NHSE/I and the timeline of this is unknown at present.	**GA**
2.	Develop a revised Integrated Strategy for Health and Social Care	STP Director / Chief Executive	30/06/2021	Strategy development delayed due to Covid-19	**D**
3.	PLACE to develop a clear, agreed, strategic approach to population health management	STP Director / Chief Executive	System Action – Timeframe to be confirmed	Framework for use of Population Health Data in place. CCG developing system population health data, timeline was end of September but not available as yet. This has been chased.	**GA**
4.	To revise workstreams in light of new planning guidance and ICS designation plan	STP Director / Chief Executive	30/07/21	Development plan in place and approved by regulators. Design Framework under review / discussion. Work plans to be reviewed as a result.	**GA**
5.	Provider Collaborative stocktake to be completed Presented to Performance, Strategy and Finance Group, Exec Forum ICS Board Variation and population health data to be collated and workstreams to be decided	UHNM Chief Executive	21/10/21	Stocktake complete. Data analytics under review in terms of expertise. In discussion with other systems and CSU as well as regulators to determine where the most appropriate expertise is. Paper to go to ICS Shadow Board in October.	**GA**
6.	Back Office Functions Workstreams to be agreed	CCG Chief Finance Officer	31/07/21	Workstreams agreed – action complete. HR, IT and Estates. Currently seeking representation/ leads and scoping will be undertaken to understand the art of the possible.	**B**

BAF 5: System Working - Horizontal

Internally Driven	
Externally Driven	✓

Risk Description

Cause	Event	Effect
If we do not effectively collaborate with other providers and commissioners (both within and out with the ICS)	**Then** some specialist services may become unsustainable and the opportunities to achieve economies of scale within clinical support functions could be lost	**Resulting in** unsustainable, fragmented, poor quality, inefficient and ineffective services that are not VFM.

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

Strategic Objectives and Risk Register

Impact on Strategic Objectives:	**High Quality**	✓	**Improving and Innovating**	
	Responsive	✓	**Systems and Partners**	✓
	People		**Resources**	✓
Links to Risk Register	n/a			
	n/a			

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3			**Likelihood:**	2	31 March 2022
Consequence:	3	3			**Consequence:**	3	
Risk Level:	**High 9**	**High 9**			**Risk Level:**	**Mod 6**	
Rationale for Risk Level:	• Work in progress to further extend our hugely successful procurement collaboration with a further acute Trust • Strategic direction with MCHFT now clear – need to formalise strategic approach with SaTH • UHNM strategy has been delayed due to Covid-19 • System strategy delayed due to Covid, recruitment to substantive CEO and considerable NHS reorganisation underway						

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Designated Lead for UHNM - Director of Strategy • Exec to Exec meetings - formalised with SaTH • Director of Stategy represents Trust on Spec Com discussions in respect of network development for Midlands • UHNM CEO leading system Provider Collaborative and self-assessment undertaken • Strategies for each Trust to be reviewed to ensure that strategic developments between UHNM / MCHFT and UHNM / SATH are taken into account	• Transformation & People Committee • Strategy and Transformation Group to be established to oversee Strategic Partnerships • Informal Exec to Exec discussions to be re-established post COVID with SaTH • Chief Executive is part of the NHS Midlands Clinical Strategy Group which is largely related to specialist services and has agreed to be part of a Task and Finish Group in respect of specialist cancer services. Therefore	• N8 Pathology collaborative completed successfully

	• Restoration and Recovery Plans robust and delivering	ensuring UHNM is contributing to and influencing developments.	
Assurances:	• Re-launch / development of governance and programmes of work will be reported through TAP with escalations to Trust Board • Trust Clinical Strategy development will be inclusive of strategic developments with other partners and the outcome of the Provider collaborative	• System working updates to the Board each month through the Chief Executive demonstrate that progress is in early stages of development. • Now a standing item on the Executive Directors meeting • Provider collaborative to report to system Finance, Performance and Strategy, Executive Forum and ICS Board • MCHFT focus is on Place / vertical integration. The arrangement we will have going forward will be contract / SLA monitoring only. There is no plan to change the current partnership arrangements and should other opportunity arise, MCHFT will consider all horizontal options.	

Gaps in Control or Assurance
What are the gaps to be addressed in order to achieve the target risk score?
• Variation data and population health management data required for the Provider Collaborative, still not yet available • Provider Collaborative Committee not yet established • Place Based Partnerships established but not still running effectively

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

No.	Action Required	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	Develop formal governance for a collaborative programme with SaTH	Director of Strategy	Post Covid	Update October 2021 – significant work underway on joint Adult Critical Care and Pathology collaboratives. No formal planned approach to strategic partnerships is yet in place.	**A**
2.	Refresh / development and agreement of UHNM Trust wide Strategy.	Director of Strategy	08/12/21	Strategic Framework identifying revised objectives and enabling strategies approved by the Board. Strategy development recommenced with the Clinical Strategy planned for presentation to the Board in December.	**GA**
3.	Review and interpretation of national operational planning guidance for 21/22.	Director of Strategy	31/05/2021	As guidance is released this is factored into strategy. Financial guidance for H2 received. Uncertainty remains until 2021/22 financial ask is clear. **Action closed.**	**B**

	BAF 6:	Delivering Responsive Patient Care	Internally Driven	
			Externally Driven	✓

Risk Description

Cause	Event	Effect
If we are unable to create sufficient capacity to deal with the increased accumulating backlog of patients as a result of Covid	**Then** we may be unable to treat patients in a timely manner	**Resulting in** potential patient harm and inability to recover services following the pandemic.

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

Strategic Objectives and Risk Register

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

Delivery of constitutional cancer quality standards	**Ext 16**
Increasing waiting list size and patients waiting greater than 18 weeks for treatment	**Ext 16**
Winter Plan – elective activity cancellations	**High 12**
Gynaecology 52 week wait patient numbers	**High 12**
Follow up Patient Backlog	**High 12**
Specialised Surgery Backlog	**High 12**
Patient Flow within the Emergency Department	**Ext 15**
Delayed Cancer Care UGI – Covid	**High 12**

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	4	4			**Likelihood:**	4	31/12/21
Consequence:	3	4			**Consequence:**	3	
Risk Level:	**High 12**	**Ext 16**			**Risk Level:**	**High 12**	

Rationale for Risk Level:

- Increased demand across non-elective, urgent and planned care pathways resulting in unprecedented use of theatres
- Reduction in activity across outpatients, theatre and diagnostic pathways due to implementation of infection prevention guidance
- Reduction in workforce due to household isolation and other sickness
- Recovery capacity and significant inability to staff the available resource to support elective recovery and other pathways
- Predictions for winter 21/22 outline a significant shortage of capacity across the system and although the winter plan mitigates some of that, more assurance is needed

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Reviewed theatre timetable to support critical care demand and focus on P1 and P2 patients • Revised contract with Independent Sector to transfer a higher volume of patients to ensure timely treatment and reduced waiting list to enable focus on more complex P2 patient	• Commissioning of In-sourcing provision to increase workforce cover to reduce loss of theatre capacity and enable traction on list continuity. • 7th Theatre at county being commissioned to sustain electives but full capacity is likely to be January 2022. • System Workforce Cell	• Winter bed and financial planning under way for early enactment of surge capacity to reduce occupancy • Bids prepared to support enablers for urgent care demand reduction across the system • Bids prepared to support elective recovery through increased throughput of critical

	clearance	scoping resources to support surge plans for Q3/4 for non-elective to enable ring fencing of elective capacity and workforce for elective plans.	care capacity
Assurances:	• Contract enacted with patient transfers for both Independent Sector providers • Independent Sector Transfer (IPT) Plan enacted with patients transferring (2500 Nuffield and 1750 Ramsay). • Additional ICF contracts to the value of £300k negotiated with both providers to support winter pressures and further discussions around non-ICF work to support oncology and radiology demand to offset service pressures	• Investment cases prepared for review. Oral surgery model already approved and Endoscopy continues – both will require funded extensions to the year end. • Investment in additional clinical audit / oversight resource to maintain waiting list vigilance required. Case to be drafted.	• Winter finance budgets approved with recruitment commenced from July 21. • Winter bed model draft completed for system discussions based on 3 scenarios. Awaiting confirmation of final draft.

Gaps in Control or Assurance
What are the gaps to be addressed in order to achieve the target risk score?
• Capacity available to ease management of non-elective / elective demand through winter • Increase in critical care capacity to ensure available resources for anticipated demand • Reduction in occupancy through enacting system winter plan

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

No.	Action Required	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1	Agreement and implementation of system wide winter plan.	Chief Operating Officer	3/11/21 (agreement)	To be taken to the UEC Board mid-October and the UHNM Board in November.	
2	UHNM winter plan to support non-elective and elective pathways.	Chief Operating Officer	31/11/21	Being developed through fortnightly winter planning meeting.	
3.	Implementation of 'winter ready' schemes to solve UHNM capacity.	Chief Operating Officer	31/11/21	6 week programme being oversee via Non-Elective Improvement Board.	
4.	Confirm funding available for elective recovery fund to support adult critical care expansion.	Chief Operating Officer	30/10/21	Bids submitted early October – funding to be confirmed.	
5.	Review UHNM bed portal to ensure appropriate allocation of nursing and medical resources.	Chief Operating Officer	30/10/21	Progress to be shared through UHNM update at Board.	
6.	Engage Independent Sector and Insourcing Teams for work during winter 21/22.	Chief Operating Officer	31/10/21	Commencing October with further initiative planned for November.	

BAF 7: Delivery of IM&T Infrastructure

Internally Driven	✓
Externally Driven	

Risk Description

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

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

Strategic Objectives and Risk Register

Impact on Strategic Objectives:	High Quality	✓	Improving and Innovating		
	Responsive	✓	Systems and Partners		
	People		Resources	✓	
Links to Risk Register	ID 20032: Pharmacy Windows 10 Compliance			**Ext 15**	
	ID 9036: Vulnerability to Cyber Attack			**Ext 15**	

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3			**Likelihood:**	1	31/03/22
Consequence:	5	4			**Consequence:**	5	
Risk Level:	**Ext 15**	**High 12**			**Risk Level:**	**Mod 5**	

Rationale for Risk Level:

- Cyber Security remains a real and relevant threat to the NHS.
- The likelihood of the risk continues to remain static whilst the consequence has been reassessed.
- If the organisations infrastructure and clinical systems are not adequately protected from either targeted or indirect Cyber-attack the greatest risk is on delivery of clinical services and potential disruption, however there are business continuity and back up processes in place.

