University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 8th December 2021 at 9.30 am to 12.30 pm via Microsoft Teams

AGENDA

Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
09:30	**PROCEDURAL ITEMS**					
20 mins	1.	Staff Story	Information	Mrs R Vaughan	Verbal	
5 mins	2.	Chair's Welcome, Apologies and Confirmation of Quoracy	Information	Mr D Wakefield	Verbal	
	3.	Declarations of Interest	Information	Mr D Wakefield	Verbal	
	4.	Minutes of the Meeting held 3rd November 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 – November 2021	Information	Mrs T Bullock	Enclosure	**BAF 6**
10:15	**PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES**					
5 mins 10 mins	8.	Quality Governance Committee Assurance Report (25-11-211) • Update on caesarean section rates	Assurance	Ms S Belfield Dr J Chan	Enclosure Presentation	**BAF 1**
5 mins	9.	IPC Board Assurance Framework - November 2021	Assurance	Mrs AM Riley	Enclosure	**BAF 1**
10:35	**ENSURE EFFICIENT USE OF RESOURCES**					
5 mins	10.	Performance & Finance Committee Assurance Report (23-11-21)	Assurance	Mr P Akid	Enclosure	**BAF 9**
30 mins	11.	H2 Plan	Assurance	Ms H Ashley Mr P Bytheway Mrs R Vaughan Mr M Oldham	Enclosure	
11:10 – 11:25: COMFORT BREAK						
11:25	**ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT AND RESEARCH**					
5 mins	12.	Transformation and People Committee Assurance Report (24-11-21)	Assurance	Prof G Crowe	Enclosure	**BAF 2 & 3**
11:30	**ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS**					
40 mins	13.	Integrated Performance Report – Month 7	Assurance	Mrs AM Riley Mr P Bytheway Mrs R Vaughan Mr J Tringham	Enclosure	
12:10	**GOVERNANCE**					
10 mins	14.	Raising Concerns Report – Quarter 2	Assurance	Mrs R Vaughan	Enclosure	
12:20	**CLOSING MATTERS**					
5 mins	15.	Review of Meeting Effectiveness and Business Cycle Forward Look	Information	Mr D Wakefield	Enclosure	
	16.	Questions from the Public **Please submit questions in relation to the agenda, by 9.00 am 6th December to nicola.hassall@uhnm.nhs.uk**	Discussion	Mr D Wakefield	Verbal	
12:25	**DATE AND TIME OF NEXT MEETING**					
	17.	**Wednesday 5th January 2022, 9.30 am via Microsoft Teams**				

University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 3rd November 2021, 9.30 am to 12.45 pm
Via Microsoft Teams

MINUTES OF MEETING

Attended	Apologies / Deputy Sent	Apologies

Voting Members:			A	M	J	J	J	A	O	N	D	J	F	M
Mr D Wakefield	DW	Chairman (Chair)												
Mr P Akid	PA	Non-Executive Director												
Ms S Belfield	SB	Non-Executive Director												
Mrs T Bowen	TBo	Non-Executive Director												
Mr P Bytheway	PB	Chief Operating Officer												
Mrs T Bullock	TB	Chief Executive												
Prof G Crowe	GC	Non-Executive Director						Chair						
Dr L Griffin	LG	Non-Executive Director												
Mr M Oldham	MO	Chief Financial Officer	JT											
Mr M Lewis	ML	Medical Director	JO	AW	JO	JO	JO	JO						
Dr K Maddock	KM	Non-Executive Director												
Mrs AM Riley	AR	Chief Nurse	SP	MR	SP	SP								
Mrs R Vaughan	RV	Director of Human Resources					JH							

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

In Attendance:	
Mrs L Dudley	Interim Head of Midwifery (item 9)
Mrs S Luyt	Patient Representative (item 1)
Dr K Karunanithi	Head of Research and Innovation (item 7)
Mrs A Grocott	Head of Patient Experience (item 1)

Members of Staff and Public via MS Teams: 7

No.	Agenda Item	Action
1.	**Patient Story**	
149/2021	Mrs Luyt recalled her son's story and highlighted that he had epilepsy and a number of other conditions which included the requirement for him to be fed via a PEG feeding tube. She recalled his experience whereby he had transitioned from paediatric care, where they both received excellent care, to adult care and the first time he was taken into the Emergency Department at Royal Stoke, as an adult, due to having a number fits with episodes of vomiting. She explained that her son remained there for over a day before being admitted into AMU at which point she told she would not be able to stay with her son, despite his complex needs, which included the inability to speak and learning difficulties. She explained that after speaking to the Matron, it was agreed she could stay with her son and did so for 3	

PROUD TO CARE

	days. She described some of the issues faced while caring for her son, which included the fact that he was cared for in a male bay, an abdominal x-ray which was not undertaken despite previous advice to do so, and no explanation given as to the reason why and the way in which she was not provided an opportunity for a break, due to the constant need for someone to be caring for her son. Mrs Luyt stated that it would have been a particular help if she had been provided with a little support to allow her comfort breaks etc in improving the overall experience. Professor Hassell queried if Mrs Luyt felt listened to and she confirmed she did not feel listened to, and felt like she was in the wrong by insisting she needed to stay with her son. Professor Hassell queried if any handover took place from paediatrics to adults in recognition of his needs and Mrs Luyt explained that this did occur between the epilepsy team. Mrs Riley referred to work which was ongoing in relation to developing a strategy for carers, to empower them so that they did not feel the need to ask for permission when caring for members of their family and it was noted that Mrs Luyt had already been invited to join the working group. Ms Ashley referred to the Children's Hospital Strategy and the associated plans for a transitional care unit which would help other families in similar situations, to transition between paediatric and adult care. She stated that it would be beneficial for Mrs Luyt to be involved in this as the work progressed. Dr Lewis agreed to liaise with Mrs Luyt in respect of future admissions so that a plan could be put in place to ensure her son's care was managed appropriately and the appropriate support provided. Ms Bowen queried if the medical team were aware of her son's background prior to being admitted to AMU and Mrs Luyt explained that his needs were not explored or recognised whilst in A&E which included the need for 24 hour care. It was clarified that the A&E department do not have access to the full patient records on attendance and are reliant on either the referrer of flags being in place on the electronic system. Mr Wakefield thanked Mr Luyt for her powerful story and apologised for her experience and summarised the actions to be taken including planning future admissions with Dr Lewis and involvement in future plans for a transitional care unit and carers strategy. **The Trust Board noted the patient story.** Mrs Luyt and Mrs Grocott left the meeting.	**ML**
2.	**Chair's Welcome, Apologies & Confirmation of Quoracy**	
150/2021	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.	
3.	**Declarations of Interest**	
151/2021	The standing declarations were noted.	

4.	**Minutes of the Previous Meeting held 6th October 2021**	
152/2021	The minutes of the meeting from 6th October 2021 were approved as an accurate record.	
5.	**Matters Arising from the Post Meeting Action Log**	
153/2021	PTB/487 – It was noted that this action had been completed and narrative included within the IPC Board Assurance Framework.	
6.	**Chief Executive's Report – October 2021**	
154/2021	Mrs Bullock highlighted a number of areas from her report. Mr Wakefield referred to Covid rates and queried whether the Trust was experiencing more admissions than other organisations. Mrs Bullock stated that it was difficult to determine given associated dynamics, but there had been more cases of Covid in the community but she not feel the Trust were an outlier in this regard. Dr Lewis referred to recent data for the Midlands and stated that the Trust's bed occupancy rate for Covid was in the middle of the pack. **The Trust Board received and noted the report and approved EREAF 8275.**	
STRATEGY		
7.	**Research Strategy**	
155/2021	Dr Karunanithi highlighted the main aim of the strategy was to move towards improving excellence in healthcare and the main vision of increasing capacity in Research and Innovation, alignment to national and local health priorities, improving performance, changing culture and improving finances to support further research. Ms Gohir referred to genomics and queried if this should be further emphasised within the strategy. She also queried the opportunity to increase recruitment of researchers. Dr Karunanithi stated that the Trust participated in the 100000 genomics project and added that funding was utilised to enable clinicians to work towards future case studies. He added that additional recruitment of researchers was being undertaken, working with Keele University, in order to bring more expertise into the Trust. Dr Lewis referred to the opportunity of working closely with nursing and allied health professionals to identify opportunities for research in other professional lines and stated that further work was required to determine a plan to realise those ambitions. Mr Akid queried whether work was undertaken with suppliers and other partners in relation to innovation and Dr Karunanithi explained that this was undertaken and commercial issues and applying intellectual property was managed between the Trust and MidTech. Dr Griffin welcomed the strategy and queried the Trust's relationship with the Academic Health Sciences Network (AHSN) and other clinical networks. He also queried next steps. Dr Karunanithi stated that the Trust was an integral member of the West Midlands clinical research strategy and stated that a third of work was	

	provided by the network, a third was commercial studies and the remaining third was academic studies i.e. via the AHSN. Dr Karunanithi stated that in terms of next steps the strategy was to be communicated to Divisional Boards and via the Trust Executive Committee. Professor Hassell queried whether a further discussion could be held in respect of implementation of the strategy, at a future Board Seminar i.e. the possible research options in the future and metrics to be monitored. Mr Wakefield welcomed the opportunity to provide increased visibility of research going forwards and requested that Dr Lewis and Dr Karunanithi work towards determining the scope for a future Board Seminar. **The Trust Board received and noted the strategy.** Dr Karunanithi left the meeting.	**ML**
PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES		
8.	**Quality Governance Committee Assurance Report (21-10-21)**	
155/2021	Professor Hassell highlighted the following from the report: • The impact of eliminating corridor waits resulting in increases in the number of ambulances waiting, although this was not the sole reason for ambulance delays as work had been undertaken to reduce these • Completion of risk assessment in relation to the Trust's ligature risk, determining clear mitigating strategies given the inherent risk • Pressure ulcers continued to be identified as an issue and this would continue to be monitored by the Committee • Consideration of the CQC warning notice • Pharmacy workforce challenge in relation to oncology whereby a business case was being developed • Positive work undertaken in respect of providing monoclonal antibodies for Covid treatment Mrs Bullock referred to the issue of ambulance waits and stated that corridor care should not return. Mr Bytheway welcomed the oversight of ambulance handovers at the Committee. Mr Wakefield referred to the timeline for completion of the portacount machine business case and it was noted that this case had been produced. **The Trust Board received and noted the assurance report.**	
9.	**Maternity Serious Incident Report – Q2**	
156/2021	Mrs Dudley provided the details of the 5 incidents reported during the quarter and explained that the quarterly review with the Healthcare Safety Investigation Branch (HSIB) commended the Trust for its openness, honesty and transparency in reporting incidents. Mr Akid referred to the action identified for one of the cases whereby a memo had been distributed, and queried how the Trust could be assured that this had been received and acted upon. Mrs Dudley stated that communications were issued via various methods including meetings with staff.	

	Ms Gohir queried if there were any alternatives to using Ondansetron, given the risks. She also queried whether there were any risks in relating to the staffing model and triage. Mrs Dudley stated that Ondansetron was commonly used in the management of severe morning sickness and whilst the medication was not a first line option, the risks and benefits were provided to women in order for an informed decision to be made. She stated that the patient information leaflet in respect of this would be reviewed to ensure it identified risks and benefits. Mrs Dudley referred to the staffing model and triage and explained that a new model had been adopted, whereby one manager remained on the Midwife Birth Centre, allowing other staff to be released to other areas depending on activity. She stated that additional midwives had been recruited to assist with triage and highlighted that an escalation policy was in place for triage. Dr Griffin referred to the case whereby a woman had waited over two hours and whether she had been triaged and Mrs Dudley explained that the wait was prior to triage therefore further actions had been determined in relation to this case. Mr Wakefield welcomed the revision to the staffing model and the changes made patient information leaflets to outline the risks and noted the actions required to improve triage. **The Trust Board received and noted the report.** Lyn left the meeting.	
10.	**IPC Board Assurance Framework – October 2021**	
157/2021	Mrs Riley highlighted the following: • Detail had been included regarding the monitoring undertaken when second swabs were not undertaken, in order to identify any correlation with future infections • In respect of the CPE outbreak in the West Building, all cases were colonised. She referred to the regular outbreak meetings held with Public Health England and NHSIE and stated that an action plan was in place. The visit undertaken on 21st October had identified a number of areas for improvement and the West Building had been rated as red for cleanliness, with a significant cleaning programme undertaken since that time and a further visit scheduled. It was noted that the actions identified following the inspection, would be considered as part of the broader learning regarding cleaning of other areas of the hospital. Ms Bowen queried why whether the outbreak in the West Building, should be referred to within the infrastructure risk on the Board Assurance Framework and Mrs Whitehead agreed to update the risk accordingly. Professor Hassell referred to the deep clean of the West Building and queried whether this resulted in the decant of patients. Mrs Riley stated that every ward was cleaned in the building which resulted in patients being moved, as every piece of equipment and every bed was cleaned. Professor Crowe acknowledged the significant disruption caused by the cleaning programme and welcomed the efforts taken. He also welcomed the learning being shared elsewhere within the Trust. Mrs Whitehead stated that the associated environmental issues with the West	**LW**

	Building would need to be considered further. Mr Wakefield stated that the scores on BAF 1 and BAF 6 were calculated incorrect and Mrs Riley agreed to update these. **The Trust Board received and noted the report.**	**AMR**
11.	**Winter Plan**	
158/2021	Mr Bytheway highlighted the following from his presentation: • The plan had been delayed due to ongoing system wide discussions although this had not delayed delivery • Work remained ongoing to assess the current bed shortage which were significant numbers (in excess of 100 in December and January) although plans did not incorporate system plans so this was expected to reduce • Additional capacity needed to be factored into the trajectories • A number of UHNM schemes were being devised to speed up processes It was agreed to provide a full paper for consideration by the Non-Executive Directors, providing oversight of the plan and the assurance required. Mr Wakefield referred to the resilience of the bed plan and queried if this could be considered when the plan was provided to the Non-Executive Directors, in respect of providing assurance of the impact of UHNM and system actions. Dr Griffin queried whether social care staff shortages had been factored into the plan and whether there was the workforce available to staff the additional beds. Mr Bytheway stated that the additional beds could be staffed, he stated that Ward 210 had opened in October and was staffed with existing resource. He added that additional capacity had also been opened at Cheadle and Haywood by Midlands Partnership NHS Foundation Trust. He stated that Ward 218 had been planned as part of the paediatric surge plan and added that releasing community care beds was the main focus, prior to identifying additional acute capacity. Mr Bytheway stated that part of the reason for the delay with the plan was associated with the ongoing discussions in respect of social care staffing. He stated that 100% assurance could not be provided in respect of this not impacting upon the Trust, but plans were in place to bolster staffing and incentivising social care staff to work the shifts required. Mr Wakefield referred to the assumption of 85% bed occupancy and queried whether this was realistic given previous performance. Mr Bytheway stated that the Trust should continue to work towards achieving that target, in order to enable patients to flow through. Professor Hassell referred to bed occupancy and queried if cases of Covid increased whether bed occupancy would reduce. Mr Bytheway stated that the model assumed between 75-95 Covid patients and if cases increased above that, additional capacity would be required, unless the number of discharges was also able to be increased. **The Trust Board received and noted the update and it was agreed that a further update would be considered by Non-Executive Directors.**	**PB**
ENSURE EFFICIENT USE OF RESOURCES		

12.	**Performance & Finance Committee Assurance Report (19-10-21)**	
159/2021	Mr Akid highlighted the following from the report: • The Committee welcomed the traction of the Executive Groups and the way in which they were escalating and highlighting issues to the Committee • In terms of operational performance additional assurance was required in respect of harm to patients in respect of ambulance turnover • Further clarity was sought on urgent care given the outstanding winter plan • The Committee agreed a further discussion was required on future investments given the associated financial limitations • The Committee noted a decrease in Data Security and Protection training and noted the actions being taken which included focussing on staff whose training was significantly out of date **The Trust Board received and noted the assurance report.**	
ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT & RESEARCH		
13.	**Transformation and People Committee Assurance Report (20-10-21)**	
160/2021	Professor Crowe highlighted the following from the report: • The Committee continued to work towards synchronising updates for innovation, improving together and culture • The Committee welcomed the continued work on the Improving Together programme • Work remained ongoing in respect of culture • The Committee acknowledged that research / innovation seemed under invested in time and resource and this required further consideration • The Committee welcomed the greater focus on workforce planning and management of workforce pressures • In terms of formal conduct cases there had been some increases in reporting and the Trust was looking to increase the turnaround times of dealing with cases **The Trust Board received and noted the assurance report.**	
ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS		
14.	**Integrated Performance Report – Month 6**	
161/2021	Mrs Riley highlighted the following in relation to quality and safety: • Pressure ulcers continued to be monitored as part of Improving Together due to being identified as a watch metric and key actions related to the care of heels and documentation of/adherence to positioning. In addition, actions were underway to identify whether damage was occurring at the beginning of the patient pathway • The impact of staffing on quality metrics was being considered • In terms of emergency caesarean section rates, assurance had been provided that those undertaken were appropriate Mr Bytheway highlighted the following in terms of urgent care performance: • Following the approval of the Emergency Department business case recruitment had commenced • Recruitment of middle grades was being undertaken and work was ongoing to	

identify bank and agency staff in order to maintain doctor fill rates during winter

- There had been a slight reduction in attendances in October and the CRIS team were managing category 3 and 4 patients with the aim of reducing attendances further
- Usage of consultant connect, the primary care interface, was at 82% providing access to same day oversight from Consultants. In addition 111 kiosks in both Emergency Departments were in place, although the impact of these were yet to be demonstrated
- Further work was due to be undertaken with the CRIS team in order to increase the number of patients being managed in the community, focussing on Consultant Connect and improving the number of calls answered in a timely manner
- The GP hub was to commence in November, ensuring patients were allocated to the correct service, supported by Consultant Connect
- A review was being undertaken of the effectiveness of senior clinical team working
- Occupancy had been affected by workforce and there continued to be significant efforts made on increasing discharges before 12 noon, focussing on long stay patients and reducing those in hospital over 21 days
- There had been an increase in medically fit for discharge (MFFD) patients in September but these had gradually decreased in October due to the opening of additional community beds
- Time to initial assessment remained challenged given current demand

Mr Wakefield queried how the Trust compared with peers. Mr Bytheway stated that the Trust had purchased Public View which would provide benchmarking against peers which would be included in future reports, and added that the Trust was presently in the bottom quartile in respect of urgent care performance.

Mr Wakefield referred to the ability to accommodate the request in relation to decision to admit and Mr Bytheway stated that this was not yet in place, due to staffing although the use of the capacity within the system was being focused on in order to make wards more efficient.

Ms Bowen referred to the use of Consultant Connect and queried whether this could be of benefit internally as well as externally. Mr Bytheway stated that referrals were being digitalised as much as possible, including internal referrals.

Professor Hassell welcomed the progress made with Consultant Connect and referred to the use of 111 kiosks. He queried how these helped patients and how the impact was to be evaluated. Mr Bytheway stated that ambulatory patients would be sent to kiosk first as part of the 111 triage, although in terms of the impact, data was not yet available to determine whether this had prevented attendance into the Department.

Dr Griffin queried the reason for the increase in numbers of long stay patients and it was agreed to discuss this outside of the meeting. **PB**

Mr Bytheway continued to summarise cancer performance:

- The Trust continued to be below the 62 day trajectory
- Additional funding had been secured for endoscopy and additional funding had been identified by the region to maximise endoscopy and improve colorectal performance
- Non-admitted work was being prioritised as well as daycases in order to maximise the number of treatments undertaken

Ms Bowen referred to the prioritisation of patients and queried when the Trust would move towards treating patients by targets rather than clinical need. Mr Bytheway stated that due to the ongoing challenges with theatres and support required for critical care, it would be difficult to move away from clinical prioritisation, although use of the independent sector and utilising mutual aid would help to increase the number of patients operated on week on week.

Mr Wakefield queried when the Trust would look towards achieving the cancer targets and Mr Bytheway stated that this would be after winter given the associated challenges with theatres.

Mr Wakefield referred to the increase in planned care, RTT and diagnostics and queried how much the position could be improved by utilising the Independent Sector. Mr Bytheway stated that in terms of diagnostics the challenges were associated with non-obstetric ultrasound and further depletion of staffing, therefore the trajectory was to be revised with the aim of achieving the target in February.

Professor Hassell referred to the future training pathway of students in non-obstetric ultrasound and queried given the increased clinical need whether this could be fed back to partners in order to address this gap. Mr Bytheway stated that use of insourcing was the main option available and Mrs Vaughan added that this had been fed into regional groups on training and education and any hotspots were discussed with Health Education England.

<u>Ambulance Handover Letter</u>
Mr Bytheway referred to the letter which had been received by all Trusts and referred to the deterioration in ambulance holds specifically for UHNM since July 2021. He stated that the Trust continued to look towards reducing occupancy and attendances in order to provide more space within the Emergency Department to receive ambulances. He added that in terms of the system actions, this included the provision of additional beds, GP out of hours and 111, in addition to the work of the CRIS. Mr Bytheway stated that a senior decision maker goes onto each ambulance to ensure patients were safe and escalate patients as required. It was noted that the main action required to address the issue was the creation of a priority admissions unit but the limiting factor related to lack of available workforce.

Mrs Vaughan highlighted the following in relation to workforce performance:

- Sickness remained a concern although there had been some improvement. Covid absence was 22% of overall absences but this continued to fluctuate
- The number of staff off with stress related absences continued to increase and staff continued to be provided with support in terms of managing burnout and managing resilience etc
- The winter wellbeing plan focussed on encouraging staff to take a break, keeping hydrated as well as increasing the options for provision of food
- There had been a deterioration in PDR rates since July due to activity levels and work continued to be undertaken with Divisions to address this
- Nurse recruitment continued to be undertaken, including overseas recruitment and utilisation of bank staff

Ms Bowen referred to the increase in the vacancy rate and the reasons for this and Mrs Vaughan stated that although there had been a slight increase, the overall trend was not of concern.

Mr Oldham highlighted the following in relation to financial performance:

	• The Trust had delivered a surplus of £13.7 m against a plan of £8.2 m • The Trust delivered £0.2 m surplus in month which was driven by a reduction in elective recovery funding • The pay award was paid in September and the Trust had accrued income associated with the award but it had not yet been received • Covid costs equated to £1.0 m in month • The system was to submit a year end balanced position • In terms of capital there had been some slippage due to the Trent programme and digital pathology • The cash position remained positive and this was expected to further improve **The Trust Board received and noted the performance report.**	
GOVERNANCE		
15.	**Audit Committee Assurance Report (21-10-21)**	
162/2021	Professor Crowe highlighted the following: • External audit planning had commenced and was on track • The move to the new Internal Auditors had been completed and was going well • A number of internal audit reports had been received and a rating of partial assurance had been provided in respect of divisional governance with an action plan in place to address the recommendations made **The Trust Board received and noted the assurance report.**	
16.	**Board Assurance Framework (BAF) – Q2**	
163/2021	Miss Rylands highlighted the document which had been considered and scrutinised by respective Committees and added that a number of changes were to be made for Quarter 3 in terms of the assurances reflecting the assurance provided to Committees during the quarter. Professor Crowe referred to receipt of the national instructions in relation to ambulance handovers etc and queried whether the associated risk of not meeting some of the national requests should be documented within the BAF. Miss Rylands stated that if the Trust was at risk of not achieving any 'national asks' she expected this would be documented within the risk register and any risks linked to the strategic risks as appropriate. Miss Rylands agreed to discuss the approach to revising the BAF with Mr Wakefield. **The Trust Board considered and approved the Quarter 2 BAF and confirmed it was satisfied that the risk scores were an accurate representation.**	**CR**
17.	**Workforce Disability Equality Standard Report**	
164/2021	Mrs Vaughan highlighted the following: • Organisations were mandated to review experiences of disabled staff compared to non-disabled staff which was largely evidenced from the results of the staff survey • The report had been presented and considered by the Transformation and	

	People Committee (TAP), and noted the overall improvement in 6 metrics, no change in 1 metric and deterioration in 4 metrics • There had been a year on year improvement in disclosure rates and year on year improvement in views in relation to career progression for staff with a disability and the extent to which staff value their work • Challenges had been identified with regards to behaviours and perceptions of how people respond to staff with a disability • A number of actions had been identified and the staff network continued to look at ways in which interaction with line managers, understanding disabilities and holding compassionate conversations could be improved Mr Wakefield welcomed the improvement in the 6 metrics and given the number of actions identified he queried how the effectiveness of all of the actions could be determined. Mrs Vaughan commented that she had challenged the team in respect of this however a number of workstreams were already underway. Mr Wakefield suggested that the actions should be prioritised in terms of anticipated impact and Mrs Vaughan agreed to review these and provide to the TAP. **The Trust Board received and noted the report and the actions identified to close the gaps in career and workplace experience between disabled staff and non-disabled staff at UHNM during 2021-22.**	**RV**
18.	**EPRR Assurance Statement**	
165/2021	Mr Bytheway highlighted that the annual EPRR oversight had identified that the Trust was compliant with the majority of areas and this has been considered and discussed at the Performance and Finance Committee. **The Trust Board received and approved the initial assessment result and annual return.**	
19.	**Calendar of Business 2022/23**	
166/2021	**The Trust Board approved the Calendar of Business for 2022/23.**	
20.	**Update on Board Development 2021/22**	
167/2021	Mr Wakefield referred to the previous discussion in relation to the Research Strategy and the need to include this on a future seminar. **The Trust Board noted the updated Board Development Programme, approved the revised timing of activities for the remainder of 2021/22 and agreed to include a session on the Research Strategy.**	
CLOSING MATTERS		
21.	**Review of Meeting Effectiveness and Business Cycle Forward Look**	
168/2021	Miss Rylands referred to the recent guidance which had been provided to authors of reports on the presentation of items at Committees and suggested that this be shared with authors so that this could be utilised for Board papers, in order to allow more time for questions.	

22.	**Questions from the Public**	
169/2021	Mr Syme paid thanks to the teams involved with the improvement in breast 2 week wait performance which he felt was remarkable given the significant pressure on the Trust. Mr Syme referred to ambulance handover delays and the associated NHSEI letter dated 26th October. He referred to 60% of ambulance delays having exceeded the national standard and queried whether the Trust considered the 48% target to attain handovers within 15 minutes was unambitious, whether in light of the letter the Trust was going to modify this if so what the new 'target' would be, along with the actions for this to be achieved. Mr Bytheway stated that whilst the Trust was not delivering the 15 minutes target, the target could be reset but action was required to support the achievement of this, given the workforce challenges. He stated that the Trust aimed to make small steps towards the target in order to provide staff with the ability to work towards a more manageable target, although staff continued to work towards the overall aim of achieving handovers within 15 minutes where ever possible. Mr Syme referred to the governance including transparency and reporting of extreme ambulance handover delays and queried why the Trust removed the data set from October 2021 Board papers onwards. He queried whether the Urgent Care Board had continued to meet and if not, why not and queried what rapid steps were being taken by the Trust and Care System as a whole to mitigate the situation. He also referred to a recent FOI request which identified 618 cases where handover was greater than 60 minutes and this did not correlate with the figures within the Integrated Performance Report. Mr Bytheway confirmed that the charts were not removed and were included within the Integrated Performance Report detailing the 60 minute ambulance handover deterioration. In addition it was noted that the difference in figures related to the ongoing validation of cases. He stated that the Urgent Care Board continued to look towards developing the CRIS, reducing MFFD's to reduce occupancy as well as other actions in place across the system to improve occupancy, improve flow and reduces ambulance wait. Mr Wakefield agreed that tackling ambulance wait was a national priority and other organisations were equally as challenged, and this remained a key priority for the Trust.	
DATE AND TIME OF NEXT MEETING		
15.	Wednesday 8th December 2021, 9.30 am, via MS Teams	

Trust Board (Open)

Post meeting action log as at 01 December 2021

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

Ref	Meeting Date	Agenda Item	Action	Assigned to	Due Date	Done Date	Progress Report	RAG Status
PTB/465	07/04/2021	Midwifery Continuity of Carer Action Plan	To discuss the document further at QGC, in terms of the specific actions to be taken and anticipated dates of delivery for the revised trajectories. In addition, to provide information on peer group comparisons.	Lynn Dudley	26/08/2021		Action delayed - due to be taken to future QGC meeting	R
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	03/11/2021	Update provided at November's meeting - complete and narrative included within the IPC Board Assurance Framework.	B
PTB/488	06/10/2021	Patient Story	To take an update to QGC on the actions taken as a result of the patient story regarding sickle cell.	Ann Marie Riley	05/01/2022		Action not yet due.	GB
PTB/489	03/11/2021	Patient Story	To liaise with Mrs Luyt in respect of planning for future admissions	Matthew Lewis	05/01/2022		Action not yet due.	GB
PTB/490	03/11/2021	Research Strategy	To provide a session on the Research Strategy at a future Board Seminar	Matthew Lewis Kam Karunanithi	TBC		Action not yet due.	GB
PTB/491	03/11/2021	IPC BAF	To update the BAF risk in relation to infrastructure, reflecting the CPE outbreak and associated learning/actions.	Lorraine Whitehead	31/01/2022		Action not yet due.	GB
PTB/492	03/11/2021	IPC BAF	To update the risk scores on BAF 1 and BAF 6	Ann Marie Riley	08/12/2021	01/12/2021	Updated IPC BAF provided to December's meeting.	B
PTB/493	03/11/2021	Winter Plan	To provide a full winter plan for consideration by the Non-Executive Directors and provide assurance of the resilience of the bed plan, taking into account the anticipated impact from the actions identified by both UHNM and system partners	Paul Bytheway	08/12/2021	02/12/2021	Meeting arranged to take place on 2nd Dec 2021	B
PTB/494	03/11/2021	IPR - Month 6	To highlight the reasons for the increase in numbers of long stay patients to Dr Griffin.	Paul Bytheway	08/12/2021	01/12/2021	Long stay patients remain under 19/20 levels and full reviews take place.	B
PTB/495	03/11/2021	BAF - Q2	To discuss the approach to revising the BAF with Mr Wakefield	Claire Rylands	05/01/2022		Action not yet due.	GB
PTB/496	03/11/2021	Workforce Disability Equality Standard Report	To prioritise the actions identified in terms of possible impact	Ro Vaughan	05/01/2022		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 1st December 2021. The meeting was held virtually using Microsoft Teams and focussed on the developments associated with the Integrated Care System.

- A presentation was provided to members with regards to the Department of Health and Social Care White Paper and the subsequent structural reform changes
- The Committee considered how Place Based Partnerships could inform strategy given it was a non-statutory body and noted the intention for PBPs to consider population health management data in order to make informed decisions for their population
- The Committee considered the impact of the earlier intervention from the Secretary of State for Health
- The Committee considered the way in which culture could be changed to empower decision making at a local level whilst continuing to build relationships across partners
- The Committee considered the role of the Clinical Senate and Clinical Assemblies and the way in which UHNM were represented in those forums and possibility of increasing representation
- It was agreed to share the associated governance of the Integrated Care Board once agreed as well as identifying which members of the Committee were current representatives on system governance forums

The Committee were advised of the CQC draft report and the timescales for the factual accuracy check.

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 October to 12th November, 1 contract award, which met this criteria, was made, as follows:

- **Supply of Ports, Trocars, Stapling and Energy (Endomechanical) Devices (REAF 8275)** supplied by J&J, Medtronic and Applied Medical at a total cost of £2,469,565.93, with savings of £10,216.56, for the period 10/11/21 – 30/11/22, approved on 03/11/21

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

Pacemakers Devices and Loop Recorders - Extension (eREAF 8392) – Extension

Contract Value £1,093,157.68 incl. VAT
Duration 01/12/21 - 30/06/22
Supplier Various

RS/1423/CAP - Project STAR - PSCP Appointment (eREAF 8325) – Extension

Contract Value £1,152,080.60 incl. VAT
Duration Capital Purchase
Supplier IHP Vinci Construction

Maintenance of Endoscopes and Electro Med Equipment (eREAF 8064)

Contract Value £3,214,593.00 incl. VAT
Duration 01/07/21 - 30/06/26
Supplier NHS Supply Chain

The Trust Board are asked to approve the above eREAFs.

2. Consultant Appointments

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

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Locum Consultant Plastic Surgeon	Vacancy	TBC	TBC
Clinical Lead for Colorectal Surgery	Vacancy	TBC	TBC
Clinical Lead for Emergency Surgery	Vacancy	TBC	TBC
Consultant Trauma Anaesthetist	Vacancy	Yes	04/01/2022
Clinical Lead for Simulation	New	Yes	01/01/2022
General Paediatric Consultant	Vacancy	Yes	TBC
General Paediatric Consultant	Vacancy	Yes	TBC
Consultant Orthopaedic Surgeon - Hip and Knee Arthroplasty	Vacancy	Yes	TBC

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

Post Title	Reason for advertising	Start Date
Consultant Histopathologist	Vacancy	01/11/2021
Consultant Chemical Pathologist	Vacancy	01/11/2021
Consultant Neurologist	Vacancy	01/11/2021
Clinical Lead - Body Radiology	Vacancy	01/11/2021
Clinical Lead - Neuroradiology	Vacancy	01/11/2021
Clinical Lead - Paediatric Radiology	Vacancy	02/11/2021
Clinical Lead - Interventional Radiology	Vacancy	03/11/2021

Post Title	Reason for advertising	Start Date
College Tutor - ED	Vacancy	08/11/2021
Consultant Radiologist	Extension	17/11/2021
Acting up Consultant in Obstetrics & Gynaecology	Extension	22/11/2021
Consultant Microbiologist	Retire & Return	22/11/2021
Locum Consultant, Colorectal & General Surgeon	Extension	01/11/2021
Locum Consultant in Emergency Medicine	Maternity	01/11/2021
Locum Consultant in Emergency Medicine	Maternity	01/11/2021

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

Post Title	Closing Date	Note
Locum GI Radiologist	10/11/2021	Applicant withdrew

3. Covid 19 and Trust Pressures

The number of Covid patients in our Hospitals has remained consistently between 70-80 for the last few weeks; however, just recently we have seen a slight drop to between 60-70. The number of Covid patients in Adult Critical Care (ACC) has remained between 10-15. As we know from previous discussion and modeling, anything above 50, with 10 or less in ACC will continue to present challenges to us in relation to patient flow within the Hospital and the recovery of elective services. Although we remain under pressure, as a result of the reduced numbers, the pressures has elevated slightly.

The drop in numbers of patients coming into Hospital with Covid is directly as a result of the drop ion Covid numbers in the Community from the 9th November onwards. Once we see a drop in community transmission, within two weeks, the numbers in the Trust also start to drop. However, we also know that community levels have significantly increased again since the 9th November numbers so we are expecting numbers to increase again within the next few weeks. On top of this, we also have the unknown impact of the Omicron variant but to date we are unable to model the impact of this until more information is available

We continue to work hard to recover our elective services and we are working 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.

I am acutely aware of the impact of the Trust pressures and the prospect of a new variant is having on our staff and our population in terms of receiving timely elective / planned care. We are continuously seeking to improve our Wellbeing offers to our staff and provide support where it is needed but this will not be easy given this may be the start of a 4th Covid surge whilst we address the usual seasonal winter pressures.

4. Vaccination as a Condition of Deployment (VCOD) for all Healthcare Workers

The Department of Health and Social Care announced on 9th November 2021, that individuals undertaking CQC regulated activities in England, must be fully vaccinated against Covid 19 no later than 1 April 2022, with first doses needing to have been provided to unvaccinated individuals by 3rd February 2022. Whilst detailed implementation guidance is anticipated in respect of this, the Trust has already commenced planning, including determining the staff classified as requiring full vaccination and taking into account those staff with medical exemptions.

5. General Medical Council (GMC) FY1 Preparedness

We are delighted to have received the most recent data from the GMC in relation to the preparedness of our Foundation Year 1 doctors, whereby Keele School of Medicine was ranked as first in the UK. This is an extraordinary result which is due to the work of everyone who has taught and supported these students over the 5 years of their undergraduate course.

6. Denise Coates Foundation

We are extremely grateful for the support of the Denise Coates Foundation (the Foundation) for funding a range of activities during the height of the Covid-19 pandemic. The £2 million received by UHNM Charity has made a significant difference to both the lives of our staff and our patients. Grant funding has enabled our 12,000 committed

workforce to benefit from new dedicated rest facilities and thousands of patients to have the equipment they need to communicate with their loved ones during restricted visiting. The equipment purchased has enabled us to detect fever in patients, staff and visitors to our hospitals therefore preventing infections from entering our hospitals. Also, the latest simulation training equipment the Foundation has funded is continuing to ensure that our staff are trained in the very latest techniques.

Following an additional bid we are delighted to be able to confirm that the Foundation has agreed to support the development of our cancer services. Made up of nine different elements, the £8.4 million investment will enable us to deliver a state-of-the-art environment, cutting-edge equipment and the latest technology. Every two minutes someone in the UK is diagnosed with cancer and 1 in 2 people in the UK born after 1960 will be diagnosed with some form of cancer during their lifetime. Here at UHNM our aim is to deliver outstanding cancer care for the populations of Staffordshire, Stoke-on-Trent and beyond, act as a training magnet for the best and brightest clinical staff and continue to develop our amazing staff in the most up-to-date techniques. The money will most certainly deliver our aims by funding:

Environment and Additional Services
This element seeks to improve the facilities and the environment (which includes sky ceilings and living windows) for cancer patients. It includes holistic therapies and a one-stop gynaecology oncology service to support patients to live well with cancer. It provides digital information directories for cancer patients through touch screen information boards. For staff it provides the latest technology to improve clinical discussions giving other hospitals better access to tertiary centre discussions. It brings free entertainment (TV and newspapers), health information whatever a patients' age, through UHNM TV and Wi-Fi for patients, relatives and staff.

The latest equipment and technology - robotic cancer surgery
This element is to purchase a range of the latest technology for cancer patients. It includes an Intuitive da Vinci Xi dual console robotic ecosystem with a dual console for training. The new robot would provide safer and more precise treatments along with better patient outcomes and faster recovery. It includes Ultrasound Probes which enhances partial nephrectomy procedures carried out by helping to define cancer boundaries and therefore reduce the amount of kidney removed during surgery. It also includes an ORBEYE 4K 3D orbital camera system which will enhance the services available to patients with complex brain tumours and investment to support faster treatment and diagnosis for skin cancer.

The generosity of the Foundation will enhance cancer services for decades to come.

7. NHS National Expert Food Panel Visit to UHNM

On Tuesday 16th November 2021 UHNM hosted a visit of members of the National Expert Panel from the NHS Food Review. Jenny Clarke, Estates, Facilities and PFI Matron is a member of the Panel which was a recommendation of the Government's Food Review, published in October 2020. UHNM is being considered as an exemplar site and the visit represented a great opportunity to showcase all that is positive about the catering services provided at UHNM. The panel visited the catering department and observed meal service delivery at the Royal Stoke site.

The panel members were very impressed with the strong partnership with Sodexo and the comprehensive array of menus and food choice available to our patients and wish to use our expertise and experience in electronic meal ordering. The Panel are keen to arrange a further visit to the County site to see our state of the art kitchen and the great work delivered by the Catering County Team.

8. Project STAR – Public Consultation

The public consultation process has now commenced in respect of Project STAR and the proposed Multi-Storey Car Parking (MSCP) development at Grindley Hill Court. This will enable the parking at the old Royal Infirmary site to be relocated once complete. A series of public consultation events are underway where the Trust will present its plans to our local community and answer any queries in respect of the new development. The consultation is pre-curser to the Trust submitting its formal Planning Application for the proposed car parking development in January 2022. Discussions are also underway with the residents of Grindley Hill Court

9. 999Critical Condition

We have been delighted to welcome back the film crews from 999 Critical Condition who are in the process of completing what promises to be another fascinating insight behind the scenes at Royal Stoke Hospital. The new series, featuring many of our staff in a wide range of departments throughout the patient pathway, is due to be aired early next year. I would like to congratulate all those involved in the last series as the programme has won the 2021

prestigious international AIBs (the Association for International Broadcasting) award for science and technology where the judges cited: “the vital interventions, actions and strategies that specialist consultants and their teams implement while delivering immediate life-saving care. For the patients in every episode, the speed of the decisions, treatments and the action taken by these extraordinary professionals are vitally important. Time is everything when you’re critically ill. It is something that could affect any one of us – our heart suddenly stopping when driving to work, being involved in a car accident, being the victim of a street attack. In each episode of the series, viewers are intimately involved in the visceral battle for life, as well as the numerous accompanying split-second life-and-death decisions. The judges were impressed by the extraordinary access which provided a breathtaking view of the fragility of life in an ER setting. They felt the programme demonstrated superb handling of a sensitive and emotional subject, with effective weaving of science into the storyline.”

10. CQC Inspection Report

On the 30th November the Trust received the CQC draft report for factual accuracy check. The results of the report are embargoed until published by the CQC. We now have 10 working days from receipt of the report to provide our response. Following this, the CQC will consider our submission and it is hoped final publication will be within the month of December.

11. Staffordshire University Vice Chancellor

We were saddened to hear that Professor Liz Barnes CBE and Vice Chancellor of Staffordshire University will be retiring at the end of December. We are very grateful to Liz for her amazing contribution over the last 6 years and we look forward to working with Martin Jones, her successor, from the 1st January 2022.

Quality Governance Committee Chair's Highlight Report to Board

25th November 2021

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• In terms of patient experience, the inpatient survey for 2020 demonstrated average performance with actions identified. In addition challenges with response times for complaints were noted given the number in excess of 40 days and the Committee considered the way in which this could be addressed. • The Committee received an update in relation to the actions being taken to address the safety notice received in relation to CPAP machines within the Trust and noted the risk in relation to the inadequacy of current systems recording the location of devices. • An update was provided in relation to a serious incident at County Hospital which had been investigated and actions focussed upon appropriate management and care of mental health patients • Quality and safety performance for month 7 highlighted an increase episodes of lapses in care for pressure ulcers although work was underway to establish whether this was in relation to the way in which cases were reported prior to being validated. Issues were also identified in relation to the coroner verdicts received in relation to pressure ulcers and the ongoing actions being taken were noted. • The escalations from the health and safety group were received which highlighted continued pressures associated with staffing which was impacting on the delay of completing risk assessments, incident reporting and statutory and mandatory training	• Further work to be undertaken in relation to improving palliative care discharges linking in with the discharge summary group • To confirm the arrangements regarding x-cube and whether the system was available at County Hospital • To provide updates to the Committee in relation to the progress being made to address the gaps in paediatric palliative care • To provide the presentation on caesarean section rates to the Trust Board • To provide further information in future reports on the numbers of patients included in research studies • To provide assurance in relation to the impact of the actions being taken to reduce falls • To provide an update in relation to retained swab serious incident and lessons learned • To provide an update in relation to SHMI at a future meeting • Sepsis team to be invited to attend a future meeting
Positive Assurances to Provide	**Decisions Made**
• The Committee received the end of life annual report for 2020/21 and noted the progress made in terms of managing end of life care during the pandemic, improving care after death and continuation of the launch of ReSPECT and GREAT discharge programmes. Challenges associated with availability of syringe drivers and effective discharge were noted and the actions to be taken. • The Committee received an update in relation to caesarean section rates focussing on Robson classification and noted the actions being taken to obtain robust data and move towards reporting on the appropriateness of caesarean sections • The Committee welcomed the 100% compliance reported in relation to perinatal mortality • In relation to research and innovation, an issue was identified in terms of the scheduling of follow-ups with actions being taken to bring in line with Trust policy as well as increasing oversight. The Committee also welcomed the positive outcome of the NIHR review. • An update on the action plan identified as a result of the HSE gap analysis was provided whereby actions were on track to be completed in line with the deadlines and assurance was provided on the way in which completed tasks would be monitored as part of business as usual. • An update was provided in relation to the NHSEI inspection following the CPE outbreak in the West Building, and the subsequent letter received was noted along with the actions being taken to address the gaps identified • It was noted that 48 serious incidents remained open and were being investigated and the Committee challenged the reasons behind the increase in falls incidents. • The quality and safety oversight group highlighted that areas of escalation had been considered and actions identified as mitigation. The Committee challenged current sepsis performance and requested an update at a future meeting	• The Committee were not required to make any decisions during the meeting.

