University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 6th October 2021 at 9.30 am to 12.00 pm via Microsoft Teams

AGENDA

Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
09:30	**PROCEDURAL ITEMS**					
20 mins	1.	Patient Story	Information	Mrs AM Riley	Verbal	
5 mins	2.	Chair's Welcome, Apologies and Confirmation of Quoracy	Information	Mr D Wakefield	Verbal	
	3.	Declarations of Interest	Information	Mr D Wakefield	Verbal	
	4.	Minutes of the Meeting held 4th August 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 – September 2021 • CQC Inspection Initial Feedback Letter	Information	Mrs T Bullock	Enclosure	**BAF 6**
10:15	**PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES**					
5 mins	7.	Quality Governance Committee Assurance Report (23-09-21)	Assurance	Ms S Belfield	Enclosure	**BAF 1**
5 mins	8.	IPC Board Assurance Framework - September 2021	Assurance	Mrs AM Riley	Enclosure	**BAF 1**
10:25	**ENSURE EFFICIENT USE OF RESOURCES**					
5 mins	9.	Performance & Finance Committee Assurance Report (21-09-21)	Assurance	Dr L Griffin	Enclosure	**BAF 9**
10:30	**ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT AND RESEARCH**					
5 mins	10.	Transformation and People Committee Assurance Report (22-09-21)	Assurance	Prof G Crowe	Enclosure	**BAF 2 & 3**
10:35 – 10:50: COMFORT BREAK						
10:50	**ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS**					
40 mins	11.	Integrated Performance Report – Month 5	Assurance	Mrs AM Riley Mr P Bytheway Mrs R Vaughan Mr M Oldham	Enclosure	
11:30	**GOVERNANCE**					
15 mins	12.	Workforce Race Equality Standard (WRES) Report - 2021	Assurance	Mrs R Vaughan	Enclosure	
11:45	**CLOSING MATTERS**					
10 mins	13.	Review of Meeting Effectiveness and Business Cycle Forward Look	Information	Mr D Wakefield	Enclosure	
	14.	Questions from the Public **Please submit questions in relation to the agenda, by 9.00 am 1st October to nicola.hassall@uhnm.nhs.uk**	Discussion	Mr D Wakefield	Verbal	
11:55	**DATE AND TIME OF NEXT MEETING**					
	15.	**Wednesday 3rd November 2021, 9.30 am via Microsoft Teams**				

University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 4th August 2021, 9.30 am to 12.35 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)						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												
Dr L Griffin	LG	Non-Executive Director												
Mr M Oldham	MO	Chief Financial Officer	JT											
Dr J Oxtoby	JO	Medical Director		AW										
Prof K Maddock	KM	Non-Executive Director												
Mrs AM Riley	AR	Chief Nurse	SP	MR	SP	SP								
Mrs R Vaughan	RV	Director of Human Resources					JH							

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

In Attendance:		
Ms G Von Bargen	GVB	NHS Management Scheme (observing)
Ms D Brayford	DB	Quality and Risk Manager (item 11)
Mrs N Hassall	NH	Deputy Associate Director of Corporate Governance (minutes)
Dr S Rajkumar	SR	Consultant Gastroenterologist (item 1)
Mrs S Roberts	SRo	Endoscopy Unit Manager (item 1)

Members of Staff and Public via MS Teams: 3

No.	Agenda Item	Action
1.	**Staff Story**	
116/2021	Dr Rajkumar highlighted a new procedure introduced at the County Hospital endoscopy unit; G-POEM. It was noted that the procedure was used for patients with a rare condition of gastroparesis and delayed gastric emptying, for which there were limited treatment options. The minimally invasive procedure provided a success rate of between 65% and 80%, with patients usually discharged the next day. Dr Rajkumar described the outcomes for a patient who had recently received the	

PROUD TO CARE

	treatment, following which they were able to tolerate liquid food and was slowly introducing solid foods. He stated that the Trust was the fourth centre in the Country to provide the technique, the first in the Midlands, and also the first site to undertake multisite remote proctoring in the UK, enabling the utilisation of national experts. Mrs Roberts described the philosophy of the Endoscopy unit and how the nursing team had been equipped and trained to help deliver the service. Dr Rajkumar noted that the service had been initially funded for 5 patients in the first year and it was hoped to expand the service going forwards. Professor Crowe welcomed the innovation and collaborative working to take forward the new procedure and welcomed the ability to showcase the procedure at County Hospital too. Ms Bowen welcomed the story and referred to remote proctoring and queried what the particular benefits from this were and any learning. Dr Rajkumar stated that it helped as part of the training, by utilising the experience of others when providing support for new cases. He stated that remote proctoring was also being considered between Royal Stoke and County as well as outside of the Trust. Dr Griffin queried the size of additional cohorts of patients and it was noted that the treatment could be used for patients with significant symptoms as well as those in nutritional failure, and it was noted that a site in London undertook 20 per year but they did not advertise the service more widely than their local area. Mr Akid referred to the reference to using Charitable Funds for endoflip and the tool for proctoring and it was noted that these devices would help with the procedures. Mr Akid queried the overall improvement to quality of life and Dr Rajkumar stated that it depended on the patient, but in the main the treatment would lessen symptoms and overall patients would require less time off work. Professor Crowe thanked Dr Rajkumar and Mrs Roberts for the presentation and thanked the team involved in bringing the service forward. **The Trust Board noted the presentation.** Dr Rajkumar and Mrs Roberts left the meeting.	
2.	**Chair's Welcome, Apologies & Confirmation of Quoracy**	
117/2021	Professor Crowe 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**	
118/2021	The standing declarations were noted.	
4.	**Minutes of the Previous Meeting held 7th July 2021**	
119/2021	The minutes of the meeting from 7th July 2021 were approved as an accurate record.	

5.	**Matters Arising from the Post Meeting Action Log**	
120/2021	There were no further updates to the post meeting action log.	
6.	**Chief Executive's Report – July 2021**	
121/2021	Mrs Bullock highlighted a number of areas from her report. Ms Gohir referred to Project SEARCH and queried if the success of the project was being widely publicised. It was noted that the project was promoted and the Board members welcomed and congratulated the Trust on its ongoing work in this respect. Mrs Bullock provided a short presentation on Covid and the importance of vaccination, reviewing data from the previous 3 weeks which demonstrated that those who had not received the vaccine were more likely to be admitted into hospital, and have an extended stay in critical care in addition to an increased mortality risk. She added that the patients also were younger than the previous waves, with no existing comorbidities and it was highlighted that there was a high rate of unvaccinated pregnant women in critical care. Mrs Thomson explained the ways in which communications were being issued to the public, mirroring the national messages as well as creating local messages, particularly focussing on pregnant women. In addition, the Trust was utilising local radio to support the campaign as well as staff films aimed at younger people and highlighting the importance of the vaccine. Professor Hassell queried if any information and data was being provided to pregnant women in antenatal clinics and Mrs Thomson referred to the ongoing work with the maternity teams, to enable staff to discuss this with patients and provide them with the information required. Ms Gohir queried if the communications messages would reach diverse communities and Mrs Thomson highlighted that work was being undertaken with the system in order to expand from utilising the traditional healthcare networks, in order to reach different groups and communities, utilising local Councils as well as contacts in education, getting messages out to parents/guardians. Ms Bowen queried if the Covid trends reflected the national picture and Mrs Bullock stated that the trends did match the national position, in that local rates were reducing in the community as well as the numbers starting to reduce in hospital. Dr Oxtoby emphasised the importance of pregnant women getting the vaccine, given the way in which the delta variant affected pregnant women differently than the other strains and waves. Professor Crowe emphasised the points made by Mrs Bullock in terms of working together with other parties, acknowledging support from system partners as well as the way in which the previous suspect package had been dealt with. **The Trust Board received and noted the report and approved EREAF 7778.**	

STRATEGY		
7.	**UHNM Strategy – Plan on a Page**	
122/2021	Miss Rylands discussed the plan on a page which was to be used as a tool to communicate the refreshed priorities with staff. She stated that these had been developed as part of the Improving Together Programme on the strategic priorities, and it was felt the opportune time to provide an update on the plan on a page. It was noted that other pieces of work supporting the strategy continued to be worked upon, such as the strategy development framework. Dr Griffin referred to strategic priorities and queried the wording in that it could affect interpretation. Mrs Bullock stated that the strategic priorities related to the Improving Together Programme and the terminology had been determined so that these were memorable for staff. Ms Bowen referred to the objectives for improving and innovation and queried whether digital should be referred to. Miss Rylands stated that the digital strategy was one of a number of enabling strategies and therefore featured across the board. Professor Crowe summarised that the Board supported the principles outlined within the summary, whilst recognising that some of the messages in terms of priorities may need finessing when being publicised with staff. **The Trust Board approved the refreshed Plan on a Page which would be communicated with all staff.**	
PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES		
8.	**Quality Governance Committee Assurance Report (22-07-21)**	
123/2021	Ms Belfield highlighted the following from the report: • The Committee held a robust discussion regarding infection prevention and assurance was provided in terms of the ongoing actions being taken in this area • The Committee noted that a number of norovirus cases had been identified, which was unusual for the time of year • The Trust had started to plan for the autumn vaccinations for both flu and covid booster vaccinations • The Committee kept a watching brief on falls, pressure ulcers and harm free care **The Trust Board received and noted the assurance report.**	
9.	**Bi-Annual Nurse Staffing Assurance Report**	
124/2021	Mrs Riley highlighted the following: • The review had been completed earlier in the year in line with national guidance, using a triangulated approach • The 1:8 ratio was a guide which was not a recommended level, but rather set an alert level however the majority of areas were better than that ratio • There were challenges with skill mix in Medicine and a deep dive was being undertaken to obtain assurance that all areas were staffed as they should be	

	• The review identified 3 areas which would require business cases; Ward 222, neonates and AMU • Maternity staffing featured within a different review which was to be re-evaluated • More work was required in relation to e-rostering and key performance indicators were being identified so that any variation could be measured, and these would be monitored and reported to the Quality Governance Committee and Transformation and People Committee • The next review would include any areas excluded from the review, and going forwards would also include the Allied Health Professional (AHP) workforce Professor Hassell requested clarification on compliance with the safe care acuity scoring, and whether the scores meant that areas were completing the scoring or whether they were meeting the requirements. Mrs Riley explained that the figures related to the way in which process was embedded and staffing figures were recorded. Professor Hassell referred to the challenges associated with Medicine and the actions being taken. Mrs Riley stated that the review clarified that investment was required in a number of areas and that the workforce needed to match capacity and the increase in growth. In addition, further work was required on assessing the changes in skill mix. Dr Griffin welcomed the future reviews for the Emergency Department and the inclusion of AHPs, and queried the timescales for addressing some of the issues raised as well as whether all Trusts would expect to fully achieve the guidance. Mrs Riley stated that Trusts adopt different methodologies to manage their workforce, and stated that the key was to obtain assurance that the right skills and care were in the right places, which is what the deep dives would seek to identify. Professor Crowe acknowledged that the review was undertaken in May at a particularly challenged time of year and welcomed the way in which the review would be refined going forwards. **The Trust Board received and noted the report.**	
10.	**Infection Prevention and Control Board Assurance Framework (BAF)**	
125/2021	Mrs Riley highlighted the following: • The national template had been updated in June, therefore the document had been updated to reflect the additions • Assurance remained unavailable for the requirement of ensuring 2 negative tests before moving patients, as assurance was not available for every patient. • The business case in relation to Portacount continued to be worked up, and the actions being taken in respect of this would continue to be highlighted • There had been 1 change in risk score in relation to BAF 6 whereby the risk score had decreased Professor Crowe referred to the requirement of 2 negative tests and queried what other actions could be taken. Mrs Riley explained that other organisations found this element a challenge in providing 100% compliance, due to balancing the risk of managing flow through areas and getting patients to where they need to be.	

	Ms Bowen referred to the 'pinging' of staff for isolation and whether the impact and associated risk of front line staff undertaking daily tests instead of isolating, was reflected in the document. Mrs Riley explained that the Trust had adopted the national guidance and each case was risk assessed on an individual basis. **The Trust Board received and noted the report.**	
11.	**Maternity Serious Incident Report – Q1**	
126/2021	Ms Brayford presented the report and highlighted the following: • During Quarter 1 there had been one incident reported • There were no immediate concerns or escalations following the incident and the baby's condition had since improved • 10 serious incidents remained ongoing • An update had been included within the report which provided details of the number of closed cases, actions taken and learning shared Professor Hassell welcomed the inclusion of learning and actions on closed incidents and queried whether this could be strengthened by highlighting the regular audits which were undertaken, to provide additional assurance. Ms Bowen suggested that it would be helpful to include the date of the incident and the time taken to review and undertake the investigation, in order to demonstrate how long it took for learning to be identified and shared. Dr Griffin queried whether the report could include overall outcomes if this would not breach confidentiality and Mrs Riley agreed that high level information could be included. **The Trust Board received and noted the report.** Ms Brayford left the meeting.	
ENSURE EFFICIENT USE OF RESOURCES		
12.	**Performance & Finance Committee Assurance Report (20-07-21)**	
127/2021	Mr Akid highlighted the following from the report: • The Committee received an update on paediatric surge planning and noted the associated risks with capacity within paediatrics • Urgent care performance continued to be challenged with a number of actions continuing to be taken • The overall patient tracking list had reduced • The Committee received a number of positive assurances in terms of planned care, data security and protection, business case reviews and review of previous investments Ms Bowen referred to paediatric surge planning and queried the age range of patients. Mr Bytheway stated that the surges usually were experienced in the autumn, but due to there being no recent surge in respiratory viruses, it was expected for there to be a surge from the end of July through to the end of March, which was unusual and affected younger children. **The Trust Board received and noted the assurance report.**	

ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT AND RESEARCH		
13.	**Transformation and People Committee Assurance Report (26-07-21)**	
128/2021	Dr Griffin highlighted the following: • There had been a robust discussion held on nursing establishment whereby the Committee requested a further deep dive to be undertaken • The Committee noted the slight risk of staff being surveyed too much as the Trust sought to capture information on their morale and wellbeing • The apprenticeship levy had not been fully utilised due to the impact of Covid and it was hoped that this would improve going forwards • A number of positive assurances were noted in relation to statutory and mandatory training compliance, progress in Improving Together and the reverse mentoring programmes **The Trust Board received and noted the assurance report.**	
ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS		
14.	**Integrated Performance Report – Month 3**	
129/2021	Mrs Riley highlighted the following in relation to quality and safety: • Deep dives were being undertaken into sepsis, falls and medication incidents which were due to be completed in September 2021 • The C-difficile target was to be refreshed, given this was 2 years old. It was noted that the majority of cases were unrelated and c-difficile was not being transmitted between patients for the vast majority of cases, although this would continue to be monitored Professor Maddock referred to sepsis screening compliance which was above target and the overall sepsis screening which was on an upward trajectory. She queried what support was being provided to staff in maternity given the challenges and Mrs Riley explained that staff were being provided with support from other teams and champions. Ms Bowen referred to the c-difficile cases and queried whether future reports could determine whether the cases were isolated or linked and Mrs Riley agreed to include this information going forwards. Mr Bytheway highlighted the following in terms of urgent care performance: • Activity had increased to above 19/20 levels, spread across a wider Emergency Department due to infection prevention measures • Performance at the end of June had deteriorated, impacted by Covid and staff absence • Good system wide working was noted in terms of the actions being taken to ensure patients were not being moved around the system and ensuring the wait to be seen time was maintained • Two pieces of system working had been agreed; the fill rate for Vocare was full and this was being utilised to support ambulatory patients, with a dedicated GP working with the Trust, helping to reduce non-admitted breaches • There continued to be work with the CRIS team in terms of hospital avoidance and at the end of July they commenced working with ambulance service, referring category 3/4 patients to CRIS rather than to A&E, to prevent waits across the department	**AMR**

- There had been a deterioration in the number of 60 minute holds of ambulances, and ambulance 15 minute assessment performance was 70% with the main concern being the overall initial assessment which had reduced to 50%
- Triage at the front door had become more challenged, but the safety of patients was being maintained by ensuring more poorly patients were being seen first rather than in sequential order
- The significant risk of norovirus, flu, covid had been recognised and patients continued to be managed separately via zoning

Professor Crowe referred to the national strategy of using NHS 111 and queried whether this was having a positive impact. Mr Bytheway stated that locally, people were using the service but sometimes the service was overwhelmed and sometimes patients chose to go against the advice provided.

Dr Griffin referred to the increase in ambulatory growth and queried whether there was any further update on system actions regarding this specifically, particularly the issue regarding children and young people presenting as emergencies. Mr Bytheway referred to the increased staffing put in place at the walk in centre, the additional GP medical support and Vocare, as well as work between CRIS and the Ambulance Service, which was hoped would make an impact. Mr Bytheway stated that paediatrics had been particularly affected and the Paediatric Intensive Care Unit (PICU) was presently full, due to increases in attendances and acuity.

It was noted that the Performance and Finance Committee would receive a business case regarding increasing the workforce in the Emergency Department, at the meeting in August.

Professor Hassell referred to the references to the size of the Emergency Department estate and the associated challenges and queried any potential changes. Mr Bytheway stated that the size of the footprint was too big and therefore it was being established whether this could be reduced in order to make more efficiencies.

Mr Bytheway continued to summarise cancer performance:

- By the end of June the Trust reached over 80% for breast 2 week waits, and performance for breast symptomatic (non-cancer pathway) was over 50% in May and was reaching towards 75% for June
- The main challenges with breast cancer performance was the significant increase in referrals, and associated difficulties with demand and capacity due to the variation
- Every breast cancer patient was managed on the 2 week wait pathway and younger patients (30 – 35 year olds) were also triaged. The Trust was compliant with relevant NG guidance and all patients were managed on the 2 week wait pathway
- Overall, cancer performance for 2 week waits had improved from the April/May position
- The patient tracking list in June had decreased and the Trust was continuing with the validation of the waiting list in order to oversee long waiters
- The main challenges with 62 day performance were access to theatres and pathology and 104 day performance was expected to improve due to improvements in endoscopy

Dr Griffin referred to non-obstetric ultrasound waits and whether this was affecting cancer services. Mr Bytheway stated that this was having an effect but not materially and therefore further work was required to establish main

challenges.

Professor Hassell queried if the challenges with ultrasound was staffing or equipment and Mr Bytheway stated that this was due to staffing, in that demand had increased by approximately 4000 pre-Covid.

Mr Bytheway added that outpatients remained in a good position and the outpatients team had been asked to consider how it was reaching diverse groups to ensure that patients were not being disadvantaged by using technology.

Professor Crowe queried when the revised trajectory would be provided and Mr Bytheway stated that he aimed for this to be provided to the Performance and Finance Committee in August.

Mr Bytheway referred to 104 day cancer performance and stated that a Root Cause Analysis (RCA) was undertaken for each patient. In addition patient tracking lists were regularly reviewed by Consultants to ensure no deterioration in condition and if any deterioration was identified, this would be escalated.

Mr Bytheway referred to diagnostics performance and the main challenges with endoscopy and ultrasound. He stated that endoscopy performance on track to recover by September and the improvements for ultrasound would be outlined at the next Performance and Finance Committee

Mrs Vaughan highlighted the following in relation to workforce performance:

- Staff absence had continued to be challenged, similar to the national picture due to Covid
- Covid related absence had decreased but future spikes were expected
- Covid risk assessments continued to be reviewed and updated for staff
- Appraisal rates had dipped due to the time of the year and annual leave etc
- Statutory and mandatory training had improved
- There had been no change in vacancy levels

Ms Gohir referred to the incoming staff from overseas and queried how these were being supported in terms of engagement, as well as supporting their wellbeing. Mrs Vaughan stated that extensive pastoral support was put in place with very positive feedback received from staff. Mrs Bullock added that she had met with recent cohorts of staff and they were also being shown the local area as well as Trust and confirmed their pastoral requirements were given as much attention as their clinical induction requirements.

Ms Bowen referred to the difference in Covid restrictions in hospitals versus the reduced restrictions nationally and queried if there were any trends in relation to people not adhering to restrictions. Mrs Vaughan stated that some issues were being identified and a number of complaints/concerns had been reported in relation to this.

Mr Oldham highlighted the following in relation to financial performance:

- The Trust had a surplus of £8.3 m against a plan of £8.2 m, which potentially would increase due to the Elective Recovery Fund (ERF)
- In month performance looked worse than planned, but included some prior period adjustments
- The ERF threshold had increased to 95%, therefore income generated from that was expected to reduce and non-pay was expected to increase due to activity
- For the second half of the year, the Trust would continue with a block

	arrangement with some adjustments; the wage award settlement and expectation that costs for Covid would reduce. In addition CIP programmes would start to established to improve the run rate going forwards • Capital was £1.2 m behind plan but no concerns were raised • The cash position remained positive **The Trust Board received and noted the performance report.**	
GOVERNANCE		
15.	**Audit Committee Assurance Report (28-07-21)**	
130/2021	Professor Crowe highlighted the following: • Positive assurance was received on a number of internal audit reports including an audit into how the Trust responded to Ockenden and external investigations/reporting framework • No weaknesses had been identified in the value for money opinion • 100% of declaration of interests forms had been provided for 20/21 • The main areas of concern related to the external auditors annual report recommendations regarding medium term financial planning as well as the ability to deliver future cost improvements **The Trust Board received and noted the assurance report.**	
16.	**Speaking Up Report – Q1**	
131/2021	Mrs Vaughan highlighted the following: • 43 contacts had been made with attitudes and behaviours being the most reported theme • Some contacts had been made from members of staff in the same area, voicing similar concerns • New national guidance had been received regarding the role of champions and ambassadors and the Trust was in the process of reviewing the implications and changes required as a result of the guidance • Further work was being undertaken to understand the issues/barriers to speaking up for disabled staff • Additional training was being provided to guardians • Actions were being taken to improve the way in which outcomes of investigations were being shared with staff Professor Hassell queried if the UHNM index was similar to national performance, or whether there were particular areas to focus on. Mrs Vaughan agreed to request detailed analysis on this and provide to Professor Hassell. **The Trust Board received and noted the speaking up data and themes raised during Quarter 1 2021-22 and the actions proposed to further encourage and promote a culture of speaking up at UHNM.**	**RV**
17.	**Board Assurance Framework (BAF) – Q1**	
132/2021	Miss Rylands highlighted the following: • The BAF had been revised, taking into account some of the recommendations from internal auditors including identifying whether risks were internally or externally driven	

	• The BAF had been discussed at respective Committees, and a number of changes had been made as a result, as well as a number of other changes which would be made for the Q2 version • Appropriateness of scoring was one of the main challenges from Committees and this would be revisited with the Executive Team to ensure the scoring of the risks reflected reality • A refreshed assurance map was being worked up and would be considered by the Trust Board in due course Professor Maddock referred to BAF 5 horizontal working and noted that most of the due dates stated 'post Covid'. She queried whether the Trust would ever get to that point and whether an actual date should be provided. Miss Rylands agreed to put actual deadlines in for Q2 version as this referred to post covid surge. Ms Bowen suggested that some of the actions identified seemed to be too long term and requested this be considered for future versions. **The Trust Board scrutinised, received and approved the BAF for Quarter 1.**	**CR**
CLOSING MATTERS		
18.	**Review of Meeting Effectiveness and Business Cycle Forward Look**	
133/2021	Mr Oldham agreed to update the business cycle to reflect the incoming planning guidance and refreshed timescales.	**MO/CR**
19.	**Questions from the Public**	
134/2021	Mr Syme raised the following question: Referring to the Integrated Performance Report for breast 2 week waits, the Trust had identified significant increases in demand impacting on diagnostic performance. He queried whether the Trust had identified the specific 'total capacity required' and whether the requirement would address 'real service demand' to ensure compliance with the Breast 2ww Constitutional Standard? Mr Bytheway referred to the information provided as part of the Integrated Performance Report and reiterated that demand and capacity was fluctuating therefore a plan was being put together to maintain demand via additional staffing resource and investment. Mr Syme referred to diagnostics for the increased referrals of breast 2 week wait patients, and those under 35, whereby UHNM Board papers in June 2021 and July 2021 repeatedly categorised those under 35 as "low risk' even though NICE NG12 'referral guidance' stipulates referrals for those 30 years or older must be placed on the Breast 2 week wait pathway. Mr Syme requested categorical assurance that as such referrals were placed on the Breast 2 week wait pathway. Mr Bytheway confirmed that the Trust was compliant with NG12 guidance and patients were placed on the relevant pathway.	
DATE AND TIME OF NEXT MEETING		
20.	Wednesday 6th October 2021, 9.30 am, via MS Teams	

Trust Board (Open)

Post meeting action log as at 29 September 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		As continuity of care had to be suspended temporarily; a short briefing paper is being prepared.	GB
PTB/481	07/07/2021	Patient Story	Regarding the issues with communication on the day of surgery, to establish how this can be improved.	John Oxtoby	08/09/2021	27/09/2021	Meeting held with the Deputy ACN (Surgery) in order to improve communication.	B
PTB/484	04/08/2021	Integrated Performance Report - M	For future reports to highlight whether c-difficile cases were isolated or linked	Ann Marie Riley	06/10/2021		**Update to be provided**	GB
PTB/485	04/08/2021	Speaking Up Report – Q1	To request detailed analysis on the UHNM speaking up index and provide to Professor Hassell.	Ro Vaughan	06/10/2021		**Update to be provided**	GB
PTB/486	04/08/2021	Board Assurance Framework (BAF	To include actual deadlines and due dates for actions, in the Q2 version.	Claire Rylands	03/11/2021		Q2 BAF being prepared and to be incorporated.	GA
PTB/487	04/08/2021	Review of Meeting Effectiveness ar	To update the business cycle to reflect the incoming planning guidance and refreshed timescales.	Mark Oldham Claire Rylands	08/09/2021	15/09/2021	Complete - business cycles updated.	B

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 29th September 2021. The meeting was held virtually using Microsoft Teams; there was no agenda as the general purpose of the meeting was to provide an opportunity to discuss current issues, key priorities and to hear from Divisions in terms of areas of focus / challenges:

- A review of the role and function of the Trust Executive Committee is underway
- Significant pressures remain across the organisation in terms of flow although some improvement seen in Covid-19 numbers, however an outbreak has occurred on ward 124
- Working on a programme to optimise independent sector capacity to support our elective activity; capital money is available to reduce backlogs – national message is clear continuing with elective activity as per our trajectories
- No financial guidance issued as yet around the funding arrangements for H2
- Decant plan for Trent has now been developed to develop the space into a ward – now progressing
- Barry Deacon, Deputy Director of Estates and Facilities retires on 15th October & will be replaced by Dave Ruscoe
- Some care flow performance issues with our IM&T system although they have now been resolved
- Electronic Prescribing and Medicines Administration System demonstration made available; next step is to undertake gap analysis between the solution and our requirements and then confirm the ability to integrate with Medway
- Digital Nurse Fellowship being developed which will provided training on the digital agenda; plan being developed to look at the feasibility of introducing a Digital Nurse into each of the Divisions
- Working across the system on a strategic approach to winter communications around 111 / admission avoidance
- Three Surveys launching in October; Brap Culture Survey, National Staff Survey and the Internal Staff Voice
- The Critical Condition film crew have enough material for two series next year
- Workforce Bureau has been reinstated and the wellbeing offer has been refreshed for the winter

Medical Division:

- NHS 111 Kiosks go live in ED on 29th September and the full medical workforce business case has now been approved on a phased basis; UHNM is one of the first ED's to introduce the Kiosks at County Hospital
- Positive impact on the rate of falls within AMU as a result of their Improving Together programme
- Associate Director for Medicine and Deputy AD for Emergency and Urgent Care join in October
- Delayed transfers of care into the community are a particular challenge

Surgical Division:

- Completed the two week 'circuit breaker' and are now in phase 2 of the plan; capacity now being reopened
- Two key areas of underlying risk; staff isolating with positive family members and bed flow / capacity – new national guidance expected to improve elective flow
- Seeing increased staff absence now that the schools have reopened, short notice staff moves are creating anxiety for staff

Children's, Women and Diagnostics:

- Significant pressures within maternity which is the same as the region and nationally
- Chemotherapy capacity is challenged at the moment due to sickness and an increase in cancer referrals – looking at a proposal to deliver a day unit
- Suzanne Crossley leaves the organisation & Sarah Jamieson has been appointed as the Director of Midwifery and will begin in January
- Participated in the Improving Together programme

Specialised Division:

- Inpatient backlog of surgical cases; backlog of P2 elective cases and are due to introduce a validation and prioritisation process in order to minimise clinical risk
- Issues with level 1 bed capacity across the trauma pathway
- Ambulatory neurology services has moved to County with an acute satellite service at Stoke and the Heart Failure Service has returned to Stoke

Part 2: Chief Executive's Highlight Report

1. Contract Awards and Approvals

Department of Health Procurement Transparency Guidance states that contract awards over £25,000 should be published in order that they are accessible to the public. Since 12th August to 13th September, 7 contract awards, which met this criteria, were made, as follows:

- **BD Blood Tubes and Collection devices Managed Service CCN (REAF 8060)** supplied by Roche at a total cost of £2,019,202.75, with savings of £150,792.28, for the period 01/10/21 - 30/09/24, approved on 25/08/21
- **Linear Accelerator 4 replacement (REAF 8046)** supplied by various at a total cost of £2,055,540.60, with savings of £523,274.29, approved on 25/08/21
- **Medical Locum Temporary Staffing Contract (REAF 8025)** supplied by various at a total cost of £11,838,435.00, with savings of £118,386.00, for the period 01/10/21 - 30/09/22, approved on 25/08/21
- **Novation of CPS Beckman Coulter MES to UHNM (REAF 7936)** supplied by Beckman Coulter at a total cost of £2,670,000.00, for the period Up to - 22/11/22, approved on 25/08/21
- **Pharmacy Dispensing Service for Ambulatory Patients (REAF 7934)** supplied by Lloyds Pharmacy at a total cost of £13,500,000.00, for the period 01/10/21 - 31/03/22, approved on 02/08/21
- **Pharmacy Dispensing Service (REAF 7930)** supplied by Lloyds Pharmacy at a total cost of £769,999.00, for the period 01/10/21 - 31/03/22, approved on 06/08/21
- **Home Delivered Peritoneal Dialysis (REAF 7910)** supplied by various at a total cost of £1,920,000.00, for the period 01/10/21 - 30/09/22, approved on 13/08/21

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

Trauma, CMF and Orthopaedic External and Internal Fixation Consumables (eREAF 8122)

Contract Value £6,353,916.14 incl. VAT
Duration 01/09/21 - 31/08/25
Supplier SCCL

The approval request is for the provision of Trauma products as used across UHNM, to include; Trauma, CMF (Crainiomaxillofacilal), Orthopaedic Internal and External Fixation and associated consumables. Spend is currently direct with various suppliers, however, there is a saving from migrating all products from the current TOS1 (Total Orthopaedic Solutions) Framework to the TOS2 (Total Orthopaedic Solutions) Framework. By re-categorisation of all of our current Trauma Products, several contracts have now been amalgamated, which places UHNM into a higher pricing band and therefore achieves a higher saving.

Total Contract Savings to include Negated Inflation - £230,221.50 incl. VAT

Services of Junior Doctors via Health Education England (eREAF 8017)

Contract Value £2,263,333.34 incl. VAT
Duration 01/09/21 - 31/03/22
Supplier Health Education England

This approval request has been raised to request approval for services of Junior Doctors via Health Education England (HEE). As of 3rd August 2016, St Helens and Knowsley Teaching Hospitals NHS Trust became the Lead Employer for all Health Education England (HEE) West Midlands GP Speciality Trainees. In August 2017 they also became the Lead Employer for Public Health, Sports Medicine & Histopathology Speciality trainees in the West Midlands. There are approximately 66 Junior Doctors on the rota and payments of these salaries are paid on invoice which is then charged to the Education Directors budget and then recharged out to UHNM clinical divisions based on each Doctors placement. An eREAF has been raised as once approved a Purchase Order can be raised on the ABS Finance System, against which, the monthly invoices from St Helens can be paid via PO as opposed to Non PO.

No savings (Pass through costs)

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 September 2021:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
College Tutor - ED	Vacancy	Yes	TBC
Clinical Lead - MSK Radiology	Vacancy	Yes	01/10/2021
Consultant Haematologist	Vacancy	Yes	TBC
Consultant Haematologist	Vacancy	Yes	TBC
Consultant Neurologist	New	Yes	04/01/2022
Consultant Orthopaedic Surgeon specialising in Fragility Fractures	Vacancy	Yes	TBC
Surgical Tutor	Vacancy	Yes	16/09/2021

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

Post Title	Reason for advertising	Start Date
Locum Plastic Surgeon	Extension	01/09/2021
General Paediatric Consultant	Vacancy	01/09/2021
Acting Up Consultant in Obstetrics & Gynaecology	Extension	03/09/2021
Consultant Paediatrician - Interest in Neurology and Epilepsy	Retire & Return	06/09/2021
Divisional Chair Surgery	Vacancy	06/09/2021
Locum Consultant General Surgeon - Upper GI (HPB)	Vacancy	06/09/2021
Consultant Vascular Surgeon	Retire & Return	13/09/2021
Consultant in Community Paediatrics	Vacancy	13/09/2021
Surgical Tutor	Vacancy	16/09/2021
Locum Consultant Orthopaedic Surgeon	Extension	29/09/2021

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

Post Title	Closing Date	Note
Locum Consultant Paediatrician with an interest in Gastroenterology	12/09/2021	No applications
Consultant Geriatrician	14/09/2021	No suitable applications
Locum Consultant General Paediatrician	22/09/2021	No applications
Consultant in Acute Medicine	26/09/2021	No applicants
Locum Consultant - Winter Pressures	26/09/2021	No applicants
Consultant Microbiologist	26/09/2021	No applicants
Consultant Histopathologist	26/09/2021	No applicants
Locum Glaucoma Consultant Ophthalmology	26/09/2021	No applicants

3. Covid 19 and Trust Pressures

September has been an extremely challenging month for us. We have seen a significant amount of people come into hospital through the front door in our Emergency Department have found it very difficult to discharge our patients who are ready to leave due to equal pressures in our system partner organisations. As a result of this we have been on a system 'Level 4' escalation and colleagues in our partner NHS and local authority organisations have been working with us to manage the volume of very sick patients in need of care and also to identify those patients who are ready to leave.

Thankfully towards the end of the month we saw these pressures easing a little and this is thanks to the heroic efforts of our staff who have worked tirelessly to de-escalation the position, along with our community partners. This means that we can now look to refocus again on our important planned care work. A two week pause took place from the 13th September to the 20th September to help decongest the pressures, elective activity resumed on the 27th September and capacity is increasing. We remain very busy and our maternity services in particular are under extreme pressure with a significant number of expectant mums due, some with multiple babies; and we are working with partners across the region to create additional capacity and to increase the numbers of staff.

4. Care Quality Commission Inspection

The Care Quality Commission (CQC) began its long-awaited planned, unannounced inspection of services at both Royal Stoke and County Hospital on Tuesday 24 August. During the two days, inspectors have visited services at both of our sites, namely the emergency department and medicine wards at Stoke and surgery and medicine at County Hospital.

The inspection is by no means concluded and in addition to our Well Led Review on 5 and 6th October there will be further additional unannounced inspections possibly after the Well Led inspection. However, we have received initial high level feedback from the CQC team and this is enclosed at **appendix 1**.

5. NHS Funding Announcements

The government has made a series of announcements on NHS funding for the remainder of 2021/22 and the next three financial years. Key headlines are as follows:

Funding for the second half of 2021/22 (H2)
The NHS will receive an extra £5.4bn over the next six months to support its ongoing response to the Covid-19 pandemic. This can be broken down into:

- £2.8bn for Covid-19 costs including infection control measures
- £600m for day to day costs
- £478m for enhanced hospital discharge
- £1.5bn for elective recovery, including £500m capital funding

There is still a lot of detail to work through and it is expected that NHSE/I will provide further information on the next steps and updated planning guidance in the coming days.

Comprehensive Spending Review (CSR) and the NHS revenue settlement
The government have also announced a new 'health and social care levy' funded by increasing National Insurance payments by 1.25% for both employers and employees. This will raise £12bn a year on average to be spent exclusively on health and social care. A significant proportion of these uplifts will go into the core NHS England revenue budget, with an additional £15.7bn allocated and spread across the next three years.

6. Project STAR

Project STAR is a major transformation programme about Strategic Transformation for the NHS and Regeneration for the city of Stoke. It is focussed around:

- providing a sustainable car parking solution for staff
- demolition of an eyesore and significant risks
- environmental improvements
- an opportunity for much needed housing
- significant job creation

During September, we were delighted to have received confirmation from the Regional NHSIE Finance Team in providing their formal support for the construction of the car park solution as part of Project STAR to proceed and confirmation that the our CRL will be adjusted to allow us to incur the additional capital spend.

We are now formalising the programme of construction including critical enabling elements such as design development, securing planning approvals and ensuring appropriate consultation with local residents.

7. Changes within the Executive Team

This month we say a fond farewell to our Medical Director, John Oxtoby as he retires. We are grateful to John for delaying his retirement to see us through the height of the pandemic. Over John's 30 plus years at UHNM he has seen many changes and developments and has made a significant contribution to our clinical services as well as the Executive Team and the Trust Board. We will miss his calm influence, his expert knowledge and most certainly his analytical mind.

Our new Medical Director, Matthew Lewis officially joins us on 1st October. Matthew has already begun his induction with us and has been out and about meeting staff and getting to know UHNM. He brings with him a wealth of experience in clinical leadership and I'm sure the Board will join me in giving him a very warm welcome.

8. Booster Vaccinations and Flu Vaccine

I am delighted that we were also in a position this month to announce that staff can now book their flu and Covid booster vaccinations via our self-booking system. This is important as we head into what we expect to be a very challenging winter. I am encouraging all staff to book their vaccinations so that we can do our very best to protect ourselves, our patients and our community.

9. Staff Awards

It is unfortunate, due to the position with Covid, that we will not be able to hold a live awards ceremony again this year. However, our planning team are putting in a huge effort to make sure that our virtual event will be even more exciting and enjoyable for all staff involved. To recognise our winners we will be using the funds which would have been spent on a venue to provide some very special wellbeing prizes and I'm looking forward to celebrating the amazing, talented people we have working at UHNM.

10. Workforce

Workforce pressures have been a significant risk for us although there has been some developments in our recruitment campaign. We were able to welcome further international nurses this month and I was pleased to welcome both the fourth cohort of international nurses as well as a group of nursing assistants. Their induction came at the same time we were notified that our first cohort of international nurses have successfully completed their training and induction and are now receiving their registration on the Nursing and Midwifery Council Register. It will be reassuring that they will be able to provide timely and much needed additional nursing skills on our wards to help alleviate some of the pressures we have due to staff absence and vacancies.

11. Black History Month

October is Black History Month and we have a calendar of events organised for our staff which are being publicised by our Communications Team to mark this, including:

- Launch through Facebook, banners, a dedicated page on our Intranet and communication through our Bulletins
- Ethnic Diversity Staff Network meeting
- Caribbean menu at Royal Stoke and County Hospital
- A series of events; 'Zero Tolerance for Racism', supporting a diverse workforce to deliver for patients; 'actions and interventions that better support and improve the lives of black colleagues'; 'leadership that makes a difference – positively transforming the culture of the NHS through leadership'
- Inspirational Black British leader profiles
- ICS system wide BAME staff network meeting
- Workforce Race Equality Standard (WRES) infographic on Facebook and Intranet

I look forward to reporting on the success of these events in my next report.

Care Quality Commission
Citygate
Gallowgate
Newcastle Upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

www.cqc.org.uk

By email

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

26 August 2021

CQC Reference Number: INS2-10959393161

Dear Mrs Bullock,

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

Following your feedback meeting with Karen Richardson, Rhian Williams, Andy Evans and Tyson Hepple on 25 August 2021, I thought it would be helpful to give you written feedback as highlighted at the inspection and given to you and your colleagues Paul Bytheway, Anne-Marie Riley, Scott Purser, Amy Freeman, Lorraine Whitehead and John Oxtonby at the feedback meeting.

This letter does not replace the draft report we will send to you, but simply confirms what we fed-back on 25 August 2021 and provides you with a basis to start considering what action is needed.

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

An overview of our feedback

General themes across The Royal Stoke and County Hospitals:

The preliminary findings that we fed back to you were:

Positive findings –

- Staff morale was good in most areas. Teams spoke positively about local leaders and demonstrated strong teamwork and MDT working.
- We saw that Infection prevention and control was good with visibly clean clinical and corridor areas. Staff were seen to be wearing appropriate PPE.
- From the case notes we reviewed, we saw that most patient risk assessments were in place, completed correctly and updated in line with local policy.
- Staff we spoke to were able to tell us about incident reporting and gave examples of where lessons had been learnt and shared.
- MCA and DoLS application were completed and staff were able to demonstrate knowledge and understanding of the process and application.
- We saw evidence of mental health support for patients in the emergency department and wider organisation.
- Staff told us they had confidence in local leadership and gave examples of where leaders had supported them.
- We observed a caring approach from all staff. Patients we spoke with also told us they were happy with the care they received.

Areas for improvement –

- We saw several patients as outliers on medical wards where clinical ownership was unclear.
- Staff told us of several examples of non clinical night moves and it was unclear if non clinical transfers were incident reported.
- We found medical and nursing notes are often untidy, difficult to read and documents were unable to be located when requested.
- Staff told us that medical staffing levels in some areas was creating safety concerns.
- We were told that delays in neuro psychiatric reviews were delayed by up to three weeks causing risk to some patients in the FEAU.

- Some staff we spoke to expressed concern that senior executive staff were not visible in the Emergency Department.

- Staff told us the new cubicle doors in ED were causing an increased risk of falls as patients cannot be heard or easily seen.

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

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

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

Telephone: 03000 616161

Write to: CQC
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

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

Yours sincerely

Sarah Dunnett

Sarah Dunnett
Head of Hospitals Inspection

c.c. Dale Byewater
CQC regional communications manager
David Wakefield Chair of Trust

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Public Trust Board	**Date:**	
Report Title:	Staffordshire and Stoke on Trent Quarterly System Review Meeting 15 September 2021	**Agenda Item:**	
Author:	Claire Rylands, Associate Director of Corporate Governance		
Executive Lead:	*Tracy Bullock, Chief Executive*		

Purpose of Report:

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

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

Executive Summary:

On 15th September, our Quarterly System Review Meeting (QSRM) was held with our regulators at NHSIE. We provided a pack of information ahead of the session based upon a jointly agreed agenda. Following the review, we have received the enclosed letter summarising the discussion and further actions agreed. To summarise their feedback:

- They were encouraged to note a number of areas where the system is recognised as a national exemplars.
- ICS development progressing well with progress noted in the governance / architecture; need to focus from leading a reactive response to current pressures to resetting a plan for the 6 months ahead – in particular around delivering elective work and wider programme commitments.
- The ICS needs to ensure that surge planning schemes are deployed effectively with all system partners playing their part in this.
- Current position with regard to Covid-19, progress with vaccination and the approach for boosters.
- Pressures in Primary Care with a 14% increase in demand compared to 2019.
- Urgent care operational pressures and planning for winter; a whole system operational response has been put into place although it is recognised that plans need to be reset for planning demand over the next 6 months.
- Utilisation of non-recurrent monies to provide one-off capacity for the period; to date the ICS has spent the lowest proportion of its Covid-19 financial envelope in the region and this needs to be taken full advantage of.
- Challenges of social care linked to domiciliary care provision
- The elective recovery and elective recovery fund with the system being urged to take all necessary action to maintain the elective programme during H2 and to ensure that capacity plans are not necessitated upon standing down elective work
- Cancer recovery and the need to work with regulators to ensure that the independent sector are maximising their activity and are treating patients consistent with previous arrangements
- Maintaining strict financial disciplines to deliver the savings agenda and to provide a realistic forecast around capital spend
- Recognition of the significant workforce risk and arrangements in place to oversee workforce initiatives to mitigate this risk
- Increasing acuity and demand for mental health services with national recognition for the Psychological Wellbeing Hub

Key Recommendations:

The Board is asked to note the contents of this letter and the actions agreed.

