University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 4th August 2021 at 9.30 am to 12.40 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 T Bullock	Verbal	
5 mins	2.	Chair's Welcome, Apologies and Confirmation of Quoracy	Information	Prof G Crowe	Verbal	
	3.	Declarations of Interest	Information	Prof G Crowe	Verbal	
	4.	Minutes of the Meeting held 7th July 2021	Approval	Prof G Crowe	Enclosure	
5 mins	5.	Matters Arising via the Post Meeting Action Log	Assurance	Prof G Crowe	Enclosure	
20 mins	6.	Chief Executive's Report – July 2021	Information	Mrs T Bullock	Enclosure	**BAF 6**
10:20	**STRATEGY**					
10 mins	7.	UHNM Strategy – Plan on a Page	Approval	Ms H Ashley	Enclosure	
10:30	**PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES**					
5 mins	8.	Quality Governance Committee Assurance Report (22-07-21)	Assurance	Ms S Belfield	Enclosure	**BAF 1**
10 mins	9.	Bi-Annual Nurse Staffing Assurance Report	Assurance	Mrs AM Riley	Enclosure	
5 mins	10.	IPC Board Assurance Framework - July 2021	Assurance	Mrs AM Riley	Enclosure	**BAF 1**
10 mins	11.	Maternity Serious Incident Report Q1	Assurance	Mrs AM Riley	Enclosure	
11:00 – 11:15: COMFORT BREAK						
11:15	**ENSURE EFFICIENT USE OF RESOURCES**					
5 mins	12.	Performance & Finance Committee Assurance Report (20-07-21)	Assurance	Mr P Akid	Enclosure	**BAF 9**
11:20	**ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT AND RESEARCH**					
5 mins	13.	Transformation and People Committee Assurance Report (26-07-21)	Assurance	Prof G Crowe	Enclosure	**BAF 2 & 3**
11:25	**ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS**					
40 mins	14.	Integrated Performance Report – Month 3	Assurance	Mrs AM Riley Mr P Bytheway Mrs R Vaughan Mr M Oldham	Enclosure	
12:05	**GOVERNANCE**					
5 mins	15.	Audit Committee Assurance Report (28-07-21)	Assurance	Prof G Crowe	Enclosure	
10 mins	16.	Speaking Up Report – Q1	Assurance	Mrs R Vaughan	Enclosure	
10 mins	17.	Board Assurance Framework – Q1	Approval	Miss C Rylands	Enclosure	
12:30	**CLOSING MATTERS**					
10 mins	18.	Review of Meeting Effectiveness and Business Cycle Forward Look	Information	Prof G Crowe	Enclosure	
	19.	Questions from the Public **Please submit questions in relation to the agenda, by 9.00 am 2nd August to nicola.hassall@uhnm.nhs.uk**	Discussion	Prof G Crowe	Verbal	
12:40	**DATE AND TIME OF NEXT MEETING**					
	20.	**Wednesday 6th October 2021, 9.30 am via Microsoft Teams** **NB. THE ANNUAL GENERAL MEETING WILL BE TAKING PLACE ON 8TH SEPTEMBER 2021,Timing TBC, VIA MS TEAMS**				

Trust Board (Open)

Meeting held on Wednesday 7th July 2021, 9.30 am to 12.35 pm
Via Microsoft Teams

MINUTES OF MEETING

Attended	Apologies / Deputy Sent	Apologies

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

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

In Attendance:		
Dr N Coleman	NC	Responsible Officer – Revalidation (Item 10)
D S Cunningham	SC	Consultant – Obs & Gynae (Item 9)
Mr B Deacon	BD	Deputy Director of Estates, Facilities & PFI
Dr L Dudley	LD	Interim Head of Midwifery (Item 9)
Mr J Dutton	JD	Corporate Governance Support Manager (Minutes)
Mr M Hadfield	MH	Deputy Associate Director of Performance (Item 13)
Ms J Hagan	JHa	Matron – Children's Services (Item 9)
Mrs J Haire	JH	Deputy Director of Human Resources
Mr & Mrs James	LJ	Patient (Item 1)
Ms E Kelsall	EK	Matron – Neonatal Unit (Item 9)
Mrs R Pilling	RP	Senior Sister - Patient Experience (Item 1)
Mr N Storey	NS	M-Prove (Item 13)

Members of Staff and Public via MS Teams: 7

No.	Agenda Item	Action
1.	**Patient Story**	
100/2021	Mrs James described her experience at the Trust following a routine screening test to when she was diagnosed with stage 2 Bowel Cancer and the subsequent	

	treatment. She described the impact this had on her and her family, highlighting that they had started to prepare for the worst in terms of getting their affairs in order. Fortunately this was treatable and within days, she underwent successful surgery to remove the cancer. Mrs James stated that the care she received was excellent and gave some examples including: • Bathing provided which made her more comfortable and well looked after. • Provision of a tablet device to allow her to communicate with her Brother in Australia. • Excellent care and aftercare from the ward staff, Imaging, Screening and Colorectal teams. Particular thanks were given to Ms Angela Power from the Bowel Screening team. • The timeliness of her treatment from diagnosis to surgery. Mrs James provided examples of where she felt her experience could have been better, including: • Quality of hospital food. • Lack of communication on the day of surgery which caused her and her husband some anxiety. • Signage around the hospital wasn't very clear. • The letter following the screening did not provide much reassurance. • Better access to some form of entertainment as Covid restrictions meant that she felt isolated at times. Mr Wakefield inquired the time period between being invited for an appointment to beginning treatment. Mrs James stated that this was just a matter of days. Mr Wakefield questioned if Mrs James would have preferred a telephone call invitation to an appointment rather than a letter. Mrs James responded that this would have been useful as the letter did not provide much reassurance, and further questions could have been asked to alleviate some concerns. Mrs Thomson noted that the Trust was in the process of providing free entertainment that patients would be able to access via their own devices. Mrs James welcomed this as she and patients around her sometimes felt isolated. Dr Oxtoby referred to the issues with communication on the day of surgery and stated he would take this away to establish how this could be improved. Mr Akid queried if Mrs James had any advice for other patients in a similar situation. Mrs James urged for patients to put their trust into those caring for them, and not to use search engines to self-diagnose. Mr Wakefield acknowledged that further consideration could be given to the personal impact on families in terms of having to get affairs in order and the initial worries felt by patients when receiving appointment letters. **The Trust Board thanked Mrs James for sharing her experience and noted her story.** *Mr and Mrs James and Mrs Pilling left the meeting.*	JO
2.	**Chair's Welcome, Apologies & Confirmation of Quoracy**	
101/2021	Mr Wakefield welcomed members of the Board and observers to the meeting and	

	the above apologies were received. It was confirmed that the meeting was quorate. Mr Wakefield welcomed Ms Riley to her first meeting as Chief Nurse.	
3.	**Declarations of Interest**	
102/2021	The standing declarations were noted.	
4.	**Minutes of the Previous Meeting held 9th June 2021 and Extraordinary Meeting held 14th June 2021**	
103/2021	The minutes of the meeting from 9th June 2021 and 14th June 2021 were approved as an accurate record.	
5.	**Matters Arising from the Post Meeting Action Log**	
104/2021	Updates to the action log were accepted.	
6.	**Chief Executive's Report – June 2021**	
105/2021	Mrs Bullock highlighted a number of areas from her report. Mr Wakefield questioned how the Board would receive assurance on the Paediatric Surge risk and mitigations. Mrs Bullock explained that this was part of formal winter planning which was included on the Board Assurance Framework. Mr Akid asked if the increase in Covid patients related to any particular age group. Mrs Bullock responded that these were a variety of age groups and some cases had been picked up incidentally when patients were in the hospital for other reasons. Professor Hassell queried the mechanism of decision making for the FMBU and consideration of the Ockenden report. Mrs Bullock explained that the mechanism was the same for any service changes whereby it needed to be agreed by commissioners. If a service was to be disbanded permanently, there was a well recognised national approach involving commissioners, overview and scrutiny committees and public engagement and potential consultations; however the Trust was only asking for a 6 month extension at this point. Recommendations from the Ockenden report would also be taken into consideration for any decisions made. Dr Griffin inquired if there were any plans in place for infection prevention measures following the relaxation of Covid restrictions on 19th July. Mrs Bullock stated that national guidance was awaited; however if this was not forthcoming, the Trust would undertake its own risk assessment. Professor Crowe referred to the bullying and harassment review and sought assurance that suitable expertise and independence was in place. Mrs Bullock responded that views were sought from other organisations who had responded to similar issues and from experts nationally and it was agreed the review would be commissioned by a joint approach between Mr Roger Kline, who had authored several a publications on race and equality in the NHS and had developed and implemented the Workforce Race Equality Standard (WRES), and Brap, a	

	charitable organisation who were recommended as skilled in this area and supporting of interventions. Mr Wakefield suggested that a Board Seminar session on the ICS Board and Provider Collaboratives would be helpful. Mr Wakefield noted that he had joined part of a school visits to the old Royal Infirmary site to watch the demolition works and expressed his thanks to all those involved in Project STAR. **The Trust Board received and noted the report and approved EREAFs 7698, 7704, 7751 and 7789.**	**CR**
PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES		
7.	**Quality Governance Committee Assurance Report (24-06-21)**	
106/2021	Ms Belfield highlighted the following from the report: • An Internal Audit report into discharge letters was received which highlighted some areas requiring improvement to be made. Regular updates on progress of implementation would be provided at future committees. • A deep dive into sepsis screening was requested as it was felt this was not consistent. • Further assurance was requested in terms of achieving timescales for moving from MediSec to Medway. Mr Wakefield acknowledged that positive progress with the Saving Babies Lives Care Bundle (SBLCB) and sought assurance around achieving full compliance with effective fetal monitoring. Dr Dudley stated that a significant amount of work had been undertaken by the team including increased training sessions and workshops, with focus on staff delivering intrapartum care. Currently around 71% of the workforce had completed training. **The Trust Board received and noted the assurance report.**	
8.	**Infection Prevention and Control Board Assurance Framework (BAF)**	
107/2021	Ms Riley highlighted the following risk assessments: • A risk assessment had been undertaken in relation to Computers on Wheels regarding dust harbouring and was deemed to be low risk; this would continue to be reviewed. • In terms of not moving patients until 2 negative Covid screens had been achieved, this was not always possible for asymptomatic patients. Screening frequency was increased for inpatients with step down guidance in place. Mr Wakefield referred to issues with portacount machines and questioned if the Trust had purchased its own unit. Mr Purser replied that a loan machine was on site whilst a business case was put together to purchase one. Dr Griffin queried the scale used for the risk matrix. Ms Riley stated that this was a 5-point scale. For assurance, the BAF had been subject to an Internal Audit review which concluded with a rating of significant assurance with minor improvement opportunities. Mr Wakefield referred to BAF Risk 6 in the document, noting there were no	

	actions assigned against it to achieve the target risk score. Ms Riley explained that she would be undertaking a full review of the BAF to understand what the actions were and this would be updated for the next meeting. **The Trust Board received and noted the report.**	**AR**
9.	**CNST Maternity Incentive Scheme**	
108/2021	Dr Dudley presented the report and stated that: • The Trust was compliant with all 10 NHS Resolution Maternity Incentive Scheme actions, albeit some areas had an action plan in place to move the Trust into being fully compliant. • Currently the registered nursing workforce within the Neonatal Unit had a deficit of 17.84 WTE and an action plan and business case were in development, whilst noting this needed to be balanced against occupancy which sat around 60%. • The Trust was progressing well with a number of elements of the saving babies lives care bundle. • Nearly all women were asked if they smoked at booking and 36 weeks gestation. • In terms of carbon monoxide monitoring, an anomaly in the data reporting was highlighted and it was noted for assurance that the Trust was compliant for the period. • The main challenge was the ability to achieve full training compliance with effective fetal monitoring; an action plan was developed to achieve the 90% target. • The Trust was currently 53.6% compliant for pre-term labour administering of corticosteroids against the 85% target; though this was higher than the regional average. • Action plans would be monitored via the Quality & Safety Oversight Group and Quality Governance Committee. Mrs Gohir queried the timescales for achieving targets for SBLCB actions and fetal monitoring. Dr Dudley replied that these were expected to be completed by the end of Quarter 2. Dr Cunningham encouraged the Trust to make this part of statutory and mandatory training. Mrs Gohir sought clarification around the regional average for administration of steroids. Dr Cunningham explained that, prior to the re-categorisation of how steroids were given, the Trust was achieving 80-90%; however this had reduced as sometimes the baby had already been delivered before the second dose could be given. This change was seen across each region. Mrs Gohir questioned how awareness of fetal monitoring was raised. Dr Dudley stated that NHS Resolution required women to be signposted by 28 weeks into their pregnancy; the Trust was doing this at their 16 week appointment. This was audited via the patient data system. Professor Hassell sought further information on the neonatal workforce business case. Ms Hagan responded that the team had used workforce and capacity planning tools to gain definitive staffing establishment numbers required and would be working with the Executive Team to ensure the business case was robust. Mr Wakefield encouraged the team to progress with the staffing business case at	

	pace and to ensure the data anomaly was corrected. **The Trust Board noted confirmed compliance against each of the 10 actions specified by NHS Resolution in their revised guidance issued March 2021 and approved for the Chief Executive to sign the self-declaration for submission to NHS Resolution with this document by 15th July 2021.** *Dr Dudley, Ms Hagan, Ms Kelsall and Dr Cunningham left the meeting.*	
10.	**Revalidation Annual Update**	
109/2021	Dr Coleman provided the following update: • The pandemic meant that medical appraisals were stopped for the first half of the appraisal year. The Trust introduced a revised process, focussing on the health, wellbeing and professional development of doctors and reducing the burden of documentation. • Overall, 90% of doctors completed an appraisal for the year which was broadly comparable with previous years. It was noted that short term contract holders had been more difficult to engage in the process. • In terms of Revalidation, the number of recommendations due for the year was considerably reduced and only 52 recommendations were made to the GMC, with no deferrals in this group, and only 1 notice of non-engagement. • Feedback from doctors had been that the changes were a positive step in developing appraisals for the future. Mr Wakefield questioned if the process would revert back and increase the burden on doctors. Dr Coleman replied that it was anticipated this would be a permanent change and was an opportunity to rebalance the process. Mr Wakefield challenged if the revised process had been made weaker in any way and could undermine public confidence in the professionalism of doctors. Dr Coleman stated he felt this actually had strengthened the process and made it more meaningful. Professor Crowe referred to the 10% of doctors who hadn't been reached in the process and questioned if this was triangulated against other indicators. Dr Coleman responded that any 'doctors in difficulty' were reviewed to establish if they hadn't been compliant in the process; however this correlation didn't appear to be evident. Dr Griffin welcomed the focus on wellbeing and urged the Trust to focus more on junior doctors. Dr Coleman replied that there were some 'transient doctors' who did not spend enough time in each hospital to remain engaged in the process and he agreed that this was an issue. Those who were at the Trust for a reasonable amount of time were absorbed into the 'appraisal family'. **The Trust Board received and noted the update.** *Dr Coleman left the meeting.*	
ENSURE EFFICIENT USE OF RESOURCES		
11.	**Performance & Finance Committee Assurance Report (22-06-21)**	
110/2021	Mr Akid highlighted the following from the report:	

	• The Committee approved the Car Parking business case, recognising the future financial risk associated. • There was a delay with the LIMs system in Pathology due to functionality not being deliverable from the supplier in the timescale. A number of mitigating actions were put in place. • The Committee requested clarification for the planning of winter care beds and assumptions made for Flu and Covid. • Challenges associated with urgent care performance were noted whilst acknowledging that the quality of care had improved but this was not translating into improved 4 hour performance. • There were a number of local actions in the community to treat lower risk Breast patients. • An update was provided on the Medical Devices Strategy. • Data Security & Protection (DSP) training was nearing the 95% target. • An update was provided in relation to the payroll partnership with Royal Wolverhampton and the progress made to date in developing the service agreement. Mr Wakefield referred to the Car Parking business case and highlighted the fact that the Trust had been willing to go at risk for this scheme that would benefit both the Trust and patients. **The Trust Board received and noted the assurance report.**	
ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT AND RESEARCH		
12.	**Transformation and People Committee Assurance Report (23-06-21)**	
111/2021	Professor Crowe highlighted the following: • Positive assurance was received on the wellbeing focus for staff, with additional information requested in terms of uptake of the Staff Psychological and Wellbeing Hub. • An update was provided on the Improving Together quality improvement programme. • A draft Research Strategy was presented the Committee provided some aspects for improvement. • Challenges associated with neonatal staffing were noted. • The increase in Covid related absence was acknowledged. Mr Wakefield requested for the Research Strategy to be presented to a later Trust Board in order to receive better engagement. **The Trust Board received and noted the assurance report.**	
ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS		
13.	**Integrated Performance Report – Month 2**	
112/2021	Ms Riley highlighted that there had been two Grade 4 pressure ulcers identified as having lapses in care. These were investigated and themes identified were around training in relation to patients who could not comply with the turning care plan, missed early interventions, continence management and products used; these were currently under review. In addition, a quality nurse was to be appointed who would oversee this and develop a strategy around continence.	

Professor Crowe sought Ms Riley's views on the current level of serious incidents and how lessons could be learned. Ms Riley responded that, as she was new to the Trust, she would be working to understand the processes in place and escalate via the governance structure but that she did not think the rates were excessive. Mr Wakefield encouraged a further understanding of the incident rates and lessons learned and whether the Board should be assured or re-assured on this.

Mrs Bullock highlighted the following in terms of urgent care performance and asked that questions be deferred until after the presentation later in the pack:

- There were significant challenges during May due to increased attendances and managing the increased elective work alongside Covid pressures and restrictions. The Trust had also broken its record in terms of the numbers of attendances in a day and the number of patients in the department at a particular time.
- An early increase in paediatric activity had also been seen and a surge plan had been developed.
- It was noted however that despite pressures, the quality of care had improved as there was no corridor care and ambulance waits were being managed overall despite some spikes.

Mrs Bullock continued to summarise Cancer performance:

- Good progress was being made in clearing the P2 backlog, with weekly validations undertaken. Any patients waiting over 12 weeks were reviewed and re-prioritised.
- The main areas of concern remained Colorectal, Urology and Skin.
- The 2 week wait (2ww) position in May was predicted to be 81% which was an improvement from April (76.7%); the main driver of this performance being Symptomatic Breast with the continued demand and where performance was low at 27% but was an improvement from April. This was a national issue and the Trust was working closely with the West Midlands Alliance, CCGs and GP representatives to mitigate.
- It was highlighted that the Trust had one of the lowest 62 day backlogs regionally and was the only Integrated Care System (ICS) with a backlog lower than 200 patients.
- The Trust had successfully appointed a Consultant Histopathologist which was a positive achievement following capacity issues in the department.
- A previously approved business case for Colorectal was progressing and staff were coming on line.
- Trajectories were improving for cancer performance, with robust capacity and demand modelling.
- The Endoscopy department were involved in a new Cytosponge diagnostic pilot for identifying pre-cancerous cells.
- A 7th Theatre was due to come online at County and would be critical in reducing waits.

Dr Griffin questioned if there could be an impact from patients presenting late due to the pandemic. Dr Oxtoby explained that he was aware of some late presenters anecdotally but was not aware of any systematic evidence at this point. There had been a small drop in 2ww referrals during the first wave but this had virtually returned to normal levels. He believed that there would be some impact from this, but not as significant.

Mr Wakefield queried timescales for achieving compliance for all standards. Mrs Bullock responded that trajectories were in place; however these would need to be revised given the high levels of staff absence being seen, and the required

actions to achieve compliance were understood.

Mrs Bullock highlighted the following in terms of Planned Care:

- The day case standard had been achieved despite increases to the Referral To Treatment (RTT) pathways.
- The Trust has reduced the number of >52 weeks to 3,606 from 4,094 in April
- RTT performance in May achieved 62.06%, a slight increase from April (61.08%).
- In terms of Diagnostics, the waiting list appeared to have plateaued off with a reduction in MRI, CT and Non-obstetric ultrasound. The majority of waits were within Non-obstetric ultrasound related to the increase in symptomatic Breast 2ww referrals.
- The current DM01 diagnostic performance for May was 79.43% compared to April (78.72%) and Divisions were asked to produce a recovery plan.

Mr Wakefield acknowledged the pressures being seen and expressed his thanks to staff for their work to manage this.

Mr Storey provided a presentation on Emergency Department (ED) performance over the previous two years to provide context and he summarised the following points:

- There had been a 43% increase in attendances since Mid-March.
- Time to treatment was consistently under 60 minutes between 10th Jan 2021 and 14th March 2021. This correlated with a combined attendance of 242 patients per day. The current ED Clinician rota was staffed to manage 277 patients per day.
- Patients managed within 4 hours had increased by around 600 per week.
- Mean time in ED began to deteriorate from mid-March.
- Ambulance handover performance was relatively well managed with a few spikes seen.
- Improvements in Time to Specialty Referral also correlated with the improved resource to activity ratios from mid-January to the end of March.
- The number of Decisions to Admit (DTA's) patients in ED at 9am each day also showed an improving position with some deterioration due to the current pressures from early April.
- Performance against the 4 hour standard correlated to emergency activity levels and it was clear performance could be achieved when activity and staffing were matched.
- May 2021 saw an increase of around 1,000 patients per month compared to the pre-Covid position in May 2019.
- Initial assessment initiatives achieved consistent improvements in Initial Assessment Times despite the changes in activity throughout the period. Walk-in patient activity was also similar to May 2019 levels.
- Ambulance handover delays had halved since May 2019 and had fallen by 75% since October 2019 (pre-pandemic).
- The number of patients Medically Optimised for Discharge had more than halved since pre-pandemic.

Mr Wakefield referred to the review of resourcing levels and questioned if extra resourcing would be justified post-pandemic. Mrs Bullock explained that there were workforce deficits pre-pandemic and so this was a genuine issue. Some interim arrangements were agreed whilst the business case for additional resource was developed which demonstrated that good staffing levels had a positive impact on achieving times. Mr Oldham added that a judgment would need to be made on activity levels in the context of not knowing what future funding arrangements would look like.

Mr Wakefield queried how the Trust could measure risks of harm to the additional patients presenting to the department. Dr Oxtoby replied that this was dependent on the types of patients coming in. The majority of risk would be for those likely requiring admission; however these had not significantly increased, but would continue to be monitored. He noted that he was encouraged by the fact that there was no corridor care taking place. Mrs Bullock added that patients were clinically prioritized and there had not been an increase in reported incidents during this period of time.

Professor Crowe questioned what was driving demand and where this was captured and reviewed and how the system was responding to this. It was agreed for this to be addressed via the relevant Board Subcommittees. In terms of the system response, Mrs Bullock listed the various actions being taken including increased media regarding alternative pathways, increased resource for the Community Rapid Intervention Service (CRIS), work with Vocare to increase accommodation and reinstate the 'Red GP', introduction of Consultant Connect, changes to the ED layout and consideration of a pod external to ED with the facility to redirect patients to ring NHS111 for potential alternatives.

Mrs Haire highlighted the following in relation to workforce performance:

- Cumulative sickness had reduced to 5.05%; however in-month sickness had increased from April.
- Covid-related absences continued to increase, with daily monitoring taking place.
- Focus continued on wellbeing and psychological support. The Staff Psychological and Wellbeing Hub had now been opened.
- Appraisal completion had improved, with trajectories to be set and monitored divisionally through Performance Reviews.
- Statutory and Mandatory training rate as at 31 May 2021 was 94.62%, an improvement on April.
- The first cohort of overseas nurses had now arrived into the country.

Mr Wakefield inquired about the trajectory for appraisals and when the required level would be achieved. Mrs Haire explained that timescales had not yet been set but teams were asked to take the effects of the pandemic into consideration. Performance would be monitored at Divisional Performance Reviews.

Mrs Bowen queried the impact of built up annual leave during the pandemic in terms of wellbeing and resources. Mrs Haire stated that this had been reviewed and annual leave taken was tracking at similar levels to 2019 and so divisionally there were currently no concerns. It was noted that an increased amount of leave had been taken in March which was a positive indicator that staff had taken time to recover.

Mr Oldham highlighted the following in relation to financial performance:

- The year to date financial position was a £7m surplus, mainly driven by the elective recovery fund and better than expected efficiency.
- There continued to be a reduction in costs against Covid; though this was expected to increase in terms of sickness absence.
- Capital was £1m behind plan, mainly driven by medical equipment and the decant solution for the Trent Building; both of which were expected to catch up. A paper regarding the capital programme was to be provided to the Performance and Finance Committee in July.
- Cash remained in a strong position.