Comments on the Effectiveness of the Meeting
• Members welcomed the discussion and the informative, high quality reports provided, in particular the updates in relation to caesarean section, CPAP and the serious incident at County Hospital

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	End of Life Annual Report 20/21	Assurance	8.	County Serious Incident Update	Assurance
2.	Q2 Patient Experience Report	Assurance	9.	Q2 Serious Incident Report	Assurance
3.	Research and Innovation Update	Assurance	10.	M7 Quality & Safety Report	Assurance
4.	• Q2 Maternity Dashboard • Perinatal Mortality Review Tool	Assurance	11.	Executive Health & Safety Group Assurance Report (November 2021)	Assurance
5.	CPAP Briefing	Assurance	12.	Quality & Safety Oversight Group Highlight Report (November 2021)	Assurance
6.	HSE Gap Analysis and Action Plan	Assurance	13.	CQC Insight Report	Information
7.	NHSE Visit to West Building Update	Assurance			

3. 2020 / 21 Attendance Matrix

			Attended	Deputy Sent	Apologies Received

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

Executive Summary

Meeting:	Trust Board	**Date:**	8th December 2021
Report Title:	Infection Prevention Board Assurance Framework	**Agenda Item:**	9.
Author:	Helen Bucior, Infection Prevention Lead Nurse Emyr Philips , Associate Chief Nurse Infection Prevention/Deputy DIPC		
Executive Lead:	Mrs Ann-Marie Riley, Chief Nurse/DIPC		

Purpose of Report:

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

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

Executive Summary:

Situation

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

Background

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

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

Assessment/risks

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

<u>Progress</u>

- External company continues to assist with mask fit testing
- Ward are currently receiving reminder calls to prompt COVID screening
- Portacount business case accepted
- CPE colonisation outbreak in West Buildings review in progress. Deep clean using steam and HPV completed , this also included FEAU and ward 122. Reduction in CPE colonisation cases
- Estates dismantled beds to aid with decontamination in the short term
- Cleaning Collaborative work stream (multi-disciplinary representation) established and using Improving Together

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

Key Recommendations:

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

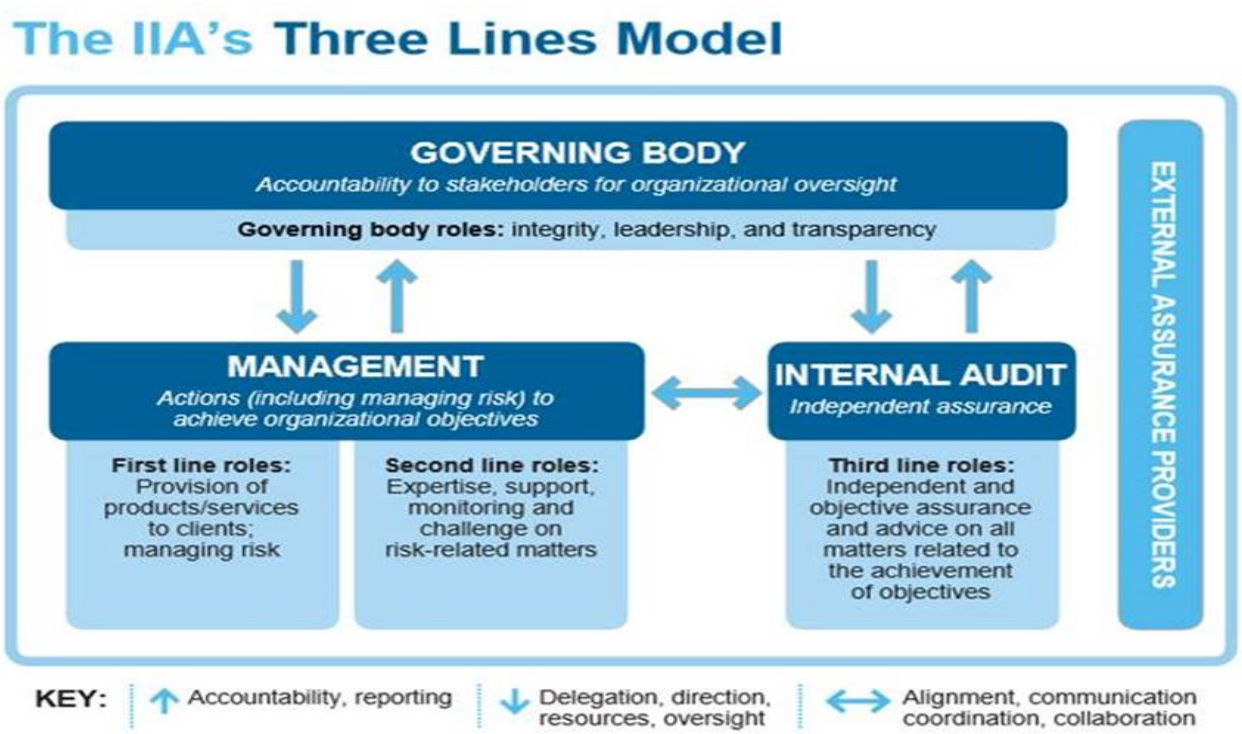
University Hospitals of North Midlands NH

Infection Prevention and Control Board Assurance Framework

December 2021

Summary Board Assurance Framework as at Quarter 1 2020/21

Ref / Page	Requirement / Objective	Risk Score				
		Q4	Q1	Q2	Q3	Change
BAF 1 Page 3	Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users.	Mod 6	Mod 6	Mod 6	High 16	↑
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 3
Consequence:	3	3	3	4		Consequence:	3	
Risk Level:	6	6	6	16		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-covid-ward-round-guicng-and-testing-for-co  guidance-on-screening-and-testing-for-co		
1.4	**All staff (clinical and non-clinical)** are trained in putting on and removing PPE, know what PPE they should wear for each setting and context and have access to the PPE that protects them for the appropriate setting and context as per national guidance. Linked NHSIE Key Action 3: Staff wear the right level of PPE when in clinical settings, including use of face masks in non-clinical settings. Linked Key Infection Prevention points – COVID 19 vaccination sites	• Key FFP3 mask fit trainers in place in clinical areas • PPE posters and information available on the Trust COVID -19 page. This provides the what, where and when guide for PPE • Infection Prevention Questions and Answers Manual include donning and doffing information. • Areas that require high level PPE are agreed at clinical and tactical • Aerosol generating procedures (AGP's) which require high level PPE agreed at clinical and tactical group	• Daily stock level of PPE distributed via email and agenda item for discussion at COVID-19 tactical group • IP complete spot check of PPE use if cluster/OB trigger • Records of Donning and Doffing training for staff trained by IP • A number of Clinical areas have submitted PPE donning an doffing records to the IP team	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
Monitoring of IP practices, ensuring resources are in place to enable compliance with IP practice of staff adherence to hand hygiene? • Staff adherence to hand hygiene • Patients, visitors and staff are able to maintain 2 metre social and physical distancing in all patient care areas, unless staff are providing clinical/personal care and wearing appropriate PPE • Staff social distancing across the workplace • Staff adherence to wearing of fluid resistant surgical face masks • a) clinical • b) non clinical setting Monitoring of staff compliance with wearing appropriate PPE, within the clinical setting The role of PPE guardians/safety champions to embed and encourage best practice has been considered	• COVID -19 Clinical Group reviews any proposed changes in PPE from the clinical areas • Link to Public Health England donning and doffing posters and videos available on Trust intranet • Chief Nurse PPE video • Extended opening hours supplies Department • Risk assessment for work process or task analysis completed by Health and Safety • PHE announced from 11th June 2020 all staff to wear mask in both clinical and non-clinical health care setting • Matrons walk rounds • Specialised division summarised BAF and circulated to matrons • ACN's to discuss peer review of areas • Poster displayed in entrances and along corridors reinforcing the use of masks social distancing and one way systems • Catch it , bin in, kill it posters in ED waiting rooms • Lessons learnt poster Lessons learnt - Non Clinical June 2021.pdf Lessons learnt - Clinical June 2021.pdf unannounced-ip-visit -template-2020-11.pdf non-clinical-assurance-visit-checklist-2020	• Donning and Doffing training also held locally in clinical areas • Cascade training records held locally by Divisions • Sodexo and Domestic service training records • IP unannounced assurance visits • Review of UHNM vaccination areas against key infection prevention points COVID -19 • Hand hygiene audits	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	There are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace	• QIA process for occasions when we risk assess that the 2 metres can be breached  SOP bed removal due to social distancir •		
1.5	National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way.	• Notifications from NHS to Chief nurse/CEO • IP team COVID lead checks Public Health England webpage daily (Monday-Friday) for updates • Changes raised at -19 clinical groups which was held originally twice weekly, reduced to weekly and now increased back to twice weekly due to surge of COVID. • Purpose of the Clinical Group - The Group receive clinical guidance and society guidance which is reviewed and if agreed used to advise clinical teams after approval at Exec COVID -19 meeting which is held twice monthly. • The clinical group initially weekly , now stepped down to Bi weekly • Tactical group – The tactical Group held daily. April 2021 now stepped down. The Group decide and agreed tactical actions Makes recommendations to Gold command • Chief nurse updates • Changes/update to staff are included in	• Clinical Group meeting action log held by emergency planning	

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

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	prevention and control interventions are optimal, the Board Assurance Framework is complete and agreed action plans are being delivered. • There are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas	• Visiting /walk round of areas by executive/senor leadership team  SOP bed removal due to social distancir		
1.8	Robust IPC risk assessment processes and practices are in place for non Covid-19 infections and pathogens.	• IP questions and answers manual • Section in IP questions and answer manual 2.1 priority of isolation for different infections and organisms • Sepsis pathway in place • Infection Risk assessment in proud to care booklets and admission documentation • C.diff care pathway • IP included in mandatory training • Pre Amms IP Screening • Birmingham paused ribotyping service for C.DIFF due to COVID-19. During periods of increased incidence ribotyping is useful to establish person to person transmission, Leeds Hospital are now undertaking this service • Proud to care booklets revised an reinstated August/September 2020	• MRSA screening compliance • Monthly Sepsis Compliance audits. Screening compliance for sepsis and time to antibiotics for Red flag patients • IP audits • Infection Prevention Health care associated infection report, including submitted to monthly to Quality and Safety. • Submission of Infection figures to Public Health England. Clostridium difficile, MRSA blood stream infections (bacteraemia) and Gram Negative blood stream infections • Seasonal influenza reporting • Audit programme for proud	CPE colonisation outbreak West Building

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

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 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. November 2021 actions continues to remain under surveillance	
4	1.3	Patient COVID -19 discharge information letter for patient who are discharged but contact of a positive case	IP Team	31/11/2020	Action at COVID weekly meeting was to create an information leaflet for patients and household members on discharge, with information on isolating, symptoms and useful information for informing the local authorities and the test and trace system. 6th November leaflet sent out for comments 22/12/2020 to Clinical Group for approval. Progressed to Outbreak Group and Tactical Group , minor changes made 12th December 2020 Submitted to Gold	Complete
5	1.4	Improving staff FFP3 mask fit staff training data recording and retention of records.	Health and Safety	31/08/2021	Proposed Fit Testing compliance improvement Task and Finish Group. Inaugural meeting took place 29th July 2020. ESR will be up and running for the purpose of recording fit test records as soon as the Trust gives the go ahead to procure Portacount fit test systems, this is a project lead by Health and Safety As at 03/02/2021 People O&D have created FFP3 mask "classes" on ESR. Health and Safety are in the process of collating fit test records which were requested at Exec Health and Safety Groups from Divisional H&S Leads. Portacount Business case : Health and Safety Head continues with Business case with target date for completed revised for end of August 2021 10/03/2020 Portacount machine obtained (on loan) by Infection Prevention Team via Midlands Coordinator for the FFP3 Mask Project. Plus mask fit tester will be available to test staff using the	Complete

					portacount machine. The portacount is a quantitative test and uses specialised equipment to measure exactly how much air is leaking through the seal of a mask. ACN'S informed and response requested to aid in identifying testing priority. Midlands Coordinator is meeting IP next week to work through plan. Mask fit testing also continues using hood and bitrex (qualitative, relies on taste) Mask fit testing option also added to e rostering to enable areas to identify staff member that have been tested and record mask model. A report can also be produced with compliance using this system. The mask fit testing certificate must also continue to be completed and filed in the staff member personal folder. Updated mask fit strategy to March which includes mask fit re test frequency. <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	complete

					This action continues to be under review during COVID Pandemic and surveillance of MRSA bacteraemia cases is on-going. 20/04/2021 Due to wave 2 COVID 19 , paper deferred to May IPCC 2021 May 2020 Screening recommenced a pre COVID 19 pandemic. DIPC advised action complete	
9.	1.8	To explore an alternative laboratory for Clostridium difficile ribotying	Kerry Rawlin Laboratory	31/08/2020	Leeds Hospital has agreed to help with ribotyping Clostridium difficile specimens. Await first batch of results to gain assurance that process is working 04/09/2020 we are experiencing problems in receiving ribotyping results back from Leeds. Usually they would arrive electronically. UHNM have contacted Leeds and are awaiting a resolution with their IT team and the PHE reference electronic reporting system. Ribotype now being received from Leeds and added to ICNET patient case	Complete

10	1.8	To Investigate, agree implement and follow-up measures. CPE colonisation outbreak in west building.	DIPC/IP team	31/10/2021 30/11/2021	<u>October 2021</u> Infection prevention review on –going Multi- disciplinary /agency approach Out Break Team/Meetings Environmental and water testing undertaken External support and visits NHSEi and UK HSA Terminal cleans using HPV in progress CPE screening continues Action plan in place including estates action plan <u>November 2021</u> 03/11/2021 Terminal clean including stream and HPV completed for West Building FEAU/ward 122Wards have reopened Screening of patients continues Outbreak meetings continue <u>05/11/2021</u> revisit by NHSEi and only minor areas for improvement noted, further visit planned for December Action plan in place Typing continues for positive cases Awaiting further typing from environmental samples FEAU Work in progress with ambulance service ESR Estates action plan in place <u>09/11/2021</u> Non-compliant hand wash sinks identified - waiting decision re replacements and funding Cleaning collaborative improvement project now underway <u>30/11/2021</u> Estates works, small designated team identified project manager assigned. Funding approved from finance point of view, awaiting formal approval from execs	On-going A

					Action plan and meetings remain in place.	
11	1.8	NHSEi visit 21/10/21 – In line with internal escalation matrix , given the extent of the outbreak and general concerns identified NHSEi are escalating the Trust from amber to RED on the matrix	DIPC/Divisions	30/11/2021 31/12/2021	<u>October 2021</u> Action plan in place Risk level raised <u>05/11/2021</u> revisit by NHSEi with only minor areas for improvement noted, further visit planned for December Action plan in place	On-going A

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	3	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 3 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:				
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	• Clinical Group action log • PPE training records which are held locally	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		• 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		
2.2	Designated cleaning teams with appropriate training in required techniques and use of PPE are assigned to Covid-19 isolation or cohort areas. Assurance processes are in place for monitoring and sign off terminal cleans as part of outbreak management	• SOP and cleaning method statements for cleaning teams • PPE education for cleaning teams • Initial meetings held with facilities/estates to discuss and plan COVID-19 requirements IP agenda item • Representatives from the division are attending the daily tactical meetings, and an E,F & PFI daily meeting is taking place which includes our partners • Discussed at March Matrons meeting. To ensure terminal cleans are signed off by the Nurse in Charge	• Clinical teams sign off any terminal cleans requested to say that clean has been completed to the agreed standard. • Spot check assurance audits completed by cleaning supervisors/managers during COVID • Cleanliness complaints or concerns are addressed by completing cleanliness audit walkabouts with clinical teams, and CPM / domestic supervisors • PPE and FFP3 mask fit training records with are held by cleaning services • GREAT training record cards are held centrally by Sodexo for all individual domestics • Key trainers record • Notes from Sodexo	• Learning from CPE outbreak. We have recognised areas we can strengthen our assurance process on standards of cleanliness

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
			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 cleaning supervisors/managers to ensure that all rooms are cleaned to the agreed cleaning standards – Any rooms that are found to be below standard are rectified immediately. • Terminal clean electronic request log • Patient survey feedback is reviewed by joint CPM / Sodexo/EFP group and action plan completed if needed.	
2.4	Increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance.	• Increased cleaning process (barrier clean) included in Infection Prevention Questions and Answers manual • Process in place for clinical areas	• Barrier clean request electronic log held by Sodexo and circulated following any updates / removal of barrier cleans to	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		with clusters and HAI cases of COVID -19 requiring increased cleaning and /or terminal cleans	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. • November 2021 Implementation of IPS audit	
2.5	Attention to the cleaning of toilets / bathrooms, as Covid-19 has frequently been found to contaminate surface in these areas.	• Cleaning schedules in place • Barrier cleans (increased cleaning frequency) process in place which includes sanitary ware and other frequent touch points • Barrier cleans also requested for other infections /period of increased incidence /outbreaks e.g C.diff , Norovirus	• Cleaning schedules are displayed on each ward • Additional ad-hoc cleaning requests can be requested by clinical teams 24/7 should the environment become contaminated between scheduled cleans.	
2.6	Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available	• Virusolve and Tristel disinfectant used • Virusolve wipes also used during	• Evidence from manufacture that these disinfectants are effective against 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**
	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.	height of pandemic	• Evidence of Virusolve weekly strength checks , held locally at ward /department level • IP checks that disinfectant is available during spot checks	
2.7	Manufacturer's guidance and recommended product 'contact 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 twice daily and when known to be contaminated with secretions, excretions and bodily fluid. • Electronic equipment, e.g. mobile phones, desk	• Cleaning of frequently touch points included in Barrier clean process • Offices and back offices also supplied with disinfectant wipes to keep work stations clean. • Non- invasive medical equipment must be decontaminated after each	• IP checks • Barrier clean request log • Terminal clean request log • Additional ad-hoc cleaning requests can be requested by clinical teams 24/7 should the environment	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	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.	use. IP Q+A manual	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 quarterly audits , undertaken by own areas, audits held locally by divisions and requested to also send to harmfreecare email • Datix reports/adverse incidents • IPS audits undertaken by the IP Team	
2.10	Single use items are used where possible and according to single use policy.	• IP question and answers manual • Medical device policy • SOP for Visor decontamination in time of shortage	• IP audits held locally by divisions and requested to also send to harmfreecare email	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
2.11	Reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance. Resuable non –invasive care equipment is decontaminated: ○ Between each use ○ After blood and/or body fluid contamination ○ At regular predefined interval as part of an equipment cleaning protocol ○ Before inspection, service or repair equipment	• IP question and answers manual covers decontamination • Air powered hoods – SOP in place which includes decontamination process for the device • Re usable FFP3 Masks – Sundstrom/ GVS Elipse. SOP's in place which includes the decontamination process • Medical device policy • Availability of high level disinfectant in clinical areas • Sterile services process • Datix process • Bed Storage Group looking at non conformities for beds that require repair	• IP audits held locally by divisions • Datix reports/adverse incident reports	• Decontamination of beds returned for repair process non conformities • Electronic beds – difficult dismantle the bed base mechanism to allow for effective cleaning –this issue has been raised regionally by NHSI
2.12	Review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission. Ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air Where possible ventilation is maximised by opening	• HTM hospital ventilation • UHNM has established a Ventilation Safety Group as recommended by the Specialised Ventilation for Healthcare Society in order to provide assurance to the Trust Board on the safe operation and reduction in risk of infection transmission through ventilation	• Estates have planned programme of maintenance • The Authorising Engineer Ventilation will provide external independent specialist advice and support as well as carrying out an annual audit for system compliance.	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	windows where possible to assist the dilution of air.	systems. TOR written • The Trust also appointed external authoring Engineers. This is in line with the NHS estates best practise and guidance from Health Technical Memorandum (HTM) namely 03/01 Specialised Ventilation for Healthcare Premises. • Lessons learnt poster which encourage regular opening of windows to allow fresh air  ventilation-air-changes-per-hour-2021-06 • • IP and estates have worked with areas know to be undertaking aerosol generating procedures and completed the fallow times		
2.13	Ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment Monitor adherence environmental decontamination with actions in place to mitigate any identified risk Monitor adherence to the decontamination of	• Regular walkabouts of all non-clinical areas are completed, and any actions found are either emailed through to helpdesk to be logged as jobs to be completed or are noted by Sodexo at time of audit – follow-up visits are completed to ensure all jobs have been completed • Quarterly Environmental Audits are completed of all clinical areas by an independent auditor plus input from nursing, cleaning and estates	• Reports produced after each visit, and re-audits completed if disciplines fail to achieve agreed %.	Strengthen cleanliness assurance process

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	shared equipment	to review environmental standards – reports produced after each visit, and re-audits completed if disciplines fail to achieve agreed %.		

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 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 cleaning teams and action plan devised Action Plan Following NHS England NHS Im NHSI action plan June 21.docx C4C audit programme in place Ward to complete quarterly environment audits	Complete

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

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

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

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		suspended by NHSE / PHE • Monthly review of antimicrobial consumption undertaken by AMS team. Available online at UHNM	• Trust and commissioners require timely reporting on compliance with AMS CQUIN targets. • Wards showing deviation from targets are followed up by targeted AMS team ward reviews generating action plans for ward teams. On hold during COVID19 due to redeployment of duties	
3.2	Mandatory reporting requirements are adhered to and boards continue to maintain oversight. Linked NHSIE Key Action 5: Daily data submissions have been signed off by the Chief Executive, the Medical Director 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.	Complete

					31/03/2021 The draft escalation protocol was approved at March ASG. It will be shared with Chief Nurse and Deputy DIPC at meeting above (15.4.21) and target wards will be identified. Protocol approved at March 2021 ASG. August 2021 Ward to be audited during September and if any wards are non-compliant this will be taken back to ASG for escalation as per the protocol October 2021 Audit to be undertaken during November. Subsequent analysis of data will determine if any areas are non-compliant	

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

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
4.1	Implementation of national guidance on visiting patients in a care setting. There is clearly displayed , written information available to prompt patients, visitor and staff to comply with hands, face and space advice	• To help protect patients and staff from Covid-19, the NHS suspended all visiting to hospitals. This national suspension has now been lifted and visiting is to be introduced in some areas of our hospitals, subject to certain conditions. From Monday 17 August 2020 visiting will be phased in across some areas and will be allowed in the West Building at Royal Stoke and in Wards 7, 12, 15 at County Hospital. All visiting will have to be pre-booked and relatives will be provided with the correct information and contact details to book in advance. Visitors will be 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	• 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
	arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from Non Covid-19 Staff are aware of agreed template for triage questions to ask 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	• 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	• 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
	Monitoring of Inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so) and is not detrimental to their physical or mental needs	in place  8th-march-2021-covid-ward-round-guidan		
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-	• 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	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		19-stay-at-home-guidance/stay-at-home-guidance-for-households-with-possible-coronavirus-covid-19-infection	• Spot check audits	
5.5	Patients with suspected Covid-19 are tested promptly. There is evidence of compliance with routine testing protocols in line with key actions	• All patients who require overnight stay are screened on admission and patients who develop symptoms – UHNM screening guidance in place	• Adverse incident monitor /Datix	
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	• Datix process	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		June 2020		

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

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

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

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

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		• Trust mask fit strategy • SOP and training for reusable FFP3 masks • SOP and training for use of air powered hoods • Critical care - Elipse FFP3 reusable introduced • PPE posters are available in the COVID -19 section of trust intranet page		
6.3	A record of staff training is maintained.	Mask fit strategy in place	• Training records originally held locally by the Clinical areas • Records held on L drive for those trained by the infection prevention team • April 2021,Option now available to enter FFP3 training onto Health Rostering this captures the model of mask and date trained • Test certificate must continue to be filed in personal folder and this is reiterated to mask fit tester. November 2021 wider spot checks commenced IP • Health and Safety leading on portacount mask fit business case which has the potential to enhance mask fit training records further as this system is capable of collected data which can be uploaded	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
			•	
6.4	Appropriate arrangements are in place so that any reuse of PPE is in line with the CAS Alert is properly monitored and managed.	• SOP in place for reuse of visors • SOP in place for use of air powered filters systems plus key trainers • SOP in place for the care of reusable FFP3 masks (Sundstrom))	• SOP 's available on Trust intranet • Training logs held divisionally for air powered systems • IP training log for air powered systems key trainers and distribution of reusable FFP3 masks (Sundstrum)	
6.5	Any incidents relating to the re-use of PPE are monitored and appropriate action taken.	• PPE standard agenda at COVID Tactical meeting • Datix process • Midlands Region Incident Coordination Centre PPE Supply Cell	• Tactical group action log • Datix process • Incidents reported by procurement to centre PPE supply Cell	
6.6	Adherence to the PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk.	• PPE Audits • PPE volume use discussed at tactical COVID-19 Group	• Spot audits completed by IP team	
6.7	Staff regularly undertake hand hygiene and observe standard infection control precautions. Linked NHSIE Key Action 1: Staff consistently practices good hand hygiene.	• Hand hygiene requirements set out in the infection prevention Questions and Answers manual • Poster for hand hygiene technique displayed at hand wash sinks and stickers on hand soap and alcohol dispensers • Alcohol gel availability at the point of care	• Monthly hand hygiene audits completed by the clinical areas • Infection Prevention hand hygiene audit programme. Overview of results fed into infection Prevention committee • Independent hand hygiene audits completed by IP Senior Health Care	
6.8	Hygiene facilities (IP measures) and messaging are available for all • Hand hygiene facilities including instructional	• Hand washing technique depicted on soap dispensers	• 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
	posters • Good respiratory hygiene measures • Staff maintain physical distancing of 2 metres wherever possible in the workplace unless wearing PPE as part of direct care • Staff maintain social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace • Frequent decontamination of equipment and environment in both clinical and non-clinical 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	• Social distance posters displayed throughout the Trust • IP assurance visits • Matrons visits to clinical areas • Car sharing question forms part of OB investigation process • Communications reminding staff re car sharing • IP Q+A decontamination 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	• Paper Towels are available for hand drying in the Clinical	• 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
	soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance Guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas	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	31/11/2021	Health and Safety progressing portacount machine business case	Complete
4	6.2	Spot audits of PPE on wards and Departments	Quality and Safety Team IP	30/04/2021	Audits are required on a weekly basis – ongoing action	Complete

7. Provide or secure adequate isolation facilities

Risk Scoring								
Quarter	Q4	Q1	Q2	Q3	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	1	1	1	1	Isolation facilities are available and hospital zoning in place.	Likelihood:	1	Q4 20/21– achieved
Consequence:	3	3	3	3		Consequence:	3	
Risk Level:	3	3	3	3		Risk Level:	3	

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

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

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

cohorting			outbreak meetings as necessary			
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	
10.2	Staff required to wear FFP3 reusable respirators	• Mask fit strategy in place	• Training records for reusable	

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board	• For staff groups that use Heather roster FFP3 mask fit testing details can be added as a skill to this system.		
10.3	Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the crossover of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance.	• Restore and Restorations plans	• Incidence process/Datix	
10.4	All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas. Health and care settings are COVID 19 secure workplaces as far as practical, that is that any work place risks are mitigated maximally for everyone Linked NHSIE Key Action 2: Staff maintain social distancing in the workplace, when travelling to work (including avoiding car sharing) and to remind staff to follow public health guidance outside of the workplace.	• Social distancing tool kit available on COVID 19 intranet page • Site circulation maps • Keep your distance posters • COVID-19 secure declaration • Social distancing risk assessment guidance for managers presentation 5th June2020 • Meeting room rules • Face masks for all staff commenced 15th June • Visitor face covering • COVID secure risk assessment process in place • November 2020 – Car sharing instructions added to COVID	• Social distance monitor walk round introduced Friday 5th June • Social distance department risk assessments • COVID-19 secure declarations	

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

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	**KLOE**	**Action Required**	**Lead**	**Due Date**	**Quarter 4 Progress Report**	**BRAG**
1.	10.2	Improving Staff FFP3 mask fit recording and retention of records	Health and Safety	31/08/2021	Proposed fit testing compliance improvement task and finish group Inaugural meeting planned for 29th July 2020. ESR will be up and running for the purpose of recording fit test records as soon as the Trust gives the go ahead to procure Portacount mas k fit systems as this is part of the project lead by Health and Safety case As at 03/02/2021 People O&D have created FFP3 mask "classes" on ESR. Health and Safety are in the process of collating fit test records which were requested at Exec Health and Safety Groups from Divisional H&S Leads. Portacount Business case : Health and Safety Head continues with Business case with target date for completed revised for end of August 2021 10/03/2020 Portacount machine obtained (on loan) by Infection Prevention Team via Midlands Coordinator for the FFP3 Mask Project. Plus external mask fit tester will be available to test staff using the portacount machine. The portacount is a quantitative test and uses specialised equipment to measure exactly how much air is leaking through the seal of a mask. ACN'S informed and response requested to aid in identifying testing priority. Midlands Coordinator is meeting IP next week to work through plan. In additional m ask fit testing also continues using hood and bitrex (qualitative, relies on taste) Mask fit testing option also added to e rostering to enable areas to identify staff member that have been tested. A report can also be produced with compliance using this system. The mask fit testing certificate must continue to be completed and filed in the staff member personal folder. Updated mask fit strategy to March IPCC with include update on	Complete

					re fit frequency May 2021 FFP3 cascade mask fit refresher in progress. This refresher includes checking that fitters are aware of e rostering and the need to file test certificate in staff members personal folder June 2021 Portacount Business case - Awaiting decision from Exec Health and Safety Group July 2021 Infection Prevention, those staff that failed on the Bitrex method referred to the Portacount machine, gave us an extra 75% pass rate on the original failures. This is a valuable additional tool for us to get as many staff trained as possible. Action complete FFP3 testing records can now be added as a skill to Health roster. The portacount machine action will be added as action below	
1	10.2	To improve FFP3 mask fit failure levels by using the portacount machine. Portacount method allows testing of individuals who are unable or unsure if they can taste the Bitrex solution	Health and Safety	November 2021	July 2021 The portacount is based on the calculation of particulates external and internal to the mask rather than reliance on staff judgement. Health and Safety to progress with portacount business case. Work to start September2021 October 2021 Business case circulated for comments by Health and Safety November 2021 Business case progressed by Health and Safety	Complete
2	10.2	Monitoring FFP3 mask fit compliance %	Divisions	31/09/2021	To monitor the mask fit compliance % for own division using	Complete

				29/10/2021	available records / Health Roster	

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

Performance and Finance Chair's Highlight Report to Board

23rd November 2021

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The Committee held a significant discussion with regards to addressing concerns raised in respect of the business cases being brought to the Committee for approval, where recurrent funding was uncertain. Context behind each of the cases was provided to the Committee and it was noted that in future, cases would continue to be brought to the Committee where it had been determined that the potential impact on patient safety and quality outweighed the financial risk. • The Committee received an update in relation to business case reviews whereby 24 reviews were outstanding and dates for review had been issued to Divisions to enable these to be presented to future meetings. • Data security and protection training stood at 87% and remained a challenge although an improvement was starting to be made, by reducing the number of staff who's training was significantly out of date. Improvement plan with a deadline of December 2021 was on track • An update was provided from the operational delivery group noting continued challenges with elective recovery, the ongoing actions being taken in relation to winter planning and bringing the 7th theatre online. • Actions continued to be taken to work towards reducing attendances although the lack of beds due to the CPE outbreak and workforce challenges impacted upon performance during October. The Committee noted the challenges affecting other regional tertiary centres and the ongoing actions being taken.	• To provide a strategic workforce overview to the Transformation and People Committee outlining associated costs and timelines including updates in relation to medical workforce • To identify the owners of the actions identified within the workforce strategy within the Critical Care Business Case, including the date for review of progress • To provide assurance to the Committee that the delays in business case reviews had not resulted in negative consequences • To undertake a deep dive into the top 10 high value contracts which had been extended to provide assurance that other options had been explored prior to the extension, to ensure best value for money
Positive Assurances to Provide	**Decisions Made**
• The Committee received an update in relation to procurement and noted the bottom line savings of £4.99 m which was above target with 161 initiatives identified for the savings. The impact of inflation was highlighted as a potential issue and the positive work in continuing with the development of integrated procurement models was noted. • In terms of the H2 financial plan the Committee noted that the system financial plan included system wide investment to support elective recovery etc. Two changes to the plan were highlighted in terms of the notification of funding received for the TIF and receipt of £426,000 for IT related schemes as additional income. It was also noted that the Trust had submitted a surplus plan. • Month 7 financial performance demonstrated a surplus of £2.2 m which was more than planned, covid costs had slight increased from the previous month and capital spending stood at £14.3 m which was slightly behind plan. It was noted that the cash position was higher than expected.	• The Committee approved the following business cases; BC-0433 Anaesthetic Workforce, BC-0434 Adult Critical Care Expansion and BC-0435 AMU Nursing Workforce • The Committee approved the following EREAFs; Pacemakers Devices and Loop Recorders - Extension (eREAF 8392), RS/1423/CAP – Project Start PSCP Appointment Extension (eREAF 8325), Maintenance of Endoscopes and Electro Med Equipment (eREAF 8064), Supply of Sutures (eREAF 8428) and Home Delivered Haemodialysis (eREAF 8203) • The Committee agreed to provide delegated authority to the Executive Team to approve non-recurrent investments until 31 March 2022 to support the deployment of the resource over a short time period.
Comments on the Effectiveness of the Meeting	
• Members reflected on the length of time spent on discussing the business cases process prior to the actual business case and agreed that authors should focus on the main 2/3 points of their papers, to enable the time spent in the meeting to be focussed on receiving questions from members. Chairs will be asked to remind business case presenters to assume the case to be read	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Business Case Approvals	Approval	7.	Month 7 Performance Report • Ambulance Handover Letter • UEC Standards	Assurance
2.	Business Case Reviews	Assurance	8.	Month 7 Finance Report - 2021/22	Assurance
3.	Authorisation of New Contract Awards and Contract Extensions	Approval	9.	H2 Financial Plan – 2021/22	Approval
4.	Quarterly Procurement Update Report	Assurance	10.	NHS System Oversight Framework Segmentation Letter	Information
5.	Executive Data Security & Protection Group Assurance Report (October 2021)	Assurance	11.	Non-Elective Improvement Group Minutes (October 2021)	Information
6.	Operational Delivery Group Assurance Report (November 2021)	Assurance	12.	Cancer Services Strategy Group Minutes (October 2021)	Information

3. 2021 / 22 Attendance Matrix

			Attended	Apologies & Deputy Sent	Apologies

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

NHS
University Hospitals of North Midlands
NHS Trust

H2 Presentation
Trust Board

8th December 2021

Together Compassion Safe Improving

NHS Operational Planning and Contracting Guidance and Priorities 2021/22

University Hospitals of North Midlands NHS Trust

2021/22 Planning Guidance

The updated guidance for the second half of the year reconfirms the priorities set out in March 2021 and reflects the financial settlement for the NHS for the final 6 months of the year

Four main guidance documents have been published setting out the detail required and the submission requirements. These can be accessed in full at *https://www.england.nhs.uk/operational-planning-and-contracting/*

The documents are:

- 2021/22 priorities and operational planning guidance: October 2021- March 2022
- Guidance on finance and contracting arrangements for H2 2021/22
- Submission guidance
- Activity, performance and workforce technical definitions

2021/22 National Priorities Summary

The six areas set out in March 2021 remain the national priorities:

- Supporting the health and wellbeing of staff and taking action on recruitment and retention.
- Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19.
- Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services.
- Expanding primary care capacity to improve access, local health outcomes and address health inequalities.
- Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (EDs), improve timely admission to hospital for ED patients and reduce length of stay.
- Working collaboratively across systems to deliver on these priorities.

Focus will also remain on the five priority areas for *tackling health inequalities* and redoubling efforts to see sustained progress across the areas detailed in the NHS Long Term Plan, including early cancer diagnosis, hypertension detection, respiratory disease, annual health checks for people with severe mental illness, continuity of maternity carer, and improvements in the care of children and young people.

Meeting both planned and unplanned patient demand, including that from Covid-19 and seasonal viral illnesses will require a robust whole system plan. It is in this context systems are asked to pay particular attention to the areas outlined in summary below. The document can be accessed in full at *https://www.england.nhs.uk/wp-content/uploads/2021/09/C1400-2122-priorites-and-operational-planning-guidance-oct21-march21.pdf*

Impact on UHNM

University Hospitals of North Midlands NHS Trust

Supporting the Health and Wellbeing of staff and taking action on Recruitment & Retention

People continue to be at the heart of all plans for recovery and transformation for the second half of 2021/22. The priorities, based on the pillars of the People Plan, therefore remain as set out in March 2021. Systems are asked to continue to deliver on these commitments as well as those made in local people plans, recognising the pressures on each and every member of staff, line manager and senior leader.

Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services.

❖ **Maximise elective activity and eliminate waits of over 104 weeks, taking full advantage of opportunities to transform the delivery of services**

Children, young people and adults should continue to be treated according to clinical priority. The aim is to return to – or exceed – pre-pandemic levels of activity across the second half of the year to reduce long waits and prevent further lengthening of waiting lists. The ambition is for systems to:

- Eliminate waits of over 104 weeks by March 2022 except where patients choose to wait longer ('P5' and 'P6' patients).
- Hold or where possible reduce the number of patients waiting over 52 weeks. We will work with systems and providers to agree individual trajectories through the planning process.
- Stabilise waiting lists around the level seen at the end of September 2021.

❖ **Restore full operation of Cancer Services**

The priorities for cancer recovery remain the same as in the first half of the year

Deliver improvements in Maternity Care, including responding to the recommendations of the Ockenden review

Systems are asked to continue to prioritise action to make maternity care safer and more personalised in line with the Maternity Transformation Programme, and to implement the emerging findings of the Ockenden review.

Transforming Community and Urgent and Emergency Care to prevent inappropriate attendance at Emergency Departments (EDs), improve timely admission to hospital for ED patients and reduce length of stay

- Reduce the number and duration of ambulance to hospital handover delays within the system – keeping ambulances on the road is key to ensuring that patients needing an urgent 999 response are seen within national Ambulance Response standards.
- Eliminate 12-hour waits in EDs – flow out of EDs ensures that expert clinical resource can be directed to those most in need.
- Ensure safe and timely discharge of those patients without clinical criteria to reside in an acute hospital, especially individuals on Pathway 0. This should be done in partnership with system colleagues, including community and social care, to ensure a focus on Pathway 1-3 discharges.

Headlines

Trajectory's included within this presentation are as per the H2 activity submission made on the 18th November, and include additional activity aligned to approved Targeted Investment Fund and Elective Recovery Fund schemes.

Slide Summary

Elective activity back to pre-pandemic levels

- Our current trajectories fall short of achieving pre pandemic activity, see slide 5. However, through the work that Deloitte have been commissioned to undertake to support the elective recovery programme, it is anticipated that further capacity will be available across the independent sector , Insourcing Companies and mutual aid from neighbouring Trusts.

Eliminate waits of over 104 weeks by March 2022 except where patients choose to wait longer ('P5' and 'P6' patients)

- The elimination of 104WW is a challenge. Our forecast is an increase in numbers by March 2022. Capacity constraints, the ability to retain elective capacity throughout the winter period, significant changes in length of stay as a result on non-elective admissions may result in capacity having to be redirected. Actions have been taken to address this by utilising the independent sector and Insourcing Company's to provide additional activity. Waiting list validation is on-going

Hold or where possible reduce the number of patients waiting over 52 weeks.

- The 52WW position is forecast to increase by c.4,057 due to capacity constraints driven by staffing deficit, on-going application of social distancing measures, theatre capacity being weighed towards non-elective demand. Actions being take are in line with those detailed above i.e. Independent sector/Insourcing capacity, validation. We are also exploring mutual aid requests with other NHS Trusts to accommodate those P4 patients who are not suitable for treatment by the Independent Sector.

Return the No. of people waiting longer than 62 days to the level we saw in February 2020 (based on the overall national average) by March 2022.

- Our trajectory shows that by March 22 we will achieve the 62 day level as seen in February 2020. We are looking to expand the cancer navigator workforce to support this trajectory as it has been proven to reduce DNA's and improve patient experience. There are however unforeseen risks to achievement i.e. low uptake of FIT in Primary Care, misalignment of capacity and demand across pathways, staff absence affecting diagnostic/outpatient services

Eliminate 12-hour waits in EDs – flow out of EDs ensures that expert clinical resource can be directed to those most in need.

The following work is being undertaken internally to support the elimination of 12 hour breaches in ED –

- Reduce the ED wait to be seen time – investment into the ED workforce to improve the ratio of clinicians to patients
- Implementation of the new UEC standards now has a specific set of actions associated with analysing and providing a set of actions behind this. The recovery against this important metric will be led via an executive confirm and challenge type forum

To ensure admission areas are prepared and ready for their next patient and avoid delays in ED egress -

- The acute portals including wards whom receive patients directly from the ED will have live real time data providing information on the expected and current demand
- All speciality wards are to challenge and interrogate patients with >14days LoS
- All ward areas are to improve their discharge times and factor in appropriate levels of escalation.

***ED and NEL activity is not covered in this presentation as it formed part of the UHNM Winter Surge & Resilience Plan which was presented at Trust Board on 3rd November 2021*

Activity - Elective

UHNM's H2 elective activity trajectory has been 'worked up' by divisions based on capacity available, which includes TIF and ERF schemes, and reviewed in confirm and challenge sessions with executives to enable activity assumptions and capacity constrains to be sighted and understood.

The charts below detail the submitted H2 trajectory v 2019/20 BAU and actual activity up to 23st November 2021.

Activity up to 23.11.21			Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Elective		19/20 BAU	1,198	1,293	1,117	973	1,126	1,295
		Trajectory	853	927	883	909	1,060	1,149
		Actual	872	690				
	%	Traj Vs BAU	71.2%	71.7%	79.0%	93.4%	94.1%	88.8%
	%	Actual Vs BAU	72.8%	53.4%				
	%	Actual Vs Traj	102.2%	74.4%				

Activity up to 23.11.21			Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Daycase		19/20 BAU	7,552	8,383	7,697	7,483	7,336	8,436
		Trajectory	6,644	6,974	6,807	7,123	7,138	7,418
		Actual	6,662	5,491				
	%	Traj Vs BAU	88.0%	83.2%	88.4%	95.2%	97.3%	87.9%
	%	Actual Vs BAU	88.2%	65.5%				
	%	Actual Vs Traj	100.3%	78.7%				

Activity up to 23.11.21			Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
OP 1st		19/20 BAU	28,926	29,391	26,371	26,661	26,405	30,366
	#	**Trajectory**	23,419	23,283	22,403	23,277	23,496	23,803
	#	**Cons Led**	17,047	16,948	16,307	16,944	17,103	17,326
	#	Actual	24,165	21,630				
	%	Traj Vs BAU	81.0%	79.2%	85.0%	87.3%	89.0%	78.4%
	%	Actual Vs BAU	83.5%	73.6%				
	%	Actual Vs Traj	103.2%	92.9%				

Activity up to 23.11.21			Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
OP Fup		19/20 BAU	41,626	44,580	39,774	40,015	38,982	44,829
		Trajectory	41,998	41,947	40,304	41,603	42,460	43,049
		Cons Led	30,588	30,551	29,354	30,300	30,924	31,353
		Actual	43,302	37,467				
	%	Traj Vs BAU	100.9%	94.1%	101.3%	104.0%	108.9%	96.0%
	%	Actual Vs BAU	104.0%	84.0%				
	%	Actual Vs Traj	103.1%	89.3%				

Key issues and risks to delivery of the H2 plan

Challenges

- Depleted workforce and high absence rates across all specialties, impacting outpatient, diagnostic and treatment capacity.
- Reduction in capacity due to winter/COVID pressures
- Patients who are P3/P4 but unable or unwilling to be treated in the independent sector
- Length of stay increases
- Increasing non elective activity
- Continued IPC restrictions impacting on capacity

Mitigations

- Continued utilisation of IS capacity where possible
- Insourcing of surgeon & theatre teams to maximise use of theatre capacity. Focus on high volume, less complex patients to free up weekday capacity for more complex patients
- Tactical analysis and management of the Incomplete RTT waiting list with support of national validation tool (Luna)
- External validators to deep dive 52+ waits
- Patient contact and validation of waiting list. Elective patients harm reviews
- Exploration of mutual aid requests for patients unable to be treated in IS e.g. RJAH IS non ICF contracts to support depleted secondary care teams
- CCG-led referral hub to optimise referrals

Activity – RTT

Provider Level	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022
Number of Completed Admitted RTT Pathways	2,408	2,098	1,917	2,430	2,158	2,335
Number of Completed Non-Admitted RTT Pathways	11,069	9,336	8,708	10,488	9,918	10,337
Number of New RTT Pathways (Clockstarts)	15,299	15,242	12,807	15,227	14,345	15,534

- RTT trajectory's have been calculated using our previous submitted RTT data for 2019/20
- Elective work is linked to our RTT admitted closure rate. We have therefore used the same % of elective activity to calculate the number of completed pathways i.e. c.80% BAU
- Non admitted pathways have been calculated in the same way but using outpatient activity
- New RTT pathways - We have assumed that demand will continue in line with referrals received for 2021/22 and have reflected this as new RTT pathway demand coming in so new pathways continue to be in line with what we have seen this year.