From the office of Fran Steele
Director of Strategic Transformation,
North Midlands

Prem Singh
ICS Independent Chair
Staffordshire and Stoke on Trent Shadow ICS

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Sent via e-mail

17th September 2021

Dear Prem,

Staffordshire and Stoke on Trent Quarterly System Review Meeting (QSRM) 15 September 2021

Thank you to you and system colleagues for attending the QSRM on 15 September, chaired by Dale Bywater, Regional Director. Thank you for providing a comprehensive pack and for working closely with the regional team to jointly agree the agenda.

Dale has asked that I begin this letter by expressing his personal gratitude to the system for the leadership and commitment demonstrated in its response to the recent period of sustained and complex operational pressures a gratitude he also expressed in the meeting. Please extend Dale's thanks to your wider colleagues.

1) Overview

The QSRM session has been timely in terms of ensuring there is alignment between the ICS and the Region in terms of understanding priorities and actions for the upcoming quarter.

It was encouraging to note a number of areas where the system is recognised as a national exemplar, including the System People Hub and adoption of national best practice for cancer pathways. In addition, the excellent leadership of the tactical response to the operational demands was noted, as was the commitment of all partners to working in partnership to address the challenges. We also discussed the strong delivery of the vaccination programme to date, and the support provided to specialist networks by the system. ICS development is deemed to be progressing well with progress noted in the governance/architecture of the system and in the detail of transition planning.

The key focus of the QSRM was on understanding how the ICS is planning to move from leading a reactive response to the current pressures, to a reset and plan for the 6 months ahead, and what support the Region can offer in achieving this. It is recognised that the challenges will continue to be substantial but it is essential the system is able to respond to the UEC/Covid demand as well as deliver elective work and wider programme commitments for its population.

The over-riding message from the Region is that the ICS needs to be bold and creative in its approach and ensure that surge planning schemes are deployed effectively to give true and tangible additionality to capacity across the system whilst continuing to deliver high quality and safe services. It is essential that the population of your ICS can continue to access the healthcare services they need and clearly all system partners have a vital role to play in this.

The remainder of this letter sets out the main points of discussion and draws out agreed actions.

2) Covid-19

The system reported a most recent 7 day case prevalence rate of 398.8 per 100,000 population which although higher than most others in the Region has been consistent for several weeks. The vaccination programme has progressed well with over 86% of cohorts 1-12 having received a first or second dose. Care home HCW vaccination uptake has also been a focus with 93% of first doses completed and 85% of second doses. 16-17 year-old uptake is currently at 53% for a first dose, with more activities planned to extend this further. A local approach to administering booster jabs has been agreed and we identified the potential for the system to become an early adopter for school-based vaccinations.

3) Primary Care

Primary care colleagues outlined the pressures facing their services with a 14% increase in demand compared to 2019. The system recognises the need to work to address public perception of primary care and has carried out access audits of each practice. Specific practices are being targeted as a result of the findings in order to ensure consistency of access across the footprint. General practice recognises the key role it will need to play in the next 6 months to provide additional capacity.

National discussions are underway around the support being provided to primary care, with the intention of a regional approach being jointly developed in response. The ICS reiterated it is keen to engage and learn in continuing to develop this support offer.

4) Urgent care operational pressures and planning for winter

A whole system operational response has been put in place to respond to daily pressures and agree tactical actions. The system agreed it now needs to reset and plan for managing the demands over the next 6 months recognising these will be multifactorial, including UEC, Covid-19, Flu, RSV and maintaining the elective programme whilst seeking to ensure the well being of your staff.

A surge plan is in development, bringing these strands together and ensuring the connectivity of plans in respect of capacity and workforce.

It was agreed that non-recurrent monies which have been allocated to the system should be utilised as required to provide additional one-off capacity for this period, these are largely sitting in the NHS providers. To date the ICS has spent the lowest proportion of its Covid-19 financial envelope in the Region with only 23% allocated as at month 4. The system also needs to take full advantage of all transformational and demand management opportunities including virtual wards and use of admission avoidance services.

We had a detailed discussion about the challenges of social care linked to domiciliary care provision, which have the potential to create further flow issues through reablement services. Given the workforce shortages in the sector, the system is looking at innovative solutions including potentially

funding families to care for relatives. In addition, there is work underway to grow the reablement in-house capacity and carry out reviews of patients earlier in the pathway.

The Region highlighted growing concerns with the level of ambulance handover delays at UHNM and asked the system to ensure that ambulance conveyance is considered as part of its surge plan. Opportunities were identified to further utilise the Community Rapid Intervention Service (CRIS) and the falls response service as an alternative to conveyance to ED.

UHNM outlined its internal work programme, building on the opportunities identified through external consultancy (M-Prove) and the recent NHSEI Missed Opportunities Audit in order to improve internal processes.

Action QSRM20210915-1 - The system will fully develop its surge capacity plan for the period September-March, ensuring that this:

a) **Encompasses the full spectrum of demand across UEC, Covid, Flu, RSV and maintains delivery of the elective programme;**
b) **Provides connectivity of plans in relation to capacity and workforce;**
c) **Is representative of the important role which all system health and care partners need to play;**
d) **Utilises non-recurrent funding allocated to the system (which is largely sat with providers) as required to develop creative and bold solutions to addressing capacity shortfalls;**
e) **Focusses on additionality and sets out tangible capacity benefits for the system of each scheme.**

5) Elective Recovery and the elective recovery fund (ERF)

Following a strong start in June and July where ERF thresholds were exceeded, elective activity has deteriorated from August onwards as a result of the growing Covid-19 and UEC pressures.

In response to the increasing critical care demand and the volume and acuity of non-elective patients UHNM has instigated a 2 week stand-down of all but time critical surgery.

Whilst the reasons for this action are understood, there has been noticeable growth in P2 clearance times to 8.5 weeks, 52 week waits have increased to 3,560 and there are 111 over 104 week waits. Without further mitigation 52 week waits will reach over 7,600 by the end of March, and 104 week waits will increase to at least 250.

UHNM confirmed that a further of transfer patients to the independent sector will take place shortly with 2,500 spinal and T&O patients being treated by Nuffield, and a further 1,700 transferring to Ramsey Health. In addition, County hospital will become focus on the elective programme whilst RSUH manages the majority of UEC demand.

Action QSRM20210915-2 – In-line with action QSRM20210915-1 the system was advised to take all necessary action to maintain the elective programme during H2, and to ensure that capacity plans for responding to winter pressures are not necessitated upon standing down elective work.

6) Cancer Recovery

Cancer backlogs have deteriorated in recent months linked to the urgent care pressures detailed above. UHNM has worked to maintain time critical surgery but there are now over 400 patients waiting beyond 62 days for their surgery compared to 200 in June. Key challenged tumour sites are colorectal and urology.

The system escalated the fact that Nuffield has changed their criteria and will not currently accept cancer patients. In recognition of the vital role that the IS plays in addressing backlogs the Region agreed to escalate this.

Action QSRM20210915-3 – NHSEI will work with the system to ensure that Nuffield are maximising their activity and are treating NHS patients consistently with previous arrangements.

7) Finance

The in-year position for the system is showing a £23m surplus at month 4, which has been locally forecast to deteriorate to a H1 outturn of £9.4m surplus. NHSEI noted concern about this deterioration and emphasised that the ICS currently has the lowest proportion of Covid-19 monies committed in the region. Monies are currently largely sat with NHS providers but should be utilised for the benefit of the whole health and care system during H2.

Action QSRM20210915-4 – The system confirmed that it will maintain strict financial disciplines in order to deliver the financial plan and savings agenda but it will seek to fund all necessary non-recurrent schemes linked to operational capacity to support H2 delivery.

The system has agreed an underlying financial outturn planned deficit for 2021/22 of £153m and an improvement trajectory to achieve a deficit of £19m by 2025/26. It was confirmed that the system leadership are working towards this aim with strong operational and clinical/professional ownership. 22 system transformation schemes have been initiated across five programme areas, each with an Executive SRO. These schemes are primarily aimed at managing growth in activity to deliver the system's 'flat-cash, flat activity' ambition.

Action QSRM20210915-5 – NHSEI is seeking a realistic forecast around capital spend in the system and will link with system colleagues to understand this.

8) Workforce

Workforce is recognised as the largest risk to delivery in H2. In addition to NHS challenges with workforce capacity and resilience across primary, acute and community care, pressures are being felt in the wider care market.

System level governance is in place to oversee workforce initiatives, and there is commitment amongst partners to work collectively to manage resources in accordance with the winter plan. Recruitment is progressing with an emphasis on ensuring that additional capacity is brought in rather than moving resource between providers.

9) Mental Health

Partners from NSC and MPFT reflected on the increasing acuity and demand for mental health services. The system welcomes the opportunities presented by the MHIS for community transformation and is grasping the opportunity to redesign pathways and engage with the voluntary sector in a different way. NHSEI noted the establishment of the Psychological Wellbeing Hub which has received national recognition.

10) ICS Development

Significant progress has been seen in the development of leadership and partnership working with 3 ICS Board development sessions held in recent months. Local Authority engagement is strong. All partners are inputting into shaping the system architecture and governance with the view to arriving at an early operating model and constitution in November 2021. Detailed progress with this work is picked up through routine NHSEI interactions with the system.

In conclusion I would like to thank you and your system colleagues for your full participation in what was a helpful and informative discussion and a further thanks for the ongoing focus and commitment being made.

Yours sincerely

Fran Steele
Director of Strategic Transformation, North Midlands
NHS England and NHS Improvement

CC.
Dale Bywater – Regional Director NHSEI
Prem Singh – ICS Independent Chair
Phil Smith - Assistant Director of Strategic Transformation

Quality Governance Committee Chair's Highlight Report to Board

23rd September 2021

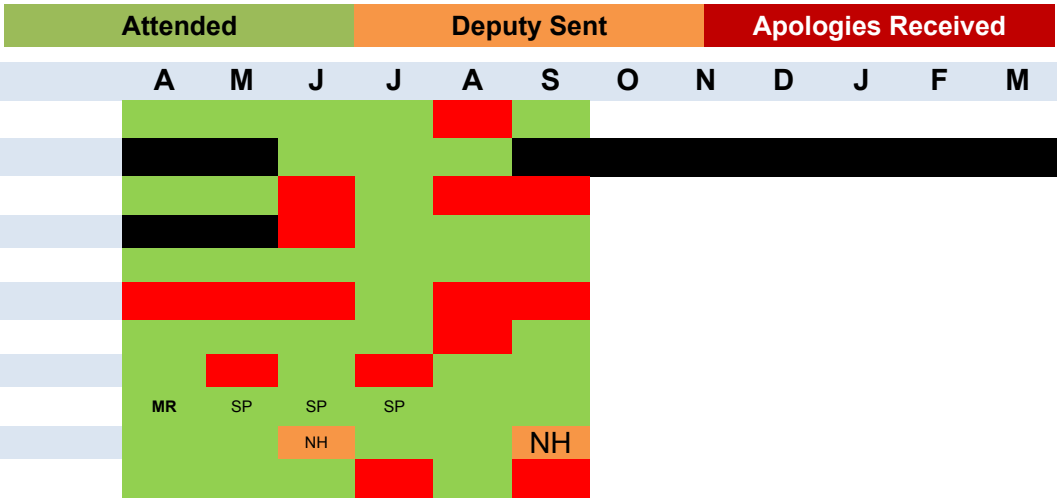
1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The Committee noted that a shorter Health and Safety meeting had been held, focussed on any areas of escalation and action and it was noted that each Division cited operational pressures and staffing issues as key risks, affecting the ability to complete some health and safety related assessments, although support was being provided by the Health and Safety Team. A risk in relation to storage of safety equipment within Pathology was noted, with actions being taken to reduce this going forwards and despite the low completion of Departmental security risk assessments, assurance was provided that any hot spot areas were provided with greater security presence. • The Committee noted that a shorter Quality Safety Oversight Group had been held, due to ongoing pressures, which focussed on key escalations. It was noted that the main issue highlighted was the ongoing staffing pressures throughout the Trust.	• To include the number of CTIMP studies within the next research and innovation report, in addition to highlighting overall studies and their purpose • Further assurance be provided in respect of emergency caesarean section rates in terms of appropriateness as well as providing an ethnic breakdown • To confirm the sample sizes associated with the maternity friends and family test • To provide assurance at a future meeting in terms of the actions being taken to improve reporting of medication incidents • To outline the measures of success associated with the Perfect Ward
Positive Assurances to Provide	**Decisions Made**
• An update was provided in terms of research and innovation, with no serious adverse events reported following the completion of monitoring reports from sponsors. A number of audits had commenced into good clinical practice training requirements and the Trust continued to recruit to the COVAC-IC study as well as commencing EDITUS and Classic PBB studies. • In general there had been positive trends associated with the quality indicators, with the main challenges associated with staffing. There had been 2 cases whereby the Trust did not meet the duty of candour target, sepsis screening had been achieved or exceeded the 90% target and the Trust's mortality indicators had shown improvement. • The Committee noted the update provided in respect of streamlining the RCA process in relation to pressure ulcers which aimed to enable quicker incident investigation. • An update was provided to the Committee on a new initiative which would provide consistency in the completion of audits; the Perfect Ward. It was noted that this would provide a digital inspection tool providing real-time automated reporting. • The Committee received the Mental Health & Learning Disability Annual Report and noted the ongoing work to develop a learning disability and autism strategy to provide direction in this area for the next 5 years with 7 key priorities having been identified as an area of focus for the next 12 months	• No decisions were required to be made
Comments on the Effectiveness of the Meeting	
• It was noted that attendance at the Committee was lower than usual	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	M5 Quality & Safety Report • Pressure ulcer exec summary from QSOG	Assurance	4.	Mental Health & Learning Disability Annual Report	Information
2.	Perfect Ward Development	Information	5.	Executive Health & Safety Group Highlight Report (September 2021)	Assurance
3.	Research & Innovation Update	Assurance	6.	Quality & Safety Oversight Group Highlight Report (September 2021)	Assurance

3. 2020 / 21 Attendance Matrix



Executive Summary

Meeting:	Trust Board (Open)	**Date:**	6th October 2021
Report Title:	Infection Prevention Board Assurance Framework	**Agenda Item:**	8.
Author:	Helen Bucior, Infection Prevention Lead Nurse Emyr Philips , Associate Chief Nurse Infection Prevention/Deputy DIPC		
Executive Lead:	Mrs Ann-Marie Riley, Chief Nurse/DIPC		

Purpose of Report:

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

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

Executive Summary:

Situation

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

Background

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

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

Assessment/risks

- Not moving patients until 2 negative COVID screens achieved. For asymptomatic patients this is not always possible and therefore remains on the action plan
- 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
- COVID screening prompt

Progress

- External company continues to assist with mask fit testing
- Wards are currently receiving reminder calls to prompt COVID screening

Key Recommendations:

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

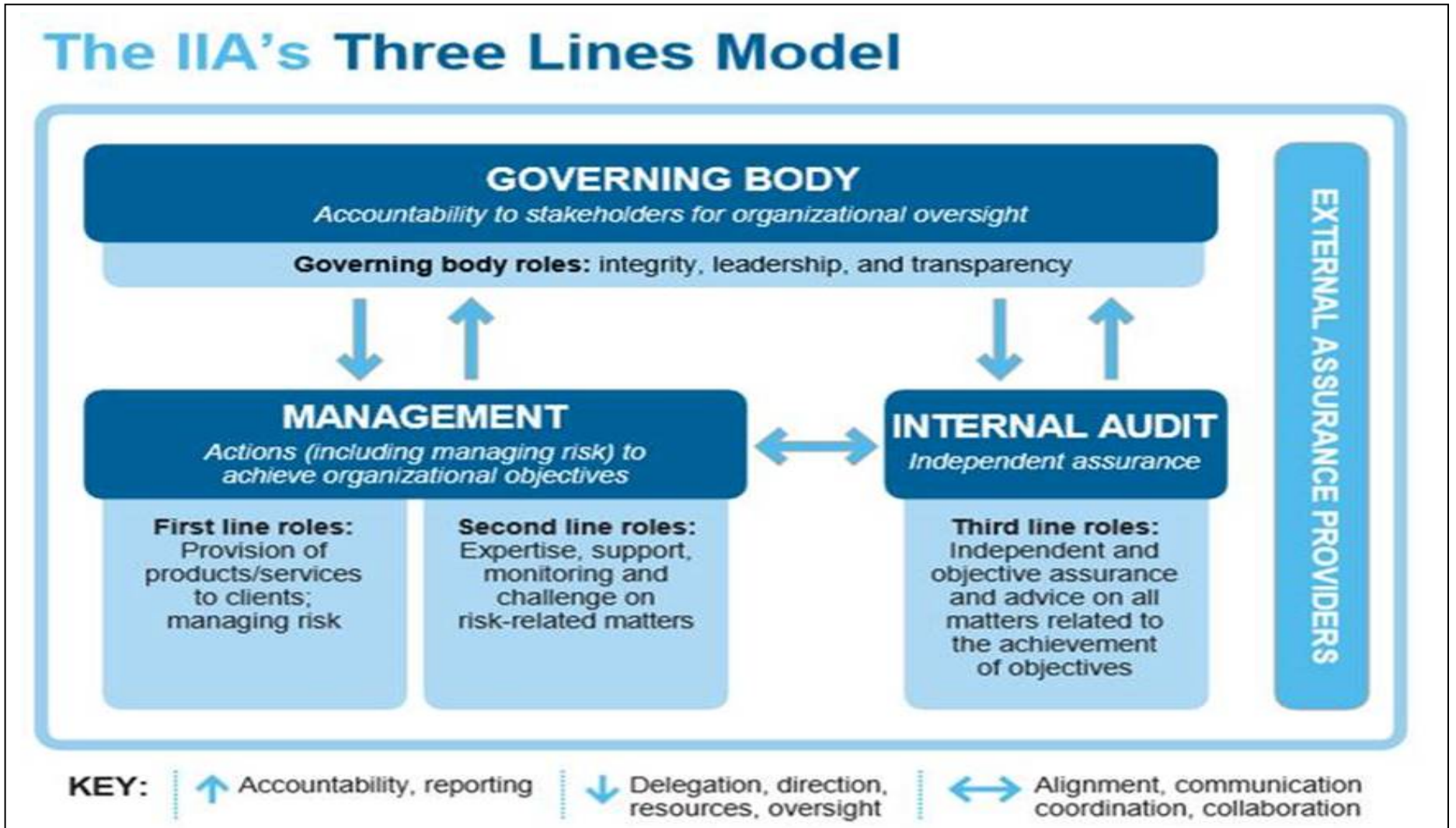
University Hospitals of North Midlands NHS

Infection Prevention and Control Board Assurance Framework

September 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		→
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		→
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		→
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		→
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		→
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		↓
BAF 7 Page 40	Provide or secure adequate isolation facilities.	Low 3	Low 3	Low 3		→
BAF 8 Page 42	Secure adequate access to laboratory support as appropriate.	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		→
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		→



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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
1.1	Systems and processes are in place ensure: • Local risk assessments are based on the measure as prioritised in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff • The documented risk assessment includes: • A review of the effectiveness of the ventilation in the area • Operational capacity • Prevalence of infections/variants concern in the local area • 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-guic  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	• FFP3 Training records further improvement part of health and safety portacount business case

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

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	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	Problematic – revised due date

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 <u>10/03/2020</u> Portacount machine obtained (on loan) by Infection Prevention Team via Midlands Coordinator for the FFP3 Mask Project. Plus mask fit tester will be available to test staff using the portacount machine. The portacount is a quantitative test and uses specialised equipment to measure exactly how much air is leaking through the seal of a mask. ACN'S informed and response requested to aid in identifying testing priority. Midlands Coordinator is meeting IP next week to work through plan.	Complete

					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	Complete

					Team. IP have a list of mask fit testers, this is also available on the Trust COVID intranet page.	
7.	1.8	Re instate admission proud to care documentation, currently emergency admission document in place	Deputy Director of Quality and Safety	30/09/2020	Original proud to care booklet reinstated now	Complete
8.	1.8	To complete an analysis (Advantages and disadvantages) to reinstating MRSA screening as per UHNM policy	Deputy Director Infection Prevention	14/06/2021	MRSA screening had reduced temporarily due to the COVID pandemic but UHNM are still following PHE 2014 guidance. This was an agreed temporary change in UHNM practice. Previously the Trust were screening over and above the 2014 guidance. Due to the COVID pandemic less elective work is taking place therefore less elective screening. High risk areas all still screen on admission. Risk based screening is for lower risk areas. Prior to the 2014 guidance the DIPC at the time (supported by the CCGs) did not want to reduce the screening policy the Trust already had in place. The CCG requested screening policy have to be approved by the CCGs. Discussed at IPCC. DIPC requested a pro's and con's exercise re screening changes due to the COVID pandemic. The Trust has not dropped below national guidance. October 2020 MRSA screening is around 50% of pre COVID screening, laboratory does not have the capacity to process COVID work and level of MRSA screens pre COVID. Paper to November IPCC. This continues to be under review during COVID Pandemic. <u>March 2021</u> Screening for elective high risk surgery to resume This action continues to be under review during COVID Pandemic and surveillance of MRSA bacteraemia cases is on-going. <u>20/04/2021</u> Due to wave 2 COVID 19 , paper deferred to May IPCC 2021 <u>May 2020</u> Screening recommenced a pre COVID 19 pandemic. DIPC advised action complete	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

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			Whilst cleaning procedures are in place to ensure the appropriate management of premises further work required re computer on wheels cleaning	Likelihood:	1	End of Quarter 2
Consequence:	3	3				Consequence:	3	
Risk Level:	6	3				Risk Level:	3	

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

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

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

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
			competency checks to ensure that they are following GREAT card training • Spot checks completed by CPM includes observation of cleaning techniques by the domestic staff.	
2.8	As per national guidance: • 'Frequently touched' surfaces, e.g. door / toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated more than twice daily and when known to be contaminated with secretions, excretions and bodily fluid. • Electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily. • Rooms / areas where PPE is removed must be decontaminated, timed to coincide with periods immediate after PPE removal by groups of staff (at least twice a day). Linked NHSIE Key Action 1: All high touch surfaces and items are decontaminated multiple times every day – once or twice a day is insufficient.	• Cleaning of frequently touch points included in Barrier clean process • Offices and back offices also supplied with disinfectant wipes to keep work stations clean. • Non- invasive medical equipment must be decontaminated after each use. IP Q+A manual	• IP checks • Barrier clean request log • Terminal clean request log • Additional ad-hoc cleaning requests can be requested by clinical teams 24/7 should the environment become contaminated between scheduled / barrier cleans. • Non-clinical areas are cleaned at regular frequencies through the day especially sanitary ware, and if additional cleans are required between scheduled cleaning, these can be requested via the helpdesk.	
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	• IP audits held locally by divisions • Datix reports/adverse incidents	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		and linen waste holds • Red alginate bags available for infected linen in the clinical areas • Infected linen route		
2.10	Single use items are used where possible and according to single use policy.	• IP question and answers manual • Medical device policy • SOP for Visor decontamination in time of shortage	• IP audits held locally by divisions	
2.11	Reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance. Resuable non –invasive care equipment is decontaminated: ○ Between each use ○ After blood and/or body fluid contamination ○ At regular predefined interval as part of an equipment cleaning protocol ○ Before inspection, service or repair equipment	• IP question and answers manual covers decontamination • Air powered hoods – SOP in place which includes decontamination process for the device • Re usable FFP3 Masks – Sundstrom/ GVS Elipse. SOP's in place which includes the decontamination process • Medical device policy • Availability of high level disinfectant in clinical areas • Sterile services process • Datix process • Bed Storage Group looking at non conformities for beds that require repair	• IP audits held locally by divisions • Datix reports/adverse incident reports	Decontamination of beds returned for repair process none conformities
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.	• 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	• Estates have planned programme of maintenance • The Authorising Engineer Ventilation will provide external independent specialist advice and	

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

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		– 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 Sodexo and action plan devised Action Plan Following NHS England NHS Im NHSI action plan June 21.docx C4C audit programme in place Ward to complete quarterly environment audits IP environment audits	Complete
3	2.4	To address dirty nursing equipment and commodes, plus computer on wheels	ACN'S / IP/ Deputy Head	31/05/2021 – re:	Dirty nursing equipment and commodes found during NHSI Visit.	Complete

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

					June 2021 Discussed at the Excecs meeting 08/06/2021 it was agreed that the risk would appear low ,however a risk assessment to be completed , if the outcome of risk assessment is low then the risk will held by the organisation and replace with new style replacement COW over time. June risk assessment completed = low To review risk in 6 months time	
4	2.8	All high touch surfaces and items are decontaminated multiple times every day – once or twice a day is insufficient. • Electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily. • Cleaning of communal toilets after each use inpatient areas – Letter -CEM/CMO /2020/043 24TH December 2020	Head of CPM Estates, Facilities & PFI Division IP Team	30/04/2021	To revisit high touch points protocol to check frequency of clean for area that area not on barrier cleans – computers , mobile phones, keyboards Cleaning of communal toilets after each use inpatient areas – Letter -CEM/CMO /2020/043 24TH December 2020. This letter was raised at IPCC 25/01/2021. 16th February Meeting with IP & Facilities colleagues to discuss the NHS/NHSE/PHE facilities cleaning requests in line with COVID 19 – letter CEM/CMO 24th December 2020 Hefma network Responses/Scoping exercise completed Trust position work in progress. Paper to next March IPCC Additional cleaning resource in place for ED Royal Stoke and overnight at County this requirement has been extended for a further 3 months Wheelchair cleaning stations also installed across both sites Clinical areas aware of the need to decontaminate high touch points such as desk top phones and keyboards <u>April 2020</u> Lessons learnt poster uploaded into the Trust intranet, including clinical and non- clinical cleaning high touch points	Complete
5	2.11	None conformities for decontamination of bed that are beds returned for repair	Divisions Facilities and Estates	30/09/2021 29/10/2021	Group in place and meetings held	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			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				Consequence:	3	
Risk Level:	9	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	• 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.	

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 national CQUINS currently suspended by NHSE / PHE • Monthly review of antimicrobial consumption undertaken by AMS team. Available online at UHNM	PHE) thought leaders members • Trust and commissioners require timely reporting on compliance with AMS CQUIN targets. • Wards showing deviation from targets are followed up by targeted AMS team ward reviews generating action plans for ward teams. On hold during COVID19 due to redeployment of duties	
3.2	Mandatory reporting requirements are adhered to and boards continue to maintain oversight. Linked NHSIE Key Action 5: Daily data submissions have been signed off by the Chief Executive, the Medical Director and the Chief Nurse and the Board Assurance Framework is reviewed and evidence of reviews is available. Linked to NHSIE Key Action 10: Local systems must review system performance and data, offer peer support and take steps to intervene as required.	• Quarterly point prevalence audits maintained by AMS team at UHNM despite many regional Trusts not undertaking any more. These have restarted in December 2020 as held during COVID-19. Results online. • Results from all AMS audits and targeted ward reviews are reported at the Antimicrobial Stewardship Group and minutes seen by IPCC • CQUIN submissions completed in timely manner and generate action plans for AMS and ward teams to follow up concerns each quarter. 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	Complete

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

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			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				Consequence:	3	
Risk Level:	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			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				Consequence:	3	
Risk Level:	3	3				Risk Level:	3	

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	Staff are aware of agreed template for triage questions to ask Triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible			
5.2	Mask usage is emphasized for suspected individuals. Face 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 in place	• 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	 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-19-stay-at-home-guidance/stay-at-home-guidance-for-households-with-possible-coronavirus-covid-19-infection	• If patient found to be positive in the bay and exposing other patient. IP liaise with clinical are, apply bay restrictions. • Patient who tested negative on admission and remain an inpatient are retested for COVID days 4 and 6, day 14 then weekly • Spot check audits	

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

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 4 Progress Report	BRAG
1.	5.1	Up- to- date COVID -19 Divisional pathways	ACN's	30/09/2020	Associate Chief Nurse contacted and request made for COVID -19 pathways 28th July 2020. ED pathways in place and also County to Royal transfer of COVID positive patients. Divisional recovery plans and identification of COVID wards due to second wave continues.	Complete
2.	5.4	Process for contacting patients who have been	Deputy of	31/08/2020	IP guide liaise with clinical areas to identify closed contacts,	Complete

		discharged home and have then been found to in close contact with a COVID -19 positive patient during their stay	Director Infection		close contact are isolated for remainder of hospital stay for 14 day or if discharged home continue isolation at home. Clinical team inform patient who have already been discharged COVID intranet page. October COVID -19 ward round guidance	
3.	5.7	Process to monitor patients who attend routine appointments who display symptoms of COVID-19 are managed appropriately	ACN'S	31/07/2020	Thermal camera located in a number outpatient areas – with SOP if patient triggers. Script in place for scheduling outpatient/ investigations	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		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			Consequence:	3	
Risk Level:	6	6	3			Risk Level:	3	

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

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		• SOP and training for reusable FFP3 masks • SOP and training for use of air powered hoods • Critical care - Elipse FFP3 reusable introduced • PPE posters are available in the COVID -19 section of trust intranet page		
6.3	A record of staff training is maintained.	Mask fit strategy in place	• Training records originally held locally by the Clinical areas • Records held on L drive for those trained by the infection prevention team • April 2021,Option now available to enter FFP3 training onto Health Rostering this captures the model of mask and date trained • Test certificate must continue to be filed in personal folder • Health and Safety leading on portacount mask fit business case which has the potential to enhance mask fit training records further as this system is capable of collected data which can be uploaded	Monitoring FFP3 mask fit compliance using Health roster
6.4	Appropriate arrangements are in place so that any reuse of PPE is in line with the CAS Alert is properly monitored and managed.	• SOP in place for reuse of visors • SOP in place for use of air powered filters systems plus key trainers	• SOP 's available on Trust intranet • Training logs held divisionally for air powered systems	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		• SOP in place for the care of reusable FFP3 masks (Sundstrom))	• IP training log for air powered systems key trainers and distribution of reusable FFP3 masks (Sundstrum)	
6.5	Any incidents relating to the re-use of PPE are monitored and appropriate action taken.	• PPE standard agenda at COVID Tactical meeting • Datix process • Midlands Region Incident Coordination Centre PPE Supply Cell	• Tactical group action log • Datix process • Incidents reported by procurement to centre PPE supply Cell	
6.6	Adherence to the PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk.	• PPE Audits • PPE volume use discussed at tactical COVID-19 Group	• Spot audits completed by IP team	
6.7	Staff regularly undertake hand hygiene and observe standard infection control precautions. Linked NHSIE Key Action 1: Staff consistently practices good hand hygiene.	• Hand hygiene requirements set out in the infection prevention Questions and Answers manual • Poster for hand hygiene technique displayed at hand wash sinks and stickers on hand soap and alcohol dispensers • Alcohol gel availability at the point of care	• Monthly hand hygiene audits completed by the clinical areas • Infection Prevention hand hygiene audit programme. Overview of results fed into infection Prevention committee • Independent hand hygiene audits completed by IP Senior Health Care	
6.8	Hygiene facilities (IP measures) and messaging are available for all • Hand hygiene facilities including instructional posters • Good respiratory hygiene measures • Staff maintain physical distancing of 2 metres	• Hand washing technique depicted on soap dispensers • Social distance posters displayed throughout the Trust • IP assurance visits • Matrons visits to clinical areas	• Hand hygiene audits • Spot checks in the clinical area • IP assurance visits	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	wherever possible in the workplace unless wearing PPE as part of direct care • Staff maintain social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace • Frequent decontamination of equipment and environment in both clinical and non-clinical areas • clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas • Staff regularly undertake hand hygiene and observe standard infection prevention precautions • Guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas	• Car sharing question forms part of OB investigation process • Communications reminding staff re car sharing • IP Q+A decontamination section • COVID Q+A • Wearing of mask posters displayed throughout the Trust • Advise and videos' on the Trust internet page • Hand hygiene posters /stickers on dispenser display in public toilets	• Cleanliness audits • IP environmental audits • Quarterly audits conducted and held by the clinical areas • Hand hygiene audits	
6.8	The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance Guidance on hand hygiene, including drying	• Paper Towels are available for hand drying in the Clinical areas	• IP audits to check availability	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	should be clearly displayed in all public toilet areas as well as staff areas			
6.9	Staff understand the requirements for uniform laundering where this is not provided on site.	• Instruction for staff laundering available on the Trust COVID - 19 section of intranet • Dissolvable bags to transport uniforms home available for staff • Communications /daily bulletin to remind staff not to travel to and from work in uniforms	• Clinical areas to monitor • Reports of member of public reporting sighting of staff in uniform	
6.10	All staff understand the symptoms of Covid-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household displays any of the symptoms.	• For any new absences employee should open and close their usual absence via Empactis system • Symptom Advice available on Trust intranet	• Cluster /outbreak investigations	
6.11	All staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE and other national guidance if they or a member of their household display any of the symptoms	• Communication /documents • Reminders on COVID bulletins Trust intranet • Staff Lateral flow testing	• Cluster /outbreak investigations	
6.12	A rapid and continued response through on- going surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patient/individuals)	• ICNET surveillance system • Reports • Trust wide daily COVID Dashboard/report • COVID -19 Tactical daily	• COVID Dashboard • COVID -19 Tactical daily briefing • COVID 19 Gold update slides	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		• briefing		
6.13	Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	• ICNet surveillance system • Reports • RCA's are required for all Probable and Definite HAI Covid-19 cases	• Theme report IPCC • RCA review	
6.15	Robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of outbreak meetings.	• ICNet surveillance system • Daily COVID reports of cases	• Outbreak investigation • Outbreak minutes	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 4 Progress Report	BRAG
1.	6.3	Improving staff FFP3 mask fit staff training data recording and retention of records	Health and Safety	31/08/2021	Proposed Fit Testing compliance improvement Task and Finish Group. Inaugural meeting planned for 29th July 2020. ESR will be up and running for the purpose of recording fit test records as soon as the Trust gives the go ahead to procure Portacount fit test system as this is part of the project lead by Health and Safety. December 2020 Health and Safety have agreement to proceed to Business case As at 03/02/2021 People O&D have created FFP3 mask "classes" on ESR. Health and Safety are in the process of collating fit test records which were requested at Exec Health and Safety Groups from Divisional H&S Leads. Business case : Head of Health and Safety's continues with business case with a revised due date end of August 2021 10/03/2020 Portacount machine obtained (on loan) by Infection Prevention Team via Midlands Coordinator for the FFP3 Mask	complete

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

					skill to Health roster. The portacount machine action will be added as separate action	
2	6.3	Monitoring FFP3 mask fit compliance %	Divisions	31/09/2021	To monitor the mask fit compliance % for own division using available records – Health Roster	On- going
3	6.2	To improve FFP3 mask fit failure levels by using the portacount machine. Portacount method allows testing of individuals who are unable or unsure if they can taste the Bitrex solution	Health and Safety	31/10/2021	Health and Safety progressing with writing a business case in relation to obtaining a permanent portacount machine	On- going
4	6.2	Spot audits of PPE on wards and Departments	Quality and Safety Team IP	30/04/2021	Audits are required on a weekly basis – ongoing action	Complete

7. Provide or secure adequate isolation facilities

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

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

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

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

8. Secure adequate access to laboratory support as appropriate.

Risk Scoring								
Quarter	Q4	Q1	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	1	1			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				Consequence:	3	
Risk Level:	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			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				Consequence:	3	
Risk Level:	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		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			Consequence:	3	
Risk Level:	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.		• Monitoring of FFP3 compliance using Health roster
10.3	Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the crossover of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance.	• Restore and Restorations plans	• Incidence process/Datix	
10.4	All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas. Health and care settings are COVID 19 secure workplaces as far as practical, that is that any work place risks are mitigated maximally for everyone Linked NHSIE Key Action 2: Staff maintain social distancing in the workplace, when travelling to work (including avoiding car sharing) and to remind staff to follow public health guidance	• 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	• 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
	outside of the workplace.	• November 2020 – Car sharing instructions added to COVID Bulletin		
10.5	Consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas.	• Social distancing tool kit • Staff encouraged to keep to 2 metre rule during breaks • Purpose build rooms for staff breaks in progress	• Social distance monitor walk rounds • Social distance posters identify how many people allowed at one time in each room	
10.6	Staff absence and wellbeing are monitored and staff who are self-isolating are supported and able to access testing.	• Team Prevent available to offer guidance and treatment to staff presenting with onset of symptoms.	• Team prevent monitoring process • Work force bureau	
10.7	Staff who test positive have adequate information and support to aid their recovery and return to work.	• Team Prevent available to offer guidance and treatment to staff presenting with onset of symptoms. • Empactis line will first ask – is the absence related to coronavirus. To which the employee must say yes or no • Once the absence is reported to the employees manger via email, the manager will categorise the absence type specified in the flow chart. • Team prevent complete COVID 19 staff screening • Areas where transmission has occurred are discussed at clinical group and relevant staff screening under an ILOG number is agreed. • Flow charts or staff returning to work available on COVID 19 section of intranet	• Via emapactis • Staff queries' through workforce bureau or team prevent	

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

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

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

21st September 2021

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The Committee received an update from the Data Security and Protection Group and noted the escalations in terms of data security and protection training which stood at 89% compared to the 95% target as well as noting a breach of confidentiality which had been reported to the Information Commissioners Officer with a root cause analysis being undertaken • In terms of cancer performance, there remained challenges associated with delivering on a number of standards, with actions continuing to be taken to prioritise patients. In terms of planned care, some tactical pieces of work were being considered which included further utilisation of the Independent Sector. It was noted that diagnostics performance for non obstetric ultrasound was expected to improve following the approval of the business case. • In terms of the pressures associated with Covid, the Trust was working with system partners to determine what actions could be taken to support the Trust; the full hospital protocol had been signed off and staff sickness continued to be a major contributory factor to the current challenges.	• To provide a monthly update in respect of investment decisions and level of ongoing commitments within the finance report • To clarify costs in relation to the reduction in unbudgeted spend within the ED business case, prior to being submitted for Board approval in addition to clarifying reductions in agency/bank staffing • To provide regular updates to the Committee on key deliverables and milestones of the ED case within the Performance Report • To clarify the reasons for the financial delays which were noted within the contract award paper
Positive Assurances to Provide	**Decisions Made**

• The Committee received an update in respect of the car parking strategy and noted the progress made in respect of securing emergency capital funding and securing additional allocations for the purchase of land.
• The Committee took the updates from the Business Intelligence Group, Operational Delivery Group and Executive Infrastructure Group as read
• The Committee noted the development and approval of the Medical Equipment Strategy
• In terms of Month 5 Finance Performance, the Trust delivered a surplus which was slightly better than planned and there continued to be an underspend in qualified nursing. It was noted that the any surplus for H1could be utilised to support spending during H2
	• The Committee held a significant discussion with regards to the Emergency Department Medical Workforce business case, and approved the case which would be taken to the Trust Board for approval
	• The Committee approved the Targeted Lung Health Check Programme and CT7 Business Case which would be taken to the Trust Board for approval
	• The Committee approved the following eREAFs;
	  ○ Trauma, CMF and Orthopaedic External and Internal Fixation Consumables (eREAF 8122)
	  ○ Contract Renewal - Recombinant Factors (eREAF 8050)
	  ○ Contract Renewal Human Albumin/Albutein (eREAF 8049)
	  ○ Services of Junior Doctors via Health Education England (eREAF 8017)
	• The Committee accepted the CRL allocation for the car parking solution and approved to fund any shortfalls from the accumulated cash balances

Comments on the Effectiveness of the Meeting	
• The Committee members welcomed the focus provided on discussing the two business cases	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Business Case Approvals: • BC-0426 ED Medical Workforce • BC-0415 Targeted Lung Health Check Programme and CT 7	Approval Approval	7.	Operational Delivery Group Assurance Report (September 2021)	Approval
2.	Authorisation of New Contract Awards and Contract Extensions	Approval	8.	Month 5 Performance Report	Assurance
3.	Update on Car Parking Strategy	Approval	9.	Month 5 Finance Report	Approval
4.	Executive Data Security & Protection Group Highlight Report (September 2021)	Assurance	10.	Non-Elective Improvement Group Minutes	Information
5.	Executive Business Intelligence Group Assurance Report (September 2021)	Assurance			
6.	Executive Infrastructure Group Assurance Report (September 2021) •Medical Equipment Strategy	Assurance			

3. 2021 / 22 Attendance Matrix

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

Due to the number of Executive apologies, Ann-Marie Riley, Chief Nurse and John Oxtoby, Medical Director joined the meeting.

Transformation and People Committee Chair's Highlight Report to Board

22nd September 2021

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The 2020 WRES report found that 30.3% of BAME staff and 27.9% of white staff reported experiencing harassment, bullying or abuse from patients, relatives or the public • Performance with PDR's continues to deteriorate with clinical pressures due to Covid being cited as the main reason. • Covid related absences have increased slowly throughout August and into September. • Visible information in the form of posters on zero tolerance to bullying across the Trust appears to be inconsistently available and will be addressed.	• Medical Workforce Race Equality Standard: issued this year as a national picture and will be focussed more specifically next year. • Ongoing work to improve WRES matrix through a range of activities. • Civility and Respect Task Force will be focussed on ensuring consistency of literacy and posters to communicate messages regarding civility and respect • Workforce Bureau has been reconvened and meets 3 times per week; campaign being launched along with system partners, as to how frontline staff can be supported, including through the use of volunteers • Winter resourcing plans are in place which has a pipeline of recruitment in place and there will be a granular deep dive into each of the recruitment cases to ensure they are progressing as planned • Future meeting to consider Workforce Planning in the shorter term in terms of the approach and over the longer term; some assurance given around nursing although it is necessary to look at the broader professions
Positive Assurances to Provide	**Decisions Made**
• Midlands Race Inclusion Strategy: have been working a system on ensuring BAME staff can progress through their career; also focussed on Talent Management. • 120 leaders going through the Gold and Platinum programme where we will be developing a cohort of inclusive leaders. • Calendar of diversity events has been scheduled to ensure awareness raising. • Business case approved by Executive Team to expand support within the OD Team to deliver the middle manager support programme; further updates will be shared with the Committee as this evolves • Low numbers of disciplinary proceedings in this organisation, partly attributable to the focus on a Just and Learning Culture which is embedded across the Trust • Statutory and Mandatory Training compliance is above target at 96%Covid	• Approval of the Strategy Development Framework

booster and Flu campaigns commencing in the next week	

Comments on the Effectiveness of the Meeting

- The second half of the meeting was a dedicated workshop on Improving Together which was found to be very helpful to Committee members, particularly the video shared by AMU staff
- Potential for meeting format to be changed over the current months based upon the current operational pressures

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Workforce Race Equality Standard	Assurance	3.	Strategy Development Framework	Approval
2.	M5 Workforce Report	Assurance	4.	Improving Together	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												
Prof K Maddock	KM	Non-Executive Director												
Mrs AM Riley	AR	Chief Nurse	MR		SP									
Miss C Rylands	CR	Associate Director of Corporate Governance			NH									
Mrs R Vaughan	RV	Director of Human Resources						JH						

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	6th October 2021
Report Title:	Integrated Performance Report, month 5 2021/22	**Agenda Item:**	11.
Author:	Quality & Safety: Jamie Maxwell, Head of Quality & safety; Operational Performance: Karan Allman, Deputy Head of Performance; Matt Hadfield, Deputy Associate Director of Performance & Information. Workforce: Claire Soper; Finance: Tringham, Jonathan		
Executive Lead:	Anne-Marie Riley: Chief Nurse Paul Bytheway: Chief Operating Officer Ro Vaughan: Director of Workforce Mark Oldham: Director of Finance		

Purpose of Report:

Assurance	✓	Approval		Information	

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

Executive Summary:

Situation

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

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

Assessment

Quality & Safety

The Trust achieved the following standards in August 2021:

- Friend & Family (Inpatients) 98.9% and 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 96.6%
- Falls rate was 5.4 per 1000 bed days and is below the average rate per 1000 bed days during COVID-19 pandemic Trust rolling 12 month HSMR continue to be below expected range.
- 100% of patients/family were informed verbally of incidents that are reported as meeting duty of candour threshold.

