University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 9th March 2022 at 9.30 am to 12.05 pm via Microsoft Teams

AGENDA

Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
09:30	**PROCEDURAL ITEMS**					
20 mins	1.	Patient Story	Information	Mrs AM Riley	Verbal	
5 mins	2.	Chair's Welcome, Apologies and Confirmation of Quoracy	Information	Mr D Wakefield	Verbal	
	3.	Declarations of Interest	Information	Mr D Wakefield	Verbal	
	4.	Minutes of the Meeting held 9th February 2022	Approval	Mr D Wakefield	Enclosure	
	5.	Matters Arising via the Post Meeting Action Log	Assurance	Mr D Wakefield	Enclosure	
20 mins	6.	Chief Executive's Report – February 2022	Information	Ms H Ashley	Enclosure	
10:15	**PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES**					
5 mins	7.	Quality Governance Committee Assurance Report (24-02-22 & 02-03-22)	Assurance	Ms S Belfield Prof A Hassell	Enclosure	**BAF 1**
5 mins	8.	IPC Board Assurance Framework –February 2022	Assurance	Mrs AM Riley	Enclosure	**BAF 1**
10 mins	9.	Care Quality Commission Action Plan	Assurance	Mrs AM Riley	Enclosure	**BAF 1**
10 mins	10.	Maternity Serious Incident Report	Assurance	Mrs AM Riley	Enclosure	**BAF 1**
10:45	**ENSURE EFFICIENT USE OF RESOURCES**					
5 mins	11.	Performance & Finance Committee Assurance Report (22-02-22)	Assurance	Mr P Akid	Enclosure	**BAF 6, 7, 8 & 9**
10:50	**ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT AND RESEARCH**					
5 mins	12.	Transformation and People Committee Assurance Report (23-02-22)	Assurance	Dr L Griffin	Enclosure	**BAF 1, 2, 3, 4 5**
10:55 – 11:10: COMFORT BREAK						
11:10	**ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS**					
40 mins	13.	Integrated Performance Report – Month 10	Assurance	Mrs AM Riley Mrs B Woodall Mrs R Vaughan Mr M Oldham	Enclosure	**BAF 1, 2, 3, 6 & 9**
11:50	**GOVERNANCE**					
10 mins	14.	Gender Pay Gap Report	Assurance	Mrs R Vaughan	Enclosure	
12:00	**CLOSING MATTERS**					
5 mins	15.	Review of Meeting Effectiveness and Business Cycle Forward Look	Information	Mr D Wakefield	Enclosure	
	16.	Questions from the Public **Please submit questions in relation to the agenda, by 9.00 am 7th March to nicola.hassall@uhnm.nhs.uk**	Discussion	Mr D Wakefield	Verbal	
12:05	**DATE AND TIME OF NEXT MEETING**					
	17.	**Wednesday 6th April 2022, 9.30 am via Microsoft Teams**				

University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 9th February 2022, 9.30 am to 12.15 pm
Via Microsoft Teams

MINUTES OF MEETING

Attended	Apologies / Deputy Sent	Apologies

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

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

In Attendance:	
Mrs L Rossiter	Patient Representative (item 1)
Mrs N Hassall	Deputy Associate Director of Corporate Governance (minutes)
Mr J James	
Mrs R Pilling	Senior Sister- Patient Experience (item 1)

Members of Staff and Public via MS Teams: 4

No.	Agenda Item	Action
1.	**Patient Story**	
015/2022	Mr James introduced Mrs Rossiter who subsequently described her admittance to UHNM. She explained that she had previously been diagnosed with suspected irritable bowel syndrome, following which, during her second pregnancy, she was transferred to her local hospital in Hereford and diagnosed with gall stones, which due to being pregnant had caused difficulties in the available treatment. She explained that it was therefore agreed for her specialist needs to be treated at Royal Stoke, although there was no ambulance available to transfer her to the hospital which resulted in an uncomfortable car journey. She explained that upon arrival to endoscopy everyone was aware of her and ready to receive her. She was seen by Dr Hebar and Mr James provided an extract of the report provided	

PROUD TO CARE

	by Dr Hebar in terms of the procedure undertaken which was different to the usual approach, due to the need to minimise risks to the baby. Mrs Rossiter explained she was subsequently discharged home and welcomed the follow up phone calls provided by Dr Hebar. Mr Wakefield queried whether, when the risks of the procedure were described to Mrs Rossiter, they were understandable and confirmed that the risks were explained clearly. Mrs Rossiter explained that she did understand the risks. Dr Lewis welcomed the approach taken by Dr Hebar in terms of the innovative solution identified to treat the problem, given the inability to utilise the usual x-ray, due to the risks to the baby. He stated that the Trust should be congratulated for taking forward such an approach. Mrs Bullock welcomed the story and stated she was proud of the innovative procedure undertaken, in addition to how the team worked with others in order to prepare for Mrs Rossiter ensuring she was treated by those with the right skills and expertise, given the associated complexities. Ms Bowen queried if Mrs Rossiter felt that there was anything which could have been improved in terms of follow up and Mrs Rossiter confirmed that the phone calls were sufficient and welcomed, and further follow up had been arranged via her local hospital. Mr Wakefield welcomed the innovative approach to treating Mrs Rossiter and apologised on behalf to the NHS for not having an ambulance available for the transfer. He in particular welcomed the follow up calls made by Dr Hebar. **The Trust Board noted the patient story.** Mrs Rossiter, Mr James and Mrs Pilling left the meeting.	
2.	**Chair's Welcome, Apologies & Confirmation of Quoracy**	
016/2022	Mr Wakefield welcomed members of the Board and observers to the meeting. It was confirmed that the meeting was quorate.	
3.	**Declarations of Interest**	
017/2022	Dr Griffin stated that he was involved with the assessment panel for the Midlands, which was referred to within the Chief Executives Report, and confirmed that he declared his UHNM interest as part of the assessment process. The standing declarations were noted.	
4.	**Minutes of the Previous Meeting held 5th January 2022**	
018/2022	The minutes of the meeting from 5th January 2022 were approved as an accurate record.	
5.	**Matters Arising from the Post Meeting Action Log**	

019/2022	PTB/498 – it was noted that further updates had been included within the IPC Board Assurance Framework and the sink replacement works were anticipated to start at the end of March to be completed by the end of Quarter 1. It was agreed that the action was complete. PTB/503 – it was noted that an announcement was awaited of when the go live of the planned care national pilot would take place, and this would be confirmed in due course. PTB/504 – it was noted that further detailed information on vacancies had been included within the Transformation and People Committee reports, although there were challenges in obtaining current benchmarking vacancy data. PTB/505 –Ms Ashley agreed to provide an update outside of the meeting. PTB/506 – It was noted that terms of the learning from the concern raised regarding confidentiality of medical records, the original storage facility involved had been replaced. It was agreed that the action was complete.	
6.	**Chief Executive's Report – January 2022**	
020/2022	Mrs Bullock highlighted a number of areas from her report. Mr Wakefield queried if the Trust was pleased with its position in terms of recruitment of Consultants and Junior Doctors and Mrs Bullock stated that she was pleased with the progress being made, although this continued to be a challenge and a main area of focus. Dr Lewis added that the challenge remained in terms of recruiting to substantive consultant posts and in particular the recruitment to hard to fill posts. Mr Akid referred to the ICS recruitment and queried if there was a possibility for the recruitment to result in UHNM staff leaving to undertake those roles. Mrs Bullock stated that for the clinical professional roles, the roles would be undertaken alongside their usual role, which may result in a reduction of PAs, but this was not expected to be an issue and was encouraged to ensure appropriate engagement in system developments. Professor Hassell queried if the report could be amended in future months, to highlight where internal appointments had been made and this was agreed. Ms Bowen queried when the military support was due to finish and Mrs Bullock confirmed that they were in place until the 11th February before being deployed elsewhere. **The Trust Board received and noted the report and approved EREAFs 8535, 8590, 8602, 8662, 8687 and 8688.**	**RV**
PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES		
7.	**Quality Governance Committee Assurance Report (27-01-22)**	
021/2022	Ms Belfield highlighted the following from the report: • Positive assurance was provided by pharmacy in terms of the ongoing actions being taken in relation to medicines safety, identifying themes and trends and establishing blocks to reporting	

	• The Committee noted their concern of the impact on staff wellbeing due to the sustained pressures on teams and were assured of the actions being taken to support staff • Further assurance was requested by the Committee in terms of pressure ulcers and in particular analysis of deep tissue incidents • Further assurance was to be provided at a future meeting in relation to readmissions **The Trust Board received and noted the assurance report.**	
8.	**IPC Board Assurance Framework (BAF) – January 2022**	
022/2022	Mrs Riley highlighted the following: • The document had been updated to reflect the new guidance from NHSEI although this did not result in additional actions being required • In terms of the deep clean of beds in the West Building, actions were being incorporated into the cleaning collaborative and once the cleaning standards had been reviewed the action would be complete • Visiting had been reviewed in line with the community transmission rate, and a phased approach to reintroducing visiting was being undertaken Mr Wakefield requested feedback from the NHSEI visit and Mrs Riley explained that the visiting team reviewed the measures in place and considered the cleaning standards and were assured of the standard of cleanliness which had been achieved and maintained. She stated that a further visit was being planned to take place in March 2022 and if performance was sustained it was anticipated that the Trust's rating would improve to green. Ms Bowen referred to BAF5 and the social distancing rules and queried what was in place. Mrs Riley stated that 2 metre social distancing was in place in high risk areas which would be reduced to 1 metre in low risk areas, based on completion of associated risk assessments and this was regularly reviewed. Ms Bowen referred to BAF8 and the changes in rules for lateral flow testing prior to elective procedures, rather than PCR testing, and she queried whether there had been any associated impact on transmission. Mrs Riley stated that the position was monitored closely and no issues had been highlighted to date. Professor Hassell referred to the expectation that visitors should continue to wear masks in hospital, and queried if the Trust expected mask wearing to continue even when Covid was less dominant. Mrs Riley stated that she felt masks worn during the winter period would be beneficial in order to reduce transmission of other seasonal illnesses and would strengthen existing infection prevention measures however the Trust would be guided by national guidance. **The Trust Board received and noted the report.**	
9.	**Bi-Annual Nurse Staffing Review Update**	
023/2022	Mrs Riley highlighted the following: • An update was provided on the progress made since the previous review and she highlighted that the full review had not been undertaken due to the impact of Covid and ward moves etc • 238 Registered Nurses had been recruited, which included 91 international	

nurses, and 142 nursing assistants. An additional 130 international nurses were to be recruited
- 81 Nurse Assistants who were Registered Nurses who were registered from another country were being supported to apply to become registered nurses with the Nursing and Midwifery Council
- 5 Registered Nurses had been appointed through the refugee nurse support programme
- Positive student evaluations had been provided
- An establishment review was expected to be completed in the summer and it was noted that the review would start to include Allied Health Professionals (AHPs) and the wider workforce ion non-ward based areas

Professor Hassell congratulated the Trust on the positive student feedback received and queried if the Trust continued to have enough capacity for students. Mrs Riley stated that capacity for students was in place, although the timing of recruiting the students was crucial to ensure staff were able to adequately support the students, ensuring they get the best experience from their training.

Dr Griffin welcomed the positive work being undertaken and queried the net increase in staffing, given the number of staff leaving. In addition he queried how the position compared to that of 2 to 3 years ago. Mrs Riley stated that nationally, the number of Registered Nurses seemed to have increased but only to 2018 levels. She stated that the main increase in registrants was due to Nursing Associates and international nurses therefore work was required in terms of growing our own. Mrs Riley agreed to provide feedback to the Transformation and People Committee (TAP) on net numbers and how the position related to previous years, including turnover rates for nurses. AMR

Ms Bowen referred to staffing levels and associated red flags and queried whether it was possible that red flags were being under reported. In addition, she queried that when Datix incidents were completed how it was established whether the incident had caused patient harm. Mrs Riley stated that the site safety dashboard provided clear oversight of staffing, which enabled information to be provided by ward and this identified any red flags raised by the Ward. She added that review of the dashboard also enabled visibility of any shortfalls where red flags had not been raised, enabling action to be taken. She added that any incidents resulting in harm were reviewed as part of a Root Cause Analysis and this included consideration of whether staffing levels were a contributing factor.

Ms Gohir referred to the reference in the document of ethical recruitment of international nurses and queried what that meant. Mrs Riley explained that there were a number of countries where the Trust does not recruit from for ethical reasons, either directly or through agencies. She stated that any direct applicants from nurses in those countries were not shortlisted.

Ms Gohir referred to the reference of overseas nursing assistants needing to meet the required level of English and she queried the timeline for individuals to reach the level required. Mrs Riley stated that the timing varied on the individual and the support required but on average could take between 3 and 4 months.

Mr Wakefield welcomed the extension of the review of the workforce to incorporate AHPs.

The Trust Board received and noted the report.

ENSURE EFFICIENT USE OF RESOURCES

10.	**Performance & Finance Committee Assurance Report (25-01-22)**	
024/2022	Dr Griffin highlighted the following from the report: • A number of business cases were agreed to provide additional staffing which aimed to address associated quality and safety concerns • The Committee recognised the main constraint of the availability and capacity of workforce to address current performance challenges, rather than finance • Cancer performance continued to be challenged • The positive impact of the targeted lung health checks in identifying potential cancer cases earlier was recognised • Consideration was given to the Board Assurance Framework and a number of changes were agreed which had been reflected in the document provided to the Board **The Trust Board received and noted the assurance report.**	
ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT & RESEARCH		
11.	**Transformation and People Committee Assurance Report (26-01-22)**	
025/2022	Professor Crowe highlighted the following from the report: • Positive assurances were received in respect of the level of activities being undertaken to support equality, diversity and inclusion • A number of concerns were raised in terms of the nursing establishment review, whilst noting the work undertaken and plans in place, that the full review had not been able to be undertaken. The Committee welcomed the approach to broaden the scope of the review to include other areas beyond ward based activities • A broader workforce plan had been scheduled to be considered by the Committee in due course • Some delays were noted in relation to taking forward some programmes of activity such as the culture programme and the Committee requested assurance of the programmes in place in terms of their coordination and deliverability, given limited resources • The Committee noted the actions being taken to reduce the number of days being taken to complete non-complex disciplinary cases • Work had continued in respect of Improving Together, although challenges with attendance and maintaining momentum were highlighted due to the pressures experienced during December and January Mr Wakefield welcomed the reference to AMU and SAU continuing with their improvement huddles, despite the pressures, which he had witnessed on a recent walkabout. **The Trust Board received and noted the assurance report.**	
12.	**Speaking Up Report – Quarter 3**	
026/2022	Mrs Vaughan highlighted the following: • 35 speaking up concerns had been raised with similar themes to previous quarters • A campaign had been launched regarding supporting staff with disabilities and as a result there had been an increase in the number of contacts being made in relation to this via the Freedom to Speak Up route	

	• A number of queries had been raised by staff in relation to vaccination as a condition of deployment (VCoD), which had since been addressed due to the anticipated change in government policy • Further reports would review and consider trends associated with divisional reporting • Recruitment to expand the diversity of Associate Freedom to Speak Up Guardians was to be undertaken, whilst recognising the diversity of the existing Employee Support Advisors • The Trust had successfully appointed to the Lead Freedom to Speak Up Guardian • The Speaking Up policy had been updated in accordance with National Guardian Office guidance and a gap analysis was to be completed in relation to learning and good practice • Speaking Up training had been launched for staff and Board Members were also required to undertake training which would be incorporated in a future Board Seminar Mr Wakefield referred to the difficulties in mandatory training compliance due to pressures and queried how this would impact upon the speaking up training. Mrs Vaughan stated that in addition to the mandatory training, this was addressed via the gateway leadership development programmes. Mr Wakefield queried the reasons for the delay in closing one of the older cases and Mrs Vaughan stated that this was a large case which required independent investigatory processes resulting in the review taking longer than usual. Professor Crowe welcomed the approach and work undertaken by Charlotte Lees, as Freedom to Speak Up Guardian, and stated that it was a positive step to make the role to full time, which demonstrated the commitment to establish this strongly in the organisation. Ms Bowen referred to previous themes and queried if these were compared to themes in previous years. Mrs Vaughan stated that trends over time were considered, in addition to triangulating information with other information available such as complaints etc. Mr Wakefield queried the progress being made to improve the diversity of Freedom to Speak Up Guardians and Mrs Vaughan stated that the staff networks were being asked to consider and promote the appointments to the additional associate roles. **The Trust Board received and noted the assurance report.**	
ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS		
13.	**Integrated Performance Report – Month 9**	
027/2022	Mrs Riley took the paper as read but highlighted the following: • Pressure ulcer rates per 1000 bed days remained static although the number with moderate harm and above had reduced. The change in reporting in June/July was highlighted which resulted in a difference between the un-validated and validated position • The main area of concern in relation to pressure ulcers, is of those with deep tissue injury and the Board noted that further information was being obtained to establish the reasons and root causes for these incidents, which would be provided to the Quality Governance Committee in March	**AMR**

- It was confirmed that pressure ulcers were reported in real time and actions undertaken at the time to identify any remedial action required

Professor Hassell queried if all deep tissue cases would be subject to a Root Cause Analysis (RCA) and Mrs Riley confirmed that all cases would be reviewed in order to establish the reasons for the increase.

Professor Maddock referred to the upward trend in reporting of pressure ulcers and queried whether this was being experienced throughout the Trust or whether the cases were in particular areas. Mrs Riley stated that each review considered the journey the patient had been on as the reporting ward may not be the same as the ward where the damage occurred.

Ms Bowen referred to the two never events and queried if further background information was available and whether any trends had been identified. Mrs Riley confirmed that the two incidents were not related, although RCAs were being undertaken, following which the findings would determine the additional learning and actions required.

Ms Gohir referred to the emergency caesarean section rates which had increased and Mrs Riley stated that the key was ensuring the sections were appropriate for the individual and this assurance had been provided by the clinical team. Professor Hassell added that once the Trust commenced reporting on the Robson criteria the position would improve in terms of identifying the appropriateness of the caesarean sections.

Mrs Bullock highlighted the following in relation to urgent care:

- There had started to be an improvement the in total number of ambulance holds but this was mostly due to validation of data and 60 minute waits continued to be a challenge, mainly due to poor flow through hospital, high bed occupancy and increasing length of stay for patients over 21 days, in addition to the number of patients who were medically optimised for discharge
- In January a number of Multidisciplinary Discharge Events (MADE) had taken place which identified the key areas to be focussed on such as simple and timely discharges, and actions for social care and system partners were focussed on reducing medically optimised for discharge patients
- Nationally, work had been undertaken in relation to expediting discharge and the report was awaited in terms of the 13 interventions to be considered, and once received this would be reviewed to establish the actions required
- Pressures in the Emergency Department continued to be experienced, and approximately 150 patients were in the Trust who were Covid positive, and this number was remaining static, with the majority of patients being cared for by the Medical Division, which was impacting on flow and productivity
- The Trust continued to consider the new Urgent and Emergency Care (UEC) standards which were to be introduced in April 2022, with the main focus on reducing the total time spent in the Emergency Department

Mr Wakefield referred to the new UEC standards and queried, given the work to be completed to improve flow and work in the system, how the programme of work would be managed. Mrs Bullock explained that this was monitored via the Non-Elective Improvement Group, and the associated work streams, one of which focused on the UEC standards. In addition the other 2 work streams aimed at identifying actions to be taken to make a difference in performance.

Mr Akid queried the progress being made to recruit additional Emergency Department workforce, and it was noted that to date a number of middle grade

doctors had been recruited and interviews were ongoing. In addition, recruitment to the Advanced Nurse Practitioners was being undertaken.

Dr Griffin referred to the focus on improving discharges and queried why the effort to increase the number of discharges prior to Christmas could not be sustained. Mrs Bullock explained that the limiting factor related to workforce and community / domiciliary care capacity. This capacity had been exhausted prior to Christmas.

Mrs Bullock highlighted the following in relation to cancer performance:

- The Trust continued to focus on validating the number of patients being treated, which was increasing
- As patients were treated, performance would deteriorate due to those patients being treated having breached the waiting time
- Breast cancer remained a significant challenge but the planned care position overall was positive and was not deteriorating

Mr Wakefield requested an update on progress in delivering the 104 week trajectory and Mrs Bullock explained that regulators had requested that the Trust reach a position of zero by the end of March 2022, although the Trust submitted a realistic and achievable trajectory, and apart from 40 patients the Trust was on track to deliver what it had planned.

Ms Bowen referred to outpatients and the reference to virtual care and queried the definition of virtual care and whether this aligned to virtual wards. Mrs Bullock explained that virtual care related to outpatients and the number of patients being seen remotely via video or telephone etc. She explained that virtual wards were different but both were used to prevent admission or expedite discharge.

Ms Ashley explained that the planning guidance included a number of targets for virtual wards and the Trust's annual plan would include a section on how it expected to support virtual care for our population.

Mrs Bullock added that in terms of DM01 performance, the main issue related to reduced capacity as a result of Covid in particular for non-obstetric ultrasound.

Mrs Vaughan highlighted the following in relation to workforce:

- At month 9 sickness absence was challenged and an increase in absences continued during December and January
- Presently, Covid related absence had reduced which was positive, to 37% of total absences
- Assurance was being sought from divisional teams on managing sickness absence management and ensuring clinical teams were provided with their management time to enable proactive management
- The workload in relation to preparing for VCoD had been particularly challenging although this had since ceased due to the change in government direction. It was noted that the Trust would continue to encourage staff to have the vaccination if they had not done so
- There had been a slight improvement in appraisal rates as at month 9
- Core statutory and mandatory training stood at 95.50%
- It was noted that the vacancy rate included the additional posts identified in recently approved business cases and reflected the associated lag in recruitment
- The Trust's risk assessment had been updated to reflect concerns of workforce availability

	Mr Wakefield referred to the planned vacancy rates and stated that the ability and timing of recruiting to those posts needed to be identified. Professor Crowe requested an update to be provided to TAP in relation to statutory and mandatory training, identifying any areas and pockets of concern and low percentages which needed to be addressed. He referred to the significant amount of work undertaken in relation to VCoD and felt that this needed to be recognised. Professor Crowe queried the consequences of the changes in guidance regarding VCoD whilst ensuring continuing engagement with staff as part of supporting their health and wellbeing. Mrs Vaughan confirmed that the Trust continued to promote vaccination with staff and awaited further guidance in respect of the national changes. She added that risk assessments continued to be undertaken for each member of staff which incorporated discussions with regards to their health status and any mitigation required. Mr Oldham highlighted the following in relation to financial performance: • A surplus of £15.6 m year to date had been identified, which was in line with forecast and driven by workforce shortages, the ability to step up activity and continuing to receive income for Covid • The Trust forecast remained at a £5.1m surplus and given the strong financial performance, this position continued to be discussed with the system and proposals were being considered which aligned the Covid allocation across the system, with some return on investment being provided to the CCG to support patients out of hospital, via the Better Care Fund • £17.9 m of capital had been spent to date, which was £2.8 m behind plan. Underspends continued to relate to digital pathology and estates backlog, with a number of schemes being brought forward from 2022/23 as mitigation. A number of schemes had been added as a result of additional Public Dividend Capital funding whereby there was a risk of these not being delivered within the timescale, relating to critical care, elective recovery and cyber security and this would form part of considerations for the 2022/23 capital plan • Cash position stood at £83 m which was £5 m better than plan and this had been driven by the slippage on capital and over performance on income and expenditure **The Trust Board received and noted the performance report.**	RV
GOVERNANCE		
14.	**Audit Committee Assurance Report (27-01-22)**	
028/2022	Professor Crowe highlighted the following from the report: • Positive assurances were provided in relation to the completion of the current years internal audit plan • The Committee considered the latest version of the Board Assurance Framework and welcomed the positive developments in terms of the format and use of the framework. The gap between the current risk scores and target risk scores were challenged and it was agreed to consider this further at the Board Seminar in March in terms of the actions required to bridge the gap • An update from External Audit was provided on the planning for their audit and the Committee requested information to be provided on the level of accruals in the accounts for annual leave	

	• An update was provided by the local counter fraud team and the Committee supported the actions being taken and approved the plan for 2022/23 • A number of concerns were raised in relation to an internal audit review relating to 18 week referral to treatment which received a partial assurance rating and an improvement plan was in place relating to training and ongoing auditing • Given the current circumstances and pressures, there had been delays in progressing previous internal audit recommendations and the Corporate Governance Team aimed to provide updates in relation to progressing the recommendations at the next meeting **The Trust Board received and noted the assurance report.** Mrs Freeman left the meeting	
15.	**Board Assurance Framework (BAF) – Quarter 3**	
029/2022	Mrs Hassall highlighted that the BAF had been considered and scrutinised by Committees during January following which a number of updates were made to the document which had been summarised in the report. During quarter 3 there had been an increase in the number of risks which had increased in risk score, mainly reflecting the staffing and operational pressures and this affected risks 1, 3 and 6. It was noted that the strategic priorities of high quality and responsive remained the most under threat. Mr Wakefield welcomed the changes to the report and inclusion of the Assurance Map. **The Trust Board received and noted the assurance report.**	
CLOSING MATTERS		
16.	**Review of Meeting Effectiveness and Business Cycle Forward Look**	
030/2022	No further comments were raised. Professor Maddock left the meeting.	
17.	**Questions from the Public**	
031/2022	Mr Syme referred to the visit by NHSEI and follow up email from Professor Fong which stated that 'pressures are unsustainable…'. He queried what level of pressures were sustainable and what was required by the Trust and its partners to reach a level of pressure that in this instance would be able to be addressed 'sustainably'. Mrs Bullock stated that there were a number of contributing factors in terms of sustainability and a number of factors required consideration prior to declaring an incident. She provided the context behind the visit which was undertaken as a result of calling the critical incident, whereby the approach and decision was reviewed to establish whether this was appropriate. It was noted that Professor Fong concluded that the Trust had no choice but to declare the incident, which enabled additional mitigation to manage the pressures to be identified.	

	Mr Syme referred to independent sector usage and the reference in the integrated performance report to Nuffield being at capacity for trauma and orthopaedics until mid-April 2022. He queried the impact this would have on UHNM performance from now until mid-April 2022 and what mitigations were being put in place by the Trust to minimise any impact on the Trusts performance. In addition he referred to the significant pressures on diagnostics whereby the report stated that 'Ramsay have improved somewhat'.. in endoscopy reporting but stated that there were still time lags in that reporting. He queried what the requisite reporting timescales were and when it was projected that such will be attained. Mrs Bullock referred to the Nuffield and stated that the levels of activity had been factored into current reporting and associated trajectory, therefore there was no deterioration in performance. She stated that the Trust's preference would be to undertake the work ourselves, and was part of the reason that the 7th theatre at County Hospital was being brought online, which would solely be utilised for trauma and orthopaedics elective activity. Mrs Bullock stated that in terms of Ramsay, endoscopy had previously been undertaken there and there had been issues in the timeliness of reporting, which had since improved but there was no national target in this regard. Mr Syme referred to the NHS constitution standards for cancer and stated that in 2021 the Trust reported a "Nurse led Community Breast Pain Clinic' would be fully operational by November 2021 to address some demand issues. He queried why the clinic had over a 2 month hiatus to commence work and queried when it would become fully operational. Mrs Bullock stated that the clinic aimed to be in place by the second week of March. She stated that initially the Trust aimed to follow the Nottingham model which was based on best practice, but as part of getting the service commissioned, the model needed to be renegotiated, resulting in delays to implementation. She added that in addition, the Trust continued to work with the CCG on a long term sustainable model but the model to be implemented in initially would be solely delivered by UHNM workforce. Mr Syme referred to cancer two week wait breast symptomatic performance in December which decreased to 4.7% attainment with 81 breaches of the 85 needing to be seen. He queried the reasons for this and queried what was being implemented to ensure standards in this metric improved. Mrs Bullock stated that the performance related to breast symptomatic patients not cancer patients, and therefore required different treatment. She stated that this had been challenged due to the need to prioritise breast cancer patients above the symptomatic patients and was why symptomatic breast performance was so poor, therefore the introduction of the breast pain clinic aimed to improve the performance. Mrs Bullock provided assurance that breast cancer patients were being seen in a timely manner in line with the NHS constitution, although the overall target was impacted on the symptomatic performance. It was noted that workforce and capacity was the main challenge to improving performance in this area, although an additional breast radiologist had been recruited and additional clinic capacity was being brought online.	
DATE AND TIME OF NEXT MEETING		
18.	Wednesday 9th March 2022, 9.30 am, via MS Teams	

Trust Board (Open)

Post meeting action log as at 02 March 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.

Ref	Meeting Date	Agenda Item	Action	Assigned to	Due Date	Done Date	Progress Report	RAG Status
PTB/498	07/12/2021	IPC Board Assurance Framework – November 2021	To obtain the information in relation to timescales and impact of the sink replacement programme	Ann Marie Riley	09/02/2022	09/02/2022	Further updates included within the IPC Board Assurance Framework and the sink replacement works were anticipated to start at the end of March to be completed by the end of Quarter 1.	B
PTB/502	07/12/2021	Integrated Performance Report - Month 7	To take an update to the QGC in terms of covid / nosocomial death reviews	Matthew Lewis	24/03/2022		Action not yet due.	GB
PTB/503	07/12/2021	Integrated Performance Report - Month 7	To confirm the timescale associated with the planned care national pilot	Helen Ashley	09/03/2022		Update provided in February, noting that an announcement was awaited of when the go live with the planned care national pilot would take place and this would be confirmed in due course.	GB
PTB/504	07/12/2021	Integrated Performance Report - Month 7	To provide benchmarking information in relation to vacancy rates.	Ro Vaughan	09/02/2022	09/02/2022	Update provided in February. Further detailed information on vacancies has been included within the Transformation and People Committee reports, although there was challenges in obtaining current benchmarking vacancy data.	B
PTB/505	07/12/2021	Integrated Performance Report - Month 7	To obtain an update in relation to the timescales associated with completion of the Digital Pathology programme.	Helen Ashley	09/03/2022		**Update required**	GB
PTB/506	07/12/2021	Raising Concerns Report – Quarter 2	To obtain further information in relation to learning associated with the case referring to storage of confidential records.	Ro Vaughan	09/02/2022	09/02/2022	Confirmed that the original storage facility involved had been replaced.	B
PTB/507	05/01/2022	Patient Story	To work with Mr Frary on ways to improve communication with transgender patients, taking forward conversations with clinical teams. To provide an update to QGC on this.	Ann Marie Riley Matthew Lewis	28/02/2022	24/02/2022	Complete - update provided to February's Quality Governance Committee.	B
PTB/508	09/02/2022	Chief Executive's Report – January 2022	To amend future reports to highlight where internal appointments had been made.	Ro Vaughan	09/03/2022	02/03/2022	Complete. Report updated to include internal clinical appointments.	B
PTB/509	09/02/2022	Bi-Annual Nurse Staffing Review Update	To provide feedback to the Transformation and People Committee (TAP) on net numbers of nursing recruitment, how the position related to previous years, including turnover rates for nurses.	Ann Marie Riley	23/03/2022		Action not yet due.	GB
PTB/510	09/02/2022	Integrated Performance Report - Month 9	To provide the Quality Governance Committee with further information in relation to deep tissue pressure ulcers	Ann Marie Riley	23/03/2022		Action not yet due.	GB
PTB/511	09/02/2022	Integrated Performance Report - Month 9	To provide an update to TAP in relation to statutory and mandatory training, identifying any areas and pockets of concern and low percentages which needed to be addressed.	Ro Vaughan	23/03/2022		Action not yet due.	GB

Chief Executive's Report to the Trust Board

FOR INFORMATION

Part 1: Trust Executive Committee

The Trust Executive Committee met virtually on the 2nd March 2022.

- The committee received a presentation from Lorraine Whitehead based on work completed by healthcare planners in relation to potential developments at the County Hospital site. These are very early discussions and significantly more detailed work is required to include activity and appropriate clinical models. Dr Matthew Lewis is chairing a group that will take this forward with Helen Ashley. Closed Board will receive updates when the work is detailed enough and sufficiently evolved.
- All Divisions highlighted the work being undertaken as part of the reset/refresh week, which included focussing on increasing the amount of elective activity, ward based processes, creating earlier discharges, reducing the number of medically fit for discharge patients, improving ambulance handover times and reducing the numbers of patients waiting over 12 hours in our Emergency Department
- Surgical Division highlighted a small drop in procedures during half term but in general productivity was on an upward trend, working towards achieving 19/20 levels in April and in particular, County theatre productivity had improved significantly. Staff absence had started to reduce and availability rates were improving but some challenges remained in theatres and critical care, in particular the critical care consultant workforce
- Medical Division highlighted the continued work being undertaken to review the urgent care model as a whole in particular care at the front door and the significant staffing challenges were noted in relation to winter escalation areas.
- Specialised Division highlighted the main risks of the 104 week position and the P2 backlog, although there had been some improvements in the orthopaedic P2 list. The timeline to return the elective orthopaedic ward at Royal Stoke had been agreed as 28th March and staff were being rotated to prepare them to restart the service. In addition an increase to orthopaedic theatre access at County was expected in April.
- Children's, Women's and Diagnostics highlighted a number of new appointments made within the Division, the positive reduction in the histology backlog was noted, which had reduced by over 2000 in the past week although there remained a lot of work to be done to improve this further
- It was noted that wellbeing and leadership development opportunities were being brought back on line and refreshed during March.
- The heightened and increased risk around cyber security was highlighted, as a result of situation with Russia and Ukraine and a number of additional steps and measures were being put in place as mitigation with awareness of the increased risk being raised with staff
- System financial performance continued to be considered in readiness for the draft submission required by 17th March, and it was noted that the system was currently forecasting a deficit and the factors impacting upon the position were being explored.
- Whilst final guidance in respect of the elective recovery fund was awaited, the Trust continued to work with PwC, part of their nationally commissioned work with the ICS to develop an overall elective recovery plan
- The planning application for the car park development at Grindley Hill Court had been submitted and a decision should be received in April.
- As a result of tracking community and hospital covid rates, which had continued to reduce, the Trust had relaxed visiting from 2nd March enabling all patients to have a named visitor for an hour and for one adult to accompany patients through emergency portals
- In response to the situation in Ukraine, the Trust was promoting donations to relevant charities such as the Red Cross

Part 2: Chief Executive's Highlight Report

1. Contract Awards and Approvals

Department of Health Procurement Transparency Guidance states that contract awards over £25,000 should be published in order that they are accessible to the public. Since 13th January to 10th February, 3 contract awards, which met this criteria, were made, as follows:

- **Blood Sciences managed service contract Y9 year-end balance** supplied by Siemens Healhineers UK at a total cost of £652,818.63, for the period 01/10/20 - 30/09/21 approved on 25/01/22
- **Shoulder Arthroplasty and Extremities (Fingers, Toes, Ankles and Elbows)** supplied by NHS Supply Chain at a total cost of £967,591.42, providing savings of £967,591.42, for the period 01/02/22 - 02/02/24, approved on 25/01/22
- **Occupational Health Services** supplied by TP Health Ltd at a total cost of £801,505.20, providing savings of £23,764.50, for the period 01/02/22 - 31/03/23, approved on 25/01/22

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

National Blood Service (eREAF 8858)

Contract Value £3,800,000.00 incl. VAT
Duration 01/04/22 - 31/03/23
Supplier NHS Blood and Transport Service

Savings - No savings

Interventional Radiology Consumables (eREAF 8831)

Contract Value £1,526,930.68 incl. VAT (plus an option to extend for 12 months)
Duration 01/04/22 - 31/03/24
Supplier Various

Savings - Cost Avoidance Saving of £85,962.00 incl. VAT
Negated Inflation Saving in Year two of £10,179.54 incl. VAT

Theatres Da Vinci Xi Eco System Surgical Robot (eREAF 8814)

Contract Value £2,038,800.00 incl. VAT
Duration Capital Purchase
Supplier Intuitive Surgical Ltd

Savings - A £526,000.00 Incl. VAT cost avoidance savings has been achieved from a trade in discount and an additional discount from this being a second system on site.

Annual Expenditure Supply Chain Coordination Limited (SCCL) and High Cost Tariff Devices (HCTED) (eREAF 8801)

Contract Value £28,790,291.08 incl. VAT
Duration 01/04/22 - 31/03/23
Supplier Supply Chain (SCCL)

Savings - Supply Chain savings are captured and recorded on an on-going basis throughout the financial year. There are no savings for HCTED as this is a pass through cost to the Trust with monies being re-charged back through NHS England.

Anticoagulation (INR) testing into the Roche Managed Service Contract (eREAF 8740)

Contract Value £1,375,664.00 incl. VAT
Duration 01/04/22 - 31/03/27
Supplier Roche Ltd

Savings - Total saving £48,893.99 incl. VAT
VAT recovery saving of £29,825.10 incl. VAT, cost reduction saving £13,160.82 incl. VAT and Negated Inflation saving £5,908.07 Incl. VAT per annum.

Endoscopy Diagnostic Services - 18 Week Support (eREAF 8693)

Contract Value £1,099,000.00 incl. VAT
Duration 01/04/21 - 31/03/22
Supplier 18 Week Support Ltd

Savings - No savings

DarkTrace (eREAF 8624)

Contract Value £1,646,328.00 incl. VAT
Duration 26/03/22 - 25/03/27
Supplier Softcat Ltd

Savings - Total Negated Inflation saving - £26,341.25 incl. VAT

Cytotoxic Dose Banded - Chemo, Immunotherapy and Monoclonal Medicines (eREAF 8547)

Contract Value £4,048,104.50 incl. VAT
Duration 01/12/21 - 26/03/22
Supplier Qualasept Bath ASU and Baxter's

Savings - No savings

The Trust Board are asked to approve the above eREAFs.

2. Consultant / Medical Management Appointments

The following provides a summary of medical staff/management interviews which have taken place during February 2022:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Locum Consultant Radiology with interest in Thoracic/Lymphoma Imaging	New	Yes	TBC
Locum Oral Max Surgeon	New	Yes	11/04/2022
Locum ENT Consultant	New	Yes	19/04/2022
Locum Medical and/or Surgical Retina Consultant Ophthalmologist	Vacancy	Yes	09/05/2022
Locum Consultant Gynae-oncologist	Vacancy	Yes	30/05/2022
Consultant Neuro Anaesthetist	Vacancy	Yes	05/09/2022

The following provides a summary of medical staff/management who have joined the Trust during February 2022:

Post Title	Reason for advertising	Start Date
Specialist Grade - Breast Radiology	Vacancy	17/02/2022
Consultant Intensivist	Extension	01/02/2022
Consultant Gastroenterologist	Retire & Return	07/02/2022
Locum Consultant Orthopaedic Surgeon - Fragility Fractures	Vacancy	14/02/2022
Locum Consultant Plastic Surgeon	Vacancy	13/02/2022
Locum Consultant, Colorectal & General Surgeon	Extension	17/02/2022
Consultant Radiologist MSK	Retire & Return	14/02/2022
Specialist Doctor in Clinical Haematology	Vacancy	10/02/2022
Locum Consultant Paediatrician - PICU	Vacancy	28/02/2022
Consultant Histopathologist	Vacancy	28/02/2022
Child Health Clinical Lead for PICU	Vacancy	01/02/2022

The following provides a summary of medical vacancies which closed without applications / candidates during February 2022:

Post Title	Closing Date	Note
Consultant Uroradiologist	27/01/2022	No Applicants
Respiratory Consultant 3 x Various specialties	27/02/2022	No Applicants
Clinical Director for Specialist Medicine	27/02/2022	No Applicants
Clinical Lead - Respiratory Medicine	27/02/2022	No Applicants

3. Covid 19 and Trust Pressures

Here at UHNM the numbers of patients we are caring for with Covid-19 has dropped from more than 150 to just over 100 in the last few weeks. The demand on our critical care services has remained very low and we are now returning to what would normally be expected for this time of year. Staff sickness is also improving, although not where we want it to be yet and the numbers of patients still in our hospitals who are medically fit for discharge has reduced from more than 220 to around 120. We continue to work with our partners to reduce this further and to at least below 100 in readiness for the reset week we are starting on 7 March where we will be focusing effort on improvement in a number of areas including ambulance handover times, the numbers of patients waiting over 12 hours in our emergency departments and further reduce the numbers of medically fit patients in our hospital beds. This improving position has meant that we are almost back to normal levels of operating with our planned teams working through the backlog of patients who have been waiting far longer than we would have wanted for their operation.

4. Operation Anzu

The Trust is undertaking a review of patient case notes as a result of an on-going police investigation. This has been widely reported in the media and is in relation to concerns about the appropriateness of care provided by an individual who worked in the NHS, and in relation to University Hospitals of North Midlands at Royal Stoke University Hospital. The individual no longer works the Trust.

As part of our review, we are writing to a number of families about the care they or their family member received and we have advised them to speak to the police. We have also set up a dedicated helpline for concerned patients 01782 672540.

As this is a police investigation, we are very limited in what we can say therefore detailed updates will be provided to future Closed Board sessions until the Police investigation has concluded.

5. JAG Accreditation

I am pleased to report that following the annual review of services at Royal Stoke and County Hospital by the Joint Advisory Group on GI Endoscopy, the Trust has met all of the required JAG accreditation standards and has had its accreditation renewed until October 2022. This is a major undertaking so thank you and congratulations to the team for achieving this high standard and for all their hard work throughout what is a very challenging accreditation process.

6. National Education and Training Survey (NETS) Report

The NETS survey is undertaken 3 times a year and the most recent results have demonstrated that UHNM are in the top quartile for providers of training and third in the West Midlands, with particularly positive results in relation to supporting and empowering learners. These results demonstrate a significant improvement, despite the pressures experienced during the Covid pandemic and the results will continue to be utilised to drive improvements in training, alongside the annual General Medical Council survey.

7. Planned Approach to the Integrated Care Board (ICB)

Preparations are underway to transition from an Integrated Care System (ICS) Board to an Integrated Care Board (ICB) format. Initial guidance recommends we operate the ICB in shadow form from April 2022 until we become a statutory body on 1 July 2022, subject to legislation. Where possible the system will also operate governance arrangements that underpin the ICB, for example, the ICB Shadow Audit Committee meetings to support due diligence activity.

On this basis the meetings in March and April will be private ICB Board meetings/development sessions and it is anticipated that a public meeting of the shadow Integrated Care Board will be held in May to transact any formal transfer requirements and introduce the public to our new arrangements. A future programme will be shared with members once finalised.

To ensure that we adopt responsibilities/processes in a timely manner, we plan to hold the first meeting of the ICB Board as a statutory organisation on 1 July 2022.

8. Integrated Care System Board Briefing

The ICS Board met on 17th February 2022 and a summary of the items considered are provided below:

- **The ICS Chair and Interim Integrated Care Board Chief Executive Officer's Report** acknowledged the system work being undertaken regarding lessons learned from the pandemic, the actions being taken to recruit to the ICB, the launch of the public conversation on the Staffordshire Health and Wellbeing Board draft strategy and development of the Strategic Community Safety Forum and the re-launch of the 'Together Against Abuse' campaign
- The work undertaken to date on the **COVID-19 summary position and update on Level 4 oversight arrangements** was noted in addition to noting the key **ICS urgent and emergency care statistics and metrics**
- The Board congratulated the Covid-19 Programme on the national recognition received, and the great work achieved in relation to the **Covid Vaccination Programme**
- The **developing a future approach to working with people and communities** engagement work was acknowledged and the Board supported the next steps in developing the associated ICB strategy
- The **system performance and finance report** highlighted a £5.7 m surplus plan for 2021/22 with a month 9 position of £27.5 m surplus
- The **National Operational Planning Round 2022/23** guidance was noted, along with the associated priorities and work to develop the 2022/23 Staffordshire and Stoke on Trent ICS Operational Plan
- The key quality and safety challenges faced by the system were acknowledged within the **System Quality and System Safety Update Report**

Papers for the meeting held on 17th February can be found on the following link: https://www.twbstaffsandstoke.org.uk/publications/730-board-papers-17-02-22/file

9. Integrated Care Partnership (ICP) Update

As you will be aware, ICPs are a requirement of all Integrated Care Systems. The core purpose is to receive the ICS long term strategy and oversee its implementation. It is anticipated that there will be an initial ICP meeting in July that will be an introductory session. This will set the scene for 2022/23 and discuss the approach to developing the ICP strategy, which is required by April 2023.

10. International Women's day

On the 8th March we once again celebrate International Women's Day, a global day that highlights the social, economic, cultural and political achievements of women. As women make up more than 70% of our workforce, it's imperative we continue to work on gender equality.

On the 8th March, we will host our own "Women in Leadership" seminar which will focus on our own gender pay gap as well as providing inspirational stories from some of our fantastic leaders.

11. Chief People Officer

With immediate effect the title of Director of HR, held by Ro Vaughan will be changed to Chief People Officer. The title aligns to the report by NHSE/I Chief people Officer, The Future of NHS Human Resources and Organisational Development and the NHS People Plan. It also recognises the breadth of the portfolio which extends beyond tradition HR and incorporates many other aspects such as OD and work force planning and strategy etc.

12. Routine Quarterly System Review Meeting (QSRM)

On the 24th February 2022, system leaders attended the QSRM. The purpose of the meeting was to review the current areas of focus across the system and to discuss the key challenges that will be faced by the system over the coming months. The recent challenges of the Omicron virus wave of infection were acknowledged, including high numbers of patients admitted and the impact on staff absence across the system.

The changes in system leadership were also noted:

- Mr Peter Axon as interim ICS CEO
- Dr Buki Adeyemo interim CEO at North Staffordshire Combined Healthcare Trust.
- We also welcomed Phil Smith who has recently taken up the role of ICS Delivery Director on an interim basis.

Areas of particular positive progress were:

- The support with mutual aid provided by UHNM to other acute providers was recognised and appreciated.
- The recent Readiness to Operate (ROS) assessment was strong and there is a clear plan in place, with robust governance and programme management arrangements, to manage the transition of CCG responsibilities to ICB establishment
- The ICB Board constitution is agreed and recruitment is progressing well with five NEDs confirmed and the executive director recruitment was expected to be completed by the end of March
- There is good progress on recovery of GP capacity with available appointments now at 103% of the 2019 baseline and face to face appointments at 61% in line with the regional average
- The system is close to achieving its adult trajectory target for Learning Disabilities and/or Autism (LD&A) and GP practices have increased the number of people on the LD register compared to the same period last year

Key challenges for the system and were also discussed in more detail:

- Sustained UEC pressures across the system which are resulting in an unacceptable level of risk being held in ambulance handover delays
- High numbers of patients waiting over 104 weeks
- Significant numbers of patients waiting over 62 days for cancer treatment with a high proportion without a decision to treat

Other areas such as Maternity and compliance with Ockenden recommendations, FIT testing, system finance for 2022/23 and ICS Development were also discussed. The meeting particularly noted the good progress on our preparation for ICB transition and the strong programme management and governance arrangements in place. Emerging concerns relating to the structure of Place following the recent White Paper were noted and the importance of GP involvement and provider collaboration were discussed.

13. Chief Executive Interim Arrangements

As I will be on leave following planned surgery for a period of approximately 6 weeks, interim arrangements have been established. Mrs Helen Ashley, Deputy Chief Executive will be the Acting Chief Executive and Mr Mark Oldham, Chief Finance Officer will be the Deputy Chief Executive.

Committee Chair's Highlight Report to Board

Quality Governance Committee

24th February 2022

NHS
University Hospitals of North Midlands
NHS Trust

1. Highlight Report

!	Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
	• The Committee received an update on the implementation of regional guidance which aimed to reduce the risk of ex-utero transfer and promote neonates under 28 weeks birthing in a level 3 unit. This has potential significant implications for UHNM (a level 3 unit). • It was agreed that further consideration was required in terms of reviewing neonatal data with the relevant UHNM team to determine further actions. • Due to unforeseen sickness absence in the maternity team, the Committee felt that the maternity papers were unable to be adequately considered, it was therefore agreed to hold a separate meeting to discuss and consider the papers separately, the outcome of which would be articulated to the Trust Board separately (see page 3) • The serious incident summary highlighted that 37 serious incidents had been reported during quarter 3, the majority of which related to falls. In addition 2 never events occurred within surgery • The Committee noted the risk highlighted by pharmacy in which staff may leave the Trust to move into community roles • The Committee noted the recent correspondence received from NHSEI regarding caesarean section rates which requested that rates stop being reported on and instead focus on Robson Group data which was being implemented • Updates from the Health and Safety Group and Quality and Safety Oversight Group highlighted ongoing challenges with staff absence which was impacting upon incident investigation and completion of risk assessments, although support was being provided by the corporate team. In addition, the Committee challenged the Divisional attendance at both meetings and it was agreed that attendance would be considered via the forthcoming Effectiveness Reviews	• To arrange a separate meeting with maternity leads to enable adequate consideration of the maternity papers and provide a separate update to the Trust Board on the assurance and discussion held • To articulate rates of instrumental births within the maternity dashboard • To address the issues with administrative support for the peer support network with the LMNS • Additional information to be obtained in relation to clinical pharmacy activities in future medicines optimisation reports • To review divisional attendance and representation at the Health and Safety group in addition to reviewing the division of responsibility and attendance required at both the Quality and Safety Oversight Group and Clinical Effectiveness Group
✓	**Positive Assurances to Provide**	**Decisions Made**
	• The Committee noted that appointments had been made to Midwife triage and it was anticipated that the new starters would be in place within 3 months. • A Getting It Right First Time (GIRFT) gap analysis was reviewed in relation to Covid-19 management. This demonstrated that the majority of recommendations had been implemented / adopted with the main challenges relating to rotas in Respiratory Medicine and availability of side rooms to provide non-invasive ventilation. • Medicines optimisation for quarter 3 highlighted that drug expenditure had continued to increase and national benchmarking metrics demonstrated positive assurance regarding the dispensing error rate, the percentage of medicines reconciliation, turnaround times for inpatient dispensing and percentage of pharmacy prescribers whereby 81% were active prescribers. • In terms of month 10 quality and safety performance, the Committee noted the ongoing work being undertaken to deep dive into deep tissue injury pressure damage, whereby all cases from point of contact to discharge were being reviewed. • Learning was shared with the Committee following the actions taken as a result of the patient story shared at Trust Board regarding improving communication with transgender patients. It was noted that this was going to be the focus of one of the patient priorities for 2022/23 and progress would be highlighted in future patient experience reports • An update from the clinical audit team was provided which demonstrated that 94% of audits has commenced and it was noted that going forwards progress would be reported to the newly established Clinical Effectiveness Group rather than Quality and Safety Oversight Group • The CQC action plan was presented which identified 9 must dos and 19 should dos. It was noted that monitoring would be undertaken via newly established performance meetings. In addition the action plan would be incorporated into the CQC compliance system and self-assessment	• No decisions were required to be made.