Activity – Incomplete RTT Pathway 104 and 52 Week waits

Below is the UHNM H2 trajectory submission for 104 week waits and the RTT waiting list.

H2 Trajectory	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022
The number of incomplete RTT pathways (patients waiting to start treatment) of 52 weeks or more at the end of the reporting period	3,663	4,391	4,896	5,625	6,450	7,720
The number of incomplete RTT pathways (patients waiting to start treatment) of 104 weeks or more at the end of the reporting period	252	339	405	475	499	452
The total number of incomplete RTT pathways at the end of the reporting period (often referred to as the size of the RTT waiting list)	70,769	73,609	75,850	77,921	79,729	81,322

- The H2 trajectory has been calculated using UHNM's previous submitted RTT data for 2019/20
- Elective work is linked to our RTT admitted closure rate. We have therefore used the same % of elective activity to calculate the number of completed pathways
- Non admitted pathways have been calculated in the same way but using outpatient activity

New RTT pathways –

- It has been assumed that demand will continue in line with referrals received for 2021/22 and have reflected this as new RTT pathway demand coming in so new pathways continue to be in line with what we have seen this year.
- The waiting list trajectory for the H2 submission was refreshed to reflect October activity levels which we did not have available for the initial draft submission. Further refinement of the model now allows us to assume the demand is set to continue at the current level of 3,400 per week. Our capacity (closure rate) does not increase enough to meet this level of demand hence the growth in the waiting list of c.10,553

The revised March position is currently standing at 452 (previously 695) however, it is recognised that work still needs to continue to conclude the possibility of other options currently being explored to improve the position further. The improvement noted is based on the following:

- Improvement to staff absence from theatres which is currently at 40%
- Some theatre vacancies being filled by January 2022
- As a result of the two points above an assumption of additional 6 theatre sessions per week, 2 patients per session
- Approval of the TIF bid for the mobile theatre at County
- Continued use of Independent Sector
- Use of insourcing surgeon and supporting theatre teams
- Seeking mutual aid from – RWT(T&O) and UHDB (ENT, Urology, General Surgery) RJAH

The Trust has made a further reasonable assumption that there will be zero non-admitted 104 week waits

On-going validation of waiting lists will continue as part of our normal BAU. To date it has been established through an audit of the current waits that that circa 80 patients wish to remain on the UHNM waiting list and do not wish for their care to be transferred to another provider even if this would expedite their care.

Of those 372 remaining patients 129 are from one of the most nationally challenged specialties (Upper Gi / bariatric).

This then leaves c243 patients that will require treating prior to March; most of these are from specialties that are challenged in terms of demand and subsequent capacity. We have sought mutual aid from Royal Wolverhampton for use of Cannock facilities (Ortho in the main) and UHDB for General Surgery, ENT and urology.

This will continue to be a dynamic and changing position as the return to work from absence and the mutual aid capacity becomes clearer.

Activity – Incomplete RTT Pathway 104 and 52 Week Waits

University Hospitals of North Midlands NHS Trust

Actions being taken –

Validation/Data Quality

- Validation of waiting lists by electronic solution with telephone backup to ensure that the Trust can develop appropriate forward looking plans to manage long waits. This will be undertaken by establishing a dedicated team to oversee the management of patient experiencing significant long waits, in order to ensure that we have a single view of patients, there current health status and choices for treatment.
- Develop an understanding of the elective patients waiting and initiate 'harm reviews' were required for long waiters to ensure quality of care is not compromised.
- Extend use of "Luna" validation tool to target validation where most effective
- Increased use of advice & guidance to divert patients who don't need to be seen in secondary care

Independent Sector/Insourcing

- Continued IPT of patients to the 2 main IS providers to maximise the use of their identified capacity. The Trust is specifically exploring Bariatric IS capacity in the West Midlands.
- Increase in non-ICF contracts to free up capacity over winter, and to support the Trust in addressing both longer waits as well as any P2 patients at risk of cancellation over winter.
- Insourcing surgeon & supporting theatre team to increase throughput on high volume low complexity cases including Trauma & Orthopaedics

Productivity

- Deloittes have recently been appointed to support the Trust in continuing to assess the scale of the elective recovery challenge in addressing long waits through an on-going focus on maximising the use of all available capacity(by driving productivity and efficiency) and waiting list management
- Further rollout of PIFU pathways and numbers of patients added to these pathways in line with planning guidance to maximise clinic capacity

Mutual Aid

- The Trust is developing contracting resource to scope out potential third party capacity/ mutual aid requests.

Rebalancing P2's v 104WW

- In the event of a P2 cancellation we will look to fill the capacity with those patients that have been waiting longest, however this isn't always possible due to the lead in time for patient work up/isolation requirements

Key assumptions / Risks

- **Assumption** - IS capacity is available; **Risk** - capacity is taken up by other providers. **Mitigation** - Locality Directors continue to "hold the ring" on the most significant contracts
- **Assumption** - theatre staffing levels improve; **Risk** - front line staffing position may worsen over winter. **Mitigation** - winter well-being support and organisational priority, focus on staff absence
- **Assumption** - there is third party capacity available and appropriate for transfer of patients; **Risk** - there may be some routine patients for whom RSUH is the only viable option; patients don't wish to be transferred elsewhere. **Mitigation** - Trust to ensure that it offers the full range of support for patients to access their treatment.

Activity – Non Elective & A&E

Non-Electives

Provider Level	Oct 2021-Mar 2022	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022
Number of Specific Acute non-elective spells in the period	51,044	8,653	8,470	8,402	8,408	7,809	9,302
Number of Specific Acute non-elective spells in the period with a length of stay of zero days	20,677	3,592	3,511	3,270	3,319	3,154	3,831
Number of Specific Acute non-elective spells in the period with a length of stay of 1 or more days	30,367	5,061	4,959	5,132	5,089	4,655	5,471
Number of Specific Acute non-elective spells in the period with a length of stay of 1 or more days (COVID)	1,661	277	271	281	278	255	299
Number of Specific Acute non-elective spells in the period with a length of stay of 1 or more days (Non-COVID)	28,706	4,784	4,688	4,851	4,811	4,400	5,172

Non Elective trajectory has been based on –

- NEL zero day set at 81% of 1920 BAU (this is slightly up on current summer actuals of 77%
- NEL 1 day+ set at 103% of 1920 BAU in line with current actuals
- COVID demand not expected to ease in line with planning guidance.

A&E

	Oct	Nov	Dec	Jan	Feb	Mar
Type 1 & 2	14,773	15,468	14,949	14,810	13,745	13,608
Type 3	5,678	5,326	5,260	5,273	4,699	4,677
Total	20,451	20,794	20,209	20,083	18,444	18,285

Octobers is actual attendances
November to February is as per 2019/20 actuals and
March is as per 2020/21actuals (2019/20 attendances seemed low Type 1&2 11,181 and Type 3,576)

Activity – Cancer

University Hospitals of North Midlands NHS Trust

Number of patients waiting 63 days or more on the Cancer PTL

Provider Level	Jul-21	Oct 2021 -Mar 2022 Average	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022
The number of cancer 62 day pathways (patients with and without a decision to treat, but yet to be treated or removed from the PTL) waiting 63 days or more after an urgent suspected cancer referral excluding non site specific symptoms	321	361	415	393	373	350	328	307

The H2 ask is……..*'Return the No. of people waiting longer than 62 days to the level we saw in February 2020 (based on the overall national average) by March 2022'.*
To achieve the number needs to reduce to 307; the 62 day back log needs to reduce by 5 patients per week.

Number of patients receiving first definitive treatment for cancer within 31-days

Provider Level	Jun-21	Oct 2021-Mar 2022 Average	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022
Total number of patients receiving first definitive treatment for cancer within 31-days for all cancers (ICD-10 C00 to C97 and D05)	363	463	463	463	463	463	463	463

Number of patients seen in a first outpatient appointment following urgent referrals

Provider Level	Jun-21	Oct 2021-Mar 2022 Average	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022
Numbers of patients seen in a first outpatient appointment following urgent referrals	3113	3566	3566	3566	3566	3566	3566	3566

Together Compassion Safe Improving

Activity – Cancer

University Hospitals of North Midlands NHS Trust

Action being taken –

Validation/Data Quality

- Micro manage the PTL
- Develop an understanding of the cancer patients waiting and initiate ‘harm reviews’ were required for long waiters to ensure quality of care is not compromised.
- Patients are scrutinised each week through cancer PTL meetings that have been extended to enable 'deep dives' and thorough review of each patient in the 62 day backlog.
- Engagement from directorate managers who take escalations and outstanding actions for patients breaching 62 days.
- Robust, data driven weekly assurance meeting with executive oversight - backed by a comprehensive 'planned care framework' which is a suite of cancer and elective patient level reports, including the whole trust surgical wait list, that is managed and scrutinised by surgical priority category, clinical validation, and supports directorate managers to understand their current waiting lists.
- Bottlenecks or barriers to care are escalated through a weekly cancer reporting mechanism to the Chief Operating Officer, in order to highlight themes or trends and solve quickly.

Independent Sector/Insourcing

- Continue to utilise IS capacity where available

Productivity

- The cancer recovery plan for H2 will also contribute to recovered 62+ positions through service reconfiguration schemes that release capacity in stretched secondary care services by implementing low risk community solutions, such as in Breast and Skin.
- Innovative pathways incorporating AI will also release consultant capacity on Skin pathways that will contribute to a reduced backlog.
- Most challenged pathways in terms of long waiters in cancer are Colorectal, Skin, Urology and UGI. Colorectal has a disproportionate 62+ and 104+ backlog due to a capacity deficit against high demand. The pathway could be transformed by FIT results being used in primary care to guide 2WW referrals, which has been implemented in other systems. This pathway has been proven to reduce the burden on diagnostic services too, as patients are directed to the most appropriate first investigation based on FIT result.

Risks

- Low uptake of FIT in primary care.
- Misalignment of capacity and demand across pathways
- Staff absence rates impacting delivery of full capacity in diagnostic and outpatient services.
- National shortage of Histopathologists is impacting UHNM; workforce pressures are impacting turnaround times which are currently suboptimal, impacting recovery capability.

Workforce - Taking Action on Recruitment and Retention

NHS University Hospitals of North Midlands NHS Trust

Workforce plan to meet planned activity levels

	2020/2021	outturn	June	September	December	Mar-22	2021/2022
	Establishment	Staff in Post	Actual	Actual	Plan	Plan	Establishment
Substantive	11023.44	10187.69	10068.74	9984.02	10159.11	10175.32	11118.59
Bank	0	524.00	520.29	527.35	677.35	677.36	
Agency	0	91.69	150.71	174.93	334.52	341.57	
Total Provider Workforce	11023.44	10803.38	10739.74	10686.30	11171.02	11194.29	11118.59

Vacancies at 31 Oct 2021	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %
Medical and Dental *(*Note 1)*	1,445.02	1,245.75	199.27	13.79%
Registered Nursing	3318.36	2881.99	436.37	13.15%
All other Staff Groups	6322.75	5852.78	469.97	7.43%
Total	11,086.13	9,980.52	1,105.61	9.97%

Note 1 - the Medical and Dental staff figure in post excludes circa 75wte GPVTS staff who are employed by St Helens and Knowsley meaning the vacancy rate is over-stated and should be around 8.60%

The overall vacancy rate at 31/10/21 was 9.97%. Bank and Agency covered 64% of this vacancy position

Specific shortages for specialities and staff groups

Theatres – Intensivists and Anaesthetists

Consultant Medical Staff: Respiratory; Gastro; Geriatricians; General and Acute Medicine; A&E consultants

Pathology - Consultant Microbiologists, Histopathologists and Chemical Pathologist

Therapies – Physiotherapists and Occupational Therapists

Soft FM – vacancy level is above the normal attrition rate. It is proving difficult to attract applicants due to the perceived risks associated with working in a hospital setting.

Mitigations

- On going recruitment campaigns
- Bank arrangements and Agency – although even premium paying companies are struggling to recruit. Gaps are managed by overtime and premium pay
- Appointment of long term locums
- Geriatricians – we are exploring CESR and Speciality doctor route
- Retire and return is offered
- On-going adverts out for MLAs, BMS and Associate Practitioners for Microbiology and Histopathology
- Soft FM are creating new literature to attract more applicants and engaging with Clinical Operations to improve the integration of support service staff into the ward culture

Future Risks

A number of business cases are progressing through the approval process which have a significant workforce demand attached and include 'Hard to Recruit' job roles, therefore carrying recruitment risk. Note: As these business cases are not yet approved, they have not been included in the H2 submission

Together Compassion Safe Improving

Workforce - UHNM Narrative Submission to the System Plan

University Hospitals of North Midlands NHS Trust

Taking Action on Recruitment and Retention

Actions being taken to increase workforce supply and support transformation

We have in place:

- System-wide processes to offer workforce support if necessary
- Internal support is provided via staff Banks, volunteers and student programmes.
- Processes are in place to monitor workforce absence so that high risk areas are flagged allowing operational business continuity plans to be implemented
- We offer Apprenticeships, Work Experience, Volunteering and Career development opportunities

We are currently

- Working with Divisions to obtain the operational view on workforce demand and supply, and how to close the gap
- Exploring development of the CESR and Speciality doctor route.
- Working with the Skills Academy and Stafford College to create recruitment literature for Soft FM to attract more applicants.
- Continuing with staff engagement activities

We will

- Implement SAS Contractual reforms and Midlands staff charter for Doctors
- Launch a Trust-wide talent management process in line with Regional/national plans
- Introduce the Carer's passport
- Review our flexible working policies and practice

Workforce - UHNM Narrative Submission to the System Plan

University Hospitals of North Midlands NHS Trust

Supporting the Health and Wellbeing of Staff

Sickness rates remain high and staff continue to be impacted by COVID. Stress-related sickness absence is the top reason for absence, although this does include both work-related and personal/domestic life stress.
Resilience is running low and is causing conflict between teams at times as the workload of trying to treat patients and resolve backlogs takes its toll

Where we are now	We are working on	In the next 6 -12 months
• Our Wellbeing Plan has been refreshed and our Winter Wellbeing Plan is being implemented • We provide a full range of wellbeing initiatives including emotional 1-1 support, Listening sessions, Schwartz rounds. Peers and managers undertake supportive wellbeing conversations using our bespoke 'RESPOND' model, and staff are trained in Critical Incident Stress Management.. • We have implemented the Staff Voice to measure staff engagement more regularly • Our ED&I strategy and framework will address any inequalities identified via the staff survey , WRES and WDES statements and our well established staff network groups ensure active engagement • A system-wide staff psychological wellbeing hub is established • We offer flexible working, agile working and Retire and Return	• Wellbeing focus groups are being set up and coaching support is available for BAME colleagues • Embedding Just and Learning/restorative Culture principles with a focus on culture change • Promoting our inclusive culture and addressing the needs of our protected groups through Staff Networks and our EDI framework • Providing support and development to line managers	We will • Increase staff awareness of civility and respect, bullying and harassment, and the impact of inappropriate behaviours, • Train managers on the importance of call backs and return to work interviews via the Empactis System as a means of supporting staff back into work • Through 'Improving Together', focus on staff engagement interventions and on improving sickness absence

2021/22 H2 System Revenue Financial Plan

University Hospitals of North Midlands NHS Trust

Primary Care £4m, Social Care £5m

Month 6 reported position £13.7m surplus
Plus £0.8m PPE adjustment

Detail	CCG £000	UHNM £000	NSCHT £000	MPFT £000	Total £000
Cfwd from H1 – declared Surplus / (Deficit)	**3,665**	**14,465**	**488**	**2,796**	**21,414**
H2 planned position - surplus / (deficit)	(22,589)	4,200	3,452	1,090	**(13,847)**
H1 Flexibility available to offset H2	10,304		-	3,420	**13,724**
Estimated system investments not reflected in H2 planned position abov	(9,000)	(6,300)	-	-	**(15,300)**
Reduced NHSE/I income				(1,150)	**(1,150)**
ERF investment				(134)	**(134)**
H2 Position - Surplus / (Deficit)	**(21,285)**	**(2,100)**	**3,452**	**3,226**	**(16,707)**
2021/22 Total - Surplus / (Deficit)	**(17,620)**	**12,365**	**3,940**	**6,022**	**4,707**
1. Contingency held against workforce investment			(274)		**(274)**
2. Non recurrent reserve		(2,636)	(437)	(1,359)	**(4,433)**
Revised 2021/22 Total - Surplus / (Deficit)	**(17,620)**	**9,729**	**3,229**	**4,663**	**0**
Redistribution of allocation to breakeven	17,620	(9,729)	(3,229)	(4,663)	0
Revised 2021/22 Total inc Contingency - Surplus / (Deficit)	**0**	**0**	**0**	**0**	**0**
ERF Projection		5,147		593	**5,740**
Revised 2021/22 Total inc ERF - Surplus / (Deficit)	**0**	**5,147**	**0**	**593**	**5,740**

Together Compassion Safe Improving

2021/22 H2 UHNM Revenue Financial Plan

University Hospitals of North Midlands NHS Trust

Surplus of £5.1m for H2 includes

- £5.1m ERF
- £5.2m Winter Plan
- £5.0m NR COVID investment
- £6.3m NR agreed system initiatives (Elective Recovery & Critical Care)
- £2.6m NR System Workforce initiatives
- £9.7m NR contribution to CCG deficit

Breakeven for H2 does not include

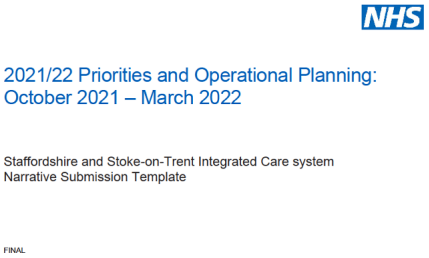
- Performance against budgets (H1 Plan underspent by £5.4m -Pay budgets & NR slippage)
- Additional income streams in-year
- Impact of significant COVID levels over Winter (likely to improve financial position)
- UHNM share of system level £5m H2 capacity funding
- Release of 2020/21 provisions

Underlying deficit £84m (excludes TSA/PSF/redistribution of IFPM/system allocations)

H2 System Narrative Submissions

University Hospitals of North Midlands NHS Trust

Below are the system narrative submissions for information. Please double click on the tabs to open.



NHS

2021/22 Priorities and Operational Planning:
October 2021 – March 2022

Staffordshire and Stoke-on-Trent Integrated Care system
Narrative Submission Template

FINAL

Elective Recovery Narrative Submission
System Template
v2.0

To be returned to: **Regional planning mailbox***
By: **12noon Thursday 21 October 2021**

Executive Summary

Meeting:	Trust Board	**Date:**	8 December 2021
Report Title:	H2 financial plan – 2021/22	**Agenda Item:**	11.
Author:	Kim da Silva, Head of Financial Management Jonathan Tringham, Director of Operational Finance		
Executive Lead:	Mark Oldham, Chief Finance Officer		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

21694	Uncertainty on H2 funding	*6*

Executive Summary

Planning guidance for H2 2021/22 was issued in September 2021 and on the back of this formal planning submissions for both the system and individual providers for H2 were required in November 2021.

The Trust set a plan at the start of the year with an H1 surplus of £8.3m and a full year deficit of £8.8m (i.e. a deficit of £17.1m for H2). However, at this point the planning arrangements for H2 were unknown and therefore the H2 plan was based on a set of high level assumptions.

The guidance for H2 has been reviewed by the Trust and in line with conversations across the System the Trust has set a revised surplus plan of £5.1m for the financial year ending 31 March 2022. The National and System conversations have indicated that the Trust is expected to carry forward the surplus of £14.5m delivered in H1 and therefore the planned position for H2 is a £9.4m deficit to achieve a surplus plan of £5.1m for the year. The plan for H2 includes the following

- An increased efficiency ask of 0.82% compared to H1 (0.28%)
- £5.2m in respect of the Winter plan
- COVID-19 funding at the levels incurred within H1
- Non-recurrent system level reserves for Elective recovery (£5m) and Critical Care (£1.3m)
- Non-recurrent workforce reserve of £2.6m.
- Planned income of £5.1m from the ERF.

Whilst there are some items which have not been captured within the H2 plan the Trust feel that given the performance in H1 and the level of non-recurrent budgets within H2 there should be enough mitigation within the plan to address these risks. The Trust will report a forecast position against this plan from Month 8 onwards.

Key Recommendations

The Board is asked to consider and review this report and note that PAF has delegated authority to the Executive Team to approve non-recurrent investments until 31 March 2022 to support the deployment of the resource over a short time period.

1. Introduction

On 25 March 2021 NHSI/E published the "NHS Operational Planning Guidance for 2021/22"; as part of this guidance was also issued on the finance and contracting arrangements for H1 2021/22. This guidance set out the arrangements for the six-month period from 1 April 2021 to 30 September 2021 ("H1"). These arrangements included a system funding envelope, comprising adjusted CCG allocations, system top-up and COVID-19 fixed allocation, based on the H2 2020/21 envelopes adjusted for known pressures and policy priorities. Systems were able to earn additional income from the Elective Recovery Fund (ERF) which funded activity above a threshold (95% from July onwards) at the National tariff. For NHS providers, a general efficiency requirement of 0.28% for H1 was applied to the growth in NHS provider block payments.

The Trust's original plan for H1 included £5.5m of additional income from the ERF based on activity plans drawn up by the Divisions. A series of confirm and challenge sessions were held where Divisions were asked to review the opportunities (with additional investment) to increase activity levels for H1. Following this process the Trust submitted final activity plans for H1; based on these plans the Trust expected to earn a total of £8.8m income from the ERF in H1. This was based on a threshold of 85% from July onwards which has subsequently revised by NHSI/E to 95%; this threshold adjustment and the impact on UHNM ERF income was not reflected in the plan. The additional non-recurrent investment requested by the Divisions to support delivery of the increased activity levels was £0.6m which was approved by the Executive Team. During June 2021 the Trust therefore re-submitted their external plan to reflect a revised H1 planned surplus position of £8.2m; internal budgets were also adjusted for this in Month 3.

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 table above shows the performance against that plan for the first 6 months of year with the in month position reflecting the performance in Month 6 and the YTD position reflecting the whole of H1 (i.e. a surplus budget of £8.3m). Whilst an annual budget was set at the start of the year the assumptions for H2 were made in advance of the H2 planning guidance being issued and were therefore expected to change when this guidance was issued.

As is noted in the table above the Trust over performed against the planned surplus for the first half of the year by £5.4m. Within the actual £13.7m surplus for H1 are costs relating to the DHSC issued PPE consumed in this year but issued (with full funding) in the prior year therefore resulting in an unfunded pressure in 2021/22 to the Trust of £0.8m. For the purposes of external reporting to NHSIE the YTD surplus is adjusted by the aforementioned £0.8m and therefore the external surplus is reported as

£14.5m for H1. This surplus has been used to inform system planning discussions and has ultimately impacted the deficit plan for the second half of the year.

2. H2 plan

Planning guidance for H2 2021/22 was issued in September 2021 and on the back of this formal planning submissions at both system and provider level for H2 are due in November 2021. The updated guidance for the second half of the year reconfirms the priorities set out in March 2021 and reflects the financial settlement for the NHS for the final 6 months of the year. The six areas set out in March 2021 remain the national priorities

1) Supporting the health and wellbeing of staff and taking action on recruitment and retention.
2) Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19.
3) Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services.
4) Expanding primary care capacity to improve access, local health outcomes and address health inequalities.
5) Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (EDs), improve timely admission to hospital for ED patients and reduce length of stay.
6) Working collaboratively across systems to deliver on these priorities.

An overview of the financial arrangements for the second half of the year is summarised below:

- H2 system envelopes are based on H1 system envelopes adjusted for higher efficiency requirement, capacity funding and inflationary impacts.
- H2 envelopes include funding for the H1 and H2 impacts of the pay award.
- Block payment arrangements remain in place – changes to blocks will be actioned to reflect changes to the overall system envelopes.
- There are 2 funds to support elective recovery during H2: a Targeted Investment Fund (TIF) worth up to £700m and an Elective Recovery Fund (ERF) with the former being accessed through bids and the latter based on actual performance against the completed referral to treatment (RTT) pathway activity.
- H2 funding in respect of NHS provider other income support has reduced to 75% of H1 funding levels.
- H1 and H2 will be treated as a single financial period and organisations need to achieve financial balance for the year as a whole.
- COVID-19 arrangements will continue in the same manner (i.e. testing and vaccination programmes will continue to be funded outside of envelope in line with service requirements) although the COVID-19 allocation will be reduced by circa 5%.

At both a National and System level an agreement has been reached that any surpluses generated in H1 should be utilised appropriately to manage winter demands and go further on elective recovery, while ensuring that the System and its constituent organisations are exiting 2021/22 with an affordable underlying run-rate and have taken action to recurrently deliver the necessary efficiencies.

To support winter and elective recovery the system has agreed system-wide investments totalling £19.8m in 5 areas; Primary Care (£4m), Social Care (£5m), Elective recovery (£5m), Adult Critical Care (£1.3m) and Workforce (£4.5m). For H2 these amounts have been included in the lead organisation for each area with the exception of Workforce (shown as Non recurrent reserve in the table below) which has been split across the 3 Provider Trusts.

At a system level we have adopted the same approach as H1 with an agreement that once the system can deliver a balanced plan resources will be redistributed on a non-recurrent basis to ensure a balanced plan for all organisations. The table below shows how each organisation's surplus position for H1 has been used as the start point of the H2 planning process, the system wide investments and the redistribution of resources between organisations.

Detail	CCG £000	UHNM £000	NSCHT £000	MPFT £000	Total £000
Cfwd from H1 – declared Surplus / (Deficit)	**3,665**	**14,465**	**488**	**2,796**	**21,414**
H2 planned position - surplus / (deficit)	(22,589)	4,200	3,452	1,090	**(13,847)**
H1 Flexibility available to offset H2	10,304		-	3,420	**13,724**
Estimated system investments not reflected in H2 planned position abov	(9,000)	(6,300)	-	-	**(15,300)**
Reduced NHSE/I income				(1,150)	**(1,150)**
ERF investment				(134)	**(134)**
H2 Position - Surplus / (Deficit)	**(21,285)**	**(2,100)**	**3,452**	**3,226**	**(16,707)**
2021/22 Total - Surplus / (Deficit)	**(17,620)**	**12,365**	**3,940**	**6,022**	**4,707**
1. Contingency held against workforce investment			(274)		**(274)**
2. Non recurrent reserve		(2,636)	(437)	(1,359)	**(4,433)**
Revised 2021/22 Total - Surplus / (Deficit)	**(17,620)**	**9,729**	**3,229**	**4,663**	**0**
Redistribution of allocation to breakeven	17,620	(9,729)	(3,229)	(4,663)	0
Revised 2021/22 Total inc Contingency - Surplus / (Deficit)	**0**	**0**	**0**	**0**	**0**
ERF Projection		5,147		593	**5,740**
Revised 2021/22 Total inc ERF - Surplus / (Deficit)	**0**	**5,147**	**0**	**593**	**5,740**

For UHNM our original plan for H2 was a surplus of £4.2m in advance of any conversations with the system. Within this plan the following items were included:

- £5.2m in respect of the Winter Plan
- £5.0m non-recurrent COVID investment for those costs within our envelope (£2.8m was included for those costs outside of original allocation/envelope and a corresponding income target set as the Trust will be reimbursed in full for these costs)
- An efficiency target of £3.4m for H2 (of which schemes amounting to £0.8m have already been transacted for this period)

This plan was in line with the guidance set out above. However, in order to bring the system plan back to financial balance several adjustments have been made which for UHNM include the following:

- £6.3m adjustment for system agreed investments which were excluded from the first draft plan relating to £1.3m for Critical Care and £5m for elective recovery both of which are funded non-recurrently.
- A non-recurrent reduction in income allocations of £9.7m which has been distributed to the CCG to support their original deficit position.
- A contingency reserve of £2.6m to support system workforce initiatives.
- A CIP requirement of 0.82% (£3.36m) as shown in the table below alongside the requirement of H1.

	H1 £m	H2 £m	Total £m	Comments
National targets (0.28% H1, 0.82% H2)	**1.16**	**3.36**	**4.52**	**As dictated by planning guidance**
Stretch target to break even	**0.24**	**-**	**0.24**	**As agreed with STP**
Total CIP target	**1.39**	**3.36**	**4.76**	
Identified schemes	**(0.77)**	**(0.77)**	**(1.55)**	**Fully transacted schemes**
Remaining CIP target	**0.62**	**2.59**	**3.21**	

Subsequent to the system (and all organisations reaching a balanced plan) adjustments were made to UHNM (£5.1m) and MPFT (£0.6m) to reflect the income expected to be earned from the ERF during H2 based on the system activity plan; there are no costs associated with this and therefore surpluses have been planned to this level by both organisations.

This has therefore resulted in a deficit plan of £9.4m for H2, which when offset against the surplus generated for H1 results in a full year surplus planned of £5.1m for the Trust for the 2021/22 financial year. A summary of this position is noted in the table below.

Income & Expenditure Summary 2021/22	Annual Budget £m	H1 Budget £m	H2 Budget £m
Income from Patient Activities	866.9	441.7	425.2
Other Operating Income	88.4	43.2	45.2
Total Income	955.3	484.9	470.4
Pay Expenditure	(560.7)	(277.3)	(283.4)
Non Pay Expenditure	(336.0)	(172.5)	(163.5)
Total Operational Costs	(896.7)	(449.9)	(446.8)
EBITDA	58.6	35.0	23.6
Depreciation & Amortisation	(29.9)	(15.0)	(14.9)
Interest Receivable	0.1	0.1	0.0
PDC	(7.6)	(3.8)	(3.9)
Finance Cost	(16.1)	(8.1)	(8.0)
Other Gains or Losses	(0.0)	0.0	(0.0)
Total Surplus / (Deficit)	5.1	8.3	(3.2)

Within the budgeted position for H2 we have made an adjustment in respect of the £6.2m H1 variance to plan (i.e. the £5.4m reported surplus plus the £0.8m adjustment in respect of PPE) to ensure that our internal financial reporting has accurately reflected this position, hence the table above shows a £3.2m deficit for H2 (i.e. £9.4m deficit less the £6.2m H1 adjustment). This adjustment has been posted in Month 7 which has skewed the in month budgetary position for Month 7 but ensures that the YTD budgetary position and variance are reflective of this adjustment.

Whilst the Trust has been able to set a surplus plan of £5.1m for the financial year it is important to note that the following items are not included:

- Any forecast under or over performance against budgets (H1 Plan underspent by £5.4m driven primarily by underspends on pay budgets and non-recurrent slippage on investments)
- Additional income streams in-year including TIF and ERF noted above
- Impact of significant COVID-19 levels over Winter (although this is likely to improve the financial position due to reduced operational activity and therefore non pay spend)
- UHNM share of system level H2 capacity funding (£5m)
- Release of 2020/21 provisions

A forecast position will now reported on a monthly basis from Month 8 against this plan as part of the monthly finance report.

3. Non recurrent investment – delegated authority

The plan noted above has a number of revenue streams within this that are yet to be allocated to specific operational plans even before any adjustments are made in respect of any further monies from the TIF and ERF funding streams. All of these funding streams are at present non-recurrent and therefore for the operational teams to access these funds on a timely basis PAF has approved for the Executive Team to be granted delegated authority to approve any non-recurrent investment up to £1m with Investments above this level requiring Trust Board approval. The Executive Team meet on a weekly basis which will therefore facilitate the Divisional teams to access this money efficiently whilst still maintaining a level of governance. The approval for these non-recurrent revenue streams will be capped at the level of the funding streams set out (e.g. £5m for Elective recovery, £2.6m for workforce etc).

4. Conclusion

The planned position for H2 is a £9.4m deficit which ensures both UHNM and the System are able to plan for a small surplus for the 2021/22 financial year. The Trust will report against this position for the remainder of the financial year.

The Trust is aware that whilst there are risks within this financial plan there are also a high level of non-recurrent budgets for the Trust to allocate over the remaining months of the financial year to support operational pressures and recovery with further non recurrent monies likely to be available.

Transformation and People Committee Chair's Highlight Report to Board

24th November 2021

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Workforce performance for month 7 demonstrated challenges with completion of appraisals and sickness absence which stood at 5.66% with an increase in stress and mental health issues. The Committee noted the planning being undertaken in relation to the national guidance of mandatory covid vaccines for front line staff • Some challenges within obstetrics and gynaecology had been flagged by the postgraduate medical and dental education and this was being discussed further with the directorate team to ensure trainees were supported	• To provide an update to a future meeting in relation to strategic workforce planning • To provide a summary of all different work streams in place for leadership development • To provide an update to a future meeting on the future of OD and HR national report • Ongoing monitoring in relation to the mandatory covid vaccine to be brought to future meetings • Future workforce reports to include staff engagement metrics • A high level summary to be provided, outlining the approach to delivering coordinated transformation, summarising the guiding principles and alignment to strategic objectives and priorities • To update the clinical strategy and bring back to the Committee • To outline the medical and dental education priorities to the Chair
Positive Assurances to Provide	**Decisions Made**
• An update from guardian of safe working was provided whereby 66 exception reports were reported for quarter 2, and any immediate safety concerns had been followed up and considered. The Committee noted the actions continuing to be taken in respect of engaging with trainees • 34 speaking up contacts were made during quarter 2, reflecting previous trends with the main theme relating to attitudes and behaviours. Actions continued to be taken to support a speaking up culture including the provision of e-learning and staff voice survey and the Committee welcomed the review of the review tool and strategy. • The organisational development and culture quarterly update highlighted that the majority of actions had been focussed on staff engagement including continuation with the civility and respect programme. The Committee recognised the importance of providing feedback to staff on the actions being taken in response to the various surveys underway within the Trust • Progress against the 5 priorities within the health and wellbeing plan was highlighted, including a winter wellbeing plan, which considered the increasing food options available for staff out of hours. • A presentation was provided in relation nurse recruitment whereby 92 overseas nurses had been accepted, 89 overseas registered nurses had successfully applied for funding as a nursing assistant, 43 nursing associates had completed and a bid had been submitted for 30 nurse apprenticeships • The Committee received an updated and refreshed approach to transformation and the aim of aligning transformation projects to the Trust strategic objectives and supporting decision making • The Committee held a significant discussion in relation to the draft clinical strategy noting the areas which would be further developed and strengthened. The Committee recognised the importance of the strategy being owned by clinical leaders and that the strategic priorities needed to inform the guiding principles for the clinical strategy and appropriate pathways • The Committee noted the commencement of wave 2 for the improving together programme whilst actions continued to be taken to implement wave 1	• No decisions were required to be made.

Comments on the Effectiveness of the Meeting
• Committee members welcomed the discussion and welcomed the momentum in taking forward strategic workforce planning

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Guardian of Safe Working Report	Assurance	7.	M7 Workforce Report	Assurance
2.	Speaking Up Report – Quarter 2 2021-22	Assurance	8.	Transformation Strategy 2021-2025	Discussion
3.	OD and Culture Quarterly Update • Civility and Respect Gap Analysis	Assurance	9.	Draft Clinical Strategy 2021-2026	Discussion
4.	Health and Wellbeing Plan Progress Report	Assurance	10.	Improving Together Highlight Report	Assurance
5.	Building Strong Integrated Care System Guidance on the ICS People Function	Information	11.	Postgraduate Medical and Dental Education Report	Assurance
6.	Quarterly Nurse Vacancy Progress Update	Assurance	12.	Executive Strategy & Transformation Group Assurance Report (Nov-21)	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					NH				
Mrs R Vaughan	RV	Director of Human Resources						JH						

Executive Summary

Meeting:	Trust Board	**Date:**	8th December 2021
Report Title:	Integrated Performance Report, month 7 2021/22	**Agenda Item:**	13.
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 HR Mark Oldham: Chief Finance Officer		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

Executive Summary

Situation

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

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

Assessment

Quality & Safety

The Trust achieved the following standards in October 2021:

- Friend & Family (Inpatients) 98.6% 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 4.7per 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.
- VTE Risk Assessment completed during admission continues to exceed 95% target with 99.2% (point

prevalence audit via Safety Thermometer).
- Zero avoidable MRSA Bacteraemia cases reported.
- There have been no Category 4 Pressure Ulcers attributable to lapses in care during October 2021.
- Inpatient IVAB within 1 hour achieved 100% and exceeded 90% target rate
- Sepsis Screening compliance in Emergency Portals exceeded the target 90% with 95.3%.
- Children's Sepsis Screening compliance 93.3% 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 31 Pressure ulcers identified with lapses in care during October 2021 and 9 Deep Tissue Injuries.
- 71% 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 87.9% below 90% target rate
- Emergency Portals IVAB in 1 hour 66.7% against the 90% target for audited patients
- Maternity Sepsis Screening 75% and IVAB in 1 hour compliance at 75% and below the targets
- Emergency C Section rate is above 15% target at 21.51%.

During October 2021, the following quality highlights are to be noted:
- The rate of complaints per 10,000 spells is 27.55 and is below (positive) the target of 35 and within normal variation. Majority of complaints in October 2021 relate to clinical treatment.
- Total number of Patient Safety Incidents decreased (1648) and the rate per 1000 bed days has also decreased at 43.25 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 total reported incidents relating to staffing shortages and lack of appropriate staff on wards/departments. However there are still extreme workforce pressures noted by Divisions and support measures continue across the Trust and system wide.
- Rate of falls reported that have resulted in harm to patients has reduced during recent months and currently at 1.0 in October 2021. The rate of patient falls with harm continues to be within the control limits and normal variation but last 4 months are below the mean rate and close to the lower confidence interval which indicates there may be some significant improvement in reducing harm from falls.
- 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.
- 8 Hospital Onset / Nosocomial COVID cases reported in October.
- 1 COVID-19 death falling in to the 'Definite' category (according to the National definition of Nosocomial deaths).
- 9 Serious Incidents reported in October 2021. All the serious incidents were reported on STEIS within the 2 working date target.

Operational Performance

Emergency Care
- The number of attendances at Royal Stoke ED has remained static over the last 2 months with an average of 345 per day. The number of ambulance arrivals fell slightly again from a daily average of 147 to 142 and the self-presenting ambulatory remained at c200/day.
- The daily average number of admissions and conversion rate increased slightly. Daily average admissions were up from 112 to 117 and the conversion rate rose to 34.3%.
- Ambulance handover delays for 30-60mins remained static and the > 60 mins rose in October along with the percentage of handovers within 15 minutes which dropped to 27%
- System-wide performance was 65% with total type 1 at 48.4%. At Royal Stoke the non-admitted performance fell to 48.9% and the admitted performance fell from 20% to 19% indicating the key issues

again were related to extended timescales to pathway processing and outcome management.
- MFFDs remained commensurate with the winter 'worst case scenario' predictors with the number of patients with > 21 days stay in October increasing commensurately.
- The department had continued days with sub 60% performance with most of the front door metrics challenged. The West Block being decommissioned on account of the CRP outbreak meant a loss of 50 beds with the need to absorb 2 wards worth of patients into the acute PFI which had a detrimental impact on performance from mid-October until resolution on 8th November.

Cancer
- The Trust is provisionally predicted to achieve the following two cancer standards for October 21: 31 day subsequent Radiotherapy at 94.1% and Rare Cancers 31 Days at 100%
- The overall 2WW position for October is predicted to achieve in the region of 64.26. Specialties with the most 14 day breaches are Breast, Skin, Colorectal and Upper GI. Performance against the 62 day standard is currently at 57.5% for October 21. This is an un-validated position that is expected to change as histology confirms a cancer or non-cancer diagnostic for patients treated.
- Number of 2WW & 62 day breaches recorded in October is consistent with September. Theatre, Oncology and Surgical workforces have been impacted resulting in breaches. The position is being managed through the reinstated daily clinical prioritisation meetings and a robust planned care assurance framework.
- 2WW and 62 day position is significantly challenged, and will be validated prior to upload.

Planned Care
- Day Case and Elective Activity delivered 85.6% for October 21 against the national ask of 95%. This is lower in Inpatients than Day case (72% IP, 87% DC).
- In month Planned Care Cell focus on elective recovery based on 10 high impact changes linked to investment bids to expedite improvement actions. Initial focus is on theatre capacity and productivity given the emergent covid risks and staff isolation rate of attrition.
- Validation of 104 weeks completed – 2/3 need treatment @ UHNM or IS with 1/3 previous DNA of IS, needing other follow on diagnostics/actions before TCI or not eligible for P5/6 as want treatment but not IS.
- 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. This work will increase with additional funding to expand the patient contact team.

Diagnostics
- For DM01 (15 nationally identified Dx tests) the total waiting list has risen slightly in October from 20,314 to 20,173.
- The Non-obstetric ultrasound the waiting list continues to grow, October 10,569 (September 10,318). Due to the challenges in Non-Obstetric Ultrasound this has adversely affected performance. The activity is increasing with the independent sector supporting c900 scans of additionally per month. Due to the challenges in Non-Obstetric Ultrasound this has adversely affected performance.
- The current DM01 diagnostic performance for October 21 has improved to 68.49% (September 68.14%).
- DM01 performance excluding non obs ultrasound would be c90%.