	Mr Wakefield queried if there was communication between the Trust and the region and Independent Sector (IS) partners. Mr Oldham responded that the last submission made was around the elective recovery fund and what income was expected against costs. The return highlighted an £8.2m surplus and so it was expected for the control total to increase. It was expected that surpluses would remain within providers and work was on-going with regional teams to ensure they were expressing underlying positions in the same way. **The Trust Board received and noted the performance report.**	
GOVERNANCE		
14.	**Board Development Programme 2021-22**	
113/2021	**The Trust Board approved the programme with the caveat that it could be flexed to adapt as time progressed and agreed to provide any comments outside of the meeting.**	
CLOSING MATTERS		
15.	**Review of Meeting Effectiveness and Business Cycle Forward Look**	
114/2021	The Trust Board agreed to provide any comments on effectiveness to Miss Rylands outside of the meeting.	
16.	**Questions from the Public**	
115/2021	Mr Syme had raised the following questions prior to the meeting: 1. Breast Cancer 2ww i. Minute 099/2021. Mr Syme asked the Board to clarify the claim that the Trust was outperforming national levels. Mrs Bullock confirmed and assured Mr Syme that the information presented at the last meeting in relation to the 2ww cancer standard was correct. She clarified that the confusion arose as Mr Syme was looking at a specific subset of the overall 2ww performance and although Mr Syme's question related to 2ww cancer the data he was using was in relation to Breast Symptomatic Pathways which are pathways that are not suspicious of cancer and which was currently at the figures presented of 27%. ii. Mr Syme queried if the Nurse led Community Breast Pain Clinic was now fully operational and if not, when it would be. Mrs Bullock responded that this was not yet operational. A bid had been put in to the West Midlands Cancer Alliance and the Trust was waiting for them to confirm funding. If agreed, this would be introduced for Quarter 3 iii. The Trust Board pointed to a difference between those over 35 years of age not being subjected to extended waits and those under 35 years of age coming in line with the 2ww cancer standard sometime in August or possibly a little later. Mr Syme queried how the 35 years of age marker was arrived at given that NICE Breast Cancer Guidance stated that those aged 30 or over needed to be referred within 2 weeks and as such shouldn't be perceived as 'low risk'. Mrs Bullock explained that there had been a massive increase in 2ww referrals and for patients under 35, these were predominantly symptomatic and were on non-cancerous pathways. These would be	

	addressed via the community and Breast Pain clinics. To manage the demand, review times were changed from 14 days to 21 days; but 14 days would still be strived for if capacity allowed. 2. Chief Executives Report - Free Standing Birthing Unit County Hospital (FMBU). Mention was made that the Trust had sought support for temporary closure for a further 6 months whilst issues were resolved or alternatives progressed, meaning the 'temporary' closure would have been for 21 months. Mr Syme queried who the Trust had sought support from and what the alternatives that could be progressed were. Mrs Bullock stated that support was always sought from commissioners for any significant service changes. In relation to alternatives, this could not yet be answered as clinical teams were devising these currently. She added that the FMBU provided a good quality service but there were sustainability issues in terms of the number of births delivered.	
DATE AND TIME OF NEXT MEETING		
15.	Wednesday 4th August 2021, 9.30 am, via MS Teams	

Trust Board (Open)

Post meeting action log as at 28 July 2021

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

Ref	Meeting Date	Agenda Item	Action	Assigned to	Due Date	Done Date	Progress Report	RAG Status
PTB/465	07/04/2021	Midwifery Continuity of Carer Action Plan	To discuss the document further at QGC, in terms of the specific actions to be taken and anticipated dates of delivery for the revised trajectories. In addition, to provide information on peer group comparisons.	Lynn Dudley	26/08/2021		Update to be provided at August's Quality Governance Committee.	GB
PTB/480	14/06/2021	Annual Accounts	To provide the working paper associated with the Royal Infirmary impairment to Mr Wakefield.	Sarah Preston	07/07/2021	14/07/2021	Complete.	B
PTB/481	07/07/2021	Patient Story	Regarding the issues with communication on the day of surgery, to establish how this can be improved.	John Oxtoby	08/09/2021		Action not yet due.	GB
PTB/482	07/07/2021	Chief Executive's Report – June 2021	To consider a Board Seminar session on the ICS Board and Provider Collaboratives.	Claire Rylands	04/08/2021	22/07/2021	Included on the board development programme.	B
PTB/483	07/07/2021	Infection Prevention and Control Board Assurance Framework (BAF)	To update IPC BAF Risk 6 in the document in terms of actions to achieve the target risk score.	Ann-Marie Riley	04/08/2021	28/07/2021	Document updated to include this.	B

University Hospitals of North Midlands NHS Trust

Chief Executive's Report to the Trust Board

FOR INFORMATION

Part 1: Trust Executive Committee

The Trust Executive Committee met on 28th July 2021. The meeting was held virtually using Microsoft Teams; there was no agenda as the general purpose of the meeting was to provide an opportunity to discuss current issues, key priorities and to hear from Divisions in terms of areas of focus / challenges:

Key highlights were as follows:

- Some difficult decisions had been made with regard to the **Statutory Maintenance Programme** on the grounds of patient safety, with alternative solutions identified
- **Project STAR** – demolition of the Royal Infirmary is going well and is ahead of programme, a decision on funding for the car parking solution is expected by the middle of August
- **Learning and Education Strategy** is currently being updated and will require feedback from divisions
- **Staff Awards** nominations have been opened with a view to a celebration event in November
- National exemptions have been made with regard to **staff isolation** although a risk assessment process is in place to support this
- Requests for staff support in areas of shortage are being managed through the **Workforce Bureau**
- **Establishment review** under review within the corporate nursing directorate and a process of escalation is being developed for wards / departments falling short in terms of staffing
- **Harm Free Care** agenda is being refreshed to ensure alignment with the **Improving Together Programme**
- Initiatives being promoted by **UHNM Charity,** including a corporate golf day
- A campaign underway within the Communications Department to **promote roles within UHNM**
- Development of a proposal underway for extended use of **FFP3 masks** in line with growing evidence
- National shortage of **immunoglobulins** which is anticipated until next summer, work underway to mitigate risk and to rationalise usage
- Internal **Level 4 incident** declared with regard to capacity – significant challenges being seen within Divisions with a focus on flow
- Positive progress being made with a number of **IM&T schemes**
- **£8m surplus** at the end of Quarter 1, which is ahead of plan, national guidance is awaited in relation to the second half of the year
- **Staffing shortages** combined with increasing numbers of patients within divisions are placing increased challenge on the day to day running of services
- Appointment to the **Associate Director of Medicine** position had been made
- Some positive progress being made within the CWD Division with regard to '**grow your own**' in terms of staff development
- Feedback from the regional chief midwife has been very positive in terms of the Internal Audit report into **Ockenden**

Part 2: Chief Executive's Highlight Report

1. Contract Awards and Approvals

Department of Health Procurement Transparency Guidance states that contract awards over £25,000 should be published in order that they are accessible to the public. Since 12th June to 11th July, 7 contract awards, which met this criteria, were made, as follows:

- **RS/1423/CAP – Project STAR / Car parking (REAF 7832)** supplied by IHP Vinci Construction at a total cost of £764,373.53, approved on 22/06/21
- **Russell Building - Modular Extension Phase 1 (REAF 7783)** supplied by PortaKabin Limited at a total cost of £753,892.80, approved on 22/06/21
- **Heart and Lung Health (HLH) (REAF 7649)** supplied by Heart and Lung Health at a total cost of £663,000.00, for the period 01/06/2021 - 31/03/2025, approved on 22/06/21
- **PWC Clarity Direct Engagement Contract (REAF 7789)** supplied by PWC at a total cost of £1,407,711.55, for the period 01/10/2021-30/09/2023, providing savings of £35,375.47, approved on 07/07/21
- **Extension of contract for outsourcing Histopathology (REAF 7751)** supplied by Source Bio-Science at a total cost of £1,008,000.00, for the period 01/09/21 -31/08/23, approved on 07/07/21
- **Clinical Waste Management Services Contract (REAF 7704)** supplied by Sharpsmart at a total cost of £1,088,186.40, for the period 16/09/2019 - 15/09/22, providing savings of £7,187.13, approved on 07/07/21
- **Services of Junior Doctors via Health Education England (REAF 7698)** supplied by Health Education England at a total cost of £1,616,666.67, for the period 01/04/2021 - 31/08/2021, approved on 07/07/21

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

Radiology Reporting Services solution (eREAF 7778)

Contract Value £1,154,265.50 incl. VAT
Duration 31/07/21 – 30/08/26
Supplier Various

Savings – £9,456.84 Negated inflation

The Trust Board are asked to approve the above eREAF.

2. Consultant Appointments

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

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Medical Support Worker - Child Health	New	Yes	TBC
Clinical Lead - Cellular Pathology	Vacancy	Yes	05/07/2021
Clinical Lead for Neurology	Vacancy	Yes	TBC
Clinical Lead for Neurology	Vacancy	Yes	TBC
Consultant in Acute Medicine	Vacancy	Yes	TBC
Clinical Director in Acute Medicine	Vacancy	Yes	TBC
Clinical Director in Emergency Medicine	Vacancy	Yes	TBC
ENT Head & Neck Consultant Surgeon	Vacancy	Yes	20/10/2021

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

Post Title	Reason for advertising	Start Date
Clinical Lead - Cellular Pathology	Vacancy	05/07/2021
Locum Consultant Orthopaedic Surgeon specialising in Fragility Fractures	Extension	31/07/2021
Acting-Up Consultant in Elderly Care	Vacancy	05/07/2021
Locum Consultant Foot and Ankle Surgeon	Extension	01/07/2021
Clinical Lead Microbiology	Vacancy	07/07/2021

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

Post Title	Closing Date	Note
Locum Consultant Breast Radiology	18/07/2021	Closed with no applications
Locum Glaucoma Consultant Ophthalmology	18/07/2021	No Applicants
Consultant Medical Oncologist - Urology & Colorectal (CRC)	19/07/2021	No applications
Surgical Tutor	25/07/2021	No applications
Locum GI Radiologist	25/07/2021	No suitable applications

3. Covid 19

Throughout July we saw a rise in the number of patients with Covid-19 on our wards and in Critical Care and whilst this has not been at the same levels as we saw last year, numbers have begun to increase. We have also seen an increase in staff absence due either having Covid-19 or self-isolating. The increasing Covid-19 numbers, along with increasing staff absence and growth in the numbers of people coming into our Emergency Department has created significant pressure on both Trust sites. This is further compounded by the significant efforts our teams have gone to in reopening our elective and planned services to reduce the high numbers of patients who have been waiting for their treatment and operations. Therefore, at the time this third surge arrived, our wards and departments were already very stretched. As a result we escalated to a level 3 and then level 4 incidents internally which means we have had to make some very difficult decisions in order to keep our staff and patients as safe as possible.

4. System Support

I have discussed ours and our system partners pressures with our regulators who were very supportive about the positive steps we have taken to manage the challenges we face and our partners across the healthcare system are working together to do what they can. One area of particular success has been our joint working to respond to falls in the community. Here teams from health and social care, with the input from the ambulance service joined together to enable patients to be treated and cared for in their own homes. The Community Rapid Intervention Service (CRIS) team is having a significant impact in preventing people having to attend our emergency departments and this latest development will mean patients benefit from immediate on the scene health and therapy support from our very own advanced nurse practitioners and therapy teams.

5. CRIS Team Shortlisted for Nursing Times Awards

I'm pleased that the success of the CRIS Team is being recognised and so I was delighted to hear that they have been shortlisted in the Nursing Times Awards under the category of 'Community Team of the Year'. This is a fantastic achievement and is a reflection of their hard work, dedication and team work. I wish them all the very best of luck!

6. Project SEARCH

I have previously updated Board on Project SEARCH, which is a work programme committed to transforming the lives of young people with learning disabilities and autism. I am very proud of our involvement in this programme, offering placements in a wide variety of services and wanted to update Board on some recent congratulations we received for an 'outstanding' achievement of 83% of those individuals who have had supported internships with UHNM through Project SEARCH, have secured employment. This is despite the challenges we have faced as a result of Covid-19. My thanks go out to all those involved in offering placements and a huge congratulations to those who have secured employment with us – welcome to the UHNM family!

7. System Updates

Changes to Direct Commissioning and ICS Boundaries Review Decision

NHSE/I has confirmed its intention to delegate some of its direct commissioning functions to Integrated Care Boards (ICBs) from 1 April 2022. NHSE/I's direct commissioning functions include primary medical services, dental, ophthalmic and pharmaceutical services, specialised services, section 7A public health services, health and justice, sexual assault and abuse services and armed forces services. Whilst the clarity on direction of travel is welcome, there is a significant amount of detail to work through include which services should be commissioned at which level (ICS, multi-ICS or national) and how changes to specialised commissioning can support better outcomes and experiences for patients. In addition, the secretary of state for health and social care announced the results of the national review of ICS boundaries.

NHS Integrated Care Board Chair Designate

Locally, regionally and nationally we are preparing for when Integrated Care Systems (ICSs) and Integrated Care Boards (ICBs) come into effect (April 2022) and in preparation for this we need to confirm who we would expect to take up senior roles for the ICB, starting with the chair designates. On the 27th July 2021 we were delighted to receive notification that Prem Singh should be NHS ICB chair designate, ready to take up the post from April 2022 should Parliament confirm the current plans. Prem had already been through a rigorous recruitment process which included system partners, regulators and approval being sanctioned by the NHSE/I Chief Executive before he took up his position in November 2020

The next stage of this process will be the confirmation of ICB lead designates, with this process expected to conclude by the end of September.

8. Major Incident in the Emergency Department

A major incident occurred within the Emergency Department at Royal Stoke on Monday 26th July which was very quickly covered by the media. A suspect package was found on our grounds and an arrest was made – thankfully nobody was hurt and we were able to de-escalate the situation later that day. I would like to thank all staff for responding to this very concerning event in a calm and professional manner and for ensuring our patients remained safe. I would also like to thank the police for their swift and thorough response.

9. Amanda Pritchard appointed NHS' Chief Operating Officer and Chief Executive of NHS Improvement

Amanda Pritchard has been appointed as the NHS' Chief Operating Officer (COO) and will take up post full time on 31 July. She is currently Chief Executive of Guy's and St Thomas' NHS Foundation Trust in London. The new NHS chief operating officer post is directly accountable to the NHS chief executive Simon Stevens, and serves as a member of the combined NHS England /NHS Improvement national leadership team. The COO oversees NHS operational performance and delivery, as well as implementation of the service transformation and patient care improvements set out in the NHS Long Term Plan. The COO is also accountable to the NHSI Board as NHS Improvement's designated accountable officer with regulatory responsibility for Monitor.

Executive Summary

Meeting:	Trust Board (Open)	Date:	4th August 2021
Report Title:	UHNM Strategy - Plan on a Page	Agenda Item:	7
Author:	Claire Rylands, Associate Director of Corporate Governance		
Executive Lead:	Tracy Bullock, Chief Executive		

Purpose of Report:

Assurance		Approval	✓	Information	

Alignment to Strategic Objectives:

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

Executive Summary:

Situation

The enclosed 'Plan on a Page' is presented to the Board for approval, following discussion by the Executive Strategy and Transformation Group and approval of the Executive Team.

Background

The existing Plan on a Page was developed a number of years ago, to provide a brief visual representation of our 2025 Vision and our Values.

However, with the introduction of our Improving Together Programme and a refresh of our strategic objectives undertaken, it was recognised that the Plan on a Page should be updated and used as a means of communicating in summary form, the refreshed strategic objectives to our staff.

Assessment

The Executive Team have satisfied themselves that the revised Plan on a Page provides the right balance of information in terms of its Vision, Priorities, Values and Objectives, pending the development of a more comprehensive strategy which will replace the 2025Vision.

Once approved by the Board, the Corporate Governance Team will ensure that the updated objectives are reflected within all corporate templates.

Key Recommendations:

The Board is asked to approve the refreshed Plan on a Page for communicating with all staff.

UHNM Summary Strategy 2021 - 2025

NHS
University Hospitals of North Midlands
NHS Trust

Our Vision

Delivering Exceptional Care with Exceptional People

Our Strategic Priorities

Our Values

Our Objectives

High Quality	Providing safe, effective and caring services
Responsive	Providing Efficient and Responsive Services
People	People for Patients: Empowering, developing and supporting for effective performance
Improving & Innovating	Achieving excellence in development and research
Systems & Partners	Leading strategic change within Staffordshire and beyond
Resources	Ensuring we get the most from the resources we have – including staff, assets and money

Quality Governance Committee Chair's Highlight Report to Board

July 2021

1. Highlight Report

Matters of Concern or Key Risks to Escalate

- Q1 Infection Prevention Report: One Hospital Acquired MRSA Bacteraemia in May associated with a very complex patient; this was a community strain of MRSA which was deemed to be unavoidable to UHNM – noted that targets have not been set for this year to date and so targets for the previous year are being used
- Q1 Infection Prevention Report: There have been confirmed Norovirus cases in the West Midlands which is normally unheard of tor this time of the year
- Q1 Infection Prevention Report: Currently beyond 50 Covid patients within the organisation with staffing posing a particular challenge with numbers at the same level as in January
- M3 Quality and Safety Report: A number of standards where the set standards were not achieved; actions to improve these were outlined, including work within Maternity with regard to Sepsis screening. Concern raised with regard to mortality rates (SHMI) which will remain under review.
- M3 Quality and Safety Report: June / July has seen a marked increase in the use of bank / agency staffing – a sustained challenge over the last 4 weeks; paper to the next meeting which outlines all of the actions undertaken, risk assessment and management approach
- HED Readmission Analysis: Analysis demonstrates that the Trust is within the expected range although slightly over the benchmark – a number of recommendations were made which will see a further review to determine actions which need to be taken
- Quality and Safety Oversight Group Assurance Report: Matters escalated with regard to medical staff compliance with Safeguarding Training, also VTE Risk Assessment Compliance, Emergency C Section rates, Duty of Candour, Sepsis Screening Compliance and national guidelines for fetal monitoring – all being actioned through the Group
- Health & Safety Group Assurance Report: Matters escalated with regard to social distancing risk assessments (work ongoing), increase in Covid related absence, increase in needlestick injuries / musculoskeletal referrals to Occupational Health and ongoing action in relation to the Sharps Gap Analysis

Major Actions Commissioned / Work Underway

- Q1 Infection Prevention Report: Lots of work being undertaken with Divisions including the establishment of a Task and Finish Group focussing on Infection Prevention and Control, particularly on Sepsis – refresher training also being delivered along
- Q1 Infection Prevention Report: Planning for Flu Vaccinations underway although new guidance is being issued regularly in light of Covid which being taken into account; current plans are to offer both vaccines at the same time
- Infection Prevention Board Assurance Framework Q1: Close working with the Learning Disabilities Lead has been undertaken, particularly in relation to visiting patients and will be reflected in the BAF
- Infection Prevention Board Assurance Framework Q1: Significant work being undertaken in response to national guidance associated with Track and Trace 'pinging' including SOP and comprehensive Risk Assessment – following same process as a system / region
- M3 Quality and Safety Report: Deep dive into falls undertaken and will be reported back to the Committee in August and a deep dive into Sepsis will report back in September
- M3 Quality and Safety Report: Work being undertaken to establish a 'Learning Alert' process in response to incidents where shared learning would be relevant
- Q1 Board Assurance Framework: Further review of risk associated with Harm Free Care to be undertaken by the Chief Nurse in readiness for Q2
- Q1 Board Assurance Framework: Key to consequence / likelihood to be included within the narrative and to ensure consistency of impact / likelihood throughout. Further review of scores to be undertaken in light of current circumstances, i.e. patient outcomes / harm free care to be reviewed in terms of risk score
- Q1 Board Assurance Framework: Patient Safety Strategy currently under development along with a review of the approach taken to incident investigation and review

Positive Assurances to Provide

- Infection Prevention Board Assurance Framework Q1: Risk associated with Computer on Wheels has been reduced following a more detailed risk assessment being undertaken – this will remain under review
- Infection Prevention Board Assurance Framework Q1: Positive feedback received from regulators with no recommendations / further action needed
- BD Cannula Risk Assessment: all cannulas are now coming through are at normal rates of supply with the exception of one which is used at a very low rate – as the risk is now very low it was noted that the risk assessment is now closed
- M3 Quality and Safety Report: Positive Internal Audit received in relation to Ockenden; this will be taken to the next Audit Committee

Decisions Made

- It was noted that as the meeting was not quorate, approval of minutes would be undertaken outside of the meeting. Approval of the BAF would be done through the Performance and Finance Committee and the Transformation and People Committee

Comments on the Effectiveness of the Meeting

- Lighter agenda which made the meeting more manageable

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Q1 Infection Prevention Report (PPI Audit)	Assurance	7.	Executive Health & Safety Group Highlight Report (July 2021)	Assurance
2.	Infection Prevention Board Assurance Framework Q1	Assurance	8.	Quality & Safety Oversight Group Highlight Report (July 2021)	Assurance & Approval
3.	BD Cannula Risk Assessment	Assurance	9.	Quality Governance Internal Audit Recommendation update	Information
4.	M3 Quality and Safety Report	Assurance	10.	Review of Meeting Effectiveness	Assurance
5.	HED Readmission Analysis	Assurance	11.	Review of Business Cycle	Assurance
6.	Q1 Board Assurance Framework	Approval	12.	Items for Escalation	Approval

3. 2020 / 21 Attendance Matrix

			Attended	Deputy Sent	Apologies Received

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

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	4th August 2021
Report Title:	Nurse Staffing Establishment Review	**Agenda Item:**	9
Author:	Helen Inwood – Director of Nursing		
Executive Lead:	Chief Nurse		

Purpose of Report:

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

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

Executive Summary:

In 2013, following the findings of the Francis Report the National Quality Board (NQB) set out 10 expectations and a framework within which organisations and staff should make decisions about safe staffing. The NQB guidance expects a review of the nursing and midwifery workforce to be presented to the Trust Board twice per year. This review occurs at the time of recovery and restoration from the Covid pandemic when many wards are in a transition stage, moving from a case mix experienced during the pandemic to their usual clinical provision

This bi-annual staff report reviews the nursing establishment for inpatient areas with the exclusion of midwifery who produce a separate report. The report also excludes theatres, outpatients and emergency departments. The report provides an overview of staffing and where possible comparison with national indicators or benchmarked against other Trusts. It then drills down into staffing within individual divisions identifying where action needs to be taken to address skill mix issues or staffing numbers.

There is evidence that recruitment has been successful in reducing the vacancy factor but this activity needs to continue to offset any turnover.

Through the implementation of a career pathway for unregistered staff there is plan to improve skill mix, but in some areas, particularly within the Medical Division, budgeted establishment needs to be amended to reflect the implementation of the Registered Nursing Associate into the workforce without reducing the current registered nurse budget. The re-organisation of some wards provides some flexibility to do this within the current budgeted establishment.

The use of e-rostering performance indicators will start to identify the effectiveness and efficiency of rostering.

Key Recommendations:

The Trust Board is asked to receive the report for assurance.

Subject: Nurse Staffing Establishment Review

May 2021

1. Introduction

In 2013, following the findings of the Francis Report the National Quality Board (NQB) set out 10 expectations and a framework within which organisations and staff should make decisions about safe staffing.

In 2016 the NQB published updated safe staffing guidance and a set of expectations regarding nursing and midwifery staffing. The guidance emphasises that the NHS provider boards are accountable for ensuring that their organisations have the right skills in place for safe, sustainable and productive staffing. The NQB guidance makes explicit the requirements of NHS providers.

Expectation One Right Staff	Expectation Two Right Skills	Expectation Three Right Place and Time
• Evidence based workforce planning. • Professional judgement. • Compare staffing with peers.	• Mandatory training, development and education. • Working with the multi-disciplinary teams. • Recruitment and retention.	• Productive workforce and eliminating waste. • Efficient deployment and flexibilities. • Efficient employment and minimise agency.

Developing Workforce Safeguards was issued by NHSi in October 2018. This publication provides detailed guidance in relation to process and systems that all NHS organisations should have in place. The Trust Board is expected to confirm this through its annual governance statement.

This paper describes the process that was carried out in undertaking a review and gives the Trust Board assurance that the national expectations with regard to safe nursing staffing are being achieved at UHNM. The paper lays out the priority areas of investment for each division and summarises the key findings with recommendations based on the findings.

2. Nursing and Midwifery Staffing Review May 2021

The NQB guidance expects a review of the nursing and midwifery workforce to be presented to the Trust Board twice per year. A full review was undertaken in May 2021. The review should enable the Trust Board to be assured that the Trust has safe staffing levels and skill mix; it should also alert the Board to areas of concern. This establishment review provides an overview.

Research suggests that harm can occur to patients if the Registered Nurse (RN) to patient staffing ratio is 1:8 or more on adult inpatient wards.
Additionally Royal College of Nursing guidance suggests on an acute ward there should be an RN: Nursing Assistant skill mix ratio of no less than 65:35 for base wards, 70:30 for specialty wards and 80:20 for specialty units e.g. ICU. This overview monitors wards against these standards.

