University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 5th April 2023 at 9.30 am to 12.00 pm
Via MS Teams

AGENDA

Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
09:30	**PROCEDURAL ITEMS**					
20 mins	**1.**	Patient Story	Information	Mrs AM Riley	Verbal	
5 mins	**2.**	Chair's Welcome, Apologies and Confirmation of Quoracy	Information	Mr D Wakefield	Verbal	
	3.	Declarations of Interest	Information	Mr D Wakefield	Verbal	
	4.	Minutes of the Meeting held 8th March 2023	Approval	Mr D Wakefield	Enclosure	
	5.	Matters Arising via the Post Meeting Action Log	Assurance	Mr D Wakefield	Enclosure	
10 mins	**6.**	Chief Executive's Report – March 2023	Information	Mrs T Bullock	Enclosure	
10:05		**HIGH QUALITY**				
5 mins	**7.**	Quality Governance Committee Assurance Report (30-03-23)	Assurance	Prof A Hassell	Enclosure	1
10 mins	**8.**	Infection Prevention Board Assurance Framework Quarter 3	Assurance	Mrs AM Riley	Enclosure	1
10:20		**PEOPLE**				
5 mins	**9.**	Transformation and People Committee Assurance Report (29-03-23)	Assurance	Prof G Crowe	Enclosure	2, 3, 4, 6, 9
15 mins	**10.**	Staff Survey 2022	Assurance	Mrs J Haire	Enclosure	
10:40		**RESOURCES**				
5 mins	**11.**	Performance & Finance Committee Assurance Report (28-03-23)	Assurance	Dr L Griffin	Enclosure	5, 7, 8
10:45 – 11:00 COMFORT BREAK						
11:00		**RESPONSIVE**				
40 mins	**12.**	Integrated Performance Report – Month 11	Assurance	Mrs AM Riley Mr P Bytheway Mrs J Haire Mr M Oldham	Enclosure	1, 2, 3, 5, 8
11:40	**CLOSING MATTERS**					
10 mins	**13.**	Review of Meeting Effectiveness	Information	Mr D Wakefield	Verbal	
	14.	Questions from the Public **Please submit questions in relation to the agenda, by 9.00 am 3rd April to** Nicola.hassall@uhnm.nhs.uk	Discussion	Mr D Wakefield	Verbal	
11:50	**DATE AND TIME OF NEXT MEETING**					
	15.	**Wednesday 3rd May 2023, 9.30 am, Trust Boardroom, Third Floor, Springfield, RSUH**				

University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 8th March 2023 at 9.30 am to 11.50 am via MS Teams

MINUTES OF MEETING

Attended | **Apologies / Deputy Sent** | **Apologies**

Voting Members:			A	M	J	J	J	A	O	N	D	J	F	M
Mr D Wakefield	DW	Chairman (Chair)												
Mr P Akid	PA	Non-Executive Director												
Ms S Belfield	SB	Non-Executive Director												
Mrs T Bowen	TBo	Non-Executive Director							Obs.					
Mr P Bytheway	PB	Chief Operating Officer							KT					
Mrs T Bullock	TB	Chief Executive												
Prof G Crowe	GC	Non-Executive Director												
Baroness S Gohir	SG	Non-Executive Director												
Dr L Griffin	LG	Non-Executive Director											Obs.	
Mr M Oldham	MO	Chief Finance Officer												
Dr M Lewis	ML	Medical Director						GH						
Prof K Maddock	KM	Non-Executive Director												
Mrs AM Riley	AR	Chief Nurse	SM				SM							
Mrs R Vaughan	RV	Chief People Officer												

Non-Voting Members:			A	M	J	J	J	A	O	N	D	J	F	M
Ms H Ashley	HA	Director of Strategy												
Mrs C Cotton	CC	Associate Director of Corporate Governance					NH				NH			
Mrs A Freeman	AF	Director of Digital Transformation												
Mrs J Haire	JH	Chief People Officer												
Prof A Hassell	AH	Associate Non-Executive Director												
Mrs L Thomson	LT	Director of Communications												
Professor S Toor	ST	Associate Non-Executive Director												
Mrs L Whitehead	LW	Director of Estates, Facilities & PFI						DR						

In Attendance:	
Ms S Caurser	Student Nurse (item 1)
Mrs D Brayford	Quality and Risk Manager (item 9)
Mrs S Jamieson	Head of Midwifery (item 9)
Mrs L Scott	Junior Care Coach (item 1)

Members of Staff and Public: 4

No.	Agenda Item	Action
PROCEDURAL ITEMS		
1.	**Staff Story**	
033/2023	Ms Caurser outlined her story whereby she started working at UHNM as a Nursing Assistant in March 2014, in Endoscopy and after 6 months joined the Nurse Bank to gain further experience. Following this she explored the opportunities available to further develop her career and completed her functional skills assessments before applying for a Band 3 role at County Hospital which provided her with additional skills and experience. In March 2019, she applied to	

join the Trainee Nurse Associate programme with Staffordshire University and after a pause due to Covid she completed this and qualified as a Registered Nursing Associate in November 2021. In March 2022, she applied for the Registered Nurse Degree Apprenticeship programme which commenced in March 2022 and was due to qualify in September 2023. She described the placements she had been on to date which had provided her with broader knowledge and experience.

Mr Wakefield congratulated Ms Caurser on her 9 year journey and queried what kept her going during that time. She stated that she had been well supported by UHNM be it professionally or supporting her personal life.

Dr Griffin thanked Ms Caurser for her story which demonstrated her resilience and highlighted a route to nursing which would be useful to share with others.

Ms Bowen thanked Ms Caurser for her inspirational story and congratulated her on her perseverance. She queried if she had any advice to inspire others to start a career at UHNM and Ms Caurser stated that the main thing was to keep going and treat every day as a new day and a new opportunity.

Professor Maddock commented on the story being a great example of what could be achieved with enough determination, utilising talent and passion. She queried what Ms Caurser's plan was after graduation to which Ms Caurser stated that whilst she had enjoyed working on all of her placements, she enjoyed working in endoscopy and would like to specialise there, but supplement this with bank shifts on other wards.

Professor Toor asked Mrs Haire to capture Ms Caurser's story so that this could be spread across the Trust and added that it would be useful to recruit further apprentices.

Mrs Scott described how proud she was of Ms Caurser and the other apprentices in the Trust and added that it was a pleasure and joy to support them and added that 'growing our own' was key for the Trust.

Mrs Freeman thanked Ms Caurser for her inspirational story and stated that it was a great way to celebrate International Women's Day.

Mr Akid queried how easy it would be for anyone else to follow a similar route and Ms Caurser stated that if they wanted it, they could make it happen although it was challenging. Mrs Scott added that there were no barriers and all students were supported throughout.

Mrs Riley stated that the story optimises what the Trust is trying to promote in terms of enabling people to move into nursing careers regardless of their background. She queried if there was anything the Trust could have done to make it easier and Ms Caurser stated that she was not initially aware of the support available for mental health and wellbeing but after discussing this with a member of staff they explained what support was available.

Ms Haire thanked Ms Caurser for her story and agreed that she would like to publicise her story further.

Mr Bytheway explained that the story demonstrated how the NHS could be a career for life if you had the energy and effort to succeed, as demonstrated by Ms Caurser.

	Mr Wakefield thanked Ms Caurser for sharing her story and the astonishing journey she had been on and he wished her well for the rest of her career. **The Trust Board noted the patient story.** Ms Caurser and Mrs Scott left the meeting.	
2.	**Chair's Welcome, Apologies and Confirmation of Quoracy**	
034/2023	Mr Wakefield welcomed Board members to the meeting. No apologies were received and the meeting was confirmed as quorate.	
3.	**Declarations of Interest**	
035/2023	There were no declarations of interest raised.	
4.	**Minutes of the Previous Meeting held 8th February 2023**	
036/2023	The minutes of the meeting held 8th February 2023 were approved as a true and accurate record.	
5.	**Matters Arising from the Post Meeting Action Log**	
037/2023	PTB/578 – It was noted that the reason for removing the internal audit paragraph in the Standing Financial Instructions had been explained to Mr Wakefield and it was therefore agreed that the action was complete.	
6.	**Chief Executive's Report – February 2023**	
038/2023	Mrs Bullock highlighted a number of items discussed at the last Trust Executive Committee. Mr Wakefield requested an update on the bid for additional bed capacity and Mrs Bullock explained that the Trust had submitted a bid for 2 wards (40-50 beds) which had been accepted regionally for national submission but no further feedback had been received. Ms Bowen referred to wage stream which she felt was an empathetic move to support staff during such difficult time and welcomed the initiative. Mrs Bullock stated that this had been brought in following consultation with staff and would be used for bank pay rather than normal wages as a result of staff feedback. Mrs Bullock highlighted that most of the industrial action had been paused whilst negotiations remained ongoing, although the British Medical Association (BMA) strike remained scheduled to go ahead on 13th, 14th and 15th March. Planning remained ongoing and discussions with the Local Negotiating Committee (LNC) had gone well with agreements reached on behalf of Consultants. It was noted the action would have a significant impact on elective and planned activity which was a similar position to other Trusts. Mr Wakefield queried whether the impact from the strikes on the backlog position had been recognised by NHS England (NHSE) and Mrs Bullock stated that they understood the challenges although the national position remained that Trusts should cancel as little as possible. She added that in reality the majority of elective and planned care activity would be impacted during that time and therefore would add to the backlog.	

	Mrs Bullock stated that the Care Quality Commission (CQC) had visited maternity on 7th March and feedback would be provided to the Board in due course. **The Trust Board approved eREAFs 10447, 10460, 10503 and 10571.**	
HIGH QUALITY		
7.	**Quality Governance Committee Assurance Report (02-03-23)**	
039/2023	Professor Hassell referred to the following: • Medicines optimisation report highlighted key challenges in relation to the national supply chain in addition to workforce issues, although these were being mitigated where possible. In addition some wards did not have pharmacy cover and as such a business case was being considered • Good performance had been demonstrated in national benchmarking regarding prescription turnaround metrics and the new Lloyds pharmacy had opened providing expanded capacity • The backlog of serious incidents requiring review was highlighted which was being addressed by setting up additional panels to review the backlog of cases • In terms of mortality, the HSMR remained below 100 which was good and the SHMI was above 100 but within the expected range, however this had been increasing and as such was being reviewed to establish any particular problems • An increase in hospital acquired thrombosis had been identified and a deep dive was to be undertaken, although an initial review had not identified any themes to date Mr Wakefield referred to the reference to sepsis whereby the deep dive highlighted that antibiotics had been given within 2 hours, despite the target to provide these within an hour. Mrs Riley stated that the deep dive was undertaken to understand the scale of the challenge in not only the screening time but what was the delay and consequence. She stated that provision of antibiotics in 2 hours was not acceptable and this would continue to be reviewed on a quarterly basis. Dr Griffin referred to medicines optimisation and the requirement for additional pharmacists, and suggested that any learning from the previous pharmacy business case regarding addressing workforce challenges should be considered. **The Trust Board received and noted the assurance report.**	
8.	**Maternity Quality Governance Committee Assurance Report (22-02-23)**	
040/2023	Professor Hassell referred to the following: • Ongoing challenges in ensuring system external clinical review of perinatal mortality cases • Continuing challenges around home births and Freestanding Midwifery Birth Unit mainly due to staffing challenges • Report and action plan following a Local Maternity and Neonatal Systems (LMNS) quality visit to the neonatal team drew attention to aspects of culture on the unit. As the Committee did not have lead clinicians in attendance this was to be considered at the next meeting • A number of positive assurances were highlighted including updates on the Ockenden action plan, training, recruitment and postnatal readmission rates	

	• NHS maternity services survey had been published and was to be discussed alongside the associated action plan at the next meeting Mr Wakefield referred to the various action plans in place in maternity and queried if the Trust was confident that the actions were being addressed adequately. Professor Hassell stated that this was challenging although there were plans to integrate these into a single action plan. Mrs Jamieson confirmed that a single delivery plan was to be produced once national guidance had been provided. **The Trust Board received and noted the assurance report.**	
9.	**Maternity Serious Incident Report Q3**	
041/2023	Mrs Jamieson highlighted the following: • 3 new serious incidents were reported in quarter 3 and 5 serious incidents continued to be investigated • A trajectory for completion of investigations had been identified Mr Wakefield referred to some of the timelines identified in the report and in particular referred to the Healthcare Safety Investigation Branch (HSIB) investigation which had lasted for a year. He queried when it was expected to see this closed. Mrs Brayford stated that 2 cases had been prolonged and the ICB were aware, meanwhile all actions were being taken to ensure prompt investigation. In addition, an immediate investigation had been undertaken to identify actions which could be taken forward while awaiting the HSIB review. It was highlighted that changes were being made to the HSIB following which it was expected that reviews would be undertaken more timely going forwards. Ms Bowen referred to the immediate actions referred to and queried the usual timeline for these. Mrs Jamieson stated that depending on the incident, a 72 hour brief was undertaken in addition to incidents being monitored on a daily basis. If any incidents were expected to be classed as serious these were reported to the Clinical Director and Mrs Jamieson and an immediate response taken. Ms Bowen referred to the incident whereby a baby slipped from the mother's arms and stated that from the immediate actions, it seemed as though all precautions were taken including those identified following a previous deep dive. She queried if there was any additional learning from this incident. Mrs Jamieson stated that each case was reviewed individually and no particular issues had been identified for this case. Mrs Brayford added that information had been requested from regional colleagues and the actions taken at UHNM were comparable to other units. In addition, the Trust had an additional falls risk assessment undertaken which continued to be audited to ensure compliance and in this case the risk assessment was completed twice daily. **The Trust Board received and noted the report.**	
PEOPLE		
10.	**Transformation and People Committee Assurance Report (01-03-23)**	
042/2023	Professor Crowe highlighted the following: • In terms of essential to role training, a report had been received which demonstrated limited assurance therefore further assurance had been requested • The progress made with talent and succession management was highlighted	

	although additional detail had been requested to be provided in the next report regarding connecting applying areas of good practice more consistently and embedding this throughout the organisation • National staff survey results were due to be issued and engagement in completing the survey was disappointing. An action plan was to be identified in response to the results in particular ensuring the actions were linked to the cultural improvement programme • An update on the transformation programmes was provided, a number of which were continuing well although there was a risk that actions were not being linked to the Improving Together programme • Strategic workforce planning had been deferred to the next meeting and this was a key consideration for the year ahead to ensure colleagues had been able to pull together a well-coordinated plan of activity Mr Wakefield queried the Committee's view of utilisation of the Improving Together tools and adoption rates and queried if this was going at the right pace. Professor Crowe stated that there had been some concern that adoption of tools was not matching the pace of individuals going through the programme. He added that Executives were committing to using the tools themselves in addition to the governance forums, although the need to improve upon the utilisation had been acknowledged, and as such a new Executive Oversight Group had been established which would consider pace and adoption of tools going forwards. **The Trust Board received and noted the assurance report.**	
11.	**Gender Pay Gap Report**	
043/2023	Mrs Haire highlighted the following: • The report highlighted the difference in earnings between men and women • A number of key enablers had been identified to remove some barriers which included ensuring strong attraction campaigns were in place, in addition to well understood development opportunities and a reward packages • There had been a slight deterioration in the position with a higher proportion of men in the upper quartile although there remained a higher representation of women in the workforce. This was linked to the number of Consultants in the Trust who were predominately male in addition to the number of males applying for Clinical Excellence Awards (CEA) • The need to design and communicate a flexible working offer to support work life balance, in particular those with caring responsibilities was recognised • The need for clear measurement of targets associated with flexible working had also been identified • Specific actions had been identified which aligned to the People Strategy which would be monitored and these included the development of a Women's Network and targeted work to understand specific barriers for women in the medical profession Mr Wakefield referred to the issues with staff satisfaction and queried if the actions would address this. Mrs Haire stated that the Trust needed to support and sponsor women to think about their career progression including how they could develop into higher level roles. Mr Wakefield queried if the gap had increased due to having recruited more males than females and Mrs Haire referred to the need to look at the recruitment pipeline and whether the Trust was attracting enough women to those roles via the training programmes.	

	Professor Hassell stated that in terms of the recruitment pipeline there were more women coming through but this would take a number of years before making a difference. Dr Griffin thanked Mrs Haire for the focus on flexible working as it was a concern for staff. Mrs Bullock agreed that it would take time to see a change given that the actions would take a number of years i.e. recruitment pipeline. Professor Toor suggested that the actions be expanded upon to make it explicit why the actions were being focussed on and the impact these were expected to have on reducing the gender pay gap. Professor Crowe referred to the discussion at the Transformation and People Committee (TAP) and highlighted that the CEA difference had been driven by the changes implemented to apply the awards during Covid. Professor Crowe summarised that the action plan and the need to clarify how the actions were expected to address the issues in addition to confirming the commitment to get more appointable people into senior positions supporting their career progression. In addition, more opportunities for flexible working were required particularly for those with caring responsibilities. Mr Wakefield expressed his concern that the gap had worsened over the past 3 to 4 years and not having yet seen an improvement, whilst accepting that the actions would take some time to have an impact **The Trust Board received and noted the report and noted the recommended actions to improve the gender pay gap at UHNM.**	
RESOURCES		
12.	**Performance & Finance Committee Assurance Report (28-02-23)**	
044/2023	Dr Griffin highlighted the following: • Financial performance in year was positive but there remained some concerns over capital expenditure, in addition to financial challenges for 2023/24 and the requirement for £26.9 m cost improvements and the challenge of ensuring sufficient elective activity to secure access to the Elective Recovery Fund • Some improvements had been experienced within urgent care and cancer performance which had been offset by challenges in elective recovery and the 78 week target • Continuing concerns were raised regarding diagnostic performance which had been exacerbated by increasing cancer workload • The Committee confirmed the focus on productivity, the utilisation of virtual wards and anticipated full business case for the community diagnostic hub Professor Maddock referred to the capital programme which was behind plan and queried whether this could be spent by the end of March. Mr Oldham referred to the number of mitigating schemes in place to catch up, in particular purchase of medical equipment. **The Trust Board received and noted the assurance report.**	
RESPONSIVE		

13.	**Integrated Performance Report – Month 10**	
045/2023	Mrs Riley highlighted the following in relation to quality and safety performance: • A focus on improving response rates to the Emergency Department Friends and Family test remained underway although improved performance was noted in month • Incidents with moderate harm and above had continued to increase and detailed analysis was underway to establish if this was due to improved reporting or whether it was attributed to patient flow, Your Next Patient or corridor care and this will be fed back to the Quality Governance Committee • Reviews of incidents associated with pressure ulcers continued to be undertaken to identify themes and establish any related to delays in admitting patients Mr Wakefield queried if Mrs Riley was comfortable that patients were receiving appropriate care and not coming to harm in the corridor to which Mrs Riley confirmed that there was no evidence of harm associated with patients being cared for on the corridor. Mr Wakefield referred to timely observations being classed as a driver metric and queried the risk of patients coming to harm. Mrs Riley stated that although there was no evidence of harm this continued to be an area of focus as these needed to be undertaken. Mr Bytheway highlighted the following: • Compared to December, performance in January had improved including a reduction in 12 hour waits and a decrease in the wait to be seen • Ambulance waits had reduced and work was continuing with system partners to maintain the improvements. My Bytheway acknowledged that there was still much to do to embed and maintain the improvements within the ED department and wider flow in the hospital. • Cancer performance continued to improve with two week performance now within target levels. Improvements were also seen with 28 day and 62 day performance with significant reductions in the waiting lists and additional resource was being utilised to manage the remaining backlog. • The Trust was unlikely to achieve the previously submitted RTT forecast and the reasons for this were being reviewed. Following questions around the Trusts reporting processes, Mr Bytheway declared that an independent review of reporting was to be undertaken. Steps had already been taken to rationalise the different reporting systems within the Divisions to improve the accuracy and ownership of the numbers. When questioned on the likely cause of the unexpected increases so close to the year-end, Mr Bytheway explained that the return of patients from the Independent Sector was a factor, although further clarification would be provided to the Performance and Finance Committee and the Board once the review was complete. When asked about the likely consequences for the deterioration in the waiting list numbers, Mr Bytheway expressed the view that the Trust was likely to be placed in Tier 1 and as such would face increased scrutiny and support from NHS England. Ms Bowen queried progress in addressing the workforce challenges in ultrasound and Mr Bytheway stated that this remained an area of focus, which included considering the Trust could use agency differently and looking at how to make the Imaging Department more attractive to new starters. Mr Wakefield added that this linked to the strategic workforce plan in addressing this hot spot.	

	Mrs Haire highlighted the following in relation to workforce performance: • There had been an improvement in a number of metrics including a reduction in the vacancy rate, an improvement in sickness absence and appraisal completion and static position for statutory and mandatory training • The staff voice response rate was low for January due to operational pressures and this was expected to increase in February • Engagement with further education and higher education institutions continued in order to develop partnerships with these in order to further develop the workforce pipeline • The national staff survey results were to be launched 9th March 2023 Mr Wakefield referred to measures in place to monitor agency expenditure and queried the actions to be taken as a result of the strike and impact on this. Mrs Haire stated that locum shifts could be put out to agency although the primary focus remained on reducing long standing agency. Mr Wakefield welcomed the improvements in vacancy rates and sickness absence. Mr Oldham referred to financial performance: • The Trust remained in a good financial position with a surplus of £0.3 m year to date, which was slightly behind plan although better than forecast and the Trust expected to continue to break even as planned • Capital was £7.2 m behind plan due to items of slippage which were expected to catch up in year • The cash position was £87m and this reflected the slippage on the capital programme and better performance on income and expenditure Mr Wakefield welcomed the break even forecast but queried the system position. Mr Oldham stated that the system was also forecast to break even and support continued to be provided to the ICB from the regional team due to escalating costs for continuing healthcare and prescribing drug costs which had increased significantly. The main concern was the nature of how the break even position was to be delivered given this was utilising non-recurrent measures and created a further challenge for 2023/24. Ms Bowen queried if information on the system position could be included in the report going forwards and Mr Oldham agreed to this. Mr Wakefield queried if the settlement for nurses / doctors would be provided by NHS England rather than from existing budgets and Mr Oldham stated that the message was that Trusts would be provided with the additional funding. **The Trust Board received and noted the report.**	
CLOSING MATTERS		
14.	**Review of Meeting Effectiveness and Business Cycle Forward Look**	
046/2023	Professor Crowe referred to the cycle of business and stated that TAP had considered how the strategy papers were being brought together. Ms Ashley highlighted that she was seeking to improve coherency of these and was to discuss this at the next Trust Board Seminar. Mrs Cotton highlighted that the Board Effectiveness Evaluation questionnaire had been circulated to members which provided an opportunity to review the business	

	cycle and confirm whether members felt that all elements of the strategy had been sufficiently covered.	
15.	**Questions from the Public**	
047/2023	No questions from the public had been received.	
DATE AND TIME OF NEXT MEETING		
16.	**Wednesday 5th April 2023, 9.30 am, via MS Teams**	

Trust Board (Open)

Post meeting action log as at 29 March 2023

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 .
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/546	08/06/2022	Integrated Performance Report - Month 1	To take an update to a future QGC meeting regarding measuring the impact on patients who had not received appropriate sepsis screening within the Emergency Department	Ann-Marie Riley	~~02/03/2023~~ 27/04/2023		A deep dive has commenced and it is hoped to provide the output of this to QGC in April.	A
PTB/569	09/11/2022	CQC Action Plan	To discuss the assurance map with Professor Crowe in order to highlight the work being undertaken to assess the adequacy of assurance.	Claire Cotton	~~31/01/2023~~ 31/05/2023		Target date moved - template drafted and discussed with AMR. Template to be populated and to be discussed with Professor Crowe once complete.	GB
PTB/571	07/12/2022	Well-Led Self-Assessment	To update the document to include additional narrative for the actions within Section 6, including target dates and to discuss at a future NED meeting.	Claire Cotton Nicola Hassall	~~31/01/2023~~ 31/05/2023		The document has been updated to include additional narrative for the actions within Section 6. Target dates in the process of being identified and initially scheduled for NED Away Day which was cancelled. Awaiting new day for Away Day.	GA
PTB/572	07/12/2022	Q2 Maternity Serious Incident Report	To expand on the ethnicity chart within the report, to clarify reasons for increases and whether any themes reflected national themes. In addition to identify the associated denominators and the total number of deliveries per ethnic group.	Ann Marie Riley Donna Brayford	~~08/03/2023~~ 24/05/2023		This was discussed at the Maternity QGC meeting in February. Further work required and the team have agreed to link in with Professor Hassell to ensure reporting is adequate.	GB
PTB/574	04/01/2023	Patient Story	To provide an update on the actions being taken to prevent deconditioning to a future meeting.	Matthew Lewis Amit Arora	05/04/2023		Action not yet due.	GB
PTB/575	04/01/2023	Corridor Care	To identify key metrics associated with corridor care and report on these to future QGC meetings.	Ann Marie Riley	30/03/2023		This will be included in the quarterly staffing paper to TAP/QGC	GB
PTB/577	08/02/2023	Integrated Performance Report – Month 9	To discuss pressure ulcer reporting with Professor Maddock	Ann Marie Riley	05/04/2023		Date being arranged.	GB
PTB/578	08/02/2023	Standing Financial Instructions (SFI) and Scheme of Delegation Policies	To provide the rationale for removing the last sentence of the internal audit paragraph, section 1.2.4 (section e)	Mark Oldham	08/03/2023	08/03/2023	Action complete. Rationale provided to Mr Wakefield	B

University Hospitals of North Midlands NHS Trust

Chief Executive's Report to the Trust Board

March 2023

Part 1: Trust Executive Committee (TEC)

The Trust Executive Committee met virtually on the 22nd March 2023. **Executive Directors** gave the following key updates:

- Thanks were given to all staff for their involvement in planning / supporting Industrial Action; the costs of the strike are currently being worked through although it is expected to be significant
- The Digital Advocates Network Event is expected to be a positive engagement session
- Procurement for network services across both sites is underway and an outcome is expected over the next 4 – 6 weeks and we are currently working with the national team on Microsoft Office and other product licencing
- We are continuing to develop the business case for the Community Diagnostic Centre with 2 potential sites being explored with a view to completing the case by the end of March
- Two business cases for County Hospital; Day Case Facility and the move of Breast Services are underway
- Work has been undertaken focussing on alignment of the enabling strategies and the metrics approved as part of Improving Together
- Clinical Effectiveness Group is drawing up plans on a forward view for each Division over the next year and the Medical Workforce Group is focussing on sign off of job plans
- An advert for a Chief Registrar is due to be shared; the individual will have a close link to the Medical Directors Office
- Dr Ann-Marie Morris had been appointed to the Deputy Medical Director leading on Quality
- We are focussing on delivering the capital programme as the year end nears and good progress is being made on the new car park at Grindley Hill Court
- Business cases for additional bed capacity currently being worked up to secure national funding
- A 24/7 deli concept is being introduced with a soft launch and free samples being planned
- Key priority as part of the urgent care plan is to reduce occupancy to 92% and there will be a further focus on discharge
- It is hoped that funding would be secured for a modular build on site for same day emergency care work, which would free up bed space
- From 1st April, 4 hour performance would start to be tracked and the reduction of 12 hours, linked to occupancy and flow through the department
- It is likely that there will be patients at the end of the year who have been waiting over 104 weeks which will result in placement into Tier 3 and additional oversight
- Due to the improvements in cancer performance it is likely the oversight arrangements would be lifted
- Team Brief which would involve face to face communication of core messages along with opportunities to listen to staff was due to be launched during April
- Pre-election period was imminent which restricts communication including social media platforms
- Charity Office over at County Hospital was due to be launched in the main entrance which is hoped will make a different to engagement with staff and the public
- Filming of innovative procedures, particularly within surgery was being supported by the Communications Team
- A good financial position was reported both for UHNM and within the system as the year end approaches although there are a number of changes / challenges as we move into 2023/24
- Work continues around IR35 compliance, to ensure that systems and processes are in place and the risks are clearly understood and managed
- There are a number of areas that require particular focus as identified through the Staff Survey, including team working, flexibility and compassion / kindness
- The Women's Network will be launched at the beginning of May
- A review of the Culture Improvement Programme has been undertaken, with a particular focus on the Hotspot Areas and a session is due to take place with Divisions which focus on areas for further action
- A small pilot of the food bank campaign had been undertaken which had proven to be a success with positive feedback

- Virtual Wellbeing Week takes place during the last week of March with a range of wellbeing initiatives planned
- The national Workforce Race Equality Scheme report has been issued and this would be taken through the Transformation and People Committee; the action plan has been assessed as 'good'
- Applications for placements on the High Potential Scheme are underway and opportunities for placements were being sought
- Interviews for an Associate Non-Executive Director take place on 3rd April as Professor Sunita Toor begins post as a voting Non-Executive Director on 1st April
- Work will commence with Divisions on the Divisional Governance Support Programme and the first round of self-assessments against the new CQC standards was due by the end of April
- All international nurse requirements have been met and congratulations have been given by Ruth May, further funding has been secured for the next round of recruitment
- The ICB have been given instructions to reduce their budgets and early discussions have commenced around potential joint working opportunities

Divisions took the opportunity to highlight any key matters requiring escalation, the following points were noted:

Medical Division
- The Division have written a letter of thanks to the Division for their ongoing hard work and efforts during Industrial Action but also as part of the rebranding of their Division
- Recruitment remains ongoing with a campaign underway and a number of new recruits have stated Medical Division as their preference
- Costing and planning will need to be undertaken if the escalation wards are to remain open

Network Division
- The Division had a successful week with a general positive feel during Industrial Action and all staff had been thanked for their efforts
- Focus has been maintained on 78 weeks, in particular Orthopaedic and Spines – this remains a huge challenge
- Activity submissions for the annual plan and the underlying clinical strategies have also been an area of focus
- Focussed negotiation will take place during April / May with Directorates in line with Improving Together
- Staff engagement, using the range of information available, including the Culture Heat Map, Staff Survey and the Staff Voice Survey will be another key priority area
- A new Divisional Business Advisor was welcomed into the Division

Surgical Division
- The main focus over recent weeks has been around planning / implementation of plans around industrial action and teams have been thanked for their efforts although outpatient activity was impacted upon
- The team are pulling together their A3's for the Performance Reviews from April onwards
- A new initiative has been introduced which sees patients being sent to theatre earlier than previously, this is not without its challenges although it is expected to generate some productivity benefits

Women, Children and Support Services
- Care Quality Commission had undertaken an inspection within Maternity Services, a large amount of evidence has been submitted and the final report is awaited
- CT7 has been on site and is in the process of being installed and CT8/9 are in discussion / planning stage
- Maternity Neonatal and Gynaecology Recruitment day being held with a view to filling some of the vacancies
- New guidelines have been issued around parents sharing a bed with their children and an initiative where staff wore pyjamas was held to raise awareness
- Radiology reporting backlog is improving, task and finish groups are supporting the longer waits and recruitment is underway to secure additional capacity
- Working with the Estates Team to understand the impact of downtime of Interventional Radiology 2
- Planning for implementation of the new Pharmacy Robot is underway and a task group will be established
- Imaging QSI submission is imminent and a submission of evidence is due to be submitted
- Staff engagement remains a key priority for the Division and a metric has been identified as part of their Improving Together / Being Kind implementation

Pathology Network
- LIMs – go live for blood sciences / blood transfusion on 10th July, there are some concerns with one of the modules and this was being picked up by the supplier
- A number of workstreams are being worked upon which will now include Shrewsbury and SATH
- Procurement has commenced for Blood Sciences Equipment which is expected to take 2 years
- Some high rates of sickness had been seen which may impact upon turnaround times – this is being monitored closely

Part 2: Contract Awards and Approvals

2.1 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 14th February to 13th March, 6 contract awards, which met these criteria, were made, as follows:

- **Services of Junior Doctors via Health Education England contract with St. Helens & Knowsley Teaching Hospitals NHS Trust** supplied by St. Helens and Knowsley Teaching Hospitals NHS Trust, for the period 01.04.23 – 31.03.24, at a total cost of £3,480,000, approved on 03/02/2023
- **Renal Services provided at Leighton Hospital for UHNM** supplied by Fresenius Medical Care Renal Services, for the duration 01.04.23 – 31.03.25, at a total cost of £3,000,000, approved on 08/02/2023
- **Maintenance of Imagex Ultrasound Scanners** supplied by Imagex via NHS Supply Chain (SCCL), for the period 01.03.23 – 29.02.28, at a total cost of £1,035,732.84, providing a cost reduction of £5,592.96 approved on 08/02/2023
- **EPR Detailed Specification of Requirements and Trust Business Case Consultancy** supplied by Deloittes, at a total cost of £780,000, providing cost avoidance of £87,060, approved on 16/02/2023
- **Respiratory Consumables – ResMed** supplied by ResMed, for the period 01.04.23 – 31.03.28, at a total cost of £5,250,000, providing Cost Reduction of £143,772 and Negated Inflation of £28,350, approved on 14/02/2023
- **Plastic Surgery DIEP Outsourcing Service** supplied by Circle Health Group, for the period 10.02.23 – 31.01.24, at a total cost of £629,000, approved on 14/02/2023

In addition, the following eREAF was approved at the Performance and Finance Committee on 28th March, and also requires Trust Board approval due to the value:

National Blood Service (eREAF 10501)

Contract Value £4,100,000 incl. VAT
Duration 01/04/23 – 31/03/24
Supplier NHS Blood and Transplant

Savings – there are no associated savings.

The Trust Board is asked to approve the above eREAF.

2.2 Consultant Appointments – March 2023

The following provides a summary of medical staff interviews which have taken place during March 2023:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Locum Consultant Cardiologist	Vacancy	N/A	TBC
Locum Consultant Body Radiologist interest in Oncological Imaging	New	N/A	TBC
Locum Consultant T&O / General Anaesthetist	New	Yes	02/05/2023
Locum Oral Maxillofacial Oncology Consultant Surgeon	Vacancy	Yes	TBC
Locum Consultant Neurosurgeon	Vacancy	Yes	TBC
Locum Consultant T&O / General Anaesthetist	New	Yes	TBC
Consultant Orthopaedic Foot and Ankle and Limb Reconstruction	New	Yes	17/07/2023
Consultant Orthopaedic Foot and Ankle	New	Yes	TBC
Locum Consultant Obstetrician and Gynaecologist	New	Yes	TBC
Locum Consultant Cardiothoracic Anaesthetist	New	Yes	TBC
Locum Consultant Cardiothoracic Anaesthetist	New	Yes	TBC
Specialist Doctor in Body Imaging	New	Yes	TBC

The following provides a summary of medical staff who have joined the Trust during March 2023:

Post Title	Reason for advertising	Start Date
Specialist Doctor in Clinical Oncology	Vacancy	01/03/2023
Consultant Gastroenterologist	Extension	01/03/2023
Consultant Plastic Surgeon	Vacancy	01/03/2023
Consultant Plastic Surgeon	Vacancy	01/03/2023
Consultant Geriatrician	Retired & Return	06/03/2023
Respiratory Consultants with Specialist Interests	Vacancy	13/03/2023
Locum Consultant Neonatologist	Vacancy	20/03/2023

The following provides a summary of medical vacancies which closed without applications/candidates during March 2023:

Post Title	Closing date	Note
Consultant Hepatologist	01/03/2023	No applications
Locum General Paediatrician - Interest in Palliative Care	12/03/2023	No suitable applicants
Locum Consultant obstetrician and Gynaecologist	12/03/2023	No suitable applicants

2.3 Internal Medical Management Appointments – March 2023

The following table provides a summary of medical management interviews which have taken place during March 2023:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Deputy Medical Director	Vacancy	Yes	01/04/2023

The following provides a summary of medical management who have joined the Trust during March 2023:

Post Title	Reason for advertising	Start Date
Associate Clinical Director, Trauma Directorate	Vacancy	01/03/2023

The following table provides a summary of medical vacancies which closed without applications / candidates during March 2023:

Post Title	Closing Date	Note
Clinical Lead - Respiratory Medicine	12/03/2023	No applications

Part 3: Highlight Report

National / Regional

3.1 NHSE Regional Team Visit

The NHSE regional team have requested a site visit on 25th April where they will be focussing on the following areas, along with any other topics which might impact on our long waiting performance:

- Performance
- Theatre
- Outpatients
- Data
- GIRFT
- Clinical input
- Mutual aid

The visit is being co-ordinated internally by our senior operations team and will involve a number of Executive Leads.

3.2 CQC Visit to Maternity Services

The CQC undertook an inspection of our maternity services as part of their national programme of inspection for maternity services and they followed up with a request for a number of documents which we have submitted. We received feedback on the day of the inspection and formal notification of some concerns. All concerns were rectified immediately and we are waiting for the final report which will be shared once it becomes available and where necessary, will develop an action plan which will be monitored via our Quality Governance arrangements.

3.3 Other Regulatory Visits

In addition to the CQC inspection, we have also been visited by UKAS which focussed on Microbiology and they provided positive feedback on the implementation of LIMS. The Human Tissue Authority also visited our mortuary service at County Hospital and they also gave positive feedback. My thanks go to all teams involved in these visits as there is a lot of work in providing evidence as well as hosting the visit.

3.4 Industrial Action

I would like to offer my personal thanks to everybody who has worked hard during the month to ensure we have the plans and procedures to treat our patients as safely as possible during the industrial action. It has been a very challenging time for us and unfortunately, disruptive for some of our patients because inevitably we had to cancel some planned procedures and outpatient appointments. A further strike is planned immediately after the Easter Bank Holiday and we are continuing with our planning to minimise the impact as far as possible.

3.5 Staff Survey

The national staff survey results have been issued and as expected, there are a number of areas where we know we can do better. Sadly the participation rate fell significantly from last year and we are working to understand how we can encourage more of our staff to complete the survey in the autumn this year. In

the meantime our People Directorate are working with divisions and directorates to work through the results and develop ways we can make UHNM a great place to work.

System Focus

3.6 NHS Oversight Meeting 9th March 2023

I attended an oversight with system partners and our regulators at NHSE on 9th March 2023. The purpose of these meetings is to provide an understanding of oversight, assurance and improvement arrangements against the key drivers that have placed us in NHS Oversight Framework (NOF) segment 3. It was noted that the key drivers for our current segmentation are in relation to system finances, ambulance handover times and long waits in ED, elective care / long waits and cancer backlog, quality and our CQC rating and governance and oversight. We have been working closely with NHSE and our system partners to agree the specific exit criteria to drive recovery and improvement in these areas. A number of actions were agreed as a result of the discussion:

- To share our oversight and governance structures and improvement plans once signed off by the Trust Board, with NHSE
- To draw out the provider related Urgent and Emergency Care issues and translate them into measurable actions to include within our Exit Criteria
- To work towards zero 78 and 104 week waits by the end of March 2023 and continue to work with ICB and regional colleagues to improve the position
- To share the findings of the recent CQC visit with NHSE
- To further develop and define Exit Criteria in relation to quality

We will continue to work on the actions identified and have a further review scheduled for 25th April 2023.

3.7 High Potential Scheme

During the month I took part in an 'on the sofa' discussion with the latest cohort on the High Potential Scheme about my career journey and the role of a Chief Executive. The scheme is a system wide scheme to develop leaders of the future and for the first time involves both our own Staffordshire and Stoke-on-Trent integrated system but also Shrewsbury, Telford and Wrekin with participants from our own UHNM cohort and I received a number of interesting questions. I wish them all the best as they continue with the scheme.

3.8 Meeting with MP's

Together with system partner leaders, I met with our MPs where we had a very useful discussion about some of our challenges such as our performance and waiting lists, our recent CQC inspection, our current financial position and challenges for the year ahead as well as the significant impact of the junior doctor's strike.

Organisational Focus

3.9 Trust Pressures

Our current performance could be described as a mixed picture, with the improved performance on cancer meaning we are likely to be out of any additional central oversight and scrutiny and our very difficult position relating to the number of patients waiting over 104 and 78 weeks for their treatment meaning that we are likely to remain under scrutiny. Nationally, the additional focuses for the year ahead includes tracking of the numbers of patients waiting over 4 hours in the Emergency Department and a reduction in the number of patients waiting over 12 hours. Also, the NHS is reporting a significant financial challenge,

with all NHS organisations looking at how they can improve productivity. How we work together and use what we have learned and continue to learn from Improving Together will make what we do more efficient and enable all of our teams involved in making positive changes for our patients.

3.10 Team Brief

As part of our drive to involve and engage our staff we will be launching a new Team Brief in April. While there are many mechanisms in place to talk to our staff, it is clear that some of our messages about our priorities and aspirations are not filtering through to all of our teams. Therefore face to face briefings will be held providing an opportunity to update our staff on the most important developments in the organisation.

3.11 Local Developments

We have received additional funds to recruit a further 110 nurses from overseas next year, we will be launching a transformation in theatres to improve productivity and patient experience and we have exciting plans for a new pharmacy robot and a new app. to support e-rostering.

3.12 Being Kind Programme

As we head into the new financial year, top of our agenda has to be how we continue our journey to improve the culture and make UHNM a great place to work for everyone. One of the key messages from the staff survey and our one Staff Voice survey is how we feel is directly affected by how we treat each other. To help us to improve this I am delighted that we are launching our Being Kind Programme and online training which everyone will be asked to complete and during the summer we will be holding half day sessions to engage with as many staff as possible, as part of a CPD accredited session.

Quality Governance Committee Chair's Highlight Report to Board

30th March 2023

1. Highlight Report

! Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
Escalation for Information: • Experiencing some issues in admitting potential **organ donors** due to capacity issues; a Standard Operating Procedure is being developed to ensure a consistent process is in place across all areas • Higher than expected risk of **readmission** - 8th of 12 Trusts for relative risk (key areas are 0-17 years and Upper GI, Colorectal and Urology electives); data quality / coding, patient record and pathway reviews are being undertaken to better understand the causes. • **Neonatal** continues to be a national outlier for mortality and there are particular risks in relation to the medical and nursing workforce; a business case has been developed and is being progressed through the Division. • **An internal audit review of the Clinical Audit** framework had concluded with a rating of partial assurance; a number of actions have been identified to address the recommendations, particularly around prioritisation and tracking. • Q3 saw a slight increase in the number of formal **complaints** received when compared to the previous year with 'Clinical Treatment' and 'Patient Care' being the highest two categories.	• **Organ Donation** Report identified that a national tissue pilot is underway, being fronted by Royal Stoke with a view to increasing Tissue Donation numbers on a national level • A recruitment trajectory of **Neonatal** workforce will be developed to provide a clear understanding of the position / gap along with a retention strategy. Further work on the broader action plan will be undertaken to provide a clearer picture of the progress / impact of actions along with performance against key metrics. An update will be provided in 3 months. • 57 audits have been prioritised on the Trusts **Clinical Audit Programme**; this is a reduction to those prioritised during 2023/24 although each division will have a local programme which will be reported through Clinical Effectiveness Group • Consideration will be given to incorporating the sharing of organisation wide learning through the new Team Brief arrangements which are due to be launched in April. • Work continues on improving compliance in relation to Duty of Candour and the letters being issued. • Indicators for consistency of incident reporting to the NRLS and completion of NPSA alerts will be added to the Quality Performance Report. • Implementation of CQC 'Must Do' and 'Should Do' actions continues underway. • Work is being undertaken within Maternity to understand the findings of the NHS Maternity Services Survey and this will be reported to the Committee in April.
✓ Positive Assurances to Provide	**Decisions Made**
• Royal Stoke is now the top donating hospital in the Midlands and second in the Country for **Organ Donation** following a very successful year during 2022/23 – the best year to date • UHNM has a significantly lower number of **personal injury claims** and was one of the lowest Trusts reporting obstetric claims during 2021/22. • Registered **Nurse fill rate** has increased slightly during Q3 up to 82% compared with 80.22% in Q2 • 110 **international nurses** are planned for recruitment in 2023/24 as well as around 80 newly qualified staff from partner universities. National thanks have been given for the recruitment of international nurses to date. • There has been a reduction in **incidents** resulting in moderate harm or above during Month 11.	• Approval of the **Clinical Audit Programme**
Comments on the Effectiveness of the Meeting	

- One of the reports presented requires further work to bring it to a Committee level standard although there were also some examples of good practice
- Beneficial to spend some additional paper on the neonatal paper
- Very good meeting, good quality of conversation / challenge and questioning

2. Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Organ/Tissue Donation and Transplantation Report	BAF 1	20	! ✓	Assurance	7.	Nursing and Midwifery Staffing and Quality Report: Quarter 3	BAF 1 BAF 3	20 16	✓	Assurance
2.	Readmissions Analysis	BAF 1	20	!	Assurance	8.	Quality & Safety Report – Month 11 22/23	BAF 1	20	✓	Assurance
3.	Neonatal Mortality Action Plan Update	BAF 1	209	!	Assurance	9.	CQC Insight Report – Verbal Update	-	-	-	Information
4.	2023 / 2024 Clinical Audit Programme	-	ID26887 ID8906 ID8896 ID8877 ID8500 ID18912	-	Approval	10.	Quality & Safety Oversight Group Assurance Report	BAF 1	20	-	Assurance
5.	Executive Clinical Effectiveness Group Highlight Report	BAF 1	20	!	Assurance	11.	Quality Impact Assessment Update	BAF 1	20	-	Information
6.	Q3 Patient Experience Report 2022/2023	BAF 1	20	!	Assurance						

3. 2022 / 23 Attendance Matrix

No.	Name	Job Title	A	M	M	J	J	A	S	O	N	D	J	F	M
1.	Prof A Hassell	Associate Non-Executive Director (Chair)				Chair									
2.	Ms S Belfield	Non-Executive Director													
3.	Mr P Bytheway	Chief Operating Officer													
4.	Ms S Gohir	Associate Non-Executive Director													
5.	Dr K Maddock	Non-Executive Director													
6.	Mr J Maxwell	Head of Quality, Safety & Compliance													
7.	Dr M Lewis	Medical Director							GH					ZD	
8.	Mrs AM Riley	Chief Nurse	SM		SM										
9.	Mrs C Cotton	Associate Director of Corporate Governance	NH		NH	NH			NH	NH	NH	NH	NH	NH	
10.	Ms S Toor	Associate Non-Executive Director													
11.	Mrs J Haire	Chief People Officer	RV	RV	RV		RV	RV	RV	RV	RV				

Attended | **Apologies & Deputy Sent** | **Apologies**

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Quality Governance Committee	**Date:**	5th April 2023
Report Title:	Infection Prevention Board Assurance Framework	**Agenda Item:**	8.
Author:	Helen Bucior, Infection Prevention Lead Nurse		
Executive Lead:	Mrs Ann-Marie Riley, Chief Nurse/DIPC		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

BAF 1	Delivering Positive Patient Outcomes	**Ext 20**

Executive Summary:

Situation

To update the Board on the self-assessment compliance with NHS England Infection Prevention and Control Board Assurance Framework version (BAF) V1.11

Nationally a refreshed IP BAF is currently under consultation and will likely replace the current IP BAF. This has been aligned with the refreshed Health and Social Care Act 2008: code of practice on the prevention and control of infections and the National Infection Prevention and Control Manual NIPCM. It is anticipated that the BAF will be published by the end of March 2023.

Background

The UKHSA guidance was archived at the end of April 2022. The proposal is that the National Infection Prevention Manual combined with this version of the Board Assurance Framework will support this transition

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 has in place and action and interventions required.

There are only minor changes since the last update. We have refreshed mask wearing guidance as noted below and communication was sent out 21st January 2023:

- masks to be worn by patients, staff and relatives in ED, portals, flu/covid/respiratory and paediatric areas and those areas with extremely clinical vulnerable patients
- For clinical staff in remaining areas –only required to wear a mask when giving care or transferring a patient or if entering any of the areas noted above
- Non clinical areas - no mask required
- Staff can choose to wear a mask if they wish to in all areas (as is currently the case)
- Relatives/visitors are asked to wear masks in ED, portals, flu/respiratory/covid areas and when visiting areas with clinically vulnerable pts in particular; and advised to wear masks on remaining wards if less than 2m from patients

Assessment/risks

- FFP3 resilience principles and cleaning standards work continues
- Assurance for isolation of clinically immunocompromised in ED and general wards
- Mask fit staff to two or more models of UK made FFP3 masks
- Transfer of FFP3 mask fit testing document from Health roster to ESR
- UHNM has a IP Q+A manual which is available on Trust desk top for easy access
- Patients moved on occasions to manage operational pressures and release available capacity

Progress

- External company continues to assist with mask fit testing

Key Recommendations:

The Committee are asked to note the document for information, and note the on-going work to strengthen the assurance framework going forward.