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 5.66% (5.36% reported at 30/08/21). The 12 month cumulative rate increased to 5.33% (5.25% at 30/09/21)

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

Specific actions being taken by the Divisions include:

- Specific interventions and focused work with line managers in the areas of concern and with further training provided as necessary
- Absence management assurance meetings continue to taking place with Directorates to obtain assurance on the management of long term and frequent absences. Divisions have highlighted staff self-care, rota issues and behavioural/ cultural issues as one cause of stress related absence and are working with the People and OD Team to enhance wellbeing conversations

As of 12th November 2021, covid-related open absences* numbered 165, which was 20.57% of all absences (28.81% at 20th October 2021) [**includes absences resulting from adhering to isolation requirements*]

Appraisals

The Non-Medical PDR compliance rate was 75.21% at 31st October 2021 (76.18% at 30 September 2021). Divisions have been asked to revise their trajectories to reflect a realistic position of what they are able to achieve and asked to continue to undertake PDR's wherever possible as opportunity to discuss wellbeing and support

Statutory and Mandatory Training

The Statutory and Mandatory training rate at 31st October 2021 was 95.38% (95.5% at 30 September 2021. This compliance rate is for the 6 'Core for All' subjects only. At 31 October 2021, 91.24% of staff had completed all 6 Core for All modules (91.80% at 30/09/21)

Vacancies

The overall Trust vacancy rate was 9.97% as a result of an uplift in budgeted establishment to account for Winter planning, rather than a reduction in staffing

- A bid is being submitted for the International Recruitment of a further 100 registered nurses for 2022/23
- The Nursing Associate apprenticeship development programme has recommenced to support with recruitment issues and provide a development platform
- Apprenticeship needs for the next 1, 3, and 5 years are being assessed

Finance

Key messages

- The Trust set a plan at the start of the year with an H1 surplus of £8.3m and a full year deficit of £8.8m. The guidance for H2 has been reviewed by the Trust and the Trust has set a revised breakeven plan for the financial year ending 31 March 2022. At both a National and System level an agreement has been reached that the Trust is expected to carry forward the surplus of £14.5m delivered in H1 and therefore the planned position for H2 is a £14.5m deficit to achieve a breakeven plan for the year.
- The Trust has delivered an actual surplus of £2.2m in month and a year to date surplus of £15.9m resulting in a favourable variance of £4.4m against the year to date plan. The positive position in month is primarily driven by an adjustment to the Managed Equipment Service (MES) replacement cost within the PFI, additional HEE income and slippage on non-recurrent investments.
- The Trust incurred £1.2m of costs relating to COVID-19 in month which is an increase of £0.2m compared with Month 6'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.
- Capital expenditure for the year to date stands at £14.3m which is £1.6m behind the plan mainly due to an underspend relating to digital pathology.
- The cash balance at Month 7 is £71.7m which is £1.1m higher than plan, the main reason being that capital payments are £1.4m lower than plan as a result of the slippage against the capital plan.
- An updated plan for H2 has been presented in November and at Month 8 and in line with NHSIE guidelines, a full year forecast position will be presented to the Committee.

Key Recommendations

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

NHS
University Hospitals of North Midlands
NHS Trust

Integrated Performance Report

Month 7 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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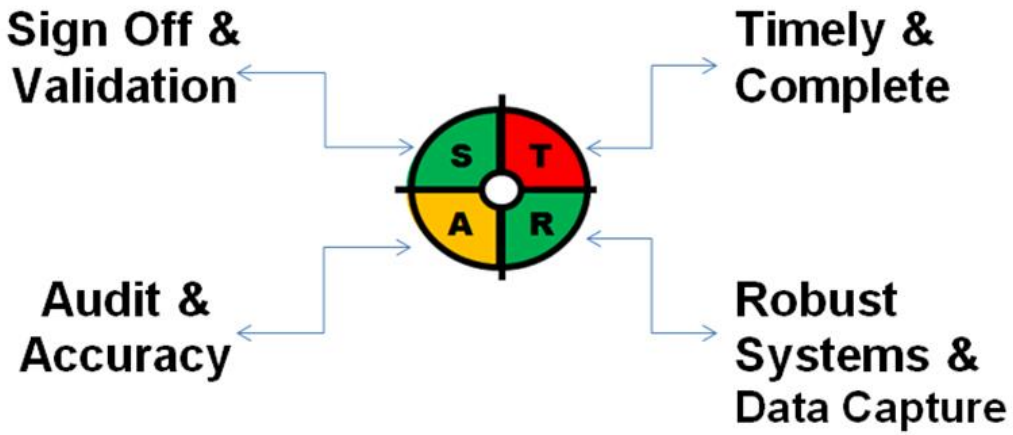
Quality | Operational | Workforce | Finance

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

Key messages

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Quality Dashboard

NHS University Hospitals of North Midlands NHS Trust

Metric	Target	Latest	Variation	Assurance
Patient Safety Incidents	N/A	1648	H	
Patient Safety Incidents per 1000 bed days	N/A	43.25	H	
Patient Safety Incidents per 1000 bed days with no harm	N/A	29.52		
Patient Safety Incidents per 1000 bed days with low harm	N/A	12.02		
Patient Safety Incidents per 1000 bed days reported as Near Miss	N/A	1.34	L	
Patient Safety Incidents with moderate harm +	N/A	12		
Patient Safety Incidents with moderate harm + per 1000 bed days	N/A	0.31		
Harm Free Care (New Harms)	95%	95.6%	L	?
Patient Falls per 1000 bed days	5.6	4.7		?
Patient Falls with harm per 1000 bed days	1.5	1.0		?
Medication Incidents per 1000 bed days	N/A	3.9		?
Medication Incidents % with moderate harm or above	TBC	0.67%		
Patient Medication Incidents per 1000 bed days	N/A	3.2		F
Patient Medication Incidents % with moderate harm or above	TBC	0.83%		

Metric	Target	Latest	Variation	Assurance
Serious Incidents reported per month	N/A	9		
Serious Incidents Rate per 1000 bed days	N/A	0.24		
Never Events reported per month	0	0	L	?
Duty of Candour - Verbal/Formal Notification	100%	71%	L	?
Duty of Candour - Written	100%	71.0%		?
All Pressure ulcers developed under UHNM Care	TBC	88	H	
All Pressure ulcers developed under UHNM Care per 1000 bed days	N/A	2.28		
All Pressure ulcers developed under UHNM Care lapses in care	12	32	H	?
All Pressure ulcers developed under UHNM Care lapses in care per 1000 bed days	0.5	0.84	H	?
Category 2 Pressure Ulcers with lapses in Care	8	12	H	P
Category 3 Pressure Ulcers with lapse in care	4	2		?
Deep Tissue Injury with lapses in care	0	9	H	
Unstageable Pressure Ulcers with lapses in care	0	8	H	?

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Quality Dashboard

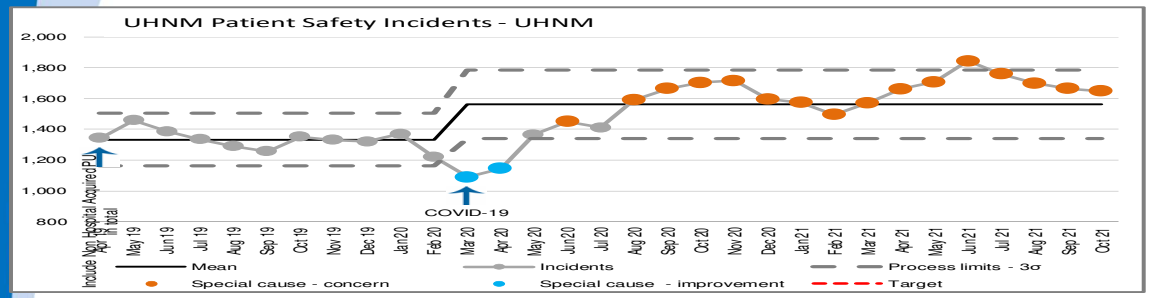
Metric	Target	Latest	Variation	Assurance
Friends & Family Test - A&E	85%	70.0%		
Friends & Family Test - Inpatient	95%	98.6%		
Friends & Family Test - Maternity	95%	100.0%		
Written Complaints per 10,000 spells	35	27.55		
Rolling 12 Month HSMR (3 month time lag)	100	93.66		
Rolling 12 Month SHMI (4 month time lag)	100	102.48		
Nosocomial COVID-19 Deaths (Positive Sample 15+ days after admission)	N/A	1		
VTE Risk Assessment Compliance	95%	99.2%		
Emergency C Section rate % of total births	15%	21.51%		
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	7		
Nosocomial "Definite" HAI COVID Cases - UHNM	0	8		

Metric	Target	Latest	Variation	Assurance
Inpatient Sepsis Screening Compliance (Contracted)	90%	87.9%		
Inpatient IVAB within 1hr (Contracted)	90%	95.1%		
Children Sepsis Screening Compliance (All)	90%	93.3%		
Children IVAB within 1hr (All)	90%	N/A		
Emergency Portals Sepsis Screening Compliance (Contracted)	90%	95.3%		
Emergency Portals IVAB within 1 hr (Contracted)	90%	80.0%		
Maternity Sepsis Screening (All)	90%	75.0%		
Maternity IVAB within 1 hr (All)	90%	75.0%		

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Reported Patient Safety Incidents

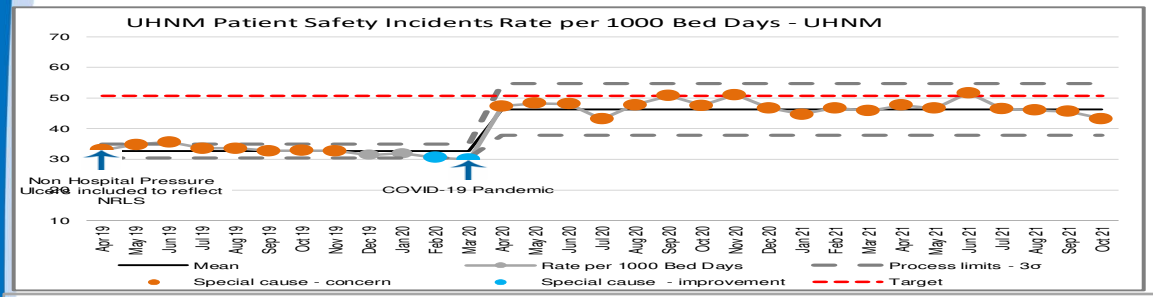


Variation	Assurance
	

Target	Aug 21	Sep 21	Oct 21
N/A	1700	1664	1648

Background

Total Reported patient safety incidents



Variation	Assurance
	

NRLS Mean	Aug 21	Sep 21	Oct 21
50.70	46.08	45.57	43.25

What is the data telling us:

The above data relates to **all** reported Patient Safety Incidents (PSIs) across the Trust. The October 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 - 178 (196)
- Clinical assessment (Including diagnosis, images and lab tests) – 80 (83)
- Patient flow incl. access, discharge & transfer - 97 (106)
- Documentation – 50 (46)
- Pressure Ulcers (Hospital acquired) – 84 (88)
- Treatment/Procedure - 62 (59)
- Medication incidents - 122 (151)
- Infection Prevention – 73 (69)
- Staffing – 33 (22)

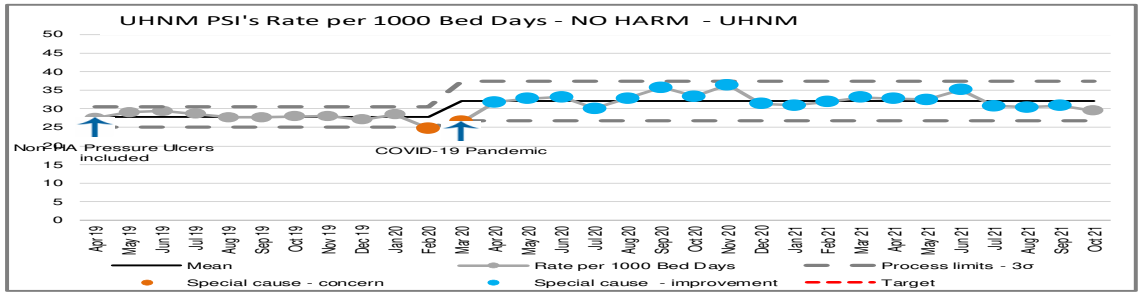
There has been a reduction during October in the total number of incident reporting relating to staffing with 61 (74 in September) incidents reported. 33 (22 in September) of these were under patient related and the remaining 28 were reported as staff related. However, these incidents do have potential 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 Anaesthetics, Critical Care & Theatres and Specialised Medicine. 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

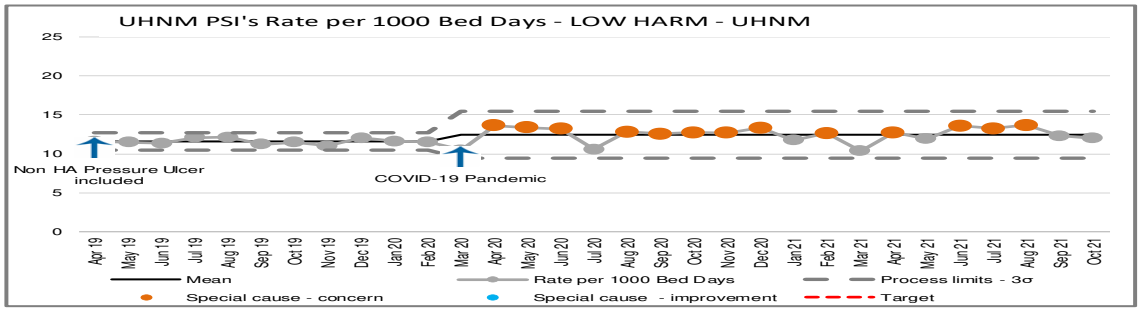


Variation	Assurance

Target	Aug 21	Sep 21	Oct 21
N/A	30.44	30.92	29.52

Background

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

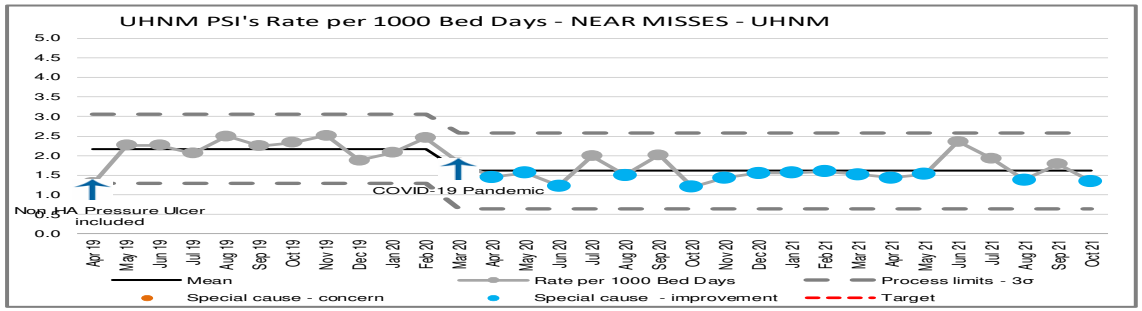


Variation	Assurance

Target	Aug 21	Sep 21	Oct 21
N/A	13.66	12.32	12.02

Background

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



Variation	Assurance

Target	Aug 21	Sep 21	Oct 21
N/A	1.38	1.78	1.34

Background

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

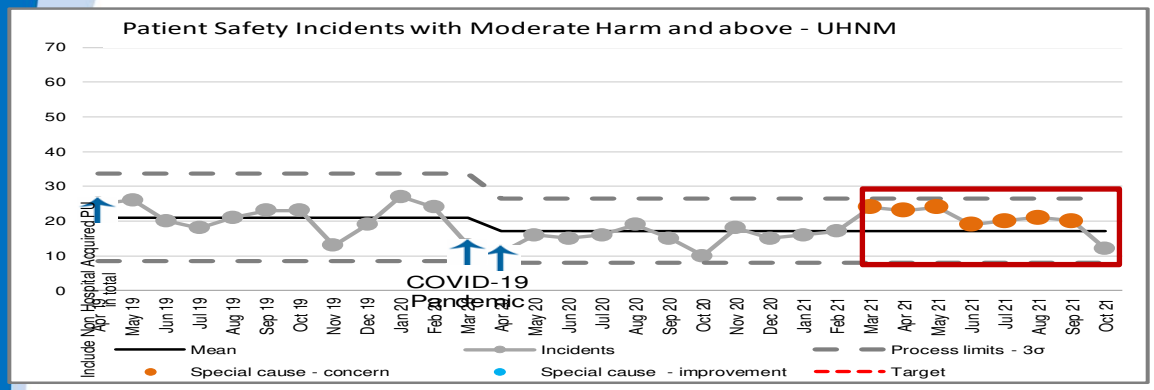
What is the data telling us:

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

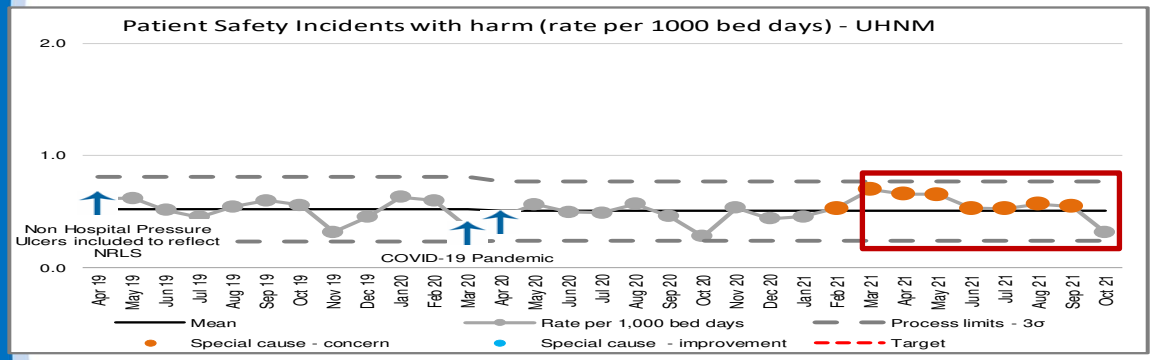


Variation	Assurance

Target	Aug 21	Sep 21	Oct 21
N/A	21	20	12

Background

Patient safety incidents with reported moderate harm and above



Variation	Assurance

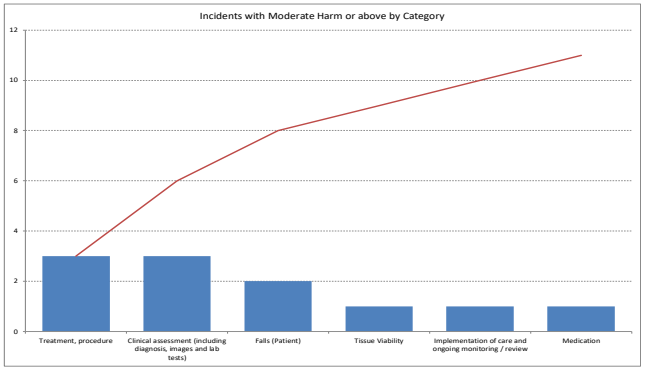
Target	Aug 21	Sep 21	Oct 21
N/A	0.57	0.55	0.31

What is the data telling us:

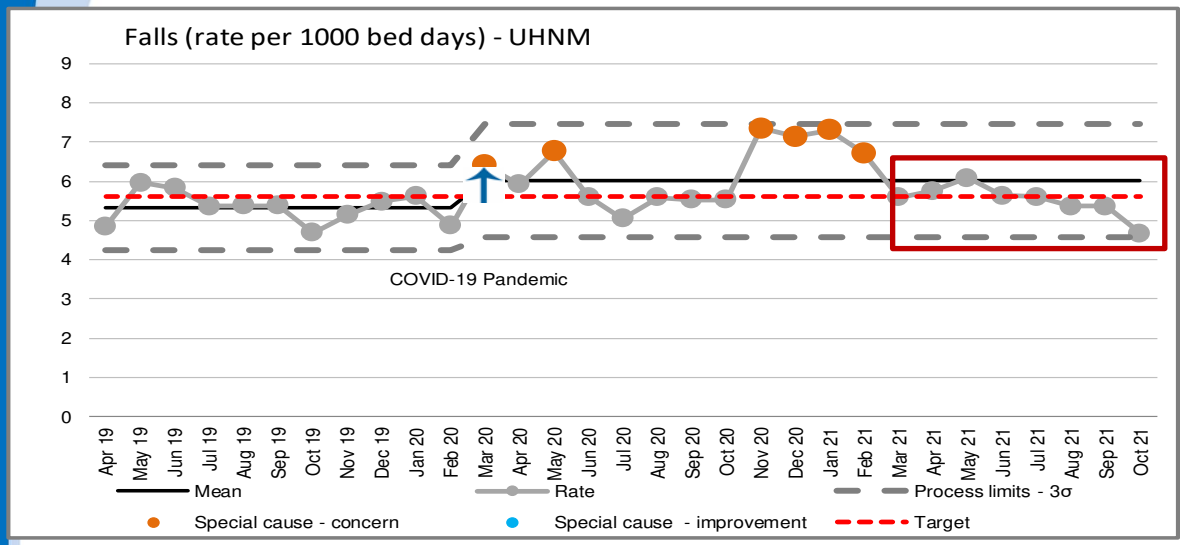
The variation noted in charts above for moderate harm or above total and rate per 1000 bed days is within normal variation and no special cause noted. Whilst noted that not statistically significant yet the previous 7 months are showing reductions in the number and rate of incidents with moderate harm or above

The top category of incidents resulting in moderate harm reflect the largest reporting categories with Clinical Assessment and Treatment related being the largest categories with 3 each.
The third largest category is Patient Fall related reported 2. This could be result of the Improving Together and Driver metrics projects across Divisions and focus on reducing falls.

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



Patient Falls Rate per 1000 bed days



Variation	Assurance

Target	Aug 21	Sep 21	Oct 21
5.6	5.4	5.4	4.7

Background

The number of falls per 1000 occupied bed days

What is the data telling us:

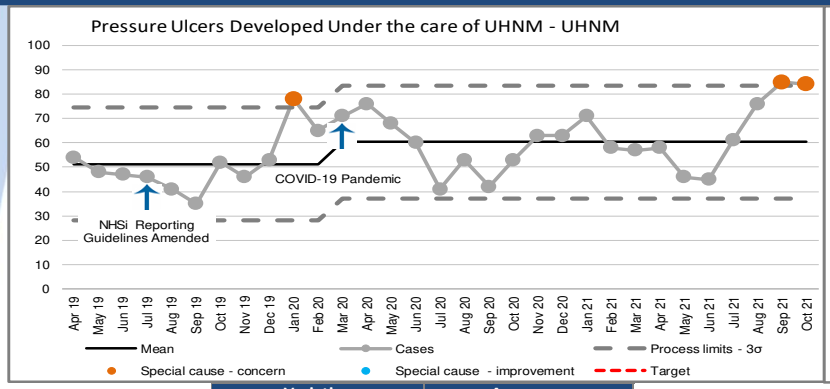
The chart shows the Trust's rate of reported patient falls per 1000 bed days is currently not showing any significant change. The Trust adopted the average rate of 5.6 patient falls per 1000 bed days from the Royal College of Physicians National Falls Audit report (2015) as a target rate.

The areas reporting the highest numbers of falls in October 2021 were:
Royal Stoke AMU, Royal ED, Ward 127, Ward 110, Ward 230, Ward 113

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

- Falls champion study day is taking place next week to update current and new falls champions.
- A request has been made that before submission of the final RCA that a consultant has signed off the updates and the improvement plan before uploading it to Datix.
- Maternity have submitted information to the governance team for approval of a falls maternity specific risk assessment that they have placed together.
- Matron Ferneyhough is linking in with ward areas to identify areas of improvement that have been highlighted during the improvement projects.
- Purchasing of 2 hover jacks has been secured to replace the current broken ones, this will assist to ensure patient are moved appropriately where there is a possibility of a serious injury

Total Pressure Ulcers developed under care of UHNM

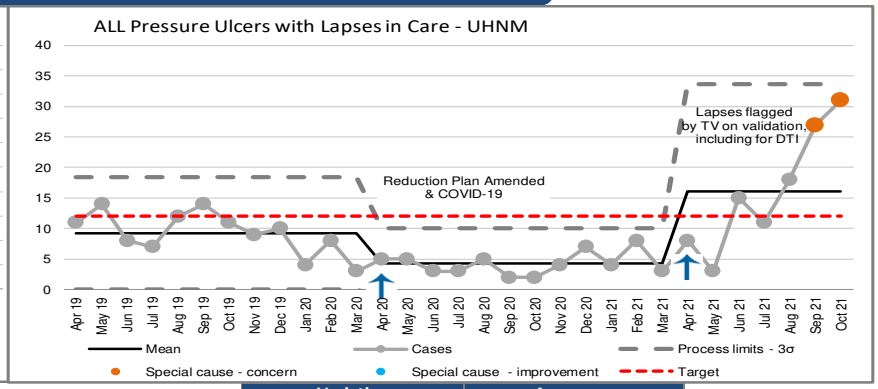


Variation	Assurance
H	

Target	Aug 21	Sep 21	Oct 21
N/A	76	85	84

Background

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



Variation	Assurance
H	?

Target	Aug 21	Sep 21	Oct 21
12	18	27	31

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 October 2021.

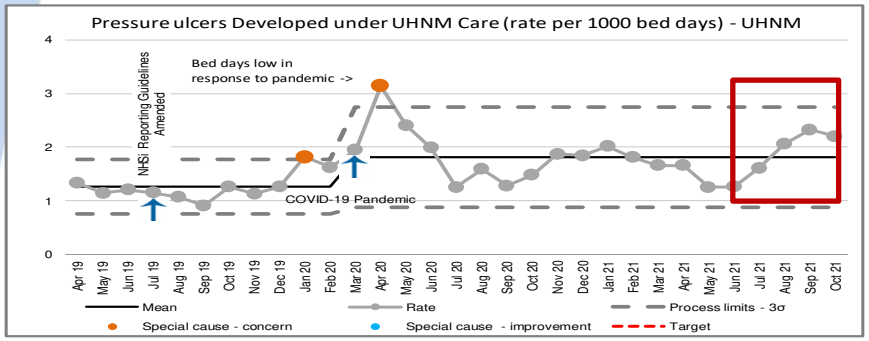
Category	Total (Oct 2021)
DTI	36
Category 2	32
Category 3	3
Category 4	-
Unstageable	13
Total	**84**

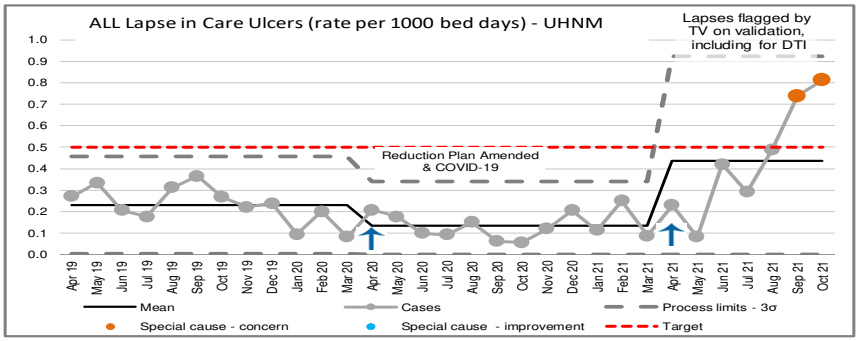
Top Body Locations	Total (Oct 2021)
Buttock	16
Heel	14
Sacrum	13
Coccyx	11

The number of pressure ulcers reported as developing under the care of UHNM in October is significantly above average. This is primarily due to numbers of Category 2 ulcers (32, compared to a 2-year monthly average of 23) and DTI's (36, compared to a 2-year monthly average of 20) . 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 once the cases are reviewed at Tissues Viability Panel.

Pressure Ulcers developed under care of UHNM per 1000 bed days





Variation	Assurance

Target	Aug 21	Sep 21	Oct 21
N/A	2.06	2.33	2.20

Background

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

Variation	Assurance

Target	Aug 21	Sep 21	Oct 21
0.5	0.49	0.74	0.81

Background

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

What the data is telling us

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

The chart above right shows the rate of pressure ulcers with lapses in care identified was significantly higher in September & October 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.

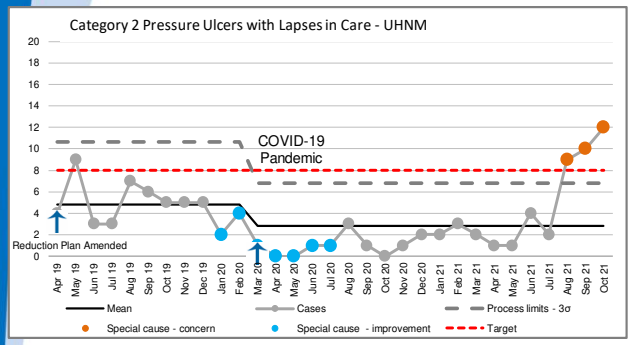
High reporting areas will be presenting all incidents at bespoke RCA panels, to allow identification of ward trends, to identify the need for focussed improvement and education supported by the Tissue Viability and Corporate Nursing Quality & Safety Teams.

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 relieving qualities due to wear and tear.
- Pressure Ulcer Prevention (PUP) education is now delivered on a multiple platform a including NA and Preceptorship induction programme as well as for new starters in ED and child health. Education and support can be requested on ad hoc basis.
- Harm Free Care alerts are now circulated 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.
- Review of surfaces in ED to enhance Pressure ulcer prevention

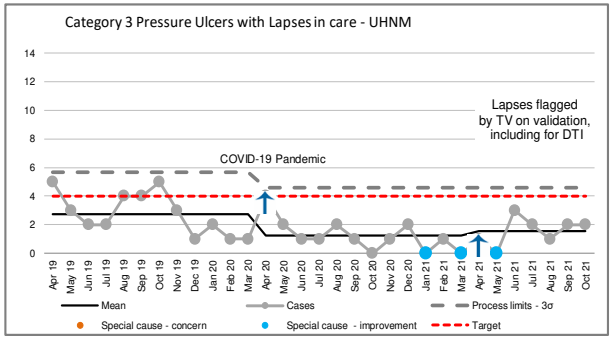
Pressure Ulcers with lapses in care



Variation	Assurance
H	P

Target	Aug 21	Sep 21	Oct 21
8	9	10	12

Background

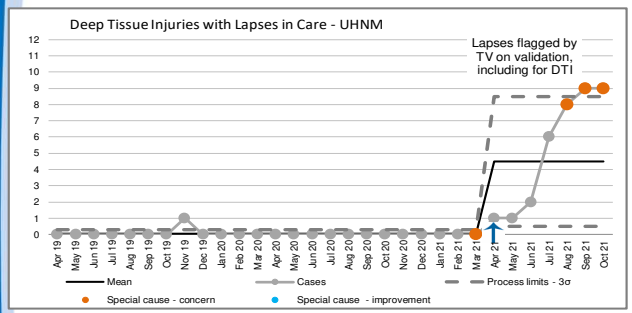


Variation	Assurance
~	?

Target	Aug 21	Sep 21	Oct 21
4	1	2	2

Background

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

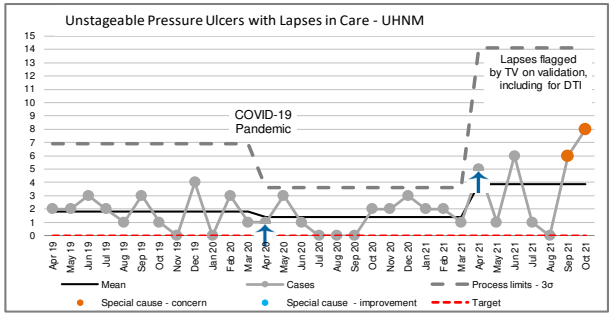


Variation	Assurance
H	

Target	Aug 21	Sep 21	Oct 21
N/A	8	9	9

Background

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



Variation	Assurance
H	?

Target	Aug 21	Sep 21	Oct 21
0	0	6	8

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

As described on slide 21, the high numbers of Category 2 ulcers and DTI's with lapses in care may be partly due to the new validation process identifying lapses on the initial assessment by the Tissue Viability Team.

As shown in the table below, common lapses identified are management of repositioning and heel offloading which will be the focus for "stop the pressure day" on the 18th November 2021. 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.

Locations with more than 1 lapse in October were: W 201 (4), Emergency Care Centre (4), AMU Stoke (3), W 76b (2), W 103 (2), W 111 (2) , W 228 (2)

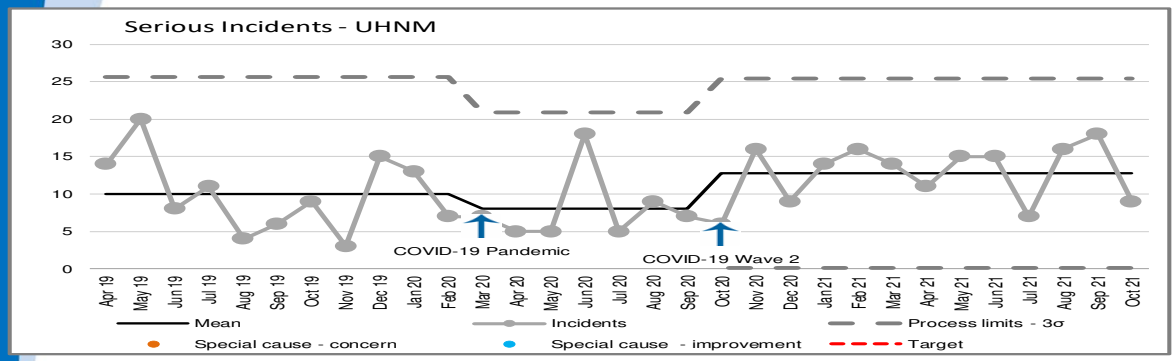
Unfortunately, recently HM Coroner has attributed a degree of neglect to 2 cases of patients with pressure ulcers. These cases are under further review by the Chief Nurse and Medical Director

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 re-commenced in October 2021 and focuses on learning from incidents.
- A 6 monthly review of the process to attribute and validate the lapses in care is currently being undertaken.

Root Cause of damage - Lapses - Oct 2021	Total
Management of repositioning	20
Management of heel offloading	5
Management of device	4
Clinical condition	1
TBC	1
Total	**31**

Serious Incidents per month

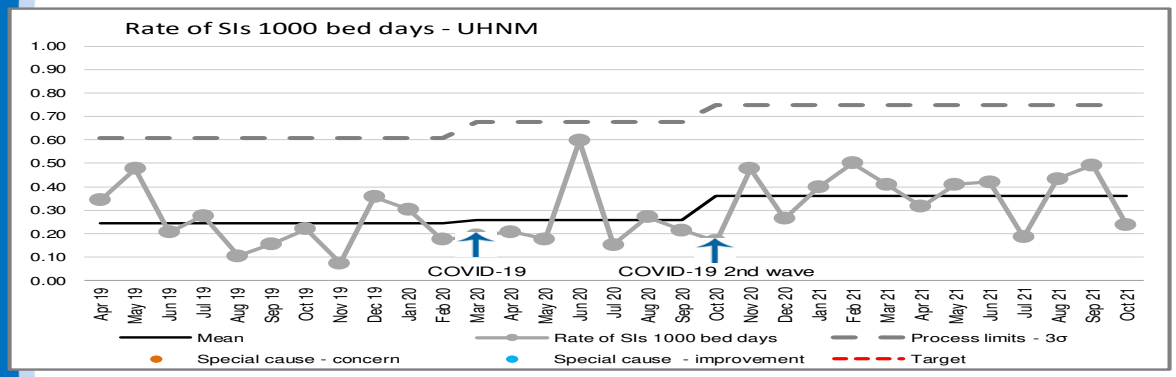


Variation	Assurance

Threshold	Aug 21	Sep 21	Oct 21
N/A	16	18	9

Background

The number of reported Serious Incidents per month



Variation	Assurance

Target	Aug 21	Sep 21	Oct 21
N/A	0.43	0.49	0.24

Background

The rate of Serious Incidents Reported per 1000 bed days

What is the data telling us:

5 Falls related incidents
2 Diagnostic related incidents
1 Treatment delay
1 Major incident (IT Network failure)
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.

There are currently 62 incidents open on STEIS for UHNM as at 31st October 2021.
20 RCAs are awaited which is decrease from previous report, 5 RCAs have been submitted to the CCG and are under going review process prior to closure and 37 RCAs are within timescale
**Reported on STEIS as SI in October 2021, the date of the identified incident may not be October 2021.*

Serious Incidents Summary

University Hospitals of North Midlands NHS Trust

Summary of new Maternity Serious Incidents

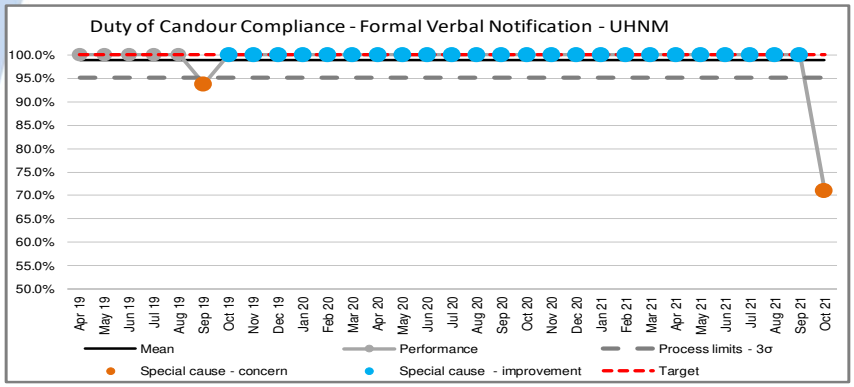
Following the formal recommendations in the Ockenden Report, below is an outline of the Maternity related serious incidents reported during June 2021. The new recommendation requires the Trust Board to receive summary on the new Maternity related Serious Incidents along with previously reported summary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

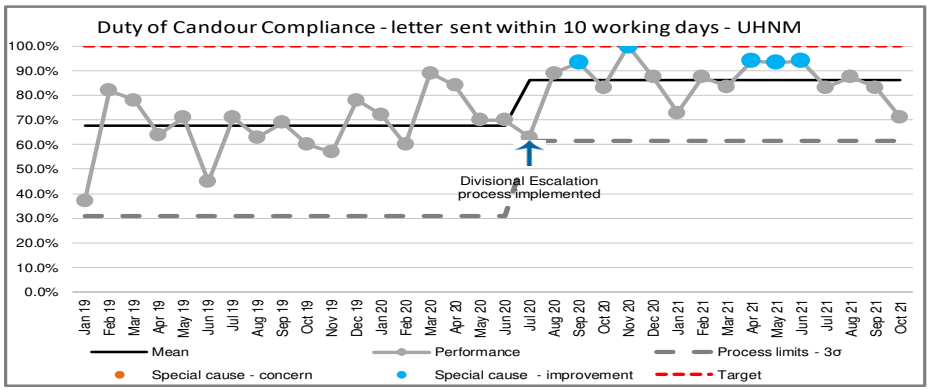
All Serious Incidents will continue to be are reported and investigated and the final Root Cause Analysis presented at Divisional meetings and Risk Management Panel for review and agreement prior to sharing with CCGs for closure.

There were 0 Maternity related Serious Incidents reported on STEIS during October 2021

Log No	Patient Ethnic Group:	Type of Incident	Target Completion date	Description of what happened:

Duty of Candour Compliance





Variation	Assurance
	

Target	Aug 21	Sep 21	Oct 21
100%	100.0%	100.0%	71.0%

Background

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

Variation	Assurance
	

Target	Aug 21	Sep 21	Oct 21
100%	87.5%	83.3%	71.0%

Background

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

What is the data telling us:

During October there were 7 incidents reported and identified that have formally triggered the Duty of Candour. 5 of these cases (71%) have recorded that the patient/relatives been formally notified of the incident in Datix.

Confirmed Follow up Written Duty of Candour compliance (i.e. receiving the letter within 10 working days of verbal notification) during October 2021 is 71%.

There were 2 cases that had not received the letter within 10 days.

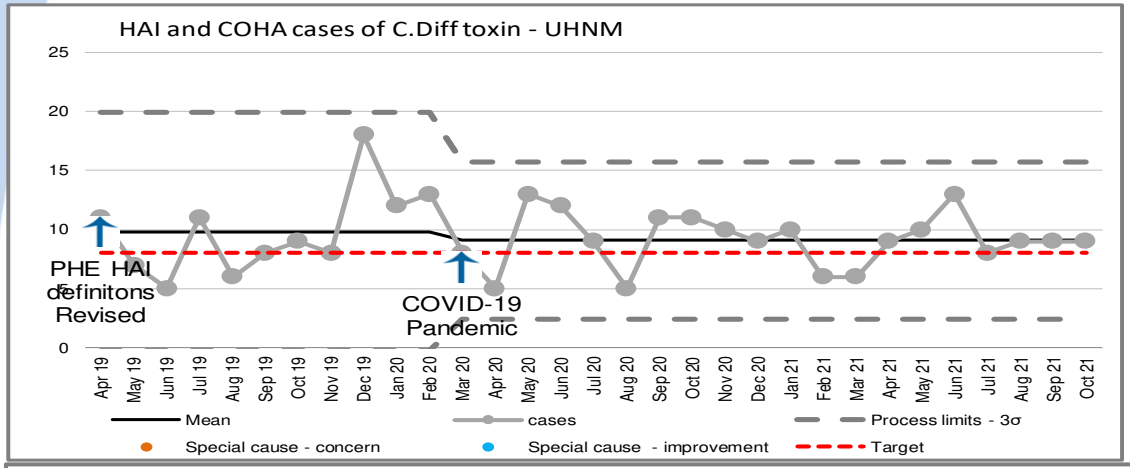
Since the new escalation process was introduced within the Divisions, with exception of October 2021, there has been an improvements in performance with smaller confidence intervals and better performance.

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	Aug 21	Sep 21	Oct 21
8	9	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 October of these 6 were Hospital Associated Infection (HAI) cases and 3 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

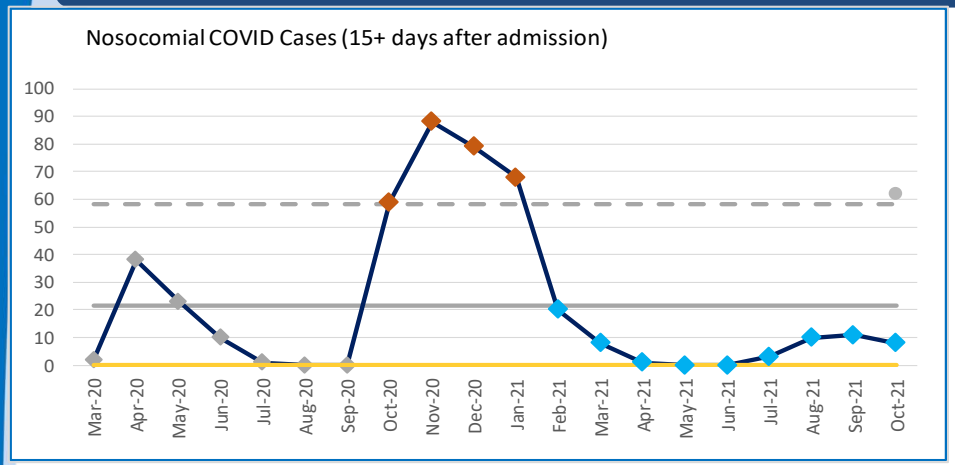
There has been one clinical area that has had more than one Clostridium *difficile* case in a 28 day period.

- Ward 102, Royal Stoke Hospital 2x HAI toxin. Ribotypes are still oustanding so it is not possible to say whether person to person transmission has occurred.
- IP measures in place

Actions:

- Continue surveillance for HAI C diff with continued immediate implementation of control measures to prevent transmission
- In all cases control measures are instigated immediately
- RCA reviews with the CCG have been paused due to COVID 19 but are due to recommence
- Each in-patient is reviewed by the C *difficile* nurse at least 3 times a week, and forms part of a multi-disciplinary review.
- Routine ribotyping of samples is now being undertaken at Leeds hospital. This will help determine if cases can be linked
- A Clostridium *difficile* task and finish Group in progress

HAI Nosocomial COVID Cases per Month



What do these results tell us?