Comments on the Effectiveness of the Meeting

• The committee noted the challenges in respect of attendance which did not enable the maternity papers to be discussed. In addition the Committee commended the quality of the pharmacy report and the summary provided at the meeting

2. Summary Agenda

No.	Agenda Item	BAF Mapping		Purpose	No.	Agenda Item	BAF Mapping		Purpose
		BAF No.	Risk				BAF No.	Risk	
1.	UHNM response to West Midlands In Utero Transfer (IUT) guidance			Assurance	7.	Clinical Audit Progress Report			Assurance
2.	GIRFT COVID-19 Report Summary			Assurance	8.	CQC Action Plan	1		Assurance
3.	Serious Incident Summary Q3 21/22	1		Assurance	9.	Executive Health & Safety Group Assurance Report (Feb-22)			Assurance
4.	M10 Quality & Safety Report	1		Assurance	10.	Quality & Safety Oversight Group Assurance Report (Feb-22)	1		Assurance
5.	Update from Trust Board Patient Story - Improving Communication with Transgender Patients			Assurance	11.	Quality Account 2021/2022 Schedule			Information
6.	Medicines Optimisation Report Quarter 3 2021-2022	1	21914, 17977, 18298, 14803, 20946, 20294, 21074, 17952, 19176	Assurance	12.	Use of Caesarean Section Rates Data Letter			Information

3. 2021 / 22 Attendance Matrix

Attended | **Deputy Sent** | **Apologies Received**

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

Committee Chair's Highlight Report to Board

Extraordinary Quality Governance Committee

2nd March 2022

NHS
University Hospitals of North Midlands
NHS Trust

1. Highlight Report

In response to the letter dated 25th January 2022 from NHSEI, the following extraordinary meeting considered a number of maternity reports demonstrating progress with the implementation of the Ockenden immediate and essential actions in addition to considering an update in relation to maternity workforce.

!	Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
•	3 new maternity serious incidents were reported during Q3. In addition, 12 incidents were ongoing. The Committee noted the actions taken in response to the 3 incidents which had been reported which included the recruitment of midwives to undertake dedicated telephone triage, 24/7, which was expected to be in place within 3 months. In addition the Committee welcomed the introduction of a Covid Surveillance Pathway tool.	• Plan and trajectory to be developed in terms of maternity staff training • To provide an update to a future meeting in relation to analysing perinatal deaths and identifying any subsequent actions in terms of independent reviews • To increase the frequency of reporting in relation to midwifery workforce reporting to quarterly
•	A 6 monthly midwifery workforce update was provided which highlighted that in terms of the midwife to birth ratio, the current ratio was 1:26 as opposed to the recommended 1:25 plus ratio, requiring staff to continually be redeployed. The Committee noted the associated impact on staff morale, wellbeing and staff retention.	
✓	**Positive Assurances to Provide**	**Decisions Made**
•	In terms of SBLCB, an improvement in compliance month on month was reported with the main challenges relating to training due to difficulties in releasing staff to attend the training; fetal monitoring training was being prioritised. The Committee discussed the challenges in respect of smoking cessation, fetal monitoring and induction of labour and noted the actions being taken in respect of these areas.	
•	In terms of the maternity dashboard dedicated data analytic support was to be identified to improve reporting going forwards	
•	The maternity family experience report highlighted trends in relation to poor experience as a result of delays with induction and visiting restrictions. The Committee challenged the reduced response in terms of the friends and family test which was a result of removing paper copies of the questionnaires, due to covid, although the questions had since been digitalised within patient's 'my pregnancy notes'.	
•	An update of compliance with the perinatal mortality standards was provided, which was required as part of the CNST requirements. The Trust was 100% compliant with all elements of safety action 1 and actions were noted in terms of improving observations of mothers given magnesium sulphate, for which there had been no incidents of harm.	• No decisions were required to be made.
•	An update on the home birth service was provided which was reintroduced from 21st February, which was being monitored on a daily basis in terms of assessing potential impact as a result of staffing challenges and operational pressures	
•	Despite the challenges identified within the midwifery workforce paper, the Committee commended the compliance highlighted in relation to the 4 CNST midwifery workforce standards, safety action 5, regarding using an evidence-based process to calculate midwifery staffing establishment, the midwifery coordinate in charge of labour having supernumerary status, all women in active labour receiving 1-1 midwifery care and provision of staffing oversight reports covering staffing/safety issues	

Comments on the Effectiveness of the Meeting
• The Committee appreciated and recognised the attendance from the varied representatives from maternity in order to discuss the papers

2. Summary Agenda

No.	Agenda Item	BAF Mapping		Purpose	No.	Agenda Item	BAF Mapping		Purpose
		BAF No.	Risk				BAF No.	Risk	
1.	Maternity New Serious Incident (SI) Report Summary Quarter 3 21/22	1	15593, 13419, 23361	Assurance	5.	Q3 2021/22 Perinatal Mortality Report	1	15593	Assurance
2.	Saving Babies Lives Care Bundle, (SBLCB) V2: UHNM Compliance Quarter 3	1	16432	Assurance	6.	Update on the Suspension of the Home Birth Service		13420, 11518, 13419	Information
3.	Maternity Dashboard – Quarter 3 21/22	1	13420, 11518, 13419, 15993, 16432	Assurance	7.	Midwifery Workforce Paper	1, 3	13419, 13420, 11518, 15993	Assurance
4.	Maternity Family Experience Report Quarter 2 21/22			Assurance					

3. 2021 / 22 Attendance Matrix

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

Executive Summary

Meeting:	Trust Board	**Date:**	9th March 2022
Report Title:	Infection Prevention BAF	**Agenda Item:**	8
Author:	Helen Bucior, Infection Prevention Lead Nurse Emyr Philips , Associate Chief Nurse Infection Prevention/Deputy DIPC		
Executive Lead:	Mrs Ann-Marie Riley, Chief Nurse/DIPC		

Purpose of Report

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

Identified throughout the document.

Executive Summary:

Situation

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

Background

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

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

Assessment/risks

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

Progress

- External company continues to assist with mask fit testing
- Ward are currently receiving reminder calls to prompt COVID screening
- Cleaning Collaborative work stream (multi-disciplinary representation) established and using Improving Together tools and methodologies to work through the actions needed to respond to the cleaning issues in West Building highlighted during the CPE Outbreak
- West Building estates non complaint hand wash sinks replacement work is in progress

Key Recommendations:

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

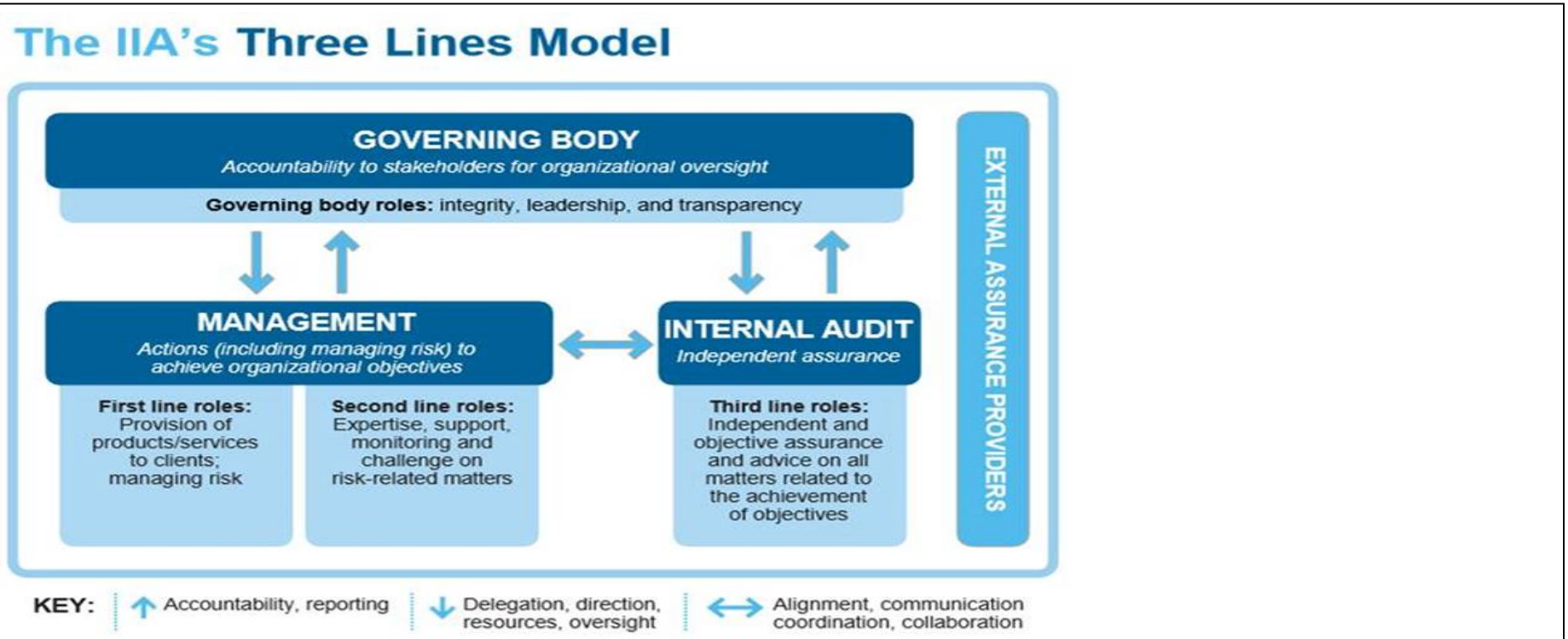
NHS
University Hospitals of North Midlands
NHS Trust

Infection Prevention and Control Board Assurance Framework

February 2022

Summary Board Assurance Framework

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



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

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

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

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

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
1.1	Systems and processes are in place ensure: Update V 1.8 A respiratory season/winter plan is in place: that includes • point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs, prevalence, and care services to enable appropriate segregations of cases depending on the pathogen • Plan for and manage increasing case numbers where they occur. • a multidisciplinary team approach is adopted with hospital leadership, estates	• All emergency patients are screened on decision to admit and set intervals of stay as per protocol. • Elective screening protocol in place • UHNM have access to rapid PCR testing circumstances that require a rapid result to facilitate placement • Elective screening protocol in place • EPRR forum • UHNM Major Incident response and recovery plan • Super serge identified and reviewed QIA completed for each area • Multidisciplinary team approach	• From June 2020 IP team to review patients that are found COVID positive and nursed in bay to ascertain compliance with pathway and IP control measures are in place Review pathways and identify theme • Theme report to IPCC • Pre AMS check COVID -19 screening results, if patient arrives in green area with no COVID screen a Datix is raised.	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	& facilities, IP Teams and clinical staff to assess and plan for creation of adequate isolation rooms/units as part of the Trusts winter plan	• Exec sign off	• Datix • OB meetings	
	• 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 respiratory infectious agents • Local risk assessments are based on the measure as prioritised in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff • The documented risk assessment includes: • A review of the effectiveness of the ventilation in the area • Operational capacity • Prevalence of infections/variants concern in the local area • Triaging and SARS-CoV-2 testing is undertaken for all patients either at the pointe of admission or soon as possible/practical following admission across all pathways;	• Nominated ventilation lead to liaise with IP • Risk assessment follow Hierarchy of controls • QIA process • Daily Tactical meetings • Work with LRF to obtain community rates • IP attends the weekly Staffordshire and Stoke on Trent , Test, Trace and Outbreak Management Group • On arrival in ED patients are immediately identified either asymptomatic for COVID -19 and apply infection prevention precautions. • ED navigator in place • Colour coded areas in ED to set out COVID		

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		and Non COVID areas. This was revised in September 2020 to mirror inpatient zoning. Purple ED with blue single rooms and respiratory assessment unit • Aerosol generating procedures in single rooms with doors closed • ED navigator records patient temperature and asked COVID screening questions. Patient then directed to either remain in purple or blue single room • ED pathways and SOP • When ambulance identify suspected COVID patients are received in respiratory assessment Unit ED • All patients screened for COVID -19 when decision made to admit • Maternity pathway in place • Elective Pre Amms Plan to swab • Patients72 hours pre admission SOP in place • Radiology /interventional flow chart • Children's unplanned admission. ED Navigator asked COVID questions then child directed to either RED of Green Areas. • All children, symptomatic or asymptomatic are swabbed in child health. This is recorded within their medical records, placed onto the nursing and medical handover so that we are made of the results and whether we need		

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		to chase if not received within a timely manner. The patient flow reports to the Child Health tactical meeting every morning how many children have been swabbed result and any outstanding • All children swabbed are placed into a sideward upon receiving their result are either kept within a side ward or moved to a bay if the swab is negative. • Screening for patients on systematic anticancer treatment and radiotherapy • Out patient flow chart in place • Thermal imaging cameras in some areas of the hospital • Iportal alert in place for COVID positive patients • Extremely vulnerable patient placement added into new COVID ward round guidelines (October 2020)  covid-19-care-plan-jan-22.pdf  4th-february-2021-covid-ward-round-guid • Doors fitted to resus areas in both ED's		
	Update V 1.8 • When an unacceptable risk of transmission remains following the risk assessment, consideration to the	• Discussed at Clinical group. Paper prepared by Deputy Medical Director		

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	extended use of respiratory RPE for patient care in specific situations should be given	which received exec approval w/c 26 July 2021 • August 2021 Introduction of FFP3 masks for all contact/ within 2 metres of COVID positive patients. The use of FFP3 masks for aerosol generating procedures remains in place • UKHSA issued updated guidance 17th January 2022 re FFP3 or equivalent for staff when with confirmed or suspected patients / organisms spread through the airborne route		
1.2	Patients with possible or confirmed Covid-19 are not moved unless this is essential to their care or reduces the risk of transmission. There are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically imperative Update V 1.8. Ensure that patients are not transferred unnecessarily between care areas unless; there is a change in their infectious status, clinical need, or availability of services. That on occasions when it is necessary to cohort COVID or non-COVID patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per guidance.	• All patients admitted to the Trust are screened for COVID -19 • All patients that test negative are rescreened on days 4, 6, 14 and weekly • Critical care plan with step down decision tree • COVID-19 Divisional pathways • Step down guidance available on COVID 19 intranet page • Barrier and Terminal clean process in place • IP PHE guidance • Isolation guidance IP Q+A manual • COVID Q+A available on Trust intranet • COVID 19 outbreak meetings • Patient COVID -19 discharge information letter for patient who are discharged but contact of a positive case	• Unannounced visits for clinical areas with clusters or HAI cases of COVID-19 • Review of HCAI COVID cases by IP Team/RCA • Datix /adverse incidence reports for inappropriate transfers	• NHSI key point 4 : Patients are not moved until at least two negative test results are obtained, unless clinically justified

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
1.3	Compliance with the national guidance around discharge or transfer of Covid-19 positive patients.	• Infection prevention step down guidance available on Trust intranet • All patients who are either positive or contacts of positives are advised to complete self –isolation if discharged or transferred within that time frame • All patients are screened 48 hours prior to transfer to care homes • New UHNM ward round guidance October 2020. This also included placement of the extremely vulnerable patient • COVID ward round guidance updated as new treatment or evidence emerges. Guidance updates are discussed at the weekly clinical COVID group  guidance-on-screening-and-testing-for-co  4th-february-2021-covid-ward-round-guic	• Datix/adverse incidence reports	
1.4	**All staff (clinical and non-clinical)** are trained in putting on and removing PPE, know what PPE they should wear for each setting and context and have access to the PPE that protects them for the appropriate setting and context as per national guidance. Linked NHSIE Key Action 3: Staff wear the right level of PPE when in clinical settings, including use of face masks in non-clinical settings.	• Key FFP3 mask fit trainers in place in clinical areas • PPE posters and information available on the Trust COVID -19 page. This provides the what, where and when guide for PPE • Infection Prevention Questions and Answers Manual include donning and doffing information. • Areas and situations that require high level PPE are agreed at clinical and tactical	• Daily stock level of PPE distributed via email and agenda item for discussion at COVID-19 tactical group • IP complete spot check of PPE use if cluster/OB trigger • Records of Donning and Doffing training for staff trained by IP • A number of Clinical areas	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
Linked Key Infection Prevention points – COVID 19 vaccination sites Monitoring of IP practices, ensuring resources are in place to enable compliance with IP practice of staff adherence to hand hygiene? • Staff adherence to hand hygiene • Patients, visitors and staff are able to maintain 2 metre social and physical distancing in all patient care areas, unless staff are providing clinical/personal care and wearing appropriate PPE • Staff social distancing across the workplace • Staff adherence to wearing of fluid resistant surgical face masks a) clinical b) non clinical setting Monitoring of staff compliance with wearing appropriate PPE, within the clinical setting The role of PPE guardians/safety champions to embed and encourage best practice has been considered There are visual reminders displayed communicating the importance of wearing face	• Aerosol generating procedures (AGP's) which require high level PPE agreed at clinical and tactical group • COVID -19 Clinical Group reviews any proposed changes in PPE from the clinical areas • Link to Public Health England donning and doffing posters and videos available on Trust intranet • Chief Nurse PPE video • Extended opening hours supplies Department • Risk assessment for work process or task analysis completed by Health and Safety • Estates in house teams and contractors • are issued with SOP for working in clinical and non- clinical areas • PHE announced from 11th June 2020 all staff to wear mask in both clinical and non-clinical health care setting • Matrons walk rounds • Specialised division summarised BAF and circulated to matrons • ACN's to discuss peer review of areas • Poster displayed in entrances and along corridors reinforcing the use of masks social distancing and one way systems • Catch it , bin in, kill it posters in ED waiting rooms • Lessons learnt poster	have submitted PPE donning an doffing records to the IP team • Donning and Doffing training also held locally in clinical areas • Cascade training records held locally by Divisions • Sodexo and Domestic service training records • IP unannounced assurance visits • Review of UHNM vaccination areas against key infection prevention points COVID -19 • Hand hygiene audits • FFP3 testing records can be added as a skill to Health roster.	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace Update V 1.8 Resources are in place to implement and measures adherence to good IP practice. This must include all care areas and all staff (permanent , agency and external contractors) The application of IP practices within this guidance is monitored e.g. • Hand hygiene • PPE donning and doffing training • Cleaning and decontamination Health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone. The Trust in not reliant on a particular mask type and ensure that a range of predominantly UK mask FFP3 masks are available to users as required Organisational/employers risk assessment in the context of managing seasonal respiratory	 Lessons learnt - Non Clinical June 2021.pdf  Lessons learnt - Clinical June 2021.pdf  unannounced-ip-visit -template-2020-11.pd  non-clinical-assuranc e-visit-checklist-2020 • QIA process for occasions when risk assess that the 2 metres can be reduced  SOP beds social distance Jan 2022.do • • PPE available • Mask fit testers throughout the Trust • PPE videos and posters available • IP Q+A manual • QIA/risk assessments • Trust Ventilation authorising engineer (AE) is the lead author of SVHP guidance around COVID. AE attends the Trust Ventilation safety group and has a fixed agenda item for any updates and changes to guidance and legislation.		

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	infectious agents are • based on the measures as prioritised in the hierarchy of controls including evaluation of the ventilation in the area, operational capacity, and prevalence of the infection/new variant of concern in the local areas • Applied in order and include elimination , substitution , engineering , administration and PPE/RP • Communicated to staff Safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems.	• The Trust has a list of available models of FFP3 masks to use. A number of staff are trained on 2 types of masks but this work is on-going as the priority it to ensure all staff who require FFP3 are tested on a suitable model first then tested on an alternative model	• Local FFP3 records held by the division • Health roster FFP3 records	
1.5	National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way.	• Notifications from NHS to Chief nurse/CEO • IP team COVID lead checks Public Health England webpage daily (Monday-Friday) for updates • Changes raised at -19 clinical groups which was held originally twice weekly, reduced to weekly and now increased back to twice weekly due to surge of COVID. • Purpose of the Clinical Group - The Group receive clinical guidance and society guidance which is reviewed and if agreed	• Clinical Group meeting action log held by emergency planning	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		used to advise clinical teams after approval at Exec COVID -19 meeting which is held twice monthly. • The clinical group initially weekly , now stepped down to Bi weekly • Tactical group – The tactical Group held daily. April 2021 now stepped down. The Group decide and agreed tactical actions Makes recommendations to Gold command • Chief nurse updates • Changes/update to staff are included in weekly Facebook live sessions • COVID -19 intranet page • COVID -19 daily bulletin with updates • IP provide daily support calls to the clinical areas		
1.6	Changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted.	• Incidence Control Centre (ICC) Governance • Clinical Group, Divisional cells, Workforce Bureau, Recovery cells subgroup feed in to tactical group. • COVID Gold command , decisions /Assurance reported to Trust Board Via CEO Report/COO	• Meeting Action log held by emergency planning • Trust Executive Group Gold command – Overall decision making and escalation • Tactical, Operational Delivery Group - The delivery of the objectives and benefits, and programme communications COVID 19 response and R&R. Co - ordination of resources. Escalation forum for linked	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
			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 measures  COVID19RRGOVERNANCE NOV20v1.pptx	
1.7	Risks are reflected in risk registers and the Board Assurance Framework where appropriate. • Linked NHSIE Key Action 5: Daily data	• Risk register and governance process • Datix incidents • Board assurance document standing agenda item Trust board and IPCC. • TOR	• IP risks are agenda item at Infection Prevention and Control committee (IPCC) • Definite Nosocomial COVID 19 case numbers are in	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
submissions have been signed off by the Chief Executive, the Medical Director or the Chief Nurse and the Board Assurance Framework is reviewed and evidence of reviews is available. • Trust Board has oversight of on going outbreaks and actions plans • The Trust Chief Executive, the Medical Director or the Chief Nurse has oversight of daily sitrep.in relation to COVID-19, other seasonal respiratory infections, and hospital onset cases • Linked NHSIE Key Action 9: Local Systems must assure themselves, with commissioners that a Trust's infection prevention and control interventions are optimal, the Board Assurance Framework is complete and agreed action plans are being delivered. • There are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas	• Outbreak IImarch submissions are copied to Chief Nurse/DIPC and exec Team • Outbreak areas are included in daily tactical meeting • Outbreak areas included in Gold update slides • Outbreak meetings attended by CCG and PHE • Definite Nosocomial COVID 19 case numbers are in included in Quality Performance Report • Nosocomial death review process • Visiting /walk round of areas by executive/senor leadership team  SOP bed removal due to social distancir	included in Quality Performance Report • Nosocomial death review process – paper to Quality and Governance Committee 20th January 2021 • COVID themes report to IPCC • RCA process for all probable and definite COVID 19	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
1.8	Robust IPC risk assessment processes and practices are in place for non Covid-19 infections and pathogens.	• IP questions and answers manual • Section in IP questions and answer manual 2.1 priority of isolation for different infections and organisms • Sepsis pathway in place • Infection Risk assessment in proud to care booklets and admission documentation • C.diff care pathway • IP included in mandatory training • Pre Amms IP Screening • Birmingham paused ribotyping service for C.DIFF due to COVID-19. During periods of increased incidence ribotyping is useful to establish person to person transmission, Leeds Hospital are now undertaking this service • Proud to care booklets revised an reinstated August/September 2020 • Revised pathways to include actions for extremely vulnerable patients who are admitted into the Trust • Advantages and disadvantages to reinstating MRSA screening as per UHNM policy undertaken and recommenced May 2021	• MRSA screening compliance • Monthly Sepsis Compliance audits. Screening compliance for sepsis and time to antibiotics for Red flag patients • IP audits • Infection Prevention Health care associated infection report, including submitted to monthly to Quality and Safety. • Submission of Infection figures to Public Health England. Clostridium difficile, MRSA blood stream infections (bacteraemia) and Gram Negative blood stream infections • Seasonal influenza reporting • Audit programme for proud to care booklets • CPE colonisation outbreak team closed the outbreak on 14th December 2021 following NHSEi whereby only minor points picked up at the inspection and the Trust was moved back to AMBER	

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**
3	1.2	NHSI key point 4 : Patients are not moved until at least two negative test results are obtained, unless clinically justified	Microbiologist/ ACN's	31/05/2020 31/08/2021 29/10/2021 31/12/2021 28/02/2022 03/04/2022	Testing and re testing, Interpretation of swabs and step down of IP precaution process in place at UHNM. Suspected or positive patients are moved on clinical need/assessment and in line with UHNM step down process. For patients who test negative on admission re screening is undertaken. 17th November NHSI guidance recommended that the second test is taken on day 3 after admission and day 5 after admission. Implementation of the new guidance is in place and a manual prompt is provided to the clinical areas. (Days 4 and 6 admission day counted as day 1). Waiting for 2 negatives swabs before moving for patients that are not COVID suspected does not always occur. September 2021 A COVID themes review paper is presented at IPCC bi monthly and is an agenda item. Investigation of themes and discussions at COVID outbreak meetings provide an opportunity to review not always achieving this standard and whether this has an impact on potential transmission or outbreak. A number of specialised ward strive to isolate admissions into a single room until COVID results are known. November & December 2021 actions continues to remain under surveillance	Action under surveillance

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

Risk Scoring								
Quarter	Q4	Q1	Q2	Q3	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2	1	1	2	Whilst cleaning procedures are in place to ensure the appropriate management of premises further work is required around cleaning responsibilities and revision of assurance processes in relation to cleanliness. The risk for this criteria was raised to 12 from Mid -September to Mid-December. Due to enhanced surveillance around the cleaning process and more assurance the risk has been reduced to 6.	Likelihood:	1	End of Quarter 1 2022/23
Consequence:	3	3	3	3		Consequence:	3	
Risk Level:	6	3	3	6		Risk Level:	3	

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

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	with PHE and other national guidance. Update V 1.8 A terminal clean /deep clean of inpatient rooms is carried out: • Following resolutions of symptoms and removal of precautions • When vacated following discharge or transfer (this includes removal and disposal /or laundering of all curtains and bed screens) • Following an AGP if room vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air changes within the room)	February 21. • High level disinfectant , Virusolve and Tristel in place and used for all decontamination cleans • Dedicated terminal clean teams introduced during the 2/3 wave of COVID for ED, AMU/AMRA/FEAU as well as Lyme Building where main ITU beds are located to ensure that quick , effective decontamination of potentially infected areas could be completed 24/7. • Terminal cleans are requested via IP Team • Terminal clean process included in IP Q+A manual	into IPCC • Completion of random 10% rooms each week by cleaning supervisors/managers to ensure that all rooms are cleaned to the agreed cleaning standards – Any rooms that are found to be below standard are rectified immediately. • Terminal clean electronic request log • Patient survey feedback is reviewed by joint CPM / Sodexo/EFP group and action plan completed if needed. • IP assurance visits and audits	
2.4	Increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance. A minimal of twice daily cleaning of • Patients isolation rooms • Cohort areas • Donning and doffing areas • Frequently touched surfaces e.g. door/toilet handles, patient call bells over bed tables and	• Increased cleaning process (barrier clean) included in Infection Prevention Questions and Answers manual • Process in place for clinical areas with clusters and HAI cases of COVID -19 requiring increased cleaning and /or terminal cleans • Feedback from NHSI provided to cleaning teams and action plan	• Barrier clean request electronic log held by Sodexo and circulated following any updates / removal of barrier cleans to Sodexo and Trust staff including IP Team. • IP spot checks for clinical areas with clusters of COVID -19 or HAI cases of COVID -19	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	bed rails. Where there may be higher environmental contamination rates including • Toilets/commodes particularly if patient has diarrhoea Update V 1.8 Increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas	 Action Plan Following NHS England NHS Im devised  NHSI action plan June 21.docx • Increased cleaning process (barrier clean) included in Infection Prevention Questions and Answers manual	• Disinfectant check completed during IP spot checks • Additional ad-hoc cleaning requests can be requested by clinical teams 24/7 should the environment become contaminated between scheduled cleans. • November 2021 Implementation of IPS audit • C4C audit programme in place	
2.5	Attention to the cleaning of toilets / bathrooms, as Covid-19 has frequently been found to contaminate surface in these areas.	• Cleaning schedules in place • Barrier cleans (increased cleaning frequency) process in place which includes sanitary ware and other frequent touch points • Barrier cleans also requested for other infections /period of increased incidence /outbreaks e.g. C.diff , Norovirus	• Cleaning schedules are displayed on each ward • Additional ad-hoc cleaning requests can be requested by clinical teams 24/7 should the environment become contaminated between scheduled cleans.	
2.6	Update V 1.8 Where patients with respiratory infection are cared for: Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution	• Virusolve and Tristel high level disinfectant used as routine for cleaning/disinfecting environment and non invasive equipment • Virusolve wipes also used during height of pandemic	• Evidence from manufacture that these disinfectants are effective against COVID -19 • Evidence of Virusolve weekly strength checks , held locally at ward	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses.		/department level • IP checks that disinfectant is available during spot checks	
2.7	Manufacturer's guidance and recommended product 'contact time' must be followed for all cleaning / disinfectant solutions / products.	• Contact times detailed in SOP and cleaning methods statements • Included in mandatory training • Included in IP Q+A • Disinfectant used routinely	• Monthly on-going training is completed with all domestic staff to ensure that core competencies such as cleaning effectively with chemicals is trained out on a frequent basis. • Where outbreaks are identified, regular staff who clean in this area have competency checks to ensure that they are following GREAT card training • Spot checks completed by CPM includes observation of cleaning techniques by the domestic staff.	
2.8	As per national guidance: • 'Frequently touched' surfaces, e.g. door / toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated more than twice daily and when known to be contaminated with secretions, excretions and bodily fluid. • Electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should	• Cleaning of frequently touch points included in Barrier clean process • Offices and back offices also supplied with disinfectant wipes to keep work stations clean. • Non- invasive medical equipment must be decontaminated after each use. IP Q+A manual	• IP checks • Barrier clean request log • Terminal clean request log • Additional ad-hoc cleaning requests can be requested by clinical teams 24/7 should the environment become contaminated	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	be cleaned at least twice daily. • Rooms / areas where PPE is removed must be decontaminated, timed to coincide with periods immediate after PPE removal by groups of staff (at least twice a day). Linked NHSIE Key Action 1: All high touch surfaces and items are decontaminated multiple times every day – once or twice a day is insufficient.		between scheduled / barrier cleans. • Non-clinical areas are cleaned at regular frequencies through the day especially sanitary ware, and if additional cleans are required between scheduled cleaning, these can be requested via the helpdesk.	
2.9	Linen from possible and confirmed Covid-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken.	• Included in IP questions and answers manual • Linen posters depicting correct linen bag displayed in clinical areas and linen waste holds • Red alginate bags available for infected linen in the clinical areas • Infected linen route	• IP quarterly audits , undertaken by own areas, audits held locally by divisions and requested to also send to harmfreecare email • Datix reports/adverse incidents • IPS audits undertaken by the IP Team	
2.10	Single use items are used where possible and according to single use policy.	• IP question and answers manual • Medical device policy • SOP for Visor decontamination in time of shortage	• IP audits held locally by divisions and requested to also send to harmfreecare email	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
2.11	Reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance. Update V 1.8 Resuable non –invasive care equipment is decontaminated: ○ Between each use ○ After blood and/or body fluid contamination ○ At regular predefined interval as part of an equipment cleaning protocol ○ Before inspection, service or repair equipment Update V 1.8 Compliance with regular cleaning regimes is monitored including that of reusable equipment	• IP question and answers manual covers decontamination • Air powered hoods – SOP in place which includes decontamination process for the device • Re usable FFP3 Masks – Sundstrom/ GVS Elipse. SOP's in place which includes the decontamination process • Medical device policy • Availability of high level disinfectant in clinical areas • Sterile services process • Datix process • Bed Storage Group looking at non conformities for beds that require repair • Clinical cleaning schedules • Domestic cleaning schedules • Cleaning of electronic beds part of collaborative cleaning	• IP audits held locally by divisions • Datix reports/adverse incident reports • IP assurance visits	• Decontamination of beds returned for repair process non conformities • Electronic beds – difficult dismantle the bed base mechanism to allow for effective cleaning –this issue has been raised regionally by NHSI
2.12	Update V 1.8 As part of heirachy of controls assessment : ventilation systems, particularly in, patient care areas (natural or mechanical) meets national recommendations for the minimum of air changes refer to specific guidance In patients care health building note 04-01 Adult in patient facilities	• UHNM has established a Ventilation Safety Group as recommended by the Specialised Ventilation for Healthcare Society in order to provide assurance to the Trust Board on the safe operation and reduction in risk of infection transmission through ventilation systems. TOR written • The Trust also appointed external	• Estates have planned programme of maintenance • The Authorising Engineer Ventilation will provide external independent specialist advice and support as well as carrying out an annual audit for system compliance.	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
The assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations authorised engineer A systematic review of the ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways Where possible air is diluted by natural ventilation by opening windows and doors were appropriate Review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission. Where a clinical space has a very low air changes and it is not possible to increase dilution effectively , alternative technologies are considered with estates/ventilation group When considering screens/partitions in reception /waiting areas , consult with estates/facilitates teams , to ensure that air flow is not affected, and cleaning schedules are in place Ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air Where possible ventilation is maximised by opening	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  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 • January 2022 Estates and IP are exploring the use of air scrubber machine to try on ward in West Building • Review of areas that request Perspex screens to check need and requirement for		

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	windows where possible to assist the dilution of air.	cleaning/ventilation not affected		
2.13	Update V 1.8 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. Update V 1.8 The organisation had systems and processes in place to identify and communicate changes in the functionality of area/rooms Update V 1.8 Ensure cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment Monitor adherence environmental decontamination with actions in place to mitigate any identified risk Monitor adherence to the decontamination of shared equipment	• Cleaning standards meetings in place, review of National standards • Cleaning collaborative improvement project now underway • Regular walkabouts of all non-clinical areas are completed, and any actions found are either emailed through to helpdesk to be logged as jobs to be completed or are noted by Sodexo at time of audit – follow-up visits are completed to ensure all jobs have been completed • Quarterly Environmental Audits are completed of all clinical areas by an independent auditor plus input from nursing, cleaning and estates to review environmental standards – reports produced after each visit, and re-audits completed if disciplines fail to achieve agreed %.	• Reports produced after each visit, and re-audits completed if disciplines fail to achieve agreed %. • C4C report presented at IPCC	Cleanliness assurance processes around

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	2.4	West Building long standing Estates issues. Reactive work	Divisions Facilities and Estates	05/11/2021 30/11/2021 End of quarter 1 2022	On going review of CPE colonisation in West Building. Long standing estates issues in West Building including a number of non- compliant hand wash sinks. Reactive estates works list identified. Long term plan to be agreed. November 2021 Capital funding agreed and allocated c £150k for the replacement of 75 non-compliant wash hand basins including associated IPS panels within the West Building Wards and FEAU. February 2022 Sink replacement in progress	In progress
7	2.13	Cleaning issues both nursing and cleaning responsibilities highlighted during CPE outbreak west Buildings. Strengthen assurance process on standards of cleanliness	Divisions Facilities/ACN	12/11/2021 31/12/2021 End of quarter 1 2022	October 2021 Terminal cleans in progress Review sign off process November 2021 03/11/2021 terminal clean west building completed Terminal clean briefing sheet designed Terminal clean of all West using steam and HPV Terminal Clean of FEAU and ward 122 using steam and HPV completed 06/11/2021 Cleaning Collaborative work stream (multi-disciplinary representation) established and using Improving Together tools and methodologies to work through the actions needed to respond to the cleaning issues in West Building highlighted during the CPE Outbreak.	In progress

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

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

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
3.1	Arrangements around antimicrobial stewardship are maintained. Update V 1.8 Previous antimicrobial history is considered The use of antimicrobials is managed an monitored: Update V 1.8 • To reduce inappropriate prescribing • To ensure patients with infections are treated promptly with correct antibiotic	• Regular, planned Antimicrobial stewardship (AMS) ward rounds • Trust antimicrobial guidelines available 24/7 via intranet and mobile device App • Antimicrobial action plan in place • Clostridium *difficile* Period of increased incidence and outbreaks are reviewed by member of AMS team and actions generated cascaded to ward teams • Regional and National networking to ensure AMS activities are optimal • Formal regional meetings and informal national network activities • AMS CQUIN further mandates key AMS principles to be adhered to • All national CQUINS currently	• Same day escalation to microbiologist, if concerns. Outcome recorded on I portal • Metric available around the number of times App accessed by UHNM staff • Compliance with guidelines and other AMS metrics reported to Infection prevention and control Committee (IPCC) • Meeting minutes reviewed and actions followed up • Real time discussions / requests for support / advice enabled via regional and national social media accounts. National (incl. PHE) thought leaders members • Trust and commissioners require	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		suspended by NHSE / PHE • Monthly review of antimicrobial consumption undertaken by AMS team. Available online at UHNM	timely reporting on compliance with AMS CQUIN targets. • Wards showing deviation from targets are followed up by targeted AMS team ward reviews generating action plans for ward teams. On hold during COVID19 due to redeployment of duties • The pharmacy team undertook a trust-wide point prevalence audit using a new electronic data capture tool. Results will be reviewed during January and shared with ACN's and Microbiologist.	
3.2	Mandatory reporting requirements are adhered to and boards continue to maintain oversight. Linked NHSIE Key Action 5: Daily data submissions have been signed off by the Chief Executive, the Medical Director and the Chief Nurse and the Board Assurance Framework is reviewed and evidence of reviews is available. Linked to NHSIE Key Action 10: Local systems must review system performance and data, offer peer support and take steps to intervene as required.	• Quarterly point prevalence audits maintained by AMS team at UHNM despite many regional Trusts not undertaking any more. These have restarted in December 2020 as held during COVID-19. Results online. • Results from all AMS audits and targeted ward reviews are reported at the Antimicrobial Stewardship Group and minutes seen by IPCC • CQUIN submissions completed in timely manner and generate action plans for AMS and ward teams to follow up concerns each quarter.	• Whilst only a snap-shot audit the Trust value the output from these audits. Work is underway Q1 and Q2 20/21 to review potential change in data collection to optimise impact. • IPCC scrutinise results. Divisions held to account for areas of poor performance. Audit outputs will be used as basis of feedback on performance to individual clinical areas going forward. • Trust CQUIN contracts manager holds regular track and update meetings to challenge progress vs AMS CQUINS, Currently	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	Update V 1.8 Risk assessments and mitigations are in place to avoid unintended consequences from other pathogens	Currently suspended.	suspended.	

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

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
4.1	Implementation of national guidance on visiting patients in a care setting. Update V 1.8 Visits from patients relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients , staff and visitors There is clearly displayed , written information available to prompt patients, visitor and staff to comply with hand washing, wearing of facemask /face coverings and physical distancing Restrictive visiting may be considered appropriate during outbreaks within inpatient areas. This is an organisational decision following a risk assessment	• To help protect patients and staff from Covid-19, the NHS suspended all visiting to hospitals. This national suspension has now been lifted and visiting is to be introduced in some areas of our hospitals, subject to certain conditions. From Monday 17 August 2020 visiting will be phased in across some areas and will be allowed in the West Building at Royal Stoke and in Wards 7, 12, 15 at County Hospital. All visiting will have to be pre-booked and relatives will be provided with the correct information and contact details to book in advance. Visitors will be instructed to wear face masks and	• 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**
Update V 1.8 If visitors are attending a care areas with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be a FRSM. Update V 1.8 Visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reason (e.g. parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible. Update V 1.8 Visitors are not present during AGPs on infectious patient unless they are considered essential following a risk assessment e.g. care/parent/guardian.	other PPE if they are providing bedside care. We will continue to monitor prevalence and changes in visiting restrictions will be reinstated with immediate effect should it be necessary • The only exceptional circumstances where on visitor , an immediate family member or carer will be permitted to visited are listed below- • The patient is in last days of life- palliative care guidance available on Trust intranet • The birthing partners are able to attend all scans and antenatal appointments induction of labour and post natal appointments • The parent or appropriate adult visiting their child • Other ways of keeping in touch with loved ones e.g. phone calls , video calls are available • EOL visiting guidance in place • Guidance to accommodate visitor if appropriate and necessary to assist a patients communication and/or to meet their health, emotional , religious or spiritual need • A familiar care/parent or guardian/support/personal assistant • Children both parents /guardian		

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
		where the family bubble can be maintained • March 2021 Visiting guidance inpatient during COVID 19 pandemic: principles discussed at Clinical Group and tactical • Visiting COVID-19 information available on UHNM internet page • August 2021 Input from Matron for Mental Health & Learning Disability re leaflets. Minor changes required. • 26TH December 2021 visiting restriction re introduced due to Omnicron • PPE information provided to visitors		
4.2	Areas in which suspected or confirmed Covid-19 patients are being treated are clearly marked with appropriate signage and have restricted access.	• ED colour coded areas are identified by signs • Navigator manned ED entrance • Hospital zoning in place	• Daily Site report for county details COVID and NON COVID capacity	
4.3	Information and guidance on Covid-19 is available on all trust websites with easy read versions.	• COVID 19 section on intranet with information including posters and videos	• COVID-19 page updated on a regular basis	
4.4	Infection status is communicated to the receiving organisation or department when a possible or confirmed Covid-19 patient needs to be moved.	• Transfer policy C24 in place and reference to Covid included • IP COVID step down process in place	• Datix process	
4.5	Implementation of the Supporting excellence in infection prevention and control behaviours toolkit has been considered	• UHNM developed material, posters • Hierarchy of controls video use on COVID 19 intranet page • UHNM wellbeing support and information		

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.

Risk Scoring								
Quarter	Q4	Q1	Q2	Q3	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	1	1	1	1	Whilst arrangements are in place ensure the screening of all patients. To continue to reinforce COVID screening protocol and monitor compliance. Surveillance of omicron cases within UHNM is in place.	Likelihood:	1	End of Q4 – achieved
Consequence:	3	3	3	3		Consequence:	3	
Risk Level:	3	3	3	3		Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
5.1	Update V 1.8 Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival Update V 1.8 Infection status of the patient is communicated to the receiving organization, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed Covid-19 symptoms and to segregate them from non Covid-19 cases to	• ED navigator records patient temperature and asked screening questions. Patient then directed to relevant coloured area • All patients who are admitted are screened for COVID 19 • Work completed to install doors to resus areas in both ED's • December 2021 – review of green resus doors and use of area • Posters in place for visitors re respiratory instructions • Clinical letter/ pre op screening in place to identify /enable early recognition of respiratory symptoms	• June 2020 IP team review patients that are found COVID positive and nursed in bay to ascertain compliance with pathway and IP control measures are in place Review pathways and identify theme . COVID 19 -Themes report to IPCC • ED pathways including transfer of COVID positive patient from County to Royal Hospital • COVID screening spot check audits	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
minimise the risk of cross-infection as per national guidance. Screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases. Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from Non Covid-19 Staff are aware of agreed template for triage questions to ask Update V 1.8 Triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible Screening for COVID -19 is undertaken prior to attendance wherever possible to enable early recognition and to clinically assess patients prior to any patients attending a healthcare environment Patients with respiratory symptoms are assessed in segregated areas, ideally a single room, and away from other patients pending their test result.	• Hospital zoning/pathways • COVID 19 care pathway • Screening protocol in place		

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	There is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved			
5.2	Mask usage is emphasized for suspected individuals. Face coverings are used by all outpatients and visitors Update V 1.8 Facemask are worn by staff and patients in all health care facilitates Provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients (particularly when moving around the ward) if this can be tolerated and does not compromise their clinical care Update V 1.8 Patients with suspected or confirmed respiratory infection are provided with a surgical face mask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated. Monitoring of Inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so) and is not detrimental to their physical or mental	• Use of mask for patients included in IP COVID -19 • question and answers manual • All staff and visitors to wear masks from Monday15th June2020 • ED navigator provide masks to individual in ED • Mask stations at hospital entrances • Covid-19 bulletin dated 12th June 2020 • 28th August updated guidance from PHE recommends in patients to also wear surgical masks if tolerated and does not compromise care • IP Assurance visits • Senior walk rounds of clinical areas • Matrons daily visits • Patient who are clinically extremely vulnerable should remain in a single room for the duration of their hospital stay • Patient are encourage to wear mask – leaflet in place 8th-march-2021-covid-ward-round-guidan covid-19-care-plan-jan-22.pdf	• Hospital entrances Mask dispensers and hand gel available • Datix /incidents • COVID-19 themes report to IPCC	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	needs Individuals who are clinically extremely vulnerable form COVID 19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room Update V 1.8 Patients at risk of severe outcomes of respiratory infection receive protective IP measures depending in their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation and risk for their families and carers accompanying them for treatments /procedures must be considered	• Trust internet and social media provide information re the need for wearing of face masks whilst in /visiting hospital • Included in COVID 19 care pathway • IP Q+A isolation manual		
5.3	Ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff. Linked NHSIE Key Action 6: Where bays with high numbers of beds are in use, these must be risk assessed, and where 2m can't be achieved, physical segregation of patients must be considered and wards are effectively ventilated. Update V 1.8 Patient visitors , and staff can maintain 1 metre or greater social and physical distancing in all patient care areas: ideally segregation should be spate spaces , but there is potential	• Colour coded areas in ED to separate patients, barriers in place. • Screens in place at main ED receptions • Colour coded routes identified in ED • Social distancing risk assessment in place • Perspex screens agreed through R+R process for other reception area • Social distance barriers in place at main reception areas • Chief Nurse/DIPC visited clinical areas to review social distancing within bays. A number of beds have been removed throughout the Trust. • January 2022 – 2 metre rule maintained. Risk assessments completed and signed off by	• Division/area social distancing risk assessments	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	to use screens e.g. to protect reception staff	DIPC for ward areas need to use closed beds due to social distancing • January 2022 - Risk assessments to be revisited for Out- patient /imaging area that need to reduce distance to 1 metre – this work is in progress		
5.4	For patients with new-onset symptoms, it is important to achieve isolation and instigation of contact tracing as soon as possible.	• Process for isolation symptom patient in place • Process for cohorting of contacts • Contacting patients who have been discharged from hospital then later found to be a close contact of a COVID-19 positive case , patient to be informed by the clinical area and self- isolation advice provided as per national guidance • https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance/stay-at-home-guidance-for-households-with-possible-coronavirus-covid-19-infection	• If patient found to be positive in the bay and exposing other patient. IP liaise with clinical are, apply bay restrictions. • Patient who tested negative on admission and remain an inpatient are retested for COVID days 4 and 6, day 14 then weekly • Spot check audits • Assurance obtained for monitoring of inpatient compliance with wearing face masks via Matrons daily walk round	
5.5	Patients with suspected Covid-19 are tested promptly. There is evidence of compliance with routine testing protocols in line with key actions	• All patients who require overnight stay are screened on admission and patients who develop symptoms – UHNM screening guidance in place • December 2021 – surveillance of Omicron cases in place to monitor number of inpatients with the variant	• Adverse incident monitor /Datix	
5.6	Patients who test negative but display or go on to develop symptoms of Covid-19 are	• Screening protocol in place which includes rescreening /re testing. Pathways in place for	• Datix process • IP reviews	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	segregated and promptly re-tested and contacts traced. Isolation , testing an instigation of contact tracing is achieved for all patients with new onset symptoms , until proven negative	positive COVID 19 patients • Iportal alert and April 2021 contact alert in place iportal/medway • The IP team have been applying a Covid-19 contact alert within the ICNET system since November 2020 and this continues. • Inpatient contacts are cohorted • COVID 19 positive patients are cared for on blue wards or single rooms or COVID 19 cohort areas on critical care unit		
5.7	Patients who attend for routine appointments and who display symptoms of Covid-19 are managed appropriately. Update V 1.8 Where treatment is not urgent consider delaying this unit resolution of symptoms providing this does not impact negatively on patient outcomes	• Restoration and Recovery plans • Thermal temperature located in a number outpatient areas – with SOP if patient triggers. Script in place for scheduling outpatient/ investigations • Mask or face coverings for patients attending appointments from Monday 15th June 2020 • Process at PREAMMS if patient positive for COVID	• Datix process	