- VTE Risk Assessment continues to exceed 95% target with 99.5% (via Safety Express audit).
- Zero avoidable MRSA Bacteraemia cases reported.
- There have been no Category 4 Pressure Ulcers attributable to lapses in care during August 2021.
- Sepsis Screening compliance in Emergency Portals exceeded the target 90% with 91%.
- Inpatients Sepsis Screening 94.1%. And Inpatient IVAB within 1 hour achieved 100% and exceeded 90% target rate
- Emergency Portals Sepsis screening 94% against 90% target and Emergency Portals IVAB in 1 hour 91% against the 90% target for audited patients
- Children's Sepsis Screening compliance 95.7% and above the 90% target.
- Maternity Sepsis Screening 90.9%
- Zero Never Events.

The Trust did not achieve the set standards for:

- Friend & Family Test for A&E 71% and below 85% target.
- There were 14 Pressure ulcers identified with lapses in care during August 2021.
- 87.5% Duty of Candour 10 day letter performance following formal verbal notification.
- C Diff YTD figures above trajectory with 9 against a target of 8.
- There were 3 Nosocomial COVID Infections reported.
- Emergency C Section rate is above target at 23.59%.

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

- The rate of complaints per 10,000 spells is 16.89 and is below (positive) the target of 35 and within normal variation. Majority of complaints in August 2021 relate to clinical treatment. This is the lowest monthly rate recorded since April 2019
- Total number of Patient Safety Incidents decreased (1677) and the rate per 1000 bed days has also decreased at 45.50 and both measures are within normal variation.
- Total incidents with moderate harm or above and the rate of these incidents have risen during August but is normal monthly variation.
- Increase in reported incident relating to staffing shortages and lack of appropriate staff on wards/departments. Escalated by Divisions and support measures being put in place 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 1.4 in August 2021. The rate of patient falls with harm continues to be within the control limits and normal variation.
- Medication related incidents rate per 1000 bed days is 4.8 and patient related 4.2. The monthly variation is within the normal expected variation but below the NRLS national mean rate of 6.0
- Hospital Onset / Nosocomial; COVID increased in August with 10 but is still well below the overall mean of 21
- Zero COVID-19 deaths falling in to the 'Definite' category (according to the National definition of Nosocomial deaths).
- 16 Serious Incidents reported in August 2021. All the serious incidents were reported on STEIS within the 2 working date target.

Operational Performance

<u>Emergency Department</u>

- Attendances at ED that had levelled off in July reduced in August to a daily average of 360 (July 348).
- The decreases in attendances were again more notable in paediatrics. So in effect the adult numbers per day remained the same at an average of 281/day. Ambulance arrivals were also lower at a daily average of 155/day.
- Whilst the daily average number of admissions fell slightly the conversion rate remained the same.
- Ambulance handover delays for 30-60mins remained static and the > 60 mins rose in August and the percentage of handovers within 15 minutes fell to around 40%, due to the periods of ambulance surges often late afternoon that require processing time to clear.

- System-wide performance was 68% (July 67.4%), with total type 1 at 53.2%. At Royal Stoke the non-admitted performance rose to 54.3% (July 51.5%) and the admitted performance rose to 24% indicating the key issues for August were related to extended timescales to securing an admitted placement. MFFDs have risen as have the number of patients with > 21 days stay.
- The department had continued days with sub 60% performance with most of the front door metrics challenged.

Cancer

- The Trust is provisionally predicted to achieve the following two cancer standards for August 21: 31 day subsequent Radiotherapy at 96.1% and Rare Cancers 31 Days at 100%
- The overall 2WW position for August is predicted to achieve in the region of 65.8%. Specialties with the most 14 day breaches are Skin, Colorectal and Upper GI.
- Performance against the 62 day standard is currently at 52.5% for August 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 August is higher than normal. 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 August position is significantly challenged, and will be validated prior to upload.

Planned Care

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

- Day Case and Elective Activity delivered 83.6% for August 21 against the national ask of 95%. This is lower in Inpatients than Day case (76.3% IP, 84.7% DC).
- Plan to release more patients to the IS to enable full optimisation of capacity through one off lift and shift of patients, starting with the Nuffield.
- Next Planned Care Cell focus on theatre capacity and productivity given the emergent covid risks and staff isolation rate of attrition.
- Scoping of schemes to support management of referred demand (Referral Hub) and waiting list management (Patient Contact Initiative)

RTT

- The indicative performance for August 21: the total number of Referral To Treatment pathways grew to 67,784 (July 65, 574).
- There has been a slight increase in the number of > 52 weeks to 3,495.
- RTT performance in August is 59.9% (July 61.4%).
- 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 reduced in August from 20,134 to 19,580. However in Non-obstetric ultrasound the waiting list continues to grow. August 10,318 (July 9,657). Due to the challenges in Non-Obstetric Ultrasound this has adversely affected performance. The current DM01 diagnostic performance for August 21 has deteriorated to 66.19% (July 71.95%).
- The greatest proportion of > 6 week waits are within Non-obstetric ultrasound and endoscopy. The ultrasound position is related to an increase in demand alongside workforce shortfalls. The waiting list is growing significantly by c250 per week against a limited workforce that is at full capacity. The independent sector has now been commissioned to provide additional capacity. An improvement is expected by the end of November 2021. For endoscopy (colonoscopy and gastroscopy). This is related to an on-going increase in demand. Improvement actions are being developed and implemented.
- The main diagnostic pressures are within histology which is having a negative impact on cancer waiting times – an improvement action plan in in place. Workforce shortfalls are the predominant cause of this situation.

Workforce

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

management and staff testing. Forthcoming staff engagement events include:

- Commencement of the NHS annual Staff Survey from October 2021. A communications campaign will commence in September and run throughout to encourage staff to take part in the survey.
- The virtual Staff Awards event will be held on 5th November, with staff having submitted 294 nominations.

Sickness

- The in-month sickness rate was 5.30% (5.43% reported at 31/07/21). The 12 month cumulative rate increased 5.18% (5.10% at 31/07/21)
- Stress-related sickness absence remains the top reason for absence, although this does include both includes both work-related and personal/domestic life stress. In the 12 months ending 31st August 2021, 28.4% of sickness absence was stress-related. The Trust has a comprehensive Wellbeing Plan in place to support staff with a focus on ensuring staff psychological wellbeing.
- Covid related absences have increased slowly throughout August and into September and, as of 23rd September 2021, covid-related open absences* numbered 253, which was 27.09% of all absences (21.52% at 11th August 2021) [**includes absences resulting from adhering to isolation requirements]*. Measures to support the Trust in reducing covid infections continue to be offered to staff and Covid-19 Booster Vaccinations will be rolled out to health and care workers alongside the flu vaccination from September 2021

Appraisals

- The Non-Medical PDR compliance rate was 78.21% at 31st August 2021 (79.84% at 31 July 2021).
- Performance in completing PDRs continues to deteriorate, with clinical pressures being cited as the main reason. Divisions have been asked to revise their trajectories to reflect a realistic position of what they are able to achieve and to continue to undertake PDR's wherever possible as opportunity to discuss wellbeing and support.

Statutory and Mandatory Training

- At 96.0%, the Statutory and Mandatory Training rate has exceeded the Trust target for the core training modules and, at 31 August 2021, 92.28% of staff had completed all 6 Core for All modules (91.30% at 31/07/21)

Vacancies

- The overall Trust vacancy rate was 8.97% and remains consistent with previous months.
- In addition to the Recruitment pipeline, mitigations against the vacancy position include offering additional PA's; extended / increased hours; On call payments and overtime. The Trust also uses Bank & Agency to cover gaps in staffing and, when necessary, will redeploy staff internally. Staff are also supported by our student cohorts and volunteer groups.

Finance

The Trust has delivered a surplus of £2.3m in month against a planned surplus of £2m. The position in month is primarily driven by a pay underspend against plan of £1.1m driven by both registered nursing and NHS infrastructure support.

ERF income recognised for the year to date is £8m against a revised planned figure of £7.3m. Based on activity plans, the plan originally assumed £8.8m of income for H1 with additional costs approved of £0.6m to support the delivery of the activity plans. Revised thresholds for receiving ERF funding have been announced for Q2 which will reduce the forecast income earned by the Trust and there will also be a significant underspend against the £0.6m anticipated spend in H1.

The Trust incurred £1.3m of costs relating to COVID-19 in month which is an increase of £0.2m compared with Month 4'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.

A detailed forecast for the remainder of H1 suggests that the Trust may have a surplus in excess of its plan

for the period of £6m. The Trust continues to formally report externally that it will deliver its planned position for the first 6 months of the year.

Capital expenditure for the year to date stands at £9.8m which is £2.3m behind the plan mainly due to an underspend relating to the lower Trent wards scheme.

The cash balance at Month 5 is £58.4m. The forecast cash balance for the end of Month 6 has increased to £66.4m from the year-end balance of £55.8m, reflecting the expected revenue surplus for H1.

Key Recommendations:

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

NHS
University Hospitals of North Midlands
NHS Trust

Integrated Performance Report

Month 5 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

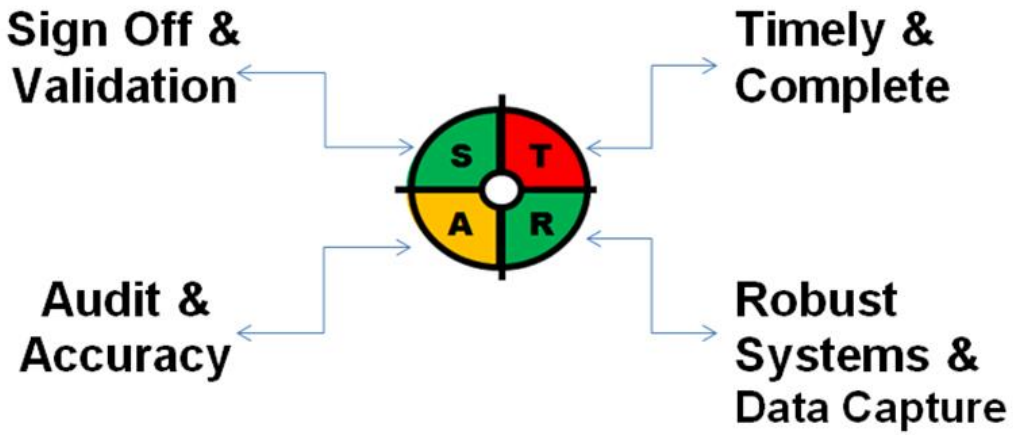
Together Compassion Safe Improving

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
NHS Trust

Key messages

The Trust achieved the following standards in August 2021:

- Friend & Family (Inpatients) 98.9% and 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 96.6%
- Falls rate was 5.4 per 1000 bed days and is below the average rate per 1000 bed days during COVID-19 pandemic Trust rolling 12 month HSMR continue to be below expected range.
- 100% of patients/family were informed verbally of incidents that are reported as meeting duty of candour threshold.
- VTE Risk Assessment continues to exceed 95% target with 99.5% (via Safety Express audit).
- Zero avoidable MRSA Bacteraemia cases reported.
- There have been no Category 4 Pressure Ulcers attributable to lapses in care during August 2021.
- Sepsis Screening compliance in Emergency Portals exceeded the target 90% with 91%.
- Inpatients Sepsis Screening 94.1%. And Inpatient IVAB within 1 hour achieved 100% and exceeded 90% target rate
- Emergency Portals Sepsis screening 94% against 90% target and Emergency Portals IVAB in 1 hour 91% against the 90% target for audited patients
- Children's Sepsis Screening compliance 95.7% and above the 90% target.
- Maternity Sepsis Screening 90.9%
- Zero Never Events.

The Trust did not achieve the set standards for:

- Friend & Family Test for A&E 71% and below 85% target.
- There were 14 Pressure ulcers identified with lapses in care during August 2021.
- 87.5% Duty of Candour 10 day letter performance following formal verbal notification.
- C Diff YTD figures above trajectory with 9 against a target of 8.
- There were 3 Nosocomial COVID Infections reported.
- Emergency C Section rate is above target at 23.59%.

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

- The rate of complaints per 10,000 spells is 16.89 and is below (positive) the target of 35 and within normal variation. Majority of complaints in August 2021 relate to clinical treatment. This is the lowest monthly rate recorded since April 2019
- Total number of Patient Safety Incidents decreased (1677) and the rate per 1000 bed days has also decreased at 45.50 and both measures are within normal variation.
- Total incidents with moderate harm or above and the rate of these incidents have risen during August but is normal monthly variation.
- Increase in reported incident relating to staffing shortages and lack of appropriate staff on wards/departments. Escalated by Divisions and support measures being put in place 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 1.4 in August 2021. The rate of patient falls with harm continues to be within the control limits and normal variation.
- Medication related incidents rate per 1000 bed days is 4.8 and patient related 4.2. The monthly variation is within the normal expected variation but below the NRLS national mean rate of 6.0
- Hospital Onset / Nosocomial; COVID increased in August with 10 but is still well below the overall mean of 21
- Zero COVID-19 deaths falling in to the 'Definite' category (according to the National definition of Nosocomial deaths).
- 16 Serious Incidents reported in August 2021. All the serious incidents were reported on STEIS within the 2 working date target.

** All data used in this report is as recorded on 8th August 2021 and figures may change following further review/investigation/update*

Quality Dashboard

NHS University Hospitals of North Midlands NHS Trust

Metric	Target	Latest	Variation	Assurance
Patient Safety Incidents	N/A	1677	H	
Patient Safety Incidents per 1000 bed days	N/A	45.50	H	
Patient Safety Incidents per 1000 bed days with no harm	N/A	29.84	H	
Patient Safety Incidents per 1000 bed days with low harm	N/A	13.27	H	
Patient Safety Incidents per 1000 bed days reported as Near Miss	N/A	1.68		
Patient Safety Incidents with moderate harm +	N/A	23		
Patient Safety Incidents with moderate harm + per 1000 bed days	N/A	0.62		
Harm Free Care (New Harms)	95%	96.6%	L	?
Patient Falls per 1000 bed days	5.6	6.0		?
Patient Falls with harm per 1000 bed days	1.5	1.8		?
Medication Incidents per 1000 bed days	N/A	4.8		?
Medication Incidents % with moderate harm or above	TBC	0.00%		
Patient Medication Incidents per 1000 bed days	N/A	4.2		F
Patient Medication Incidents % with moderate harm or above	TBC	0.00%	L	

Metric	Target	Latest	Variation	Assurance
Serious Incidents reported per month	N/A	16		
Serious Incidents Rate per 1000 bed days	N/A	0.18		
Never Events reported per month	0	0	L	?
Duty of Candour - Verbal/Formal Notification	100%	100%	H	?
Duty of Candour - Written	100%	87.5%		?
All Pressure ulcers developed under UHNM Care	TBC	64		
All Pressure ulcers developed under UHNM Care per 1000 bed days	N/A	1.69		
All Pressure ulcers developed under UHNM Care lapses in care	12	14		?
All Pressure ulcers developed under UHNM Care lapses in care per 1000 bed days	0.5	0.45	H	P
Category 2 Pressure Ulcers with lapses in Care	8	2		P
Category 3 Pressure Ulcers with lapse in care	4	1		?
Category 4 Pressure Ulcers with lapses in care	0	0		?
Unstageable Pressure Ulcers with lapses in care	0	0		?

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Quality Dashboard

NHS University Hospitals of North Midlands NHS Trust

Metric	Target	Latest	Variation	Assurance
Friends & Family Test - A&E	N/A	71.0%		
Friends & Family Test - Inpatient	N/A	98.9%		
Friends & Family Test - Maternity	N/A	100.0%		
Written Complaints per 10,000 spells	35	16.89		
Rolling 12 Month HSMR (3 month time lag)	100	93.66		
Rolling 12 Month SHMI (4 month time lag)	100	102.48		
Nosocomial COVID-19 Deaths (Positive Sample 15+ days after admission)	N/A	0		
VTE Risk Assessment Compliance	95%	99.5%		
Emergency C Section rate % of total births	15%	23.59%		
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	13		
Nosocomial "Definite" HAI COVID Cases - UHNM	0	10		

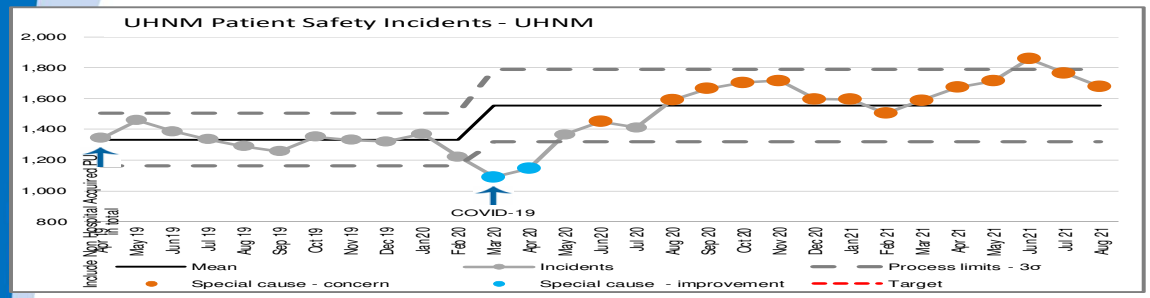
Metric	Target	Latest	Variation	Assurance
Inpatient Sepsis Screening Compliance (Contracted)	90%	94.4%		
Inpatient IVAB within 1hr (Contracted)	90%	83.3%		
Children Sepsis Screening Compliance (All)	90%	92.3%		
Children IVAB within 1hr (All)	90%	N/A		
Emergency Portals Sepsis Screening Compliance (Contracted)	90%	94.1%		
Emergency Portals IVAB within 1 hr (Contracted)	90%	90.9%		
Maternity Sepsis Screening (All)	90%	90.9%		
Maternity IVAB within 1 hr (All)	90%	N/A		

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Reported Patient Safety Incidents

University Hospitals of North Midlands NHS Trust

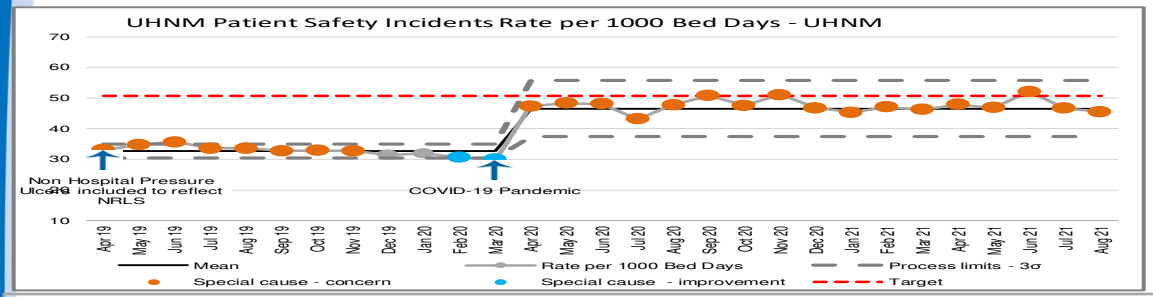


Variation	Assurance
	

Target	Jun 21	Jul 21	Aug 21
N/A	1858	1766	1677

Background

Total Reported patient safety incidents



Variation	Assurance
	

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

What is the data telling us:

The above data relates to **all** reported Patient Safety Incidents (PSIs) across the Trust. The August 2021 total is near the upper confidence limit which demonstrates that the increase in reported incidents is significant and 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:

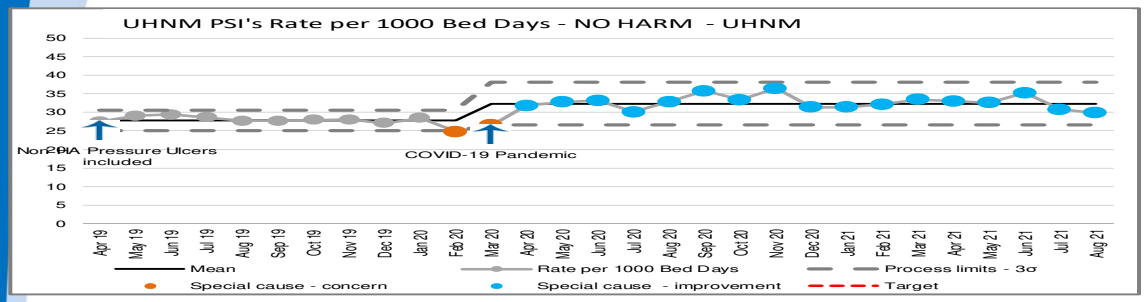
- Patient related Slip/Trip/Fall - 198 (212)
- Clinical assessment (Including diagnosis, images and lab tests) – 88 (79)
- Patient flow incl. access, discharge & transfer - 107 (134)
- Documentation – 34 (39)
- Treatment/Procedure - 71 (69)
- Medication incidents - 151 (156)
- Infection Prevention – 82 (70)
- Staffing – 74 (51)

There have been increases in Infection Prevention, Clinical assessment and Treatment/Procedure related incidents compared to July 2021 totals (in brackets).
There has also been increase in the total number of incident reporting relating to staffing with 74 incidents reported. 33 of these were under patient related and the remaining 41 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, Specialised Medicine, Anaesthetics/Theatres/Critical Care, General Surgery & Urology and Trauma. Specific incidents are reviewed at specialist forums for themes / trends as well at Divisional level.

The rate of reported PSIs per 1000 bed days has remained relatively stable following the change at the start of COVID-19 pandemic but is 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

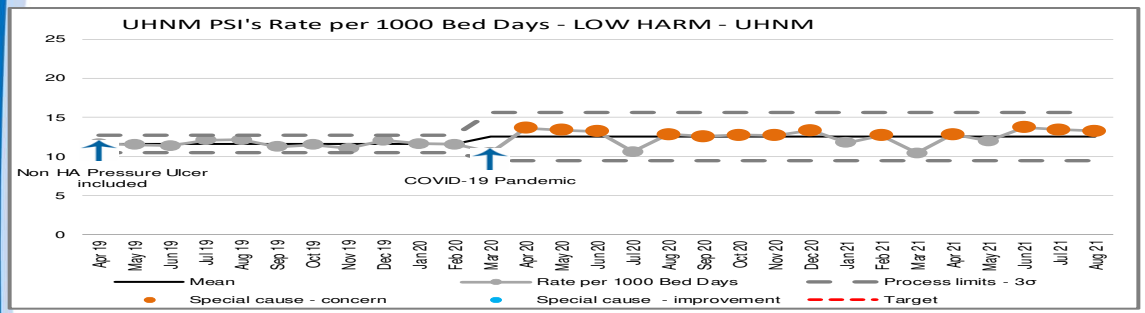


Variation	Assurance

Target	Jun 21	Jul 21	Aug 21
N/A	35.26	30.80	29.84

Background

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

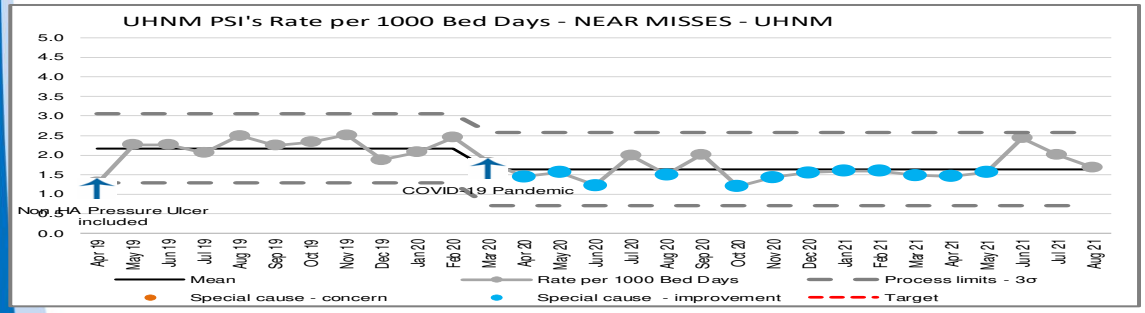


Variation	Assurance

Target	Jun 21	Jul 21	Aug 21
N/A	13.74	13.40	13.27

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	Jun 21	Jul 21	Aug 21
N/A	2.44	2.01	1.68

Background

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

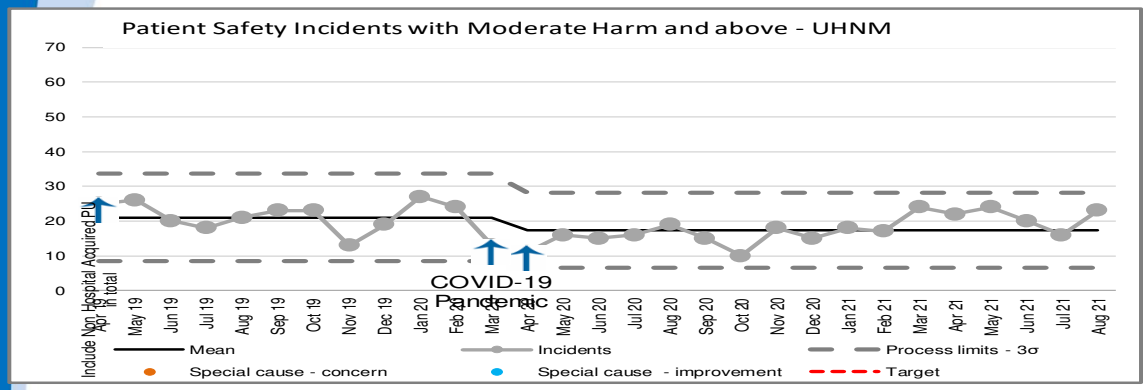
What is the data telling us:

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

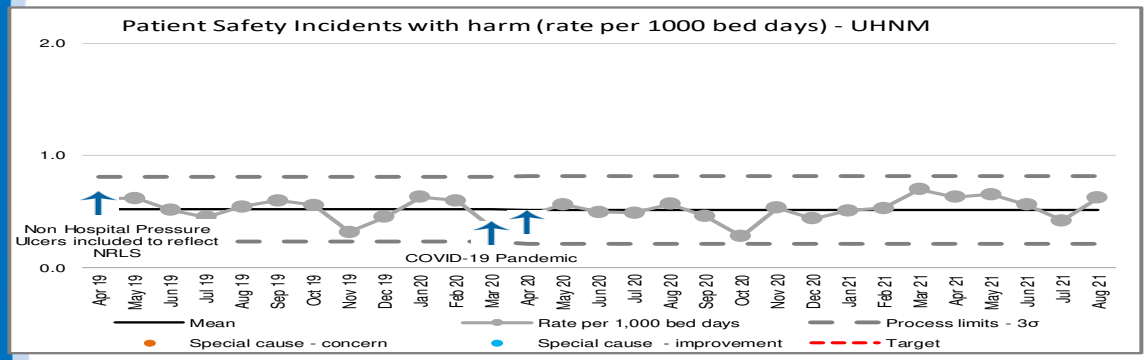


Variation	Assurance

Target	Jun 21	Jul 21	Aug 21
N/A	20	16	23

Background

Patient safety incidents with reported moderate harm and above



Variation	Assurance

Target	Jun 21	Jul 21	Aug 21
N/A	0.56	0.42	0.62

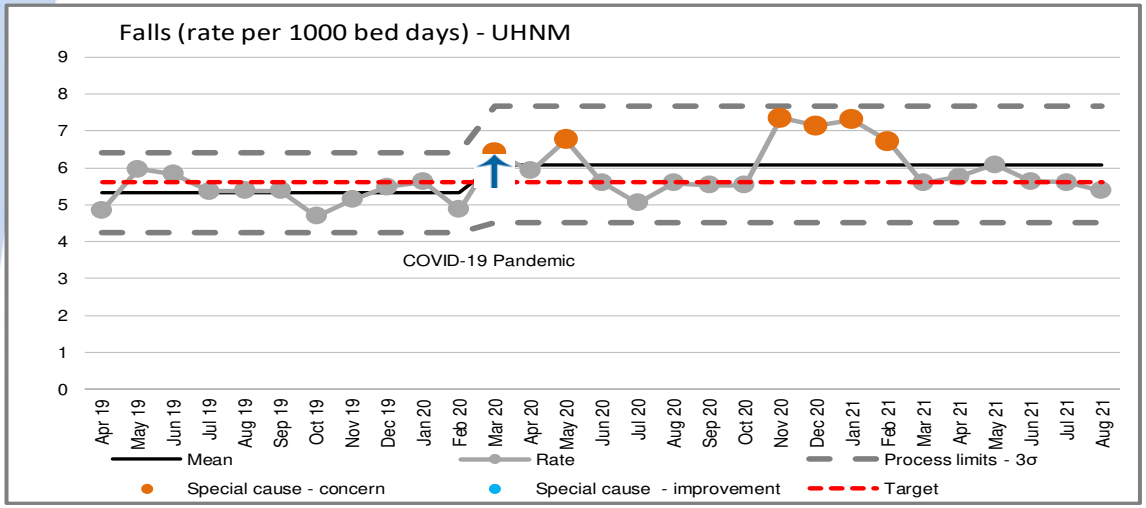
What is the data telling us:

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.

The top category of incidents resulting in moderate harm reflect the largest reporting categories with Slips/Trips/Falls being the largest category with 6.
The second largest category is Treatment/Procedure related reported 4 followed by Infection Prevention with 2 .

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

Patient Falls Rate per 1000 bed days



Variation	Assurance

Target	Jun 21	Jul 21	Aug 21
5.6	5.6	5.6	5.4

Background

The number of falls per 1000 occupied bed days

What is the data telling us:

The data shows the Trust's rate of reported patient falls per 1000 bed days. Using the rate makes allowance for changes in activity/increased patient numbers. The Trust set a target rate, based on the Royal College of Physicians National Falls Audit published rate for acute hospitals, of 5.6 patient falls per 1000 bed days. August 2021 shows 5.4 and remains below the current Trust mean rate.

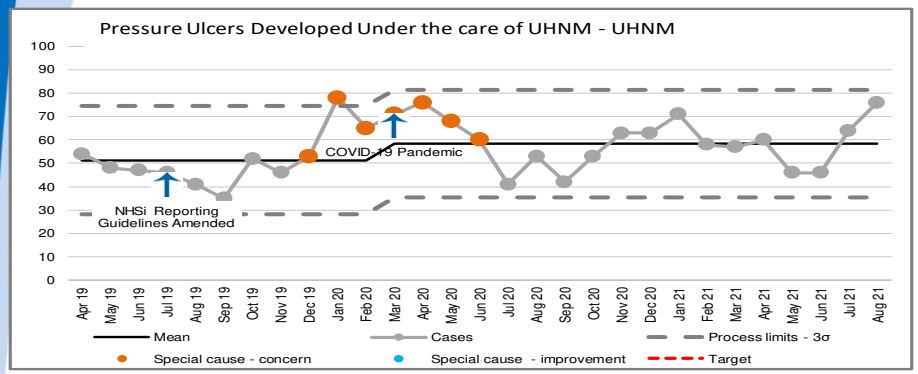
The Top areas for total falls in August 2021 were:

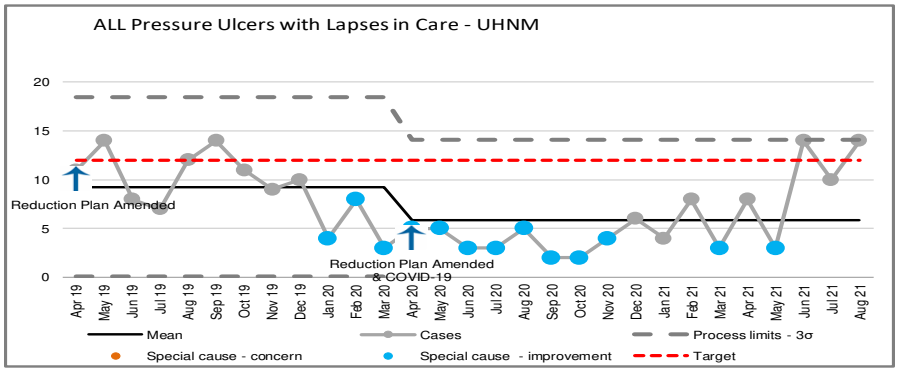
Ward 79 - Female Elderly Care Royal ED Ward 228 – Neurosurgery Ward 124 – Renal Ward 233 Short Stay Unit

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

- Following CQC's visit discussions around the doors in Majors have begun to decide the level of patient risk due to visibility.
- Despite the trust pressure the Fall's Conference is still planned to go ahead on 24th September. This will be reviewed again on Monday 20th September. Speakers have been confirmed. Speakers and delegates have been confirmed.
- Falls awareness week plans continue and resources will be shared throughout the week.
- The Quality and Safety team continues to carry vacancies. We have had one new team member join us during September and a second new member is due to join us in October.
- Data has been shared with SSU, Ward 79, Ward 228, ED and Ward 124 to highlight the position in the top falling areas, number of unwitnessed falls and to encourage them to share the data with the team. It is widely acknowledged that talking about falls to increase awareness often leads to a reduction in falls numbers.

Total Pressure Ulcers developed under care of UHNM





Variation	Assurance

Target	Jun 21	Jul 21	Aug 21
N/A	46	64	76

Background

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

Variation	Assurance

Target	Jun 21	Jul 21	Aug 21
12	14	10	14

Background

ALL pressure ulcers which developed whilst under the care of UHNM which had lapses of care associated

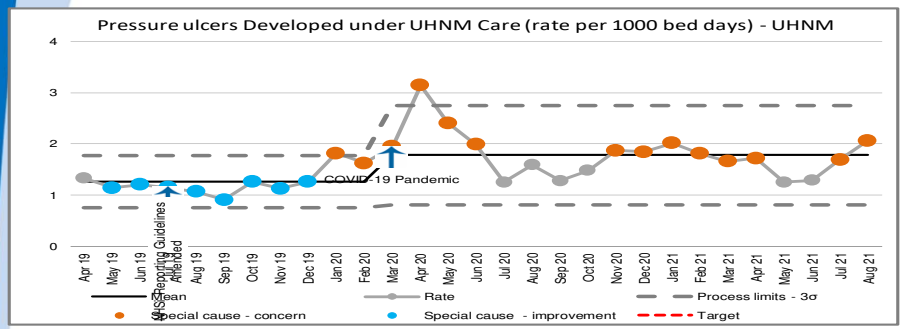
During August 2021 the 76 reported pressure ulcer related incidents were split between the following categories:

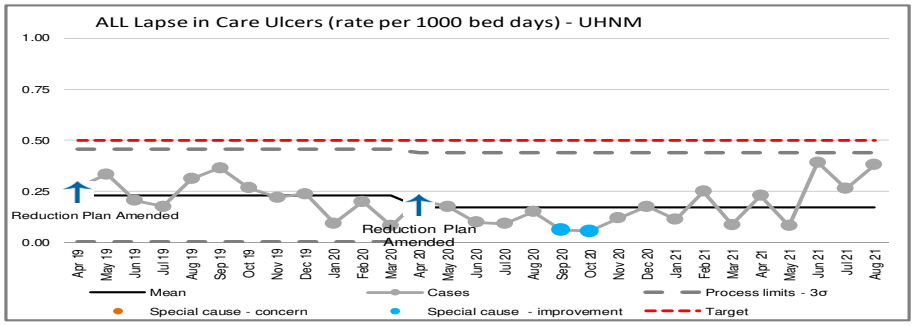
	Total (August 2021)
DTI	26
Category 2	40
Category 3	7
Category 4	0
Unstageable	3
Total	**76**

Pressure Ulcers with lapses in care have fluctuated over the last three months but continue to remain below the upper process limits.

These results are consequence of the continued improvement work in relation to assessment and management of pressure ulcers by the Corporate Nursing Quality & Safety Nursing Team and frontline staff.

Pressure Ulcers developed under care of UHNM per 1000 bed days





Variation	Assurance
H	

Target	Jun 21	Jul 21	Aug 21
N/A	1.29	1.69	2.06

Background

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

Variation	Assurance
	P

Target	Jun 21	Jul 21	Aug 21
0.5	0.39	0.26	0.38

Background

Rate of ALL pressure ulcers which developed whilst under the care of UHNM which had lapses of care associated

What the data is telling us

Chart 1 shows that for three consecutive months the rate of pressure ulcers developed under the care of UHNM have risen and in August have exceeded the mean.

There is a similar rising trend in pressure ulcers developed under the care of UHNM with lapses in care. However, these remain below the upper process limit.

All lapses in care are fully investigated and an action plan with evidence of actions completed or in progress are presented at MDT panel. Spot audits are also presented at this panel to provide assurance that actions and learning from RCAs have resulted in actual improvements in preventative practice.

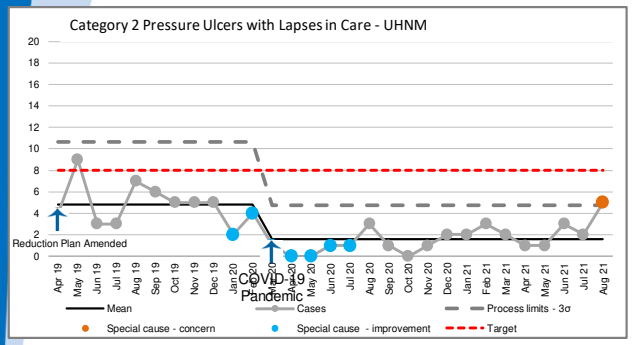
High reporting areas will be presenting all incidents at bespoke RCA panels, to allow identification of ward trends, to identify the need for focussed improvement and education supported by the Tissue Viability and Corporate Nursing Quality & Safety Teams.

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

Actions

- Themes and incidents are under constant review by the Quality & Safety team to identify and discuss any emerging themes.
- The aSSKINg bundle has been amended to promote a focus on Air Mattress pump checking. This is in response to a number of incidents where the Air Mattress pump was found to be faulty.
- A Trustwide audit of chairs is underway following the identification of a number of chairs that have lost their pressure reliving qualities due to wear and tear.
- PUP Champion training is due to recommence on September 24th.
- Learning alerts are now circulated Trustwide in response to incidents and the themes identified during the rise in incidents during 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 .

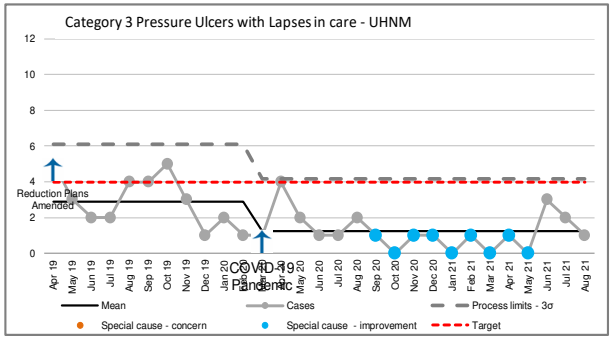
Pressure Ulcers with lapses in care



Variation	Assurance
H	P

Target	Jun 21	Jul 21	Aug 21
8	3	2	5

Background

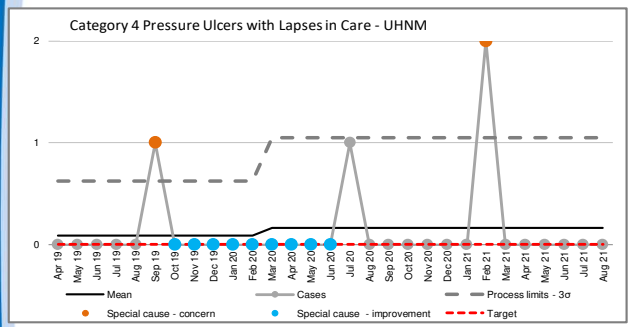


Variation	Assurance
	?

Target	Jun 21	Jul 21	Aug 21
4	3	2	1

Background

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

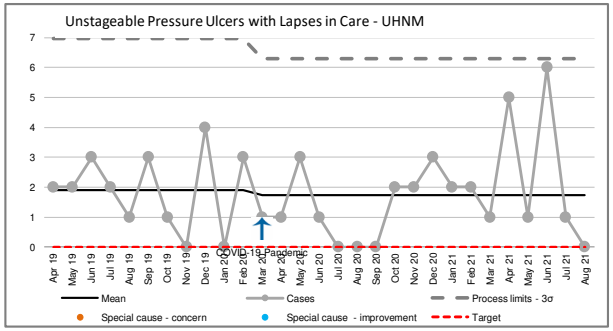


Variation	Assurance
	?

Target	Jun 21	Jul 21	Aug 21
0	0	0	0

Background

Category 4 pressure ulcers which developed under the care of UHNM with lapses of care associated



Variation	Assurance
	?

Target	Jun 21	Jul 21	Aug 21
0	6	1	0

Background

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

What is the data telling us:

The data above shows that there has been 5 Pressure Ulcer with lapses in care during August 2021, 4 Category 2, 1 Category 3.
However, it should be noted that there are ongoing validations requiring RCA presentation in panel and therefore these numbers may change.

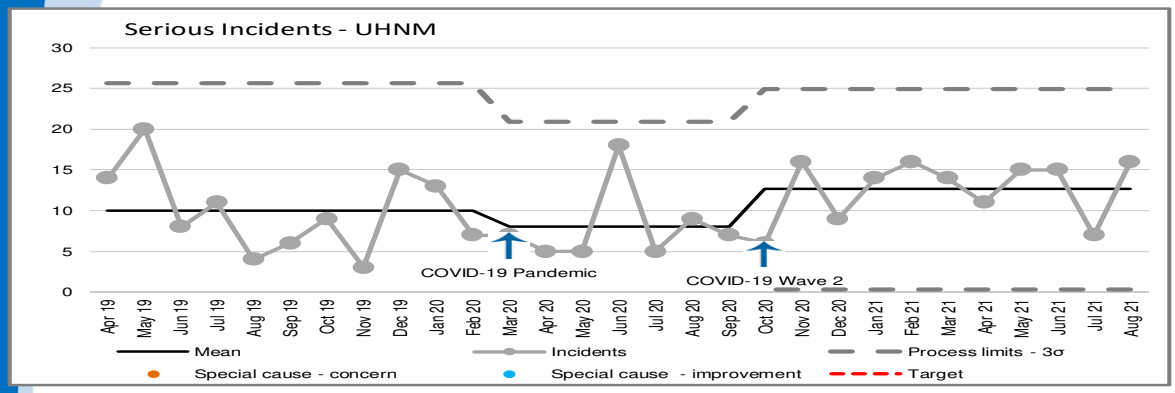
The Category 2 pressure ulcers developed on surgical wards where patients did not have the appropriate heel offloading. These wards are actively engaged in feedback to staff and reviewing their heel offloading equipment.

The Category 3 pressure ulcer developed on a Critical Care patient who received preventative measures was attributed with lapses in care as it was noted that the pressure relieving mattress was not turned on.

Actions:

- In response to two incidents that occurred in July, in there will be an educational focus on the use of profiling beds.
- In response to a theme identified in three incidents there will be an amendment to the aSSKINg bundle to ensure that staff check that alternating air mattress pumps are turned on at all times.
- Pressure Ulcer Prevention (PUP) Champions training is due to re-commenced in September 2021 and focuses around learning from incidents.

Serious Incidents per month

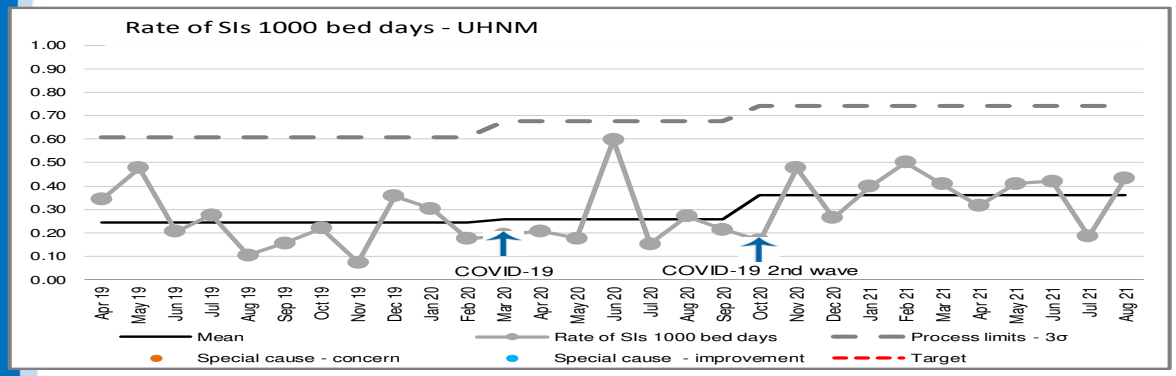


Variation	Assurance

Threshold	Jun 21	Jul 21	Aug 21
N/A	15	7	16

Background

The number of reported Serious Incidents per month



Variation	Assurance

Target	Jun 21	Jul 21	Aug 21
N/A	0.42	0.19	0.43

Background

The rate of Serious Incidents Reported per 1000 bed days

What is the data telling us:

August 2021* saw 16 incidents reported:

- 9 Falls related incidents
- 2 surgical procedure related
- 1 Medical Equipment related
- 1 Pressure Ulcer related
- 1 Maternity related (Baby Only)
- 1 Maternity related (Mother only)
- 1 Treatment related

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

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

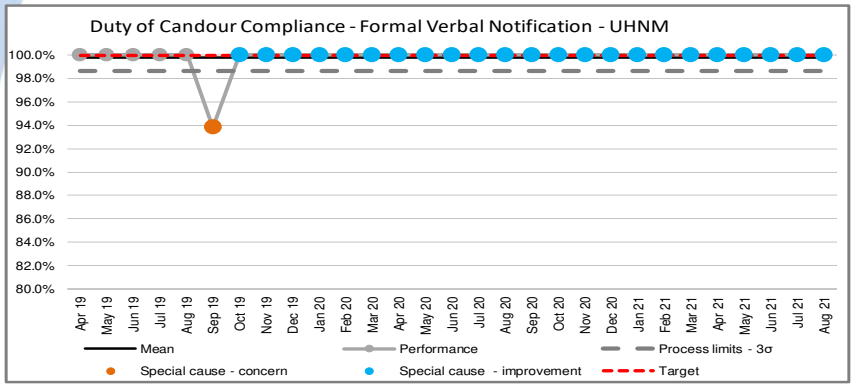
All Serious Incidents will continue to be are reported and investigated and the final Root Cause Analysis presented at Divisional meetings and Risk Management Panel for review and agreement prior to sharing with CCGs for closure.