NHS
University Hospitals of North Midlands
NHS Trust

Infection Prevention and Control Board Assurance Framework

February 2023

Delivering Exceptional Care with Exceptional People

Summary Board Assurance Framework

Ref / Page	Requirement / Objective	Risk Score					
		Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Change
BAF 1 Page 4	Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users.	High 9	Mod 6	Low 3	Low 3		→
BAF 2 Page 8	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	Mod 6	Mod 6	Mod 6	Mod 6		→
BAF 3 Page 14	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	Mod 6	Mod 6	Low 3	Low 3		→
BAF 4 Page 17	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care, in a timely fashion.	Low 3	Low 3	Low 3	Low 3		→
BAF 5 Page 20	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	Low 3	Low 3	Low 3	Low 3		→
BAF 6 Page 25	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.	Low 3	Low 3	Low 3	Low 3		→
BAF 7 Page 27	Provide or secure adequate isolation facilities.	Low 3	Low 3	Low 3	Low 3		→
BAF 8 Page 29	Secure adequate access to laboratory support as appropriate	Low 3	Low 3	Low 3	Low 3		→
BAF 9 Page 32	Have and adhere to policies for the individual's care and provider organisations that will help to prevent and control infections	Low 3	Low 3	Low 3	Low 3		→
BAF 10 Page 34	Have a system in place to manage the occupational health needs and obligations of staff in relation to infection	Low 3	Low	Mod 6	Mod 6		→

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	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	2	1	1		There are a number of controls in place. UHNM Risk assessment are in place where deviation from regional COVID guidelines and testing recommendations	Likelihood:	1	End of Quarter 4
Consequence:	3	3	3	3			Consequence:	3	
Risk Level:	9	6	3	3			Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
1.1	Systems and processes are in place to ensure that: • A respiratory plan incorporating respiratory seasonal viruses that includes: ○ Point of care testing (POCT) methods for infectious patients known or suspected to have a respiratory infection to support patient triage/placement according to local needs, prevalence, and care services ○ Segregation of patients depending on the infectious agent taking into account those most vulnerable to infection e.g. clinically	• UHNM use PCR testing for patients suspected to have respiratory infection - Laboratory24 hour service • A number of rapid PCR is result is available when required • Triage system in place in ED , use of single rooms with doors for those suspected or confirmed respiratory infection • On arrival to ED patients are immediately identified either asymptomatic for COVID -19 symptoms and infection prevention precautions applied. • ED navigator in place • Aerosol generating procedures in single rooms with doors closed • Major's resuscitation area for all patients	• COVID outbreak • DATIX • Monitoring COVID patient numbers at UHNM for any increase in cases • Monitoring the number of COVID outbreaks for any increase • 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	• Although rapid PCT testing option in place for situations where a rapid results would benefit , trust re visit POCT options • Assurance from Emergency portal and wards re isolation of the clinically vulnerable

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	immunocompromised. ○ A surge/escalation plan to manage increasing patient/staff infections.	requiring this level of medical care. This area consists of single rooms with sliding doors and neutral pressure ventilation. Signage in place to set out level of PPE required for each room depending on infectious status of patient. • Patients are asked to wear face covering/mask • Extremely vulnerable patient placement in COVID ward round guidance and IP Q+A manual • COVID screening guidance includes COVID screening for the immunocompromised • Incident Control Centre (ICC) • Major incident plan • Surge plan • Weekly clinical Group • Tactical group structure in place, meetings currently paused. COO stands up group when required. • COVID Gold command , decisions /assurance report to Trust Board via CEO/COO • Daily COVID report , inpatient status, COVID related staff absences • Demographic and Health responsive staff	and benefits, and programme communications COVID 19 response and R&R. Co - ordination of resources. Escalation forum for linked Groups and Cells ensuring that the interdependencies are effectively managed, including system. Makes recommendations to Gold Command for key decisions. • Clinical steering Group – Coordinate clinical decision – making to underpin continual service delivery and COVID 19 related care • Workforce Group – Lead the plan and priorities for our people recovery. Health and Wellbeing. Agree significant pipeline changes in working practices. Agree the impact if change made during COVID and priorities to support recovery • Divisional Groups – Agree infection Prevention  COVID19RRGOVERNANCE NOV20v1.pptx measures	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	○ A multidisciplinary team approach is adopted with hospital leadership, operational teams, estates & facilities, IP teams and clinical and non-clinical staff to assess and plan for creation of adequate isolation rooms/cohort units as part of the plan. • Organisational /employers risk assessments in the context of managing infectious agents are: ○ Based on the measures as prioritised in the hierarchy of controls. ○ Applied in order and include elimination; substitution, engineering, administration and PPE/RPE. ○ Communicated to staff. ○ Further reassessed where there is a change or new risk identified e.g. changes to local prevalence.	risk assessment -COVID risk assessments • Isolation of suspected or Confirmed infectious patients • Advised window opening for a minimum of 10 minutes per hour • Cleaning of work station remains/cleaning of the environment • Down time for areas undertaking AGP's  ventilation-air-changes-per-hour-2021-06 • COVID 19 prevalence rates discussed at weekly clinical group although difficult due to no community testing and screening as per low prevalence guidelines. • Updates are via UKHSA • Maintain routine wearing of face masks in all clinical areas and corridors. • FFP3 masks when caring for confirmed or highly suspected COVID 19 patients and AGP's with patients with infection transmitted by the respiratory route or unknown infectious status • Patient mask wearing where tolerated by patient • Corporate and local risk assessments • Risk assessment policy and template • Risk assessment through COVID governance	• Audit programme • Datix /inappropriate transfers • Monitoring COVID patient numbers at UHNM for any increase in cases • Monitoring the number of COVID outbreaks for any increase	

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 completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems. • Risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with the infectious agents. • Ensure that transfers of infectious patients between care areas are minimised and made only when necessary for clinical reasons. • Resources are in place to monitor and measure adherence to the NIPCM (national infection prevention and control manual). This must include all care areas and all staff (permanent, flexible, agency and external contractors). • The application of IP practices within the NIPCM is monitored. • The IPC Board Assurance Framework (BAF) is reviewed, and evidence of assessments are made available and discussed at Trust board level. • The Trust Board has oversight of incidents/outbreaks and associated action plans	• COVID care plan • Transfer policy • IP Q+A manual • Audit programme • Matrons walk round • Agenda item Trust Board • National definition of outbreak in place • Outbreak meetings • Outbreak areas included in daily tactical information • Definite Nosocomial COVID 19 numbers are included in Quality performance report • Nosocomial Death review process		• Patients moved on occasions to manage operational pressures and release available capacity

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
1.2	• The Trust is not reliant on a single respirator mask type and ensures that a range of predominantly UK made FFP3 masks are available to users as required.	• A number of mask models are available, however, further work is required to ensure staff are fitted on 2 models of FFP3 masks – see criteria 10	• Staff training records • Procurement – mask usage	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	**KLOE**	**Action Required**	**Lead**	**Due Date**	**Quarter 3 Progress Report**	**BRAG**
1	1.1	Segregation of patients depending on the infectious agent taking into account those most vulnerable to infection e.g. clinically immunocompromised	Matrons/IP	February 2023	November 2022 – to explore gaining assurance around segregation of clinically immunocompromised from emergency portals and wards	
2	1.1	To revisit POCT testing options	Laboratory	April 2023	November 2022 – Although rapid PCR option in place for situations where rapid response is required, to revisit PCOT options and reliability. It is vital that the tests are POCT are accurate. System in place in place, fast track PCR. To review after April 2023	
3	1.1	Ensure that transfers of infectious patients between care areas are minimised and made only when necessary for clinical reasons.	DIPC	February 2023	Patients moved on occasions to manage operational pressures and release available capacity. Cases discussed with DIPC /IP Team. Risk assessment in place to mix COVID contacts with Similar dates. To revisit risk assessment Risk Assessment COVID IPC reducing	

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	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2	2	2	2		Whilst cleaning procedures are in place to ensure the appropriate management of premises further work is in progress re cleaning standards and role and responsibilities	Likelihood:	1	End of Quarter 4 2022
Consequence:	3	3	3	3			Consequence:	3	
Risk Level:	6	6	6	6			Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
2.1	Systems and processes are in place to ensure that: • The Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level. • The organisation has systems and processes in place to identify and communicate changes in the functionality of areas/room • Cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment. • Enhanced/increased frequency of cleaning should be incorporated into environmental decontamination protocols for patients with suspected/known infections as per the NIPCM (Section 2.3) or local policy and staff are appropriately trained.	• Currently The Royal PFI Operating to 2002 standards • Currently Royal retained and county Operating to 2007 standards • A multi-disciplinary Cleaning Standards Group established to work through the implications of the new standards and identify the actions needed to achieve compliance and any resource requirements • SOP and cleaning method statements for cleaning teams • High level disinfectant , Virusolve and Tristel in place and used for all decontamination cleans	• CEF audits • C4C audits • Audits and assurance visits by IP • Ward audits • Spot check assurance audits completed by cleaning supervisors/managers • Cleanliness complaints or concerns are addressed by completing cleanliness audit walkabouts with clinical teams, and CPM / domestic supervisors	• Implementation of National Standards of cleanliness 2021

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

	• Manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.
	
	• For patients with a suspected/known infectious agent the frequency of cleaning should be increased particularly in:
	  ○ patient isolation rooms
	  ○ cohort areas
	  ○ donning & doffing areas – if applicable
	  ○ 'Frequently touched' surfaces e.g., door/toilet handles, chair handles, patient
		• Increased cleaning process (barrier clean) included in Infection Prevention Questions and Answers manual available on all Trust desk top
		• Process in place for clinical areas with clusters and HAI cases of COVID -19 requiring increased cleaning and /or terminal cleans
		• Cleaning schedules in place
		• Barrier cleans (increased cleaning frequency) process in place which includes sanitary ware and other frequent touch points
		• Process and designated staff for ED to ensure cleans are completed timely
		• Responsibility framework
		• Who cleans what posters
		• IP Q+A manual - bed cleaning posters
		• IP Q+A manual - decontamination
		• Use of Medical Device/equipment policy MDM02
		• Terminal clean process
			• Patient survey feedback is reviewed by joint CPM / Sodexo/EFP group and action plan completed if needed.
			
			• Reports produced after each visit, and re-audits completed if disciplines fail to achieve agreed %.
			• C4C report presented at IPCC
			
			• 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
			
			• 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**
call bells, over bed tables and bed/trolley rails. ○ where there may be higher environmental contamination rates, including: ▪ toilets/commodes particularly if patients have diarrhoea and/or vomiting. • The responsibility of staff groups for cleaning/decontamination are clearly defined and all staff are aware of these as outlined in the National Standards of Healthcare Cleanliness • A terminal clean of inpatient rooms is carried out: ○ when the patient is no longer considered infectious ○ when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens). ○ following an AGP if clinical area/room is vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room). • Reusable non-invasive care equipment is decontaminated: ○ between each use ○ after blood and/or body fluid contamination ○ at regular predefined intervals as part of an equipment cleaning protocol ○ before inspection, servicing, or repair equipment.	• Audit process • IP Q+A manual - decontamination • Use of Medical Device/equipment policy MDM02	• IP unannounced 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. • IP audits held locally by divisions • Datix reports/adverse incident reports • IP Audits • Clinical cleaning schedule records	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	• Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.			
2.2	• Ventilation systems, should comply with HBN 03:01 and meet national recommendations for minimum air changes https://www.england.nhs.uk/publication/specialised-ventilation-for-healthcare-buildings/ • Ventilation assessment is carried out in conjunction with organisational estates teams and or specialist advice from the ventilation group and/ or the organisations, authorised engineer and plans are in place to improve/mitigate inadequate ventilation systems wherever possible. • where possible air is diluted by natural ventilation by opening windows and doors where appropriate	• UHNM has established a Ventilation Safety Group as recommended by the Specialised Ventilation for Healthcare Society in order to provide assurance to the Trust Board on the safe operation and reduction in risk of infection transmission through ventilation systems. TOR written • The Trust also appointed external 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. • Trust Estates Ventilation Aps attended week long Specialized ventilation in health care at Leeds University – Much of this content contact relates to airborne respiratory infections • Lessons learnt poster which encourage regular opening of windows to allow fresh air	• Estates have planned programme of maintenance • The Authorising Engineer Ventilation will provide external independent specialist advice and support as well as carrying out an annual audit for system compliance.	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		ventilation-air-changes-per-hour-2021-06 • IP and estates have worked with areas know to be undertaking aerosol generating procedures and completed the fallow times • IP have nominated point of contact re ventilation advise • Most wards have mechanical ventilation in core areas and natural ventilation in bays e.g. window opening • Estates and IP are exploring air scrubber technology • IP and Estates are compiling a list of high risk area and current air changes. This work will then extend to other general inpatient areas.		

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 3 Progress Report	BRAG
2	2.1	Review of cleaning standards	Divisions Facilities/ACN	12/11/2021 31/12/2021 End of quarter 1 2022	July 2022 Discussion and agreement with NHSEI the dismantling of beds to the level undertaken during the CPE would be considered during planned deep cleans/ ward refurbishments and continue with standard and terminal clean process as usual.	
	2.1	Plan for implementation of National Standards of cleanliness 2021	Facilities/Estates PFI	Quarter 4 22/23	A multi-disciplinary Cleaning Standards Group established earlier this year ,including representatives from retained estate, CPM, Sodexo and Infection Prevention to work through	

					the implications of the new standards and identify the actions needed to achieve compliance and any resource requirements. Options analysis paper submitted against the 2021 standards. The Trust are pursuing option 2 which is the implementation of the National Standards of Cleanliness 2021 and the business case is awaiting formal approval On review of all options it has been noted that Option 2 will align all operational processes to allow us to achieve full compliance with the 2021 standards and comparison of cleaning standards will be easy to track via the prescribed star rating system. There will be defined responsibility for cleaning across all disciplines with consistency of approach across the Royal and County sites. There is a need for further work to conclude in respect of quantifying the Nursing elements	
	2.2	To explore alternative technologies to enhance ventilation in bays that have natural ventilation	Infection Prevention Team/Estates	March 2023	IP and Estates compiled a list of high risk areas and current air changes for these areas and other general inpatient areas and current air changes. Areas such as critical care, theatres, ED resus, and endoscopy have mechanical. Most general ward bays are natural ventilation e.g. window opening. To be discussed at the ventilation group	

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	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2	2	1	1		Antimicrobial prescribing is reviewed by ward pharmacy teams on each drug chart review. The AMS team also undertakes targeted ward rounds in clinical areas where the monitoring of antimicrobial consumption indicates areas may need additional support. The AMS team are contactable by clinicians requesting advice re: optimising antimicrobial therapy and this may include escalation to duty Consultant microbiologist if necessary	Likelihood:	1	End of Quarter 1 2023
Consequence:	3	3	3	3			Consequence:	3	
Risk Level:	6	6	3	3			Risk Level:	3	

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

3.1	• arrangements for antimicrobial stewardship (AMS) are maintained and a formal lead for AMS is nominated
	• NICE Guideline NG15 https://www.nice.org.uk/guidance/ng15 is implemented – Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use
	• the use of antimicrobials is managed and monitored:
	  • to optimise patient outcomes
	  • to minimise inappropriate prescribing
	  • to ensure the principles of Start Smart, Then Focus https://www.gov.uk/government/publications/antimicrobial-stewardship-start-smart-then-focus are followed
	• contractual reporting requirements are adhered to, and boards
		• Regular, planned Antimicrobial stewardship (AMS) ward rounds
		• Formal lead is the Lead Consultant Microbiologist supported by the Advanced Pharmacist Practitioner- ID & Antimicrobials
		• Trust antimicrobial guidelines available 24/7 via intranet and mobile device App
		• Antimicrobial action plan in place
		• Clostridium-*difficile* Period
			• 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	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
continue to maintain oversight of key performance indicators for prescribing including: • total antimicrobial prescribing; • broad-spectrum prescribing; • intravenous route prescribing; adherence to AMS clinical and organisational audit standards set by NICE: https://www.nice.org.uk/guidance/ng15/resources • • Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency and external contractors).	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 • Regular meetings held between commissioners, Trust leads and AMS team to monitor compliance with contractual reporting requirements. CQUIN compliance reported to IPCC • Monthly review of antimicrobial consumption undertaken by AMS team. Available online at UHNM • Reintroduction of point prevalence audits as the Trust comes out of pandemic pressures. Results will be made available to divisional teams and support provided by AMS team to	reviewed and actions followed up • Real time discussions / requests for support / advice enabled via regional and national networks for challenging cases where additional expert advice around optimal choice of antimicrobials is needed • 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. •	

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

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 3 Progress Report	BRAG
1						

4. 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	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	1	1	1	1		There is a substantial amount of information available to provide to patients this requires continuous update as national guidelines change	Likelihood:	1	
Consequence:	3	3	3	3			Consequence:	3	
Risk Level:	3	3	3	3			Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
4.1	Systems and processes are in place to ensure that: • IP advice/resources/information is available to support visitors, carers, escorts, and patients with good practices e.g. hand hygiene, respiratory etiquette, appropriate PPE use • Visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors • National principles on inpatient hospital visiting and maternity/neonatal services will remain in place as an absolute minimum standard. national guidance on visiting patients	• Posters and signage in place • Mask available at hospital entrance • Information available on Trust internet site • 30th May visiting updated .The majority of inpatients are permitted to have two visitors, between 2pm and 4pm and again between 6pm and 8pm. In the majority of cases these do not have to be the same two visitors.	• Monitored by clinical areas • PALS complaints/feedback from service users • Outbreak meetings	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	in a care setting is implemented. • Patients being accompanied in urgent and emergency care (UEC), outpatients or primary care services, should not be alone during their episode of care or treatment unless this is their choice. • Restrictive visiting may be considered by the incident management team during outbreaks within inpatient areas This is an organisational decision following a risk assessment and should be communicated to patients and relatives.	• UHNM visiting information public internet site  Visiting at UHNM internet site.docx • Outbreak management • Discussed at outbreak meeting		
4.2	• There is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, respiratory hygiene and cough etiquette. The use of facemasks/face coverings should be determined following a local risk assessment.	• Posters and signage in place • Mask available at hospital entrance • Refreshed mask wearing communication sent out 21st January 2023 • At UHNM FFP3 is recommended for all contact with COVID or high suspected COVID patient	• Monitored by clinical areas • PALS complaints/feedback from service users • Outbreak meetings	
4.3	• If visitors are attending a care area to visit an infectious patient, they should be made aware of any infection risks and offered appropriate PPE. • Visitors, carers, escorts who are feeling unwell and/or who have symptoms of an infectious	• PPE available • Clinical area to advise visitor • Support from IP Team and Consultant Microbiologist when	• Monitored by clinical areas • PALS complaints/feedback from service users • Outbreak meetings • Datix	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	illness should not visit. Where the visit is considered essential for compassionate (end of life) or other care reasons (e.g., parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting. • Visitors, carers, escorts should not be present during AGPs on infectious patients unless they are considered essential following a risk assessment e.g., carer/parent/guardian.	required • Information available on COVID intranet page • Advice from IP Team and Consultant Microbiologist Infection Prevention triage desk which provides advice and support to clinical areas		
4.4	• Implementation of the supporting excellence in infection prevention and control behaviours Implementation Toolkit has been adopted where required C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	• Resources reviewed • Implementation of a number of controls e.g. staff well being	• Audits • Staff feedback • PAL/complaints - feedback	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	**KLOE**	**Action Required**	**Lead**	**Due Date**	**Quarter 3 Progress Report**	**BRAG**

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	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	1	1	1	1		Arrangements are in place to ensure the screening of patients in line for National guidance. – COVID testing in periods of low prevalence. To continue to reinforce COVID screening protocol.	Likelihood:	1	
Consequence:	3	3	3	3			Consequence:	3	
Risk Level:	3	3	3	3			Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
5.1	Systems and processes are in place to ensure that: • all patients are risk assessed, if possible, for signs and symptoms of infection prior to treatment or as soon as possible after admission, to ensure appropriate placement and actions are taken to mitigate identified infection risks (to staff and other patients). • Signage is displayed prior to and on entry to all health and care settings instructing patients with symptoms of infection to inform receiving reception staff, immediately on their arrival (see NIPCM).	• **COVID Testing** C1662_covid-testing -in-periods-of-low-pre • Routine asymptomatic testing in a number of setting will pause 31st August 2022 • High – risk patient identified for COVID19 MAB and antiviral treatment - PCR • Admission to high risk area at UHNM(Haematology, oncology, real wards Critical care, ward 222, SSCU and PICU)	• COVID 19 -Themes report to IPCC • COVID screening spot check audits • Datix • Outbreak investigation	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		• Symptomatic patients for clinical diagnostic pathway • Symptomatic or immunococompromised patients who are admitted as an emergency or maternity care • Symptomatic or immunocompromised elective care patients prior to acute day case/overnight pre-admission • Transfer into or within hospital for immunocompromised patients • Discharge patients to care home/hospices • Outbreak testing in healthcare settings  uhnm-guidance-on-testing-and-re-testing  Elective and Planned Admission Covid-19 F  emergency-and-non-elective-admissions-c		

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		• Signage in place - instruction for patients if they have symptoms of infection • Screening questions ED		
5.2	• The infection status of the patient is communicated prior to transfer to the receiving organisation, department or transferring services ensuring correct management /placement • Triaging of patients for infectious illnesses is undertaken by clinical staff based on the patients' symptoms/clinical assessment and previous contact with infectious individuals, the patient is placed /isolated or cohorted accordingly whilst awaiting test results. This should be carried out as soon as possible following admission and a facemask worn by the patient where appropriate and tolerated. • Patients in multiple occupancy rooms with suspected or confirmed respiratory infections are provided with a surgical facemask (Type II or Type IIR) if this can be tolerated. • Patients with a suspected respiratory infection are assessed in a separate area, ideally a single room, and away from other patients pending their test result and a facemask worn by the patient where appropriate and tolerated (unless in a single room/isolation suite). • Patients with excessive cough and sputum production are prioritised for placement in single	• Transfer policy • COVID screening for patients discharged to Nursing /Care homes • Process in place for screening and cohorting COVID contacts exposed during inpatient stay • COVID contact areas reviewed daily by the IP team • COVID contacts are cohorted with similar isolation periods to reduce risk • Where possible cohort nursing staff to provide care for the contact and the negative or positive patients separately • PPE changed when moving between cohorts • Clinical equipment where possible designed to cohort and decontaminated after use	• COVID 19 -Themes report to IPCC • COVID screening spot check audits • Datix • Outbreak investigation • Inappropriate patient moves reported via Datix. Daily process Discuss at outbreak meetings as necessary • COVID electronic Contact tag to electronic records applied by IP Team • COVID electronic record tag on place • Electronic tag/alert for other infections e.g. Cdiff/MRSA in place	• Assurance that transfer policy is followed and hand over received

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 whilst awaiting test results and a facemask worn by the patient where appropriate and tolerated only required if single room accommodation is not available.	• ED triage • IP Q-A manual – isolation of patient if infection is suspected or confirmed • COVID 19 screening and step down guidance • Screening for other resistant organisms is included in the IP Q+A manual • Facemasks available for patients and encourage if appropriate and tolerated		
5.3	• Patients at risk of severe outcomes of infection receive protective IP measures depending on their medical condition and treatment whilst receiving healthcare e.g., priority for single room protective isolation	• Single rooms recommended for patients who are at severe risk from COVID 19 - included in IP Q+A manual • COVID 19 care plan	• Outbreak investigation • COVID themes report • Complaints • Datix	
5.4	• The use of facemasks/face coverings should be determined following a local risk assessment. • Patients that attend for routine appointments who display symptoms of infection are managed appropriately, sensitively and according to local policy.	• Patient are encourage to wear mask – leaflet in place • Mask stations in place • OPD process for patients who display symptoms	• Spot check audits	
5.5	• Staff and patients are encouraged to take up appropriate vaccinations to prevent developing infection	• Staff Covid /flu vaccination hub in place • Vaccination information available on the Trust intranet	• Staff vaccination uptake reported	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		• Team Prevent have system in place staff vaccination programme other than flu and COVID		
5.6	• Two or more infection cases linked in time, place and person trigger an incident/outbreak investigation and are reported via reporting structures.	• Outbreak process in place	• Outbreak investigation • COVID 19 -Themes report to IPCC	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 3 Progress Report	BRAG
1	5.2	Assurance that transfer policy is followed and hand over received	DIPC/Quality Lead	February 2023	To gain assurance that transfer policy is followed and hand over received. Datix process already in place which allows the receiving ward to log any incidents	

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

Risk Scoring									
Quarter	Q4	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	1	1	1	1		Information and communication/controls are in place to ensure staff are aware of their responsibilities spot audits continue.	Likelihood:	1	
Consequence:	3	3	3	3			Consequence:	3	
Risk Level:	3	3	3	3			Risk Level:	3	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
6.1	Systems and processes are in place to ensure that: • IP education is provided in line with national guidance/recommendations for all staff commensurate with their duties. • Training in IPC measures is provided to all staff, including: the correct use of PPE	• Trust induction and mandatory training • IP Q+A manual • COVID 19 intranet page • PPE posters • Donning and Doffing posters, videos and PHE available on Covid-19 section of Trust intranet • Matron walk rounds	• Audits • Unannounced IP checks	
6.2	• All staff providing patient care and working within the clinical environment are trained in hand hygiene technique as per the NIPCM and the selection and use of PPE appropriate	• Trust induction and mandatory training • IP Q+A manual • PPE posters	• Audits • Unannounced IP checks • Mandatory training compliance records	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	for the clinical situation and on how to safely put it on and remove it (NIPCM); • Adherence to NIPCM, on the use of PPE is regularly monitored with actions in place to mitigate any identified risk • Gloves and aprons are worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP's. • Hand hygiene is performed: o before touching a patient. o before clean or aseptic procedures. o after body fluid exposure risk. o after touching a patient; and o after touching a patient's immediate surroundings. o 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 (NIPCM	• IP assurance visits • Matrons visits to clinical areas • UHNM recommend staff use of for highly suspected or confirmed COVID 19 patients • FFP3 mask /hood • Eye protection • Gloves • Apron(gown for AGP • IP Q+A manual – five moments for hand hygiene posters and education • Hand washing technique depicted on soap dispensers • Social distance posters displayed throughout the Trust Alcohol gel availability at the point of care • Hand dryers are not available within clinical areas	• Audits • Datix • Hand hygiene audits • Unannounced visits • Audits • Building/clinical space design guidance	
6.3	• Staff understand the requirements for uniform laundering where this is not provided for onsite.	• Laundering of own uniform - information available on Trust Intranet page	• Monitor for any updates in National guideline • Datix/adverse incident	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 3 Progress Report	BRAG
6						

7. Provide or secure adequate isolation facilities

Risk Scoring									
Quarter	Q4	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	1	1	1	1		Single rooms are available throughout the Trust , however there is a need to explore increasing single room availability (pods).	Likelihood:	1	
Consequence:	3	3	3	3			Consequence:	3	
Risk Level:	3	3	3	3			Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
7.1	Systems and processes are in place to ensure: • That clear advice is provided; and the compliance of facemask wearing for patients with respiratory viruses is monitored (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs.	• IP Q+A manual • COVID poster • Mask stations	• IP Spot checks • Assurance obtained for monitoring of inpatient compliance with wearing face masks via Matrons daily walk round	• To gain further assurance re patient mask wearing and documentation if unable to wear a mask
7.2	• Patients who are known or suspected to be positive with an infectious agent where their treatment cannot be deferred, care is provided following the NIPCM. • Patients are appropriately placed i.e.; infectious patients are ideally placed in a single isolation room. If a single/isolation room is not available, cohort patients with confirmed respiratory infection with other patients confirmed to have the same infectious agent.	• IP Q+A manual • PPE chapter • Infection Prevention triage desk which provides advice and support to clinical areas	• Audit • Spot checks • Datix • Outbreak/incidents	• Work in progress to assess the need for more single room availability to facilitate patient flow and surgical pathway

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
7.3	• Standard infection control precautions (SIPC's) are applied for all, patients, at all times in all care settings • Transmission Based Precautions (TBP) may be required when caring for patients with known / suspected infection or colonization	• IP Q+A manual • PPE chapter	• Audit • Spot checks • Datix • Outbreak/incidents	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	**KLOE**	**Action Required**	**Lead**	**Due Date**	**Quarter 3 Progress Report**	**BRAG**
7	7.1	The compliance of facemask wearing for patients with respiratory viruses is monitored (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs.	DIPC/Matrons	End of January 2023	To gain further assurance re patient mask wearing and documentation if unable to wear a mask	
7	7.2	To assess the need for further single room isolation facilities (PODS) to facilitate COVID patients remaining on their original ward, facilitate flow and surgical pathway	DIPC	End of October 2022	May 2022 Request made to analyst to map/predict isolation need. August 2022 single room capacity modelling being added to the acute patient flow work stream' Surgical Division are exploring the use of PODS in a number of wards	

8. Secure adequate access to laboratory support as appropriate.

Risk Scoring									
Quarter	Q4	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	1	1	1	1		Laboratory services for UHNM are located in the purpose built Pathology Laboratory on-site at RSUH. The Laboratory is United Kingdom Accreditation Service (UKAS) accredited.	Likelihood:	1	
Consequence:	3	3	3	3			Consequence:	3	
Risk Level:	3	3	3	3			Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
8.1	There are systems and processes in place to ensure: • Laboratory testing for infectious illnesses is undertaken by competent and trained individuals.	• Testing takes place in the pathology Laboratory • 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.	• Laboratory accreditation	
8.2	• Patient testing for infectious agents is undertaken promptly and in line with	• IP Q+A Manual • COVID screening	• Occupational Health monitoring	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	national guidance. • Staff testing protocols are in place for the required health checks, immunisations and clearance • There is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available. • Inpatients who go on to develop symptoms of infection after admission are tested/retested at the point symptoms arise	information Trust intranet • COVID Testing and step down guidance • Occupational Health Service in place • Turnaround times included in tactical slides • Screening guidelines • IP Q+A Manual	• Report to IPCC • Outbreak investigation • Datix	
8.3	COVID-19 Specific • Patients discharged to a care home are tested for SARS-CoV-2, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge. Coronavirus (COVID-19) testing for adult social care services - GOV.UK (www.gov.uk) • For testing protocols please refer to: COVID-19: testing during periods of low	• High – risk patient identified for COVID19 MAB and antiviral treatment - PCR • Admission to high risk area at UHNM(Haematology, oncology, real wards Critical care, ward 222, SSCU and PICU) • Symptomatic patients for clinical diagnostic pathway • Symptomatic or immunococompromised patients who are admitted as an emergency or	• Reviewed as part of outbreak investigation • Spot checks/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
	prevalence - GOV.UK (www.gov.uk) C1662_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk)	maternity care • Symptomatic or immunocompromised elective care patients prior to acute day case/overnight pre-admission • Transfer into or within hospital for immunocompromised patients • Discharge patients to care home/hospices • Outbreak testing in healthcare settings uhnm-guidance-on-testing-and-re-testing Elective and Planned Admission Covid-19 F emergency-and-non-elective-admissions-c • Process in place for staff COVID testing screening via empactis system		

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	**KLOE**	**Action Required**	**Lead**	**Due Date**	**Quarter 3 Progress Report**	**BRAG**

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**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	**1**	**1**	**1**	1		There is a range of information, procedures, and pathways available along with mechanism to monitor.	**Likelihood:**	**1**	
Consequence:	**3**	**3**	**3**	3			**Consequence:**	**3**	
Risk Level:	**3**	**3**	**3**	3			**Risk Level:**	**3**	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
Systems and processes are in place to ensure:				
9.1	Systems and processes are in place to ensure that • Resources are in place to implement, measure and monitor adherence to good IP and AMS practice. This must include all care areas and all staff (permanent, flexible, agency and external contractors). • staff are supported in adhering to all IPC and AMS policies.	• 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 • AMS audits	
	• Policies and procedures are in place for the identification of and management	• Included in IP Q+A manual	• Outbreak investigation • Datix	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	of outbreaks of infection. This includes the documented recording of an outbreak.			
9.2	• All clinical waste and infectious linen/laundry used in the care of known or suspected infectious patients is handled, stored and managed in accordance with current national guidance as per NIPCM	• Waste policy in place • Waste and stream included in IP mandatory training • Waste and Linen included in IP Q+A Manual	• Audits and spot checks • 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 • 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.	
9.3	• PPE stock is appropriately stored and accessible to staff when required as per NIPCM	• Procurement and stores hold supplies of PPE • PPE at clinical level stores in store rooms • Donning and doffing stations at	• PPE availability agenda item on Tactical Group meeting • Audits • Datix	

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

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	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)	Target Date
Likelihood:	1	1	2	2		There are clear control in place for management of occupational needs of staff through team prevent to date Monitoring of adhere to PPE requirements continues. Work in progress to further improve develop a long term, sustainable fit testing to ensure staff are fit tested to at least two masks and records entered onto ESR	Likelihood: 1	
Consequence:	3	3	3	3			Consequence: 3	
Risk Level:	3	3	6	6			Risk Level: 3	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
10.1	Systems and processes are in place to ensure that: • Staff seek advice when required from their occupational health • bank, flexible, agency, and locum staff follow the same deployment advice as permanent staff	• Occupational Health Provision in place at UHNM		

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
10.2	• Staff understand and are adequately trained in safe systems of working commensurate with their duties.	• Induction and Mandatory Training • At UHNM FFP3 recommended for all contact with COVID19 confirmed or suspected	• Induction and Mandatory Training compliance records • Audits	
10.3	• A fit testing programme is in place for those who may need to wear respiratory protection.	• Mask fit strategy in place • List of mask fit testers within a clinical areas available on the intranet. • Ashfields external mask fitters assisting currently with testing programme. The support from external trained tester via supply chain is until March 2023 which would leave a gap in support provision after this date if support is not extended	• Mask fit training records • List of mask fit testers	
10.4	• Where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: • lead on the implementation of systems to monitor for illness and absence. • facilitate access of staff to treatment where necessary and implement a vaccination programme for the healthcare workforce as per public health advice. • lead on the implementation of systems to monitor staff illness, absence and vaccination.	• Team Prevent contract and service in place	• Outbreak • Datix /adverse incident review	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	• encourage staff vaccine uptake.			
10.5	• Staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in NIPCM.	• COVID 19 advice available on Trust intranet • Team Prevent Service/advice and follow up • Advice from Consultant Microbiologist	• Audit	
10.6	• A risk assessment is carried out for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza or severe illness from COVID-19. ○ A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups. ○ that advice is available to all health and social care staff, including specific advice to those at risk from complications. ○ Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff. A risk assessment is required for health and	• All managers carry our risk assessment • Process available on the COVID 19 Trust intranet page • Linked to Empactis	• 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 via empactis	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	social care staff at high			
10.7	• Testing policies are in place locally as advised by occupational health/public health.	• Staff testing as per National guidance • Information available on Trust intranet • COVID communications	• Outbreak investigation	
10.8	• NHS staff should follow current guidance for testing protocols: C1662_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk)	• Process in place • Information available on Trust intranet	• Outbreak investigation • Datix	
10.9	• staff required to wear fit tested FFP3 respirators undergo training that is compliant with HSE guidance and a record of this training is maintained by the staff member and held centrally/ESR records. • Staff who carry out fit test training are trained and competent to do so. • Fit testing is repeated each time a	• Certificate of testing issued to staff Member • Electronic record currently held locally and on Health Roster • In house train the tester/cascade trainers programme place • Support from external mask fit testers in place Ashfields • A number of mask fit testers have been trained to use the portacount machine using an external company/trainer and results uploaded onto ESR • Air powered hoods and reusable P3 mask available for those that have failed on FFP3 mask • IP Q+A Manual details mask fitting	• Mask fitting is currently recorded Health Roster records • Test certificate also retained in staff personal folders	• Further work is required to record training on ESR. Currently FFP3 mask fit is recorded on Health roster and ESR for some staff

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
different FFP3 model is used. • All staff required to wear an FFP3 respirator should be fit tested to use at least two different masks • Those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators or an alternative is offered such as a powered hood. • That where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions • Members of staff who fail to be adequately fit tested: a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm. • 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	• SOP's in place • Initial priority to ensure staff that are required to wear are FFP3 masks are fit tested. • Further work is required to ensure staff are fitted to use at least two different models of masks • Air powered system hoods and SOP • In situations when staff member fails FFP3 mask fitting. Alternative models available and air powered system. • Discussion should be held in personal folders		• Further work is required to ensure staff are fitted to use at least two different models of masks to ensure FFP3 resilience

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	Occupational health. • 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.	• Mask fitting certificate to be held in personal folder • Currently added to health roster but further work required to transfer to ESR		
10.10	• Staff who have symptoms of infection or test positive for an infectious agent should have adequate information and support to aid their recovery and return to work.	• All managers carry our risk assessment • Team Prevent available to offer guidance and treatment to staff presenting with onset of symptoms • 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 3 Progress Report	BRAG
10	10.9	**FFP3 resilience principles**. Currently Health roster is used to record mask fit testing. Capturing the data on ESR will allow the information to transfer with the staff member if they transfer between Trusts.	**IP**	March 2023	October 2022 Delivery Manager – National FFP3 Fit Test Team has made contact with UHNM to arrange meeting/support to discuss FFP3 resilience principles and transfer of mask fit data to the ESR system February 2023 Various meetings held regarding ESR and recording of mask fit testing. ESR aligned with National system/criteria on ESR. Progress has been made, however, further discussion required regarding the uploading of data process	
10	10.9	**FFP3 Resilience principles** FFP3 users should be tested on two different models of masks (	**IP**	**Quarter 2 2023**	October 2022 - The focus has been to ensure all staff that require FFP3 masks are fitted. Work to ensure staff are fitted	

		ideally 3)			to 2 models of FFP3 masks will required working through to establish resources required. IP have appointed a band 3 for a 6 month period to help with fit testing. FFP3 resilience principles paper submitted to IPCC November 2022	

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.

Transformation and People Committee Chair's Highlight Report to Board

29th March 2023

1. Highlight Report

! Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Actions continued to be taken with regards to essential to role training and all subject matter experts had been contacted to establish a 12 month improvement trajectory. • The Committee noted the ongoing impact on staffing associated with the Industrial Action • The Executive Digital and Data Security Group highlighted ongoing challenges with compliance with freedom of information (FOI) requests and DSP toolkit. In addition a review of the use of cameras was being undertaken, due to previous incidents. • The Committee held a focussed discussion on the strategic workforce plan for 2023/24 and considered the future workforce supply and confidence levels in meeting that workforce demand. The workforce gaps highlighted, required a multifaceted approach to close these although the Committee sought further assurance on actions to close the gap. It was agreed to highlight high priority areas such as hard to fill posts, or posts to ensure quality and safety was maintained in future updates	• The Committee welcomed the work undertaken in relation to the RACE Equality Code self-assessment and considered the need to bring the actions to life for staff and requested regular updates on progress • Discussions at the Executive Workforce Assurance Group continued to focus on staff availability, employee engagement and motivation in addition to considering the actions required as a result of the staff survey • Further assurance was requested in terms of the actions taken to support staff following instances of abuse from patients, including proactively seeking views on any support required. • To highlight the issues of compliance with RIDDOR reporting and FOI's to the Audit Committee, to establish if further action was required in terms of ongoing monitoring • To consider the way in which digital KPIs should be reported to the Committee for future reports, avoiding including too much operational detail
✓ Positive Assurances to Provide	**Decisions Made**
• No immediate safety concerns were identified within the Guardian of Safe Working report and the main issues related to not taking breaks although these were not always escalated and the Committee noted the actions being taken to promote escalation • The Organisational Development team highlighted the continued roll out of Enable training, whereby it was expected to achieve the 85% attendance target. In addition the roll out of Being Kind and Civility and Respect continued. • The workforce performance report highlighted that the Trust was on track for all metrics and the particular improvement in recruitment time to hire was noted • The Committee noted the detailed workforce strategy report which gave greater insight into the workforce demand and supply in the year ahead to enable a discussion on future assurances. • Improving together highlighted that training was on trajectory and the completion of wave 4 at County Hospital was noted. The adoption of tools had seen some improvement although this remained variable • The Executive Digital and Data Security Group highlighted the go live of LIMS, the introduction of theatre check in and positive number of IM&T resolutions made • The outputs of the review undertaken into the cultural improvement programme were provided and a robust discussion was held on the key findings such as progress made to date, the opportunities to share learning between teams, provision of ongoing support to the hotspot areas and continued roll out of development programmes. The Committee considered the need to ensure internal messaging was improved, in particular communicating the golden thread and moving away from the term 're-humanisation' to being kind. The Committee were assured of the plan and requested that objectives be included within the next quarterly update, to communicate the actions being focussed on which have the most impact	• The Committee approved the RACE Equality Code Assessment Statement

Comments on the Effectiveness of the Meeting

- Members welcomed the re-structuring of the agenda to enable the discussion to focus on two key areas of the agenda. Members welcomed the quality of papers provided

2. Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Guardian of Safe Working Q3 Report	BAF 3	ID18842 ID24272 ID23787 ID10868	✓	Assurance	7.	Executive Workforce Assurance Group Assurance Report	BAF 2/3	12 16	-	Assurance
2.	OD, Culture & Inclusion Team Quarterly Update	BAF 2	12	✓	Assurance	8.	Executive Health & Safety Group Assurance Report	-	-	!	Assurance
3.	Race Equality Code	BAF 2	12	-	Assurance	9.	IM&T Service Delivery Performance Report	BAF 6	ID9036	-	Assurance
4.	Strategic Workforce Plan 2023-24	BAF 3	16	! ✓	Assurance	10.	Improving Together Countermeasure Summary	-	ID27153 ID27152	✓ !	Assurance
5.	Culture Improvement Programme Update	BAF 2	12	✓	Assurance	11.	Assurance Report from Digital and Data Security and Protection Group	BAF 6	12	✓ !	Assurance
6.	Workforce Report – M11 2022/23	BAF 2/3	12 16	✓ !	Assurance						

3. 2022 / 23 Attendance Matrix

No.	Name	Job Title	A	M	J	J	A	S	O	N	D	J	F	M
1.	Prof G Crowe	Non-Executive Director (Chair)												
2.	Ms H Ashley	Director of Strategy and Transformation												
3.	Ms S Belfield	Non-Executive Director												
4.	Ms T Bowen	Non-Executive Director												
5.	Mrs T Bullock	Chief Executive												
6.	Mr P Bytheway	Chief Operating Officer						OW						
7.	Mrs C Cotton	Associate Director of Corporate Governance					NH			NH				NH
8.	Baroness S Gohir	Non-Executive Director												
9.	Mrs J Haire	Chief People Officer												
10.	Dr L Griffin	Non-Executive Director												
11.	Dr M Lewis	Medical Director				NC		ZD					ZD	
12.	Prof K Maddock	Non-Executive Director												
13.	Mrs A Riley	Chief Nurse												
14.	Prof S Toor	Associate Non-Executive Director												

Attended | **Apologies & Deputy Sent** | **Apologies**

Executive Summary

Meeting:	Trust Board	**Date:**	5th April, 2023
Report Title:	National Staff Survey Results (2022)	**Agenda Item:**	10.
Author:	Eddie O'Grady, Assistant Chief People Officer – OD, Culture and Inclusion		
Executive Lead:	Jane Haire, Chief People Officer		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

BAF2	If we are unable to ensure the leadership culture reflects our values and aspirations, then a negative cultural environments could be established, resulting in an adverse impact on patient care, staff disengagement and ineffective performance	**High 12**
BAF3	If we are unable to sustain our workforce at the required levels, taking into account the impact of Covid on staff resilience and retention, then we may not have staff with the right skills in the right place at the right time, resulting in adverse impact on patient outcomes, increase in premium costs, staff disengagement and inability to take forward continuous improvement and innovation	**Ext 16**

Executive Summary

Situation

Each year all NHS staff are invited to take part in the NHS Staff Survey, the largest survey of staff opinion in the UK. The national survey gathers views on staff experience at work around key areas including staff engagement and involvement, health and wellbeing, and safety culture. The reporting is designed to track progress against the seven national people promise elements.

This staff survey report for UHNM provides information to assess the above-mentioned risks on the Board Assurance Framework (BAF 2 and 3) and provides mitigating actions.

Background

The 2022 NHS Staff Survey was carried out between September and December 2022. The Survey was open to all our staff and 3685 UHNM colleagues took part (4749 in 2021). This was a response rate of 33% which is lower than 2021 at 43%. Nationally, there has been a slight drop in survey engagement in the benchmark group, where the overall response rate of 44% is down from 46% the previous year.

This decline in response rate at UHNM is exceptionally disappointing. We started from a lower baseline overall from the previous year and this naturally impacts our ability to "read across" from these and draw firm conclusions around overall staff experience at the Trust.

For 2022, the results of the NHS Staff Survey are measured against the seven national people promise elements and against the two themes 'Staff Engagement' and 'Morale' which have been reported in previous years. However, this does mean that historic trend data is not available for many of the questions asked in the Survey.

Assessment

Context

In 2021 the Trust commissioned a culture review (Brap/Kline) and in April 2022 widely published the report in full. This report showed that there were areas of deficit and therefore focus. The narrative and actions proposed were widely publicised during the 6 months leading upto the national staff survey 2022. The insight from this review suggested that staff perception in areas such as morale and engagement was starting from a low baseline. When coupled with the sustained level of pressure as we moved to post-covid recovery, this is likely to have had a significant impact on our results for 2022.

Most Improved Areas

- Staff reporting that their team meets to discuss effectiveness
- Staff reporting having choice in deciding how to do their work
- Staff have indicated that their ability to access the right learning and development opportunities has increased.
- More staff also reported feeling that their work is valued by the organisation

Lowest Performing Areas

Our lowest performing areas are:

Promise 1: We are compassionate and inclusive – This element is created from 8 questions of which the one negatively impacting UHNM's score is "immediate manager takes effective action to help me with any problems I face" which has fallen 2 percentage points since 2021. At a national level the 2022 Staff Survey results showed that 'We are compassionate and inclusive' score remained unchanged compared to 2021.

Promise 6: We work flexibly – This element split into two sub-scores. The results show that on both sub-scores UHNM has not improved. At a national level the 2022 Staff Survey results showed that 'We are flexible' score remained unchanged compared to 2021.

Promise 7: We are a team – Looking at the survey in greater depth it is apparent that the biggest contributing factor is teams "work well together to achieve their objectives" which decreased by 6 percentage points whilst the benchmark score stayed stable. At a national level the 2022 Staff Survey results showed that 'We are a team' score has increased since 2021.

Staff Engagement

At 6.6, the Staff Engagement score reduced slightly from the score of 6.7. The Trust remains just below the Acute Trust average of 6.8 and this position is unchanged from the previous year. Staff morale also reduced to 5.5 from 5.6. The Trust's score remains just below the Acute Trust average of 5.7 and this position is also unchanged from the previous year.

At a national level the 2022 Staff Survey results showed that staff engagement theme has stayed the same as in 2021 (6.8) and remains lower than in 2018-2020 (7.0).

Areas of Opportunity and Focus

There has been a significant amount of progress against our People Delivery Plan / People Strategy during 2022-23. Indeed, results from the 2021 Survey and our monthly UHNM Staff Voice engagement survey have informed the development of our People Strategy.

We will continue to focus our work across the Trust in line with our 2023-24 People Delivery Plan in the following for areas:

- We will look after our people
- We will create a sense of belonging where we are kind and respectful to each other
- We will grow and develop our workforce for the future
- We will develop our people practices and systems

In order to demonstrate that we are actively listening to our staff around these results, Divisions will produce local, tailored communications and action plans to address the issues which staff say are important to them. Staff engagement is a key measure for all Divisions and will be tracked monthly as well as agreed areas of focus emerging from a review of the Survey results.

We will track the overarching staff engagement score at both organisational and divisional level on a monthly basis. We will use consistent framework to track delivery of the People Strategy delivery plan and the key performance metrics.

We are developing a corporate engagement plan which will seek to improve overall engagement and will provide our divisional teams a framework to use to support their locally led activities.