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

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
6.1	Update V 1.8 Appropriate infection prevention education is provided for staff, patients and visitors All staff (clinical and non-clinical) have appropriate training, in line with the latest PHE and other guidance, to ensure their personal safety and working environment is safe. Patient pathways and staff flow are separated to minimise contact between pathways. E.g. this could include provisions of spate entrances/exits or use of one way system , clear signage and restricted access to communal areas,	• PPE discussed at tactical group • Training videos available • FFP3 mask fit key trainers • Donning and Doffing posters, videos and PHE available on Covid-19 section of Trust intranet • Posters in corridors - keep to the left • One way signs in place along corridors	• Tactical group action log • Divisional training records • Mandatory training records	
6.2	All staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation, and on how to safely don and doff it. Update V 1.8 Training in IP measures is provided to all staff,	• PPE and standard precautions part of the infection prevention Questions and Answers manual. • FFP3 train the trainer	• Training records • IP spot checks of PPE on wards and Departments undertaken	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	including : the correct use of PPE including an intial face fit test/and fit check each time when wearing a filters face piece (FFP3) respirator and the correct technique of putting on and removing (donning/diffing) PPE safely. Gloves 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	programme in place • Trust mask fit strategy • SOP and training for reusable FFP3 masks • SOP and training for use of air powered hoods • Critical care - Elipse FFP3 reusable introduced • PPE posters are available in the COVID -19 section of trust intranet page		
6.3	A record of staff training is maintained.	Mask fit strategy in place	• Training records originally held locally by the Clinical areas • Records held on L drive for those trained by the infection prevention team • April 2021,Option now available to enter FFP3 training onto Health Rostering this captures the model of mask and date trained • Test certificate must continue to be filed in personal folder and this is reiterated to mask fit tester. November 2021 wider spot checks commenced IP • Health and Safety leading on portacount mask fit business case which has the potential to	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
			enhance mask fit training records further as this system is capable of collected data which can be uploaded	
6.4	Appropriate arrangements are in place so that any reuse of PPE is in line with the CAS Alert is properly monitored and managed.	• SOP in place for reuse of visors • SOP in place for use of air powered filters systems plus key trainers • SOP in place for the care of reusable FFP3 masks (Sundstrom))	• SOP 's available on Trust intranet • Training logs held divisionally for air powered systems • IP training log for air powered systems key trainers and distribution of reusable FFP3 masks (Sundstrum)	
6.5	Any incidents relating to the re-use of PPE are monitored and appropriate action taken.	• PPE standard agenda at COVID Tactical meeting • Datix process • Midlands Region Incident Coordination Centre PPE Supply Cell	• Tactical group action log • Datix process • Incidents reported by procurement to centre PPE supply Cell	
6.6	Adherence to the PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk.	• PPE Audits • PPE volume use discussed at tactical COVID-19 Group	• Spot audits completed by IP team	
6.7	Staff regularly undertake hand hygiene and observe standard infection control precautions. Linked NHSIE Key Action 1: Staff consistently practices good hand hygiene.	• Hand hygiene requirements set out in the infection prevention Questions and Answers manual • Poster for hand hygiene technique displayed at hand wash sinks and stickers on hand soap and alcohol dispensers • Alcohol gel availability at the point of care	• Monthly hand hygiene audits completed by the clinical areas • Infection Prevention hand hygiene audit programme. Overview of results fed into infection Prevention committee • Independent hand hygiene audits completed by IP Senior Health Care	
6.8	Hygiene facilities (IP measures) and messaging are		• Hand hygiene audits	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
available for all • Hand hygiene facilities including instructional posters • Good respiratory hygiene measures • Staff maintain physical distancing of 1 metre or greater wherever possible in the workplace unless wearing PPE as part of direct care • Staff maintain social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace • Frequent decontamination of equipment and environment in both clinical and non-clinical areas • clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas • Staff regularly undertake hand hygiene and observe standard infection prevention precautions • Guidance on hand hygiene, including drying should be clearly displayed in all public toilet	• Hand washing technique depicted on soap dispensers • Social distance posters displayed throughout the Trust • IP assurance visits • Matrons visits to clinical areas Recommendation that physical distancing should be at least 1 metre, increasing whenever feasible to2 metres across all health and care settings. • Car sharing question forms part of OB investigation process • Communications reminding staff re car sharing • IP Q+A decontamination section • COVID Q+A • Wearing of mask posters displayed throughout the Trust • Advise and videos' on the Trust internet page • Hand hygiene posters /stickers	• Spot checks in the clinical area • IP assurance visits • Cleanliness audits • IP environmental audits • Quarterly audits conducted and held by the clinical areas • Hand hygiene audits	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	areas as well as staff areas	on dispenser display in public toilets		
6.8	The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance Guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas	• Paper Towels are available for hand drying in the Clinical areas	• IP audits to check availability	
6.9	Staff understand the requirements for uniform laundering where this is not provided on site.	• Instruction for staff laundering available on the Trust COVID - 19 section of intranet • Dissolvable bags to transport uniforms home available for staff • Communications /daily bulletin to remind staff not to travel to and from work in uniforms	• Clinical areas to monitor • Reports of member of public reporting sighting of staff in uniform	
6.10	All staff understand the symptoms of Covid-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household displays any of the symptoms (even if experiencing mild symptoms) Update V 1.8 To monitor compliance and reporting for asymptomatic staff testing	• For any new absences employee should open and close their usual absence via Empactis system • Symptom Advice available on Trust intranet • Communications updated to reflect changing national guidance • Staff report Lateral flow testing via the national route only	• Cluster /outbreak investigations	
6.11	All staff understand the symptoms of COVID-19	• Communication /documents	• Cluster /outbreak investigations	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	and take appropriate action (even if experiencing mild symptoms) in line with PHE and other national guidance if they or a member of their household display any of the symptoms	• Reminders on COVID bulletins Trust intranet • Staff Lateral flow testing • Communications updated to reflect changing national guidance		
6.12	A rapid and continued response through on- going surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patient/individuals)	• ICNET surveillance system • Reports • Trust wide daily COVID Dashboard/report • COVID -19 Tactical daily • briefing	• COVID Dashboard • COVID -19 Tactical daily briefing • COVID 19 Gold update slides	
6.13	Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	• ICNet surveillance system • Reports • RCA's are required for all Probable and Definite HAI Covid-19 cases	• Theme report IPCC • RCA review	
6.15	Robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of outbreak meetings.	• ICNet surveillance system • Daily COVID reports of cases	• Outbreak investigation • Outbreak minutes	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 4 Progress Report	BRAG
2	6.3	Monitoring FFP3 mask fit compliance %	Divisions	31/09/2021	To monitor the mask fit compliance % for own division using available records – Health Roster	On- going

7. Provide or secure adequate isolation facilities

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

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
7.1	Patients with possible or Covid-19 are isolated in appropriate facilities or designated areas where appropriate. Restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff Areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas Update V 1.8 That clear advice is provided , and monitoring is carried out of inpatients compliance with wearing face masks (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	• Hospital zoning in place • Recovery and Restoration plans for the Trust – • December 2020 –another increased wave of COVID 19 • COVID prevalence considered when zones identified • Purple wards • Blue COVID wards identified at both sites created during second wave • Green wards for planned screened elective patients • Recovery and Restoration plans • Ward round guidance available on COVID 19 intranet page • Patient are offered and encouraged to wear masks – stickers have been developed to record if patients are unable to	• June 2020 IP team to review patients that are found COVID positive and nursed in bay to ascertain compliance with pathway and IP control measures are in place Review pathways and identify themes which are presented at IPCC . • Themes report to IPCC • Inappropriate patient moves reported via Datix. Daily process Discuss at outbreak meetings as necessary	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		wear masks		
7.2	Patients with suspected or confirmed COVID -19 are isolated in appropriate facilities or designated areas where appropriate; Areas used to cohort patients with possible or confirmed Covid-19 are compliant with the environmental requirements set out in the current PPE national guidance. Update V 1.8 On -going regular assessment of physical distancing an bed spacing, considering potential increases in staff to patient ratios and equipment needs (dependent on clinical requirements) Separation ins space and /or time is maintained between patients with and without suspected respiratory infection by appointment or clinic scheduling to reduce waiting times in receptions areas and avoid mixing of infectious and non-infectious patient Patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where treatment cannot be deferred, their care is provided from services able to operate in a way which minimises the risk of spread of virus to other patients/individuals Standard infection prevention precautions (SPIC's) are used at the point of care for patient who have been	• Areas agreed at COVID-19 tactical Group • Restoration and Recovery plans • QIA process • Hospital zoning in place • Pre Amms process • IP Q+A isolation section	• Action log and papers submitted to COVID-19 tactical and Clinical Group	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	screened , triaged and tested and have a negative result The principles of SICPs and TBPs continued to be applied when caring for the deceased	• PPE posters • COVID 19 information available Trust intranet • IP Q+A manual		
7.3	Patients with resistant / alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement.	• Infection Prevention Questions and Answers Manual includes alert organisms/resistant organism • Support to Clinical areas via Infection Prevention triage desk • Site team processes • Clostridium *difficile* report • Patients received from London to critical care unit – screening policy for resistant organisms in place	• RCA process for Clostridium *difficile* • CDI report for January Quality and Safety Committee and IPCC • Outbreak investigations • MRSA bacteramia investigations • Datix reports	

8 Secure adequate access to laboratory support as appropriate.

Risk Scoring								
Quarter	Q4	Q1	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	1	1	1	1	Laboratory services for UHNM are located in the purpose built Pathology Laboratory on-site at RSUH. The Laboratory is United Kingdom Accreditation Service (UKAS) accredited. Work continues to improve COVID-19 screening compliance as per screening protocol.	Likelihood:	1	Q4 20/21– target achieved
Consequence:	3	3	3	3		Consequence:	3	
Risk Level:	3	3	3	3		Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
8.1	Testing is undertaken by competent and trained individuals. • Regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	• How to take a COVID screen information available on Trust intranet. This has been updated in November 2020 • Swabbing training package in place and swabbing Champions identified • Laboratory services for UHNM are located in the purpose built Pathology Laboratory on-site at RSUH. The Laboratory is United Kingdom Accreditation Service (UKAS) accredited. • Turnaround times included in tactical slides	• Review of practice when patient tests positive after initial negative results	
8.2	Patient and staff Covid-19 testing is undertaken promptly and in line with PHE and other national guidance. Linked NHSIE Key Action 7: Staff Testing:	• All patients that require an overnight stay are screened for COVID-19 on admission or pre admission if planned/elective surgery	• Empactis reporting • Team Prevent systems • Datix/adverse incidence reporting • Cluster /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
a) Twice weekly lateral flow antigen testing for NHS patient facing staff is implemented. Whilst lateral flow technology is the main mechanism for staff testing, this can continue to be used alongside PCR and LAMP testing. b) If your Trust has a high nosocomial infection rate you should undertake additional targeted testing of all NHS Staff, as recommended by your local and regional infection prevention and control team. Such cases must be appropriately recorded, managed and reported back. That all emergency patients are tested for COVID -19 and other respiratory infections appropriate on admission Linked to NHSIE Key Action 8: Patient Testing: a) All patients must be tested at emergency admission, whether or not they have symptoms. b) Those with symptoms of Covid-19 must be retested at the point symptoms arise after admission. c) Those who test negative upon admission must have a second test 3 days after admission and a third test 5 – 7 days post admission. Letter 6th April NHS October 2020 the region implemented requirement for screening on day 13 d) All patients must be tested 48 hours prior	• Screening process in place for elective surgery and some procedures e.g. upper endoscopy • Process in place for staff screening via empactis system and Team Prevent • Patients who test negative are retested 4, day 6 and day 14 and weekly • Patient who develop COVID symptoms are tested • Staff screening instigated in outbreak areas • November 2020 - Lateral flow device staff screening to be implemented to allow twice weekly. Staff are asked to submit results via text. Jan 2021 Recent communications on COVID bulletin to remind staff to submit results • Questions and answers available on the COVID 19 page Trust intranet re lateral flow including actions to take for reporting both a negative or positive result • All patient discharged to care setting as screened 48 hours prior to transfer/discharge • Designated care setting in	procedures • Report received by Deputy Chief Nurse on a daily basis with list of patients that are due for re screen. Clinical areas then contacted and prompt to re screen. Day 14 and weekly screening in place.	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
to discharge directly to a care home (unless they have tested positive within the previous 90 days) and must only be discharged when the test result is available and communicated to receiving organisation prior to discharge. Care home patients testing positive can only be discharged to CQC designated facilities. Care homes must not accept discharged patients unless they have that persons test result and can safely care for them. e) Elective patient testing must happen within 3 days before admission and patients must be asked to self-isolate from the day of the test until the day of admission. There is regular monitoring and reporting that identified cases have been tested and reported I line with the testing protocols (correctly recorded data) Staff testing protocols are in place • That sites with high nosocomial rates should consider testing COVID negative patients daily. • That those being discharged to a care facility	place for positive patients requiring care facilities on discharge – Trentham Park • 11th May 2021 introduction of day 14 screen and also weekly screen for negative patients • From 29th April 2021 a team from HR are supporting the IP Team by contacting the clinical area to advise when screens are due • In addition to the above from 11th May 2021 inpatients who have not tested covid 19 positive within the previous 90 days are to be rescreened on day 14 and then weekly • Reviewed as part of outbreak investigation • Matrons and ACN'S aware of retesting requirement • Not required currently but kept under review • Patients are tested as part or outbreak investigation • Designated home identified- Trentham Park		

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	within their 14 day isolation period should be discharged to a designated care setting, where they should complete their remaining isolation. Update V 1.8 There is an assessment of the need for a negative PCR and 3 days self-isolation before certain elective procedures on selected low risk patient who are fully vaccinated, asymptomatic, and not a contact of cases suspected/confirmed cases of COVID-19 within the last 10days. Instead these patients can take a lateral flow test (LFT) on the day of the procedure as per national guidance	• UHNM continue with PCR testing pre operatively but are exploring using lateral flow tests for day case surgery		
8.3	Screening for other potential infections takes place.	• Screening policy in place, included in the Infection Prevention Questions and Answers Manual • MRSA Screening recommenced in May 2021	• MRSA screening compliance • Prompt to Protect audits completed by IP • Spot check for CPE screening	

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

Risk Scoring								
Quarter	Q4	Q1	Q2	Q3	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	1	1	1	1	There is a range of information, procedures, and pathways available along with mechanism to monitor.	Likelihood:	1	Q4 20/21 – target achieved
Consequence:	3	3	3	3		Consequence:	3	
Risk Level:	3	3	3	3		Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
9.1	Update V 1.8 The application of IP practices and monitored and that resources are in place to implement and measures adherence to good IP practice. This must include all care areas and all staff (permanent , agency and external contractors) Staff are supported in adhering to all IPC policies, including those for other alert organisms. Update V 1.8 Safe spaces for staff break areas/changing facilities are provided	• 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 • • Rest pods are in place • Additional rest areas in place • List of changing areas available on the Trust intranet	• IP audit programme • Audits undertaken by clinical areas • CEF audits recommenced Sept 2020 • Proud to care booklet audits recommenced Sept 2020 • Compliance with correct mask wearing and Doctors complaint with Bare Below the Elbow monitored via senior walk rounds of clinical areas	
9.2	Any changes to the PHE national guidance on PPE are quickly identified and effectively	• Notifications from NHS to Chief nurse/CEO	• Clinical Group meeting action log held by emergency planning	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	communicated to staff.	• IP team COVID lead checks Public Health England webpage daily (Monday-Friday) for updates • Changes raised at COVID clinical group which is held twice weekly • Daily tactical group • Incident control room established where changes are reported through • Chief nurse updates • Changes/update to staff are included in weekly Facebook live sessions • COVID -19 intranet page • COVID -19 daily bulletin with updates		
9.3	All clinical waste and linen/laundry related to confirmed or possible Covid-19 cases is handled, stored and managed in accordance with current national guidance.	• Waste policy in place • Waste stream included in IP mandatory training	The Trust has a Duty of Care to ensure the safe and proper management of waste materials from the point of generation to their final disposal (Cradle to Grave). This includes: • Ensuring the waste is stored safely. • Ensuring the waste is only transferred to an authorised carrier and disposer of the waste. • Transferring a written description of the waste • Using the permitted site code on all documentation. • Ensuring that the waste is	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
			disposed of correctly by the disposer. • Carry out external waste audits of waste contractors used by the Trust.	
9.4	PPE stock is appropriately stored and accessible to staff who require it.	• Procurement and stores hold supplies of PPE • Stores extended opening hours • PPE at clinical level stores in store rooms • Donning and doffing stations at entrance to wards	• PPE availability agenda item on Tactical Group meeting	

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

Risk Scoring								
Quarter	Q4	Q1	Q2	Q3	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	1	1	1	1	There are clear control in place for management of occupational needs of staff through team prevent to date Monitoring of adhere to social distancing and PPE continues. Work in progress to further improve retention of FFP3 mask fit training records	Likelihood:	1	End of quarter 2 2021 - achieved
Consequence:	3	3	3	3		Consequence:	3	
Risk Level:	3	3	3	3		Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
10.1	Update V 1.8 Staff seek advice when required from their Occupational l Health department/GP or employer as per their local policy Update V 1.8 Bank, agency and locum staff follow the same deployment advice as permanent staff Update V 1.8 Staff who are fully vaccinated against COVID-10 and are a close contact of a case of COVID-19 are able to return to work without the need to self isolate \9 see staff isolation : approach following updated government guidance) Update V 1.8	• All managers carry our risk assessment • Process available on the COVID 19 Trust intranet page • BAME risk assessment • Young persons risk assessment • Pregnant workers risk assessment • Risk assessment to identify vulnerable workers • Isolation tool available for staff on Trust intranet • UHNM follow National guidance	• Risk assessment and temporary risk mitigation will be reported to the workforce bureau. To protect confidentiality individual risk assessments will not be requested as these should be kept in the employees personal file • Managers required to complete , review and update risk assessments for vulnerable persons	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Staff understand and are adequately trained in safe systems of working including donning and doffing of PPE Staff in 'at risk' groups are identified and managed appropriately, including ensuring their physical and psychological wellbeing is supported. That risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic and pregnant staff Update V 1.8 A risk assessment is carried for health and social care staff including pregnant and specific ethnic minority groups who may be a high risk of complications from respiratory infection such as influenza and 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 onto these categories should follow the same deployment advice as permanent staff ○ A risk assessment is required for health and social care staff at high risk of	• PPE donning and doffing videos available on the intranet • PPE posters • IP Q+A manual • Staff risk assessment process already in place at UHNM • Staff risk assessment information available on the Trust intranet page	• IP assurance visits	

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board Update V 1.8 A fit testing programme is in place for those who may need to wear respiratory protection Staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection prevention precautions, including PPE and outlined in national guidance	• For staff groups that use Heather roster FFP3 mask fit testing details can be added as a skill to this system. • Fit testing in place • PPE requirement applicable to all staff , no exemptions for those who have recovered or received vaccination		
10.3	Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the crossover of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance.	• Restore and Restorations plans	• Incidence process/Datix	
10.4	All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas.	• Social distancing tool kit available on COVID 19 intranet page • Site circulation maps • Keep your distance posters	• Social distance monitor walk round introduced Friday 5th June • Social distance department risk assessments	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	Health and care settings are COVID 19 secure workplaces as far as practical, that is that any work place risks are mitigated maximally for everyone Linked NHSIE Key Action 2: Staff maintain social distancing in the workplace, when travelling to work (including avoiding car sharing) and to remind staff to follow public health guidance outside of the workplace.	• COVID-19 secure declaration • Social distancing risk assessment guidance for managers presentation 5th June2020 • Meeting room rules • Face masks for all staff commenced 15th June • Visitor face covering • COVID secure risk assessment process in place • November 2020 – Car sharing instructions added to COVID Bulletin	• COVID-19 secure declarations	
10.5	Consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas.	• Social distancing tool kit • Staff encouraged to keep to 2 metre rule during breaks • Purpose build rooms for staff breaks in progress	• Social distance monitor walk rounds • Social distance posters identify how many people allowed at one time in each room	
10.6	Staff absence and wellbeing are monitored and staff who are self-isolating are supported and able to access testing.	• Team Prevent available to offer guidance and treatment to staff presenting with onset of symptoms.	• Team prevent monitoring process • Work force bureau	
10.7	Staff who test positive have adequate information and support to aid their recovery and return to work. Update V 1.8 Where there has been a breach in infection prevention procedures staff are reviewed by Occupational Health , who will • Lead on the implementation of system	• Team Prevent available to offer guidance and treatment to staff presenting with onset of symptoms. • Empactis line will first ask – is the absence related to coronavirus. To which the employee must say yes or no • Once the absence is reported to the employees manger via email, the manager will categorise the absence type specified in the flow	• Via emapactis • Staff queries' through workforce bureau or team prevent	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	to monitor for illness and absence • Facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the health care workforce • Lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19	chart. • Team prevent complete COVID 19 staff screening • Areas where transmission has occurred are discussed at clinical group and relevant staff screening under an ILOG number is agreed. • Flow charts of staff returning to work available on COVID 19 section of intranet		

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.

Executive Summary

Meeting:	Trust Board	**Date:**	9th March 2022
Report Title:	CQC Action Plan	**Agenda Item:**	9.
Author:	Scott Malton, Deputy Chief Nurse/Debra Meehan, Lead Nurse Quality & Safety		
Executive Lead:	Ann-Marie Riley, Chief Nurse		

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

14958	*Triage times*	***Ext 16***
8550	*Medical staffing in the Emergency Department*	***High 9***
23272	*Mental Health Act assessment*	***High 9***

Executive Summary

The University Hospitals of North Midlands CQC report was published on 22 December 2021 (https://api.cqc.org.uk/public/v1/reports/8fe418d6-6fba-4380-a453-b0e0e9fd1799?20211223165327). The inspection took place 24 and 25 August 2021 and involved:

- Royal Stoke -urgent and emergency care; medicine
- County – medicine; surgery

The CQC also spoke with 179 members of staff, 25 patients and they reviewed 61 patient records. A Well Led inspection took place 5 and 6 October 2021. Following the initial inspection, the Trust was served a warning notice under Section 29a of the Health and Social Care Act 2008. The warning notice served to notify the Trust that the CQC had formed the view that the quality of health care provided in relation to medical staffing in urgent and emergency care at the Royal Stoke University Hospital and the risk management of patients with mental health need in medicine at County Hospital required significant improvement. The remedial actions were required to be completed by the end November 2021 and evidence to support the actions completed have been submitted to the CQC. As of 17th February 2022, we are still awaiting notification if we have met the requirements.

The CQC rated the following services:

- Medicine (County) - Requires Improvement
- Surgery (County) – Good
- Urgent and Emergency Care (RSUH) - Requires Improvement
- Medicine (RSUH) - Good

The CQC rated the Trust overall as 'Requires Improvement' overall but we did see improvement in two domains:

- Caring improved to a rating of 'Outstanding'
- Well Led improved to a rating of 'Good'

The report noted the actions the Trust must take (9) and should take (19) to improve. The attached action plan, addresses both the 9 actions that the CQC stipulated that the Trust must take and the 19 actions that the CQC suggested the Trust should take and includes sections to document progress and assurance.
Panel meetings will be convened on a monthly basis, with action leads, to refine the actions, monitor progress against the actions and to enable escalation of problematic actions.

Key Recommendations

The Trust Board is asked to note the contents of the CQC action plan and to note the proposed panel review process to monitor progress against the actions and to enable escalation of problematic actions.

CQC Action Plan

2022 / 2023

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

Action Number	Domain	Site	Division	Core Service	Observation / Issue	Improvement Required	Operational Lead	Target Date for Completion	Revised Target Date	Current Progress Rating	Assurance Mechanism	Assurance Based Progress Report	Responsible Committee / Group
A1	SAFE	**Royal Stoke**	**Medicine**	**Urgent and Emergency**	The Trust MUST ensure that there are enough suitably qualified, competent, skilled and experienced medical staff on each shift to deliver safe and effective care and treatment. **Regulation 18 (1)**	The Directorate will develop a Standard Operating procedure to mitigate gaps in the ED Medical Staffing Rota.	Richard Hall Clinical Director Nik Kennelly Directorate Manager	Complete			Staffing figures Number of incidents relating to staffing levels		Quality Safety Oversight Group Quality Governance Committee
						The Directorate will continually monitor gaps in the rota and associated mitigation by the ED Senior Leadership Team.	Richard Hall Clinical Director Nik Kennelly Directorate Manager	Apr-22			Staffing figures Number of incidents relating to staffing levels		Quality Safety Oversight Group Quality Governance Committee
						The Directorate will introduce Emergency Department Operational and Safety Huddles (8 times each day)	Richard Hall Clinical Director Nik Kennelly Directorate Manager	Complete			Minutes / actions from Safety Huddles		Quality Safety Oversight Group Quality Governance Committee
						The agreed actions to mitigate the risk to patient safety from Medical Staff Shortages in ED will be included as points of consideration for the ED Safety Huddles	Richard Hall Clinical Director Nik Kennelly Directorate Manager	Complete			Staffing figures Number of incidents relating to staffing levels		Quality Safety Oversight Group Quality Governance Committee
						To recruit to the approved establishment in the ED business case	Richard Hall Clinical Director Nik Kennelly Directorate Manager	Apr-22			Recruitment against plan monitored through CQC action plan oversight group		Quality Safety Oversight Group Quality Governance Committee
A2	SAFE	**Royal Stoke**	**Medicine**	**Urgent and Emergency**	The Trust MUST ensure they provide patients with a first assessment within 15 minutes of arrival to the ED in line with the conditions placed upon their registration. **Regulation 12 (1) (2) (a)**	Compliance with the 15 minute assessment times will be monitored following implementation of the new model that was developed following successful Emergency Department Test of Change.	Rebecca Viggars Deputy Associate Director	May-22			Clinical Audit of time to triage times		Quality Safety Oversight Group Quality Governance Committee
						Compliance with the 15 minute assessment time will be reported to the CQC on a monthly basis in line with the Section 31 conditions placed upon our registration.	Rebecca Viggars Deputy Associate Director	Complete			Monthly Section 31 Reports		Quality Safety Oversight Group Quality Governance Committee
						The new national standards and guidance on triage assessment times will be reviewed to ensure full compliance with the new regulations.	Rebecca Viggars Deputy Associate Director	May-22			SOP incorporating new standards Clinical Audit of time to triage times		Quality Safety Oversight Group Quality Governance Committee
A3	SAFE					The Trust will implement the new Triage Model that was developed following successful Emergency Department Test of Change	Claire Tooth Matron	May-22			Clinical audit of Documentation CEF		Quality Safety Oversight Group Quality Governance Committee
						The Directorate will conduct harm reviews for patients experiencing long ambulance and trolley waits in order to identify any potential harm and areas for improvement in the standard of care delivered	Claire Tooth Matron	Apr-22			Review of incidents relating to harm in the ED Department		Quality Safety Oversight Group Quality Governance Committee

Action Number	Domain	Site	Division	Core Service	Observation / Issue	Improvement Required	Operational Lead	Target Date for Completion	Revised Target Date	Current Progress Rating	Assurance Mechanism	Assurance Based Progress Report	Responsible Committee / Group
		Royal Stoke	**Medicine**	**Urgent and Emergency**	The Trust MUST ensure that patients are risk assessed appropriately, in a timely way and provide mitigation for risks when identified. **Regulation 12 (1) (2) (b)**	To review the MH proforma and actions to include the risk assessment of MH patients behind the cubicle doors	Claire Tooth Matron	Apr-22			Review of incidents relating to harm in the ED Department		Quality Safety Oversight Group Quality Governance Committee
						Directorate Governance Meetings will ensure that all incidents are discussed in a timely manner and mitigating actions are put in place	Claire Tooth Matron	Apr-22			Meeting agenda Meeting minutes Review of risk register		Quality Safety Oversight Group Quality Governance Committee
						The Directorate will continue the daily Matron CEF reviews supported by the corporate nursing team assurance process	Claire Tooth Matron	Feb-22			Clinical Audit of Documentation		Quality Safety Oversight Group Quality Governance Committee
A4	**SAFE**	**Royal Stoke**	**Medicine**	**Urgent and Emergency**	The Trust MUST ensure patients are kept safe from infection and avoidable harm and staff receive appropriate guidance and support to enable them to do this. **Regulation 12 (1) (2) (h)**	Infection Prevention poster which describes correct PPE for red and green areas to be displayed through ED	Claire Tooth Matron	Apr-22			Review of incidents relating to harm in the ED Department		Quality Safety Oversight Group Quality Governance Committee
						The Directorate will ensure that all staff receive updates in PPE training/mask fit training, according to latest National Guidance	Claire Tooth Matron	Apr-22			Training figures		Quality Safety Oversight Group Quality Governance Committee
						To ensure all appropriate clinical assessments are undertaken as appropriate (eg.VTE, Falls, MH etc.)	Richard Hall Clinical Director	May-22			Escalation paper to Divisional Governance Group		Quality Safety Oversight Group Quality Governance Committee
						Weekly CEF reviews to include equipment cleaning checks	Claire Tooth Matron	Mar-22			Review of incidents relating to harm in the ED Department		Quality Safety Oversight Group Quality Governance Committee
A5		**Royal Stoke**	**Medicine**	**Urgent and Emergency**	the Trust **MUST** ensure all risks are appropriately identified, assessed and mitigation put in place where possible. **Regulation 17 (1)**	The risk register will be updated to include all current risk relating to the ED Department	Richard Hall Clinical Director	Mar-22			Escalation paper to Divisional Governance Group		Quality Safety Oversight Group Quality Governance Committee
						The Directorate will develop a harm review process against the new Emergency Care Standards	Chris Pickering	May-22			Review of incidents relating to harm in the ED Department		Quality Safety Oversight Group Quality Governance Committee
						The Trust will further develop the ED Mental Health Assessment Tool to accompany the patient on admission and facilitate ongoing mental health assessment in assessment and ward areas.	Kirsty Smith	Apr-22			Clinical Audit of the Mental Health Assessment Tool Review of incidents relating to the provision of mental health assessments		Quality Safety Oversight Group Quality Governance Committee

Action Number	Domain	Site	Division	Core Service	Observation / Issue	Improvement Required	Operational Lead	Target Date for Completion	Revised Target Date	Current Progress Rating	Assurance Mechanism	Assurance Based Progress Report	Responsible Committee / Group
A6	SAFE	**County**	**Medicine**	**Medicine Care**	The Trust must ensure associated with acute mental health needs are assessed, recorded and mitigated. **Regulation 12 (1) (2) (a) (b)**	The Trust will report and monitor the number of mental health referrals via the Mental Health Operational Group, which has representation from all clinical divisions, the mental health liaison team and psychiatric liaison team. The Group will oversee operational priorities such as referrals, access to Mental Health Act assessment, training and incidents. Areas of escalation and assurance will be reported into the Trust Mental Health and Learning Disability Group.	Kirsty Smith Matron	May-22			Mental Health Operational Group agenda and minutes Escalation report to the Trust Mental Health and Learning Disability Group		Quality Safety Oversight Group Quality Governance Committee
						The Trust will further develop the current audit tool of the ED Mental Health Assessment Tool (Report published June 2020) to reflect it's use through to AMU and all Ward areas. The Revised audit will be prioritised on the Trust Clinical Audit Programme 2022 / 2023	Kirsty Smith Matron	Jun-22			Clinical Audit of the Mental Health Assessment Tool Review of incidents relating to the provision of mental health assessments		Quality Safety Oversight Group Quality Governance Committee
						Development of a Trust-Wide Harm Free Care Alert	Kirsty Smith Matron	Nov-21			Review of incidents relating to the provision of mental health assessments		
A7	SAFE	**County**	**Medicine**	**Medicine Care**	The Trust MUST ensure nutritional risk assessments and care plans are completed in line with their policy. **Regulation 12 (1) (2) (b)**	The Trust will relaunch a training programme emphasising key learning around assessing, managing and monitoring patients nutrition	Ann Griffiths Chief Dietician	May-22			Training compliance CEF visits		Quality Safety Oversight Group Quality Governance Committee
						A Focus Group will be convened to review the current Nutrition bundle (evidence of care planning). Representatives from Ward teams and Dietetics will explore the barriers to its use, how we can revitalise and consider its digitalisation journey.	Ann Griffiths Chief Dietician	Apr-22			CEF Visits Clinical Audit of Nutritional Management		Quality Safety Oversight Group Quality Governance Committee
						The Trust will develop a process of sharing Vital Pac reports detailing MUST compliance with Ward teams	Ann Griffiths Chief Dietician	May-22			CEF Visits Clinical Audit of Nutritional Management		Quality Safety Oversight Group Quality Governance Committee
						In order to promote on-going monitoring around the assessment and management of nutrition, a spot check audit will be developed using the Tendable Audit Programme	Ann Griffiths Chief Dietician	Jul-22			Tendable Audit Spot Check results		Quality Safety Oversight Group Quality Governance Committee
A8	SAFE	**County**	**Medicine**	**Medicine Care**	The Trust MUST ensure patients receive timely swallow assessments. **Regulation 12 (1) (2) (a) (b)**	A position paper will be presented at the Acute Patient Flow group which will highlights the shortfalls in the service provision to inpatient medical wards, across both sites	Lois Dale Head of Speech and Language Therapy	May-22					Quality Safety Oversight Group Quality Governance Committee
						The Trust will develop an education programme to support ward teams regarding 'what makes a good referral' and how to escalate referrals	Lois Dale Head of Speech and Language Therapy	Jun-22			Review of incidents relating to insufficient referrals Review of the number of rejected referrals		Quality Safety Oversight Group Quality Governance Committee
						MNP/ANP nurse swallow screening training will be implemented at RSUH to support service provision. Consider rollout at County Hospital	Lois Dale Head of Speech and Language Therapy	Jun-22			Review of incidents relating to SALT provision at Ward level		Quality Safety Oversight Group Quality Governance Committee

Action Number	Domain	Site	Division	Core Service	Observation / Issue	Improvement Required	Operational Lead	Target Date for Completion	Revised Target Date	Current Progress Rating	Assurance Mechanism	Assurance Based Progress Report	Responsible Committee / Group
A9	SAFE	County	Medicine	Medicine Care	The Trust MUST ensure Mental Capacity Act Assessments are consistently completed in a timely and responsive manner. **Regulation 11 (1) (2) (3)**	The Clinical Audit Programme will be reviewed to ensure that all audits relating to the delivery of care include questions around whether mental capacity should have/was assessed	Dr Matthew Lewis Medical Director	Apr-22			Clinical Audit results		Vulnerable Adult Group Quality Safety Oversight Group Quality Governance Committee
						The following audits will be prioritised on the Trust Clinical Audit programme to monitor compliance with Trust Policy: Audit of the Mental Capacity Act Audit of Deprivation of Liberty	Clinical Audit Department	Apr-22			Clinical Audit results		Vulnerable Adult Group Quality Safety Oversight Group Quality Governance Committee
						The Trust will introduce a template to remind / guide staff through the MCA assessment process	Dr Matthew Lewis Medical Director	May-22			Clinical Audit results		Vulnerable Adult Group Quality Safety Oversight Group Quality Governance Committee
						The Trust will undertake a baseline review of current training compliance in relation consent training. A trajectory of improvement will be developed and monitored	Dr Matthew Lewis Medical Director	Apr-22			Clinical Audit of the Consent Process		Vulnerable Adult Group Quality Safety Oversight Group Quality Governance Committee
						A review of the current training packages will be undertaken to ensure that any training around the provision of care to vulnerable patients, includes MCA information	Dr Matthew Lewis Medical Director	Apr-22			Clinical Audit of the Mental Capacity Act		Vulnerable Adult Group Quality Safety Oversight Group Quality Governance Committee

CQC Action Plan

2022 / 2023

CURRENT PROGRESS RATING		
	Complete / Business as Usual	Completed: Improvement / action delivered with sustainability assured.
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	Delayed	Off track / trajectory – milestone / timescales breached. Recovery plan required.

Action Number	Domain	Site	Division	Core Service	Observation / Issue	Improvement Required	Operational Lead	Target Date for Completion	Revised Target Date	Current Progress Rating	Assurance Mechanism	Assurance Based Progress Report	Responsible Committee / Group
B1	Safe	**Trust wide**	**Corporate**	**Trust wide**	The Trust SHOULD ensure it reviews and investigates significant incidents in a timely manner and in line with Trust Policy	The Trust has developed a twice weekly Serious Incident review meeting to review new incidents and ensure that 72 hour reports and plans for investigation are confirmed	Jamie Maxwell Head of Quality, Safety and Compliance	Complete			Quality and Safety Report		SI Review Group Risk management Panel Quality Safety Oversight Group Quality Governance Committee
						The Trust will work collaboratively with the local CCG to monitor timescales for submission on STEIS and to redefine the TOR of the SI Sub-Group	Jamie Maxwell Head of Quality, Safety and Compliance	Mar-22			SI Sub Group Presentation		SI Review Group Risk management Panel Quality Safety Oversight Group Quality Governance Committee
B2	Responsive	**Trust wide**	**Corporate**	**Trust wide**	The Trust SHOULD ensure all complaints are reviewed, investigated and responses are managed in a timely manner and in line with Trust policy	The Trust are reviewing the current formal complaints process to improve the quality and timeliness of reports and to streamline the sign off process	Debra Meehan Lead Nurse: Quality and	Apr-22			Complaints Report		Patient Experience Group Quality Safety Oversight Group Quality Governance Committee
B3	Well Led	**Royal Stoke**	**Medicine**	**Urgent and Emergency**	The Trust SHOULD ensure that measures are in place to keep patients records secure.	The Data Protection and Security Team will conduct a review of patient records storage in the ED, Royal Stoke to identify any risks and mitigating actions	Jean Lehnert Data Protection and Security Manager	Apr-22			Review of incidents around record management and storage		Urgent and Emergency Medicine Directorate Governance Meeting
B4	Well Led	**Royal Stoke**	**Medicine**	**Urgent and Emergency**	The Trust SHOULD ensure there is a recovery process in place to ensure all staff complete mandatory training and essential role training	The Directorate Team will develop a trajectory to improve compliance with mandatory training and essential role training. Progress will be monitored via the Directorate Governance Meeting	Richard Hall Consultant Claire Tooth Matron	Apr-22			Training figures		Urgent and Emergency Medicine Directorate Governance Meeting
						The Departmental rotas will be adapted to highlight identifying on rotas when time is allocated for individuals to complete training	Richard Hall Consultant Claire Tooth Matron	May-22			Training figures		Urgent and Emergency Medicine Directorate Governance Meeting
B5	Safe	**Royal Stoke**	**Medicine**	**Urgent and Emergency**	The Trust SHOULD ensure all staff follow best practice when completing care records to ensure they are an accurate record of care and treatment provided	The Trust will introduce digitalised care records to ensure the provision of individualised, accurate care plans.	Richard Hall Consultant Claire Tooth Matron	TBC			CEF Clinical Audit of documentation		Urgent and Emergency Medicine Directorate Governance Meeting
						The Department will continue daily Matron CEF reviews supported by the Corporate Nursing Team	Claire Tooth Matron	Mar-22			CEF Clinical Audit of documentation		Urgent and Emergency Medicine Directorate Governance Meeting
B6	Responsive	**Royal Stoke**	**Medicine**	**Urgent and Emergency**	The Trust SHOULD consider how they can improve information management for certain patient groups	A review of current documentation will be undertaken to ensure the provision of standardised templates for electronic referrals and Medical/Nursing handovers	Richard Hall Consultant Claire Tooth Matron	May-22			Directorate Quality Report		Urgent and Emergency Medicine Directorate Governance Meeting
B7	Safe	**Royal Stoke**	**Medicine**	**Urgent and Emergency**	The Trust SHOULD consider how the current layout of the Department is impacting on the safe running of the Department	The Directorate will conduct a feasibility Study to explore options to mitigate risk of patients being nursed in majors cubicles with doors, from both an infection prevention and avoidable harm perspective	Richard Hall Consultant Claire Tooth Matron	Apr-22			Review of incidents relating to harm in the ED Department		Quality Safety Oversight Group Quality Governance Committee
B8	Well Led	**Royal Stoke**	**Medicine**	**Medical Care**	The Trust SHOULD ensure that it continues to work toward meeting	The Divisional Management Team will develop a trajectory to improve compliance with mandatory training and essential role training. Progress will be monitored via the Directorate Governance Meeting	Gwen Hatton Associate Chief Nurse	Apr-22			Training figures		Directorate and Divisional Governance Meetings

B8	Well Led	Royal Stoke	Medicine	Medical Care	trust targets for all mandatory training	The Divisional rotas will be adapted to highlight identifying on rotas when time is allocated for individuals to complete training	Gwen Hatton Associate Chief Nurse	May-22			Training figures		Directorate and Divisional Governance Meetings
B9	Effective	Royal Stoke	Medicine	Medical Care	The Trust SHOULD ensure that all wards display up to date audit results such as results from hand hygiene audits	up to date audit results to form part of Perfect Ward audit system	Gwen Hatton Associate Chief Nurse Vicky Lewis Quality Assurance Manager	May-22			CEF Visits, perfect ward		Directorate and Divisional Governance Meetings
B10	Safe	Royal Stoke	Medicine	Medical Care	The Trust SHOULD ensure medical wards are provided with adequate storage space	Ward teams will be encouraged to take part in "Dump the Junk" initiatives	Estates Team / Medical Division Matrons	Jun-22			CEF Visits		Directorate and Divisional Governance Meetings
						Ward Teams will be encouraged to adopt Lean Methodologies with regard to equipment/storage as part of their Improving together/Shared Governance projects	Estates Team / Medical Division Matrons	Sep-22			CEF Visits		Directorate and Divisional Governance Meetings
B11	Safe	Royal Stoke	Medicine	Medical Care	The Trust SHOULD ensure patient records are kept in a structured and consistent format so that staff can easily access them	The Trust will conduct an options appraisal of available standardised formats for health records	Documentation Group/Health records Department	Sep-22			Record Keeping Clinical Audit		Quality Safety Oversight Group Quality Governance Committee
B12	Responsive	Royal Stoke	Medicine	Medical Care	The Trust SHOULD ensure complaints are managed in a timely way	The Trust are reviewing the current formal complaints process to improve the quality and timeliness of reports and to streamline the sign off process	Debra Meehan Lead Nurse: Quality and Safety Gwen Hatton Associate Chief Nurse	Apr-22			Complaints Report		Quality Safety Oversight Group Quality Governance Committee
B13	Responsive	Royal Stoke	Medicine	Medical Care	The Trust SHOULD ensure that waiting times from referral to treatment and arrangement to admit, treat and discharge to be in line with national standards	Monitor waiting times and assign mitigating actions through Directorate, Divisional and Corporate meeting structures	Divisional Leadership Team	Mar-22			Divisional Performance Report		Quality Safety Oversight Group Quality Governance Committee
B14	Well Led	County	Medicine	Medical Care	The Trust SHOULD ensure that it continues to work toward meeting trust targets for all mandatory training	The Divisional Management Team will develop a trajectory to improve compliance with mandatory training and essential role training. Progress will be monitored via the Directorate Governance Meeting	Gwen Hatton Associate Chief Nurse Dr Tony Cadwgan Divisional Chair	Apr-22			Training figures		Directorate and Divisional Governance Meetings
						The Divisional rotas will be adapted to highlight identifying on rotas when time is allocated for individuals to complete training	Gwen Hatton Associate Chief Nurse Dr Tony Cadwgan Divisional Chair	May-22			Training figures		Directorate and Divisional Governance Meetings
B15	Safe	County	Medicine	Medical Care	The Trust SHOULD ensure all serious incidents are investigated effectively and in a timely manner to reduce the risk of future harm	The Division will ensure that immediate mitigating actions are identified and shared, following all Serious Incidents	Gwen Hatton Associate Chief Nurse Dr Tony Cadwgan Divisional Chair	Mar-22			Quality and Safety Report		Directorate and Divisional Governance Meetings
						The Division will monitor timeliness of investigations and share learning through Divisional Governance Structures	Gwen Hatton Associate Chief Nurse Dr Tony Cadwgan Divisional Chair	Mar-22			Quality and Safety Report		Directorate and Divisional Governance Meetings
B16	Safe	County	Medicine	Medical Care	The Trust SHOULD consider taking action to ensure key information about patients care is consistently recorded. For example, ensuring	A review of the proposed Clinical Audit programme will be undertaken to ensure that appropriate documentation audits are in place to review the standards of patient documentation and identify areas for improvement	Victoria Lewis Quality Assurance Manager	Apr-22			Clinical Audit Progress Report		Clinical Effectiveness Group

B16	Safe	County	Medicine	Medical Care	about patients care in consistently recorded. For example, ensuring clear wound care plans are in place for all patients with a wound	The Trust has developed a Wound Care Document. The document is currently being ratified and a roll-out plan is being finalised	Katie Leek Lead Nurse: Tissue Viability	May-22			Review of Tissue Viability incidents		Quality Safety Oversight Group Quality Governance Committee
B17	Safe	County	Medicine	Medicine Care	The Trust SHOULD consider making the speech and language therapy service provision equitable across County Hospital	A position paper will be presented at the Acute Patient Flow group which will highlight the shortfalls in the service provision to inpatient medical wards, across both sites	Lois Dale Head of Speech and Language Therapy	May-22			Meeting Minutes		Quality Safety Oversight Group Quality Governance Committee
						The Trust will develop an education programme to support ward teams regarding 'what makes a good referral' and how to escalate referrals	Lois Dale Head of Speech and Language Therapy	Jun-22			Review of incidents relating to insufficient referrals Review of the number of rejected referrals		Quality Safety Oversight Group Quality Governance Committee
						MNP/ANP nurse swallow screening training will be implemented at RSUH to support service provision. Consider rollout at County Hospital	Lois Dale Head of Speech and Language Therapy	Jun-22			Review of incidents relating to SALT provision at Ward level		Quality Safety Oversight Group Quality Governance Committee
B18	Safe	County	Medicine	Medicine Care	The Trust SHOULD continue to work towards the provision of a full multidisciplinary seven-day service at the County Hospital site	The Division will initiate a number of promotional activities to ensure that Ward staff are aware of the services available at County Hospital across seven days	Claire Mackirdy Site Director of Operations	Jul-22			Divisional Performance Report		Operational Groups
						The Trust will include consideration of seven-day service provision in all service reviews at County Hospital	Claire Mackirdy Site Director of Operations	Jul-22			Divisional Performance Report		Operational Groups
B19	Well Led	County	Surgery	Surgical Care	The Trust SHOULD ensure that medical staff are up to date with all mandatory training	The Divisional Management Team will develop a trajectory to improve compliance with mandatory training and essential role training. Progress will be monitored via the Directorate Governance Meeting	Dr Stephen Merron Clinical Director	Apr-22			Training Figures		Directorate and Divisional Governance Meetings
						The Divisional rotas will be adapted to highlight identifying on rotas when time is allocated for individuals to complete training	Dr Stephen Merron Clinical Director	May-22			Training Figures		Directorate and Divisional Governance Meetings

Executive Summary

Meeting:	Trust Board	**Date:**	9th March 2022
Report Title:	Q3 Maternity New Serious Incident (SI) Report	**Agenda Item:**	10.
Author:	Donna Brayford, Quality & Risk Manager		
Executive Lead:	Ann-Marie Riley, Chief Nurse		

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

13419	*Midwifery Safe Staffing*	***Extreme(16)***
15593	*Maternity Assessment Unit Triage*	***Extreme (15)***

Executive Summary

Situation

This report provides a summary of the numbers and types of Serious Incidents reported by Maternity during Quarter 3 (2021). As of 31.12.21, maternity have 12 ongoing serious incidents (including new incidents).

Investigation in progress: 11 serious incidents (5 local Root Cause Analysis, 3 Healthcare Safety Investigation Branch Investigations, 3 Perinatal Mortality Review Tools).

Investigations completed/awaiting to be presented and closed by Risk Management Panel and CCG SI Group: 1 incidents.

A Serious Incident report is presented to the Directorate and CWD Division monthly.

Background

Following the publication of the Ockenden review, Trust Boards are to have specific sight of Maternity Serious Incidents on a quarterly basis.

Assessment

In Q3, 3 new serious incidents were reported:

- October 2021 1 serious incident
- November 2021 2 serious incidents
- December 2021 0 serious incidents

Category of Incidents:

- 1 Healthcare Safety Investigation Branch (HSIB) investigation.
- 1 new incident to be investigated by local Root Cause Analysis (RCA).
- 1 new incident investigated by the Perinatal Mortality Review Tool (PMRT).

Immediate Actions:

- The Risk Register score for maternity triage has been increased to 15. Maternity are currently identifying how this service can be supported within our establishment. The plan has been included in a workforce paper which will be presented throughout UHNM and to the executive teams
- Development of a Covid Surveillance Pathway for pregnant women who are covid positive. This will include a standardised risk assessment at first telephone contact and oximetry at home monitoring for 14 days which will include daily monitoring calls for symptomatic pregnant women
- New standard implemented - A Consultant Obstetrician should review all pregnant and recently pregnant women with suspected or confirmed COVID-19 who are in hospital at least daily, particularly if they are admitted to a bed outside of the maternity unit.
- Implementation of a COVID documentation template in maternity electronic records for vaccination discussion and safety netting advice at each contact.

Areas of concern/escalation:

Maternity have implemented the covid surveillance pathway without additional establishment. This is being supported by the non – clinical team working clinically daily.

Key Recommendations

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

Maternity New Serious Incident Reporting Process – for information.

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

HSIB Investigations and SI Reporting.

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

1. Definitions

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

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

Cooling Therapies are described as:
Passive – turning off heating equipment and removing covering from the baby.
Active – placing the baby on a temperature controlled cooling mattress or using a temperature controlled cooling cap.
Therapeutic - is a procedure where the infant is cooled to between 33 and 34 degrees Celsius, with the aim of preventing further brain injury following a hypoxic (lack of oxygen) injury. Hypothermia is usually induced by cooling the whole body with a blanket or mattress.

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

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

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

2. New Serious Incidents

Maternity have reported 3 Serious Incidents during Q3 (2021), October (n=1), November (n= 2) and December (= 0). Table 1 gives a brief description of the incident and immediate actions taken. It has been agreed by the Directorate, Division and Trust Board that all HSIB investigations will be reported as Serious Incidents and then de-escalated if required.

Table 1 - Brief description of new serious incidents and immediate action taken.

SI ID	Datix ID/ Incident Date	Incident description	Immediate Actions	Outcome
2021/23613	248261 June 2021	• Neonatal Death at 25+6 corrected gestation. • Triage Telephone call to the Maternity Assessment Unit (MAU) answered by ward clerk and not a registered midwife, incorrect advice given to mother.	• Verbal and written duty of candour completed. • Maternity services have recruited 3.64 WTE midwives to assist in providing 24/7 telephone triage cover . • Retrospective SI following completion of PMRT review.	• Mother and family continue to be supported by the bereavement team
2021/23088	257852 November 2021	• Healthcare Safety Investigation Branch (HSIB) Referral. • Maternal Death, 24 days post-partum following an emergency caesarean section at 40 weeks and 2 days gestation. Covid positive. • Raised Body Mass Index • Coroner's Inquest • Had not received Covid vaccination.	• Written duty of candour to Next of Kin completed. • Development of Covid Surveillance Pathway for pregnant women who are covid positive including development of Covid 19 Triage Tool for pregnant or postnatal women (up to 6 weeks) • Implementation of Covid Care Plan in Obstetrics, updated inline with Coronavirus (COVID-19) infection and pregnancy (V14.3) • New standard implemented - A Consultant Obstetrician should review all pregnant and recently pregnant women with suspected or confirmed COVID-19 who are in hospital at least daily • Implementation of standard COVID documentation template for vaccination discussion at each contact.	• Awaiting HSIB report • Staff support arranged.

SI ID	Datix ID/ Incident Date	Incident description	Immediate Actions	Outcome
2021/24638	259191 November 2021	• Maternal Death, 61 days post-partum, Covid positive • Raised Body Mass Index • Black, Carribean • Had not received Covid vaccination	• Verbal and written duty of candour completed • Safety netting advice to include increased risk factors such as ethnic minority and increased BMI.	• Local RCA in progress.

3. Current Serious Incidents in progress

Maternity have 12 ongoing serious incidents (including new incidents) of which 11 serious incidents are in progress (5 local RCA, 3 HSIB, 3 PMRT) and 1 iInvestigations is completed/awaiting to be presented and closed by Risk Management Panel and CCG SI Group.