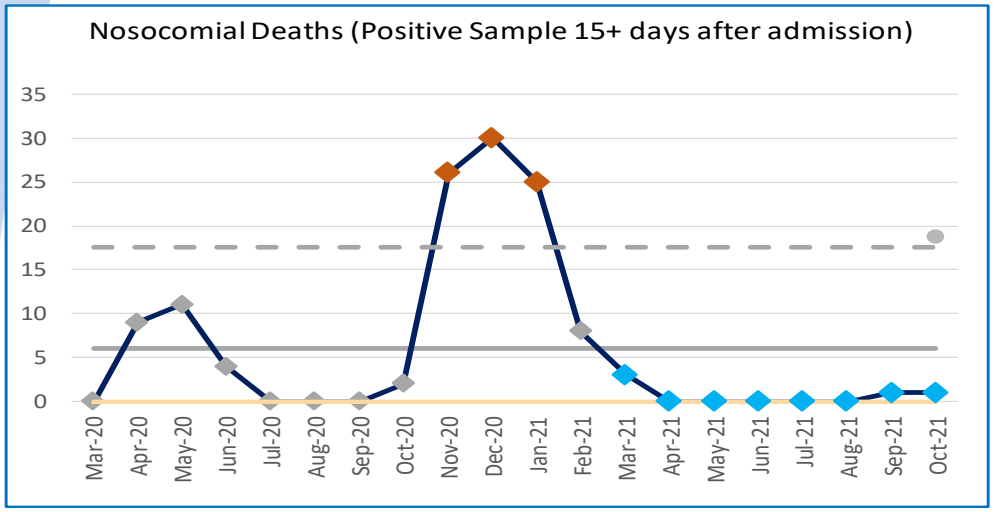
- The data shows an in month decrease in definite Healthcare Acquired COVID - 19 cases with 8 in October 2021 (these patients were within CWD)
- Local, Regional and National community COVID-19 rates have increased in August 2021 (see table opposite)
- October has seen slight decrease in Probable and definite Hospital Onset COVID but is below Wave 2 figures during October and March.

	Community COVID-19 rate per 100,000 population (as at month end)				UHNM		
	England	W Mids	Staffs	Stoke	Total Admissions	COVID cases	
						Prob	Def
Oct 20	232.1	273.7	352.2	373.3	17006	63	59
Nov 20	152.2	188.0	206.0	350.3	14956	109	88
Dec 20	526.0	404.1	370.2	318.7	14701	107	79
Jan 21	283.0	328.0	296.0	239.5	14255	128	68
Feb 21	86.60	113.2	104.6	125.2	14101	31	20
Mar 21	56.0	61.6	56.2	76.8	17105	12	8
Apr 21	24.1	23.6	17.7	35.1	16554	3	1
May-21	49.0	36	27.9	18.3	17273	0	0
Jun-21	100.4	76.9	62.4	93.6	18527	0	0
Jul-21	290.1	273.5	242.9	223.3	18168	4	3
Aug-21	310.8	321.7	360.5	375.6	17160	14	10
Sep-21	355.3	414.0	512.2	423.3	17327	11	10
Oct-21	484.9	468.8	569.7	532.7	17055	8	8

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 October 2021
- Total 118 hospital acquired COVID-19 deaths with 1st positive results 15 days or more following admission recorded since March 2020.
- The mean number of deaths per month since March 2020 is 6

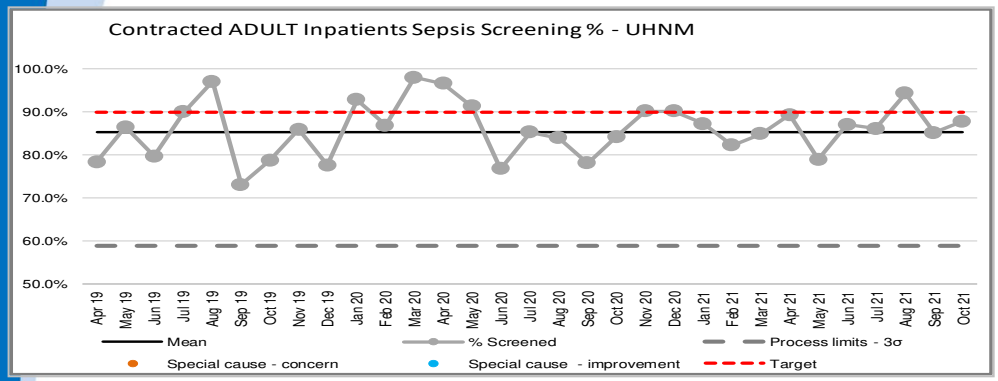
Actions :

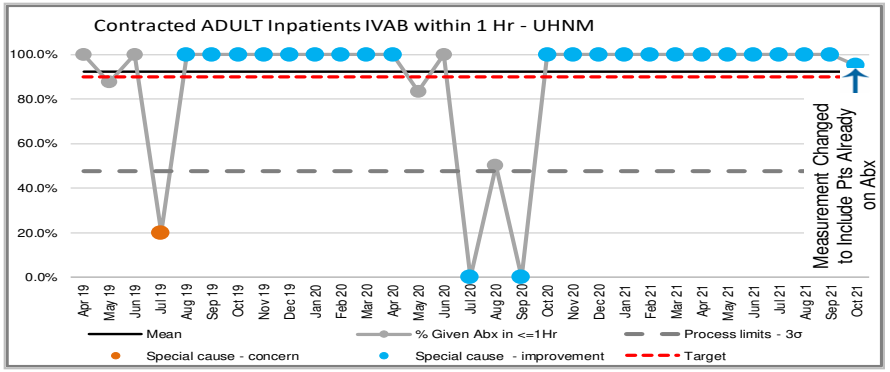
The online SJR form has been adapted to include specific COVID related questions following pilot review by Deputy Medical Director.

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

Sepsis Screening Compliance (Inpatients Contract)

University Hospitals of North Midlands NHS Trust





Variation	Assurance

Target	Aug 21	Sep 21	Oct 21
90%	94.4%	85.2%	87.9%

Background

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

Variation	Assurance

Target	Aug 21	Sep 21	Oct 21
90%	100.0%	100.0%	95.1%

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:

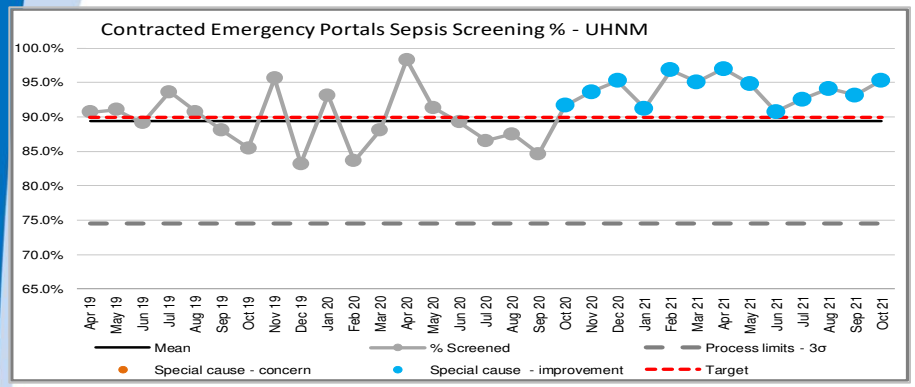
Inpatients October results show improvement in screening compliance to 87.9%. However, compliance for IVAB within an hour has dropped from 100% to 95.1% . Of the 99 Inpatients that triggered a sepsis screen, 73 had sepsis red flags present, 1 of these patients were given IVAB within hour and the 2 delayed IVAB were given within two hours. For the remaining 68 patients, 32 had alternative diagnosis that were deemed as not sepsis related . The remaining 36 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.

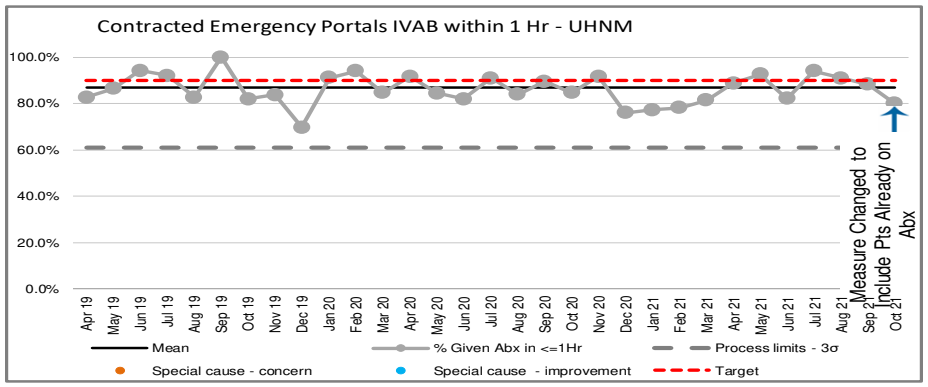
Actions:

- 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)

NHS University Hospitals of North Midlands NHS Trust





Variation	Assurance
H	?

Target	Aug 21	Sep 21	Oct 21
90%	94%	93%	95%

Background

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

Variation	Assurance
	?

Target	Aug 21	Sep 21	Oct 21
90%	91%	88%	80%

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 October 2021 achieved 95% for the 64 patients audited.

The performance for IVAB within 1hr has further dropped to 80% in October. There were 56 red flag sepsis patients identified from the 64 patients audited in the screening sample. Out of the 56 red flag patients, 18 received IVAB within an hour whilst 18 were already on IVAB and 11 had an alternative diagnosis.

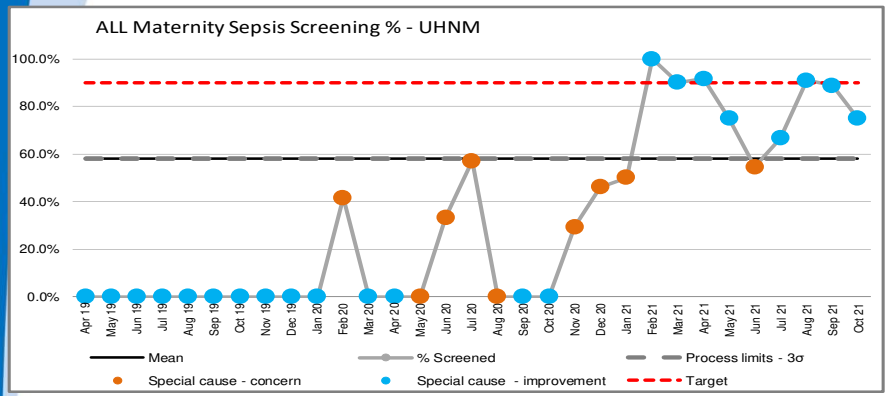
There was 9 late IVAB within an hour, 8 from A&E Royal Stoke site and one from A&E County which 8 were administered within 2 hours and 1 administered > 2 hours. This has been escalated to both A&E Royal & County senior teams.

Actions:

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

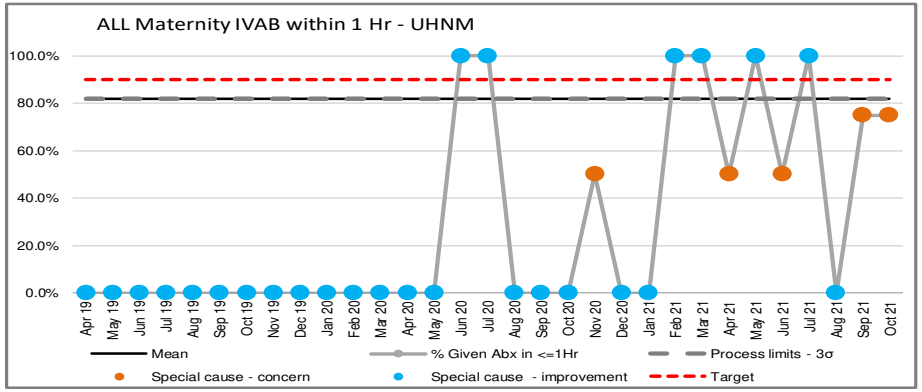


Variation	Assurance
H	F

Target	Aug 21	Sep 21	Oct 21
90%	90.9%	88.9%	75.0%

Background

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



Variation	Assurance
L	F

Target	Aug 21	Sep 21	Oct 21
90%	N/A	75%	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 decline in October 2021. Screening compliance achieved 75%, from the 8 patients that trigger with MEOWS >4. From the 8 patients audited, only 1 missed screening identified from each of the two inpatient wards.

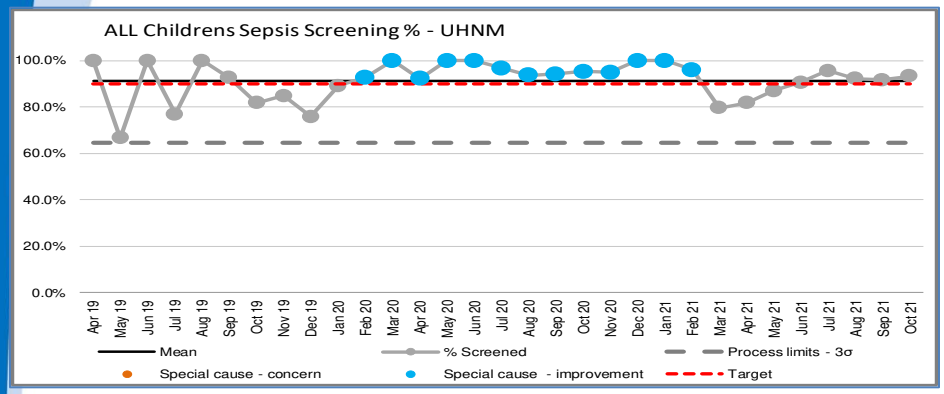
IVAB within an hour achieved 75% with only 1 delayed IVAB administered within 2 hours from the emergency portal (MAU) and inpatient wards achieved 100%. Overall, considering the small size samples for October audit, the Maternity sepsis screening compliance has only missed 2 screening and 1 delayed IVAB in emergency portals (MAU).

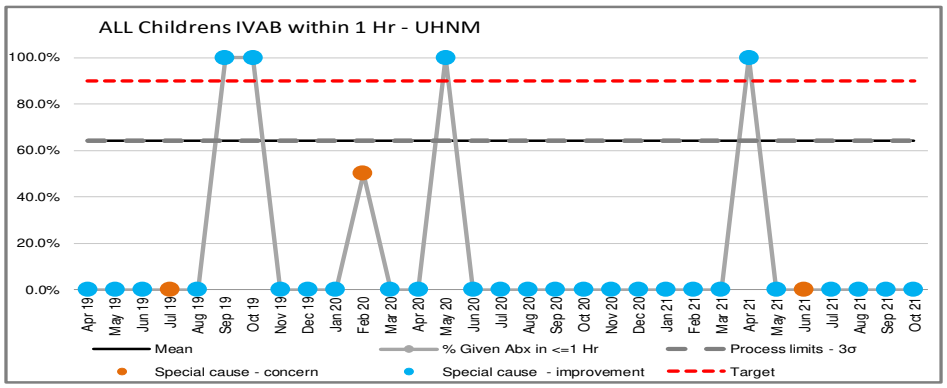
Actions:

- 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	Aug 21	Sep 21	Oct 21
90%	92.3%	91.7%	93.3%

Background

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

Variation	Assurance
H	F

Target	Aug 21	Sep 21	Oct 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 improvement in sepsis compliance compare to July, August & Sep 2021, with a result of 93.3%.and above the target rate.
CAU screening compliance has improved by achieving 100% however, Children A&E has dropped <90% from October 2021. IVAB within hour compliance for CAU & Children A&E are not applicable or no red flags trigger. Children Inpatients ward 216 and ward 217 have no PEWS 5> triggers during randomised audits. Most inpatients Paediatrics are already on oral antibiotics or IV antibiotics prior to trigger of PEWS >5 (this is both of moderate and high risks).

Actions:

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

Together Compassion Safe Improving

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Operational Performance

2025 Vision "Achieve NHS Constitutional patient access standards"

Spotlight Report from Chief Operating Officer

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Emergency Care

- The number of attendances at Royal Stoke ED has remained static over the last 2 months with an average of 345 per day. The number of ambulance arrivals fell slightly again from a daily average of 147 to 142 and the self presenting ambulatory remained at c200/day.
- The daily average number of admissions and conversion rate increased slightly. Daily average admissions were up from 112 to 117 and the conversion rate rose to 34.3%.
- Ambulance handover delays for 30-60mins remained static and the > 60 mins rose in October along with the percentage of handovers within 15 minutes which dropped to 27%
- System-wide performance was 65% with total type 1 at 48.4%. At Royal Stoke the non-admitted performance fell to 48.9% and the admitted performance fell from 20% to 19% indicating the key issues again were related to extended timescales to pathway processing and outcome management. MFFDs remained commensurate with the winter 'worse case scenario' predictors with the number of patients with > 21 days stay in October increasing commensurately. The department had continued days with sub 60% performance with most of the front door metrics challenged. The West Block being decommissioned on account of the CRP outbreak meant a loss of 50 beds with the need to absorb 2 wards worth of patients into the acute PFI which had a detrimental impact on performance from mid October until resolution on 8th November.

Cancer

- The Trust is provisionally predicted to achieve the following two cancer standards for October 21: 31 day subsequent Radiotherapy at 94.1% and Rare Cancers 31 Days at 100%
- The overall 2WW position for October is predicted to achieve in the region of 64.26. Specialties with the most 14 day breaches are Breast, Skin, Colorectal and Upper GI. Performance against the 62 day standard is currently at 57.5% for October 21. This is an un-validated position that is expected to change as histology confirms a cancer or non cancer diagnostic for patients treated.
- Number of 2WW & 62 day breaches recorded in October is consistent with September. Theatre, Oncology and Surgical workforces have been impacted resulting in breaches. The position is being managed through the reinstated daily clinical prioritisation meetings and a robust planned care assurance framework. 2WW and 62 day position is significantly challenged, and will be validated prior to upload.

Spotlight Report from Chief Operating Officer

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Planned Care

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

- Day Case and Elective Activity delivered 85.6% for October 21 against the national ask of 95%. This is lower in Inpatients than Day case (72% IP, 87% DC).
- In month Planned Care Cell focus on elective recovery based on 10 high impact changes linked to investment bids to expedite improvement actions. Initial focus is on theatre capacity and productivity given the emergent covid risks and staff isolation rate of attrition.
- Validation of 104 weeks completed – 2/3 need treatment @ UHNM or IS with 1/3 previous DNA of IS, needing other follow on diagnostics/actions before TCI or not elegible for P5/6 as want treatment but not IS.
- 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. This work will increase with additional funding to expand the patient conact team.

RTT

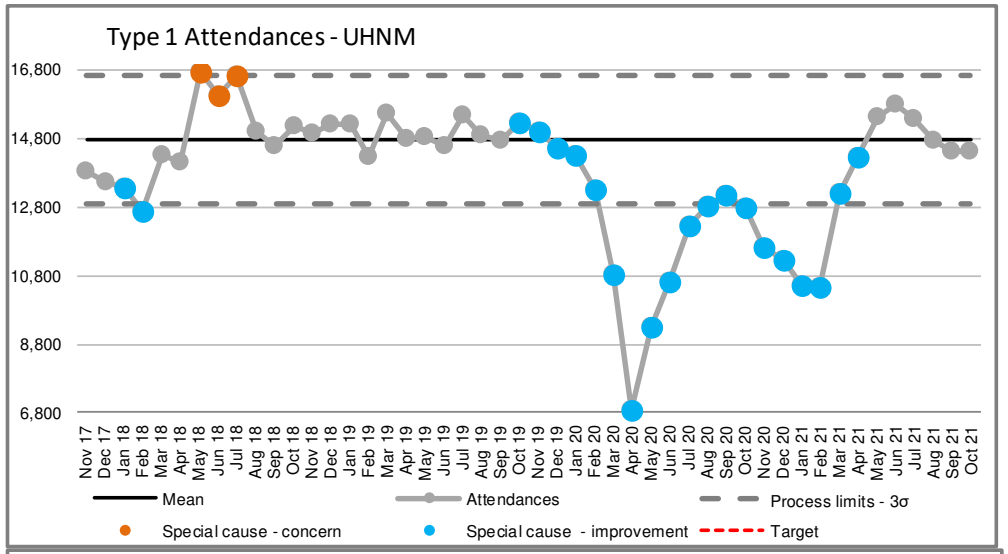
- The indicative performance for October 21: the total number of Referral To Treatment pathways grew to 68,054 (September 67,714). There has been a slight increase in the number of > 52 weeks from 3,563 to 3,870. This rise is expected to continue over winter due to the usual NEL surge/winter pressures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

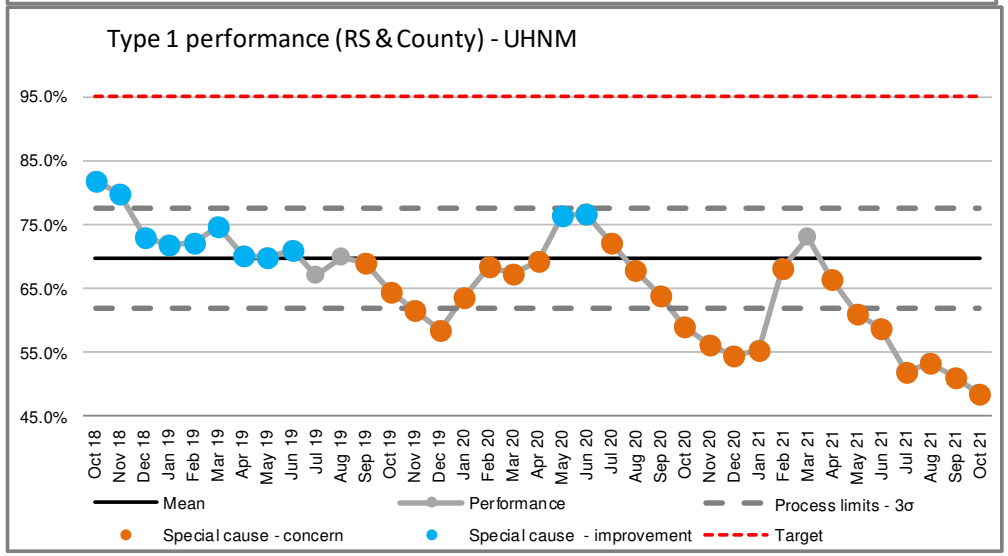
Diagnostics

- For DM01 (15 nationally identified Dx tests) the total waiting list has increased in October from 20,173 to 20,134. The Non-obstetric ultrasound the waiting list continues to grow, October 10,569 (September 10,318). Due to the challenges in Non-Obstetric Ultrasound this has adversely affected performance. The current DM01 diagnostic performance for October 21 has improved to 68.49% (September 68.14%).
- 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.

Section 1: NON ELECTIVE IMPROVEMENT

Urgent Care – Attendances and 4 hour performance





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Urgent Care

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SUMMARY

Attendances; Total type 1 attendances remained static from September to October. At the RS site, the daily average attendances were 345 day. Children's attendances rose again up to an average of 75 per day. Whilst the adult attendances remained the same.

Triage; Initial assessment within 15 minutes continued a downward trend in October. Performance is influenced most where there are surges of over 30 attendances within the hour, particularly in the evening. This can be where staff shortages, particularly decision makers has been a challenge. The department are aiming to stop the decline in triage time with re-deployment of staff in the department at the time. A business case addressing workforce challenges was approved in early October and staff are being recruited to as per the planning timescale in that case

Ambulance; The percentage of ambulance handovers within 15mins declined on recent months and remains 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 also declined in October to 44%. 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 .

Long waits; The number of patients in the department for > 12 hours is of significance in October with a continuation of the high numbers seen in previous months with a spike at the end of the month to around 460 in one week. There were 277 validated, 12 hour trolley waits, a significant rise on previous months.

Admissions; The number of patients attending and admitted with Covid-19 began to increase again with admissions to wards and critical care proving challenging (up to 15 new hospitalisations a day mid October). Beds were also restricted for infection prevention with medical beds closed throughout the month whilst deeps cleans and NHSE/I inspections took place and beds reopened with several moves required.
The total number of admissions increased slightly from 110 to 116 a day. 1+ LoS spell are at around 97% of 1920 BAU. The average LoS for patients admitted in October was c 1 day longer than that in 1920. The high number of patients waiting to be admitted at 9am remained. Discharges pre-noon remained much the same as September but remains above the 12 month average.

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

Urgent Care

University Hospitals of North Midlands NHS Trust

2. Completed Actions to Support Improvements in Performance

2.1 Time to Initial Assessment

- **111 Kiosks**
  Kiosks are operational at both sites and high level data indicates a 4% diversion rate from the ED. In response, a deep dive into the following will be undertaken in the next 2 weeks to develop the necessary improvement actions;
  - The clinical appropriateness of the kiosk outcome threshold for diversion and the directory of services pathways
  - The uptake of the recommended outcome.
- **Navigation**
  The navigation test of change will go live on 24th November. Pathways will be streamlined for specialty patients presenting to the ED with a letter from the GP or a primary care presentation. A workshop was held with the Navigator team to agree the process and ensure a standardised approach. Success will be measured as follows;
  - Increase in the numbers of patients diverted to the most appropriate service
  - A reduction in the number of patients triaged
  - A reduction in the time to initial assessment.

  Key enablers will be CCG engagement for diversion to the UCC, portal and specialty acceptance of the trusted assessor model and appropriate medical governance for patients appropriately diverted away from the ED.
- **Triage**
  The analysis of the triage test of change data demonstrated that the triage resource is not at the level required to consistently achieve the time to initial assessment standard. In response, an ACP post will be temporarily converted into 2 additional 12 hour triage shifts.

2.2 Median Time to Treatment and Mean Time in the Emergency Department

- **Senior Decision Makers within the Ambulatory Pathway**
  To reduce the wait to be seen and in preparation for the new UEC standards, senior decision makers will be positioned early within the ambulatory pathway allowing for assessments, investigations and reviews to occur simultaneously rather than sequentially. Success will be measured through;
  - a reduction in the mean time in the department
  - a reduction in the time to treatment.
- **Electronic Referrals**
  Electronic referrals have gone live for AMU and cardiology and SAU go live with a 2 week trial on 23rd November. A schedule has been agreed to ensure the following specialties go live before the end of December;
  - Stroke
  - Neurology
  - Trauma
  - Spinal
  - County MRU

  This initiative will support the implementation of Clinically Ready to Proceed (CRTP) within the new UEC standards by ensuring that decisions to admit are seamless and in line with referral criteria. Road shows have been scheduled to promote CRTP which will support the implementation of electronic referrals. A Quality assurance framework has been developed to facilitate joint ED and specialty case reviews to promote shared learning and collaborative working.
- **Medical Workforce Business Case**
  Following approval of the ED medical workforce case, 9 SHOs have been recruited. Table 1 shown in Appendix 1 outlines progress against the recruitment timeline to date. Success will be measured through;
  - A reduction in time to treatment
  - A reduction in arrival to referral
  - A reduction in the mean-time in department.

Urgent Care

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ACTIONS

Attendances:

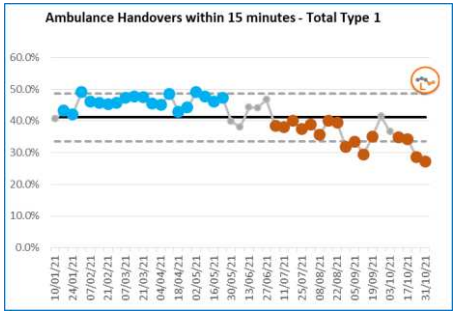
- Navigator at the front door to support redirection to alternative places of care for ambulatory non acute patients
- 'RED' GP reinstated and capacity increased - daily monitoring of referrals demonstrates that Vocare are currently seeing on average 23 Children (increase from 17) and 31 adults per day (decrease from 38). ED are still experiencing increasing Children's attendance with 75 per day on average.
- WIC increase in staff to support ambulatory demand
- Use of GP referral hub and consultant connect to prevent GP admissions
- Regular social media campaigns to highlight alternative services on offer in the community and use of 111First
- 111 Kiosks went live in both emergency departments in September – early review of the data available indicates that only 4% of patients are being redirected to alternative pathways avoiding ED
- Continue to attempt to Increase staff within ED to support attendance surges (SIFT and RAT) however fill rate remains low.
- Separate hot and cold ambulance arrival areas to segregate COVID and non COVID ambulance arrivals in continued use over Winter

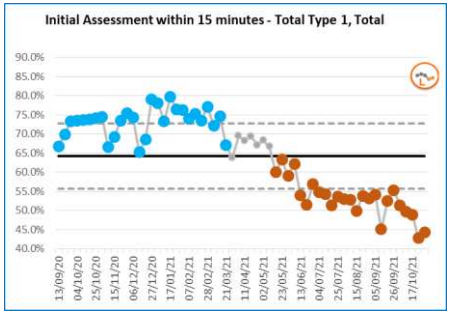
National bundle:

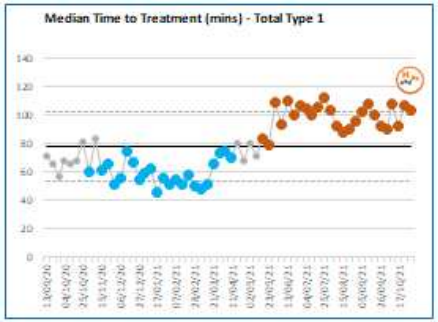
- Review of Test of Change data for new triage pilot at RSUH completed, Plan has been reached to streamline and implement from Mid November and is under review with the CCG and Vocare on how to sustain triage nurse numbers
- The electronic referral system introduced has shown some real benefits with a reduction in time spent on the telephone – Further roll out now happened across Cardiology and SAU.
- 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 as part of UEC standards and will be reported on from December 2021
- 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
- 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.

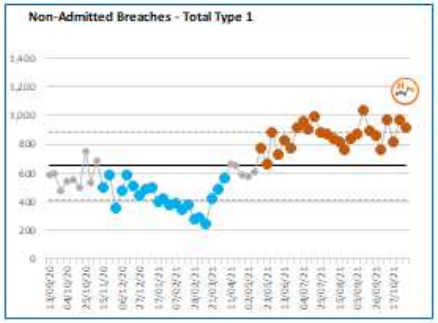
Workforce:

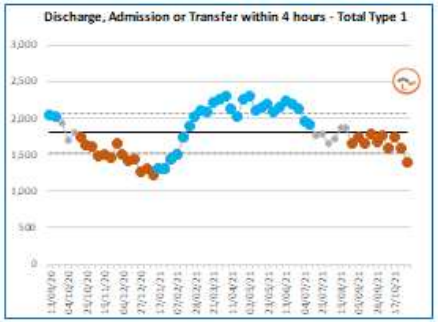
- ED medical workforce business case to address workforce issues with clear key metrics to measure improvements approved by Trust Board in October. Initial interviews have recruited 9 SHO's with 2 commencing as early as December 21.
- Engage senior clinicians. Re-set department structures and revise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

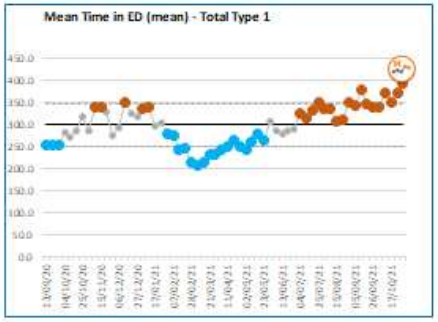

Ambulance Handovers within 15 minutes - Total Type 1

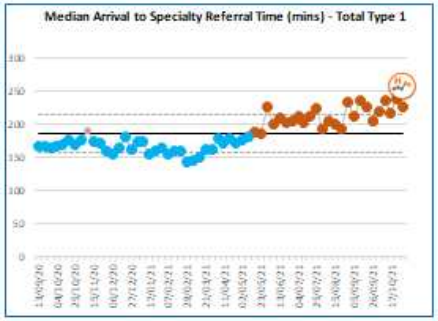

Initial Assessment within 15 minutes - Total Type 1, Total

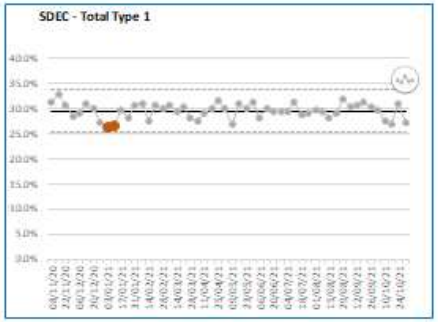

Median Time to Treatment (mins) - Total Type 1

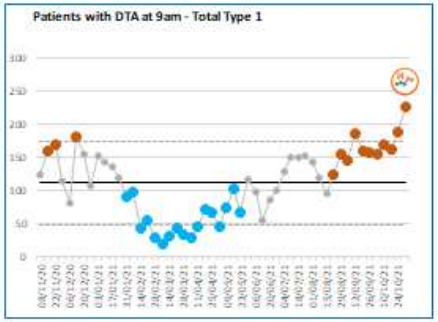

Non-Admitted Breaches - Total Type 1

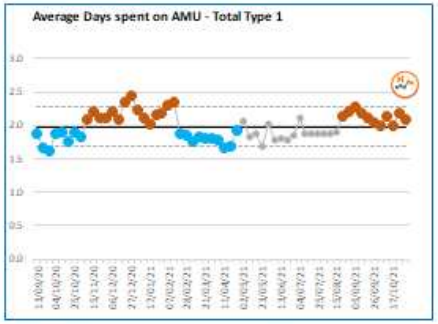

Discharge, Admission or Transfer within 4 hours - Total Type 1

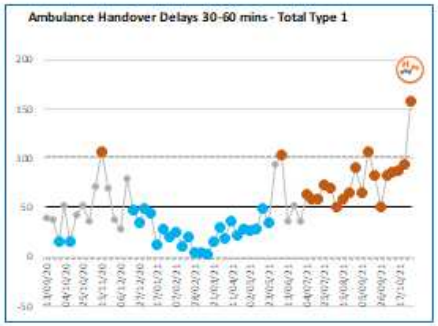

Mean Time in ED (mean) - Total Type 1

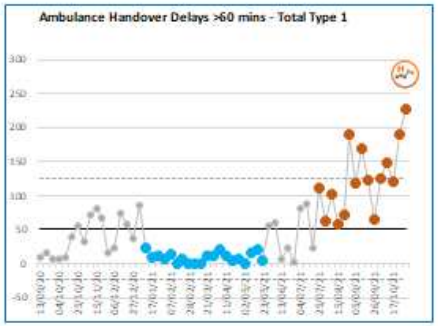

Median Arrival to Specialty Referral Time (mins) - Total Type 1

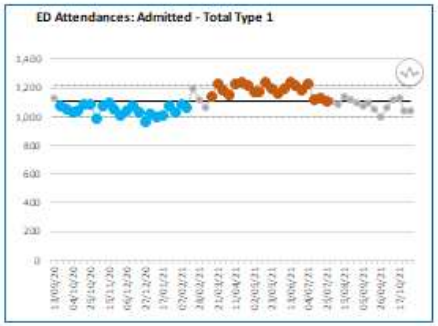

SDEC - Total Type 1

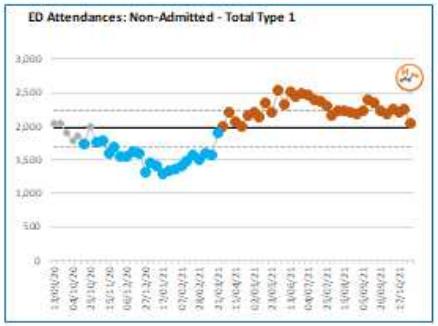

Patients with DTA at 9am - Total Type 1

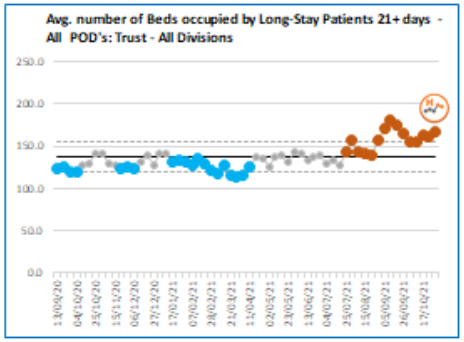

Average Days spent on AMU - Total Type 1

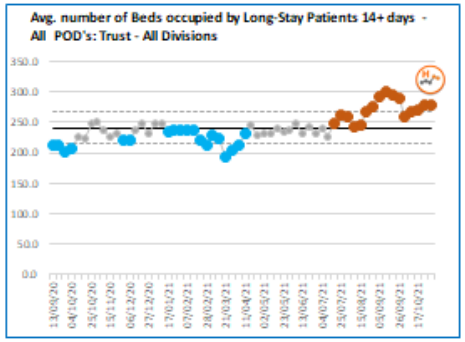

Ambulance Handover Delays 30-60 mins - Total Type 1

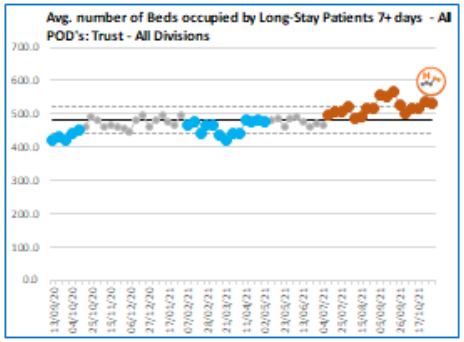

Ambulance Handover Delays >60 mins - Total Type 1

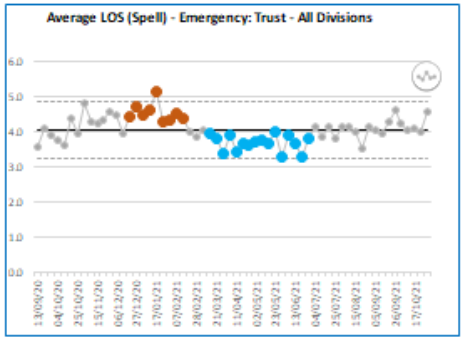

ED Attendances: Admitted - Total Type 1

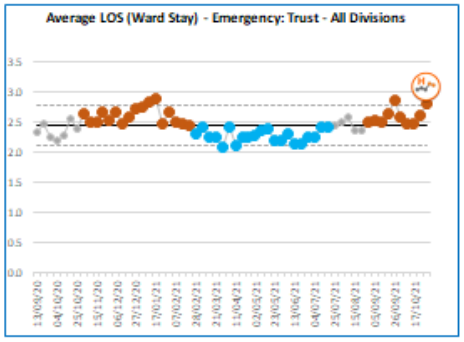

ED Attendances: Non-Admitted - Total Type 1

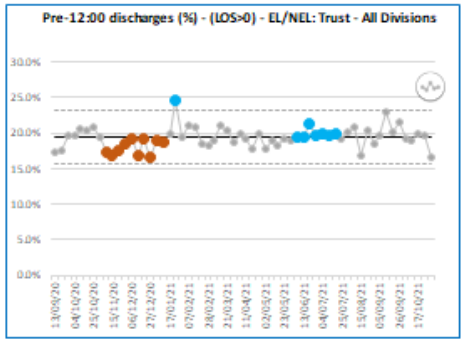

Avg. number of Beds occupied by Long-Stay Patients 21+ days - All POD's: Trust - All Divisions

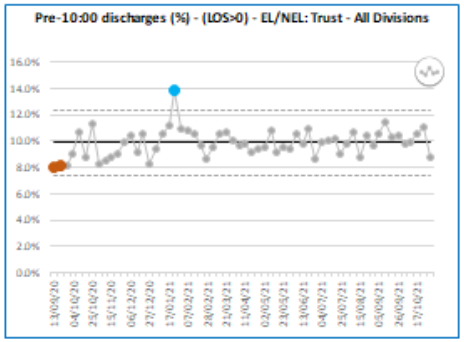

Avg. number of Beds occupied by Long-Stay Patients 14+ days - All POD's: Trust - All Divisions

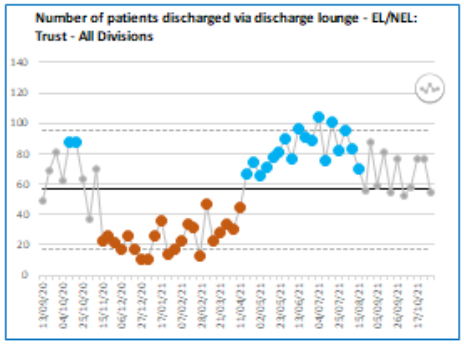

Avg. number of Beds occupied by Long-Stay Patients 7+ days - All POD's: Trust - All Divisions

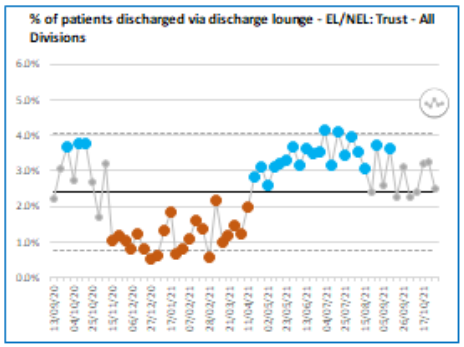

Average LOS (Spell) - Emergency: Trust - All Divisions

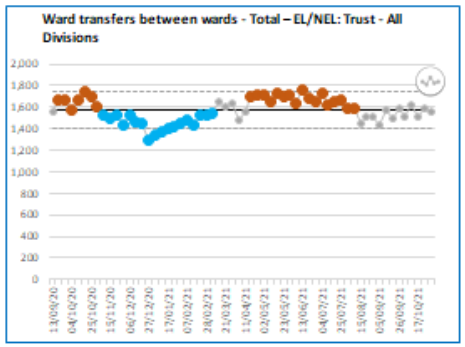

Average LOS (Ward Stay) - Emergency: Trust - All Divisions

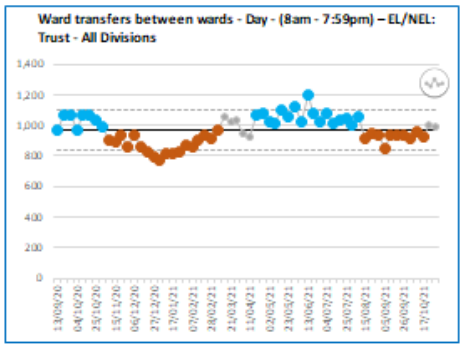

Pre-12:00 discharges (%) - (LOS>0) - EL/NEL: Trust - All Divisions

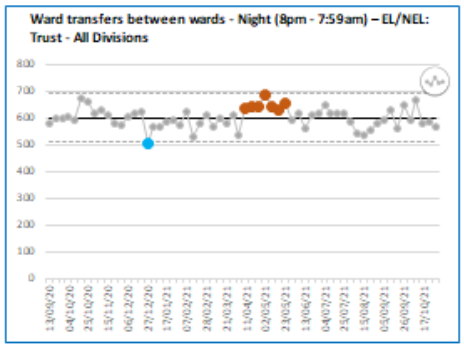

Pre-10:00 discharges (%) - (LOS>0) - EL/NEL: Trust - All Divisions


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

Section 2: ELECTIVE CARE

Cancer

University Hospitals of North Midlands NHS Trust

Cancer Summary:

- Workforce and emergency pressures across the trust: Theatre, Oncology and Surgical workforce impacted due to emergency pressures or Covid. Radiologist capacity resulting in waits for reports and some appointments. Skin consultant workforce affected by Covid. Workforce and Covid pressures are impacting on cancer pathways as theatre allocations are flexed and MDT meetings are not quorate or cases have to be postponed.

- Lower GI RDC pathway – **this pathway constitutes the biggest risk to cancer performance** and request for programme management support to pull together all the enabler actions required across primary care and internally to support rapid traction on activities to deliver improved pathway management. Primary care Fit requested together with 2WW referral was implemented 16/08. Early indications are that 40% of referrals are coming in with a FIT requested however an internal audit will follow to provide evidence base and inform targeted efforts. There are still some 2WW referrals that come through without bloods requested which delays the pathway. The team are keen to engage directly with GPs and have suggested a 'live lounge' or a podcast type of format. This idea was endorsed at the STP Cancer Board with UHNM internal comms team cited and ready to support.

- A Cancer Summit has been scheduled for the end of November 2021 where the system will be cited on 10 high impact actions that could enable cancer recovery. The event aims to work towards system collaboration and commitment to improving cancer services

- A new Radiology protocol allows for identifying patients who are on a 28 day FDS or who require rapid cancer diagnostics – this enables the team to prioritise workload and facilitate faster diagnosis.

- The Cancer Services Manager and the Breast team, led by Mr Marla, presented the Breast Pain in the Community paper to the Stafford & Surrounds CCG Membership Board. The Membership Board approved the paper. The team are now working with community colleagues to identify locations, rooms and agreed start dates which is an excellent response and welcomed. The Breast Pain paper was presented at the Northern ICP Clinical Assembly on November 2021. Feedback on community take up awaited.

- Cancer PTL performance report has been amended to include patients waiting in the RAS to be appointed. This will enable all patient who are waiting for an appoint to be visible in one report.