Finally, section 6 of this report outlines a high level plan for 2023 which sets the key programmes of work to be delivering in 2023-24 to drive sustainable improvements in employee experience. These actions are the underpinning elements of our People Strategy 2022-2025 "***Making UHNM a Great Place to Work".***

Key Recommendations

- The Trust Board is asked to note the National Staff Survey Report and the corporate priorities planned for 2023/24 aimed at ***Making UHNM a Great Place to work*** by improving organisational culture, improving behaviours and supporting and maximising the potential of our people to improve patient outcomes.

NHS Annual Staff Survey 2022 - Findings

February 2023

1. Introduction

The 2022 NHS Annual Staff Survey was carried out between September and December 2022.

The Annual NHS Staff Survey was open to all staff and 3685 took part (4749 in 2021) with a response rate of 33% (43% in 2021). The national trend overall was a decline in response rates with a reduction in the national average for the similar Acute Trusts to 44% (46% in 2021)

For 2022, the questions in the NHS Staff Survey continue to be aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of the following seven elements:

In support of this, the results of the NHS Staff Survey are measured against these seven People Promise elements and against the two themes 'Staff Engagement' and 'Morale' which have been reported in previous years. However, this does mean that historic trend data is not available for many of the questions asked in the Survey.

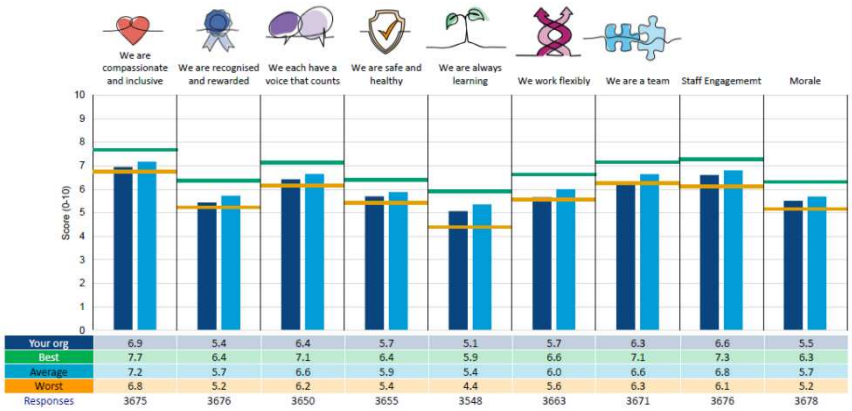
2. National Trends

The results of the benchmark group, Acute and Acute & Community Trusts, do indicate an overall down-turn in staff survey results, across all questions and UHNM results follow this trend.

3. UHNM Staff Survey Results

3.1 Overview

The following table presents an overview of the 7 themes, staff engagement and morale scores and compares this Trust's results to the national average for our benchmarking groups, and indicating the scores of the best and worst performing Acute Trusts. This Trust scored lower than national average against all 7 themes, as well as staff engagement and morale.



In 2021 the Trust commissioned a culture review (Brap/Kline) and in April 2022 widely published the report in full. This report showed that there were areas of deficit and therefore focus. The narrative and actions proposed were widely publicised during the 6 months leading upto the national staff survey 2022. The insight from this review suggested that staff perception in areas such as morale and engagement was starting from a low baseline. When coupled with the sustained level of pressure as we moved to post-covid recovery, this is likely to have had a significant impact on our results for 2022.

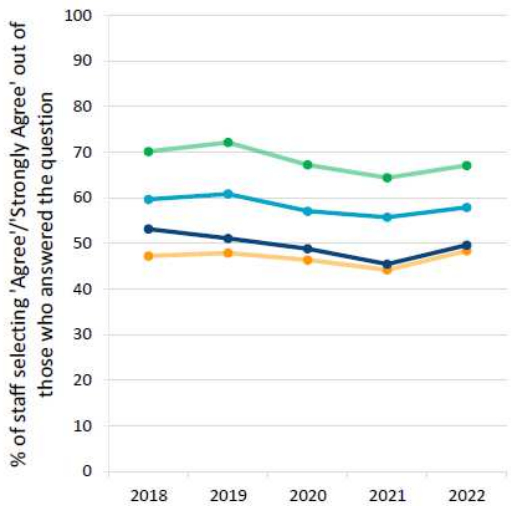
Below we expand on the data as follows:

- The 3 areas that have shown the most improvement
- The 3 areas that we are performing least favourably compared to the average
- Staff engagement and morale scores as these underpin and drive all elements of the survey

3.2 Areas most improved

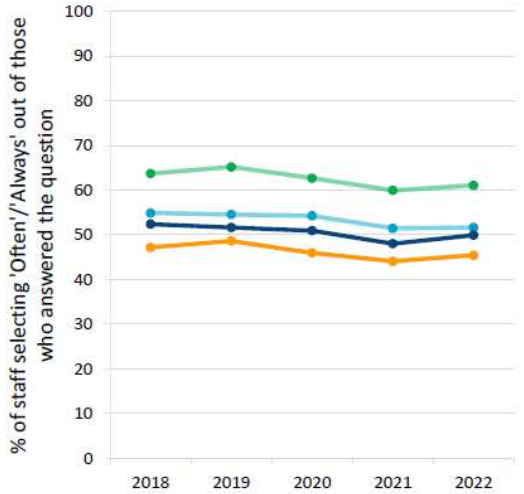
- The items on which the Trust improved most compared to 2021 are shown below.
- The chart below (Q7b) shows a significant increase in the percentage of staff reporting that their team meets to discuss effectiveness (up 4 percentage points). This may have been influenced by the introduction of the Improving Together methodology which encourages colleagues to get together in regular "huddles" to discuss key issues. This trend is in line with the average for similar Acute Trusts. This item should be considered in line with the scores on team working which have not shown an upward trajectory.
- Another area of improvement is that staff reporting having choice in deciding how to do their work (Q5b) which has improved almost 2 percentage points. This is a greater increase than the benchmark average.

Q7b The team I work in often meets to discuss the team's effectiveness.



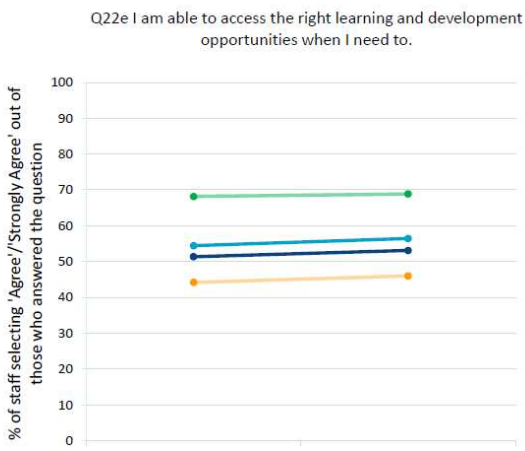
	2018	2019	2020	2021	2022
Your org	53.1%	51.1%	48.8%	45.4%	49.6%
Best	70.1%	72.1%	67.2%	64.4%	67.1%
Average	59.6%	60.8%	57.0%	55.7%	57.9%
Worst	47.2%	47.9%	46.4%	44.2%	48.4%
Responses	4256	4558	4604	4639	3668

Q5b I have a choice in deciding how to do my work.

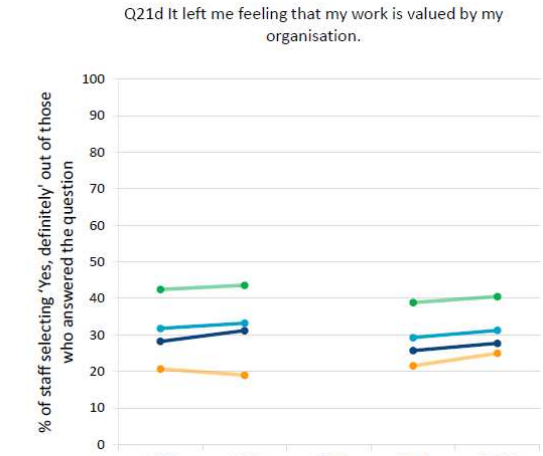


	2018	2019	2020	2021	2022
Your org	52.4%	51.7%	50.9%	48.0%	49.9%
Best	63.7%	65.2%	62.7%	60.0%	61.1%
Average	54.9%	54.6%	54.3%	51.5%	51.7%
Worst	47.2%	48.6%	46.0%	44.1%	45.4%
Responses	4217	4525	4578	4664	3662

- The last two items of improvement fall within the "We are always learning" promise. Staff have indicated that their ability to access the right learning and development opportunities has increased which may be a reflection upon the work the Trust has put into promoting apprenticeships. More staff also reported feeling that their work is valued by the organisation. Both of these increases are in line with the average for similar Acute Trusts.

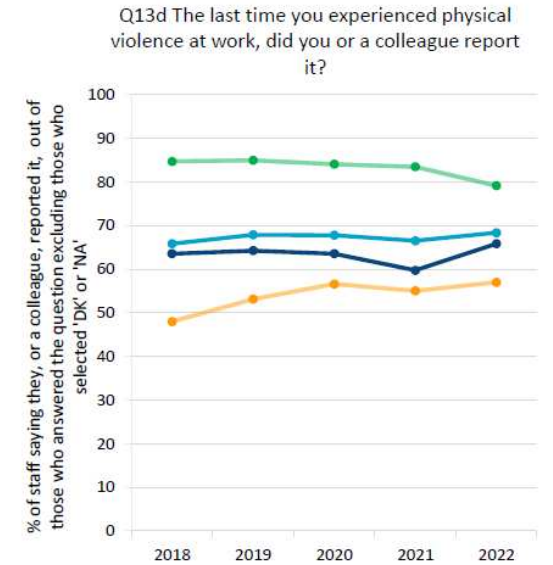


	2021	2022
Your org	51.4%	53.1%
Best	68.2%	68.9%
Average	54.4%	56.4%
Worst	44.2%	46.0%
Responses	4560	3664



	2018	2019	2020	2021	2022
Your org	28.2%	31.2%	-	25.7%	27.7%
Best	42.4%	43.6%	-	38.9%	40.5%
Average	31.8%	33.2%	-	29.3%	31.3%
Worst	20.7%	19.0%	-	21.5%	25.0%
Responses	3269	3770	-	3869	2995

- One final area of note is around physical violence. UHNM scores close to average on experience of physical violence from managers, colleagues and patients/service users with the majority of instances being from patients/service users. However, between 2021 and 2022 there has been a significant increase in the percentage of staff stating that the incident was reported (up 6 percentage points). This reflects that staff feel more confident in reporting incidents.

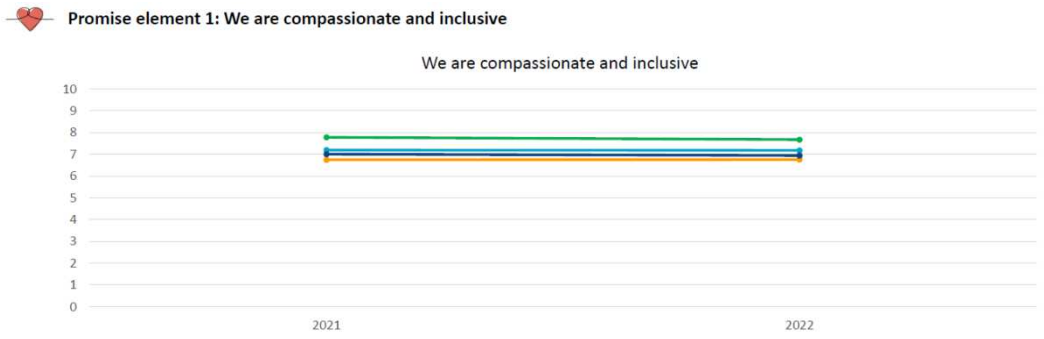


	2018	2019	2020	2021	2022
Your org	63.5%	64.2%	63.5%	59.7%	65.8%
Best	84.6%	84.9%	84.0%	83.4%	79.1%
Average	65.8%	67.8%	67.8%	66.5%	68.3%
Worst	47.9%	53.1%	56.6%	55.0%	57.0%
Responses	539	608	604	548	480

3.3 Least performing areas

Reviewing the data we have highlighted areas where the Trust has performed less well compared to similar Acute Trusts and consequently should be the areas of focus to achieve improvements. Below we explore these areas.

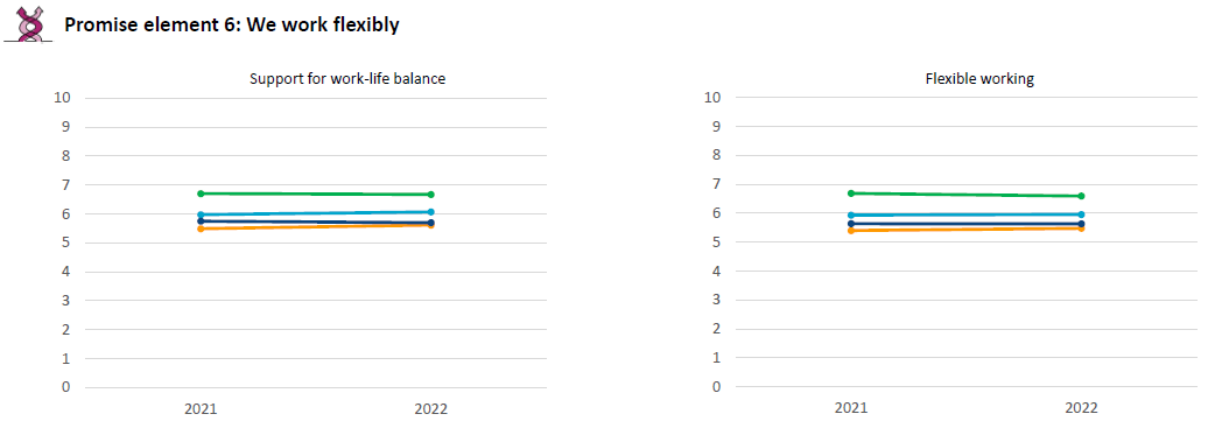
Promise 1: We are compassionate and inclusive – This element is created from 8 questions of which the one negatively impacting UHNM's score is "immediate manager takes effective action to help me with any problems I face" which has fallen 2 percentage points since 2021.



	2021	2022
Your org	7.0	6.9
Best	7.8	7.7
Average	7.2	7.2
Worst	6.7	6.8
Responses	4589	3675

At a national level the 2022 Staff Survey results showed that 'We are compassionate and inclusive' score remained unchanged compared to 2021.

Promise 6: We work flexibly – This element split into two sub-scores. The charts below show that on both sub-scores UHNM has not improved.



	2021	2022
Your org	5.7	5.7
Best	6.7	6.7
Average	6.0	6.1
Worst	5.5	5.6
Responses	4663	3674

	2021	2022
Your org	5.6	5.6
Best	6.7	6.6
Average	5.9	6.0
Worst	5.4	5.5
Responses	4676	3668

Note: At a national level the 2022 Staff Survey results showed that 'We are flexible' score remained unchanged compared to 2021.

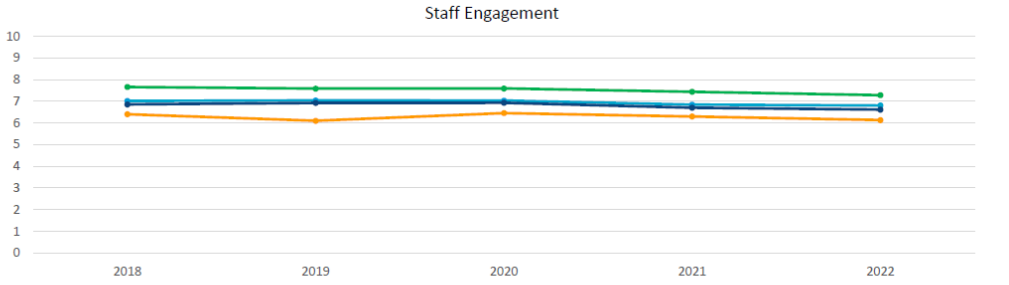
Promise 7: We are a team – This element is split into two sub-scores. Looking at the survey in greater depth it is apparent that the biggest contributing factor is teams "work well together to achieve their objectives" which decreased by 6 percentage points whilst the benchmark score stayed stable.

	2021	2022
Your org	6.3	6.3
Best	7.1	7.1
Average	6.6	6.6
Worst	6.2	6.3
Responses	4610	3671

Note: At a national level the 2022 Staff Survey results showed that 'We are a team' score has increased since 2021.

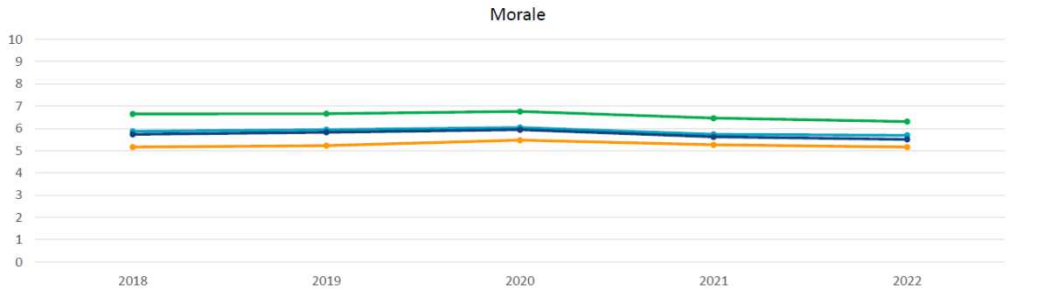
Staff Engagement

Staff engagement – At 6.6, the staff engagement score reduced slightly. The score for the benchmark group overall stayed stable at 6.8. The Trust continues to remain just below the Acute Trust average score.



	2018	2019	2020	2021	2022
Your org	6.9	6.9	6.9	6.7	6.6
Best	7.7	7.6	7.6	7.4	7.3
Average	7.0	7.0	7.0	6.8	6.8
Worst	6.4	6.1	6.5	6.3	6.1
Responses	4278	4579	4612	4684	3676

Staff morale – Overall, the benchmark group results remained stable at 5.7 compared to 2021 and the Trust's score experienced a slight reduction of 0.1. At 5.5, the Trust's score remains just below the Acute Trust average of 5.7, as it did in 2021.



	2018	2019	2020	2021	2022
Your org	5.7	5.8	5.9	5.6	5.5
Best	6.6	6.7	6.8	6.5	6.3
Average	5.9	5.9	6.0	5.7	5.7
Worst	5.2	5.2	5.5	5.3	5.2
Responses	4232	4549	4584	4679	3678

The local monthly **Staff Voice Survey** indicates that, since the national survey, there may have been a more recent upturn in factors affecting staff engagement given a rise in the staff engagement score under this survey tool which is conducted on a monthly basis (scored out of 10):

Based on the National Staff Survey results the key areas for focus will be around continuing to support our leaders/managers around developing a more compassionate and inclusive style when working with others (Promise 1 and Promise 7 results).

Within the results **(Promise 1)** there is an indication of the link between compassion and kindness both from managers and colleagues in order to positively and consistently impact staff experience. There are clear indications within the results that a renewed focus on enabling teams to work effectively is required **(Promise 7)** underpinned by improving staff work-life balance, offering more flexible working arrangements **(Promise 6)** and addressing concerns relating to stressors are critical to enhancing employee experience.

The UHNM People Strategy states that "workforce supply is affected by a range of factors: those that are within our control, those that are within our influence and those that are outside our control". The areas of focus highlighted above are within our influence and they impact both directly and indirectly upon the availability of staff across UHNM and as such will be given priority going forward.

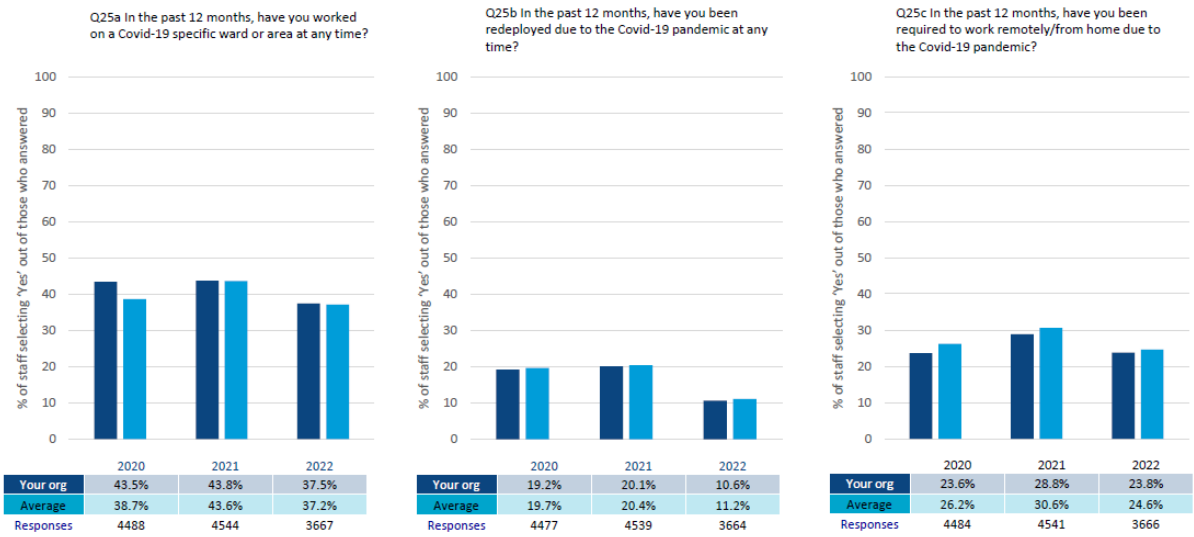
4. Staff Experience During Covid-19

In the 2022 Staff Survey, staff were asked 3 questions relating to their experience during the Covid-19 pandemic:

a) In the past 12 months, have you worked on a Covid-19 specific ward or area at any time?
b) In the past 12 months, have you been redeployed due to the Covid-19 pandemic at any time?
c) In the past 12 months, have you been required to work remotely/from home due to the Covid-19 pandemic?

There was little distinction between the Trust results and the average for similar Acute Trusts, except that, when compared to the benchmark group, slightly fewer Trust staff said they had been redeployed or been required to work from home due to the pandemic.

Compared to 2021, there was a significant reduction both nationally and locally in the number of staff that reported being redeployed. This reflects how the nation is recovering from the impact of the pandemic.



	2020	2021	2022
Your org	43.5%	43.8%	37.5%
Average	38.7%	43.6%	37.2%
Responses	4488	4544	3667

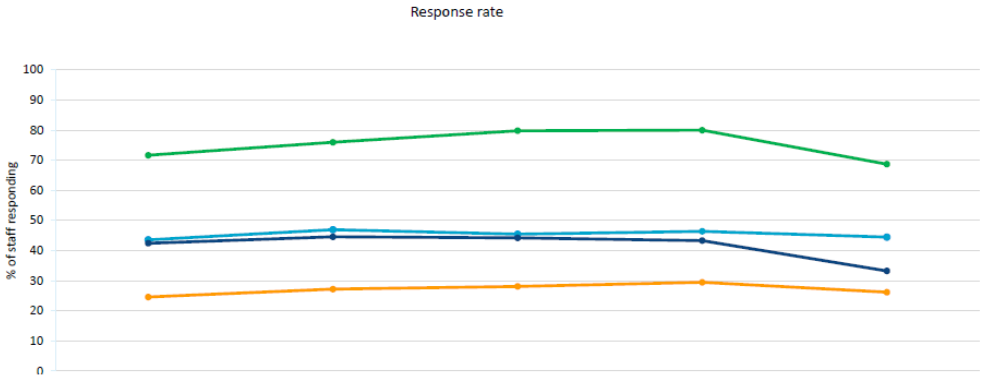
	2020	2021	2022
Your org	19.2%	20.1%	10.6%
Average	19.7%	20.4%	11.2%
Responses	4477	4539	3664

	2020	2021	2022
Your org	23.6%	28.8%	23.8%
Average	26.2%	30.6%	24.6%
Responses	4484	4541	3666

5. Response Rate

Considerable efforts were made across the Trust to encourage all staff members to complete the staff survey in 2022; however we experienced some technical issues from which we have identified lessons learnt. Fewer staff completed the Survey in 2022 (3685 staff in 2022 compared to 4749 in 2021) resulting in only 33% response rate compared to 43% in 2021.

It is notable that the highest performing organisations showed a decline of 11 percentage points in response rate that is even larger than UHNM's decrease of 10 percentage points (see graph below).



	2018	2019	2020	2021	2022
Your org	42.4%	44.6%	44.2%	43.3%	33.2%
Highest	71.6%	76.0%	79.8%	79.9%	68.7%
Average	43.6%	46.9%	45.4%	46.4%	44.5%
Lowest	24.6%	27.2%	28.1%	29.5%	26.2%
Responses	4307	4596	4699	4749	3685

6. Improvement Focus

Our areas of focus follow the domains within the People Strategy, *"Making UHNM a Great Place to Work"*. The undernoted forms a structured plan aimed at driving improvement in employee experience quickly and progressively throughout 2023/24.

Improvement Activity	We will look after our people
What we will do in the next 12 months	• We will implement a network of trained workplace wellbeing champions and embed the Board-level Wellbeing Guardian role • We will communicate widely all of our support networks such as Employee Support Advisors, Guardians and Disability Champions • We will launch a system wide occupational health system • We will continue to support the wellbeing of our staff through our comprehensive wellbeing plan and financial wellbeing • We will ensure that additional learning is made available for all staff and managers around stress identification and management

Improvement Activity	We will create a sense of belonging where we are kind and respectful to each other
What we will do in the next 12 months	• We will deliver our commitments set out in the RACE Code and Equality and Diversity and Inclusion strategy • We will create team improvement tools that support respectful and open conversations • We will develop team timeout resources to support team development and effective working • We will continue to embed our Being Kind tools including our set of expected behaviours of all our people supported by our leadership programmes • We will develop and support our people form under-represented groups into leadership roles including reciprocal mentoring We will promote widely our employee offer/package

Improvement Activity	We will grow and develop our workforce for the future
What we will do in the next 12 months	• We will undertake a 6 to 12 months evaluation piece around the ENABLE leadership programme which will evidence behavioural change impact in relation to programme attendees • We will promote the development of our leaders through our internal and external (West Midlands Collaborative) coaching network • We will review all our leadership programmes for alignment to our culture change programme activities • We will implement training for managers in flexible working best practice • We will implement succession planning and talent management approaches to underpin staff training/development/appraisals and support fair access to career progression opportunities • We will work with our system partners to develop joint roles/rotational posts • We will strengthen partnerships with education providers on learner placements support including T-levels

Improvement Activity	Improving Staff Engagement
What we will do in the next 12 months	• We will deliver a “culture heat map” tool which will quickly enable the Trust to identify how culture change initiatives are delivering and impacting on staff experience and quickly identify any culture improvement initiatives which are not adding the desired impact • We will hold a Staff Experience conference which will bring together a range of internal colleagues – Wellbeing Champions, Professional Nurse Advocates, Staff Networks to share best practice around enhancing staff experience • We will “close the feedback loop” in order that staff can see that we are listening to and acting upon their views, feedback and comments • We will develop communication approaches which staff can access via a range of channels that demonstrates that we are actively listening to them and taking appropriate action • We will develop an annual calendar which will clearly set out key staff engagement events and activities and how staff can get involved • We will develop a staff engagement and communications plan which will clearly outline to staff our main engagement approaches and how they can access these offerings • We will ensure that Divisional management teams have staff engagement levels as a watch metric” to be reviewed on a monthly basis

7. Measuring progress

Progress will be measured in terms of the Staff Survey Themes and Engagement and Morale scores for the 2023 National Staff Survey.

We will track the overarching staff engagement score at both organisational and divisional level on a monthly basis through the Divisional Performance Reviews. We will use our Quality Improvement Academy methodology to track delivery of the People Strategy delivery plan and the key performance metrics.

8. Recommendations

The Trust Board is asked to note the National Staff Survey Report and the corporate priorities planned for 2023/24 aimed at ***Making UHNM a Great Place to Work*** by improving organisational culture and behaviours and maximising the potential of our people to improve patient outcomes.

Performance and Finance Committee Chair's Highlight Report to Board

28th March 2023

1. Highlight Report

!	Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
	• An update was provided on the timeline of business case reviews and dates for all outstanding reviews were in the process of being planned. The actions being taken to strengthen the governance process associated with obtaining these in a more timely manner were highlighted, whilst recognising the impact of operational pressures on completion • Analysis into winter highlighted that compared to previous year, UHNM were unable to enact increased discharges before Christmas which constrained capacity. In addition an increased length of stay was highlighted for complex patients. Learning from the debrief would be taken into account for future planning • Planned care performance demonstrated deteriorations in the 78 week and 104 week position, citing challenges in accessing mutual aid • The system 2023/24 financial plan highlighted a planned deficit of £79 m • Whilst the capital programme remained behind plan it was expected that this would be delivered • A backlog in clinical coding was escalated as an issue from the Executive Business Intelligence Group and agency support was being sought as mitigation	• The business case update in relation to colorectal cancer pathway redesign highlighted an improvement to the triage to test wait time from over 40 days to under 4 days although a further update was to be considered at the next meeting • Independent review into planned care performance being undertaken and to be reported to the Committee in due course • Ongoing actions were being taken to address and improve productivity with progress updates to be provided to the Committee in due course
✓	**Positive Assurances to Provide**	**Decisions Made**
	• Urgent care performance had seen a sustained improvement in ambulance handovers in addition to improvements in triage times, reduction in patients waiting over 12 hours and improvement in 4 hour performance • Cancer performance demonstrated a continued reducing trajectory for 62 day backlog, which had improved from 346 patients to 295 patients of which 99 patients had been waiting over 104 days • DM01 performance was on an upward trajectory, supported in the main by an improvement in non-obstetric ultrasound • Month 11 financial performance demonstrated a breakeven position which was better than forecast. In addition, the system financial position for 2022/23 remained a forecast breakeven • The annual operating plan submission was provided and the actions and assumptions in relation to urgent and emergency care, diagnostics, cancer, outpatients and planned care were highlighted	• The Committee approved the following eREAFs; Enhanced Primary Care: GP Federation Service Extension up to 30/04/2023 (eREAF 10002), Franking Machine Postage Charges (eREAF 10455), National Blood Service (eREAF 10501), Supply of IV Fluids (eREAF 10570), Additional Funds for Salary Sacrifice Home Electronics (eREAF 10590), DaVinci XI Dual Console System Maintenance (eREAF 10642) and Respiratory Consumables – Breas (eREAF 10677) • The Committee approved the proposed approach to cost pressure and inflation funding for 2023/24 budgets

Comments on the Effectiveness of the Meeting

- No comments were made by members

2. Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Colorectal Cancer Pathway Redesign – Business Case Review Update	-	22570	-	Approval	6.	Budgetary Cost Pressures (Non-Pay) 2023/24	BAF 8	High 9	-	Approval
2.	Business Case Review Schedule	-	-	!	Assurance	7.	System 2023/24 Financial Plan Update	BAF 8	High 9	!	Assurance
3.	Performance Report – Month 11 2022/23 •Update on Discharges / Ambulance Holds •Drivers of Non-delivery of 104, 78 week and cancer targets •Winter Analysis 2022/23 •UHNM National UEC Recovery Plan Gap Analysis	1/5	Ext 20	! ✓	Assurance	8.	Finance Report – Month 11 2022/23	BAF 8	High 9	! ✓	Assurance
4.	Planned Care Improvement Group Highlight Report	5	Ext 20	-	Information	9.	Annual Operating Plan Submission 2023/24	-	-	✓	Assurance
5.	Authorisation of New Contract Awards, Contract Extensions and Non-Purchase Order (NPO) Expenditure	-	-	-	Approval	10.	Executive Business Intelligence Group Assurance Report	-	-	!	Assurance

3. 2022 / 23 Attendance Matrix

No.	Name	Job Title	A	M	J	J	A	S	O	N	D	J	F	M
1.	Dr L Griffin (Chair)	Non-Executive Director												
2.	Mr P Akid	Non-Executive Director	Chair											
3.	Ms H Ashley	Director of Strategy												
4.	Ms T Bowen	Non-Executive Director												
5.	Mrs T Bullock	Chief Executive												
6.	Mr P Bytheway	Chief Operating Officer						KT/OW	KT					
7.	Mr M Oldham	Chief Finance Officer												
8.	Mrs S Preston	Strategic Director of Finance												
9.	Mrs C Cotton	Associate Director of Corporate Governance			NH	NH	NH	NH		NH	NH	NH	NH	NH
10.	Mr J Tringham	Director of Operational Finance												

Attended | **Apologies & Deputy Sent** | **Apologies**

Executive Summary

Meeting:	Trust Board	**Date:**	05th April 2023
Report Title:	Integrated Performance Report, Month 11 2022/23	**Agenda Item:**	
Author:	Quality & Safety: Jamie Maxwell, Head of Quality & Safety; Operational Performance: Warren Shaw, Strategic Director of Performance & Information; Matt Hadfield, Associate Director of Performance & Information. Workforce: Paul Williams, Assistant Director of Human Resources; Finance: Jonathan Tringham, Director of Operational Finance		
Executive Lead:	Anne-Marie Riley: Chief Nurse Paul Bytheway: Chief Operating Officer Jane Haire: Director of Workforce Mark Oldham: Director of Finance		

Purpose of Report

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

Alignment with our Strategic Priorities

High Quality		People		Systems & Partners	
Responsive		Improving & Innovating		Resources	

Risk Register Mapping

Executive Summary

Situation

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

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

Quality & Safety

Assessment

During the increased operational pressures experienced by UHNM and health system there has been continued pressure on the achievement of the various quality and safety indicators.

Friends & Family Test for A&E has declined during February 2023 and remains below the 85% target of patients recommending the service and the Patient Experience Team are continuing to work with the ED Teams to promote the FFT surveys and improve feedback from completed surveys which identify the long waits in ED as main reason for

poorer experience.

Inpatient FFT results are still above the 95% target but have seen ongoing reductions since July 2022. There are key improvement initiatives underway to try and improve these results which are focussing on key priorities identified within the FFT returns – timely medications, better pain management and improving the involvement of patients and/or family in care and decision making

Following improvement last month, Maternity FFT has again achieved the 95% target and the text messaging service went live in February 2023.

The number of reported patient safety incidents remain above the long term mean but have reduced during February 2023, however the rate per 1000 bed days has remained relatively stable. The reduction in raw numbers reflecting the shorter month of February.

The largest categories for reported PSIs excluding Non Hospital Acquired Pressure Ulcers continue to be Patient Falls, Medication, Patient Flow and then Clinical Assessment related incidents. Within these incidents 170 (previously 228) are related to 'Your Next Patient' which accounts for 9.8% (12% in January 2023) of total patient safety incidents. As the extreme operational and capacity pressures were slightly reduced in February that the number of incidents reported relating to Your Next Patients has also reduced.

There has been reduction in the percentage of these YNP incidents in Medicine Division with 67% (previously 76%) but there has been increase in the percentage that relate to pressure damaged and 62% were Tissue viability. 78.8% of these were NOT hospital acquired but recording pressure damage on admission/attendance at UHNM. Reviews of these incident continue to identify themes and relate to delays in admitting patients.

Moderate harm or above incidents, both raw numbers and rate per 1000 bed days have reduced in February and are within normal variation following previous increases reported in December 2022 and January 2023. There is still a longer term increase and remain above the long term mean. As noted previously, the reason for the increases in these incidents remain patient flow related incidents. Different working practices and patient flow pathways have been introduced to mitigate the risks and to keep patients as safe as possible and these changes have appear to have started to take effect with reductions noted during February 2023.

Serious Incidents have also seen reductions which supports the noted reductions in incidents with moderate harm of above and overall patient safety incident reporting. Falls continue to be the main reason for serious incidents being reported.

Duty of Candour compliance for evidence in written notification has improved to 58.3% and is the best performance for 5 months since September 2022. The dedicated sessions with various Directorates and clinical teams appear to have had positive impacts along with the increased support and escalations from the Divisional Quality & Safety Managers.

Whilst there have been improvements, there is still large improvements required to evidence Duty of Candour has been completed within Datix within Medicine Division primarily and especially Specialised and General Medicine Directorates. Enhanced support is continuing to be provided at Divisional and Corporate levels.

Divisions include updates on local actions being undertaken to improve compliance at QSOG and individual Divisional Performance Reviews.

Timely Observations are continuing to improve across the Trust and there are now only 3 wardss/departments with less than 50% of patients having timely observations recorded on VitalPack. Medicine, Surgery and Network Services have all now included Timely Observations as Driver Metrics and focussing as priority to improve compliance.

Nosocomial COVID infections have seen reduction in February 2023, however, linked to the increased number of cases during January 2023 there has been an increase in the number of deaths reported. This is likely due to the lag between new cases reported and then patients unfortunately deteriorating.

Hospital Associated Thrombosis have reduced in February 2023 but these remain under review are under review with deep dive at the VTE Steering group. Currently of the 36 investigations that have been completed all have been unavoidable. It was noted last month that there has been an increase in COVID/RSV and FLU positive patients amongst the incidents and whether this is of significance is to be assessed as part of the ongoing investigations.

All data used in this report is as recorded on 8th March 2023 and figures may change following further review/investigation/update

Operational Performance

Emergency Care

- February was agained an improved month for Urgent & Emergency Care performance following a recovery in January from a December of significant challenge. This is mirrored when triangulated nationally which showed time spent in the Emergency Department performing above the median. Triage also maintained above median performance nationally. Type 1 Four Hour Standard however does remain a challenge and will be addressed as part of the Workstream 1 WTBS and productivity initiatives.

- Following momentum built in January the Escalation SOP was updated to ensure more senior oversight and intervention early when operational challenges are escalating. This will support the continued delivery of our improved ambulance handover position demonstrated by our performance relative to peers (least or second least WMAS hours lost) in the Regional Ambulance Handover Improvement Group through February and continued thus far in March (consistently least hours lost).

- The operational improvements, reduction in attendances, and stabilisation of IP restrictions seen in February resulted in a number of KPI returning to their COVID-19 pandemic levels, with Triage Times, Ambulance Handovers, 12+ Hours In ED, and Four Hour Performance achieving highest performing months since Summer 2021.

- The UHNM Annual Operational Plan is currently undergoing final refinements before submission with a Non-Elective focus on achieving 76% against the Four Hour Standard and 92% G&A Occupany by March 2024. This has been tied to the now delayed (as a result of Indutrial Actions) refresh of the Non-Elective Improvement Plan which will ensure an achieveable but ambitious trajectory to reach these targets in 2023 and build in resilience ahead of anticipated winter pressures.

- In order to support this delivery UHNM placed a bid for a capital allocation to implement a SDEC Modular which would release 40 G&A inpatient beds which has now been confirmed as placed in the highest category for funding with final confirmation pending. In advance of this a Task & Finish Group has been established to ensure clinical engagement and a robust project plan to ensure completion by the stipulated deadline of December 1st. This will effectively form the 2023/24 Winter acute escalation capacity and represents an excellent opportunity to embed nationally recognised best practice SDEC pathways across medicine, surgery, and frailty.

Cancer

- Two week wait performance is now booking within standard at 14 days, currently at 97%. This has been maintained in the face of high referral volumes.
- The 28 Day Faster Diagnosis position is currently 73.2% for February; this is showing signs of improvement towards the 75%target. This standard is the focus of an Improving together project covering all pathways.
- In February the backlog of patients has seen a significant reduction from 1041 at the end of August to 346 at the end of February.
- The incremental decrease of the Skin and Colorectal backlogs have been modelled up to the end of March 2023.
- Most recent submitted Cancer Waiting Times position is January which was 47.6% for 62 day performance. February is currently predicted to be 45.6% although this will improve post validation, this is due to the number of treatments for our longest waiting patients increasing.
- The 62 day target is expected to continue an improvement trajectory as additional capacity is put into managing the backlog.
- Cancer will form a workstream as part of the Planned Care governance structure – this will initially focus on our challenged pathways of Skin and Colorectal, alongside 2WW and FDS more generally.
- The Trust remains in Tier 2 for cancer performance with weekly meetings with the Regional NHSE team, however discussions have been started about stepping cancer down from the tier 2 process.

Planned Care

- Day Case and Elective Activity delivered 97% and 100% respectively for January 22 against the

national ask of 110%/108%. Day case as a % of all elective work is currently 86.3%.

- There is a real focus on 104w cases, many of whom were complex and required whole/half lists. As this number is being driven down the focus is moving to our 78week+ patients however there are currently as at 12th March there are 68 patients in this cohort and mitigation actions are still being implamended to reduce this number .
- Theatre transformation has been added as an additional workstream under Planned Care and begins with a focus on the 6-4-2 booking process with support from the regional theatres team. This is now a driver for the surgical Improving together programme, the deep dive week took place w/c 27 Feb, learning from this will be taken into the improving together programme, the first action to be taken is the reintroduction of the early call for the first patient on the list to support the lists starting on time – the identification of the golden patient.
- The focus has moved to 78 week waiters and the Trust Annual Plan submitted an initial position of 292 patients by March 2023, the National ask is to achieve 0 patients waiting over 78 weeks by the end of March. All non-admitted (Outpatient) patients have an appointment booked to ensure they get a decision to treat or discharge however the majority will move to our admitted pathway. The gap on the 12th March was 699; mitigation actions are being worked through to reduce this number and the predicted month end March position is 570.

RTT

- The overall Referral To Treatment (RTT) Waiting list has slightly decreased from 77,991 in January to 77,148 in January (unvalidated).
- The number of patients > 52 weeks continues to increase – from 4377 in August to now 5,307 in February.
- At the end of February the numbers of > 104 weeks was 69. The Trust has continues to achieve the national standard of all eliminating all 104 week waits purely due to capacity, there is considerable work now on the Trusts route to zero for 104 week waiting patients, with challenges around complex pathways, patient choice and fitness for treatment.
- The Trust remains in Tier 2 for 104> & 78> performance with weekly meetings with the Regional NHSE team.

Diagnostics

- Overall DM01 performance was 74%, an increase in performance on last month's 66%.
- Within DM01, the greatest proportions of > 6 week waits are within endoscopy. Non-obstetric ultrasound while still not meeting target have shown considerable improvements, however Endoscopy remains a concern.
- Full DM01 recovery plan agreed which sees a plan for the Trust achieving 6ww, the timeline on this is dependant on the modalit. This will be monitored through the planned care group. Key risk has been identified in endoscopy with weekly performance meetings instigated for the specialty and a risk to the March delivery target. There is now a challenge to the recovery of non obstetric ultrasound and we are now having weekly performance improvement meetings which Endoscopy and Imaging. This is the same process followed with LGI and Skin in the cancer pathways.
- Radiology backlog of reporting risk remains.
- Activity has remained largely consistent against previous months. Incentive schemes starting to improve activity (non-obs ultrasound notably)

Workforce

Key messages

- Our two main areas of focus continue to be on addressing staff availability in relation to absence rates and turnover.
- The 12m Turnover rate in February 2023 sat at 10.29% with the figure remaining below the trust target of 11% for a 5th month. The trust vacancy rate decreased to 12.62% due to decreases in budgeted establishment and increases in staff in post.
- For February 2023, the in-month sickness rate decreased by 0.56% to 5.02% (5.58% in January 2023). The 12-month cumulative rate marginally decreased to 5.99% (6.07% in January 2023).

- Chest and respiratory (which includes Covid) remains top at 23.4%, closely followed by Anxiety and Stress at 22.4%.
- 12th March 2023 covid-related absences stood at 127, which was 19.7% of the 645 open absences. This is 9.8.% increase on same time the previous month.
- On 28 February 2023, the PDR Rate increased 1.5% by to 82.2.% (81.7% on 31 January 2023). The current PDR policy is under review and meetings are taking place with key stakeholders to understand what improvements can be built into the process to drive compliance and making the process enhance employee experience.
- The Statutory and Mandatory training rate on 28 February 2023 was 93.0% (93.0% on 31 January 2023) and has remained static month on month. This compliance rate is for the 6 'Core for All' subjects only.
- The Oliver McGowan Mandatory Training on Learning Disability & Autism is now live and will be reported separately for 12 months and The Being Kind e-learning will be mandated from 1 April 2023, and this will be communicated Trust wide.
- The National Staff Survey 2022 results have now been published. This year, our response rate was 33%, much lower than 2021 which was 43%. However, this is reflected across all NHS Trusts.
- Areas with the largest improvements include:
    - Teams meeting to discuss effectiveness.
    - Last experience of physical violence reported.
    - Appraisal left you feeling the organisation values your work.
- Areas with the largest decrease include:
    - Reduction is satisfaction with level of pay.
    - Enough staff to do job properly.
    - Never or rarely frustrated by work.
- The Staff Voice trust survey for February 2023 received a total of 746 submissions providing an overall engagement score of 6.99.
- Internal measures to monitor reduction is agency expenditure continue. Divisional targets for agency ceilings have been calculated. As part of the monitoring divisions were asked to present an update on their action plan to reduce expenditure to Executive Workforce Assurance Group (EWAG). New targets for the upcoming year will be provided based on 3.75% of total wage bill.

Finance

Key elements of the financial performance year to date are:

- For the year to date the Trust has delivered a breakeven position against a planned surplus of £1.2m; this adverse variance is primarily driven by underperformance against the Trust's in year CIP target.
- The Trust incurred £0.3m of costs relating to COVID-19 in month; with £0.2m of this being chargeable for COVID-19 testing costs. The Trust has overspent by £3.2m against its original in envelope allocation due to the in envelope funding allocation ceasing after Month 2.
- To date the trust has validated £11.2m CIP savings in year; these schemes have a full year impact of £5.3m, which presents a considerable variance to the Trust's recurrent target of £13.6m which was identified as a key risk in the Trust's financial plan submission. This variance was reflected in the revised underlying position presented to the Committee in December.
- Capital expenditure in Month 11 is £41.4m which is 5.8m behind the plan of £47.2m. Of the expenditure to date £13.1m is the pre-committed repayment of the PFI and IFRS16 lease liabilities.
- The cash balance at Month 11 is £97.2m, which is £27.2m higher than plan. Cash received is above plan due to Capacity and Virtual Ward income received from the ICB.
- The Trust's forecast for the year continues to improve with the actual position at Month 11 being £0.7m better than the forecast carried out at Month 8; the Trust is confident that it will deliver a breakeven position for the year although this is heavily reliant on non-recurrent mitigations.

Key Recommendations

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

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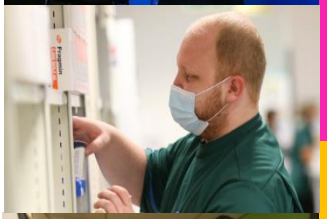


Integrated Performance Report

Month 11 2022/23

Delivering Exceptional Care with Exceptional People

NHS
University Hospitals of North Midlands
NHS Trust

Contents

A note on SPC

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

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

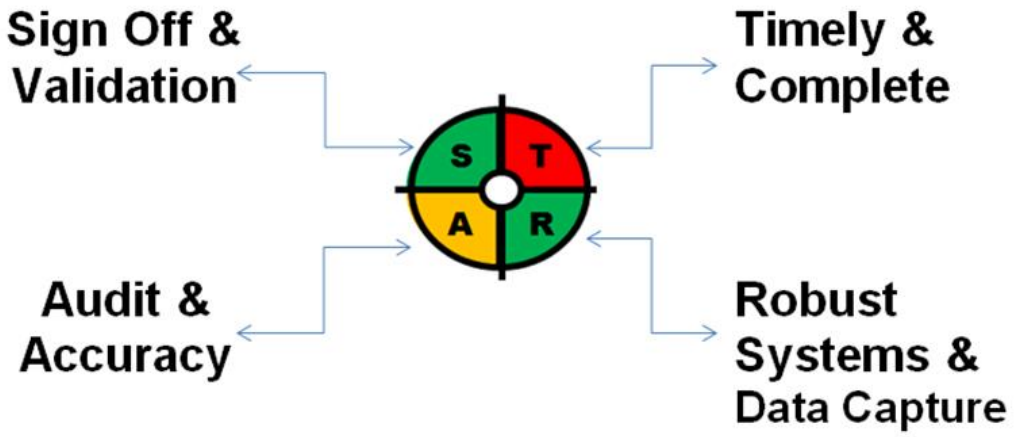
Assurance - how assured of consistently meeting the target can we be?