SI ID/ Date on STEIS	Datix ID/ Incident Date	Incident description	Immediate Actions	Outcome
2021/16483 July 2021	248229 June 2021	• Inappropriate induction at 34 and 6 days. • Mother received a caesarean section and spinal anaesthesia. • Baby delivered at 35 weeks and required admission to the neonatal unit. • Potential impact upon subsequent labour for the mother.	• Individual practitioner met with educational supervisor. • Verbal and written Duty of Candour completed. • Local Root Cause Analysis in progress.	• Mother and Baby well. • Awaiting outcome of investigation.
2021/16264 August 2021	250418 July 2021 HSIB	• Early Neonatal Death. • Cord Prolapse at home. • Deteriorating maternal condition on admission to Maternity, transferred to intensive care.	• HSIB referral completed. • Verbal and written Duty of Candour completed • Immediate staff de-brief performed. Staff support arranged. • Staff de-brief offered to ambulance crew. • No further immediate safety actions identified.	• Mum well, discharged home. • HSIB investigation in progress, awaiting report.

SI ID Date on STEIS	Datix ID/ Incident Date	Incident description	Immediate Actions	Outcome
2021/19485 September 2021	251596 Sept 2020	• Term baby born with Cleft Lip and Palate. • Unable to locate record of discussion of risk of Ondansetron when administered to mother at less than 12 weeks gestation. • Medicines and Healthcare products Regulatory Agency (MHRA) update states 'Ondansetron: small increased risk of oral clefts following use in the first 12 weeks of pregnancy'. Recommendation: if the clinical decision is to offer Ondansetron in pregnancy, women must be counselled on the potential benefits and risk of use, both to her and to her unborn baby and the final decision should be made jointly.	• Memo sent to all medical staff to remind medical staff to counsel women appropriately. • Spot case audit on women who have received ondansetron – 5 cases identified in ED. Immediate joint learning implemented with ED. • Verbal and written Duty of Candour completed. • Local Root Cause in progress. Joint RCA with pharmacy. • Delay in reporting as incident report triggered by GP complaint during the post-natal period. • Adverse drug reaction reported to MHRA.	• Baby and family continue to receive support from Birmingham Cleft Lip and Palate team and UHNM paediatric gastroenterology.
2021/19478 September 2021	252148 August 2021	• Ante partum Stillbirth at 31 weeks and 4 days gestation. • Delay in triage on admission to Maternity Assessment Unit (MAU).	• Plan to implement 2nd triage midwife to assist in performing triage as per UHNM guidelines. • Maternity services have recruited 3.64 WTE midwives to assist in providing 24/7 telephone triage cover . • Due to the frequency of inability to triage risk register score increased to 15. • Datix completed for every triage breach. • PMRT Multi–disciplinary review will be completed. • Verbal and written DOC completed.	• Mother and family continue to be supported by the bereavement team.
2021/19762 September 2021	254486 September 2021	• Neonatal Death at 30 weeks and 6 days gestation. • Parents have requested a coroner's inquest due to their concerns around	• Staff support arranged from the Professional Midwifery Advocate. • Coroner's inquest to be held. • External Consultant Obstetrician present at	• Mother and family continue to be supported by the bereavement team.

SI ID Date on STEIS	Datix ID/ Incident Date	Incident description	Immediate Actions	Outcome
		care provided on the antenatal ward prior to baby's delivery. • Local media reporting.	review as a lead reviewer to give parents reassurance of openness and transparency. • Verbal and written DOC completed.	
2021/3124 Investigation Completed	218366 March 2020	• A category 1 caesarean section at 37 weeks and 6 days for a pathological cardiotocograph (CTG); a pathological CTG is a CTG with 1 abnormal feature or 2 non reassuring features. • Baby needed transferring to the neonatal unit and required active cooling. • Retrospective Incident.	• This is an obstetric emergency which was managed in accordance with guidance from the maternity team. • Retrospective Serious Incident, a brief overview took place at the time of the incident but it was not formally investigated. COVID-19 escalations were being discussed apace at the time and the Directorate also experienced a maternal death in the unit at a similar time point which could account for why the incident was overlooked at the time. Recognised through failsafe audit that an RCA required. Sincere apologies given to parents for delay. • Parents given option to request a HSIB investigation in view of late formal investigation, declined. • No immediate actions. Local RCA ongoing.	• Baby continues to be care of the paediatric team. • Some motor reflex delay noted, parents report abnormal jerky movements. • Baby currently waiting for a further MRI and follow up.
2021/3974 Investigation In progress	237628 January 2021	• Sudden unexpected post-natal neonatal collapse at 25 minutes of age. • Baby was intubated and transferred to the neonatal unit. • Active cooling was commenced on admission to the neonatal unit.	• HSIB referral rejected as MRI reported to be normal, local RCA ongoing. • Immediate action - the neonatal team were not crash bleeped following the neonatal collapse. MDT decision that clinical staff should crash bleep the neonatal team for any sudden unexpected postnatal collapse of a newborn baby. Memo sent to all areas. • Local RCA completed –waiting to be presented at directorate.	• Baby is well, feeding on demand, with normal reflexes on her last examination. • To be reviewed again in 3 months then if remains well will be discharged by the neonatology team.
2021/6701	239973	• Acute collapse following major maternal haemorrhage.	• Potentially two opportunities to identify issue and instigate different management plan	• Mum remains under the care of the

SI ID Date on STEIS	Datix ID/ Incident Date	Incident description	Immediate Actions	Outcome
Investigation in progress	February 2021	• 17+4 weeks pregnant with twins, Findings of a ruptured rudimentary horn of the uterus (a uterine abnormality). Both fetus's in the abdomen. • Ultrasound scans did not diagnose that the pregnancy had implanted in a rudimentary uterine horn.	• Local RCA ongoing.	midwifery team • Seen at 6 weeks post – operatively, and mum is recovering well. Debrief given.
2021/9749 Investigation in progress	243402 Aug 2021	• Baby required transfer to the neonatal unit and required active cooling. • Forceps delivery following a prolonged fetal bradycardia possibly due to placental abruption.	• Case reported to HSIB for investigation • Support provided to the family. • Draft HSIB report received by the trust to be reviewed for factual accuracy and shared with staff for approval.	• MRI report revealed no convincing abnormality to suggest HIE or structural changes to explain seizures. • Baby was discharged home with mum at 24 days of age. Baby continues to receive anti convulsants. Plan to repeat MRI if seizures persist.

4. Serious Incidents closed during Q3 – Learning and Actions

2021/685 - Serious Incident de - escalated

Incident Date: December 2020

- A category 2 emergency caesarean section (CS) (Category 2 CS is maternal or fetal compromise which is not immediately life threatening) for failure to progress in labour.
- Impacted fetal head (fetal head is stuck in the pelvis).
- Baby required transfer to the neonatal unit for passive cooling.
- Baby is well, feeding as expected, good reflexes, no concerns with vision or hearing.
- Care provided has been managed in accordance with UHNM Maternity and Neonatal guidelines. No care issues identified.

LEARNING AND ACTIONS

What has changed?

- Impacted fetal head included in yearly mandatory skills drills training

2021/684 - Serious Incident de - escalated

Incident Date: December 2020

- A category 1 emergency caesarean section (Category 1 CS immediate threat to life of woman or fetus) at 36+6 weeks for antepartum haemorrhage; a placental abruption (placenta separates from the uterus) was confirmed at CS.
- Baby needed transferring to the neonatal unit and required therapeutic cooling.
- Baby is well
- Care provided has been managed in accordance with UHNM Maternity and Neonatal guidelines. No care issues identified.

LEARNING AND ACTIONS

What has now changed?

- Positive feedback given to team complementing on teamwork and communication during the Obstetric Emergency.

2021/ 2331 Serious Incident de - escalated

Incident Date: January 2021

- A category 2 emergency caesarean section at 37 weeks for suspicious cardiotocograph (CTG).
- Baby neededed transferring to the neonatal unit and required active cooling. The cooling was discontinued on day 3. The baby continued to be ventilated and experienced seizures.
- Baby sadly passed away
- HSIB reported no care issues that contributed to the outcome for mother and baby. However, incidental findings were reported.

LEARNING AND ACTIONS

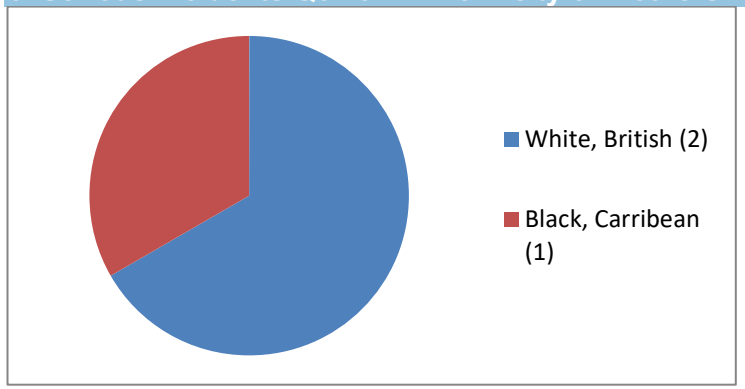
What has now changed?

- Flow Co-ordinator role to have oversight of activity and acuity on the Maternity Assessment Unit. Role includes assisting midwifery staff to obtain a medical review
- Development of jump call escalation poster to assist prompt medical review.
- When a decision is made for a caesarean section, the time by which the baby needs to be delivered is documented on the Delivery suite handover board, theatre board and on K2 electronic maternal records.
- Implementation of a Category 1 Caesarean section bleep to expedite prompt delivery.

5. Current HSIB Cases

3 Current HSIB cases ongoing

6. Serious Incidents Q3 2021 – Ethnicity of Mothers whose Care was Reported as a Serious Incident



PROUD TO CARE

Committee Chair's Highlight Report to Board

Performance and Finance Committee
22nd February 2022

NHS
University Hospitals of North Midlands
NHS Trust

1. Highlight Report

!	Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
	• Whilst progress had been made in reducing the number of overdue business case reviews, there remained 10 which were overdue and these had been provided with a 4 week extension due to operational pressures • Continuing high levels of sickness absence were impacting on urgent care performance in particular admitted and non-admitted performance and ambulance holds, whereby occupancy levels and bedded capacity were the main challenges. • The Committee highlighted its concern in relation to cohorting patients and the development of a Standard Operating Procedure, although it was noted that majority of Trusts had put this in place in order to reduce the pressure upon ambulance holds. • The Business Intelligence Group highlighted concerns regarding implementation of the care cube in cardiology which had not incorporated IT input and this was being considered with the Director of Digital Transformation. In addition staffing vacancies in the clinical coding team were noted, although recruitment was being undertaken. • An update was provided by the Executive Infrastructure Group highlighting the delays to the Capital Programme associated with Lower Trent works, introduction of LIMS and EPMA. In addition risks were identified in respect of substitute equipment being provided, which was being monitored by the Medical Devices Steering Group, as well as noting risks in relation to obtaining vacant possession of Grindley Hill Court, as part of Project STAR. • The Digital and Data Security Protection Group highlighted issues with real-time bed templates which was impacting upon effective bed management and this was a main area of focus. An additional IT vulnerability had been identified and mitigation was being identified and the group noted the actions being taken to reduce inappropriate access to records	• To identify the additional KPIs within the Expansion of GI Business Case • To bring the full business case in relation to enhanced primary care in ED to March's meeting, including the overall vision for urgent care • To improve visibility of the progress being made by the operational performance workstreams within the performance report • In terms of the 104 week trajectory, this was expected to reduce through clinical validation and insourcing and it was agreed to clarify these numbers at a future meeting • To provide a further update on the financial plan at March's meeting • To provide a further update in April on the progress made in reducing the number of outstanding actions in relation to Log4J • To consider holding an extraordinary meeting in March to review any business cases separately, to release time during the meeting so that the usual items can be fully considered
✓	**Positive Assurances to Provide**	**Decisions Made**
	• An update was provided following the previously approved investment for ED medical workforce, whereby recruitment continued to progress well, although there remained 2 substantive SHO gaps which were expected to be addressed by 1st April. Updates were also provided in relation to rota development and recruitment to CESR posts • The Committee noted the draft budget for 2022/23 although some guidance was outstanding which would be factored into the final plan. The progress made to date was noted, and the recurrent position of £30.1 m deficit excluding the elective recovery fund • An update on capital planning for 2022/23 was provided which highlighted the central funding allocation, overall Trust funding and the commitments to date • The month 10 financial position demonstrated £0.4 m surplus in month which was on plan, with a year to date surplus of £15.1 m. It was noted that Covid costs had increased slightly in month but this was within the allocation. Capital expenditure was £20.4 m which was behind plan, mainly due to digital pathology and estates infrastructure • An update was provided in relation to Log4J and the actions taken following the incident in addition to the ongoing actions to strengthen current processes	• The Committee approved business cases BC0441 Expansion of GI, BC0447 Purchase of Intuitive Da Vinci Xi Dual Console Robotic Ecosystem and BC0443 Darktrace Renewal • The Committee approved the following eREAFs; 8624, 8547, 8442, 8801, 8740, 8693, 8831, 8858, 8814, 8968 and 8981

Comments on the Effectiveness of the Meeting
• The Committee recognised the challenges in adequately discussing all of the items on the agenda and suggested considering business cases separately to enable the time to be utilised more efficiently ….

2. Summary Agenda

No.	Agenda Item	BAF Mapping		Purpose	No.	Agenda Item	BAF Mapping		Purpose
		BAF No.	Risk				BAF No.	Risk	
1.	BC-0441 Expansion of GI (Colorectal & Upper GI) Emergency General Surgery Business Case	1 & 3	10187, 10259, 18154	Approval	10.	Month 10 Performance Report – 2021/22			Assurance
2.	BC-0447 Purchase of Intuitive Da Vinci Xi Dual Console Robotic Ecosystem Business Case			Approval	11.	Executive Infrastructure Group Assurance Report (Feb-22)	7 & 8		Assurance
3.	Enhanced Primary Care (EhPC) in Emergency Department		16636, 16643, 8542, 19463	Information	12.	Executive Digital and Data Security & Protection Group Assurance Report (Feb-22)	7		Assurance
4.	ED Medical Workforce Update	1 & 3	8580, 8442	Assurance	13.	Financial Plan Update 2022/23	9		Assurance
5.	BC-0443 Darktrace Renewal Business Case	7		Approval	14.	Capital Planning update 2022/23	9		Assurance
6.	Authorisation of New Contract Awards and Contract Extensions			Approval	15.	Month 10 Finance Report 2021/22	9		Assurance
7.	Business Case Review Update			Assurance	16.	Non-Elective Improvement Group Minutes (Feb-22)			Information
8.	Executive Business Intelligence Group Assurance Report (Feb-22)			Assurance	17.	Cancer Services Strategy Group Minutes (Dec-21)			Information
9.	Operational Delivery Group Assurance Report (Feb-22)	6		Assurance	18.	Log4J Progress Update	7	22938	Assurance

3. 2021 / 22 Attendance Matrix

Attended | Apologies & Deputy Sent | Apologies

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

Committee Chair's Highlight Report to Board

Transformation and People Committee
23rd February 2022

University Hospitals of North Midlands NHS Trust

1. Highlight Report

!	Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
•	75% doctors were noted has having completed their appraisal in the past year which was a reduction on previous years, although the focus during Covid was on holding supportive reviews. The Committee noted 21% rate of deferrals in the past year, which were largely due to not including patient/colleague feedback, again due to the restrictions from the pandemic.	
•	The Committee commended the work undertaken to produce the workforce plan which concluded that the Trust had a stable workforce based but could be impacted by a number of factors over the coming year, such as risks associated with retirements within the nursing workforce, internal movement of nurses and attrition, retention risks within the pharmacy workforce and challenges with pathology	• To obtain information on the protected characteristics associated with the revalidation deferrals
•	The Committee noted the update within the gender pay gap report that whilst the Trust had 78% female representation, this was not reflected across all pay quartiles, with men having greater representation in the upper pay quartile and the main challenge and focus relating to medical and dental staff groups	• To share the workforce plan with Board members in addition to the strategically aligned transformation paper
•	On-going challenges regarding staff absence and unavailability were highlighted via the Workforce Assurance Group in addition to a particular challenge in accessing training rooms as well as reduced capacity to provide functional skills training, with actions being taken to address this	• To triangulate quality of care data with the red flags within the NETS survey to identify any themes/trends

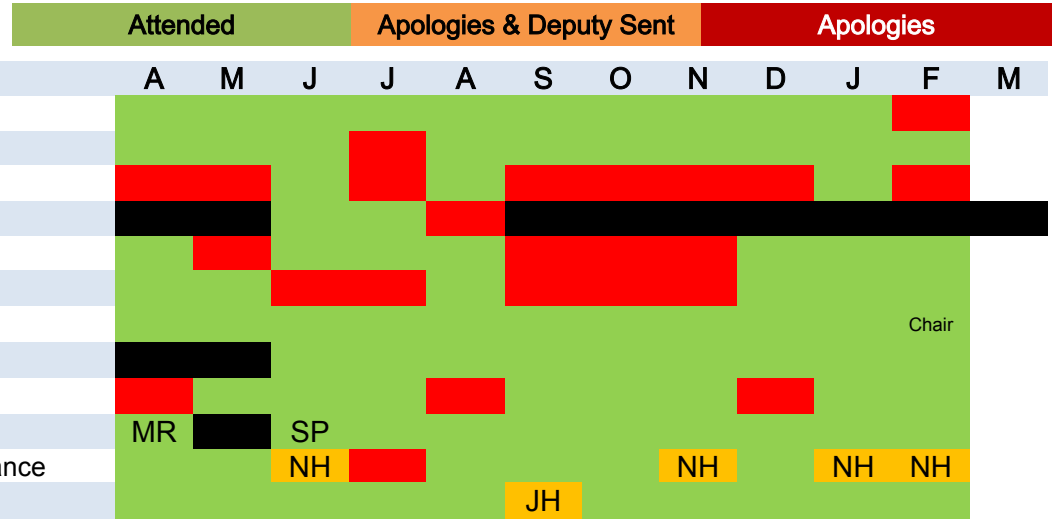
✓	Positive Assurances to Provide	Decisions Made
•	77 exception reports were reported via the Guardian of Safe Working, which were similar numbers reported for previous quarters and it was noted that engagement continued to be held with junior doctors	
•	An update was provided on succession planning and talent management whereby the main risk related to having capacity within the Divisions to release staff for development, in addition to having the capacity to adequately consider succession planning on a proactive basis	
•	In terms of organisational development and culture, the planned activities were highlighted to Committee members, particularly the 'enable' programme which was to be launched at the end of March for middle managers. The Committee noted that the Connects programme for clinicians had been well received. The Committee considered the difficulties of staff having survey fatigue given the frequency of recent surveys which was recognised and factored into the timing of internal pieces of work	• The Committee approved the implementation of the proposed strategically aligned approach to support the delivery and monitoring of Trust-wide transformation projects
•	Workforce performance at month 10 was considered, whereby appraisals were slightly reduced due to the pause associated with operational pressures, although statutory and mandatory training remained on target. It was noted that essential to role training information would be provided in future reports and Covid related absence was continuing to reduce, which was presently at 23% of all absences	• The Committee approved the revised Clinical Strategy which was to be taken to the Trust Board in April, following presentation to the Trust Executive Committee
•	The Committee welcomed the steady improvements made within the NETs survey which was positive overall, although issues relating to local induction of new employees had been highlighted and were an area of focus	
•	The Committee received an update in relation to ICS transformation to provide members with additional context and progress in relation to specific workstreams	
•	Delays in training staff via the Improving Together programme were highlighted due to the critical incident although this had recommenced and the Trust was in the main on trajectory to achieve the target of 80% of core managers having been trained	

Comments on the Effectiveness of the Meeting
• Despite the heavy agenda the Committee members felt that there was sufficient discussion of the items included

2. Summary Agenda

No.	Agenda Item	BAF Mapping		Purpose	No.	Agenda Item	BAF Mapping		Purpose
		BAF No.	Risk				BAF No.	Risk	
1.	Guardian of Safe Working Report Q3	1, 3		Assurance	8.	ICS Transformation Update	5		Assurance
2.	Revalidation and Appraisal Report	2, 3		Assurance	9.	Clinical Strategy			Assurance
3.	Succession Planning and Talent Management	2		Assurance	10.	Strategically Aligned Transformation			Approval
4.	OD and Culture Quarterly Update	2		Assurance	11.	Improving Together Highlight Report			Assurance
5.	Workforce Plan	3		Discussion	12.	National Education and Training Survey (NETS)	2, 3		Assurance
6.	M10 Workforce Report	2, 3		Assurance	13.	Executive Workforce Assurance Group Assurance Report (Feb-22)	2, 3		Assurance
7.	Gender Pay Gap Report	2		Assurance					

3. 2021 / 22 Attendance Matrix



Executive Summary

Meeting:	Trust Board	**Date:**	9th March 2022
Report Title:	Integrated Performance Report, month 10 2021/22	**Agenda Item:**	13.
Author:	Quality & Safety: Jamie Maxwell, Head of Quality & safety; Operational Performance: Warren Shaw, Associate Director of Performance & Information; Matt Hadfield, Deputy Associate Director of Performance & Information. Workforce: Claire Soper, Assistant Director of Human Resources; Finance: Jonathan Tringham, Director of Operational Finance		
Executive Lead:	Anne-Marie Riley: Chief Nurse Paul Bytheway: Chief Operating Officer Ro Vaughan: Chief People Officer 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 (>15)

BAF 1	Delivering positive patient outcomes	Ext 20
BAF 3	Sustainable workforce	Ext 16
BAF 6	Delivering responsive patient care	Ext 20
10342	Delivery of constitutional cancer quality standards	Ext 16
21101	Waiting Times	Ext 16

Executive Summary

Situation

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

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

Assessment

Quality & Safety

The Trust achieved the following standards in January 2022:

- Friend & Family (Inpatients) 98.5% and exceeds 95% target.
- Harm Free exceeded 95% target rate with 96.9%
- Trust rolling 12 month HSMR continue to be below expected range.
- VTE Risk Assessment completed during admission continues to exceed 95% target with 98.9% (point prevalence audit via Safety Thermometer).

- Zero avoidable MRSA Bacteraemia cases reported.
- Diff YTD figures below trajectory with 6 against a target of 8.
- There have been no Category 4 Pressure Ulcers attributable to lapses in care during January 2022.
- Sepsis Screening compliance in Emergency Portals exceeded the target 90% with 90.5%.
- Inpatients Sepsis Screening 94% above 90% target rate and Inpatient Sepsis IVAB within 1 hour achieved 100% and exceeded 90% target rate
- Children's Sepsis Screening compliance 96.6% and above the 90% target.
- Maternity Sepsis Screening compliance 92.9% against 90% target

The Trust did not achieve the set standards for:

- Friend & Family Test for A&E has improved to 77.4% but is below 85% target.
- Falls rate was 6.5 per 1000 bed days
- There were 21 Pressure ulcers including Deep Tissue Injury identified with lapses in care during January 2022.
- 90.9% Duty of Candour 10 working day letter performance following formal verbal notification. All patients have received written notification but 1 case was over 10 day target.
- 1 Never Event reported
- Emergency Portals Sepsis IVAB in 1 hour 77.8% and is below the 90% target for audited patients

Operational Performance

Emergency Care

- Attendances remain under forecast in January 2022 from previous months. High numbers of DTA's were held in ED overnight due to bed based acuity, high numbers of MFFD with all escalation capacity being open and utilised.
- Ambulance handover delays over 60 minutes were a worsening picture. The percentage of handovers within 15 minutes was 61.4% for the month. Instances of surge evidenced for WMAS attends which provides challenges for triage, especially when stand by patients have to be managed on clinical need.
- Time to initial assessment mean position was slightly reduced at 56.14% for the month
- Time to Treatment in ED was reduced in January and under 80 minutes

Cancer

- The Trust continues to conduct a high number of 1st appointments, with over 3000 patients being seen in January.
- The overall 2WW position for January 22 is predicted to achieve in the region of 55%. Specialties with the most 14 day breaches are Breast, Skin and Upper GI.
- The 28 Day Faster Diagnosis position is currently at 39% with the majority of breaches in Colorectal and Skin. Most patients on the colorectal pathway now have FIT requested at the same time of referral however this is outside of WMCA and best practice guidance which states FIT **results** should accompany referrals. This means the Trusts chases patients to complete their FITs and waits for the results for directing to the most appropriate investigation. System challenge for Q4 to secure primary care traction on this pathway given the direct link to improved performance potential.
- The overall 62 day position for January 22 is currently at 44.7%. This is an incomplete and un-validated position that is expected to change as histology confirms a cancer or non cancer diagnosis for patients treated.

Planned Care

- Day Case and Elective Activity delivered 84% and 76% respectively for December 21 against the national ask of 95%, a deterioration on December's position for Day Case (86%) (choice and increased NCEPOD operating over the Christmas period).
- In month Planned Care Cell focus on elective recovery based on 10 high impact changes in accordance with the elective plan.
- Theatre plan for Q4 gives 89.5% of 19/20 capacity. Targeted booking on-going to meet P2 demand and 104+ waits.
- CCG Commissioned Deloitte review of capacity options is complete - UHNM are asking for extra capacity with CCG colleagues at the IS.
- CCG have an interim commissioning manager who is supporting elective opportunities in Tier 2 sector/regionally around mutual aid.
- Referral Hub – awaiting specification from 18 week source group and reviewing use of electronic ERS

to manage referrals.
- Some work has already taken place at specialty level with respect to patient contact with the test of change outcomes used to scale up with ERF funding.

RTT
- The overall Referral To Treatment (RTT) Waiting list continues to rise. For January the indicative number of Incomplete pathways has risen to 71,382 (December 70,951).
- The number of patients > 18 weeks has risen to a level of 32,147 (December 31,599).
- The numbers of 52 week waits in January has increased with a reported 4,463 (December 4,393) this figure is below the trajectory.
- At the end of January the numbers of > 104 weeks reported were 521. The Planned Care group is monitoring progress against treatment plans for these patients.
- Performance has slightly decreased at 55.0% (December 56.0%).
- Work plans around long wait patient validation and treatment tracking are in progress to support the Data Quality Strategy & Audit requirements.

Diagnostics
- For DM01 (15 nationally identified Dx tests) the validated position for total waiting list has increased in December from 20,134 to 20,665. The Non-obstetric ultrasound waiting list reduced slightly from 9,935 to 9,382. Due to the challenges in Non-Obstetric Ultrasound this has adversely affected performance. The current DM01 diagnostic performance for December 21 is at 68% (November 69 %).
- Within DM01, the greatest proportion of > 6 week waits are within Non-obstetric ultrasound and endoscopy. The ultrasound position is related to an increase in demand alongside workforce shortfalls, a number of actions are in place. Non obstetric ultrasound performance remains a Driver Metric for CWD and has specific focus for improvement, albeit this is related to workforce retention, recruitment and innovative ways to train and recruit.
- DM01 performance excluding non obs ultrasound would be c93%.

Workforce

Sickness
The in-month sickness rate was 7.44% (6.23% reported at 31/12/21). The 12 month cumulative rate increased to 5.41% (5.25% at 31/12/21).

Covid-related absence increased significantly from 26th December 2021. At the peak, 5th January saw 1332 staff absences of which 748 (56.16%) were covid-related. Since then, both the total absences and covid-related absence has continued to fall, albeit gradually.

The focus remains on areas with high sickness levels, with actions including:
- Assurance meetings taking place in the Divisions, focussing on the top 10 long term and top 10 frequent absences .
- Continued daily monitoring of sickness absences, specifically all COVID related absence and stress related absence.
- Joint focused absence huddles for Medicine and Surgery taking place with the HR Director and Divisional Representatives

Appraisals
The Non-Medical PDR compliance rate was 75.91% (76.18% at 31st December 2021). Central Function and the Surgical Division saw small improvements in January 22. Performance in the remaining Divisions deteriorated. Overall performance remains below target and completion of PDRs was suspended while the Trust was at Critical Incident level

Statutory and Mandatory Training
The Statutory and Mandatory training rate at 31st January 2022 was 95.41% (95.50% at 31st December 2021). This compliance rate is for the 6 ‘Core for All’ subjects only. At 31st January 22, 91.25% of staff had completed all 6 Core for All modules (91.5% at 31/12/21)

Vacancies
- The overall Trust vacancy rate was 11.43% as a result of an uplift in budgeted establishment to account

for Winter planning and a decrease in staff in post. Bank and Agency covered 70% of the vacancy position and there is sufficient activity in the recruitment pipeline to cover the vacancies, should all of that activity be converted to staff in post.

Finance

- The Trust set a plan at the start of the year for a H1 surplus of £8.3m and a full year deficit of £8.8m. The guidance for H2 was issued in September 2021 and at both a National and System level an agreement was reached that the Trust was to carry forward the surplus of £14.5m delivered in H1 and therefore the planned position for H2 was a £14.5m deficit to achieve a breakeven plan for the financial year ending 31 March 2022. Since then, the Trust has worked through the submitted activity plans and calculated an expected income of £5.1m against the Elective Recovery Fund. Therefore in November 2021, the Trust formally submitted a revised annual plan of a £5.1m surplus for the financial year ending 31 March 2022.
- The Trust has delivered an actual deficit of £0.4m in month against an in month planned surplus of £0.5m and a year to date surplus of £15.1m resulting in a favourable variance of £7.5m against the year to date plan. The positive position against plan in month is primarily driven by underspends against non-recurrent investment funds.
- A full year forecast has been undertaken at Month 9 and reviewed at Month 10 which presents a £5.2m surplus. This includes material movements expected in Q4 including no ERF income and a release of part of the prior year annual leave accrual.
- The Trust incurred £1.4m of costs relating to COVID-19 in month which is an increase of £0.3m compared with Month 9's figure. This remains within the Trust's YTD fixed allocation with £0.7m being chargeable on top of this allocation for COVID-19 testing costs.
- Capital expenditure for the year to date stands at £20.4m which is £2.5m behind the plan mainly due to an underspend relating to digital pathology and estates infrastructure.
- The cash balance at Month 9 is £82.4m which is £2.9m higher than plan, the main reason being lower than forecast capital payments which reflects the overall slippage against the capital plan.

Key Recommendations

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

NHS
University Hospitals of North Midlands
NHS Trust

Integrated Performance Report

Month 10 2021/22

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Contents

A note on **SPC**

University Hospitals of North Midlands NHS Trust

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

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

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

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

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

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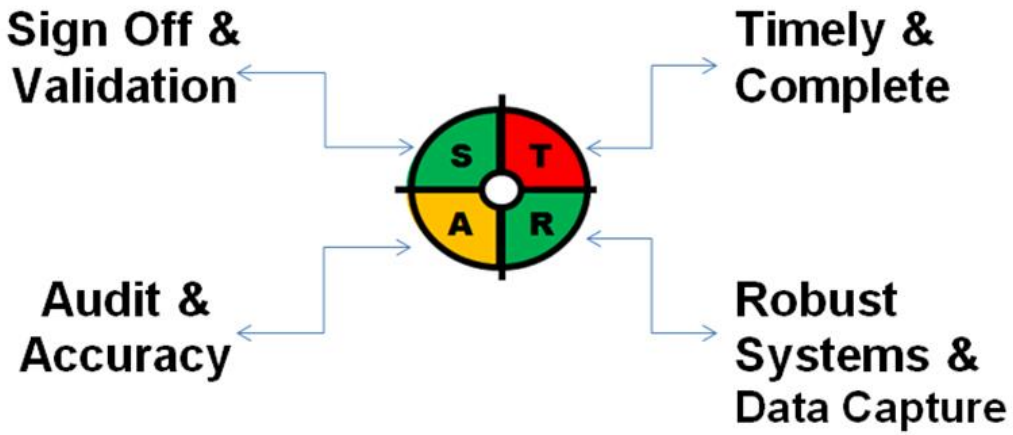
A note on **Data Quality**

University Hospitals of North Midlands NHS Trust

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



Explaining each domain

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

RAG rating key

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

Quality

Caring and Safety

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

Quality Spotlight Report

NHS University Hospitals of North Midlands NHS Trust

Key messages

The Trust achieved the following standards in January 2022:

- Friend & Family (Inpatients) 98.5% and exceeds 95% target.
- Harm Free exceeded 95% target rate with 96.9%
- Trust rolling 12 month HSMR continue to be below expected range.
- VTE Risk Assessment completed during admission continues to exceed 95% target with 98.9% (point prevalence audit via Safety Thermometer).
- Zero avoidable MRSA Bacteraemia cases reported.
- Diff YTD figures below trajectory with 6 against a target of 8.
- There have been no Category 4 Pressure Ulcers attributable to lapses in care during January 2022.
- Sepsis Screening compliance in Emergency Portals exceeded the target 90% with 90.5%.
- Inpatients Sepsis Screening 94% above 90% target rate and Inpatient Sepsis IVAB within 1 hour achieved 100% and exceeded 90% target rate
- Children's Sepsis Screening compliance 96.6% and above the 90% target.
- Maternity Sepsis Screening compliance 92.9% against 90% target

The Trust did not achieve the set standards for:

- Friend & Family Test for A&E has improved to 77.4% but is below 85% target.
- Falls rate was 6.5 per 1000 bed days
- There were 21 Pressure ulcers including Deep Tissue Injury identified with lapses in care during January 2022.
- 90.9% Duty of Candour 10 working day letter performance following formal verbal notification. All patients have received written notification but 1 case was over 10 day target.
- 1 Never Event reported
- Emergency Portals Sepsis IVAB in 1 hour 77.8% and is below the 90% target for audited patients

During January 2022, the following quality highlights are to be noted:

- The rate of complaints per 10,000 spells is 21.1 and is below (positive) the target of 35 and within normal variation. Majority of complaints in January 2022 relate to clinical treatment.
- Total number of Patient Safety Incidents increased in month (1731) and the rate per 1000 bed days has also decreased at 45.02 and both measures are within normal variation.
- Total incidents with moderate harm or above and the rate of these incidents within normal monthly variation.
- Decrease in total reported incidents relating to staffing shortages and lack of appropriate staff on wards/departments during January 2022. 60 in total although 31 were coded as patient related, the remaining 29 were reported as staff related incidents.
- Rate of falls reported that have resulted in harm to patients currently at 1.7 per 1000 bed days in January 2022. The rate of patient falls with harm continues to be within the control limits and normal variation and is around the mean rate which indicates there may be improvement in reducing harm from falls.
- Medication related incidents rate per 1000 bed days is 4.4 and patient related 3.8 which are increases compared to previous months. The monthly variation is within the normal expected variation and consistent with Trust mean rates. However whilst it is below the previously published NRLS national mean rate of 6.0 the arte is nearer to the this national mean rate.
- Pressure Ulcers developed under UHNM care has seen a decrease during January 2022 along with a similar decrease in number with lapses in care.
- 69 Definite Hospital Onset / Nosocomial COVID-19 cases reported in January 2022.
- 10 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).
- 10 Serious Incidents reported January 2022. All the serious incidents were reported on STEIS within the 2 working date target following confirmation of SI criteria.

Quality Dashboard

NHS University Hospitals of North Midlands NHS Trust

Metric	Target	Latest	Variation	Assurance
Patient Safety Incidents	N/A	1731		
Patient Safety Incidents per 1000 bed days	N/A	45.02		
Patient Safety Incidents per 1000 bed days with no harm	N/A	30.07		
Patient Safety Incidents per 1000 bed days with low harm	N/A	12.02		
Patient Safety Incidents per 1000 bed days reported as Near Miss	N/A	1.48		
Patient Safety Incidents with moderate harm +	N/A	25		
Patient Safety Incidents with moderate harm + per 1000 bed days	N/A	0.65		
Harm Free Care (New Harms)	95%	96.9%		
Patient Falls per 1000 bed days	5.6	6.5		
Patient Falls with harm per 1000 bed days	1.5	1.7		
Medication Incidents per 1000 bed days	6	4.4		
Medication Incidents % with moderate harm or above	0.50%	2.96%		
Patient Medication Incidents per 1000 bed days	6	3.8		
Patient Medication Incidents % with moderate harm or above	0.50%	3.42%		

Metric	Target	Latest	Variation	Assurance
Serious Incidents reported per month	0	10		
Serious Incidents Rate per 1000 bed days	0	0.26		
Never Events reported per month	0	1		
Duty of Candour - Verbal/Formal Notification	100%	100%		
Duty of Candour - Written	100%	90.9%		
All Pressure ulcers developed under UHNM Care	TBC	71		
All Pressure ulcers developed under UHNM Care per 1000 bed days	N/A	1.85		
All Pressure ulcers developed under UHNM Care lapses in care	12	21		
All Pressure ulcers developed under UHNM Care lapses in care per 1000 bed days	0.5	0.55		
Category 2 Pressure Ulcers with lapses in Care	8	4		
Category 3 Pressure Ulcers with lapse in care	4	0		
Deep Tissue Injury with lapses in care	0	13		
Unstageable Pressure Ulcers with lapses in care	0	4		

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Quality Dashboard

NHS University Hospitals of North Midlands NHS Trust

Metric	Target	Latest	Variation	Assurance
Friends & Family Test - A&E	85%	77.6%	L	F
Friends & Family Test - Inpatient	95%	98.6%		P
Friends & Family Test - Maternity	95%	100.0%		
Written Complaints per 10,000 spells	21.11	21.11		?
Rolling 12 Month HSMR (3 month time lag)	100	97.33	H	P
Rolling 12 Month SHMI (4 month time lag)	100	101.79		
Nosocomial COVID-19 Deaths (Positive Sample 15+ days after admission)	N/A	10	L	
VTE Risk Assessment Compliance	95%	0.0%	L	?
Emergency C Section rate % of total births	15%	20.21%	H	F
Reported C Diff Cases per month	8	9		?
Avoidable MRSA Bacteraemia Cases per month	0	0		?
HAI E. Coli Bacteraemia Cases per month	8	6	L	?
Nosocomial "Definite" HAI COVID Cases - UHNM	0	69	H	

Metric	Target	Latest	Variation	Assurance
Inpatient Sepsis Screening Compliance (Contracted)	90%	94.0%		?
Inpatient IVAB within 1hr (Contracted)	90%	100.0%	H	?
Children Sepsis Screening Compliance (All)	90%	96.6%		?
Children IVAB within 1hr (All)	90%	N/A	H	F
Emergency Portals Sepsis Screening Compliance (Contracted)	90%	90.5%	H	?
Emergency Portals IVAB within 1 hr (Contracted)	90%	77.8%		?
Maternity Sepsis Screening (All)	90%	92.9%	H	F
Maternity IVAB within 1 hr (All)	90%	66.7%	L	F

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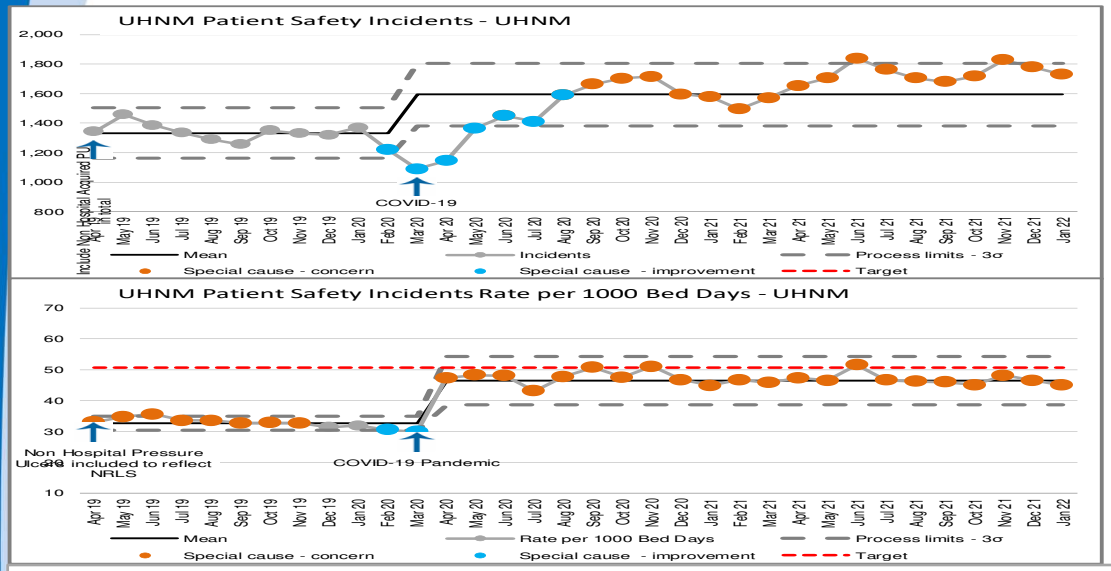
Reported Patient Safety Incidents



Variation	Assurance
	

Target	Nov 21	Dec 21	Jan 22
N/A	1829	1781	1731

Background

Total Reported patient safety incidents

Variation	Assurance
	

NRLS Mean	Nov 21	Dec 21	Jan 22
50.70	48.15	46.50	45.02

What is the data telling us:

The above data relates to **all** reported Patient Safety Incidents (PSIs) across the Trust. The January 2022 total remains above the mean total since COVID-19 started. However, the reporting of incidents and near misses should continue to be encouraged and promoted and increasing rates and numbers of total incidents is not necessarily to be viewed as concern. It is important to review the different levels of harm within the overall totals.

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

- Patient related Slip/Trip/Fall - 249 (227)
- Clinical assessment (Including diagnosis, images and lab tests) – 84 (76)
- Patient flow incl. access, discharge & transfer - 81 (91)
- Documentation – 51 (37)
- Pressure Ulcers (Hospital acquired) – 79 (92)
- Treatment/Procedure - 63 (78)
- Medication incidents - 149 (126)
- Infection Prevention – 62(54)
- Staffing – 31 (30)

There has been increase in the number of staffing related incidents submitted during January with 60 (74 in December, 60 in November and 61 in October) incidents reported. 31 of these were under patient related and the remaining 29 were reported as staff related. All of these incidents were relating to lack of suitable trained staff. Individual incidents may relate to lack of different staff groups and during January 2022 the following were reported:

49 (69 in December 2021) – insufficient professional healthcare staff

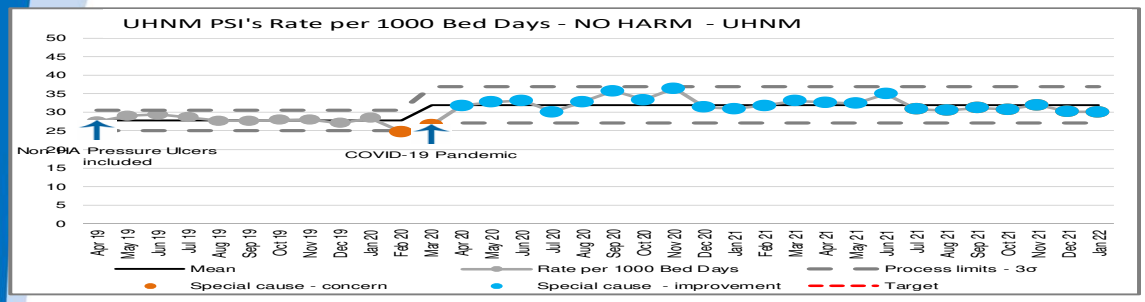
13 (7 in December 2021) – insufficient non professional healthcare staff (6 of these were reported at County Hospital Ward 1)

9 (6 in December 2021) – insufficient support staff

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

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

University Hospitals of North Midlands NHS Trust

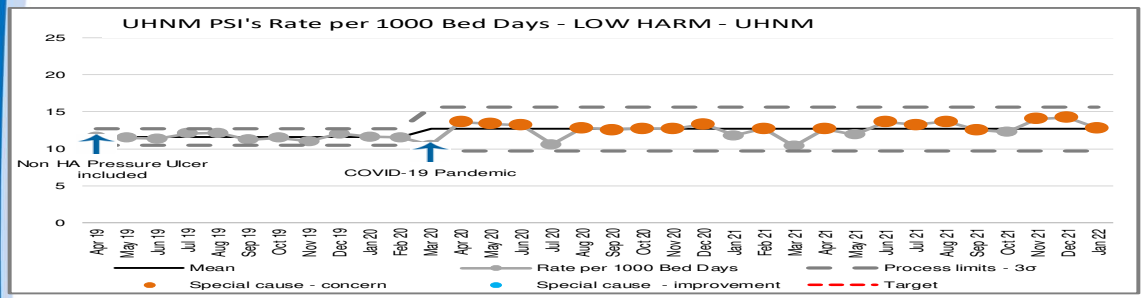


Variation	Assurance
	

Target	Nov 21	Dec 21	Jan 22
N/A	31.96	30.23	30.07

Background

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

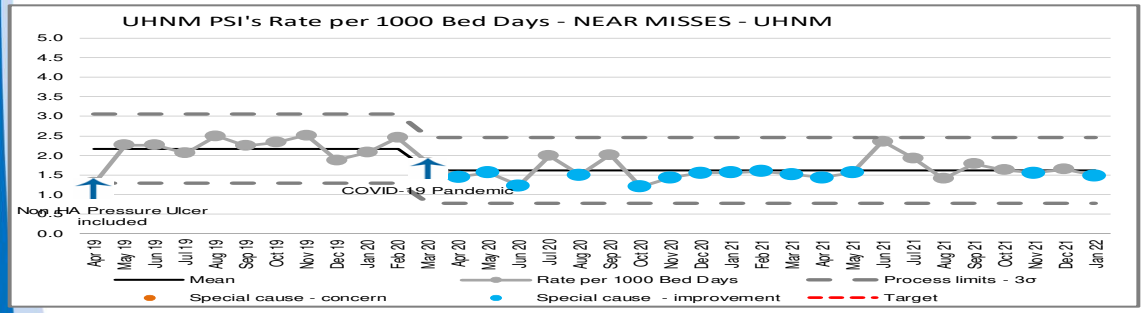


Variation	Assurance
	

Target	Nov 21	Dec 21	Jan 22
N/A	14.06	14.25	12.77

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	Nov 21	Dec 21	Jan 22
N/A	1.55	1.64	1.48

Background

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

What is the data telling us:

The Rate of Patient Safety Incidents per 1000 bed days with no harm or low harm are showing consistent trends. Although Low harm has seen increase in recent months the rate is still within normal variations and around the long term mean for no harm, low harm and near miss incidents.

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.

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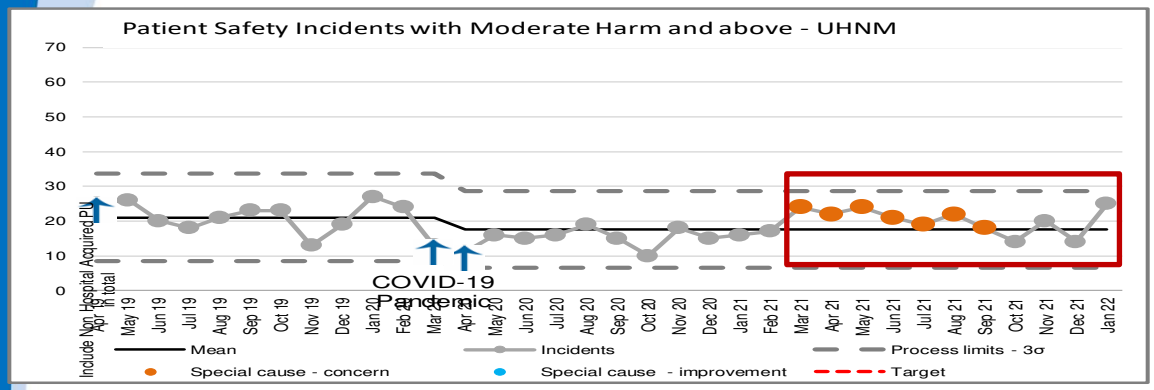
Reported Patient Safety Incidents with Moderate Harm or above

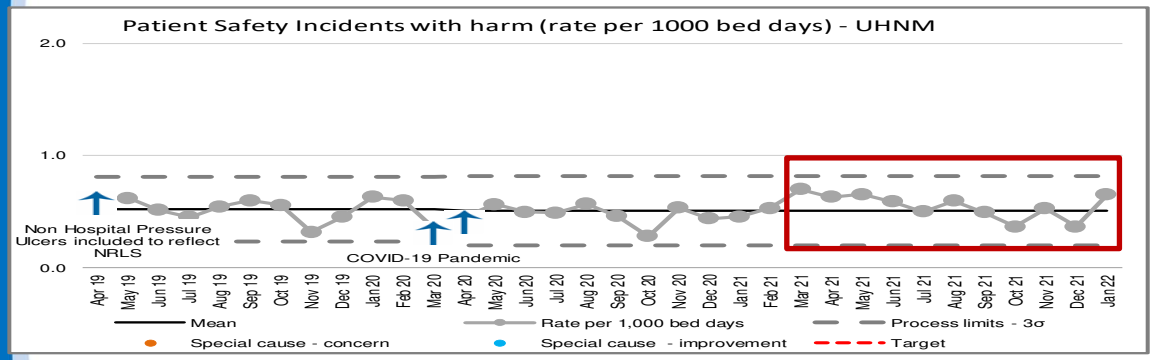


Variation	Assurance

Target	Nov 21	Dec 21	Jan 22
N/A	20	14	25

Background

Patient safety incidents with reported moderate harm and above



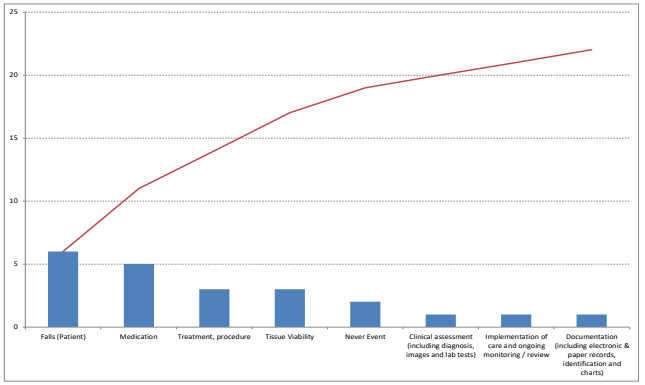
Variation	Assurance

Target	Nov 21	Dec 21	Jan 22
N/A	0.53	0.37	0.65

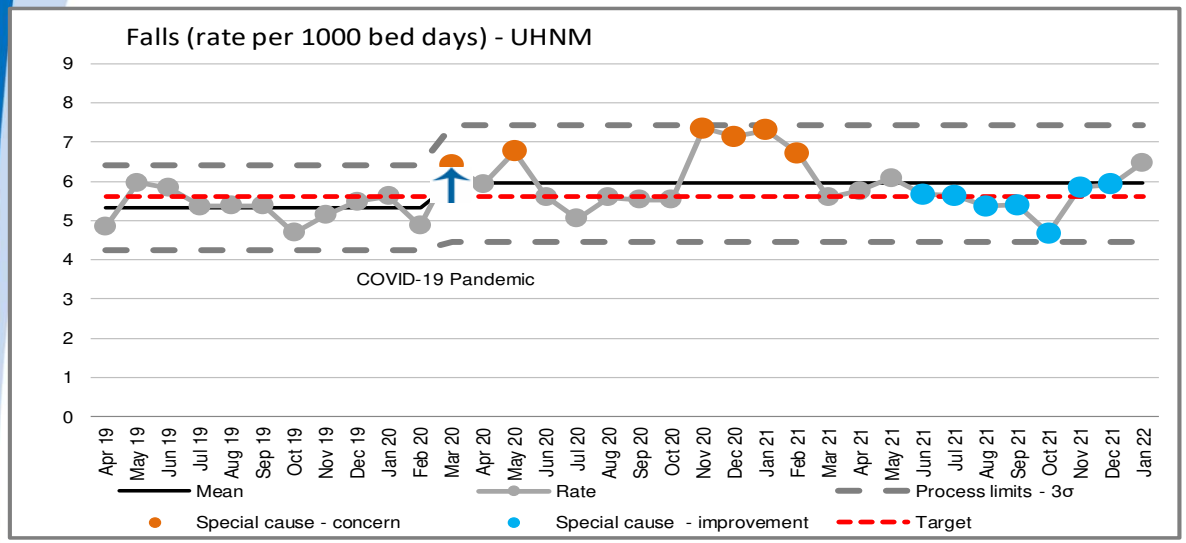
What is the data telling us:

The variation noted in charts above for moderate harm or above total and rate per 1000 bed days is within normal variation and no special cause noted.