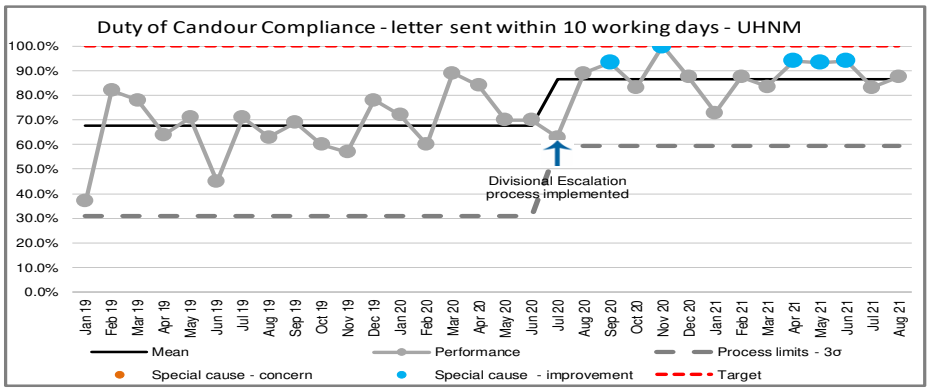
There were 2 Maternity related Serious Incidents reported on STEIS during August 2021

STEIS Ref. No.	Target Completion Date	SI Category	Incident Synopsis
2021/16483	03/11/2021	Maternity/Obstetric incident meeting SI criteria: mother only	Induction of labour at 34 weeks and 6 days for spontaneous rupture of membranes (SRM). Speculum to confirm SRM not performed as per local guideline on admission No sign of liquor through induction of labour Consequence of Incident: Inappropriate induction at 34 and 6 days. Mother received a caesarean section and spinal anaesthesia. Baby delivered at 35 weeks and required admission to the neonatal unit. Potential impact upon subsequent labour for the mother.
2021/16264	01/11/2021	Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus. neonate and infant)	Case Summary: Fifth Pregnancy, 38 weeks and 6 days gestation SRM and Cord prolapse at home, attended by paramedics Admitted directly to theatre, no fetal heart on ultrasound, mother ?acute respiratory distress Instrumental delivery Resuscitation attempted of baby, decision after 1 hour to re-orientate to comfort care Mother transferred to Intensive Care

Duty of Candour Compliance

University Hospitals of North Midlands NHS Trust





Variation	Assurance
H	?

Target	Jun 21	Jul 21	Aug 21
100%	100.0%	100.0%	100.0%

Background

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

Variation	Assurance
	?

Target	Jun 21	Jul 21	Aug 21
100%	94.1%	83.3%	87.5%

Background

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

What is the data telling us:

During August there were 16 incidents reported and identified that have formally triggered the Duty of Candour. All of these cases (100%) have been formally notified of the incident.

Confirmed Follow up Written Duty of Candour compliance (i.e. receiving the letter within 10 working days of verbal notification) during August 2021 is 87.5%.

There 2 cases that have not received the letter within 10 days. Of these 1 has been received and 1 is awaiting final letter to be sent out (as at 11/08/2021)

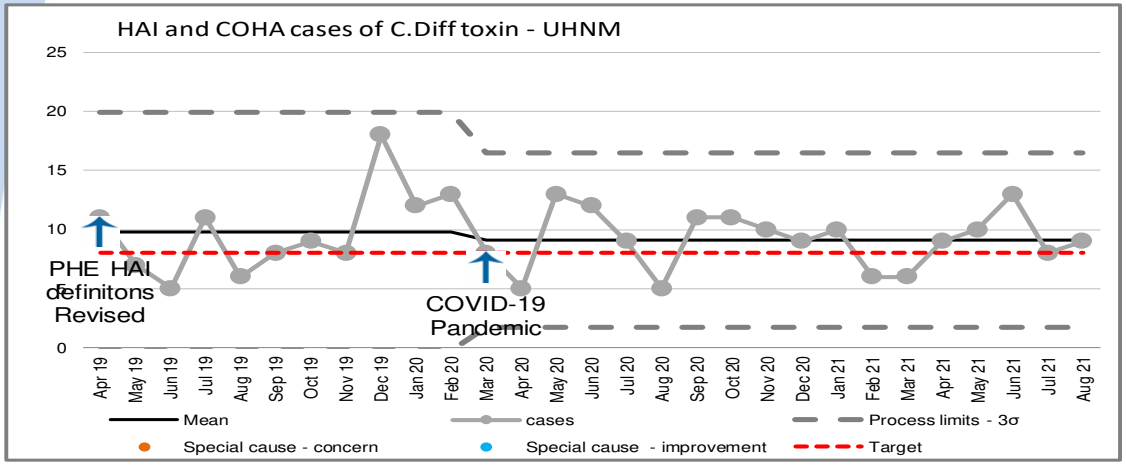
Since the new escalation process was introduced within the Divisions there has been an improvements in performance with smaller confidence intervals and performance above the mean. There has been improved compliance during the past 3 months above the mean rate and close to the 100% target.

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	Jun 21	Jul 21	Aug 21
8	13	8	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 August of these 5 were Hospital Associated Infection (HAI) cases and 4 Community Onset Healthcare Associated (COHA) cases.

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

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

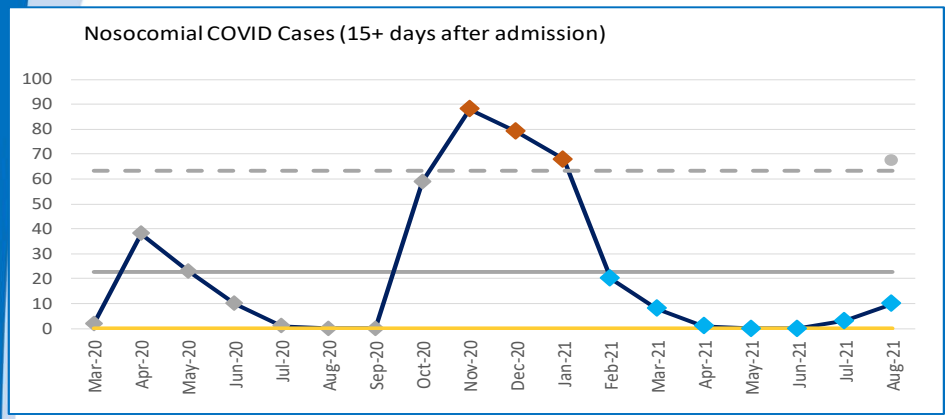
There has been one clinical area , ward 226 , one Toxin HAI and one toxin COHA within a 28 day period:

Awaiting ribotype results, all Infection Prevention measures are 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 10 in August 2021 (these patients were within CWD)
- Local, Regional and National community COVID-19 rates have increased in August 2021 (see table opposite)
- August has seen slight increase in Probable and definite Hospital Onset COVID but is below Wave 2 figures during October and March.

Actions :

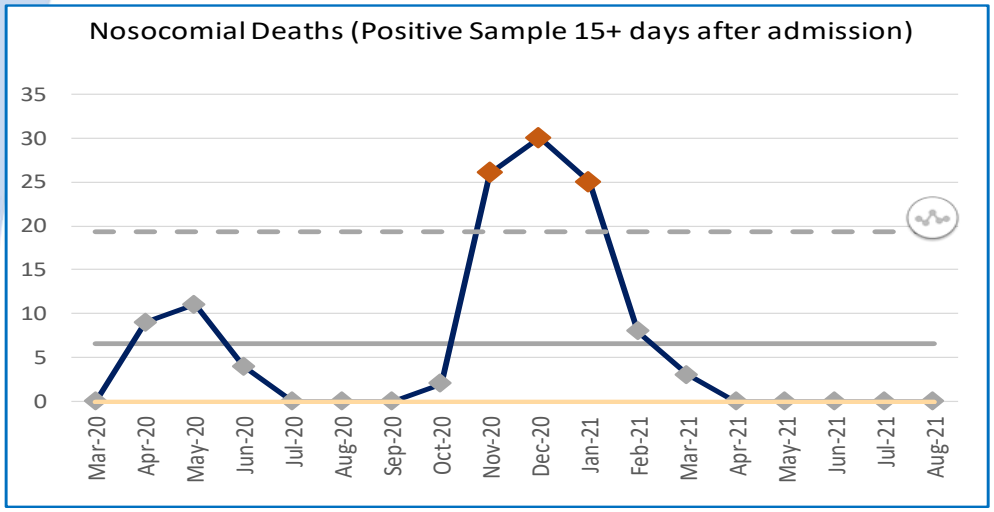
- All Emergency patients continue to be screened for COVID 19 on admission to UHNM, screening programme in place for planned surgery/procedures.
- All inpatients who have received a negative COVID 19 screen have a repeat COVID 19 screen on day 4 , 6 and weekly
- COVID 19 themes report provided to IPCC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

	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

Percentage breakdown of COVID Cases per onset category per month

Month	Community Onset	Indeterminate	Probable	Definite
Apr-20	73.5%	9.5%	9.7%	7.2%
May-20	65.6%	10.7%	14.6%	9.1%
Jun-20	67.2%	10.3%	13.8%	8.6%
Jul-20	92.3%	3.8%	0.0%	3.8%
Aug-20	78.6%	21.4%	0.0%	0.0%
Sep-20	100.0%	0.0%	0.0%	0.0%
Oct-20	66.7%	8.7%	12.7%	11.9%
Nov-20	67.7%	13.0%	10.7%	8.6%
Dec-20	68.5%	11.4%	11.5%	8.5%
Jan-21	66.7%	12.9%	13.3%	7.1%
Feb-21	69.4%	14.3%	9.9%	6.4%
Mar-21	71.3%	10.2%	11.1%	7.4%
Apr-21	81.8%	6.1%	9.1%	3.0%
May-21	90.0%	10.0%	0.0%	0.0%
Jun-21	92.0%	8.0%	0.0%	0.0%
Jul-21	92.3%	4.1%	2.1%	1.5%
Aug-21	81.2%	8.8%	5.9%	4.2%
Grand Total	71.0%%	11.0%	10.6%	7.5%

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 zero recorded definite hospital onset COVID-19 deaths during July 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 7

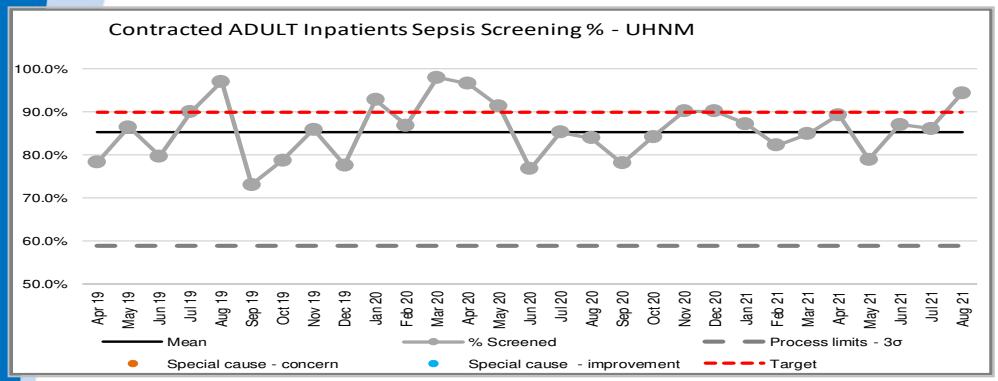
Actions :

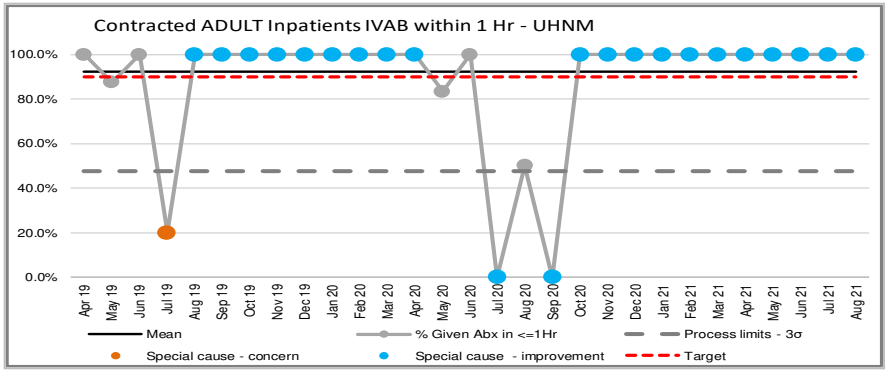
The online SJR form has been adapted to include specific COVID related questions following pilot review by Deputy Medical Director.

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

Sepsis Screening Compliance (Inpatients Contract)

University Hospitals of North Midlands NHS Trust





Variation	Assurance

Target	Jun 21	Jul 21	Aug 21
90%	87.1%	86.1%	94.4%

Background

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

Variation	Assurance
H	

Target	Jun 21	Jul 21	Aug 21
90%	100.0%	100.0%	100.0%

Background

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

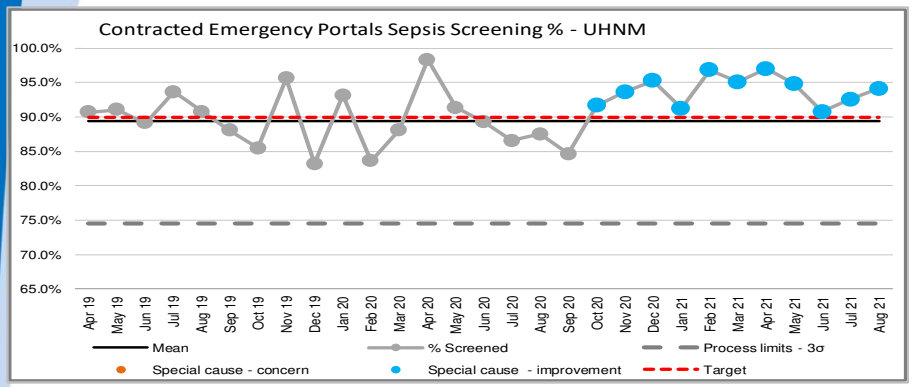
What is the data telling us:

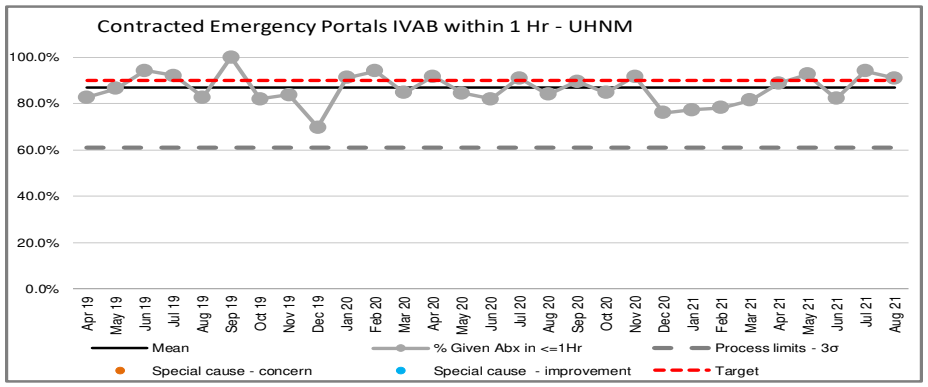
Inpatients August results now show 94.4% compliance for screening and continues to maintain 100% compliance for IVAB within an hour. Of the 107 Inpatients that triggered a sepsis screen, 71 had sepsis red flags present, 5 of these patients were given IVAB within hour and of the remaining 66 patients, 32 had alternative diagnosis that were deemed as not sepsis related and IVAB were not indicated. The remaining 34 patients were already receiving IVAB prior to the identified red flag trigger. Surgery Division screening compliance has improved significantly and achieved 100% while both Medicine & Specialised achieved above 90% screening compliance.

Actions:

- The sepsis team have continued to provide sepsis re-enforcement, kiosks, visiting ward areas to update clinical staff and promote awareness around sepsis
- 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 the Surgery division to maintain and sustain this excellent compliance this month:
- The Sepsis Team have organised two days sepsis awareness and campaign on World Sepsis Day (13th & 14th September 2021) by visiting clinical areas both sitesa and giving recognition of the great work and excellent standard of sepsis practice to the clinical team and individuals.

Sepsis Screening Compliance (Emergency Portals Contract)





Variation	Assurance
H	?

Target	Jun 21	Jul 21	Aug 21
90%	91%	93%	94%

Background

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

Variation	Assurance
	?

Target	Jun 21	Jul 21	Aug 21
90%	82%	94%	91%

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 August 2021 achieved 94% for the 68 patients audited.

The performance for IVAB within 1hr was 91% in August. There were 55 red flag sepsis patients identified from the 68 patients audited in the screening sample. Out of the 55 red flag patients, 20 received IVAB within an hour whilst 18 were already on IVAB and 15 had an alternative diagnosis.

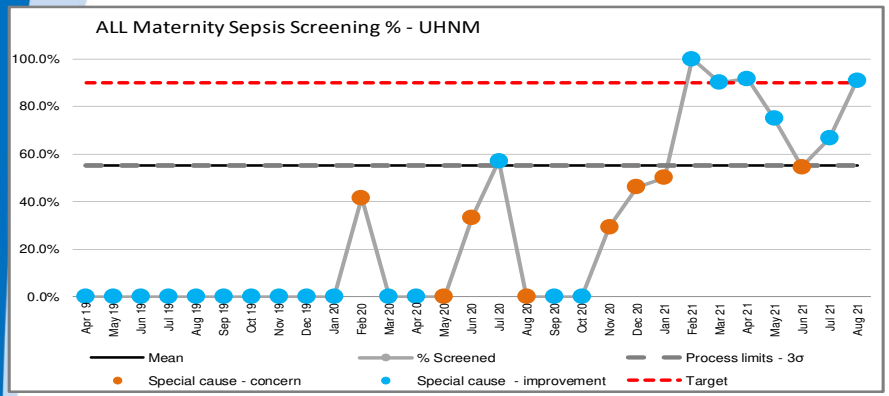
There was 2 late IVAB from A&E Royal Stoke site which was administered within 3 and 5 hours. This has been escalated to the A&E senior teams and awaiting further update for learning.

Actions:

- The Sepsis team continue to closely monitor the compliance by visiting the A&E regularly and offering department based sepsis reinforcement when staffing and acuity allows; on-going
- The Sepsis Team is working collaboratively with the A&E Quality nurses, senior staff and A&E Sepsis clinical lead for providing solutions to late IVAB incidents and robust actions put in place. The late IVAB have been addressed through escalation and training for individual staff involved.
- Promoted further sepsis awareness and campaign on 13th and 14th of September 2021, World Sepsis Day. The Sepsis team had visited both A&E sites and met few nursing staff, senior staff, nursing assistants and clinicians.
- 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

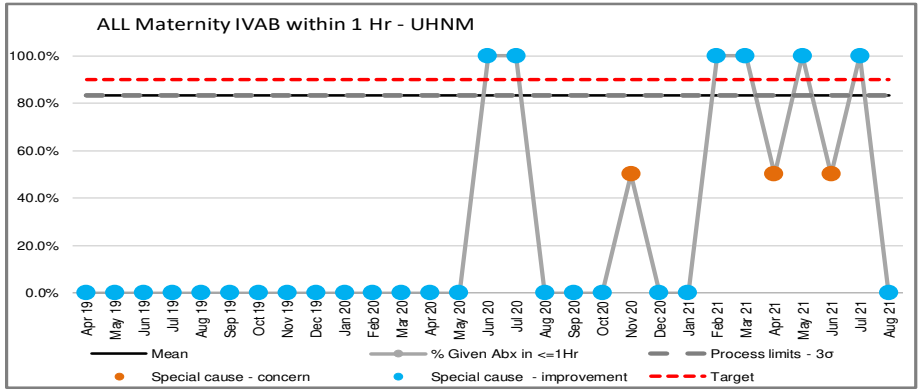


Variation	Assurance
H	F

Target	Jun 21	Jul 21	Aug 21
90%	54.5%	66.7%	90.9%

Background

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



Variation	Assurance
H	F

Target	Jun 21	Jul 21	Aug 21
90%	50%	100%	N/A

Background

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

What is the data telling us:

Maternity Inpatients and Emergency portal (MAU) audited by the Sepsis Team in August 2021 shows that 90.9% of patients that trigger with MEOWS >4 were audited via K2 electronic system. This result was taken from 11 patients audited with 1 missed screens from the inpatient ward.

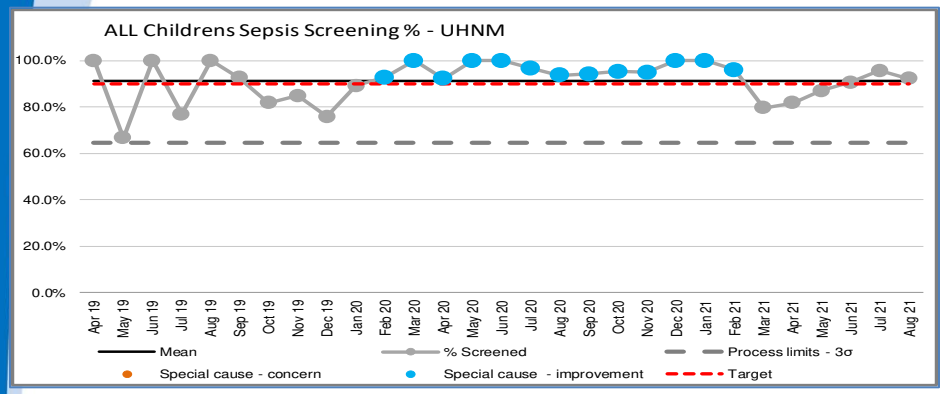
Nil or Not applicable for IVAB within an hour as red flags triggers were either with alternative diagnosis or patients were already on IVAB treatment prior to MEOWS triggers. Overall, the Maternity sepsis screening compliance this month is a huge and significant improvement from the previous months.

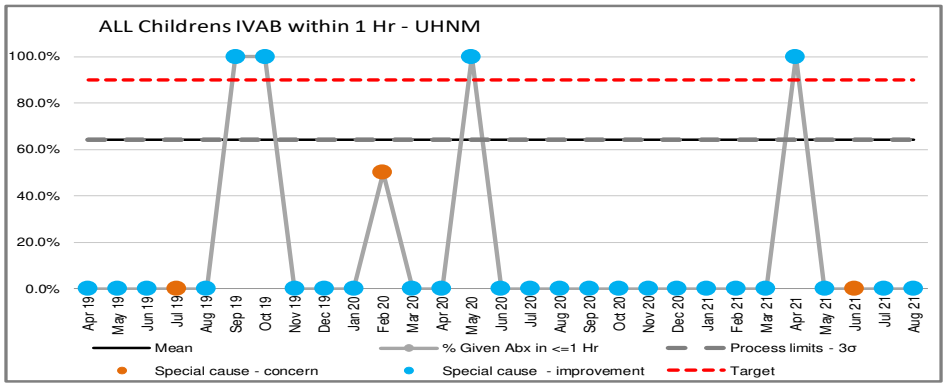
Actions:

- The Maternity Senior team 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.
- 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.
- Maternity educator is supporting the sepsis team by conducting independent sepsis audits in the whole Maternity department with good effect.
- The plan of delivering Maternity 5 hour sepsis CPD champion training remain in the pipeline for future collaborative work.

Sepsis Screening Compliance ALL Children

NHS University Hospitals of North Midlands NHS Trust





Variation	Assurance
	?

Target	Jun 21	Jul 21	Aug 21
90%	90.6%	95.7%	92.3%

Background

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

Variation	Assurance
H	F

Target	Jun 21	Jul 21	Aug 21
90%	0.0%	N/A	N/A

Background

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

What is the data telling us:

The charts above show slight decline in sepsis compliance compare to July 2021, with a result of 92.3%.and above the target rate.
CAU continued to sustain and maintain compliance of > 90% and a good improvement for Children A&E from June to August by achieving >90% for screening compliance, IVAB within hour compliance for CAU & Children A&E are not applicable or no red flags trigger. Children Inpatients ward 217 has missed 1 screen while ward 216 have no PEWS 5> triggers during randomised audits. 1 missed screens has been escalated to the senior team. Most inpatients Paediatrics are already on oral antibiotics or IV antibiotics prior to trigger of PEWS >5 (this is both of moderate and high risks).

Actions:

- The Sepsis Team will continue to deliver re-enforcement and kiosks to specific areas when falls in compliance are identified. Ward managers and seniors teams are encouraged to forward concerns and ad hoc training is offered to all areas when required; on-going
- The Sepsis Team has continued to adjust the audit process 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; on-going
- The Sepsis Team will continue issuing certificates in recognition of clinical areas and individual staff who demonstrate a high standard for sepsis practice

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Operational Performance

2025 Vision "Achieve NHS Constitutional patient access standards"

Spotlight Report from Chief Operating Officer

NHS
University Hospitals of North Midlands
NHS Trust

Emergency Care

- Attendances at ED that had levelled off in July reduced in August to a daily average of 360 (July 348).
- The decrease in attendances were again more notable in paediatrics. So in effect the adult numbers per day remained the same at an average of 281/day. Ambulance arrivals were also lower at a daily average of 155/day.
- Whilst the daily average number of admissions fell slightly the conversion rate remained the same.
- Ambulance handover delays for 30-60mins remained static and the > 60 mins rose in August and the percentage of handovers within 15 minutes fell to around 40%, due to the periods of ambulance surges often late afternoon that require processing time to clear.
- System-wide performance was 68% (July 67.4%), with total type 1 at 53.2%. At Royal Stoke the non-admitted performance rose to 54.3% (July 51.5%) and the admitted performance rose to 24% indicating the key issues for August were related to extended timescales to securing a admitted placement. MFFDs have risen as have the number of patients with > 21 days stay.
- The department had continued days with sub 60% performance with most of the front door metrics challenged.

Cancer

- The Trust is provisionally predicted to achieve the following two cancer standards for August 21: 31 day subsequent Radiotherapy at 96.1% and Rare Cancers 31 Days at 100%
- The overall 2WW position for August is predicted to achieve in the region of 65.8%. Specialties with the most 14 day breaches are Skin, Colorectal and Upper GI.
- Performance against the 62 day standard is currently at 52.5% for August 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 August is higher than normal. 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 August position is significantly challenged, and will be validated prior to upload.
- PTL Updates:

  The 2WW PTL remains high when compared to February and March 21.
  The 2WW 62 day backlog is continuing to increase as treatment capacity is reduced due to covid pressures.
  The number of patients waiting over 104 days has increased to 80. Of these 55 are on a Colorectal pathway. All specialties asked to do a further clinical review of these pathways as it is considered there are at least 6 who do not fit the criteria for this pathway.
  2WW 62+ Day backlog validation exercise was completed with outstanding reviews escalated. Other contributing factors include delays to urology robotic surgery due to capacity, complex pathways and an increasing element of patient choice.

Spotlight Report from Chief Operating Officer

NHS University Hospitals of North Midlands NHS Trust

Planned Care

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

- Day Case and Elective Activity delivered 83.6% for August 21 against the national ask of 95%. This is lower in Inpatients than Day case (76.3% IP, 84.7% DC).
- Plan to release more patients to the IS to enable full optimisation of capacity through one off lift and shift of patients, starting with the Nuffield.
- Next Planned Care Cell focus on theatre capacity and productivity given the emergent covid risks and staff isolation rate of attrition.
- Scoping of schemes to support management of referred demand (Referral Hub) and waiting list management (Patient Contact Initiative)

RTT

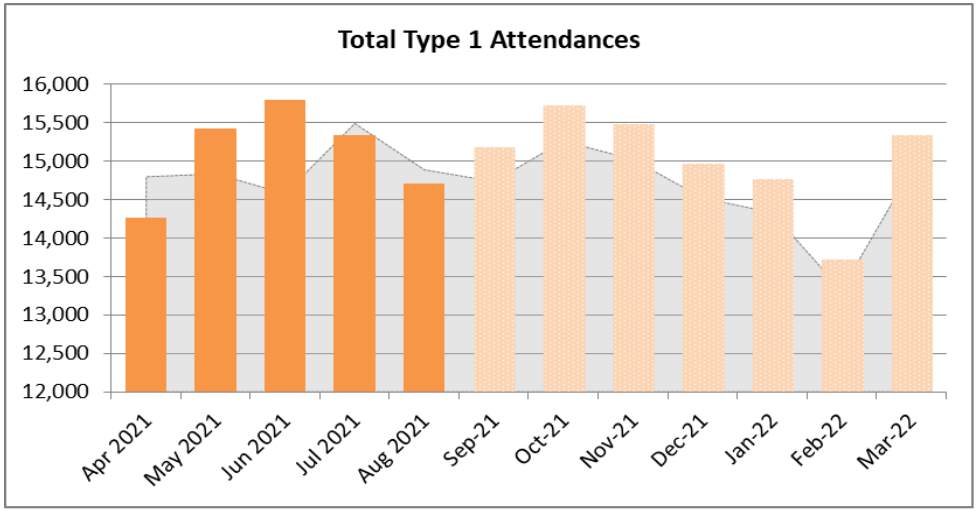
- The indicative performance for August 21: the total number of Referral To Treatment pathways grew to 67,784 (July 65, 574).
- There has been a slight increase in the number of > 52 weeks to 3,495.
- RTT performance in August is 59.9% (July 61.4%).
- Work plans around long wait patient validation and treatment tracking are in progress.

Diagnostics

- For DM01 (15 nationally identified Dx tests) the total waiting list has reduced in August from 20,134 to 19,580. However in Non-obstetric ultrasound the waiting list continues to grow. August 10,318 (July 9,657). Due to the challenges in Non-Obstetric Ultrasound this has adversely affected performance. The current DM01 diagnostic performance for August 21 has deteriorated to 66.19% (July 71.95%).
- 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.
- The main diagnostic pressures are within histology which is having a negative impact on cancer waiting times – an improvement action plan in in place. Workforce shortfalls are the predominant cause of this situation.

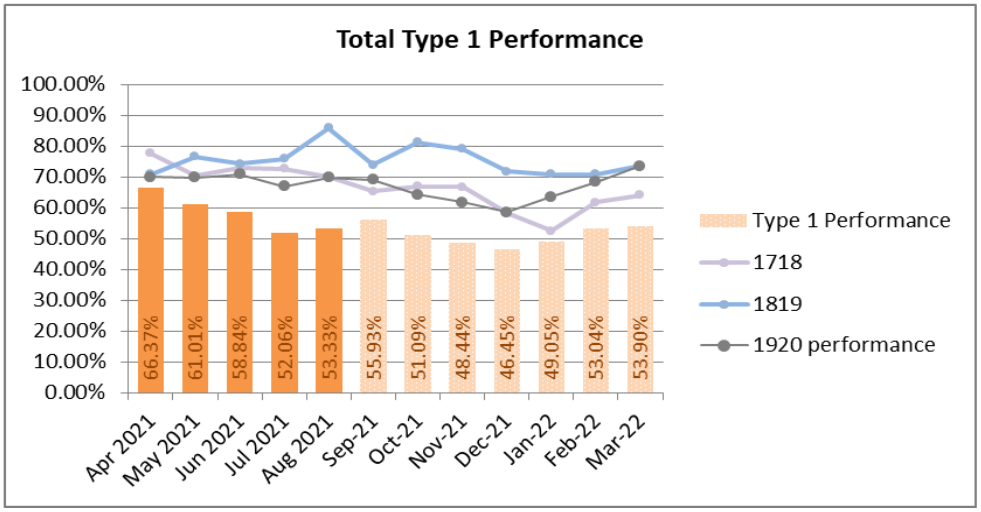
Section 1: NON ELECTIVE IMPROVEMENT

Urgent Care – Trajectory

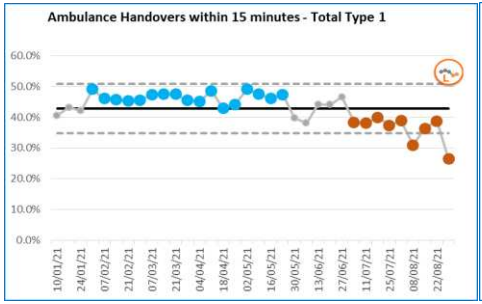


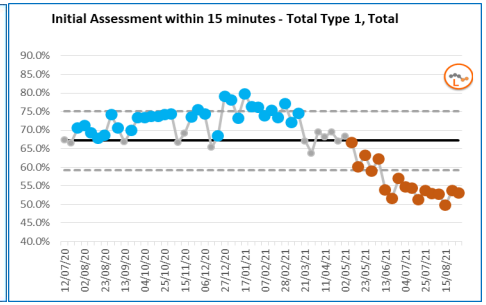
3% growth on 1920 BAU modelled for Type 1 attendance numbers.

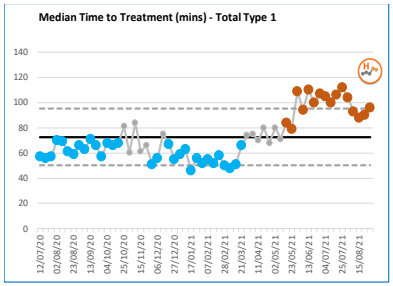
This is based on Q1 actual (2.6% increase) however July 21 saw fewer patients than in July 19 indicating the growth may have been temporary unmet demand.

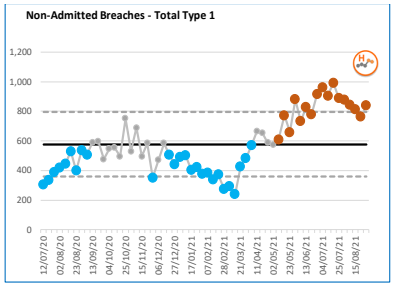


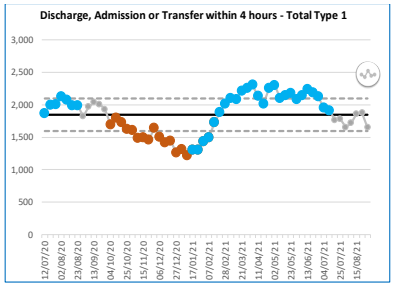
With demand in line with 1920 numbers - 4 hour performance has been set to track 1920 BAU going into Winter, but starting at July's lower performing starting point. a more conservative performance improvement out of winter has been taken more in line with other years.

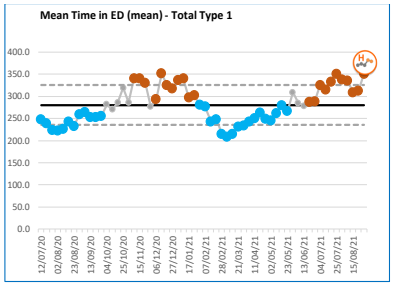


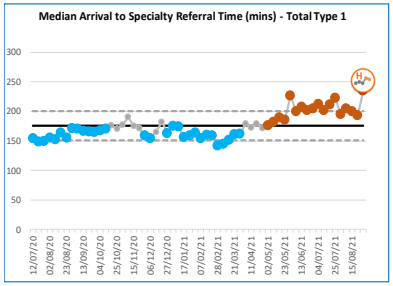


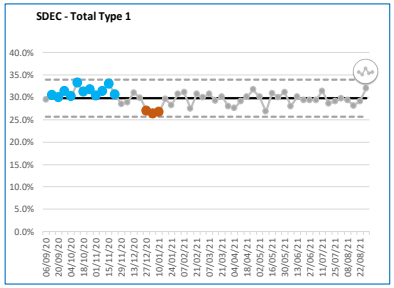


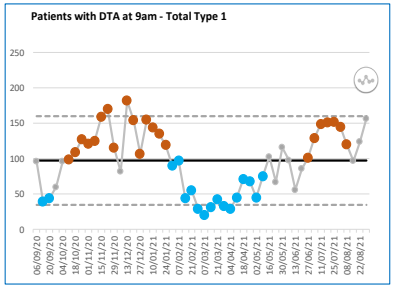


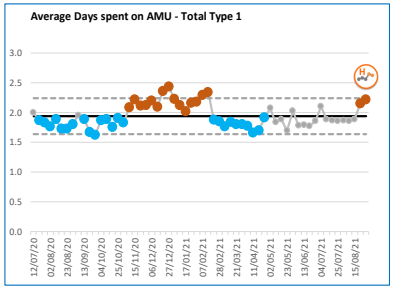


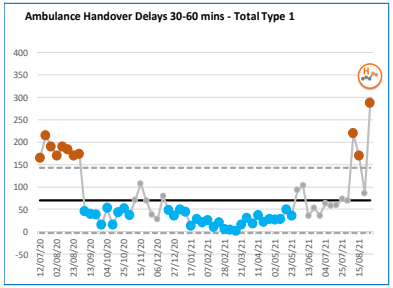


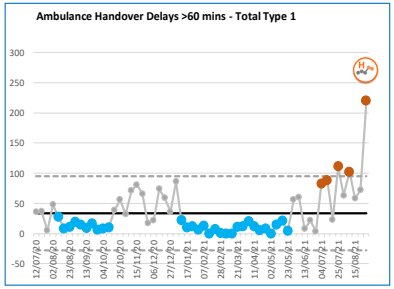


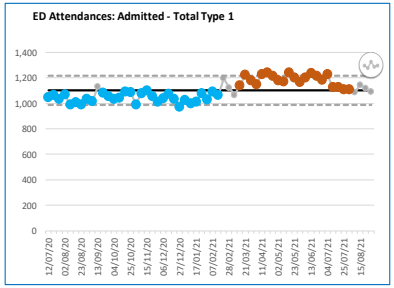


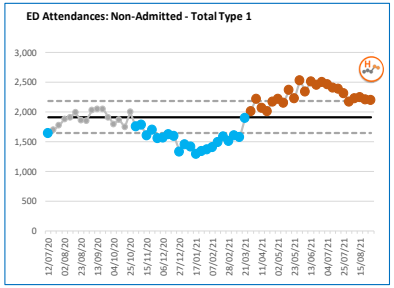












Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Urgent Care – Work stream 1: Front Door

NHS University Hospitals of North Midlands NHS Trust

SUMMARY

Total type 1 attendances reduced further in August. At the RS site, the daily average attendances were 348/ day (compared to July 360/ day). The main fall in attendances was seen again in the children's area where the daily averages fell by c10/day whilst the adult attendances remained similar to July. Notably the number of patients attending and admitted with suspected Covid began to increase again with admissions to wards and critical care proving challenging. The 7-day rolling average reached 64 compared to the 44 seen in July. Beds were also restricted for infection prevention and the numbers increased most at the end of the month with 13 beds restricted on some days.

The percentage of ambulance handovers within 15mins did not recover in August with one spike towards the end of the month where the percentage fell to 26%. This spike 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 failed to recover from the July performance and was maintained c53%. In the last week the non-admitted triage percentage rose whereas the ambulance triage fell. 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 and self isolating.

The number of patients in the department for > 12 hours is of significance in that UHNM is reported to have the highest numbers. August saw a continuation of the high numbers seen in July with a spike at the end of the month to around 400 in one week.

The total number of admissions fell slightly in August with a daily average of 118/day (compared to 121 in July). The number of patients referred to all specialties fell slightly to an average of 123/day in compared to 131 in July with an average referral to discharge time of 309 minutes (July 321mins). The high number of patients waiting to be admitted at 9am seen in July was maintained through August with the exception of one week in the middle of August.

The admitted performance did not improve from the position in July and overall achieved 24%. Non-admitted performance improved slightly to 54.3% (July 51.4%).

Downstream indications were that patients were staying longer. The daily average Nos. of beds occupied in Medicine rose again slightly from 432 to 439 . The number of patients > 14 & 21 days increased as did the number of MFFDs which steadily increased in August to around 80 compared to 70 in July. Discharges pre-noon showed some deterioration through August. The number of patients in medical beds at midnight rose in August and was higher than at the same time in 2019/20.

August saw seven 12 hour trolley waits.

Urgent Care – Work stream 1: Front Door

National bundle

- The percentage of ambulance handovers in 15mins has continued to show signs of deterioration. However, there is a robust process for patients who are held on ambulances with a navigator at the front door and clinicians who review and check the patients.
- The percentage of patients whose Time to initial Assessment maintained an overall position of c52%-54%, however ambulance triages fell from 71.7% to 67%.
- The rises that impact on performance the most are where there are surges of over 30 attendances within the hour particularly in the evening where staff shortages, particularly decision makers has been a challenge. The department are aiming to maintain the triage time with re-deployment of staff in the department at the time. A business case addressing workforce issues is underway.
- Targeting of SIFT and RAT has seen WTBS reduce from a median of 120 minutes in July to 100 minutes in August.
- The MEAN time in the department has also risen for both admitted and non-admitted patients
- The number of patients spending over 12 hours in the department has remained above the mean. Specialty requests have increased by 716 based on August 19/20 figures and AMU LoS has increased leading to periods of exit block from ED

Performance

- System-wide performance is down to 67.4% (June 69.8%), with total type 1 at 52.0%. At Royal Stoke the non-admitted performance fell to 51.4% (June 56.6%) and the admitted performance fell to 23.4% .
- The community based CRIS team and WMAS are targeting interventions at C3 and C4 non life threatening ambulance calls. This is in its early days, the average number of ambulance conveyance for the relevant age range has remained steady at 78 per day for July and August.

Urgent Care – Work stream 1: Front Door

NHS University Hospitals of North Midlands NHS Trust

ACTIONS

Attendances:

Improvement and system wide actions which include;

- 'RED' GP reinstated and capacity increased - daily monitoring of referrals demonstrates that Vocare are currently seeing on average 17 Children and 38 Adults per day. ED are still experiencing Children's attendance with 66 per day on average. From the manual collection of numbers we have for Red GP they are seeing 18 patients per day, split by 10 Children and 8 Adults:
- WIC increase in staff to support ambulatory demand
- Use of GP referral hub to prevent GP admissions
- Enhanced access for NHS 111 to support admissions to SDEC / AEC. First NHS 111 Patient Redirection Tool kiosk in place at County ED w/c 05th Sept, roll out to RSUH in October
- Continue to attempt to Increase staff within ED to support attendance surges (SIFT and RAT) however fill rate remains low.