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Investment already made in enhanced Cyber Tools and defence (Intercept-X) to protect against 'wannacry' type attacks. • Server and PC patching in place and enhanced network firewalls and other network perimeter controls. • Deployment of Microsoft Advanced threat detection to improve cyber defences • Infrastructure – the increasing move to cloud based services and infrastructure as a service revenue based models reduce the reliance on available capital. • Moved to a service contract for PCs and Laptops • Implementation of Darktrace to	• Raised staff awareness and understanding of cyber security through education and communication • NHS Digital accredited awareness training provided to Board members • NHS Digital Cyber essentials best practice being progressed • IM&T Programme Board in place • Executive Data, Security & Protection Group in place • Infrastructure – warranty extensions can provide cover for infrastructure if funding is not available for replacement • Cyber action plan in place • Dedicated Cyber defence lead role and cyber defence technician appointed	• Annual external Penetration Testing has been undertaken and a remediation plan developed • External assessment to undertake IT health check and gauge the Trust's position to apply for cyber essentials accreditation • Annual DSPT toolkit submission. Current rating is *standards not fully met (plan agreed)* • Annual internal auditor's report. DSP audit report and Network Security audit reports for 20/21

	detect and respond to subtle, stealth attacks inside the network — in real time. • IT Health dashboard implemented to provide real-time visibility and overview of the network and systems, identifying any potential cyber security issues that warrant attention and assurance on the cyber security environment • Implementation of ORDR at County Hospital to monitor network activity of medical devices and Internet of Things (IoT) devices • Implementation of National Cyber Security Centre recommendations on passwords		rated the Trust as *significant assurance with minor improvement opportunities*
Assurances :	• Policies and procedures in place for data, security and protection • DSP statutory and mandatory training • IT Health Dashboard real monitoring of activity • DarkTrace real time monitoring with action taken where appropriate • DMARC real time monitoring with action taken where appropriate	• DSP training report • DSP report presented to PAF on a quarterly basis • DSP assurance reports to the Executive DSP Group: o Asset Management o Registration Authority o Information Security o Cyber Security o Data Quality o Records Management (includes Freedom of Information and Subject Access Requests) o Learning and Assurance Report • DSP Newsletter (which includes monthly reminders on cyber security) • Quarterly DSP Incident newsletter to share learning and best practice • Records management and confidentiality audits	

Gaps in Control or Assurance

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

- Network segregation of devices is required; actions are in place to address this
- ORDR (or equivalent) for monitoring of clinical technology devices at RSUH; options being explored at network segregation group)
- Immutable back-ups on site solution in the process of being implemented with a view to moving this to the cloud
- Delivery and resource plan for ISO27001

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

No.	Action Required	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	Deployment of Windows 10 with improved in built security and based on National Cyber Security Centre and Microsoft best practice	Director of IM&T	30/04/2021	This project is 95%. 307 of the original devices still require upgrade, however there are delays due to outstanding software issues and hardware deliveries. Additionally, in September, a further 107 devices were seen on the network that also require upgrade. Audits of these are in progress before final procurement.	D
2.	Continue work towards the toolkit Cyber Essentials and ISO27001 compliance.	Director of IM&T	31/03/2022	Improvement plan developed and will be monitored via the Executive DSP Group. However unlikely to achieve the March deadline.	
3.	Implement IT Health dashboard to provide real-time visibility and overview of the network and systems, identifying any potential cyber security	Director of IM&T	30/03/2021	Solution procured via NHS Digital funding with an implementation due date of the 30th March	

	issues that warrant attention and assurance on the cyber security environment				
4.	Implementation of network segregation	Director of IM&T	31/03/22	Task and finish group to be established to scope and develop action plan	GB
5.	Implementation of ORDR at Royal Stoke	Director of IM&T	31/03/22	Discussions underway to agree timescales for implementation	GB
6.	BYOD implementation	Director of IM&T	31/12/2021	Currently migrating licences to the cloud with plans to register devices on the cloud.	GB

BAF 8: Infrastructure to Deliver Compliant Estate Services

Internally Driven	✓
Externally Driven	

Risk Description

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

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

Strategic Objectives and Risk Register

Impact on Strategic Objectives:

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

ID 12720: Absence of side rooms in modular wards	High 12
ID 20315: Interventional room 5 removed from use for AGP procedures due to limited extract ventilation	High 12

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3			Likelihood:	2	31 March 2022
Consequence:	4	3			Consequence:	4	
Risk Level:	High 12	High 9			Risk Level:	High 8	

Rationale for Risk Level:

- **Infirmary Site (Project STAR):** Small number of building remain with Trust (EF&PFI building, ICT building, Windsor House) including car parks. IHP increased security to reflect increased possession. Phased handover to IHP – Phases 1, 2, 3 & 4 (asbestos removal) completed. Phases 5 (asbestos removal) underway and within program.
- **Estate Condition:** Key risks are funding constraints and physical access. PFI Statutory Maintenance programme underway but facing access difficulty in some areas due to high levels of bed occupation and activity. This will be mitigated by compressing the works in some areas such as theatres, which will attract additional costs.
- **Estate configuration / utilisation / optimisation / adjacencies:** Lowe Trent, which is phase 2 of a £17.6m capital funding additional ward scheme, stalled due to decant but is now developing a reworked decant solution. This will entail keeping the building at the infirmary (currently occupied by IM&T) until Spring of 2022.
- **Clinical Service Strategy:** Estate Strategy refreshed in July 2020 and will be refreshed again once the Clinical Service Strategy is concluded.

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	Infirmary Site (Project STAR): • Emergency capital bids produced; fire Risk assessments completed, manned 24/7 security. Condition of the estate: • PPM; competent estates staff/APs; estates KPI's monitored through CEF/	Infirmary Site (Project STAR): • NHSEI provided capital for site remediation and GHC acquisition • FBC approved by Trust Board and funding coverage provided by NHSIE for full scheme Condition of the Estate • Estates Capital bids submitted to Trust Capital Investment Group	• NHSEI Review of Progress on Project STAR • Regulatory inspection/validation programmes including: CQC, PLACE, PAM and ERIC • External audits including

	Environmental Audits. • Maintenance Operational Board; Operational policies; Service Specifications PFI. COVID-19 Impact: • Capital schemes; social distancing methodology; zoning proposals agreed through ET & R&R. Estate configuration / optimisation / adjacencies: • Clinical Service Strategy Review to conclude and inform changes to Estate Strategy/DCP. Fire / Security • Fire Safety/ Security Policies; Protocols; Guidelines; patrolling; CCTV; FRA's in place.	(CIG) from 7 facet findings, investment prioritised. COVID-19 Impact • Appropriate control of all schemes – ET & R&R. Estate configuration / optimisation / adjacencies: • Prioritised clinical service developments, as identified by Clinical Divisions, used to inform Estate Strategy. Fire/Security • 'On the spot' fire improvement notices by Fire Officers. • Fire Safety KPIs & ad-hoc audits/inspections. • LSMS close working with local Police and visibility on site	those undertaken by the Fire and Police Service and external audit i.e. KPMG • Authorising Engineers Audits, appointed to provide external audit and assurance (governance) of building services and associated maintenance regimes. • Participation in National Programme hosted jointly by Cabinet Office & HM Treasury, showcasing the most successful Private/Public Sector Strategic Partnerships.
Assurances :	Project STAR: • Project Team, PRINCE principles applied. Condition of the estate • Estate-code 7 facet property appraisals conducted; Maintenance Operational Board; estates maintenance/validation audits; PFI performance against Service Spec; Divisional Board review. COVID-19 Impact • Updates ET & R&R Fire / Security • FRAs; ad-hoc inspections; improvement notices; progress monitored FSG and EH&SG.	Project STAR • Regular updates to internal/external key stakeholders Condition of the estate • Estate Strategy, informed by Estate-code 7 facet property appraisal, Trust Strategy & clinical developments. • Regular reporting to CIG, H&S, QGC, EIG, IPC, TJNCC and LNC. • Strategic partnership - reviewed at Liaison Committee and EIG. COVID-19 Impact: • Regular updates on progress on Risk Assessments/R&R Fire / Security: • FRAs monitored through Trust Fire Committee; Divisional Management Board and Divisional H&S Meetings.	

Gaps in Control or Assurance

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

- Delivery of Project STAR Programme in its entirety (due 2022)
- Delivery of Trent Programme (due 2023)
- Completion of Statutory Maintenance Programme (majority of programme delivered, some areas deferred due to demand on activity / capacity constraints)

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

No.	Action Required	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	RI Site - Asbestos removal/demolition	Director of E,F & PFI	2022	Asbestos removal Phase 1 - 5 handed over to the principle contractor IHP. Phases 1-4, completed removal	GA
2.	RI/COPD - Create car parking solution	Director of E, F&PFI	2023	FBC approved by Trust Board. NHSEI funded demolition, GHC acquisition and provided funding coverage for construction of car park.	GA
3.	RI/COPD - Release land for land sale	Director of E,F& PFI	2023	Will be released upon completion of construction and new car park at GHC.	GA
4.	Trent Business Case	Director of E,F&PFI	2023	Alternative decant solution identified and revised programme currently being worked up.	GA
6.	Sodexo Market Testing BC	Director of E,F&PFI	31/11/21	BC approved Trust Board. Approval now being sought from NHSI/E and PFU. Variation being worked up with Project Co with a view to completing by November 2021.	GA
7.	PFI Statutory maintenance	Director of E,F&PFI	Jan 2021	Programme underway, significant challenges bed occupation/activity, mitigated by compressing the programme in some areas, which has attracted additional costs.	GA

9.	Strategic Supplier Programme	Director of E,F & PFI	2022	Programme continues, some schemes now nearing completion, refresh of the Business Plan in October 2021.	GA
10.	Estates Workforce Reviews	Director of E,F & PFI	31/08/21	Capital completed and being reviewed by Execs. Ops near completion to be completed in October.	GA

BAF 9: Financial Performance

Internally Driven	
Externally Driven	✓

Risk Description

Cause	Event	Effect
If we, or system partners, are unable to operate within available resources	**Then** the system financial plan for 2021/22 may not be delivered	**Resulting in** increasing Cost Improvement Programmes, and a lack of ability to invest in the development of future services

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

Strategic Objectives and Risk Register

Impact on Strategic Objectives:	**High Quality**		**Improving and Innovating**		
	Responsive		**Systems and Partners**	✓	
	People		**Resources**	✓	
Links to Risk Register	VAT recovery on car park development			**High 12**	
	Costs of recovery outstrip revenue from elective recovery fund going forward			**High 12**	

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2	2			**Likelihood:**	1	31/03/22
Consequence:	3	3			**Consequence:**	3	
Risk Level:	**Mod 6**	**Mod 6**			**Risk Level:**	**Low 3**	
Rationale for Risk Level:	Actual performance for the first half of the year is a surplus of £13.6m with a requirement to breakeven for the year. Allocations for H2 have recently been published with an initial assessment indicating that these will be sufficient to deliver a broadly breakeven position for H2. The surplus from H1 will therefore be available to support other system partners if necessary, recovery, winter and additional non-recurrent cost pressures in H2.						

Control and Assurance Framework – 3 Lines of Defence

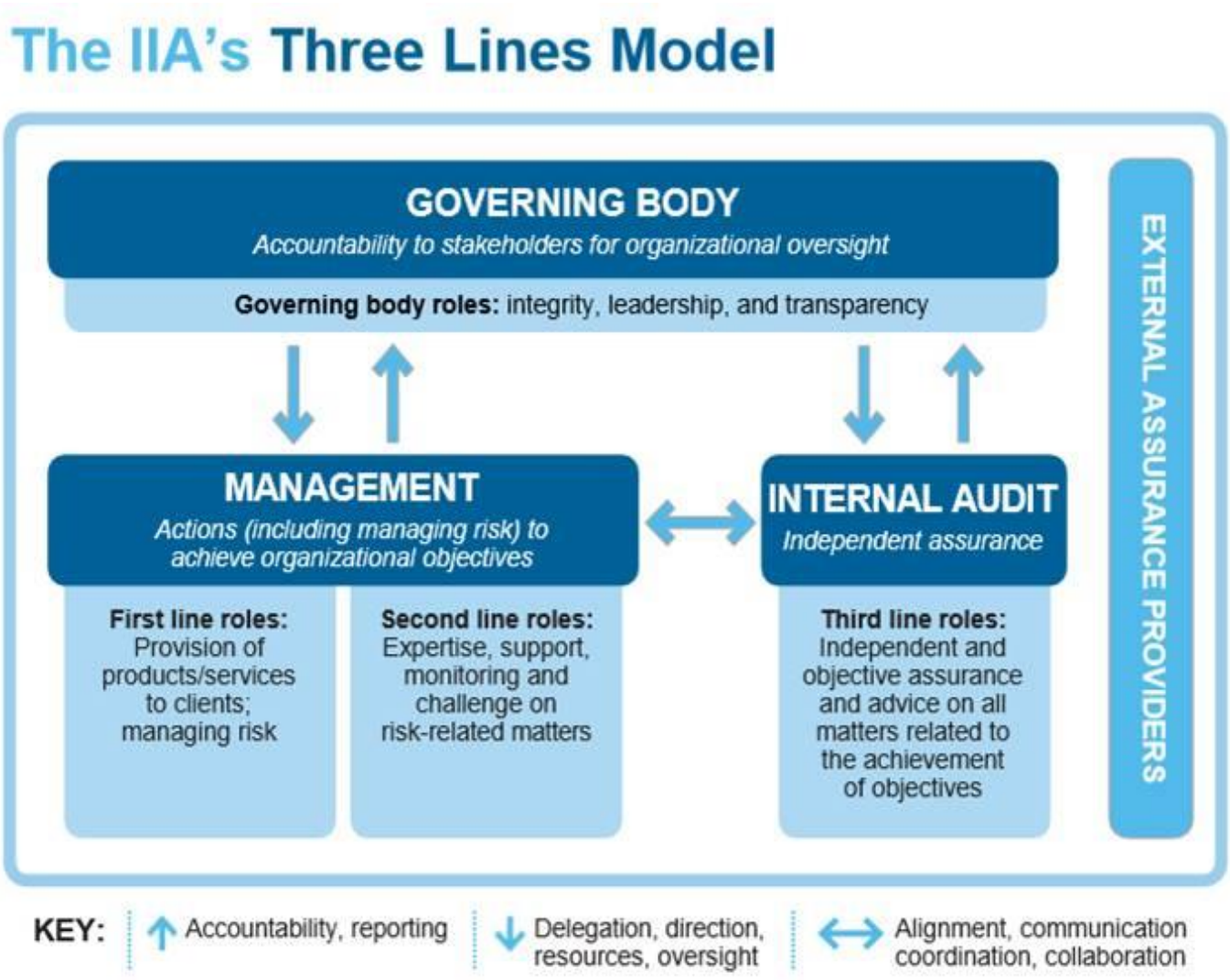
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Performance Management meetings in place with Divisions • Financial codes and procedures • Restoration and recovery group scrutiny • Exec Team approval of additional investment up to £250k • STP Finance Director meeting established to consider system position • Ongoing discussions with NHSIE on underlying position to inform improvement trajectories	• Finance report in place to performance and Finance Committee with associated scrutiny; enhanced to include run rate performance and analysis of additional COVID related expenditure • Standing Financial Instructions	• Consideration of Internal audit programme to reflect changing risks on COVID • STP Capital Programme in place in Line with Capital Resource Limit (CRL) • External audit programme in place • NHSE/I allocations confirmed
Assurances:	•	• Performance at Month 6 is an actual surplus of £13.6m • System partners agreed allocations across STP for both income and capital	