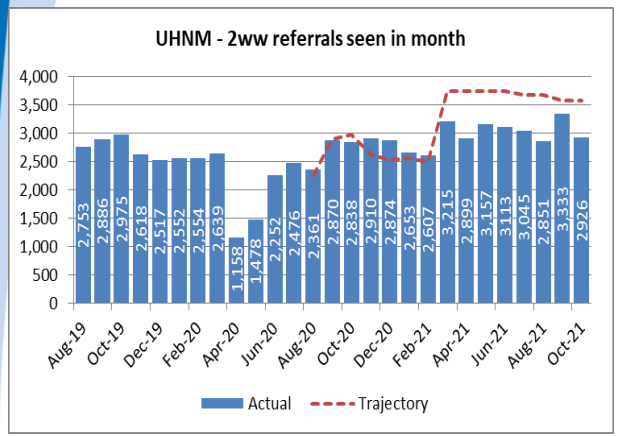
- Gastro update on Endoscopy wait list: The endoscopy booking manager is to confirm propofol list sessions to clear the backlog. The Endoscopy reporting software upgrade will improve performance reporting of the 28 day Faster Diagnosis Standard.

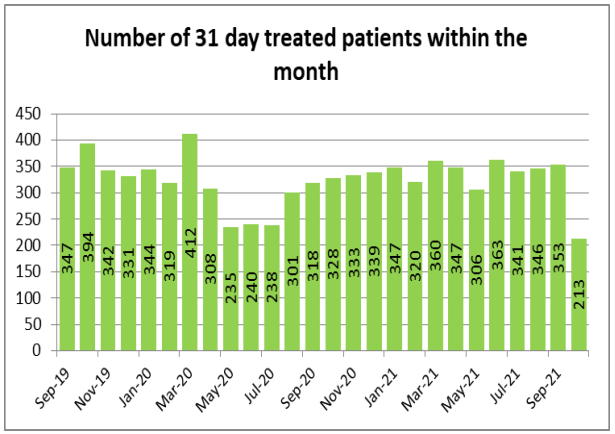
Cancer

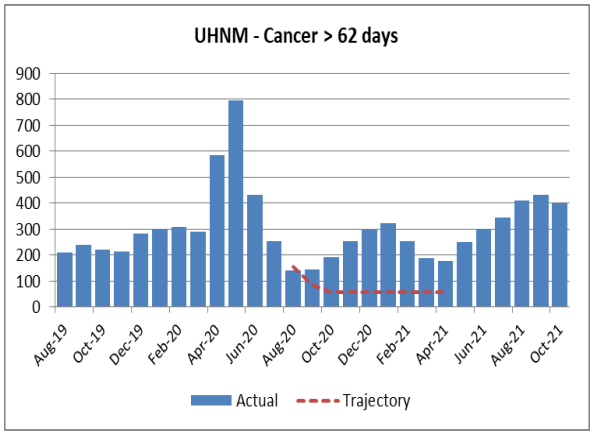
- Trajectories have been agreed and are being tracked against the actual positions. Most recent published data is for August:
  - 14 Day Trajectory September: 82.0%. Actual 68.7%. Actual Seen. 3333. Actual Breaches 1042. The trust is below the set trajectory on this standard.
  - 31 Day Trajectory September: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

Trust			Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
14 Day Standard 93% *(suspected cancer, excluding breast symptom)*	TRAJECTORY	First Seen	3745	3745	3745	3666	3666	3566	3566	3566	3566	3566	3566	3566
		Breaches	809	769	699	961	901	641	481	366	306	246	186	166
		Performance	78.3%	79.4%	81.3%	73.7%	75.4%	82.0%	86.5%	89.7%	91.4%	93.1%	94.7%	95.3%
	ACTUALS	First Seen	2899	3157	3113	3045	2851	3333	2910	2016	48	0	0	0
		Breaches	640	593	318	665	961	1042	1040	1223	48	0	0	0
		Performance	77.9%	81.2%	89.7%	78.1%	66.2%	68.7%	64.2%	39.3%	0.0%			
		Variation	-0.4%	1.8%	8.4%	4.4%	-9.2%	-13.3%	-22.3%	-50.4%	-91.4%			
		Regional (Midlands)	81.7%	85.0%	81.1%	83.4%	84.0%							
		National	85.4%	87.5%	84.9%	85.6%	84.7%	84.1%						
31 Day First Treatment Standard 96%	TRAJECTORY	Treatment	463	463	463	463	463	463	463	463	463	463	463	463
		Breaches	49	46	43	38	34	29	25	23	22	20	19	18
		Performance	89.4%	90.0%	90.7%	91.7%	92.6%	93.7%	94.6%	95.0%	95.2%	95.6%	95.8%	96.1%
	ACTUALS	Treatment	347	306	363	341	346	353	260	29	0	0	0	0
		Breaches	23	19	22	22	29	46	31	9	0	0	0	0
		Performance	93.3%	93.7%	93.9%	93.5%	91.6%	86.9%	88.0%	68.9%				
		Variation	3.9%	3.7%	3.2%	1.8%	-1.0%	-6.9%	-6.7%	-26.1%				
		Regional (Midlands)	91.9%	92.5%	91.9%	91.9%	90.2%							
		National	94.2%	95.1%	94.6%	94.7%	93.7%	92.6%						
62 Day (2ww) Standard 85%	TRAJECTORY	Treatment	246.0	246.0	246.0	246.0	246.0	246.0	246.0	246.0	246.0	246.0	246.0	246.0
		Breaches	75.5	71.5	67.5	62.5	59.5	57.5	50.0	44.0	38.0	32.0	32.0	32.0
		Performance	69.3%	70.9%	72.5%	74.5%	75.8%	76.6%	79.6%	82.1%	84.5%	86.9%	86.9%	86.9%
	ACTUALS	Treatment	181.0	166.5	198.0	186.5	187.5	199.0	133.0	14.5	0.0	0.0	0.0	0.0
		Breaches	42.0	48.5	59.0	64.0	69.5	84.0	56.5	6.5	0.0	0.0	0.0	0.0
		Performance	76.7%	70.8%	70.2%	65.6%	62.9%	57.7%	57.5%	55.1%				
		Variation	7.4%	-0.1%	-2.3%	-8.9%	-12.9%	-18.9%	-22.1%	-27.0%				
		Regional (Midlands)	69.9%	66.4%	66.4%	63.3%	61.6%							
		National	75.4%	73.0%	73.3%	72.1%	70.7%	68.0%						

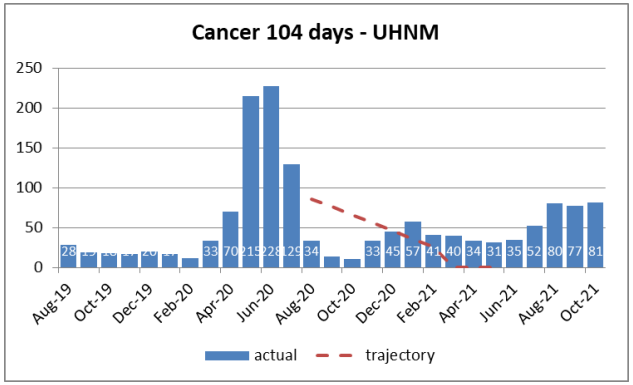
Cancer







October Provisional	Target	Trust Actual	Clock Stops	Breaches	Breaches Over	Needed Treatments
TWW Standard	93%	64.0%	2926	1052	848	12103
TWW Breast Symptomatic	93%	55.6%	27	12	11	145
31 Day First	96%	89.7%	213	22	14	338
31 Day Subsequent Anti Cancer Drugs (inc Chemo)	98%	97.6%	41	1	1	10
31 Day Subsequent Surgery	94%	70.0%	30	9	8	121
31 Day Subsequent Radiotherapy	94%	96.3%	82	3	Achieved!	Achieved!
62 Day Standard	85%	57.0%	111.5	48	32	209.5
Rare Cancers - 31 Day RTT pathway	85%	-	0	0	1	1
62 Day Screening	90%	74.4%	21.5	5.5	4	34.5
28 Day FDS Standard	75%	63.9%	2116	764	236	941
62 Day Consultant Upgrade	93%	70.3%	64	19	15	208
Closed Pathways > 104 Day			13			



Quality | Operational | Workforce | Finance

Planned care - *Inpatients*

NHS University Hospitals of North Midlands NHS Trust

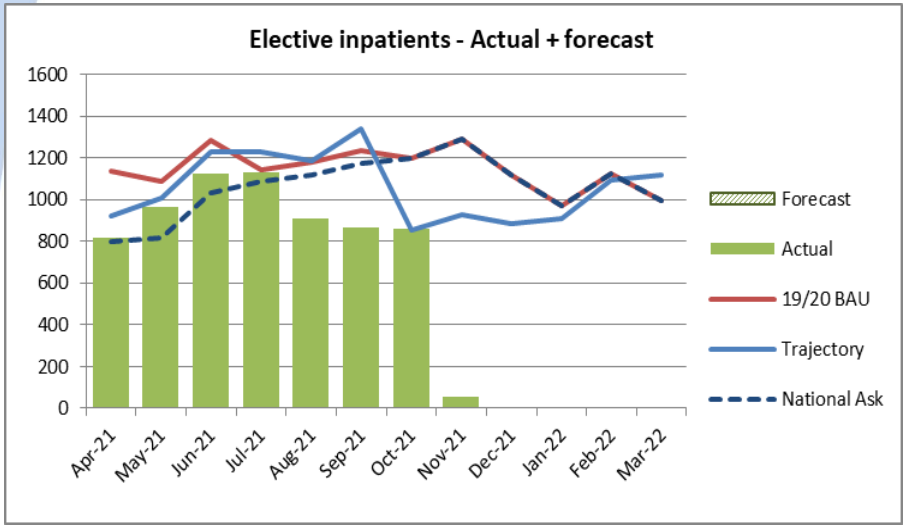
Elective inpatients Summary

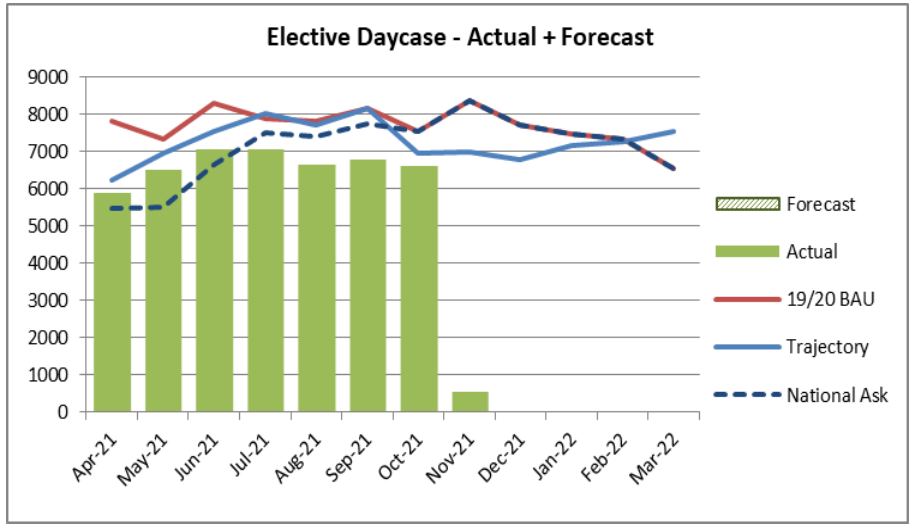
- For October the total inpatient actuals against BAU was 85.7%. This is lower in Inpatients than Day case (72.1% IP, 87.8% DC).
- Cases continue to be treated at the Independent Sector and County.
- Surgery have SHS sessions commissioned for oral surgery at the week ends.
- Endoscopy have SHE sessions commissioned for endoscopy procedures at the week end (164)
- Commissioners supporting challenge to IS around doing additional work:
- IPT contracts in place since September (2,500 Nuffield of which 900 rejected, and 1753 Ramsay – progressing)
- ICF contracts still in place with Nuffield (T&O spine only) Ramsay, full range of surgery and specialised procedures.
- Non ICF contracts under discussion to support cancer/winter pressures:
- Nuffield asked to commit to endosocopy urology, release 1 theatre and support week end day case activity.
- Ramsay asked to review additional ICF and Non ICF cases they will support.

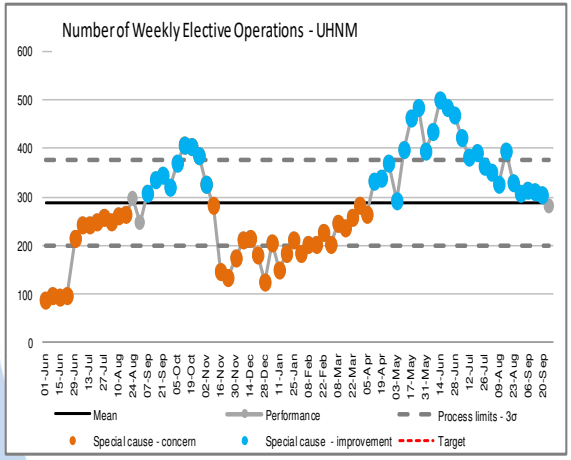
Actions

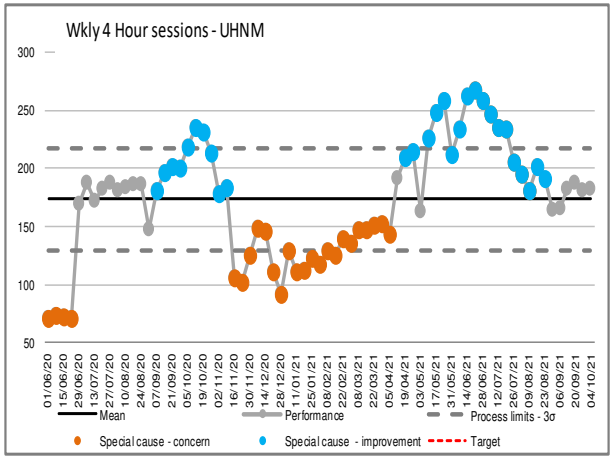
- **Patient contact initiative:** 104 week validation completed. 270 patients of which 183 need TCI.
- **Elective referral hub:** CCG Led initiative to support triage of OPD referrals to protect acute capacity for high threshold referrals. Progress update received from CCG who are exploring specialty 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. ERS system being scoped to support more focussed protocolisation with ability to reject non NG compliant referrals and offer step down pathways.
- **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.
- **In sourcing:** elective recovery bids submitted to support capacity enablers from In sourcing companies. Outcomes awaited but specialties scoping works already commenced.

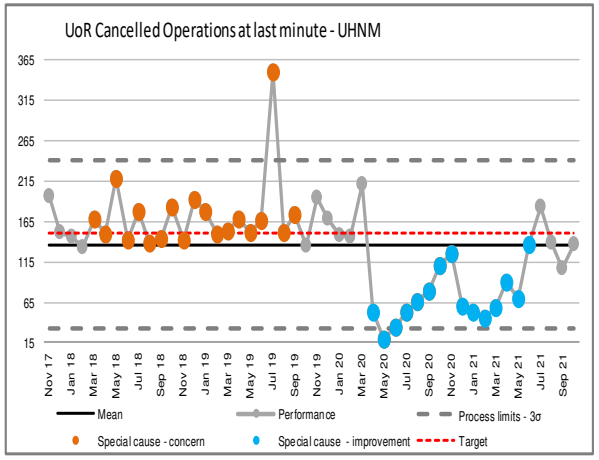
Planned care – *Inpatient Activity*











Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Planned care - *Outpatients*

NHS University Hospitals of North Midlands NHS Trust

Summary

- For October, the total outpatient actuals against BAU for outpatients was 95%. This is higher in Follow ups than new (83% New, 103% follow up).
- Oct update - For outpatient appointments (appointment type) the Trust delivered **72.5%** F2F and **27.5%** non F2F(Telephone & Video). For new appointment types F2F was **73.9%** & non F2F **26.1%** & follow ups F2F **71.8%** & non F2f **28.2%**.
- October's performance for ASIs position increased by 1.2% to 81.9% within 3 days (from 80.7% in September).
- 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 9,516 as at end of October

RTT

- The overall Referral To Treatment (RTT) Waiting list continues to rise. For October the indicative number of Incomplete pathways has risen to 68,054 (September 67,714).
- The number of patients > 18 weeks has risen to a level of 28,252 (September 27,670).
- The numbers of 52 week waits in October has increased slightly with a reported 3,870 (September 3,563).
- At the end of October the numbers of > 104 weeks reported were 273. The Planned Care group is monitoring progress against treatment plans for these patients.
- Performance however, was similar to that of the previous month at 58.5% (September 59.8%).
- Follow up backlog decreased to 69,663 (September 70,501).

Planned care - *Outpatients*

NHS
University Hospitals of North Midlands
NHS Trust

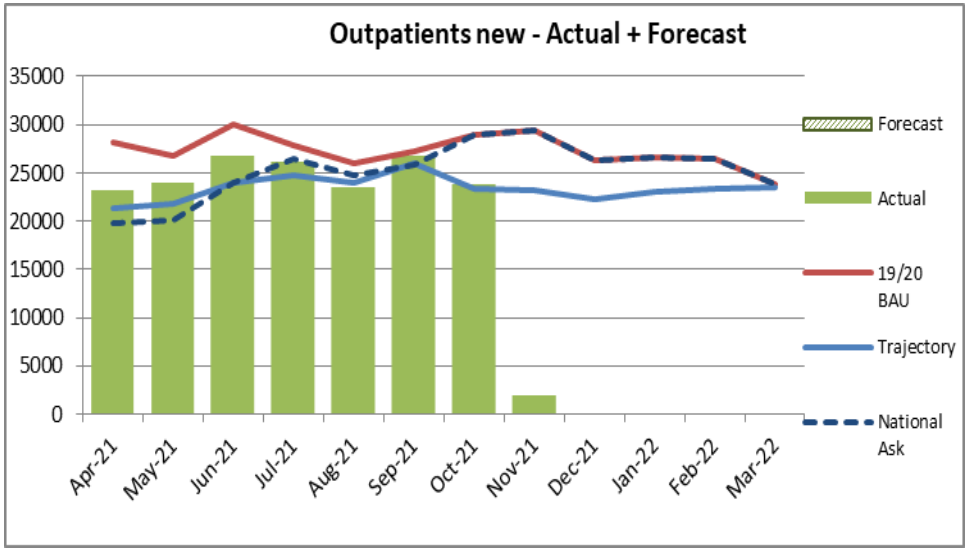
Actions

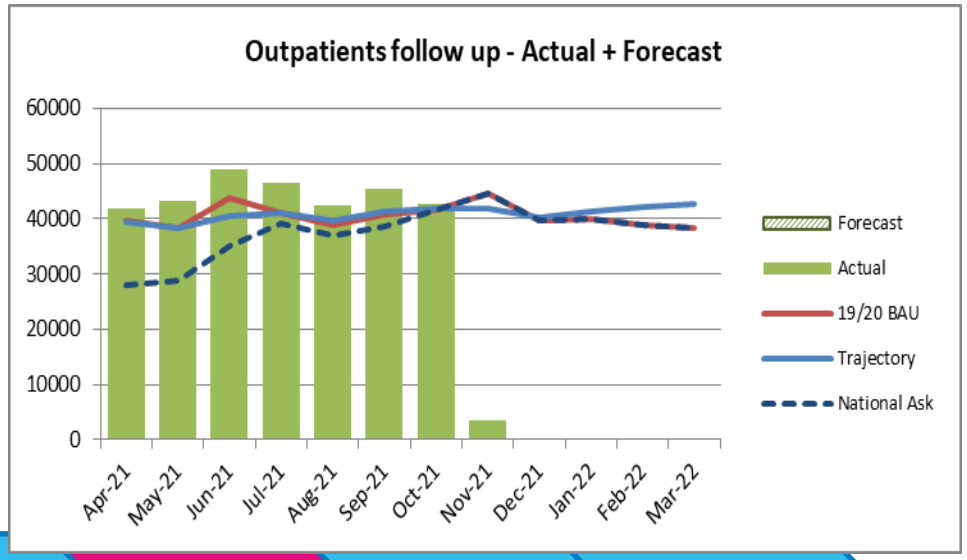
- Key actions identified around Divisional Waiting List Management with a focus on validation, data quality and >52 weeks patients. Clear reporting now in place to support this approach. Neurology, Cardiology & Ophthalmology have fed back from their Divisional A3s relating to follow up backlog plans.
- 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.
- Enhanced Advice & Guidance sub workstream (linking with system). Meetings held with specialties (with clinical & managerial representation) discussing associated specialty data packs, to confirm the initial 6 specialties. Task & Finish Groups now underway for Urology, Neurology, Respiratory and Gastroenterology to take actions forward to increase A&G, develop pathways FAQs etc. Update and initial opportunities to be presented at the next steering group. 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
- 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. 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; meetings being set up to start discussions and share approach.
- 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 PIFU flag, alongside plan to test measures for established self-managed cancer pathways to see if possible in principle.
- Virtual Care 25%; SUS submission 'fix' progressing (with BI) whilst longer term alignment of clinic booking and media type outcome continues.

Risks:

- Deteriorated waiting list position vs pre-covid; volume of patients requiring DQ and clinical validation very challenging, raised on Divisional Risk Registers.
- 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 2% of all outpatient activity moved or discharged to PIFU (1.5% by December). Whilst achieving rollout to additional specialties in low volumes and continuing to progress to other specialties, significant shortfall projected currently against this target.
- H2 planning guidance has confirmed a target of at least 12% A&G requests when compared to new referrals by March 2022. As of August as a system we were at 10.8% (UHNM were at 14.5%)
- Challenge of level 4 pressures recently at organisation & system level.

Planned care – *Outpatient activity & RTT*





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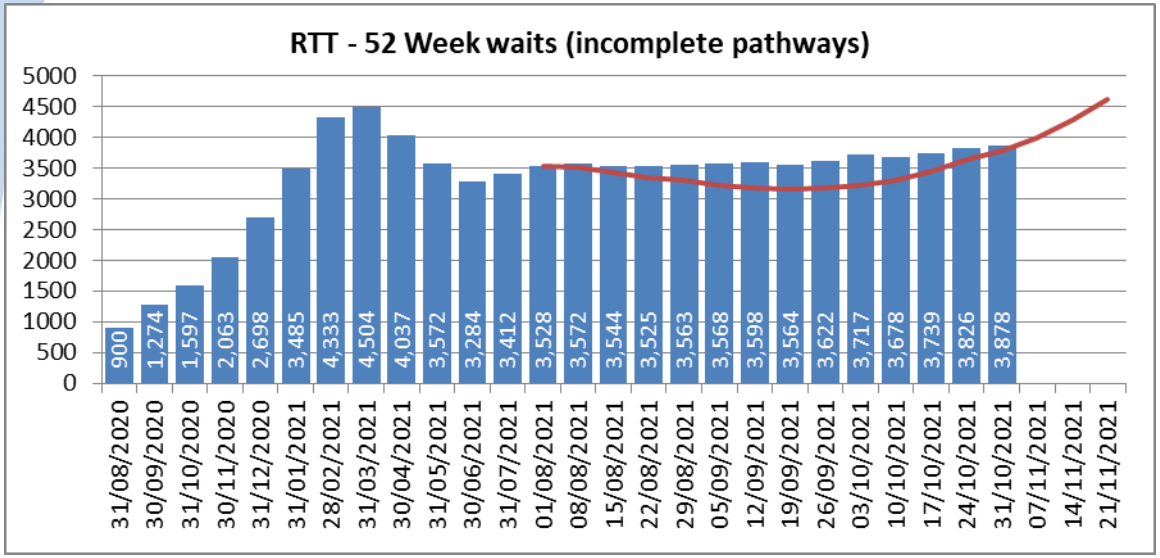
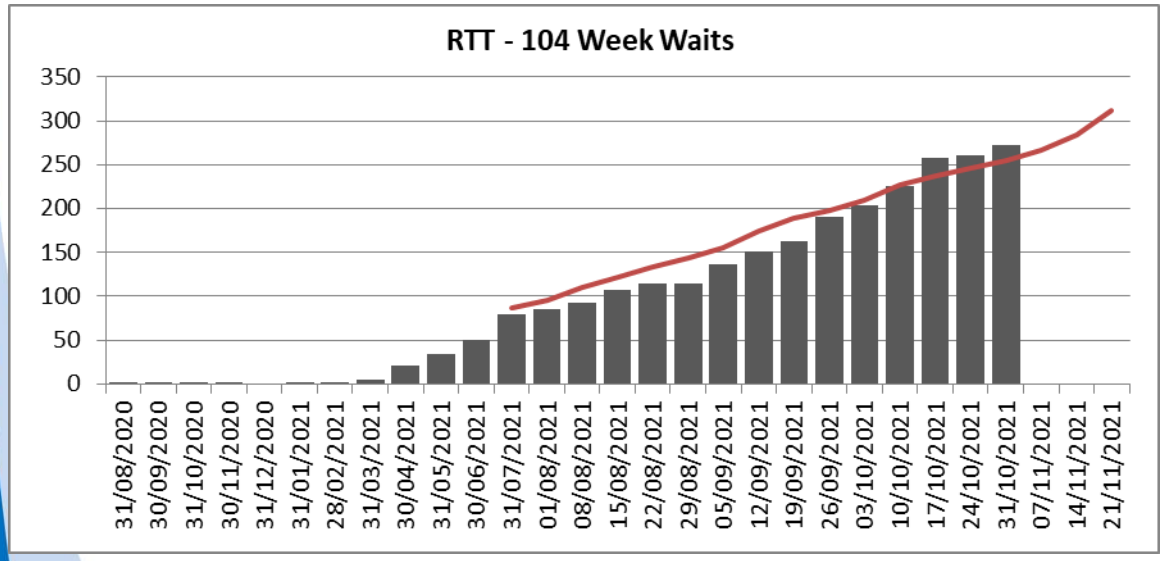
Planned care – *RTT Trajectories*

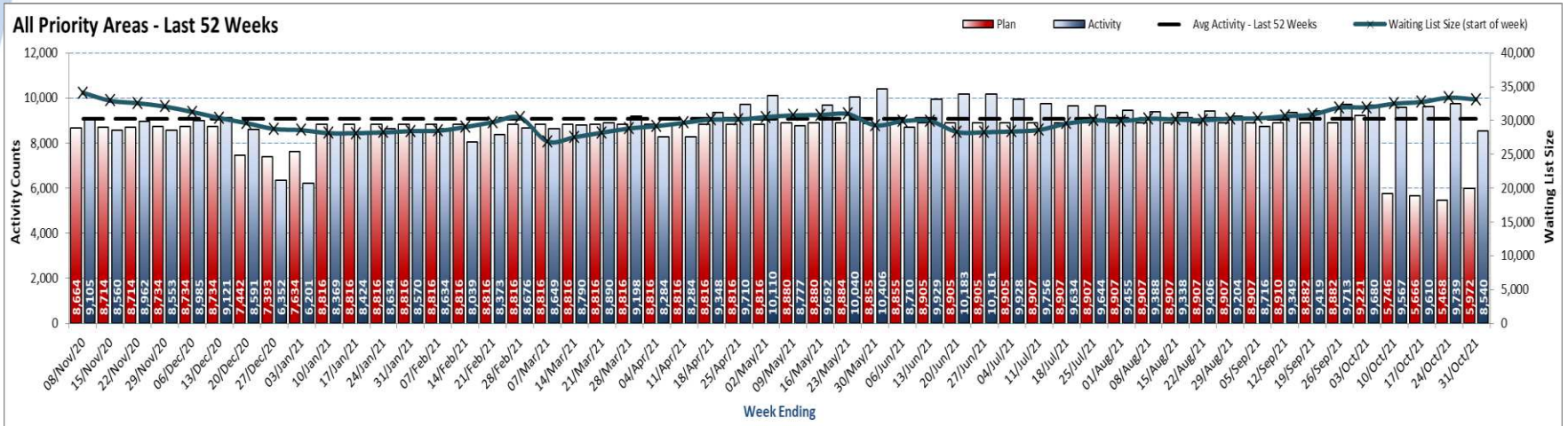


52 Week Waits are expected to increase over the next 6 months with a total of 7,590 at the end of March.



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 risen slightly in October from 20,314 to 20,173.
- The Non-obstetric ultrasound the waiting list continues to grow, October 10,569 (September 10,318). Due to the challenges in Non-Obstetric Ultrasound this has adversely affected performance.; the activity is increasing with the independent sector supporting c900 scans of additionally per month. Due to the challenges in Non-Obstetric Ultrasound this has adversely affected performance.
- The current DM01 diagnostic performance for October 21 has improved to 68.49% (September 68.14%).
- DM01 performance excluding non obs ultrasound would be c90%.
- The greatest proportion of > 6 week waits are within Non-obstetric ultrasound and is related to the significant increase in demand and staffing shortfalls. Non obstetric ultrasound performance is a Driver Metric for CWD and has specific focus for improvement.
- Capacity and Demand work is being planned in the next quarter and is reliant on Information services capacity.
- Histology and Endoscopy remain high risk areas both have plans for improvement. Histology turnaround times are showing signs of improvement.

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 Transformation team and Network partners. Improvements are evident – work in progress

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:

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

Continuing to try to source locum sonographers

Reviewing workforce plans and AFC banding in line with other Trusts

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

Impact:

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

Mitigation:

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

Diagnostic Trajectory

DM01 Modality	Nov	Dec	Jan	Feb	Mar
Gastro (Endoscopy)	60%	65%	75%	80%	85%
Respiratory (Sleep)	100%	100%	100%	100%	100%
401 Clinical Neurophysiology	100%	100%	100%	100%	100%
Colposcopy	100%	100%	100%	100%	100%
Hysteroscopy	100%	100%	100%	100%	100%
Urodynamics	100%	100%	100%	100%	100%
Child Health - Skin prick testing	100%	100%	100%	100%	100%
Child Health - Food challenges	100%	100%	100%	100%	100%
Child Health - Sleep studies	100%	100%	100%	100%	100%
Child Health - Bronchoscopies	100%	100%	100%	100%	100%
Child Health - Endoscopy	100%	100%	100%	100%	100%
Magnetic Resonance Imaging	97%	97%	97%	97%	97%
Computed Tomography	99%	99%	99%	99%	99%
Non-obstetric ultrasound	60%	75%	85%	95%	97%

- DM01 trajectory based on modality

APPENDIX 1

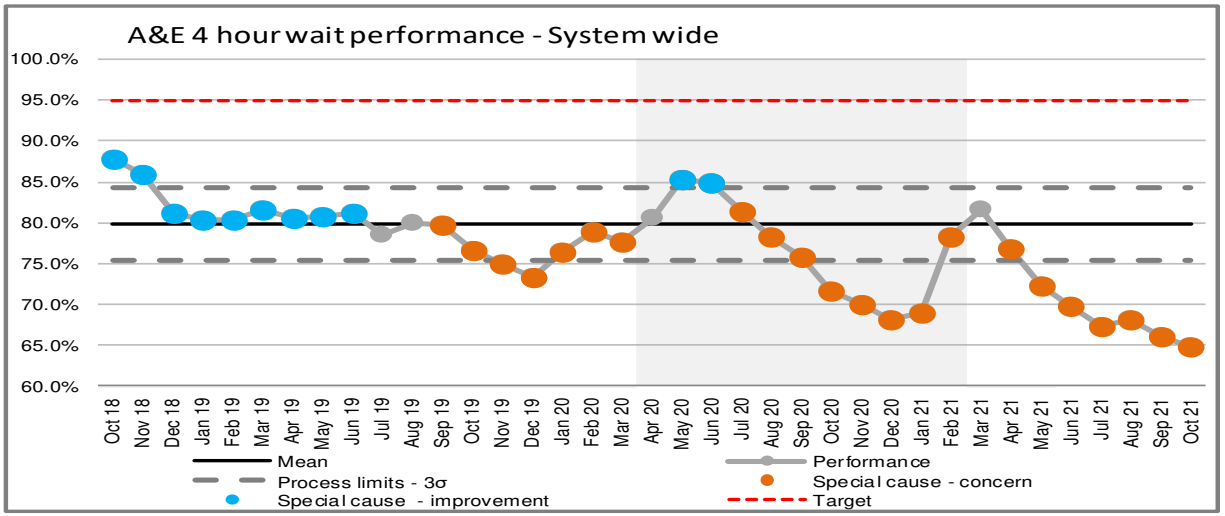
Operational Performance

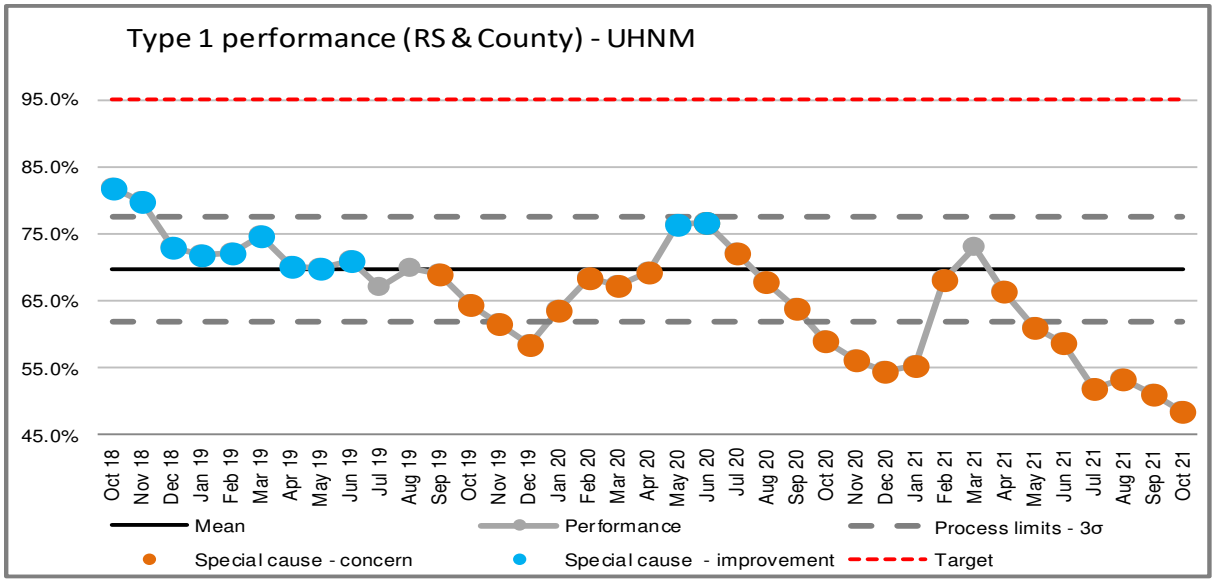
Constitutional standards

	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	

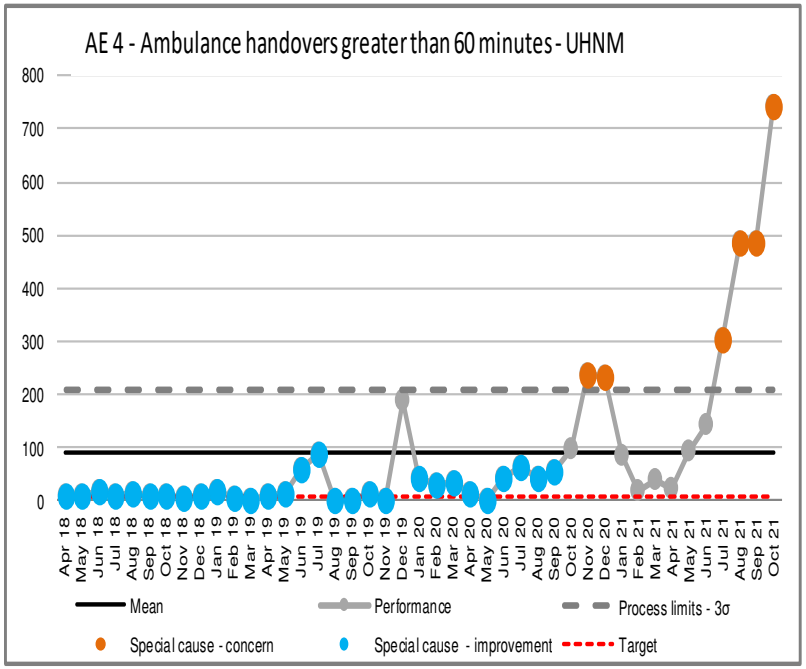
	Metric	Target	Latest	Variation	Assurance	DQAI
Use of Resources	DNA rate	7%	7.3%		?	
	Cancelled Ops	150	138		?	
	Theatre Utilisation	85%	76.0%			
Inpatient / Discharge	Same Day Emergency Care	30%	30.1%	H	?	
	Super Stranded	183	174	H	P	
	DToC	3.5%	2.10%	L	?	
	Discharges before Midday	30%	19.0%	L	F	
	Emergency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

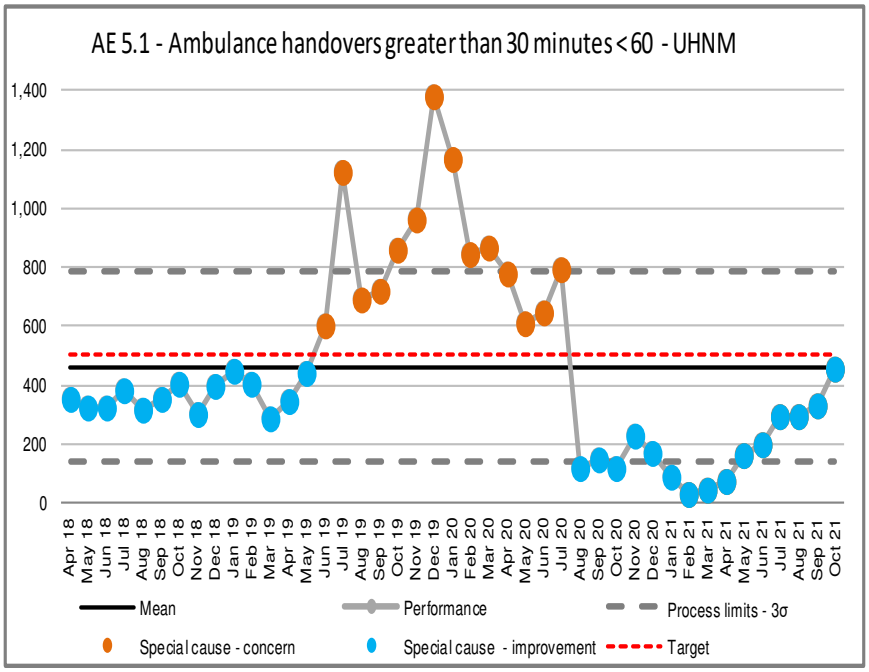
URGENT CARE – 4 hour access performance





URGENT CARE – 4 hour access – ambulance handovers

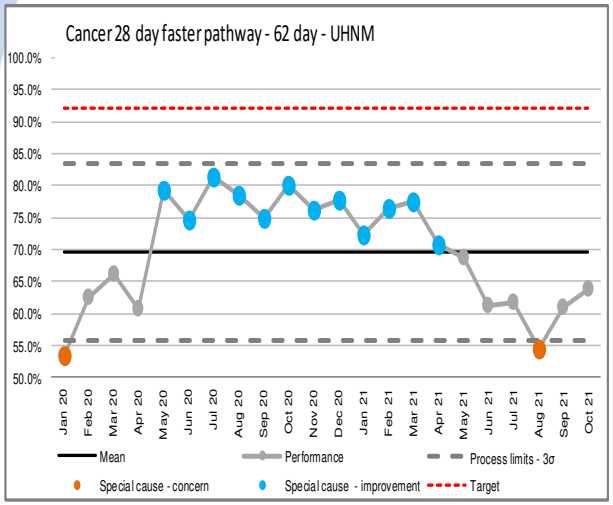


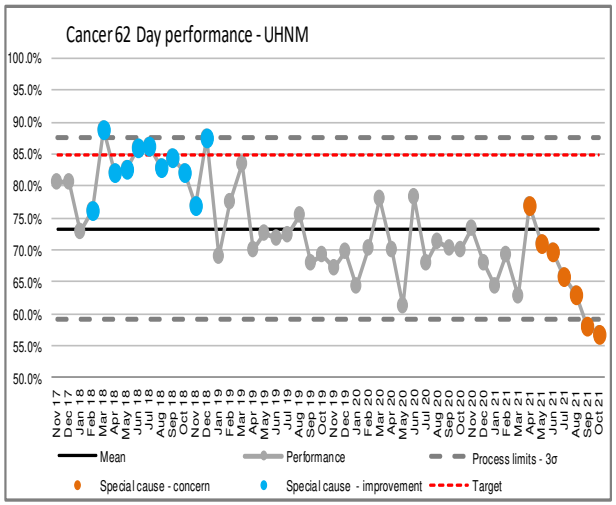


From August – internal validation of > 30 minutes

Quality | Operational | Workforce | Finance

Cancer – 62 Day





Variation	Assurance
L	?

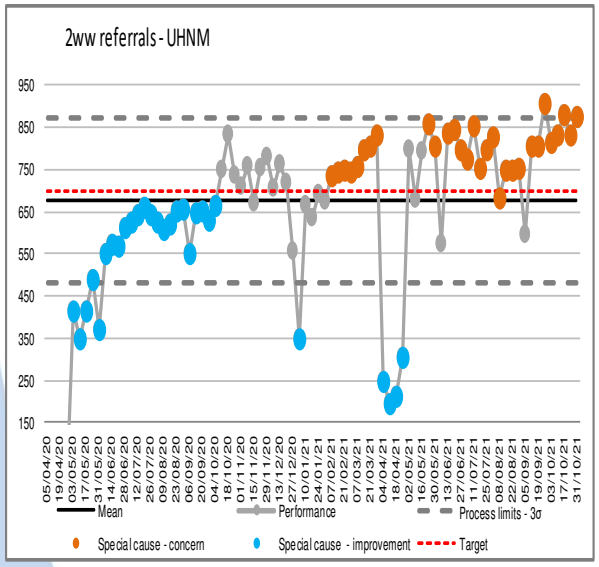
Target	Aug 21	Sep 21	Oct 21
85%	62.9%	58.1%	57.0%

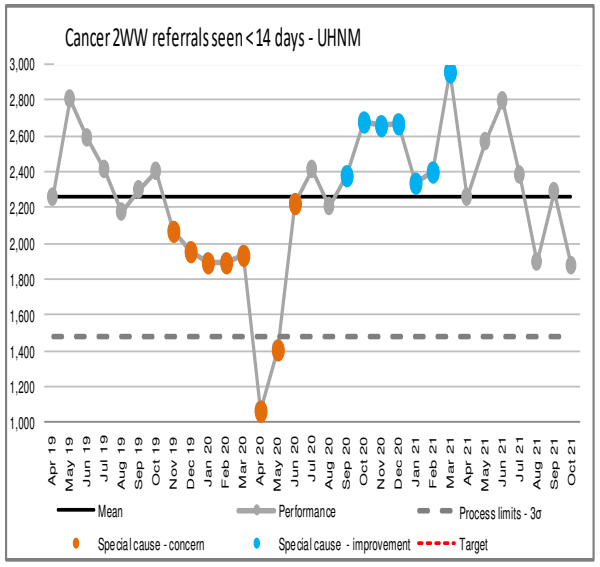
Background

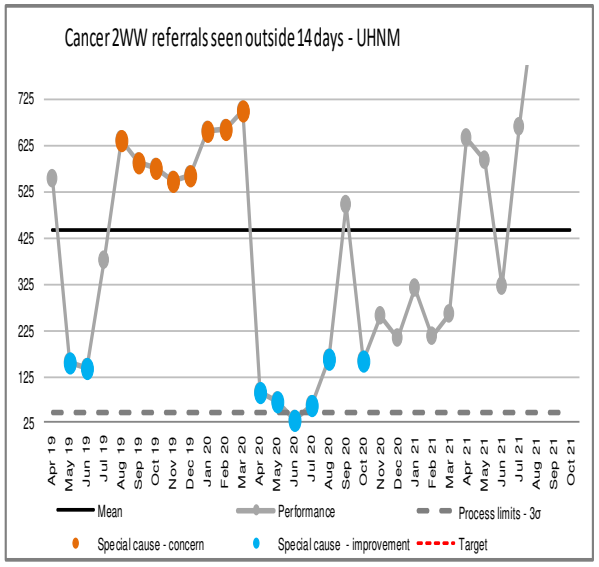
% patients beginning their treatment for cancer within 62 days following an urgent GP referral for suspected cancer

What is the data telling us?