Bed Provision	Description	Expected Staffing Level	Skill Mix Suggested
Intensive Care	Beds identified – critical care areas	1 Registered Nurse: 1 patient.	80:20
High Dependency	Designated beds in a defined unit/area.	1 Registered Nurse: 2 patients.	80:20
Level 1	Designated beds on general Wards.	1 Registered Nurse: 4 patients.	70:30
General Care	Majority of inpatient Wards	No less than 1 RN: 8 patients during the day.	65:35

3. Approach

The Associate Director of Nursing for Education and Workforce led a discussion with each ward team; the team included the Ward Sister, the Matron, the Associate Chief Nurse, and the finance lead. The information collected at the reviews included, funded establishment (which was agreed by Finance), quality and HR metrics, shift patterns, key performance indicators for staff rostering and a discussion about ward layout and other professional judgement factors that might affect the number of registrants and non-registrants required.

Quality metrics for the previous 3 months were also considered, including harm free care metrics, Clinical Excellence Framework (CEF) score, relevant HR data and rostering key performance indicators. Key performance indicators for rostering were included in response to an internal audit which identified that wards were not familiar with the indicators and this helped to raise the profile and demonstrated that ward managers were aware of the indicators.

For those inpatient wards where the Safecare tool is appropriate the information gained from this tool was used to inform the debate, However, with the response to Covid, wards had generally not experienced their usual patient group and some wards had restricted beds so the reliance on the Safecare tool at this time could not be used as reflective of usual working patterns. However, the compliance with recording acuity for the safer care tool was recorded and individual ward compliance was discussed at the reviews to ensure that it becomes a reliable indicator of patient acuity as we enter the restoration phase of the Covid pandemic.

At the end of the discussion a decision was taken based on all the information as to whether the current shift pattern was safe or whether it requires adapting.

Findings

This section of the paper will firstly describe the overall findings from across the Trust and then the findings from each Division.

Trust-wide Findings

Staffing Ratio

Overall, in adult areas across the Trust the staffing ratio for Registered Nurses to patients is at the expected rate of 1RN:8 patients or better in the day time hours which is very encouraging, however over night the ratio was identified as 1 RN:10 patients in a small number of areas and this does need addressing. This issue was only identified within Medicine, although day case areas that may be required

to accommodate increased number of patients overnight may be affected if patient numbers were to increase and this needs to be monitored.

Skill Mix

The skill mix (registered to non-registered) was generally acceptable in 3 Divisions; however, the skill mix in the Medicine Division is poor. In the main this is due to the high number of nursing assistants, band 2's 3's and band 4's. The Trust has embarked on a programme of career development for the unregistered workforce which will see a number of nursing assistants' progress onto the professional register either through the apprenticeship framework or through adaptation programmes enabling their overseas nursing registration to be recognised by the NMC. These developments will have a positive impact the skill mix ratio.

Skill Mix Ratio	Number of wards
Less the 50% RN	14
50% - 59% RN	21
Greater than 60% RN	18

Prior to Covid the Model Hospital was suggesting that the care hours per patient day were high at our Trust compared with peers and this information was largely influenced by the high number of health care support workers. These reviews confirmed this to be the case as in some areas the geographical layout of the wards mean additional staff are required to allow visibility of all patients, this has been considered as part of the review using the Sister/charge nurse professional judgement.

There may be some additional factors influencing the high health care support worker levels:

- When extra capacity was introduced to the new PFI build on a number of wards no additional Registered Nurses were identified for these extra beds, but health care support workers were increased in some areas. This was in relation to the increased number of side rooms and the need to improve the visibility of patients.

- Skill mix reviews have occurred with the conversion of band 5 posts into Band 4 posts to accommodate the new roles of assistant practitioner and nursing associate.

- Some wards have a team of Allied Health Professionals (AHP) who contribute to the care of patients but are not included within the skill mix or staffing ratio. This is particularly relevant to the fracture neck of femur ward (Ward 225) and Stroke ward (Ward 127)

The agreed business cases to enable Nursing Assistants to access the registered nurse degree apprenticeship and the Assistant Practitioners to undertake the top up registered nurse degree have been enacted and will commence in September 2021. The Trust have also now welcomed the first registered nursing associates who are now included against the registered workforce.

Vacancies

The Trust has circa 100 Registered Nurse vacancies on the inpatient wards, of which around 50% sit within the Medical Division. This is a significant reduction on the 300 vacancies the previous year. This figure does include staff who have been appointed but not yet started. This cohort of staff includes student nurses currently coming to the end of their course and 48 international nurses many of whom now have a delayed start due to the current health crisis in India.

Further international recruitment is planned during May 2021 and over the next 6 months nursing assistants who are registrants within their own country should start to gain registration with the NMC as they are supported through the English courses and OSCE preparation.

There are approximately 20 vacancies for nursing assistants once nursing assistants recruited following a corporate recruitment campaign start.

Rostering key performance indicators

The 4 indicators reviewed were

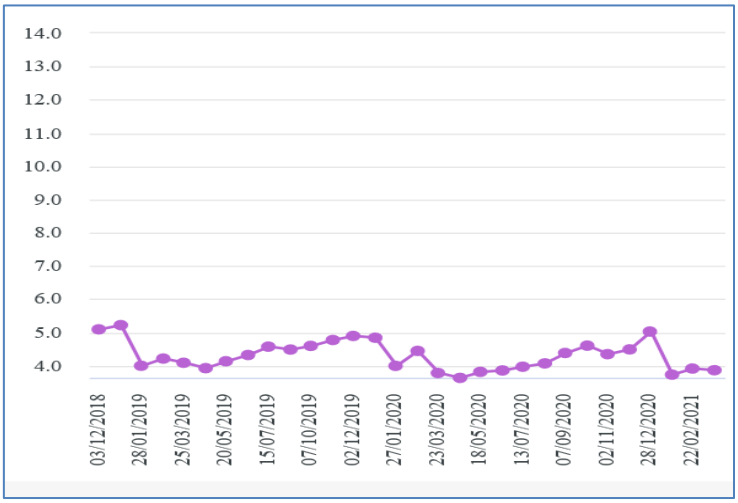
- Rosters in advance
- Compliance with Safecare acuity scoring
- Bank/agency usage
- Unavailability

Rosters in Advance

One of the key performance indicators included within the reviews this year relates to how far in advance rosters are produced. Evidence suggests that rosters produced 4 weeks or more before the shifts promotes for effective and efficient staff deployment and potentially reduces bank/agency usage. Wards are requested to meet this requirement.

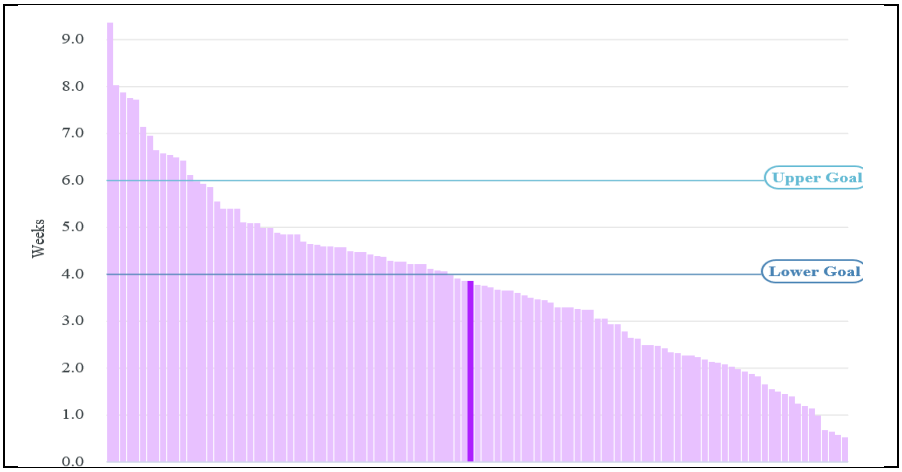
Rosters in Advance	Number of wards
Less than 4 weeks	23
4 – 6 weeks	20
Greater than 6 weeks	5

The graph below shows our average lead in time, in weeks, for all nursing rosters on the Allocate system, and does not therefore solely reflect the inpatient wards.



13 wards are now using a self rostering system where staff determine their own working shifts against agreed rules shift which supports flexible working patterns and has again been shown to reduce the use of bank and agency staff.

The graph below illustrates the performance of our clinical areas utilising the Allocate e-rostering system against other Acute Trusts.



On average our Trust is reporting rosters being completed on average 3.9 weeks in advance compared to 2.6 weeks of comparable Trusts, but more work is required to achieve the minimal recommended target. However, theatres and out-patient department currently work to rosters being agreed 2 weeks in advance to enable the rosters to be more reflected of booked activity. This will reduce overall compliance and further discussion is warranted to determine whether 4 week compliance should be applied to these areas.

Compliance with Safecare Acuity Scoring

Wards which cater for in-patients are requested to submit acuity data onto the Safecare tool 3 times daily in relation to the individual patients. Critical care units, high dependency units are exempt from this as they have the national dependency requirements. Where units fail to enter the scores 3 times daily then the acuity score may not be fully accurate if used to assess whether staffing numbers are adequate for the caseload. During this review the wards compliance with the scoring was discussed. At this moment in time many of the wards who are entering the data have not had full occupancy, or the caseload has changed for a temporary period as part of the Covid response.

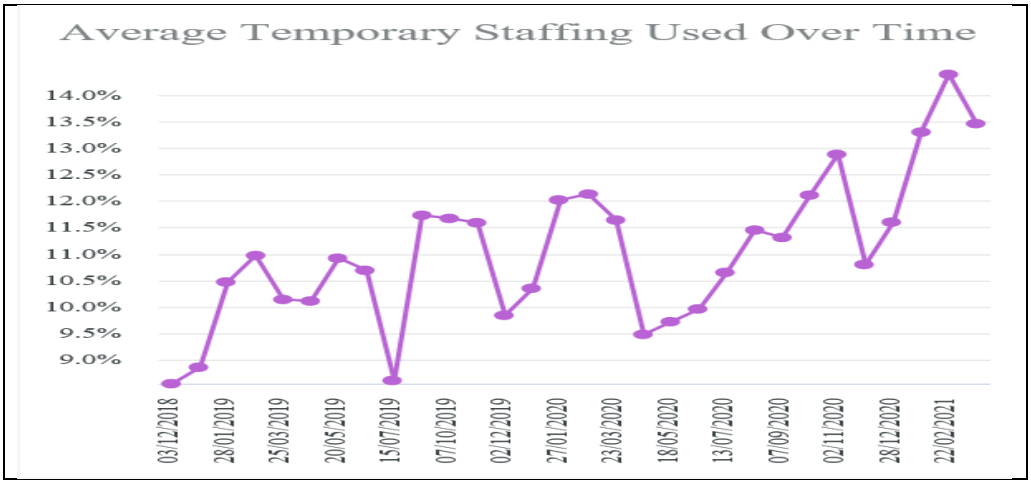
Compliance	Number of Wards
Compliance over 90%	15
Compliance 75% – 89%	14
Compliance less than 74%	14

This safecare score is different to the care hours per patient day that the Trust reports on nationally on a monthly basis. Care hours per patient day is a crude measurement which reflects the total number of inpatients at 23.59 hours on a daily basis with the number of staff on duty. This measure has continued to be measured during the Covid period and appears to have increased. However this is more reflective of reduced bed occupancy than a change in establishments.

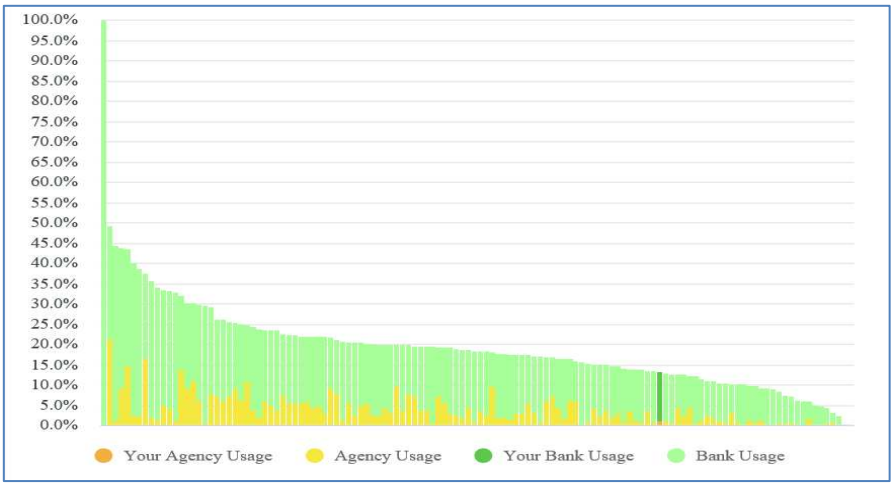
Bank/Agency Usage

The Trust continues to have a substantial number of staff available through the nurse bank. During Covid they have been widely deployed to all areas, particularly critical care and there has been a slight increase in our use of agency. The Trust will now look to reduce the number of agency shifts deployed and the Divisions receive a report on a weekly basis of all shifts booked to enable them to review that control measures are effective.

Through the allocate system we can see our usage for every 4 week rostering period and the graph below demonstrates that during the Covid pandemic our use of bank/ agency did increase.

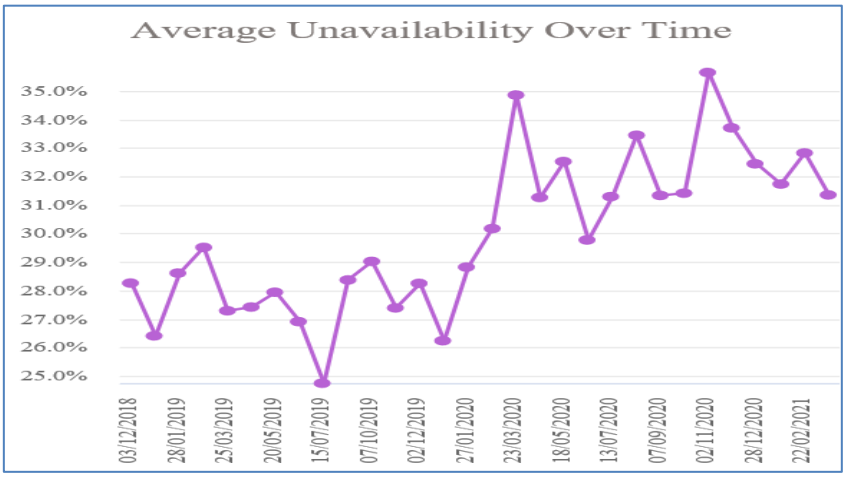


Against our peers the Trust utilisation is 13.5% compared to 20.7% for Acute Trusts. Of the 13.5% usage only 8% of the total 13.5% is comprised of agency usage. The table below identifies our Trusts performance against other units.



Unavailability

Nursing rosters contain 21.5% headroom to accommodate annual leave entitlement, sickness and study leave. Effective rosters should demonstrate a figure close to 21.5% unavailability. This figure will show an increased deviation in the presence of high sickness, maternity leave or vacancies. A high deviation from 21.5% does not necessarily demonstrate ineffective rosters but there is a requirement that ward leaders can articulate why their unavailability can be showing higher and plans that may be in place to reduce it.



On average the Trust is showing an unavailability of 31.4% against the national average of 29.9%.

There is growing opinion from national guidance that the amount of headroom added into an establishment should range from 22% - 25%. Critical care, theatres and ED have already had the uplift amended to 23% but with the increasing requirement for mandatory training there may be an increased requirement to increase the uplift to the minimal level suggested. An uplift of 22% should be considered as a minimum as part of any additional business cases required for inpatient wards.

MEDICAL DIVISION

At a previous workforce review it was identified that there were a number of wards within the Medical Division which demonstrated discrepancies between the budget and the establishment required. Some of these discrepancies have been addressed through ward moves and career progression. There is however a number of areas where activity does not reflect the establishment in post and a high number of areas demonstrating a poor skill mix of less than 50% Registered Nurses. Some of the skill mix issues will be addressed through the career progression actions that have been introduced, but the main issue of concern is that Band 4 posts, predominantly in the form of Nursing Associates have become a recognised part of the workforce in the future but the establishments do not recognise these posts, and to implement the Band 4 post at the expense of a Band 5 post would further hinder the skill mix position.

Ward 222 which provides non-invasive ventilation beds and Acute Medical Admission Unit at Stoke currently have more beds than staffing provides for. Business cases are required for both these units to enable safe staffing to be fully achieved. For these wards to continue to provide the identified beds there will be high usage of bank and agency staff. The gastroenterology ward (ward 230) is also contemplating the introduction of Level 1 beds onto the ward. The current establishment would not support this development and a further business case would be required.

Three wards, (117, 80 and 81) all have periods during a 24 hours period when only 2 RN are rostered on shift. Whilst these wards have a relatively small bed base which means they meet the 1:8 requirement on days, it means that during breaks on one RN remains on the ward which could delay some nursing interventions such as the administration of controlled drugs. It also reduces flexibility in times of sickness.

Ward	RN Vacancies	NA Vacancies	RN:Patient ratio	Current RN: NA Ratio	Safecare Compliance	Roster in advance (Weeks)
AMU (county)	0.44	2.5	1:6	58/42	100%	2.9
AMU	0.15	4.58	L1 = 1:4 1:6	52/48	51%	3.9
FEAU	2.82	0	1:5	53/47	78%	2.8
SSU	2.76	0	1:5	45/55	91%	3.8
Ward 222	3.59	0	L2 =1:2 L1 = 1:4 1:8	68/32	30%	6.6
Ward	RN Vacancies	NA Vacancies	RN:Patient ratio	Current RN: NA Ratio	Safecare Compliance	Roster in advance (Weeks)
Ward 124	3.62	1	1:5.5	58/42	76%	9.6
Ward 113	0.16	0.11	1:6.5	42/58	94%	3.9
Ward 117	0.5	0	1:5	46/54		
Ward 122	0	0	1:6	53/47	86%	6.5
Ward 230	3.44	1.84	1:6	49/51	91%	3.8
Ward 121	3.88	3.4	1:6	46/51		
Ward 126	1.34	0	1:7	46/54	100%	5.5
Ward 76a	5.38	0	1:7	48/52	47%	5.6
Ward 76b	1.22	2	1:6	44/56	80%	0.8

Ward 78	2.8	1.5	1:7	43/57	100%	4.6
Ward 80	1.2	2.8	1:6	40/60	10%	2.6
Ward 81	1.7	1	1:6	40/60	89%	4.4
Ward 79	1.94	2.69	1:8	43/57	85%	5.9
Ward 12	0.6	0	1:7	57/43	94%	2.6
Ward 14	3	0	1:7	50/50	83%	1.9
Ward 15	5	0	1:7	47/53	96%	1.9
Ward 7	0.97	0	1:6	51/49	63%	2.6
	46.51	**23.42**				

Divisional compliance with e-rostering performance indicators

Rosters in Advance	Bank/Agency Usage	Unavailability	Safecare compliance
3.88 weeks	18.25%	29.51%	79.0%

SURGICAL DIVISION

It was noticeable from the review of surgical wards that the use of Level one beds with a required staffing ratio of one RN to 4 beds was under review. A previous review had identified that some of the establishments would not support an increase of level 1 beds without further investment. The addition of winter pressure resource on some wards causes confusion in relation to establishment and a perceived over staffing outside of the winter months and this needs to be taken into consideration and off set against bank requirements outside of the winter period.

All the wards within the Surgical Division had a skill mix greater than 50% RN and a further improvement will be seen as trainee Nursing Associates complete the training and enter the professional register. Theatre staffing was not considered as part of this review but needs to be incorporated within future reviews.

Ward	RN Vacancies	NA Vacancies	RN:Patient ratio	Current RN: NA Ratio	Safecare Compliance	Roster in advance (Weeks)
SAU	-3.44	-1.8	1:3	61/39	N/A	5.3
SSCU	2.87	0.4	1:2	80/20	N/A	5.6
Pods 3 & 6	0	0	1:1	87/13	N/A	5.3
Ward 103	0	0.46	L 1 =1:4 1:6	54/46	54%	4.9
Ward 111	1.2	0.9	1:4 L1 1:6	54/46	100%	3.3
Ward 110	4.56	0.64	1:5.5	53/47	89%	3.9
Ward 102	1	1.93	1:6	59/41	71%	3.9
Ward 106/7	2.6	0	1:7	57/43	56%	4.2
Ward 108	3.59	0	1:5.5	63/37	90%	6.6
Ward 109	4.6	0.3	1:6	64/36	67%	3.9
Ward 8	1.6	1.8	1:7	54/46	N/A	5.5
Ward 112	0	2.84	1:6	55/45	N/A	1.6
	18.58	**7.47**				

Divisional compliance with e-rostering performance indicators

Rosters in Advance	Bank/Agency Usage	Unavailability	Safecare compliance
3.66 weeks	10.7%	28.01%	76.3&

SPECIALISED DIVISION

Within the Specialised Division only one ward fell below a 50% RN ratio and this was the neurology ward. This ward ran a sleep service which requires a NA per shift and this has had a slight influence on the ratio. However, with the development of Nursing Associates it is likely the skill mix will improve over the next 12 months as these staff gain registration. Ward 225 caters for patients suffering from a fractured next of femur and has experienced challenges with recruitment also the position is improving. There had been an increase in the RN establishment on this ward as suggested in the previous review.

Previously the establishment for Ward 220 incorporated the coronary care unit beds, but this has now been established as a separate unit with its own establishment. Whilst this development is fairly recent it will help determine whether the establishment accurately reflects the acuity on the acute cardiology ward. The Stroke ward has relocated during the pandemic and the establishments does not reflect the team of AHP's based on this ward and supplements the workforce during the day. The Stroke Early Assessment Team (SEAT) also supports the ward at periods during the day if there are not patients within ED requiring their input. Although the nurses for this service are not within the establishment their contribution needs to be considered when considering the staffing within the ward.

The Elective orthopaedic day surgery unit at Stoke moved location and function during the Covid pandemic but was returning to its original location after the review. Should the function change to an in-patient ward the establishment is likely to need an uplift supported by a business case.

Currently part of the ward is occupied by a Specialised Decisions Unit to support the flow of patients out of ED. This area has been predominantly staffed by staff pulled from other units within the Division but going forward if this unit is to continue it needs to be appropriately funded and a business case has been produced with a cost of circa £700k.

Ward	RN vacancies	NA Vacancies	RN:Patient ratio	Current RN: NA Ratio	Safecare compliance	Roster in advance (Weeks)
Pods 1 & 2	0	0	10 x 1:1 2 x 1:2	87:13	N/A	4.2
Ward 127	3.9	2.2	1:4 1:6 1:9	53:47	89%	4.7
ARTU (Ward 227)*	3	2.8	L1 + 1:4 1:6	56:44	89%	5.6
CCU	0.3	0.3	1:4	79:21	62%	1.4
Ward 220*	0	0	1:7	73:27	83%	1.4
Ward 223*	1.4	0	L1 = 1:4 1:5	60/40	100%	3.8
Ward 228*	2.49	0.79	L1 + 1:4 1:8	59/41	97%	5.9
EOU (County)	1.95	0	1:6	59/41	95%	3.7
EOU (Stoke)	2.01	0	1;5.5	61:39	N/A	
Ward 218	0.5	0	1:7	49:51	89%	3.9
Ward 221*	0	0	1:7	60:40	77%	4.4
Ward 225*	8.87	3.74	1:7	50:50	89%	5.3
Ward 226*	0.93	1.74	1:6	57:43	92%	5.3
	25.35	11.57				

Divisional compliance with e-rostering performance indicators

Rosters in Advance	Bank/Agency Usage	Unavailability	Safecare compliance
5.01 weeks	13.7%	28.55%	91.9%

CHILDREN, WOMENS AND DIAGNOSTICS

The inpatient wards in this Division are predominantly within Child Health with one adult Oncology ward. The maternity wards did not feature within this review as these were part of the maternity workforce review. There was good recruitment into all areas. Since the last review the establishment required for the beds within the Emergency Assessment Unit within Oncology had been separated out from the Oncology ward as suggested.

The nursing establishment for the Neonatal Unit does not meet the BAMP requirements and a business case is currently being prepared to address this.

Ward	RN vacancies	NA Vacancies	RN:Patient ratio	Current RN: NA Ratio	Safecare compliance	Roster in advance (Weeks)
201	1.56	0	1:4/1:6	61/39	100%	6.5
216	0	3.8	1:3/1:4	67/33	41%	4.9
217	-0.7	2.24	1:4/1:8	69/31		
NICU	5	0.5		83/17	N/A	3.9
PICU	1.61	0	1:1	81/17	38%	4.9
CHDU	0	0	1:2	71/29	38%	4.9
	7.47	**6.54**				

Divisional compliance with e-rostering performance indicators

Rosters in Advance	Bank/Agency Usage	Unavailability	Safecare compliance
3.51 weeks	3.74%	29.1%	65.2%

4. Conclusions

Vacancy rates on the inpatient wards are showing improvement but active recruitment must continue. A final international recruitment campaign is planned and this in addition to supporting the overseas nurses currently working as nursing assistants to join the professional register will have a significant impact on reducing this further. A career structure for unregistered staff will see on-going transition of unregistered staff onto the professional register helping to build the Trusts reputation in developing staff. Similar structures need to be embedded for registered staff to ensure we maximise retention and continue to build on this reputation.