Gaps in Control or Assurance
What are the gaps to be addressed in order to achieve the target risk score?
• The lack of detail about recurrent income levels may result in an increase in spend as temporary investments are less financially efficient than ones

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

No.	Action Required	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	Clarity in respect of Funding regime	MO	31/12/21	National guidance expected towards the end of the year or early 2022.	A
2.	Investment Assurance report to PAF	MO	31/07/21	Positive assurance report presented at Performance and Finance Committee in July with update to October Committee.	B

Appendix 1: Three Lines of Defence



Appendix 2: Risk Appetite Matrix

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

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

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board	**Date:**	3rd November 2021
Report Title:	Workforce Disability Equality Standard (WDES) Report 2021	**Agenda Item:**	17.
Author:	Raising Concerns & Workforce Equality Manager		
Executive Lead:	Director of HR		

Purpose of Report:

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

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

Executive Summary:

As set out in the NHS Long Term Plan, respect, equality and diversity are central to changing culture and are at the heart of the NHS England workforce implementation plan.

The Workforce Disability Equality Standard (WDES), commissioned by the Equality and Diversity Council is mandated through the NHS Contract. The WDES is a set of 10 specific measures (metrics) which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. Using the information to develop and publish an action plan. Year on year comparison enables NHS organisations to demonstrate progress against the indicators of disability equality.

In this third year of reporting the WDES it is positive that we can see improvement in 6 of the metric indicators when compared with the 2020 report. There is no change in one metric and deterioration in four.

The report also outlines the actions we intend to take to further close the gaps in career and workplace experience between our disabled staff and non-disabled staff at UHNM during 2021-22.

The Trust is required to publish our WDES indicators and action plan on our Trust Website by 31st October 2021.

Key Recommendations:

Trust Board is requested to consider this WDES Report and the actions we intend to take to close the gaps in career and workplace experience between our disabled staff and non-disabled staff at UHNM during 2021-22.

Workforce Disability Equality Standard (WDES)
2021 Report

1. Introduction

The Workforce Disability Equality Standard (WDES) has been introduced across the NHS to advance disability workplace equality. Previous initiatives have not reduced the longstanding gaps that exist between the workplace experiences and career opportunities of Disabled and non-disabled people.

The rationale for the WDES is founded upon the wider context of Disabled people and their experiences in employment and work. The WDES is underpinned by the Social Model of Disability, which proposes that people are disabled because of societal barriers, rather than a long-term health condition. With the social model in mind, the WDES will help inform year on year improvements in reducing those barriers that impact most on the career and workplace experiences of Disabled staff; driving changes in attitudes, increasing employment and career opportunities, and implementing long-lasting change for Disabled people.

The WDES is mandated to all NHS Trusts and Foundation Trusts in England through the NHS Standard Contract and comprises of 10 Metrics that incorporate data from the following primary sources: the NHS Electronic Staff Record (ESR), the NHS Staff Survey and local HR and recruitment systems.

There are three mandated reporting requirements for the WDES, which are to:

- verify, complete and submit our metric data on a pre-populated excel spread sheet;
- submit an online reporting form;
- publish our WDES report on the trust's external website, which includes our metrics, evidence of engagement with Disabled staff and our action plan.

The national WDES Team advise that the 2020 WDES data analysis report (published October 2021) 'continues to show that that staff with a disability have poorer experiences in areas such as bullying and harassment, feel less valued for their contribution, and feel more pressure to attend work when feeling unwell.'

The key national findings from the 2020 WDES analysis found:

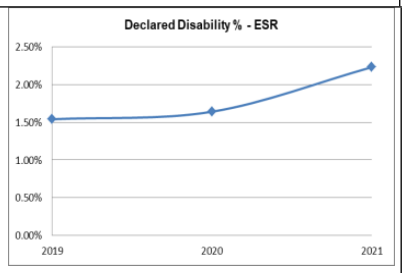
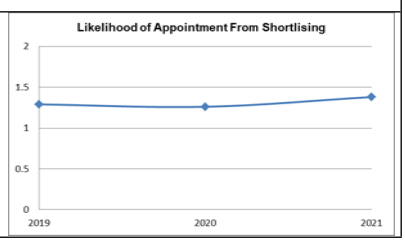
3.5% of staff have declared a disability on NHS Electronic Staff Record (ESR) up 0.4% from 2019	Non-disabled job applicants were **1.2 times** more likely to be appointed from shortlisting	Disabled staff were **1.54 times** more likely to enter the formal performance management capability process
26.3% of disabled staff reported harassment, bullying or abuse, compared to 18.5% of non-disabled staff	**78.2%** of disabled staff believe they have equal opportunities for career progression. This has improved from 77.6% last year	**30.6%** of disabled staff stated they had experienced presenteeism. This compares to 21.2% of non-disabled staff. This has improved from 32.1%
39.1% of disabled staff said they felt values, compared to 50.4% of non-disabled staff. This has improved from 37.3% the year before	**26.2%** of disabled staff felt that their employer had not made adequate adjustments	**3%** of board members have declared a disability. This is up from 2% in 2019 and two thirds of trusts do not have any board members who have declared a disability

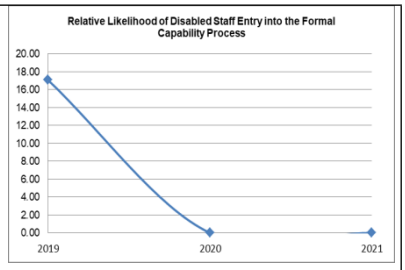
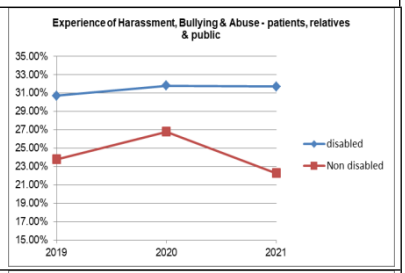
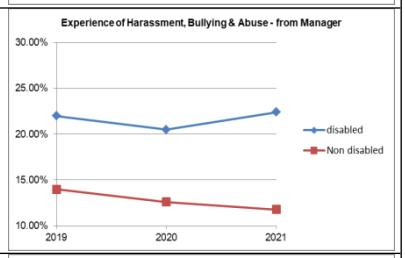
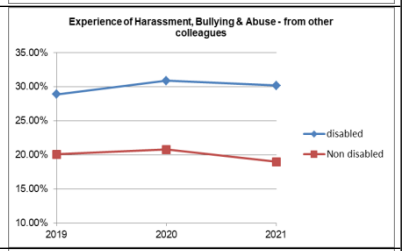
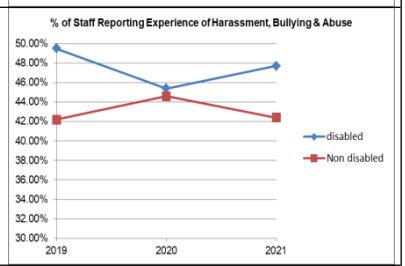
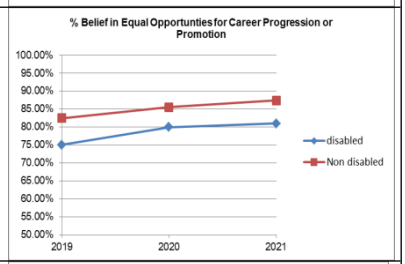
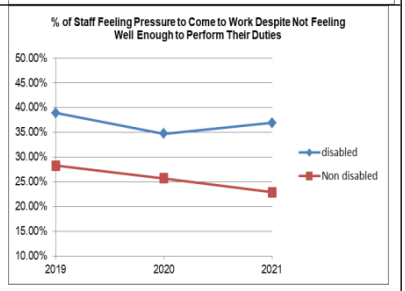
WDES Metrics and UHNM Performance

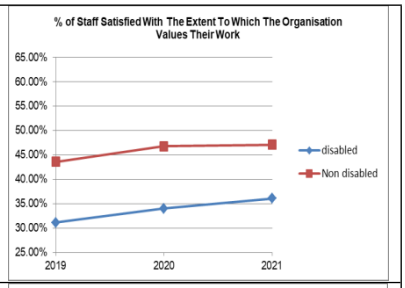
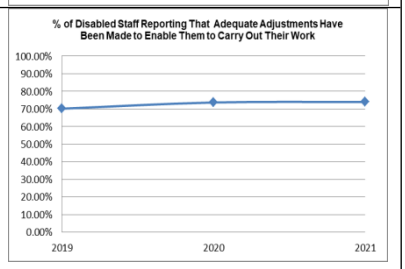
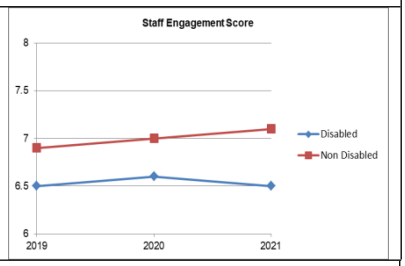
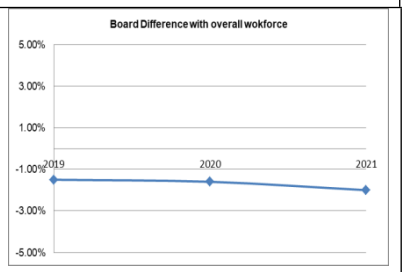
A detailed analysis of the WDES Metrics is attached as Appendix 1 and includes comparison of our performance against benchmarking data where this is available from the 2020 NHS Staff Survey and the 2020 National WDES data analysis report.

A summary of our 2021 WDES metrics is outlined below.

Note: data for Metrics 2 and 3 is auto calculated using the WDES pre populated excel spread sheet to produce a relative likelihood score. A relative likelihood of 1.00 indicates that there is no difference between Disabled and non-disabled staff. For example, for Metric 2, a result above 1.00 indicates that non-disabled staff have an increased likelihood of being appointed from shortlisting compared to disabled staff and for Metric 3 a result above 1.00 would indicate that disabled staff are more likely to enter the formal capability process than non-disabled staff.