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

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

A note on Data Quality

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



Explaining each domain

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

RAG rating key

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

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Quality

Caring and Safety

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

Quality Spotlight Report

NHS
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The Trust achieved the following standards in February 2023:

- Friend & Family (Inpatients) 95.4% and exceeds 95% target.
- Friend & Family (Maternity) 95.3%%.
- Harm Free Care achieved 96.7% against 95% target rate
- Falls rate was 5.4 per 1000 bed days for February 2023
- 0 Never Event
- Trust rolling 12 month HSMR continue to be below expected range.
- VTE Risk Assessment completed during admission continues to exceed 95% target with 99.5% (point prevalence audit via Safety Thermometer).
- Zero avoidable MRSA Bacteraemia cases reported.
- There have been no Category 4 Pressure Ulcers attributable to lapses in care.
- E. Coli Bacteraemia cases below trajectory with 9 in February compared to target of 16.
- Inpatients Sepsis Screening above 90% target rate at 93.6%.
- Inpatient Sepsis IVAB within 1 hour achieved 100% and above 90% target rate
- Children's Sepsis Screening compliance 90.9% and above the 90% target.

The Trust did not achieve the set standards for:

- Friend & Family Test for A&E remains below 85% target at 71.2%, despite improvement in month
- There were 18 Pressure ulcers including Deep Tissue Injury identified with lapses in care.
- 87.5% verbal Duty of Candour compliance recorded in Datix
- 58.3% compliance with Duty of Candour 10 working day letter performance following formal verbal notification and under review for completion and upload of letter on Datix
- Timely Observations remain below the 90% target at 68.8% during February 2023 but has seen significant improvement during recent months
- C Diff YTD figures above trajectory with 13 against a target of 8.
- Sepsis Screening compliance in Emergency Portals declined to 84.2% below the target 90%.
- Emergency Portals Sepsis IVAB in 1 hour improved to 78.1% but remains below the 90% target for audited patients
- Maternity Sepsis Screening compliance improved to 85.7% against 90% target
- Maternity IVAB compliance declined to 75% and below the 90% target for audited patients

During February 2023, the following quality highlights are to be noted:

- The rate of complaints per 10,000 spells is 28.2 and is below the target of 35 and within normal variation. Majority of complaints in February 2023 continue to relate to clinical treatment.
- Total number of Patient Safety Incidents decreased in month (1720) and the rate per 1000 bed days has also decreased at 45.35. Reduction in number of Your Next Patient related incidents in February 2023
- Total incidents with moderate harm or above and the rate of these incidents are within control limits and normal variation levels.
- Rate of falls reported that have resulted in harm to patients currently at 1.1per 1000 bed days in January 2023. 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 5.1 and patient related 4.6 which are higher than previous month and mean rates. The monthly variation is within the normal expected variation and consistent with Trust mean rates.
- Pressure Ulcers per 1000 bed days developed under UHNM care has seen a decrease during February 2023
- Hospital Associated Thrombosis has decreased and is within normal variation and cases are under review.
- Decreased numbers of Definite Hospital Onset / Nosocomial COVID-19 cases reported with 46 in total.
- 6 COVID-19 death falling in to the 'Definite' category (according to the National definition of Nosocomial deaths of first positive result 15 days or more after admission to hospital).
- 7 Serious Incidents reported during February 2023 with 6 falls related.
- SHMI has seen increases and under review for diagnosis groups but is within expected range (see funnel plot chart)

Quality Dashboard

NHS
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NHS Trust

Metric	Target	Previous	Latest	Variation	Assurance
Patient Safety Incidents	N/A	1930	1720		
Patient Safety Incidents per 1000 bed days	50.70	46.26	45.35		
Patient Safety Incidents per 1000 bed days with no harm	N/A	28.88	31.37		
Patient Safety Incidents per 1000 bed days with low harm	N/A	14.50	11.42		
Patient Safety Incidents per 1000 bed days reported as Near Miss	N/A	1.51	1.58		
Patient Safety Incidents with moderate harm +	N/A	55	34		
Patient Safety Incidents with moderate harm + per 1000 bed days	N/A	1.32	0.90		
Harm Free Care (New Harms)	95%	94.4%	96.7%		
NRLS risk of potential under reporting (CQC Insights)	1.0	0.79	0.89		
Patient Falls per 1000 bed days	5.6	5.8	5.4		
Patient Falls with harm per 1000 bed days	1.5	1.3	1.1		
Medication Incidents per 1000 bed days	6	4.7	5.1		
Medication Incidents % with moderate harm or above	0.50%	1.55%	0.52%		
Patient Medication Incidents per 1000 bed days	6	4.1	4.6		
Patient Medication Incidents % with moderate harm or above	0.50%	1.18%	0.57%		

Metric	Target	Previous	Latest	Variation	Assurance
Serious Incidents reported per month	0	12	7		
Serious Incidents Rate per 1000 bed days	0	0.29	0.00		
Never Events reported per month	0	0	0		
Duty of Candour - Verbal/Formal Notification	100%	93%	88%		
Duty of Candour - Written	100%		58.3%		
All Pressure ulcers developed under UHNM Care	TBC	83	60		
All Pressure ulcers developed under UHNM Care per 1000 bed days	N/A	1.99	1.58		
All Pressure ulcers developed under UHNM Care lapses in care	12	32	18		
All Pressure ulcers developed under UHNM Care lapses in care per 1000 bed days	0.5	0.8	0.47		
Category 2 Pressure Ulcers with lapses in Care	8	5	5		
Category 3 Pressure Ulcers with lapse in care	4	2	1		
Deep Tissue Injury with lapses in care	0	20	10		
Unstageable Pressure Ulcers with lapses in care	0	5	2		

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Quality Dashboard

NHS
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NHS Trust

Metric	Target	Previous	Latest	Variation	Assurance
Friends & Family Test - A&E	85%	75.4%	71.2%	L	F
Friends & Family Test - Inpatient	95%	96.6%	96.9%		P
Friends & Family Test - Maternity	95%	100%	95.3%		
Written Complaints per 10,000 spells	21.11	29.38	28.20		?
Complaints received by the CQC (feb 21 - Jan 22)	N/A	49	76		
Rolling 12 Month HSMR (3 month time lag)	100	98.54	97.27		P
Rolling 12 Month SHMI (4 month time lag)	100	107.57	107.00	H	?
Nosocomial COVID-19 Deaths (Positive Sample 15+ days after admission)	N/A	3	6		
VTE Risk Assessment Compliance	95%	97.9%	99.5%		
Reported C Diff Cases per month	8	14	13		?
Avoidable MRSA Bacteraemia Cases per month	0	0	0		?
HAI E. Coli Bacteraemia Cases per month	8	15	9		?
Nosocomial "Definite" HAI COVID Cases - UHNM	0	34	46		

Metric	Target	Previous	Latest	Variation	Assurance
Inpatient Sepsis Screening Compliance (Contracted)	90%	89.7%	93.6%		?
Inpatient IVAB within 1hr (Contracted)	90%	91%	100.0%	H	P
Children Sepsis Screening Compliance (All)	90%	97%	90.9%		?
Children IVAB within 1hr (All)	90%	N/A	N/A	H	P
Emergency Portals Sepsis Screening Compliance (Contracted)	90%	91%	84.2%	L	?
Emergency Portals IVAB within 1 hr (Contracted)	90%	60%	78.1%	L	?
Maternity Sepsis Screening (All)	90%	77%	85.7%	H	F
Maternity IVAB within 1 hr (All)	90%	100%	75.0%	L	F

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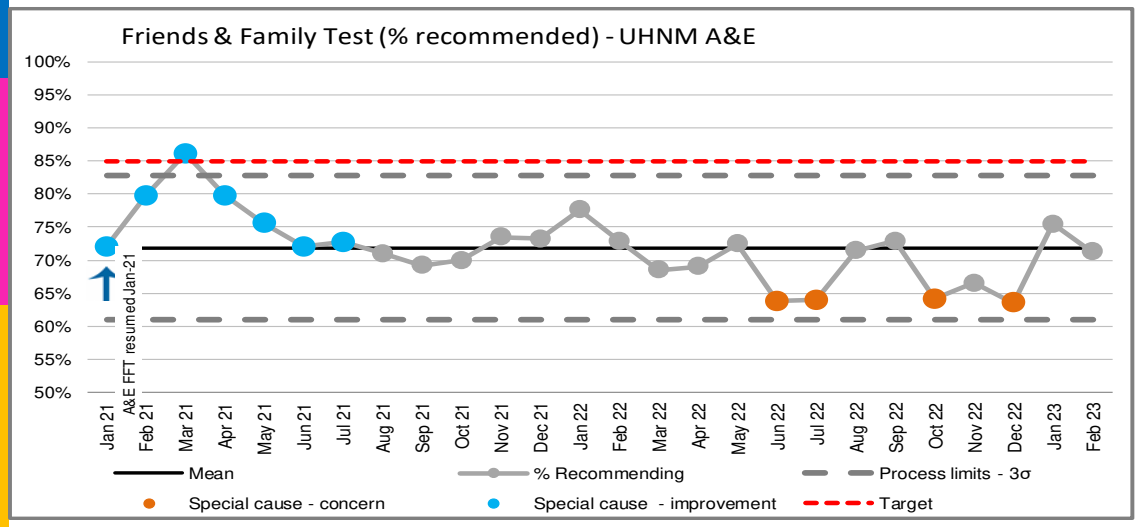
Friends & Family Test (FFT) – A&E



Variation	Assurance

Target	Dec 22	Jan 23	Feb 23
85%	63.5%	75.4%	71.2%

Background

The % of patients who would recommend the service to friends and family if they needed similar care or treatment

What do the results tell us?

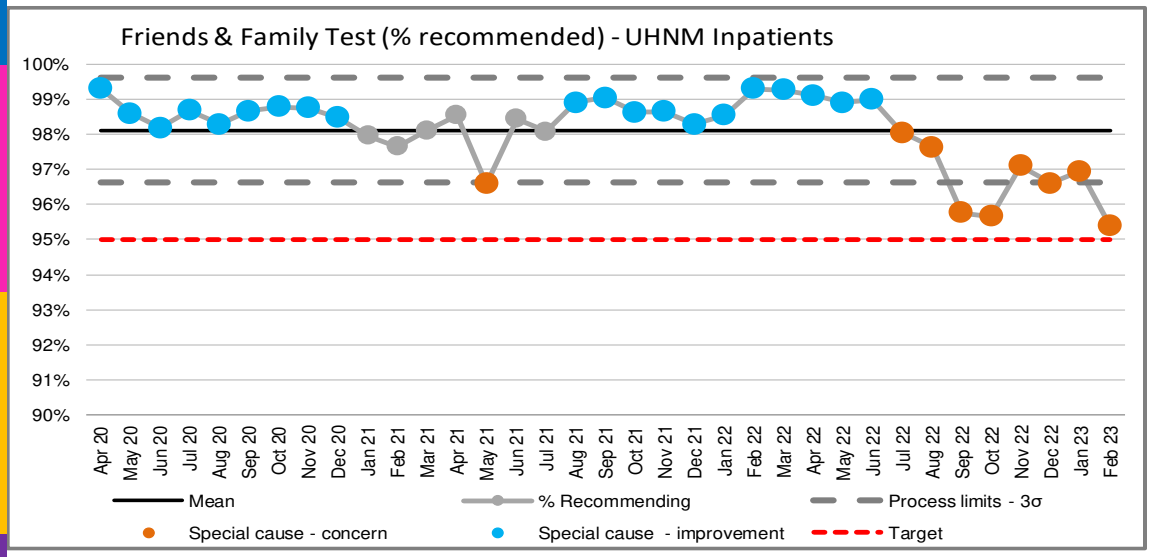
- The satisfaction rate for ED remains below our internal target at 75% for February 2023.
- The Trust received 775 responses which is decrease on the previous month with a 9% response rate for overall. The Trust's overall satisfaction rate is slightly lower than the national average of 73% (NHS England December 2022 latest figure). UHNM is 37th out of 122 Trusts for number of responses in ED (NHS England December 2022).
- Feedback from patient experience of using 111First and the kiosks is being monitored. Only 25% of respondents in February 23 reported to have used 111First prior to attending ED, which is the same as in January 23. Key themes from February 2023 are long waits, especially related to Royal Stoke; lack of compassion, staff attitude and patient's feeling dismissed. And these are similar across RSUH and County Hospital.

Actions :

- Work streams have been re-established to look at individual processes
- A new audio announcement has been put in place to support with keeping patient's updated regarding wait times.
- On-going work with the team to increase FFT response rate.

Friends & Family Test (FFT) - Inpatient

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

Target	Dec 22	Jan 23	Feb 23
95%	96.6%	96.9%	95.4%

Background

Percentage of Friend & Family Tests that would recommend UHNM Inpatient Services

What do the results tell us?

- The monthly satisfaction rate for inpatient areas continue to exceed both the internal target rate of 95% and the national average of 94% (December 2022 NHS England)
- In February 2023 a total of 2432 responses were collected from 64 inpatient and day case areas (9350 discharges) equating to a 26% return rate which is an increase on the previous month but remains lower than the internal target of 30%. UHNM obtained the 14th highest response rate for all reporting Trusts in the country (151) NHS England December 2022).

Actions:

- Continue to ensure that FFT surveys are available in other formats to ensure accessibility for all patients.

Work continues around a suite of patient priorities based on patient feedback:

- Timely medications
- Pain management
- Involvement in care and decision making
- Improving the experience of our oncology patients

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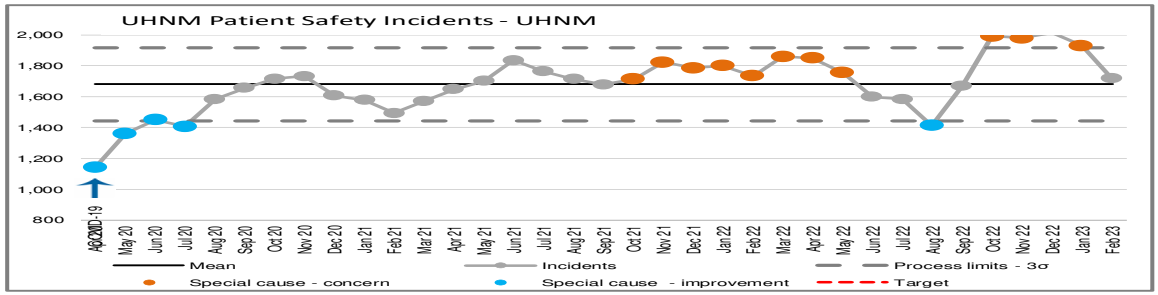
Reported Patient Safety Incidents

University Hospitals of North Midlands NHS Trust

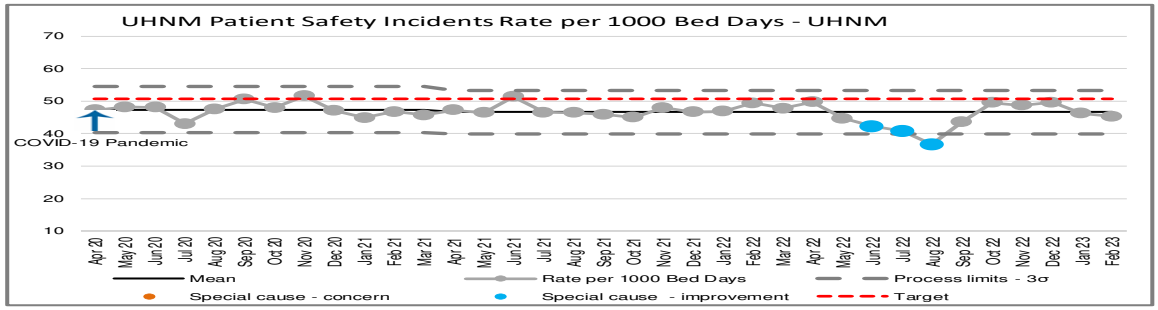


Variation	Assurance
	

Target	Dec 22	Jan 23	Feb 23
N/A	2014	1930	1720

Background

Total Reported patient safety incidents



Variation	Assurance
	

NRLS Mean	Dec 22	Jan 23	Feb 23
50.70	49.61	46.26	45.35

What is the data telling us:

The above data relates to **all** reported Patient Safety Incidents (PSIs) across the Trust. The February 2023 total is above the mean total since COVID-19 started but this may be due to increased activity throughout the Trust. The rate per 1000 bed days has, despite increases in total numbers remain relatively stable.

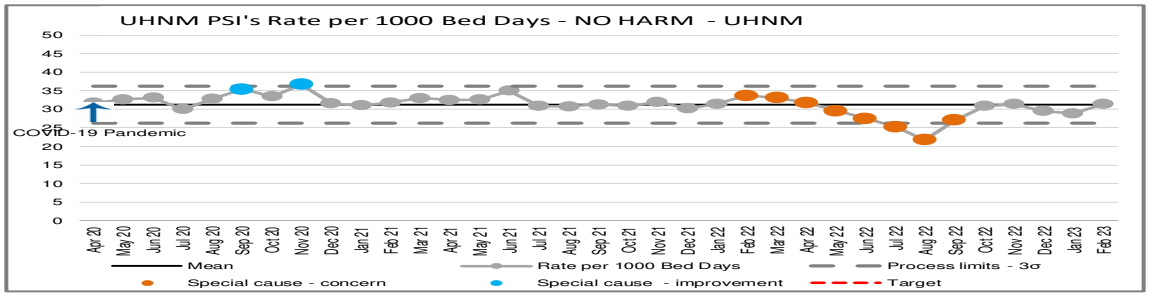
However, the reporting of incidents and near misses should continue to be encouraged and promoted and increasing rates and numbers of total incidents is not necessarily to be viewed as concern. It is important to review the different levels of harm within the overall totals.

The largest categories for reported PSIs excluding Non Hospital Acquired Pressure Ulcers are Patient Falls, Medication, Patient Flow and Clinical Assessment related incidents. There has been no significant changes in these categories compared to previous months. There have been 170 (reduction from 228 in January 2023) of the incidents identified as related to 'Your Next Patient' which accounts for 9.8% (January 2023 was 12%) of total patient safety incidents. 68.6% (62% previously) were Tissue viability. However, 78.5% of these were NOT hospital acquired but recording pressure damage on admission/attendance at UHNM. A Deep Dive to better understand the correlation of additional pressure of YNP on patient harm is to be completed and reported via QSOG and QGC.

The rate of reported PSIs per 1000 bed days remains similar to the long term mean rate and well within control limits and normal variation.

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

NHS University Hospitals of North Midlands NHS Trust

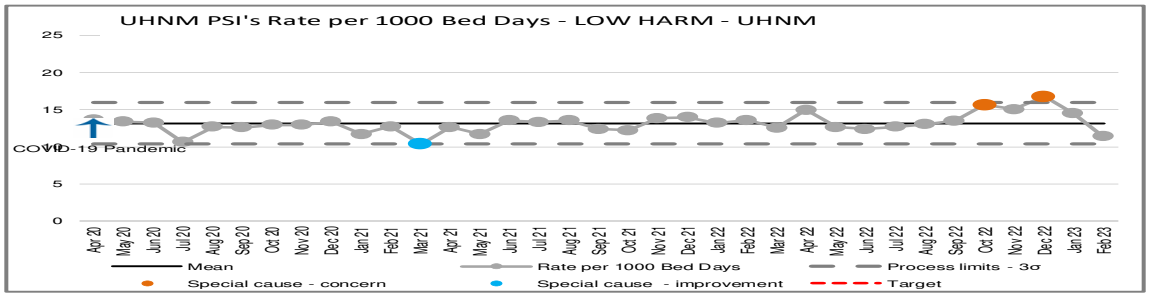


Variation	Assurance

Target	Dec 22	Jan 23	Feb 23
N/A	29.48	28.88	31.37

Background

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

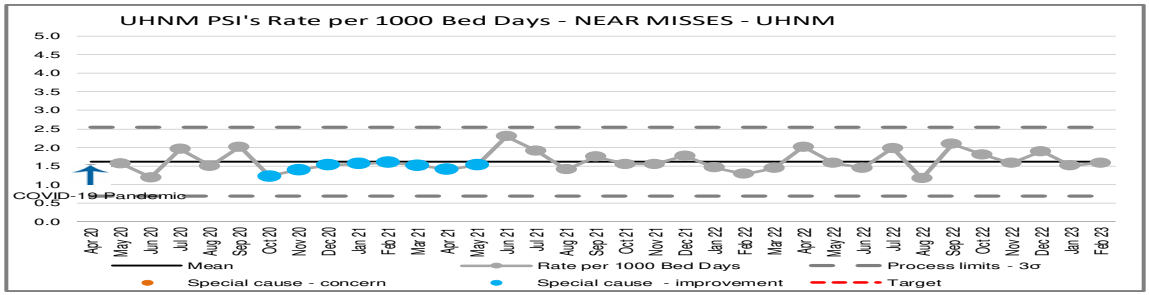


Variation	Assurance

Target	Dec 22	Jan 23	Feb 23
N/A	16.77	14.50	11.42

Background

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



Variation	Assurance

Target	Dec 22	Jan 23	Feb 23
N/A	1.90	1.51	1.58

Background

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

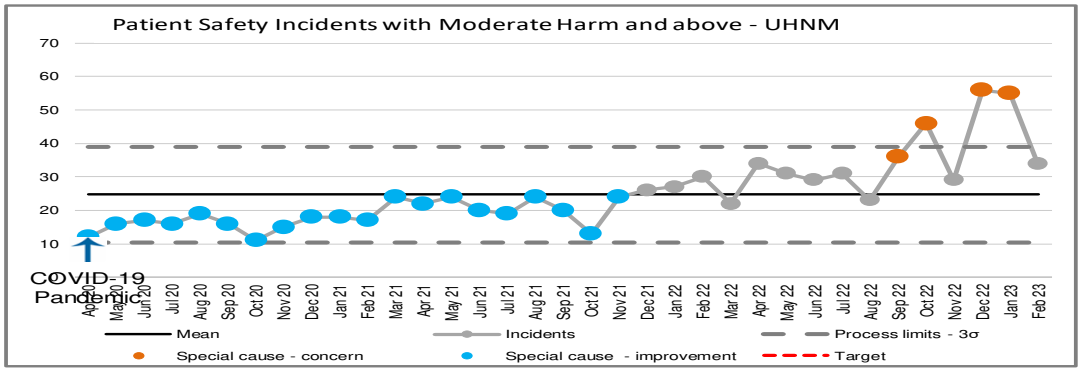
What is the data telling us:

The Rate of Patient Safety Incidents per 1000 bed days with low harm or near misses are showing more consistent trends. The no harm incidents have seen rates back to the mean rate in recent months. With slight reduction in low harm and near misses.

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

NHS University Hospitals of North Midlands NHS Trust

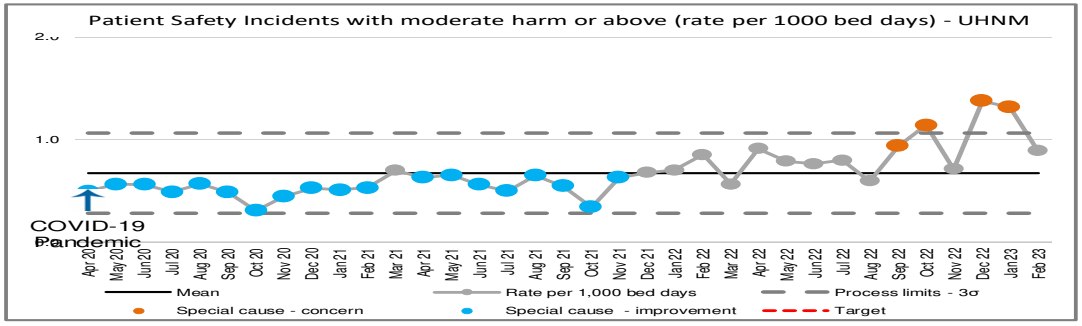


Variation	Assurance

Target	Dec 22	Jan 23	Feb 23
N/A	56	55	34

Background

Patient safety incidents with reported moderate harm and above



Variation	Assurance

Target	Dec 22	Jan 23	Feb 23
N/A	1.38	1.32	0.90

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 above the upper process control limit and has shown increasing total numbers since August 2022. February 2023 total has seen reductions from previous months. The rate of moderate harm and above has also reduced in February so is not just a result of less days per month but is reduction based on standardised activity rates too.

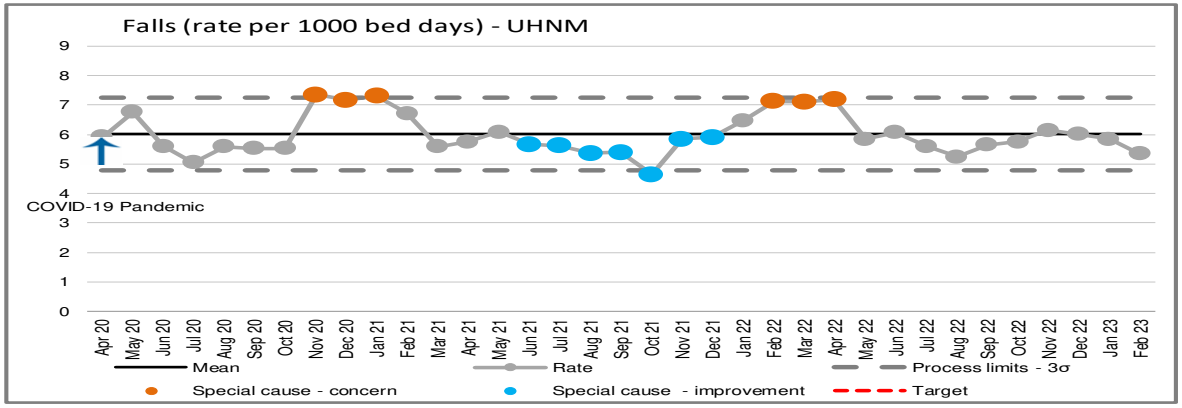
The top category of incidents resulting in moderate harm reflect the largest reporting categories with 8 Falls (11 in January 2023), 6 Clinical Assessment (4 in January 2023) , 2 Pressure Ulcer (Hospital acquired) (10 in January 2023), 1 Patient Flow (reduced from 8 in January 2023), 4 treatment related (6 previously), 1 Medication (5 previously),

None of these moderate harm and above incidents were noted as relating to **'Your Next Patient'**

A Deep Dive to better understand the correlation of additional pressure of YNP on patient harm is to be completed and reported via QSOG and QGC

Patient Falls Rate per 1000 bed days

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Dec 22	Jan 23	Feb 23
N/A	6.0	5.8	5.4

Background

The number of falls per 1000 occupied bed days

What is the data telling us:

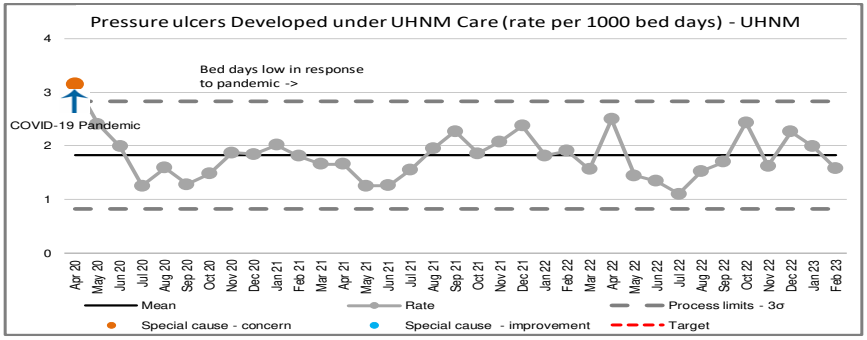
The Trust's rate of reported patient falls per 1000 bed days was within the normal range in February.

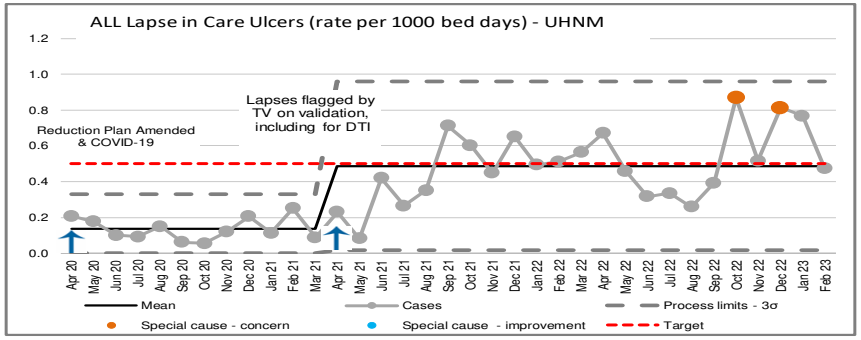
The areas reporting the highest numbers of falls in February 2023 were:
Royal Stoke ED – 15 falls, Royal Stoke AMU – 15 falls, Ward 126 (neuro) – 10 falls, Ward 14 – 9 falls , Ward 228 – 8 falls
ED falls numbers per month have doubled since Autumn 2020, however, the rate per 1000 attendances has been 77% higher since Autumn 2020 indicating that the increased activity is a significant factor in increased falls. During this period 17 ED cubicles were converted into side rooms with solid doors due to infection prevention mitigation actions during COVID-19. This has made observation of patients more difficult and may have contributed to increased falls

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

- Audits continue to be taken in all of these TOP 5 reporting areas.
- Falls training has been delivered to the new Nursing Assistants.
- A trial audit has been carried out by the physiotherapy and the Q&S team in the emergency portal to identify if patients who have not brought there mobility aids in, that there has been a referral to the physiotherapy team and the appropriate documentation has been completed.
- Following the discussion with the ECC team, one aspect of falls has been delivered for 2 weeks. This will be audited next week to ensure that learning has been embedded before moving on to another facet of falls.
- Re-audit is to be carried out on AMU on the areas where improvements were required.
- Ward 126 has had a falls audit completed and information has been fed back. Unfortunately ward 126 has had a patient for the last 6 weeks that has been a multiple faller which will have increased the falls in this area. The ward have been supported to ensure all preventative measures are in place for this gentleman, however the patient declines to use the call bell for assistance.
- February's audits on Ward 14 and Ward 228 shows that further improvement is required regarding completion of multifactorial risk assessments and lying and standing blood pressures . A request was made from the Network division Matron to meet and discuss plans in which we can support the reduction in falls. Meeting held and falls discussed, actions have been put into place.

Pressure Ulcers developed under care of UHNM per 1000 bed days





Variation	Assurance

Target	Dec 22	Jan 23	Feb 23
N/A	2.27	1.99	1.58

Background

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

Variation	Assurance

Target	Dec 22	Jan 23	Feb 23
0.5	0.81	0.77	0.47

Background

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

What the data is telling us

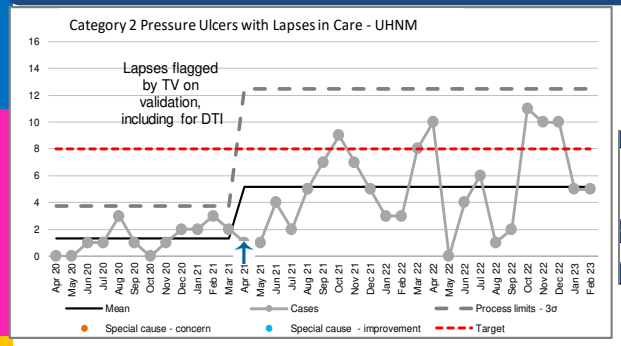
The rate of pressures ulcers reported as developed under UHNM care, and cases with lapses were within expected limits in February.
Acuity for ward areas is taken into account in line with lapses in care.
High reporting areas will be presenting all incidents at bespoke RCA panels, to allow identification of trends, and establish their improvement and educational focus. The Tissue Viability team and Corporate Nursing Quality & Safety Teams will support with this.
Pressure Ulcer prevention is an annual objective and a key driver metric as part of the Trust's Improving Together programme.

Actions

- Training continues for PUP champions, nursing assistants and on ED new starter days, Preceptorship days
- Pressure ulcer prevention conference was held on 7th March with good attendance
- Requests being made by wards for further training on skin bundles, investigation process, categorisation and dressing selection
- Categorisation training dates have now been confirmed for this year. Training has now been provided to registered nurses and nursing assistants through nurse bank.
- ESR training approved and need to go through patient safety
- Training video has been made for care of catheters after an increase in urethral damage, along with the catheter life chart being updated and plans to re-launch
- CQUIN audit to commence 23/24 on pressure ulcer risk assessment and documentation

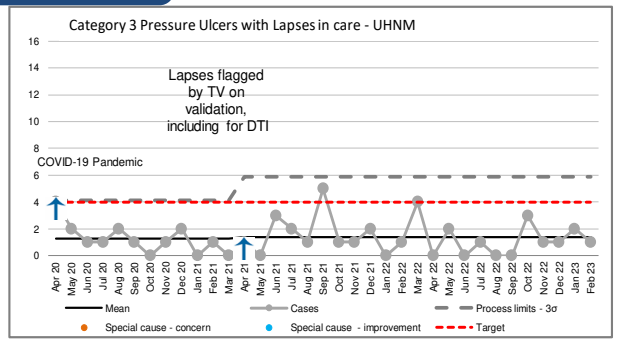
Pressure Ulcers with lapses in care

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance

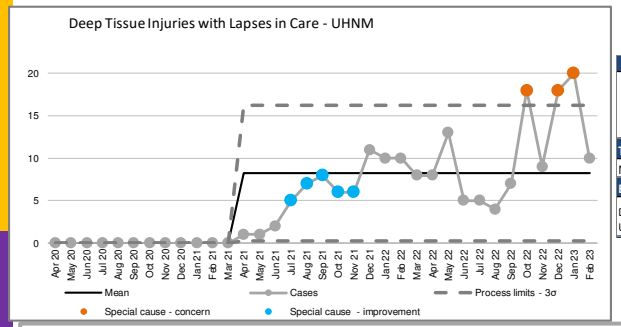
Target	Dec 22	Jan 23	Feb 23
	8	10	5	5
Background			



Variation	Assurance

Target	Dec 22	Jan 23	Feb 23
	4	1	2	1
Background			

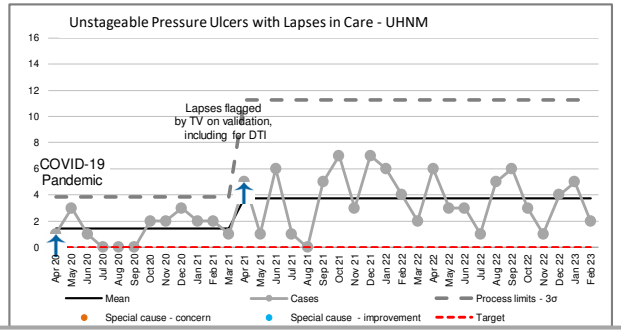
Category 3 pressure ulcers which developed under the care of UHNM with lapses in care associated



Variation	Assurance

Target	Dec 22	Jan 23	Feb 23
N/A	18	20	10
Background			

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



Variation	Assurance

Target	Dec 22	Jan 23	Feb 23
	0	4	5	2
Background			

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

What is the data telling us:

The numbers of cases with lapses identified in all categories are showing only normal variation for February. As shown in the table below, the most common lapses identified remain management of heel offloading & repositioning.

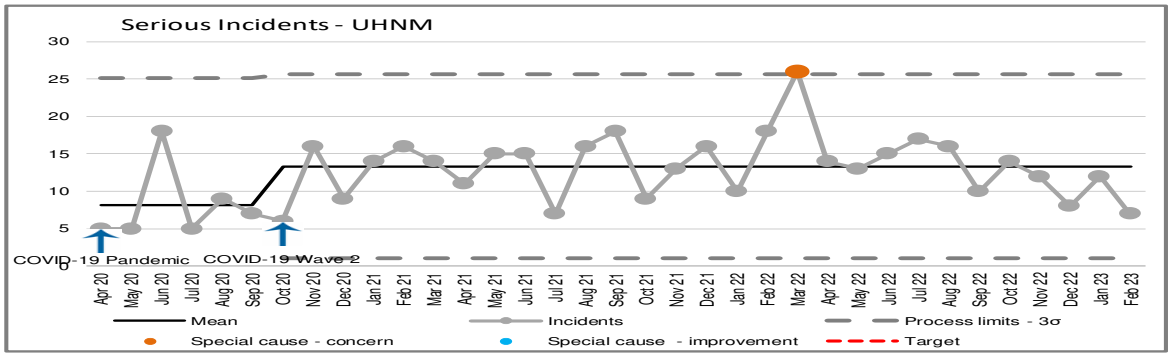
Locations with more than 1 lapse in February 2023 were:
County Ward 1 (2)

Root Cause(s) of damage - Lapses - Feb 2023	Total
Management of heel offloading	8
Management of repositioning	6
Management of device	2
Management of non-concordance	3

Actions:

- Feedback will be given to governance for ED and AMU to seek assurances
- Plan are underway to a line investigation process with PSIRF
- High reporting wards will be visited to complete audits, action plans to be implemented to support improvement. Visit will involve education to staff during the visit
- Training video on accountability and documentation requires approval through patient safety
- Potential deep dive into increase into unstageable damage and deep tissue injuries for Q3 and Q4

Serious Incidents per month

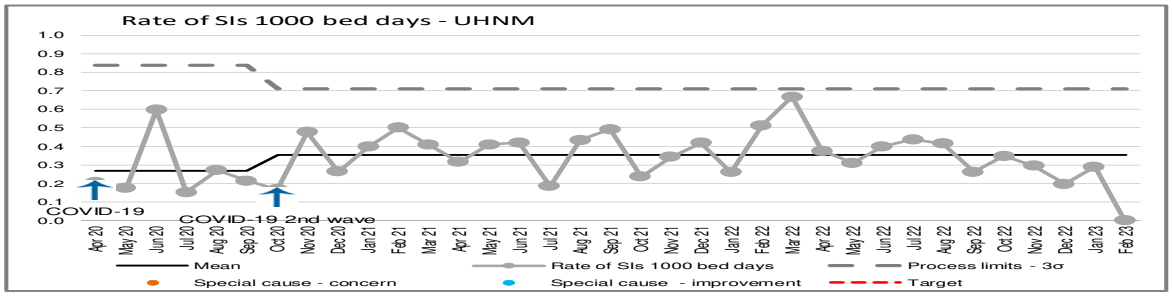


Variation	Assurance
	F

Threshold	Dec 22	Jan 23	Feb 23
0	8	12	7

Background

The number of reported Serious Incidents per month



Variation	Assurance
	?

Target	Dec 22	Jan 23	Feb 23
0	0.20	0.29	0.00

Background

The rate of Serious Incidents Reported per 1000 bed days

What is the data telling us:

Monthly variation is within normal limits. Target has been set at 0 for serious incidents but this remains under review to develop trajectory for reducing serious incidents across UHNM. February 2023* saw 7 incidents reported:

6 Falls related incidents

1 Maternity related

The rate of SIs per 1000 bed days has varied consistently within confidence limits indicating normal variation and there has not been any significant trends. The current rate of SIs per 1000 bed days is 0.18 and is lower than the long term mean of 0.4 since COVID-19 started in December 2020. The previous 6 months have seen reporting rate lower than log term mean.

**Reported on STEIS as SI in February 2023, the date of the incident may not be February 2023.*

Serious Incidents Summary

University Hospitals of North Midlands NHS Trust

Summary of new Maternity Serious Incidents

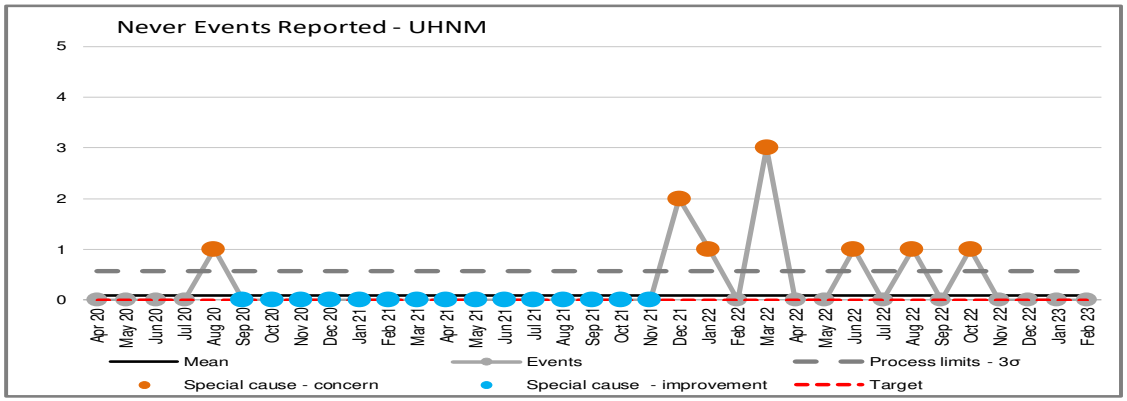
Following the formal recommendations in the Ockenden Report, below is an outline of the Maternity related serious incidents reported during February 2023. The new recommendation requires the Trust Board to receive summary on the new Maternity related Serious Incidents along with previously reported summary 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 was 1 Maternity related Serious Incidents reported on STEIS during February 2023

Log No	Patient Ethnic Group:	Type of Incident	Target Completion date	Description of what happened:
2023/2456	White - British	Maternity/Obstetric incident (baby only)	27/04/2023	Neonatal death Reported following completion of PMRT of 24+1 weeks baby. Potential to act sooner on abnormal blood gas result may have had impact on deterioration of baby.

Never Events



Variation	Assurance

Target	Dec 22	Jan 23	Feb 23
0	0	0	0

Background

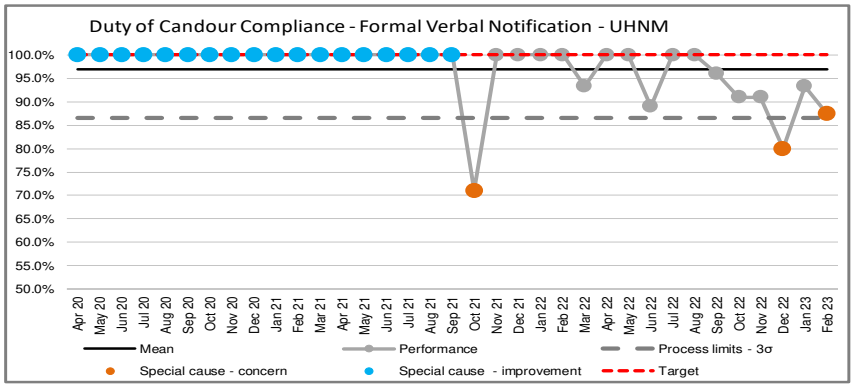
Defined as Serious Incidents that are wholly preventable, as strong systemic protective barriers should be in place

There has been 0 reported Never Event in February 2023. The target is to have 0 Never Events.

Log No.	STEIS Category	Never Event Category	Description	Target Completion date

Duty of Candour Compliance

NHS
University Hospitals of North Midlands
NHS Trust

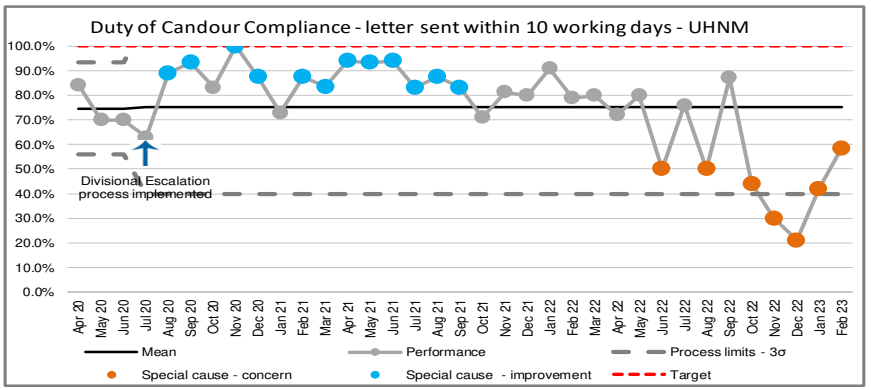


Variation	Assurance
	

Target	Dec 22	Jan 23	Feb 23
100%	80.0%	93.3%	87.5%

Background

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



Variation	Assurance
	

Target	Dec 22	Jan 23	Feb 23
100%	21.0%	42.0%	58.3%

Background

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

What is the data telling us:

During February there were 24 incidents reported and identified that have formally triggered the Duty of Candour. 87.5% have recorded that the patient/relatives been formally notified of the incident in Datix and within normal variation although remains below target rate.

Confirmed Follow up Written Duty of Candour compliance (i.e. receiving the letter within 10 working days of verbal notification **and recorded in Datix**) during February 2023 has improved to 58.3% as at 6th March 2023 including those letters that are still within timescale. Outstanding letters / information uploaded to Datix has been escalated with individual wards/departments and via Directorate/Divisional structures. Medicine Division, in particular Specialised and General Medicine, have lowest compliance for written evidence of completion.

Actions taken:

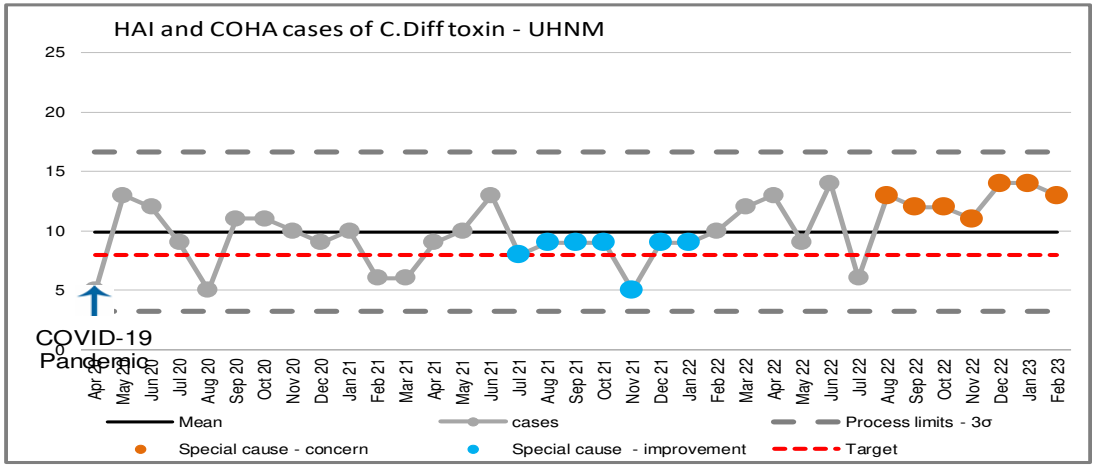
Divisions are continuing to work with and support clinicians and Q&S teams to raise further awareness and education on how and why Duty of Candour is to be completed.

The initial actions taken within Emergency Medicine to support the clinicians with uploading and updating on Datix to evidence Duty of Candour completed especially during the continued increased extraordinary operational pressures have seen improvements locally.

Compliance is included in Divisional reports for discussion and action and escalations are made prior to deadline to support completion as much as possible.

Reported C Diff Cases per month

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

Target	Dec 22	Jan 23	Feb 23
8	14	14	13

Background

Number of HAI + COHA cases reported by month

What do these results tell us?

Number of C Diff cases cases are within SPC limits and normal variation .

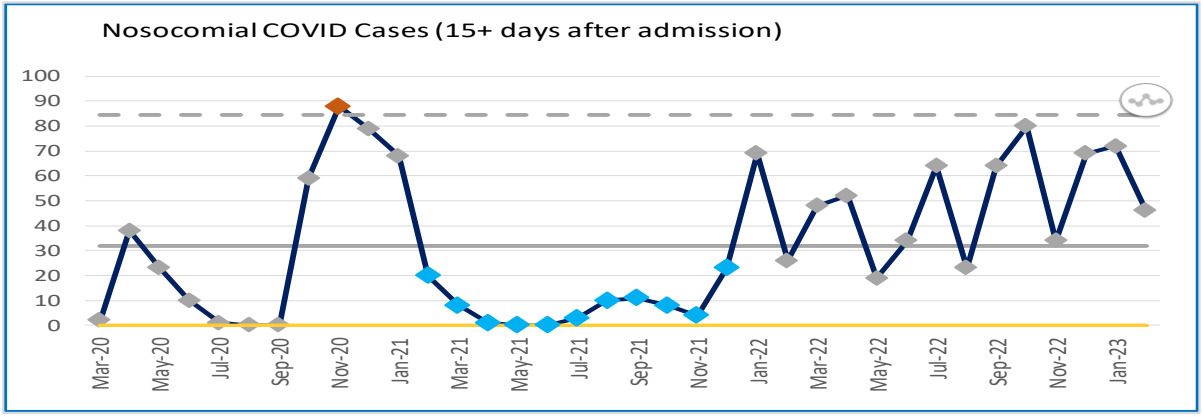
There have been 13 reported C diff cases in January 2023 with 8 being Hospital Associated Infection (HAI) cases and 5 COHA cases. The top 3 areas for C Diff during February 2023 were Ward 108, Ward 122 and Ward 15 (County)

HAI: cases that are detected in the hospital three or more days after admission (day 1 is the day of admission)
COHA: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks
There has been one clinical area that has had more than one Clostridium *difficile* case in a 28 day period. Ribotyping results have not been reported on cases involved to date.