National bundle:

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

Workforce:

- ED medical workforce business case to address workforce issues with clear key metrics to measure improvements to Paf in September
- Engage senior clinicians. Re-set department structures.
- Working on A&E internal improvements including roles and responsibilities, huddles and rounding to improve grip, supported by visible improvement and escalation dashboards

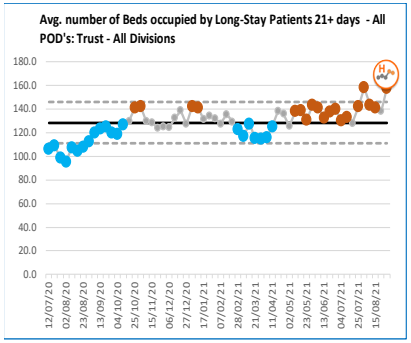
Urgent Care – Work stream 1: Front Door

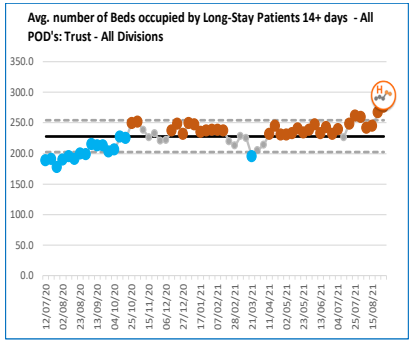
University Hospitals of North Midlands NHS Trust

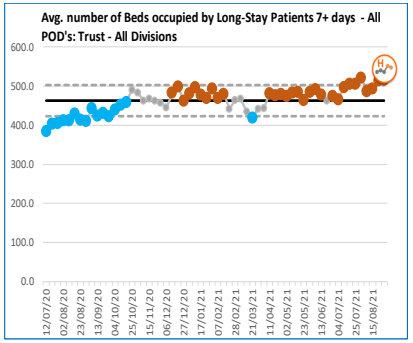
Reset of Acute Front Door priorities and action plan;

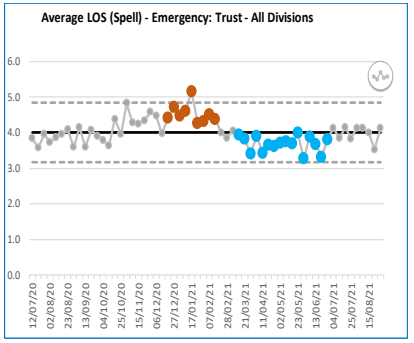
- Admitted and non admitted themes to be retained – some items transfer to BAU
- Re prioritisation of self presenting pathway to include;
  - Digital solutions, implementation of NHS 111 patient redirection tool
  - Development of directory of service to support patient redirection tool
  - Role and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

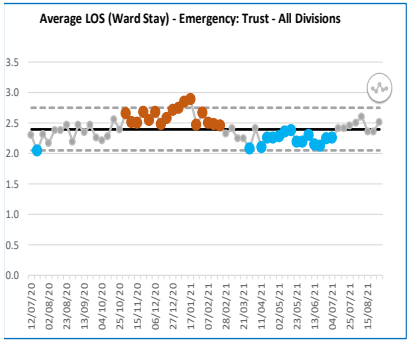
Urgent Care – Work stream 2: Flow

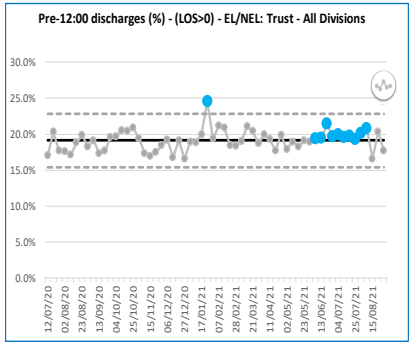


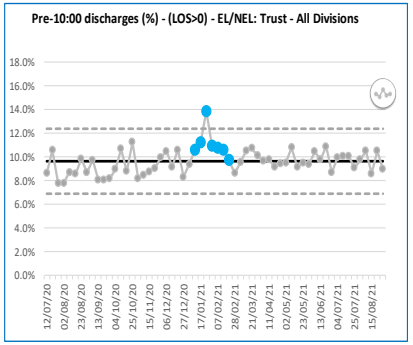


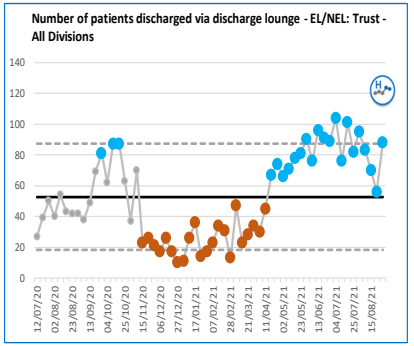


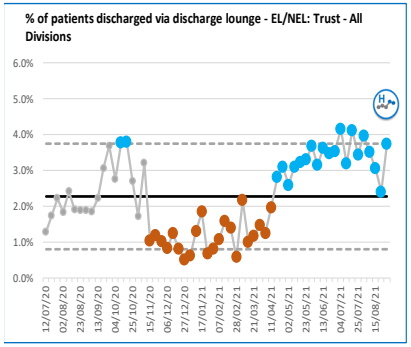


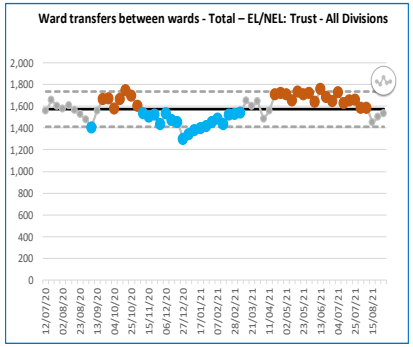


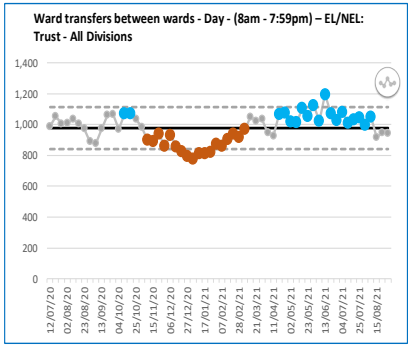


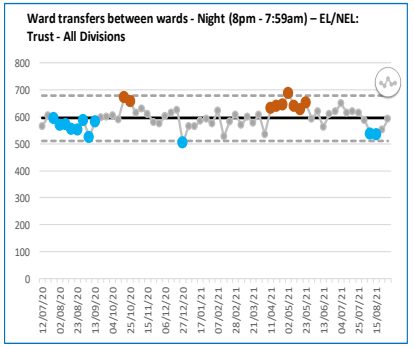












Urgent Care – Work stream 2: Flow

SUMMARY

- Long stay patients (14 & 21 days or more); The average number of beds used remained high for all groups of patients. Rises were more notable in Medicine and Specialised Divisions. The average LOS (ward stay) for emergency admissions maintained the July position at around 2.5 days Trust total. This was more notable in Medicine and Specialised.
- MFFD numbers have risen to a Trust total of 109, a gradual but constant rise from has seen the numbers move from 50 in May and June.
- The pre-noon discharge percentage of 30% was not reached and the overall steady rate of c20% across all areas dipped to below 20% in two weeks. Pre-noon discharges need to be seen jointly with LoS as areas have brought forward discharges to the previous afternoon/evening. Average Los (spell) for emergency admissions was maintained at around the Mean at 4 days.
- The significant increased numbers of patients discharged via the discharge lounge was maintained. There was one week when performance fell and this as notable in Medicine.

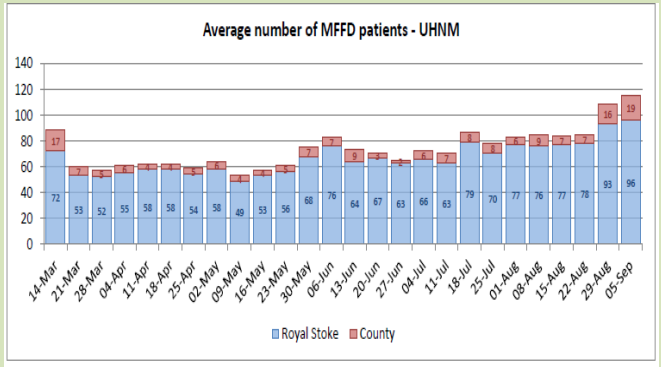
ACTIONS

- Maintain focus of discharges before midday through improvement workshops. Teams aim to deliver 25% plus pre noon discharges. Surgery have increased their pre-noon discharges to 20% with a new action to identify two early discharge 'golden' patients in helping to achieve the 25% required
- Maintain focus on the use and future opportunities for the UHNM discharge Lounge as part of surge plans and winter.
- Support length of stay by using directorate Teams – support improvements seen.
- Importance of young persons rehab Unit working with MPFT.
- Set up Task and Finish Groups with each division to support sustained improvements and prepare more focused plan on improvements ahead of winter.

Work stream 3: Clinical Site Management

Summary

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



Actions

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

Section 2: ELECTIVE CARE

Cancer

NHS University Hospitals of North Midlands NHS Trust

Cancer Summary:

- Workforce pressures across the trust: Theatre, Oncology and Surgical workforce impacted due to self isolation or positive cases of Covid. Radiologist capacity resulting in waits for imaging reports. Other workforce pressures impacting on cancer pathways as operations or clinics are cancelled at the last minute and MDT meetings are not quorate. There is currently a 4 week wait for Systemic Anti Cancer Treatment. The Oncology team are collating a list of patients to send to the region to seek mutual aid. Independent sector providers are also being explored. Nuffield contract now in progress.

- The trusts annual cancer quality surveillance report was presented and endorsed at the Performance and Finance Committee. It included examples of accelerated innovative practices that have developed at specialty level over the past 12 months, and also highlighted challenges the past year has brought clinical teams e.g. Pathology, CNS & Dietetics workforce. As a result, the committee know to expect up and coming business cases that seek to address these areas.

- Lower GI RDC pathway – 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.

- Gastro update on Endoscopy wait list: There is a small volume of patients waiting outside of 14 days, this is due to DNAs, cancellations, clinical prioritisation of low risk Polyps, requests awaiting clinical vetting, unable to contact some patients (these have been sent to faster diagnosis cancer navigators for support). The endoscopy booking manager is working on obtaining propofol lists – this will be additional activity based on TIs from the anaesthetist to clear the backlog that has accumulated. The Endoscopy reporting software is due to be updated which will include a standardised cancer pathway outcome made mandatory when reporting. This will reduce inefficiency and improve performance against the 28 day Faster Diagnosis Standard.

- Best practice pathways – The corporate cancer team conducted an initial review, looking at how the Prostate, Colorectal and OG pathways are being monitored and audited within each specialty. Findings were that the Prostate pathway was being closely monitored with improvements tracked and reported on – the clinical team have a good awareness on how long it typically takes patients to move between steps on the pathway and understand their pressure points. The West Midlands Cancer Alliance will now support trusts with a deep dive into compliance against these pathways, with Quality Improvement Facilitators leading manual audits to standardise the regional approach to monitoring best practice pathways.

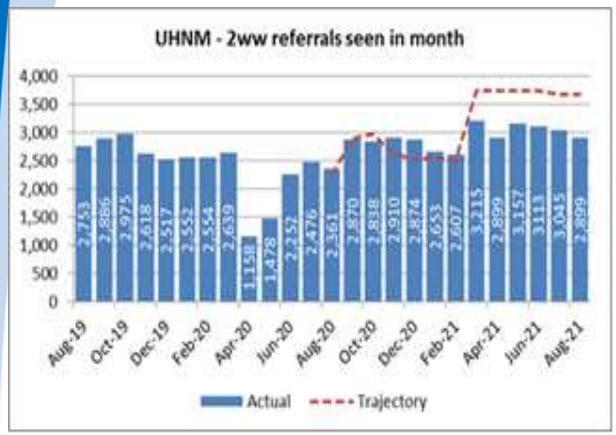
Cancer

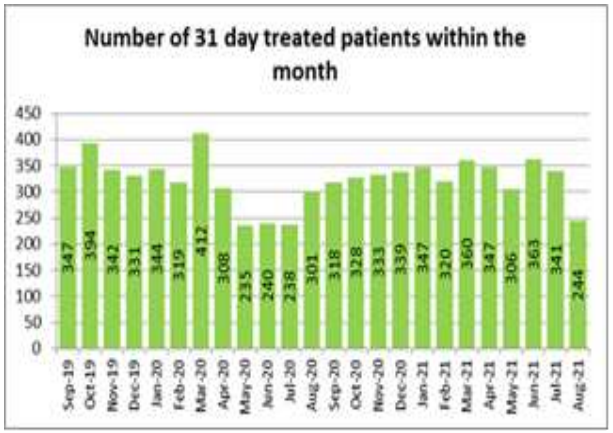
NHS University Hospitals of North Midlands NHS Trust

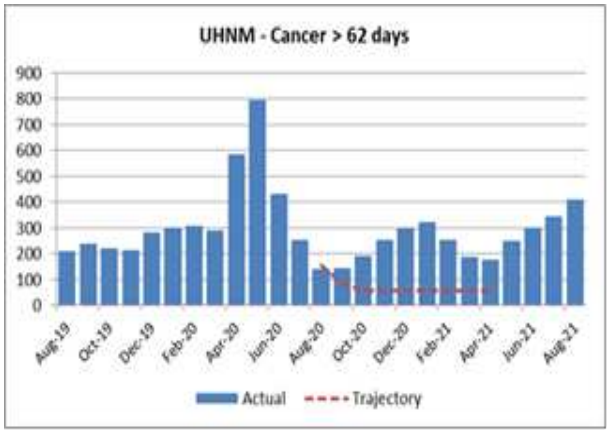
- Trajectories have been agreed and are being tracked against the actual positions. Most recent published data is for July:
  - 14 Day Trajectory July: 73.7 %. Actual 78.1%. Actual Seen. 3045. Actual Breaches 665. The trust is currently performing better than the set trajectory on this standard.
  -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

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	2899	1528	1	0	0	0	0	0
		Breaches	640	593	318	665	991	729	1	0	0	0	0	0
		Performance	77.9%	81.2%	89.7%	78.1%	65.8%	52.2%	0.0%					
		Variation	-0.4%	1.8%	8.4%	4.4%	-9.6%	-29.8%	-86.5%					
		National	85.4%	87.5%	84.9%									
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	244	22	0	0	0	0	0	0
		Breaches	23	19	22	22	23	5	0	0	0	0	0	0
		Performance	93.3%	93.7%	93.9%	93.5%	90.5%	77.2%						
		Variation	3.9%	3.7%	3.2%	1.8%	-2.1%	-16.5%						
		National	94.2%	95.1%	94.6%									
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	127.5	9.5	0.0	0.0	0.0	0.0	0.0	0.0
		Breaches	42.0	48.5	59.0	64.0	60.5	8.5	0.0	0.0	0.0	0.0	0.0	0.0
		Performance	76.7%	70.8%	70.2%	65.6%	52.5%	10.5%						
		Variation	7.4%	-0.1%	-2.3%	-8.9%	-23.3%	-66.1%						
		National	75.4%	73.0%	73.3%									

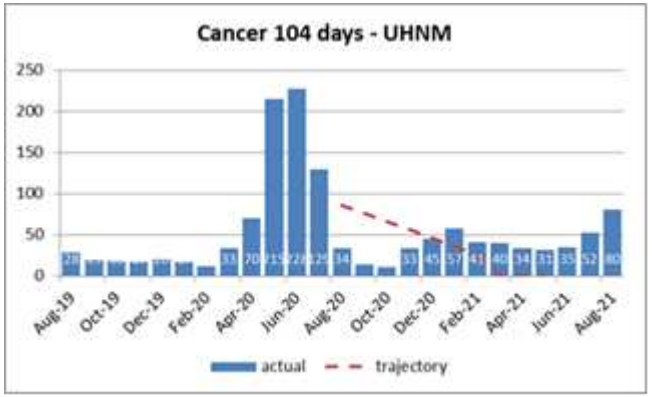
Cancer







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



Planned care - *Inpatients*

University Hospitals of North Midlands NHS Trust

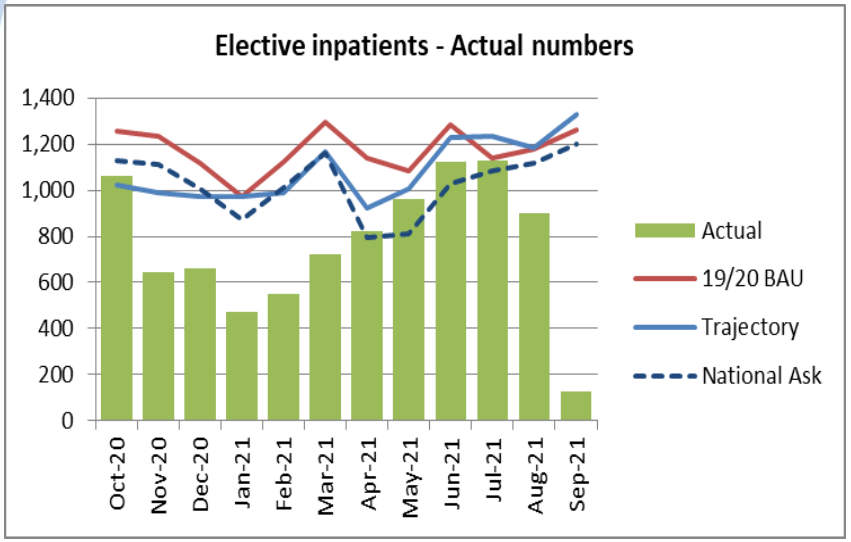
Elective inpatients Summary

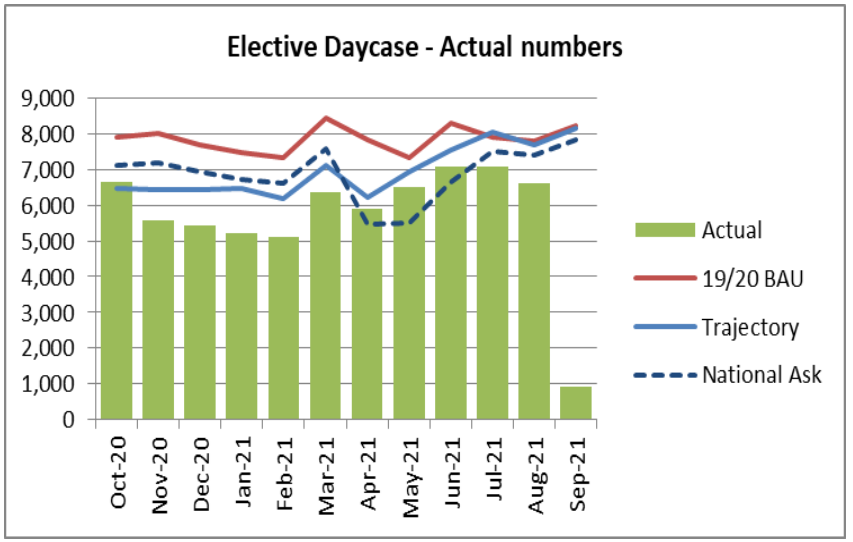
- For August the total inpatient actuals against BAU has risen to 83.6%. This is lower in Inpatients than Day case (76.3% IP, 84.7% DC).
- Cases continue to be treated at the Independent Sector and some electives at County.
- 2,500 Planned Transfer of T&O & Spine Cases to the Nuffield for treatment to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

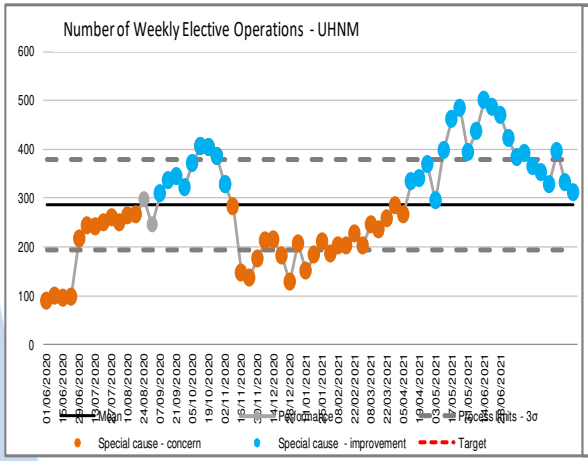
Actions

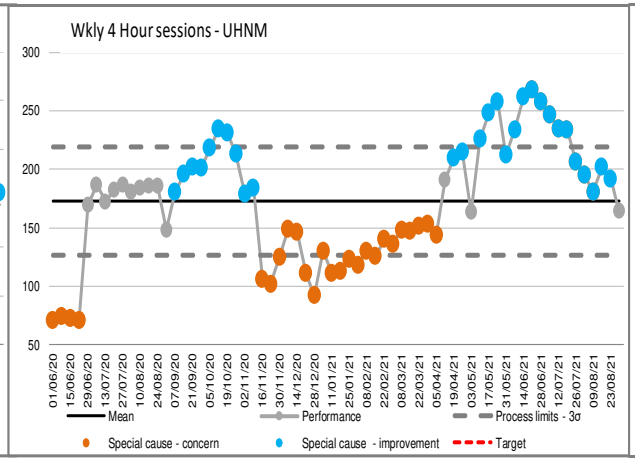
- **Patient contact initiative:** Webform developed to capture patient responses electronically and enable easy management and reporting of responses. Corporate validation team focus will be on validation of 104 week patients to determine how many are true TCIs.
- **Elective referral hub:** CCG Led initiative to support triage of OPD referrals to protect acute capacity for high threshold referrals. Progress update received from CCG who are exploring specialty demand in order to optimise the impact of any pilot. UHNM are exploring the opportunity of scoping a fire break referral hub for cancer referrals to triage out high volume and low threshold referrals to protect 2ww cancer capacity.
- **Theatres:** Surgical division have amended trajectory for returning to 100% of 19/20 activity due to continued staffing issues (sickness & redeployment). "New normal" theatre plan set to enable a sustainable timetable and reduction in cancellations. Plan is in two phases but is reliant on theatre workforce restoration from mutual aid support to critical care and return to work of staff currently isolating/sick as the Division has been under significant challenge with regard to ODP staffing.
- **IS subcontracting:** as well as 4280 patients to be transferred to IS as an IPT, £600k has been approved to continue to send patients under a subtracting arrangement o Nuffield & Ramsay. This is to be used for any patients agreed under the original contract, and any patients suitable for treatment in the IS, but not continuing follow-up. NHSEI support requested for the IS to support with cancer/other off framework procedures required to support winter pressures.

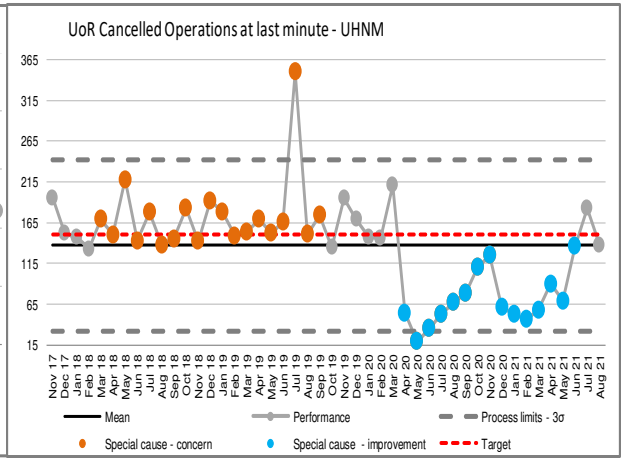
Planned care – *Inpatient Activity*











Planned care - *Outpatients*

NHS University Hospitals of North Midlands NHS Trust

Summary

- For August the total outpatient actuals against BAU for outpatients was 100%. This is higher in Follow ups than new (89% New, 107% follow up).
- August 21 numbers recorded to date were 64,173. However this may increase further as the outstanding outcomes are completed.

Outpatients

- For outpatient appointments (appointment type) the Trust delivered **72.7%** F2F and **27.3%** non F2F(Telephone & Video). For new appointment types F2F was **74.7%** & non F2F **25.3%** & follow ups F2F **71.7%** & non F2f **28.3%**.
- July's performance for ASIs position decreased by 1.9% to 85.8% within 3 days (from 87.7% in June).
- OP Cell A3 work has helped to define current overall waiting list position by category; vs pre covid increase of 15,000 (6.5%) to 250,000, and increase in those >52 weeks (vs Review Date) by 7,800 (200%) to c.12,000 (half of increase attributable to use of Review Date).
- Reduction from 11,631 (end of June) to 10,010 (25th July) in >52 week patients (14%). Further reduction to 9,184 as at 5th September (21% vs end of June).

RTT

- The overall Referral To Treatment (RTT) Waiting list continues to rise. For August the indicative number of Incomplete pathways has risen to 67,784 (July 65,574).
- The number of patients > 18 weeks has risen to a level of 27,160 (July 25,466).
- The numbers of 52 week waits in August has increased slightly with a reported 3495 (July 3,477).
- However, there are now patients who have reached 104 weeks. At the end of August the numbers reported were 121. The Planned Care group is monitoring progress against treatment plans for these patients.
- Performance however, has reduced slightly to 59.9% (July 61.4%).
- Follow up backlog increased to 70,388 (July 68,697).

Planned care - *Outpatients*

University Hospitals of North Midlands NHS Trust

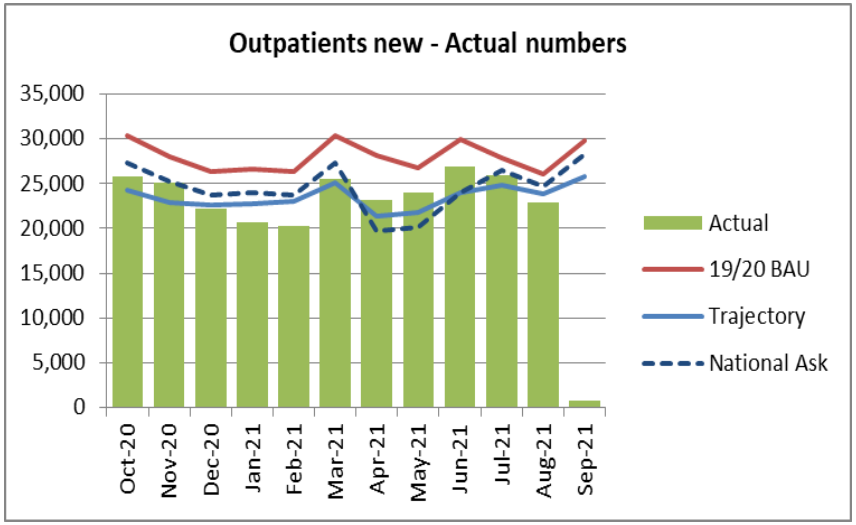
Actions

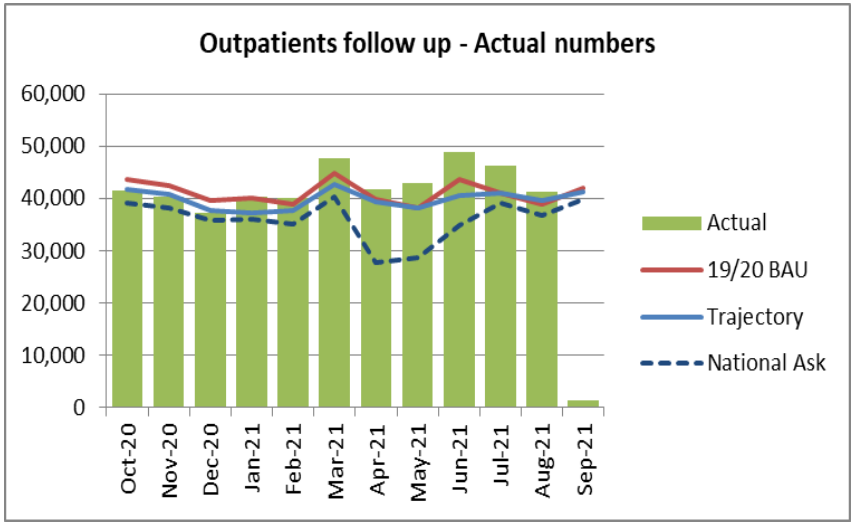
- Key actions identified around Divisional Waiting List Management with a focus on validation, data quality and >52 weeks patients. Clear reporting now in place to support this approach.
- ASI performance / unoutcomed activity monitoring in place; assurances around triage processes and clinical prioritisation of new patients provided from Divisions.
- Outpatient Service Delivery & Performance workstream delivering vs. plans for Partial Booking Rollout, Netcall Rollout, CAF Issues Action Plan, and OP Clinic Process vs. Maturity model. Real time Room utilisation feedback being trialled. Session flags updated to support utilisation monitoring. Review Date training prioritised; Review Date DQ Alert circulated & Quick Reference Guides created, plus floor walking support. Wider training plan being developed including e-learning plans and embedded SME.
- Enhanced Advice & Guidance sub workstream (linking with system). Meetings held with specialties (with clinical & managerial representation) discussing associated specialty data packs, to confirm the initial 6 specialties. Task & Finish Groups are being established following initial meetings. Work continues to ensure we are able to capture all the A&G data outside of eRS.
- PIFU sub-workstream rolling out vs plan. Patients added to pain and respiratory PIFU pathways; cardiology waiting lists set up and on track to roll out in 3 pathways in September. Interest from other specialties incl. T&O, gastro, haem, neurology, derm.

Risks:

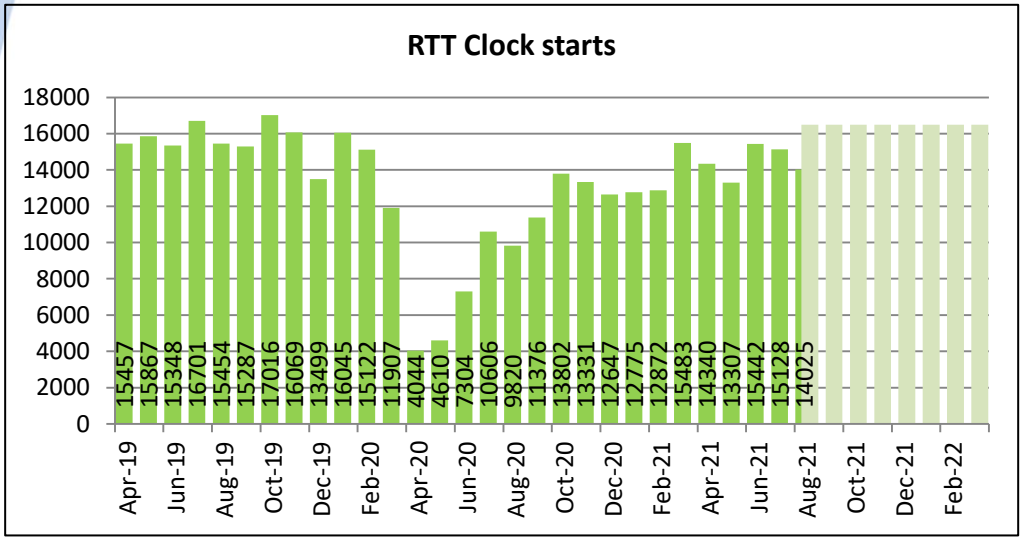
- Deteriorated waiting list position vs pre-covid; volume of patients requiring DQ and clinical validation very challenging, raised on Divisional Risk Registers.
- FTF activity limitations for ENT, Oral & Eyes in non-shared OP areas; need to increase but restricted by social distancing.

Planned care – *Outpatient activity & RTT*



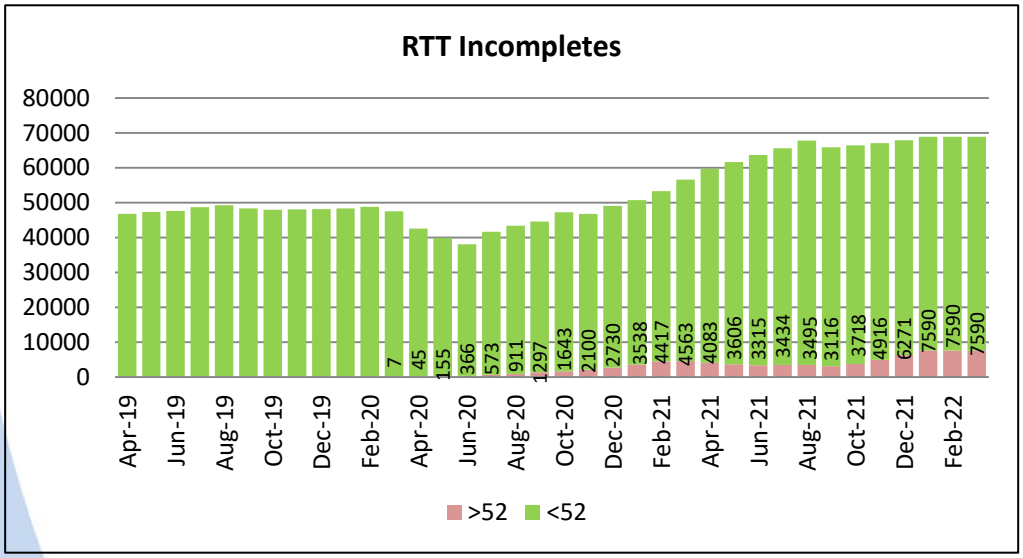


Planned care – *RTT Trajectories*



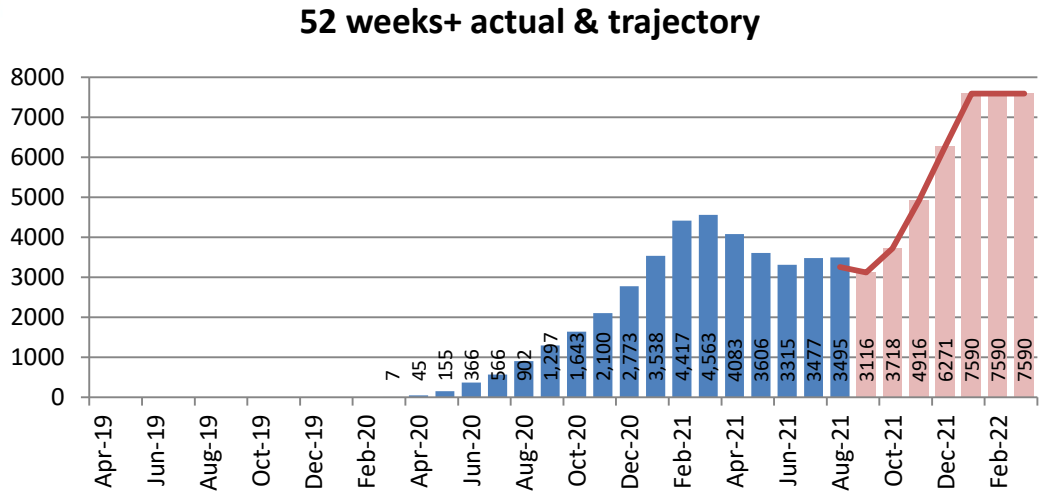
Modelling done based on these two key assumptions

- Demand has risen back in line with 19/20 BAU
- Activity is planned to be in line with (or above, through the use of IS) the 19/20 BAU.

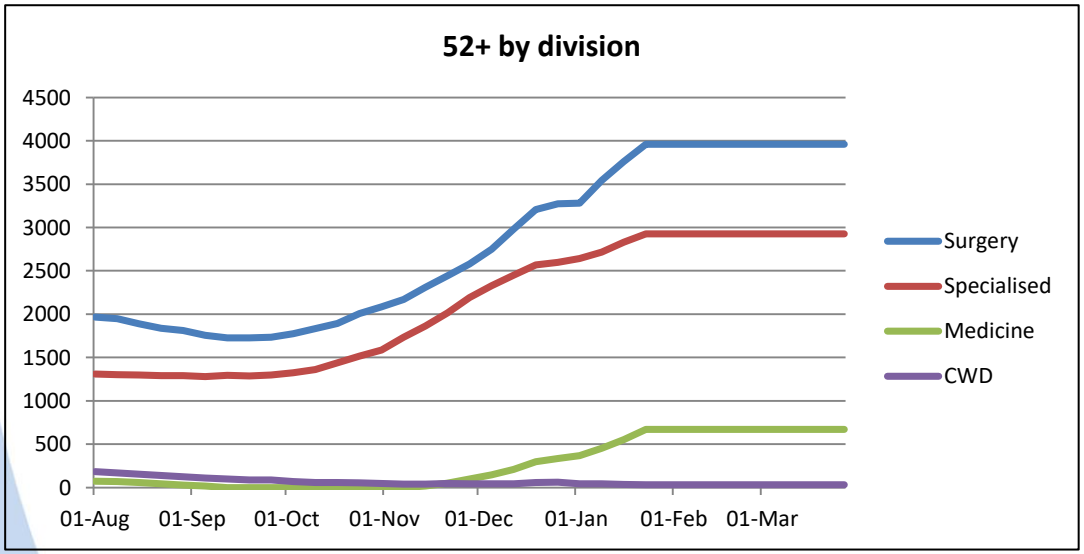


- 19/20 saw little overall movement in the total number of incomplete waits.
- The same is therefore expected given the above assumptions. the waiting list is therefore expected to be around 68,800 at the end of March

Planned care – *RTT Trajectories*

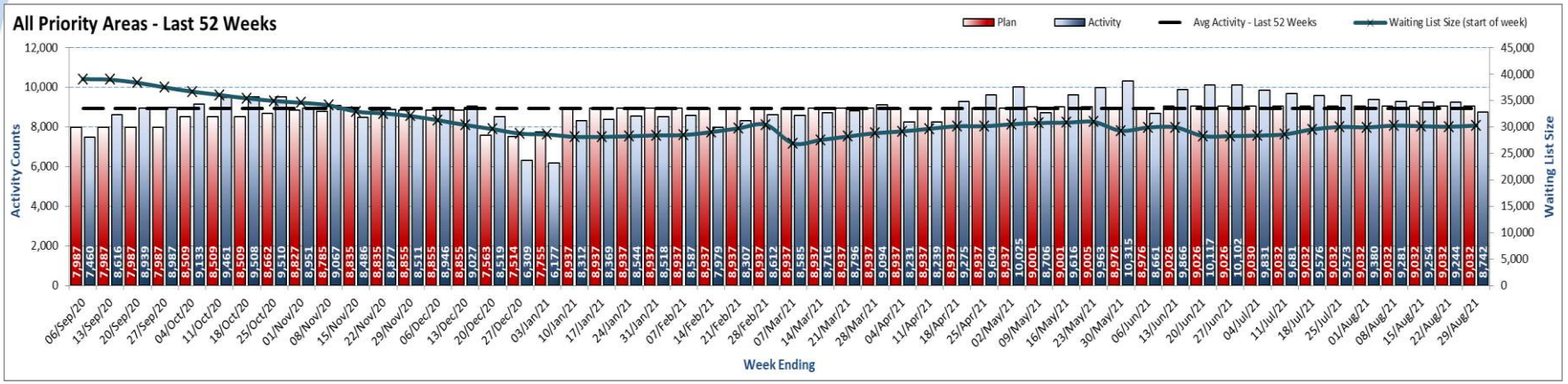


52 Week Waits are expected to increase over the next 6 months with a total of 7,590 at the end of March.



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 reduced in August from 20,134 to 19,580. However in Non-obstetric ultrasound the waiting list continues to grow. August 10,318 (July 9,657). Due to the challenges in Non-Obstetric Ultrasound this has adversely affected performance. The current DM01 diagnostic performance for August 21 has deteriorated to 66.19% (July 71.95%).
- The greatest proportion of > 6 week waits are within Non-obstetric ultrasound, which has doubled to 10,318 since Mar-21 and is related to the significant increase in demand. The waiting list is growing significantly by c250 per week against a workforce that is at full capacity. A request for additional investment in workforce has been completed but no approval has yet been given to outsource activity.
- Capacity and Demand work is being planned in the next quarter and is reliant on transformation and corporate support
- A working group is set up comprising of imaging, breast surgery and the cancer to team to review the increase in breast referral s and total capacity required. There also seems to be more referrals from Primary care for patients under the age 35. Cancer team are engaging with the PCN/CCG regarding referrals, and within radiology effort is being made to put on additional capacity out of hours to clear the backlog with more joint working with surgery.
- Imaging – average demand over last 6mths was 9,000 patient requests per week.

Diagnostic Activity

University Hospitals of North Midlands NHS Trust

Areas of Concern:

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

Impact :

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

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

Increase in outsourcing and locum costs

Increasing staff sickness due to workplace pressures

Mitigation:

- A remedial plan has been developed with Network partners. A trajectory for improvement is being finalised, improvements planned by end Sept 21

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

Impact:

Increase in waiting times and backlog for non urgent scans

Inability to meet DM0-1 standards

Increased stress for current staff

Poor patient experience

Mitigation:

Paper for approval for additional staffing resource to July ODG.