	WDES Metric		2019	2020	2021	
	Workforce Metrics					
1.	Percentage of staff in AfC pay-bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff:		1.54%	1.64%	2.23%	
	Cluster 1: AfC Band 1, 2, 3 & 4	Non Clinical	2.6%	3.0%	4.0%	
		Clinical	0.9%	1.1%	1.9%	
	Cluster 2: AfC Band 5, 6 & 7	Non Clinical	2.3%	2.2%	2.8%	
		Clinical	1.5%	1.5%	2.0%	
	Cluster 3: AfC Band 8a & 8b	Non Clinical	0.0%	1.0%	3.7%	
		Clinical	2.2%	2.1%	2.7%	
	Cluster 4: AfC Band 8c, 8d, 9 and VSM (including Executive Board members)	Non Clinical	0.0%	0.0%	0.0%	
		Clinical	3.6%	3.9%	4.2%	
	Cluster 5: Medical and Dental staff, Consultants		0.8%	0.6%	0.54%	
	Cluster 6: Medical and Dental staff, Non-consultant career grade		0.9%	0.4%	0.66%	
	Cluster 7: Medical and Dental staff, Medical and dental trainee grades		0.7%	0.9%	0.00%	
2.	Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts		1.29	1.26	1.38	

3.	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure. This metric applies to capability on the grounds of performance and not ill health		17.07	0.00	0.00	
	NHS Staff Survey Metrics					
4a.	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from patients /service users, their relatives or other members of the public	Disabled	30.7%	31.8%	31.7%	
		Not disabled	23.8%	26.8%	22.3%	
	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Managers	Disabled	22.0%	20.5%	22.4%	
		Not Disabled	14.0%	12.6%	11.8%	
	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from other colleagues	Disabled	28.9%	30.9%	30.2%	
		Not Disabled	20.1%	20.8%	19.0%	
4b.	Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	Disabled	49.5%	45.4%	47.7%	
		Not Disabled	42.2%	44.6%	42.4%	
5.	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion	Disabled	75.0%	80.0%	81.0%	
		Not Disabled	82.5%	85.5%	87.4%	
6.	Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	Disabled	38.9%	34.7%	36.9%	
		Not Disabled	28.3%	25.7%	22.9%	

7.	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work	Disabled	33.1%	34.0%	36.1%	
		Not Disabled	43.6%	46.8%	47.1%	
8.	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work		70.2%	73.7%	74.0%	
9.	The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation	Disabled	6.5	6.6	6.5	
		Not Disabled	6.9	7.0	7.1	
	Board Representation Metric					
10.	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated: • By voting membership of the Board. • By Executive membership of the Board		-1.5%	-1.6%	-2%	

Six of the WDES metrics are drawn from the national NHS Annual Staff Survey. The response rate for the 2020 staff survey was 44% with 20.4% of respondents stating that they had a physical or mental health condition or illness lasting or expected to last 12 months or more.

UHNM uses recruitment monitoring and the ESR system to capture and record employee disability status. The Trust regularly encourages our workforce to update their ESR record and the number of records where staff have not disclosed their status regarding disability has improved from 41% last year to 34.6% at 31st March 2021. Nationally it is recognised that there is a significant under reporting across the country of the numbers of staff who declare themselves to be disabled on ESR, compared to those disclosing this information whilst completing the NHS Staff Survey.

2. Disability Equality Actions Undertaken during 2020/21

During 2020/21, we have undertaken the following actions and activities against our agreed priorities:

Engaging with our disabled staff to facilitate the voices of disabled staff being heard

- Worked with our Disability Staff Network in developing our WDES Action Plan
- Listening to our disabled staff throughout the Covid-19 pandemic to ensure that we are effectively supporting them, this has included creating comprehensive wellbeing support and guidance for shielding employees and their line managers
- Raised the profile of disability equality and workplace inclusivity through regular newsletters, personal stories, videos and infographics
- Encouraged staff to declare their disability status on ESR through our newsletters and a video during Equality, Diversity & Human Rights Week where our Staff Network Chairs explaining why

declaring disability status is important and how we use the information to better understand disability representation within our workforce
- With our system partners we have introduced a system wide Disability and Neurodiversity Staff Network which meets on a quarterly basis
- As part of system working, a series of inclusion school events have been held, including masterclasses, focussing on topics such as allyship, unconscious bias, true self and imposter syndrome
- Launched the UHNM Speaking Up Charter to promote the Trusts commitment to a healthy speaking up culture and a focus on the safe routes to raise issues was the topic of the first system network meeting with presentations from the FTSU Guardians

Improving workplace experiences of our disabled staff

- Continued to promote and raise awareness with staff and line managers of the Tailored Adjustments Plan – a document designed to be a living record of adjustments agreed between an employee and their line manager
- Prioritised employee safety during the pandemic with Covid-19 risk assessments, employee guidance and provisions in place to effectively support shielding employees and their safe return to the workplace
- Reviewed and promoted disabled workers rights by including our Disability Leave provisions in the Special Leave Policy
- Continued with our Wellbeing Strategy and held a series of wellbeing events
- Enhanced our Disability Awareness section on the intranet for our employees and managers to access supportive and informative resources and guidance
- Created a UHNM Disability & Long Term Conditions Facebook Page aimed at connecting our disabled employees and providing key updates including regular updates from the Network Chair
- The UHNM 'Belonging in the NHS' Inclusivity Masterclass has been introduced to the Gold and Platinum Connects Leadership Programmes. The Masterclass was created to introduce cultural intelligence and diversity awareness into our compassionate leadership development

Ensuring we are a fair and compassionate employer

- Continued to embed the Just and Learning Culture and decision tree across the organisation and our commitment to learning rather than blaming. This has been embedded into the revised Disciplinary Policy and Speaking Up Policy
- Reviewed the content of our Capability Training for line managers to ensure that it includes elements about performance management issues and disability
- Updated the Absence Management Training for line managers to include Disability Leave and the Tailored Adjustments Plan
- The HR Department continues to work closely with Trade Unions to monitor consistency of approach to formal employee relations cases through a monthly joint meeting

Attracting and retaining staff with disabilities

- Continued our programme of work with local schools and colleges, and through a range of events, promotional material, social media and engagement with our local communities to promote the various roles and routes into employment as part of our Widening Participation Strategy
- Continued to reach out to disabled and other protected groups, promoting UHNM as an employer of choice for people with disabilities and raising awareness of the various routes into NHS careers, such as apprenticeships
- Welcomed a further cohort of Project Search students, and celebrated the achievements of the previous cohorts, with 83% of students now in paid employment across the two hospital sites
- Created an Equality, Diversity and Inclusion section on our Working Here page of the UHNM website, promoting our commitment to a fair and diverse workforce and the role of our staff networks in actively engaging and contributing to equality acceptance and inclusion within the Trust

- Revised and updated the equality & inclusion in recruitment e-learning package. The training is a pre requisite for all staff who are undertaking the Trust's Gateway to Management leadership development programme. This includes the practical application of the Trust Recruitment Policy, including awareness of fair recruitment practice and an understanding of unconscious bias
- Work with the Disability & Long Term Conditions Staff Network on our Disability Confident self-assessment and sought feedback from the Network on the accessibility of our recruitment platforms and processes and to identify any barriers faced by people with a sensory disability

3. Conclusions

The WDES has been developed and continues to be underpinned by the ethos of 'nothing about us without us' this means that any decisions that impact on disabled people must involve disabled people. We are committed to ensuring that our disabled staff are involved in shaping our equality, diversity and inclusion work and have opportunities to contribute and influence our activities to improve disability equality at UHNM. We do this working collaboratively with our Staff Network and through a range of workforce engagement activities, for example surveys and awareness events in addition to the National NHS Staff Survey. We know that by working in partnership with our staff that we can develop human resource practices and policies that enable all of our employees to thrive.

The WDES is important because evidence shows that a well-motivated inclusive and valued workforce helps to deliver high quality patient care, increased patient satisfaction and improved safety for the people we care for. The aim of the WDES is to enable NHS organisations to better the experiences of their disabled staff and supports positive change for all employees by creating a more inclusive environment for disabled people working and seeking employment in the NHS.

This year's metrics show some positive improvements, for example the improvement in disability disclosure rates; representation in clinical and non-clinical roles and the continued year on year improvement in the metrics relating to disabled staff belief in equal opportunities for career progression or promotion; the proportion of disabled staff saying that they are satisfied with the extent to which their organisation values their work and the percentage of disabled staff who feel that adequate workplace adjustments have been put in place to enable them to carry out their work.

However there is little change in experiences of bullying, harassment and discrimination from the public and other colleagues, and an increase in the percentage of disabled staff compared to non-disabled staff reporting experiencing harassment, bullying or abuse from Managers, and in contrast with the experiences of staff without disabilities, our disabled staff reported an increase of feeling pressure from their manager to come to work, despite not feeling well enough to perform their duties.

We have identified a number of actions, supported by our Disability and Long Term Conditions Staff Network that we will focus on during 2021-22 with a particular emphasis on increasing line manager awareness in recruiting and managing employees with a disability or long term condition, and to continue to close the gaps in career and workplace experience between our disabled staff and non-disabled staff, and this is outlined in the following Action Plan.

Progress will be measured by improved metric results in the 2022 WDES submission, NHS Staff Survey results and the monitoring of other relevant metrics.

UHNM WDES Action Plan 2021-22			
WDES Metric	**Action / Recommendation**	**Timescale**	**Progress Rating**
Percentage of staff in AfC pay-bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.	• Continue to act upon the under representation of staff declaring disability by regularly encouraging all staff to validate their disability status via ESR and other communications. Provide further awareness of what conditions fall into the category of disability • Use staff with disabilities as role models to showcase UHNM's commitment to being an inclusive employer in promotional material, in to further non-disabled staff awareness	Ongoing Ongoing	
Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts	• Launch the Disability Awareness Toolkit for line managers to improve knowledge and understanding of recruiting and supporting employees with disabilities/long term health conditions • Develop a network of inclusive recruitment guardians, supported with a training package to participate in selection interviews and provide inclusion expertise to recruitment panels • The Trust Recruitment Manager is a member of the Disability Staff Network and works with the group to improve recruitment practice based on feedback from the Network, including review of on-boarding • Continue with our Widening Participation Strategy, Project Search and other recruitment initiatives like the guaranteed interview scheme	Q4 Q3 Ongoing Ongoing	
Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure	• Introduction of a Workplace Reasonable Adjustments procedure • Ongoing promotion of Just and Learning Culture and launch of the UHNM Just and Learning training across the Trust • Development and introduction of MerseyCare 4 step process of restorative justice • Raise cultural awareness amongst senior leaders through the Belonging in the NHS Inclusivity Masterclass and reciprocal mentorship programmes • Continue to work closely with our Staff Side colleagues to ensure that all reasonable adjustments have been made available for disabled staff and that the capability policy has been applied in a consistent and supportive manner	Q4 Q4 Q4 Q2 Ongoing	

Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from • patients /service users, their relatives or other members of the public • Managers • Other colleagues	• Launch the UHNM Violence Reduction and Prevention Strategy • Introduce the Sunflower Hidden Disabilities Scheme • Development of a Behavioural Compact with the input from our Staff Networks • Launch of the UHNM Middle Management Programme with a focus on civility and respect • Review of Dignity at Work Policy • Increase the number of internal mediators • Introduction of the 'Taking the Heat Out of Conflict' Masterclass • Delivery of the Belonging in the NHS Inclusivity Masterclass through the Gold and Platinum Connects Leadership Programme • Introduction of equality, diversity and inclusion conversations within Personal Development Reviews • Increase the number of Employee Support Advisors from protected groups and provide a development session to Freedom to Speak Up Guardians and Employee Support Advisors on disability to enable them to support individuals experiencing workplace difficulties relating to their disability more effectively	Q4 Q3 Q4 Q4 Q3 Complete Q2 – pilot complete Q2 - Ongoing Q4 Q4	
Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	• Launch the Speak Up Listen Up mandatory staff training • Recruit additional FTSU Guardians, expanding the team to reflect the diversity of the workforce • Continue to work closely in enabling safe speaking up channels for our disabled workforce and build confidence of our staff to speak up • Include staff with disabilities in the second cohort of the Reciprocal Mentorship Programme	Q3 Q4 Ongoing Q3	
Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion	• Progress plans to develop a UHNM development centre working with divisions, including introducing more aspirational roles with supporting development plans, piloting a career development planning toolkit and signposting to higher level apprenticeships. Plan to increase numbers of informal secondment and shadowing opportunities across the Trust • Revise the Performance & Development Review to encompass a more strength based development and forward looking annual appraisal • Promote access to career conversations and coaching to our disabled workforce	Ongoing	

Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	• Launch Disability Awareness Toolkit for managers to improve knowledge and understanding of recruiting and supporting employees with long term health conditions • Bid for funding from the NHS WDES Innovation Fund for external disability training for managers	Q4 Q3	
Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work	• Continue to promote the UHNM Disability and Long Term Conditions staff network and increase membership. Work with the group to understand the issues that matter to them and identify actions to increase their wellbeing and feeling of value • Use national campaigns such as Disability History Month to drive engagement and raise understanding and awareness across the organisation • Introduction of the Disability Toolkit and bid for external training for line managers • Continue to promote health and wellbeing conversations – in accordance with the People Plan line managers should discuss equality, diversity and inclusion as part of health and wellbeing conversations to empower people to reflect on their lived experience, support them to become better informed on the issues and determine what they and their teams can do to make further progress	Ongoing Q4 Q4	
Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work	• Introduction of a Workplace Reasonable Adjustments Procedure • Introduction of the Sunflower Hidden Disabilities Scheme • Further promotion and inclusion within leadership training material of the importance of the Tailored Adjustments Plan • Introduce Disability Toolkit and bid for external training for line managers	Q4 Q3 Ongoing Q3	
Percentage difference between the organisation's Board voting membership and its organisation's overall workforce	• Encourage all Board members to declare their disabilities. • Disability Network Executive Sponsor to continue to champion disability issues with the Trust Board • Launch cohort 2 of the Reciprocal Mentorship Programme with our Disability and Long Term Conditions Staff Network	Ongoing Ongoing Q3	

Appendix 1 – UHNM WDES 2021 Metric Analysis

Further detail is provided below on each of the WDES Metrics, including comparisons of our performance against benchmarking data where this is available from the 2020 NHS Staff Survey and 2020 WDES Data Analysis Report (published in October 2021).

Metric 1: **Representation of Disabled staff in Agenda for Change (AfC) paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce**

The following table demonstrates disabled representation in the organisation. Positively, the percentage of staff that have declared their status has improved to 65.4% compared to 59% the previous year.

Disability Status	Headcount	%
Disabled	261	2.2%
Not Disabled	7,399	63.2%
Not Declared/Unspecified	4055	34.6%
Total	**11,715**	**100%**

The following table lists the health condition declared on ESR:

Disability Category	Headcount	% of Workforce
Learning disability/difficulty	44	0.4
Long-standing illness	56	0.5
Mental Health Condition	28	0.2
Other	27	0.2
Physical Impairment	32	0.3
Sensory Impairment	28	0.2
Yes - Unspecified	80	0.7

3.7% of non-clinical and 2.0% of the clinical workforce (excluding Medical and Dental) have declared a disability on ESR. This compares to the most recent national picture available of 3.6% of non-clinical and 2.9% of clinical staff in 2019. Nationally it is recognised that Medical and Dental staff are less likely to declare a disability compared to other clinical and non-clinical staff, and this is reflected at UHNM, where only 0.4% of this staff group has declared a disability.

Staff Group	Disabled	Not Disabled	Unknown/Not Stated	Total
Non-clinical	102	1593	1062	2747
Clinical (excluding Medical & Dental)	154	4809	2675	7638
Medical & Dental	5	997	318	1320
Total	**261**	**7399**	**4055**	**11715**

The percentage of staff with a disability has increased in all clinical and non-clinical pay clusters compared to the previous year with a reduction in the number of unknown/not stated.

Metric 2: **The relative likelihood of disabled staff compared to non-disabled staff being appointed from shortlisting across all posts**

Disability Status	Shortlisted	Appointed
Not stated/ Do not wish to disclose	889	445
Not Disabled	9700	1137
Disabled	517	44

This indicates a relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts score of **1.38**. (A figure below 1.00 indicates that Disabled staff are more likely than non-disabled staff to be appointed from shortlisting). This is a deterioration from the previous year, where the metric was 1.26, with the national average from the 2020 WRES data analysis being 1.2.

Metric 3: The relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure

This metric is based on data from a two year rolling average of the current year and the previous year of entry into a formal capability process as recorded on the HR Case Tracker. (It is important to note that this metric is related to entry into the formal capability process due to performance issues only, and not ill health related issues).

Our Capability Policy is designed to be supportive and encouraging to enable our employees to reach the desired performance level through informal processes and hence very small numbers of staff enter the formal stage of the Policy. Reasonable adjustments must have been implemented where these have been identified for staff with a disability.

Our data for the last two years tells us that only 9 individuals have entered the formal stage of the Capability Policy due to performance issues. None of these individuals had a declared disability. This results in a relative likelihood of Disabled staff entering the formal capability process compared to non-disabled staff score of **0.00**. The national average for this metric reported in the 2020 WDES data analysis report was 1.54.

Metric 4a: Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:

- **Patients/service users, their relatives or other members of the public**
- **Managers**
- **Other colleagues**

The following metrics are taken from the 2020 NHS Staff survey. The results show that our disabled staff have the perception that they are more likely than non-disabled staff to experience harassment, bullying or abuse:

Metric		UHNM Result	Staff Survey Acute Sector Average	WDES 2020 National Result
% of staff experiencing harassment, bullying or abuse from patients / service users	Disabled	31.7%	30.9%	34.2%
	Non-Disabled	22.3%	24.5%	27.4%
% of staff experiencing harassment, bullying or abuse from Managers	Disabled	22.4%	19.3%	18.5%
	Non-Disabled	11.8%	10.8%	10.8%
% of staff experiencing harassment, bullying or abuse from other colleagues	Disabled	30.2%	26.9%	26.3%
	Non-Disabled	19.0%	17.6%	17.3%

Disabled staff experiencing harassment, bullying abuse decreased slightly compared to the previous year, with the exception of the percentage of disabled staff reporting experience of bullying or abuse from Managers, which increased by 1.9%.

Metric 4b: **Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it**

Positively our disabled staff are more likely to report experience of harassment, bullying or abuse at work, and is an increase of 2.4% compared to last year and better than the acute sector average.

	UHNM Result	Staff Survey Acute Sector Average
Disabled staff	47.7%	47.0%
Non-Disabled staff	42.4%	45.8%

Metric 5: **Percentage of disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion**

This metric shows that our Disabled staff are less likely to believe that the Trust provides equal opportunities for career progression or promotion compared to non-disabled staff; however, this 2020 staff survey result continues the year on year improvement in this metric for both disabled and non-disabled staff, and is better than the acute sector average and the WDES 2020 national result.

	UHNM Result	Staff Survey Acute Sector Average	WDES 2020 National Result
Disabled staff	81.0%	79.6%	78.2%
Non-Disabled staff	87.4%	86.3%	85.2%

Metric 6: **Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties**

This metric demonstrates that our disabled staff are significantly more likely to report feeling pressure from their manager to come to work, despite not feeling well enough to perform their duties compared to non-disabled staff at **36.9%** and is worse than the staff survey average and WDES 2020 national result. This metric has deteriorated from 34.7% reported last year, but is better than our baseline figure of 38.9% in 2019.

	UHNM Result	Staff Survey Acute Sector Average	WDES 2020 National Result
Disabled staff	36.9%	33.0%	30.6%
Non-Disabled staff	22.9%	23.4%	21.2%

Metric 7: **Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work**

This metric has improved by 2.1% to **36.1%** and has improved year on year for both disabled and non-disabled staff but are slightly worse than the acute sector average and WDES 2020 national result. This metric demonstrates that disabled staff are notably less likely to be satisfied with the extent to which the organisation values their work compared to non-disabled staff.

	UHNM Result	Staff Survey Acute Sector Average	WDES 2020 National Result
Disabled staff	36.1%	37.4%	39.1%
Non-Disabled staff	47.1%	49.3%	50.4%

Metric 8: **Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work**

This metric demonstrates an improvement on the previous year with **74.0%** of our disabled staff reporting that adequate adjustments were made to enable them to carry out their work. This is an improvement on the previous year but is slightly worse than the acute sector average but better than the WDES national average.

UHNM Result	Staff Survey Acute Sector Average	WDES 2020
74.0%	75.5%	73.8%

Metric 9a: The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation

The Staff Engagement score for our Disabled staff has deteriorated by 0.1% to **6.5%** and is less than the acute sector average and the WDES national average 2020 result**,** whilst for non-disabled staff the score has improved by 0.1% to 7.1.

	UHNM Result	Staff Survey Acute Sector Average	WDES 2020 National Result
Disabled staff	6.5	6.7	6.64
Non-Disabled staff	7.1	7.1	7.13

Metric 9b: Action to facilitate the voices of Disabled staff in the organisation to be heard

UHNM has a Disability and Long Term Conditions Staff Network, which meets on a quarterly basis. The Network has an executive sponsor, Helen Ashley who champions disability at Board level. The Network have actively supported the implementation of our Tailored Adjustment Plan (a disability passport) and have been heavily involved in the development of our disability awareness toolkit for line managers, which will be launched shortly and the network are taking the lead with the sunflower hidden disabilities scheme, which we plan to launch during Disability Month 2021. The network have informed the support the organisation has put in place for staff with disabilities and long term conditions throughout the Covid-19 pandemic. We have launched our second cohort of reciprocal mentoring with members of our staff network having received their Mentor training in readiness of being partnered with Trust Board and senior leaders with the aim of educating and raising awareness of disabled experiences and enhancing allyship amongst non-disabled colleagues. As an organisation we have worked in partnership with our Integrated Care System colleagues in North Staffordshire and now run system wide Disability and Neurodiversity staff networks where UHNM participants can link with employees from other health, social and local government organisations.

Metric 10: The percentage difference between the organisations board voting membership and its overall workforce

Boards are expected to be broadly representative of their workforce. At UHNM there is no Board member, voting or non-voting with a disclosed disability. This means that this metric has deteriorated, as the number of staff with a disability has increased. The 2020 WDES data analysis indicates that the average board representation is 3%.

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	3rd November 2021
Report Title:	EPRR Annual Statement / Assurance	**Agenda Item:**	18.
Author:	Richard Lamine, Head of Resilience and Emergency Response		
Executive Lead:	*Paul Bytheway, Chief Operating Officer*		

Purpose of Report:

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

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

Executive Summary:

Situation

- *The* Trust maintains a good standard of preparedness allowing it to respond to incidents and to maintain services in the face of disruption.
- With the support of staff at all levels UHNM will continue to improve arrangements for Emergency Preparedness, Resilience and Response.
- Continued close working with other health agencies will support the Local Health Economy to improve wider planning and response arrangements.

Work continues to ensure that a good level of preparedness is maintained and continual improvements are made against the NHS England Core Standards for EPRR.

Annual EPRR assurance submission has taken place. This year and for the first time NHSE&I requested an earlier return covering a four week window and not the usual eight weeks. UHNM submitted a draft assessment paper before executive approval due to the stipulation from NHSE&I. The initial feedback has been positive with an overall comprehensive assessment.

Initial supporting documents have been requested and submitted , these are

- *EPRR Policy and Strategy*
- *Incident Response Plan*
- *Business Continuity Plan*
- *Business Continuity Policy*

Assessment

- *Key findings are that UHNM are compliant with the requirements, due to the Covid response and cancellation of face to face training has had an impact on training and live exercises which is duly noted.*

Key Recommendations:

Recommendation that the initial assessment result is noted, and for the Trust Board to approve the annual return.