Actions:

- Routine ribotyping of samples continues
- Recruitment to the C Diff Nurse role has been successful and commenced 20th February 2023. This role is 50% patient reviews/50% staff training.
- The bi-weekly Cdiff MDT meeting has been re-commenced
- Review of the RCAs demonstrate a theme where patients have been admitted with documented diarrhoea, yet a sample is not submitted until day 3 or later – this then becomes hospital apportioned. At the clinical group meeting all clinicians were reminded of the importance of early sampling, and the Alert Group is exploring any options for an electronic alert for early sampling
- RCAs continue to be reviewed by ICB in relation to avoidability

HAI Nosocomial COVID Cases per Month



What do these results tell us?

- Decrease in cases throughout February 2023 with 46 definite Healthcare Acquired COVID-19 cases.
- Monthly total is within normal variation
- Follows national profile for increasing cases within the community during February 2023
- COVID screening guidance changed 14/09/2022. Patients only swabbed on admission if being admitted to high risk area, immunocompromised or symptomatic for COVID. Otherwise patients are now not routinely screened. Asymptomatic cases are being identified when screening patients as part of an outbreak but currently

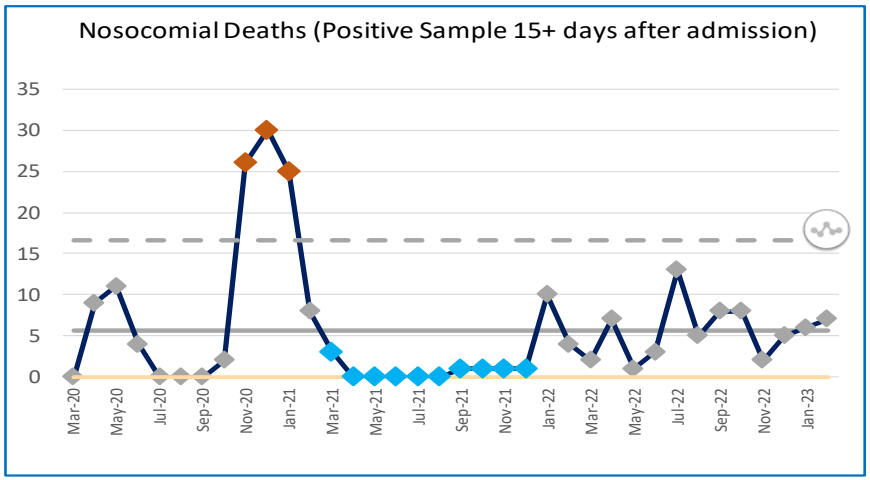
Actions :

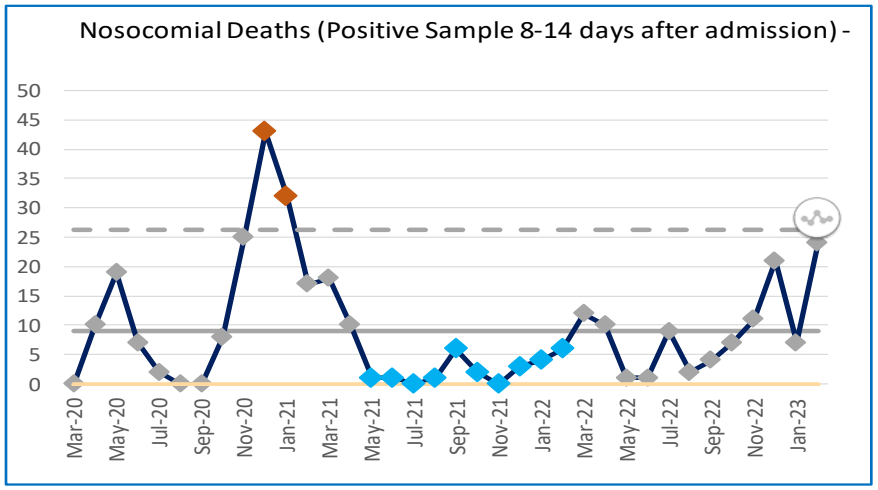
- UHNM COVID screening changed in line with National guidance 14th September 2022.
- No routine asymptomatic admission screening for COVID
- Screening for symptomatic, admission to high risk areas and immunocompromised patients
- In addition close patient contacts of a COVID case are also screened and patients who develop symptoms during their hospital stay
- COVID 19 themes report provided to IPCC
- UHNM Guidance on Testing and re-testing for COVID 19 plus step down of suspected/positive cases
- Isolate suspected patients on identification of symptoms
- Process for patients identified as a contact with positive patients
- Process in place for outbreak management and reporting

	UHNM		
	Total Admissions	COVID cases	
		Prob	Def
Feb 21	14101	31	20
Mar 21	17105	12	8
Apr 21	16554	3	1
May-21	17273	0	0
Jun-21	18527	0	0
Jul-21	18168	4	3
Aug-21	17160	14	10
Sep-21	17327	11	10
Oct-21	17055	8	8
Nov-21	17700	4	4
Dec-21	16688	13	23
Jan-22	16109	67	69
Feb-22	16278	39	26
Mar-22	18518	71	48
Apr-22	16538	72	52
May-22	18484	14	19
Jun-22	18380	34	34
Jul-22	17983	45	64
Aug-22	18247	16	24
Sep-22	18279	58	64
Oct-22	18351	81	80
Nov-22	19607	29	34
Dec-22	18240	78	69
Jan-23		81	72
Feb-23		65	46

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

University Hospitals of North Midlands NHS Trust





What do these results tell us?

Increase in monthly total but within normal variation limits

The criteria for the Definite Hospital acquired/Nosocomial COVID-19 is that the patient had **first positive** COVID-19 swab result 15 days or more following admission to UHNM.

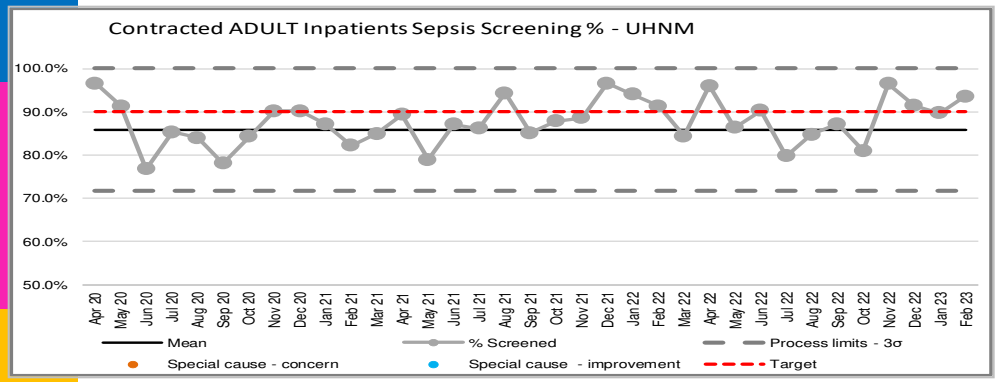
- 7 recorded definite hospital onset COVID-19 deaths in February 2023
- Total 301 hospital acquired COVID-19 deaths with 1st positive results 15 days or more following admission recorded since 1st March 2020 up to 28th February 2023
- 66 Definite Hospital acquired COVID-19 deaths during 2022/23 YTD
- The mean number of deaths per month since March 2020 is 6.

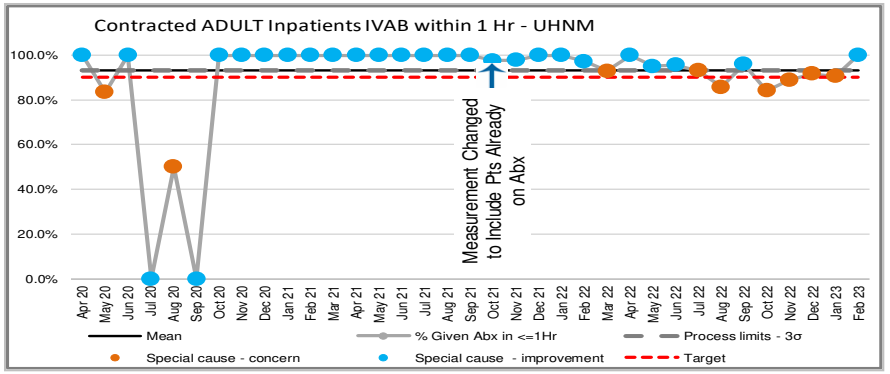
Actions :

Nosocomial COVID-19 deaths are continuing to be reviewed as part of Trust mortality review processes.

Sepsis Screening Compliance (Inpatients Contract)

University Hospitals of North Midlands NHS Trust





Variation	Assurance

Target	Dec 22	Jan 23	Feb 23
90%	91.4%	89.7%	93.6%

Background

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

Variation	Assurance

Target	Dec 22	Jan 23	Feb 23
90%	91.7%	90.6%	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:

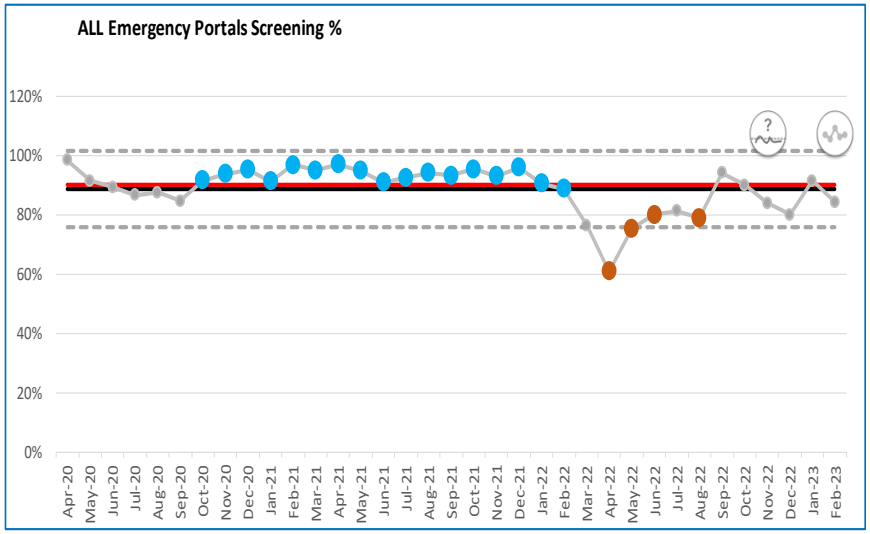
Inpatient areas failed to achieve the screening but did achieve the IVAB within 1 hour target in January 2023. There were 116 cases audited with 12 missed screening from different ward areas or divisions. Out of 116 cases audited, 70 cases were identified as red flags sepsis with 38 cases having alternative diagnosis and 32 cases were true red flags. Out of 32 true red flag cases, 29 were already on IVAB treatment, 2 delayed treatment in which given above two hours (both from Medicine Division).

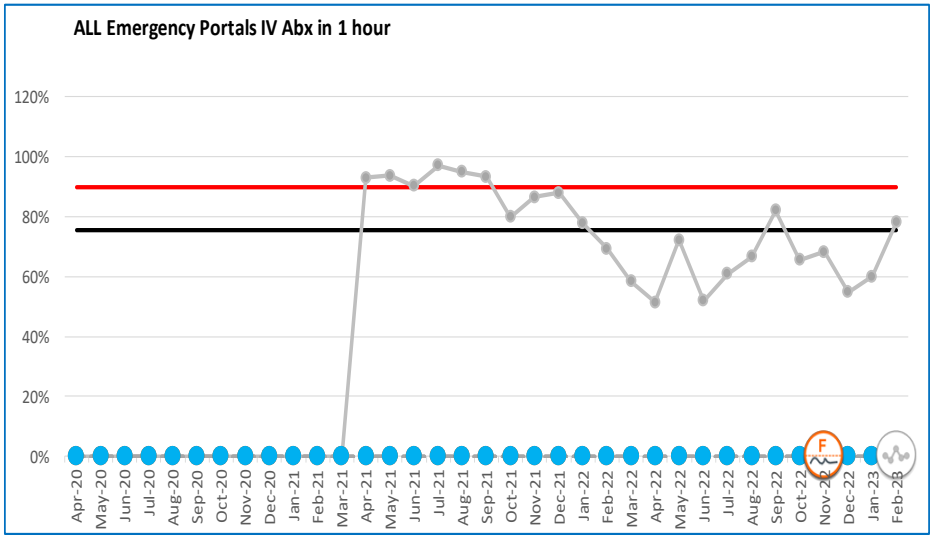
Actions:

- The Sepsis team have continued to focus on providing ward based sepsis drop in session/kiosks on targeted clinical areas and division: on-going
- The Sepsis team regularly identify areas of poor compliance and prioritise those areas for more focused sepsis re-enforcement: on-going
- The Sepsis team continued to work closely with the VitalPac team in order to address issues in timely manner: on-going
- Continued focus and support provided to all divisions to maintain and sustain compliance: on-going
- The Sepsis Team continue to raise awareness of importance of sepsis screening by being involved in HCA, students and new nursing staff induction programmes
- The Sepsis team will continue to promote sepsis awareness in both sites and will prioritise areas to visit with the clinical lead consultant

Sepsis Screening Compliance (Emergency Portals Contract)

NHS
University Hospitals of North Midlands
NHS Trust





What is the data telling us:

Adult Emergency Portals screening met the target for January 2023. There were 76 cases audited with 7 missed screening in total from the 6 emergency portals audited.

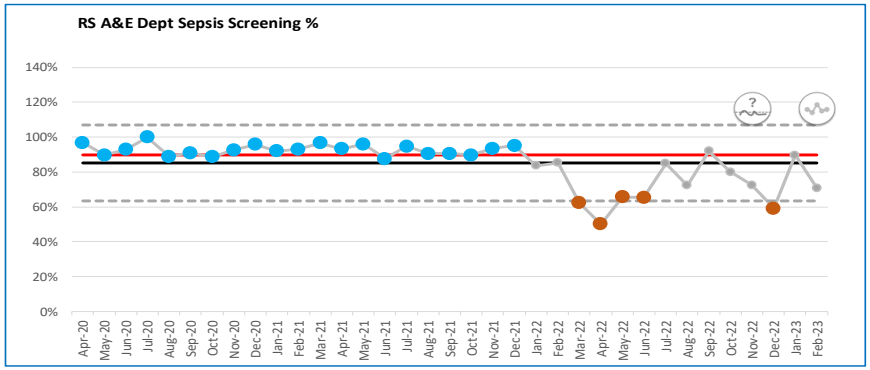
The performance for IVAB within 1hr below target rate in January 2023 is at 57%. Out of 76 cases, there were only 65 red flags sepsis in which the 10 cases already on IVAB, 36 cases were newly identified sepsis and 19 cases have alternative diagnosis. There were 20 delayed IVAB with 16 cases delayed within 2 hours and 4 cases above 2 hours. Delayed IVAB within 1 hour and screening, mainly contributed by both ED Royal Stoke and County for this month.

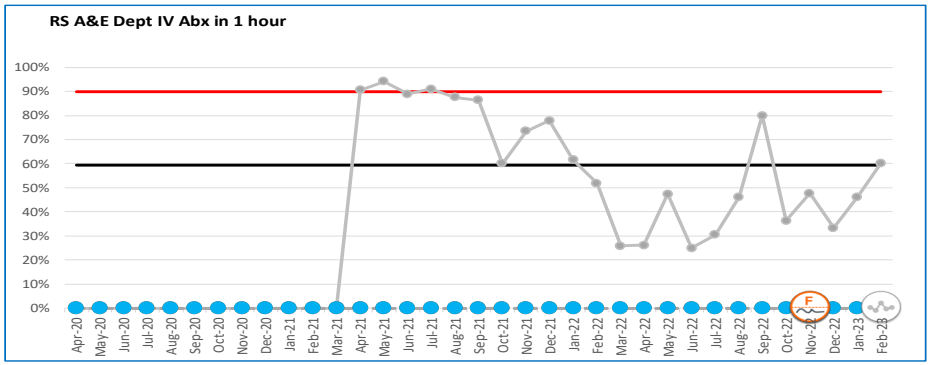
Actions:

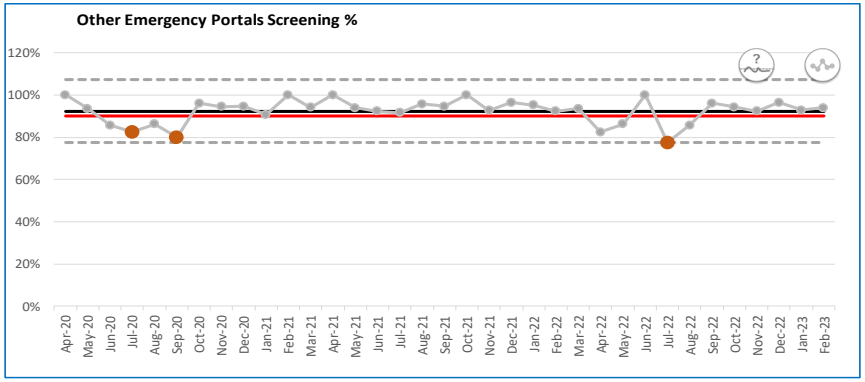
- The Sepsis team continued to closely monitor compliance by visiting and auditing A&E regularly. Provide sepsis session when staffing and acuity allows
- The Sepsis team is working collaboratively with the A&E Quality nurses, sepsis champions, senior team and A&E sepsis clinical lead to provide support with late IVAB incidents and missed screens. Issue with holding ambulances remain a challenge.
- Face to face A&E sepsis induction for new nursing staff, nursing assistant and medical staff will recommence once capacity pressure/flow improve in the department
- Regular meeting with A&E senior team reinstated to review current robust actions in place
- Monitoring impact of long ambulance waits on timely assessment and treatment of sepsis

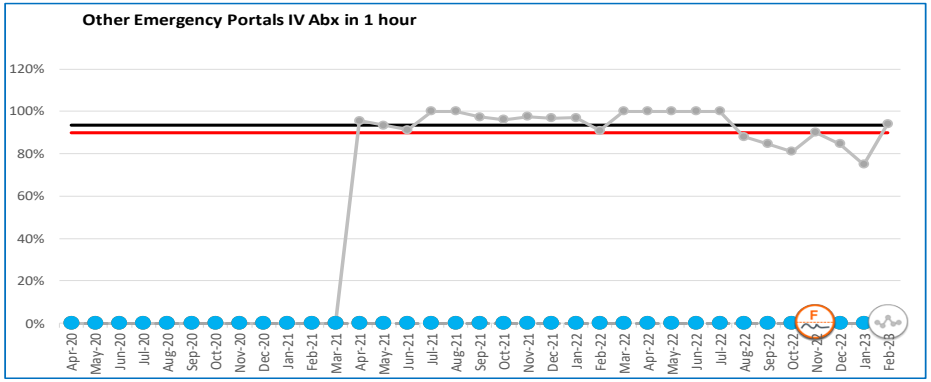
Sepsis Screening Compliance (Emergency Portals RSUH ED & Other Portals)

NHS
University Hospitals of North Midlands
NHS Trust









What is the data telling us:

RSUH Emergency Department performance in February 2023 remains below target rate and compliance is significantly lower than control limits. The RSUH ED is driving the overall Emergency Portals performance as other emergency portals are achieving Screening compliance but slightly below target for IVAB in hour target. During February 2023 there have been improvements at RSUH for IVAB in 1 hour but still below targets.

Actions:

- CAS card has been updated to reflect the sepsis pathway and to ensure all staff are following the correct guidance
- Directorate to devise a SOP for nursing staff to advise of agreed actions of Ambulance assessment nurse to escalate NEWS and sepsis trigger to the Resus Consultant between the hours of 8am-12midnight, EPIC 12midnight to 8am using the vocera call system. This will enable accurate and safe assessment of the patients sepsis trigger and to ensure correct urgent antibiotic prescription and administration.

Sepsis Screening Compliance ALL Maternity

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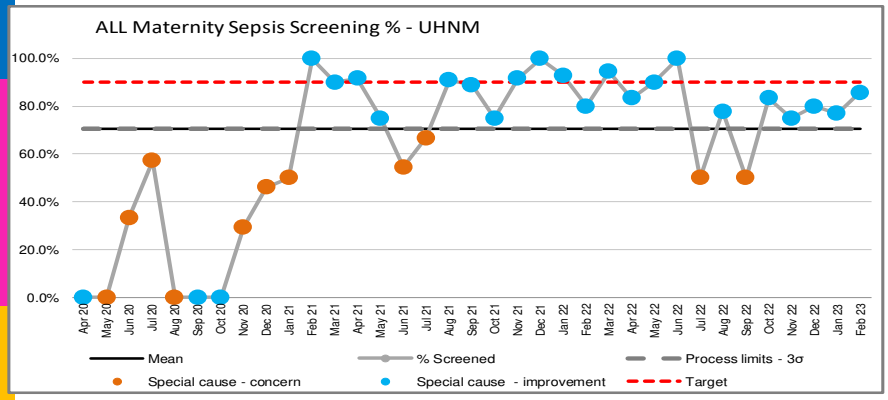

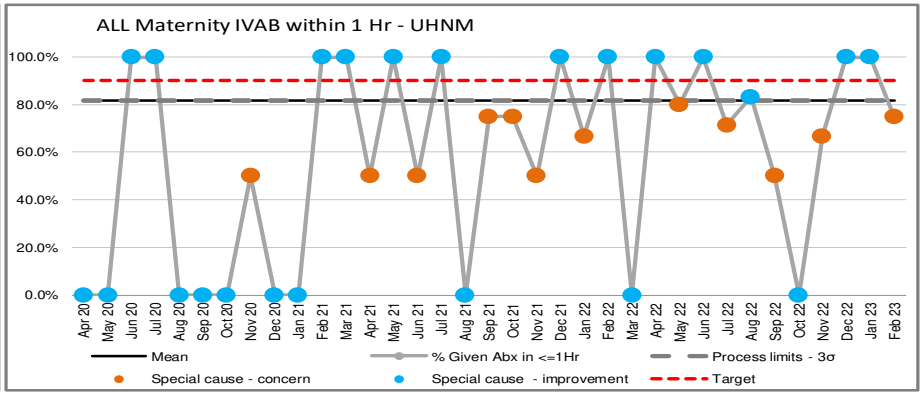

Variation	Assurance
H	F

Target	Dec 22	Jan 23	Feb 23
90%	80.0%	76.9%	85.7%

Background

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

Variation	Assurance
L	F

Target	Dec 22	Jan 23	Feb 23
90%	100%	100%	75%

Background

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

What is the data telling us:

Maternity audits in screening compliance is below the target at 77% but IVAB within 1 hour is reported at 100% during January 2023. This compliance score is based on a very small number, however a regular spot checks audit is being conducted monthly.

There were only a total of 13 cases audited from emergency portal (MAU) and inpatients with 3 missed screening. There were 3 true red flags identified from the randomise audits, 1 is already on IVAB treatment and 2 cases received IVAB within 1 hour.

Actions:

- Maternity have already developed and awaiting finalisation of their antibiotic PGD: on-going
- Maternity educator is supporting the sepsis team by conducting independent / in-depth sepsis audits in the whole Maternity department , staff who had missed the screening documentation will be given constructive feedback and offered support/ training: on-going
- Future plan for Maternity 5 hour sepsis CPD champion training remain in the pipeline however, has been temporarily put on-hold due to current operational pressures: on-going
- Plan of delivering sepsis awareness in each clinical areas in September-October with the support of the clinical educator

Sepsis Screening Compliance ALL Children

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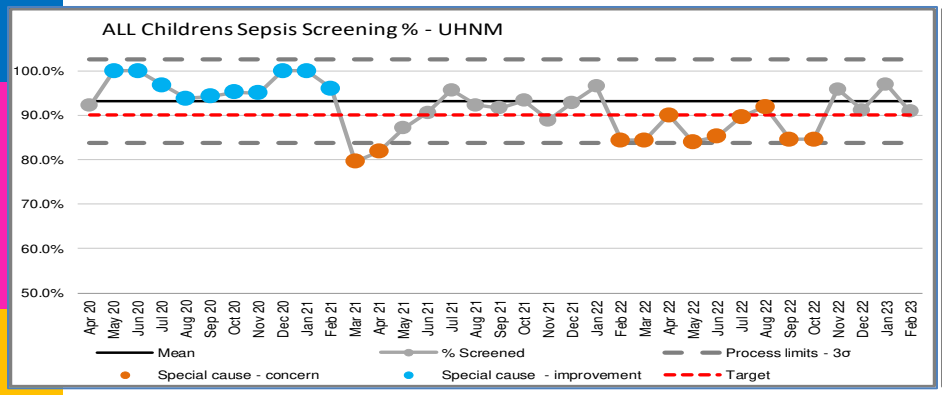

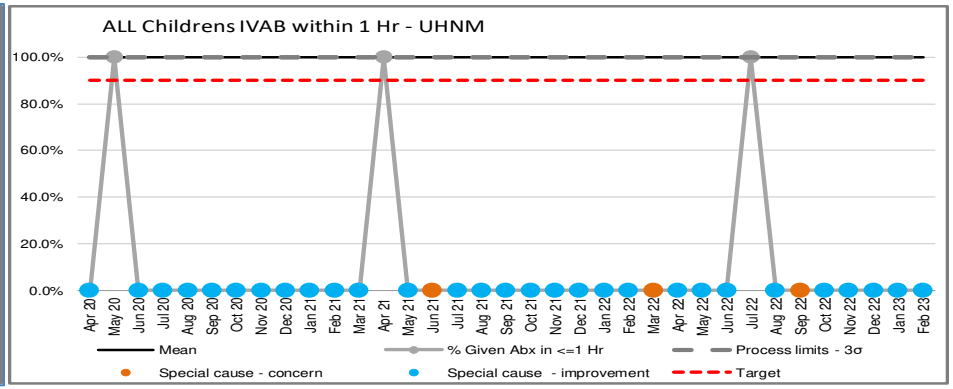

Variation	Assurance
	?

Target	Dec 22	Jan 23	Feb 23
90%	91.2%	97.0%	90.9%

Background

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

Variation	Assurance
H	P

Target	Dec 22	Jan 23	Feb 23
90%	N/A	N/A	N/A

Background

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

What is the data telling us:

Children's Services show normal variation and higher than target of 90%. Still seen small numbers of children trigger with PEWS > 5 & above in Inpatients areas.

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).

There were 33 cases audited for emergency portals with 1 missed screening (from CAU). No red flags were identified from the randomise audits. None was identified trigger with PEWS 5> in Inpatients areas during audits.

Actions:

- The Sepsis Team will continue to deliver sepsis drop in session (ward base training) as well as providing sepsis Induction session for newly qualified staff
- The Sepsis Team has continued to adjust the audit process in emergency portals to take smaller samples over a wider range of dates to give a more comprehensive perspective; on-going
- Plan of collaborative work with Children education lead and aiming to deliver 3-5 hour Sepsis CPD champion training and ward based sessions: on- hold but plan to reinstate in the next few months

Operational Performance

2025 Vision "Achieve NHS Constitutional patient access standards"

Spotlight Report from Chief Operating Officer

NHS
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NHS Trust

Urgent & Emergency Care

- February saw an improvement in the majority of the Urgent & Emergency Care metrics against a backdrop of reduced attendances and significantly fewer IP restrictions. Industrial Action has been on-going with several days of actions taking place within the month.

    - Four Hour performance increased again from 64% to 66%, the highest performance since Summer 2021
    - 12 Hour Trolley Waits in the ED decreased from approximately 1000 to 690
    - ED WTBS remained static around 100 minutes with performance in February at 97 minutes
    - 12+ Hours In ED drastically improved to 1618, the highest performance again since Summer 2021

Cancer

- Trust overall 2WW Performance achieved 97% in January – a sustained achievement since last month.
- The Trust also predicted to achieve the 2WW in February. This sustained improvement is as a result of schemes such as the Lower GI Community Referral hub and Community Teledermatology pathways being successfully implemented.
- Breast symptomatic (where cancer is not suspected) has also achieved at 93% in January.
- The 62 Day Standard achieved better than predicted in January at 47%. The current provisional position for February is 45%. This is an un-validated and incomplete position that is expected to change as pathology confirms or excludes cancer for treated patients. Contributing factors include treatment and diagnostic capacity, with robust plans in place to tackle the most challenged specialties (Skin & LGI) over the next quarter.
- The 31 Day Standard achieved 86% for January and is predicted to land at 88% in February.
- The 31 day Subsequent Radiotherapy achieved the standard in January at 95% and is expected to achieve again in February.
- The 28 Day Faster Diagnosis Standard for all referrals was reported at 61.4% in January.
- The 28 Day Faster Diagnosis Standard for 2WW referrals in February is currently being validated as histology reports confirm or exclude cancer.
- The 28 Day Faster Diagnosis Standard for Breast and Gynae Screening is predicted to achieve the FDS in February.
- Suspected Breast Cancer, Skin and Lower GI continue to book 2WW referrals within 7 days, for first appointments.
- The backlog has reduced since last month and total PTLs in Skin and LGI has significantly reduced.
- In August the PTL was over 6000 – this has now **reduced by around 2500** patients to around 3500 in total.

Spotlight Report from Chief Operating Officer

NHS
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Planned Care

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

- Day Case activity and Elective Activity have moved from delivering 99% and 101% in January to 97% and 100% respectively for February. A small decrease due to winter pressures, but early indications show that the trust was on course to reach 112% elective activity for March before IA impact. There is a real focus on the reintroduction of 6-5-4 with support from the regional theatres team. Day case as a % of all elective work is currently 86.3%.
- The focus has moved to 78 week waiters with an Annual Plan to reduce them to below 300 patients by March 2023. The major change will be managing the non-admitted (Outpatient) patients to ensure they get a decision to treat or discharge as soon as possible so any treatment can be carried out to meet the 78 week standard. This is currently predicted not to achieve with the actual number for the end of March pre mitigation 676.

RTT

- The overall Referral To Treatment (RTT) Waiting has decreased from 77,991 January to 77,148 in February.
- The number of patients > 52 weeks has decreased for the first time since summer 2022 4377 in August, 4,569 in September, 4628 in October, 4979 in November, 5318 in December, 5,389 in January and now 5,122 in February.
- At the end of February the numbers of >104 patients was 69. An increase of 6 from the end of January (albeit largely different patients).
- The Trust has continued to achieve the national standard of all eliminating all 104 week waits purely due to capacity, there is considerable work now on the Trusts route to zero for 104 week waiting patients, with challenges around complex pathways, patient choice and fitness for treatment. The Trust remains challenged in the delivery treating all patients waiting over 104 weeks, and the current unmitigated risk for the end of March is 64.

Diagnostics Summary

- During February the reported activity for Diagnostics fell to 98% when compared with 19/20 BAU.
- DM01 performance was 74%, an improvement compared to 66% in January. Non-obstetric ultrasound while still not meeting target have shown considerable improvements, however Endoscopy remains a concern.

Histology position – as at 16th February:

- Urgent (diagnostic cancer and other very urgent biopsy specimens): 95% reported at Day 25 (previously Day 32), 80% reported by Day 13
- Accelerated (include all Cancer Resections): 95% reported at Day 52 (previously Day 46), with 80% reported by Day 33 (previously Day 37)
- Routine (all Specimens not in above categories): 95% reported at Day 54 (previously Day 57),
- 80% of cases reported by Day 32 (Previously day 45)

Radiology reporting backlog:

- High risk relating to 'routine / non cancer reporting' due to reporting capacity and delays in diagnosis Risk 25512 remains at score - 20

Endoscopy:

- Improvement plan being developed and there are now weekly performance meeting for this service

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Section 1: Urgent Care

Headline Metrics

Urgent Care – monthly *(context)*

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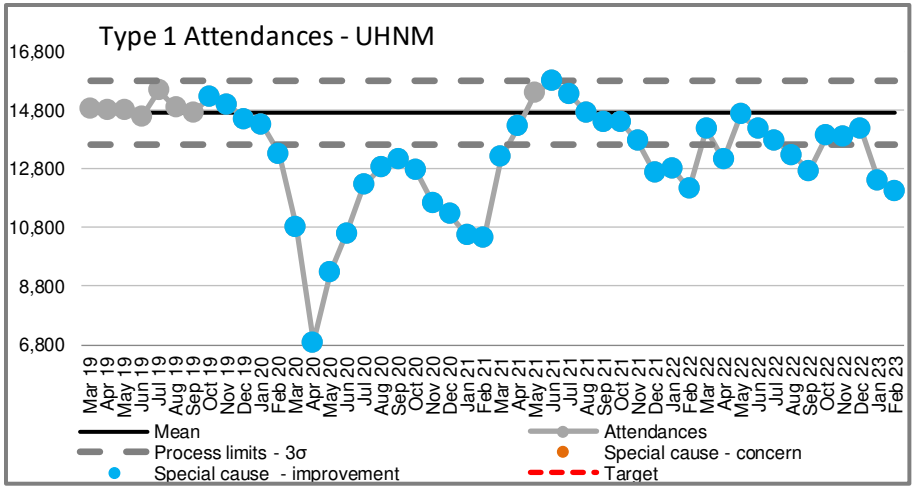
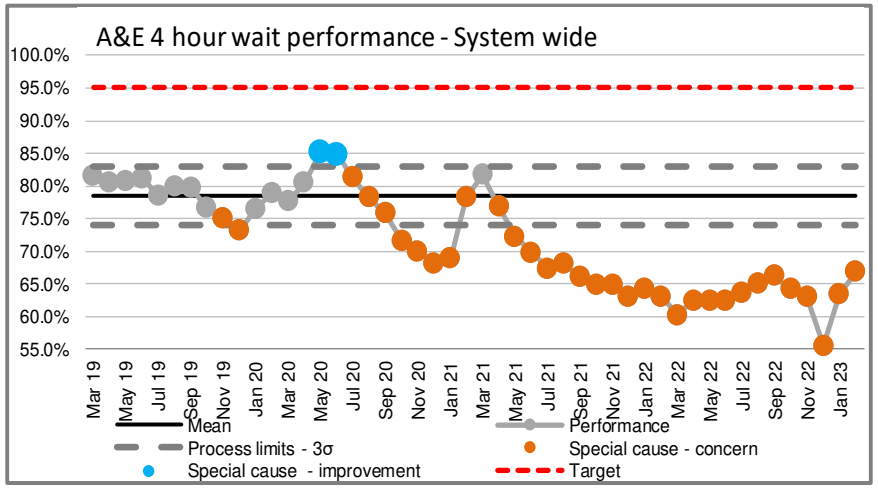
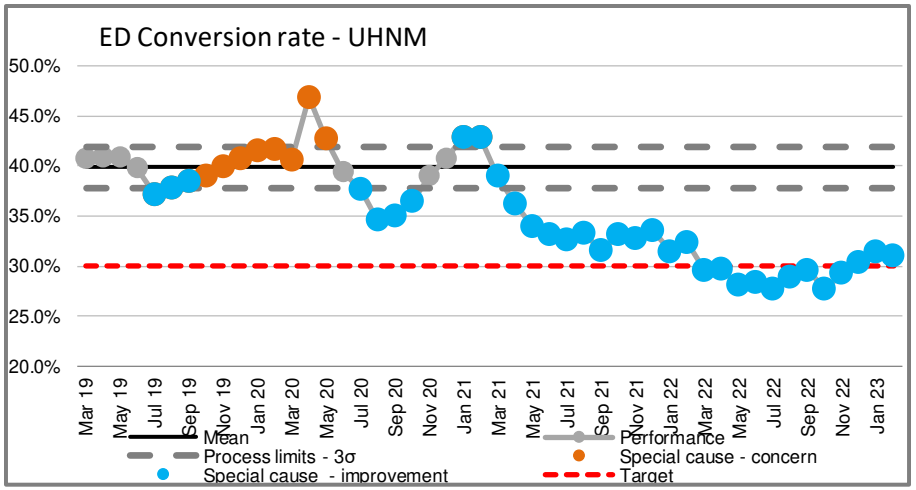
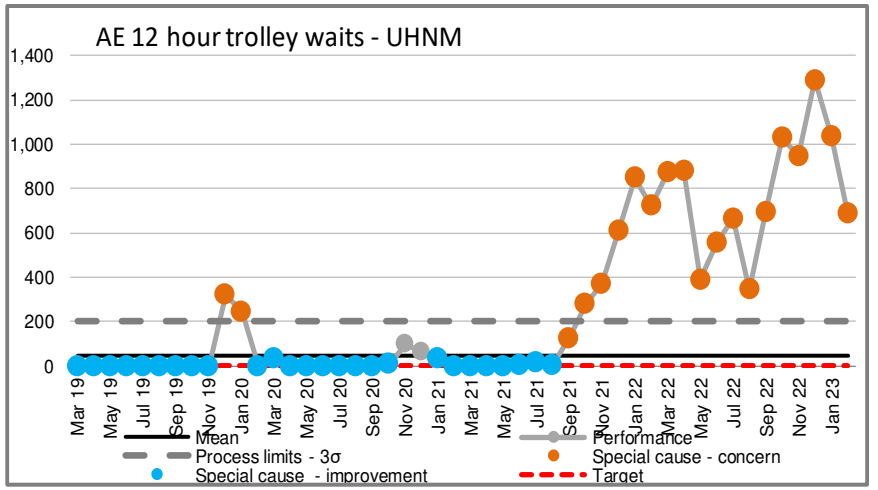


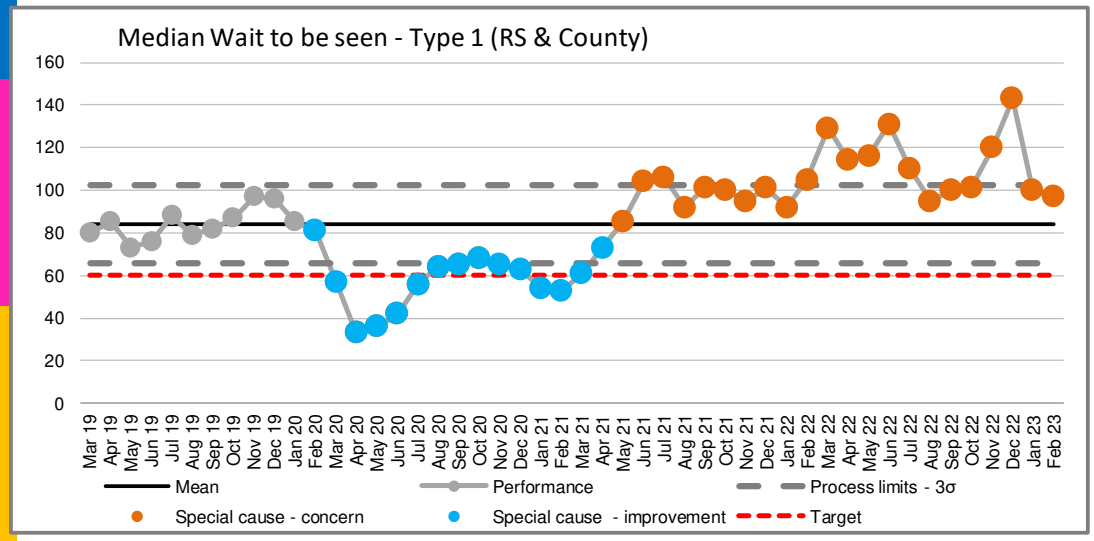






Delivering Exceptional Care with Exceptional People

WTBS & 12 Hour in department



Variation	Assurance
H	F

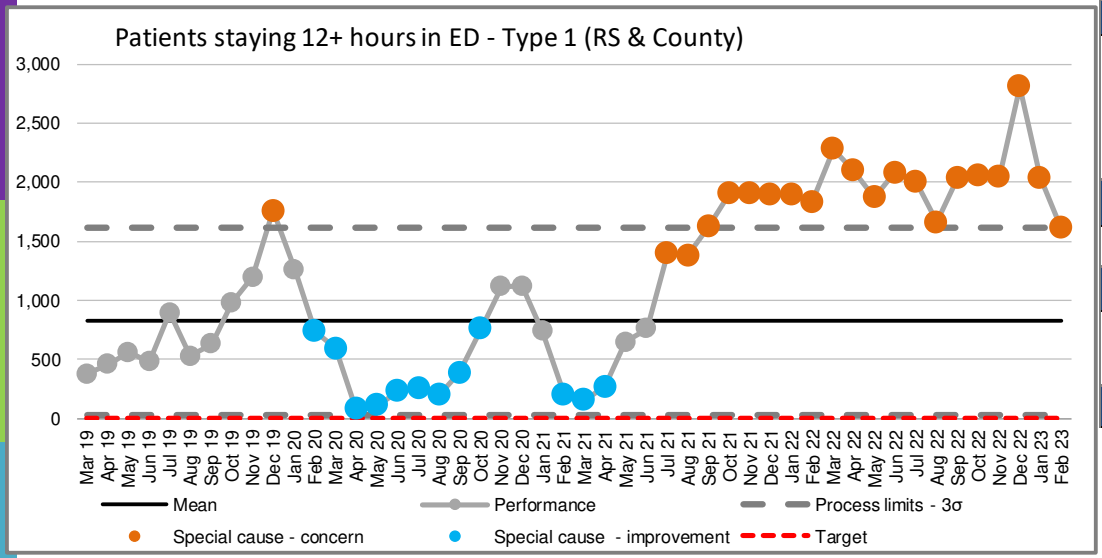
Target	Dec 22	Jan 23	Feb 23
60	143	100	97

Background

The average (median) time in minutes for a patient to be first seen

What is the data telling us?

Median wait to be seen has reduced down to within the upper control limit.



Variation	Assurance
H	F

Target	Dec 22	Jan 23	Feb 23
0	2810	2038	1618

Background

The number of patients admitted,transferred or discharged over 12 hours after arrival at A&E

What is the data telling us?

Volumes in February are back within the upper control limit.

Urgent Care – Time to Treatment

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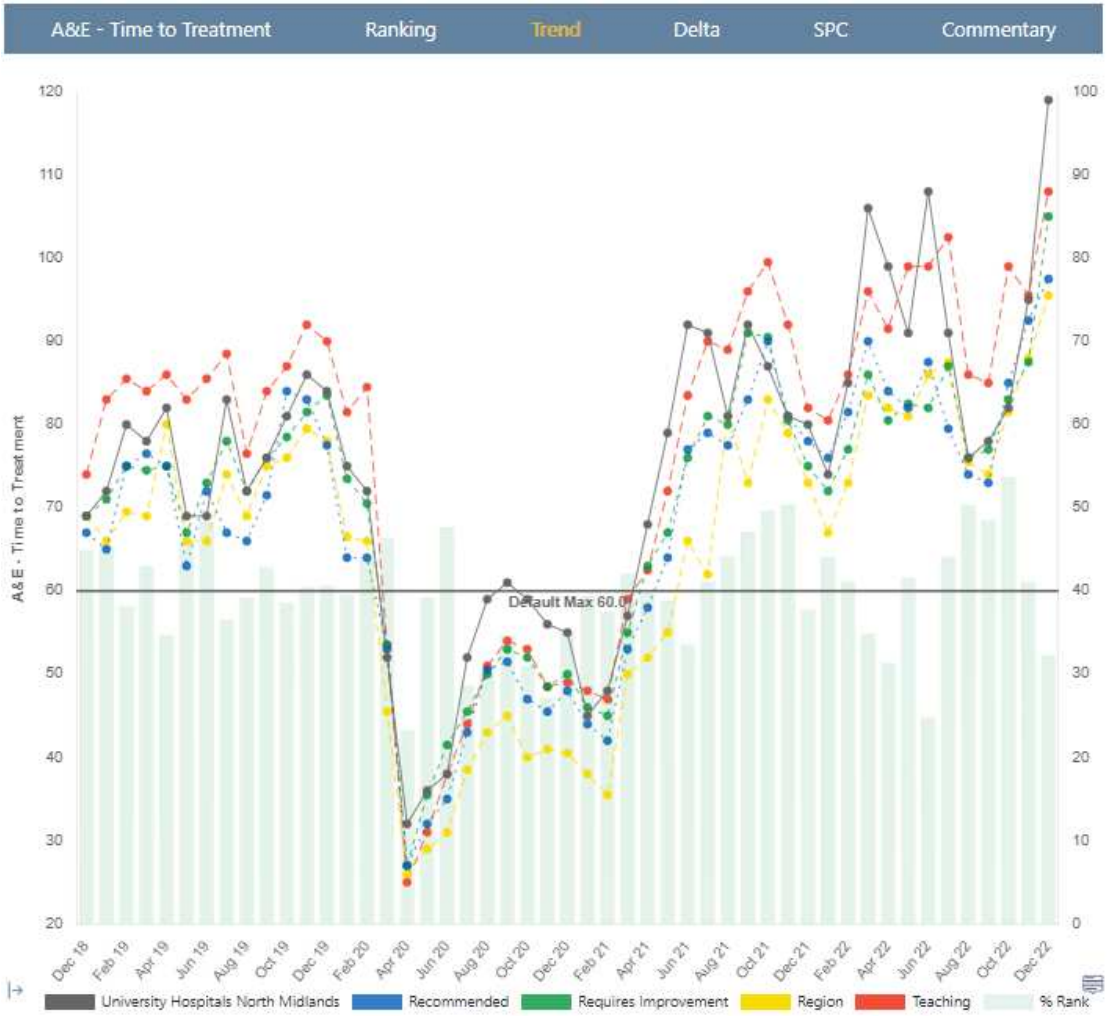
Key Performance Indicator

Key Performance Indicator	Period	Target		SPC	
A&E - 4 Hour Standard	Dec 22	95.00%	55.6%	L	27
A&E - 4 Hour Standard (Type 1)	Dec 22	95.0%	36.4%	L	7
A&E - 4 Hour Standard (Type 2...	Dec 22	95.0%	83.3%	L	19
A&E - Conversion Rate	Dec 22	25.0%	22.0%	L	30
A&E - DTA to Admission >12 H...	Dec 22	0.0%	24.4%	H	27
A&E - DTA to Admission >12 H...	Dec 22	0.0	1,289.0	H	3
A&E - DTA to Admission >4 Ho...	Dec 22	10.00%	39.6%	H	63
A&E - Left Without Being Seen	Dec 22	5.00%	10.7%	C	18
A&E - Reattendance Rate	Dec 22	5.0%	9.4%	H	17
A&E - Time to Initial Assessment	Dec 22	15.0	11.0	H	52
A&E - Time to Treatment	Dec 22	60.0	119.0	H	32
A&E - Total Time in A&E	Dec 22	160.0	222.0	H	54
A&E - Total Time in A&E (Admi...	Dec 22	180.0	502.0	C	51
A&E - Total Time in A&E (Non-...	Dec 22	140.0	200.0	C	48



- Time to treatment pre pandemic was in line with peers
- Throughout 2022 UHNM have generally been higher than all peer groups.