Attempting to source locum sonographers

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

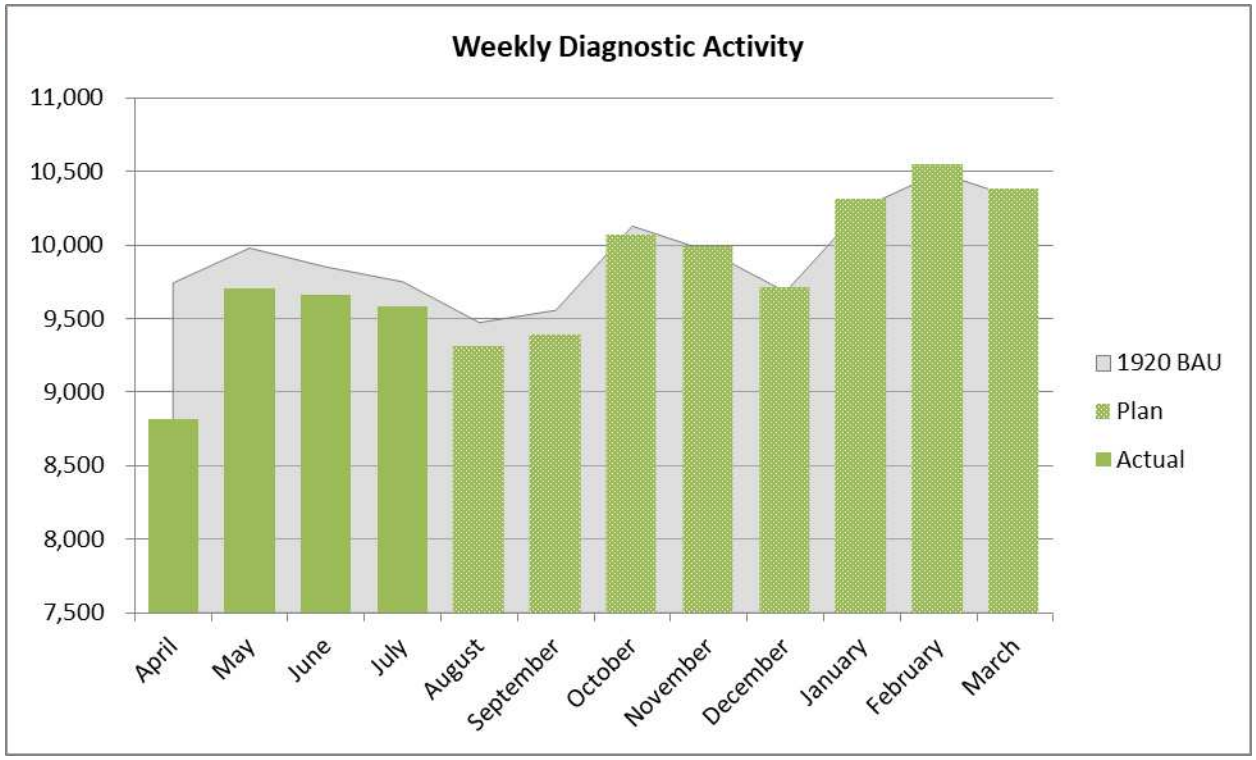
Impact:

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

Mitigation:

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

Diagnostic Trajectory



- Current plan is below current actual levels and below 19/20 BAU.
- Plain film and CT being the main driver for this

APPENDIX 1

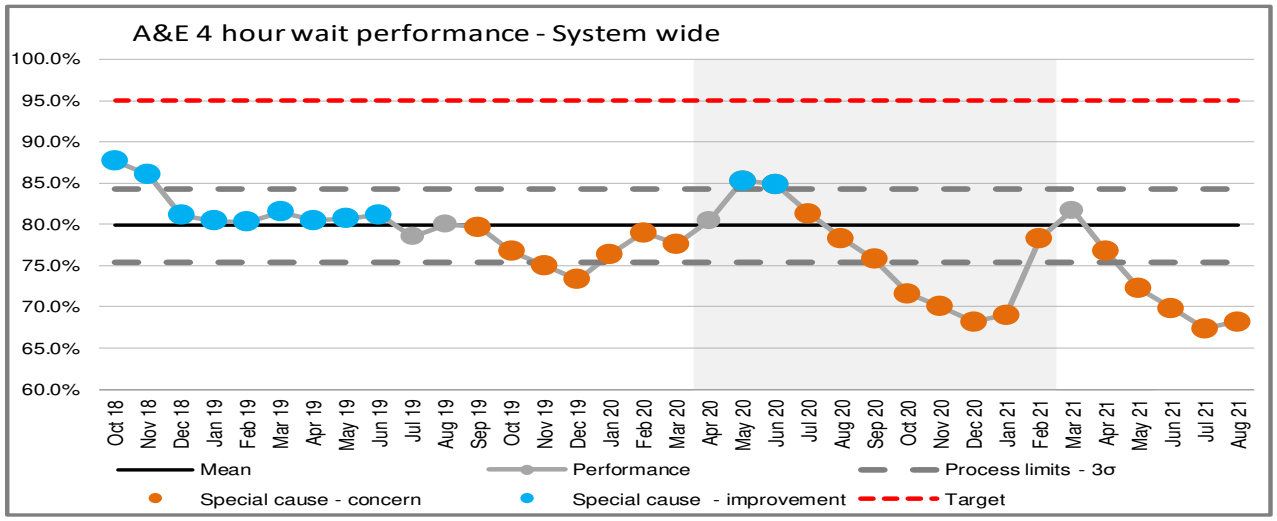
Operational Performance

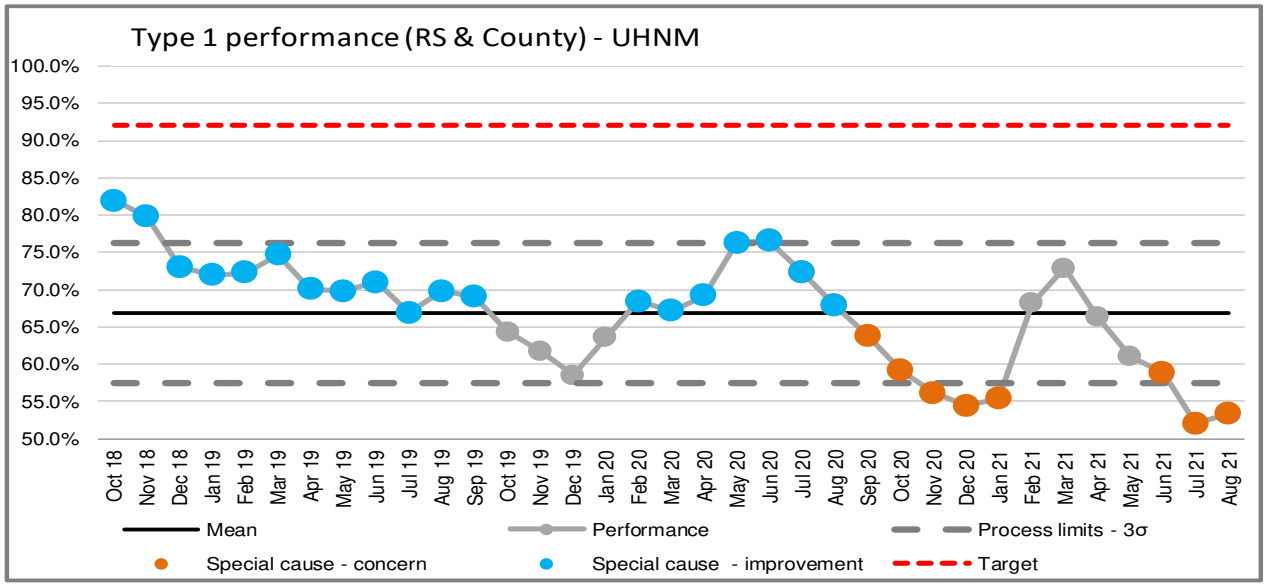
Constitutional standards

	Metric	Target	Latest	Variation	Assurance	DQAI
A&E	A&E 4 hour wait Performance	95%	68.20%	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%	59.90%	L	F	
	RTT 52+ week waits	0	3550	H	F	
	Diagnostics	99%	69.19%	L	F	

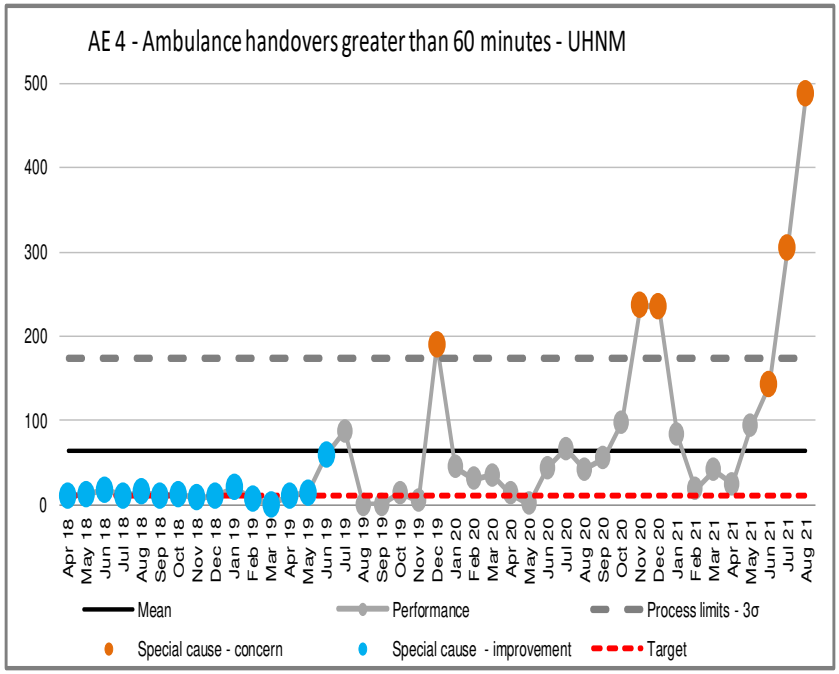
	Metric	Target	Latest	Variation	Assurance	DQAI
Use of Resources	DNA rate	7%	7.3%		?	
	Cancelled Ops	150	138		?	
	Theatre Utilisation	85%	76.0%			
Inpatient / Discharge	Same Day Emergency Care	30%	30.1%	H	?	
	Super Stranded	183	174	H	P	
	DToC	3.5%	2.10%	L	?	
	Discharges before Midday	30%	19.0%	L	F	
	Emergency Readmission rate	8%	11.7%	L	F	
	Ambulance Handover delays in excess of 60 minutes	10	488	H	?	

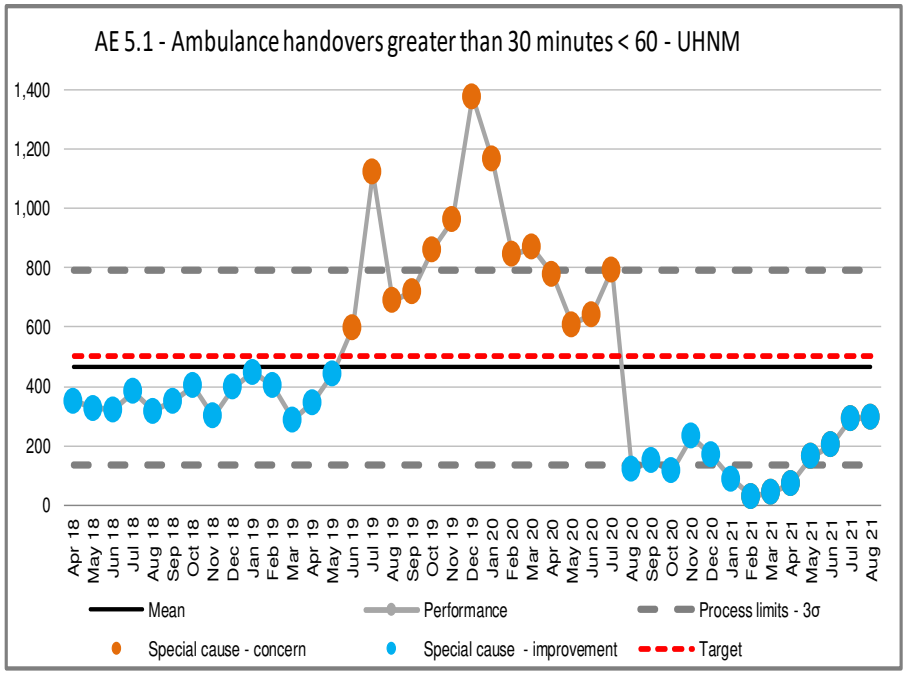
URGENT CARE – 4 hour access performance





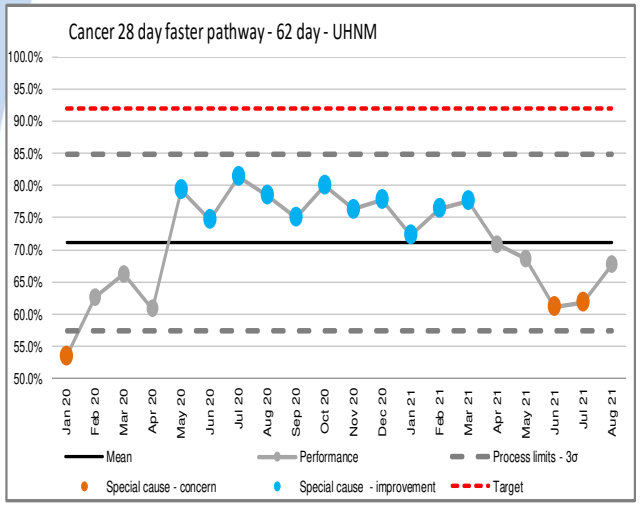
URGENT CARE – 4 hour access – ambulance handovers

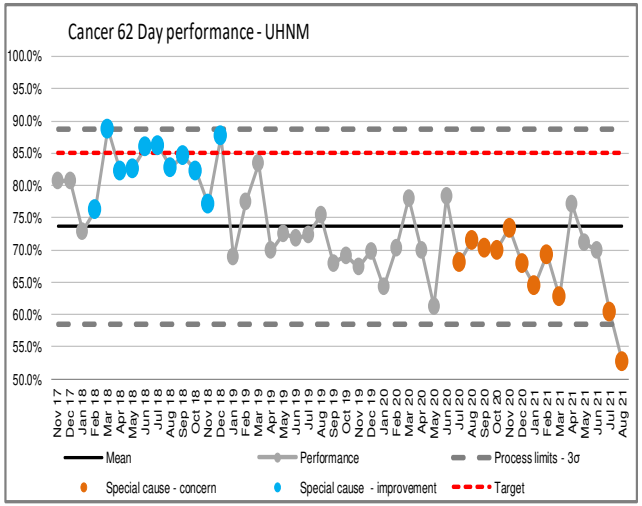




From August – internal validation of > 30 minutes

Cancer – 62 Day





Variation	Assurance

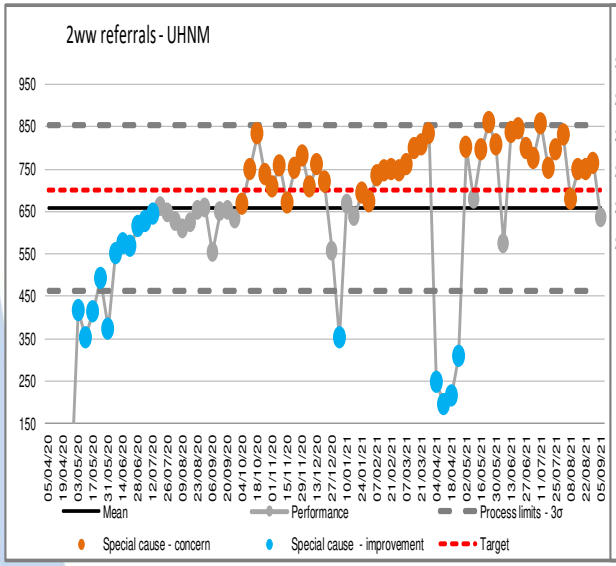
Target	Jun 21	Jul 21	Aug 21
85%	69.9%	60.4%	52.6%

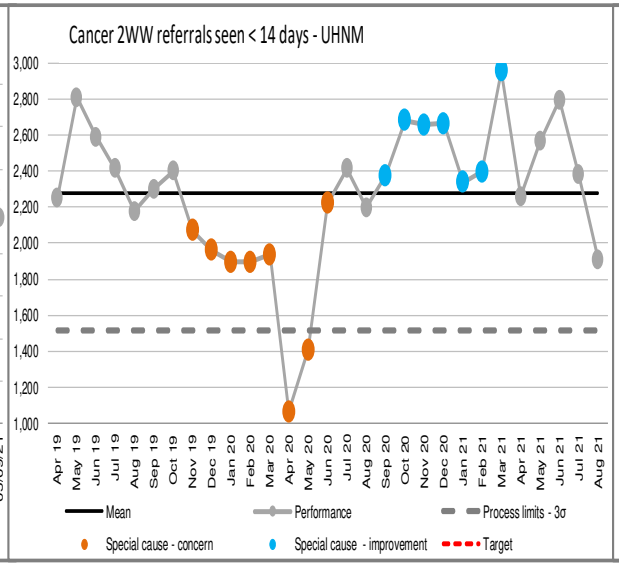
Background

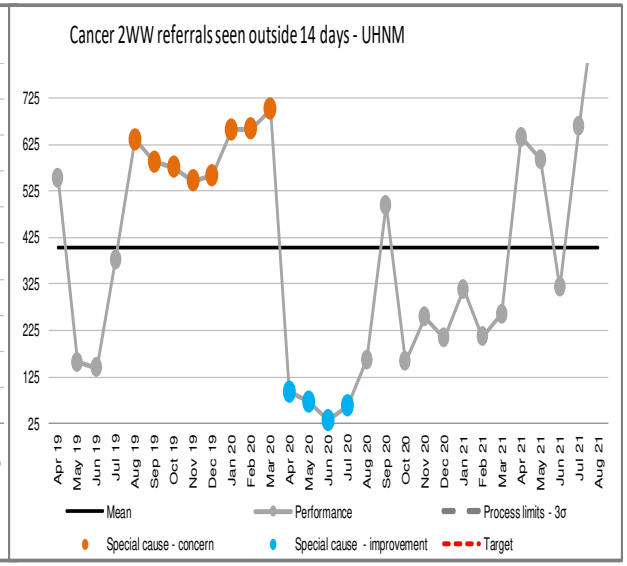
% patients beginning their treatment for cancer within 62 days following an urgent GP referral for suspected cancer

What is the data telling us?

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



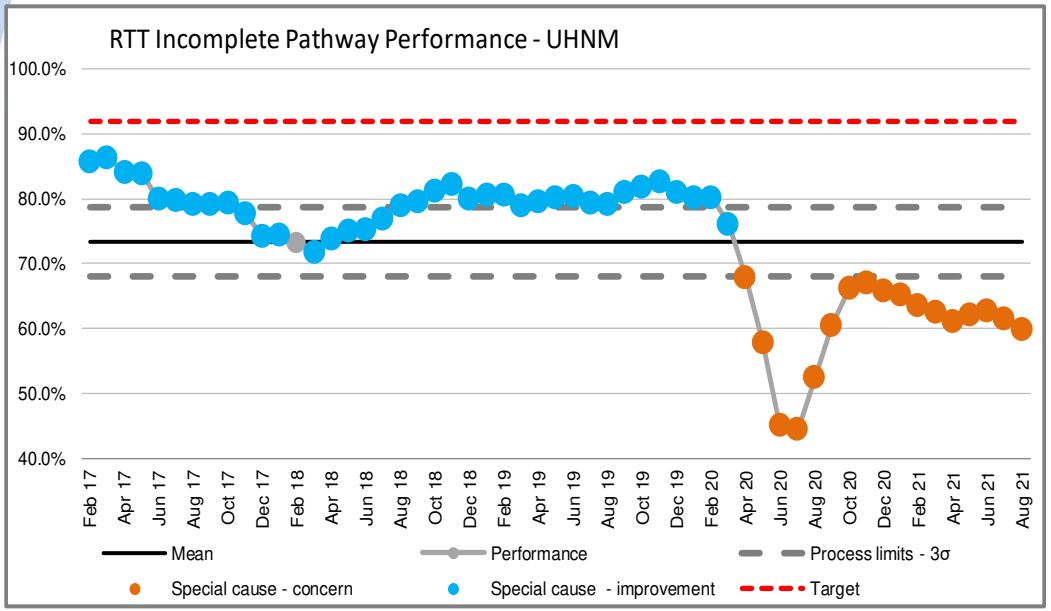




Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Referral To Treatment



Variation	Assurance
	

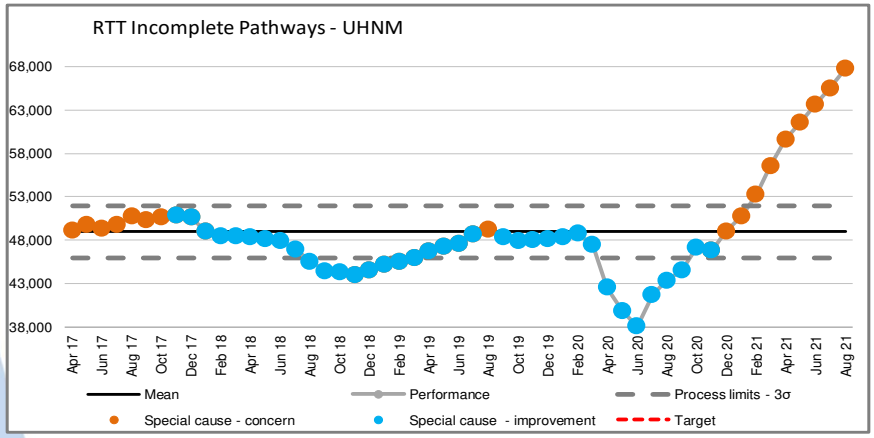
Target	Jun 21	Jul 21	Aug 21
92%	62.7%	61.4%	59.9%

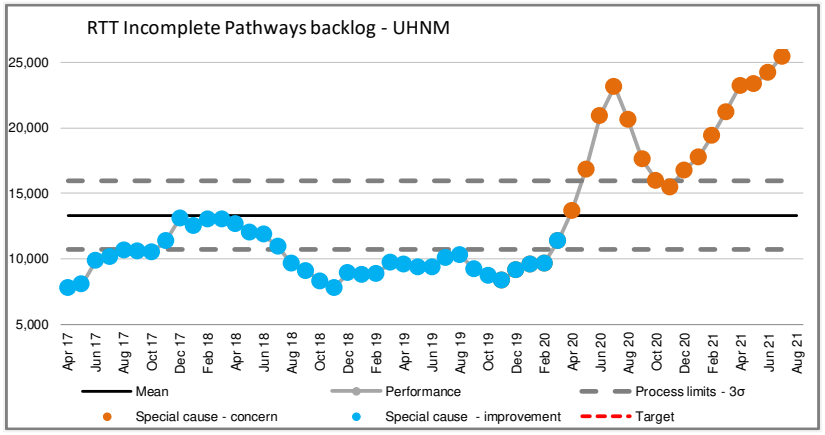
Background

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

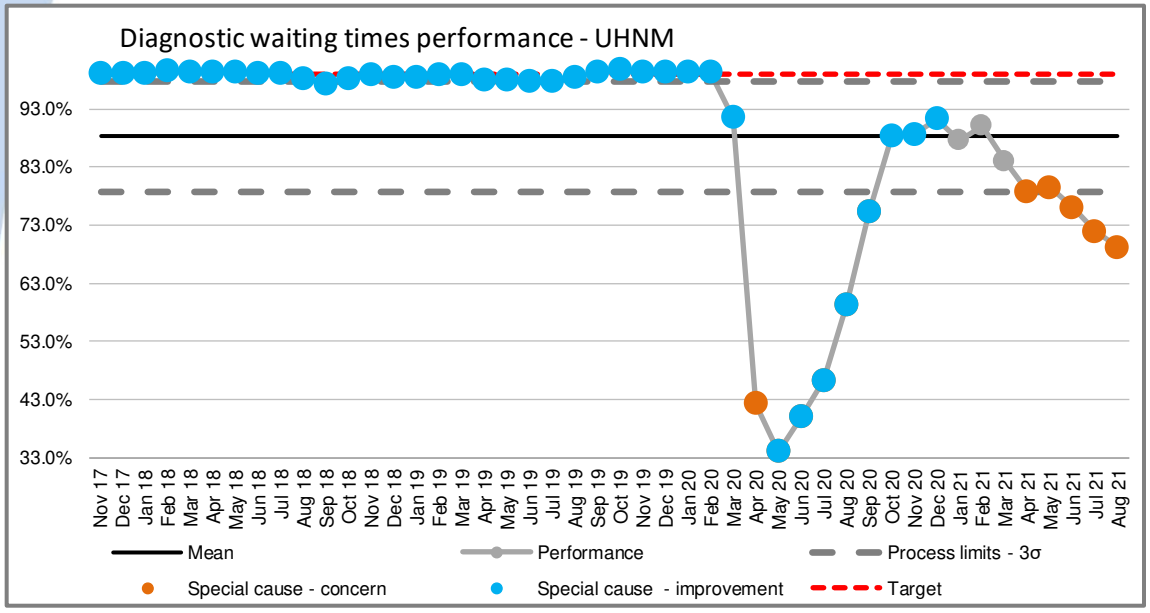
What is the data telling us?

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





Diagnostic Standards



Variation	Assurance
	

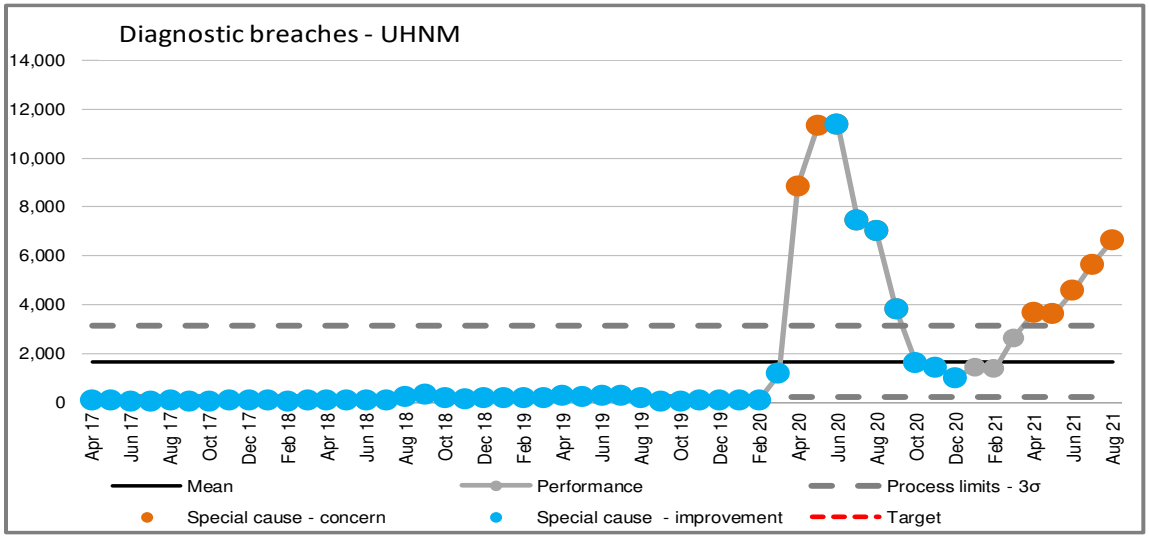
Target	Jun 21	Jul 21	Aug 21
99%	76.1%	72.0%	69.2%

Background

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

What is the data telling us?

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



Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

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.

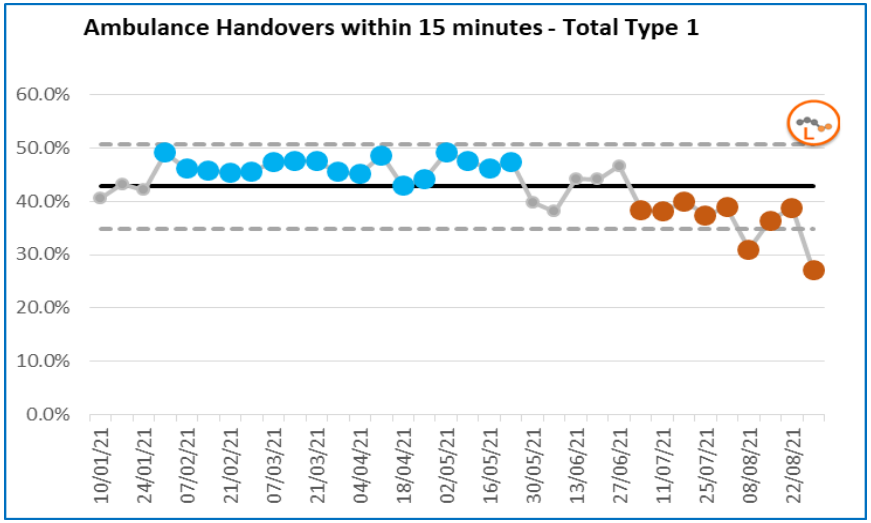
Governance

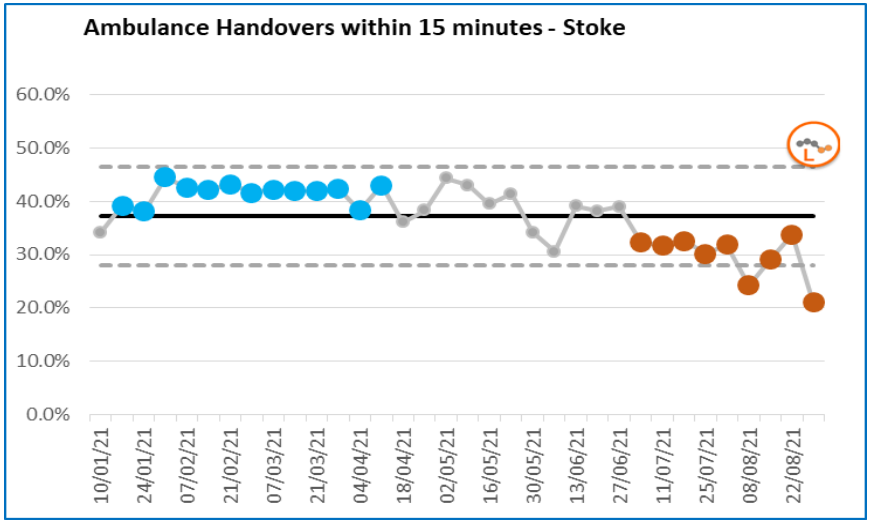
The newly proposed UEC standards will be monitored through both ED performance review and Medicine Divisional board meetings. Organisationally oversight will be through the Urgent Care Programme Board in addition to relevant trust committees

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 July.
Patients spending more than 12 hours in department	The number of patients spending over 12 hours in the department rose in July.

2. Percentage of Ambulance Handovers within 15 minutes

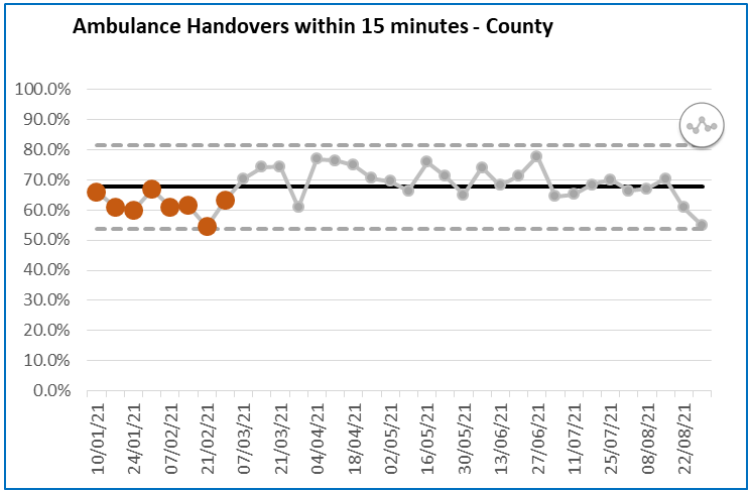




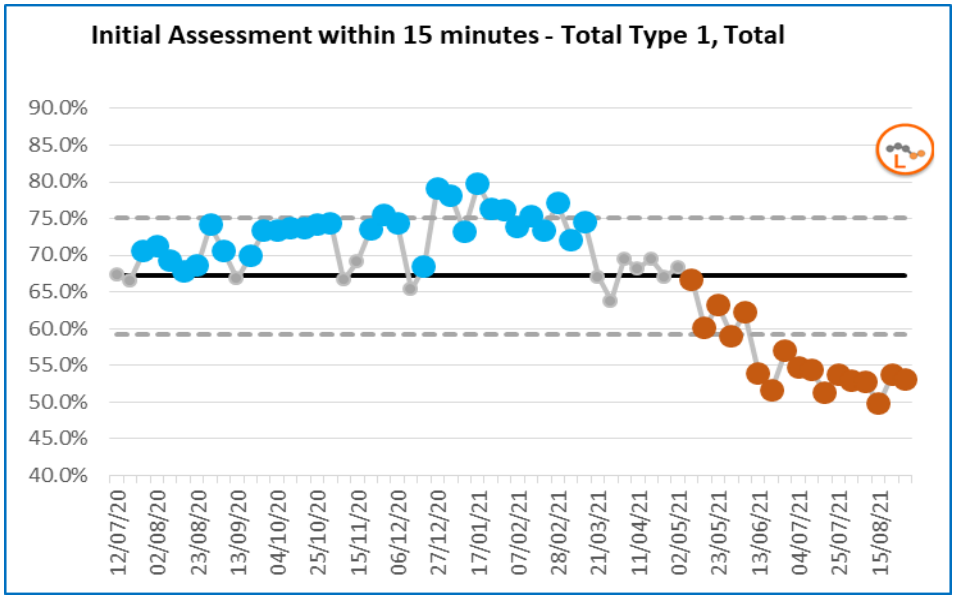
Internal collection of data for Ambulance handovers within 15 minutes began at the beginning of January 21. This is the time taken for the ambulance service to hand over the care to the ED.
N.B. this is un-validated performance and also includes handover time related to direct ambulance conveyance to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

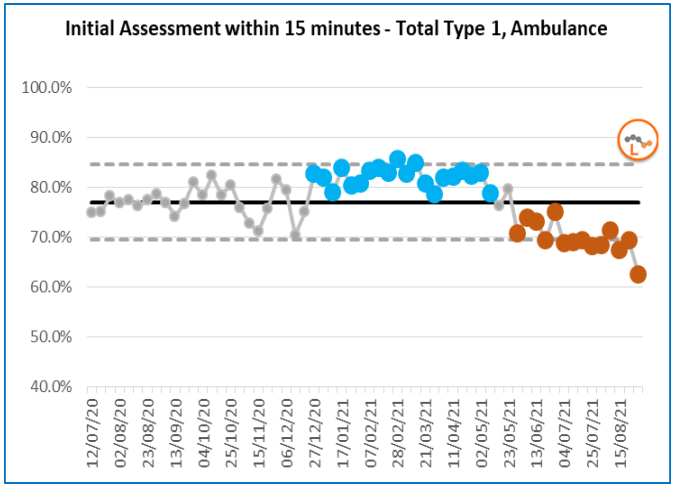
For total ambulance handovers at UHNM in August, the percentage within 15 minutes fell below the 30% or below in two weeks of the month. A local UHNM target of 48% has been set as the goal to improve to as part of the NEL Improvement programme.

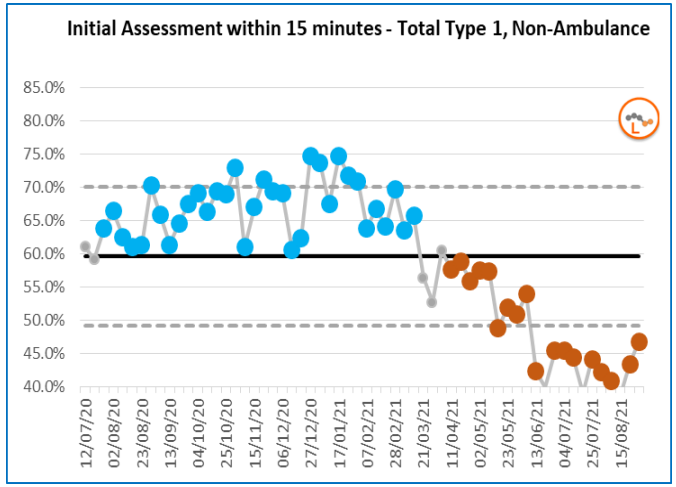
County have maintained a much higher percentage than Royal Stoke albeit with much smaller numbers.



3. Time To Initial Assessment – percentage within 15 minutes





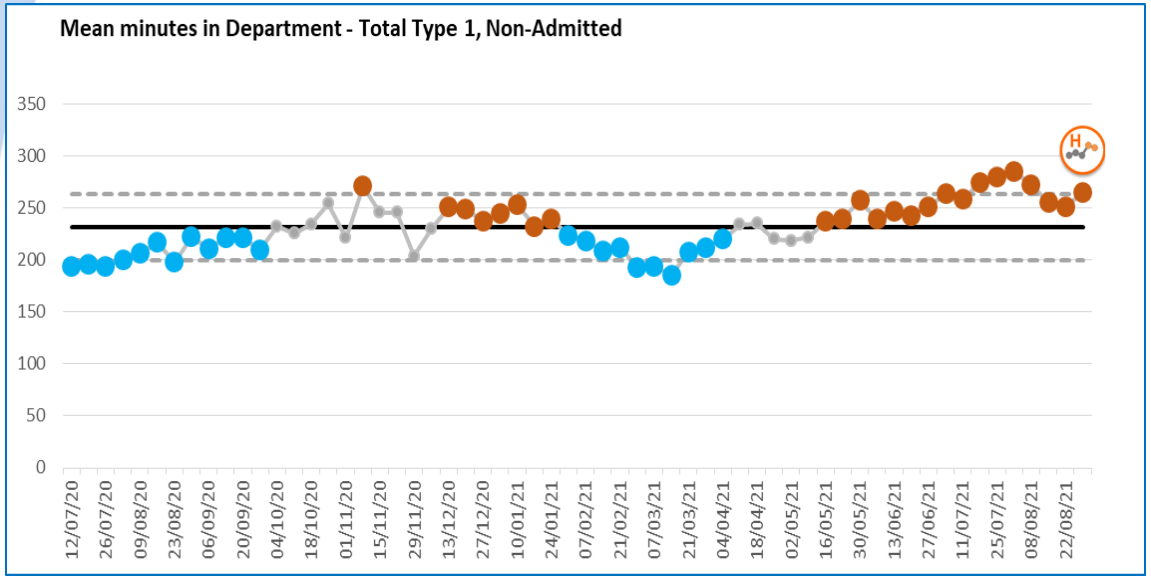


Time to Initial assessment is the time from arrival to when the patient is first triaged.

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

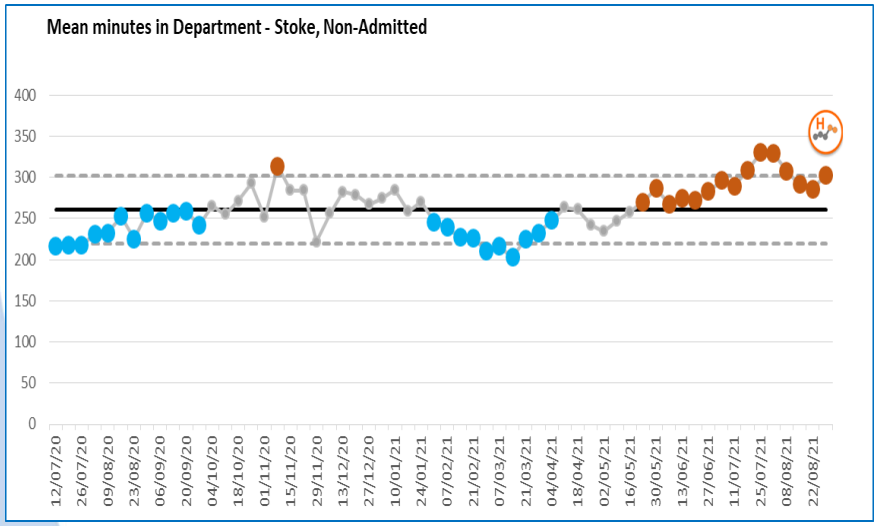
A local UHNM improvement target of 85% has been set.

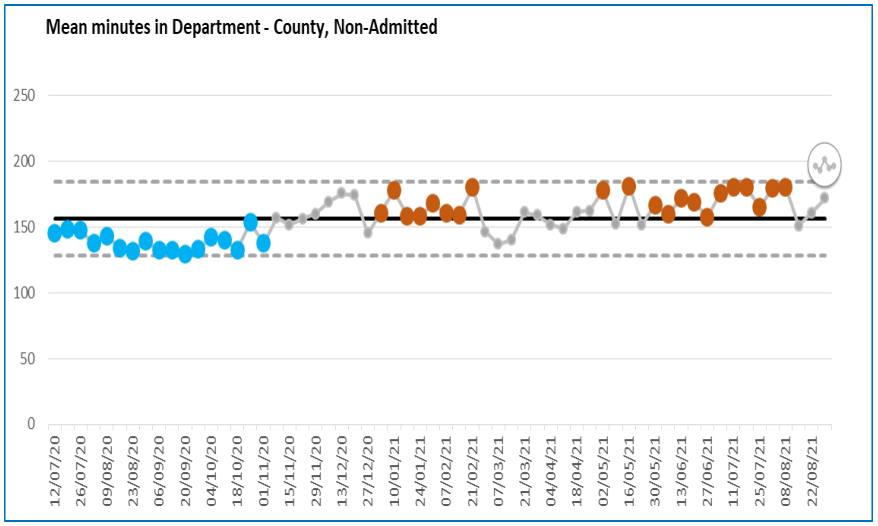
4. Average (mean) time in Department – non admitted patients



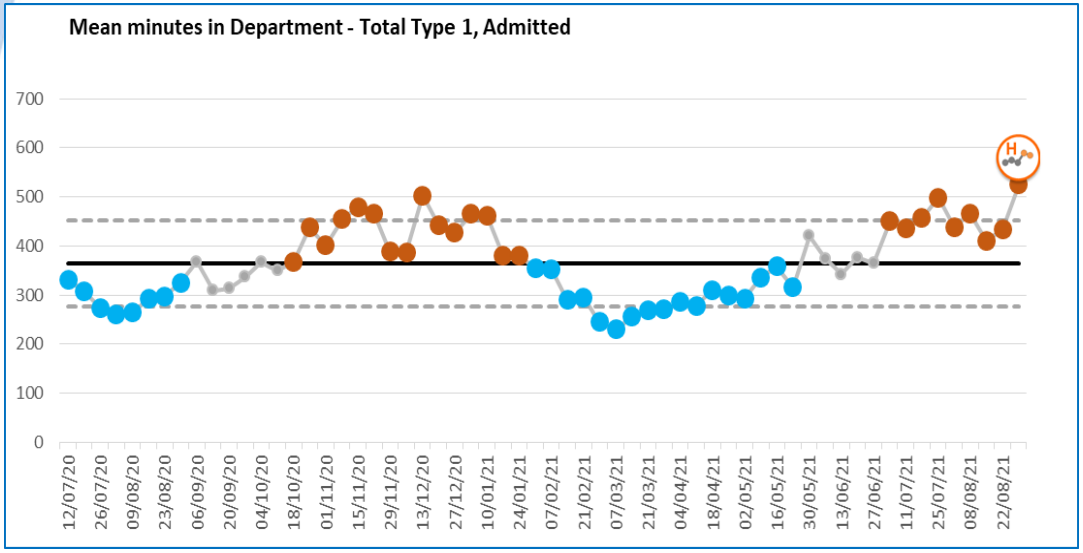
The mean time in the department through August remained above the mean but was however, lower than that seen in July. On average over the month this was 260mins.
The rise was more notable at Royal Stoke.

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





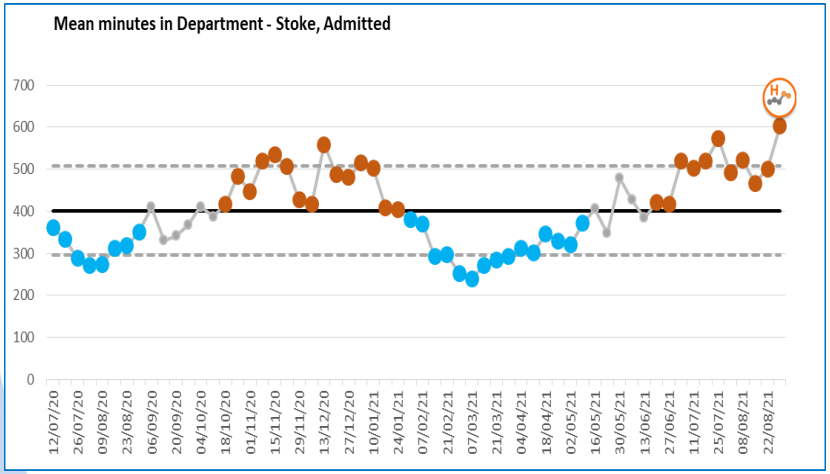
5. Average (mean) time in Department – admitted patients

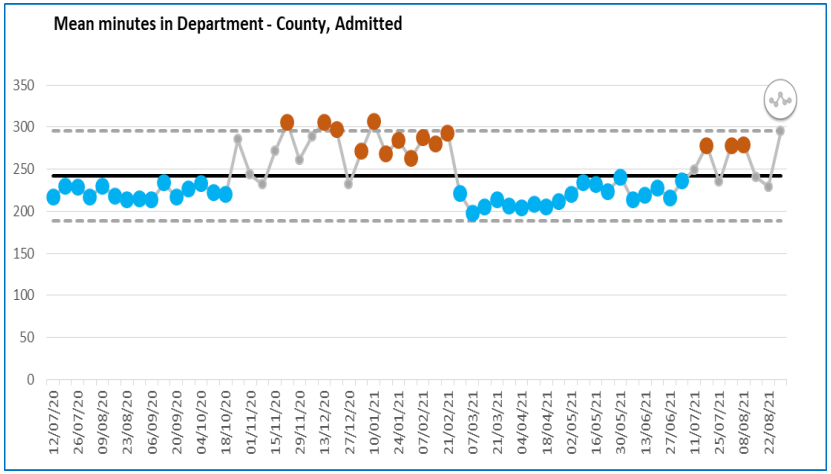


The mean time in the department for admitted patients rose to 600 mins at the end of August.

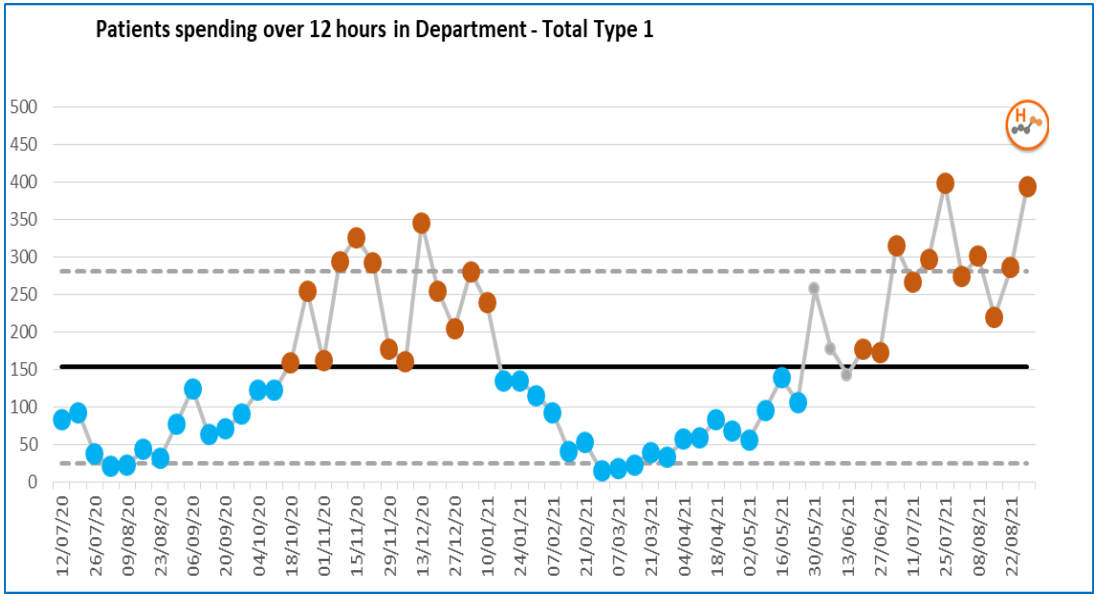
This was notable at both Royal Stoke and County.