Ref	Domain	Standard	Detail	Evidence - examples listed below	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Comments
Domain 1 - Governance								
1	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	• Name and role of appointed individual	n/a	Fully compliant	No action required	Paul Bytheway, Chief Operating Officer in post, Paul is AEO with delegated duties to Deputy COO and Head of Resilience Leigh Griffin nominated as Non Executive Director Lead for EPRR at UHNM.
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	• EPRR Strategy Sept 2021 V 2.1	Fully compliant	No action required	Approved EPRR strategy in place as of September 2018, scheduled for review in September 2020. Strategy is currently out for comment / endorsement . Only changes to note are that of job titles within the EPRR team
3	**Governance**	**EPRR board reports**	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process.	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board	•Network Incident 2019 •Annual Assurance 2020 • December 2020 board pack with the EPRR annual assurance report • Minutes from December Board • Highlight reports from the network incident committee that were presented to Closed Board. •Minutes agreeing to stand the Network task and finish committee down.	Fully compliant	No action required	December 2018 Board report includes all prerequsistes detailed in Core Standards . March 2019 Board report icludes T&F Group progress against Fire Evacuation Incident recommendations. April 2019 Board report includes 2018 Core Standards letter from CCG and progress from recommendations as agreed with NHS England and CCG.
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	• EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	• EPRR Strategy Sept 2021 V 2.1	Fully compliant	No action required	EPRR Strategy in place, appropriate resources in terms of EPRR staffing in place. Receruited Head of Resilience July 2020 on a permanent post, recruited x2 EPRR manager post on a permanent basis from September 2020, EPRR PA remains in post
6	**Governance**	**Continuous improvement process**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	• Process explicitly described within the EPRR policy statement	•EPRR Strategy Sept 2021 V 2.1 •Network IncidentDebrief •Biochemisty Analyser Outage •ICC Covid Operational Plan	Fully compliant	No action required	EPRR Team maintained an ICC as per NHSE Incdent requirements durin gthe pandemic at all levels of declared incicents, full learning caputted in the Covid Operatiional Plan Within EPRR Strategy, process demonstrated with recent suspect package outside ED (most recent incident at UHNM August 2021) Set up Change Advisory Bureau for any System / network works / maintenace required with exeutive and divisional sign off - following learnings from Network Incident 2019
Domain 2 - Duty to risk assess								
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register	•UHNM Risk Management Policy	Fully compliant	No action required	UHNM Risk management Policy in Place, updated policy February 2021 EPRR risks reveiwed on Datix and updated August 2021 by Head of Resilieience
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	•UHNM Risk Management Policy •EPRR Strategy Sept 2021 V 2.1	Fully compliant	No action required	UHNM Risk management Policy in Place, updated policy February 2021, EPRR Strategy in place with reference to Risk assessment.
Domain 3 - Duty to maintain plans								

11	Duty to maintain plans	Critical incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	•Major Incident Response and Recovery Plan.	Fully compliant	No action required	Major Incident Response Plan in place. Currenly under review following the Pandemic with associated policies / procedures to ensure reflection of new ways of working and national guidance Critical Incident referenced as part of inclusion of NHSE EPRR Framework. Decision process in place guiding staff to declaration of Critical, BC or Major Incident
12	Duty to maintain plans	Major incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	•Major Incident Response and Recovery Plan	Fully compliant	No action required	Major Incident Response Plan in place. Currenly under review following the Pandemic with associated policies / procedures to ensure reflection of new ways of working and national guidance, and will obtain executive signoff as per UHNM Governance arrangements for sign off Critical Incident referenced as part of inclusion of NHSE EPRR Framework. Decision process in place guiding staff to declaration of Critical, BC or Major Incident
13	Duty to maintain plans	Heatwave	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	•Trust Severe Weather plan	Fully compliant	No action required	UHNM Severe Weather Plan in place Full Communications support for public awareness Summary plan issued during heat health risk period in July 2021
14	Duty to maintain plans	Cold weather	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	•Trust Severe Weather Plan	Fully compliant	No action required	UHNM Severe Weather Plan in place if required summary plan to be issued during cold weather period durng Winter 2021 Full Communications support for public awareness
18	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	•Mass Casualty Plan • Mass Cas TOR •Mass Cas Agenda •Mins from Mass Cas Working Group •letter from UHNM to WMAS re P1 P2 and P3 allocation •confirmation response from WMAS	Fully compliant	No action required	Internal Plans will accommodate 10% within 6 hrs utilising fast-track discharges, Day surgery suite, cancellation of elective procedures, utilising the Discharge Lounge, converting the surgical day ward into a decanting /co-horting area and using day-surgery model of care for P3 patients. Mass Casualty Working Group restarted since the Pandemic, Mass Casulaty overarching plan under review along with Divisions reviewing speciality plans and developing Action Cards. Confirmation sent to WMAS regarding number of P1s at RS that can be accomodated, and removal of P2 / P3 from County Hospital
19	Duty to maintain plans	Mass Casualty - patient identification	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	•Adult and Paediatric temporary admission packs Photographic Evidence from ED	Fully compliant	No action required	ED has over x100 Adult and Paediatric patient admission packs each with unique non-sequential identification numbers. These numbers would follow the patients after admission via Medway through investigation departments (Haematology, X-Ray, Biochemistry, etc.), Theatres, Critical care and the wards. The tempoary patient identification packs have been utilised during network mainteannce down time with good effect
20	Duty to maintain plans	Shelter and evacuation	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	•Evacuation Policy	Fully compliant	No action required	Evacuation Policy in place, due for review January 2022
21	Duty to maintain plans	Lockdown	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	•Security policy • Lockdown permiter door table	Fully compliant	No action required	EPRR currently in the process of working with our LSMS to carry out risk assessments for all operational areas to update the opertional plan to meet NHS guidance These lockdown plans have been compiled into a series of instructions for use in the ICC that will facilitate lockdown of indicvisiual buildings on UHNM sites.
22	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	•Trust Policy for Managing Visits by Celebrities, VIP's and other Official Visitors to UHNM •Staffordshire Resilience Partners Operation Bridge Plan	Fully compliant	No action required	Trust Policy for Managing Visits by Celebrities, VIP's and other Official Visitors to UHNM UHNM actively particpated with local health partners in devceloipment with the Staffordshire resilience Operation Bridge Response Plan
Domain 4 - Command and control								

24	**Command and control**	**On-call mechanism**	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.	•EPRR Strategy Sept 2021 V 2.1 •Silver Command Training Programme Agenda •Silver Command Training Presentation •UHNM Escslation Additional Slides •Gold Incident Command Presentation •UHNM Mass Casualty Presentation	Fully compliant	ongoing training for further staff to be arranged during 2021 / 2022	All Bronze, Silver and Gold on call staff are drawn from senior experienced operational and management roles and have recevied EPRR Major Incident training Updated Silver / Gold training provided by C4 in September 2020 Commencement of Site Matron / Patient Flow training specifically Defensible Decisions, Major Incident and Mass Casualty, CBRN
Domain 5 - Training and exercising								
Domain 6 - Response								
30	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has Incident Co-ordination Centre (ICC) arrangements		• ICC Covid Rota January - March 2021 •ICC Covid Operational plan •SOC / GOC rota template	Fully compliant		EPRR Team maintained an ICC as per NHSE Incdent requirements durin gthe pandemic Rot in place to cover 12 hr 7/7 rota with additioanl support from other areas Processes in place to set up ICC, tested during Pandemic and suspect package Locations identiifed in training materials ICC training as part of Silver and Gold training programmes Action cards and roles documented in incident response plan Resilient communications in place including mobile telephony and radios. Alternative venue identified due to Covid the ICC can be extended to Microsoft teams facilities and iutilisation of the trust boardroom for social distancing purposes can accomodate x12 people if required Royal Stoke ICC manages County Hospital inciients with EPRR Manager relocated to County to support any incidents
32	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	• Business Continuity Response plans	•Major Incident Response and Recovery Plan •OP02 Business Continuity Management Plan	Fully compliant		All divisions have Business Continuity Leads and Directorates have completed BC plans. BC Policy (OP02) revised July 2018 and approved by TEC and Trust Board. Incident Response Plan to be implemented to ensure robust management including recovery processes.
34	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	• Documented processes for completing, signing off and submitting SitReps	•Covid RS Daily report template • Covid CH Daily report template •Covid Daily Discharge report template •August Bank Holiday slide pack	Fully compliant		EPRR are the trust covid reporting mechanism 7 days a week including bank holidays since commencement of Covid reporting. EPRR ensure summary of submitted Covid reports is circulated interally to exeutives SitReps completed daily during times of business continuity incidents, critical incidents and major incidents (also Bank Holidays). Shared with NHS England North Midlands and Staffordshire community providers.
35	**Response**	**Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'**	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	• Guidance is available to appropriate staff either electronically or hard copies	•Clinical Guidelines for Major Incident •Clinical Guidelines for Major Incident •Photographic Evidence from ED	Fully compliant	No action required	Guidance is available to ED staff both electronically and hard copy (the latter are stored in the Major Incident Box
36	**Response**	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	• Guidance is available to appropriate staff either electronically or hard copies	•PHE Clinical Guidelines for Clinical Management and Health Protection of CBRN patients •PHE Clinical Guidelines for CBRN Photographic Evidence from ED •Code Black Policy	Fully compliant	Code Black plan under current review	Guidance is available to appropriate staff either electronically or hard copies. Hard copies kept in ED Offices and also working copies in the Major Incident folders trolley with other documentation such as NHSE 'Clinical Guidance for Major Incidents' handbook & PHE 'CBRN incident: Clinical Management and health protection' guidance.
Domain 7 - Warning and informing								
37	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work	•Exercise Mercury end of resilience test • Mercury end of submission test • GOC, SOC and MOD on call rota •Staffordshire On call Rota	Fully compliant	No action required	UHNM have robust links with partner organisations that are tested on a regular basis via NHSE and CCG led multiagency exercises. Contact directories located in ICC (NHSE and UHNM developed) with availability of key contacts for all Silver and Gold staff and EPRR team.
38	**Warning and informing**	**Warning and informing**	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing	•Confirmer System SoP •Snapshot of MI grouping for confirmer	Fully compliant	No action required	Confirmer System in place Red phones in place in key areas at Royal Stoke and County Hospital should network fail Comms team link with external partners

39	**Warning and informing**	**Media strategy**	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a media spokespeople able to represent the organisation to the media at all times.	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy	•Trust Policy for Media	Fully compliant	No action required	Media policy in place Media Trained GOCs and Execs Tracy Bullock Chief Executive Paul Bytheway, Chief Operating Officer Dr John Oxtoby, Medical Director Helen Ashley, Chief Officer Finance and Performance Dr Chris Pickering, Clinical Lead and Emergency Medicine Consultant Naomi Duggan, Director of Communications
Domain 8 - Cooperation								
42	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate	•MOU for Mutual Aid •MACA	Fully compliant	No action required	UHNM signed up to MOU. MACA form available to on call teams in the event of assistance required. Activation processes for CCU available to on call teams.
43	**Cooperation**	**Arrangements for multi-region response**	Arrangements outlining the process for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.	• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs	•Major Incident Plan •NHSE Concept of Operations •NHSE EPRR Framework	Fully compliant	No action required	Outlined in the NHSE EPRR Framework and West Midlands Concept of Operations (NHSE). UHNM plans work alongside these plans with robust communication links in place.
44	**Cooperation**	**Health tripartite working**	Arrangements are in place defining how NHS England, the Department of Health and Social Care and Public Health England will communicate and work together, including how information relating to national emergencies will be cascaded.	• Detailed documentation on the process for managing the national health aspects of an emergency	•Major Incident Plan •NHSE Concept of Operations •NHSE EPRR Framework	Fully compliant	No action required	Outlined in the NHSE EPRR Framework and West Midlands Concept of Operations (NHSE). UHNM plans work alongside these plans with robust communication links in place.
46	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.	•Trust Information Governance Policy •Major Incident Response and Recovery plan	Fully compliant	No action required	Detailed in Incident Response Plan and covered in MOU to which we are signed up. In addition UHNM has an information sharing policy outlined in the IG Policy
Domain 9 - Business Continuity								
47	**Business Continuity**	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continutiy Management System (BCMS) in alignment to the ISO standard 22301.	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement	•OP02 Business Continuity Management Policy	Fully compliant	No action required	Business Continuity Policy September 2021 updated and ratified
48	**Business Continuity**	**BCMS scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders	•OP02 Business Continuity Management Policy	Fully compliant	No action required	Scope and objectives detailed in Business Continuity Policy
50	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Statement of compliance	•Action Plan	Fully compliant	Resubmission confirmation	Following review and identifying a shortfall against one standard of the Data Protection and Security Toolkit Therefore, in line with NHSD guidance an improvement plan has been developed and approved by NHSD. The improvement plan is scheduled for implementation by 30th September and is currently on track. Once implemented wil be contacting NHSD to determine if we can re-submit our assessment to achieve standards met rating from 1st October 2021
51	**Business Continuity**	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	•BAU County Theatres •BIA County HSDU •HR Business Continuity Plan •Biochemistry Analyser Outage Debrief	Fully compliant	No action required	Complete review of Business Continuity Management is being undertaken, Identified Critical Functions have Business Impact Analysis and Business Continuity Plans in place, with debriefs undertaken following disruption events (actual or simulated) so that learning's can be incorporated into the continuous cycle of improvement culture the Trust has.
53	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports	•monthly EIG paper - July 2021 •weekly EPRR storyboard - week 33 •EPRR monthly review - July 2021	Fully compliant	No action required	Monthly EIG paper Weekly EPRR storyboard to DCOO Monthly EPRR update with AEO to support board updates