The key performance indicators that can be pulled down from the e-rostering system are now included within the monthly quality and safety report and these need to be embedded in discussions at Divisional and ward level. Supporting self- rostering will improve the flexibility and well-being for staff.

5. Recommendations

- Undertake deep dives on the wards with the lowest RN:NA skill mix to determine the impact on quality
- Ensure QIA completed where skill mix adjustments being made
- Medical Division to ensure that Band 4 posts are appropriately funded without further compromising skill mix
- Future reviews to include ED, theatres and outpatients
- Future reviews should consider the contribution of nurse specialists and nurse practitioners to patient care including the utilisation of job plans

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	4th August 2021
Report Title:	Infection Prevention Board Assurance Framework July 2021	**Agenda Item:**	10
Author:	Helen Bucior, Infection Prevention Lead Nurse Emyr Philips , Associate Chief Nurse Infection Prevention/Deputy DIPC		
Executive Lead:	Mrs Ann-Marie Riley, Chief Nurse/DIPC		

Purpose of Report:

Assurance	✓	Approval		Information	

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

Executive Summary:

Situation

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

Background

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

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

Assessment

- NHS Infection Prevention and Control board assurance framework updated version published 30th June 2021 V1.6 New recommendation incorporated into BAF
- Not moving patients until 2 negative COVID screens achieved. For asymptomatic patients this is not always possible and therefore remains on the action plan
- There has been 1 change in risk score since previously reported; in relation to BAF 6 risk score has decreased , Mask fit testing can be captured on Health Roster and there improve mask fit testing records

Progress

- Mask fit testing skill is now available on Health Roster. This will enable areas to record model of FFP3 mask and date of mask fit testing electronically and also compile compliance data using this system. The mask fit testing certificate must continue to be completed manually and filed in the staff member personal folder. Compliance and mask fit failure rate to be monitored by the Divisions.

Key Recommendations:

The Board is asked 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

July 2021

Summary Board Assurance Framework as at Quarter 1 2020/21

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

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**			There are a number of controls in place, however evidence of assurance monitoring has demonstrated some gaps which will be addressed through the action plan	**Likelihood:**	**1**	End of Quarter 2
Consequence:	**3**	**3**				**Consequence:**	**3**	
Risk Level:	**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: NEW June 2021 • 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	• Trust has a nominated ventilation lead • Work with LRF to obtain community rates • Risk assessment follow Hierarchy of controls • IP attends the weekly Staffordshire and Stoke on Trent , Test, Trace and Outbreak Management Group • Daily Tactical meetings	• From June 2020 IP team to review patients that are found COVID positive and nursed in bay to ascertain compliance with pathway and IP control measures are in place Review pathways and identify theme • Theme report to IPCC • Pre AMS check COVID -19 screening results, if patient arrives in green area with no COVID screen a Datix is raised.	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	• 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;	• On arrival in ED patients are immediately identified either asymptomatic for COVID -19 and apply infection prevention precautions. • ED navigator in place • Colour coded areas in ED to set out COVID and Non COVID areas. This was revised in September 2020 to mirror inpatient zoning. Purple ED with blue single rooms and respiratory assessment unit • Aerosol generating procedures in single rooms with doors closed • ED navigator records patient temperature and asked COVID screening questions. Patient then directed to either remain in purple or blue single room • ED pathways and SOP • When ambulance identify suspected COVID patients are received in respiratory assessment Unit ED • All patients screened for COVID -19 when decision made to admit • Maternity pathway in place • Elective Pre Amms Plan to swab • Patients72 hours pre admission SOP in place • Radiology /interventional flow chart • Children's unplanned admission. ED Navigator asked COVID questions then child directed to either RED of Green Areas.		

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		• All children, symptomatic or asymptomatic are swabbed in child health. This is recorded within their medical records, placed onto the nursing and medical handover so that we are made of the results and whether we need to chase if not received within a timely manner. The patient flow reports to the Child Health tactical meeting every morning how many children have been swabbed result and any outstanding • All children swabbed are placed into a sideward upon receiving their result are either kept within a side ward or moved to a bay if the swab is negative. • Screening for patients on systematic anticancer treatment and radiotherapy • Out patient flow chart in place • Thermal imaging cameras in some areas of the hospital • Iportal alert in place for COVID positive patients • Extremely vulnerable patient placement added into new COVID ward round guidelines (October 2020)  8th-march-2021-covi d-ward-round-guidan		

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	• NEW June 2021When an unacceptable risk of transmission remains following the risk assessment, consideration to the extended use of respiratory RPE for patient care in specific situations should be given	• Discussed at Clinical group. Paper prepared by Deputy Medical Director which received exec approval w/c 26 July 2021		
1.2	Patients with possible or confirmed Covid-19 are not moved unless this is essential to their care or reduces the risk of transmission. There are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically imperative That on occasions when it is necessary to cohort COVID or non-COVID patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per guidance.	• All patients admitted to the Trust are screened for COVID -19 • All patients that test negative are rescreened on days 4, 6, 14 and weekly • Critical care plan with step down decision tree • COVID-19 Divisional pathways • Step down guidance available on COVID 19 intranet page • Barrier and Terminal clean process in place • IP PHE guidance • COVID Q+A available on Trust intranet covid-19-faq-v6-10-6-2021.docx	• Unannounced visits for clinical areas with clusters or HAI cases of COVID-19 • Review of HCAI COVID cases by IP Team • Datix /adverse incidence reports for inappropriate transfers	• NHSI key point 4 : Patients are not moved until at least two negative test results are obtained, unless clinically justified
1.3	Compliance with the national guidance around discharge or transfer of Covid-19 positive patients.	• Infection prevention step down guidance available on Trust intranet • All patients who are either positive or contacts of positives are advised to complete self –isolation if discharged or	• Datix/adverse incidence reports	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
		transferred within that time frame  Patient Information Lealfet - Contact 202  Testing and lifting IP precautions.pdf • All patients are screened 48 hours prior to transfer to care homes • New UHNM ward round guidance October 2020. This also included placement of the extremely vulnerable patient  4th-february-2021-c ovid-ward-round-gui  guidance-on-screeni ng-and-testing-for-co		
1.4	**All staff (clinical and non-clinical)** are trained in putting on and removing PPE, know what PPE they should wear for each setting and context and have access to the PPE that protects them for the appropriate setting and context as per national guidance. Linked NHSIE Key Action 3: Staff wear the right level of PPE when in clinical settings, including use of face masks in non-clinical settings. Linked Key Infection Prevention points – COVID 19 vaccination sites Monitoring of IP practices, ensuring resources	• Key FFP3 mask fit trainers in place in clinical areas • PPE posters and information available on the Trust COVID -19 page. This provides the what, where and when guide for PPE • Infection Prevention Questions and Answers Manual include donning and doffing information. • Areas that require high level PPE are agreed at clinical and tactical • Aerosol generating procedures (AGP's) which require high level PPE agreed at clinical and tactical group • COVID -19 Clinical Group reviews any proposed changes in PPE from the clinical	• Daily stock level of PPE distributed via email and agenda item for discussion at COVID-19 tactical group • IP complete spot check of PPE use if cluster/OB trigger • Records of Donning and Doffing training for staff trained by IP • A number of Clinical areas have submitted PPE donning an doffing records to the IP team • Donning and Doffing training also held locally in	• FFP3 Training records further improvement part of health and safety portacount business case

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	are in place to enable compliance with IP practice of staff adherence to hand hygiene? • Staff adherence to hand hygiene • New June 2021 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	areas • Link to Public Health England donning and doffing posters and videos available on Trust intranet • Chief Nurse PPE video • Extended opening hours supplies Department • Risk assessment for work process or task analysis completed by Health and Safety • PHE announced from 11th June 2020 all staff to wear mask in both clinical and non-clinical health care setting • Matrons walk rounds • Specialised division summarised BAF and circulated to matrons • ACN's to discuss peer review of areas • Poster displayed in entrances and along corridors reinforcing the use of masks social distancing and one way systems • Catch it , bin in, kill it posters in ED waiting rooms • Lessons learnt poster  Lessons learnt - Non Clinical June 2021.pdf  Lessons learnt - Clinical June 2021.pdf  unannounced-ip-visit-template-2020-11.pdf  non-clinical-assurance-visit-checklist-2020 • QIA process for occasions when we risk	clinical areas • Cascade training records held locally by Divisions • Sodexo and Domestic service training records • IP unannounced assurance visits • Review of UHNM vaccination areas against key infection prevention points COVID -19 • Hand hygiene audits	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace	assess that the 2 metres can be breached  SOP bed removal due to social distancir •		
1.5	National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way.	• Notifications from NHS to Chief nurse/CEO • IP team COVID lead checks Public Health England webpage daily (Monday-Friday) for updates • Changes raised at -19 clinical groups which was held originally twice weekly, reduced to weekly and now increased back to twice weekly due to surge of COVID. • Purpose of the Clinical Group - The Group receive clinical guidance and society guidance which is reviewed and if agreed used to advise clinical teams after approval at Exec COVID -19 meeting which is held twice monthly. • The clinical group initially weekly , now stepped down to Bi weekly • Tactical group – The tactical Group held daily. April 2021 now stepped down. The Group decide and agreed tactical actions Makes recommendations to Gold command • Chief nurse updates • Changes/update to staff are included in weekly Facebook live sessions • COVID -19 intranet page	• 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**
		• COVID -19 daily bulletin with updates • IP provide daily support calls to the clinical areas		
1.6	Changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted.	• Incidence Control Centre (ICC) Governance • Clinical Group, Divisional cells, Workforce Bureau, Recovery cells subgroup feed in to tactical group. • COVID Gold command , decisions /Assurance reported to Trust Board Via CEO Report/COO	• Meeting Action log held by emergency planning • Trust Executive Group Gold command – Overall decision making and escalation • Tactical, Operational Delivery Group - The delivery of the objectives and benefits, and programme communications COVID 19 response and R&R. Co - ordination of resources. Escalation forum for linked Groups and Cells ensuring that the interdependencies are effectively managed, including system. Makes recommendations to Gold Command for key decisions. • Clinical steering Group – Coordinate clinical decision – making to underpin continual service delivery and COVID 19 related care • Workforce Group – Lead the plan and priorities for our people recovery. Health	

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

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

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	**KLOE**	**Action Required**	**Lead**	**Due Date**	**Quarter 4 Progress Report**	**BRAG**
1.	1.1	Up- to- date COVID -19 Divisional pathways	ACN's	30/09/2020	Associate Chief Nurse contacted and request made for COVID -19 pathways 28th July 2020. ED pathways in place and also County to Royal transfer of COVID positive patients. Divisional restoration plans in progress	Complete
2	1.1	Revised pathways to include actions for extremely vulnerable patients who are admitted into the Trust	ACN's	31/10/2020	4th September Chief Nurse DIPC request at senior meeting that extremely vulnerable patients are included in revised pathways. October 2020 Extremely vulnerable patient recommendations included into the COVID ward round guidance document. November 2020 – Confirmation from ED County highly vulnerable patients are admitted into single cubicle. Consultant ED Royal confirms the same process. Children's – highly vulnerable have direct access to ward	Complete
3	1.2	NHSI key point 4 : Patients are not moved until at least two negative test results are obtained, unless clinically justified	Microbiologist/ ACN's	31/05/2020 31/08/2021	Testing and re testing, Interpretation of swabs and step down of IP precaution process in place at UHNM. Suspected or positive patients are moved on clinical need/assessment and in line with UHNM step down process. For patients who test negative on admission re screening is undertaken. 17th November NHSI guidance recommended that the second test is taken on day 3 after admission and day 5 after admission. Implementation of the new guidance is in place and a manual prompt is provided to the clinical areas. (Days 4 and 6 admission day counted as day 1). Waiting for 2 negatives swabs before moving for patients that are not COVID suspected does not always occur. April 2021 Chief Nurse reminded ACN's of testing guidance June 2021 – Day 14 and weekly COVID testing for patients who test negative and remain an inpatient - in place	Problematic – revised due date
4	1.3	Patient COVID -19 discharge information letter for patient who are discharged but contact of a positive case	IP Team	31/11/2020	Action at COVID weekly meeting was to create an information leaflet for patients and household members on discharge, with information on isolating, symptoms and useful information for informing the local authorities and the test and trace system. 6th November leaflet sent out for comments	Complete

					22/12/2020 to Clinical Group for approval. Progressed to Outbreak Group and Tactical Group , minor changes made 12th December 2020 Submitted to Gold	
5	1.4	Improving staff FFP3 mask fit staff training data recording and retention of records.	Health and Safety	31/08/2021	Proposed Fit Testing compliance improvement Task and Finish Group. Inaugural meeting took place 29th July 2020. ESR will be up and running for the purpose of recording fit test records as soon as the Trust gives the go ahead to procure Portacount fit test systems, this is a project lead by Health and Safety As at 03/02/2021 People O&D have created FFP3 mask "classes" on ESR. Health and Safety are in the process of collating fit test records which were requested at Exec Health and Safety Groups from Divisional H&S Leads. Portacount Business case : Health and Safety Head continues with Business case with target date for completed revised for end of August 2021 10/03/2020 Portacount machine obtained (on loan) by Infection Prevention Team via Midlands Coordinator for the FFP3 Mask Project. Plus mask fit tester will be available to test staff using the portacount machine. The portacount is a quantitative test and uses specialised equipment to measure exactly how much air is leaking through the seal of a mask. ACN'S informed and response requested to aid in identifying testing priority. Midlands Coordinator is meeting IP next week to work through plan. Mask fit testing also continues using hood and bitrex (qualitative, relies on taste) Mask fit testing option also added to e rostering to enable areas to identify staff member that have been tested and record mask	Complete

					model. A report can also be produced with compliance using this system. The mask fit testing certificate must also continue to be completed and filed in the staff member personal folder. Updated mask fit strategy to March which includes mask fit re test frequency. <u>May 2021</u> FFP3 cascade mask fit refresher in progress. This refresher includes checking that fitters are aware of e rostering and the need to file test certificate in staff members personal folder <u>June 2021</u> Portacount Business case - Awaiting decision from Exec Health and Safety Group <u>July 2021</u> Portacount Business case withdrawn at Health and Safety <u>July 2021 update</u> Infection Prevention, those staff that failed on the Bitrex method referred to the Portacount machine, gave us an extra 75% pass rate on the original failures. This is a valuable additional tool for us to get as many staff trained as possible. <u>Action complete</u> FFP3 testing records can now be added as a skill to Health roster. The portacount machine action will be added as criteria 6 and 10 as business case re-instated	
6.	1.4	Divisions to retain current mask fit training records and compliance score for their areas whilst central recording and retention of records process is agreed	ACN'S	30/09/2020	Associate Chief Nurse contacted and request made for assurance with staff mask fit compliance. Compliance also added to Divisional papers for infection Prevention and Control Committee (IPCC). Current process that clinical areas hold their own training records and can also enter basic details on Health Rostering including model of mask staff fitted with. A number of clinical areas have also forwarded training records to the IP Team. IP Team. IP have a list of mask fit testers, this is also available on the Trust COVID intranet page.	Complete
7.	1.8	Re instate admission proud to care documentation, currently emergency admission document in place	Deputy Director of Quality and	30/09/2020	Original proud to care booklet reinstated now	Complete

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

9.	1.8	To explore an alternative laboratory for Clostridium difficile ribotying	Kerry Rawlin Laboratory	31/08/2020	Leeds Hospital has agreed to help with ribotyping Clostridium difficile specimens. Await first batch of results to gain assurance that process is working 04/09/2020 we are experiencing problems in receiving ribotyping results back from Leeds. Usually they would arrive electronically. UHNM have contacted Leeds and are awaiting a resolution with their IT team and the PHE reference electronic reporting system. Ribotype now being received from Leeds and added to ICNET patient case	Complete

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

Risk Scoring								
Quarter	Q4	Q1	Q2	Q3	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2	1			Whilst cleaning procedures are in place to ensure the appropriate management of premises further work required re computer on wheels cleaning	Likelihood:	1	End of Quarter 2
Consequence:	3	3				Consequence:	3	
Risk Level:	6	3				Risk Level:	3	

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

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

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

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
			competency checks to ensure that they are following GREAT card training • Spot checks completed by CPM includes observation of cleaning techniques by the domestic staff.	
2.8	As per national guidance: • 'Frequently touched' surfaces, e.g. door / toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated more than twice daily and when known to be contaminated with secretions, excretions and bodily fluid. • Electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily. • Rooms / areas where PPE is removed must be decontaminated, timed to coincide with periods immediate after PPE removal by groups of staff (at least twice a day). Linked NHSIE Key Action 1: All high touch surfaces and items are decontaminated multiple times every day – once or twice a day is insufficient.	• Cleaning of frequently touch points included in Barrier clean process • Offices and back offices also supplied with disinfectant wipes to keep work stations clean. • Non- invasive medical equipment must be decontaminated after each use. IP Q+A manual	• IP checks • Barrier clean request log • Terminal clean request log • Additional ad-hoc cleaning requests can be requested by clinical teams 24/7 should the environment become contaminated between scheduled / barrier cleans. • Non-clinical areas are cleaned at regular frequencies through the day especially sanitary ware, and if additional cleans are required between scheduled cleaning, these can be requested via the helpdesk.	
2.9	Linen from possible and confirmed Covid-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken.	• Included in IP questions and answers manual • Linen posters depicting correct linen bag displayed in clinical areas	• IP audits held locally by divisions • Datix reports/adverse incidents	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
		and linen waste holds • Red alginate bags available for infected linen in the clinical areas • Infected linen route		
2.10	Single use items are used where possible and according to single use policy.	• IP question and answers manual • Medical device policy • SOP for Visor decontamination in time of shortage	• IP audits held locally by divisions	
2.11	Reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance. NEW June 2021 Resuable non –invasive care equipment is decontaminated: ○ Between each use ○ After blood and/or body fluid contamination ○ At regular predefined interval as part of an equipment cleaning protocol ○ Before inspection, service or repair equipment	• IP question and answers manual covers decontamination • Air powered hoods – SOP in place which includes decontamination process for the device • Re usable FFP3 Masks – Sundstrom/ GVS Elipse. SOP's in place which includes the decontamination process • Medical device policy • Availability of high level disinfectant in clinical areas • Sterile services process • Datix process • Bed Storage Group looking at non conformities for beds that require repair	• IP audits held locally by divisions • Datix reports/adverse incident reports	Decontamination of beds returned for repair process, none conformities
2.12	Review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission. Ensure the dilution of air with good ventilation e.g.	• HTM hospital ventilation • UHNM has established a Ventilation Safety Group as recommended by the Specialised Ventilation for Healthcare Society in order to provide assurance to the Trust	• Estates have planned programme of maintenance • The Authorising Engineer Ventilation will provide external independent specialist advice and	

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

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

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 4 Progress Report	BRAG
1.	2.3	To re instate C4C cleanliness audits and patients survey	Head of CPM Estates, Facilities & PFI Division	30/09/2020	Soft FM cleaning services and Sodexo recovery plan in place which includes the process for reinstating the monitoring process and patient surveys which have commenced 6th July 2020. 04/09/2020 The C4C audits programme are now covering all areas but are not fully multi-disciplinary audit team e.g. only CPM on them due to social distancing. (yet to invite Sodexo, Nurse)We are likely to expand this out during October 2020 December 2020 – email confirmation from Sodexo and retained that C4C audits are in place 01/10/20 – Fully disciplinary team are now invited to C4C audits with strict social distancing in place at all times. Audits remain fluid to allow maximum access during the 3rd wave of Covid.	Complete
2	2.4	To address cleaning issues and environmental damage highlighted during NHSI visit	Head of CPM Estates, Facilities & PFI Division	14/12/2020	Feedback from NHSI provided to Sodexo and action plan devised Action Plan Following NHS England NHS Im NHSI action plan June 21.docx C4C audit programme in place Ward to complete quarterly environment audits IP environment audits	Complete
3	2.4	To address dirty nursing equipment and commodes, plus computer on wheels	ACN'S / IP/ Deputy Head	31/05/2021 – re:	Dirty nursing equipment and commodes found during NHSI Visit.	Complete

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

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

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

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

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
Systems and processes are in place to ensure:				
3.1	Arrangements around antimicrobial stewardship are maintained.	• Regular, planned Antimicrobial stewardship (AMS) ward rounds • Trust antimicrobial guidelines available 24/7 via intranet and mobile device App • Clostridium *difficile* Period of increased incidence and outbreaks are reviewed by member of AMS team and actions generated cascaded to ward teams • Regional and National networking to ensure AMS activities are optimal • Formal regional meetings and informal national network activities • AMS CQUIN further mandates key AMS principles to be adhered to	• Same day escalation to microbiologist, if concerns. Outcome recorded on I portal • Metric available around the number of times App accessed by UHNM staff • Compliance with guidelines and other AMS metrics reported to Infection prevention and control Committee (IPCC) • Meeting minutes reviewed and actions followed up • Real time discussions / requests for support / advice enabled via regional and national social media accounts. National (incl.	

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

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	**KLOE**	**Action Required**	**Lead**	**Due Date**	**Quarter 4 Progress Report**	**BRAG**
1.	3.1	Further controls are required to improve compliance	ACN'S	30/04/2021	Antimicrobial audits results discussed at IPCC 27th July 2020. Separate meeting with chief nurse/IP and ACN's to be arranged during August to discussed results and any corrective actions. Feedback meeting completed 4th September 2020. – Senior meeting. To review escalation of areas that are not compliant with antimicrobial guidelines. New point prevalence audits undertaken by AMS pharmacists during December 2020 to provide updated snapshot for ACNs. Results will be discussed at March IPCC meeting 31/03/2021 Following discussion of these results at March 2021 IPCC a meeting has been arranged between Chief Nurse, deputy DIPC, lead AMS pharmacist and lead AMS microbiologist to discuss ways in which divisions can be supported to improve their stewardship performance. Individual clinical areas can be identified from Pharmacy audit data. Meeting date 15.4.21 April 2021 Meeting held between ASG leads, CD Pharmacy, Deputy DIPC and DIPC on 15th April 2022. Action plan in place	Complete
2.	3.1	To review current escalation of areas that are not compliant with antimicrobial guidelines	DIPC	30/04/2021	Raised at September Antimicrobial Pharmacist Group and IPCC. Escalation process to be agreed. Meeting between Antimicrobial Pharmacist and Deputy DIPC undertaken. Escalation process to be discussed at November Antimicrobial Stewardship Group. January 2021 discussed at Trust Board to be discussed at ASG, then to IPCC Following discussions between DIPC and AMS Pharmacist a draft escalation protocol has been produced and was presented at January ASG as the November meeting cancelled (clinical pressures) the group have 2 weeks to review. Will thereafter to be forwards to IPCC for discussion and ratification at the March	Complete

					IPCC meeting. 31/03/2021 The draft escalation protocol was approved at March ASG. It will be shared with Chief Nurse and Deputy DIPC at meeting above (15.4.21) and target wards will be identified. Protocol approved at March 2021 ASG.	