The top category of incidents resulting in moderate harm reflect the largest reporting categories with 6 Falls, 5 medication and 3 Implementation of care related being top 3 categories.
National Comparison taken from latest CQC Insight Report is that 26.1% of reported patient safety incidents to NRLS resulted in harm. UHNM latest results are 22.8% .



Patient Falls Rate per 1000 bed days



Variation	Assurance

Target	Nov 21	Dec 21	Jan 22
5.6	5.8	5.9	6.5

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 remains within the control limits. And normal variation.

The Trust adopted the average rate of 5.6 patient falls per 1000 bed days from the Royal College of Physicians National Falls Audit report (2015) as a target rate.

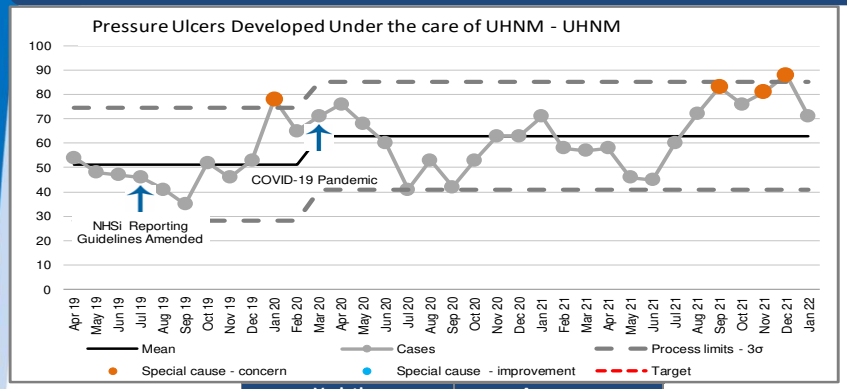
The areas reporting the highest numbers of falls in January 2022 were:

Royal Stoke AMU – 22 falls Royal Stoke ED- 14 falls County Ward 14 – 12 falls Royal Stoke Ward 228 – 9 falls County Ward 12 – 9 falls

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

- Those areas that have a patient identified as having multiple falls have their risk assessments checked and any further highlighted preventative measures are put into place.
- Discussions continue with ED and AMU to identify the patients that is transferring with a falls risk.
- Wards have been encouraged to utilise the STOP 5 Hot Debrief Tool when any fall occurs, this is to identify on reflection what areas we can improve and focus on.
- Information on how to use bed rails safely and effectively, policy Risk Management 10 has been placed on to the Hot Topics information. This area has also been discussed when visiting the ward areas, the importance of following the prescribed bed rail risk assessment has been shared on the induction day for the new nursing assistants.

Total Pressure Ulcers developed under care of UHNM

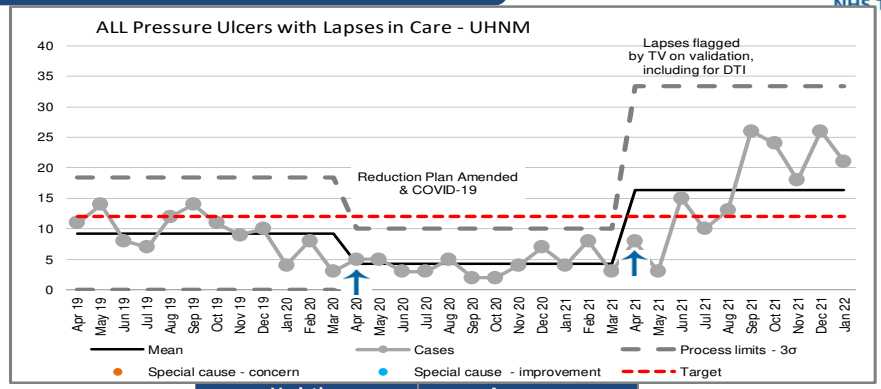


Variation	Assurance

Target	Nov 21	Dec 21	Jan 22
N/A	81	88	71

Background

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



Variation	Assurance

Target	Nov 21	Dec 21	Jan 22
12	18	26	21

Background

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

Noted that the increases are within normal variation for pressure ulcers developed under UHNM care and with lapses in care.

The tables below show breakdowns of the pressure ulcers reported in January 2022.

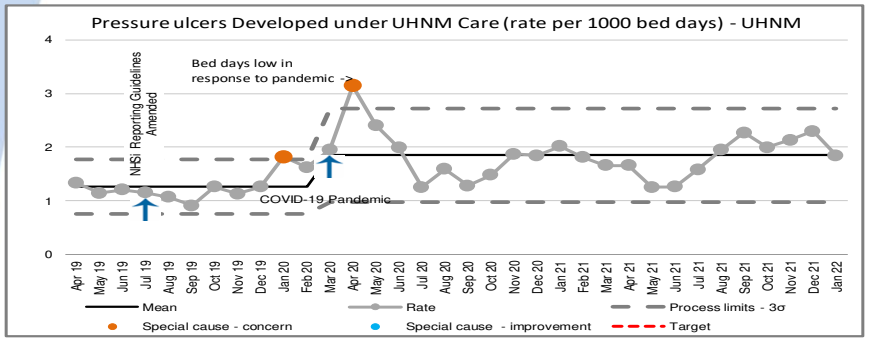
Category	Total (Jan 2022)
DTI	35
Category 2	22
Category 3	4
Category 4	0
Unstageable	10
Total	**71**

Top Body Locations	Total (Jan 2022)
Heel	24
Sacrum	9
Buttock	7
Toe	6

The number of pressure ulcers reported as developing under the care of UHNM in January is within expected limits. Within this, the number of DTI's reported is once again significantly above average. Numbers within other categories are stable.

The number of pressure ulcers reported as developing under the care of UHNM in January, where lapses in care have been identified, was significantly higher than in previous years, but there does not currently appear to be a further increasing trend.

Pressure Ulcers developed under care of UHNM per 1000 bed days

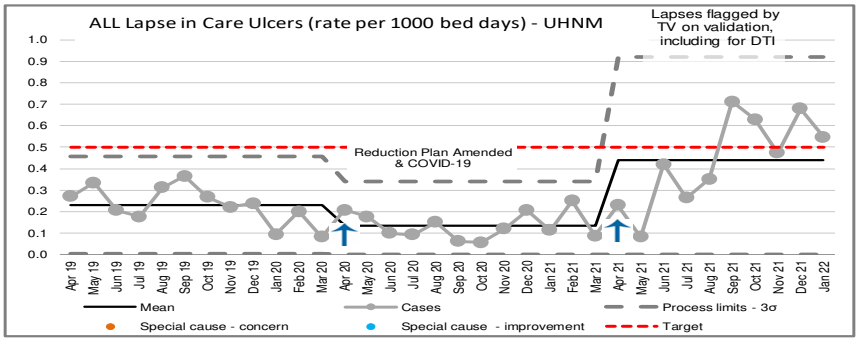


Variation	Assurance

Target	Nov 21	Dec 21	Jan 22
N/A	2.13	2.30	1.85

Background

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



Variation	Assurance

Target	Nov 21	Dec 21	Jan 22
0.5	0.47	0.68	0.55

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

Rate of pressures ulcer developed under UHNM care and with lapses in care are similar to previous months and within normal variation

Acuity for ward areas is taken into account in line with lapses in care.

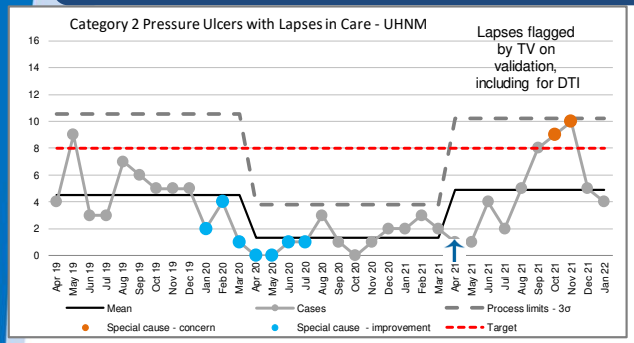
High reporting areas will be presenting all incidents at bespoke RCA panels, to allow identification of trends, and establish their improvement and educational focus. The Tissue Viability team and Corporate Nursing Quality & Safety Teams will support with this.

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

Actions

- Documentation is under constant review to reduce identified lapses, aSSKINg bundle has recently been amended to address panel themes
- Pressure Ulcer Prevention (PUP) education is now delivered on multiple platforms including the Nursing Assistant, adaptation nurse and Preceptorship induction programme , new starters in ED and child health, Mandatory ED training and ward champions . Education and support can also be requested as required.
- Communication is provided by SSR for Q&S to multiple reporting wards to highlight learning needs and support formulation of the action panel ahead of RCA panel.
- Following RCA panel assurance is sought from clinical areas by SSR for Q&S, spot audits are completed during the visit.
- Seating audits are being completed across the trust and a proposal for new chairs has been submitted for the Royal Stoke site. Care of the elderly received their new chairs with funds supported by PHE. The County site have also been audited identifying poor pressure relief within the cushion. Action to be taken.
- Review of surfaces in ED to enhance Pressure ulcer prevention, 15 Stryker trollies with high quality pressure relieving mattresses have been purchased. ED will be ordering repose companions for all surfaces. An Ambulance assessment tool has been devised to implement early intervention of PUP however support is still being sought from WMAS.

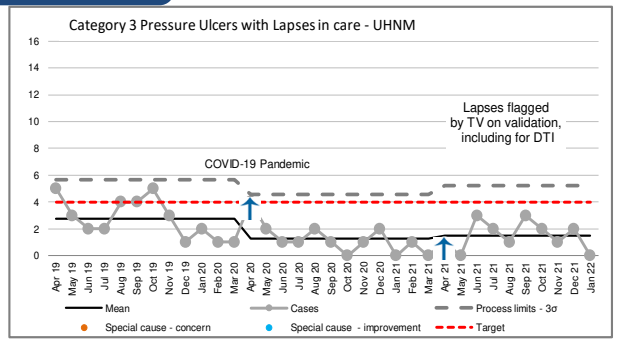
Pressure Ulcers with lapses in care



Variation	Assurance
	

Target	Nov 21	Dec 21	Jan 22
8	10	5	4

Background

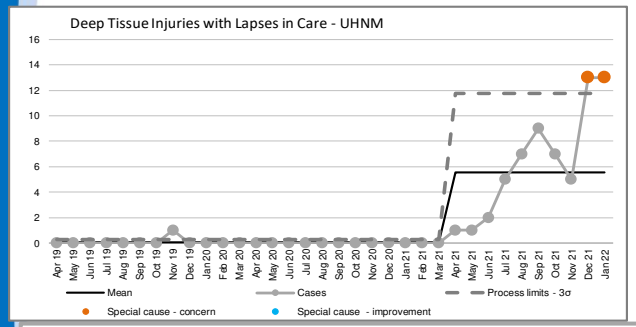


Variation	Assurance
	

Target	Nov 21	Dec 21	Jan 22
4	1	2	0

Background

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

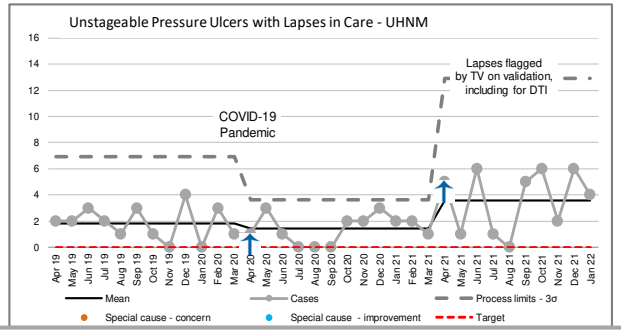


Variation	Assurance
	

Target	Nov 21	Dec 21	Jan 22
N/A	5	13	13

Background

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



Variation	Assurance
	

Target	Nov 21	Dec 21	Jan 22
0	2	6	4

Background

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

What is the data telling us:

Deep Tissue Injuries are noted with potential special cause variation and Deep Dive into these DTIs is currently ongoing with the Tissue Viability team and will report the outcome of the review at March 2022 Quality Governance Committee. This analysis is being undertaken to assess the potential causes for increased pressure ulcers with lapses in care and whether this is result of the current operational pressures across the Trust and potentiallinks with long waits in Emergency Department and/or on ambulances.

As shown in the table below, common lapses identified are management of repositioning and heel offloading .

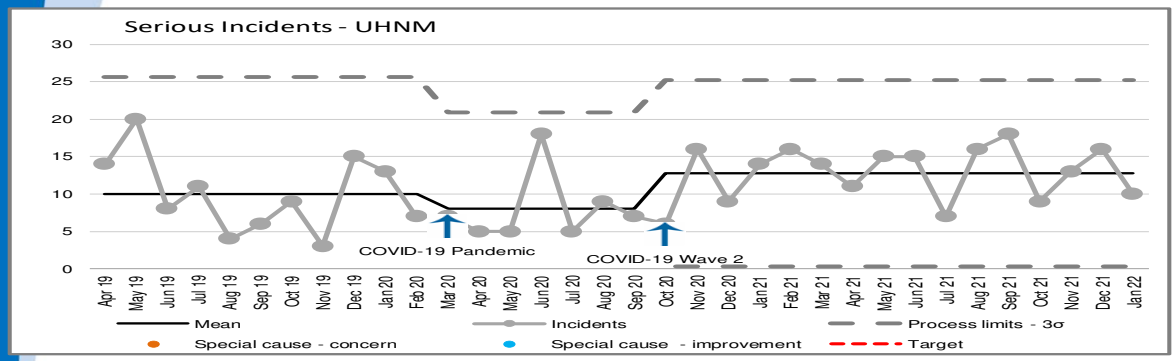
Locations with more than 1 lapse in January 2022 were:
Ward 221 (3), Ward 126 (2), Emergency Care Centre (2), (County) Ward 15 (2), (County) Ward 14 (2)

Root Cause(s) of damage - Lapses - Jan 2022	Total
Management of repositioning	11
Management of heel offloading	8
Management of device	1
Management of non-concordance	2

Actions:

- High reporting wards will be sent notification, with Hot Debriefs taking place on the wards
- Education continues on high reporting areas from TV Team and Corporate team
- Pressure Ulcer Prevention (PUP) Champions training is in process planning for next year and focuses on learning from incidents.
- Engage house keepers to support wards with ensuring adequate equipment is available for heel offloading.
- Learning form RCA's educational guide has been shared with staff.

Serious Incidents per month

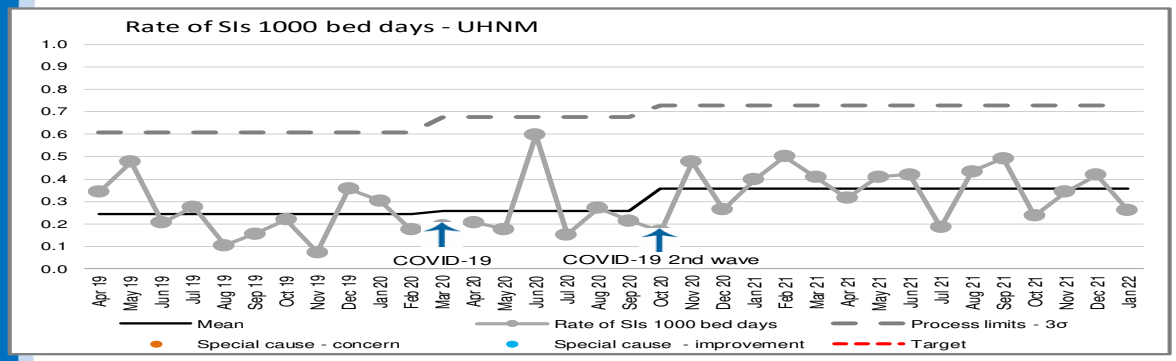


Variation	Assurance
	F

Threshold	Nov 21	Dec 21	Jan 22
0	13	16	10

Background

The number of reported Serious Incidents per month



Variation	Assurance
	?

Target	Nov 21	Dec 21	Jan 22
0	0.34	0.42	0.26

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 is under review to develop trajectory for reducing serious incidents across UHNM.

January 2022* saw 10 incidents reported with all 10 at RSUH:

- 7 Falls related incidents
- 1 Surgical/invasive procedure related incidents
- 1 Diagnostic related incidents
- 1 Pending Category – awaiting confirmation of cause of death

**Reported on STEIS as SI in January 2022, the date of the identified incident may not be January 2022.*

Serious Incidents Summary

University Hospitals of North Midlands NHS Trust

Summary of new Maternity Serious Incidents

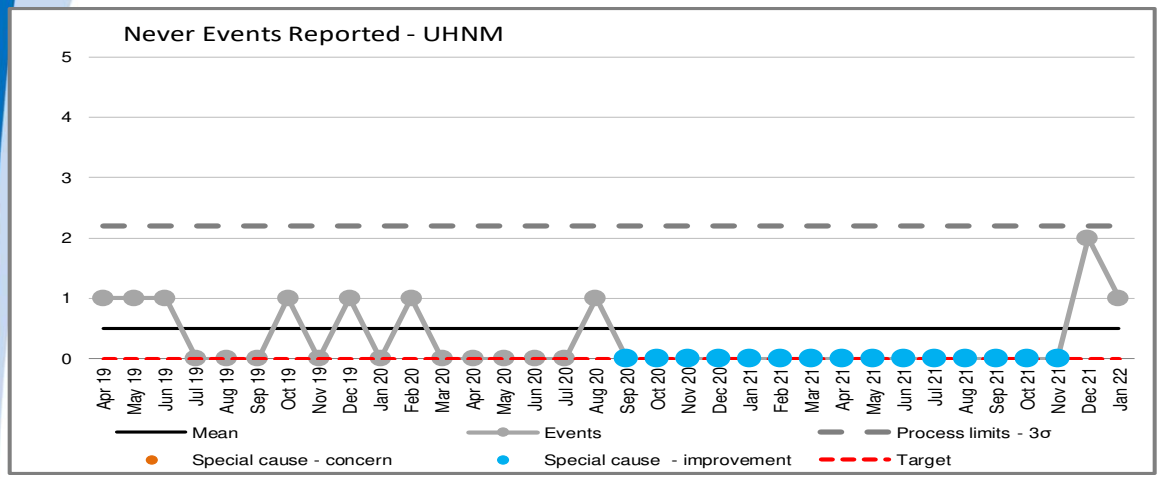
Following the formal recommendations in the Ockenden Report, below is an outline of the Maternity related serious incidents reported during December 2021. The new recommendation requires the Trust Board to receive summary on the new Maternity related Serious Incidents along with previously reported summary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

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

There were 0 Maternity related Serious Incidents reported on STEIS during January 2022

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

Never Events



Variation	Assurance

Target	Nov 21	Dec 21	Jan 22
0	0	2	1

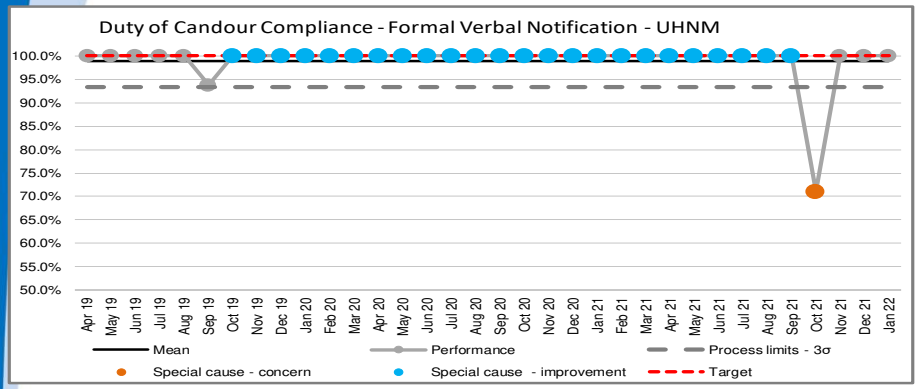
Background

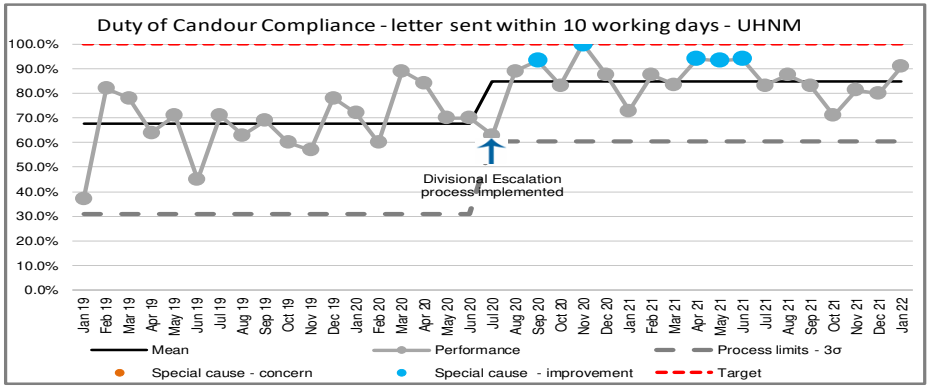
Defined as Serious Incidents that are wholly preventable, as strong systemic protective barriers should be in place

There has been 1 reported in January 2022 and 3 in total for year to date 2021/22. The target is to have 0 Never Events.

Log No.	STEIS Category	Description	Target Completion date
2022/1446	Surgical invasive procedure incident	On 11/1/2022 it was identified that there had been an issue detected with a patient that had been operated on the 2/1/2022. The surgery which was carried out on the 2/1/2022 had required further intervention due to poor reduction and there was a foreign body detected on x-rays. This looks like a radio opaque fibre from a swab.	19/04/2022

Duty of Candour Compliance





Variation	Assurance

Target	Nov 21	Dec 21	Jan 22
100%	100.0%	100.0%	100.0%

Background

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

Variation	Assurance

Target	Nov 21	Dec 21	Jan 22
100%	81.3%	80.0%	90.9%

Background

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

What is the data telling us:

During January there were 11 incidents reported and identified that have formally triggered the Duty of Candour. All 11 of these cases (100%) have recorded that the patient/relatives been formally notified of the incident in Datix.

Confirmed Follow up Written Duty of Candour compliance (i.e. receiving the letter within 10 working days of verbal notification) during January 2022 is 90.%.

Whilst there was 1 case that had not received the letter within 10 days, the letters has subsequently been circulated .

The decrease in performance in competing the written notifications within 10 days links with the increased pressures and increased staff absences/shortages caused by COVID-19.

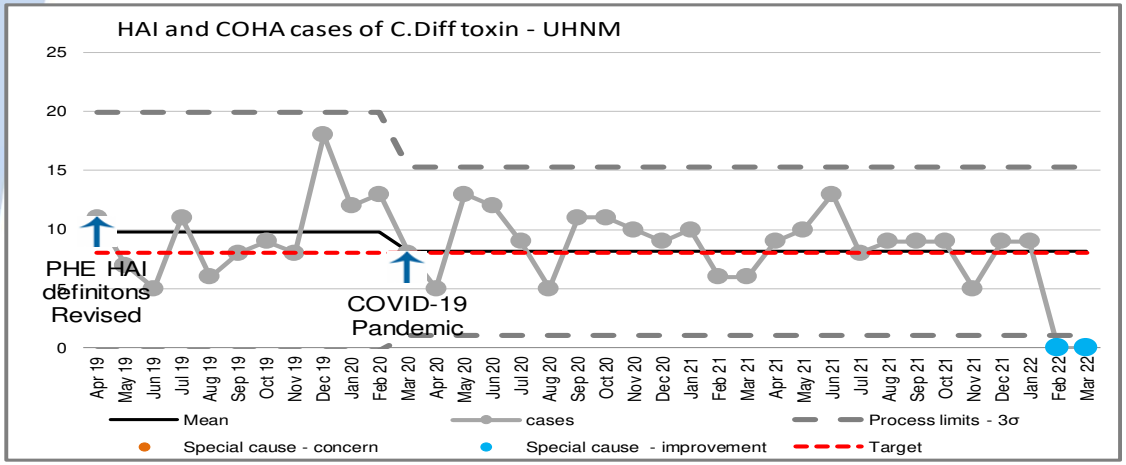
Actions taken:

The previous decline in performance had been escalated with Divisions via Quality & Safety Oversight Group and support is being provided to facilitate the completion of the written notifications during the increased pressures and staffing shortages. January 2022 has seen improvement in the compliance with the 10 day target.

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

Compliance is included in Divisional reports for discussion and action.

Reported C Diff Cases per month



Variation	Assurance
	

Target	Jan 22	Feb 22	Mar 22
8	9	0	0

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 9 reported C diff cases in January with 6 being Hospital Associated Infection (HAI) cases and 3 COHA cases.

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

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

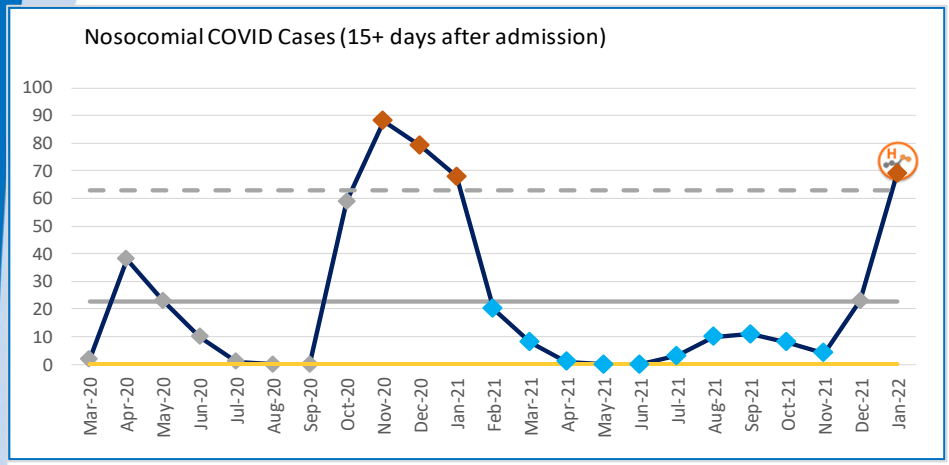
There has been one clinical area that has had more than one Clostridium *difficile* case in a 28 day period.

- Ward 102 (2*HAI) and Ward 110 (2 * HAI). Ribotypes are still outstanding so it is not possible to say whether person to person transmission has occurred.
- IP measures in place

Actions:

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

HAI Nosocomial COVID Cases per Month



What do these results tell us?

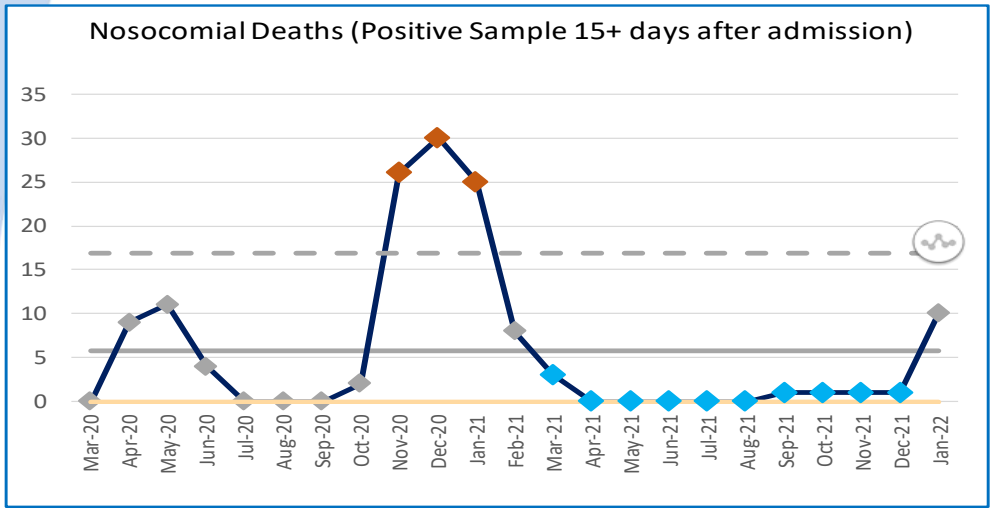
- Significant increase in cases throughout January 2022 with 67 definite Healthcare Acquired COVID -19 cases. This was contributed by Ward 79 Outbreak during January 2022
- January has seen increase in Probable and definite Hospital Onset COVID but is below January 2021 figures for probable cases and 1 more definite case with 69 compared to 68

	Community COVID-19 rate per 100,000 population (as at month end)				UHNM		
	England	W Mids	Staffs	Stoke	Total Admissions	COVID cases	
						Prob	Def
Oct 20	232.1	273.7	352.2	373.3	17006	63	59
Nov 20	152.2	188.0	206.0	350.3	14956	109	88
Dec 20	526.0	404.1	370.2	318.7	14701	107	79
Jan 21	283.0	328.0	296.0	239.5	14255	128	68
Feb 21	86.60	113.2	104.6	125.2	14101	31	20
Mar 21	56.0	61.6	56.2	76.8	17105	12	8
Apr 21	24.1	23.6	17.7	35.1	16554	3	1
May-21	49.0	36	27.9	18.3	17273	0	0
Jun-21	100.4	76.9	62.4	93.6	18527	0	0
Jul-21	290.1	273.5	242.9	223.3	18168	4	3
Aug-21	310.8	321.7	360.5	375.6	17160	14	10
Sep-21	355.3	414.0	512.2	423.3	17327	11	10
Oct-21	484.9	468.8	569.7	532.7	17055	8	8
Nov-21	476.1	400.2	455.2	492.2	17700	4	4
Dec-21	1591.6	1461.3	1574.0	1298.4	16688	13	23
Jan-22	904.4	856.7	824.5	1044.7	16109	67	69

Actions :

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

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



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.

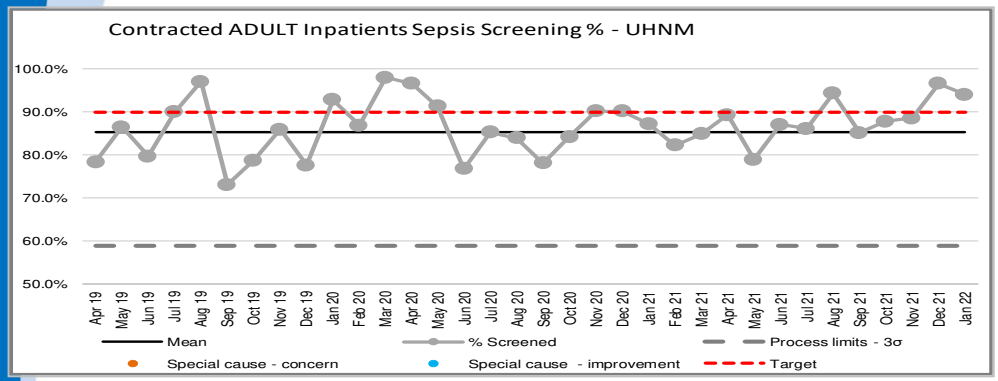
- 10 recorded definite hospital onset COVID-19 deaths in January 2022
- Total 136 hospital acquired COVID-19 deaths with 1st positive results 15 days or more following admission recorded since 1st March 2020 up to 31st January 2022
- The mean number of deaths per month since March 2020 is 6.

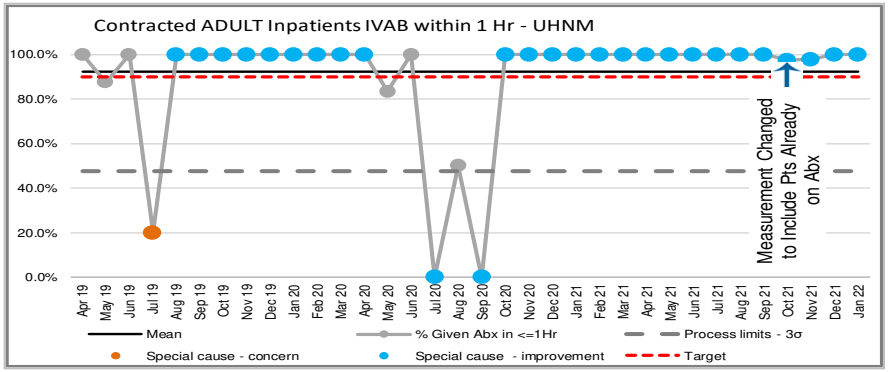
Actions :

All definite Nosocomial COVID-19 deaths have been reviewed and report has been submitted to the Mortality Review Group identifying the outcome of the case reviews assessing the aspects of COVID-19 management of the patients. Reviews for any further deaths will be undertaken and outcomes compared to the reviews already completed.

Sepsis Screening Compliance (Inpatients Contract)

University Hospitals of North Midlands NHS Trust





Variation	Assurance

Target	Nov 21	Dec 21	Jan 22
90%	88.6%	96.6%	94.0%

Background

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

Variation	Assurance

Target	Nov 21	Dec 21	Jan 22
90%	97.8%	100.0%	100.0%

Background

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

What is the data telling us:

Inpatient areas are exceeding the screening target but variation is within normal ranges.

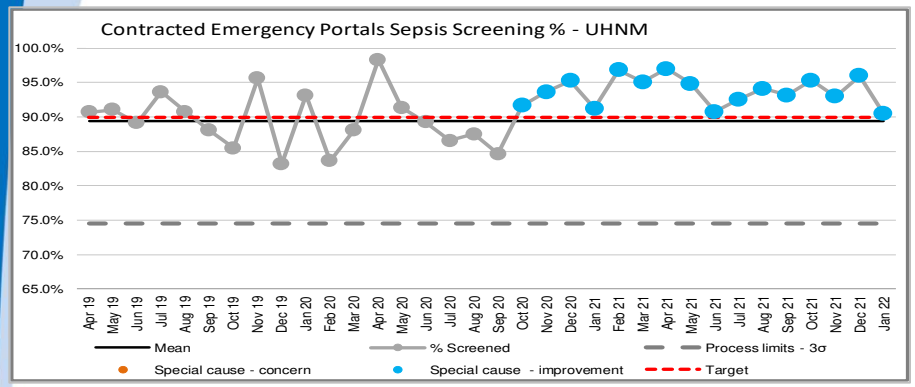
IVAB within 60 minutes is also above target rate with consistently high results.

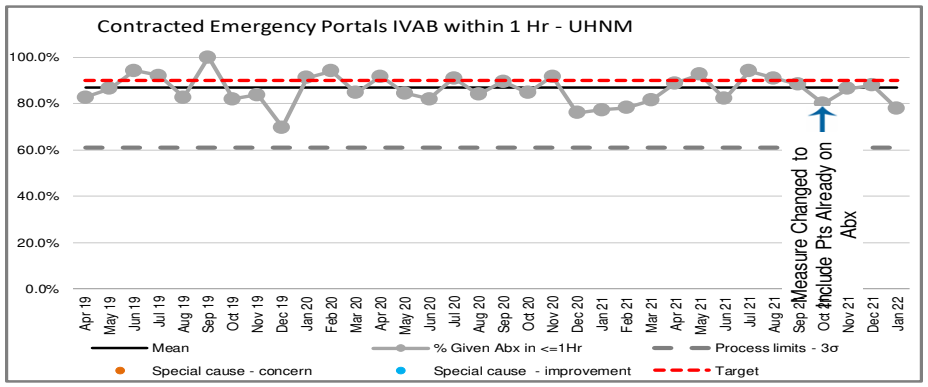
Actions:

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

Sepsis Screening Compliance (Emergency Portals Contract)

NHS University Hospitals of North Midlands NHS Trust





Variation	Assurance
H	?

Target	Nov 21	Dec 21	Jan 22
90%	93%	96%	90%

Background

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

Variation	Assurance
	?

Target	Nov 21	Dec 21	Jan 22
90%	86%	88%	78%

Background

The percentage of Emergency Portals patients from sepsis audit receiving IVAB within 1 hour for Sepsis Contract purposes

What is the data telling us:

Adult Emergency Portals screening exceeding target and performance is embedded with consistent achievement above the target rate..

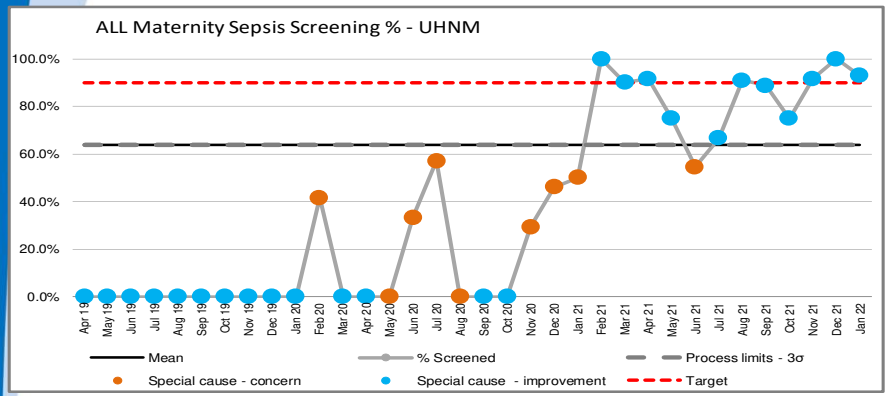
The performance for IVAB within 1hr below target rate but within normal variation.

Actions:

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

Sepsis Screening Compliance ALL Maternity

University Hospitals of North Midlands NHS Trust

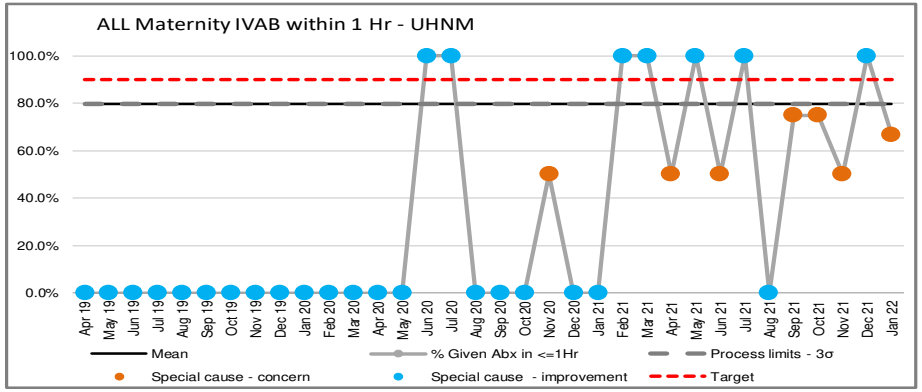


Variation	Assurance
H	F

Target	Nov 21	Dec 21	Jan 22
90%	91.7%	100.0%	92.9%

Background

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



Variation	Assurance
L	F

Target	Nov 21	Dec 21	Jan 22
90%	50%	100%	67%

Background

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

What is the data telling us:

Maternity Inpatients and Emergency portal (MAU) audits show significant improvement in screening compliance with 100%, from the 11 patients that triggered with MEOWS >4. IVAB within an hour also achieve 100% in Emergency portal and nil red flags in inpatient wards.

Overall, considering the small size samples for December, the Maternity sepsis screening and IVAB within hour compliance were excellent.

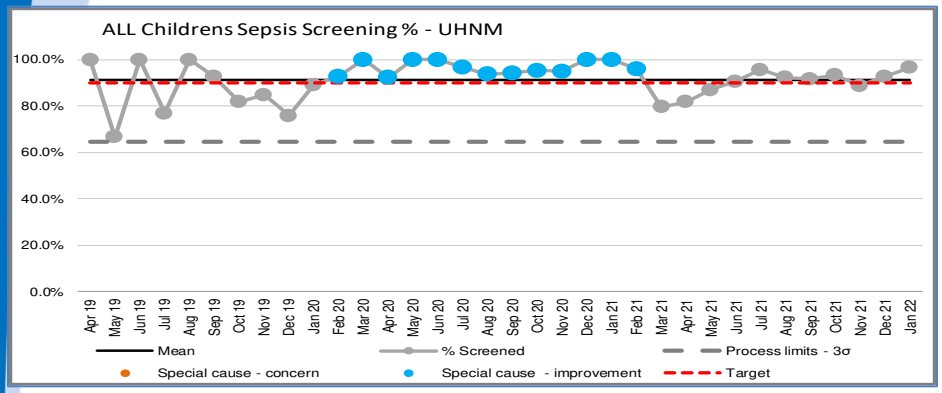
Actions:

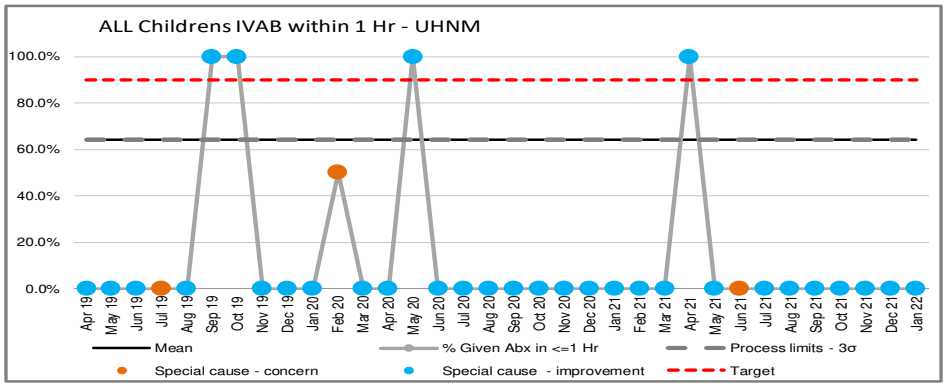
- The Maternity Senior team and clinical staff have continued to work collaboratively with the sepsis team to ensure patient safety; on-going
- The Sepsis team will continue to audit Maternity comprehensively to ensure maintenance of high standard of sepsis practice and compliance: on-going
- Maternity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

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Sepsis Screening Compliance ALL Children





Variation	Assurance
	?

Target	Nov 21	Dec 21	Jan 22
90%	88.9%	92.9%	96.6%

Background

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

Variation	Assurance
H	F

Target	Nov 21	Dec 21	Jan 22
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 for Sepsis Screening and have achieved the target rate but as yet not consistently achieving the 90% rate.

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) and hence N/A results returned for IVAB in 60 minutes compliance

Actions:

- The Sepsis Team will continue to deliver re-enforcement and kiosks to specific areas when falls in compliance are identified: on-going
- The Sepsis Team has continued to adjust the audit process in emergency portals to take smaller samples over a wider range of dates to give a more comprehensive perspective
- Plan of collaborative work with Children education lead and aiming to deliver 3-5 hour Sepsis CPD champion training and ward based sessions: on- hold due to current situation

Operational Performance

2025 Vision "Achieve NHS Constitutional patient access standards"

Spotlight Report from Chief Operating Officer

NHS University Hospitals of North Midlands NHS Trust

Emergency Care

- Attendances remain under forecast in January 2022 from previous months. High numbers of DTA's were held in ED overnight due to bed based acuity, high numbers of MFFD with all escalation capacity being open and utilised.
- Ambulance handover delays over 60 minutes were a worsening picture. The percentage of handovers within 15 minutes was 61.4% for the month. Instances of surge evidenced for WMAS attends which provides challenges for triage, especially when stand by patients have to be managed on clinical need.
- Time to initial assessment mean position was slightly reduced at 56.14% for the month
- Time to Treatment in ED was reduced in January and under 80 minutes.

Cancer

- The Trust continues to conduct a high number of 1st appointments, with over 3000 patients being seen in January.
- The overall 2WW position for January 22 is predicted to achieve in the region of 55%. Specialties with the most 14 day breaches are Breast, Skin and Upper GI.
- The 28 Day Faster Diagnosis position is currently at 39% with the majority of breaches in Colorectal and Skin. Most patients on the colorectal pathway now have FIT requested at the same time of referral however this is outside of WMCA and best practice guidance which states FIT **results** should accompany referrals. This means the Trusts chases patients to complete their FITs and waits for the results for directing to the most appropriate investigation. System challenge for Q4 to secure primary care traction on this pathway given the direct link to improved performance potential.
- The overall 62 day position for January 22 is currently at 44.7%. This is an incomplete and un-validated position that is expected to change as histology confirms a cancer or non cancer diagnosis for patients treated.
- In January, Theatre, Oncology, Diagnostic and Surgical workforces were impacted by covid, affecting performance. The position is being managed through the reinstated daily clinical prioritisation meetings and a robust planned care assurance framework.
- After a focus on reducing the number of patients waiting to be appointed, the volumes in the RAS have reduced. Significant improvements have been made in Skin as the volume of patients waiting has reduced from over 400 down to around 100 currently.

Spotlight Report from Chief Operating Officer

NHS University Hospitals of North Midlands NHS Trust

Planned Care

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

- Day Case and Elective Activity delivered 84% and 76% respectively for December 21 against the national ask of 95%, a deterioration on December's position for Day Case (86%) (choice and increased NCEPOD operating over the Christmas period).
- In month Planned Care Cell focus on elective recovery based on 10 high impact changes in accordance with the elective plan.
- Theatre plan for Q4 gives 89.5% of 19/20 capacity. Targeted booking on-going to meet P2 demand and 104+ waits.
- CCG Commissioned Deloitte review of capacity options is complete - UHNM are asking for extra capacity with CCG colleagues at the IS.
- CCG have an interim commissioning manager who is supporting elective opportunities in Tier 2 sector/regionally around mutual aid.
- Referral Hub – awaiting specification from 18 week source group and reviewing use of electronic ERS to manage referrals.
- Some work has already taken place at specialty level with respect to patient contact with the test of change outcomes used to scale up with ERF funding.

RTT

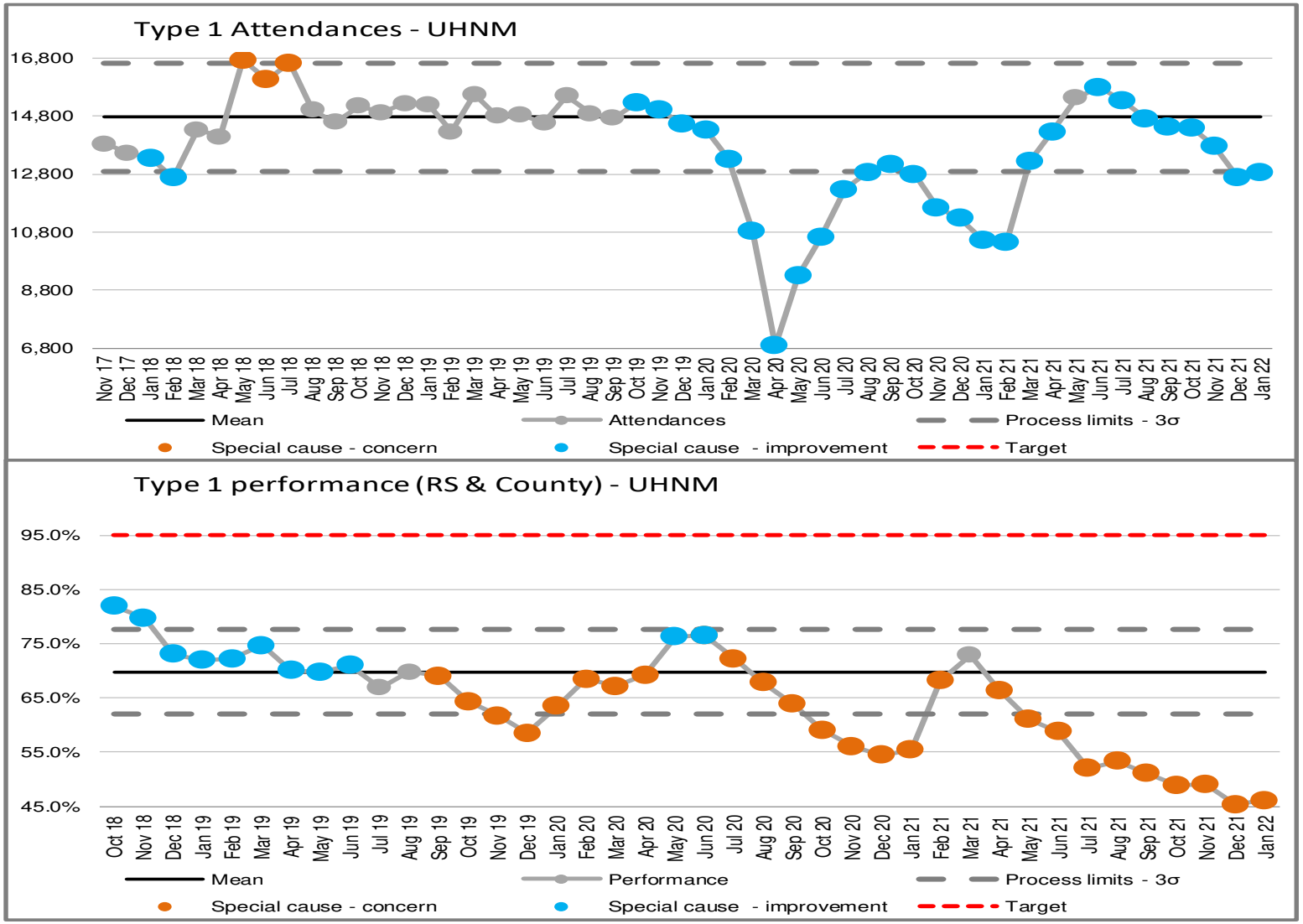
- The overall Referral To Treatment (RTT) Waiting list continues to rise. For January the indicative number of Incomplete pathways has risen to 71,382 (December 70,951).
- The number of patients > 18 weeks has risen to a level of 32,147 (December 31,599).
- The numbers of 52 week waits in January has increased with a reported 4,463 (December 4,393) this figure is below the trajectory.
- At the end of January the numbers of > 104 weeks reported were 521. The Planned Care group is monitoring progress against treatment plans for these patients.
- Performance has slightly decreased at 55.0% (December 56.0%).
- Work plans around long wait patient validation and treatment tracking are in progress to support the Data Quality Strategy & Audit requirements.