54	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectivness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans	•PTS Booking Office BIA	Fully compliant	No action required	BIAs and Plans reviewed every two years and learning's from activations (real or simulated) are included in the revisions. As part of the Business Continuity Magament System continual review and update utulising from incidents or training exercises
55	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	•Supplies and Procurement BCP	Fully compliant	No action required	Detailed in Business Continuity Policy. BC assessment part of procurement and contracting processes.
Domain 10 CBRN								
56	**CBRN**	**Telephony advice for CBRN exposure**	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	•Code Black Policy	Fully compliant	No action required	Numbers/advice locations contained within local CBRN Policy Please note Code Black Plan under current review with sign off September / October 2021
57	**CBRN**	**HAZMAT / CBRN planning arrangement**	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	•Code Black Plan •Trust CBRN Exercise Plan •Trust Training CBRN Slides / Package	Fully compliant	No Action Required	Code Black Plan Decontamination processes reviewed Exercise conducted at both RS and CH site in preparation for WMAS Audit visit in 14th October (provisional date)
58	**CBRN**	**HAZMAT / CBRN risk assessments**	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	• Impact assessment of CBRN decontamination on other key facilities	•Code Black Policy •CBRN Risk Assessment •Trust Waste Management Policy •Management of Substances Hazardous to Health	Fully compliant	No action required	Code Black Policy, Trusts Risk Assessment on Corporate Register Waste guidance through UHNM Policy EF05 (Waste Management) and HS20 (Control of Substances Hazardous to Health).
59	**CBRN**	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.		•Code Black Plan	Fully compliant	No action required	RS - Fixed decontamination units, staffed by RSUH ED 24/7 . Flow rate of showers and waste water capacity allows for up to 6 patients per hour or per cycle of waste tank due to tank capture and flow rating CH - Fixed decontamination units, staffed by CH ED 08:00 - 22:00 . Flow rate of showers and waste water capacity allows for up to 6.1 patients per hour or per cycle of waste tank due to tank cpature and flow rating
60	**CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	• Completed equipment inventories; including completion date	•Code Black Policy	Fully compliant	No action required	Appropriate equipment held including: PRPS Ram-Gene FFP3 Dis-Robe & Re-Robe packs Antidote stock held in ED (as per National Poisons Information Service) Sufficient antibiotic stock held centrally for Major Incidents (Anthrax, Plague, Tularemia)
62	**CBRN**	**Equipment checks**	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	• Record of equipment checks, including date completed and by whom. • Report of any missing equipment	•PRPS Respirex Recertification •RAMGENE Check	Fully compliant	No Action Required	PRPS serviced as per national and manufacturers guidelines. Tents NA RS - Integral Decontamination Chamber on a service/maintenance program including the waste tank, Showers flushed by Sodexo staff in line with IP protocols. CH - Integral Decontamination Chamber on a service / mainteance programe including the waste bladder with 500l capacity x2 and showers flushed by Retained Estate staff in line with IP protocols RAM-GENE (x4 at RS and x2 at CH) owned by the Medical Physics Dept., checked/serviced on an annual basis (June 2021) by Medical Physics Major Incident Storeroom stock checked physically and manually recorded in conjunction with the electronic system set up through Supplies and Procurement dept

65	**CBRN**	**HAZMAT / CBRN training lead**	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	• Maintenance of CPD records	•RAMGene Training Package •Code Black Training Slides for ED •Major Incident / CBRN awareness for site team •PRPS Training Package •ED Reception Staff training Package	Fully compliant	No action required	All new ED staff have 2hrs training on CBRN/HAZMAT policies and procedures on Trust Induction within ED, training is provided by a team of three trainers, in additional 16 UHNM staff are "Train the Trainer trained" in PRPS which was delivered by WMAS during September 2021 ED, Site Matrons, OMOD, Silver and Gold currently receiving awareness and training in CBRN / Major Incident Trust now has x2 designated Silver tactical Advisors
67	**CBRN**	**HAZMAT / CBRN trained trainers**	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	• Maintenance of CPD records	•Code Black Training Slides •Major Incient / CBRN awareness •Training Record Attendance Sheets from •County •Training Record Attendance Sheets from •Royal Stoke	Fully compliant	No action required	Training in ED is provided by senior team of three trainers and supported y the Trusts EPRR team
68	**CBRN**	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	• Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • All service providers - see Guidance for the initial management of self presenters from incidents involving hazardous materials - https://www.england.nhs.uk/publication/eprr-guidance-for-the-initial-management-of-self-presenters-from-incidents-involving-hazardous-materials/ • All service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • A range of staff roles are trained in decontamination technique	•Code Black Plan	Fully compliant	No action required	Covered in Trust ED Induction, Code Black Policy and actioncards, ED Local Lock-Down Policy Divisions inreach into department and will be covered within their diisional induction Clinical, Nursing, Administration, Security and Support staff in both Adult & Paediatric Emergency Departments trained in IOR Dry and Wet Decontamination and the route patients should take
69	**CBRN**	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.		•FFP3 Mask fitting testing dates	Fully compliant	No action required	Compliant in all Trust areas due to the Covid-19 Pandemic and NHSE/I directive for masks to be worn by all personnel on Trust sites Continual Mask Fit testing provision on all key identified personnel with patient facing contact, continue to provide this testing service for all new staff, juniors and nursing students In addition staff are mask fit tested in other providers of masks

Ref	Domain	Standard	Detail	Evidence - examples listed below	Organisational Evidence	Self assessment RAG **Red (not compliant) =** Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Comments
Deep Dive - Oxygen Supply **Domain: Oxygen Supply**								
DD1	**Oxygen Supply**	**Medical gasses - governance**	The organisation has in place an effective Medical Gas Committee as described in Health Technical Memorandum HTM02-01 Part B.	• Committee meets annually as a minimum • Committee has signed off terms of reference • Minutes of Committee meetings are maintained • Actions from the Committee are managed effectively • Committee reports progress and any issues to the Chief Executive • Committee develops and maintains organisational policies and procedures • Committee develops site resilience/contingency plans with related standard operating procedures (SOPs) • Committee escalates risk onto the organisational risk register and Board Assurance Framework where appropriate • The Committee receives Authorising Engineer's annual report and prepares an action plan to address issues, there being evidence that this is reported to the organisation's Board	• Medical Gas Working Group • ToR • Medical Gas Working Group Minutes • AE Audit	Fully compliant	No action required	• Medical Gas Working Group meets every 2 months • TOR signed off and in place • Minutes of each meeting recorded and reviewed • Relevant issues escalated to Trust Board • All relevant policies and procedures reviewed by the Medical Gas Working Group • Site resiliance/contingency plans developed by the relevant division and reviewed at the Medical Gas Working Group • Risks are escalated onto the organisational risk register by the relevant department and reviewed by the Medical Gas Working Group • The Trust AE carries out an annual audit which includes an action plan. This is presented at the Medical Gas Working Group.
DD2	**Oxygen Supply**	**Medical gasses - planning**	The organisation has robust and tested Business Continuity and/or Disaster Recovery plans for medical gases	• The organisation has reviewed and updated the plans and are they available for view • The organisation has assessed its maximum anticipated flow rate using the national toolkit • The organisation has documented plans (agreed with suppliers) to achieve rectification of identified shortfalls in infrastructure capacity requirements. • The organisation has documented a pipework survey that provides assurance of oxygen supply capacity in designated wards across the site • The organisation has clear plans for where oxygen cylinders are used and this has been discussed and there should be an agreement with the supplier to know the location and distribution so they can advise on storage and risk, on delivery times and numbers of cylinders and any escalation procedure in the event of an emergency (e.g. understand if there is a maximum limit to the number of cylinders the supplier has available) • Standard Operating Procedures exist and are available for staff regarding the use, storage and operation of cylinders that meet safety and security policies • The organisation has breaching points available to support access for additional equipment as required • The organisation has a developed plan for ward level education and training on good housekeeping practices • The organisation has available a comprehensive needs assessment to identify training and education requirements for safe management of medical gases	• Action Plan	Fully compliant	No action required	• Action plan approved by Gold Tactical and in place for the management of oxygen during periods of high demand. Emergency procedures in place within Estates. • Flowrates monitored daily using supplier telemetry data (both sites) and oxygen meters installed monitoring each building (Royal Stoke). • Capital developement scheme commissioned to install a second VIE plant and increase the size of the pipework to identified sections of the ring main at Royal Stoke. Oxygen infacstructure at County Hospital meets requirements following the IHSS scheme. • Oxygen supply capacity for each ward tested by specialist contractor and documented. • The Trust and BOC (supplier) colaborate on cylinder requirements, cylinder storage, delivery points, emergency supply criteria and cylinder audits to determine the correct number of cylinders required. • Training module developed via the Medical Gas Working group for clinical staff. Training for non-clinical staff delivered by external provider and records kept. • NIST points installed at line valve positions and are also incorporated within department AVSU's to enable connection of additional equipment. • Training module developed via the Medical Gas Working group for clinical staff includes good houskeeping practices. • All training requirements reviewed by the Medical Gas Working Group and implemented by each department.
DD3	**Oxygen Supply**	**Medical gasses - planning**	The organisation has used Appendix H to the HTM 0201 part A to support the planning, installing, upgrading of its cryogenic liquid supply system.	• The organisation has clear guidance that includes delivery frequency for medical gases that identifies key requirements for safe and secure deliveries • The organisation has policy to support consistent calculation for medical gas consumption to support supply mechanisms • The organisation has a policy for the maintenance of pipework and systems that includes regular checking for leaks and having de-icing regimes • Organisation has utilised the checklist retrospectively as part of an assurance or audit process	• Consumption record	Fully compliant	No action required	• Delivery frequency requirement is constantly monitored by the supplier via telemetry. Dedicated delivery zones in accordance with HTM02 are in place to ensure safe and secure deliveries • Consumption is monitored and recorded daily by Estates • Planned Preventative Maintenance carried out by Estates Staff and Specialist Contractor in accordance with HTM02 • Appendix H checklist is used as part of the AE annual audit.