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

Risk Scoring

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

Control and Assurance Framework

Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
4.1	Implementation of national guidance on visiting patients in a care setting. There is clearly displayed , written information available to prompt patients, visitor and staff to comply with hands, face and space advice	• To help protect patients and staff from Covid-19, the NHS suspended all visiting to hospitals. This national suspension has now been lifted and visiting is to be introduced in some areas of our hospitals, subject to certain conditions. From Monday 17 August 2020 visiting will be phased in across some areas and will be	• Monitored by clinical areas • PALS complaints/feedback from service users	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		allowed in the West Building at Royal Stoke and in Wards 7, 12, 15 at County Hospital. All visiting will have to be pre-booked and relatives will be provided with the correct information and contact details to book in advance. Visitors will be instructed to wear face masks and other PPE if they are providing 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		

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
		• Guidance to accommodate visitor if appropriate and necessary to assist a patients communication and/or to meet their health, emotional , religious or spiritual need • A familiar care/parent or guardian/support/personal assistant • Children both parents /guardian where the family bubble can be 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		
4.2	Areas in which suspected or confirmed Covid-19 patients are being treated are clearly marked with appropriate signage and have restricted access.	• ED colour coded areas are identified by signs • Navigator manned ED entrance • Hospital zoning in place	• Daily Site report for county details COVID and NON COVID capacity	
4.3	Information and guidance on Covid-19 is available on all trust websites with easy read versions.	• COVID 19 section on intranet with information including posters and videos	• COVID-19 page updated on a regular basis	
4.4	Infection status is communicated to the receiving organisation or department when a possible or confirmed Covid-19 patient needs to be moved.	• Transfer policy C24 in place , expires November 2020 • IP COVID step down process in place	• Datix process	
4.5	NEW JUNE 2020 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		

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

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter Progress Report	BRAG
1.	4.4	To include COVID-19 in transfer policy	Deputy Director of Quality and Safety	31/12/2020	3rd August 2020 Meeting arranged between IP and Quality and Safety to commence review of transfer policy to include COVID -19. Policy for the Handover, Transfer and Escort Arrangements of Adults patients between wards and Departments which Expires November 2020. October IP have now submitted IP/COVID information for incorporation in to this Policy.	Complete

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

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

Control and Assurance Framework

Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
5.1	Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed Covid-19 symptoms and to segregate them from non Covid-19 cases to minimise the risk of cross-infection as per national guidance. Screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases. Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from Non Covid-19 Staff are aware of agreed template for triage questions to ask Triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible	• ED navigator records patient temperature and asked screening questions. Patient then directed to colour coded area • All patients who are admitted are now screened for COVID 19	• June 2020 IP team review patients that are found COVID positive and nursed in bay to ascertain compliance with pathway and IP control measures are in place Review pathways and identify theme . COVID 19 -Themes report to IPCC • ED pathways including transfer of COVID positive patient from County to Royal Hospital	
5.2	Mask usage is emphasized for suspected individuals. Face coverings are used by all outpatients and visitors Face masks are available for all patients and they are always advised to wear them	• 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	• Hospital entrances Mask dispensers and hand gel available	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	NEW June 2021 Individuals who are clinically extremely vulnerable form COVID 19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room Provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients (particularly when moving around the ward) if this can be tolerated and does not compromise their clinical care NEW June 2021 patients are encouraged to wear face masks Monitoring of Inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so) and is not detrimental to their physical or mental needs	• 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	• Datix /incidents • COVID-19 themes report to IPCC	
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	• 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	• 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**
	must be considered and wards are effectively ventilated.	• 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.		
5.4	For patients with new-onset symptoms, it is important to achieve isolation and instigation of contact tracing as soon as possible.	• Process for isolation symptom patient in place • Process for cohorting of contacts • Contacting patients who have been discharged from hospital then later found to be a close contact of a COVID-19 positive case , patient to be informed by the clinical area and self- isolation advice provided as per national guidance • https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance/stay-at-home-guidance-for-households-with-possible-coronavirus-covid-19-infection	• If patient found to be positive in the bay and exposing other patient. IP liaise with clinical are, apply bay restrictions. • Patient who tested negative on admission and remain an inpatient are retested for COVID days 4 and 6, day 14 then weekly • Spot check audits	
5.5	Patients with suspected Covid-19 are tested promptly. There is evidence of compliance with routine testing protocols in line with key actions	• All patients who require overnight stay are screened on admission and patients who develop symptoms – UHNM screening guidance in place	• Adverse incident monitor /Datix	
5.6	Patients who test negative but display or go on to develop symptoms of Covid-19 are segregated and promptly re-tested and contacts traced.	• Screening protocol in place which includes rescreening /re testing. Pathways in place for positive COVID 19 patients • Iportal alert and April 2021 contact alert in place iportal/medway • The IP team have been applying a Covid-19 contact alert within the ICNET system since November 2020 and this continues.	• 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**
		• 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.	• Restoration and Recovery plans • Thermal temperature checks in imaging, plan to extent to other hospital entrances • Mask or face coverings for patients attending appointments from Monday 15th June 2020	• Datix process	

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

		wearing face masks particularly when moving around the ward (if clinically ok to do so)			face masks. Matrons daily walk round	

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

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

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

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		manual. • FFP3 train the trainer 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 • Health and Safety leading on portacount mask fit business case which has the potential to enhance mask fit training records further as this system is capable of collected data which can be uploaded	Monitoring FFP3 mask fit compliance using Health roster

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

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

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

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

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

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

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

7. Provide or secure adequate isolation facilities

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

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

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

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

8. Secure adequate access to laboratory support as appropriate.

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
8.1	Testing is undertaken by competent and trained individuals. • Regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	• How to take a COVID screen information available on Trust intranet. This has been updated in November 2020 • Laboratory services for UHNM are located in the purpose built Pathology Laboratory on-site at RSUH. The Laboratory is United Kingdom Accreditation Service (UKAS) accredited. • Turnaround times included in tactical slides	• Review of practice when patient tests positive after initial negative results	
8.2	Patient and staff Covid-19 testing is undertaken promptly and in line with PHE and other national guidance. Linked NHSIE Key Action 7: Staff Testing: a) Twice weekly lateral flow antigen testing for NHS patient facing staff is implemented. Whilst lateral flow	• All patients that require an overnight stay are screened for COVID-19 on admission or pre admission if planned/elective surgery • Screening process in place for elective surgery and some procedures e.g. upper	• Empactis reporting • Team Prevent systems • Datix/adverse incidence reporting • Cluster /outbreak investigation procedures	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	technology is the main mechanism for staff testing, this can continue to be used alongside PCR and LAMP testing. b) If your Trust has a high nosocomial infection rate you should undertake additional targeted testing of all NHS Staff, as recommended by your local and regional infection prevention and control team. Such cases must be appropriately recorded, managed and reported back. Linked to NHSIE Key Action 8: Patient Testing: a) All patients must be tested at emergency admission, whether or not they have symptoms. b) Those with symptoms of Covid-19 must be retested at the point symptoms arise after admission. c) Those who test negative upon admission must have a second test 3 days after admission and a third test 5 – 7 days post admission. Letter 6th April NHS October 2020 the region implemented requirement for screening on day 13 d) All patients must be tested 48 hours prior to discharge directly to a care home and must only be discharged when the test result is available. Care home patients testing positive can only be discharged to CQC designated facilities. Care homes must not accept discharged patients unless they have that persons test result and can safely care for them.	endoscopy • Process in place for staff screening via empactis system and Team Prevent • Patients who test negative are retested 4, day 6 and day 14 and weekly • Patient who develop COVID symptoms are tested • Staff screening instigated in outbreak areas • November 2020 - Lateral flow device staff screening to be implemented to allow twice weekly. Staff are asked to submit results via text. Jan 2021 Recent communications on COVID bulletin to remind staff to submit results • Questions and answers available on the COVID 19 page Trust intranet re lateral flow including actions to take for reporting both a negative or positive result • All patient discharged to care setting as screened 48 hours prior to transfer/discharge • Designated care setting in place for positive patients requiring care facilities on discharge – Trentham Park		

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	e) Elective patient testing must happen within 3 days before admission and patients must be asked to self-isolate from the day of the test until the day of admission. There is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control and testing document • That sites with high nosocomial rates should consider testing COVID negative patients daily. • That those being discharged to a care facility within their 14 day isolation period should be discharged to a designated care setting, where they should complete their remaining isolation.	• 11th May 2021 introduction of day 14 screen and also weekly screen for negative patients • From 29th April 2021 a team from HR are supporting the IP Team by contacting the clinical area to advise when screens are due • In addition to the above from 11th May 2021 inpatients who have not tested covid 19 positive within the previous 90 days are to be rescreened on day 14 and then weekly • Reviewed as part of outbreak investigation • Matrons and ACN'S aware of retesting requirement • Not required currently but kept under review • Patients are tested as part or outbreak investigation • Designated home identified- Trentham Park		
8.3	Screening for other potential infections takes place.	• Screening policy in place, included in the Infection	• MRSA screening compliance • Prompt to Protect audits	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		Prevention Questions and Answers Manual	completed by IP • Spot check for CPE screening	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 2 Progress Report	BRAG
1.	8.1	Champions COVID-19 swabbing technique in clinical areas	Deputy Director if infection Prevention	31/12/2020	Training package and recording system to be devised. Work to commence. 1st September swabbing video recorded, minor changes to be completed week commencing 14th September then video will be circulated to key people for preview and comments. Child positioning included in video Screening video now complete and uploaded on to Trust intranet November 2020. A number of areas have identified swabbing Champions, request sent to ACN's. Implementation of champions in progress.	Complete
2	8.2	NHSIE Key Action - Those who test negative upon admission must have a second test 3 days after admission and a third test 5-7 days post admission	Microbiologist/IP Team	07/12/2020	Following NHSI new guidance Those who test negative for COVID on admission are to be retested on day 4 and day 6, with admission day counted as day one. Implementation of this is underway and prompt is provided to clinical areas	Complete
3	8.2	Those who test negative upon admission must have a second test 3 days after admission and a third test 5 days post admission	Deputy Chief Nurse	07/12/2020	Report received by Deputy Chief Nurse on a daily basis with list of patients that are due for re screen. Clinical areas then contacted and prompt to re screen.	Complete
4.	8.3	To complete an analysis (Advantages and disadvantages) to reinstating pre COVID 19 UHNM screening policy	Deputy Director if infection Prevention	14/06/2021	MRSA screening had reduced temporarily due to the COVID pandemic but UHNM are still following PHE 2014 guidance. This was an agreed temporary change in UHNM practice. Previously the Trust were screening over and above the 2014 guidance. Due to the COVID pandemic less elective work is taking place therefore less elective screening. High risk areas all still screen on admission. Risk based screening is for lower risk areas. Prior to the 2014 guidance the DIPC at the time (supported by the CCGs) did not want to reduce the screening policy the Trust	Complete

					already had in place. The CCG requested screening policy have to be approved by the CCGs. Discussed at IPCC. DIPC requested a pro's and con's exercise re screening changes due to the COVID pandemic. The Trust has not dropped below national guidance. October MRSA screening is around 50% of pre COVID screening; laboratory does not have the capacity to process COVID work and level of MRSA screens pre COVID. Paper to November IPCC. This continues to be under review during COVID Pandemic. Feb 2020 This continues to be under review during COVID pandemic <u>March 2020</u> Elective screening for high risk surgery and overnight surgery to resume MRSA bacteraemia surveillance continues <u>20/04/2021</u> Due to wave 2 COVID 19 , paper deferred to May IPCC 2021 <u>May 2020</u> Screening recommenced a pre COVID 19 pandemic. DIPC advised action complete	

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

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

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
9.1	Staff are supported in adhering to all IPC policies, including those for other alert organisms.	• IP included in mandatory update • Infection Prevention Questions and Answers manual with ICON on every desk top for ease of use • Infection Prevention triage desk which provides advice and support to clinical areas	• IP audit programme • Audits undertaken by clinical areas • CEF audits • Proud to care booklet audits	
9.2	Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff.	• Notifications from NHS to Chief nurse/CEO • IP team COVID lead checks Public Health England webpage daily (Monday-Friday) for updates • Changes raised at COVID clinical group which is held twice weekly • Daily tactical group • Incident control room established where changes are reported through • Chief nurse updates	• Clinical Group meeting action log held by emergency planning	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		• Changes/update to staff are included in weekly Facebook live sessions • COVID -19 intranet page • COVID -19 daily bulletin with updates		
9.3	All clinical waste and linen/laundry related to confirmed or possible Covid-19 cases is handled, stored and managed in accordance with current national guidance.	• Waste policy in place • Waste stream included in IP mandatory training	The Trust has a Duty of Care to ensure the safe and proper management of waste materials from the point of generation to their final disposal (Cradle to Grave). This includes: • Ensuring the waste is stored safely. • Ensuring the waste is only transferred to an authorised carrier and disposer of the waste. • Transferring a written description of the waste • Using the permitted site code on all documentation. • Ensuring that the waste is disposed of correctly by the disposer. • Carry out external waste audits of waste contractors used by the Trust.	
9.4	PPE stock is appropriately stored and accessible to staff who require it.	• Procurement and stores hold supplies of PPE • Stores extended opening hours • PPE at clinical level stores in store	• PPE availability agenda item on Tactical Group meeting	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		rooms • Donning and doffing stations at entrance to wards		

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 2 Progress Report	BRAG
1.	9.1	CEF Audits to recommence	Deputy Director of Quality and Safety	30/09/2020	Review of tool kit with Chief Nurse planned, aiming to trial during August and reinstate audits fully during September 2020. CEF audits reinstated.	Complete
2.	9.1	Proud to care booklet audits paused. Plan for recommencing	Deputy Director of Quality and Safety	30/09/2020	Original proud to care booklets reinstated	Complete
3.	9.1	Compliance with correct mask wearing and Doctors complaint with Bare Below the Elbow	Deputy DICP/Medical Director/ ACN's	Revised 31/03/2021	NHSI Action plan devised. Senior walk rounds of clinical areas in place.	Complete

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

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
10.1	Staff in 'at risk' groups are identified and managed appropriately, including ensuring their physical and psychological wellbeing is supported. That risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic and pregnant staff	• All managers carry our risk assessment • Process available on the COVID 19 Trust intranet page • BAME risk assessment • Young persons risk assessment • Pregnant workers risk assessment • Risk assessment to identify vulnerable workers	• Risk assessment and temporary risk mitigation will be reported to the workforce bureau. To protect confidentiality individual risk assessments will not be requested as these should be kept in the employees personal file • Managers required to complete , review and update risk assessments for vulnerable persons	

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

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	remind staff to follow public health guidance outside of the workplace.	process in place • November 2020 – Care sharing instructions added to COVID Bulletin		
10.5	Consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas.	• Social distancing tool kit • Staff encouraged to keep to 2 metre rule during breaks • Purpose build rooms for staff breaks in progress	• Social distance monitor walk rounds • Social distance posters identify how many people allowed at one time in each room	
10.6	Staff absence and wellbeing are monitored and staff who are self-isolating are supported and able to access testing.	• Team Prevent available to offer guidance and treatment to staff presenting with onset of symptoms.	• Team prevent monitoring process • Work force bureau	
10.7	Staff who test positive have adequate information and support to aid their recovery and return to work.	• Team Prevent available to offer guidance and treatment to staff presenting with onset of symptoms. • Empactis line will first ask – is the absence related to coronavirus. To which the employee must say yes or no • Once the absence is reported to the employees manger via email, the manager will categorise the absence type specified in the flow chart. • Team prevent complete COVID 19 staff screening • Areas where transmission has occurred are discussed at clinical group and relevant staff screening under an ILOG number is agreed. • Flow charts or staff returning to work available on COVID 19 section	• Via emapactis • Staff queries' through workforce bureau or team prevent	

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

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

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

					Health and Safety to progress with portacount business case. Work to start September2021	
2	10.2	NEW action Monitoring FFP3 mask fit compliance %	Divisions	31/09/2021	To monitor the mask fit compliance % for own division using available records / Health Roster	On-going

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

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	4th August 2021
Report Title:	Maternity New Serious Incident Report Summary Quarter 1 2021	**Agenda Item:**	11
Author:	Donna Brayford, Quality & Risk Manager		
Executive Lead:	Ann-Marie Riley, Chief Nurse		

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

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

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

Situation:
Following the publication of the Ockenden review, Trust boards are to have specific sight of Maternity Serious Incidents on a quartely basis. The report provides a summary of the numbers and types of Serious Incidents formally logged on STEIS (national reporting system) by Maternity during Quarter 1 (2021). A Serious Incident report is presented to the Directorate and CWD Division monthly

Assessment:
Maternity currently have 10 ongoing serious incidents.

1 new serious incident was reported in Q1

- April 2021 1 serious incident: Unexpected term admission to the neonatal unit for therapeutic hypothermia (cooling)
- May 2021 0 serious incident
- June 2021 0 serious incident

Category of Incidents:

- 1 Healthcare Safety Investigation Branch (HSIB) investigation
- 0 Retrospective incidents following completion of investigation
- 0 new incidents to be investigated by local Root Cause Analysis (RCA)

Immediate Actions:

- Check fetal monitoring training compliance of clinical staff involved in serious incident

Areas of concern/escalation:

- All learning and action plans will be followed up by CWD Assurance Forum and Risk Management Panel
  - CCG SI group to be made aware of a potential increase in reporting of SIs due to the decision to report all HSIB investigations as SIs

Key Recommendations:

The Trust Board is asked to note and receive this report for assurance.

Maternity New Serious Incident Reporting Process – for information (Quarter 1 2021)

The Maternity Team strive to declare Serious Incidents as soon as possible. The Quality and Risk Team are informed of the incident by Datix, a clinician or mother's concern or on completion of an investigation such as a Perinatal Mortality Review Tool (PMRT). The Clinical Director (CD) and Head of Midwifery (HOM) are immediately informed. The incident will be discussed at the weekly multi-disciplinary Obstetric Risk meeting to establish facts and ensure all immediate actions are implemeted. A 72 hour brief will be prepared and once approved by the HOM and CD will be 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 have 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 SIs 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, whilst UHNM are receiving HSIB reports in a more timely manner they can take up to 12 months to complete and this represents a significant delay in SI reporting. Therefore, following correspondence from the Medical Director and Chief Nurse, as of 25/11/20 the decision was made to SI report and then de-escalate after if appropriate.

Contents

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 celcius, 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

Dawes Redman CTG – it is a software tool which provides a numeric analysis of the CTG trace and an interpretation based on Dawes-Redman Criteria.

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.

2. New Serious Incidents

Maternity have reported 1 Serious Incident (SI) during Q1 (2021), April (n=1), May (n= 0) and June (n =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 all HSIB investigations will be reported as Serious Incidents, and then de-escalated if required

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

SI ID	Datix ID	Incident description	Immediate Actions	Outcome
2021/9749	243402 HSIB	• Unexpected term admission to the neonatal unit for therapeutic hypothermia (cooling) following an instrumental delivery for abnormal electronic fetal heart monitoring (Cardiotocograph/ CTG). Cooling is a specialist treatment that lowers the baby's body temperature from 37 degrees to 33.5 degrees to aid with the healing process of the baby's brain. • HSIB investigation in progress	• HSIB referral completed • Verbal and written Duty of Candour completed • Staff support arranged • Parents informed of NHS Resolution referral • All members of staff involved have already completed mandatory fetal monitoring training. • No further immediate actions have been taken	• Baby has received a MRI which has not suggested any obvious abnormality. Baby was feeding well at discharge and is growing with normal neurology. • The baby experienced seizures requiring treatment with medications and remains on anti-convulsant medication

3. Current Serious Incidents in progress

Maternity currently have 10 ongoing serious incidents.

Investigation in progress: 4 incidents (3 local RCA, 1 HSIB)
Investigation completed, awaiting to be presented and closed by Risk Management Panel and CCG SI Group: 5 incidents

4. Serious Incidents Closed – Learning and Actions

2021/1244 **Datix ID: 225370 - Datix trigger : Low Cord gases**						
No	**Learning identified**	**Action**	**Action status**	**Responsible**	**Date for completion /update**	**Completed date & evidence**
1	**Unmet criteria on Dawes Redman CTG (multiple times) were not systematically reviewed and actioned.**	1.1 Develop a Dawes-Redman electronic CTG training package and establish an assessment of competency	**In progress**	**Saving Babies Lives Care Bundle Lead Midwife /Consultant Lead**	**31.08.21**	
2.	**Maternity services need to promote an 'its ok to ask' culture to ensure that all members of the team feel able to seek early**	2.1 Maternity services need to ensure that all Midwifery and obstetric medical staff at all levels attend mandatory interactive multi-disciplinary CTG workshops that focus upon the human factors of CTG interpretation	**In progress**	**Saving Babies Lives Care Bundle Lead Midwife and**	**31.08.21**	

	involvement of the Consultant Obstetrician into decision making in complex clinical situations.			**Consultant Lead**		
3	**The interpretation of the admission CTG was incorrect**	3.1 Consider the introduction of Antenatal fresh eyes of the CTG (2 clinicians reviewing the CTG and agreeing the findings) This was previously introduced for use with the intrapartum CTG. This is not routine practice with antenatal CTGs at UHNM and there is variation in the UK of this practice for antenatal CTGs.	**Ante-natal sticker developed**	**Saving Babies Lives Care Bundle Lead Midwife and Consultant Lead**	**31.08.21 Sticker approved, currently being printed. Not yet available in the clinical area.**	
4	**There was poor communication, documentation and handover practices of the teams involved in care**	4.1 Establish barriers towards compliance with the SBAR tool 4.2 Develop an action plan to address compliance with the SBAR tool giving consideration to: K2 functionality SBAR principles 4.3 Conduct an audit to identify a benchmark for compliance 4.4 Add SBAR audit to the Directorate rolling audit programme 4.5 Add use of the SBAR tool to local mandatory training programs	**In progress**	**Lead Midwives for Education and Development Consultant Obstetrics & Gynaecology Training Lead**	**31.08.21**	

2021/1236 Datix ID: 215762 - Datix trigger : Uterine rupture						
No	**Learning identified**	**Action**	**Action status**	**Responsible**	**Date for completion/ update**	**Completed date & evidence**
1.	**Women requiring opiate analgesia for latent phase should be reviewed by a member of the medical staff to exclude other causes of pain**	1.1 (ASQUAM) Latent Phase of Labour guideline: June 2016 to be reviewed	**In progress**	**Midwife Birth Centre Manager**	**31.08.21**	
2.	**Poor record keeping regarding the administration of analgesia and monitoring the effectiveness.**	1.2 Maternity services to conduct an audit of clinical records to establish clinical record keeping standards, regarding the documentation of pain relief and its effects.	**In progress**	**Professional Midwfery Advocate**	**31.08.21**	

No	Learning identified	Action		Responsible	Date for completion/ update	Completed date & evidence
3	**Signs and symptoms displayed by the patient were suspicious of the latent phase of labour; however with the accompanying need for increasing pain relief and the obstetric history this should have triggered the need for continuous fetal monitoing** **There is no specific local or national guidance on care of women in the latent phase of labour with a uterine scar.**	3.1 ASQUAM: Guideline for Vaginal Birth after Caesarean Section (VBAC): May 2016 to be reviewed to reflect the latent phase of labour with uterine scar.	**In progress**	**Delivery Suite Manager**	**31.08.21**	
4	**There is no requirement within current guidelines to review and upgrade the category status of a caesarean section when the clinical picture changes.**	4.1 Ensure that the prioritistaion of theatre lisitng is conducted with the Consultant and either the Delivery Suite Coordinator/Delivery Suite Manager/In-patient Matron and theatre teams.	**Completed**	**Delivery Suite Manager**	**31.08.21**	**30.03.21**

5. Current HSIB Cases

1 HSIB case was referred in April
Unexpected term admission to the neonatal unit for therapeutic hypothermia

PROGRESS
Staff interviews currently in progress

Performance and Finance Chair's Highlight Report to Board

20th July 2021

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The Committee received an update in relation to paediatric surge planning, due to ongoing challenges being experienced within paediatrics due to increases in respiratory viruses and the anticipated demand from August 2021 to March 2022. • A further update was provided on urgent care and the actions being taken to address the challenges in performance via the various work streams, whilst acknowledging the outstanding issue regarding workforce for which funding had been approved non-recurrently for additional staff in the short term • In relation to cancer performance, 2 week performance had increased and the patient tracking list had reduced, although there were significant delays noted in pathology and a plan was to be identified in terms of improving performance going forwards. In addition, some diagnostic ultrasound challenges were highlighted.	• To further clarify the link with paediatric surge planning on BAF6 • To articulate the links with the paediatric surge plan within the overall Trust's winter planning • To provide the trajectories associated with reducing the overall size of the waiting lists to the next meeting • To review the Data Security and Protection training package to establish whether the elements in relation to reporting incidents and transferring data securely could be strengthened or supported by further information provided separately to staff
Positive Assurances to Provide	**Decisions Made**
• In terms of planned care, the number of procedures had increased to over 500 a week which was positive, in addition to a reduction in 52 week waits • In terms of Data Security & Protection, updates were provided against the key areas of work, in which the 95% training target had been achieved, and the 2020/21 toolkit had been submitted with an assessment of standards not fully met – plan agreed, mainly due to the inability to provide sufficient evidence in relation to offline back up. • An update was provided by the Data Security and Protection Group and the items considered during their last meeting • In relation to business case reviews, 21 reviews had been requested; 11 were outstanding, 5 were being presented to Divisional Boards, 2 were being amended and 3 had been presented at Executive Team with further comments made which were being addressed. • The Committee noted the strategic risks for quarter 1 and challenged the impact of the risk scores and whether these should be higher. It was noted that the consequence of the risk reflected the current effectiveness of the controls in place, and whilst the possible impact could be higher, the score reflected current assurances. The Committee queried the timing of the system strategy and it was noted that this was to be determined by the system. • The Committee received assurance from the Business Intelligence Group and the items of business covered during the last meeting, and noted the risks in relation to the recording of patients on the follow up backlog as well as the ongoing work in relation to capacity and demand modelling • The Committee received an update on the investments made by the Trust and it was noted that from what been committed so far, was affordable, but there remained a risk in relation to future recurrent investments which had no funding source identified. • The Committee noted the revised capital programme for 2021/22 which further clarified outstanding sources of funds and proposed expenditure with the main changes relating to Project STAR. • In terms of month 3 financial performance, the Trust delivered a surplus in month of £1.3 m which was less than planned, due to a number of non-recurrent items. The Committee noted the main elements of financial performance relating to the elective recovery fund, Covid related costs, capital expenditure and cash position, as well as the risks associated with the delay in receiving the H2 guidance	• The Committee approved the following eREAFs; Supply of IV Fluids (eREAF 7831) and Radiology Reporting Services Solution (eREAF 7778) • The Committee approved the Quarter 1 Board Assurance Framework which would be submitted to the Trust Board • The Committee approved the revised capital plan for 2021/22 and noted the associated cost pressure