Diagnostics

- For DM01 (15 nationally identified Dx tests) the validated position for total waiting list has increased in December from 20,134 to 20,665. The Non-obstetric ultrasound waiting list reduced slightly from 9,935 to 9,382. Due to the challenges in Non-Obstetric Ultrasound this has adversely affected performance. The current DM01 diagnostic performance for December 21 is at 68% (November 69 %).
- Within DM01, the greatest proportion of > 6 week waits are within Non-obstetric ultrasound and endoscopy. The ultrasound position is related to an increase in demand alongside workforce shortfalls, a number of actions are in place. Non obstetric ultrasound performance remains a Driver Metric for CWD and has specific focus for improvement, albeit this is related to workforce retention, recruitment and innovative ways to train and recruit.
- DM01 performance excluding non obs ultrasound would be c93%.

Section 1: NON ELECTIVE IMPROVEMENT

Urgent Care – Attendances and 4 hour performance



Urgent Care – In Month Performance Summary

NHS
University Hospitals of North Midlands
NHS Trust

SUMMARY

Attendances; Total type 1 attendances rose slightly from that in December. Numbers were down on the pre pandemic average by 1849. The drop is in line with previous drops in attendances numbers due to surges in Covid prevalence.

Triage; Initial assessment within 15 minutes decreased in January to 56%. Performance is influenced most where there are surges of over 30 attendances within the hour, particularly in the evening. This can be where staff shortages, particularly decision makers has been a challenge. The department are aiming to stop the decline in triage time with re-deployment of staff in the department at the time and are looking at tiered rotas in line with RCEM guidance. A business case addressing workforce challenges was approved in early October and staff are being recruited to as per the planning timescale in that case, a separate paper is coming to PAF this month to share the current position against the funding.

Ambulance; The percentage of ambulance handovers within 15mins at RSUH site decreased over the December position but was much improved over pre November 2021. Handover delays over 60 minutes was a worsening picture. However longer delays occurred during peak ambulance arrival times in early evening, when multiple Crews arrive on site in succession. An action plan to improve ambulance holds is now in progress

Long waits; The number of patients in the department for > 12 hours is of significance again in January at 416, slightly higher than seen in December. There were 762 validated, 12 hour trolley waits in January .

Admissions; The number of patients attending and admitted with Covid-19 continued to increase through January with admissions to wards and critical care proving challenging (33 new hospitalisations a day by 23rd Jan). 1+ LoS spell are at around 92% of 1920 BAU. Discharges pre-noon remained much the same as previous months.

4 hour Performance; In January the 4 hour performance rose to 46.1% from 45% seen in December. Set in the context of an increase in spells over 21 day LoS the number of stranded and MFFD all rising.

Improvement Overview and Focus

University Hospitals of North Midlands NHS Trust

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

Acute Front Door

STREAMING & DEFLECTION REDESIGN:

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

COMPLEX TRIAGE:

- Go Look Learn - 15 min triage standard review
- Go Look Learn - Ambulance handover processes

MEASURED BY

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

Acute Front Door

WORKFORCE REVIEW & RECRUITMENT:

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

MEASURED BY

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

Ward based Principles

REDUCING CONGESTION:

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

MEASURED BY

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

Together Compassion Safe Improving

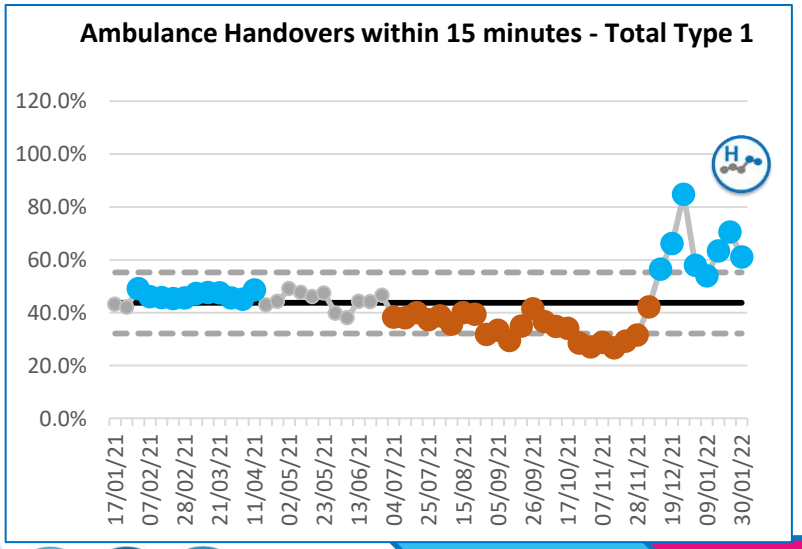
Quality | Operational | Workforce | Finance

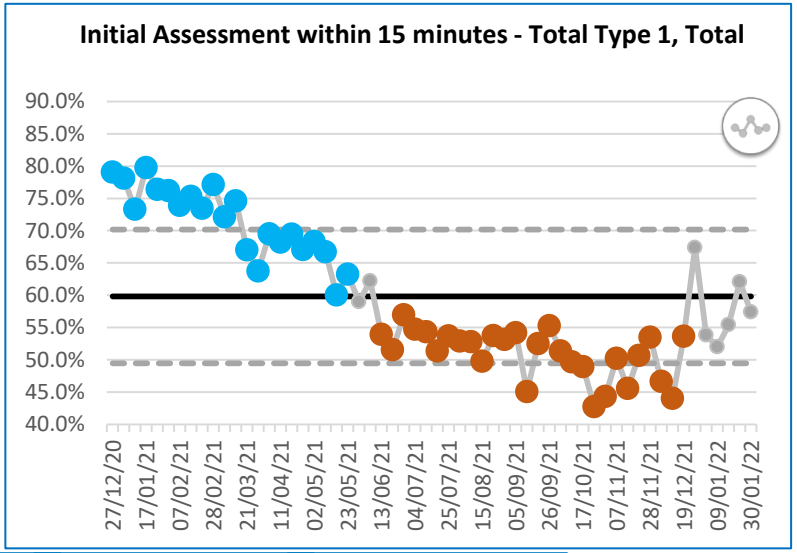
TIME FOCUSED METRICS / UEC Standard

Front Door - Attendance Management

RECENT AND IMMINENT ACTIONS

- Test of change from Navigator at the front door fully embedded which continues to support redirection to alternative places of care including portals (if attending with GP letter) and primary care services from December. Increases seen in patients being deflected to UCC and reductions in those needing to go for triage assessment. Phase 2 of Non specific GP letters planned go live of 07.02.22
- Internal UHNM – UCC model group commenced reporting to COO with a view of delivering 'UCC like' model from April 1st, initial intention paper to ask for support approved at PAF in January but now seeking support from CCG and Vocare for their continuation in running the service until July 2022
- Working closely with WMAS to effect earlier handover against 'rapid handover' policy should it be implemented by WMAS. Go Look Learn for Ambulance handovers planned for early February and will support actions to improve.
- 'RED' GP reinstated and capacity increased - daily monitoring of referrals demonstrates that Vocare are currently seeing on average 23 Children (increase from 17) and 31 adults per day (decrease from 38).
- Use of GP referral hub and consultant connect to prevent GP walk in directed to ED
- Regular social media campaigns to highlight alternative services on offer in the community and use of 111First
- 111 Kiosks - early review of the data available indicates that only 4% of patients are being redirected to alternative pathways

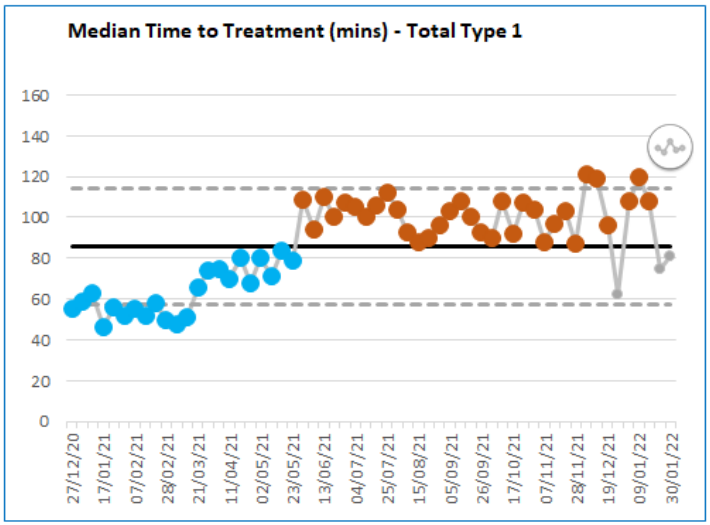


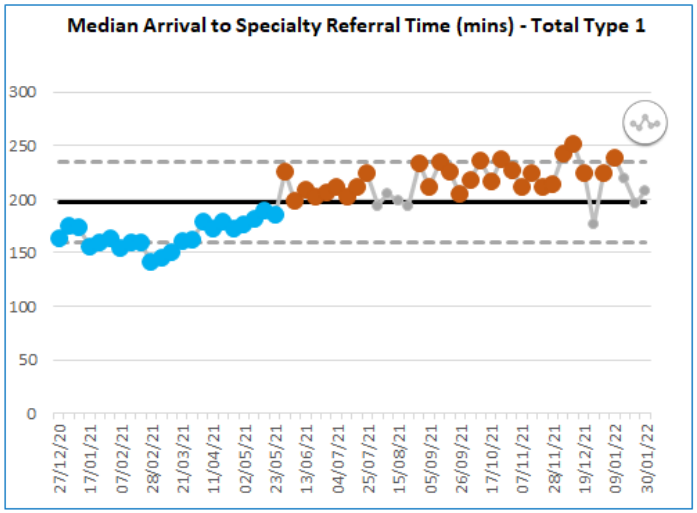


Front Door - Prompt Decisions

RECENT AND IMMINENT ACTIONS

- ED Medical Workforce business case, initial review paper coming to PAF February 2022.
- Engage senior clinicians. Re-set department structures and revise rotas, commenced Nov 21 – further work being planned
- Medical rota alignment to the new Tier's recommended by RCEM is underway
- A&E internal improvements including roles and responsibilities, huddles and rounding to improve grip, supported by visible improvement and escalation dashboards

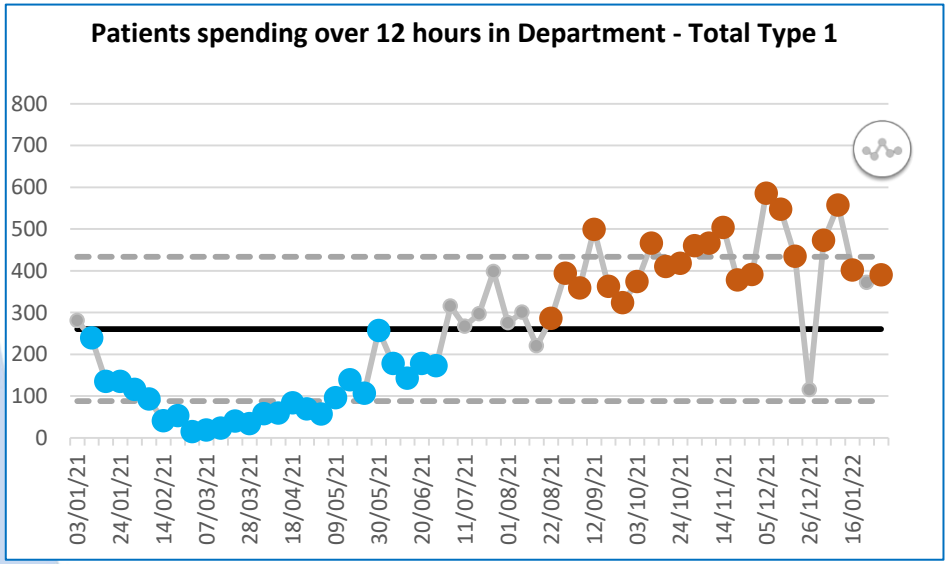


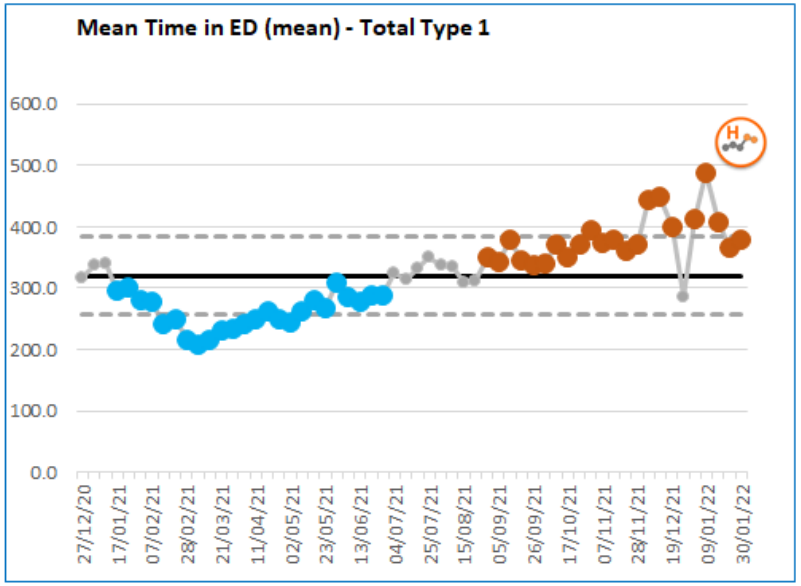


Ward based Principles - Early Egress for Admissions

RECENT AND IMMINENT ACTIONS

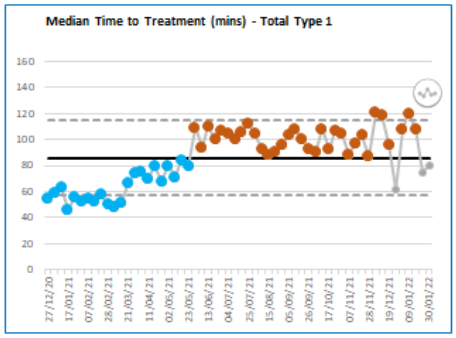
- Medicine division piloting new approach to EDD management to define true capacity/demand at start of the day and to drive behaviours at ward level
- Daily touch points with IPC and Red to Green Meetings in place in January to aid flow
- Application of MFFD and possible transition to Medically Optimised for Transfer (MOFT) to be reviewed and wards instructed on use
- Continued LOS work on stranded patients – great success seen in 21+ day waits.

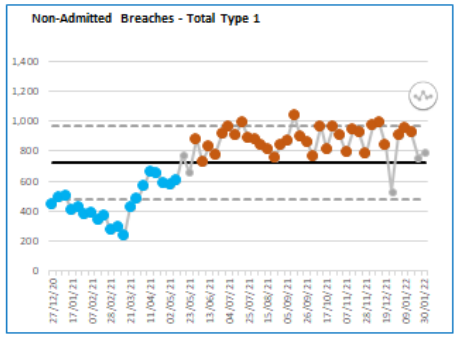


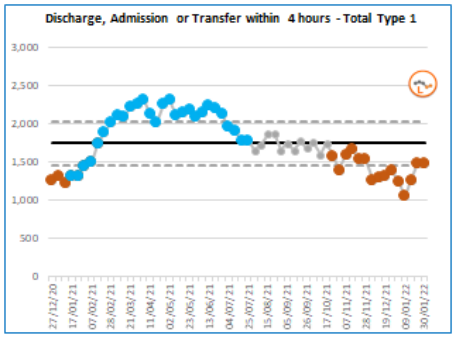


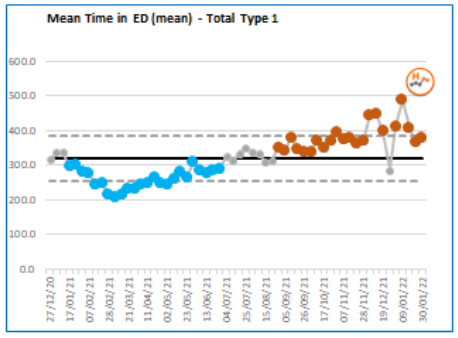
Quality | Operational | Workforce | Finance

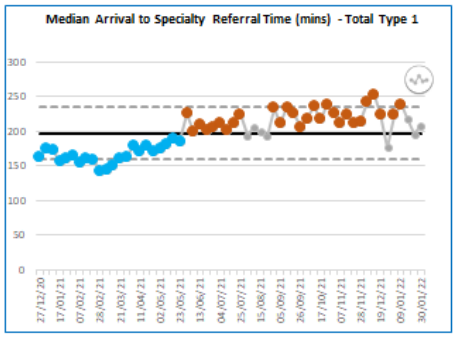
Front door

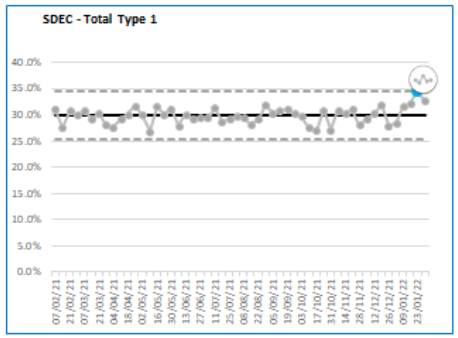


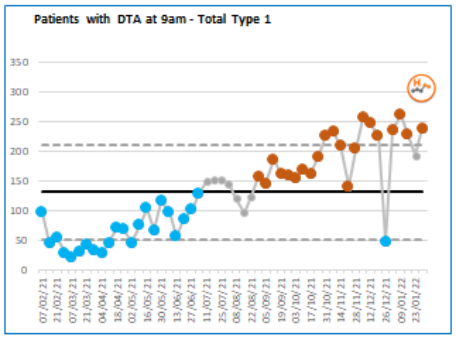


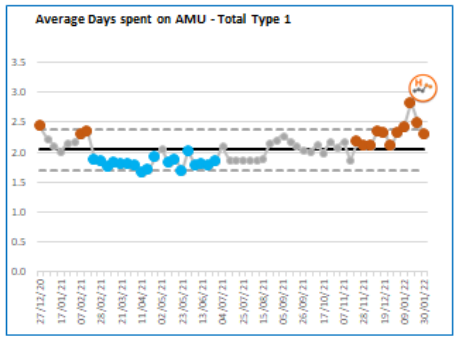


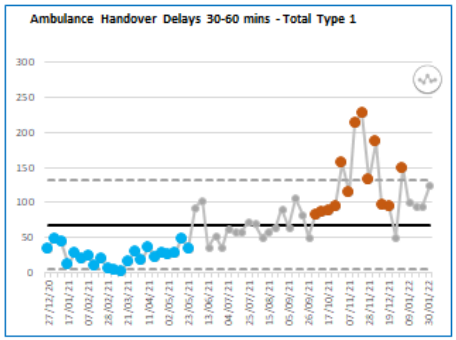


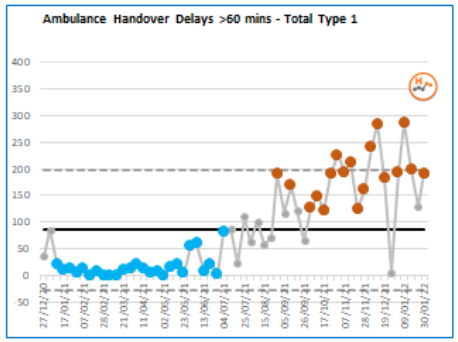


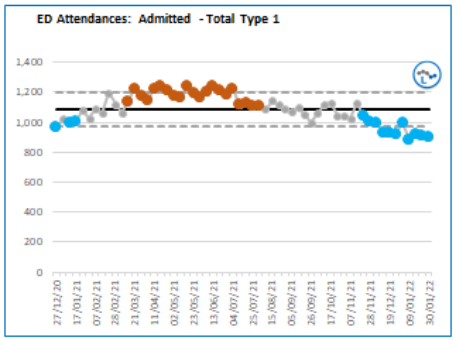


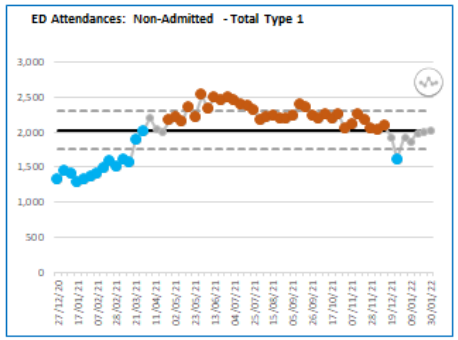








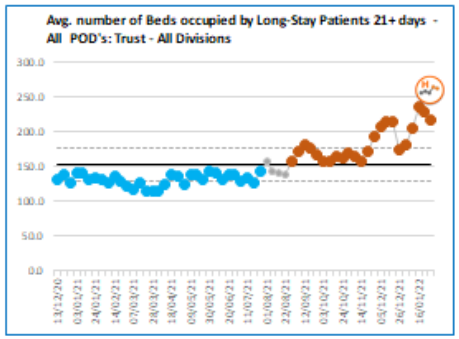


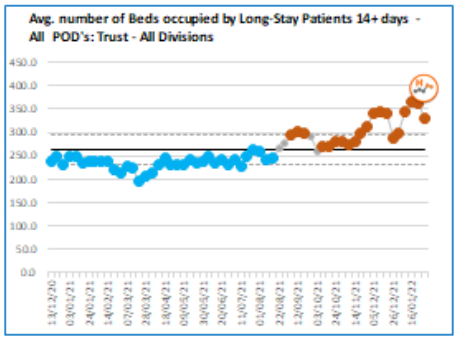


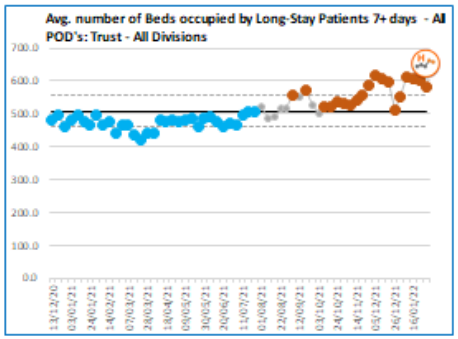
Together Compassion Safe Improving

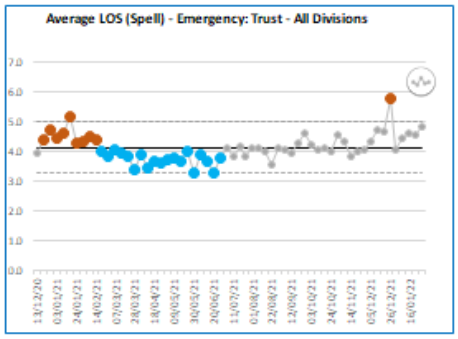
Quality | Operational | Workforce | Finance

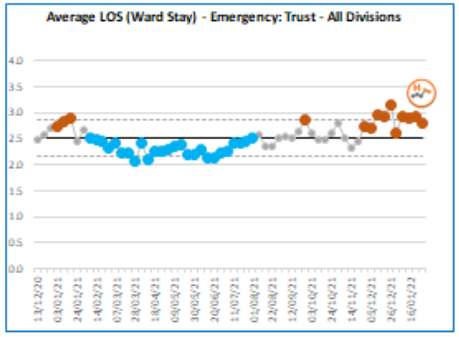
Flow

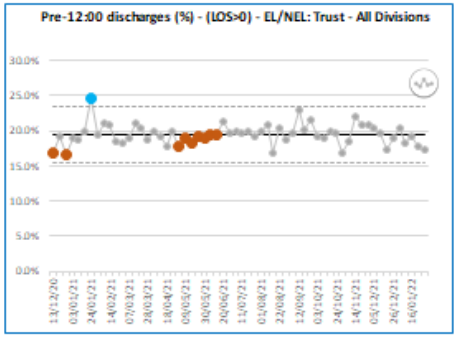

Avg. number of Beds occupied by Long-Stay Patients 21+ days - All POD's: Trust - All Divisions

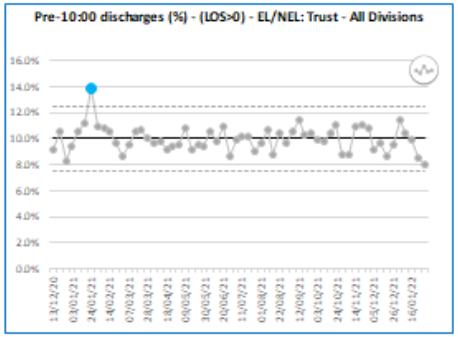

Avg. number of Beds occupied by Long-Stay Patients 14+ days - All POD's: Trust - All Divisions

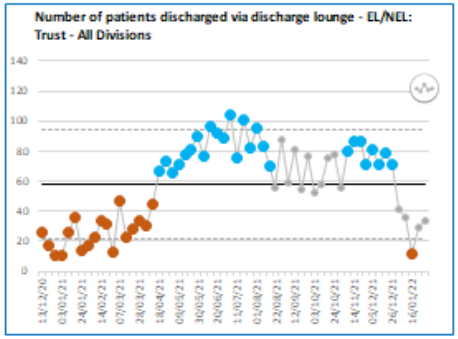

Avg. number of Beds occupied by Long-Stay Patients 7+ days - All POD's: Trust - All Divisions

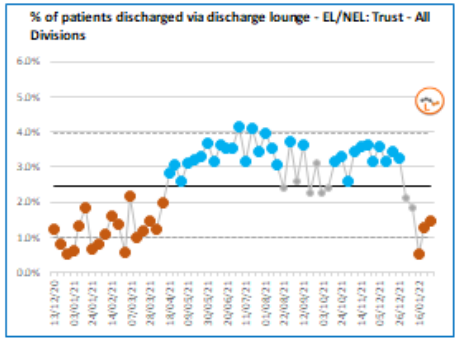

Average LOS (Spell) - Emergency: Trust - All Divisions

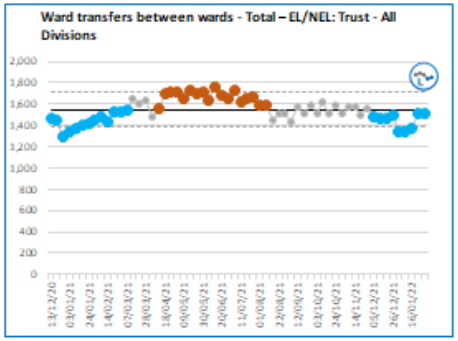

Average LOS (Ward Stay) - Emergency: Trust - All Divisions

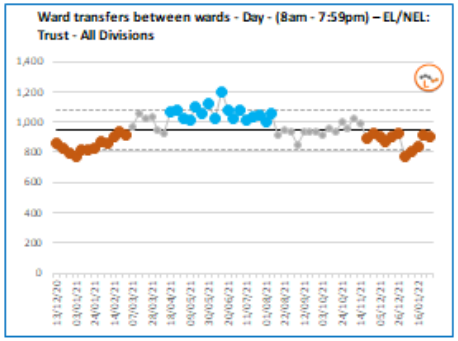

Pre-12:00 discharges (%) - (LOS>0) - EL/NEL: Trust - All Divisions

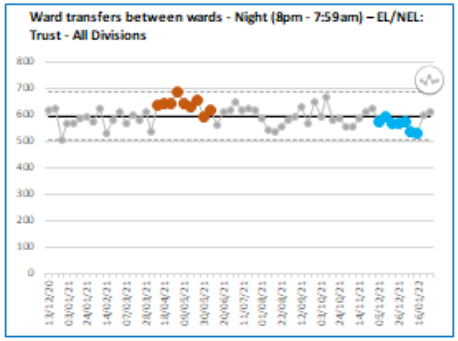

Pre-10:00 discharges (%) - (LOS>0) - EL/NEL: Trust - All Divisions


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


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


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


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


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

Section 2: ELECTIVE CARE

Cancer

Challenges:

- Oncology pathways challenged due to workforce pressures. The division is recruiting to consultant positions which will increase resilience I the long term.
- Histology turn around times are still outside of optimal pathway targets – a Quality Summit is being convened to understand potential risk and mitigating actions across the network. Other networks have also been approached to seek mutual aid.
- There are a growing number of outstanding clinical reviews on the Colorectal PTL. Patient level detail escalated to DAD level. Once reviewed, the 104+ position will improve as a result of pathway step down and discharges where appropriate.

Actions:

- After a number of extra clinics, the waits for 1st appts in Skin have been dramatically reduced and are now within target. This will be reflected in February performance.
- Following targeted comms the number of patients being referred on the LGI pathway with FIT requested has increased. However this position is still sub-optimal against the West Midlands Cancer Alliance directive that LGI referrals should have FIT results included in referral. This affects the Trusts 28 Day FDS position with the majority of 28 Day FDS breaches attributable to Colorectal. A system plan to support pathway compliance is in progress via a task and finish group.
- The Trust is communicating the COVID recovery plan through assurance meetings. The plan sets out priorities for cancer to: Return the number of patients waiting over 62 days to levels seen pre-pandemic, Meet the 28 day Faster Diagnosis Standard. Divisions are aware and managing the PTL accordingly.
- Digital Outpatient Transformation Funding – UHNM was successful in a bid to implement a trust wide Patient Portal. The digital platform will have many functions such as allowing patients to amend or cancel appointments and will also facilitate initiatives such as Patient Stratified Follow Up. A portal scoping workshop was hosted and well attended. Priorities for the portal function were identified by stakeholders before the procurement commences. The portal will release CNS capacity through remote surveillance of patients living with and beyond cancer.
- A 'National Cancer CNS Day' is being planned for 15th March, aiming to showcase the role of a cancer CNS, raise awareness of the position to encourage interest, and show gratitude to those already in position. The national team are drafting comms material, and internally cancer services will link in with the comms team to take part in the day. UHNM Cancer CNS have been asked to create content for the day and will feed back to Dorinda.
- DCF Schemes are progressing - A new steering group has been set up to guide and implement the vision for holistic therapies services within the newly refurbished cancer centre.

Cancer

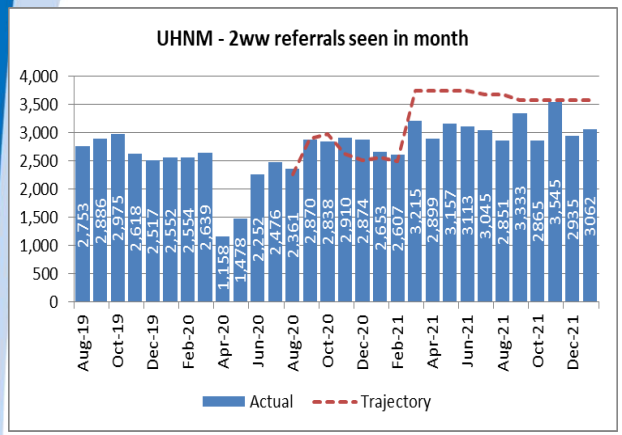
University Hospitals of North Midlands NHS Trust

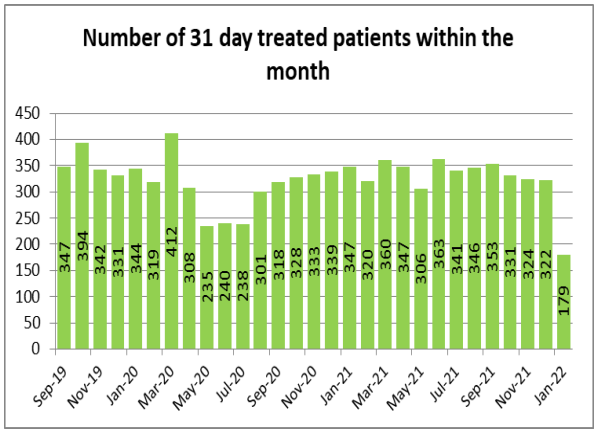
- Trajectories have been agreed and are being tracked against the actual positions. Most recent published data is for December but provisional January figures are below:
  - 14 Day Trajectory January: 93.1%. Actual 54.5%. Actual Seen. 3062. Actual Breaches 1391. The trust is below the set trajectory on this standard.
  - 31 Day Trajectory January: 95.6%. Actual 89.3%. Actual Treated 179. Actual Breaches 19. The trust is below the set trajectory on this standard however this represents an incomplete position currently.
  - 62 Day Trajectory January: 86.9%. Actual 44.7%. Actual Treated 109.5 Actual Breaches 60.5. The trust is below the set trajectory on this standard.

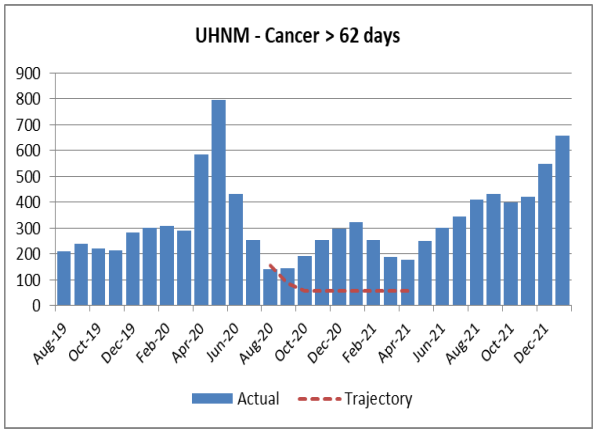
January and February are predicted to have a high proportion of breaches as the trust has been impacted in the Omicron wave. It is predicted that as this backlog of patients waiting is cleared that performance against the 62 day standard will improve from March 22.

Trust			Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
14 Day Standard 93% *(suspected cancer, excluding breast symptom)*	TRAJECTORY	First Seen	3745	3745	3745	3666	3666	3566	3566	3566	3566	3566	3566	3566
		Breaches	809	769	699	961	901	641	481	366	306	246	186	166
		Performance	78.3%	79.4%	81.3%	73.7%	75.4%	82.0%	86.5%	89.7%	91.4%	93.1%	94.7%	95.3%
	ACTUALS	First Seen	2899	3157	3113	3045	2851	3333	2865	3545	2967	3062	1695	0
		Breaches	640	593	318	665	961	1042	1019	1927	1264	1391	869	0
		Performance	77.9%	81.2%	89.7%	78.1%	66.2%	68.7%	64.4%	45.6%	57.3%	54.5%	48.7%	
		Variation	-0.4%	1.8%	8.4%	4.4%	-9.2%	-13.3%	-22.1%	-44.1%	-34.1%	-38.6%	-46.0%	
		Regional (Midlands)	81.7%	85.0%	81.1%	83.4%	84.0%	81.4%	79.9%	73.5%	74.8%			
		National	85.4%	87.5%	84.9%	85.6%	84.7%	84.1%	81.3%	77.4%	78.6%			
31 Day First Treatment Standard 96%	TRAJECTORY	Treatment	463	463	463	463	463	463	463	463	463	463	463	463
		Breaches	49	46	43	38	34	29	25	23	22	20	19	18
		Performance	89.4%	90.0%	90.7%	91.7%	92.6%	93.7%	94.6%	95.0%	95.2%	95.6%	95.8%	96.1%
	ACTUALS	Treatment	347	306	363	341	346	353	331	324	322	179	34	0
		Breaches	23	19	22	22	29	46	42	46	22	19	7	0
		Performance	93.3%	93.7%	93.9%	93.5%	91.6%	86.9%	87.3%	85.8%	93.1%	89.3%	79.4%	
		Variation	3.9%	3.7%	3.2%	1.8%	-1.0%	-6.9%	-7.4%	-9.3%	-2.1%	-6.4%	-16.4%	
		Regional (Midlands)	91.9%	92.5%	91.9%	91.9%	90.2%	88.7%	90.2%	89.7%	90.3%			
		National	94.2%	95.1%	94.6%	94.7%	93.7%	92.6%	93.5%	93.0%	93.4%			
62 Day (2ww) Standard 85%	TRAJECTORY	Treatment	246.0	246.0	246.0	246.0	246.0	246.0	246.0	246.0	246.0	246.0	246.0	246.0
		Breaches	75.5	71.5	67.5	62.5	59.5	57.5	50.0	44.0	38.0	32.0	32.0	32.0
		Performance	69.3%	70.9%	72.5%	74.5%	75.8%	76.6%	79.6%	82.1%	84.5%	86.9%	86.9%	86.9%
	ACTUALS	Treatment	181.0	166.5	198.0	186.5	187.5	199.0	168.0	178.0	172.5	109.5	24.0	0.0
		Breaches	42.0	48.5	59.0	64.0	69.5	84.0	70.0	87.0	81.0	60.5	16.0	0.0
		Performance	76.7%	70.8%	70.2%	65.6%	62.9%	57.7%	58.3%	51.1%	53.0%	44.7%	33.3%	
		Variation	7.4%	-0.1%	-2.3%	-8.9%	-12.9%	-18.9%	-21.3%	-31.0%	-31.5%	-42.2%	-53.6%	
		Regional (Midlands)	69.9%	66.4%	66.4%	63.3%	61.6%	58.3%	57.3%	56.9%	57.1%			
		National	75.4%	73.0%	73.3%	72.1%	70.7%	68.0%	67.8%	67.5%	67.0%			

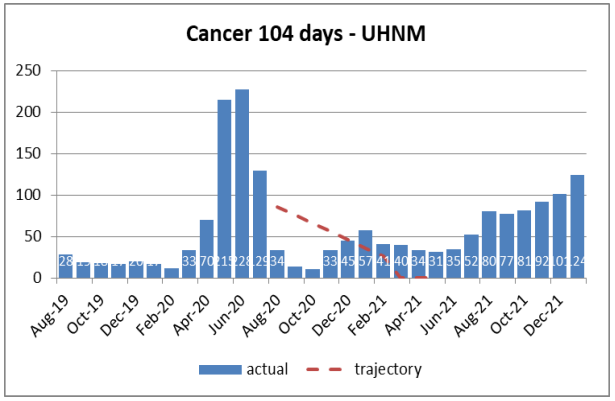
Cancer







January Provisional	Target	Trust Actual	Clock Stops	Breaches	Breaches Over	Needed Treatments
TWW Standard	93%	54.6%	3062	1391	1177	16810
TWW Breast Symptomatic	93%	4.8%	83	79	74	1046
31 Day First	96%	89.4%	179	19	12	297
31 Day Subsequent Anti Cancer Drugs (inc Chemo)	98%	94.1%	34	2	2	66
31 Day Subsequent Surgery	94%	79.4%	34	7	5	83
31 Day Subsequent Radiotherapy	94%	83.0%	47	8	6	87
62 Day Standard	85%	44.7%	109.5	60.5	45	294.5
Rare Cancers - 31 Day RTT pathway	85%		0	0	1	1
62 Day Screening	90%	36.4%	22	14	12	119
28 Day FDS Standard	75%	39.0%	2391	1459	862	3446
62 Day Consultant Upgrade	93%	78.0%	41	9	7	88
Closed Pathways > 104 Day			14			



Position is an underachieve on all standards(pending validation). 2ww and 62 day performance impacted by capacity available as workforce used to support Covid surge based on workforce attrition of front line services. Clinicians asked to focus on cancer pathway review > 62 days and focus on 104 day decisions and outcomes to reduce these volumes and ensure appropriate clinical validation of next step pathways.

Planned care - *Inpatients*

University Hospitals of North Midlands NHS Trust

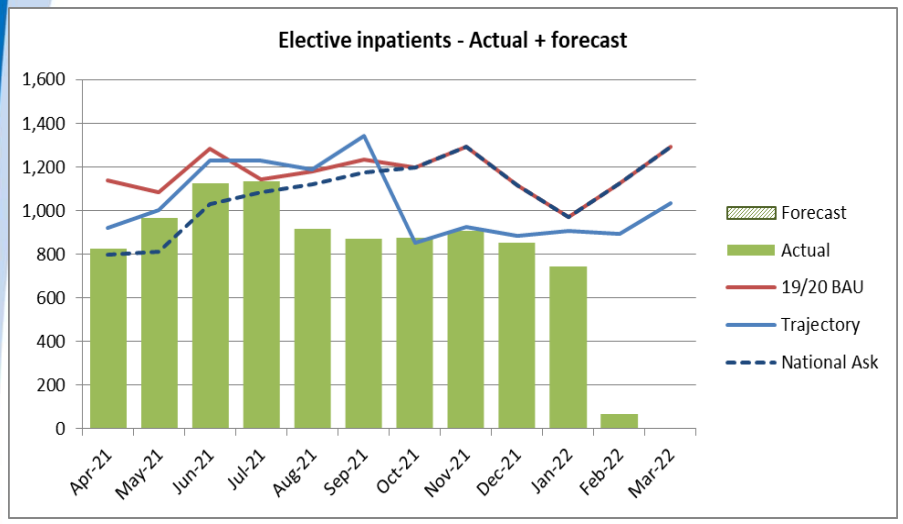
Elective inpatients Summary

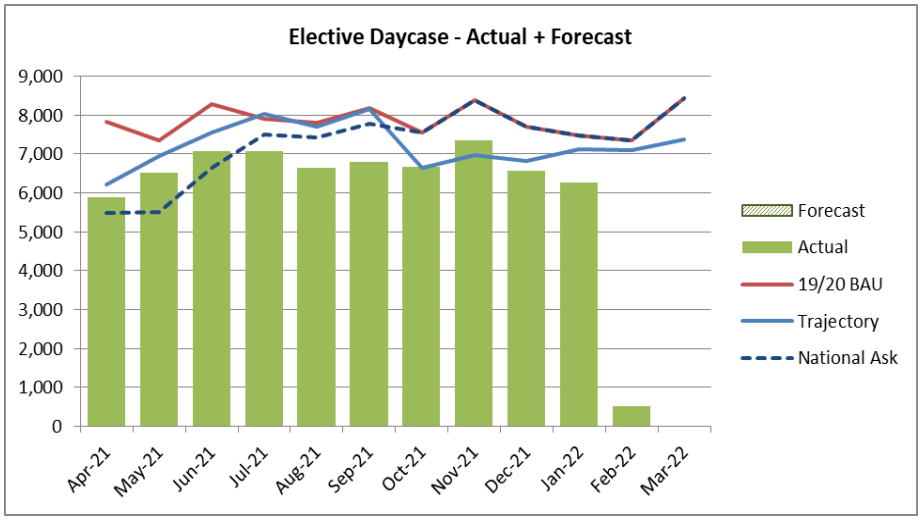
- For January the total inpatient actuals against BAU was 83.3%. This is lower in Inpatients than Day case (76% IP, 84% DC).
- Insourcing arrangements at week ends continue and have been bolstered to provide more weekend capacity in T&O started Feb.
- CCG offer of Spire for additional capacity and patients going via CCG Choose and Book Service.
- Nuffield have now reached capacity for T&O until mid-April. No further patients to be sent until 2022/23 contracting arrangement confirmed.
- Ramsay continue to treat patients to contract but again their admin processes are impacting on our numbers reported. This has improved with renewed focus on chasing for missing discharge summaries/patient updates.
- Referral Hub has been scoped and further developed to encompass triage functions as well as investigation requesting and review and discharge if necessary or handover to internal team.
- Work with Deloitte to understand capacity across the region completed. Cataract patients have largely declined to transfer due to transportation issues (UHNM funding taxis being investigated). Hand/foot and Hernia transfers underway.

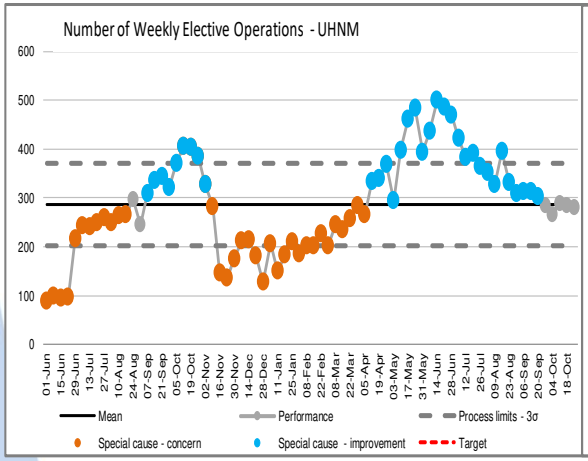
Actions

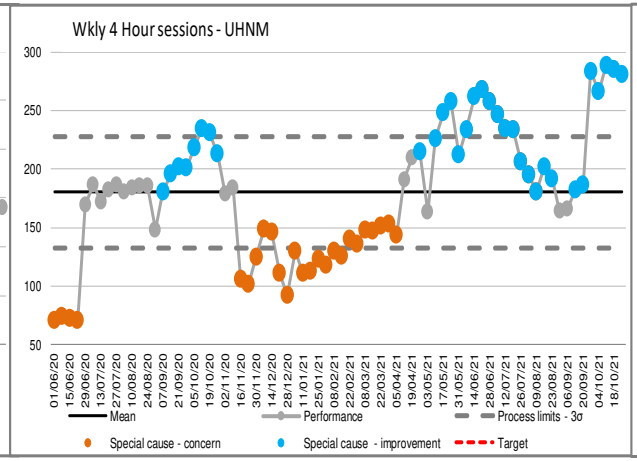
- Progressing resource plan to support increased validation for Q4.
- Progressing with transferring additional patients to the IS on the back of Deloitte or own internal reviews of capacity.
- Demand scoping for 22/23 IS underway to influence IS capacity available.
- Elective Storyboard and Slide set finalised that covers off internal and external performance measures for assurance of a consistent approach to tracking activity linked to performance. Shared with Regional Director of Performance at NHSEI and well received.
- Corporate validation plan currently being rewritten alongside external validation support to ensure a clean PTL and highlight areas for targeted training.
- Theatres have completed Q4 capacity plan to deliver 89.5% of 19/20 activity. Booking processes reviewed & improved.
- Training continues on RTT for new staff and where post validation has found incorrect actioning of pathway for staff to be retrained. Extra training capacity sought to provide clinciian & refresher training, as well as “at elbow” bespoke training & support for groups of staff.

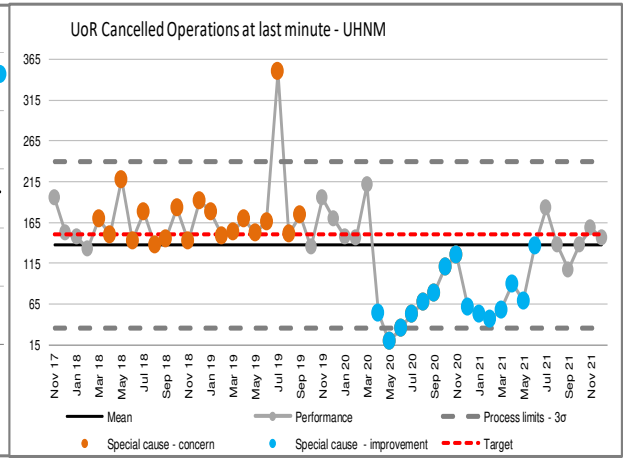
Planned care – *Inpatient Activity*











Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Planned care - *Outpatients*

NHS University Hospitals of North Midlands NHS Trust

Summary

- For January (as at 07/02) , the total outpatient actuals against BAU for outpatients was 100%. This is higher in follow ups than new (90% New, 106% follow up).
- OP Cell A3 work has helped to define current overall waiting list position by category; vs pre covid increase of 15,000 (6.5%) to 250,000, and increase in those >52 weeks (vs Review Date) by 7,800 (200%) to c.12,000 (half of increase attributable to use of Review Date). As at 30/01/2021, total WL has increased further to 263,000. Recent increases in the waiting list attributed to 2 categories; New (18 weeks) & Follow Up Backlog.
- Reduction from 11,631 (end of June) to 10,010 (25th July) in >52 week patients (14%). Further reduction to 9,184 as at 5th September (21% vs end of June). Up to 9,989 as at 30th January; has been at a similar level for last 13 weeks.