Urgent Care – DTA waits over 12 hours

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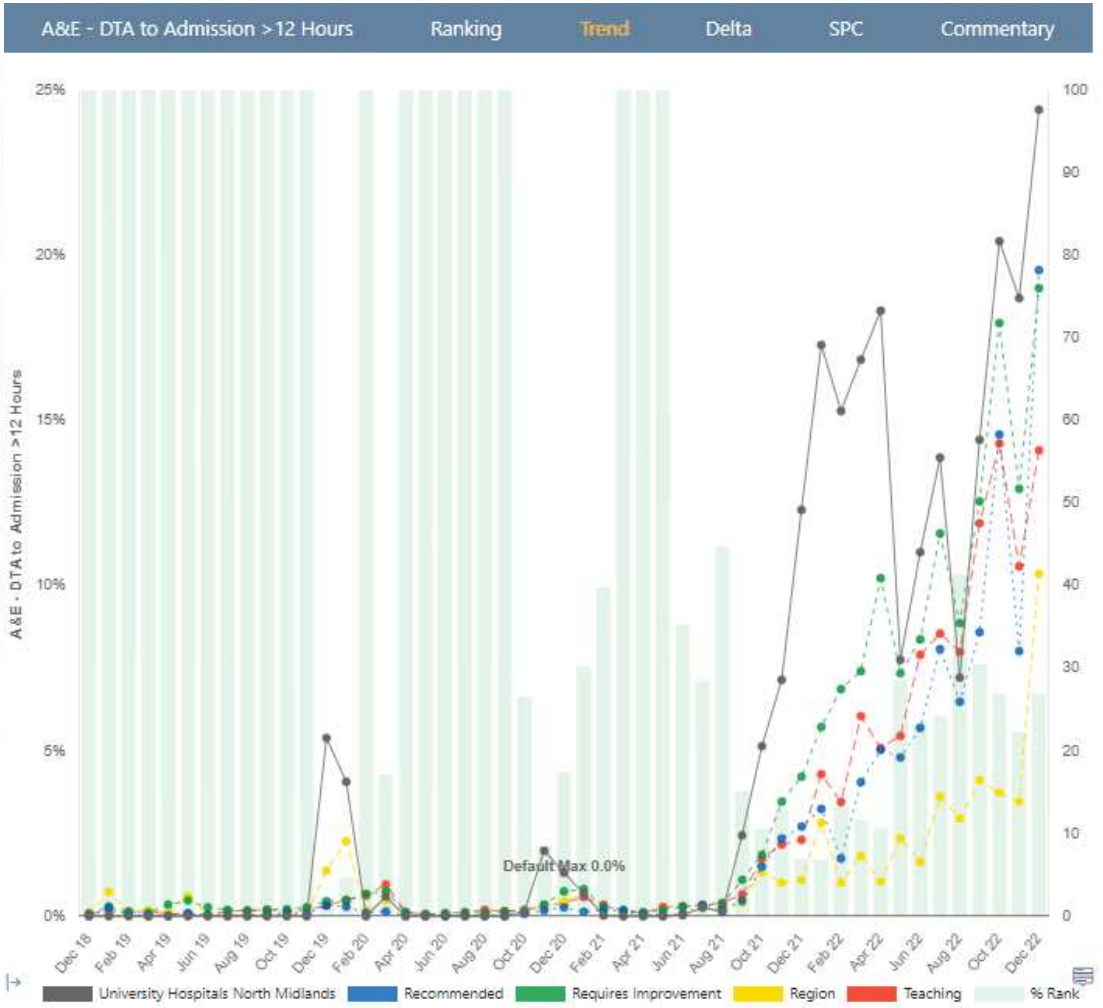
NHS Trust

Key Performance Indicator

Key Performance Indicator	Period	Target		SPC	
A&E - 4 Hour Standard	Dec 22	95.00%	55.6%		27
A&E - 4 Hour Standard (Type 1)	Dec 22	95.0%	36.4%		7
A&E - 4 Hour Standard (Type 2...	Dec 22	95.0%	83.3%		19
A&E - Conversion Rate	Dec 22	25.0%	22.0%		30
A&E - DTA to Admission >12 H...	Dec 22	0.0%	24.4%		27
A&E - DTA to Admission >12 H...	Dec 22	0.0	1,289.0		3
A&E - DTA to Admission >4 Ho...	Dec 22	10.00%	39.6%		63
A&E - Left Without Being Seen	Dec 22	5.00%	10.7%		18
A&E - Reattendance Rate	Dec 22	5.0%	9.4%		17
A&E - Time to Initial Assessment	Dec 22	15.0	11.0		52
A&E - Time to Treatment	Dec 22	60.0	119.0		32
A&E - Total Time in A&E	Dec 22	160.0	222.0		54
A&E - Total Time in A&E (Admi...	Dec 22	180.0	502.0		51
A&E - Total Time in A&E (Non-...	Dec 22	140.0	200.0		48



- The percentage of patients waiting over 12 hours from the point of DTA has been much higher for UHNM than peers since September 21.
- During quarter 3 UHNM continue to be above peers.

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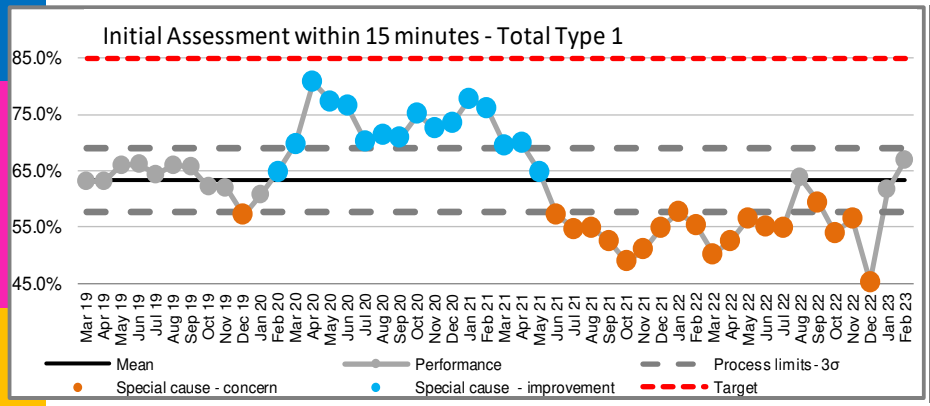
Section 1: Urgent Care

Workstream 1; Acute Front Door

Time To Triage, Ambulance Handover, & Non Admitted Average Time

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
	F

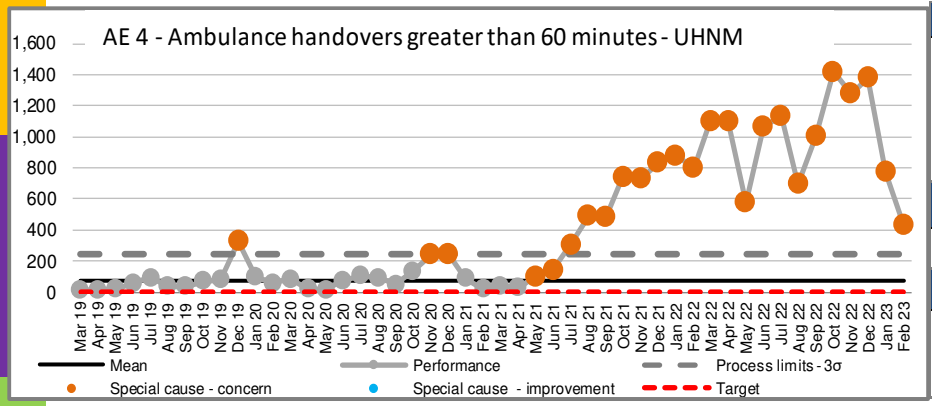
Target	Dec 22	Jan 23	Feb 23
85%	45.2%	61.6%	66.9%

Background

The Percentage of patients attending Type 1 A&E, triaged within 15 minutes of arrival

What is the Data telling us?

Performance in February has reached the highest level since April 2021.



Variation	Assurance
H	?

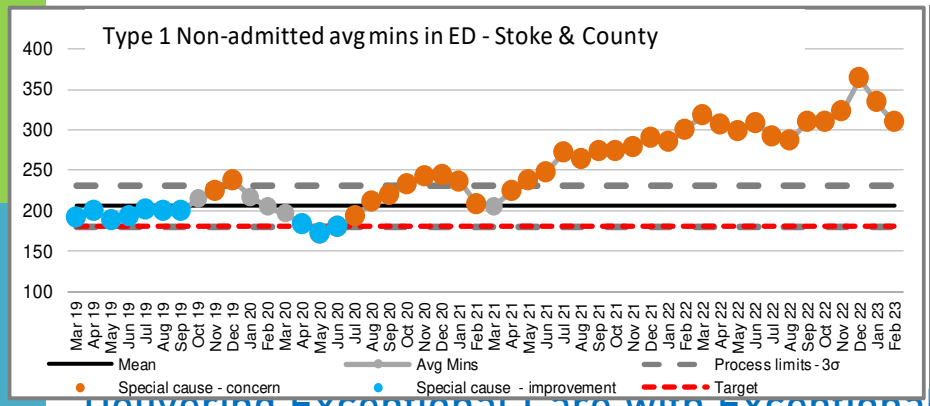
Target	Dec 22	Jan 23	Feb 23
0	1379	774	433

Background

The number of ambulance handovers greater than 60 mins

What is the Data telling us?

Handover delays over 1 hour continues to see improvements since the spikes during 2022.



Variation	Assurance
H	?

Target	Dec 22	Jan 23	Feb 23
180	364	334	309

Background

The mean time spent in A&E department for patients not admitted to an inpatient bed

What is the Data telling us?

Mean time in department has also seen an improvement in February, but still remains high.

Time To Triage, Ambulance Handover, & Non Admitted Average Time

University Hospitals of North Midlands NHS Trust

Summary

- Time to Initial Assessment improved to 66.9% in February from 61.6% in January. This was the highest performing month since April 2021. County Hospital triage performance was at the highest it has been in 14 months at 68.0% for February.
- Ambulance Handovers remain a challenge but those over 60 minutes reduced to significantly from 774 January to 433 in February. This is again a continued and significant improvement and is the lowest number of holds since June 2021.
- The Non-Admitted Average Time In ED reduced from 334 minutes in January to 309 in February. While this represents an improvement month on month, further work is required as this is well above target levels. This will be targeted as part of the Workstream 1 focus on achieving 76% Four Hour Performance.

Actions

- Workstream 1 meetings continue to be stood down due to Industrial Actions. However, informal meetings have taken place to update the Workstream 1 A3 and support identification of the next tranche of counter measures.
- Work has begun under the leadership of the ED Clinical Lead on the non-admitted Four Hour Standard with a particular focus on overnight performance.
- There has been an update to the Escalation SOP supported by the an increase in senior oversight focussing on Ambulance Handovers, the Four Hour Standard, and 12 Hour Trolley Waits to ensure senior intervention earlier as challenges arise.
- Conversations are on going with Totally (formally Vocare) to relocate the GPOOH service alongside EhPC from the CDC building. The date for this move has now been set for 22/03/23.

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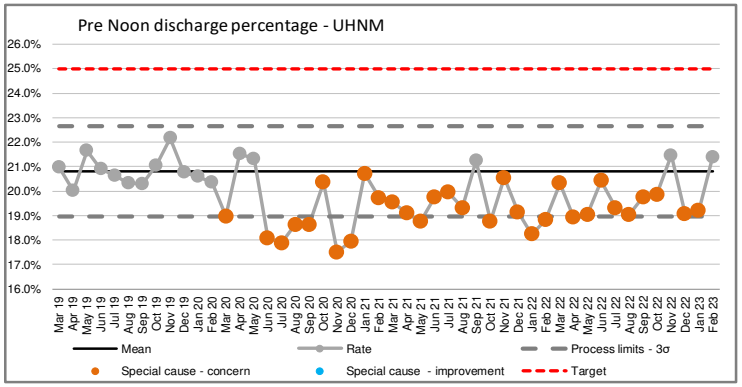
Section 1: Urgent Care

Workstream 2; Acute Patient Flow

Pre-Noon, Simple & Timely, & Occupancy

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
	F

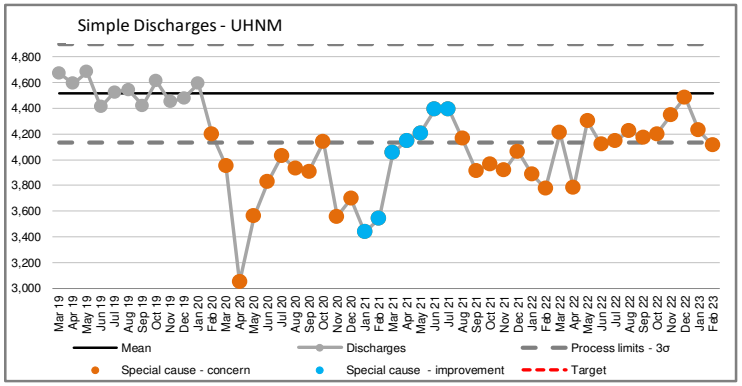
Target	Dec 22	Jan 23	Feb 23
25%	19.1%	19.2%	21.4%

Background

The percentage of discharges complete before 12 noon.

What is the data telling us?

Pre noon discharges in February exceeded the two year average, but still remain below target at 21.4%.



Variation	Assurance
L	

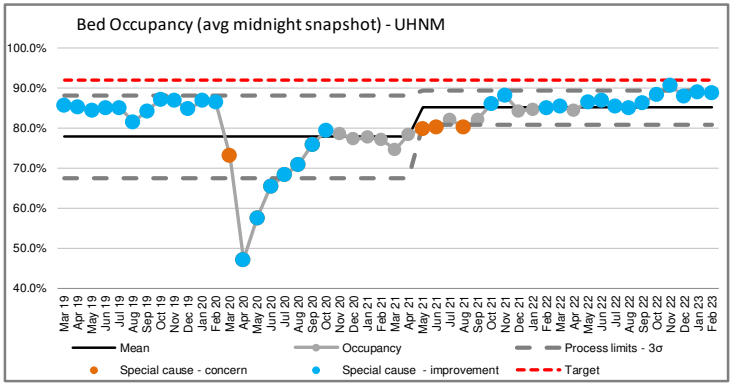
Target	Dec 22	Jan 23	Feb 23
N/A	4488	4231	4112

Background

Patients discharged without complex needs

What is the data telling us?

Simple discharges in February have dropped to below the lower control limits.



Variation	Assurance
H	F

Target	Dec 22	Jan 23	Feb 23
92%	87.9%	89.0%	88.8%

Background

The percentage of general and acute beds occupied overnight at UHNM

What is the data telling us?

Bed Occupancy levels remain above the two year average.

Pre-Noon, Simple & Timely, & Occupancy

University Hospitals of North Midlands NHS Trust

Summary

- Pre-Noon Discharges improved significantly from 19.2% in January to 21.4% in February. This represents only the third time since May 2020 that a performance above 21.0% has been achieved.
- The number of Simple & Timely Discharges deteriorated again from 4231 in January to 4112 in January. While this is poorer performance; lower attendances, lower conversion rates, and an improved MFFD position supported the overall improvement in performance seen from January to February.
- Bed Occupancy remained relatively stable moving from 89.0% in January to 88.8% in February. Bed Occupancy featured heavily in the National UEC Recovery Plan and so work is currently underway to ensure our reported figures are both accurate and relevant, for example not including day case capacity in this figure.

Actions

- Following the release of the UEC Recovery Plan work remains ongoing as part of the Annual Plan process driven by intended heightened scrutiny of occupancy as a key performance indicator. It is critical to ensure that occupancy is reported for the adult G&A inpatient bed base so as not to give a falsely inflated position.
- UHNM has now received confirmation that is has been placed in the highest priority group for funding allocation to build additional acute bedded capacity and so a Task & Finish Group has been established. This group has begun to start work on how exactly we would implement the proposed SDEC Modular structure which would release in excess of 40 adult G&A inpatient beds (there by improving occupancy).
- The Regional Productivity Team update is still awaited and has now been escalated. This will focus on frailty pathways (both SDEC and admitted pathways), and Simple & Timely discharge optimisation.

Section 1: Urgent Care

Workstream 3; Delivering UEC Standards

CRPT+1, SDEC Utilisation, & Mean Time In ED

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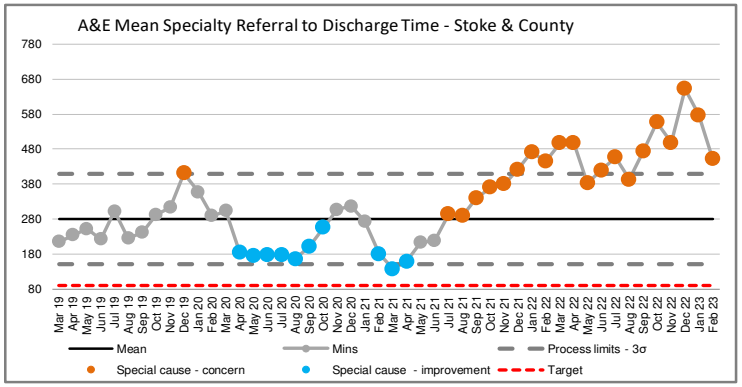


Variation	Assurance
H	F

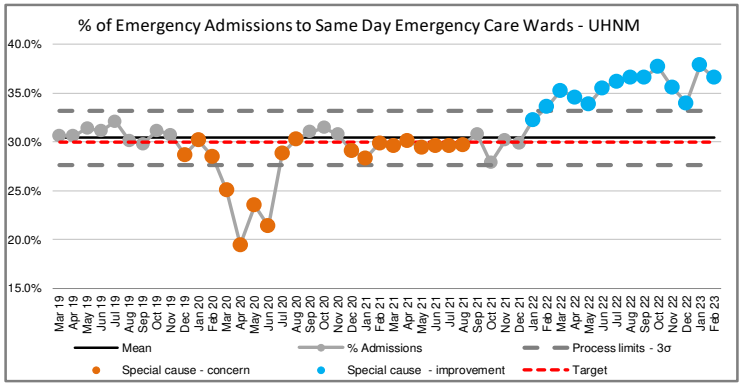
Target	Dec 22	Jan 23	Feb 23
90	653	577	453

Background

The average time from the ED referral to a specialty to discharge from the ED

What is the data telling us?

The average time from referral to discharge continues to see an improving trend, but still remains outside of the normal variation levels.



Variation	Assurance
H	?

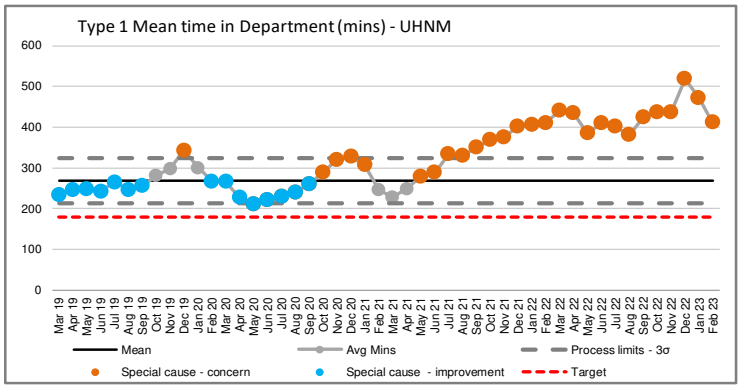
Target	Dec 22	Jan 23	Feb 23
30%	34.0%	37.8%	36.6%

Background

% of emergency admissions that are admitted to the Trust's SDEC wards, and discharged within 24 hours

What is the data telling us?

The Trust has been consistently above the upper control limits since January 2022.



Variation	Assurance
H	F

Target	Dec 22	Jan 23	Feb 23
180	518	473	412

Background

The mean time (in minutes) spent in the A&E department

What is the data telling us?

Total time in department continues to see an improving trend, but still remains outside of the normal variation levels.

CRTP+1, SDEC Utilisation, & Mean Time In ED

NHS University Hospitals of North Midlands NHS Trust

Summary

- Mean Specialty Referral To Discharge Time improved again from 577 minutes in January to 453 minutes in February. Throughout Industrial Actions escalation to specialty teams to attend the ED has been anecdotally more timely as a result of increased senior medical and operational presence and this has undoubtedly continued to contribute to this reduction.
- SDEC Utilisation decreased slightly from 37.8% in January to 36.6% in February. However, this still represents a relative high point in an overall improvement trend.
- The Mean Time In ED for all patients also decreased from 470 minutes in January to 412 minutes in February. This continues performance from December to January and continuing reduced IP restrictions across the bed base and an reduction in MFFD numbers resulting in improved flow throughout the Trust.

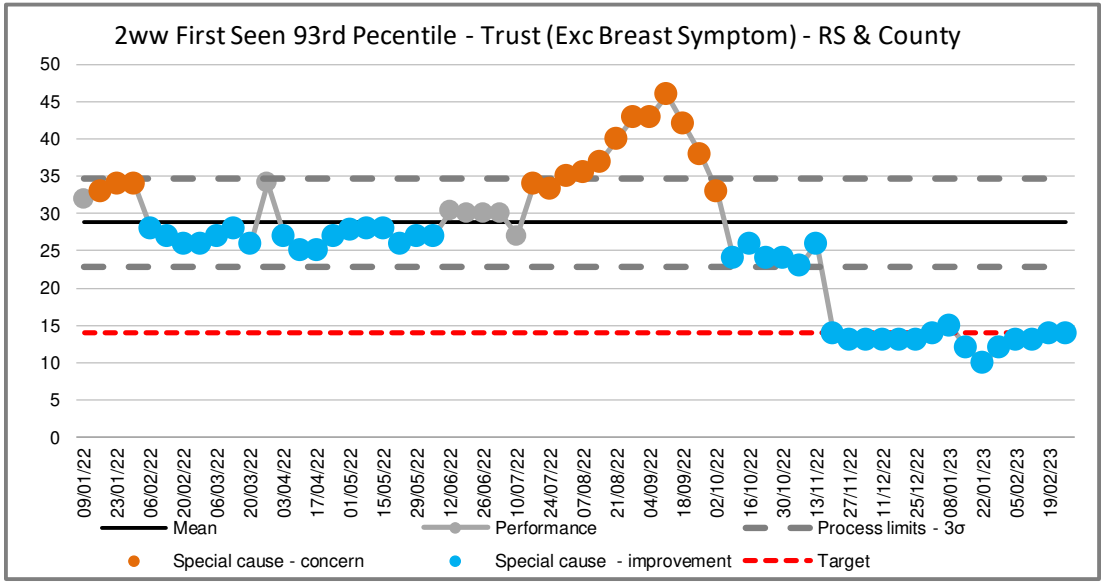
Actions

- The Front Door Reconfiguration was completed on 23/01/23. SDU has moved to its new footprint on Ward 126 but requires 12 weeks of minor works to provide the full footprint of the portal. Engagement with medical leadership as to how the potential of this space can be maximised has commenced and updates will be tracked through Workstream 3.
- It has been identified that there are a small number of specialised surgical pathways (predominantly Max Fax, ENT, and Plastics) that still do not adhere to the Referral & Admission SOP. This is scheduled to be addressed with the Divisional Medical Director in March.
- WMAS direct access to Trust wide portals and SDEC areas is under review as part of Workstream 3 to ensure appropriate and highly utilised access.

Section 2: ELECTIVE CARE

Cancer – Headline metrics

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

Target	12/02/2023	19/02/2023	26/02/2023
14	13	14	14

Background

The standard is for 93% of patients to be seen within 14 days. This SPC demonstrates within which day 93% of patients were seen on across all tumour sites.

What is the data telling us?

Trust wide – all suspected cancer 2WW referrals. Excluding Breast symptomatic referrals where cancer is not suspected.
93 % of patients first seen for the last week in January had a 14 day clock stop within day 12 of the pathway.
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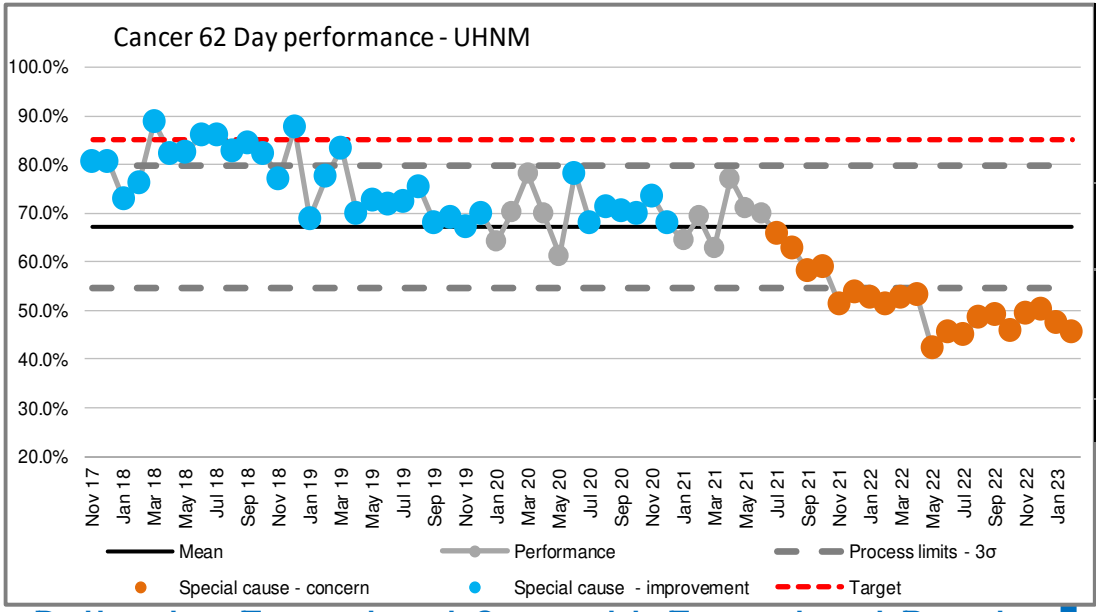


Variation	Assurance
	

Target	Dec 22	Jan 23	Feb 23
85%	50.2%	47.6%	45.6%

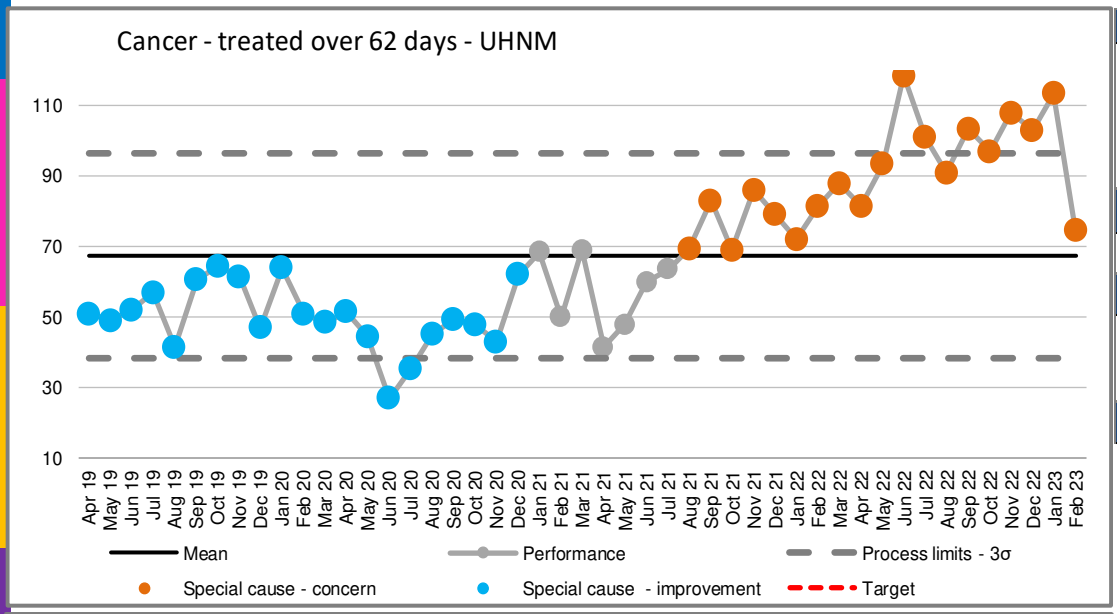
Background

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

What is the data telling us?

Performance significantly challenged and below standard for the past 12 months with a steep decline in May and landed at 47-% for January

Cancer - Headline metrics



Variation	Assurance
	

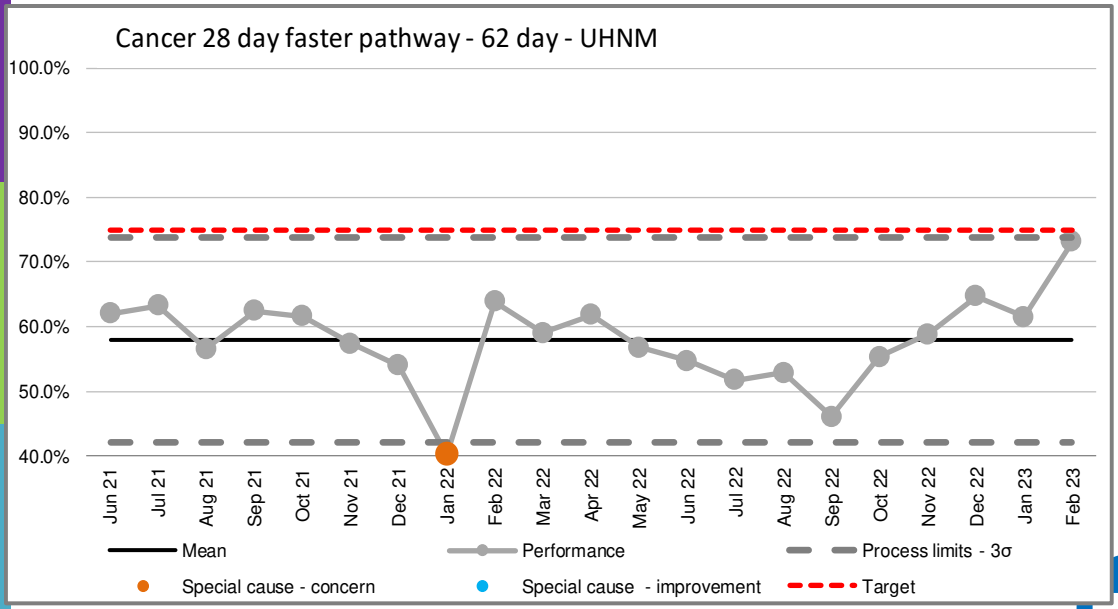
Target	Dec 22	Jan 23	Feb 23
N/A	103.0	113.5	74.5

Background

The number of patients treated over 62 days

What is the data telling us?

Demonstrates total volume of patients who have been treated beyond day 62 is a cause for concern and has been rising over the past 12 months. As the trust clears and treats the backlog of patients waiting, this metric is expected to further decline before improving.



Variation	Assurance
	

Target	Dec 22	Jan 23	Feb 23
75%	64.7%	61.5%	73.2%

Background

Performance of confirmation or exclusion of cancer communicated with patients within the 28 day timeframe.

What is the data telling us?

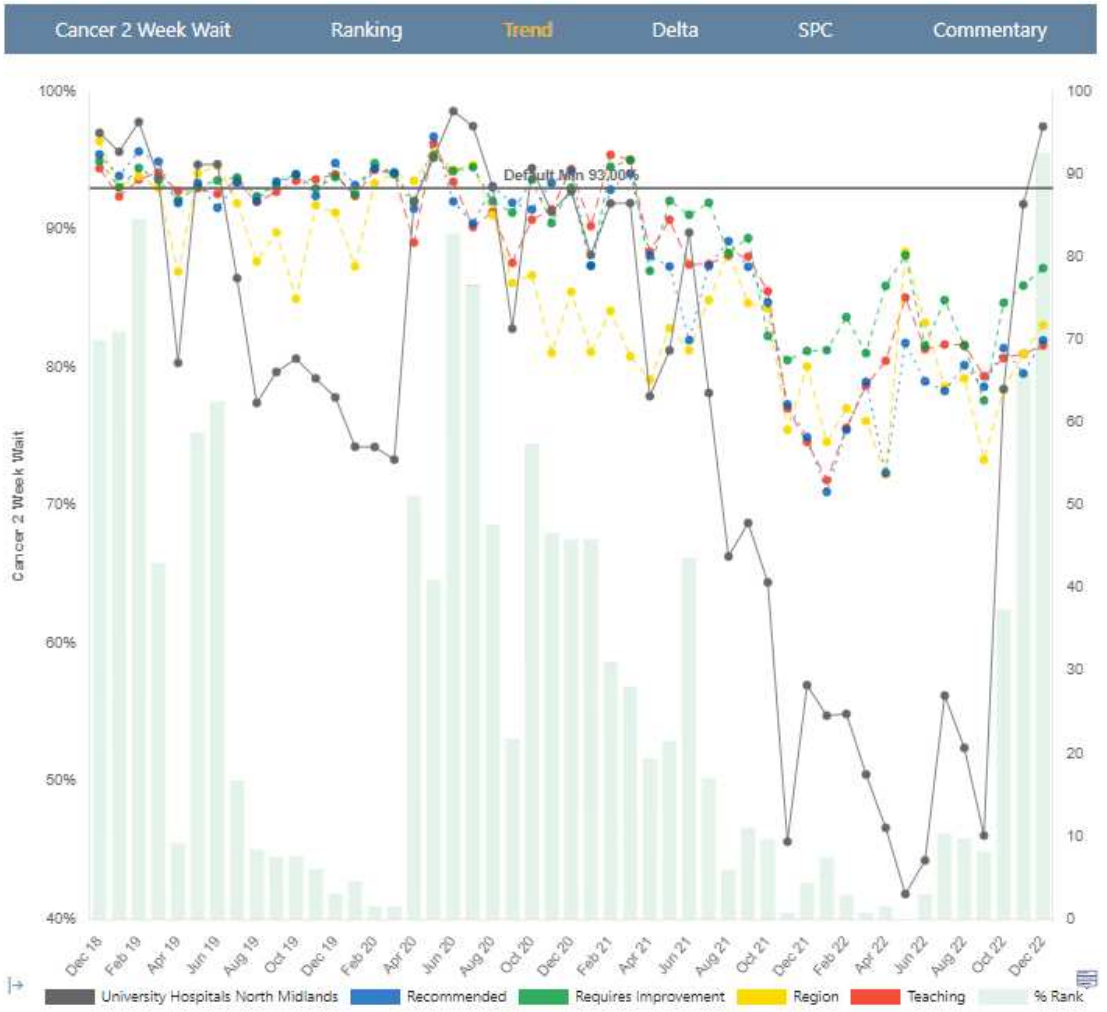
The FDS performance remains stable with pockets of good practice. E.g. Breast, Lung and Upper GI all achieve the standard . The January position landed at 61.4%

Cancer – benchmarked

NHS University Hospitals of North Midlands NHS Trust

Key Performance Indicator

Key Performance Indicator	Period	Target		SPC	
Cancer 2 Week Wait	Dec 22	93.00%	97.5%	C	93
Cancer 2 Week Wait Breast Sym...	Dec 22	93.0%	90.1%	C	54
Cancer 31 Day First Treatment	Dec 22	96.00%	86.9%	L	12
Cancer 31 Day Subsequent Trea...	Dec 22	96.0%	93.9%	L	39
Cancer 62 Day All Sources	Dec 22	85.00%	63.7%	L	30
Cancer 62 Day Consultant Upgr...	Dec 22	85.0%	85.7%	L	69
Cancer 62 Day Screening	Dec 22	90.0%	87.0%	C	66
Cancer Sub Treat Drugs	Dec 22	96.0%	100%	C	100
Cancer Sub Treat Radiotherapy	Dec 22	96.0%	95.8%	C	38



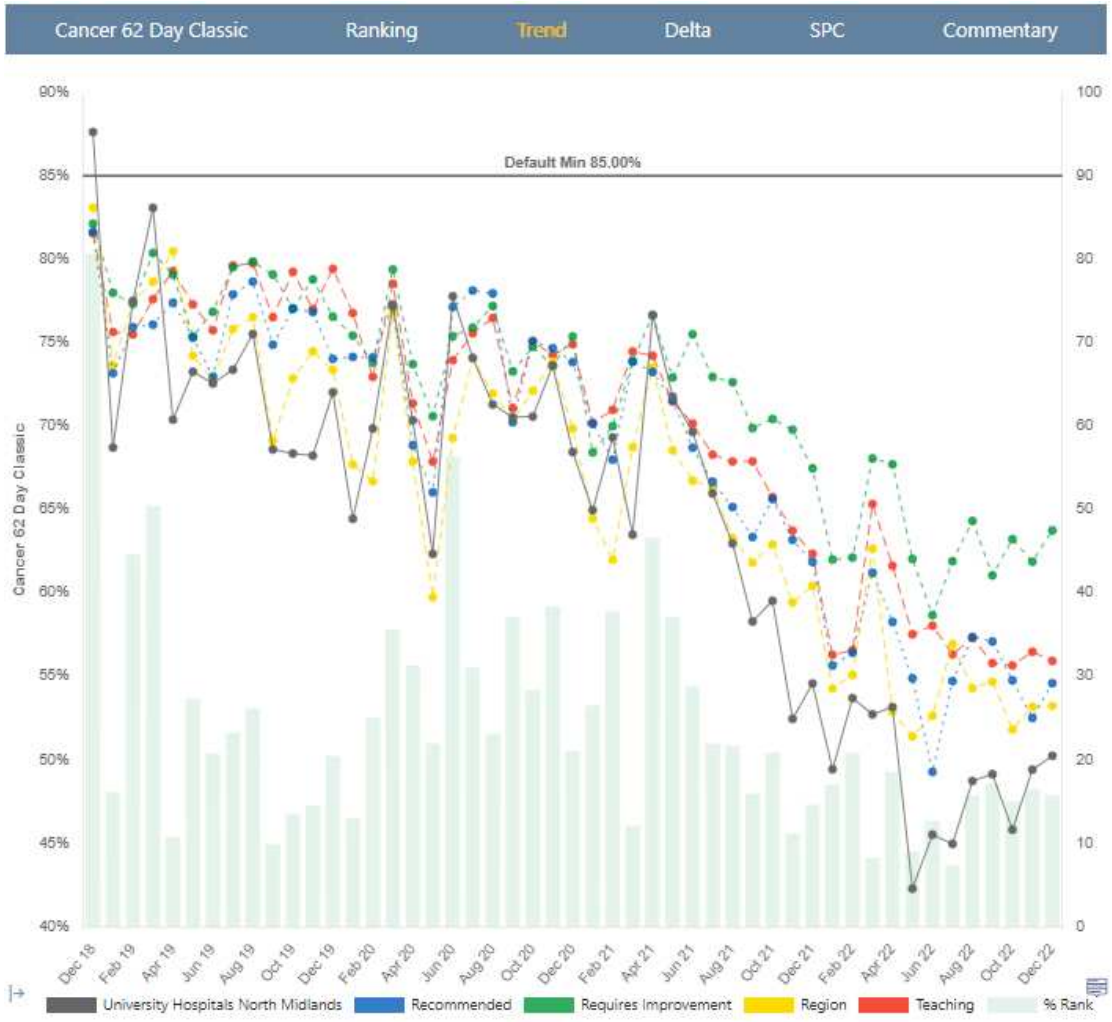
- UHNM saw 14 day performance deteriorate around July 2021.
- Since November 2022 UHNM performance has been above all peer groups and in December achieved target.

Cancer - Benchmarked

NHS
University Hospitals of North Midlands
NHS Trust

Key Performance Indicator

Key Performance Indicator	Period	Target		SPC	
Breast Cancer	Dec 22	85.00%	63.6%		23
Cancer 62 Day Classic	Dec 22	85.00%	50.2%		16
Lower Gastrointestinal Cancer	Dec 22	85.00%	20.0%		16
Lung Cancer	Dec 22	85.00%	57.9%		53
Other Cancer	Dec 22	85.00%	38.0%		19
Skin Cancer	Dec 22	85.00%	62.3%		17
Urological Cancer	Dec 22	85.00%	60.2%		57



- Deterioration has been seen across all peer groups since August 2021 with UHNM seeing this more dramatically.
- Improvements have been made since May 22, however UHNM continue to struggle and remain lower than all peers.

Cancer

Key Performance Indicator

Key Performance Indicator	Period	Target		SPC	
Cancer - 28 Day Faster Diagnosis	Dec 22	75.0%	64.7%	C	18
FDS Acute Leukaemia	Dec 22	75.0%	-	C	-
FDS Brain Tumours	Dec 22	75.0%	-	C	-
FDS Breast Cancer	Dec 22	75.0%	96.1%	H	77
FDS Breast Symptoms	Dec 22	75.0%	97.4%	H	71
FDS Children's Cancer	Dec 22	75.0%	68.0%	L	18
FDS Gynaecological Cancer	Dec 22	75.0%	55.0%	L	30
FDS Haematological Malignanci...	Dec 22	75.0%	42.9%	C	31
FDS Head & Neck Cancer	Dec 22	75.0%	71.4%	C	32
FDS Lower Gastrointestinal Can...	Dec 22	75.0%	39.4%	C	21
FDS Lung Cancer	Dec 22	75.0%	80.5%	C	54
FDS Missing or Invalid	Dec 22	75.0%	-	C	-
FDS Other Cancer	Dec 22	75.0%	-	C	-
FDS Sarcoma	Dec 22	75.0%	80.0%	C	78
FDS Skin Cancer	Dec 22	75.0%	66.2%	C	12
FDS Testicular Cancer	Dec 22	75.0%	89.5%	H	57
FDS Upper Gastrointestinal Can...	Dec 22	75.0%	88.0%	H	90
FDS Urological Malignancies	Dec 22	75.0%	46.5%	L	32

- The 28 Day Faster Diagnosis position for UHNM has been lower than all peer groups since June 2021.
- Since September 2022, improvement have been made with December performance being much closer to peer groups.

Cancer Trajectories

University Hospitals of North Midlands NHS Trust

Provider Level					April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022	December 2022	January 2023	February 2023	March 2023
RJE	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	E.B.32	Count	The number of cancer 62-day pathways (patients with and without a decision to treat, but yet to be treated or removed from the PTL) waiting 63 days or more after an urgent suspected cancer referral excluding non-site specific symptoms	462	440	420	400	380	360	340	320	300	280	250	191
				UHNM snap-shot PTL position	579	632	639	815	1041	894	887	730	558	477	346	

National planning guidance 22/ 23 set out the ambition to return the number of patients waiting over 62 days on the live PTL to the levels seen pre-pandemic. The PTL Backlog trajectory for UHNM is set out above; the actuals shown above are a snap shot in time of the PTL position. This is for the week ending last full week of the month per PAF report.

For the month of February 2023, the backlog position was 346 - this includes patients with a decision to treat and a future treatment date scheduled. The majority of the backlog is attributable to Skin and Colorectal. High proportion of patients waiting over 62 days in both tumour sites have future scheduled treatment dates. A further improvement continues into the early weeks of February.

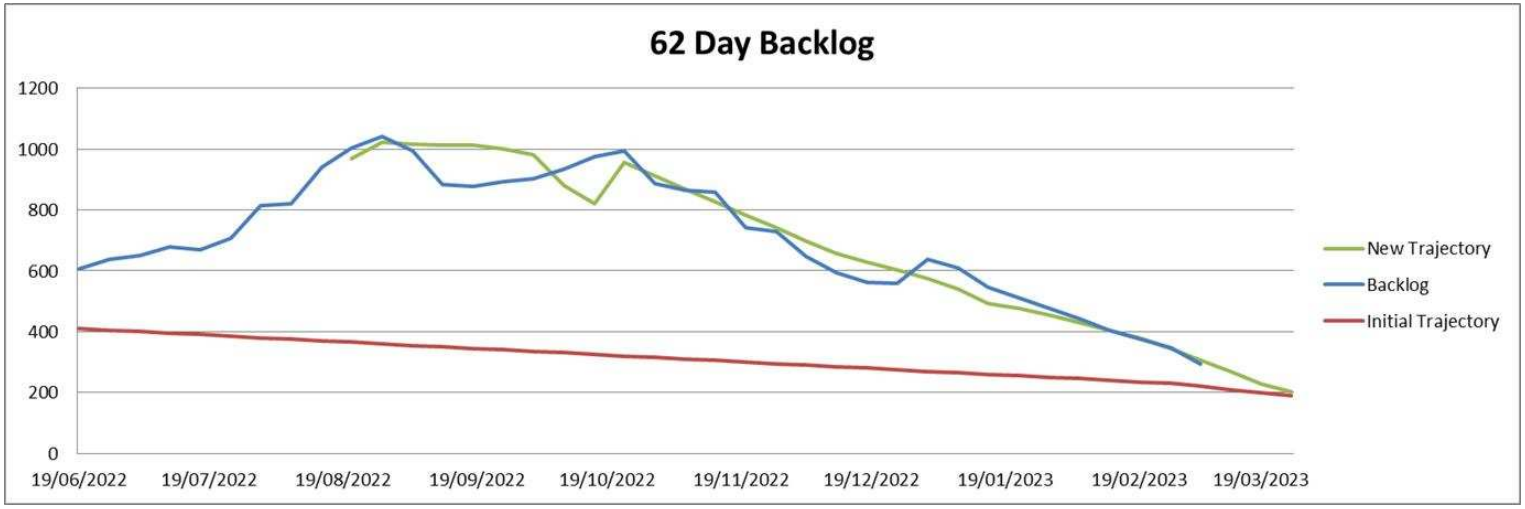
There are multiple contributing factors include delays to diagnostic reporting in pathology and imaging, urology robotic surgery capacity, oncology capacity, complex pathways, increasing element of patient choice and outstanding clinical reviews.

All divisions are focusing on the backlog and discharge patients where appropriate. Pathway plans are detailed overleaf – there is a concentration on the first appointments and diagnostics and treatments including Surgical and Oncology. All diagnostic modalities have submitted plans for a reduction in waiting times which includes additional staffing, insourcing and outsourcing and building additional capacity through CDC's.
Intensive exec level support is being provided to Skin and Colorectal pathways, which are the main drivers for the backlog position.

Cancer

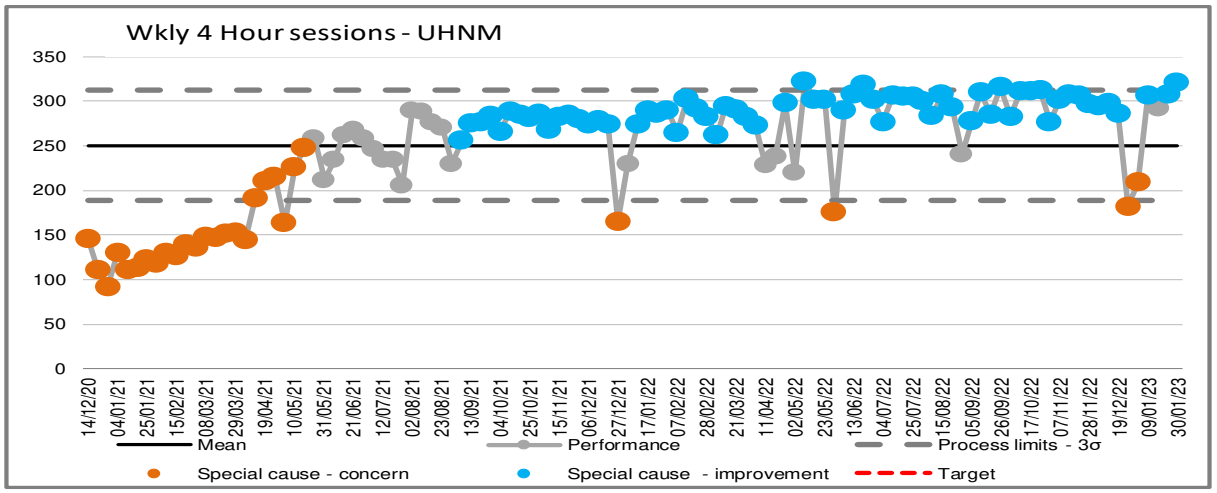
Actions

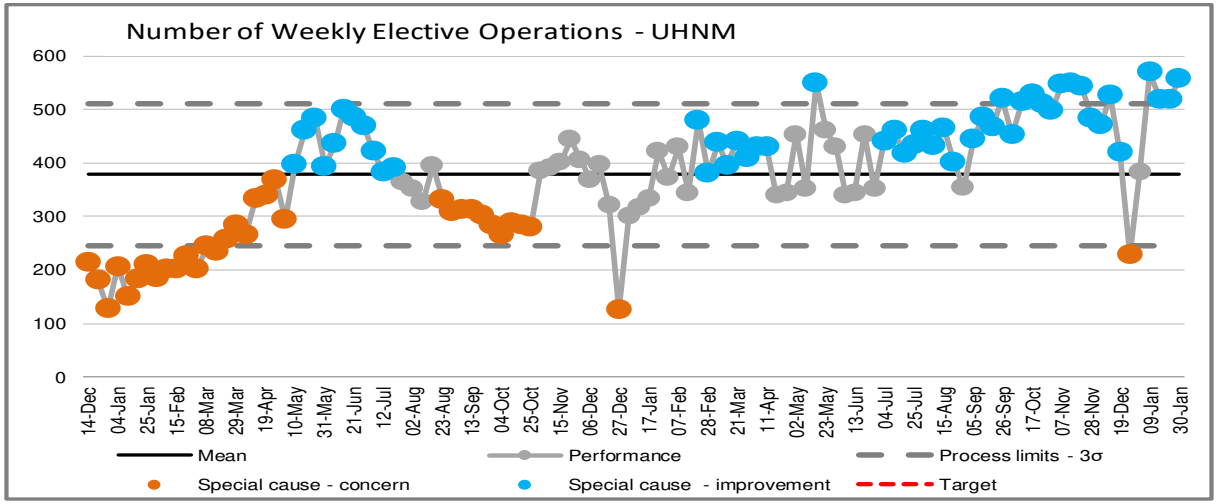
- The backlog has reduced – UHNM provide assurance to the regional NHSEI team, with detailed plans, on a weekly basis.