Comments on the Effectiveness of the Meeting
• The Committee welcomed the items considered and discussed during the meeting

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Paediatric Surge Planning	Assurance	7.	Q1 Board Assurance Framework	Approval
2.	Month 3 Performance Report • Urgent Care Review	Assurance	8.	Executive Business Intelligence Group Highlight Report (July 2021)	Assurance
3.	Data Security & Protection Update	Assurance	9.	Investment Assurance Report	Assurance
4.	Executive Data Security & Protection Group Highlight Report (July 2021)	Assurance	10.	Capital Programme – Revised Plan 2021/22	Approval
5.	Business Case Review Update	Assurance	11.	Month 3 Finance Report	Assurance
6.	Authorisation of New Contract Awards and Contract Extensions	Approval			

3. 2021 / 22 Attendance Matrix

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

Transformation and People Committee Chair's Highlight Report to Board

July 2021

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The bi-annual nursing establishment review was undertaken, with the Medical Division being the main area of concern due to skill mix being below recommended 65:35 split. A review will be undertaken to assess any potential impact and recommendations will be presented at TAP in the follow on report in November 2021. • Sickness absence increased in-month to 4.55%. 26% of absences were Covid related; though this had reduced slightly from the previous week, in part due to some staff being exempt from isolation guidance. • The Committee urged caution around the number of surveys staff were being asked to complete as some low response rates were seen. • 43 issues were raised through the Speaking Up route during quarter 1, with the most common themes being Attitudes and Behaviours followed by Polices and Processes • The Trust wasn't able to spend all of the Apprenticeship Levy – a further report would be provided next month.	• A workshop session on the Quality Improvement agenda to be held in September. • Future iterations of the Board Assurance Framework to further draw out the risks involving system working aspects – this will be considered as part of the Board Development Programme. • Future Speaking Up reports to reflect on follow-up questions to evidence where individuals were satisfied or dissatisfied with the actions taken in response to their concerns • To further explore gaps between essential to role training requirements and current compliance at the next meeting.
Positive Assurances to Provide	**Decisions Made**
• Trust Statutory and Mandatory Training compliance was nearing the 95% target, at 94.97%. • There was an improved position in terms of nursing vacancies; previously these stood at approximately 300 and this was expected to reduce to 100 by September. • The Committee noted that the work plan associated with Improving Together was on track and a positive update was provided in terms of social media activity generated from individuals attending the training. • The Reverse Mentoring Programme had reached the end of its first cohort and was well received by participants. • An update on Equality, Diversity & Inclusion was presented, with positive actions noted in relation to building race inclusion and closing the ethnicity gap in recruitment and promotion outcomes. • The Q1 Formal Disciplinary Activity Report was presented. The Committee noted the improvements in the overall case timelines and the actions that had been put in place to address lengthy investigations. • The Q1 Speaking Up Report was presented and the Committee welcomed the focus given to creating an environment where staff felt able speak up. • A number of positive achievements were highlighted in the Learning, Education and Widening Participation annual report including post-medical trainers adapting to new ways of working, supporting staff into volunteer posts during the pandemic and a high pass rate for Keele Medical Students.	• The Committee approved the Q1 Board Assurance Framework for submission to the Trust Board pending some amendments.

Comments on the Effectiveness of the Meeting

- More focus to be given to Workforce agenda items next month.
- Agenda managed well and to time.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Nurse Staffing Establishment Review	Assurance	5.	Learning, Education and Widening Participation – Annual Report 2020/21	Assurance
2.	Q1 Formal Disciplinary Activity	Assurance	6.	M3 Workforce Report	Assurance
3.	Equality, Diversity & Inclusion Progress Report	Assurance	7.	Improving Together Highlight Report	Assurance
4.	Q1 Speaking Up Report	Assurance	8.	Q1 Board Assurance Framework	Approval

3. 2021 / 22 Attendance Matrix

			Attended			Apologies & Deputy Sent			Apologies					
Members:			A	M	J	J	A	S	O	N	D	J	F	M
Prof G Crowe	GC	Non-Executive Director (Chair)												
Ms H Ashley	HA	Director of Strategy and Transformation												
Ms S Belfield	SB	Non-Executive Director												
Mrs T Bowen	TBo	Non-Executive Director												
Mrs T Bullock	TB	Chief Executive												
Mr P Bytheway	PB	Chief Operating Officer												
Dr L Griffin	LG	Non-Executive Director												
Mrs S Gohir	SG	Associate Non-Executive Director												
Dr K Maddock	KM	Non-Executive Director												
Mrs AM Riley	AR	Chief Nurse	MR		SP									
Miss C Rylands	CR	Associate Director of Corporate Governance			NH									
Mrs R Vaughan	RV	Director of Human Resources												

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board	**Date:**	4th August 2021
Report Title:	Integrated Performance Report, month 3 2021/22	**Agenda Item:**	14
Author:	Quality & Safety: Jamie Maxwell, Head of Quality & safety; Operational Performance: Karan Allman, Deputy Head of Performance; Matt Hadfield, Deputy Associate Director of Performance & Information. Workforce: Claire Soper; Finance: Tringham, Jonathan		
Executive Lead:	Scott Purser: Interim Chief Nurse Paul Bytheway: Chief Operating Officer Ro Vaughan: Director of Workforce Mark Oldham: Director of Finance		

Purpose of Report:

Assurance	✓	Approval		Information	

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

Executive Summary:

Situation

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

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

Assessment

Quality & Safety

The Trust achieved the following standards in June 2021:

- Friend & Family (Inpatients) 96.6% and improvement from previous months and exceeds 95% target.
- Harm Free Care 96.9% and continues to be above the national 95% target.
- Falls rate was 5.7 per 1000 bed days and is below the average rate per 1000 bed days during COVID-19 pandemic.
- Trust rolling 12 month HSMR continues to be below expected range.
- 100% of patients/family were informed verbally of incidents that are reported as meeting duty of candour threshold.

- VTE Risk Assessment continues to exceed 95% target with 99.1% (via Safety Express audit).
- Zero avoidable MRSA Bacteraemia cases reported.
- There has been no Category 2 or 4 Pressure Ulcers attributable to lapses in care during May 2021. However, there was 1 Category 3 PU reported. The number of pressure ulcers developed under UHNM care with identified lapses in care has been reducing and showing positive variation and assurance that numbers are significantly reduced and below long term mean.
- Sepsis Screening compliance in Emergency Portals exceeded the target 90% with 91%.
- Inpatients IVAB within 1 hour achieved 100% for audited patients.
- Children's Sepsis Screening compliance 90.6% below the 90% target.
- Zero Never Events.
- There were 0 Nosocomial COVID Infections reported.

The Trust did not achieve the set standards for:
- Friend & Family Test for A&E 73% and below 85% target.
- Friends & Family Test for Maternity returned 3%. The Midwifery team have been reminded that National reporting of the FFT has resumed and escalated to Head of Midwifery.
- 92.3% Duty of Candour 10 day letter performance following formal verbal notification. 1 further case awaiting letter being sent out but is within timeframe.
- C Diff YTD figures are above trajectory with 13 against a target of 8.
- Inpatient Sepsis Screening compliance (adult Inpatients) 87.1% and below the target of 90%.
- Emergency Portals IVAB in 1 hour 82% against the 90% target.
- Maternity Sepsis Screening recorded 54.5 and IVAB in 1 hour 50%.

During June 2021, the following quality highlights are to be noted:
- The rate of complaints per 10,000 spells is 26.99 is below (positive) the target of 35 and is within normal variation. Majority of complaints in June 2021 relate to clinical treatment.
- Total number of Patient Safety Incidents increased and the rate per 1000 bed days was relatively stable at 50.72 and is within normal variation. Rate is June was same as the NRLS mean 50.7.
- Incidents with moderate harm or above and the rate of these incidents have remained relatively stable and within normal variation. Positive trend in increasing reporting of incidents but level harm is not increasing and in percentage terms reducing.
- Rate of falls reported that have resulted in harm to patients has remained relatively stable but currently at 1.7 in June 2021. The rate of patient falls with harm continues to be within the control limits and normal variation.
- Medication related incidents rate per 1000 bed days has increased to 5.7 and patient related 4.6. Zero COVID-19 deaths falling in to the 'Definite' category (according to the National definition of Nosocomial deaths).
- 15 Serious Incidents reported in June 2021 with falls the largest category of incidents and all incidents were reported on STEIS within the 2 working date target.

Operational Performance

Emergency Care

Emergency care at the front door has been further challenged in June 21 by:
Continued rise in attendances. Non-ambulances attendances are rising month on month. Mostly seen at RS site, with daily average attendances of 386 (a rise of 16/day since previous month) and this is above the levels seen in 2019 which averaged 360/day. The increase in attendances coincided with the mid-March relaxation of government restrictions. The rise directly correlates to the reduction in some front door metrics such as time to initial assessment and mean time in the department.

Despite the consistent week on week rise since March, Ambulance handover delays and corridor care have been well managed and only saw deterioration in the last week of June.

System-wide performance is down to 69.8% (May 72.2%), with total type 1 at 58.8%. At Royal Stoke the non-admitted performance fell to 58.2% (May 61.1%) and the admitted performance maintained a performance at 33.6%. The department had continued days with sub 60% performance with most of the front door metrics challenged.

Cancer

The Trust is currently predicted to achieve the following cancer standard for June 21: a 31 day subsequent treatment for Radiotherapy is expected to achieve a high 96% compliance.

- The 2WW PTL has shown a decrease overall.
- The 2WW backlog is continuing to increase.
- The number of patients waiting over 104 days remains stable. All specialties have been asked to review those waiting over 104 days and expedite next steps accordingly.

62 day performance is predicted at this point to achieve 65% in June and continues with one of the lowest backlogs regionally. This position will change as more treatments are recorded. In addition, the number of patients waiting over 104 days at the end of June with a diagnosis of Cancer is 8.

Planned Care

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

- Day Case and Elective Activity delivered for June 21 and numbers of patients treated rising week on week over 500 elective operations w/e 21st June 21.
- Plan to release more patients to the IS to enable full optimisation of capacity through one off lift and shift of patients, starting with the Nuffield.
- Next Planned Care Cell focus on theatre capacity and productivity given the emergent covid risks and staff isolation rate of attrition.
- Scoping of schemes to support management of referred demand (Referral Hub) and waiting list management (Patient Contact Initiative)

RTT

The indicative performance for June 21: the total number of Referral To Treatment pathways grew to 63,537 (May 61, 608). The Trust has continued to reduce the number of > 52 weeks to 3,322 (May 3,606). Recovery plans have been reviewed. RTT performance in June is 61.89% (May 62.06%).

Diagnostics

For DM01 (15 nationally identified Dx tests) however, the waiting list, continues to grow. Although reduction is seen in some modalities i.e. MRI, this has been offset by the increase in Non-obstetric ultrasound. The greatest proportion of > 6 week waits is within Non-obstetric ultrasound, which has doubled since Mar-21 and is related to the significant Increase in demand and activity for breast 2ww referrals where the prioritisation over the long waiters, has impacted on performance. A working group is set up comprising of imaging, breast surgery and the cancer to team to review the referrals and total capacity required. There also seems to be more referrals from Primary care for patients under the age 35. Cancer team are engaging with the PCN/CCG regarding referrals, and within radiology effort is being made to put on additional capacity out of hours to clear the backlog with more joint working with surgery.

The DM01 diagnostic performance for June 21 is provisionally 76.08% (May 79.43%).

Workforce

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

Statutory and Mandatory Training

At 94.97%, rounded to 95%, the Statutory and Mandatory Training rate has achieved the Trust target for the core training modules. At 30 June 2021, 91.16% of staff had completed all 6 Core for All modules (90.86% at 31/05/21).

The key performance issues are:

Sickness

The sickness rate remains above target. The in-month sickness rate was 4.86% (4.55% reported at 31/05/21). The 12 month cumulative rate reduced to 5.02% (5.05% at 31/05/21)
Covid-related absences have been increasing since mid-June, albeit at a slower rate than other sickness

absences. As of 9th July 2021, covid-related open absences* numbered 226, which was 27.10% of all absences (13.46% at 9th June 2021)
[** includes absences resulting from staff adhering to isolation requirements*].

- Sickness and covid-related absences continue to be monitored daily. Staff showing symptoms, or with household members showing symptoms, are tested and results returned within 24-48 hours.
- Actions towards improving sickness rates are being developed through the Improving Together Programme and A3 process. Divisional Teams are developing specific actions to address sickness and improve compliance with completing call backs and return to work interviews.
- Stress-related sickness absence increased as a proportion of all sickness absences in June and communications have been issued reminding staff of the importance for rest; recovery; health and wellbeing. Managers and team members have been asked to plan annual leave so that time off is shared equitably and evenly distributed throughout the annual leave year

Appraisals
The Non-Medical PDR compliance rate was 81.03% (80.61% at 31 May 2021) and compliance remains below target.

- Overdue PDRs are required to be scheduled from Q2 onwards and the compliance rate has improved over each of the last 4months.

Finance

The Trust has delivered a surplus of £1.3m in month against a planned surplus of £3.3m. The position in month is driven by overspends against clinical supplies due to a stock adjustment in respect of DHSC issued PPE and because of a reduction of the planned ERF expenditure reserve on the back of the planning resubmission.

ERF income recognised for the year to date is £5.4m against a revised planned figure of £3.3m. Based on activity plans, £8.8m of income is forecast for H1 with additional costs approved of £0.6m to support the delivery of the activity plans. Revised thresh holds for receiving ERF funding have been recently announced for Q2 which will reduce the income earned by the Trust; the full impact of this will be reported to the Committee in August.

The Trust incurred £1.0m of costs relating to COVID-19 in month which is an increase in comparison with Month 2's figure primarily due to an increase in testing costs. This remains within the Trust's fixed allocation with £0.5m being chargeable on top of this allocation for COVID-19 testing costs.

A high level forecast for the year suggest that the Trust may have a surplus in excess of its plan for the year of £3.8m if no corrective action is taken; a full forecast is being carried out and will be reported to the Committee in August.

Capital expenditure for the year to date stands at £4.8m which is £1.2m behind the plan mainly due to an underspend within the medical equipment sub group, commitments brought forward from 2020/21 and the lower Trent wards scheme.

The cash balance at Month 3 of £63.3m shows an increase of £8.5m from the beginning of the year. This increase reflects the revenue surplus at Month 3.

Key Recommendations:

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

NHS
University Hospitals of North Midlands
NHS Trust

Integrated Performance Report

Month 3 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?

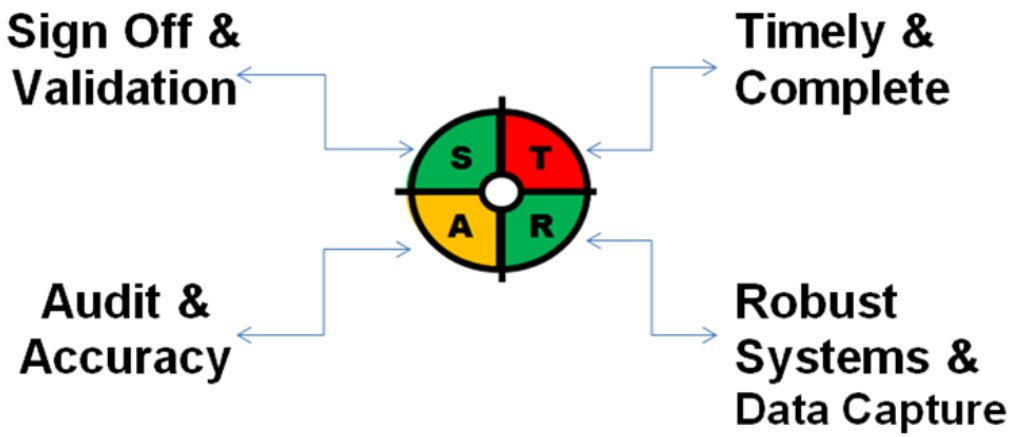
The below key and icons are used to describe what the data is telling us;

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

A note on **Data Quality**

NHS
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

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

Quality Dashboard

Metric	Target	Latest	Variation	Assurance
Patient Safety Incidents	N/A	1809		
Patient Safety Incidents per 1000 bed days	N/A	50.72		
Patient Safety Incidents per 1000 bed days with no harm	N/A	30.70		
Patient Safety Incidents per 1000 bed days with low harm	N/A	12.59		
Patient Safety Incidents per 1000 bed days reported as Near Miss	N/A	1.78		
Patient Safety Incidents with moderate harm +	N/A	22		
Patient Safety Incidents with moderate harm + per 1000 bed days	N/A	0.62		
Harm Free Care (New Harms)	95%	96.9%		
Patient Falls per 1000 bed days	5.6	5.7		
Patient Falls with harm per 1000 bed days	1.5	1.8		
Medication Incidents per 1000 bed days	N/A	5.7		
Medication Incidents % with moderate harm or above	TBC	0.00%		
Patient Medication Incidents per 1000 bed days	N/A	4.1		

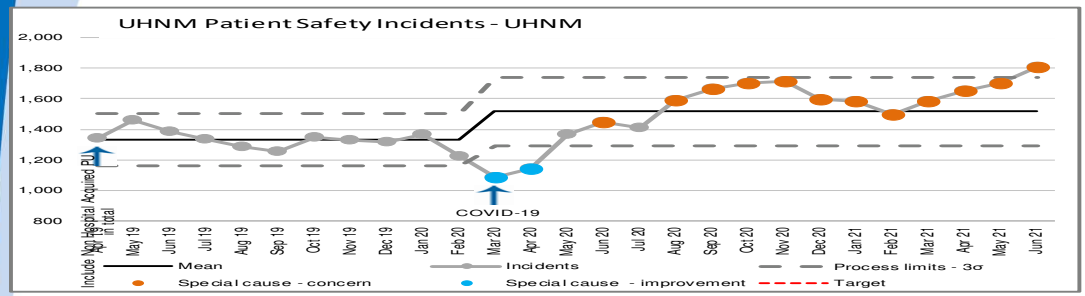
Quality Dashboard

Metric	Target	Latest	Variation	Assurance
Friends & Family Test - A&E	N/A	73.0%		
Friends & Family Test - Inpatient	N/A	98.0%		
Friends & Family Test - Maternity	N/A	3.0%		
Written Complaints per 10,000 spells	35	22.58		
Rolling 12 Month HSMR (3 month time lag)	100	96.73		
Rolling 12 Month SHMI (4 month time lag)	100	106.38		
Nosocomial COVID-19 Deaths (Positive Sample 15+ days after admission)	N/A	0		
VTE Risk Assessment Compliance	95%	99.1%		
Emergency C Section rate % of total births	15%	16.51%		
Reported C Diff Cases per month	8	13		
Avoidable MRSA Bacteraemia Cases per month	0	0		
HAI E. Coli Bacteraemia Cases per month	N/A	4		

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Reported Patient Safety Incidents

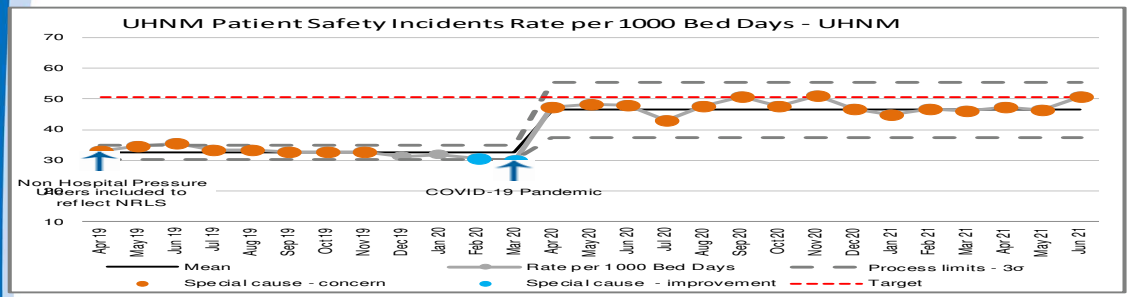


Variation	Assurance
	

Target	Apr 21	May 21	Jun 21
N/A	1652	1700	1809

Background

Total Reported patient safety incidents



Variation	Assurance
	

NRLS Mean	Apr 21	May 21	Jun 21
50.70	47.34	46.45	50.72

What is the data telling us:

The above data relates to **all** reported Patient Safety Incidents (PSIs) across the Trust. The June 2021 total has exceeded the upper confidence limit which demonstrates that the increase in reported incidents is significant and has been increasing for over 6 months. 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 - 204 (223)
- Clinical assessment (Including diagnosis, images and lab tests) – 87 (80)
- Patient flow incl. access, discharge & transfer - 165 (125)
- Documentation – 57 (53)
- Treatment/Procedure - 83 (75)
- Medication incidents - 166 (156)
- Infection Prevention – 43 (52)
- PU developed under UHNM Care - 51

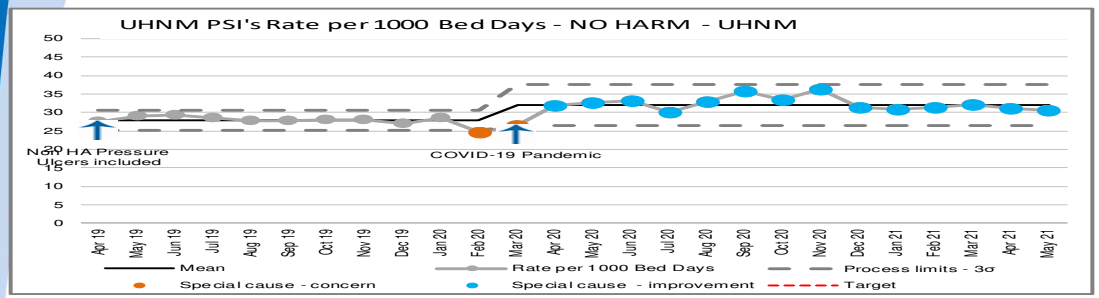
There have been increases in Medication, Treatment, Clinical Assessment and Patient Flow related incidents compared to May 2021 totals (in brackets). Reductions in number of Falls related incidents.
PSIs are reviewed and analysis undertaken on locations and themes.

The Directorates reporting most PSIs are Emergency Medicine, General Medicine, Obstetrics & Gynaecology, Specialised Medicine, Anaesthetics/Theatres/Critical Care, General Surgery & Urology and Trauma. Specific incidents are reviewed at specialist forums for themes / trends as well at Divisional level.

The rate of reported PSIs per 1000 bed days has stable for the past 6 months following the change at the start of COVID-19 pandemic.