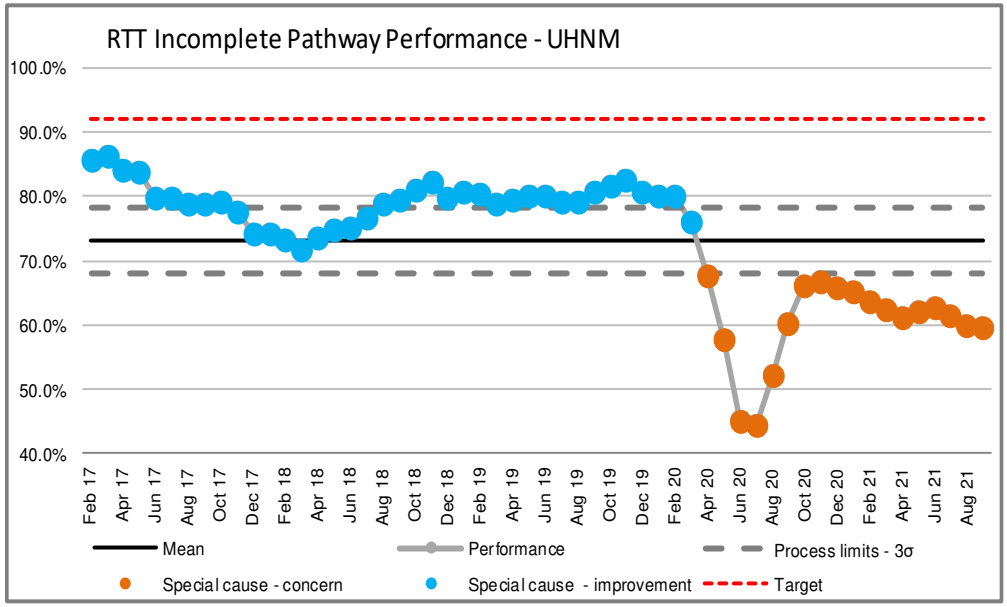
Apart from three occasions the standard has been below the mean since Sept-19.







Referral To Treatment



Variation	Assurance
	

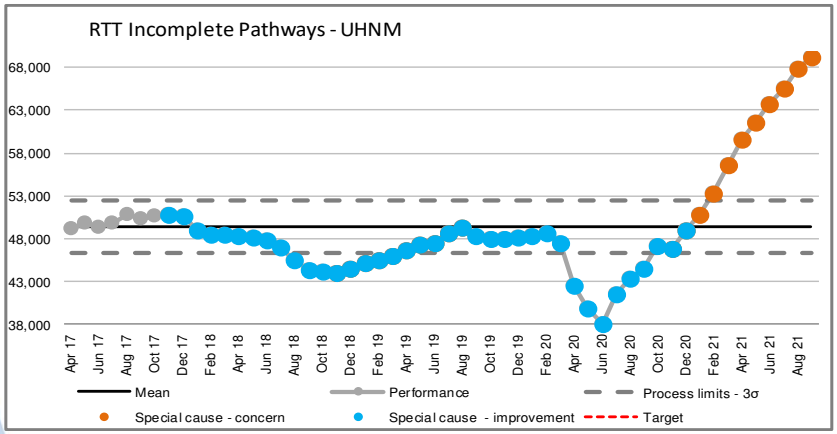
Target	Jul 21	Aug 21	Sep 21
92%	61.4%	59.9%	59.8%

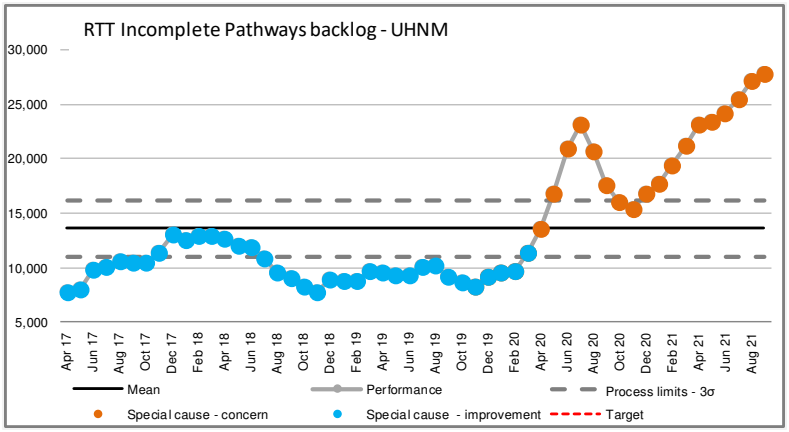
Background

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

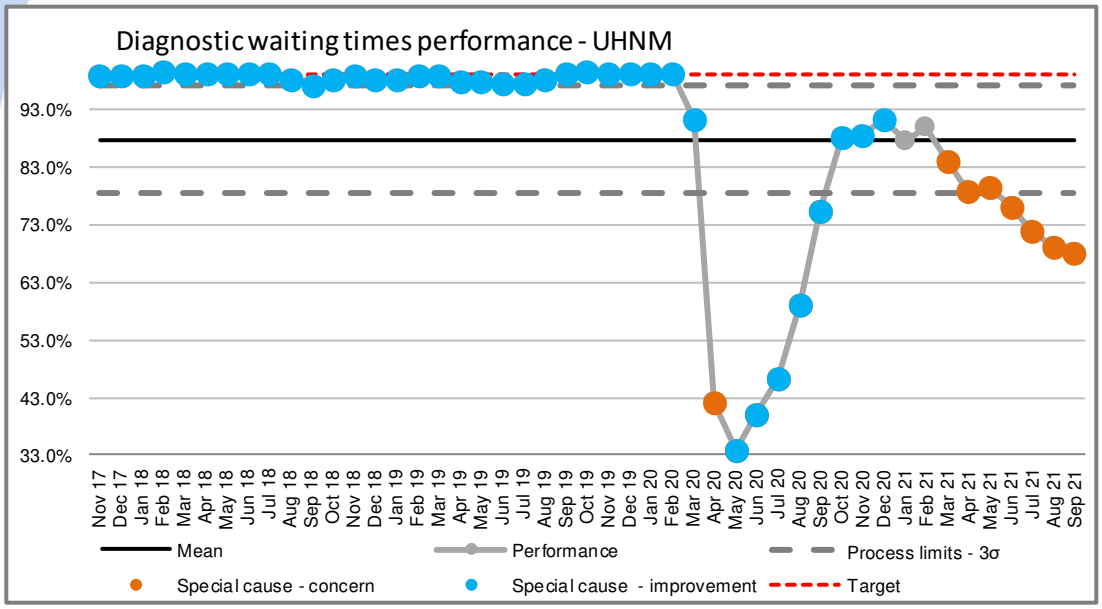
What is the data telling us?

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
	

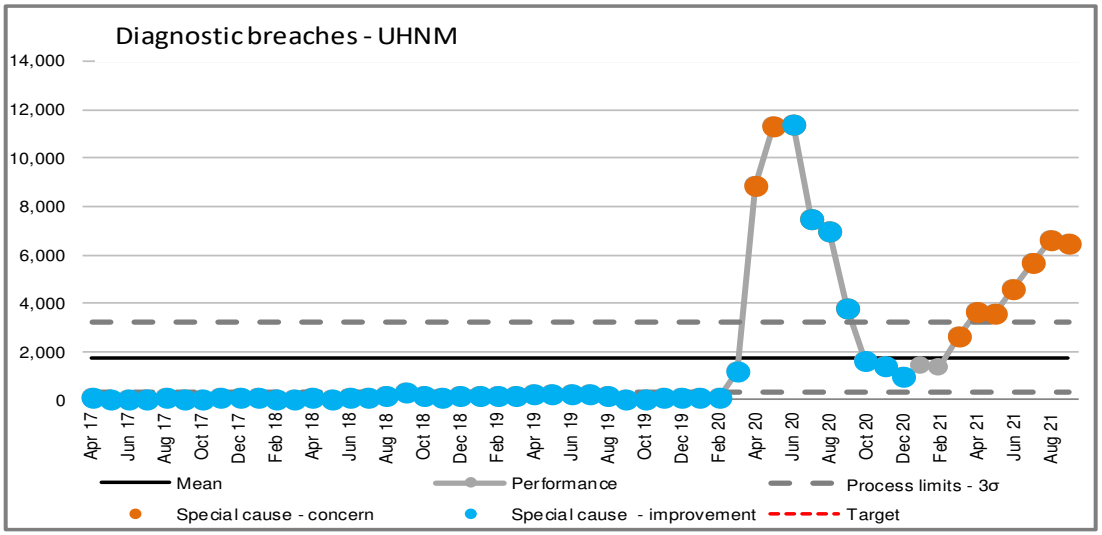
Target	Jul 21	Aug 21	Sep 21
99%	72.0%	69.2%	68.1%

Background

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

What is the data telling us?

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



Quality | Operational | Workforce | Finance

National Benchmarked Data- Oct 2021

- **A&E 4hr-** Nationally UHNM are 107th (out of 133) for this metric and against the 4 peer trusts we are better than UHB and UHL with UHCW being better than UHNM (NB- NUH do not report nationally on this metric)
- **A&E Conversation Rates**- Nationally UHNM are 109th (out of 147)for this metric and against the 4 peer trusts we are better than UHCW and UHL with NUH & UHB being better than UHNM
- **A&E 12hr Breaches-** Nationally UHNM are 120th (out of 147)for this metric and against the 4 peer trusts we are better than NUH and UHL with UHCW & UHB being better than UHNM
- **A&E Time to Initial Assessment-** Nationally UHNM are 51st (out of 120) for this metric and against the 4 peer trusts we are better than UHB, NUH and UHL with UHCW being better than UHNM
- **Bed Occupancy-** Nationally UHNM are 58th (out of 160) for this metric and against the 4 peer trusts we are better than UHB, UHCW, NUH and UHL with none being better than UHNM
- **Cancer 2WW-** Nationally UHNM are 123rd (out of 138) for this metric and against the 4 peer trusts we are better than none of the peers with all being better than UHNM
- **Cancer 62 day-** Nationally UHNM are 112th (out of 135) for this metric and against the 4 peer trusts we are better than UHB and UHL with UHCW and NUH being better than UHNM
- **DM01-** Nationally UHNM are 118th (out of 160) for this metric and against the 4 peer trusts we are better than UHCW with UHB, UHL and NUH being better than UHNM
- **RTT 52 Wk Breaches-** Nationally UHNM are 118th (out of 170) for this metric and against the 4 peer trusts we are better than UHB, NUH and UHL with UHCW being better than UHNM
- **RTT Average Waiting Times-** Nationally UHNM are 145th (out of 170) for this metric and against the 4 peer trusts we are better than UHB, NUH and UHL with UHCW being better than UHNM
- **RTT Incomplete Performance-** Nationally UHNM are 146th (out of 171) for this metric and against the 4 peer trusts we are better than UHB, NUH and UHL with UHCW being better than UHNM
- **Sickness Absence-** Nationally UHNM are 126th (out of 215) for this metric and against the 4 peer trusts we are better than UHL and NUH with UHB and UHCW being better than UHNM

- **Key-**
- **University Hospitals Birmingham (UHB)**
- **University Hospitals Coventry & Warwick (UHCW)**
- **Nottingham University Hospitals (NUH)**
- **University Hospitals Leicester (UHL)**

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.

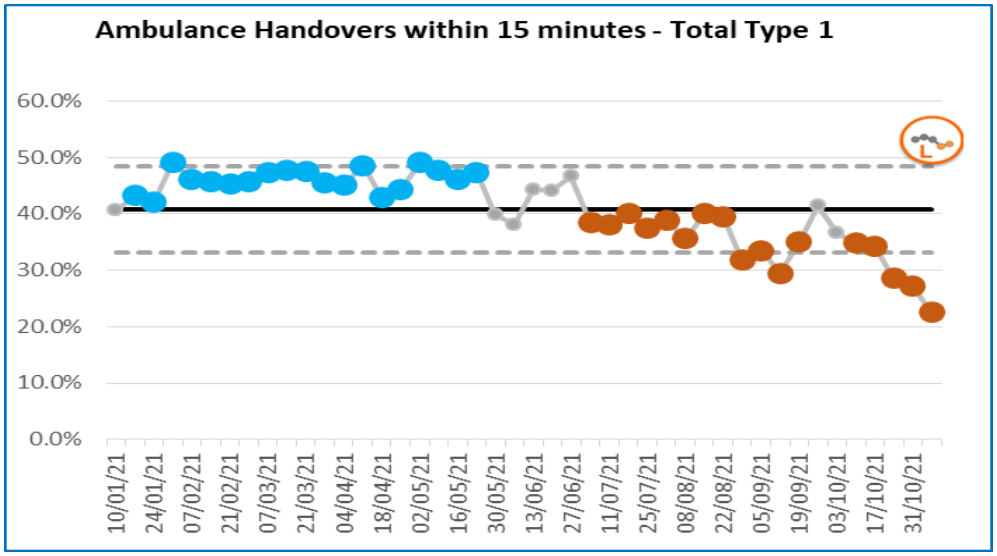
Governance

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

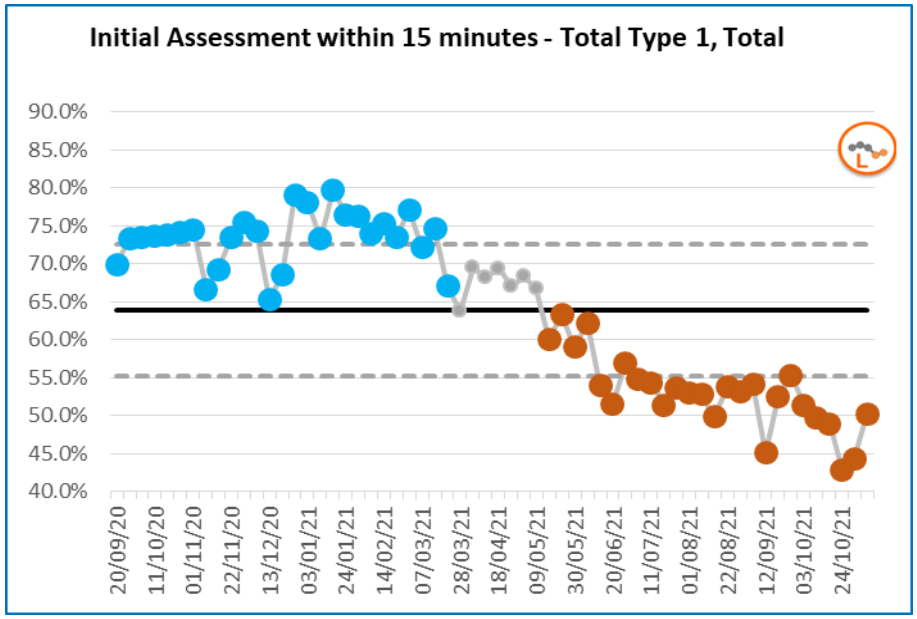


Internal collection of data for Ambulance handovers within 15 minutes began at the beginning of January 21. This is the time taken for the ambulance service to hand over the care to the ED.
N.B. this is un-validated performance and also includes handover time related to direct ambulance conveyance to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

For total ambulance handovers at UHNM in October, the percentage within 15 minutes remained below the lower control limit of 34% and has deteriorated to below 25%. 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.

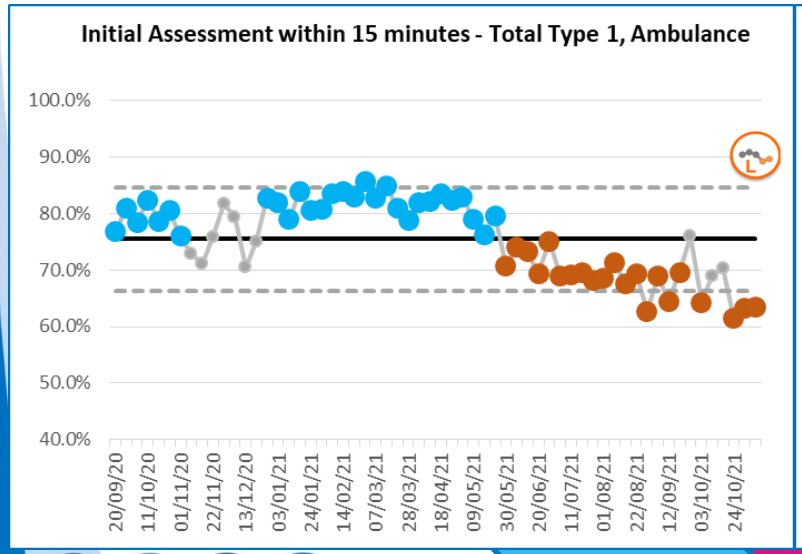
3. Time To Initial Assessment – percentage within 15 minutes

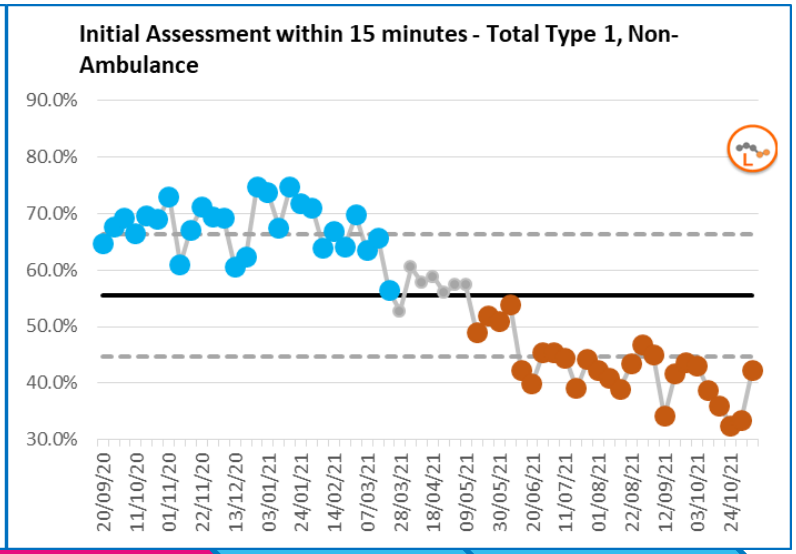


Time to Initial assessment is the time from arrival to when the patient is first triaged.

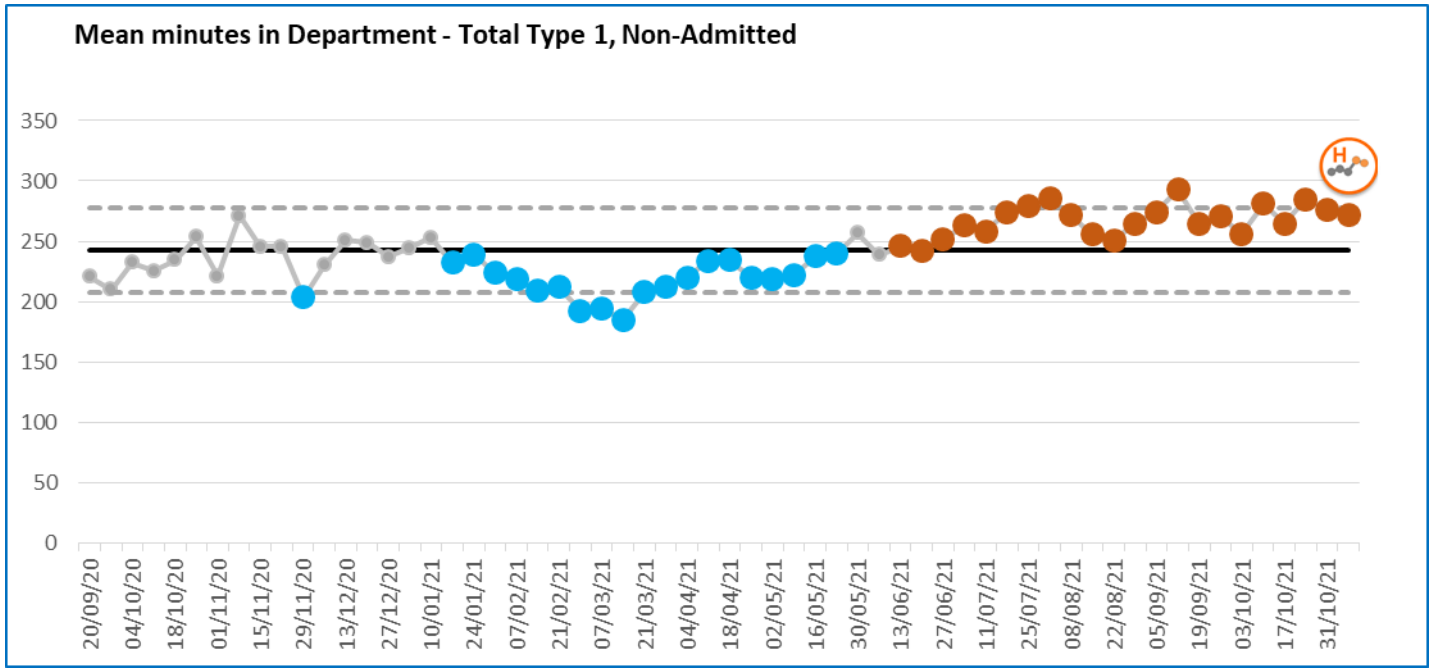
The total proportion of patients waiting under 15 minutes for their initial assessment maintained a performance of **50% or under %.**

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





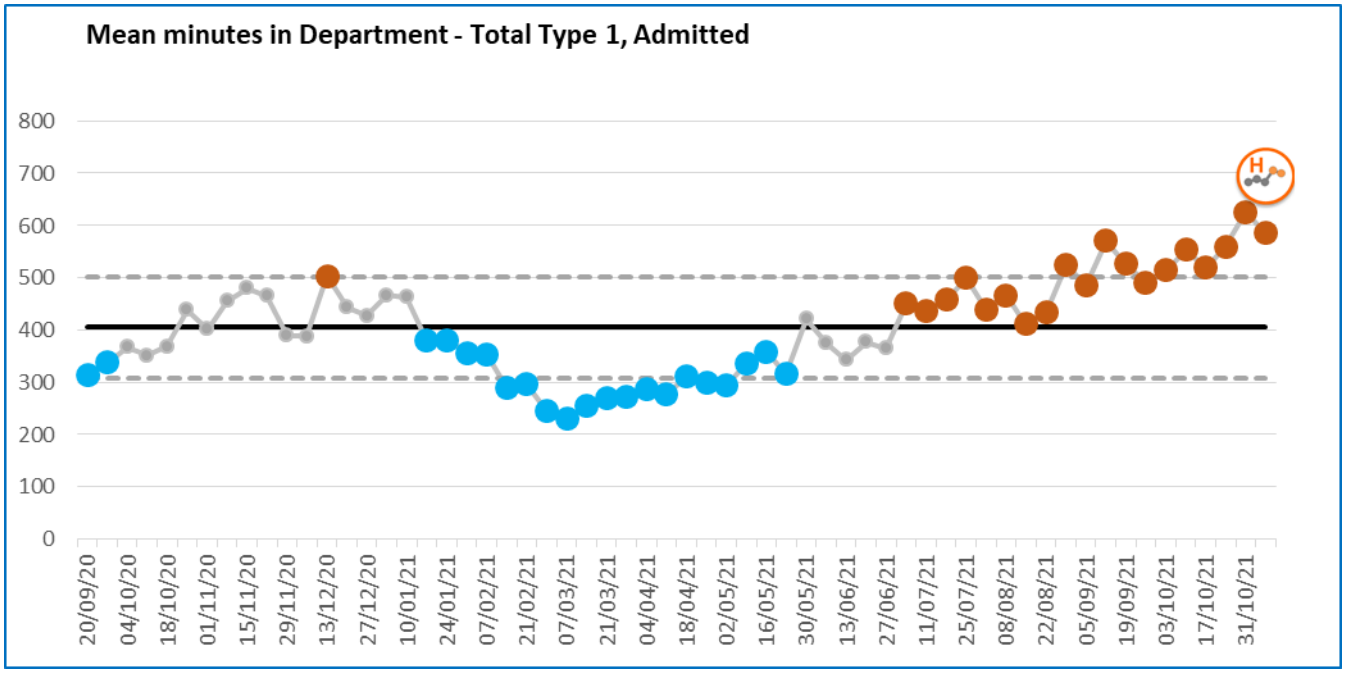
4. Average (mean) time in Department – non admitted patients



The mean time in the department through October remained above the mean and was for one week the highest seen. On average over the month this was 260mins (September 270mins).
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

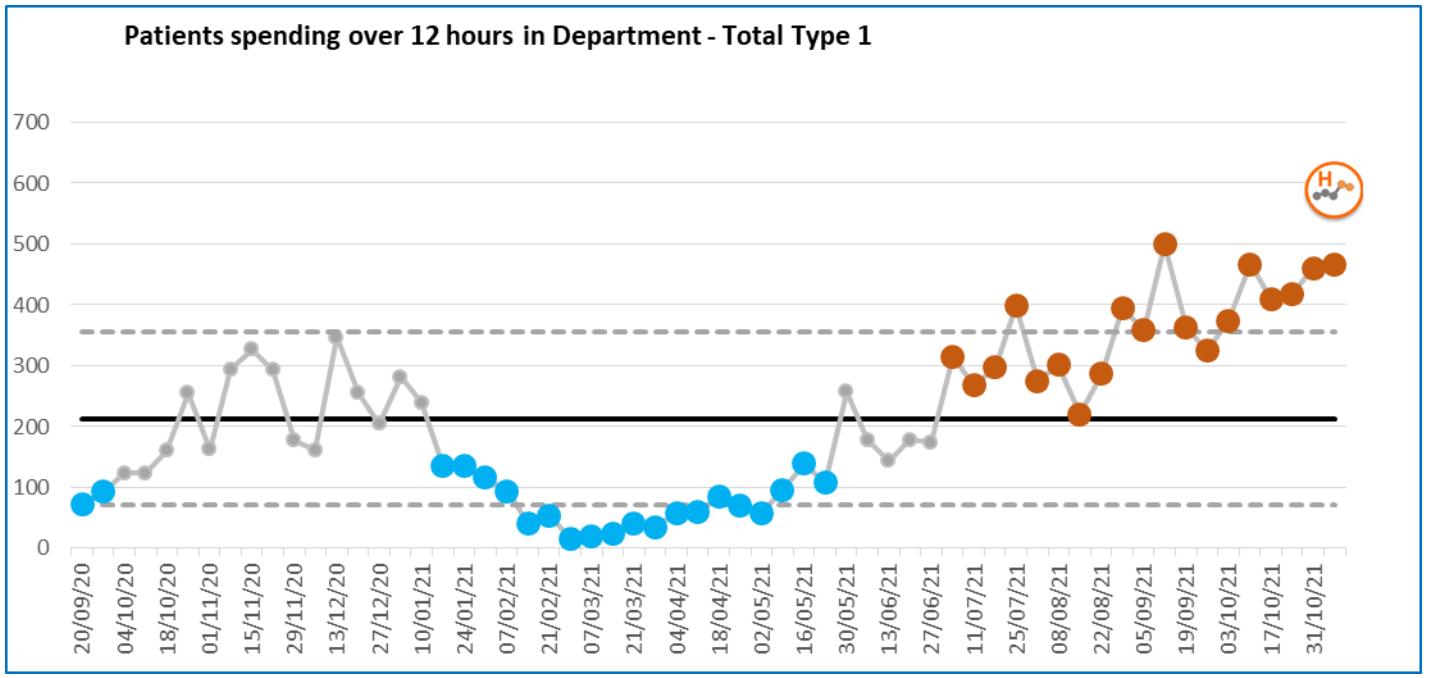


The mean time in the department for admitted patients rose to 610 mins in October. Higher than seen in September.

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 October with a spike up to 470. 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

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 5.66% (5.36% reported at 30/08/21). The 12 month cumulative rate increased to 5.33% (5.25% at 30/09/21) The Trust has a comprehensive Wellbeing Plan in place to support staff with a focus on ensuring staff psychological wellbeing. Wellbeing courses available from now until December 2021 have been promoted. Wellbeing focus groups are being held and the Winter Wellbeing Plan has been put into place

Specific actions being taken by the Divisions include:

- Specific interventions and focused work with line managers in the areas of concern and with further training provided as necessary
- Absence management assurance meetings continue to taking place with Directorates to obtain assurance on the management of long term and frequent absences. Divisions have highlighted staff self-care, rota issues and behavioural/ cultural issues as one cause of stress related absence and are working with the People and OD Team to enhance wellbeing conversations

As of 12th November 2021, covid-related open absences* numbered 165, which was 20.57% of all absences (28.81% at 20th October 2021) [**includes absences resulting from adhering to isolation requirements*]

Appraisals

The Non-Medical PDR compliance rate was 75.21% at 31st October 2021 (76.18% at 30 September 2021).

Divisions have been asked to revise their trajectories to reflect a realistic position of what they are able to achieve and asked to continue to undertake PDR's wherever possible as opportunity to discuss wellbeing and support

Statutory and Mandatory Training

The Statutory and Mandatory training rate at 31st October 2021 was 95.38% (95.5% at 30 September 2021. This compliance rate is for the 6 'Core for All' subjects only. At 31 October 2021, 91.24% of staff had completed all 6 Core for All modules (91.80% at 30/09/21)

Vacancies

The overall Trust vacancy rate was 9.97% as a result of an uplift in budgeted establishment to account for Winter planning, rather than a reduction in staffing

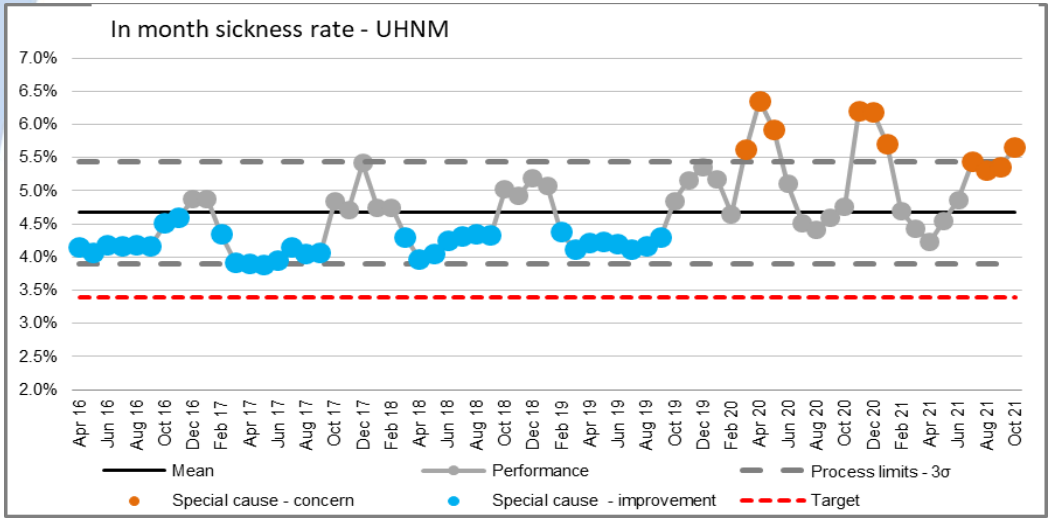
- A bid is being submitted for the International Recruitment of a further 100 registered nurses for 2022/23
- The Nursing Associate apprenticeship development programme has recommenced to support with recruitment issues and provide a development platform
- Apprenticeship needs for the next 1, 3, and 5 years are being assessed

Workforce Dashboard

Metric	Target	Latest	Variation	Assurance
Staff Sickness	3.4%	5.66%		
Staff Turnover	11%	9.30%		
Statutory and Mandatory Training rate	95%	95.38%		
Appraisal rate	95%	75.21%		
Agency Cost	N/A	3.75%		

Quality | Operational | Workforce | Finance

Sickness Absence



Variation	Assurance
H	F

Target	Aug 21	Sep 21	Oct 21
3.4%	5.3%	5.4%	5.7%

Background

Percentage of days lost to staff sickness

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 5.66% (5.36% reported at 30/08/21). The 12 month cumulative rate increased to 5.33% (5.25% at 30/09/21)

The Wellbeing Plan is in place to support staff with a focus on ensuring staff psychological wellbeing.

Wellbeing courses available from now until December 2021 have been promoted. Wellbeing focus groups are being held and the Winter Wellbeing Plan has been put into place

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

As of 12th November 2021, covid-related open absences* numbered 165, which was 20.57% of all absences (28.81% at 20th October 2021) [**includes absences resulting from adhering to isolation requirements*]

Actions

Overdue tasks on the Empactis System are flagged to managers

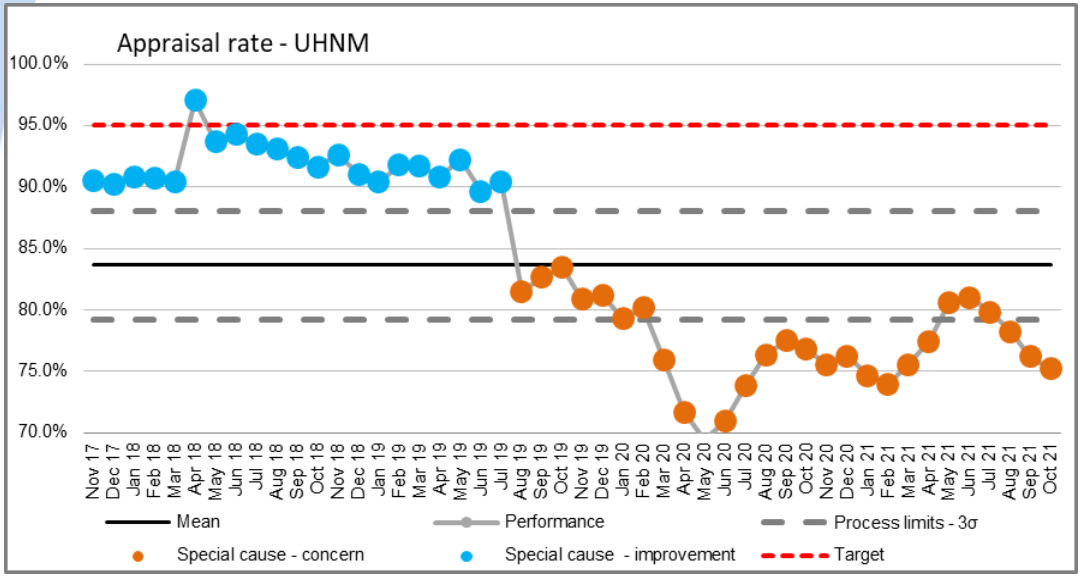
There are specific interventions and focused work with line managers in the areas of concern and further training is being provided

Absence management assurance meetings continue to take place with Directorates to go through long term and frequent absences for assurance on case management

Staffing levels are being reviewed on a daily basis and recruitment plans in place.

Promotion and signposting of wellbeing resources takes place within the Divisions

Appraisal (PDR)



Variation	Assurance
L	F

Target	Aug 21	Sep 21	Oct 21
95.0%	78.2%	76.2%	75.2%

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 75.21% at 31st October 2021 (76.18% at 30 September 2021).

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.

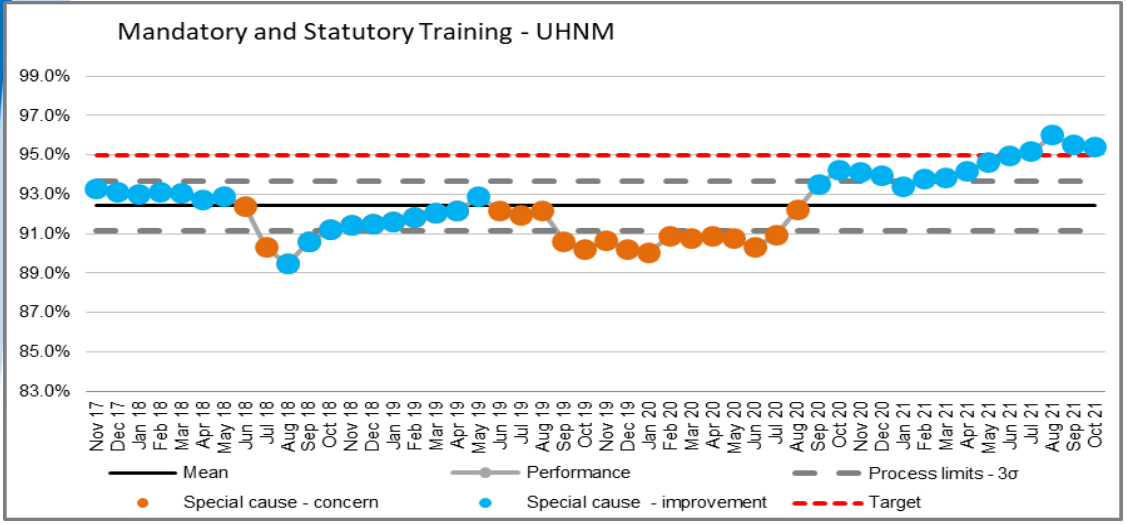
Actions

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

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

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

Statutory and Mandatory Training



Variation	Assurance
H	F

Target	Aug 21	Sep 21	Oct 21
95.0%	96.0%	95.5%	95.4%

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 31st October 2021 was 95.38% (95.5% at 30 September 2021. This compliance rate is for the 6 'Core for All' subjects only.

At 31 October 2021, 91.24% of staff had completed all 6 Core for All modules (91.80% at 30/09/21)

Competence Name	Assignment Count	Required	Achieved	Compliance %
205|MAND|Security Awareness - 3 Years|	10622	10622	10077	94.87%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	10622	10622	10156	95.61%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	10622	10622	10089	94.98%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	10622	10622	10127	95.34%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	10622	10622	10118	95.26%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	10622	10622	10221	96.22%

Compliance rates for the Annual competence requirements were as follows:

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 1 Year|	10622	10622	9031	85.02%
NHS|CSTF|Information Governance and Data Security - 1 Year|	10622	10622	9361	88.13%

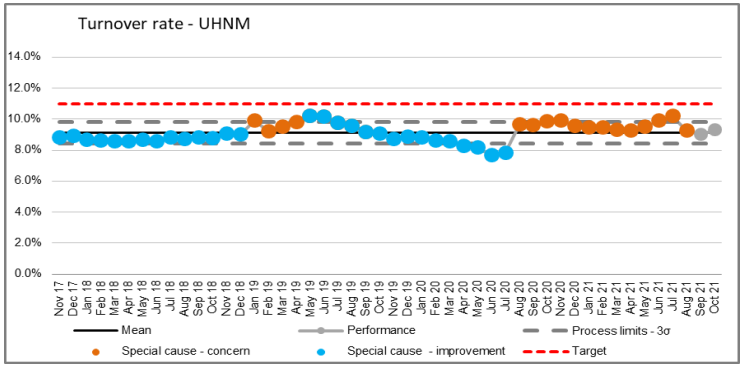
Actions

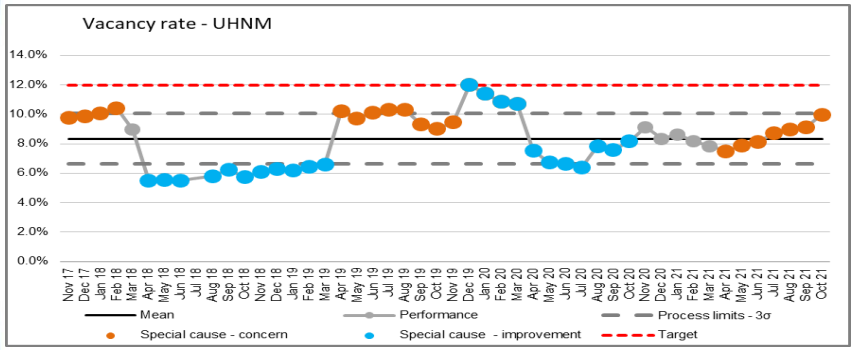
We continue to raise the issue of compliance with Divisions and communicate to staff the need to complete statutory and mandatory training.

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	Aug 21	Sep 21	Oct 21
11.0%	9.3%	9.0%	9.3%

Background

Turnover rate

What is the data telling us?

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

Summary

The overall Trust vacancy rate was 9.97% as a result of an uplift in budgeted establishment, not a reduction in staffing

Vacancies at 31 Oct 2021	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous month %
Medical and Dental ***(*Note 1)***	1,445.02	1,245.75	199.27	13.79%	12.62%
Registered Nursing	3318.36	2881.99	436.37	13.15%	12.78%
All other Staff Groups	6322.75	5852.78	469.97	7.43%	6.40%
Total	11,086.13	9,980.52	1,105.61	9.97%	9.11%

The change in the vacancy rate was a result of an increase in budgeted establishment

Note 1 - the Medical and Dental staff figure in post excludes circa 75wte GPVTS staff who are employed by St Helens and Knowsley meaning the vacancy rate is over-stated and should be around 8.60%

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

Registered Nursing: A bid is being submitted for International Recruitment of a further 100 registered nurses for 2022/23

Nursing Support: Applications have opened for a two year Nursing Associate apprenticeship development programme. The development of the Nursing Associate role is part of the Nursing workforce strategy to help support recruitment issues and provide a platform for the development of support roles.

Apprenticeships: Work has commenced with Divisions to assess the apprenticeship need over the next 1, 3, 5 years. This will then help to streamline the engagement offers and promotions used to connect with our communities and to target future workforce effectively

Finance

2025 Vision "Ensure efficient use of resources"

Finance Spotlight Report

NHS University Hospitals of North Midlands NHS Trust

Key messages

- The Trust set a plan at the start of the year with an H1 surplus of £8.3m and a full year deficit of £8.8m. The guidance for H2 has been reviewed by the Trust and the Trust has set a revised breakeven plan for the financial year ending 31 March 2022. At both a National and System level an agreement has been reached that the Trust is expected to carry forward the surplus of £14.5m delivered in H1 and therefore the planned position for H2 is a £14.5m deficit to achieve a breakeven plan for the year.
- The Trust has delivered an actual surplus of £2.2m in month and a year to date surplus of £15.9m resulting in a favourable variance of £4.4m against the year to date plan. The positive position in month is primarily driven by an adjustment to the Managed Equipment Service (MES) replacement cost within the PFI, additional HEE income and slippage on non-recurrent investments.
- The Trust incurred £1.2m of costs relating to COVID-19 in month which is an increase of £0.2m compared with Month 6'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.
- Capital expenditure for the year to date stands at £14.3m which is £1.6m behind the plan mainly due to an underspend relating to digital pathology.
- The cash balance at Month 7 is £71.7m which is £1.1m higher than plan, the main reason being that capital payments are £1.4m lower than plan as a result of the slippage against the capital plan.
- An updated plan for H2 has been presented in November and at Month 8 and in line with NHSIE guidelines, a full year forecast position will be presented to the Committee.