- The incremental decrease of the Skin and Colorectal backlogs have been modelled up to the end of March 23, where the new trajectory meets the initial trajectory submitted in 22/23 operational plans. Both specialties have enacted recovery plans and reducing the number of patients waiting beyond 62 days on the pathway.
- UHNM is still recording a high number of first treatments.
- The 62 day backlog has reduced from 1041 in August to a position for WE 05.03.23 of 295.
- The overall PTL is down to levels seen 6 months ago.
- In August the PTL was over 6000 – this has now **reduced by around 2000** patients to around 4000.
- Improvements have mainly been in the overall Skin PTL – which was at 2259 in Aug and has **reduced to 797** currently.
- As the backlog is cleared there has been a dip in FDS performance in September = 46% however this has improved in October to 55% and in November to 58%. The December position has been finalised at 64.7%.
- Recovery schemes continue to be successful – with the LGI hub optimising referrals, and the community Teldermatology service contributing to a huge reduction in wait times for patients on a skin cancer pathway. The system is working towards next steps for the optimal Lower GI pathway – by expediting alternative pathways for FIT negative patients.
- The day by which 93% of patient receive a 2WW 14 day Clock Stop on the LGI pathway has reduced by over 45 days since September – to a current position of within 14 days.

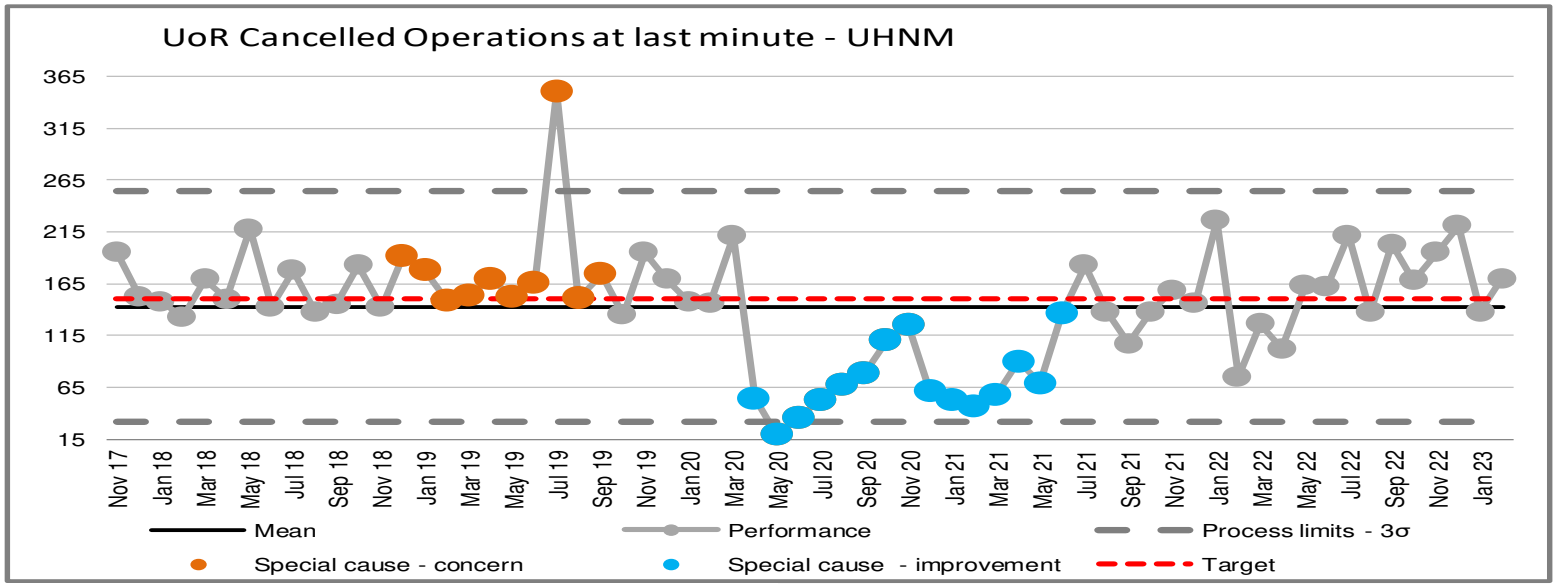
Planned care – *Inpatient Activity*





The number of 4 hour sessions taking place had remained fairly consistent, This dipped w/c 19/12/22 due to critical incident, however this is now back up to a consistent level.
The number of elective operations is now back to a consistent level.

Planned care – *Inpatient Activity*



Row Labels	Count of COMMENTS
Consultant - Cancelled for an Emergency	25
Consultant - Cancelled for more Urgent Case	31
Hospital Cancelled Admin Error	25
Hospital COVID-19	2
No Anaesthetist Available	7
No Consultant Available	30
No Equipment Available - Equipment Faulty/Failed	4
No Equipment Available - Equipment Not Booked	5
No ITU/HDU Beds Available	9
No Nursing Staff Available	19
No Suitable Beds Available	31
No Theatre Staff Available	3
No Theatre Time Available	16
No Theatre Time Available - List Overbooked	1
No Theatre Time Available - List Overrun	14
Grand Total	**222**

The numbers of patients cancelled remains higher than targets, largely due to consultant availability on the day, a more urgent case or bed suitability. Hospital cancelations due to admin error are usually where the patient has not attended and the TCI has been an administratively created error.

Planned care - *Inpatients*

University Hospitals of North Midlands NHS Trust

Elective inpatients Summary

- Day Case and Elective Activity delivered 97% and 100% respectively for February 22 against the national ask of 110%/108%. Day case as a % of all elective work is currently 86.3%.
- There is a real focus on 104w cases, many of whom were complex and required whole/half lists. As this number is being driven down the focus is moving to our 78week+ patients.
- At the end of January the numbers of > 104 weeks was 69. The Trust has continues to achieve the national standard of all eliminating all 104 week waits purely due to capacity. This has increased by 11 due to a National directive around the recording or corneal transplant patients. There is a challenge for some specific directorate in treating some of our long waiting complex patients within timeframe due to the size of the backlog.
- Insourcing arrangements at weekends continue and have been bolstered to provide more weekend capacity in T&O through County Hospital. This is planned to continue through to the end of the financial year.
- The IS have agreed to take all T&O patients at risk of breaching 78 weeks by end of March who are clinically suitable. Not all of the patients have agreed to be transferred and the IS is not able to treat all on clinical review.
- During week commencing the 27th February there is a focused theatre piece of work on theatre start times and forward loading of lists to continue the focus on theatre. This was an intensive go-look-learn and the learning from this will now been taken through the surgical division into the theatres driver metric.

Actions

- The Trust is currently at 98.7% of all pathways over 52 weeks having ben validated within the last 12 weeks.
- Trust wide revamp of validation & training underway, focusing on tracking long waiters, exposing and addressing bottlenecks in pathways. Phase 1 to deep dive training needs analysis complete. Phase 2 underway – RTT Bitesize training now available to divisions., focused on key areas requiring improvement.
- RTT Training now available on 'Articulate' eLearning software.
- Active reporting focus on ensuring the right patients (urgent and longest waiters) are the patients booked into all available capacity so that the limited resource available continues to be used for the right patients by clinical need
- Patient by patient monitoring by each specialty and by the corporate team on the small number of patients at risk of the breaching 104 weeks by end of month, combined with forecasting for January and onwards. This monitoring has now been extended to 78 weeks also.
- Key enablers to the continued focus on long waiting patients are ring fencing of beds for Orthopaedics as RSUH, modular theatre at County and improvement in theatre utilisation and booking.
- Increased focus on non-admitted patients and increasing outpatient & diagnostic capacity, improving utilisation and business processes to move patients to a decision to admit. This will be supported by the IST RTT training programme which takes place in February and March.
- Roll-out of Palantir's Foundry platform underway, with working group to be up and running with plans for initial rollout end Jan subject to technical testing.

Planned care – *RTT Trajectories*

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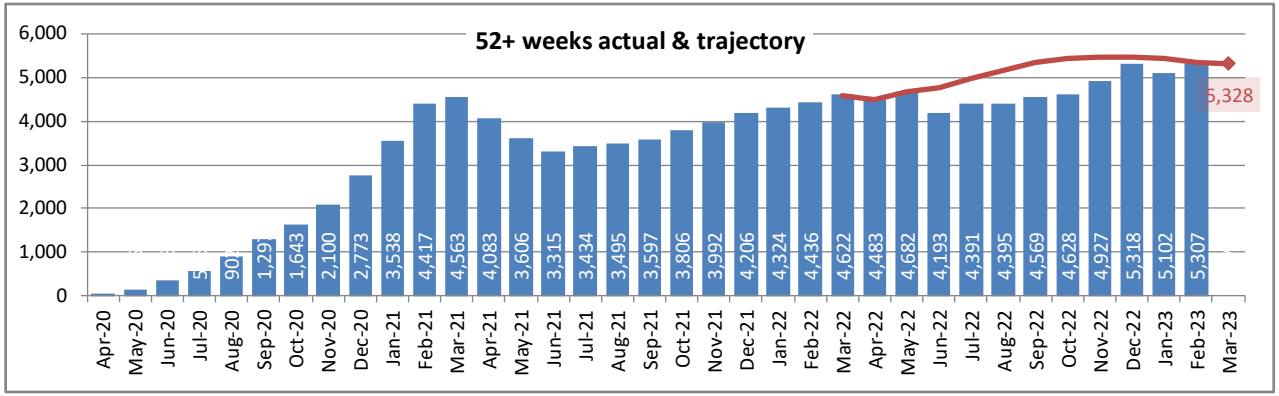
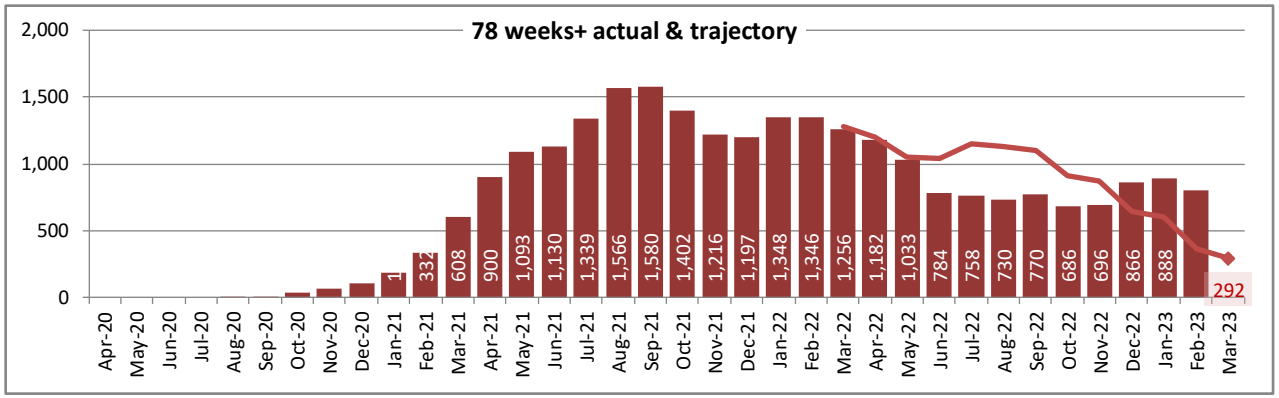
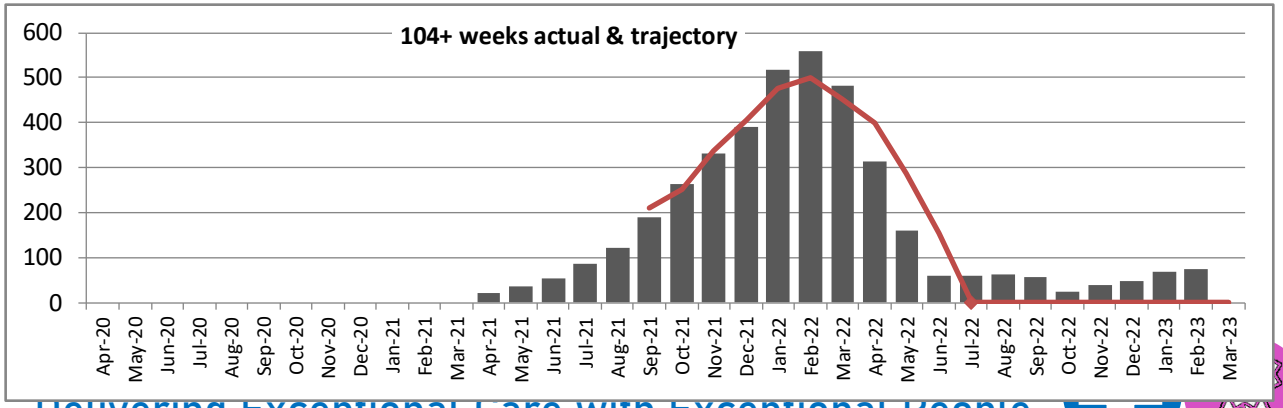


Although 52 Week Waits have been gradually growing since June 21, levels are within trajectory. February data is unvalidated, but indicates a decrease in 52 week waits for the first time in 8 months.



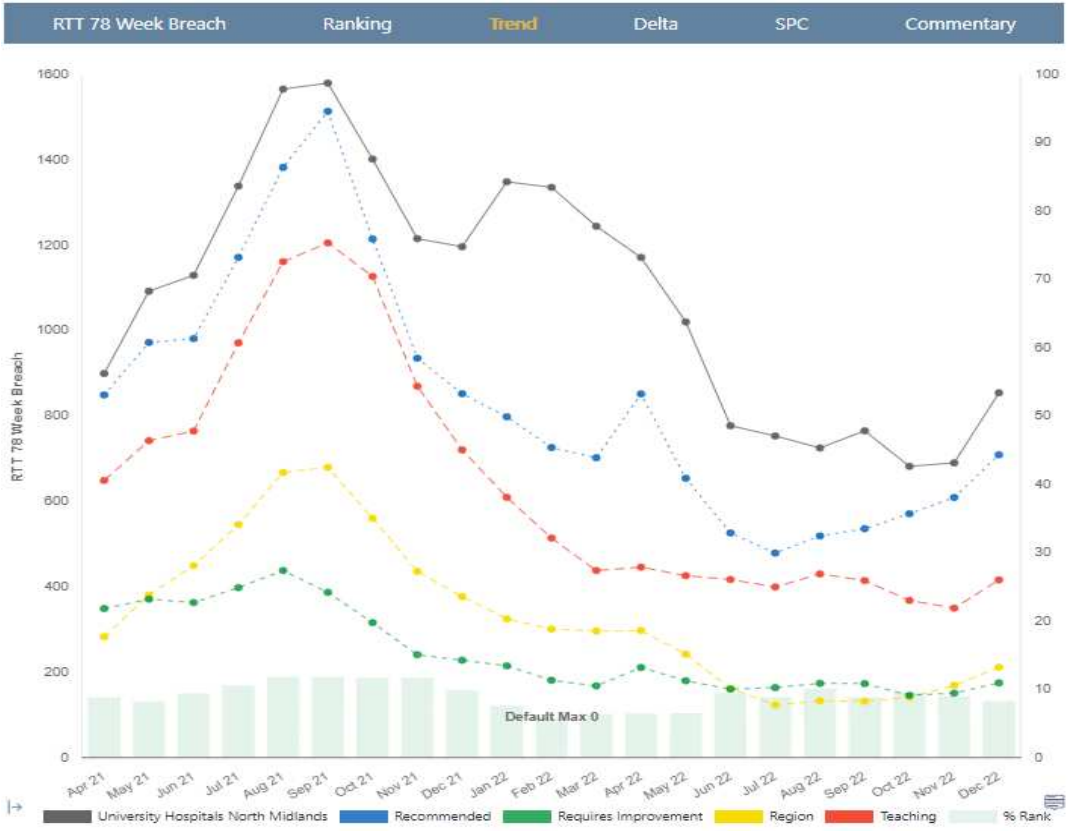
Since December 2022, 78 Week Waits have been above trajectory. February data is unvalidated.



104 Week Waits saw a sharp drop since February 2022, however since October volumes have been increasing gradually. (February data is unvalidated). This is made up of patient choice, patients presenting unwell or complex pathways.

RTT - Benchmarked

Key Performance Indicator	Period	Target		SPC	
RTT 104 Week Breach	Dec 22	0	48	L	2
RTT 52 Week Breach	Dec 22	0	5,300	H	9
RTT 78 Week Breach	Dec 22	0	855	L	8
RTT 95th Percentile Admitted W...	Dec 22	18.0	78.1	H	10
RTT 95th Percentile Non-Admitt...	Dec 22	18.0	51.7	H	33
RTT Admitted Treatment Within...	Dec 22	90.0%	57.8%	L	35
RTT Average (Median) Admitte...	Dec 22	9.0	12.8	H	40
RTT Average (Median) Non-Ad...	Dec 22	5.0	7.7	H	55
RTT Average Wait for Incomplete	Dec 22	7.00	17.6	H	13
RTT Incomplete 92nd Percentile	Dec 22	-	49.6	H	19
RTT Incomplete Pathways With ...	Dec 22	25.0%	15.1%	H	48
RTT Non-Admitted Treatment ...	Dec 22	95.0%	70.8%	L	49
RTT Total Clock Starts	Dec 22	-	12,579	C	82
RTT Total Clock Stops	Dec 22	-	11,125	C	84
RTT Total Incompletes	Dec 22	-	77,889	H	12



- 78 Week waits saw a reduction each month since January 2022, however December saw an increase.
- All peer groups increased in December.
- UHNM remain in the lowest quartile.

Planned care

NHS
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NHS Trust

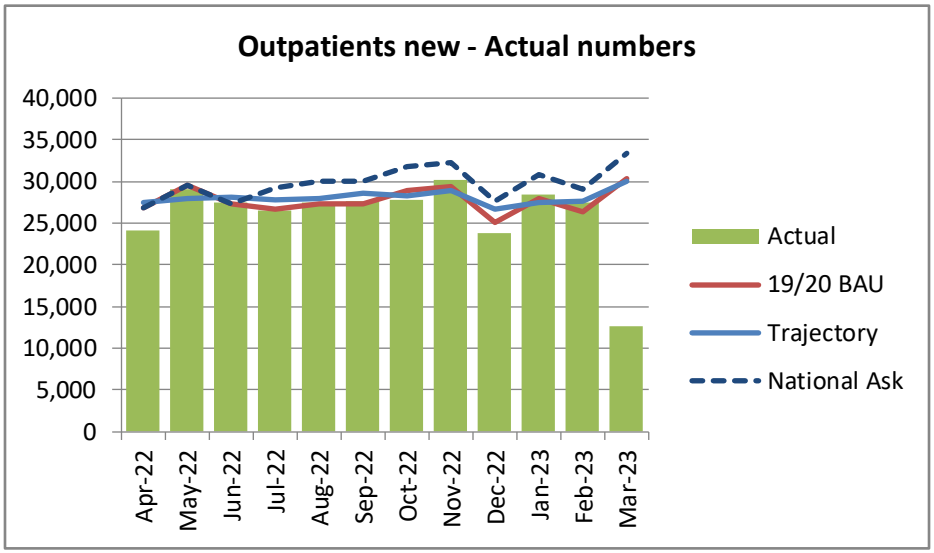
Summary

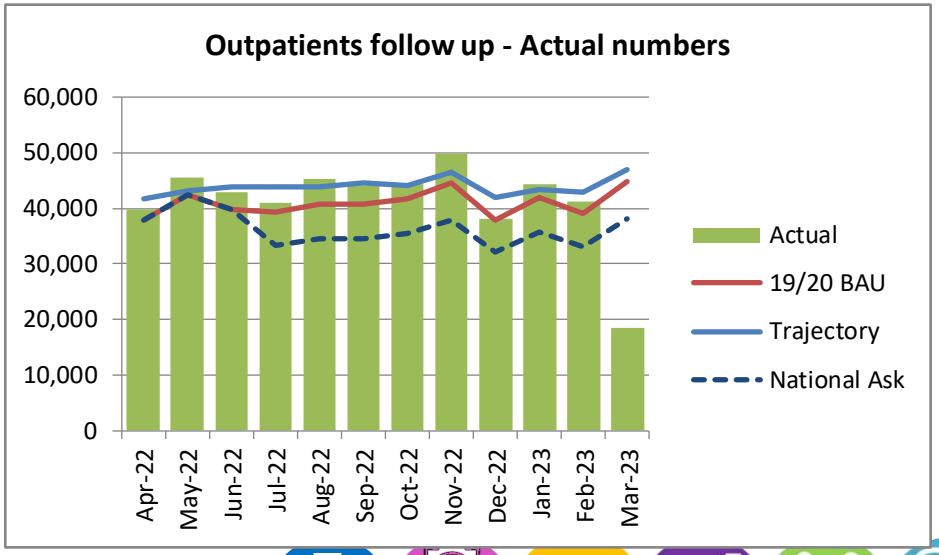
- 52+ week patients decreased in January to 5,122
- 78+ patients have been gradually reducing, but had reached a plateau in November at 725. This has increased in December to 863, due to winter pressures in combination with industrial action and in January rose to at 936. The number has decreased throughout February, with a provisional month end position of 806.
- The trust is no longer on trajectory to eliminate 78 weeks waits by end of March 2023. Plans are in place to minimise the number of breaches, so that only patients who choose not to be treated before end of March or who have a highly complex case are still waiting at 78+ weeks.
- At the end of February the numbers of > 104 weeks was 69. The Trust has continues to achieve the national standard of all eliminating all 104 week waits purely due to capacity. This has increased by 11 due to a National directive around the recording or corneal transplant patients.
- The overall Referral To Treatment (RTT) Waiting list has started to show signs of stabilisation. April was 76,023, May 75,858, June 75,538 , July 77,242 and August 76,838, September 77,985, October 77,546, November 77,727., December 77,991. Whilst this did decrease over the festive period, the (un-validated) list now sits 77,148 end of February.

RTT

- Validation has increased with extra resource. This will provide an accurate picture of the resource required in the medium term to reduce the list.
- Performance sits at 53.1%, and improvement from 51.2% for January
- Work plans around long wait patient validation and treatment tracking are in progress to support the Data Quality Strategy & Audit requirements.

Planned care – *Outpatient activity & RTT*





Planned care – *Outpatients*

NHS University Hospitals of North Midlands NHS Trust

Actions

- **OP Cell Programme Structure** & TOR 22/23 reflecting Elective Recovery Planning Guidance. Linking with Business Planning re 23/24 plans.
- **Work stream 1 Outpatient Service Delivery & Performance**

  Utilisation; OP Cell Dashboard revised to support focus, booking & DNA Divisional / UHNM target & trajectories, utilisation Feb 86.4% vs 84.5% plan. Corporate action: link with 'Action on DNAs' NHSE initiative (see 2 Way Messaging below), plus Divisions have identified specialty-specific actions.

  Unoutcomed; DQ leading remedial actions, insights to inform prospective measures. Reduction; 1815 (08/01) prior to current month to 1062 (09/03)
- **Work stream 2 Outpatient Transformation**

  OP GIRFT: issued Nov/Dec, aimed at clinicians & operational teams in 15 specialties. UHNM baseline assessment complete vs customised maturity model. Met with general surgery, gynaecology & cardiology to review actions & comments. Timeline agreed for all Specialty Meetings & Reviews.

  PIFU; on track for trajectory to meet 5% in March 2023. Feb 4.7% vs 4.4% plan. Benchmarking vs national median Feb 2022- UHNM: 24th of 143 providers (4.6% vs 2.3%). Clarifying requirements for new CDS from June 2023. Additional PIFU pathway opportunities from OP GIRFT guidance.

  Enhanced Advice & Guidance ICS Referral Optimisation Steering Group set up (now termed Demand Management Steering Group).

  Virtual Care >25%; SUS submission 'fix' implemented from Nov 2021 (with BI); longer term, alignment of clinic booking and media type outcomes. NHS Remote Monitoring Toolkit issued early December, baseline assessment submitted 19th December.

  Digital Enablers

  - **2 Way Messaging; Waiting List Validation (OP/IP) -** Netcall module solution proposed as interim ahead of PKB functionality & coverage: improvement on current Netcall SMS approach (see below), quick to implement, simple patient interface, customisable options, worklist for effective action & governance, plus reporting tool. 19K quote plus setup cost, WC&CSS have included in list of developments, subject to approval.
  - **2 Way Messaging; DNA reduction / Short Notice Booking** - Extension of current Netcall reminder functionality to 2 way messaging; confirm / cancel appointments, and worklist to support short notice booking. 4K quote; WC&CSS have included in list of developments, subject to approval.
  - **SMS via Netcall to Waiting List**., Partial Booking module used to contact follow ups in top 14 backlog specs. Gastro, Urology, Gynae & Skin have run campaigns. 7K patients contacted; response rate nearly 50%, 7% of contacted (>450) no longer need appointment. Next neuro, paeds.
  - **Robotic Process Automation (RPA); Outpatient Outcomes -** All OP outcomes captured by a clinician on iportal / paper forms need completing on Careflow. Circa 200K attendances annually with 'simple' outcomes eg discharge, could be completed via RPA. UHNM BI progressing.
  - **RPA; PIFU Discharge Letters (at Review Date) -** Scoping with UHNM BI (where pre-agreed by specialties), to pilot with Neuro & Urology.
  - **Patient Portal**; IM&T invited to OP Cell for updates. Director of Digital Transformation attended OP Cell in October to share Digital Vision. Patient Portal live in January, invites from February 2023 by letter or SMS to register for PKB via the NHSApp. Able to view appts & test results initially.

Risks

- Deteriorated waiting list position vs pre-covid; volume of patients requiring DQ and clinical validation very challenging, on Divisional Risk Registers.
- Clinical Validation requirement; risk of achieving vs resources available.
- Lack of pace on schemes linked to System Partners, escalated at Planned Care Improvement Board.
- Potential impact of Industrial Action on M12 performance, including volume of PIFU patients.

Diagnostic Activity

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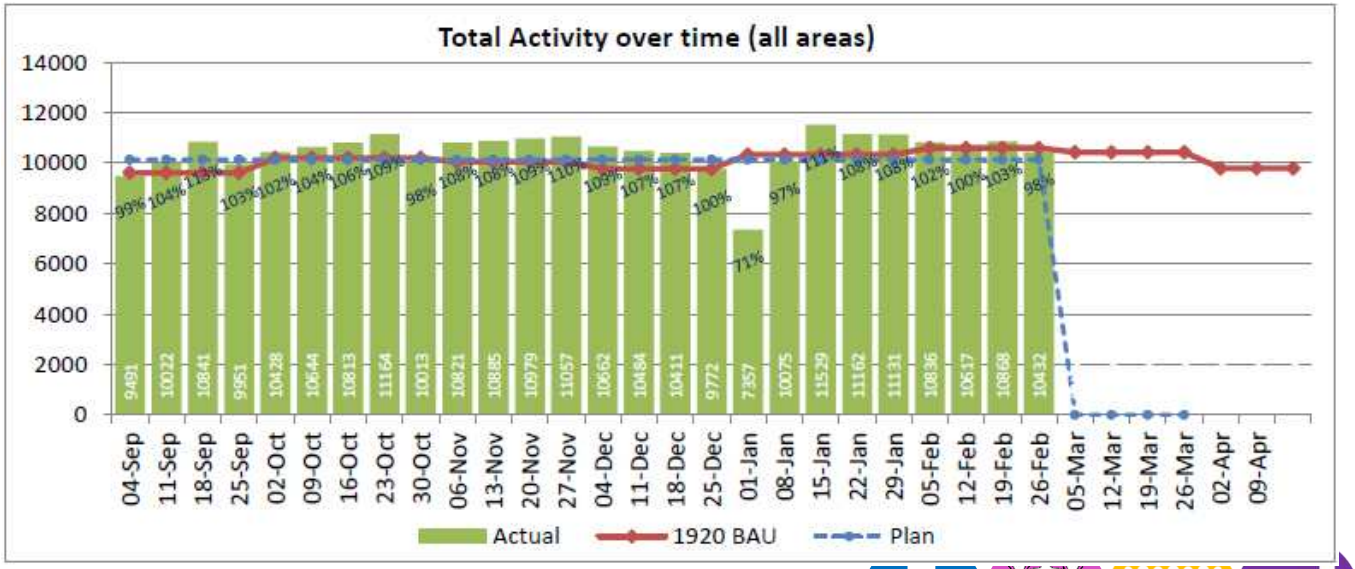
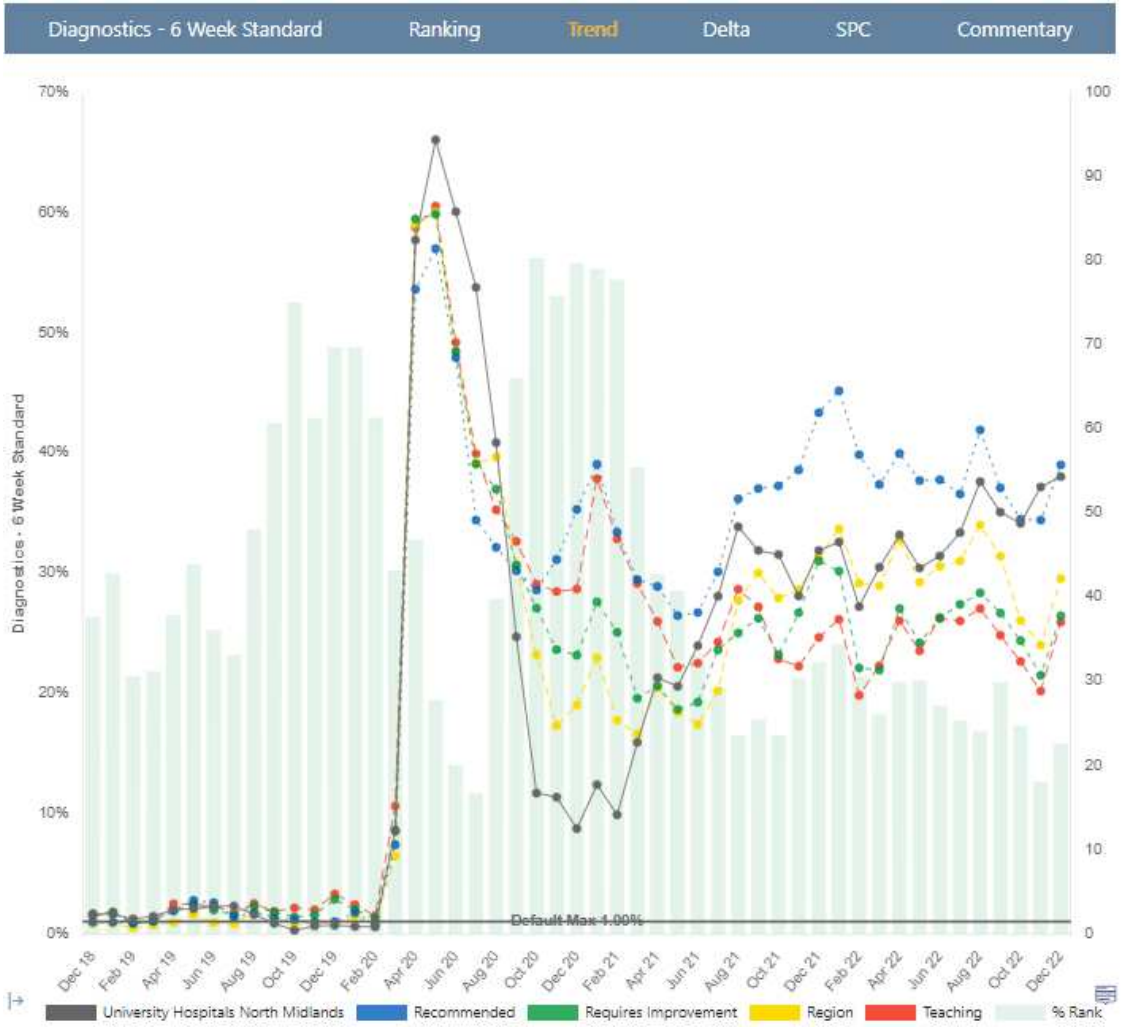
PROVISIONAL DATA

Area	DM01 Test	Dec-22 Total WL	Dec-22 6+	Dec-22 %	Dec-22 Activity	Jan-23 Total WL	Jan-23 6+	Jan-23 %	Jan-23 Activity	Feb-23 Total WL	Feb-23 6+	Feb-23 %	Feb-23 Activity
Imaging	Magnetic Resonance Imaging	4,267	959	77.5%	3,348	3,968	831	79.1%	3,770	3,886	504	87.0%	3,510
	Computed Tomography	3,633	86	97.6%	8,072	3,711	44	98.8%	8,532	4,122	23	99.4%	7,959
	Non-obstetric ultrasound	9,667	5,597	42.1%	5,087	8,357	4,187	49.9%	6,582	7,513	2,512	66.6%	5,870
	Barium Enema				0	0	0		0				
	DEXA Scan												
Physiological Measurement	Audiology - Audiology Assessments	274	3	98.9%	284	297	4	98.7%	313	448	28	93.8%	293
	Cardiology - echocardiography	2,502	862	65.5%	1,047	2,491	1,087	56.4%	1,195	2,491	1,002	59.8%	1,019
	Cardiology - electrophysiology	1	0	100.0%	1	0	0		2	0	0		
	Neurophysiology - peripheral neurophys	292	0	100.0%	233	243	0	100.0%	317	298	0	100.0%	233
	Respiratory physiology - sleep studies	456	48	89.5%	210	472	64	86.4%	274	481	43	91.1%	284
	Urodynamics - pressures & flows	0	0		0	0	0		0	1	0	100.0%	
Endoscopy	Colonoscopy	919	571	37.9%	256	911	620	31.9%	224	1,079	737	31.7%	16
	Flexi sigmoidoscopy	554	351	36.6%	50	542	341	37.1%	41	666	465	30.2%	2
	Cystoscopy	179	20	88.8%	171	125	14	88.8%	266	120	15	87.5%	225
	Gastroscopy	679	402	40.8%	607	689	328	52.4%	476	958	461	51.9%	36
	Totals	23,423	8,899	62%	19,366	21,806	7,520	66%	21,992	22,063	5,790	74%	19,447



Diagnostics - benchmarked

Key Performance Indicator	Period	Target		SPC	
Audiology	Dec 22	1.00%	1.1%		74
Colonoscopy	Dec 22	1.00%	62.1%		13
Computed Tomography	Dec 22	1.00%	2.4%		59
Cystoscopy	Dec 22	1.00%	11.2%		66
DM01 Waiting <13 Weeks	Dec 22	100.00%	90.1%		37
Diagnostics - 6 Week Standard	Dec 22	1.00%	38.0%		23
Diagnostics - 6 Week Standard ...	Dec 22	99.00%	62.0%		23
Echocardiography	Dec 22	1.00%	34.5%		44
Electrophysiology	Dec 22	1.00%	0.0%		100
Flexi Sigmoidoscopy	Dec 22	1.00%	63.4%		13
Gastroscopy	Dec 22	1.00%	59.2%		8
Magnetic Resonance Imaging	Dec 22	1.00%	22.5%		32
Neurophysiology	Dec 22	1.00%	0.0%		100
Non-obstetric Ultrasound	Dec 22	1.00%	57.9%		6
Sleep Studies	Dec 22	1.00%	10.6%		56
Urodynamics	Dec 22	1.00%	-		-



- Performance at UHNM is showing the same trend as all other peers and in line with the "Recommended" group.
- As with all peer groups, UHNM performance to the national target of 1% is deteriorating.
- UHNM remains in the bottom quartile nationally.

Planned care - *Diagnostics*

NHS University Hospitals of North Midlands NHS Trust

Diagnostics Summary

- During January the Diagnostic activity improved on the December position and increased above 100% when compared with 19/20 BAU at 104%.
- DM01 performance was 66% overall, with key areas of underperformance in non-obstetric ultrasound and Endoscopy

Histology position – as at 16th February:

- Urgent (diagnostic cancer and other very urgent biopsy specimens): 95% reported at Day 25 (previously Day 32), 80% reported by Day 13
- Accelerated (include all Cancer Resections): 95% reported at Day 52 (previously Day 46), with 80% reported by Day 33 (previously Day 37)
- Routine (all Specimens not in above categories): 95% reported at Day 54 (previously Day 57),
- 80% of cases reported by Day 32 (Previously day 45)

The 7 day reporting turnaround time (TAT) for Urgent cases is at 52.4% against the Royal College of Pathologists' target of 80% within 7 days.

Actions

Top 6 contributors for DM01 performance have developed recovery plans, and have been requested to refresh these plans in line with National timescales for recovery (March 23). To be monitored once complete by Planned Care Group.

DM01 performance 74%: 5790 patients waiting 6 weeks+;

Top Contributors – in order of highest breach %

1.	Flexi Sigmoidoscopy (30.2%)	465 breaches of 666 patients
2.	Colonoscopy (31.7%)	737 breaches of 1079 patients
3.	Gastroscopy (51.9%)	461 breaches of 958 patients
4.	Echo (59.8%)	1002 breaches of 2491 patients
5.	Non-Obstetric Ultrasound (66.6%)	2512 breaches of 7513 patients (total waiting list size reduced by 1675 patients in month)

Radiology reporting backlogs;

- Radiology workforce business case part approved – approval to recruit to 10wte radiology consultants; 2 Locum radiologists have been recruited and started in post.
- Weekly Radiology backlog risk management meetings are now in place with the speciality clinical leads, divisional and directorate management representatives with specialty specific action plans and individual risk register entries
- Price per scan TI payment model approved until Dec 2023 to support an increase in reporting and outsourcing remains in place
- Risk 25512 remains at score - 20

Non – obs Ultrasound capacity for routine patients New outsourced provider procured & reflected in boost in activity. Trajectory to meet DM01 by March '23

Endoscopy; Fluctuating cancer referral demand against lack of scopist availability. Full recovery plan in negotiation, this remains of concern

Inpatient and Outpatient Decile & Ethnicity

"In line with NHS Planning Guidance the Trust must ensure board papers are published that include an analysis of waiting times disaggregated by ethnicity and deprivation" The Trust has only recently had the capability to analyse this information and will therefore spend the coming months seeking to understand what the data and take action to positively impact upon unwarranted variation

Inpatient IMD Decile	1	2	3	4	5	6	7	8	9	10	Unknown
Weeks Waited- >104	10.66%	8.94%	9.33%	7.53%	7.45%	11.22%	12.59%	10.46%	13.97%	7.28%	0.56%
Weeks Waited- 78-104	14.76%	13.49%	8.14%	7.46%	7.21%	10.26%	10.94%	8.48%	11.96%	5.68%	1.61%
Weeks Waited- 52-77	14.24%	11.78%	9.59%	9.07%	6.97%	11.62%	10.44%	8.58%	12.01%	4.81%	0.88%
Weeks Waited- Under 52	13.74%	11.61%	10.13%	9.16%	7.56%	10.93%	10.34%	8.99%	11.03%	5.27%	1.25%

Outpatient IMD Decile	1	2	3	4	5	6	7	8	9	10	Unknown
Weeks Waited- >104	11.12%	10.37%	9.14%	9.01%	7.80%	11.30%	11.38%	9.96%	12.46%	6.45%	1.01%
Weeks Waited- 78-104	13.05%	10.69%	9.80%	8.77%	7.64%	10.59%	10.74%	9.10%	11.86%	6.52%	1.23%
Weeks Waited- 52-77	12.43%	11.11%	9.83%	9.20%	7.82%	10.93%	10.72%	8.74%	11.63%	6.39%	1.21%
Weeks Waited- Under 52	13.31%	11.35%	10.14%	8.90%	7.52%	10.65%	10.51%	9.06%	11.36%	5.96%	1.22%

Inpatient Ethnicity	African	Any Other Asian Background	Any Other Black Background	Any other ethnic group	Any Other Mixed Background	Any other White background	Bangladeshi	Caribbean	Chinese	Indian	Pakistani	White & Asian	White & Black African	White & Black Caribbean	White British	White Irish	Not Specified	Not Stated	Unknown
Weeks Waited- >104	0.17%	0.39%	0.08%	0.37%	0.31%	0.65%	0.06%	0.08%	0.20%	0.39%	0.51%	0.22%	0.06%	0.03%	93.28%	0.37%	0.76%	1.77%	0.31%
Weeks Waited- 78-104	0.25%	0.51%	0.17%	0.42%	0.34%	1.02%	0.08%	0.08%	0.34%	0.59%	0.85%	0.08%	0.08%	0.08%	90.16%	0.25%	2.29%	1.19%	1.19%
Weeks Waited- 52-77	0.43%	0.62%	0.29%	0.52%	0.56%	1.15%	0.13%	0.13%	0.13%	0.59%	1.60%	0.16%	0.20%	0.20%	87.63%	0.36%	2.03%	1.70%	#N/A
Weeks Waited- Under 52	0.43%	0.67%	0.28%	0.73%	0.63%	1.27%	0.15%	0.19%	0.18%	0.49%	1.51%	0.24%	0.14%	0.20%	84.19%	0.29%	2.91%	2.54%	2.97%

Outpatient Ethnicity	African	Any Other Asian Background	Any Other Black Background	Any other ethnic group	Any Other Mixed Background	Any other White background	Bangladeshi	Caribbean	Chinese	Indian	Pakistani	White & Asian	White & Black African	White & Black Caribbean	White British	White Irish	Not Specified	Not Stated	Unknown
Weeks Waited- >104	0.27%	0.44%	0.24%	0.54%	0.45%	0.86%	0.11%	0.13%	0.11%	0.43%	1.45%	0.22%	0.18%	0.14%	87.88%	0.40%	2.61%	2.11%	1.42%
Weeks Waited- 78-104	0.25%	0.61%	0.18%	0.40%	0.40%	0.96%	0.16%	0.09%	0.10%	0.65%	1.99%	0.38%	0.12%	0.22%	86.52%	0.33%	2.44%	2.14%	2.05%
Weeks Waited- 52-77	0.47%	0.68%	0.21%	0.76%	0.56%	1.10%	0.12%	0.19%	0.23%	0.56%	1.61%	0.27%	0.18%	0.19%	84.59%	0.28%	2.90%	2.52%	2.60%
Weeks Waited- Under 52	0.48%	0.66%	0.19%	0.63%	0.59%	1.28%	0.15%	0.17%	0.14%	0.61%	1.80%	0.33%	0.16%	0.23%	82.66%	0.29%	3.25%	2.77%	#N/A

APPENDIX 1

Operational Performance

Constitutional standards

NHS University Hospitals of North Midlands NHS Trust

	Metric	Target	Latest	Variation	Assurance	DQAI
A&E	Percentage of Ambulance Handovers within 15 minutes	0%	69.53%	H		
	Ambulance handovers greater than 60 minutes	0	433	H	?	
	Time to Initial Assessment - percentage within 15 minutes	85%	66.89%		F	
	Average (mean) time in Department - non-admitted patients	180	309	H	?	
	Average (mean) time in Department - admitted patients	180	412	H	F	
	Clinically Ready to Proceed	90	453	H	F	
	12 Hour Trolley Waits	0	690	H	?	
	Patients spending more than 12 hours in A&E	0	1618	H	F	
	Median Wait to be seen - Type 1	60	97	H	F	
	Bed Occupancy	92%	88.76%			
Cancer Care	Cancer 28 day faster pathway	75%	73.19%		F	
	Cancer 62 GP ref	85%	45.62%	L	F	
	Cancer 62 day Screening	90%	31.03%	L	?	
	31 day First Treatment	96%	88.16%	L	?	
	2WW First Seen (exc Breast Symptom)	93%	96.38%	H	?	

	Metric	Target	Latest	Variation	Assurance	DQAI
Use of Resources	DNA rate	7%	6.8%		?	
	Cancelled Ops	150	170		?	
	Theatre Utilisation	85%	76.7%			
Inpatient / Discharge	Same Day Emergency Care	30%	37%	H	?	
	Super Stranded	183	207	H	?	
	MFFD	100	97	L	F	
	Discharges before Midday	25%	21.4%		F	
	Emergency Readmission rate	8%	7.0%	L	F	
Elective waits	RTT incomplete performance	92%	52.12%	L	F	
	RTT 52+ week waits	0	5307	H	F	
	Diagnostics	99%	73.76%	L	F	

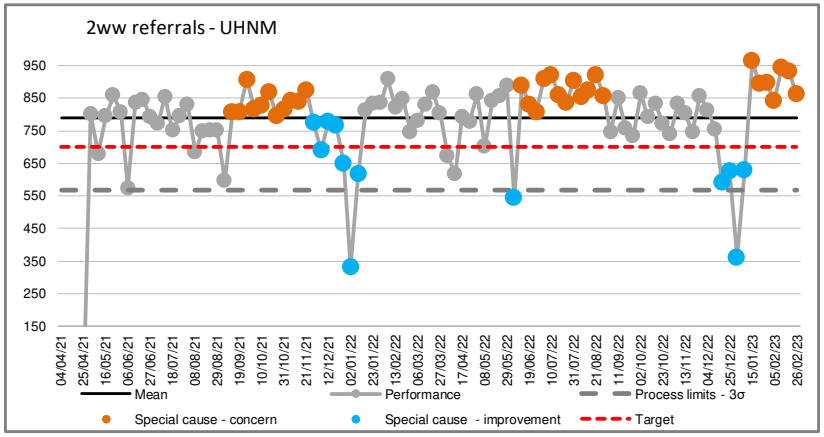
Delivering Exceptional Care with Exceptional People

Cancer – 62 Day

Target	Dec 22	Jan 23	Feb 23
700	945	932	861

Background

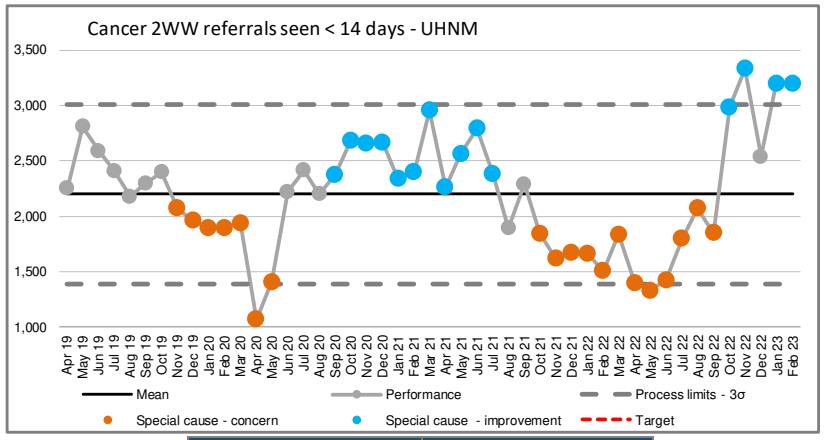
The number of patients referred on a cancer 2ww pathway.