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

University Hospitals of North Midlands NHS Trust

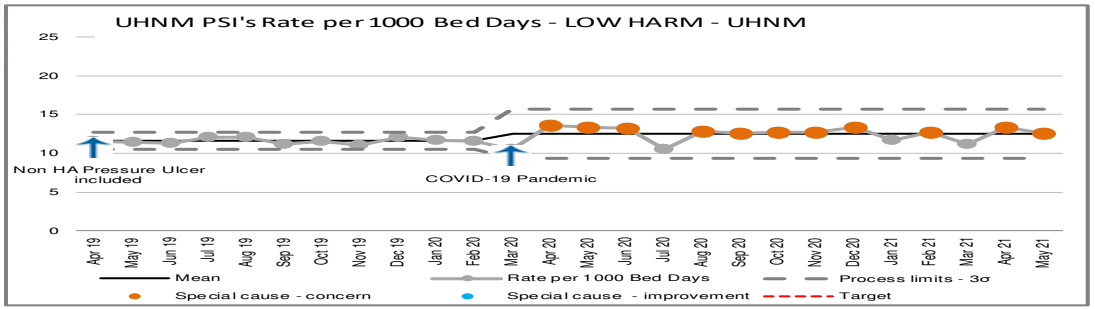


Variation	Assurance

Target	Mar 21	Apr 21	May 21
N/A	32.22	31.15	30.70

Background

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

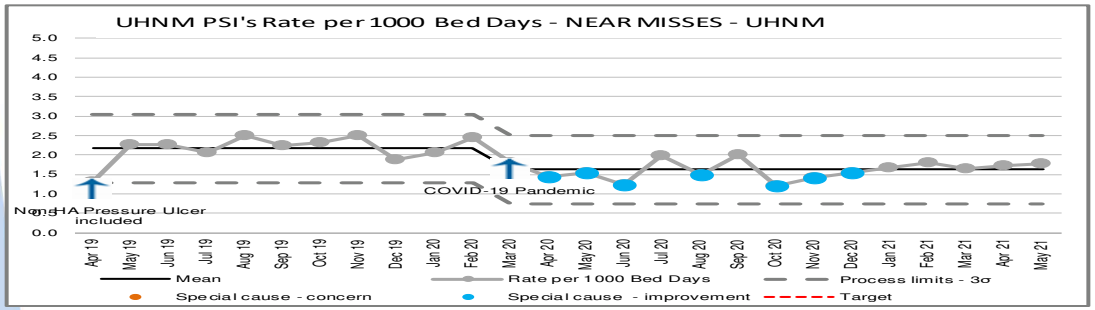


Variation	Assurance

Target	Mar 21	Apr 21	May 21
N/A	11.15	13.35	12.59

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	Mar 21	Apr 21	May 21
N/A	1.66	1.72	1.78

Background

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

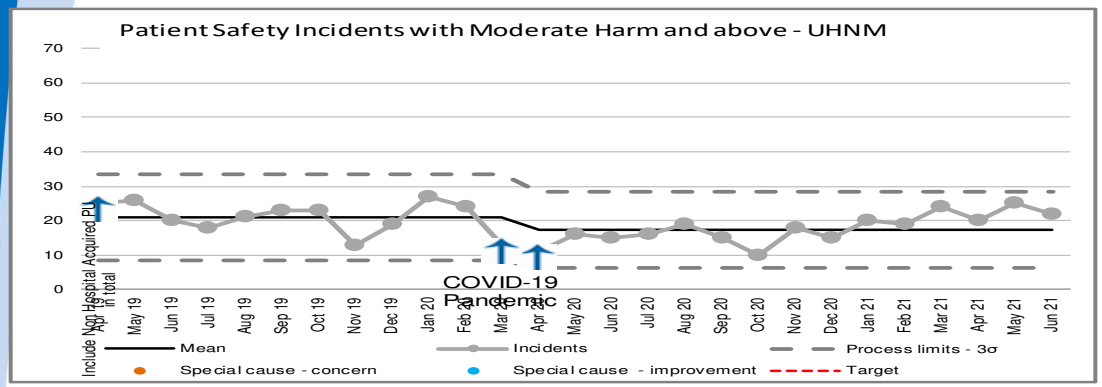
What is the data telling us:

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

The rate of both no harm and low harm incidents have increased since the start of the COVID-19 pandemic. This indicates that there are higher numbers of no and low harm incidents being reported when compared to moderate harm and above (see next page) which has remained relatively stable since March 2020.

The reporting of all incidents and near misses should continue to be encouraged so that mitigating actions and learning can be identified via these incidents to further improve the quality of care and services provided and reduce risk of serious harm.

Reported Patient Safety Incidents with Moderate Harm or above

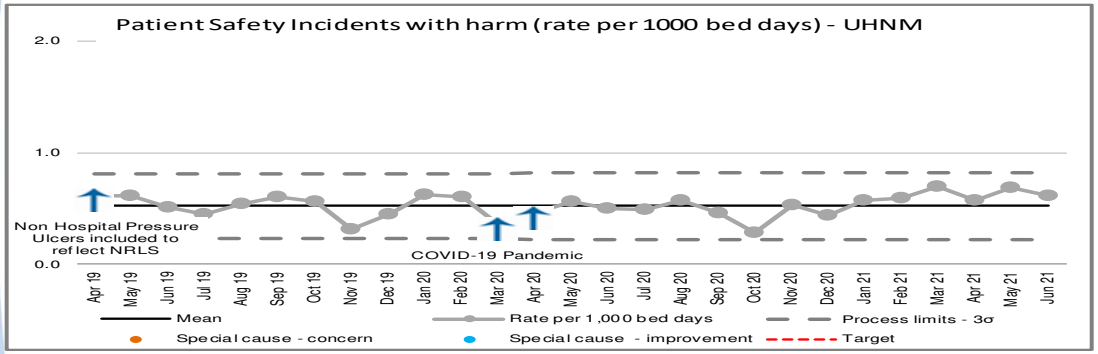


Variation	Assurance

Target	Apr 21	May 21	Jun 21
N/A	20	25	22

Background

Patient safety incidents with reported moderate harm and above



Variation	Assurance

Target	Apr 21	May 21	Jun 21
N/A	0.57	0.68	0.62

What is the data telling us:

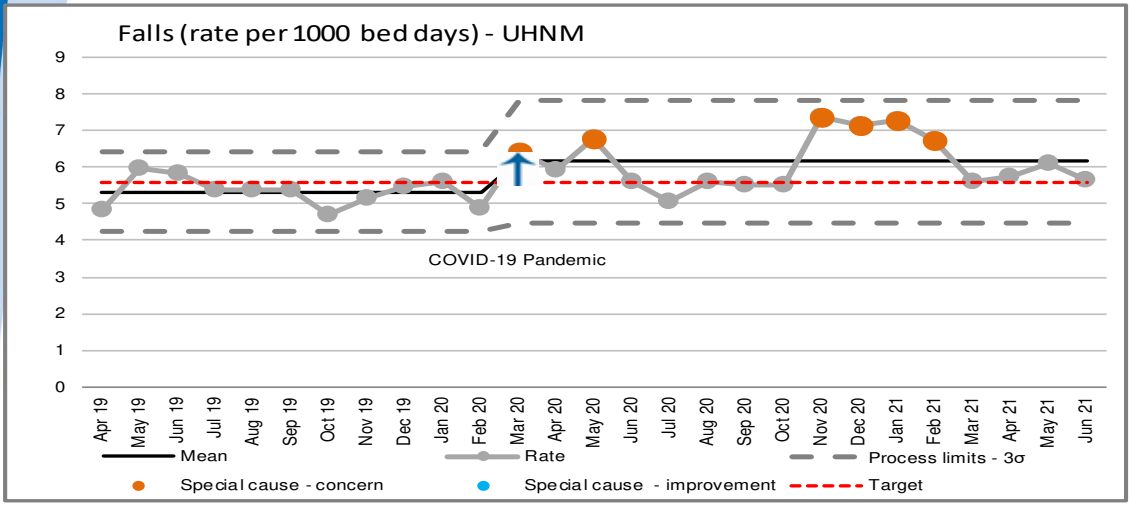
The variation noted in charts above for moderate harm or above total and rate per 1000 bed days is within normal variation and special cause noted. However the last 5 months have seen overall increase above the mean total and rate since the start of COVID-19 pandemic.

The cause for this is related to increase during 2nd wave of COVID in falls and treatment/procedure related incidents

The top category of incidents resulting in moderate harm reflect the largest reporting categories with Slips/Trips/Falls being the largest category with 9.
The second largest category is Medication with 5 followed by Treatment/Procedure related reported 4.

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

Patient Falls Rate per 1000 bed days



Variation	Assurance

Target	Apr 21	May 21	Jun 21
5.6	5.8	6.1	5.7

Background

The number of falls per 1000 occupied bed days

What is the date telling us:

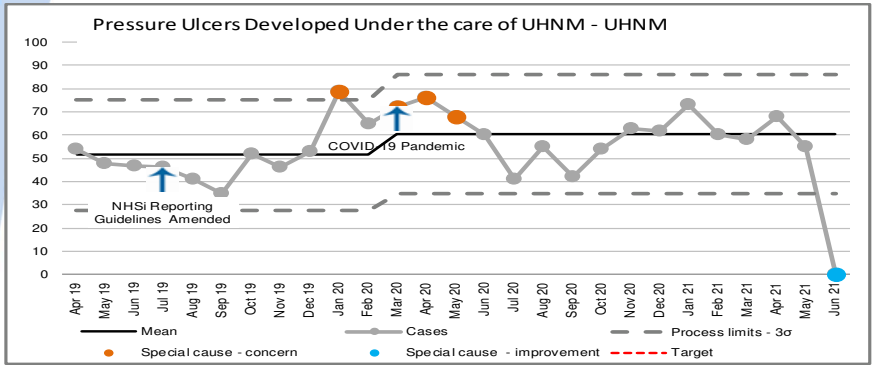
The data shows the Trust's rate of reported patient falls per 1000 bed days. Using the rate makes allowance for changes in activity/increased patient numbers. The Trust set a target rate, based on the Royal College of Physicians National Falls Audit published rate for acute hospitals, of 5.6 patient falls per 1000 bed days. June 2021 shows 5.7 and remains below the current Trust mean rate.

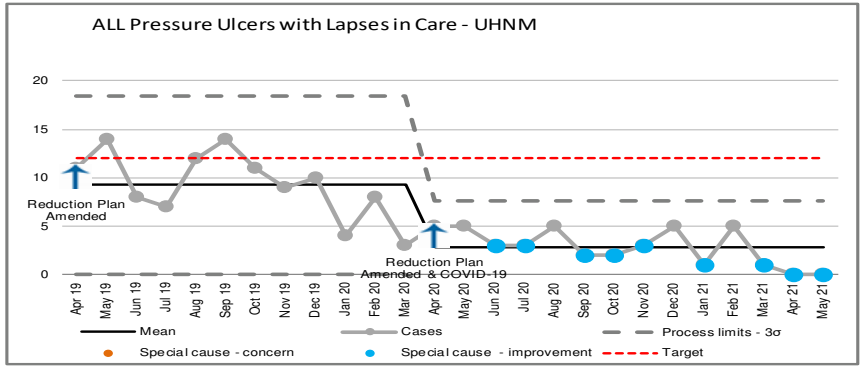
The Top areas for total falls in June 2021 were:
Royal Stoke AMU Royal ED Ward 124 – Renal Ward 113 - Respiratory Medicine Ward 228 - Neurosurgery

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

- Extra support with falls awareness sessions has been given to ward 228 and training for a new champion has been given.
- Work continues with ED and AMU who remain the highest falling areas within the trust. A trial of assistive technology (chair sensors) is commencing on AMU (Stoke) supported by Medline.
- A deep dive is currently being completed looking into falls for presentation at QSOG and QGC.
- Sessions have been planned throughout August for falls champions to share good practice and also challenges within their areas. There are dates for Stoke and County site.
- A falls conference is planned for the finale of falls awareness week in September 2021. This will be held in the PGMC at County site on 24th September 9-4.
- The plans for falls awareness week are being supported across the region by our involvement in the regional falls group.
- Although ward 124 and ward 113 remain in the top falling areas numbers are improving from the data currently available for July.

Total Pressure Ulcers developed under care of UHNM





Variation	Assurance
L	

Target	Apr 21	May 21	Jun 21
N/A	68	55	0

Background

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

Variation	Assurance
L	P

Target	Mar 21	Apr 21	May 21
12	1	0	0

Background

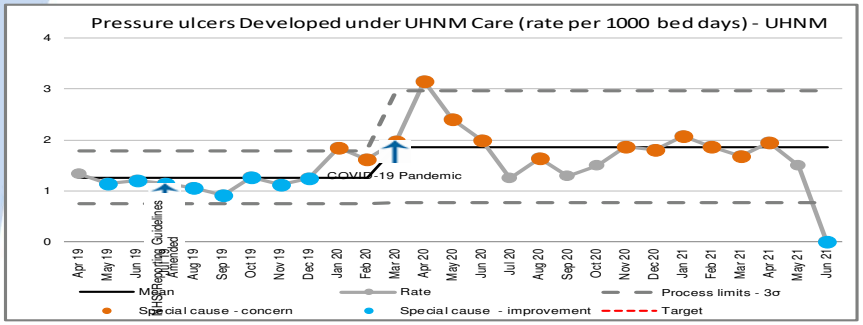
ALL pressure ulcers which developed whilst under the care of UHNM which had lapses of care associated

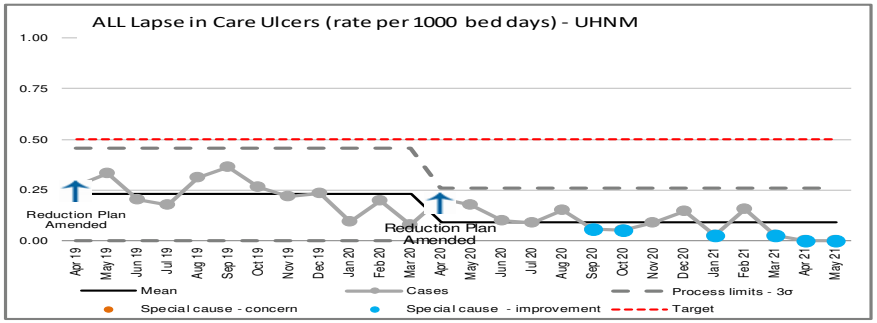
During June 2021 the 51 reported pressure ulcer related incidents were split between the following categories:

	Total (June 2021)
DTI	14
Category 2	24
Category 3	4
Category 4	0
Unstageable	9
Total	51

Pressure Ulcers with lapses in care continue to show positive assurance re: low numbers per month. Positive indicators for variation and consistently below the agreed monthly upper limit. These results are consequence of the continued improvement work in relation to assessment and management of pressure ulcers by the Corporate Nursing Quality & Safety Nursing Team and frontline staff.

Pressure Ulcers developed under care of UHNM per 1000 bed days





Variation	Assurance
L	

Target	Apr 21	May 21	Jun 21
N/A	1.95	1.50	0.00

Background

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

Variation	Assurance
L	P

Target	Mar 21	Apr 21	May 21
0.5	0.03	0.00	0.00

Background

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

What the data is telling us

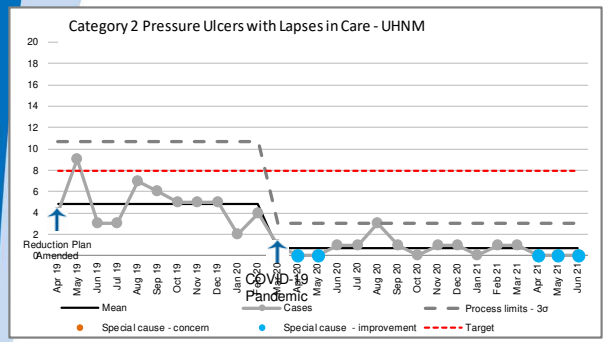
Chart 1 shows that for two consecutive months the rate of hospital acquired pressure ulcers are now below the mean and predicted to be returning to pre-COVID-19 numbers as UHNM exits the second wave of COVID-19. High reporting areas will be presenting all incidents at bespoke RCA panels, to allow identification of ward trends, to identify the need for focussed improvement and education supported by the Tissue Viability and Corporate Nursing Quality & Safety Teams.

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

Actions

- The learning from the Category 4 Pressure Ulcers reported in the May 2021 Quality report has been shared Trustwide through the quality nurses group and via divisional hot topics newsletters and will be the focus of a harm free care learning alert
- The focused improvement of the classification of pressure ulcers continues . This includes work with the Quality Nurses to cascade updates and the inclusion of categorization pictures in the Skin Health booklet due for launch in July 2021.
- Work continues to determine if the capability of Vitalpac can be optimized to allow the use of QR codes to provide more extensive reference points for staff on a number of different aspects including categorization, management pathways, dressing selection.

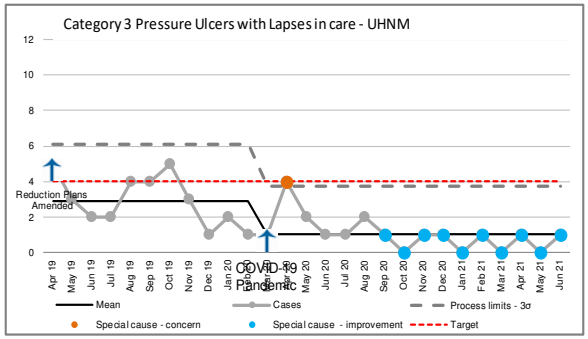
Pressure Ulcers with lapses in care



Variation	Assurance

Target	Apr 21	May 21	Jun 21
8	0	0	0

Background

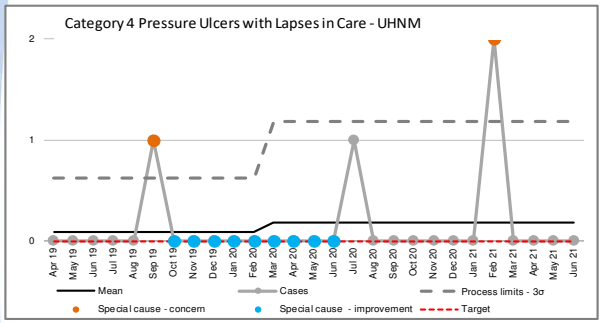


Variation	Assurance

Target	Apr 21	May 21	Jun 21
4	1	0	1

Background

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

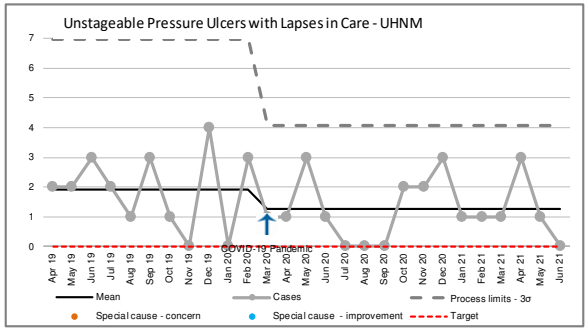


Variation	Assurance

Target	Apr 21	May 21	Jun 21
0	0	0	0

Background

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



Variation	Assurance

Target	Apr 21	May 21	Jun 21
0	3	1	0

Background

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

What is the data telling us:

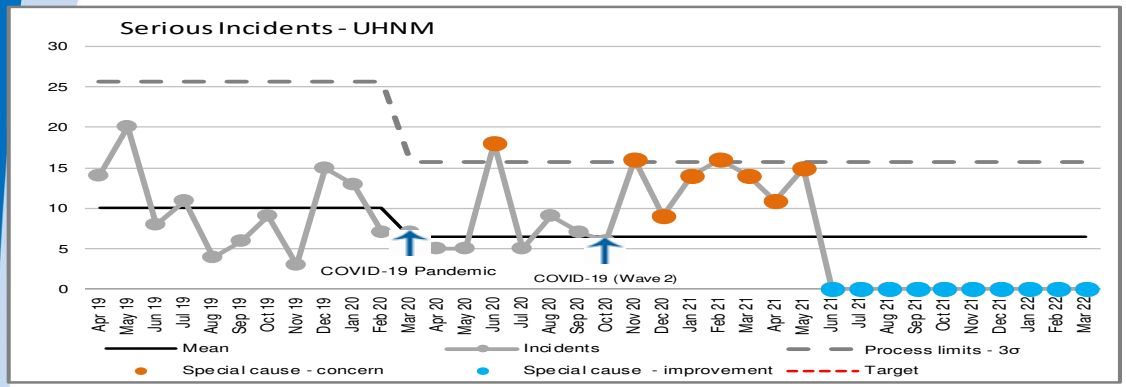
The data above shows that there has been 1 Pressure Ulcer with lapses in care during June 2021.

However, it should be noted that there are ongoing validations requiring RCA presentation in panel and therefore these numbers may change.

Actions:

- Pressure Ulcer Prevention (PUP) Champions training will re-commence in July 2021 following a re-launch of Tissue Viability Link roles at a large introductory event held in June 2021. There has been an identified trend in lapses across the trust in being lack of the understanding of repositioning. Therefore focused education has been scheduled for PUP champions monthly to allow cascade training .
- PUP training is now facilitated by the Senior Sister for Quality and Safety as part of the Nursing assistants induction, and this will include appropriate use of the SSKIN bundle.

Serious Incidents per month

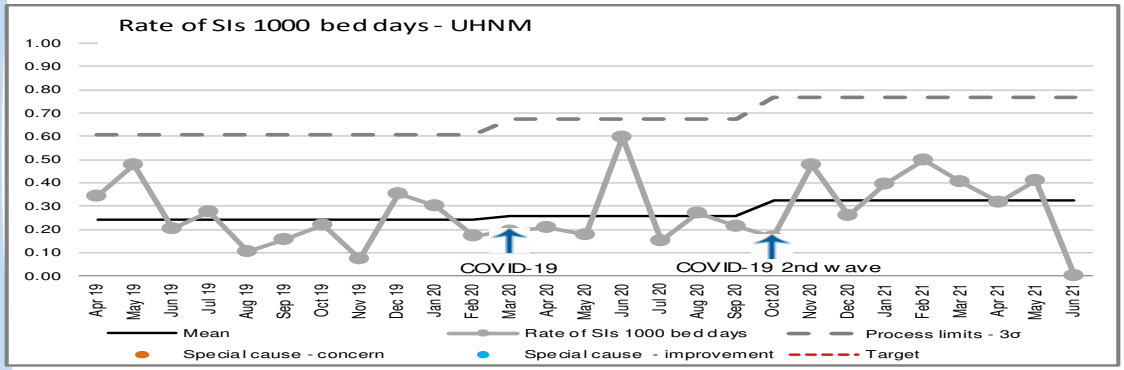


Variation	Assurance

Threshold	Jan 22	Feb 22	Mar 22
N/A	0	0	0

Background

The number of reported Serious Incidents per month



Variation	Assurance

Target	Apr 21	May 21	Jun 21
N/A	0.32	0.41	0.00

Background

The rate of Serious Incidents Reported per 1000 bed days

What is the data telling us:

June 2021* saw 15 incidents reported:

- 10 Falls related incidents
- 1 Maternity (baby only)
- 4 Diagnostic related

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

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

Serious Incidents Summary

University Hospitals of North Midlands NHS Trust

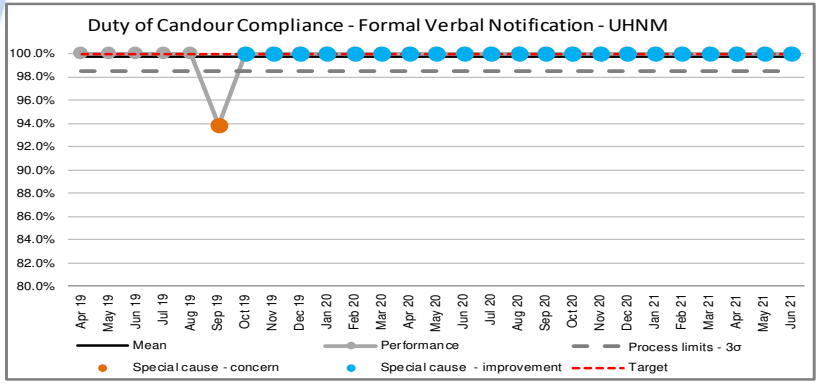
Summary of new Maternity Serious Incidents

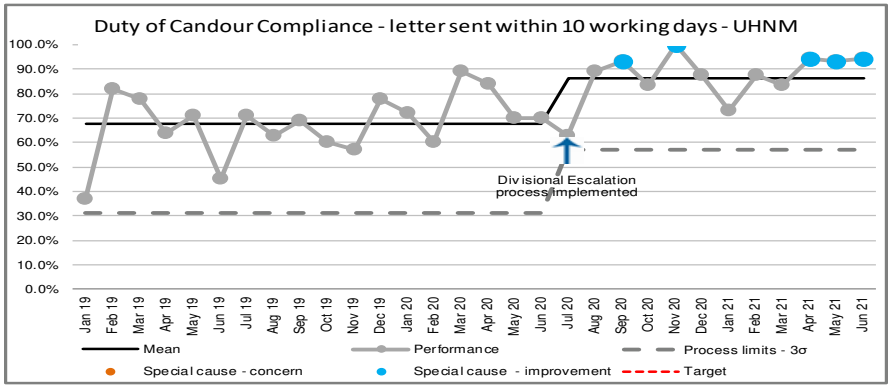
Following the formal recommendations in the Ockenden Report, below is an outline of the Maternity related serious incidents reported during June 2021. The new recommendation requires the Trust Board to receive summary on the new Maternity related Serious Incidents along with previously reported summary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

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

STEIS Ref. No.	Target Completion Date	SI Category	Incident Synopsis
2021/12572	09/09/2021	Maternity/Obstetric incident meeting SI criteria: baby only (this includes foetus, neonate and infant)	Following ROP laser surgery baby developed Necrotising Enterocolitis (NEC), deteriorated and required time critical transfer to a neonatal surgical centre. • Difficult to establish from patient records the nursing or medical observations undertaken • Bed available in Alder hey but difficult to secure time critical transfer, bed available in Birmingham Women's and Children's Hospital (BCH) delay in securing transport Baby sadly passed away shortly after arrival at BCH

Duty of Candour Compliance





Variation	Assurance
H	?

Target	Apr 21	May 21	Jun 21
100%	100.0%	100.0%	100.0%

Background

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

Variation	Assurance
H	?

Target	Apr 21	May 21	Jun 21
100%	94.1%	93.3%	94.1%

Background

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

What is the data telling us:

During June there were 17 incidents reported and identified that have formally triggered the Duty of Candour. All of these cases have been formally notified of the incident.