DD4	**Oxygen Supply**	**Medical gasses -workforce**	The organisation has reviewed the skills and competencies of identified roles within the HTM and has assurance of resilience for these functions.	• Job descriptions/person specifications are available to cover each identified role • Rotating of staff to ensure staff leave/ shift patterns are planned around availability of key personnel e.g. ensuring QC (MGPS) availability for commissioning upgrade work. • Education and training packages are available for all identified roles and attendance is monitored on compliance to training requirements • Medical gas training forms part of the induction package for all staff.	• Training module slide set	Fully compliant		• The requirement to cover each role as identified in HTM02 is included in clinical/non-clinical job descriptions and person specifications • Shift patterns planned and in place including on call systems. On site QC available for all testing and commissioning requirements. • Training module developed via the Medical Gas Working group for clinical staff. Training for non-clinical staff delivered by external provider and records kept. • Medical gas training included within induction for clinical staff, but not non-clinical staff.
DD5	**Oxygen Supply**	**Oxygen systems - escalation**	The organisation has a clear escalation plan and processes for management of surge in oxygen demand	• SOPs exist, and have been reviewed and updated, for 'stand up' of weekly/ daily multi-disciplinary oxygen rounds • Staff are informed and aware of the requirements for increasing de-icing of vaporisers • SOPs are available for the 'good housekeeping' practices identified during the pandemic surge and include, for example, Medical Director sign off for the use of HFNO	• Oxygen Escalation SoP Action Plan	Fully compliant	No action required	• Action plan approved by Gold Tactical and in place. This covers clinical and non-clinical 'stand up' requirements triggered by comsumption levels and includes ward round team assure checks, increased de-icing of vaporisers, good housekeeping and high level sign off by COO/Deputy COO.
DD6	**Oxygen Supply**	**Oxygen systems**	Organisation has an accurate and up to date technical file on its oxygen supply system with the relevant instruction for use (IFU)	• Reviewed and updated instructions for use (IFU), where required as part of Authorising Engineer's annual verification and report		Fully compliant	No action required	IFU to be included in the next AE annual audit
DD7	**Oxygen Supply**	**Oxygen systems**	The organisation has undertaken as risk assessment in the development of the medical oxygen installation to produce a safe and practical design and ensure that a safe supply of oxygen is available for patient use at all times as described in Health Technical Memorandum HTM02-01 6.6	• Organisation has a risk assessment as per section 6.6 of the HTM 02-01 • Organisation has undertaken an annual review of the risk assessment as per section 6.134 of the HTM 02-01 (please indicated in the organisational evidence column the date of your last review)		Fully compliant	Risk assessment to be developed and reviewed	Risk assessment be developed and reviewed To be completed in line with the 2nd VIE installation at Royal Stoke

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	3rd November 2021
Report Title:	Calendar of Business 2022/23	**Agenda Item:**	19.
Author:	Nicola Hassall, Deputy Associate Director of Corporate Governance		
Executive Lead:	All		

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 and Background

The Trust Calendar of Business includes dates for all Board, Committee and Executive Group meetings. Dates have been set based on the 2021/22 cycle, to enable reports to be considered at respective Executive Groups and Committees prior to submission to the Trust Board.

Assessment

The Calendar of Business for 2022/23 follows the similar sequencing of meetings as per 2021/22, although a number of changes should be noted as follows:

- Dates of Committees have been moved to a week later, in order to enable performance data to be considered and scrutinised at Divisional Performance Reviews prior to presentation at Committees
- Performance Review meetings are to be held a week earlier than the 2021/22 schedule
- Some changes have been made to the timing of Executive Groups to increase attendance and enable the presentation of up to date information at the meetings

It should be noted that although the scheduling of Committee meetings follow the same pattern as for 2021/22, in December meetings are held earlier due to the Bank Holiday and Christmas periods, therefore some information may not be available for these meetings.

Key Recommendations:

The Trust Board is asked to **approve** the Calendar of Business for 2022/23.

Calendar of Business 2022 / 2023

NHS University Hospitals of North Midlands NHS Trust

	Sat	Sun	Mon	Tue	Wed	Thur	Fri	Sat	Sun	Mon	Tue	Wed	Thur	Fri	Sat	Sun	Mon	Tue	Wed	Thur	Fri	Sat	Sun	Mon	Tue	Wed	Thur	Fri	Sat	Sun	Mon	Tue	Wed	Thur	Fri	Sat	Sun
April							1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
M12 Reporting											EBI	PTB CTB CT		EIG			QSOG		EST ERI	EHSG ODG	BH			BH	PRC PRS		PRM PRSp	EWAG				PAF	TAP	QGC	AC		
May		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31					
M1 Reporting			BH		PTB CTB							TBS NRC	DSP							EHSG ODG				QSOG	PRC PRS		PRM PRSp	CC				PAF TAP					
June					1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30			
M2 Reporting					QGC AC	BH	BH				EBI	PTB CTB		EIG					EST ERI	EHSG ODG				QSOG	PRC PRS		PRM PRSp	EWAG				PAF	TAP	QGC			
July							1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
M3 Reporting												PTB CTB	DSP						TBS NRC	EHSG ODG				QSOG	PRC PRS		PRM PRSp					PAF	TAP	QGC AC	CC		
August			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31				
M4 Reporting					PTB CTB						EBI			EIG					EST ERI	EHSG ODG				QSOG	PRC PRS		PRM PRSp	EWAG			BH	PAF	TAP				
September						1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30		
M5 Reporting						QGC						CTB AGM	DSP						TBS NRC	EHSG ODG				QSOG	PRC PRS		PRM PRSp					PAF	TAP	QGC	CC		
October	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31						
M6 Reporting					PTB CTB						EBI		DSP	EIG					EST ERI	EHSG ODG				QSOG	PRC PRS		PRM PRSp	EWAG									
November				1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30				
M7 Reporting				PAF	TAP	QGC	AC					PTB CTB						BTO	BTO	EHSG ODG				QSOG	PRC PRS		PRM PRSp					PAF	TAP				
December						1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
M8 Reporting						QGC	CC				EBI	PTB CTB	DSP	EIG			QSOG	PRC PRS	EST ERI	PRM PRSp ODG	EHSG EWAG				PAF	TAP	QGC				BH	BH					
January		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31					
M9 Reporting			BH		PTB CTB CT							TBS NRC								EHSG ODG				QSOG	PRC PRS		PRM PRSp					PAF					
February					1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28					
M10 Reporting					TAP	QGC AC	CC				EBI	PTB CTB	DSP	EIG					EST ERI	EHSG ODG				QSOG	PRC PRS		PRM PRSp	EWAG				PAF					
March					1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		
M11 Reporting					TAP	QGC						PTB CTB	DSP						TBS NRC	EHSG ODG				QSOG	PRC PRS		PRM PRSp					PAF	TAP	QGC	CC		

COLOUR KEY		TIME
Public Trust Board	PTB	9:30 - 12.30 pm
Closed Trust Board	CTB	1.00 - 2.30 pm
Trust Board Seminar	TBS	9.00 - 1.00 pm
Trust Board Time Out	BTO	9.00 - 4.30 pm
Annual General Meeting	AGM	1.00 - 3.00 pm
Performance and Finance Committee	PAF	9.00 - 12.00 pm
Executive Infrastructure Group	EIG	10.00 - 12.00 pm
Executive Business Intelligence Group	EBI	9.30 - 11.30 am
Executive Data Security and Protection Group	DSP	2.00 - 4.00 pm
Executive Operational Delivery Group	ODG	4.00 - 5.00 pm
Audit Committee	AC	12.30 - 3.00 pm
Quality Governance Committee	QGC	9.00 - 11.30 am
Executive Health and Safety Group	EHSG	10.00 - 12.00 pm
Executive Quality and Safety Oversight Group	QSOG	2.00 pm - 4.00 pm
Nomination & Remuneration Committee	NRC	1.30 - 3.00 pm
Transformation and People Committee	TAP	9.00 - 11.30 am
Executive Research & Innovation Group	ERI	2.00 - 4.00 pm
Executive Workforce Assurance Group	EWAG	9.00 - 11.00 am
Executive Strategy and Transformation Group	EST	9.00 - 11.00 am
Performance Management Reviews	PR	C 8.30 - 10.30 am S 11.00 - 1.00 pm M 9.00 - 11.00 am Sp 11.30 - 1.30 pm
Corporate Trustee	CT	3.00 - 4.00 pm
Charity Committee	CC	10.00 - 12.00 pm

Staffordshire School Holidays	

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	3rd November 2021
Report Title:	Update on Board Development Programme	**Agenda Item:**	20.
Author:	Claire Rylands, Associate Director of Corporate Governance		
Executive Lead:	Tracy Bullock, Chief Executive		

Purpose of Report:

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

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

Executive Summary:

Situation

This paper is to provide the Board with an overview on progress against the topics identified within the 2021/22 Board Development Programme.

Background

The Board Development Programme was approved by the Board in July 2021. This comprised a range of development work / activities that had been identified by the Board and the programme was aligned to the Trust's Strategic Priorities.

Assessment

A review of the Board Development Programme has been undertaken and the attached demonstrates the topics which have been covered as planned, items which have been deferred to future meetings, in addition to items which have been added to the programme since July.

Key Recommendations:

The Board is asked to note the updated Board Development Programme, approve the revised timing of activities for the remainder of 2021/22 in addition to identifying any other items for inclusion.

Board Development Programme

2021 / 2022 Timetable

NHS
University Hospitals of North Midlands
NHS Trust

Strategic Priority	Topic	Development (D) or Business (B)	Purpose / Outcome	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
					12th				15th		9th / 10th		12th		16th
Resources	UHNM Charity	D	Understanding of Charity Governance and future direction												
Systems & Partners	Draft System Plan	B	Understanding and agreement of the core elements of the System Plan submission, including key risks			Closed Board 9th									
Resources	Clinical Strategy	B	Contribute to and / approve the revised Clinical Strategy.					Closed Board 4th				Closed Board 8th			
Improving & Innovating	Well Led Assessment	B	To self-assess against the Well Led Framework, identifying any gaps to be addressed					Virtual							
Improving & Innovating	Improving Together	D	Understanding of programme progress to date, key risks, Board / Committee assurance and next steps.						Closed Board 9th						
Improving & Innovating	Digital Transformation	D	Session provided by NHS Providers					→							
High Quality	Patient Safety Specialist Role	D & B	NEW: Overview of the introduction of the role including Executive and Board requirements							Closed Board 6th					
Resources	Cyber Security	D & B	NEW: Session provided by NHS Digital								Time Out 9th				
People	Race Equality Code	D & B	NEW: Awareness of the Code encompassing the standards, overarching accountability framework								Time Out 9th				
Systems & Partners	The White Paper	D & B	Session provided by Browne Jacobson								Time Out 10th				
People	Board Development	D	Content and timing to be confirmed								Time Out 10th				
Resources	New Financial Regime – H2	D & B	Understanding of, and key issues/implications								Time Out 10th				
Systems & Partners	Provider Collaboratives	D & B	Understanding the work undertaken to date and any key issues to be addressed							→		Closed Board 8th			
People	Culture Review	B	Report from Independent Review into bullying and harassment – October								→			Open Board 9th	

Together Compassion Safe Improving

PROUD TO CARE

Strategic Priority	Topic	Development (D) or Business (B)	Purpose / Outcome	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
					12th				15th		9th / 10th		12th		16th
			Trust response and actions taken – November												
Systems & Partners	ICS Development	D & B	Understanding progress made with the Integrated Care System (ICS) and any key issues to be addressed.									→			
Improving & Innovating	Risk Appetite	B	Understanding of the revised Risk Appetite Statement and how this should be applied to the BAF.												
Improving & Innovating	Strategic Risks – BAF	B	Agreement of the Strategic Risks for the Board Assurance Framework (BAF) for 2022/23.												
Responsive	'State of the Nation'	D	External Speaker to be confirmed												
Resources	System Oversight Framework	D	Understanding of the new SOF and key issues/ implications for NHS Trusts												

Key:

	Complete
	Planned
	Delayed

Trust Board

2021/22 BUSINESS CYCLE

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

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Notes
		7	5	9	7	4	8	6	3	8	5	9	9	
PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES														
Chief Executives Report	Chief Executive													
Patient Story	Chief Nurse													
Quality Governance Committee Assurance Report	Associate Director of Corporate Governance													
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer													
Care Quality Commission Action Plan	Chief Nurse													Highlighted as part of QGC Assurance Summary
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													
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													
Annual Plan	Chief Finance Officer													
Capital Programme 2021/22	Chief Finance Officer													
GOVERNANCE														

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Notes
		7	5	9	7	4	8	6	3	8	5	9	9	
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.