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

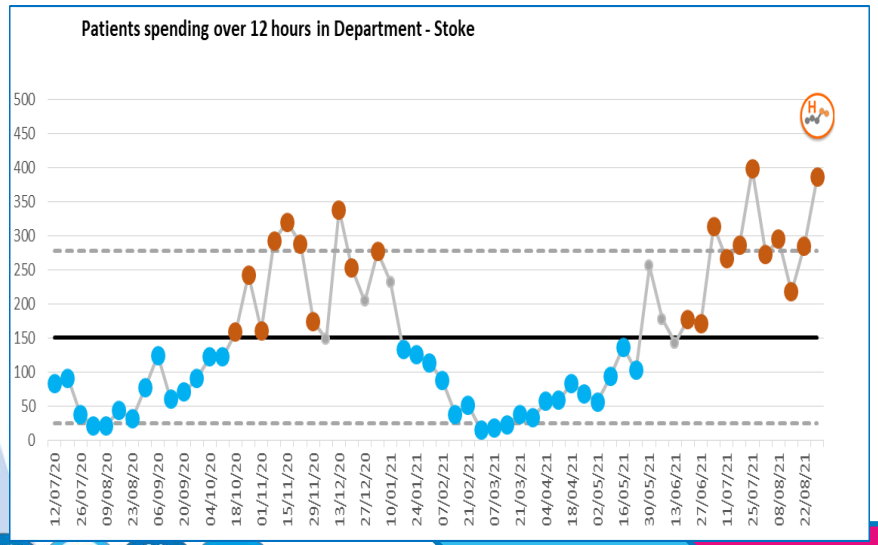


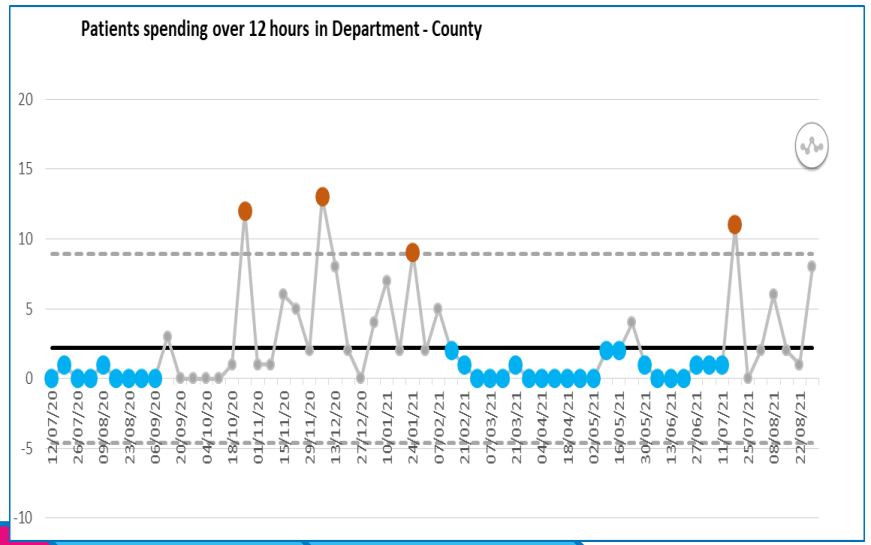


6. Patients spending more than 12 hours in the department



The number of patients spending over 12 hours in the department rose in August. 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. Forthcoming staff engagement events include:

- Commencement of the NHS annual Staff Survey from October 2021. A communications campaign will commence in September and run throughout to encourage staff to take part in the survey.
- The virtual Staff Awards event will be held on 5th November, with staff having submitted 294 nominations.

Sickness

The in-month sickness rate was 5.30% (5.43% reported at 31/07/21). The 12 month cumulative rate increased 5.18% (5.10% at 31/07/21)

Stress-related sickness absence remains the top reason for absence, although this does include both includes both work-related and personal/domestic life stress. In the 12 months ending 31st August 2021, 28.4% of sickness absence was stress-related. The Trust has a comprehensive Wellbeing Plan in place to support staff with a focus on ensuring staff psychological wellbeing.

Covid related absences have increased slowly throughout August and into September and, as of 23rd September 2021, covid-related open absences* numbered 253, which was 27.09% of all absences (21.52% at 11th August 2021) [**includes absences resulting from adhering to isolation requirements]*. Measures to support the Trust in reducing covid infections continue to be offered to staff and Covid-19 Booster Vaccinations will be rolled out to health and care workers alongside the flu vaccination from September 2021

Appraisals

The Non-Medical PDR compliance rate was 78.21% at 31st August 2021 (79.84% at 31 July 2021).

Performance in completing PDRs continues to deteriorate, with clinical pressures being cited as the main reason. Divisions have been asked to revise their trajectories to reflect a realistic position of what they are able to achieve and to continue to undertake PDR's wherever possible as opportunity to discuss wellbeing and support.

Statutory and Mandatory Training

At 96.0%, the Statutory and Mandatory Training rate has exceeded the Trust target for the core training modules and, at 31 August 2021, 92.28% of staff had completed all 6 Core for All modules (91.30% at 31/07/21)

Vacancies

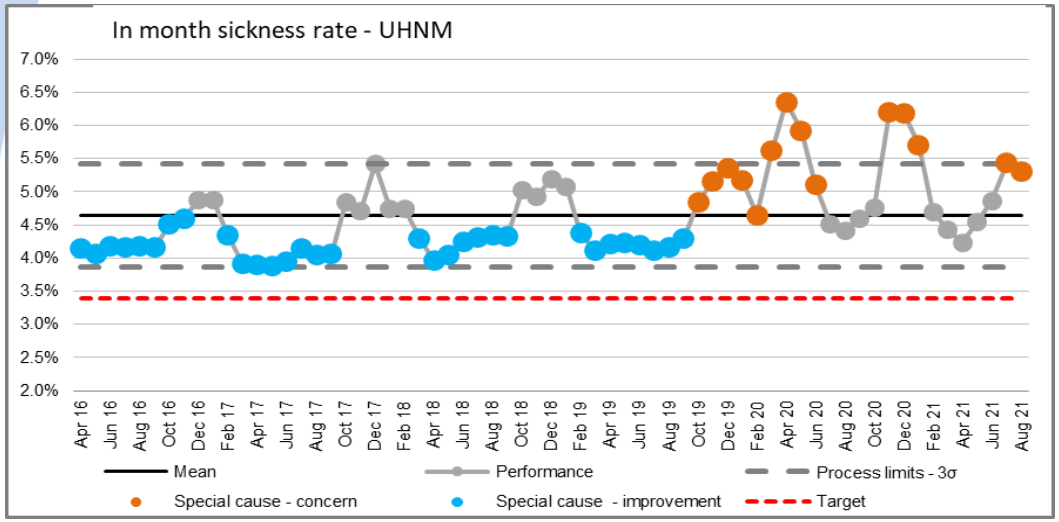
The overall Trust vacancy rate was 8.97% and remains consistent with previous months.

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

Workforce Dashboard

Metric	Target	Latest	Variation	Assurance
Staff Sickness	3.4%	5.30%		
Staff Turnover	11%	9.26%		
Statutory and Mandatory Training rate	95%	96.00%		
Appraisal rate	95%	78.21%		
Agency Cost	N/A	3.21%		

Sickness Absence



Variation	Assurance
H	F

Target	Jun 21	Jul 21	Aug 21
3.4%	4.9%	5.4%	5.3%

Background

Percentage of days lost to staff sickness

What is the data telling us?

Sickness rate is consistently above the target of 3.4%.

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

Summary

The in-month sickness rate was 5.30% (5.43% reported at 31/07/21). The 12 month cumulative rate increased to 5.18% (5.10% at 31/07/21)

Stress-related sickness absence remains the top reason for absence, although this does include both work-related and personal/domestic life stress. In the 12 months ending 31 August 2021, 28.4% of sickness absence was stress-related.

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

Covid related absences have increased slowly throughout August and into September and, as of 23rd September 2021, covid-related open absences* numbered 253, which was 27.09% of all absences (21.52% at 11th August 2021) [**includes absences resulting from adhering to isolation requirements*]*

- A self-isolation tool is available for staff to use if they are identified as a close contact

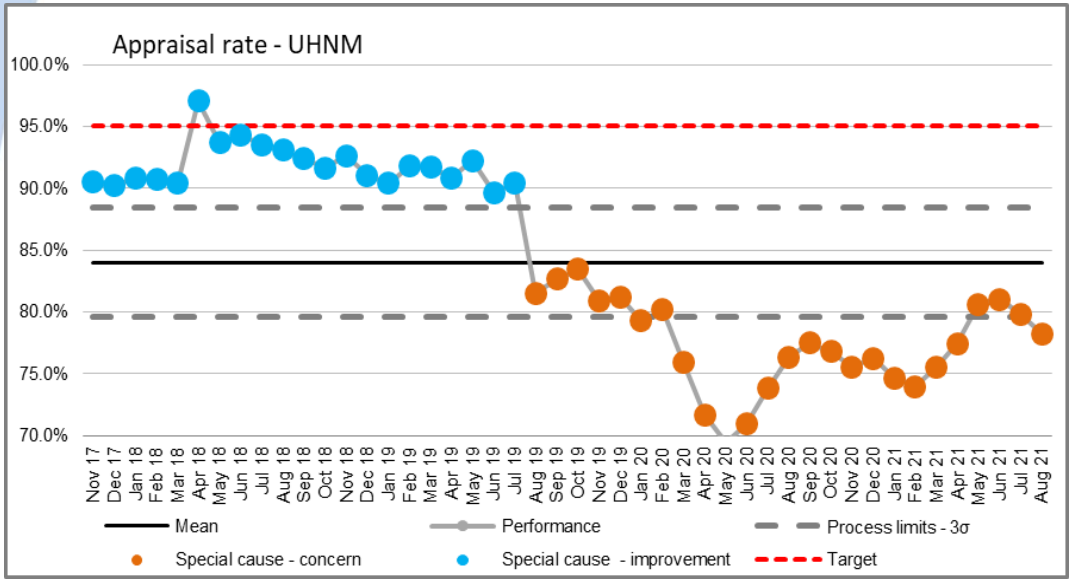
Actions

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

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

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

Appraisal (PDR)



Variation	Assurance
	

Target	Jun 21	Jul 21	Aug 21
95.0%	81.0%	79.8%	78.2%

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 improved month-on-month from Feb to June 21 has deteriorated since then.

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

Summary

The Non-Medical PDR compliance rate was 78.21% at 31st August 2021 (79.84% at 31 July 2021). Clinical pressures due to covid have been cited as the main reason for the drop in performance.

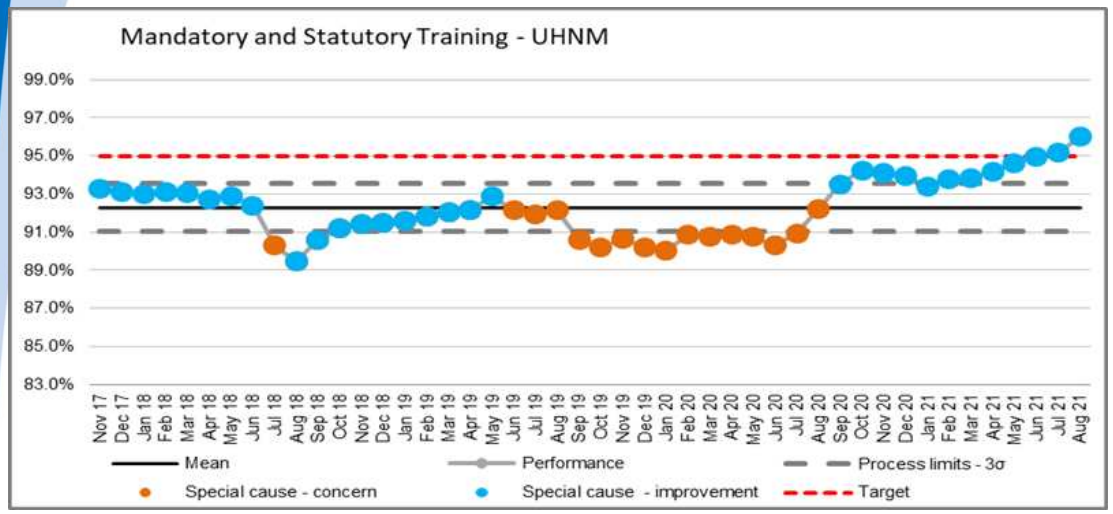
Actions

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

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

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

Statutory and Mandatory Training



Variation	Assurance
H	F

Target	Jun 21	Jul 21	Aug 21
95.0%	95.0%	95.2%	96.0%

Background

Training compliance

What is the data telling us?

At 96.0%, the Statutory and Mandatory Training rate has achieved the Trust target for the core training modules

Summary

The Statutory and Mandatory training rate at 31 August 2021 was 96.0% (95.16% at 31 July 2021). This compliance rate is for the 6 'Core for All' subjects only. At 31 August 2021, 92.28% of staff had completed all 6 Core for All modules (91.30% at 31/07/21)

Competence Name	Assignment Count	Required	Achieved	Compliance %
205|MAND|Security Awareness - 3 Years|	10449	10449	10009	95.79%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	10449	10449	10057	96.25%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	10449	10449	9986	95.57%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	10449	10449	10027	95.96%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	10449	10449	10026	95.95%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	10449	10449	10084	96.51%

Compliance rates for the Annual competence requirements were as follows:

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 1 Year|	10449	10449	9101	87.10%
NHS|CSTF|Information Governance and Data Security - 1 Year|	10449	10449	9417	90.12%

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

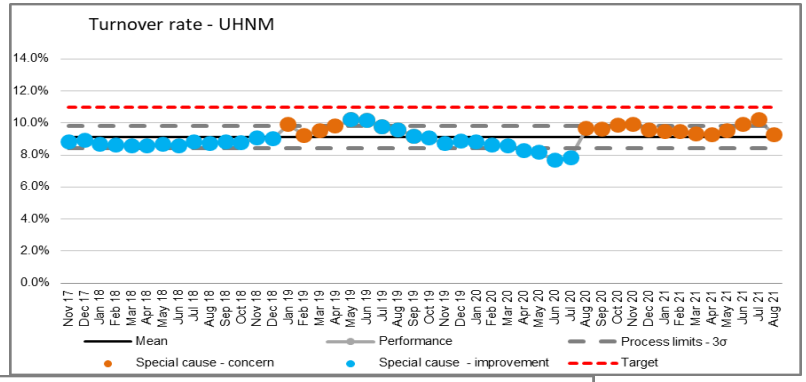
Actions

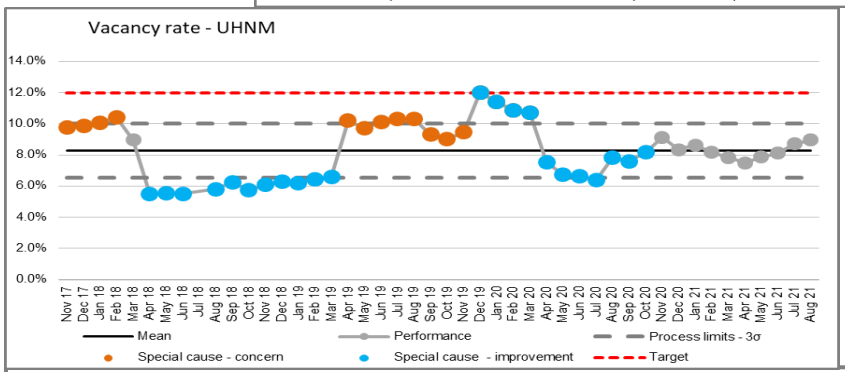
We continue to raise the issue of compliance with Divisions and communicate to staff the need to complete statutory and mandatory training.

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

Workforce Turnover

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





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

Summary

The overall Trust vacancy rate was 8.97% and remains consistent with Previous months.

Vacancies at 31 August 2021	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous month %
Medical and Dental	1,429.29	1,239.12	190.17	13.31%	13.10%
Registered Nursing	3270.87	2869.86	401.01	12.26%	11.58%
All other Staff Groups	6280.50	5886.44	394.06	6.27%	6.25%
Total	10,980.66	9,995.42	985.24	8.97%	8.72%

There was a 26.81FTE increase in vacancies between July and August

- Medical & Dental +3.97 vacancies
- Registered Nursing + 22.29 vacancies and
- An increase of 1.05 vacancies across all other staff group vacancies

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

Variation	Assurance
H	P

Target	Jun 21	Jul 21	Aug 21
11.0%	9.9%	10.2%	9.3%

Background

Turnover rate

What is the data telling us?

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

Actions

A further 17 international nurses will join us w/c 27 September and will quarantine/isolate.

20 international nurses will undergo their OSCE on 8/9 October, receiving their PIN cards 14 days later if successful

The month long campaign to recruit registrants on to the Nurse Bank has commenced with support from Indeed – we have separate adverts for nurses, midwives and ODPs.

Finance

2025 Vision "Ensure efficient use of resources"

Finance Spotlight Report

NHS University Hospitals of North Midlands NHS Trust

Key messages

- The Trust has delivered a surplus of £2.3m in month against a planned surplus of £2m. The position in month is primarily driven by a pay underspend against plan of £1.1m driven by both registered nursing and NHS infrastructure support.
- ERF income recognised for the year to date is £8m against a revised planned figure of £7.3m. Based on activity plans, the plan originally assumed £8.8m of income for H1 with additional costs approved of £0.6m to support the delivery of the activity plans. Revised thresholds for receiving ERF funding have been announced for Q2 which will reduce the forecast income earned by the Trust and there will also be a significant underspend against the £0.6m anticipated spend in H1.
- The Trust incurred £1.3m of costs relating to COVID-19 in month which is an increase of £0.2m compared with Month 4'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.
- A detailed forecast for the remainder of H1 suggests that the Trust may have a surplus in excess of its plan for the period of £6m. The Trust continues to formally report externally that it will deliver its planned position for the first 6 months of the year.
- Capital expenditure for the year to date stands at £9.8m which is £2.3m behind the plan mainly due to an underspend relating to the lower Trent wards scheme.
- The cash balance at Month 5 is £58.4m. The forecast cash balance for the end of Month 6 has increased to £66.4m from the year-end balance of £55.8m, reflecting the expected revenue surplus for H1.

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 05 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	816.4	73.2	72.6	(0.7)	362.5	360.4	(2.1)
Other Operating Income	94.6	7.3	6.7	(0.5)	35.9	34.9	(1.0)
Total Income	911.0	80.5	79.3	(1.2)	398.4	395.3	(3.2)
Pay Expenditure	(541.4)	(45.2)	(44.0)	1.1	(225.8)	(220.3)	5.5
Non Pay Expenditure	(330.2)	(28.9)	(28.5)	0.4	(143.4)	(139.2)	4.2
Total Operational Costs	(871.5)	(74.1)	(72.5)	1.5	(369.2)	(359.5)	9.7
EBITDA	39.5	6.4	6.7	0.3	29.2	35.8	6.6
Depreciation & Amortisation	(29.9)	(2.5)	(2.5)	0.0	(12.6)	(12.4)	0.2
Interest Receivable	0.3	0.0	0.0	(0.0)	0.1	0.0	(0.1)
PDC	(7.6)	(0.6)	(0.6)	0.0	(3.2)	(3.2)	0.0
Finance Cost	(16.1)	(1.3)	(1.3)	0.0	(6.7)	(6.7)	0.0
Other Gains or Losses	0.0	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)
Surplus / (Deficit)	(13.8)	2.0	2.3	0.3	6.9	13.5	6.6
Financial Recovery Fund	5.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	(8.8)	2.0	2.3	0.3	6.9	13.5	6.6

The Trust delivered a £2.3m surplus for Month 5 against a planned surplus of £2.0m and a year to date surplus position of £13.5m against a planned surplus position of £6.9m; this surplus is measured against the Trust's financial plan which was re-submitted in June 2021 to take into account the full impact of the ERF. The main variances in month are:

- Income from patient activities has underperformed in month due to underperformance in respect of ERF (£1.2m). The trust has received £0.9m of ERF income in month all of which relates to prior periods. Additional pass-through device income has been received in month in excess of plan (£0.9m). This over performance is offset by Independent Sector (IS) under performance of £0.5m (both of which are offset by corresponding movements in non-pay).
- The primary reason the underperformance of other operating income in month relates to an adjustment for deferred income relating to Cancer Transformation Funding in line with actual spend year to date.
- Pay is underspent in month by £1.1m which is driven by underspends across registered nursing and NHS infrastructure support. This is further driven by COVID-19 funding underutilised in month.
- Non-pay is underspent against plan in month by £0.4m due to reduced spend on the Independent Sector contract and underspends against the COVID-19 and contingency reserves. Although the pass-through device non pay has overspent against plan, this has been offset by a reduction in other supplies and services – clinical spend due to a reduction in elective activity in month.

Capital Spend

Capital Expenditure as at Month 5 2021/22 £m	Total approved scheme cost - schemes > 1 yr (excl PFI)	Revised 2021/22 Plan	In Month			Year to Date		
	Plan	Plan	Budget	Actual	Variance	Budget	Actual	Variance
PFI & finance lease liability repayment	-	(9.2)	(0.8)	(0.8)	-	(3.8)	(3.8)	-
Pre-committed items	-	(9.2)	(0.8)	(0.8)	-	(3.8)	(3.8)	-
PFI lifecycle and equipment replacement	-	(5.3)	(0.2)	(0.2)	-	(0.8)	(0.8)	-
PFI enabling cost	-	(0.8)	-	-	-	-	-	-
PFI related costs	-	(6.1)	(0.2)	(0.2)	-	(0.8)	(0.8)	
RI demolition	(7.4)	(0.9)	(0.3)	(0.3)	(0.0)	(0.5)	(0.5)	(0.0)
Project STAR multi-storey car park	(1.5)	(1.2)	-	(0.0)	(0.0)	(0.2)	(0.2)	(0.0)
Thornburrow decant office accommodation	(2.4)	(1.9)	(0.3)	(0.2)	0.1	(1.8)	(1.5)	0.4
Wave 4b Funding - Lower Trent Wards	(9.5)	(7.1)	(0.6)	(0.1)	0.5	(2.0)	(0.4)	1.6
CT7 scanner enabling cost	-	(1.1)	-	-	-	-	-	-
STP diagnostic Funding and Cancer funding CT7	-	(1.0)	-	-	-	-	-	-
Schemes funded by PDC and Trust funding	(20.8)	(13.1)	(1.1)	(0.5)	0.6	(4.5)	(2.6)	1.9
LIMS (Laboratory Information Management System)	(2.7)	(0.6)	(0.1)	(0.0)	0.0	(0.3)	(0.3)	(0.0)
EPMA (Electronic Prescribing)	(4.7)	(0.5)	(0.0)	(0.0)	(0.0)	(0.2)	(0.2)	(0.0)
Completion of RSUH ED doors	(0.4)	(0.2)	-	-	-	(0.2)	(0.0)	0.2
Pathology integration	(0.2)	(0.1)	-	-	-	-	-	-
Medical devices fleet replacement	(4.9)	(0.7)	-	-	-	-	-	-
Schemes with costs in more than 1 financial year	(12.9)	(2.2)	(0.1)	(0.1)	0.0	(0.7)	(0.5)	0.1
ICT Infrastructure	-	(0.6)	(0.0)	(0.0)	0.0	(0.2)	(0.1)	0.1
Estates Infrastructure	-	(4.4)	(0.2)	(0.2)	0.0	(0.3)	(0.3)	0.0
Medical Equipment Replacement	-	(2.5)	(0.4)	(0.3)	0.1	(1.2)	(1.2)	0.0
Health & Safety Compliance	-	(0.2)	-	-	-	(0.0)	(0.0)	0.0
Beds, mattresses and hoists	-	(0.1)	-	-	-	-	-	-
Critical Risk Infrastructure	-	(0.3)	(0.1)	(0.1)	0.0	(0.1)	(0.1)	0.1
4th Linear Accelerator Replacement	-	(2.5)	-	-	-	-	(0.0)	(0.0)
West building doctors accommodation	-	(0.1)	-	(0.0)	(0.0)	(0.1)	(0.1)	-
Commitments b/f from 2020/21	-	(0.3)	-	-	-	(0.3)	(0.3)	(0.0)
Lloyds dispensary footprint	-	(0.7)	-	-	-	-	-	-
Digital Pathology (MES)	-	(0.7)	-	-	-	-	-	-
Isolation PODs ward 127 - BC approved	-	(0.1)	-	-	-	-	-	-
County ward 7 - Winter Plan	-	(0.1)	-	-	-	-	-	-
Potential embedded leases from approved cases	-	(0.1)	-	-	-	-	-	-
2021/22 schemes	-	(12.8)	(0.7)	(0.5)	0.2	(2.4)	(2.1)	0.2
Balance to be allocated in updated Plan	-	(1.7)	-	-	-	-	-	-
Funds to be allocated to schemes	-	(1.7)	-	-	-	-	-	-
Donated/Charitable funds expenditure	-	(0.3)	(0.1)	(0.1)	-	(0.3)	(0.3)	-
Charity funded expenditure	-	(0.3)	(0.1)	(0.1)	-	(0.3)	(0.3)	-
Overall capital expenditure	(33.7)	(45.0)	(2.8)	(2.0)	0.8	(12.2)	(9.8)	2.3

- The Lower Trent scheme is £1.6m behind plan. The scheme has been reviewed and reported to the Executive Team with the agreement that additional decant accommodation will be provided in ward 80. The impact of these changes has been quantified in terms of the overall cost and the phasing of the scheme and will result in a reduction to the expected expenditure in 2021/22.
- There was a £0.4m underspend on the Thornburrow office accommodation decant scheme at Month 5 due to delays on the medical records storage area however the scheme is expected to be completed for all staff to decant by the autumn.
- The plan shown in the table above shows a balance to be allocated of £1.7m, cost pressures in excess of the available funding have been identified for schemes that require approval of a red risk rated business case or a statement of need through Capital Investment Group. As schemes are approved they will be added to the approved capital programme above.

Balance sheet

Balance sheet as at Month 5	31/03/2021	31/08/2021			
	Actual £m	Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment	531.2	529.2	527.4	(1.8)	Note 1
Intangible Assets	22.8	20.2	20.2	(0.0)	
Other Non Current Assets	-	-	-	-	
Trade and other Receivables	0.5	0.5	0.5	-	
Total Non Current Assets	554.5	549.9	548.1	(1.8)	
Inventories	15.0	15.0	15.8	0.8	Note 2
Trade and other Receivables	47.4	50.7	55.6	4.9	Note 3
Cash and Cash Equivalents	55.8	58.4	58.5	0.1	
Total Current Assets	118.2	124.2	129.9	5.7	
Trade and other payables	(98.5)	(97.0)	(94.2)	2.7	Note 4
Borrowings	(8.3)	(8.3)	(8.3)	(0.0)	
Provisions	(3.6)	(3.6)	(3.6)	0.0	
Total Current Liabilities	(110.4)	(108.9)	(106.2)	2.8	
Borrowings	(268.5)	(264.8)	(264.7)	0.0	
Provisions	(2.2)	(2.2)	(2.1)	0.1	
Total Non Current Liabilities	(270.7)	(266.9)	(266.9)	0.1	
Total Assets Employed	291.5	298.2	304.9	6.7	
Financed By:				-	
Public Dividend Capital	637.9	637.9	637.9	0.0	
Retained Earnings	(465.3)	(458.6)	(452.0)	6.6	Note 5
Revaluation Reserve	118.9	118.9	119.1	0.2	
Total Taxpayers Equity	291.5	298.2	304.9	6.8	

The balance sheet plan reflects the impact on the balance sheet of the 2021/22 revenue plan submitted to NHSI/E in June 2021. Variances to the plan at Month 5 are explained below:

1. Property, Plant and Equipment is £1.8m lower than plan and reflects the underspend in the capital plan to Month 5 which is due to lower than planned capital expenditure of £2.3m. 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 5 reflects the value of high cost devices held mainly in relation to the pace makers inventory count. The increase is partly offset by reductions in the balance of DHSC donated consumables that was held at 31 March 2021.
3. Trade and other receivables are £4.9m higher than plan and reflect increased accruals mainly in relation to the Elective Recovery Fund for Q1 of £7.9m.
4. Trade and other payables are £2.7m lower than plan which reflects the impact of the revenue and capital underspends year to date and the reduction in capital creditors from the 31 March 2021.
5. Retained earnings show a variance of £6.6m from plan which reflects the year to date revenue underspend at Month 5.

Expenditure - Pay and Non Pay

NHS University Hospitals of North Midlands NHS Trust

Pay Summary Month 05 2021/22	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Medical	(161.4)	(13.5)	(13.7)	(0.3)	(67.2)	(68.2)	(1.0)
Registered Nursing	(160.1)	(13.3)	(12.4)	0.9	(66.5)	(62.7)	3.9
Scientific Therapeutic & Technical	(66.4)	(5.5)	(5.3)	0.2	(27.7)	(26.7)	1.0
Support to Clinical	(70.9)	(6.0)	(6.1)	(0.2)	(29.9)	(30.3)	(0.4)
Nhs Infrastructure Support	(82.5)	(6.9)	(6.5)	0.4	(34.5)	(32.4)	2.1
Total Pay	(541.4)	(45.2)	(44.0)	1.1	(225.8)	(220.3)	5.5

Pay –Key variances:

The overspend on medical staffing is largely due to additional premium (agency) spend on Consultants against vacancies and absences primarily in Medicine (Emergency Medicine) and CWD (Radiology backlog reporting and Paediatrics).

The underspend on registered nursing remains in line with the prior year trend as a result of the number of vacancies across the trust.

NHS infrastructure support is underspent by £0.4m in month driven by a high number of vacancies across the Trust but primarily within Central Functions.

Non Pay Summary Month 05 2021/22	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Tariff Excluded Drugs Expenditure	(78.2)	(6.5)	(6.6)	(0.1)	(32.4)	(33.8)	(1.5)
Other Drugs	(22.5)	(1.9)	(1.9)	0.0	(9.4)	(9.4)	(0.1)
Supplies & Services - Clinical	(87.9)	(7.3)	(7.5)	(0.1)	(36.4)	(35.4)	0.9
Supplies & Services - General	(7.5)	(0.6)	(0.5)	0.1	(3.1)	(2.6)	0.5
Purchase of Healthcare from other Bodies	(26.3)	(3.0)	(2.6)	0.4	(14.8)	(10.7)	4.0
Consultancy Costs	(1.5)	(0.1)	(0.1)	(0.0)	(0.7)	(1.0)	(0.3)
Clinical Negligence	(25.4)	(2.2)	(2.2)	0.0	(11.0)	(11.0)	0.0
Premises	(33.9)	(3.0)	(3.2)	(0.2)	(14.6)	(14.9)	(0.3)
PFI Operating Costs	(35.5)	(2.9)	(3.0)	(0.0)	(14.7)	(14.8)	(0.0)
Other	(11.5)	(1.4)	(1.0)	0.4	(6.5)	(5.5)	1.0
Total Non Pay	(330.2)	(28.9)	(28.5)	0.4	(143.4)	(139.2)	4.2

Non Pay key variances:

Supplies and services - clinical is slightly overspent in month in part due to overperformance against the planned figure for pass through devices (£0.9m) offset by reduced activity and spend due to elective cancellations because of operational pressures and annual leave.

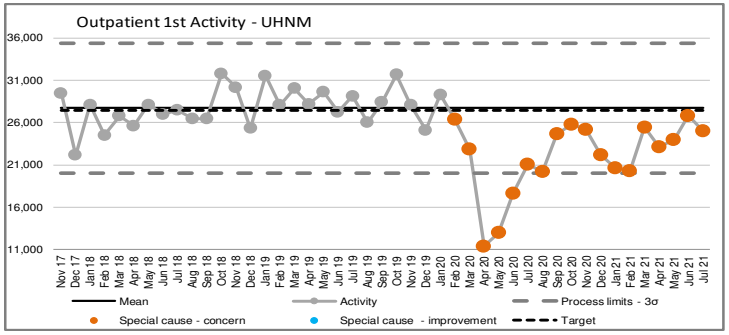
Purchase of healthcare from other bodies is underspent in month largely as a result of the IS contract as the Trust had planned a £1.4m cost in month against an actual cost of £0.9m (year to date variance of £3.3m).

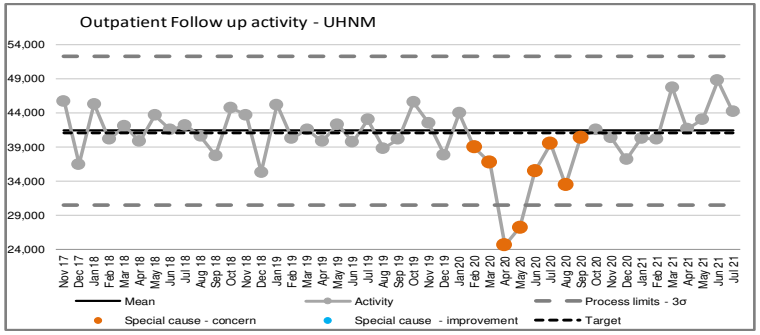
Other non-pay is underspent against plan by £0.4m in Month 5. This is primarily as a result of the unallocated contingency reserve in month of £0.3m, against which there was no related spend.

Activity

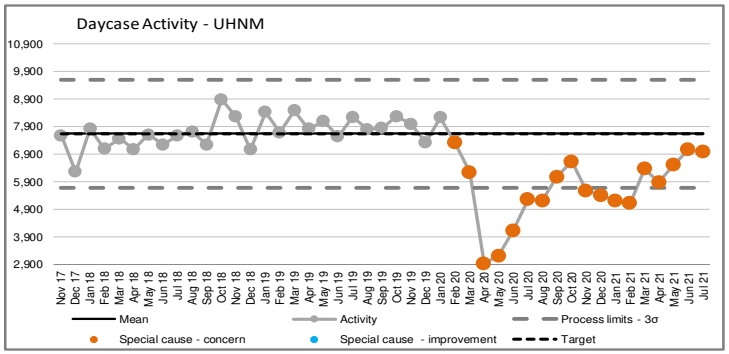
NHS University Hospitals of North Midlands NHS Trust

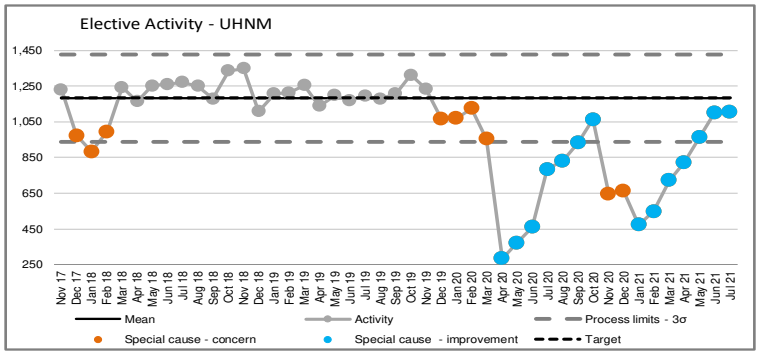
Planned care Outpatient



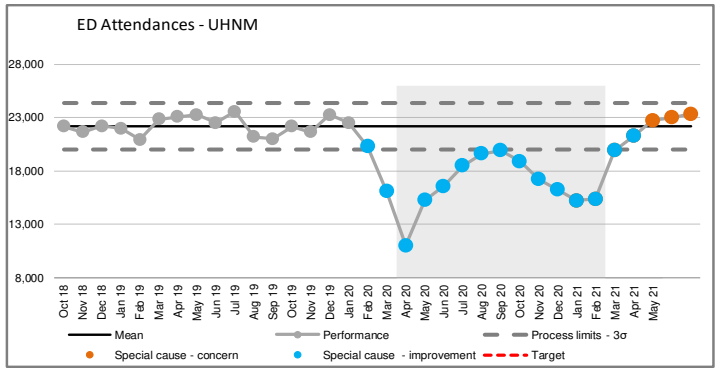


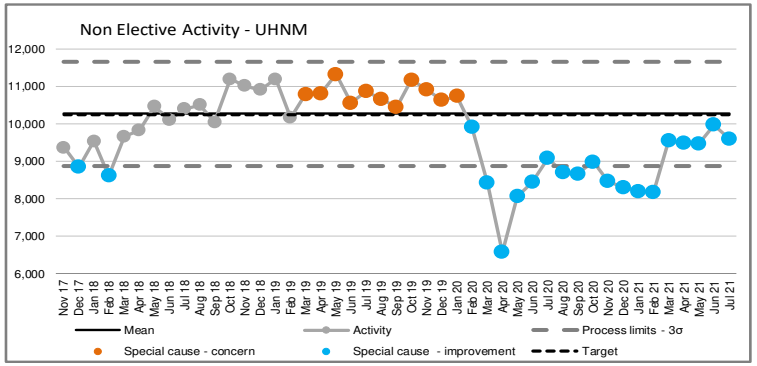
Planned care Inpatient





Urgent Care





Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	6th October 2021
Report Title:	Workforce Race Equality Standard (WRES) Report - 2021	**Agenda Item:**	12.
Author:	Raising Concerns & Workforce Equality Manager		
Executive Lead:	Director of HR		

Purpose of Report:

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

Impact on Strategic Objectives (positive or negative):

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

Executive Summary:

As set out in the NHS Long Term Plan and The People Plan respect, equality and diversity are central to changing culture and are at the heart of the NHS People Promise.

The Covid-19 pandemic, and Black Lives Matters movement has exposed and exacerbated longstanding inequalities affecting Black, Asian and Minority Ethnic (BAME) groups in the UK. These inequalities can often extend into the experiences of BAME staff working within the NHS.

National evidence shows that people from Black, Asian and Minority Ethnic (BAME) backgrounds are less likely to be appointed from shortlisting compared to white applicants, more likely to be under represented in senior and leadership positions, more likely to be bullied at work and more likely to go through formal disciplinary action. The Workforce Race Equality Standard (WRES) mandated since 2015 through the NHS Contract aims to enable NHS Trusts to understand what they need to do to improve workforce race equality and to embed the WRES within their organisations.

The WRES requires healthcare providers to self-assess against nine indicators. Four of the indicators relate specifically to workforce data; four are based upon data from the national NHS Staff Survey and one considers BAME representation on boards. The WRES seeks to highlight differences between the experience and treatment of BAME staff in the NHS, with a view to closing the gap in those metrics.

This report demonstrates progress we have made during the past year, in the context of the ongoing global pandemic and the actions we intend to take to further close the gaps in career and workplace experience of our BAME staff at UHNM during 2021-22.

As an organisation our equality and inclusion workforce priorities for 2021- 2024 are:

Priority 1: To listen to, understand and learn from the experience of all staff
Priority 2: To respect and value all colleagues and their contribution and have a strategic focus on

dignity and respect

Priority 3: To develop a culture of inclusive and compassionate leadership

Priority 4: To ensure that people are recruited, trained and promoted according to their abilities and in the proportions one would expect for the populations represented

The Trust is required to publish our WRES Metrics and Action Plan on our Trust Website by 30th September 2021.

Note on Terminology: The term Black, Asian and Minority Ethnic (BAME) will be used throughout this report as this is currently the preferred term. Race terminology has been a subject of debate at national level during 2021and the NHS Race Observatory has recently conducted a survey around preferences on this topic. As an organisation we await further guidance on recommended terminology going forward.

Key Recommendations:

Trust Board is requested to consider this WRES Report and the actions we intend to take to close the gaps in career and workplace experience between our BAME staff and the overall workforce at UHNM during 2021-22.

Workforce Race Equality Standard (WRES)

2021 Report

1. Introduction

The NHS was established on the principles of social justice and equity, but evidence tells us that the treatment of our employees from Black, Asian and Minority Ethnic (BAME) groups can fall short. Covid 19 has intensified social and health inequalities, with the pandemic having had a disproportionate impact on our BAME colleagues. The NHS is the largest employer of BAME people in the country yet the Workforce Race Equality Standard (WRES) programme, by collecting data on race inequality for five years, is holding up a mirror to the service and revealing the disparities that continue to exist for Black, Asian and minority ethnic staff compared to their white colleagues.

The national evidence from each WRES report over the years has shown that our BAME staff members are less well represented at senior levels, have measurably worse day to day experiences of life in NHS organisations, and have more obstacles to progressing in their careers.

It is in recognition of these realities that the People Plan 2020/21 has 'Belonging' as one of its four pillars. The NHS People Plan calls for a time of national awakening, that each of us must listen and learn from our colleagues and from society and take considered, personal and sustained action to improve the working lives of our NHS people and the diverse communities we serve.

The WRES has been designed to deliver tangible and lasting improvements in race inclusion. NHS providers are expected to show progress against a number of indicators of workforce equality. The WRES is intended to provide a platform and direction to encourage and help NHS organisations to:

- Reduce the differences in the treatment and experience between BAME and white staff in the NHS
- Compare not only their progress in reducing the gaps in treatment and experience but to make comparisons with similar organisations about the overall level of such progress over time
- Identify and take necessary remedial action on the causes of ethnic disparities in the metric outcomes

The WRES is mandated annually as part of the NHS Standard Contract. NHS Organisations are required to publish their data and action plan on their public facing website. The key national findings from the 2020 WRES analysis found:

+2.9%
21% (273,359) of staff working in NHS Trusts and CCGs in England were from a BAME background. This is an increase from 18.1% in 2017

X1.16
BAME staff were 1.16 times more likely to enter the formal disciplinary process compared to white staff. This is an improvement on 2019 (1.22)

X1.61
White applicants were 1.61 times more likely to be appointed from shortlisting than BAME applicants. There's been year on year fluctuation but no overall improvement in the past 5 years

+41.7%
The total number of BAME staff at Very Senior Manager (VSM) pay band has increased from 108 in 2017 to 153 in 2020

30.3%
30.3% of BAME staff and 27.9% of white staff reported experiencing harassment, bullying or abuse from patients, relatives or the public.

+ 1.6%
10.0% of board members in NHS trusts were from a BAME background. An improvement from 8.4% in 2019

No Change
The national WRES indicators relating to perceptions of bullying, harassment and abuse and on beliefs regarding equal opportunities in the workplace have not improved over time for both BAME and white staff

Key publications released in 2021 that have influenced the race inclusion agenda include the NHSI/E Midlands Workforce, Race, Equality and Inclusion Strategy and the Medical Workforce Race Equality Standard (MWRES).

The Midlands Workforce, Race Equality and Inclusion Strategy identifies the following key priorities:

The NHS People Plan	Regional Strategic Priorities
Looking after our people	1. Removing barriers to inclusive and compassionate health and wellbeing support
Belonging in the NHS	1. Leading with compassion and inclusion 2. Removing barriers to help staff speak up 3. Tackling racism and other types of discrimination (including bullying and harassment) 4. Eliminating bias and racism in disciplinaries 5. Reward and celebration when good practice is identified
New ways of delivering care	1. A collaborative approach across systems 2. Building accountability
Growing for the future	1. Eliminating racism and bias in recruitment and progression

The Medical Workforce Race Equality Standard (MWRES) 2020 report is the first publication with a specific focus on doctors and dental staff measured against eleven indicators. The report has the following key roles:

- To enable organisations to understand the challenges that exist in the medical workforce, with the aim of encouraging improvement by learning and sharing good practice
- To provide a national picture of WRES in practice, to colleagues, NHS organisations, royal colleges and the public on the developments in the workforce race equality agenda

This report is the first publication of the MWRES data, and will provide baseline evidence to quantify discrimination in the NHS trust-based medical workforce at the national level, and hence identify the targets for organisations to pursue with corrective action.

The report has found that, nationally, the shortlisting and interview process discriminates against BAME applicants for consultant appointments. BAME doctors reported a worse experience than their white colleagues when it comes to harassment, bullying, abuse and discrimination from staff. BAME doctors have a worse experience when it comes to examinations (medical school and post-graduation examinations) and regulation (revalidation, referrals/complaints to GMC, Annual Review of Competence Progression). This discrimination begins early in the career, with BAME students less likely to attain a place in medical school than white students.