Target	Dec 22	Jan 23	Feb 23
N/A	2541.0	3202.0	3196.0

Background

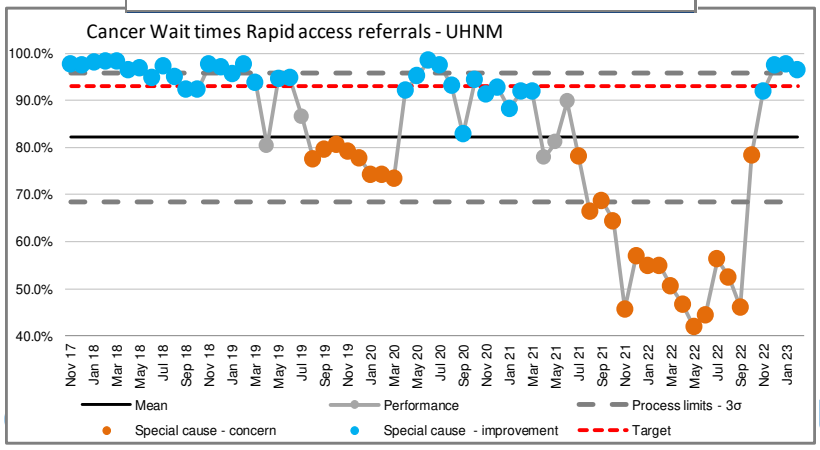
The percentage of patients waiting over 18 weeks for treatment since their referral.



Target	Dec 22	Jan 23	Feb 23
93%	97.5%	97.6%	96.4%

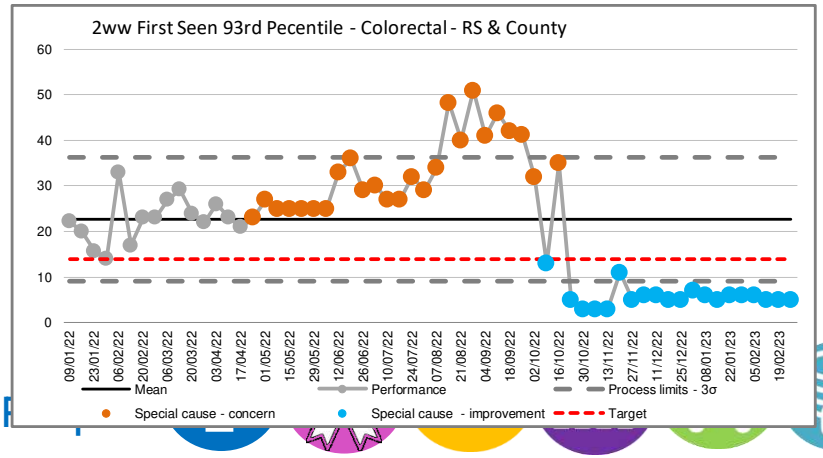
Background

% patients referred on a cancer 2ww seen by a specialist within 2 weeks of referral from GP

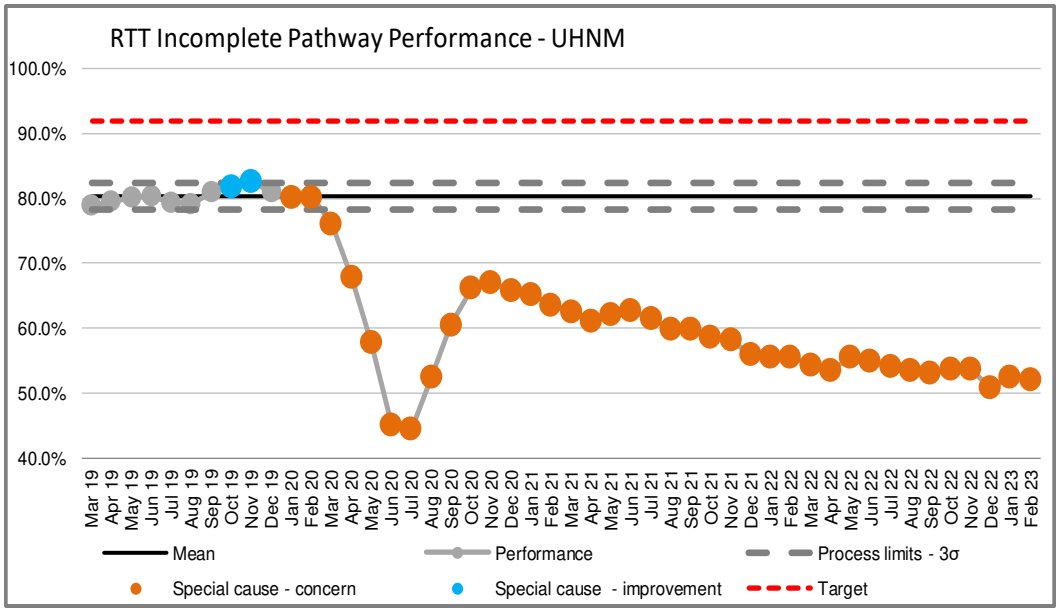


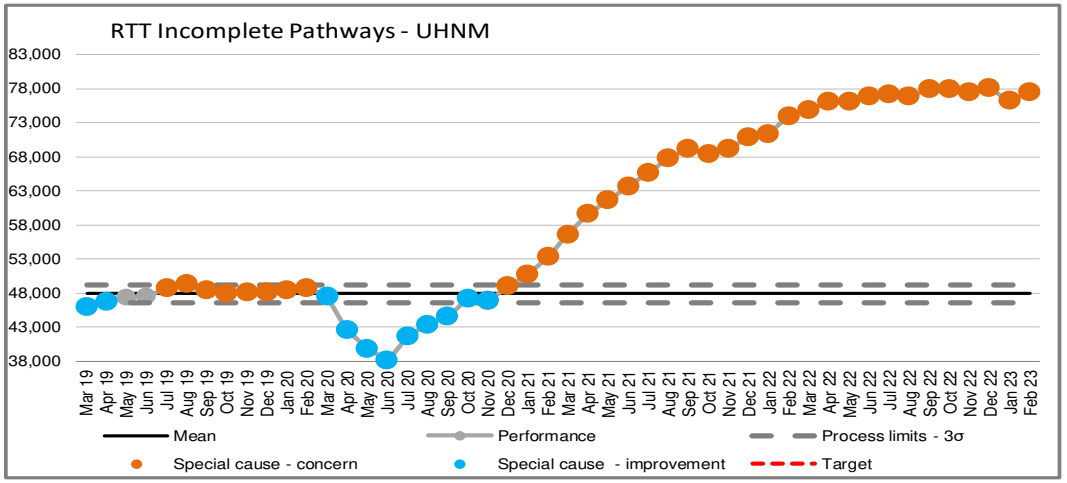
Variation	Assurance

Target	Feb 23	Feb 23	Feb 23
14	5	5	5



Referral To Treatment





Variation	Assurance
	

Target	Dec 22	Jan 23	Feb 23
92%	50.7%	52.5%	52.1%

Background

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

What is the data telling us?

Steady decline in performance since the pandemic began.

Diagnostic Standards

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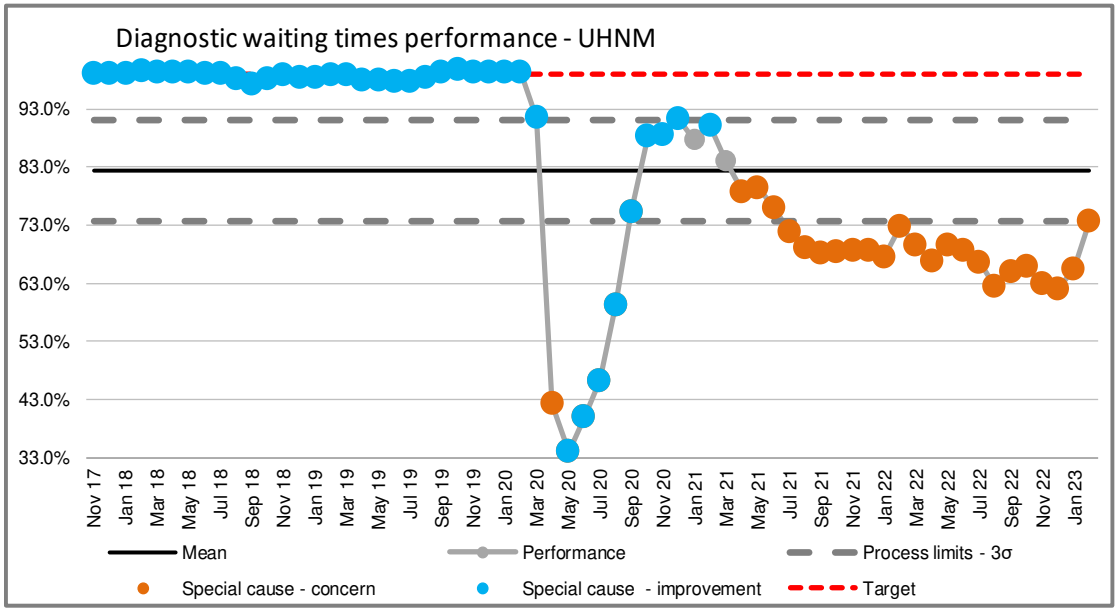


Variation	Assurance
	

Target	Dec 22	Jan 23	Feb 23
99%	62.0%	65.5%	73.8%

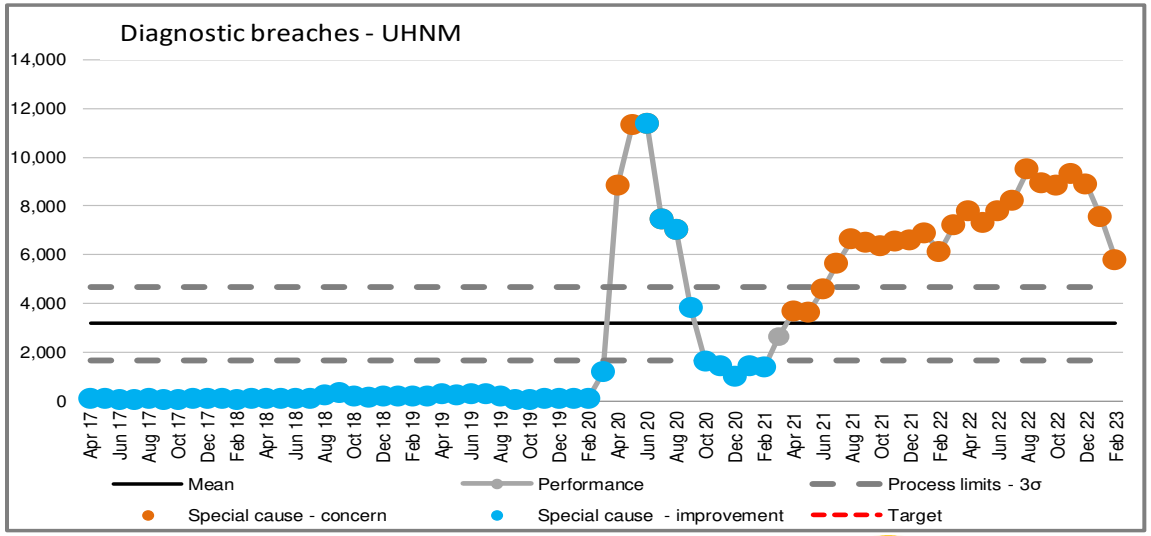
Background

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

What is the data telling us?

Waiting times performance saw a sharp improvement in February to 74% and reached the lower control limit.

The volume of breaches is continuing to see a reduction, but still remains above the upper control limit.



Workforce

NHS
University Hospitals of North Midlands
NHS Trust

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

Delivering Exceptional Care with Exceptional People

Workforce Spotlight Report

NHS
University Hospitals of North Midlands
NHS Trust

Key messages

The Trust's People Strategy 2022-2025 sets identifies the workforce priorities required to support delivery of the Trust's strategic ambitions, vision and objectives whilst demonstrating our values in all that we do. To deliver this four key domains of focus have been identified within the strategy.

- We will look after our people
- We will create a sense of belonging
- We will grow and develop our workforce for the future
- We will develop our people practices and systems

Overall, the level of workforce risk remains at ext16 due to the cultural issues highlighted by the brap report, high sickness levels and the impact on workforce availability. There are measures in place to mitigate risks including a recruitment pipeline

The Cultural Improvement Plan has been updated following a monthly review of progress.

- The Being Kind e-learning will be mandated from 1 April 2023 and this will be communicated Trust wide.

Chest and respiratory (which includes Covid) remains top at 23.4%, closely followed by Anxiety and Stress at 22.4%. Focusing specifically on Covid related absence by 12th March 2023 covid-related absences stood at 127, which was 19.7% of the 645 open absences. This is 9.8.% increase on same time the previous month.

The National Staff Survey 2022 results have now been published. This year, our response rate was 33%, much lower than 2021 which was 43%. However, this is reflected across all NHS Trusts.

Areas with the largest improvements include:

- Teams meeting to discuss effectiveness
- Last experience of physical violence reported
- Appraisal left you feeling the organisation values your work

Areas with the largest decrease include:

- Reduction is satisfaction with level of pay
- Enough staff to do job properly
- Never or rarely frustrated by work

The Staff Voice trust survey for February 2023 received a total of 746 submissions providing an overall engagement score of 6.99.

At 28 February 2023, the PDR Rate increased 1.5% by to 82.2.% (81.7% at 31 January 2023. The current PDR policy is under review and meetings are taking place with key stakeholders to understand what improvements can be built into the process to drive compliance.

Internal measures to monitor reduction is agency expenditure continue. Divisional targets for agency ceilings have been calculated. As part of the monitoring divisions were asked to present an update on their action plan to reduce expenditure to Executive Workforce Assurance Group (EWAG). New targets for the upcoming year will be provided based on 3.75% of total wage bill.

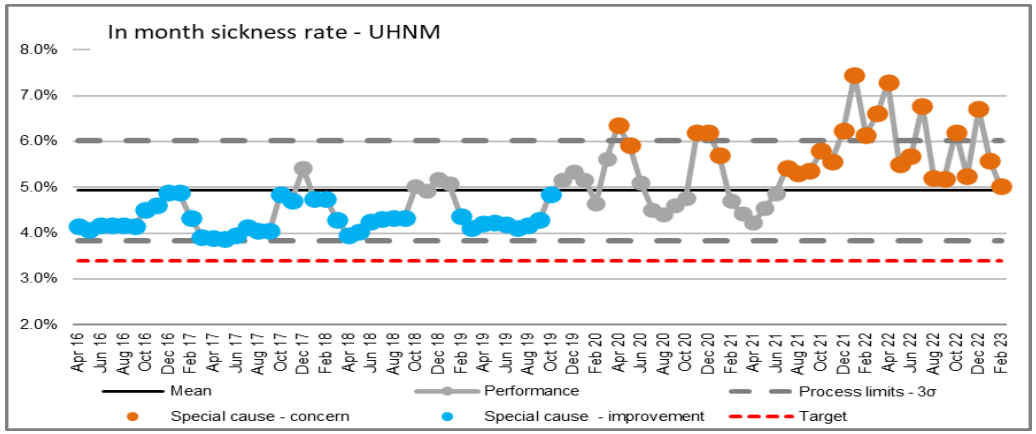
Workforce Dashboard

NHS
University Hospitals of North Midlands
NHS Trust

Metric	Target	Latest	Variation	Assurance
Staff Sickness	3.4%	5.02%		
Staff Turnover	11%	10.29%		
Statutory and Mandatory Training rate	95%	92.97%		
Appraisal rate	95%	82.21%		
Agency Cost	N/A	3.90%		

Sickness Absence

University Hospitals of North Midlands NHS Trust



Variation	Assurance
H	F

Target	Dec 22	Jan 23	Feb 23
3.4%	6.7%	5.6%	5.0%

Background

Percentage of days lost to staff sickness

Sickness rate is consistently above the target of 3.4%.

Summary

(12m cumulative Absence FTE %)

Org L2	Divisional Trajectory - March 2023	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Trajectory
205 Central Functions	3.39%	3.89%	4.13%	4.13%	4.11%	4.19%	4.21%	4.20%	3.74%	3.71%	3.85%	3.79%	3.90%	↑
205 Women's, Children's & Clinical Support Services	5.25%	5.53%	5.88%	5.94%	5.97%	6.03%	6.07%	6.25%	6.35%	6.29%	6.32%	6.22%	6.19%	↓
205 Estates, Facilities and PFI Division	5.25%	5.56%	5.81%	5.75%	5.76%	5.85%	5.98%	6.04%	6.20%	6.22%	6.15%	6.02%	6.00%	↓
205 Medicine and Urgent Care	5.25%	6.33%	6.56%	6.64%	6.67%	6.76%	6.82%	6.85%	6.94%	6.86%	6.90%	6.55%	6.41%	↓
205 Division of Network Services	5.25%	4.96%	5.32%	5.47%	5.69%	5.89%	5.81%	5.78%	5.73%	5.75%	5.80%	5.59%	5.48%	↓
205 Division of Surgery, Theatres and Critical Care	4.50%	6.75%	7.02%	7.18%	7.30%	7.45%	7.39%	7.31%	7.30%	7.20%	7.12%	6.94%	6.81%	↓
205 North Midlands & Cheshire Pathology Service (NMCPS)	5.25%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	5.57%	5.61%	5.64%	5.65%	5.68%	↑

For M11, the in-month sickness rate decreased by 0.5% to 5.02% (5.58% in January 2023

Chest and respiratory (which includes Covid) remains top at 23.4%, closely followed by Anxiety and Stress at 22.4%.

Divisional trajectories for achieving a reduction in Sickness Absence can be seen in the table above. Almost all of the Divisions saw a decrease sickness against the previous month.

Focusing specifically on Covid related absence by 12th March 2023 covid-related absences stood at 127, which was 19.7% of the 645 open absences. This is 9.8.% increase on same time the previous month..

Actions

The focus remains on managing areas of high sickness, and continued daily monitoring of sickness absence rates:

For the Medicine division Sickness absence continues to be monitored at monthly directorate performance reviews. and are having targeted support and input from People advisor on long term sickness cases

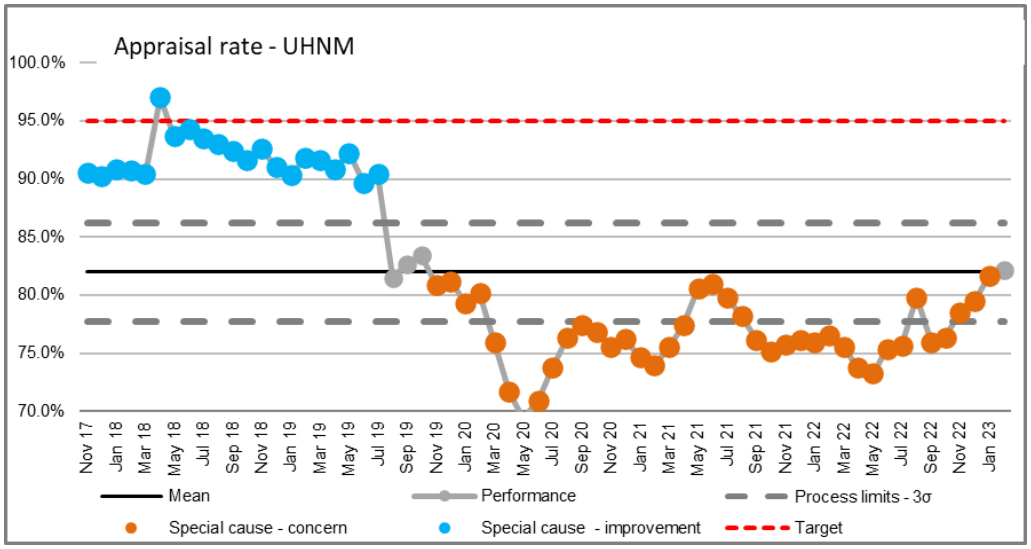
Surgery Division reviewing top 5 ST/LT absence and deep dive of short term sickness absence management.

Network Division have commenced sickness assurance meetings.

Women's Children's and Clinical Division. Will be undertaking a deep dive into specific areas of high absence. Alongside sickness surgeries to support managers.

Appraisal (PDR)

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	F

Target	Dec 22	Jan 23	Feb 23
95.0%	79.5%	81.7%	82.2%

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%.

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

Summary

At 28 February 2023, the PDR Rate increased 1.5% by to 82.2.% (81.7% at 31 January 2023).

This is the 5th month that has shown a upward trend; however, this figure still sits below the overall target and divisions have been asked to review key issues and actions to work towards meeting target..

The current PDR policy is under review and meetings are taking place with key stakeholders to understand what improvements can be built into the process to drive compliance and also making the process enhance employee experience.

Actions

The focus on ensuring completion of PDRs is continuing with:

Medicine Division are having weekly updates reports on compliance. With focused assistance on those areas with the lowest compliance.

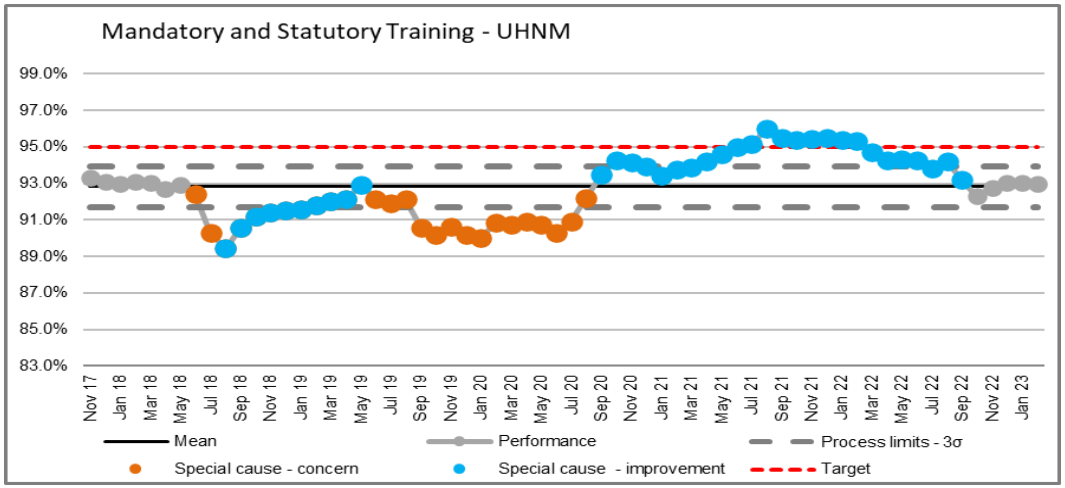
Surgery Division are undertaking a review of PDRs per reviewer and review of ESR upload errors.

Network Division a dedicated weekly PDR compliance hotspot and assurance meeting is being held. Continuing go, look, learn approach to support on ESR upload.

Women's Children's and Clinical Division clarity about accountability for PDR confirmed. Weekly people metric meeting put in place. All Divisions are arranging for proxy access to be setup as a support mechanism for uploading completed PDRs on ESR.

Statutory and Mandatory Training

University Hospitals of North Midlands NHS Trust



Target	Dec 22	Jan 23	Feb 23
95.0%	93.0%	93.0%	93.0%

Background

Training compliance

What is the data telling us?

At 93%, the Statutory and Mandatory Training rate is just below the Trust target for the core training modules

Summary

The Statutory and Mandatory training rate on 28 February 2023 was 93.0% (93.0% at 31 January 2023) and has remained static month on month. This compliance rate is for the 6 'Core for All' subjects only.

Competence Name	Assignment Count	Required	Achieved	Compliance %
205|MAND|Security Awareness - 3 Years|	10963	10963	10209	93.12%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	10963	10963	10202	93.06%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	10963	10963	10218	93.20%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	10963	10963	10198	93.02%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	10963	10963	10267	93.65%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	10963	10963	10013	91.33%

Compliance rates for the Annual competence requirements were as follows:

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 1 Year|	11165	11165	9908	88.74%
NHS|CSTF|Information Governance and Data Security - 1 Year|	11165	11165	9908	88.74%

Actions

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

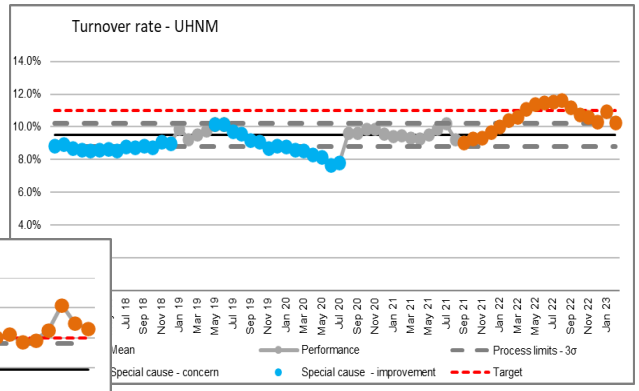
Compliance is monitored and raised via the Divisional performance review process.

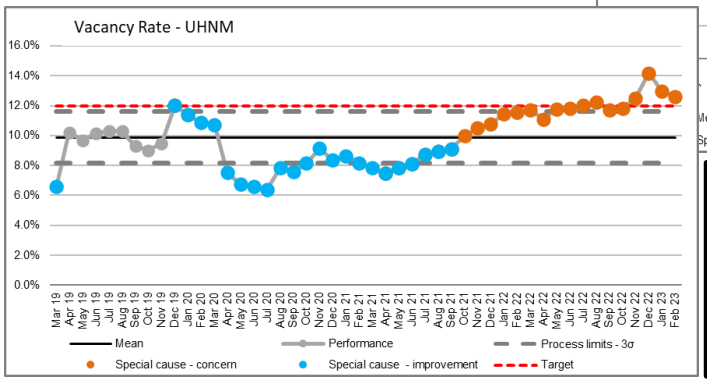
The Oliver McGowan Mandatory Training on Learning Disability & Autism is now live and will be reported separately for 12 months.

Workforce Turnover

University Hospitals of North Midlands NHS Trust

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





The overall Trust vacancy rate calculated as Budgeted Establishment. The vacancy rate is influenced by changes to budgeted establishment for Winter Workforce Plan and approved business cases, as well as changes to staff in post.

Variation	Assurance
H	P

Target	Dec 22	Jan 23	Feb 23
11.0%	10.3%	10.9%	10.3%

Background

Turnover rate

What is the data telling us?

The turnover rate for February 2023 remains below the trust target of 11%.

Vacancy rate has decreased from 12.96% last month to 12.62% due to decreases in budgeted establishment and increases in staff in post

Summary

The 12m Turnover rate in January 2023 sat at 10.29% figure sitting below the trust target of 11%.

The summary of vacancies by staff groupings highlight a small decrease in the vacancy rate over the previous month.

Vacancies at 28-02-23	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous month %
Medical and Dental	1,574.61	1,341.17	233.44	14.82%	15.01%
Registered Nursing	3,552.25	3,021.05	531.20	14.95%	15.46%
All other Staff Groups	6,737.21	6,004.91	732.30	10.87%	11.17%
Total	11,864.07	10,367.14	1,496.93	12.62%	12.96%

The M11 figure of 12.62% highlights a decrease in the overall vacancy rate over the previous month. The staff in post increased in February 2023 by 46.02 FTE, budgeted establishment also increased by 5.90 fte, which decreased the vacancy fte by 40.12 FTE overall [*Note: the Staff in Post fte is a snapshot at a point in time, so may not be the final figure for 28/02/23]

Actions

Processing new Qualified nurses in progress.

Medical Staffing currently implementing Rota changes.

Significant amount of recruitment events targeting specific roles across multiple divisions.

Targeted social media campaign, resulting in higher applicant numbers and increased engagement as a whole.

Finance

2025 Vision "Ensure efficient use of resources"

Finance Spotlight Report

NHS University Hospitals of North Midlands NHS Trust

Key elements of the financial performance year to date are:

- For the year to date the Trust has delivered a breakeven position against a planned surplus of £1.2m; this adverse variance is primarily driven by underperformance against the Trust's in year CIP target.
- The Trust incurred £0.3m of costs relating to COVID-19 in month; with £0.2m of this being chargeable for COVID-19 testing costs. The Trust has overspent by £3.2m against its original in envelope allocation due to the in envelope funding allocation ceasing after Month 2.
- To date the trust has validated £11.2m CIP savings in year; these schemes have a full year impact of £5.3m, which presents a considerable variance to the Trust's recurrent target of £13.6m which was identified as a key risk in the Trust's financial plan submission. This variance was reflected in the revised underlying position presented to the Committee in December.
- Capital expenditure in Month 11 is £41.4m which is 5.8m behind the plan of £47.2m. Of the expenditure to date £13.1m is the pre-committed repayment of the PFI and IFRS16 lease liabilities.
- The cash balance at Month 11 is £97.2m, which is £27.2m higher than plan. Cash received is above plan due to Capacity and Virtual Ward income received from the ICB.
- The Trust's forecast for the year continues to improve with the actual position at Month 11 being £0.7m better than the forecast carried out at Month 8; the Trust is confident that it will deliver a breakeven position for the year although this is heavily reliant on non-recurrent mitigations.

Finance Dashboard

	Metric	Target	Latest	Variation	Assurance
I&E	TOTAL Income	variable	80.1		
	Expenditure - Pay	variable	49.6		
	Expenditure - Non Pay	variable	30.4		
Activity	Daycase/Elective Activity	variable	8,348		
	Non Elective Activity	variable	9,680		
	Outpatients 1st	variable	26,655		
	Outpatients Follow Up	variable	41,830		

Income & Expenditure

Income & Expenditure Summary Month 11 2022/23	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Income From Patient Activities	917.0	77.7	76.8	(0.9)	839.6	839.9	0.2
Other Operating Income	89.4	7.5	8.7	1.1	81.9	83.7	1.7
Total Income	1,006.3	85.3	85.5	0.2	921.6	923.5	2.0
Pay Expenditure	(610.5)	(53.2)	(52.2)	1.0	(557.9)	(539.4)	18.5
Non Pay Expenditure	(335.4)	(27.7)	(28.8)	(1.1)	(307.1)	(330.9)	(23.7)
Total Operational Costs	(945.9)	(80.9)	(81.0)	(0.1)	(865.0)	(870.3)	(5.3)
EBITDA	60.4	4.4	4.5	0.1	56.6	53.3	(3.3)
Depreciation & Amortisation	(33.6)	(2.8)	(2.9)	(0.1)	(30.8)	(30.9)	(0.1)
Interest Receivable	0.3	0.0	0.3	0.3	0.3	1.8	1.5
PDC	(9.0)	(0.8)	(0.7)	0.0	(8.2)	(8.2)	0.0
Finance Cost	(18.1)	(1.5)	(1.4)	0.1	(16.6)	(16.4)	0.2
Other Gains or Losses	0.0	0.0	0.0	0.0	0.0	0.2	0.2
Surplus / (Deficit)	0.0	(0.7)	(0.3)	0.4	1.2	(0.3)	(1.5)
DHSC PPE adjustment	0.0	0.0	0.0	0.0	0.0	0.3	0.3
Total	0.0	(0.7)	(0.3)	0.4	1.2	(0.0)	(1.2)

The main variances for the year to date are:

- Income from patient activities is £0.2m above plan due to additional income in respect of pass through devices and drugs for which corresponding additional costs have been noted with non-pay.
- Other operating income has over performed year to date and this is primarily driven by additional educational and training income and additional income from the North Midlands and Cheshire Pathology Alliance. Car parking and research income continue to under deliver against plan.
- Pay is underspent year to date by £18.5m which is impacted by the £3.1m release of the premium element of the annual leave accrual in Month 3. The remaining variance is driven by underspends across registered nursing and NHS Infrastructure. Within the year to date budget is £3.4m non-recurrent CIP of which the nursing and NHS Infrastructure elements have delivered.
- Non-pay is overspent for the year to date by £23.7m; key points to note within this position are:
  - The non-delivery of recurrent CIP continues to impact the position by £7.0m.
  - There is a cost pressure of £1.2m relating to in-envelope COVID-19 costs as funding was only available for Months 1& 2
  - Pass through drugs and devices are overspent by £1.4m for the year to date (offset by additional income).
  - The Pathology network hosted by the Trust is overspent against its non-pay budgets by £4.7m; this represents the gross overspend for the service with UHNM's share being £3.1m. Income is assumed from other members the network in accordance with the agreed risk share governance.

Capital Spend

NHS University Hospitals of North Midlands NHS Trust

Capital Expenditure as at Month 11 2022/23 £m	2022/23 Plan June PAF	2022/23 Forecast Revised/ plan M11	In Month			Year to Date		
	Plan	Actual	Plan	Actual	Variance	Plan	Actual	Variance
PFI lease liability repayment	(10.5)	(10.5)	(0.9)	(0.9)	-	(9.7)	(9.7)	-
Repayment of IFRS16 leases	(3.7)	(3.7)	(0.3)	(0.3)	-	(3.4)	(3.4)	-
Pre-committed items	(14.3)	(14.3)	(1.2)	(1.2)	-	(13.1)	(13.1)	-
PFI lifecycle and equipment replacement (MES/PAC	(3.5)	(3.5)	(0.2)	(0.2)	(0.0)	(2.6)	(1.9)	0.6
PFI enabling cost	(0.3)	(0.0)	-	-	-	-	-	-
PFI related costs	(3.8)	(3.5)	(0.2)	(0.2)	(0.0)	(2.6)	(1.9)	0.6
Wave 4b Funding - Lower Trent Wards	(5.2)	(5.1)	(0.1)	(0.1)	(0.0)	(5.0)	(5.0)	0.0
Project STAR multi-storey car park	(6.8)	(7.8)	(1.0)	(1.0)	0.0	(4.4)	(4.6)	(0.2)
TIF 2 PDC (CTS Phase 1)	(3.9)	(4.6)	(0.7)	(0.6)	0.1	(4.6)	(2.4)	2.2
TIF 2 PDC (Day case unit)	(0.4)	(0.1)	(0.1)	(0.3)	(0.2)	(0.3)	(0.0)	0.3
TIF 2 PDC (Women's Hospital)	(0.6)	(0.1)	(0.2)	(0.0)	0.1	(0.2)	(0.0)	0.1
TIF 2 PDC (CTS Phase 2)	(0.1)	-	-	-	-	-	-	-
Emergency Department (restatement costs)	-	-	-	-	-	-	-	-
Home reporting breast care - PDC	-	(0.2)	-	(0.0)	(0.0)	(0.2)	(0.2)	(0.0)
MRI acceleration upgrades	-	(0.2)	(0.2)	(0.2)	0.0	(0.2)	(0.2)	0.0
Endoscopy equipment and works - PDC ICB allocatic	-	(0.4)	-	-	-	-	-	-
CT9 enabling and equipment - PDC	-	(1.2)	(0.0)	(0.0)	(0.0)	(0.1)	(0.1)	0.0
Frontline digitalisation equipment/ EPR - PDC	-	(0.7)	-	-	-	-	-	-
Diagnostic funding - CT8 and ultrasound	(1.4)	(1.5)	-	-	-	-	-	-
PDC - iRefer CDS	-	(0.2)	-	-	-	-	-	-
PDC - Cyber security	-	(0.1)	-	-	-	-	-	-
Schemes funded by PDC and Trust funding	(18.4)	(22.1)	(2.2)	(2.3)	(0.1)	(14.9)	(12.4)	2.5
Schemes with costs in more than 1 financial year	(3.6)	(3.7)	(0.2)	(0.5)	(0.2)	(3.3)	(2.5)	0.7
ICT Infrastructure	(2.5)	(2.3)	(0.1)	(0.2)	(0.1)	(1.6)	(0.9)	0.7
Estates Infrastructure	(3.6)	(4.7)	(0.2)	(1.0)	(0.8)	(3.3)	(3.6)	(0.3)
Medical Equipment Replacement	(2.2)	(3.7)	(0.3)	(0.3)	(0.1)	(1.3)	(2.1)	(0.8)
Health & Safety Compliance	(0.2)	(0.2)	-	0.0	0.0	(0.1)	(0.1)	(0.0)
Beds, mattresses and hoists	(0.1)	(0.1)	-	-	-	(0.1)	(0.1)	-
2021/22 commitments	(0.2)	(0.2)	-	-	-	(0.2)	(0.2)	0.1
Minor approved business case	(0.3)	(0.4)	-	-	-	(0.3)	(0.3)	(0.0)
Bi plane enabling and equipment (BC 425)	(0.4)	-	-	-	-	(0.4)	-	0.4
County theatre equipment and enabling costs	(0.8)	(1.1)	(0.1)	(0.1)	(0.0)	(0.6)	(0.4)	0.2
Purchase of modular Children's Outpatients	-	(1.5)	-	-	-	(1.5)	(1.5)	-
Lower Trent ward equipment (ward 80/81 retention	-	(0.4)	-	(0.0)	(0.0)	(0.4)	(0.2)	0.1
Emergency Department Cubicle Doors	(0.6)	(0.1)	(0.1)	-	0.1	(0.1)	-	0.1
Net zero carbon initiatives	(0.1)	(0.1)	-	-	-	-	(0.0)	(0.0)
Investment funding - minor cases	(0.5)	(0.7)	(0.0)	(0.3)	(0.2)	(0.1)	(0.4)	(0.3)
Central Contingency & risk	(0.3)	-	-	-	-	-	-	-
Risk reserve	(0.2)	-	-	-	-	-	-	-
Balance to allocate	-	0.0	-	-	-	-	-	-
2022/23 schemes	(11.9)	(15.3)	(0.8)	(1.9)	(1.1)	(9.9)	(9.8)	0.1
IFRS 16 New Vehicles lease	(0.1)	(0.1)	(0.1)	(0.1)	-	-	(0.1)	(0.1)
IFRS 16 County Theatres TIF1 (IFRS16)	(2.1)	(2.1)	(0.1)	(0.1)	-	(2.1)	-	2.1
IFRS16 lease additions (incremental impact of IFRS1	-	(0.7)	-	-	-	-	(0.1)	(0.1)
Lease liability re-measurement	(0.1)	(0.1)	-	-	-	(0.1)	(0.1)	(0.0)
IFRS16 funded schemes	(2.3)	(3.0)	(0.2)	(0.2)	-	(2.2)	(0.3)	1.9
Donated/Charitable funds expenditure	(4.7)	(2.6)	(0.2)	(0.2)	-	(1.3)	(1.3)	-
Charity funded expenditure	(4.7)	(2.6)	(0.2)	(0.2)	-	(1.3)	(1.3)	-
Overall capital expenditure	(59.0)	(64.5)	(5.0)	(6.4)	(1.4)	(47.2)	(41.4)	5.8

Key variances at Month 11 are:

- PFI lifecycle and equipment replacement is £0.6m behind plan at Month 11 due to no refreshes of MES or PACS equipment having taken place in the year to date. The element of the PFI unitary payment relating to this is accounted for as a pre-payment therefore this does not represent a slippage in the capital programme in respect of capital financing, however additions of £0.6m to the PPE balance in respect of this replacement were expected at Month 11.
- The TIF County CTS scheme is £2.6m behind schedule at Month 11 with slippage to the scheme in to April 2023.
- The IM&T infrastructure sub-group has a £0.7m underspend at Month 11 with slippage on a number of schemes, including the server and SQL upgrade; data centre utility refresh; firewall deployment; and the diamond linac. A majority of the underspend is due to the unavailability of staff resource.
- Medical Equipment is £0.8m ahead of plan at Month 11 due to the delivery of the monitor fleet replacement programme ahead of schedule.
- The bi-plane equipment and enabling scheme is £0.4m behind plan at Month 11 due to delays on agreement on the scope and costing of the enabling work, this work will now be undertaken in 2023/24.
- The County Theatres TIF1 (IFRS16) scheme is £2.1m behind plan due to delays in the process and enabling works for the modular theatre. The modular building and lease are expected to be in place in sufficient time to enable the asset and lease to be recognised at the year end, and to be operational early in 2023/24

Balance sheet

Balance sheet as at Month 11	31/03/2022	28/02/2023			
	Actual £m	Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment	576.4	581.3	577.7	(3.6)	Note 1
Right of Use Assets	-	16.1	15.7	(0.4)	Note 1
Intangible Assets	20.7	16.1	16.0	(0.1)	
Trade and other Receivables	1.4	1.4	1.4	-	
Total Non Current Assets	598.6	615.0	610.8	(4.2)	
Inventories	16.3	15.8	16.4	0.6	
Trade and other Receivables	41.6	39.8	36.0	(3.8)	Note 2
Cash and Cash Equivalents	87.6	70.0	97.2	27.2	Note 3
Total Current Assets	145.5	125.5	149.6	24.0	
Trade and other payables	(116.6)	(110.3)	(116.5)	(6.2)	Note 4
Borrowings	(10.7)	(13.0)	(13.0)	(0.0)	
Provisions	(2.5)	(2.5)	(3.3)	(0.8)	Note 5
Total Current Liabilities	(129.8)	(125.8)	(132.8)	(7.0)	
Borrowings	(257.8)	(256.8)	(256.8)	0.0	
Provisions	(3.9)	(3.9)	(2.7)	1.2	Note 5
Total Non Current Liabilities	(261.6)	(260.7)	(259.5)	1.2	
Total Assets Employed	352.6	354.0	368.0	14.1	
Financed By:				-	
Public Dividend Capital	648.2	648.2	662.3	14.1	Note 6
Retained Earnings	(437.0)	(435.6)	(435.6)	0.1	
Revaluation Reserve	141.4	141.4	141.3	(0.1)	
Total Taxpayers Equity	352.6	354.0	368.0	14.1	

Note 5. Provisions are £0.4m lower than plan due to unforeseen new provisions arising in 2022/23 and the release of provisions brought forward that are no longer required. A £1.1m provision relating to future commitments of the PFI managed equipment scheme has been released as this is not required following confirmation of the arrangements after market testing.

Note 6. Public Dividend Capital is £14.1m higher than plan at Month 11. The £14.1m received in February includes the STP wave 4b funding for the Lower Trent development (£6.755) and County TIF2 development (£4.5m) and drawn down in February 2022 to align with the national NHSE and DHSC drawdown timetable.

Note 1. This variance reflects slippage in capital expenditure in the revised year to date capital plan and the timing of PFI equipment replacement as part of the managed equipment scheme, which is funded through the PFI unitary payment.

Note 2. This variance is due to a number of factors.

1. The debt remaining on the NHS sales ledger of £3.2m is lower than plan and reflects cash received for invoices raised including Health Education England and relating to the pathology alliance.
2. Pre-payments have reduced in month relating to clinical negligence (NHS Resolution) and also in relation to prepayment for the Roche and Beckman Coulter managed service contracts.

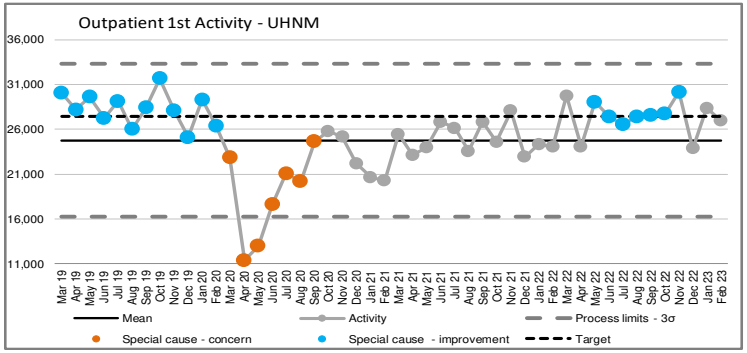
Note 3. Cash is £27.2m higher than plan. Cash received in the year to date is £21.7m higher than plan. Cash received from ICB's is £7.9m ahead of plan and reflects additional funding received from local commissioners. Cash received from Health Education England is £4.7m ahead of plan which includes higher than expected levels of training income and funding for the Imaging Academy received in prior months. PDC capital funding is £7.3m ahead of plan and includes the STP wave 4b funding for the Lower Trent development (£6.755) and County TIF2 development (£4.5m). Year to date payments are £5.5m behind plan which is mainly due to slippage in the capital programme and the increased level of capital creditors.

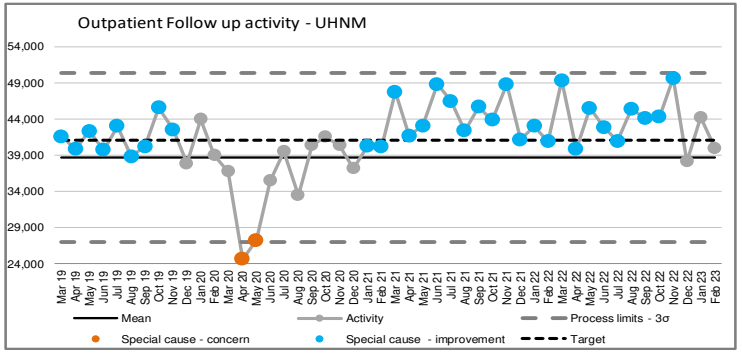
Note 4. Payables are £6.2m higher than plan mainly due to the level of deferred income being higher than plan at month 11.The higher than plan level of deferred income is partly as a result of £3.5m cash received from Staffordshire and Stoke on Trent ICB for a number of schemes. The deferred income balance also includes significant balances relating to Health Education England training (£5.1m); and high cost devices (£4.5m).

Activity

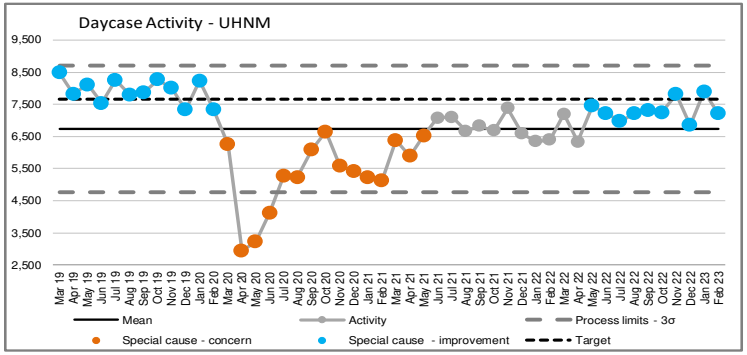
NHS University Hospitals of North Midlands NHS Trust

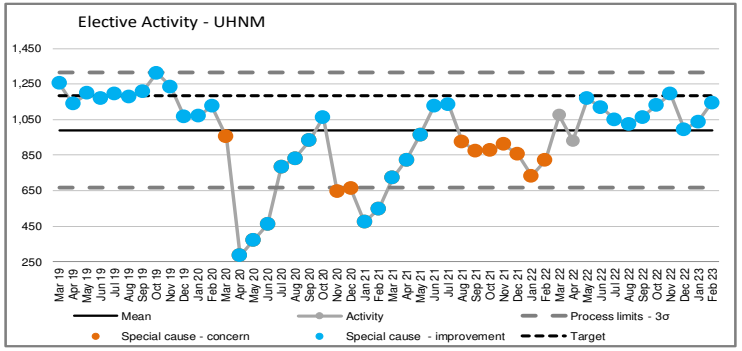
Planned care Outpatient



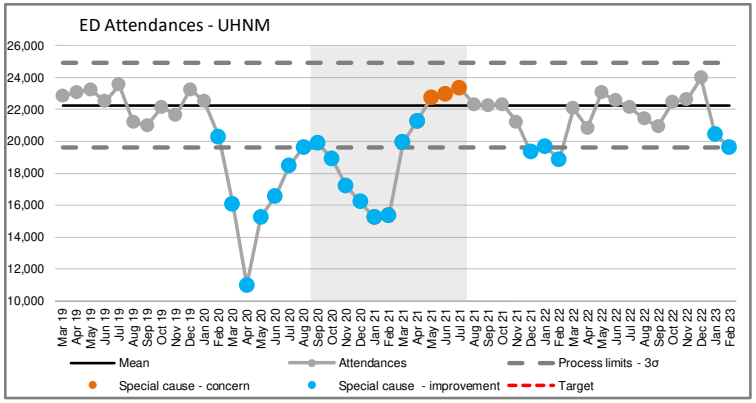


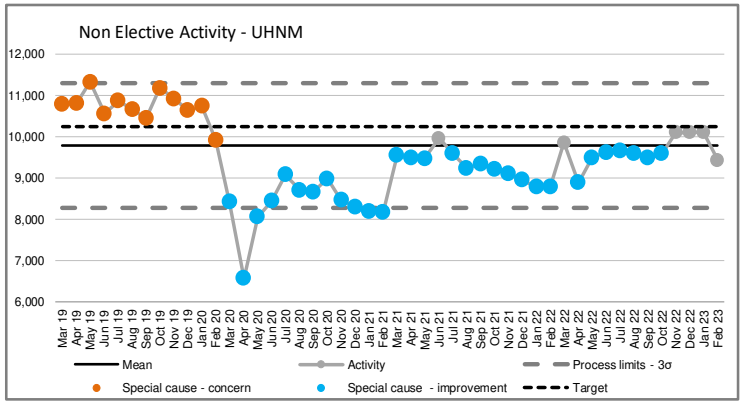
Planned care Inpatient





Urgent Care





Delivering Exceptional Care with Exceptional People