RTT

- The overall Referral To Treatment (RTT) Waiting list continues to rise. For January the indicative number of Incomplete pathways has risen to 71,382 (December 70,951).
- The number of patients > 18 weeks has risen to a level of 32,147 (December 31,599).
- The numbers of 52 week waits in January has increased with a reported 4,463 (December 4,393) this figure is below the trajectory.
- At the end of January the numbers of > 104 weeks reported were 521. The Planned Care group is monitoring progress against treatment plans for these patients.
- Performance has slightly decreased at 55.0% (December 56.0%).
- Work plans around long wait patient validation and treatment tracking are in progress

Planned care - *Outpatients*

NHS University Hospitals of North Midlands NHS Trust

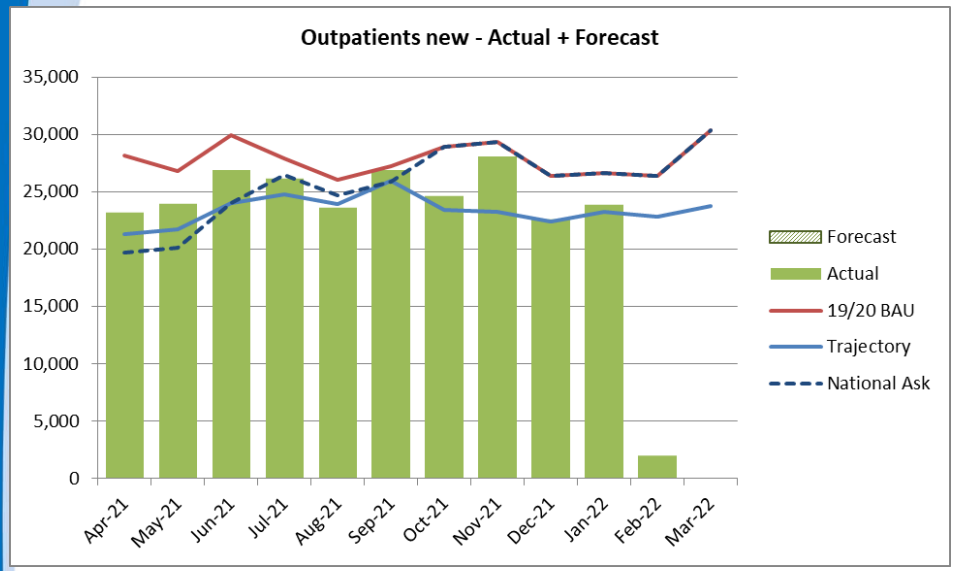
Actions

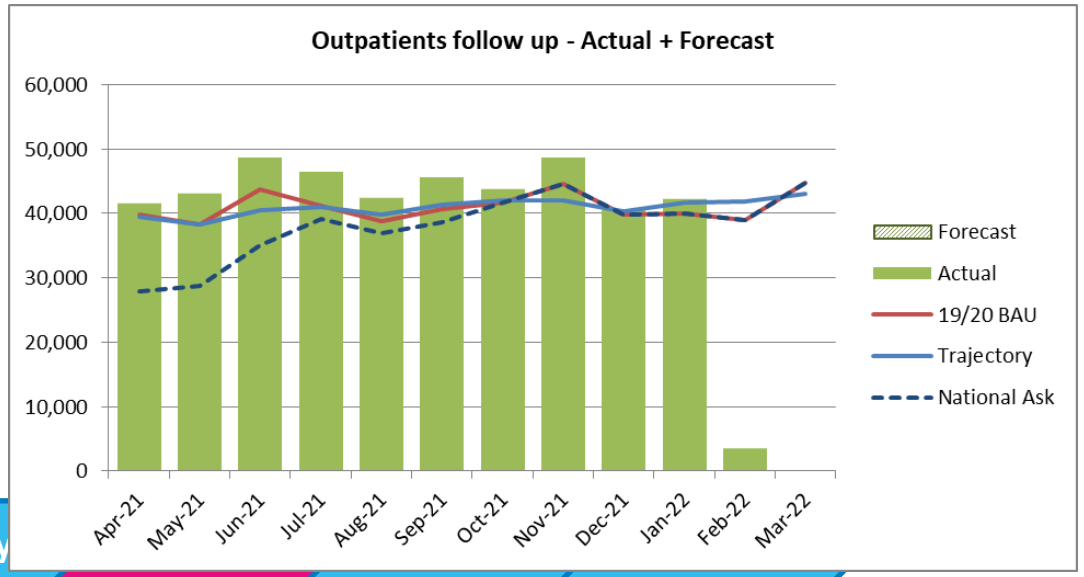
- Key actions identified around Divisional Waiting List Management with a focus on validation, data quality and >52 weeks patients. Clear reporting now in place to support this approach. Divisions have fed back details of their plans relating to OP New Waits >16 weeks & >52 week patients. Check and Challenge meeting planned for March for New Waits (104/78/52/21 wks), plus review of follow ups.
- ASI performance reports actively monitored (with live reporting now available); assurances around triage processes and clinical prioritisation of new patients provided from Divisions.
- Outpatient Service Delivery & Performance workstream delivering vs. plans for Partial Booking Rollout, Netcall Rollout, CAF Issues Action Plan, and OP Clinic Process vs. Maturity model. Review Date training prioritised; DQ Alert circulated & Quick Reference Guides created, plus floor walking support. Wider training plan being developed with Ongoing input into Trust training considerations (systems & processes), and links to DQ group.
- Enhanced Advice & Guidance sub workstream (linking with system). Task & Finish Groups for Urology, Neurology, Respiratory and Gastro to take actions forward to increase A&G, develop pathways FAQs. Work commenced to directly contact 21 GP practices not using A&G and a further 32 practices with a high volume of referrals and less than 12% A&G usage. CCG developing training cohorts for PLT to include A&G and liaising directly with practice managers to increase awareness & uncover barriers.
- PIFU sub-workstream rolling out vs plan. Regular meetings with 7 live specialties (neurology & plastics went live in January), including information sharing NHSE meeting re heart failure in cardiology; meetings with ENT & T&O to discuss specific pathways & work through checklist. Watch & wait report / benchmarking used to identify potential target areas for PIFU. Actions around Discharge to PIFU approach to support wider rollout. Plan to more formally contact all specialties in February to further identify existing and potential PIFU pathways.
- Submissions to Elective Recovery Fund in place for A&G & PIFU. Consultant Connect data is included and confirmed, community RAS data now included and backdated. Method of recording of PIFU removals/conversions still to be determined; testing option of PIFU flag for recording activity.
- Virtual Care 25%; SUS submission 'fix' implemented from Nov 2021 (with BI); longer term, alignment of clinic booking and media type outcomes.
- Elective Recovery 2022/23; narrative plan submissions due in February for EAG (16% target), PIFU (5% target) & Virtual Care (25% target).

Risks:

- Deteriorated waiting list position vs pre-covid; volume of patients requiring DQ and clinical validation very challenging, on Divisional Risk Registers.
- Need to increase FTF activity in some OP areas, restricted by social distancing, 1m+ plans discussed, subject to approval.
- PIFU H2 end target of 2% of all outpatient activity moved or discharged to PIFU (1.5% by December). Whilst achieving rollout to initial specialties in low volumes, shortfall projected currently against this target (nationally an issue). Actions identified to extend rollout and close the gap as outlined above, moving towards 5% March 2023 target including all 'major' outpatient specialties. Meeting Feb with NHSE for further support /advice.
- H2 planning guidance has confirmed a target of at least 12% A&G requests (achieving 16.2% Nov) when compared to new referrals by March 2022.

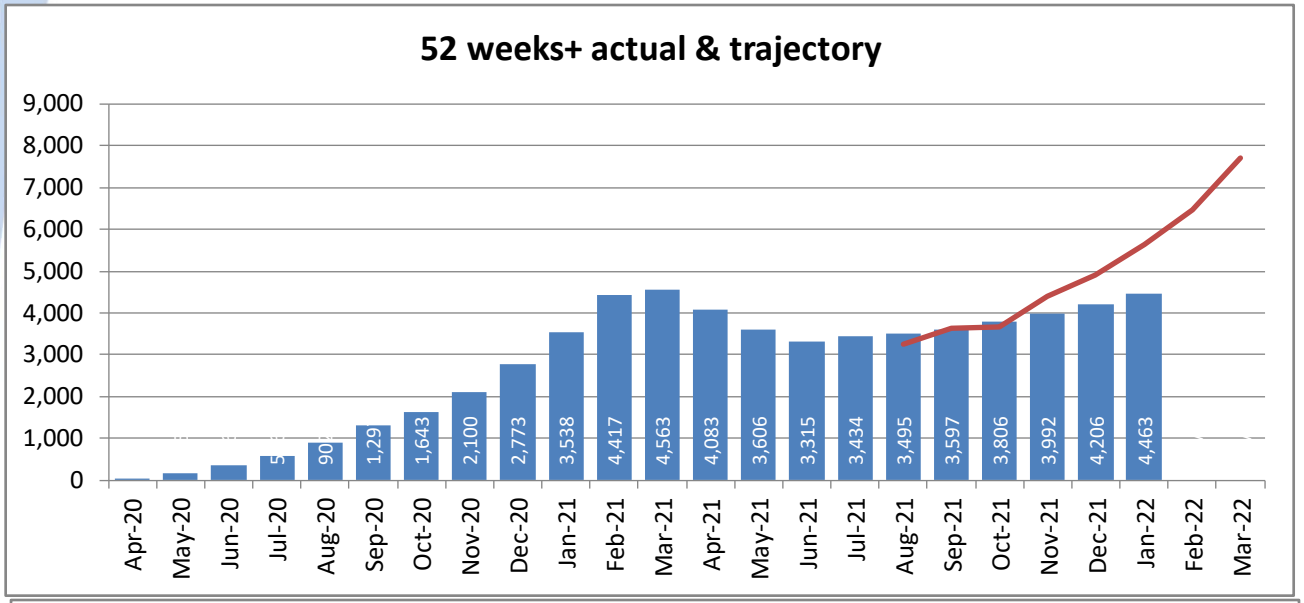
Planned care – *Outpatient activity & RTT*





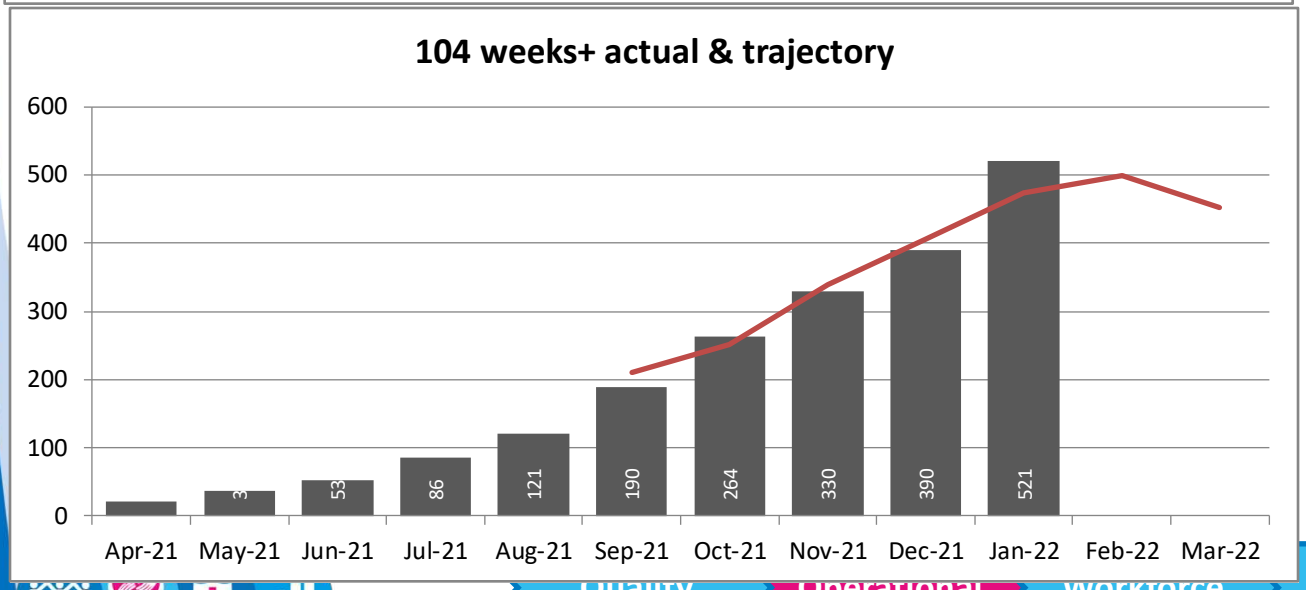
Quality

Planned care – *RTT Trajectories*



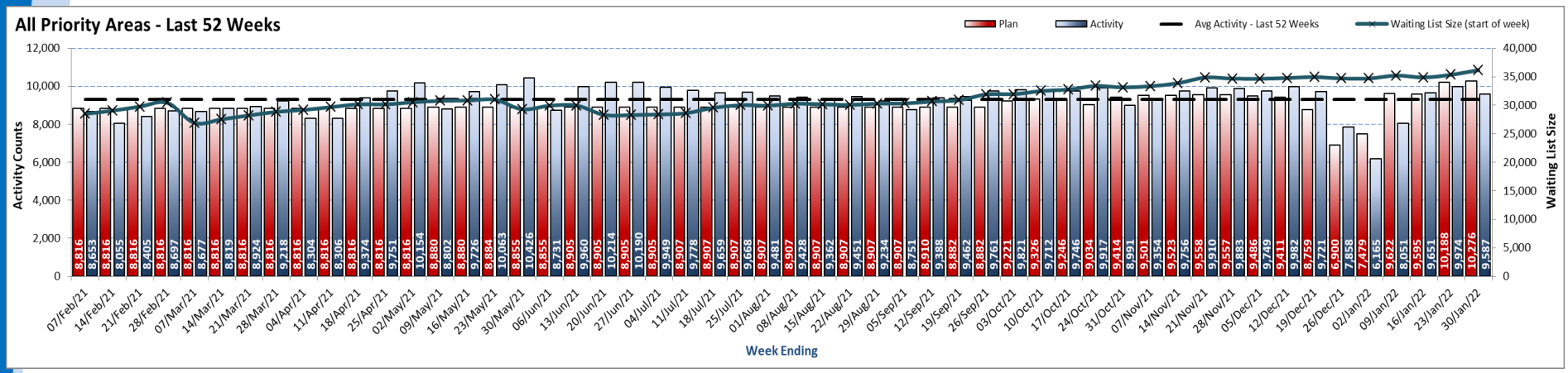
52 Week Waits are expected to increase over the next 3 months with a total of 7,721 at the end of March.

The Trust is currently ahead of trajectory and expecting to finish well ahead of trajectory. Current number of patients at risk of breaching 52 weeks by end of is 6,444.



104 Week Waits are also expected to increase before decreasing throughout March.

Diagnostic Activity



Summary

- For DM01 (15 nationally identified Dx tests) the validated position for total waiting list has increased in December from 20,134 to 20,665. The Non-obstetric ultrasound waiting list reduced slightly from 9,935 to 9,382. Due to the challenges in Non-Obstetric Ultrasound this has adversely affected performance. The current DM01 diagnostic performance for December 21 is at 68% (November 69 %).
- Within DM01, the greatest proportion of > 6 week waits are within Non-obstetric ultrasound and endoscopy. The ultrasound position is related to an increase in demand alongside workforce shortfalls, a number of actions are in place. Non obstetric ultrasound performance remains a Driver Metric for CWD and has specific focus for improvement, albeit this is related to workforce retention, recruitment and innovative ways to train and recruit.
- DM01 performance excluding non obs ultrasound would be c93%.
- A recovery plan is being developed within the Diagnostic Cell, this will include identification of temporary and longer term resources required.
- Capacity and Demand work is being planned in the next quarter and is reliant on Information services capacity.
- Histology and Endoscopy remain high risk areas both have plans for improvement. A Quality Summit on 15th February is planned for pathology.
- Plain film is also an area with a high volume of waiters.
- Neurophysiology service experienced a deterioration in DM01 performance in late Dec / early January further plans to extend locums and workforce support is being progressed.

Diagnostic Activity

NHS University Hospitals of North Midlands NHS Trust

Areas of Concern:

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

Impact :

Turnaround times not to required standard for some specialties for Cancer and non-cancer
Delays in results available for MDT and / or patient treatment – delayed treatment risk.
Increase in outsourcing and locum costs
Increasing staff sickness due to workplace pressures

Mitigation:

- A remedial plan has been developed with Transformation team and Network partners.
- 2wte consultants were appointed on 28.01.22, plans for an overseas specialty Dr to be appointed during Feb and 4 further consultants from April 2022
- A comprehensive Action Plan is being progressed which supports improvements in admin, laboratory processes and reporting capacity
- A new approach to recruitment for lower band posts in the lab and admin will be progressed

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

Impact:

Increase in waiting times and backlog for non urgent scans
Inability to meet DM01 standards
Increased stress for current staff, Poor patient experience
Delays in the scanning and return of patient reports from the Independent Sector provider

Mitigation:

Approval of funding for temporary Independent Sector Capacity – now in place – scanning c 900 patients per month
Continuing to try to source locum sonographers
Reviewing workforce plans and AFC banding in line with other Trusts
Extension of bank rates for sonographers

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

Impact:

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

Mitigation:

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

APPENDIX 1

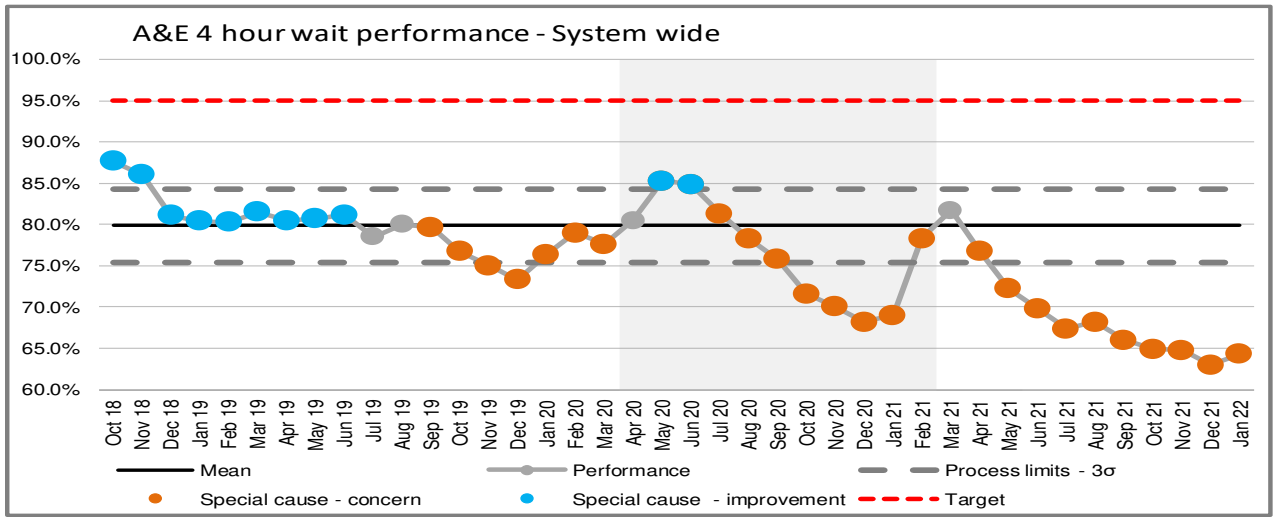
Operational Performance

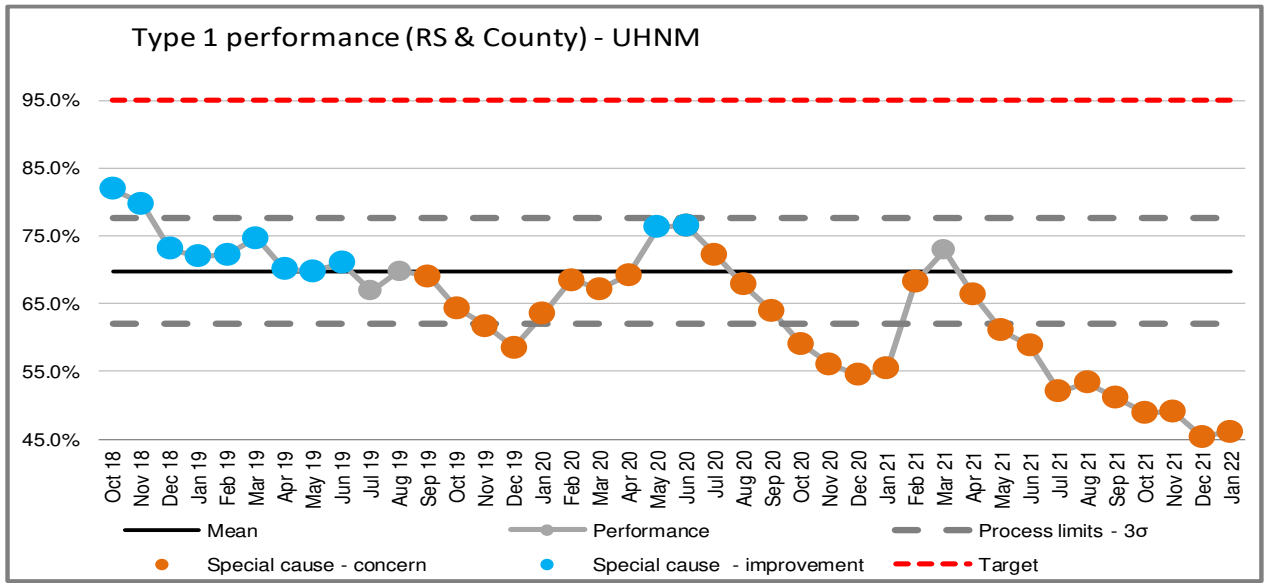
Constitutional standards

	Metric	Target	Latest	Variation	Assurance	DQAI
A&E	A&E 4 hour wait Performance	95%	64.30%	L	F	
	12 Hour Trolley waits	0	372	H	?	
Cancer Care	Cancer Rapid Access (2 week wait)	93%	47.18%	L	?	
	Cancer 62 GP ref	85%	44.75%	L	?	
	Cancer 62 day Screening	90%	61.90%		?	
	31 day First Treatment	96%	85.26%	L	?	
Elective waits	RTT incomplete performance	92%	54.96%	L	F	
	RTT 52+ week waits	0	4463	H	F	
	Diagnostics	99%	68.70%	L	F	

	Metric	Target	Latest	Variation	Assurance	DQAI
Use of Resources	DNA rate	7%	7.3%		?	
	Cancelled Ops	150	146		?	
	Theatre Utilisation	85%	76.0%			
Inpatient / Discharge	Same Day Emergency Care	30%	30.1%	H	?	
	Super Stranded	183	205	H	P	
	DToC	3.5%	3.40%		?	
	Discharges before Midday	30%	20.2%		F	
	Emergency Readmission rate	8%	11.8%	L	F	
	Ambulance Handover delays in excess of 60 minutes	10	880	H	F	

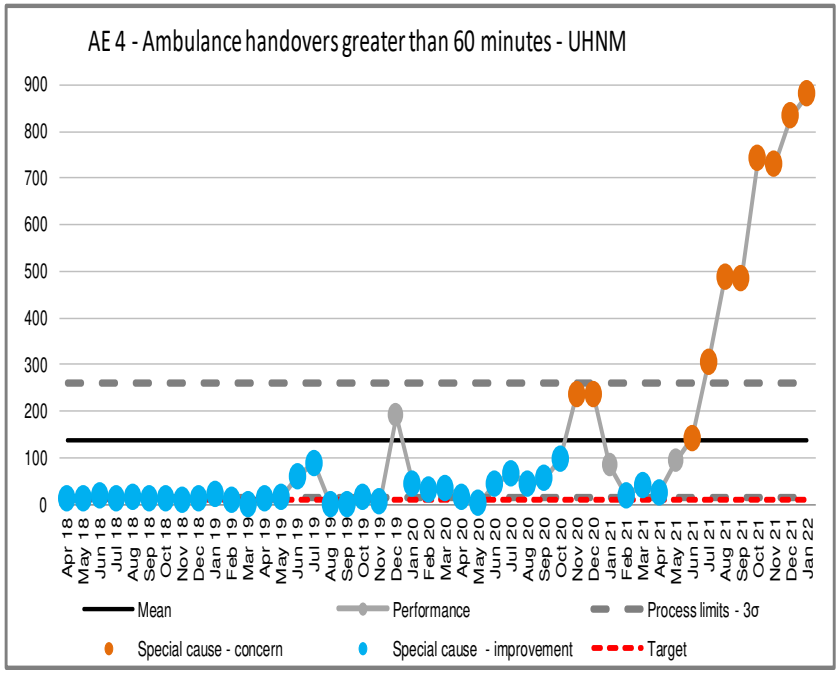
URGENT CARE – 4 hour access performance

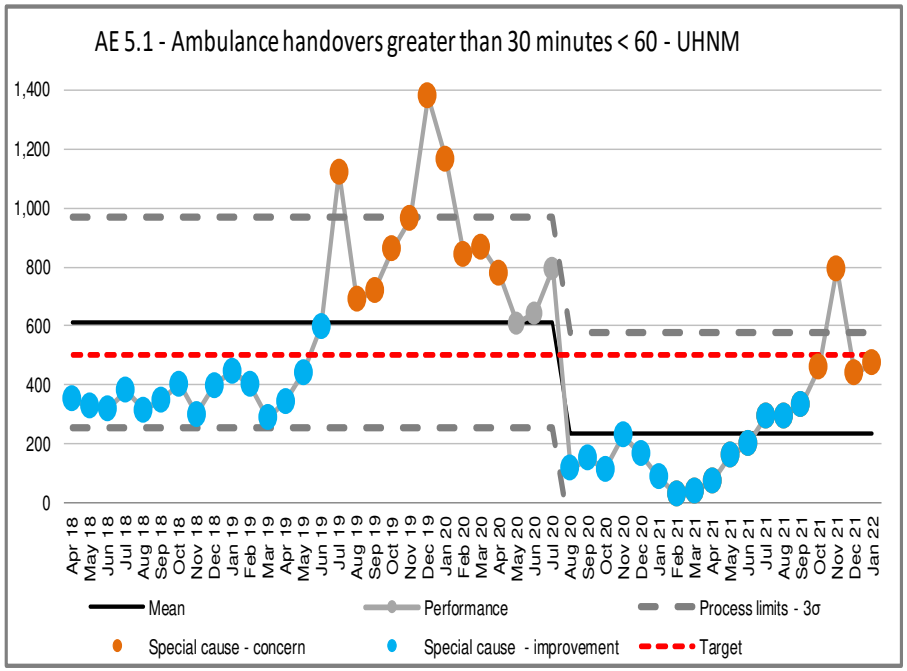




Quality | Operational | Workforce | Finance

URGENT CARE – 4 hour access – ambulance handovers

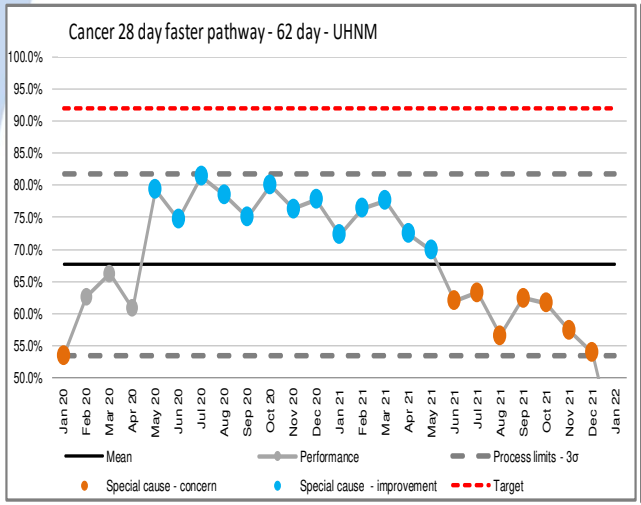


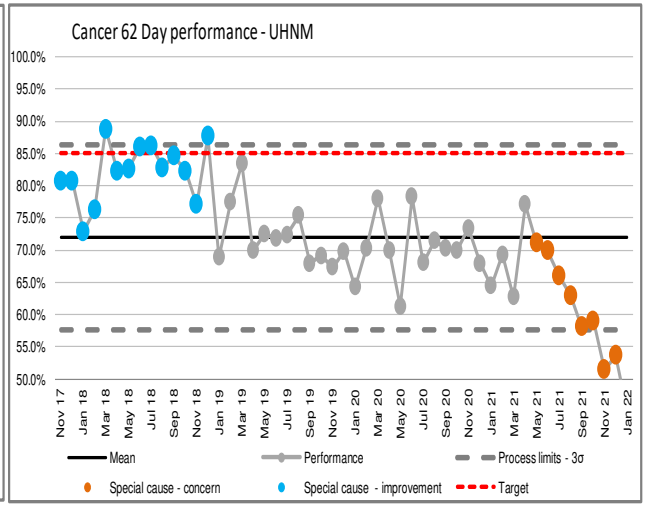


From August – internal validation of > 30 minutes

Quality | Operational | Workforce | Finance

Cancer – 62 Day





Variation	Assurance
	

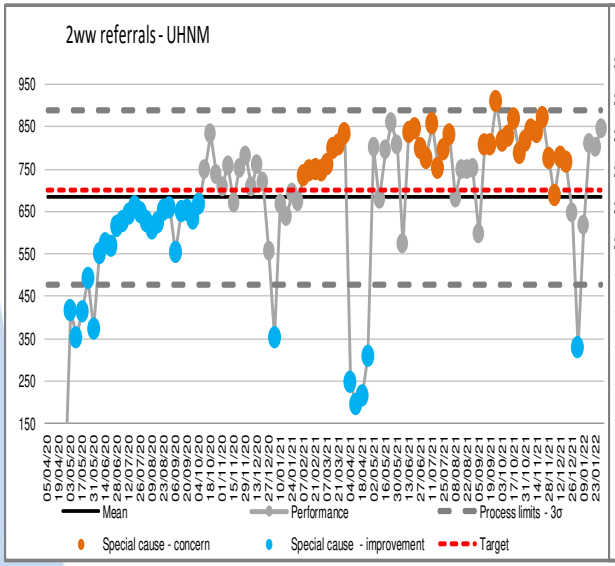
Target	Nov 21	Dec 21	Jan 22
85%	51.4%	53.7%	44.8%

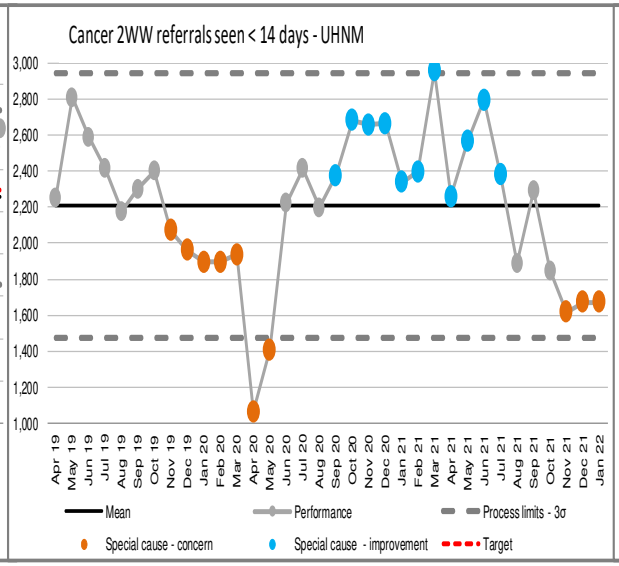
Background

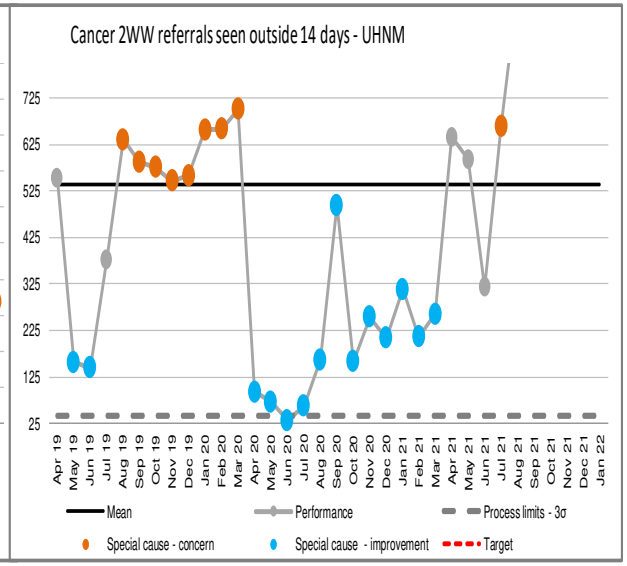
% patients beginning their treatment for cancer within 62 days following an urgent GP referral for suspected cancer

What is the data telling us?

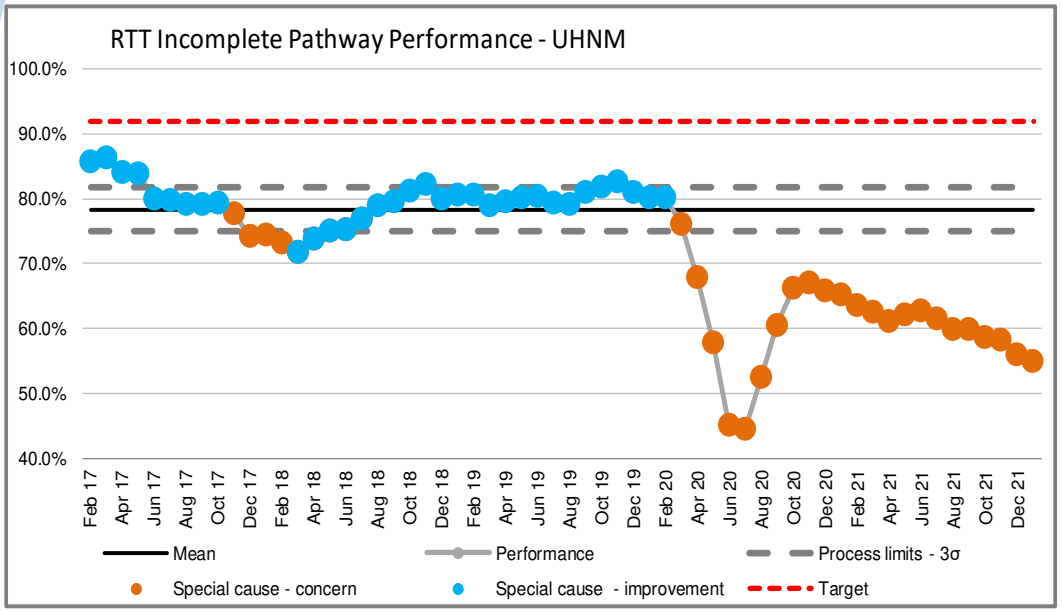
Apart from three occasions the standard has been below the mean since Sept-19.







Referral To Treatment



Variation	Assurance
L	F

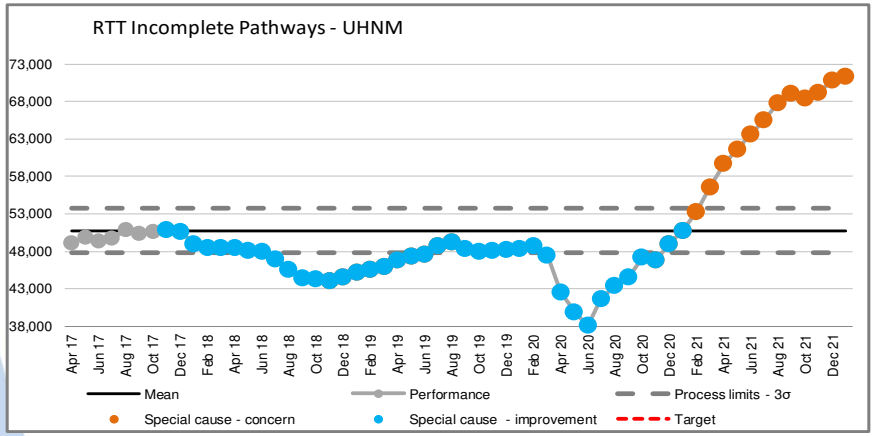
Target	Nov 21	Dec 21	Jan 22
92%	58.2%	56.0%	55.0%

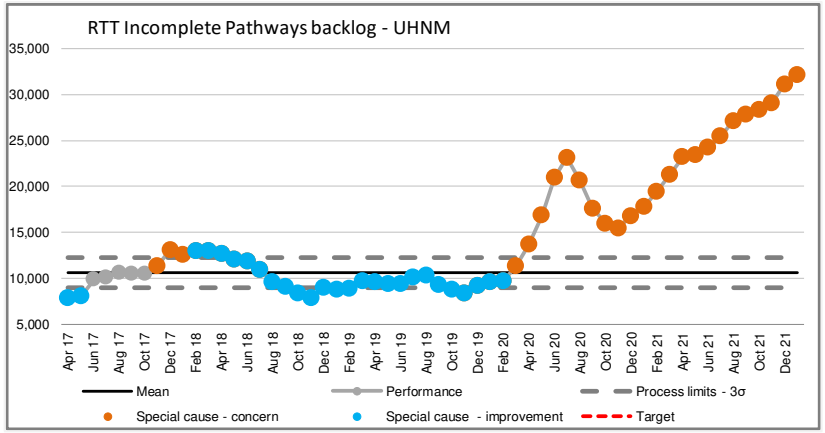
Background

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

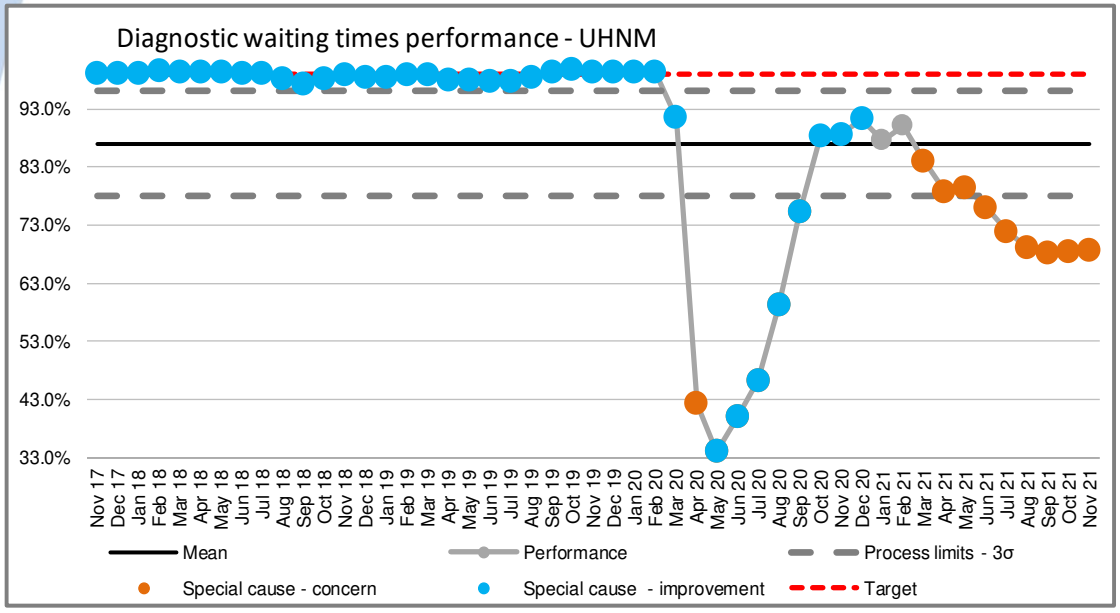
What is the data telling us?

Steady decline in performance since the pandemic began.





Diagnostic Standards



Variation	Assurance
	

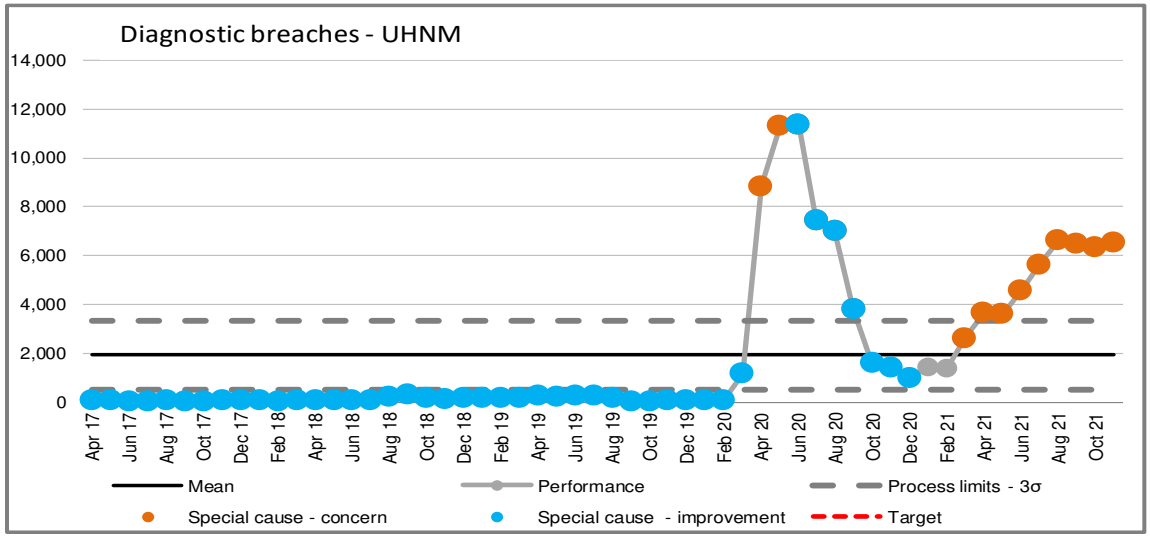
Target	Sep 21	Oct 21	Nov 21
99%	68.1%	68.5%	68.7%

Background

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

What is the data telling us?

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



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Workforce

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

Workforce Spotlight Report

Key messages

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

Resources were diverted to implementing the new mandatory vaccination regulations throughout December and January. On 31 January 2022, the Secretary of State announced that the legislation requiring mandatory vaccination of front line health care workers was to be reconsidered. The Government's decision is subject to Parliamentary process and will require further consultation and a vote to be passed into legislation. As a result, the Trust has stood down the Task and Finish Group responsible for implementing the legislation. However, the Trust does continue to encourage staff to get vaccinated. The guidance from the legal advisors to NHS Employers is to continue with the vaccination rules for new hires until further notice given that the legislation is still in place.

Sickness

The in-month sickness rate was 7.44% (6.23% reported at 31/12/21). The 12 month cumulative rate increased to 5.41% (5.25% at 31/12/21).

Covid-related absence increased significantly from 26th December 2021. At the peak, 5th January saw 1332 staff absences of which 748 (56.16%) were covid-related. Since then, both the total absences and covid-related absence has continued to fall, albeit gradually

The focus remains on areas with high sickness levels, with actions including:

- Assurance meetings taking place in the Divisions, focussing on the top 10 long term and top 10 frequent absences .
- Continued daily monitoring of sickness absences, specifically all COVID related absence and stress related absence.
- Joint focused absence huddles for Medicine and Surgery taking place with the HR Director and Divisional Representatives

Appraisals

The Non-Medical PDR compliance rate was 75.91% (76.18% at 31st December 2021). Central Function and the Surgical Division saw small improvements in January 22. Performance in the remaining Divisions deteriorated. Overall performance remains below target and completion of PDRs was suspended while the Trust was at Critical Incident level

Statutory and Mandatory Training

The Statutory and Mandatory training rate at 31st January 2022 was 95.41% (95.50% at 31st December 2021). This compliance rate is for the 6 'Core for All' subjects only.

At 31st January 22, 91.25% of staff had completed all 6 Core for All modules (91.5% at 31/12/21)

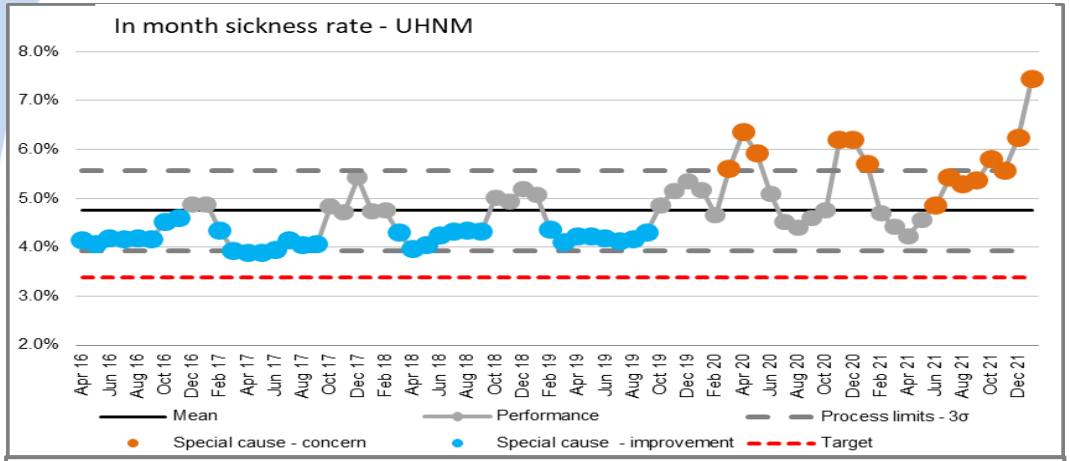
Vacancies

The overall Trust vacancy rate was 11.43% as a result of an uplift in budgeted establishment to account for Winter planning and a decrease in staff in post. Bank and Agency covered 70% of the vacancy position and there is sufficient activity in the recruitment pipeline to cover the vacancies, should all of that activity be converted to staff in post.

Workforce Dashboard

Metric	Target	Latest	Variation	Assurance
Staff Sickness	3.4%	7.44%		
Staff Turnover	11%	10.01%		
Statutory and Mandatory Training rate	95%	95.41%		
Appraisal rate	95%	75.91%		
Agency Cost	N/A	3.22%		

Sickness Absence



Variation	Assurance
H	F

Target	Nov 21	Dec 21	Jan 22
3.4%	5.6%	6.2%	7.4%

Background

Percentage of days lost to staff sickness

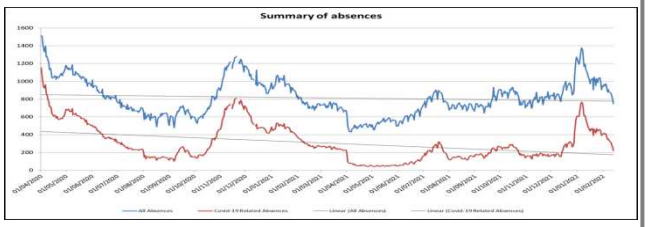
What is the data telling us?

Sickness rate is consistently above the target of 3.4%. The special cause variation from April 2020 is a result of covid-19.

Summary

The in-month sickness rate was 7.44% (6.23% at 31/12/21). The 12 month cumulative rate increased to 5.41% (5.25% at 31/12/21). Covid-related absence increased significantly from 26th December 2021. At the peak, 5th January saw 1332 staff absences of which 748 (56.16%) were covid-related. Since then, both the total absences and covid-related absence has continued to fall, albeit gradually

As of 13th February 2022, covid related open absences* numbered 222 which was 29.72% of all absences (46.17% at 14th January 2022) [**includes absences resulting from adhering to isolation requirements*]



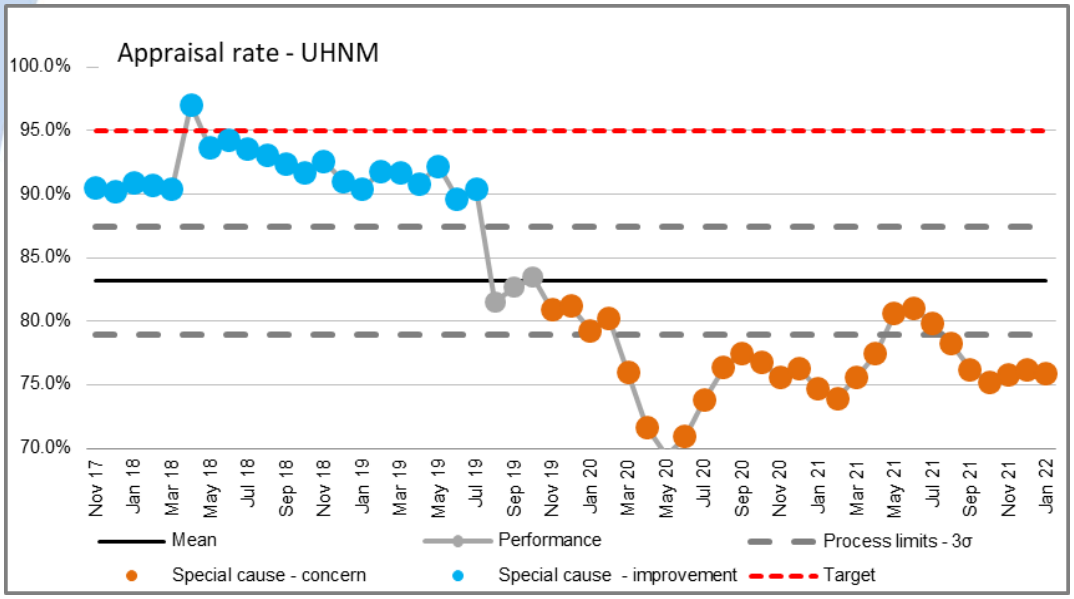
On 31 January 2022, the Secretary of State announced that the legislation requiring mandatory vaccination of front line health care workers was to be reconsidered. (subject to Parliamentary process prior to becoming legislation). As a result, the Trust has stood down the Task and Finish Group responsible for implementing the legislation. However, the Trust continues to encourage staff to get vaccinated and guidance from the legal advisors to NHS Employers is to continue with vaccination rules for new hires until further notice, given that the legislation is still in place

Actions

The focus remains on areas with high sickness levels, with:

- Assurance meetings taking place in the Divisions with a focus on the top 10 long term and top 10 frequent absences by specialty.
- Continued daily monitoring of sickness absence rates, specifically all COVID related absence and stress related absence.
- Joint focused absence huddles for Medicine and Surgery taking place with the HR Director and Divisional Representatives
- Improved access to Empactis so that non-clinical staff can support clinical managers during this of significant Trust pressures. Targeted training is taking place early in 2022 with areas with compliance with Empactis requirements is low.
- Daily monitoring on the numbers of overdue absences with targeted intervention

Appraisal (PDR)



Variation	Assurance
L	F

Target	Nov 21	Dec 21	Jan 22
95.0%	75.8%	76.2%	75.9%

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

The Non-Medical PDR compliance rate was 75.91% (76.18% at 31st December 2021)

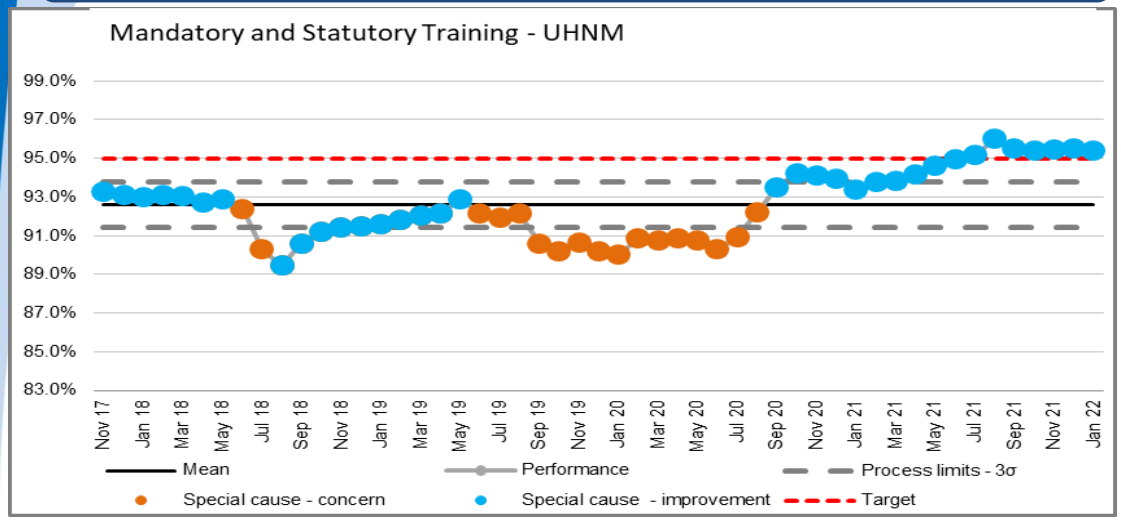
Central Function and the Surgical Division saw small improvements in January 22. Performance in the remaining Divisions deteriorated.