Finance Dashboard

	Metric	Target	Latest	Variation	Assurance
I&E	TOTAL Income	variable	80.1		
	Expenditure - Pay	variable	44.0		
	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 07 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	861.8	67.2	70.6	3.4	508.9	508.9	(0.1)
Other Operating Income	88.4	7.3	8.6	1.2	50.5	50.2	(0.3)
Total Income	950.2	74.6	79.1	4.6	559.5	559.1	(0.4)
Pay Expenditure	(560.7)	(43.2)	(45.9)	(2.7)	(320.5)	(317.0)	3.5
Non Pay Expenditure	(336.0)	(23.5)	(26.6)	(3.1)	(196.0)	(194.8)	1.3
Total Operational Costs	(896.7)	(66.7)	(72.5)	(5.8)	(516.5)	(511.8)	4.8
EBITDA	53.5	7.9	6.7	(1.2)	42.9	47.3	4.4
Depreciation & Amortisation	(29.9)	(2.5)	(2.5)	(0.0)	(17.5)	(17.6)	(0.0)
Interest Receivable	0.1	(0.1)	0.0	0.1	0.0	0.0	(0.0)
PDC	(7.6)	(0.7)	(0.6)	0.1	(4.5)	(4.5)	0.0
Finance Cost	(16.1)	(1.3)	(1.3)	(0.0)	(9.4)	(9.4)	0.0
Other Gains or Losses	0.0	0.0	0.0	(0.0)	0.0	0.0	(0.0)
Surplus / (Deficit)	(0.0)	3.3	2.2	(1.1)	11.5	15.9	4.4
Financial Recovery Fund	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	(0.0)	3.3	2.2	(1.1)	11.5	15.9	4.4

The Trust delivered a £15.9m surplus year to date for Month 7 against a planned surplus of £11.5m; this surplus is measured against the Trust's financial plan which will be re-submitted in November 2021 to take into account the adjustments required for H2. The main variances in month are:

- For Month 7 no income has been assumed in respect of ERF. At present there is no income target for this income stream in the H2 plan.
- The primary drivers for the underperformance of other operating income in month are research income (£0.1m), Provider to Provider contracts (£0.1m) and car parking income (£0.1m) which continue to underperform due to the impact of COVID-19.
- Pay is underspent in month by £3.5m which is primarily driven by underspends across registered nursing and NHS infrastructure and non-recurrent funding underutilised in month. There has also been a year to date adjustment to uplift the pay budgets in month as a result of the updated HEE allocation for the Trust (£1.2m).
- Non-pay is underspent against plan in month by £1.3m primarily due to the year to date adjustment made in respect of the MES element of the PFI contract.

Capital Spend

Capital Expenditure as at Month 7 2021/22 £m	Revised 2021/22 Plan	2021/22 year end forecast	In Month			Year to Date		
	Plan	Actual	Budget	Actual	Variance	Budget	Actual	Variance
PFI & finance lease liability repayment	(9.2)	(9.2)	(0.8)	(0.8)	-	(5.3)	(5.3)	-
Pre-committed items	(9.2)	(9.2)	(0.8)	(0.8)	-	(5.3)	(5.3)	-
PFI lifecycle and equipment replacement	(5.3)	(5.3)	(0.2)	(0.2)	-	(1.2)	(1.2)	-
PFI enabling cost	(0.8)	(0.2)	-	-	-	-	-	-
PFI related costs	(6.1)	(5.6)	(0.2)	(0.2)	-	(1.2)	(1.2)	
RI demolition	(0.9)	(1.2)	(0.2)	(0.1)	0.1	(1.0)	(0.9)	0.1
Project STAR multi-storey car park	(1.2)	(1.2)	-	(0.1)	(0.1)	(0.2)	(0.4)	(0.3)
Thornburrow decant office accommodation	(1.9)	(1.9)	-	(0.1)	(0.1)	(1.9)	(1.9)	-
Wave 4b Funding - Lower Trent Wards	(2.2)	(2.3)	(0.7)	(0.2)	0.5	(0.8)	(0.9)	(0.1)
CT7 scanner enabling cost	(1.2)	(0.4)	-	-	-	-	-	-
STP diagnostic Funding and Cancer funding CT7	(1.0)	(1.0)	-	-	-	-	-	-
Increased Critical Care Capacity (BC) TIF funding	(0.3)	(0.3)			-	-	-	-
Schemes funded by PDC and Trust funding	(8.7)	(8.4)	(0.8)	(0.5)	0.3	(3.8)	(4.1)	(0.3)
LIMS (Laboratory Information Management System)	(0.6)	(0.6)	(0.1)	-	0.1	(0.5)	(0.3)	0.1
EPMA (Electronic Prescribing)	(0.5)	(0.5)	(0.0)	(0.0)	0.0	(0.2)	(0.3)	(0.0)
Completion of RSUH ED doors	(0.2)	(0.2)	-	-	-	(0.2)	(0.2)	0.0
Pathology integration	(0.1)	(0.2)	-	-	-	-	-	-
Medical devices fleet replacement	(0.7)	(0.7)	-	-	-	-	-	-
Schemes with costs in more than 1 financial year	(2.2)	(2.2)	(0.1)	(0.0)	0.1	(0.9)	(0.8)	0.1
2021/22 schemes	(13.9)	(14.6)	(1.0)	(0.5)	0.5	(4.7)	(3.0)	1.7
Balance to be allocated in updated Plan	(1.1)	(1.2)	-	-	-	-	-	-
Funds to be allocated to schemes	(1.1)	(1.2)	-	-	-	-	-	-
Donated/Charitable funds expenditure	(0.4)	(0.4)	(0.0)	(0.0)	-	(0.4)	(0.4)	-
Charity funded expenditure	(0.4)	(0.4)	(0.0)	(0.0)	-	(0.4)	(0.4)	-
Overall capital expenditure	(41.2)	(41.2)	(2.8)	(2.0)	0.8	(15.9)	(14.3)	1.6

The table sets out the capital plan and forecast expenditure for 2021/22 and shows both Trust funded and externally funded schemes. The main changes to the plan and forecast are to reflect:

- PDC funding of £1.895m to purchase the 4th linear accelerator in 2021/22
- the re-phasing of the Lower Trent ward refurbishment (funding and expenditure)
- additional costs on RI demolition and critical risk infrastructure
- potential slippage on CT7 enabling work
- schemes to be funded through allocation of remaining funds.

The remaining balance of £1.2m is to be allocated. Potential schemes have been identified and are in the process of being approved through either the business cases process or statement of need via CIG.

The main variances are explained below.

- Project Star multi storey car park costs are £0.3m higher than plan due to expenditure relating to additional budget being incurred earlier than expected.
- Within 2021/22 schemes the following are behind plan ICT sub-group £0.2m, Estates infrastructure £0.2m, Digital Pathology £0.7m and the scheme to increase to the footprint of the pharmacy dispensary area £0.3m.

Balance sheet

Balance sheet as at Month 7	31/03/2021	31/10/2021			
	Actual £m	Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment	531.2	528.0	526.1	(1.9)	Note 1
Intangible Assets	22.8	19.3	19.1	(0.2)	
Other Non Current Assets	-	-	-	-	
Trade and other Receivables	0.5	0.5	0.5	-	
Total Non Current Assets	554.5	547.8	545.7	(2.1)	
Inventories	15.0	15.0	16.3	1.3	Note 2
Trade and other Receivables	47.4	46.3	50.2	3.9	Note 3
Cash and Cash Equivalents	55.8	70.6	71.7	1.1	Note 4
Total Current Assets	118.2	131.9	138.2	6.3	
Trade and other payables	(98.5)	(97.6)	(99.4)	(1.9)	Note 5
Borrowings	(8.3)	(8.3)	(8.3)	0.0	
Provisions	(3.6)	(3.6)	(3.6)	0.0	
Total Current Liabilities	(110.4)	(109.5)	(111.3)	(1.8)	
Borrowings	(268.5)	(263.2)	(263.3)	(0.1)	
Provisions	(2.2)	(2.2)	(2.1)	0.1	
Total Non Current Liabilities	(270.7)	(265.4)	(265.4)	(0.0)	
Total Assets Employed	291.5	304.8	307.2	2.4	
Financed By:				-	
Public Dividend Capital	637.9	637.9	637.9	0.0	
Retained Earnings	(465.3)	(452.0)	(449.8)	2.2	Note 6
Revaluation Reserve	118.9	118.9	119.1	0.2	
Total Taxpayers Equity	291.5	304.8	307.2	2.4	

Variances to the plan at Month 7 are explained below:

1. Property, Plant and Equipment is £1.9m lower than plan and reflects the underspend in the capital plan to Month 7. The main areas of underspend are the Digital pathology scheme £0.7m, medical equipment replacements and the expansion of the pharmacy dispensary area. This is partly offset by lower than forecast depreciation and upward revaluations to Wilfred Place and the crèche at County to reflect the sale of the land.
2. The inventory balance at Month 7 reflects the value of high cost devices held mainly in relation to the pace makers inventory count, a £1.9m increase compared 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. Trade and other receivables are £3.9m higher than plan. This is due to the invoice for Q3 Health Education England training income being raised in month and also accrued income balances in respect of the annual leave provision at 31 March 2021, DHSC transitional support income for 2021/22 and Out of envelope costs for Months 4-7.
4. The higher cash balance is mainly due to lower than planned payments in respect of capital and the PDC dividend partly offset by lower than planned cash received from HEE in respect of training income for Months 1-6.
5. Trade and other payables are £1.9m higher than plan mainly due to an increase in deferred income in relation to cancer funding received for RDC and cancer transformation from NHS Stoke on Trent CCG in Month 7.
6. Retained earnings show a variance of £2.2m from plan which reflects the revenue surplus in month.

Expenditure - Pay and Non Pay

Pay Summary Month 07 2021/22	Annual Budget £m	Year to Date		
		Budget £m	Actual £m	Variance £m
Medical	(169.9)	(98.4)	(97.4)	1.0
Registered Nursing	(163.4)	(91.7)	(90.4)	1.3
Scientific Therapeutic & Technical	(68.1)	(38.9)	(38.5)	0.4
Support to Clinical	(75.1)	(43.9)	(43.8)	0.1
Nhs Infrastructure Support	(84.2)	(47.7)	(46.9)	0.7
Total Pay	(560.7)	(320.5)	(317.0)	3.5

Pay –Key variances

- Within the budget for Month 7 is £2.5m of reserves which have not been spent with the main elements being £1.2m in respect of HEE as a result of the updated contract in Month 7 and £0.5m for the non-recurrent investment reserve relating to ACC and Elective recovery.
- The underspend on registered nursing remains in line with the prior year trend as a result of the number of vacancies across the trust.
- The underspend on medics in month is primarily driven by the updated and increased HEE contract schedule. This is reflective of the first 7 months of the year and as a result an uplifted income target has been noted at Month 7 and an offsetting pay reserve created.

Non Pay Summary Month 07 2021/22	Annual Budget £m	Year to Date		
		Budget £m	Actual £m	Variance £m
Tariff Excluded Drugs Expenditure	(79.8)	(47.4)	(47.9)	(0.6)
Other Drugs	(23.0)	(13.4)	(13.2)	0.2
Supplies & Services - Clinical	(89.7)	(51.1)	(51.2)	(0.2)
Supplies & Services - General	(7.0)	(3.9)	(4.2)	(0.3)
Purchase of Healthcare from other Bodies	(23.9)	(14.0)	(13.6)	0.4
Consultancy Costs	(2.0)	(1.4)	(1.4)	(0.0)
Clinical Negligence	(25.4)	(15.4)	(15.4)	0.0
Premises	(31.8)	(19.3)	(19.4)	(0.1)
PFI Operating Costs	(35.5)	(20.7)	(20.7)	(0.0)
Other	(17.9)	(9.6)	(7.8)	1.7
Total Non Pay	(336.0)	(196.0)	(194.8)	1.3

Non Pay key variances:

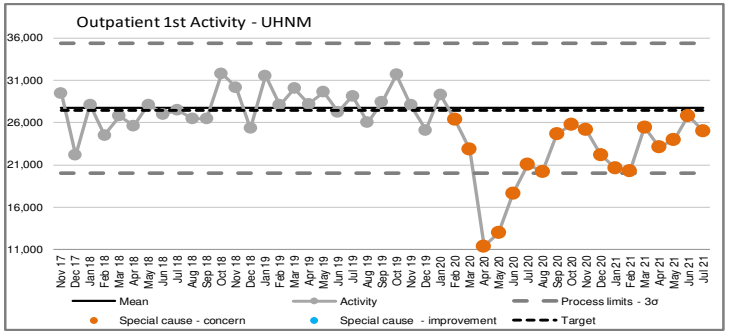
Purchase of Healthcare is underspent primarily as a result of £0.7m budget relating to the System wide elective investment against which there is no spend in month; this is offset by Independent Sector spend in month of £0.4m.

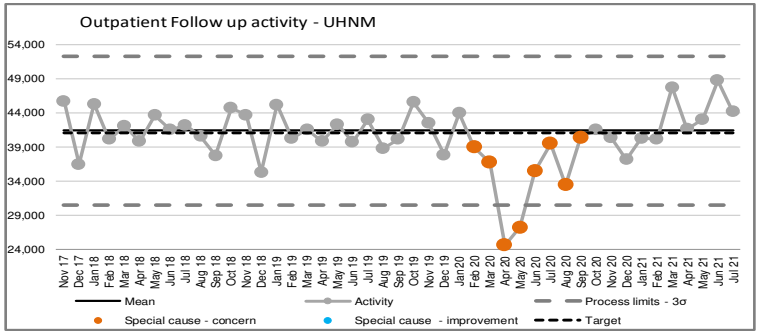
Whilst the year to date adjustment to the PFI spend in month relates to premises costs, an equal and opposite adjustment has been made to the premises budget in month and this excess budget has been moved to other non-pay in month against which there is no spend.

Activity

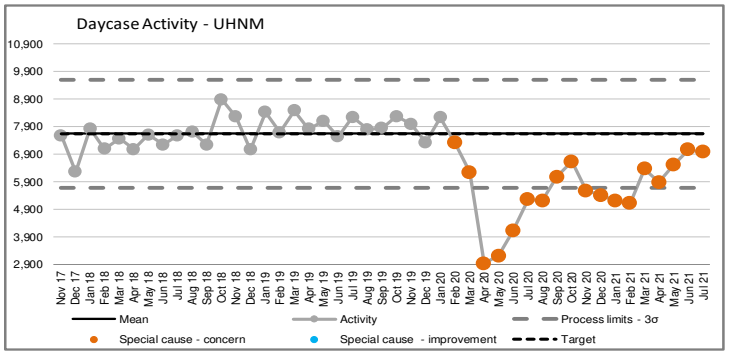
NHS University Hospitals of North Midlands NHS Trust

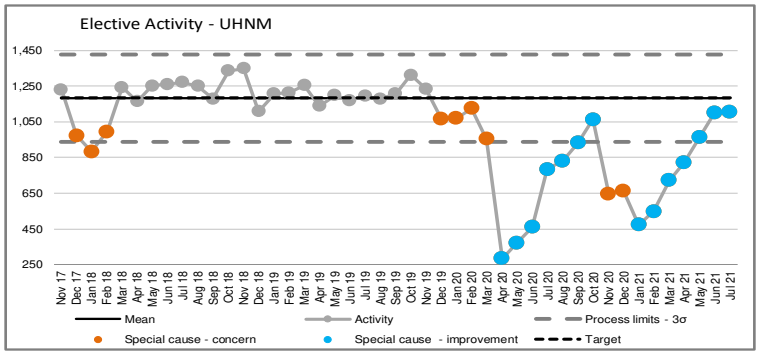
Planned care Outpatient



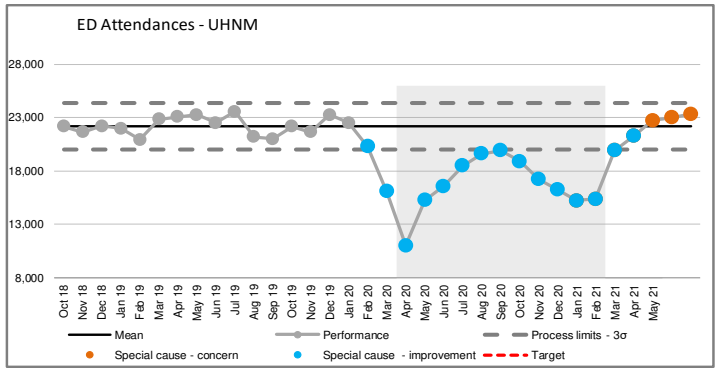


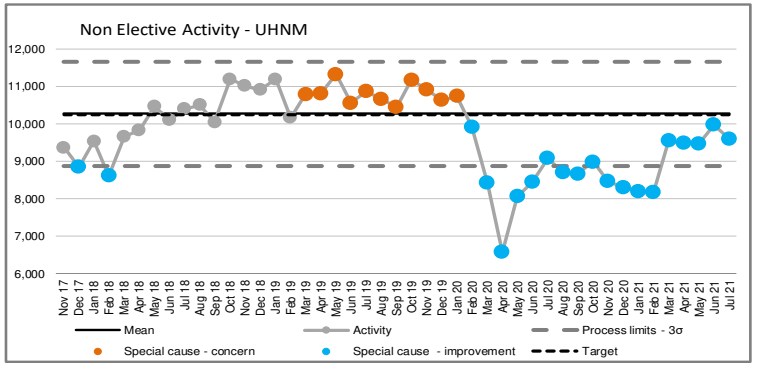
Planned care Inpatient





Urgent Care





Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Executive Summary

Meeting:	Trust Board	**Date:**	5th December 2021
Report Title:	Speaking Up Report – Quarter 2 2021-22	**Agenda Item:**	14
Author:	Raising Concerns & Workforce Equality Manager		
Executive Lead:	Director of Human Resources		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

Executive Summary

Situation - when things go wrong we need to make sure that lessons are learnt and improvements are made. If we think something might go wrong, it's important we feel able to speak up so that potential harm is avoided. Even when things are going well, but could be made even better we should feel able to say something and should expect that what we say is listened to and used as an opportunity for improvement. Speaking Up is about all of these things.

Background - this quarterly Speaking Up Report provides an update to Trust Board on progress in relation to developing our speaking up culture, relevant national speaking up guidance published, and a summary of concerns raised at UHNM for the Quarter 2 period of July – September 2021.

Assessment – during the quarter 34 speaking up contacts were received. 23 concerns were recorded on the speaking up tracker, which includes concerns raised with the Freedom to Speak Up Guardians and those raised to the Chief Executive's Office, within a division, or via CQC/other routes that have then been notified to the FTSU Guardian for inclusion on the speaking up tracker. One of the concerns was raised anonymously. 11 contacts were made to our Employee Support Advisors, and are included in our reportable speaking up data.

Key Recommendations

Trust Board is asked to note:

- The speaking up data and themes raised during Quarter 2 2021-22.
- The actions proposed to further encourage and promote a culture of speaking up at UHNM.

Speaking Up
Quarter 2 2021-22

1. Introduction

This Quarter 34 speaking up contacts have been made via the UHNM speaking up routes, which include 23 concerns recorded on the speaking up tracker which records issues raised with the Freedom to Speak Up Guardians; the Chief Executive's Office; within a division or via CQC/other routes that have then been notified to the FTSU Guardian for inclusion on the speaking up tracker. One of these concerns was raised anonymously. 11 contacts have also been made to our Employee Support Advisors, who act as speaking up champions across the Trust.

2. National Guardians Office (NGO) Update

National Guardian

Dr Jayne Chidgey-Clark has been appointed as the new National Guardian commencing on 1st December 2021, and is a clinical leader and registered nurse, with more than 30 years' experience in the NHS, higher education, voluntary and private sectors. Her most recent roles include as non-executive director at NHS Somerset Clinical Commissioning Group (CCG) where she was a Freedom to Speak Up Guardian.

National Guardians Office Case Review – Blackpool Teaching Hospitals NHS Foundation Trust

In October the NGO published its report which analyses the themes and learning for the whole health sector from their review of the speaking up culture at Blackpool Teaching Hospitals. Case reviews seek to identify learning, recognise innovation and support improvement.

The NGO had received information indicating that a speaking up case may not have been handled following good practice. The information received also suggested black and minority ethnic workers had comparatively worse experiences when speaking up.

Based on focus groups and interviews with Trust workers, and analysis of internal processes and data, the report reviews information about the trust's speaking up culture and arrangements and the trust's support for its workers to speak up.

The review found that work was underway to improve the organisation's speaking up culture, but there were long-standing issues with the trust's speaking up culture. There was a perception among some workers that speaking up was futile. Black and minority ethnic workers – and other groups – also reported facing barriers to speaking up. The review also found that some workers who had spoken up to national bodies had variable experiences.

37 recommendations were made by the NGO. Learning for UHNM includes:

- Ensure that workers who speak up can have input into the terms of reference for subsequent investigations. This is best practice and as an action will be built into the UHNM Speaking Up Policy
- The NGO recommends ring fenced time for FTSU Guardians. Following a business case a dedicated Lead FTSU Guardian with ring fenced time will be appointed at UHNM
- To ensure that all staff are aware of freedom to speak up arrangements, we should review the communications strategy about speaking up and regularly assess its effectiveness

- Recommendations from the NGO related to ensuring workers who speak up are responded to in accordance with trust policies and procedures, including recommendations on confidentiality, detriment and communication. These topics are covered in the new UHNM Speaking Up mandatory training, which meets the expectations set out in guidelines from the NGO
- Promote and facilitate the use of mediation where appropriate – In July 2021 we trained an additional cohort of UHNM internal mediators and promote informal resolution as part of our dignity at work policy. Since April 2021, 15 mediation referrals have been received.
- Review the use of Freedom to Speak Up Champion role and the effectiveness of the network – a review is currently underway at UHNM of our Employee Support Advisor roles, and this includes seeking the input of the NGO
- It is also recommended that UHNM reviews its Freedom to Speak Up Board Self Review Tool, which should be completed yearly and shared with NHS E/I, and also review our associated Speaking Up Strategy during the next quarter.

3. Freedom to Speak Up Index

The NHS Staff Survey, which is currently live, has undergone significant changes in line with the People Plan. As a result, some of the questions which comprised the FTSU Index have been dropped. In light of this, the NGO has made the decision to no longer publish the FTSU Index.

Last year's survey included a new question asking whether workers feel safe to speak up about anything that concerns them in their organisation. The question remains in this year's survey and is accompanied by a new follow-up question: 'If I spoke up about something that concerned me, I am confident my organisation would address my concern'.

The NGO has invited all organisations to consider using this question as an indicator of their speaking up culture and effective arrangements.

Instead of publishing the FTSU Index, the NGO will look at the results of these questions and others in the NHS Staff Survey as part of a broader and more holistic view of the speaking up landscape in healthcare. Additionally, the results of this year's NHS Staff Survey will be presented on the Model Health System, so guardians in trusts will be able to use this tool to look at results from the survey in the same way we have been able to do with the FTSU Index.

4. Independent Review into Bullying and Harassment

BRAP have been undertaking focus groups and the bullying and harassment Staff Survey has been launched with a significant communications promotion. A meeting has been held involving the Director of HR, Head of Employee Relations and the Lead FTSU Guardian with Ghiyas Somra, People, Policy & Research Manager from BRAP to discuss and review the bullying and harassment and civility and respect interventions undertaken by UHNM, and the work currently taking place around civility and respect.

5. Supporting a Speaking Up Culture

UHNM Speaking Up Training Update

The new UHNM mandatory speaking up e-learning has been launched during October's Speaking Up Month and is based on the resources released by the NGO and Health Education England 'Speaking Up' and 'Listen Up' will give all staff and understanding of the importance of speaking up and how to speak up, whilst the listen up elements equip line managers with the skills to respond effectively when issues are raised to them.

These packages are also pre-requisite training for the UHNM Gateway to Management programme and will also be available for any member of staff to access via ESR to increase their awareness of a speaking up culture. Including the training within the corporate induction package will be the next action to be taken forward in the coming months.

The next phase of the NGO training will a Trust Board awareness package, which is expected to be released shortly.

Additional Routes to Raise Issues

- **Staff Voice**

The Staff Voice survey has been developed internally as a method of receiving more frequent feedback from staff than offered by the annual National Staff Survey, and is an additional route for staff to voice their experiences in the organisation. The survey was launched on 1st of June 2021, and runs for the first 10 days of each month. It is completely anonymous.

Drawing on feedback from the national Staff Survey, Culture and Leadership Programme Phase 1 and Listen & Learn results, an initial set of 5 standard questions were determined, as follows:

- I am enthusiastic about my job
- I am able to make suggestions
- Patient care/service is a top priority
- The Trust supports my wellbeing
- I am happy with the support provided by my line manager

The two key areas which staff have consistently fed back on in terms of lower satisfaction levels are in relation to support from their line manager and wellbeing. The ability of staff to make suggestions has also been one of the less favourable areas of feedback from staff.

Divisions have received their full data sets to review. Wellbeing Focus Groups have been established and these groups will review the wellbeing results and plan wider staff wellbeing focus sessions. Further actions also include the launch of the mandatory Middle Management Programme and wider civility and respect programme of work. A You Said, We Did summary has been published on the Trust Intranet.

- **Work in Confidence System**

A paper is being produced regarding next steps with the Work in Confidence tool, which is an employee involvement platform providing a secure environment for sharing issues and concerns and also enables two way anonymous conversations to take place.

Lead/Freedom to Speak Up Guardian Recruitment

The Lead Freedom to Speak Up Guardian role is being reviewed prior to being re-advertised after an appointment could not be made at the first attempt.

An internal advertisement for the voluntary FTSU Guardian positions is currently open to expressions of interest.

6. Internal Audit of Freedom to Speak Up – Update on Actions

The final of the recommendations from the Audit of Freedom to Speak Up has been actioned, which was to increase the number of FTSU Guardians. An advertisement has been placed, as mentioned above in the Trust Bulletin for expressions of interest in these voluntary roles.

7. Quarterly Speaking Up Cases – Quarter 2 – July – September 2021

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

Month	No. of contacts in the Quarter	Of which were raised anonymously	Of Which are Closed	Reports of detriment/ victimisation as a result of speaking up
July	7	2	2	1
August	9	0	4	0
September	7	0	2	0
Total	**23**	**2**	**8**	**1**

Two cases were reported anonymously, one to the CEO office and the other via the Lead FTSU Guardian. A signal of a healthy speaking up culture is that staff feel able to raise issues and concerns openly, as opposed to anonymously.

Theme	Number
Attitudes and behaviours	11
Equipment and maintenance	0
Staffing levels	1
Policies, procedures and processes	3
Quality and safety	4
Patient experience	0
Performance capability	1
Service Changes	1
Other	2
Total	**23**

Summary of speaking up contacts recorded on the Speaking Up Tracker during Quarter 2 July - September 2021:

No.	Theme	Summary	Status
1.	Attitudes & Behaviours	Active grievance process underway. Reporter raised further issues with FTSUG which were submitted as an additional grievance.	Active Grievance Investigation.
2.	Service Changes	Reporter raised concerns about potential management of change process.	Support and guidance provided. No further action required at this time. Reporter satisfied with action taken.
3.	Attitudes & Behaviours	Reporter sought input of FTSUG about grievance outcome and appeal and the mediation process.	Reporter given advice and guidance and support is now in place by a Trade Union Representative.
4.	Attitudes & Behaviours	Anonymous letter of concern received in CEO office regarding behaviours of ward leadership.	Active investigation.
5.	Attitudes & Behaviours	Reporter wished to bring to the attention of the FTSUG concerns about behaviours including perceptions of racial discrimination.	Reporter did not want to take further action. FTSUG meeting held with Directorate Manager to discuss concerns. Plan in place involving HR and Organisational Development.
6.	Performance Capability	FTSUG contacted for support with concerns relating to Alcohol and Substance Abuse Policy.	FTSUG escalated to Matron and HR Business Partner and

No.	Theme	Summary	Status
			immediate action taken. Closed. Reporter satisfied with outcome.
7.	Attitudes & Behaviours	Anonymous letter of concern sent to FTSUG about department leadership behaviours.	Escalated to Deputy ACN and an action plan in place, supported by HR to respond to the issues raised.
8.	Quality & Safety	Reporter concerned about impact of service change on quality, safety and staff wellbeing.	FTSUG supported reporter to raise with Medical Director. Active.
9.	Quality & Safety	Reporter concerned about the impact of a service change on quality, safety and personal grievance.	As above. Active.
10.	Attitudes & Behaviours	Reporter raised concerns with FTSUG about micromanagement within their team.	FTSUG supported reporter to raise issues with Deputy AD, who with the agreement of the reporter created a plan to address the issues with the department manager. Reporter satisfied with outcome.
11.	Attitudes & Behaviours	Ex-employee raised issues with FTSUG about behaviours in their previous team.	Escalated issues to next level manager and made arrangements for reporter to have an Exit Interview with a senior manager. Reporter failed to engage. A review and OD intervention is currently underway in this team.
12.	Other	Reporter contacted FTSUG to arrange meeting.	Meeting being arranged.
13.	Policy, Procedures & Processes	Reporter raised issues with FTSUG about how their health condition was being managed and perceptions of unfairness.	Guidance provided and supported through grievance process.
14.	Other	Reporter raised issues relating to previously investigated employee relations concerns.	Meeting held with Chief Nurse – fact finding investigation underway.
15.	Staffing Levels	Reporter and Trade Union representative raised concerns about failure to adequately respond when concerns were raised about quality and safety and staffing levels in a clinical department.	Meeting held with Chief Nurse and FTSUG. Investigation underway.
16.	Quality & Safety	Concerns raised about escalation ward arrangements. Concerns were about staffing levels, availability of equipment and that staff were unfamiliar with the layout.	Staff met with Deputy ACN, and it was acknowledged that the arrangements had not been ideal and that lessons had been learnt and whilst escalation wards may still be required in the future that safeguards are in place to prevent a recurrence. Reporters satisfied with outcome.
17.	Quality & Safety	Team raised concerns regarding excessive numbers of patients in their clinics and a lack of	Meetings held with the Directorate Management team,

No.	Theme	Summary	Status
		cover when they are on leave leading to a backlog of work.	clinic numbers reduced, and assurances provided that issues will be addressed through a service re-evaluation review. Reporters satisfied with outcome.
18.	Policies, Procedures & Processes	Reporter raised concerns with FTSUG about safe storage of confidential records and workplace behaviours.	FTSUG escalated to next level manager. Meeting has been arranged with reporter to further explore issues and identify next steps. Listening events organised for the team.
19.	Policies, Procedures & Processes	Reporter raised concerns with FTSUG about compliance with covid safety and management of own long term health condition.	FTSUG supported reporter to meet with next level manager to discuss concerns. Grievance process active.
20.	Attitudes & Behaviours	Reporter sought guidance from FTSUG on behaviours in the clinical team and grievance process.	Issues have been escalated and a Speaking Up investigation is underway.
21.	Attitudes & Behaviours	Worker contacted FTSUG as struggling with issues in team.	Worker has been redeployed into another area and given appropriate support. Reporter satisfied with action taken.
22.	Attitudes & Behaviours	FTSUG contacted by staff member reporting experience of micro management and derogatory behaviour from a colleague.	FTSUG supported reporter to raise with manager and a plan is in place to address the issues.
23.	Attitudes & Behaviours	Reporter contacted FTSUG seeking guidance on a number of issues impacting on wellbeing.	Supported to raise issues with line manager who has put a supportive wellbeing plan in place.

Open Speaking Up Cases from Previous Quarters

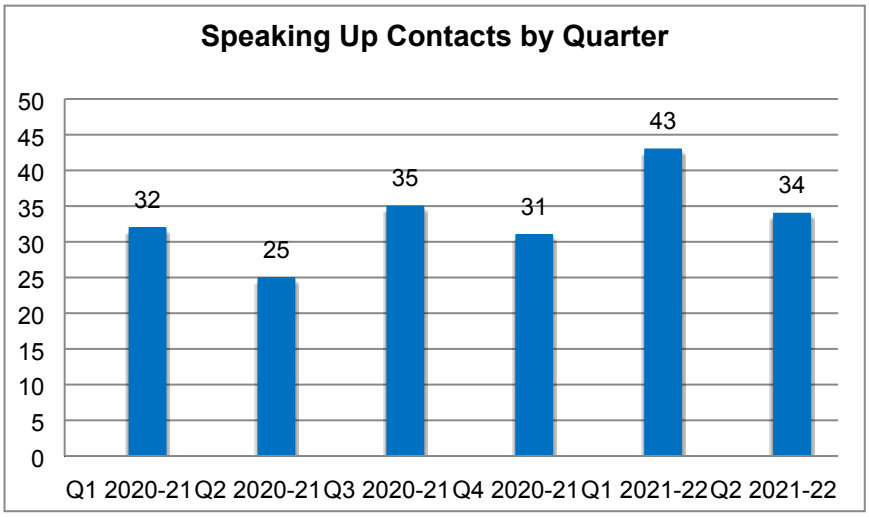
Theme	Summary	Month Case Raised	Status
Attitudes & Behaviours	Multiple grievances submitted with reporter dissatisfied with process.	June 2020	External active investigation is underway, additional grievances raised.
Attitudes & Behaviours	Multiple concerns raised through speaking up routes regarding team behaviours.	April 2021	Action Plan being implemented.
Quality & Safety / Attitudes & Behaviours	Concerns raised with Chief Nurse about quality and safety and behaviours. Actions identified and communicated to reporters.	May 2021	Ongoing communication with reporters on status of actions and satisfaction with outcome.
Attitudes & Behaviours	Speaking Up Investigation undertaken in response to issues raised by ex-employee. Reporter dissatisfied with outcome.	October 2020	Reporter supported by FTSUG to meet with Non-Executive Director. A number of actions identified. FTSUG working with divisional team to implement actions.

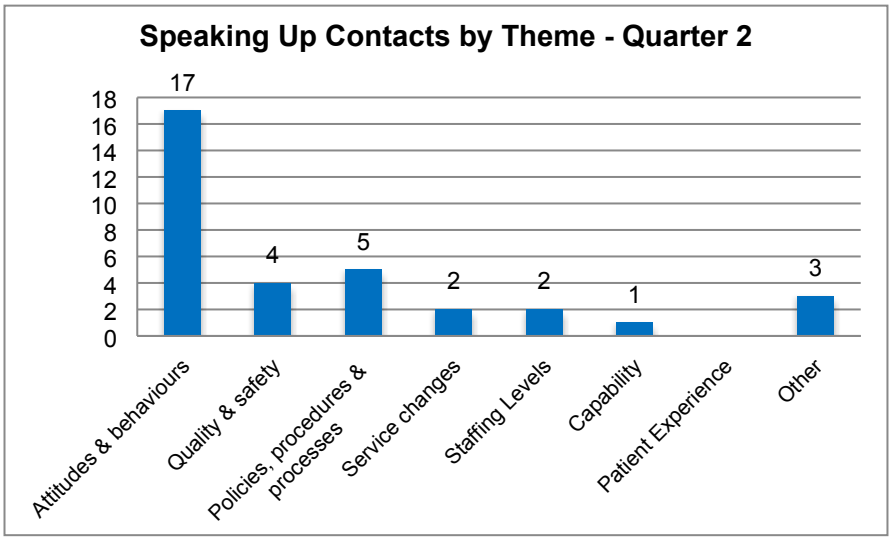
Issues Raised with our Employee Support Advisors

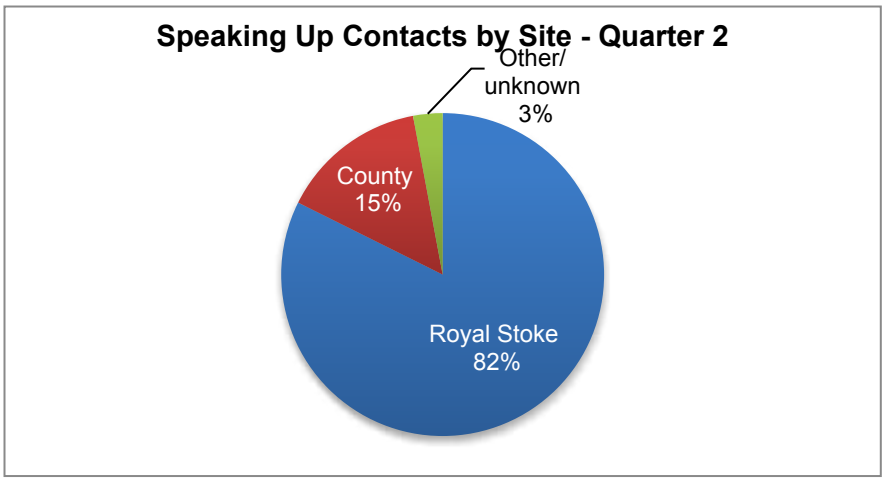
The NGO requests on a quarterly basis the number of issues raised through freedom to speak up channels (i.e. Freedom to Speak Up Guardians and champions). Our Employee Support Advisors act as speaking up champions and therefore their activity is included in NGO data submissions. During the quarter our ESA's have received 11 contacts relating to the following themes:

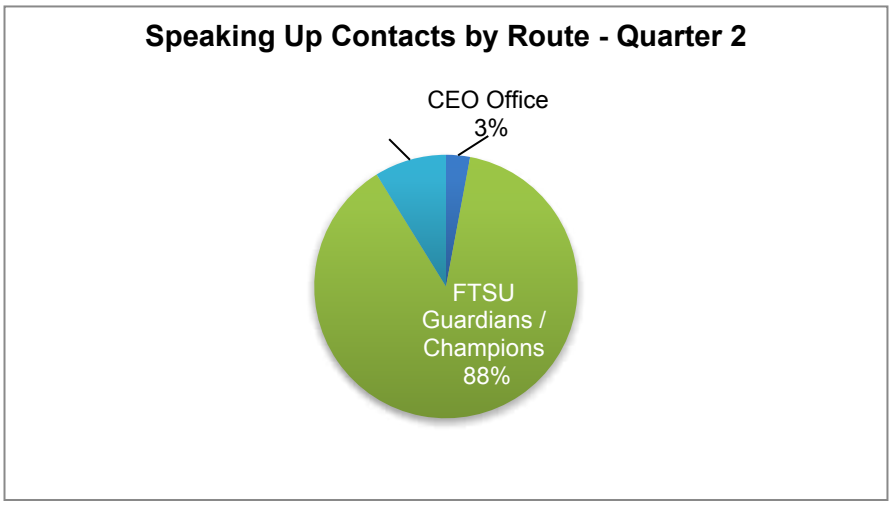
Theme	Number
Attitudes and behaviours	6
Equipment and maintenance	-
Staffing levels	1
Policies, procedures and processes	2
Quality and safety	-
Patient experience	-
Performance capability	-
Service Changes	1
Performance capability	1
Total	**11**

Quarter 2 Data Summary of All Speaking Up Contacts:

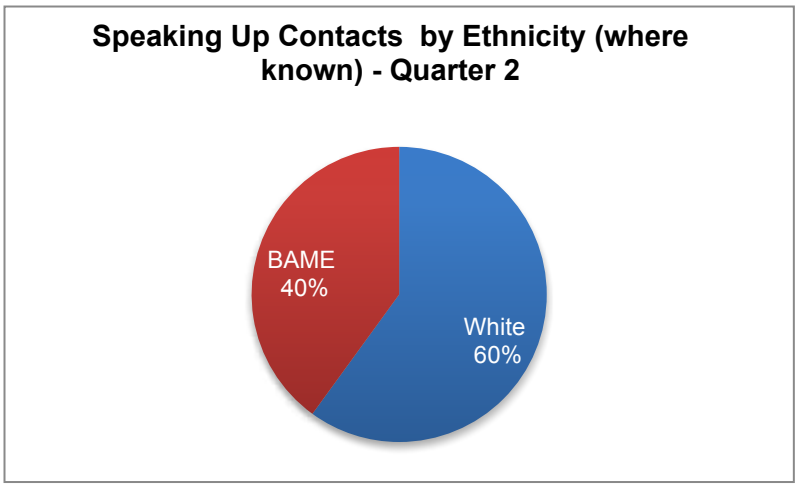





Speaking Up Contacts by Site - Quarter 2
Other/ unknown 3%
County 15%
Royal Stoke 82%


Speaking Up Contacts by Route - Quarter 2
CEO Office 3%
FTSU Guardians / Champions 88%


Speaking Up Contacts by Professional Group - Quarter 2
Anonymous 6%
Allied Health Professionals 15%
Medical & Dental 12%
Registered Nurses & Midwives 35%
Nursing or Healthcare Assistants 3%
Clerical & Maintenance/ Ancilliary 29%



8. Recommendations

Trust Board is asked to note the activity and actions relating to speaking up undertaken in the Quarter 2 of 2021-22, and the focus going forward over the next quarter, which will be:

- Review the Speaking Up Self Review Tool and UHNM Speaking Up Strategy
- Update the Speaking Up Policy to state that where an investigation into issues raised is required, that that reporters (where known) will be involved in shaping the terms of reference
- Progress the recruitment of Lead FTSU and FTSU Guardians
- Produce a written case for the extension of the Work in Confidence reporting system
- Update the corporate induction to include the speaking up training
- Report back on the review of speaking up champion network arrangements against the NGO Guidelines undertaken in partnership with our Employee Support Advisors

Trust Board

2021/22 BUSINESS CYCLE

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

Title of Paper	Executive Lead	Apr 7	May 5	Jun 9	Jul 7	Aug 4	Sep 8	Oct 6	Nov 3	Dec 8	Jan 5	Feb 9	Mar 9	Notes
PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES														
Chief Executives Report	Chief Executive													
Patient Story	Chief Nurse													
Quality Governance Committee Assurance Report	Associate Director of Corporate Governance													
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer													
Care Quality Commission Action Plan	Chief Nurse													Highlighted as part of QGC Assurance Summary
Bi Annual Nurse Staffing Assurance Report	Chief Nurse													Deferred - awaiting presentation at TAP prior to bringing to Board.
Quality Account	Chief Nurse													
7 Day Services Board Assurance Report	Medical Director													Timing TBC
NHS Resolution Maternity Incentive Scheme	Chief Nurse													
Maternity Serious Incident Report	Chief Nurse													
Winter Plan	Chief Operating Officer													
PLACE Inspection Findings and Action Plan	Director of Estates, Facilities & PFI													Timing TBC
Infection Prevention Board Assurance Framework	Chief Nurse													
ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS STANDARDS														
Integrated Performance Report	Various													
ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT & RESEARCH														
Transformation and People Committee Assurance Report	Associate Director of Corporate Governance													
Gender Pay Gap Report	Director of Human Resources													
People Strategy Progress Report	Director of Human Resources													
Revalidation	Medical Director													
Workforce Disability Equality Report	Director of Human Resources													
Workforce Race Equality Standards Report	Director of Human Resources													
Research Strategy	Medical Director													
Staff Survey Report	Director of Human Resources													
LEAD STRATEGIC CHANGE WITHIN STAFFORDSHIRE AND BEYOND														
System Working Update	Chief Executive / Director of Strategy													
ENSURE EFFICIENT USE OF RESOURCES														
Performance and Finance Committee Assurance Report	Associate Director of Corporate Governance													
Revenue Business Cases / Capital Investment / Non-Pay Expenditure £1,000,001 and above	Director of Strategy													
IM&T Strategy Progress Report	Director of IM&T													Deferred to May due to annual leave
Going Concern	Chief Finance Officer													
Estates Strategy Progress Report	Director of Estates, Facilities & PFI													Timing TBC - waiting to refresh once the clinical strategy has been determined
H2 Plan	Chief Finance Officer													

Title of Paper	Executive Lead	Apr 7	May 5	Jun 9	Jul 7	Aug 4	Sep 8	Oct 6	Nov 3	Dec 8	Jan 5	Feb 9	Mar 9	Notes
Annual Plan	Chief Finance Officer													
Capital Programme 2021/22	Chief Finance Officer													
GOVERNANCE														
Nomination and Remuneration Committee Assurance Report	Associate Director of Corporate Governance													
Audit Committee Assurance Report	Associate Director of Corporate Governance													
Board Assurance Framework	Associate Director of Corporate Governance		Q4			Q1			Q2			Q3		
Raising Concerns Report	Director of Human Resources		Q4			Q1			Q2			Q3		
Annual Evaluation of the Board and its Committees	Associate Director of Corporate Governance													
Annual Review of the Rules of Procedure	Associate Director of Corporate Governance													
G6 Self-Certification	Chief Executive													
FT4 Self-Certification	Chief Executive													
Board Development Programme	Associate Director of Corporate Governance													Deferred to July's meeting to allow discussion with Executive Team prior to being presented to the Trust Board.