For this launch report, the data is only available at the national level. In future years, it is intended to present the data at trust, royal college or specialty level as appropriate, and the analyses of trends can begin as soon as methodology for data analysis are finalised, and the data completeness and accuracy permit valid comparisons.

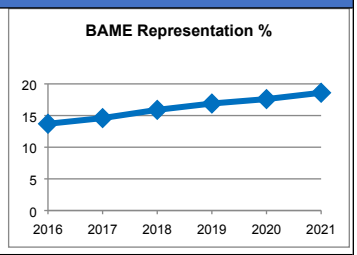
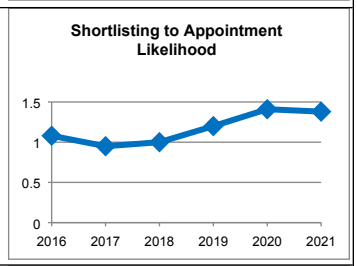
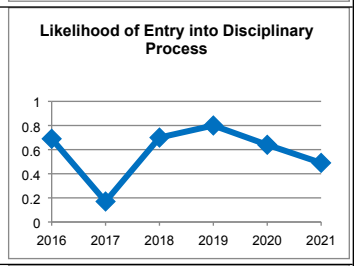
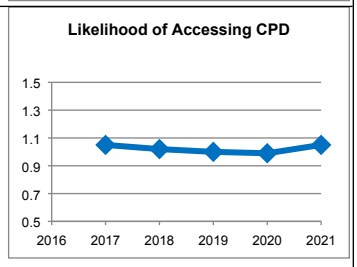
The report has been released at a particularly pertinent time when the experiences of medical and dental colleagues at UHNM has highlighted concerns about bullying and harassment and discrimination.

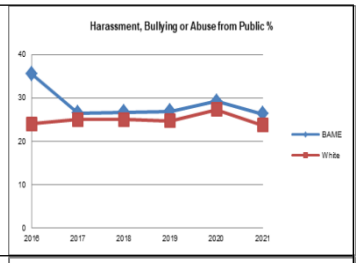
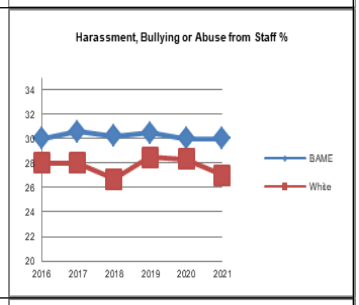
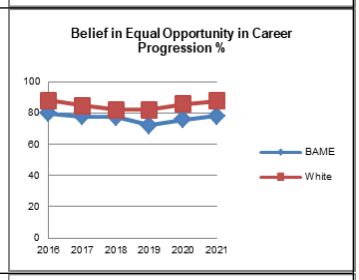
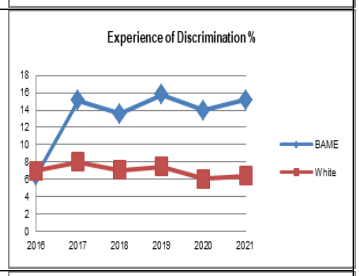
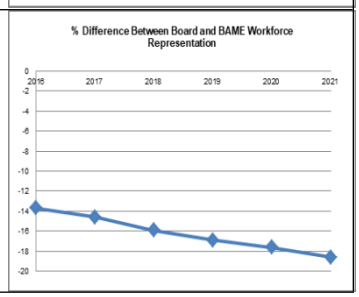
Appendix 2 provides a data summary of experiences of UHNM medical and dental staff from currently available sources. It is anticipated that the outputs from the BRAP Independent Review will help shape our future work with this group of staff and the wider organisation and that future MWRES reports, will, like the WRES, enable meaningful analysis and benchmarking to monitor progress against key metrics and indicators.

2. WRES Metrics and UHNM Performance

A detailed analysis of the UHNM WRES Metrics is attached as Appendix 1 and includes comparison of our performance against benchmarking data where this is available from either the 2020 NHS Staff Survey, or the 2020 National WRES data analysis report. A summary of our 2021 WRES Metrics is outlined below.

Note: data for Metrics 2, 3 and 4 is auto calculated using the WRES pre populated excel spread sheet to produce a relative likelihood score. A relative likelihood of 1.00 indicates that there is no difference between BAME and white staff. For example, for Metric 2, a result above 1.00 indicates that white staff have an increased likelihood of being appointed from shortlisting compared to BAME staff and for Metric 3 a result above 1.00 would indicate that BAME staff are more likely to enter the formal disciplinary process than white staff.

	WRES Metric	2016	2017	2018	2019	2020	2021	Progress
1	Percentage of BAME staff in each of the AfC Bands 1 – 9 or medical and dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce	13.7%	14.6%	15.9%	16.9%	17.6%	18.6%	
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BAME applicants	1.08	0.95	1.0	1.20	1.41	1.38	
3	Relative likelihood of BAME staff entering the formal disciplinary process compared to white staff	0.69	0.17	0.70	0.80	0.64	0.49	
4	Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BAME staff	-	1.05	1.02	1.0	0.99	1.05	

5	Percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	BAME	35.5%	26.5%	26.7%	26.9%	29.2%	26.3%	
		White	24%	25%	25.%	24.7%	27.3%	23.7%	
6	Percentage of BAME staff experiencing harassment, bullying or abuse from staff in the last 12 months	BAME	30%	30.6%	30.2%	30.5%	30.0%	30.0%	
		White	28%	28%	26.7%	28.5%	28.3%	27.0%	
7	Percentage of BAME staff believing that the Trust provides equal opportunities for career progression or promotion	BAME	80%	78%	77.5%	72.2%	76.0%	78.2%	
		White	88%	85%	82.2%	82.2%	86.0%	87.8%	
8	Percentage of BAME staff experiencing discrimination at work from a manager, team leader or other colleagues in the last 12 months	BAME	6.5%	15.1%	13.6%	15.8%	14.0%	15.2%	
		White	7%	8%	7.1%	7.5%	6.1%	6.4%	
9	Percentage difference between the organisations' board voting membership and its overall workforce		-13.7%	-14.6%	-15.9%	-16.9%	-17.6%	-18.6%	

3. Race Equality Actions Undertaken in 2020/21

Our key areas of focus for 2020/21 identified in last year's WRES Report were to:

- Take a strategic focus on respect and dignity
- Review our recruitment and promotion practices to make sure that our staffing reflects the diversity of the community
- Progression of our Model Employer goals to ensure that our workforce leadership is representative of the overall BAME workforce
- Launch the UHNM Reverse Mentorship Programme
- Introduce Cultural Intelligence Training

During 2020/21, we have undertaken the following actions to deliver against these priorities:

Take a strategic focus on respect and dignity

- Launch of the UHNM Speaking Up Charter to promote the Trusts commitment to a healthy speaking up culture
- Focus on support for vulnerable groups with safe routes to raise issues in the first Staffordshire and Stoke on Trent System Wide BAME Staff Network
- Held a focus session with our Ethnic Diversity Staff Network on racial discrimination that has informed the development of the Trust Violence Prevention and Reduction Strategy
- UHNM's Freedom to Speak Up Guardians have joined the Keele University Professionalism Committee and Raising Concerns Group to understand, support and address BAME doctor in training concerns at work whilst placed at UHNM
- Raised the profile of race equality and workplace inclusivity through our annual calendar of diversity and inclusion campaigns and engagement activities such as Black History Month, South Asian Heritage Month and Show Racism the Red Card
- Promoted the important role of BAME Allies through our UHNM animation 'how to be an effective ally'
- Created a WRES infographic to raise awareness of race inequalities across the organisation
- System leaders cultural intelligence race training introduced with 'Comfortable Being Uncomfortable with Race' immersive development for Very Senior Managers delivered in June and July 2021
- Race Equality Board Development Seminar held in September 2021
- Winter and Summer system wide Inclusion School sessions for all leaders to gain a greater understanding of key concepts of inclusion

Review our recruitment and promotion practices to make sure that our staffing reflects the diversity of the community

- Reviewed and updated our Recruitment and Selection Policy, ratified in December 2020 to state that 'recruiting mangers will be held accountable for ensuring diverse shortlisting and interview panels. UHNM stipulate that it is a requirement that all Band 6 Agenda for Change posts and above have an ethnically diverse shortlist and interview panel. All of which need to be recorded against the vacancy on TRAC and will be audited'
- Revised and updated the equality & inclusion in recruitment e-learning package to reflect this change. The training is a pre requisite for all staff who are undertaking the Trust's Gateway to Management leadership development programme. This includes the practical application of the Trust Recruitment Policy, including awareness of fair recruitment practice and an understanding of unconscious bias

Progression of our Model Employer goals to ensure that our workforce leadership is representative of the overall BAME workforce

- Continued our programme of work with local schools and colleges, and through a range of events, promotional material, social media and engagement with our local communities to promote the various roles and routes into employment as part of our Widening Participation Strategy
- Created an Equality, Diversity and Inclusion section on our Working Here page of the UHNM website, promoting our commitment to a fair and diverse workforce and the role of our staff networks in actively engaging and contributing to equality acceptance and inclusion within the Trust
- Monitoring of our BAME and other protected group representation on internal leadership development programmes ensuring that this is representative of the workforce and to ultimately support action to address the disparity of BAME staff in senior roles
- Actively sought diverse applications to the Staffordshire High Potential Scheme and put forward a nomination to the Midlands 'Developing Aspirant BAME Nurse and Midwifery Leaders Programme'
- The UHNM cohort of Staffordshire Stepping Up graduates continue to be supported through the Stepping Up Alumni programme including a session in November 2020 which celebrated the impact the programme has had with multiple graduates successfully achieving promotions and other development opportunities and focused on the what next?, this was followed by an Alumni Survey in July 2021to inform future positive action interventions

- The February 2021 meeting of the Ethnic Diversity Network was a dedicated session on the leadership development opportunities available both internally and externally and how colleagues can access these. This was followed by a toolkit of information with details of the programmes
- Increased the pool and diversity of Coaches available to UHNM colleagues to access

Launch the UHNM Reverse Mentorship Programme

- The first cohort of our Reverse Mentorship programme, launched in August 2020, with members of the UHNM Ethnic Diversity Staff Network matched with Board and senior leaders. A mid-point review session held in January 2021 with the Mentors and a short mid-point evaluation questionnaire was also sent to all participants. Our end of programme virtual Celebration Event was held in June 2020, with resounding positivity from both mentees and mentors of the experience they have had. All attendees stated that it was great to have had the opportunity to listen from and share stories with their partner in the process. There has been significantly more learning and development impact arising from the relationships beyond the original scope of the programme - for example mentors attending a Divisional Board to talk about reverse mentoring, an Executive Director attending as a panel member on Schwartz rounds, mentees shadowing a Trust Board Meeting etc. During the session participants were asked to vote on which themes they felt the Trust should prioritise over the next 6 months, with the following being the top responses:

    1. Culture - To work with our staff networks to identify ways to improve the inclusive culture we aspire for = 77%
    2. Careers - To enhance career progression opportunities for those from under-represented groups = 62%
    3. Diversity - To demonstrate our commitment to broader and deeper representation of those currently underrepresented = 54%

Introduce Cultural Intelligence Training

- The UHNM 'Belonging in the NHS' Inclusivity Masterclass has been introduced to the Gold and Platinum Connects Leadership Programmes. The Masterclass was created internally to introduce cultural intelligence and diversity awareness into our compassionate leadership development following members of the HR/Organisational Development team and Ethnic Diversity Staff Network attending specialist Cultural Intelligence training in 2020. Feedback from the pilot delivery of the Belonging in the NHS Masterclass has been extremely positive.

4. Conclusions

Our 2021 WRES data shows modest improvement and some deterioration. While there is year on year increases in the diversity of our workforce, their experiences, particularly regarding behaviours from other colleagues, managers and the public remain a key challenge for the organisation.

There are positive stories with progress against our Model Employer targets, and improvement in the race disparity ratio from its baseline position. BAME staff perceptions of equality in career progression opportunities have also improved year on year. BAME staff also continue to be less likely than white staff to enter the formal disciplinary process, in direct contrast with the national picture.

We are committed to ensuring that our BAME staff are involved in shaping our equality, diversity and inclusion work and have opportunities to influence our activities to improve race equality at UHNM. We do this by working collaboratively with our Ethnic Diversity Staff Network and through a range of workforce engagement activities, for example survey's and awareness events in addition to the National Staff Survey. We know that by working in partnership with our staff that we can develop workplace cultures where everyone feels they belong, and that enables all of our employees to thrive.

Our WRES Action Plan is based on the commitments of the NHS People Plan, Midlands Workforce Race, Equality and Inclusion Strategy and from listening to the voices of our staff. To maximise

meaningful action we are working collaboratively as a system to drive systemic change particularly in the recruitment and progression of BAME colleagues.

This report is written in advance of the findings of the BRAP review into bullying and harassment that the organisation has commissioned. Once these findings and any recommendations are received these will be included in the action plan that accompanies this report.

It is also acknowledged that the NHSEI Workforce Race Equality Standard (WRES) team is developing a five-year race equality strategy, to establish a standard for advancing race equality, eliminating discrimination, and fostering good relations for staff and workers across organisations, operations and services. The strategy is due for publication in October 2021, and will also shape our actions in this important agenda.

Our UHNM equality and inclusion workforce priorities for 2021- 2024 are:

Priority 1: To listen to, understand and learn from the experience of all staff
Priority 2: To respect and value all colleagues and their contribution and have a strategic focus on dignity and respect
Priority 3: To develop a culture of inclusive and compassionate leadership
Priority 4: To ensure that people are recruited, trained and promoted according to their abilities and in the proportions one would expect for the populations represented

Progress against these priorities and our WRES Action Plan will be measured by improved scores in the 2022 WRES submission, 2021 Staff Survey results and the monitoring of other relevant metrics including regular engagement with our BAME workforce. Progress against this Action Plan will be monitored at the Trust Transformation and People Committee.

UHNM WRES Action Plan 2021 – 2022

WRES Metric	Action / Recommendation	Timescale	Progress Rating
Percentage of BAME staff in each of the AfC Bands 1 – 9 or medical and dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce	• Continue our Widening Participation strategy of targeting local ethnic minority communities and schools to promote NHS Careers. • Showcase the diversity of our workforce and celebrate BAME role models in our promotional and recruitment material, to demonstrate our commitment to being an inclusive employer • Continue with the tailored support given to the overseas nursing programme which includes input from the Ethnic Diversity Staff Network Chair and FTSU Guardians • Continue our focus of increasing BAME representation in senior leadership positions through positive action programmes including ICS sponsored Staffordshire Stepping Up Programme, • Introduction of a self nomination route to internal leadership development • Progress the system and UHNM actions in relation to the 6 High Impact actions identified to close the ethnicity gap in recruitment and promotion outcomes from the Midlands Race Equality and Inclusion Strategy: 1. Ensuring Executive Senior Managers own the agenda 2. Introduce a system of 'comply or explain' about recruitment process 3. Organise talent panels 4. Enhance equality, diversity and inclusion support 5. Overhaul interview processes 6. Adopt resources, guides and tools for productive conversations about race	Ongoing Ongoing Ongoing Q4 Q4	
Relative likelihood of white applicants being appointed from shortlisting compared to BAME applicants	• Develop a network of inclusive recruitment guardians, supported with a training package to participate in selection interviews to support our commitment to ethnically diverse recruitment practices • Recruitment team to work with areas where audits indicate that diverse recruitment panels are not consistently applied • Further Staffordshire and Stoke on Trent ICS sponsored cohorts of the Staffordshire Stepping Up positive action BAME leadership development programme	Q3 Ongoing Q4	

Relative likelihood of BAME staff entering the formal disciplinary process (as measured by entry into a formal disciplinary investigation) compared to white staff	• Ongoing promotion of Just and Learning Culture and launch of the UHNM Just and Learning training across the Trust • Development and introduction of MerseyCare 4 step process of restorative justice • Ensure that no disciplinary process is instigated without a JLC decision tree checklist having been undertaken • Continue with embedding learning from post disciplinary action reviews by the Just and Learning panel • Collaborative working with Staff Side to ensure consistency in application of the Trust Disciplinary Procedure and Maintaining High Professional Standards Policies • Raise cultural awareness amongst senior leaders through the Belonging in the NHS Inclusivity Masterclass and reciprocal mentorship programmes	Q4 Q4 Ongoing Ongoing Ongoing Ongoing	
Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BAME staff	• Update the talent management process to ensure there is greater prioritisation and consistency of diversity in talent, by proposing self-nomination assessment centres as pre cursor for our Gold and Platinum Connects programmes • Additional Staffordshire and Stoke on Trent ICS sponsored cohorts of the Staffordshire Stepping Up positive action BAME leadership development programme • Actively promote leadership development opportunities through the Ethnic Diversity Network and Leaders Network • Promote access to coaching and career conversations and system wide pool of diverse coaches • Continue to monitor the diversity of participants in UHNM non mandatory learning and development	Q4 Q4 Ongoing Ongoing Ongoing	
Percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	• Launch the Violence Reduction and Prevention Strategy • Ethnic Diversity Staff Network to work with the Trust Security Lead in developing resources to tackle hate crime and race related incident incidents, including conflict resolution training • Continue to promote health and wellbeing conversations – in accordance with the People Plan line managers should discuss equality, diversity and inclusion as part of health and wellbeing conversations to empower people to reflect on their lived experience, support them to become better informed on the issues and determine what they and their teams can do to make further progress	Q4 Q2-4 Ongoing	

Percentage of BAME staff experiencing harassment, bullying or abuse from staff in the last 12 months	• Development of a Behavioural Compact • Launch of the UHNM Middle Management Programme with a focus on civility and respect • Review of Dignity at Work Policy • Increase the number of internal mediators • Introduction of the 'Taking the Heat Out of Conflict' Masterclass • Delivery of the Belonging in the NHS Inclusivity Masterclass through the Gold and Platinum Connects Leadership Programme • Extend the reach of the ICS Cultural Awareness system leaders training 'Comfortable Being Uncomfortable Talking About Race' by delivering the sessions in the 2021 Connects Programme as part of the 100 Day EDI Project initiative. • Introduction of equality, diversity and inclusion conversations within Personal Development Reviews • Launch the Speak Up Listen Up mandatory staff training • WRES Expert and FTSU Guardian Network to be established in the Midlands region to identify best practice • Recruit additional FTSU Guardians, expanding the team to reflect the diversity of the workforce • Continue to work closely in enabling safe speaking up channels for our BAME workforce and build confidence of our staff to speak up	Q4 Q4 Q3 Q2 Complete Q2 – pilot complete Ongoing Q2 Q4 Q3 Q3 Q3 Ongoing	
Percentage of BAME staff believing that the Trust provides equal opportunities for career progression or promotion	• Additional system wide cohorts of the Staffordshire Stepping Up positive action programme • Progress plans to develop a UHNM development centre working with divisions, including introducing more aspirational roles with supporting development plans, piloting a career development planning toolkit and signposting to higher level apprenticeships. Plan to increase numbers of informal secondment and shadowing opportunities across the Trust • Revise the Performance & Development Review to encompass a more strength based development and forward looking annual appraisal • Promote access to career conversations and coaching	Q4 Q4 Q4 Ongoing	
Percentage of BAME staff experiencing discrimination at work from a manager, team leader or other colleagues in the last 12 months	• Delivery of further cohorts of the Gold and Platinum Leadership Development Programme, containing the 'Belonging in the NHS Inclusivity Masterclass' • Through the EDI 100 Day Challenge Project extend the session to a full day to include an expansion of the system funded cultural education programme 'Comfortable Being Uncomfortable Talking About Race'. This will reach a wider audience with the aim of embedding a deeper understanding and active commitment to building race inclusion and	Ongoing Q2	

	addressing racism amongst senior leaders, translating into action. • Raise awareness through the diversity events calendar of the Trusts commitment to zero tolerance of discrimination, including Show Racism the Red Card Events and individual responsibility of Allyship • Launch Cohort 2 of the UHNM Reciprocal Mentoring Programme with organisational leaders • Update our UHNM Values Based Recruitment (VBR) pack to include EDI questions as standard, including the introduction of a requirement for recruitment of Band 8a and above for candidates to demonstrate their EDI work and legacy • Build audit of VBR recruitment question compliance into the recruitment audit process	Ongoing Q3 Q3 Q3	
Percentage difference between the organisations' board voting membership and its overall workforce	• Cohort 2 of the Reciprocal Mentorship Programme with members of our Ethnic Diversity Staff and our Trust Board • Continue with strong board leadership internally and externally on race inclusion	Q3 Ongoing	

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.

Appendix 1 – UHNM WRES 2021 Metric Analysis

Further detail is provided below on each of the WRES metrics, including comparisons of our performance against benchmarking data where this is available from either the 2020 NHS Staff Survey, or the 2020 National WRES data analysis report, which was published in February 2021.

Four of the WRES indicators are drawn from the national NHS Staff Survey. The response rate for the 2020 staff survey was 44%. 15.2% of these were from BAME respondents.

Metric 1: Representation of BAME staff in each of the Agenda for Change (AfC) Bands 1 – 9, or Medical and Dental subgroups and Very Senior Manager (including executive Board members) compared with the percentage of staff in the overall workforce

96.6% of the workforce has disclosed their ethnicity, and the percentage of BAME staff in our total workforce has increased from 17.4% in 2020 to 18.6% at 31st March 2021:

Ethnic Group	% of Total Workforce
White	78.0%
BAME	18.6%
Not Stated/Null	3.4%
Total	**100%**

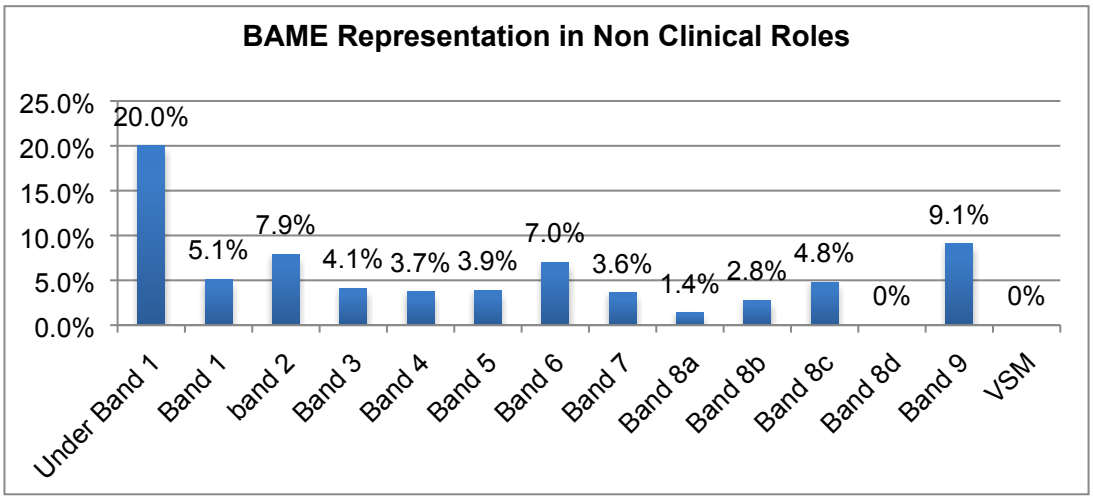
These latest figures compare favourably with BAME representation within our local communities, as recorded in the 2011 Census, which indicated that across Staffordshire 6.4% of the population is from a Black and Minority Ethnic background. The BAME population of Stoke on Trent is 13.4%, and Staffordshire & Stoke on Trent together being 8.1%. The latest available data for BAME staff representation working in the Midlands NHS is 23% (April 2020).

The following table and graphs demonstrate BAME representation across Agenda for Change (AfC) pay bands and Medical and Dental workforce:

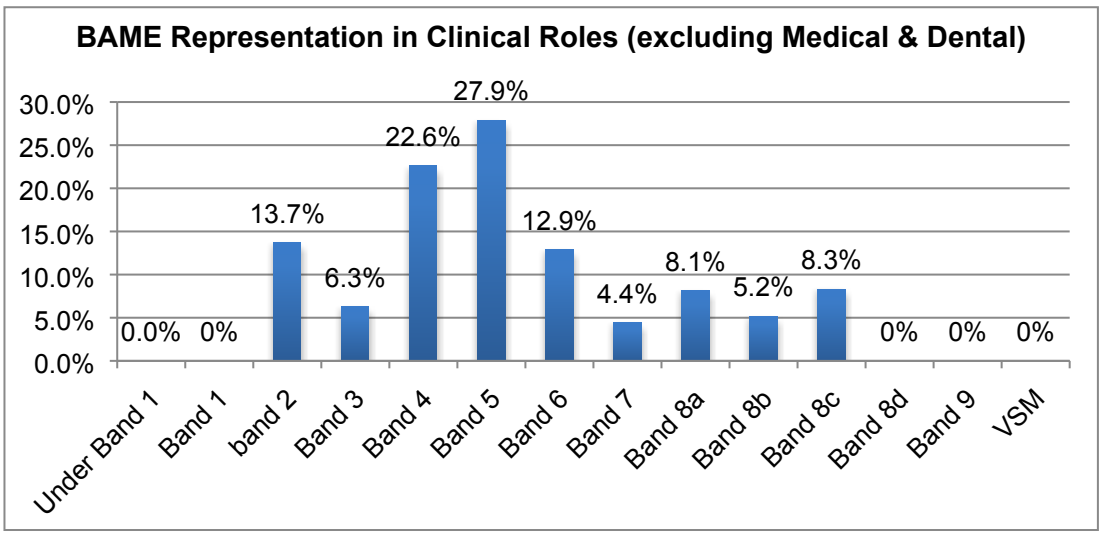
WRES Metric	2019	2020	2021	Narrative
Percentage of BAME staff in each of the AfC Bands 1 – 9 or medical and dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce	Under Band 1: 0.0% Band 1: 20.4% Band 2: 9.9% Band 3: 4.8% Band 4: 10.4% Band 5: 23.8% Band 6: 10.5% Band 7: 4.0% Band 8a: 5.9% Band 8b: 2.4% Band 8c: 6.5% Band 8d: 0.0% Band 9: 0.0% VSM: 0.0% Medical & Dental: 55.6%	Under Band 1: 11.1% Band 1: 5.0% Band 2: 11.6% Band 3: 5.2% Band 4: 10.7% Band 5: 24.4% Band 6: 11.0% Band 7: 4.8% Band 8a: 6.4% Band 8b: 2.3% Band 8c: 6.5% Band 8d: 0.0% Band 9: 0.0% VSM: 0.0% Medical & Dental: 58.4%	Under Band 1: 6.1% Band 1: 5.1% Band 2: 11.9% Band 3: 5.1% Band 4: 11.9% Band 5: 26.2% Band 6: 12.4% Band 7: 4.3% Band 8a: 6.9% Band 8b: 4.3% Band 8c: 6.1% Band 8d: 0.0% Band 9: 8.3% VSM: 0.0% Medical & Dental: 60.8%	There has been year on year increase in the ethnic diversity of our organisation

At UHNM BAME staff have significantly better representation within clinical roles compared to non-clinical roles:

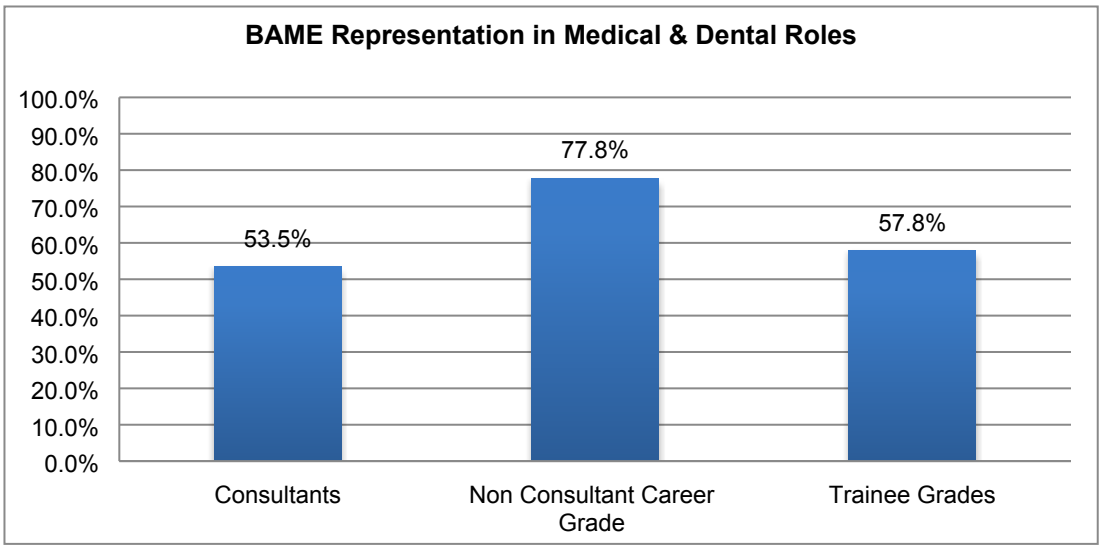
	Non-Clinical Roles	Clinical Roles	Medical & Dental
BAME Representation in UHNM Workforce:	5.4%	16.0%	60.8%



BAME representation in non-clinical roles has remained consistent, but below the ethnicity profile within the local population of Staffordshire and Stoke on Trent in the majority of pay bands.



BAME representation has increased across all clinical pay bands except Band 1 and under, Band 8b and there remains no representation above Band 8c.



BAME representation has increased across all medical and dental roles, a year on year increase since we began reporting the WRES.

'A Model Employer: Increasing black and minority ethnic representation at senior levels across the NHS', forms part of a strategy within the overarching WRES programme of work to support organisations to meet the workforce equality commitments set out in the NHS Long Term Plan. Assurance is needed that the composition of leadership not only includes the best range of talent, skill sets and experience available to us, but that it also broadly reflects those who work in our organisation. Our staff should look at their leaders and see themselves represented. As such the WRES has identified a need for further accelerated improvement in the representation of BAME staff at leadership levels.

The table below shows the 10-year trajectory for the UHNM workforce to reach equality by 2028 for AfC Bands 8a to VSM. The numbers show the required staff in post for each year:

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Band 8a	17	21	24	28	31	35	38	42	45	49	52
Band 8b	3	4	5	6	7	9	10	11	12	13	14
Band 8c	2	2	3	3	3	4	4	4	5	5	5
Band 8d	0	0	1	1	1	2	2	2	3	3	3
Band 9	0	0	0	1	1	1	1	1	1	2	2
VSM	0	0	0	1	1	1	1	1	1	2	2

The table below demonstrates the UHNM BAME staff in post as at 31st March 2021 and is compared to the 2021 trajectory for the Trust:

	2018 actual	2019 actual	2020 actual	2021 actual	2021 ambition	Gap
Band 8a	17	20	22	26	28	-2
Band 8b	3	2	2	4	6	-2
Band 8c	2	2	2	2	3	-1
Band 8d	0	0	0	0	1	-1
Band 9	0	0	0	1	1	
VSM	0	0	0	0	1	-1

This indicates continued progress in increasing representation in senior positions, but recognises that more work is needed to achieve our aspirations of BAME representation that matches our organisational make-up across all pay bands.

Race Disparity Ratio

The Race Disparity Ratio, a new monitoring metric was introduced in June 2021 and is the difference in the proportion of BAME staff at various Agenda for Change bands in the Trust compared to the proportion of white staff at those bands. It is presented at three tiers:

- Bands 5 and below ('lower')
- Bands 6 and 7 ('middle')
- Bands 8a and above ('upper')

UHNM Race Disparity Ratio	Progress	2021	2020
Disparity ratio – lower to middle	↓	1.63	1.72
Disparity ratio – middle to upper	↓	1.74	1.83
Disparity ratio – lower to upper	↓	2.82	3.14

Midlands Race Equality Heat Map

In addition to the Race Disparity Ratio, the NHSI/E Midlands Equality Team have created a regional data pack, which includes a WRES Heat Map and is a useful tool for benchmarking and monitoring progress, as this will be updated annually. The data is extracted from the 2020 WRES submission. The areas where UHNM is falling into the red category are:

Indicator 1 - Lower to upper career progression race disparity ratio
Indicator 6 – the percentage of BAME staff experiencing harassment, bullying or abuse from staff in the last 12 months
Indicator 9 - Board representation

	Indicator 1			Indicator 2	Indicat or 3	Indicator 4	Indicator 5		Indicator 6		Indicator 7		Indicator 8		Indicator 9	
Trust Name	Lower to Middle	Middle to Upper	Lower to Upper	Likelihood			Rank BME	Rank difference	Rank BME	Rank difference	Rank BME	Rank difference	Rank BME	Rank difference	Voting board rank	Diff staff non-voting rank
UHNM	1.72	1.83	3.14	1.41	0.64	0.99	97	104	171	67	83	65	116	123	213	167

Metric 2: The relative likelihood of white applicants being appointed from shortlisting compared to BAME applicants

This indicator, which is extracted from our TRAC recruitment system, indicates that across all recruitment, BAME applicants are less likely to be appointed from shortlisting than white staff with a metric of **1.38**. A metric of 1.0 would indicate no difference between BAME and white applicants.

A review of the TRAC System indicates that for the 12 month period July 2020 – June 2021 demonstrated:

Ethnic Group	Applicants Shortlisted	Applicants appointed	% of applicants appointed from shortlisting	% of Appointed
White	7216	915	12.7%	55.9%
BAME	2992	274	9.2%	16.8%
Not Stated	898	447	49.8%	27.3%
Total	**11,106**	**1,636**	**-**	**100%**

(As per WRES guidance, this data excludes Deanery and bank appointments)

This metric has slightly improved compared to the previous year, which was 1.41. Data indicates that our performance is better than the average for this indicator.

2021 UHNM Result	2020 National Result
1.38	1.61

Metric 3: The relative likelihood of BAME staff entering the formal disciplinary process compared to white staff

To be a model employer, the NHS needs to be an inclusive employer with a diverse workforce at all levels. However, staff also need to feel fully engaged and supported within the workplace.

This indicator is based on data from a two year rolling average of the current year and the previous year of entry into our formal disciplinary process as recorded on the HR Case Tracker. The data indicates that our BAME staff are not disproportionally represented in entry to the formal disciplinary process, but is outside of the non-adverse range of 0.8 – 1.25 (as measured by the WRES), meaning that white staff are more likely to enter the formal disciplinary process.

2021 UHNM Result	2020 National WRES Result
0.49	1.19

Metric 4: Relative likelihood of white staff accessing non-mandatory training and career progression and development (CPD) compared to BAME staff

This indicator measures the relative likelihood of white staff accessing non-mandatory training (recorded on ESR) compared to BAME staff. Our data has shown year on year improvement in this indicator but it has slightly deteriorated this time. Our result of 1.05 compares well with other NHS comparable benchmarks:

2021 UHNM Result	2020 National WRES Result	2020 WRES Result by Midlands Region
1.05	1.14	1.11

Metric 5: Percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months

This indicator is taken from the 2020 NHS Staff Survey, and shows that 26.3% of the 665 BAME staff who responded to the survey reported experiencing harassment bullying or abuse from patients, relatives or the public in the last 12 months, compared with 29.2% the previous year.

Our data is better than the acute sector average for both White and BAME staff on this indicator:

Staff Group	2020 UHNM Staff Survey Result	2020 Result for Staff Survey Acute Sector Average
BAME	26.3%	28.0%
White	23.7%	25.4%

Metric 6: Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months

This indicator measures the percentage of BAME staff reporting experience of harassment, bullying or abuse from other staff in the 2020 NHS Staff Survey in comparison with the organisation as a whole.

The data tells us that there is no change in the percentage of BAME staff reporting experience of harassment, bullying or abuse from other staff, which has been around 30% for the past 4 years.

Staff Group	2020 UHNM Staff Survey Result	2020 Result for Staff Survey Acute Sector Average	2020 WRES Average for NHS Trusts in England
BAME	30.0%	29.1%	28.4%
White	27.0%	24.4%	23.6%

Metric 7: Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion

This indicator is taken from the 2020 NHS Staff Survey and shows year on year improvement on this indicator over the past 5 years. The percentage of our BAME staff that believe that the Trust provides equal opportunities for career progression or promotion improved to 78.2%, compared to 76.0% the previous year, and is better than the acute trust average, however it remains lower than the white staff comparator.

Staff Group	2020 UHNM Staff Survey Result	2020 Result for Staff Survey Acute Sector Average	2020 Average for NHS Trusts in England
BAME	78.2%	72.5%	71.2%
White	87.8%	87.7%	86.9%

Metric 8: Percentage of staff experiencing discrimination at work from a manager, team leader or other colleagues

This indicator is taken from the 2020 NHS Staff Survey, and demonstrates staff experience of discrimination in the workplace from a manager, team leader or other colleagues. Our data shows an increase to 15.2% of BAME staff reported experience of discrimination, compared to 14.0% the previous year.

Staff Group	2020 UHNM Staff Survey Result	2020 Staff Survey Result for Acute Sector Average	2020 Average for NHS Trusts in England
BAME	15.2%	16.8%	14.5%
White	6.4%	6.1%	6.0%

Metric 9: The percentage difference between the organisations board voting membership and its overall workforce

Boards are expected to broadly representative of their workforce. There has been no change in BAME representation within the voting or non-voting Board membership as at 31st March 2021. This indicator has therefore deteriorated from last year due to the percentage of BAME membership of the total workforce increasing. The percentage difference between board membership and its BAME workforce is now -18.6%.

However it is very positive that in recent months new appointments to the Trust Board include colleagues from an ethnically diverse background in both Executive Director and Non-Executive Director positions and next year's WRES submission will reflect this progressive step.

Appendix 2: MWRES Analysis of UHNM BAME Medical & Dental Workforce

The WRES was launched in 2015 to document the different experience of white and BAME staff in the NHS, and to provide guidance on how to achieve better race equality in the workforce. However, there are several ways in which the medical workforce differs from the rest of the NHS workforce; hence the development of the Medical Workforce Race Equality Standard (MWRES) and its 11 indicators, introduced in September 2020. This first report of the MWRES data provides baseline evidence to quantify discrimination in the NHS trust-based medical workforce but only at a national level. The National MWRES Report has identified the following key areas:

- Organisations and institutions expressly communicating their intention to address inequality
- International Medical Graduates (IMGs) appropriate induction to ensure their integration
- Providing IMGs with development opportunities as a valued part of the workforce rather than just a clinical resource
- Ensuring institutional and organisational websites, prospectuses, application packs and monitoring forms are couched in inclusive language
- Stakeholder organisations to aim to have a workforce, in both voluntary and staff roles at all levels, that reflects the diversity of their membership
- Setting targets and timelines for reducing the ethnic disparity in representation at consultant, clinical director and academic levels
- Narrowing the ethnicity gap in appointment of consultants after shortlisting: a potential role for the royal college member often present on consultant interview panels
- NHS trust based medical leaders to enhance local capacity and skills to resolve complaints and avoid their referral to the GMC if appropriate
- Enhancing the leadership diversity of the royal colleges and arm's length bodies
- Having senior officers in these organisations include performance objectives for measurable delivery of diversity outcomes as part of appraisal
- Obtaining fuller and more granular data by clinical specialty and by region (including primary care)
- Obtaining detailed data on the performance of undergraduate medical students and postgraduate trainees in their assessments and examinations
- Undertaking research to identify what works, in terms of addressing differential attainment in training and assessments

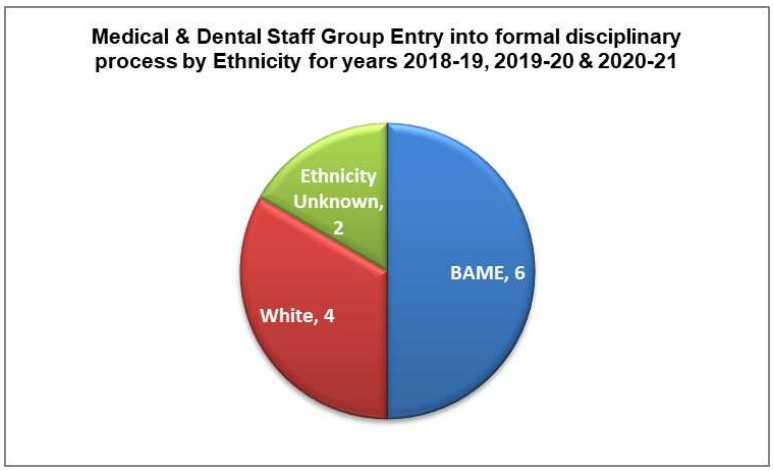
Limited analysis of MWRES indicators can be undertaken at an organisational level from this first MWRES Report, however a review of UHNM data presently available disaggregated by staff group and ethnicity is presented below:

The following below demonstrates the breakdown of the UHNM Medical and Dental workforce by ethnicity. There is a greater representation of BAME colleagues in every professional group.

Medical & Dental Group	White (Headcount)	BAME (Headcount)	Unknown Ethnicity (Headcount)
Consultant	235	288	17
Non Consultant Career Grade	59	245	11
Trainee Grade	177	269	19
Total	**471**	**802**	**47**

The table below is an analysis of medical and dental staff group entry into the formal disciplinary process for the last three financial years. This indicates small numbers of total cases (12), with 6 or 50% being from a BAME staff group. BAME representation in the medical and dental workforce is 60.8%,

suggesting that BAME staff are not over represented in the Managing High Professional Standards Policy formal processes.



Year	No. of cases
2018-19	3
2019-20	6
2020-21	3
Total	**12**

The table below represents analysis of medical and dental recruitment for the period July 2020 – June 2021 excluding Deanery appointments and Bank. When applying the auto calculation from the WRES this tells us that white applicants are 2.65 times more likely to be appointed than a BAME applicant. It should be noted however that there is a very high percentage of applicants selecting to not provide their ethnicity information at application stage, of which more than half are appointed and this impacts on the validity of this metric.

Medical Recruitment Ethnicity	Applied	Shortlisted	Appointed	% appointed from Shortlisting	% of total appointed
White	865	128	41	32.00%	15.1%
BAME	7781	735	89	12.10%	32.7%
Not Stated	434	220	142	64.50%	52.2%
Total	**9080**	**1083**	**272**	**-**	**100%**

An analysis of Medical & Dental staff enrolment onto non-mandatory training, as recorded on the Trust ESR system indicates that white staff are slightly more likely to access this development than BAME staff:

Ethnicity	Headcount	Enrolment Headcount	Ratio
White	472	415	0.88
BAME	803	687	0.86
Not Stated	45	41	0.91

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													Timing TBC
Care Quality Commission Action Plan	Chief Nurse													Highlighted as part of QGC Assurance Summary
Bi Annual Nurse Staffing Assurance Report	Chief Nurse					→								Deferred - awaiting presentation at TAP prior to bringing to Board.
Quality Account	Chief Nurse													
7 Day Services Board Assurance Report	Medical Director													Timing TBC
NHS Resolution Maternity Incentive Scheme	Chief Nurse													
Maternity Serious Incident Report	Chief Nurse													
Winter Plan	Chief Operating Officer													
PLACE Inspection Findings and Action Plan	Director of Estates, Facilities & PFI													Timing TBC
Infection Prevention Board Assurance Framework	Chief Nurse													
ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS STANDARDS														
Integrated Performance Report	Various													
ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT & RESEARCH														
Transformation and People Committee Assurance Report	Associate Director of Corporate Governance													
Gender Pay Gap Report	Director of Human Resources													
People Strategy Progress Report	Director of Human Resources													
Revalidation	Medical Director													
Workforce Disability Equality Report	Director of Human Resources													
Workforce Race Equality Standards Report	Director of Human Resources													
Staff Survey Report	Director of Human Resources													
LEAD STRATEGIC CHANGE WITHIN STAFFORDSHIRE AND BEYOND														
System Working Update	Chief Executive / Director of Strategy													
ENSURE EFFICIENT USE OF RESOURCES														
Performance and Finance Committee Assurance Report	Associate Director of Corporate Governance													
Revenue Business Cases / Capital Investment / Non-Pay Expenditure £1,000,001 and above	Director of Strategy													
IM&T Strategy Progress Report	Director of IM&T		→											Deferred to May due to annual leave
Going Concern	Chief Finance Officer													
Estates Strategy Progress Report	Director of Estates, Facilities & PFI													Timing TBC - waiting to refresh once the clinical strategy has been determined
H2 Plan	Chief Finance Officer													
Annual Plan	Chief Finance Officer													
Capital Programme 2021/22	Chief Finance Officer													
GOVERNANCE														

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