Overall performance remains below target.

Actions

Completion of PDRs has been suspended while the Trust is at Critical Incident level

Statutory and Mandatory Training



Variation	Assurance
H	F

Target	Nov 21	Dec 21	Jan 22
95.0%	95.5%	95.5%	95.4%

Background

Training compliance

What is the data telling us?

At 95.41%, the Statutory and Mandatory Training rate is better than the Trust target for the core training modules

Summary

The Statutory and Mandatory training rate at 31st January 2022 was 95.41% (95.50% at 31st December 2021). This compliance rate is for the 6 'Core for All' subjects only

At 31st January 22, 91.25% of staff had completed all 6 Core for All modules (91.5% at 31/12/21)

Competence Name	Assignment Count	Required	Achieved	Compliance %
205|MAND|Security Awareness - 3 Years|	10556	10556	10028	95.00%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	10556	10556	10089	95.58%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	10556	10556	10037	95.08%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	10556	10556	10067	95.37%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	10556	10556	10078	95.47%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	10556	10556	10131	95.97%

Compliance rates for the Annual competence requirements were as follows:

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 1 Year|	10613	10613	9201	86.70%
NHS|CSTF|Information Governance and Data Security - 1 Year|	10613	10613	9445	88.99%

Actions

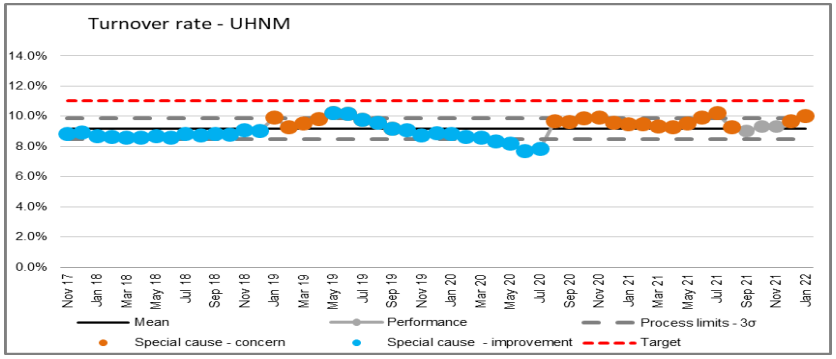
We continue to raise the issue of compliance with Divisions and communicate to staff the need to complete statutory and mandatory training.

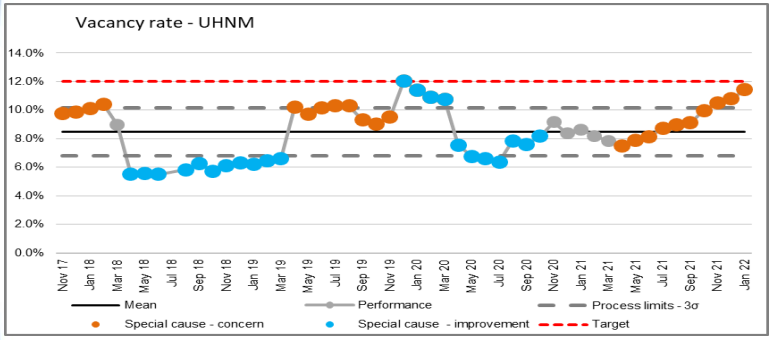
Compliance is monitored and raised via the Divisional performance review process.

Workforce Turnover

NHS
University Hospitals of North Midlands
NHS Trust

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





The overall Trust vacancy rate is calculated as Budgeted Establishment less staff in post.
The vacancy rate is influenced by an increase in budgeted establishment to account for the Winter Workforce Plan as well as approved business cases

Variation	Assurance
H	P

Target	Nov 21	Dec 21	Jan 22
11.0%	9.3%	9.7%	10.0%

Background

Turnover rate

What is the data telling us?

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

Benchmarking

Regional vacancy benchmarking data is available via NHS Digital. The data is only updated quarterly and the latest available data is Sept 2021. The UHNM position, compared to the regional vacancy rates was as follows:

Vacancy Rates (Regional)	Jun-21	Sep-21
London	9.0%	9.6%
East of England	8.3%	8.6%
UHNM	8.1%	9.1%
Midlands	7.8%	8.3%
Median	7.4%	7.7%
South East	7.6%	7.0%
North West	6.2%	6.5%
NE & Yorkshire	5.7%	5.4%
South West	5.4%	5.0%

Summary

The 12m Turnover rate was 10.01% (9.67% at 31/12/21).
Staff in post decreased in January 2022 by 22.58fte, and budgeted establishment increased by 56.42fte. This increased the vacancy position by 79.0fte, and the in-month vacancy rate to 11.43%. Bank and Agency covered 70% of the vacancy position and there is sufficient activity in the recruitment pipeline to cover the vacancies, should all of that activity be converted to staff in post. In addition to the Recruitment pipeline, mitigations against the vacancy position include offering Additional PA's; extended / increased hours; On call payments and overtime. The Trust also uses Bank & Agency to cover gaps in staffing and, when necessary, will redeploy staff internally . Staff are also supported by our student cohorts and volunteer groups

Vacancies at 31 Jan 22	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous month %
Medical and Dental	1,468.80	1,263.85	204.95	13.95%	13.89%
Registered Nursing	3367.08	2922.55	444.53	13.20%	12.83%
All other Staff Groups	6430.71	5792.63	638.08	9.92%	8.99%
Total	11,266.59	9,979.03	1,287.56	11.43%	10.78%

Staff in post decreased in January 2022, and budgeted establishment increased. This resulted in an overall increase in the vacancy position by 79.0fte

Actions

The Trust is working to accelerate recruitment plans where possible, including for healthcare support workers.

Together Compassion Safe Improving

Finance

2025 Vision "Ensure efficient use of resources"

Finance Spotlight Report

University Hospitals of North Midlands NHS Trust

Key messages

- The Trust set a plan at the start of the year for a H1 surplus of £8.3m and a full year deficit of £8.8m. The guidance for H2 was issued in September 2021 and at both a National and System level an agreement was reached that the Trust was to carry forward the surplus of £14.5m delivered in H1 and therefore the planned position for H2 was a £14.5m deficit to achieve a breakeven plan for the financial year ending 31 March 2022. Since then, the Trust has worked through the submitted activity plans and calculated an expected income of £5.1m against the Elective Recovery Fund. Therefore in November 2021, the Trust formally submitted a revised annual plan of a £5.1m surplus for the financial year ending 31 March 2022.
- The Trust has delivered an actual deficit of £0.4m in month against an in month planned surplus of £0.5m and a year to date surplus of £15.1m resulting in a favourable variance of £7.5m against the year to date plan. The positive position against plan in month is primarily driven by underspends against non-recurrent investment funds.
- A full year forecast has been undertaken at Month 9 and reviewed at Month 10 which presents a £5.2m surplus. This includes material movements expected in Q4 including no ERF income and a release of part of the prior year annual leave accrual.
- The Trust incurred £1.4m of costs relating to COVID-19 in month which is an increase of £0.3m compared with Month 9's figure. This remains within the Trust's YTD fixed allocation with £0.7m being chargeable on top of this allocation for COVID-19 testing costs.
- Capital expenditure for the year to date stands at £20.4m which is £2.5m behind the plan mainly due to an underspend relating to digital pathology and estates infrastructure.
- The cash balance at Month 9 is £82.4m which is £2.9m higher than plan, the main reason being lower than forecast capital payments which reflects the overall slippage against the capital plan.

Finance Dashboard

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

Income & Expenditure

Income & Expenditure Summary Month 10 2021/22	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Income From Patient Activities	868.6	73.7	71.3	(2.4)	725.1	722.7	(2.4)
Other Operating Income	89.8	7.8	8.4	0.6	74.3	74.6	0.3
Total Income	958.4	81.6	79.7	(1.8)	799.4	797.3	(2.1)
Pay Expenditure	(561.7)	(48.5)	(46.3)	2.1	(464.8)	(455.2)	9.7
Non Pay Expenditure	(338.0)	(28.2)	(29.4)	(1.2)	(282.3)	(282.2)	0.2
Total Operational Costs	(899.7)	(76.6)	(75.7)	0.9	(747.2)	(737.3)	9.8
EBITDA	58.7	4.9	4.0	(0.9)	52.2	59.9	7.7
Depreciation & Amortisation	(29.9)	(2.5)	(2.5)	(0.0)	(25.0)	(25.1)	(0.1)
Interest Receivable	0.1	0.0	0.0	(0.0)	0.1	0.0	(0.1)
PDC	(7.6)	(0.6)	(0.6)	0.0	(6.4)	(6.4)	0.0
Finance Cost	(16.1)	(1.3)	(1.3)	0.0	(13.4)	(13.4)	0.0
Other Gains or Losses	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Surplus / (Deficit)	5.1	0.5	(0.4)	(0.9)	7.6	15.1	7.5
Financial Recovery Fund	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	5.1	0.5	(0.4)	(0.9)	7.6	15.1	7.5

The Trust delivered a £0.4m deficit for Month 10 against a planned surplus of £0.5m and a year to date surplus position of £15.1m against a planned surplus position of £7.6m; the main variances in month are:

- Income from patient activities has underperformed in month primarily due to ERF as the trust has received no ERF income in month against a plan of £3m.
- Other operating income has over performed in month and this is primarily driven by an updated HEE education contract received in Month 10 (£0.4m).
- Pay is underspent in month by £2.1m which is primarily driven by underspends across registered nursing and NHS infrastructure (see Winter detail below) and non-recurrent funding underutilised in month for the System Elective Recovery fund and the System Workforce Funding.
- Non-pay is overspent against plan in month by £1.2m primarily due to continued spend above budget in respect of pass-through drugs for which we have received additional income.

Capital Spend

NHS University Hospitals of North Midlands NHS Trust

Capital Expenditure as at Month 10 2021/22 £m	Revised 2021/22 Plan	2021/22 year end forecast	In Month			Year to Date		
	Plan	Actual	Budget	Actual	Variance	Budget	Actual	Variance
PFI & finance lease liability repayment	(9.2)	(9.2)	(0.8)	(0.8)	-	(7.6)	(7.6)	-
Pre-committed items	(9.2)	(9.2)	(0.8)	(0.8)	-	(7.6)	(7.6)	-
PFI lifecycle and equipment replacement	(5.3)	(5.3)	(0.2)	(0.2)	-	(1.7)	(1.7)	-
PFI enabling cost	(0.8)	-	-	-	-	-	-	-
PFI related costs	(6.1)	(5.3)	(0.2)	(0.2)	-	(1.7)	(1.7)	
RI demolition	(0.9)	(1.2)	(0.2)	(0.2)	(0.0)	(0.9)	(0.9)	(0.1)
Project STAR multi-storey car park	(1.2)	(1.2)	(0.1)	(0.1)	(0.0)	(0.8)	(0.8)	-
Thornburrow decant office accommodation	(1.9)	(2.0)	-	(0.0)	(0.0)	(1.9)	(2.0)	(0.1)
Wave 4b Funding - Lower Trent Wards	(2.2)	(2.2)	(0.2)	(0.2)	0.1	(1.9)	(1.4)	0.5
CT7 scanner enabling cost	(1.2)	(0.1)	-	-	-	-	-	-
STP diagnostic Funding and Cancer funding CT7	(1.0)	(1.0)	-	-	-	-	-	-
PDC funding - elective recovery (critical care) TIF	(0.3)	-	-	-	-	-	-	-
PDC funding - elective recovery (CTS/theatre) TIF	(1.5)	-	-	-	-	-	-	-
PDC funding Cyber Security/Home working TIF	(0.3)	(0.1)	-	-	-	-	-	-
PDC funding - Unified Tech funding	(1.6)	(1.5)	-	-	-	-	-	-
PDC funding - Digital Maternity Tech funding	(0.3)	(0.1)	-	-	-	-	-	-
PDC funding - Imaging Academy	(0.5)	(0.5)	-	-	-	-	-	-
PDC funding - Radiology digital	(0.5)	(0.5)	-	-	-	-	-	-
PDC funding - Pathology digital diagnostics	(0.2)	(0.2)	-	-	-	-	-	-
PDC funding - LIMS	(0.4)	(0.4)	-	-	-	-	-	-
Schemes funded by PDC and Trust funding	(14.0)	(11.0)	(0.5)	(0.5)	0.0	(5.4)	(5.2)	0.2
LIMS (Laboratory Information Management System)	(0.6)	(0.7)	(0.0)	(0.1)	(0.0)	(0.6)	(0.4)	0.2
EPMA (Electronic Prescribing)	(0.5)	(0.5)	(0.0)	(0.0)	0.0	(0.3)	(0.3)	0.0
Completion of RSUH ED doors	(0.2)	(0.2)	-	-	-	(0.2)	(0.2)	0.0
Pathology integration	(0.3)	(0.3)	-	-	-	-	(0.1)	(0.1)
Medical devices fleet replacement	(0.7)	(0.7)	-	-	-	-	(0.0)	(0.0)
Schemes with costs in more than 1 financial year	(2.3)	(2.5)	(0.1)	(0.1)	(0.0)	(1.1)	(1.0)	0.1
2021/22 schemes	(15.4)	(16.5)	(0.7)	(0.9)	(0.2)	(7.1)	(4.9)	2.2
Donated/Charitable funds expenditure	(0.7)	(0.7)	(0.1)	(0.1)	-	(0.7)	(0.7)	-
Charity funded expenditure	(0.7)	(0.7)	(0.1)	(0.1)	-	(0.7)	(0.7)	-
Overall capital expenditure	(47.0)	(44.5)	(2.2)	(2.4)	(0.2)	(23.0)	(20.4)	2.5

The main variances are explained below.

- Lower Trent is £0.5m behind the revised plan at Month 10 due to delays but is expected to be in line with plan at the year end.
- Estates infrastructure expenditure is £1.1m behind plan mainly due to delays in the Lyme building chiller replacement project (£0.291m), Ward 122 refurbishment (£0.331m), Trent pipework replacement (£0.238m), AHU replacement (£0.261m) and the theatre lighting scheme (£0.117m); expenditure is expected to be in line with plan by the year end.
- Within 2021/22 schemes the Digital Pathology scheme is £0.7m behind plan; this scheme is a finance lease asset as part of the managed equipment scheme. This is expected to be completed by the year-end.
- The scheme to increase to the footprint of the pharmacy dispensary area is £0.5m behind plan due to delays in the legal agreement with Project Co for the changes to the building. There is a potential risk against the remaining in-year expenditure. The Estates team are working to establish the value at risk of not being spent by 31 March 2022 and any mitigating actions.
- The year-end forecast expenditure of £44.5m is £2.5m lower than the plan of £47.0m; this is due to the Trust currently not forecasting to incur £2.5m of expenditure in 2021/22 in relation to the TIF schemes for critical care, County CTS and theatres, digital and maternity digital. There is no agreement to be able to carry forward the TIF funding to 2022/23 and scheme leads are continuing to progress the projects.

Balance sheet

Balance sheet as at Month 10	31/03/2021	31/01/2022			
	Actual £m	Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment	531.2	525.3	523.5	(1.8)	Note 1
Intangible Assets	22.8	17.9	17.8	(0.1)	
Other Non Current Assets	-	-	-	-	
Trade and other Receivables	0.5	0.5	0.5	-	
Total Non Current Assets	554.5	543.7	541.7	(1.9)	
Inventories	15.0	16.5	17.0	0.5	Note 2
Trade and other Receivables	47.4	40.1	44.7	4.6	Note 3
Cash and Cash Equivalents	55.8	79.5	82.4	2.9	Note 4
Total Current Assets	118.2	136.1	144.1	8.0	
Trade and other payables	(98.5)	(105.6)	(104.6)	1.0	Note 5
Borrowings	(8.3)	(8.3)	(8.2)	0.1	
Provisions	(3.6)	(3.6)	(3.5)	0.1	
Total Current Liabilities	(110.4)	(117.6)	(116.3)	1.3	
Borrowings	(268.5)	(260.9)	(261.2)	(0.3)	
Provisions	(2.2)	(2.2)	(2.1)	0.1	
Total Non Current Liabilities	(270.7)	(263.1)	(263.3)	(0.2)	
Total Assets Employed	291.5	299.1	306.3	7.2	
Financed By:				-	
Public Dividend Capital	637.9	637.9	637.9	0.0	
Retained Earnings	(465.3)	(457.7)	(450.3)	7.4	Note 6
Revaluation Reserve	118.9	118.9	118.7	(0.2)	
Total Taxpayers Equity	291.5	299.1	306.3	7.2	

Variances to the plan at Month 10 are explained below:

1. Property, Plant and Equipment is £1.8m lower than plan and reflects the underspend in the capital plan to month 10. The main areas of underspend are the Digital pathology scheme £0.7m, estates infrastructure £1.1m and the expansion of the pharmacy dispensary area £0.6m. This is partly offset by the upward revaluations to Wilfred Place and the crèche at County to reflect the sale of the land.
2. Inventories are £0.5m higher than plan and reflects the inclusion of high cost devices and the recent purchase of ICD devices.
3. Trade and other receivables are £4.6m higher than plan. The main reasons for the variance are accrued income balances in respect of:
    - DHSC transitional support income for 2021/22
    - out of envelope costs not yet reimbursed

   The increases are partly offset by a credit note provision for the Specialised Services block payments in relation to high cost devices where activity has not matched the income received.
4. Cash is £2.9m higher than plan at Month 10, this is mainly due to higher than planned other income and lower than planned capital payments due to slippage in the capital programme.
5. Trade and other payables are £1m lower than plan. This is mainly due to lower than planned capital creditors as a result of the slippage in the capital programme to Month 10. This is partly off-set by higher than planned deferred income in relation to West Midlands Cancer alliance for system development funding.
6. Retained earnings show a variance of £7.4m from plan which reflects the revenue surplus year to date.

Expenditure - Pay and Non Pay

NHS University Hospitals of North Midlands NHS Trust

Pay Summary Month 10 2021/22	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Medical	(170.1)	(14.4)	(14.5)	(0.1)	(141.2)	(140.3)	0.9
Registered Nursing	(163.3)	(14.3)	(13.3)	1.0	(134.5)	(130.1)	4.4
Scientific Therapeutic & Technical	(68.2)	(5.9)	(5.5)	0.4	(56.5)	(54.9)	1.6
Support to Clinical	(75.5)	(6.4)	(6.2)	0.2	(62.9)	(62.5)	0.4
NHS Infrastructure Support	(84.5)	(7.5)	(6.8)	0.7	(69.7)	(67.3)	2.3
Total Pay	(561.7)	(48.5)	(46.3)	2.1	(464.8)	(455.2)	9.7

Pay –Key variances

Within the above budget for Month 10 is £1.3m of reserves which have not been spent (split across numerous expenditure headings) with the main elements being £0.4m for the non-recurrent investment reserve primarily relating to System Elective recovery, £0.4m in respect of Specialised Commissioners and £0.3m against the System Workforce Funding.

The underspend on registered nursing remains in line with the prior year trend as a result of the number of vacancies across the trust. Within the Month 10 budget there is £0.4m of underutilised budget in reserves (part of the £1.3m noted above) and within the Month 10 actual were total premium costs (bank and agency) of £1.4m covering existing workforce vacancies and absences.

Non Pay Summary Month 10 2021/22	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Tariff Excluded Drugs Expenditure	(79.8)	(6.2)	(7.7)	(1.4)	(67.0)	(69.5)	(2.6)
Other Drugs	(24.4)	(2.0)	(2.0)	0.1	(20.3)	(20.3)	0.0
Supplies & Services - Clinical	(88.9)	(7.5)	(7.2)	0.3	(73.5)	(74.3)	(0.8)
Supplies & Services - General	(7.0)	(0.8)	(0.6)	0.1	(5.8)	(6.2)	(0.4)
Purchase of Healthcare from other Bodies	(24.8)	(2.2)	(1.6)	0.6	(20.7)	(18.8)	2.0
Consultancy Costs	(1.9)	(0.1)	(0.1)	0.0	(1.7)	(1.7)	0.0
Clinical Negligence	(25.4)	(2.2)	(2.2)	0.0	(21.9)	(21.9)	0.0
Premises	(32.1)	(2.7)	(3.3)	(0.6)	(27.1)	(28.2)	(1.1)
PFI Operating Costs	(35.5)	(2.9)	(3.0)	(0.0)	(29.5)	(29.5)	(0.0)
Other	(18.2)	(1.4)	(1.8)	(0.3)	(14.7)	(11.7)	3.0
Total Non Pay	(338.0)	(28.2)	(29.4)	(1.2)	(282.3)	(282.2)	0.2

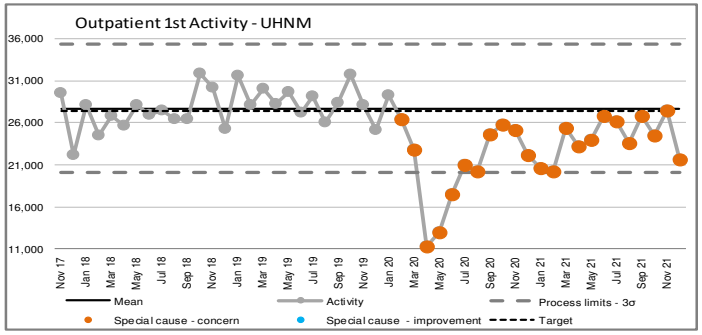
Non Pay key variances:

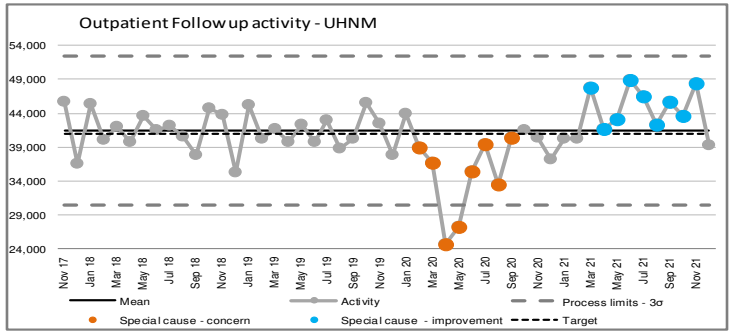
- Tariff Excluded Drugs Expenditure which is overspent in month by £1.4m across numerous specialities; primarily Neurology (£0.4m) and Adult Cystic Fibrosis (£0.3m). Additional income has been received against some of this additional spend.
- Purchase of Healthcare from other Bodies is reporting a variance of £0.6m as a result of an underspend against the System Elective Funding (£0.3m) due to on-going staff absences and an underspend against the IS contract (£0.1m).
- Premises is overspent in month by £0.6m of which £0.2m relates to increased charges for gas and electricity with the remainder relating to additional IT kit and renovation work (part of which the Trust has received commensurate income for).
- Other expenditure shows an overspend in month of £0.3m which is primarily driven by an increase in the bad debt provision in month with £0.2m relating to overseas patients and £0.1m for private patients.

Activity

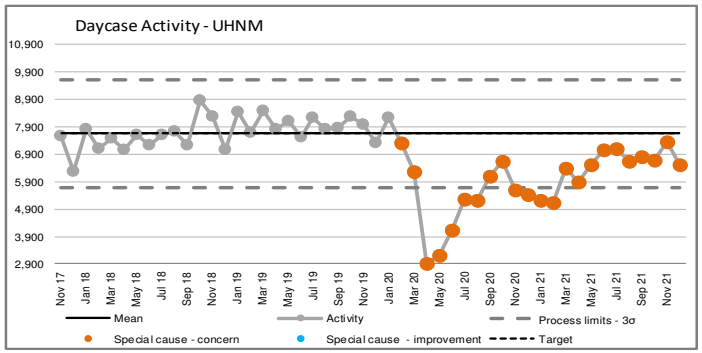
NHS University Hospitals of North Midlands NHS Trust

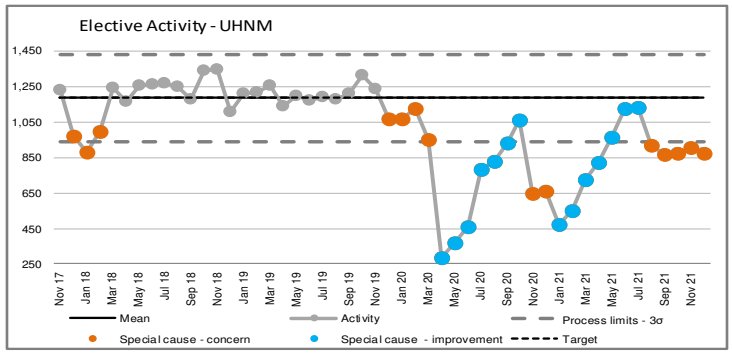
Planned care Outpatient



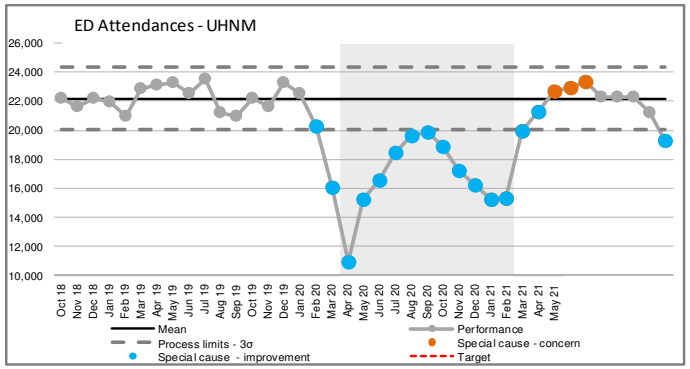


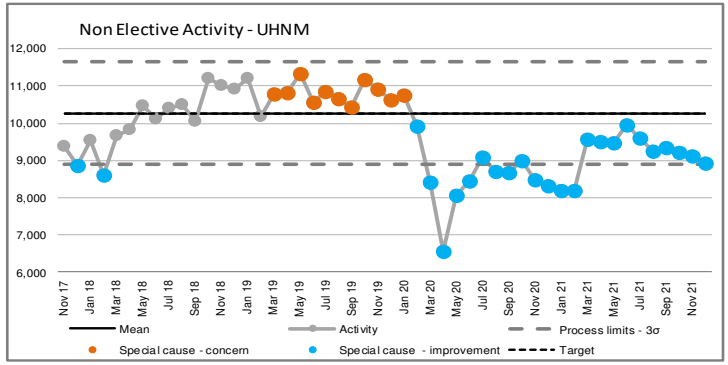
Planned care Inpatient





Urgent Care





Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Executive Summary

Meeting:	Trust Board	Date:	9th March 2022
Report Title:	Gender Pay Gap Report	Agenda Item:	14
Author:	Assistant Director of HR/Head of HR Governance and Workforce Information Workforce Equality Manager		
Executive Lead:	Director of Human Resources		

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

	No associated risks identified.	

Executive Summary

Situation

UK organisations employing 250 or more employees are required to publicly report on their gender pay gap in six different ways:

- the mean gender pay gap
- the median gender pay gap
- the mean gender bonus gap
- the median gender bonus gap
- the proportion of men and women who received bonuses, and
- the number of men and women according to quartile pay bands

Background

The gender pay gap is a measure that shows the difference in average earnings between men and women across an organisation. It is expressed as a percentage of men's earnings. It is important to recognise that the gender pay gap differs to equal pay. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value, which is unlawful.

The issues that surround the gender pay gap and its reporting are complex and the causes are a mix of work, family and societal influences. As employers we will only be able to influence those factors associated with the workplace. The NHS People Plan recognises that to become a modern and model employer the NHS should place a strong emphasis on taking steps to expand opportunities for staff to work more flexibly so that they can achieve a better work-life balance. These are key enablers to increasing the representation of women and removing barriers to progression. Our UHNM People Strategy focuses on developing our culture and supporting all that we do to attract, recruit, develop, retain, support and reward our diverse workforce.

Assessment

This 2021 Gender Pay Gap shows a mixed position, with a slight increase (deterioration) in the median pay gap but decrease (improvement) in the median bonus pay gap (the difference between the mid points in the ranges of hourly earnings of men and women), however the mean gender pay gap has reduced (improved) whilst the mean bonus gap has slightly deteriorated (the difference between the average hourly earnings of women compared to men).

Whilst UHNM has 78 per cent female representation, this is not reflected across all pay quartiles, with men having greater representation in the upper pay quartile, which includes medical and dental staff groups, where women have the least representation of all pay groups.

Key Recommendations

The Trust Board is asked to approve this report and the recommended actions to further improve the Gender Pay Gap at UHNM.

Gender Pay Gap

Introduction

All organisations with 250 or more employees are mandated by the government to report annually on their gender pay gap. The gender pay gap is calculated as the percentage difference between average hourly earnings for men and women and organisations are required to publish information relating to pay for six specific measures outlined in this report.

Equal pay and gender pay

Equal pay means that men and women in the same employment who are performing equal work must receive equal pay, as set out in the Equality Act 2010. The gender pay gap is different to equal pay and is a measure that shows the difference in average earnings between men and women across an organisation or the labour market. It is expressed as a percentage of men's earnings.

UHNM's pay approach supports the fair treatment and reward of all staff irrespective of gender. This is in line with our Equality, Diversity and Inclusion policy. Remuneration to all staff, regardless of gender, is made in accordance with National Terms and Conditions.

This report fulfils the Trust's reporting requirements, analyses the figures in more detail and sets out what we are doing to close the gender pay gap in the organisation. The six measures are:

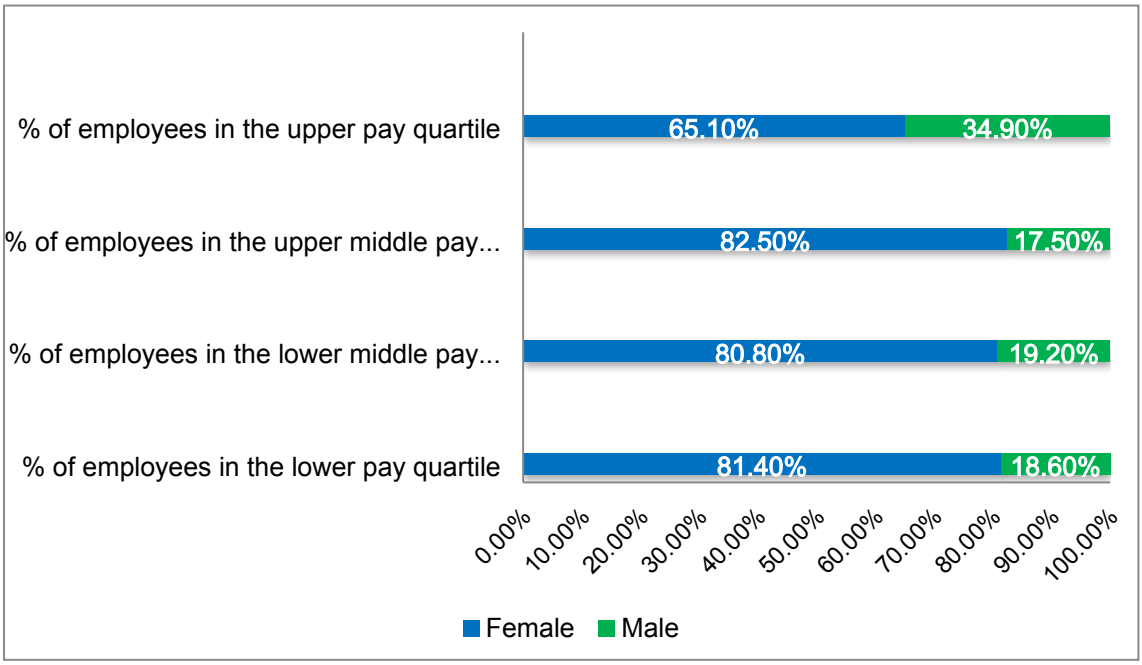
Median gender pay gap	This is the difference between the hourly pay of the median man and the hourly pay of the median woman. The median for each is the man or woman who is in the middle of a list of hourly pay ordered from highest to lowest paid. Medians are useful to indicate what the 'typical' situation is. They are not distorted by very high or low hourly pay.
Mean gender pay gap	The mean gender pay gap uses hourly pay of all employees to calculate the difference between the mean hourly pay of men, and the mean hourly pay of women. A mean involves adding up all of the numbers and dividing the result by how many numbers (employees) in the list. Mean averages are useful because they place the same value on every number they use, giving a good overall indication of gender pay but very high or low hourly pay can dominate and distort the figure.
Median bonus gender pay gap	This is the difference between the bonus pay of the median man and the bonus pay of the median woman. The median for each is the man or woman who is in the middle of a list of bonus pay ordered from highest to lowest paid.
Mean bonus gender pay gap	The mean gender bonus pay gap uses bonus pay of all relevant employees (which at UHNM is Consultant Medical staff in receipt of a Clinical Excellence Award) to calculate the difference between the mean bonus pay of men, and the mean bonus pay of women. A mean involves adding up all of the numbers and dividing the result by how many numbers (employees) in the list.
Proportion of males and females receiving a bonus	The proportions of relevant male and female employees who were paid a bonus payment. For UHNM this refers to local and national clinical excellence awards.
Proportion of males and females in each quartile band	The proportions of male and female relevant employees in the lower, lower middle, upper middle and upper pay quartile pay bands

Our Gender Pay Gap Data

The data is a snapshot of pay taken on 31st March 2021:

Based on Hourly Pay	At 31st March 2018	At 31st March 2019	At 31st March 2020	At 31st March 2021	What this means
Median gender pay gap	10.3%	8.8%	12.6%	13.3%	There has been a small decrease in the percentage of women, and a small increase in the percentage of men in the upper pay quartiles while at the same time there has also been a small increase in the percentage of women, and decrease in the percentage of men in the lower pay quartiles which has resulted in the median pay gap increasing.
Mean gender pay gap	28.1%	27.6%	27.7%	27.5%	
We are confident that our gender pay gap is a result of the workforce distribution, rather than an equal pay issue. This is because we adhere to the Agenda for Change system, national terms and conditions of service (TCS) for Medical staff and, for very senior managers (VSMs), there is a specific VSM pay framework. The Trust also has a robust job evaluation process in place.					
Bonus Pay Gap	**At 31st March 2018**	**At 31st March 2019**	**At 31st March 2020**	**At 31st March 2021**	**What this means**
Median gender bonus gap	1.2%	29.2%	20.5%	19.4%	The number of consultants (both male and female), in receipt of a Clinical Excellence Award has reduced, however it is positive that the median bonus pay gap has decreased. With only a very small proportion of employees receiving clinical excellence awards any fluctuation in the profile can impact on the pay gap.
Mean gender bonus gap	1.5%	11.0%	19.1%	19.5%	
*At UHNM bonus payments relates only to Clinical Excellence Award (CEA) payments made to eligible Medical Consultant Staff. Clinical Excellence Awards recognise and reward NHS consultant medical staff who perform 'over and above' the standard expected of their role and who can demonstrate achievements in developing and delivering high quality care, and commitment to the continuous improvement of the NHS. There are two award types - Local and National. Both have eligibility criteria which means that not all consultants can apply (the criteria is explained in our Clinical Excellence Award Policy HR47). The local scheme changed in 2018 to a 3 year non pensionable award programme, each year the total number of applicants has decreased year on year. Due to the current pandemic the scheme has changed to an automatic allocation of the award which is to be paid to all eligible consultants in March 2021, as a result this is likely to see no change to the pay gap associated to this group.					

The proportion of male and female workforce in each pay quartile was as follows at 31st March 2021:



	Female	Male
Number of employees receiving bonus pay (i.e. a Clinical Excellence Award)	43 (0.45% of all female employees in the organisation)	175 (6.28% of all male employees in the organisation)

Our workforce is 78 per cent female; therefore ideally women should make up 78 per cent of each quartile. Having a predominantly female workforce means that even small fluctuations in the proportion of male to female employees in each quartile, or in receipt of bonus pay will have a significant impact on our gender pay gap.

Supporting Gender Equality at UHNM:

- UHNM actively promotes careers and roles within the organisation and the wider NHS through our Widening Participation strategy and this includes breaking down traditional stereotypes and demonstrating female role models
- We ensure the consistent application of Agenda for Change job evaluation rules through the job evaluation process including consistency panels
- We use a transparent structured approach to shortlisting and interviews with agreed criteria to reduce bias in the recruitment process and we provide recruitment training to our managers
- We actively promote and publicise our commitment to flexible working options for all staff and through the provision of a range of family friendly policies and benefits including shared parental leave and paternity leave and staff self rostering practices
- We promote our internal leadership development brochure to all staff and monitor applications to ensure all protected groups are represented
- We provide career coaching and mentoring
- We demonstrate through our inclusive recruitment strategy a range of women role models in various clinical and non-clinical roles
- We ensure all staff have a Personal Development Review, which uses the Maximising Potential Tool as an inclusive approach to identifying talent
- We use a Values Based approach in our recruitment processes

Progress from our previous Gender Pay Gap Report

The following actions have, by formalising our commitment to flexible working at recruitment stage and enhanced family friendly policies, and the support for aspiring women leaders in our organisation, demonstrated our inclusive approach to tackling the gender pay gap:

- Flexible Working is now promoted at recruitment stage, adopting a flexible by default approach with all jobs advertised as available for flexible working unless there is a strong justification not to
- Further enhanced our Values Based Recruitment approach and apprenticeship opportunities
- Embedded a requirement for diverse recruitment panels for AfC Band 6 and above roles
- Ran 4 cohorts of the Gold and Platinum leadership development programmes and continued the High Potential Scheme for aspiring executive leaders
- Continued our focus on menopause and the workplace promoting the normalising of menopause conversations and the support and adjustments available for workers experiencing menopausal symptoms
- Undertook an Agile working review across the organisation which informed the creation and launch of an Agile Working Policy
- Reviewed our PDR processes to focus on a wellbeing conversation
- The provision of extensive Covid-19 staff support and wellbeing strategy
- Promoted national women's network events and celebrated UHNM women role models for our 2021 International Women's Day campaign

Proposed Actions to reduce the Gender Pay Gap:

We will build upon the flexible working changes that have emerged though Covid-19. Whilst evidence is showing that nationally there has been a negative impact of Covid-19 on the gender pay gap (with women taking a disproportional share of the economic hardship caused by the virus, taking a greater responsibility for childcare and home schooling meaning women have been more likely than men to work fewer hours and be away from work temporarily or drop out of the labour market altogether since the pandemic struck). However; in the longer term it could bring dividends, with agile working during the pandemic demonstrating how flexibility could be achieved.

The information from this gender pay gap audit will be used to help understand any underlying causes for the gender pay gap so that the Trust can take suitable steps to minimise it. Whilst structural changes to the NHS workforce will take time to work through, we are prioritising the following areas that will support the NHS People Plan aspirations of making flexible working and inclusive talent management a reality for our workforce.

Action / Recommendation	Timescale
1. Introduction of a revised and inclusive talent management approach which will include the launch a dedicated management programme open to both Divisional nominees and any other member of staff to apply by a self-nomination route. "A day in the life of a UHNM leader" events will be held to promote awareness and attract a diverse range of applicants, with a diverse panel to review all applications and progression to a development centre	Q3 2022-23
2. Working with Carers UK we will recognise and support our working carers through the launch of our own Carer's passport	Q3 2022-23
3. Review our compassionate leave best practice with a view of extending our special leave provision and support for employees going through fertility treatment, premature birth, and miscarriage and baby loss	Q4 2022-23
4. Increase awareness of the flexible and agile working policies and provision through our management programmes and policy toolkits. Encourage staff to embrace compassionate conversations about what support would be helpful to support work life balance including flexible working	Q3 2022-23
5. Re-start the focused work with women in our medical profession to understand the challenges facing female doctors in training and in senior medical roles to identify actions for UHNM to complement the national recommendations from the Mend the Gap report	Q1 2022-23

Action / Recommendation	Timescale
6. Hold a range of engagement events with staff to understand the experiences, challenges and needs of women working at UHNM to inform our gender equality plans	Q1 2022-23

This report must be published on the UHNM website and the data reported on a designated government website at www.gov.uk/genderpaygap

Appendix 1

Notes and Explanations

1 Explaining the Gender Pay gap:

Our gender pay gap is influenced by the make-up of our workforce which has:

- A greater proportion of male employees in the upper pay quartile compared to lower quartiles and
- A greater proportion of female employees in the lower pay quartiles compared to the upper quartile

Having a predominantly female workforce means that even small fluctuations in the proportion of male to female employees in each quartile will have a significant impact on our gender pay gap

An example of how a Gender Pay Gap can come about

- *An organisation comprises 10 staff and 1 manager*
- *The 10 staff are 9 females and 1 male and they all earn exactly £50,000 per year so they are all on equal pay*
- *The manager, who is a man, earns £100,000 per year*
- *The average salary for women in this organisation is £50,000*
- *The average salary for men is (£50,000 + £100,000 / 2) = £75,000*
- *The gender pay gap is therefore £25,000 or 50%*

2 Explaining the Data

The data is a snapshot of pay taken on 31st March 2020 with the data presented in line with six key indicators:

- Average gender pay gap as a mean average
- Average gender pay gap as a median average
- Average bonus gender pay gap as a mean average
- Average bonus gender pay gap as a median average
- Proportion of males and females receiving a bonus payment
- Proportion of males and females when divided into four quartile pay bands

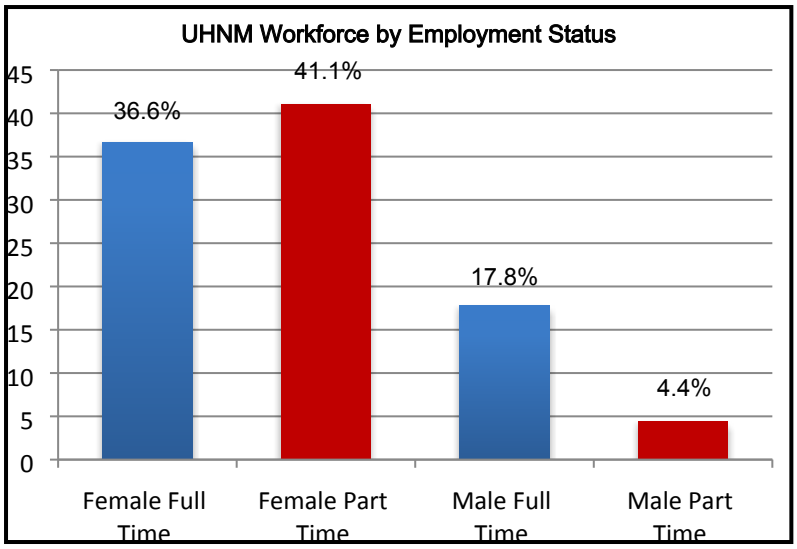
It is important to note that the gender pay gap may vary by occupation, age group and even working patterns.
Note: The Trust does use agency workers who are not included in the data because they are part of the headcount of the agency company that provides them

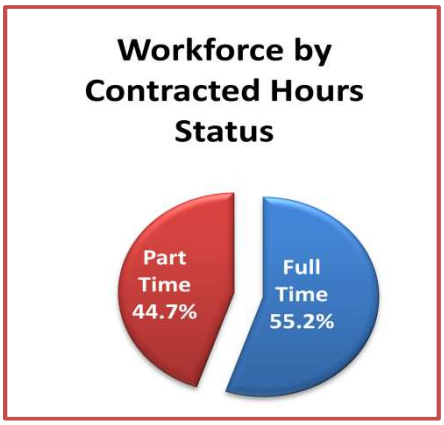
3 How our workforce was made up (as at 31st March 2021)

UHNM is typical of any NHS Trust in that it has a higher number of females than males in its workforce. From a total headcount of 11,513; 78% were female compared to 22% men.

Staff Group	Female	Male
Add Prof Scientific and Technical	79%	21%
Additional Clinical Services	84%	16%
Administrative and Clerical	82%	18%
Allied Health Professionals	78%	22%
Estates and Ancillary	53%	47%
Healthcare Scientists	66%	34%
Medical and Dental	36%	64%
Nursing and Midwifery Registered	92%	8%
Students	100%	0%
Grand Total	**78%**	**22%**

Payscale	Female	Male
Apprenticeship	79%	21%
B1	88%	13%
B2	81%	19%
B3	84%	16%
B4	83%	17%
B5	87%	13%
B6	85%	15%
B7	81%	19%
B8a	77%	23%
B8b	65%	35%
B8c	64%	36%
B8d	56%	44%
B9	67%	33%
Medical & Dental	36%	64%
Directors/Very Senior Managers	70%	30%
Grand Total	**78%**	**22%**





PROUD TO CARE

How do we compare with other similar organisations?

We can compare our gender pay performance against our Model Hospital recommended peers using the gender pay gap data from the last report (**31st March 2020** snapshot), which is available from the Government Gender Pay Gap Service website.

This tells us that overall UHNM is performing positively when compared with this group:

Trust	Median Pay Gap	Mean Pay Gap	Median Bonus Pay Gap	Mean Bonus Pay Gap	% of Women & Men in receipt of a bonus	% of Women in the highest paid roles
UHNM	**12.6%**	**27.7%**	**20.5%**	**19.1%**	**0.5% of women, 6.5% of men**	**65.2%**
Derby Teaching Hospitals NHS Foundation Trust	19.6%	32%	98.2%	74.9%	2.1% of women, 7.5% of men	65.8%
Nottingham University Hospitals NHS Trust	6.1%	24.2%	33.3%	40.8%	54% of women 42.5% of men	78.7%
Royal Wolverhampton NHS Trust	17.3%	28%	0%	9.6%	26.6% of women, 74.5% of men	65.2%
Sheffield Teaching Hospitals NHS Foundation Trust	11.5%	21.3%	94.7%	74.5%	3.7% of women, 9.4% of men	64.6%
University Hospitals Southampton NHS Foundation Trust	10%	24.8%	33.3%	33.7%	1.6% of women, 8.7% of men	61.6%
University Hospitals Birmingham NHS Foundation Trust	13.2%	28.1%	66.7%	44.9%	0.8% of women, 6.3% of men	62.7%
University Hospitals Coventry and Warwickshire NHS Trust	23.1%	33.2%	50.6%	42.7%	0.6% of women, 5.4% of men	60.3%

Trust Board
2021/22 BUSINESS CYCLE

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

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Notes
		7	5	9	7	4	8	6	3	8	5	9	9	
PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES														
Chief Executives Report	Chief Executive													
Patient Story	Chief Nurse													
Quality Governance Committee Assurance Report	Associate Director of Corporate Governance													
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer													
Care Quality Commission Action Plan	Chief Nurse													Highlighted as part of QGC Assurance Summary. Not provided to December as awaiting finalised CQC Inspection report and updated action plan for 2022.
Bi Annual Nurse Staffing Assurance Report	Chief Nurse													Deferred to February although full bi-annual report not undertaken.
Quality Account	Chief Nurse													
7 Day Services Board Assurance Report	Medical Director													Timing TBC
NHS Resolution Maternity Incentive Scheme	Chief Nurse													
Maternity Serious Incident Report	Chief Nurse													
Winter Plan	Chief Operating Officer													
PLACE Inspection Findings and Action Plan	Director of Estates, Facilities & PFI													Due to COVID 19 there are no PLACE inspections again for 2021. A PLACE Lite (internal inspection) is hoping to be undertaken in the Spring.
Infection Prevention Board Assurance Framework	Chief Nurse													
ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS STANDARDS														
Integrated Performance Report	Various													
ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT & RESEARCH														
Transformation and People Committee Assurance Report	Associate Director of Corporate Governance													
Gender Pay Gap Report	Director of Human Resources													
People Strategy Progress Report	Director of Human Resources													
Revalidation	Medical Director													
Workforce Disability Equality Report	Director of Human Resources													
Workforce Race Equality Standards Report	Director of Human Resources													
Research Strategy	Medical Director													
Staff Survey Report	Director of Human Resources													Results under embargo until 30 March
LEAD STRATEGIC CHANGE WITHIN STAFFORDSHIRE AND BEYOND														
System Working Update	Chief Executive / Director of Strategy													
ENSURE EFFICIENT USE OF RESOURCES														
Performance and Finance Committee Assurance Report	Associate Director of Corporate Governance													
Revenue Business Cases / Capital Investment / Non-Pay Expenditure £1,000,001 and above	Director of Strategy													
IM&T Strategy Progress Report	Director of IM&T													Deferred to May due to annual leave

Title of Paper	Executive Lead	Apr 7	May 5	Jun 9	Jul 7	Aug 4	Sep 8	Oct 6	Nov 3	Dec 8	Jan 5	Feb 9	Mar 9	Notes
Going Concern	Chief Finance Officer													
Estates Strategy Progress Report	Director of Estates, Facilities & PFI													Timing TBC - waiting to refresh once the clinical strategy has been determined
H2 Plan	Chief Finance Officer													
Annual Plan	Chief Finance Officer													
Capital Programme 2021/22	Chief Finance Officer													
GOVERNANCE														
Nomination and Remuneration Committee Assurance Report	Associate Director of Corporate Governance													
Audit Committee Assurance Report	Associate Director of Corporate Governance													
Board Assurance Framework	Associate Director of Corporate Governance		Q4			Q1			Q2			Q3		
Raising Concerns Report	Director of Human Resources		Q4			Q1			Q2			Q3		
Annual Evaluation of the Board and its Committees	Associate Director of Corporate Governance													
Annual Review of the Rules of Procedure	Associate Director of Corporate Governance													
G6 Self-Certification	Chief Executive													
FT4 Self-Certification	Chief Executive													
Board Development Programme	Associate Director of Corporate Governance													Deferred from February and update to be considered as part of developing 2022/23 Board Development Programme