Confirmed Follow up Written Duty of Candour compliance (i.e. receiving the letter within 10 working days of verbal notification) during June 2021 is 94.1%.

There is 1 case awaiting confirmation of letter being sent out.

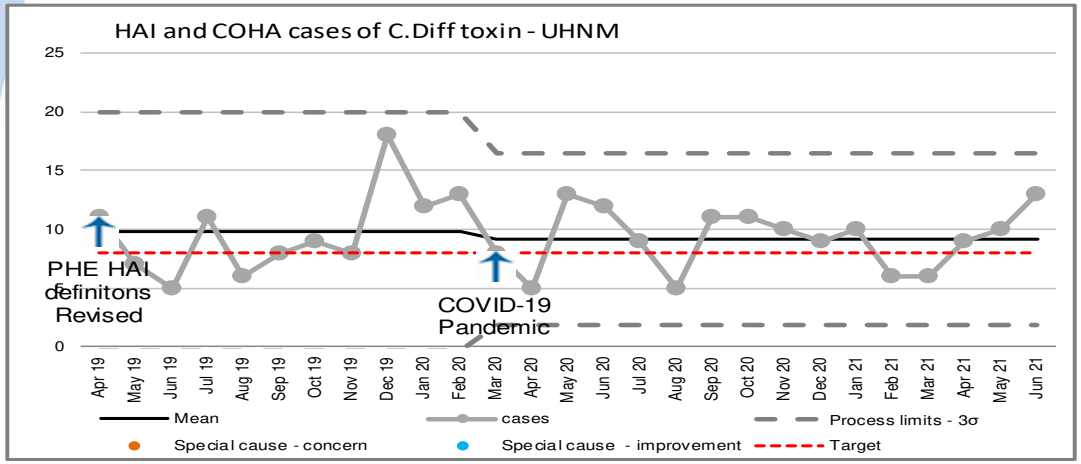
Since the new escalation process was introduced within the Divisions there has been an improvements in performance with smaller confidence intervals and performance above the mean. There has been improved compliance during the past 3 months above the mean rate and close to the 100% target.

Actions taken:

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

Compliance is included in Divisional reports for discussion and action.

Reported C Diff Cases per month



Variation	Assurance

Target	Apr 21	May 21	Jun 21
8	9	10	13

Background

Number of HAI + COHA cases reported by month

What do these results tell us?

Chart shows the number of reported C diff cases per month at UHNM. Previous 12 months are predominantly above the Trust mean for monthly cases but within SPC limits since the change in healthcare associated infections definition by PHE in April 2019.

There have been 13 reported C diff cases in June which is above monthly trajectory target of 8

11 of these were Hospital Associated Infection (HAI) cases and 2 Community Onset Healthcare Associated (COHA) cases.

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

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

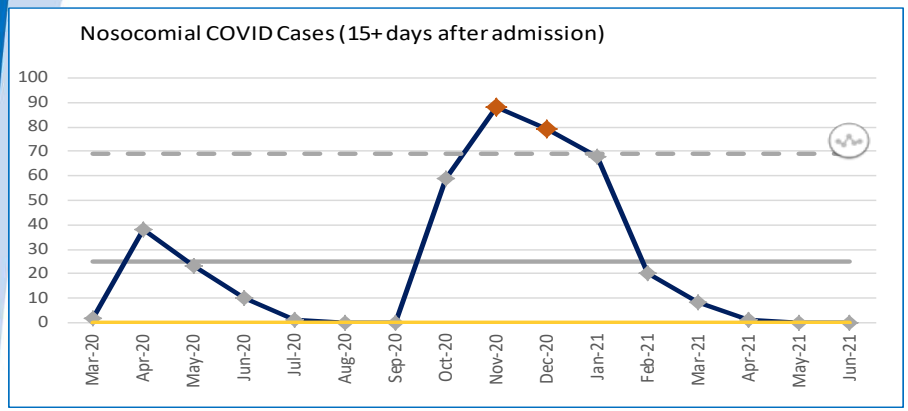
There has been one clinical area , ward 201 that has had more that one case of C diff toxin to report within a 28 day period:

2x HAI toxin reported and 1 COHA toxin reported in June – to date only 2 of the ribotype results have been received both of which are different which would indicate **no** person to person transmission for those cases

Actions:

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

HAI Nosocomial COVID Cases per Month



What do these results tell us?

- The data shows an in month decrease in definite Healthcare Acquired COVID - 19 cases with zero in June 2021
- Local, Regional and National community COVID-19 rates have increased in June 2021 (see table opposite)

Actions :

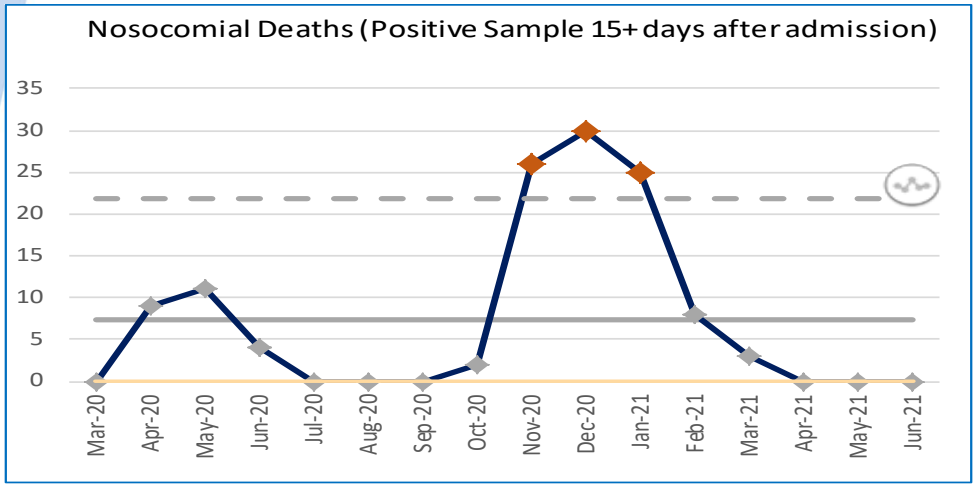
- All Emergency patients screened for COVID 19 on admission to UHNM, screening programme in place for planned surgery/procedures.
- All inpatients who have received a negative COVID 19 screen have a repeat COVID 19 screen on day 4 and 6 as per NHS key actions
- The introduction of weekly COVID 19 screening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

	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

Percentage breakdown of COVID Cases per onset category per month

Month	Community Onset	Indeterminate	Probable	Definite
Mar-20	89.4%	6.8%	2.5%	1.2%
Apr-20	73.5%	9.5%	9.7%	7.2%
May-20	65.6%	10.7%	14.6%	9.1%
Jun-20	67.2%	10.3%	13.8%	8.6%
Jul-20	92.3%	3.8%	0.0%	3.8%
Aug-20	78.6%	21.4%	0.0%	0.0%
Sep-20	100.0%	0.0%	0.0%	0.0%
Oct-20	66.7%	8.7%	12.7%	11.9%
Nov-20	67.7%	13.0%	10.7%	8.6%
Dec-20	68.5%	11.4%	11.5%	8.5%
Jan-21	66.8%	13.1%	13.2%	7.0%
Feb-21	70.8%	13.9%	9.3%	6.0%
Mar-21	73.8%	9.8%	9.8%	6.6%
Apr-21	82.9%	5.7%	8.6%	2.9%
May-21	90.0%	10.0%	0.0%	0.0%
Jun-21	92.3%	7.7%	0.0%	0.0%
Grand Total	69.9%	11.2%	11.0%	7.8%

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



What do these results tell us?

The data shows the total number of recorded deaths per month which are classified as 'Definite' hospital acquired COVID-19. The criteria for this is that the patient had **first positive** COVID-19 swab result 15 days or more following admission to UHNM.

- There have been zero recorded definite hospital onset COVID-19 deaths during June 2021
- Total 118 hospital acquired COVID-19 deaths with 1st positive results 15 days or more following admission recorded since March 2020.
- The mean number of deaths per month since March 2020 is 7

Actions :

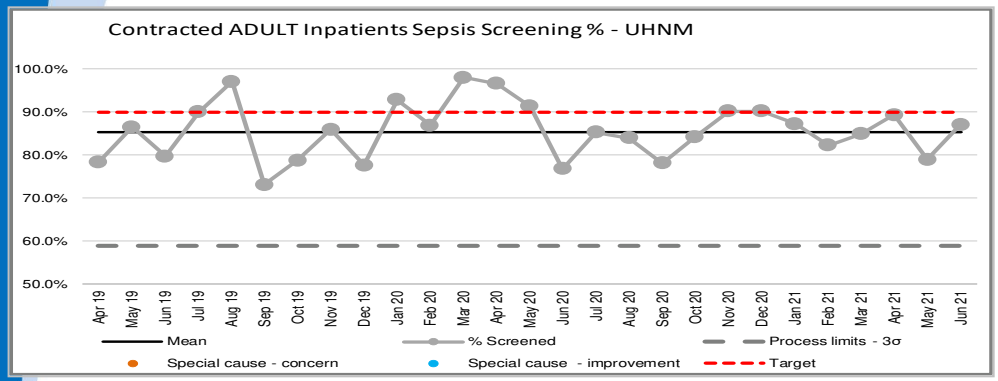
On-going work to identify the ward outbreaks and cross reference with patients involved is being undertaken with support from the Infection prevention Team to support the review of the nosocomial deaths.

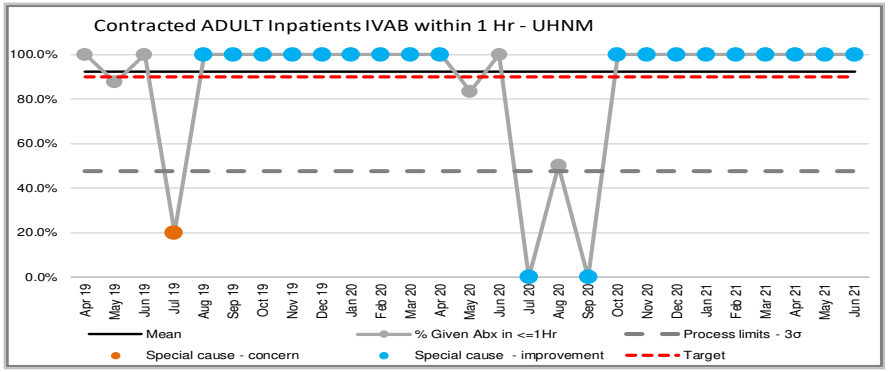
The online SJR form has been adapted to include specific COVID related questions following pilot review by Deputy Medical Director.

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

Sepsis Screening Compliance (Inpatients Contract)

University Hospitals of North Midlands NHS Trust





Variation	Assurance

Target	Apr 21	May 21	Jun 21
90%	89.4%	78.9%	87.1%

Background

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

Variation	Assurance

Target	Apr 21	May 21	Jun 21
90%	100.0%	100.0%	100.0%

Background

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

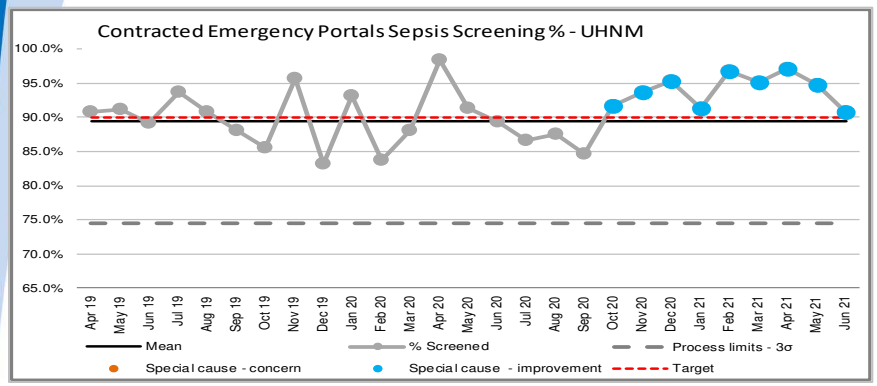
What is the data telling us:

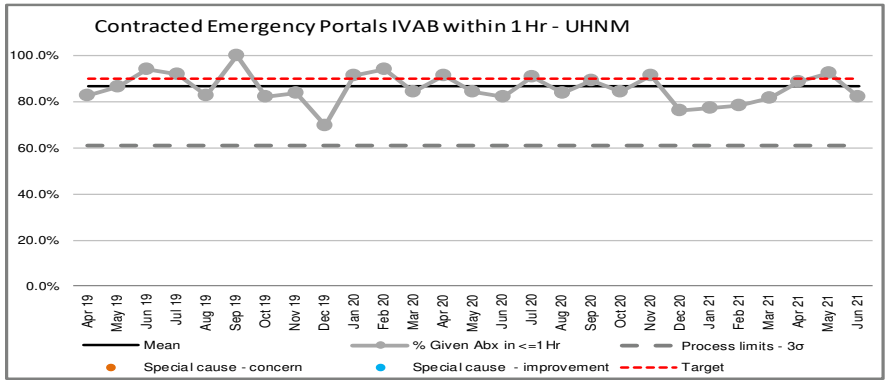
Inpatients June results now show a improvement from 78.9% to 87.1% for screening and continues to maintain 100% compliance for IVAB within an hour. Of the 101 Inpatients that triggered a sepsis screen, 82 had sepsis red flags present, 1 of these patients were given IVAB within hour and of the remaining 81 patients, 39 had alternative diagnosis that were deemed as not sepsis related and IVAB were not indicated. The remaining 42 patients were already receiving IVAB prior to the identified red flag trigger. Surgery Division screening compliance has improved to 85% while both Medicine & Specialised achieved between 82%-90% screening compliance.

Actions:

- The sepsis team have continued to provide sepsis re-enforcement, kiosks, visiting ward areas to update clinical staff and promote awareness around sepsis
- The Sepsis team regularly identify areas of poor compliance and prioritise those areas for more focused re-enforcement and sepsis kiosks each month; on-going
- The team has continued to offer 30 minutes drop in sessions for particular areas of UHNM (both Royal & County sites).
- The Sepsis Team continue to work closely with the VitalPac team in order to address issues around staff access and sepsis vitals reporting.
- The Sepsis Team continue to provide unannounced ward visits out of hours to deliver reinforcement to those staff who work regular nights.
- The Sepsis team have delivered Sepsis Champion Day (5 hour CPD) on the 12th July to all levels of clinical staff which included simulation & workshops; was a great success and over-subscribed.
- Task & Finish Group is being convened with the ACNs involvement to improve compliance.

Sepsis Screening Compliance (Emergency Portals Contract)





Variation	Assurance
H	?

Target	Apr 21	May 21	Jun 21
90%	97%	95%	91%

Background

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

Variation	Assurance
	?

Target	Apr 21	May 21	Jun 21
90%	89%	93%	82%

Background

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

What is the data telling us:

Adult Emergency Portals screening in June 2021 achieved 91% for the 76 patients audited.
The performance for IVAB within 1hr decline to 82% in June. There were 66 red flag sepsis patients identified from the 76 patients audited in the screening sample.
Out of the 66 red flag patients, 23 received IVAB within an hour whilst 24 were already on IVAB and 14 had an alternative diagnosis.
There were 5 late IVAB from A&E both sites, 2 of which were administered within 2 hours. This have been escalated to the respective areas' senior teams.

Actions:

- The Sepsis Team continue to closely monitor the compliance by visiting the A&E regularly and offering department based sepsis reinforcement when staffing and acuity allows; on-going
- The Sepsis Team is working collaboratively with the A&E Quality nurses, senior staff and A&E Sepsis clinical lead for providing solutions to late IVAB incidents and robust actions put in place. The late IVAB have been addressed through escalation and training for individual staff involved.
- Staff were invited to attend the 5 hour CPD Sepsis champion training arranged in July which was a great success.
- The Sepsis Team will continue issuing certificates in recognition of individual staff who demonstrate a high standard for sepsis compliance and practice.

Sepsis Screening Compliance ALL Maternity

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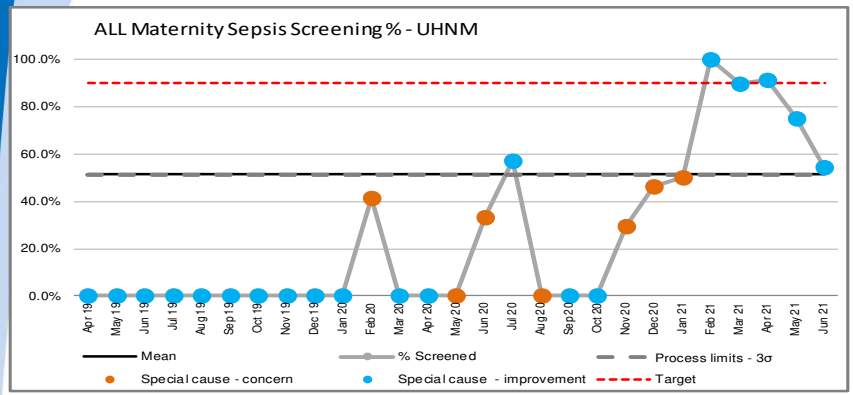
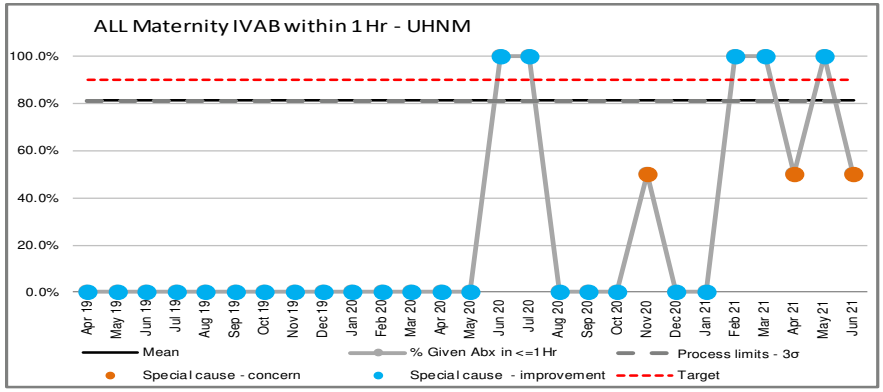


Variation	Assurance
H	F

Target	Apr 21	May 21	Jun 21
90%	91.7%	75.0%	54.5%

Background

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



Variation	Assurance
L	F

Target	Apr 21	May 21	Jun 21
90%	50%	100%	50%

Background

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

What is the data telling us:

Maternity Inpatients and Emergency portal (MAU) audited by the Sepsis Team in June 2021 shows that 54.5% of patients that trigger with MEOWS >4 were audited via K2 electronic system. This result was taken from 11 patients audited with five missed screens from the inpatient wards.

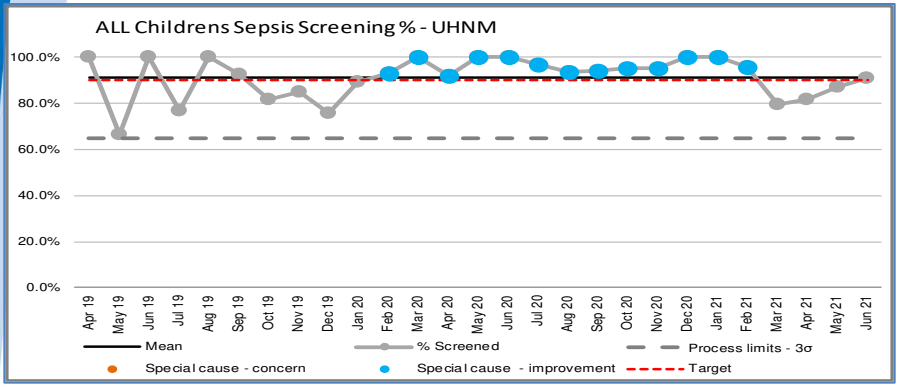
50% compliance was achieved for IVAB within an hour from the 2 cases audited in Inpatient ward, in which 1 delayed IVAB was due to difficult access.

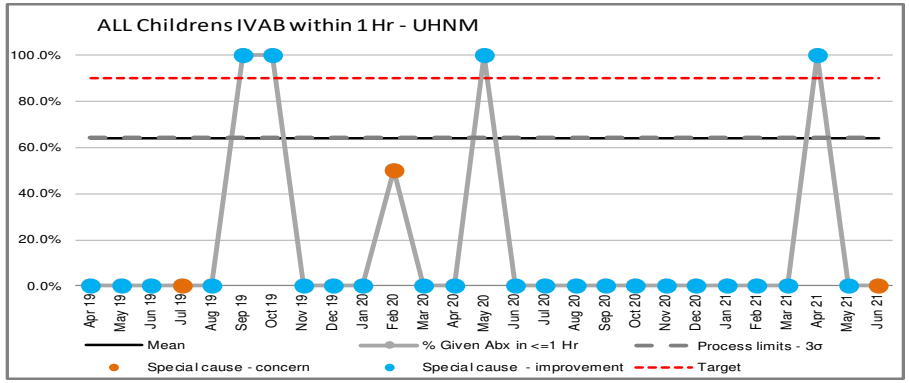
Actions:

- The Maternity Senior Team have continued to work collaboratively with the sepsis team to ensure patient safety.
- The sepsis team will continue to audit Maternity comprehensively to ensure the maintenance of high standard of sepsis practice and compliance.
- Missed screening and delayed IVAB within an hour has been escalated and communicated to the Maternity senior team for learning and an action plan is pending.
- The Maternity clinical educator team was invited and attended the recent 5 hour sepsis CPD champion training with the plan to work collaboratively with the sepsis team on providing/delivering this aspect of learning to Maternity staff and clinicians.

Sepsis Screening Compliance ALL Children

NHS University Hospitals of North Midlands NHS Trust





Variation	Assurance
	?

Target	Apr 21	May 21	Jun 21
90%	81.8%	87.1%	90.6%

Background

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

Variation	Assurance
L	F

Target	Apr 21	May 21	Jun 21
90%	100.0%	N/A	0.0%

Background

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

What is the data telling us:

The charts above show improvement in sepsis compliance for June 2021, with a result of 90.6%.
Whilst CAU continued to sustain and maintain compliance of > 90% and a significant improvement for Children A&E from May (85%) to June (91%) for screening compliance, however IVAB compliance scored 0% for 1 case with delayed IVAB within an hour. Inpatients ward 216 has 2 missed screening and ward 217 have no PEWS 5> triggers during randomised audits. Delayed IVAB and missed screens has been escalated to the senior team in Child Health Wards. Most inpatients Paediatric patients are already on oral antibiotics or IV antibiotics prior to trigger of PEWS >5 (this is both of moderate and high risks).

Actions:

- The Sepsis Team will continue to deliver re-enforcement and kiosks to specific areas when falls in compliance are identified. Ward managers and seniors teams are encouraged to forward concerns and ad hoc training is offered to all areas when required. The subsequent audits suggest that the poor result for Children A&E delayed IVAB within hour is an isolated incident and we are hopeful of better results in the coming month.
- The Sepsis Team has continued to adjust the audit process to take smaller samples over a wider range of dates to give a more comprehensive perspective.
- Formal training is underway.

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Operational Performance

2025 Vision "Achieve NHS Constitutional patient access standards"

Spotlight Report from Chief Operating Officer

NHS
University Hospitals of North Midlands
NHS Trust

Emergency Care

Emergency care at the front door has been further challenged in June 21 by:

- Continued rise in attendances. Non-ambulances attendances are rising month on month. Mostly seen at RS site, with daily average attendances of 386 (a rise of 16/day since previous month) and this is above the levels seen in 2019 which averaged 360/day.
- The increase in attendances coincided with the mid March relaxation of government restrictions. The rise directly correlates to the reduction in some front door metrics such as time to initial assessment and mean time in the department.
- Despite the consistent week on week rise since March, Ambulance handover delays and corridor care have been well managed and only saw a deterioration in the last week of June.
- System-wide performance is down to 69.8% (May 72.2%), with total type 1 at 58.8%. At Royal Stoke the non-admitted performance fell to 58.2% (May 61.1%) and the admitted performance maintained a performance at 33.6%.
- The department had continued days with sub 60% performance with most of the front door metrics challenged.

Cancer

- The Trust is currently predicted to achieve the following cancer standard for June 21: 31 day subsequent treatments for Radiotherapy is expected to achieve a high 96% compliance.
    - The 2WW PTL has shown a decrease overall.
    - The 2WW backlog is continuing to increase.
    - The number of patients waiting over 104 days remains stable. All specialties have been asked to review those waiting over 104 days and expedite next steps accordingly.

- 62 day performance is predicted at this point to achieve 65% in June and continues with one of the lowest backlogs regionally. This position will change as more treatments are recorded. In addition, the number of patients waiting over 104 days at the end of June with a diagnosis of Cancer is 8.

Together Compassion Safe Improving

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Spotlight Report from Chief Operating Officer

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Planned Care

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

- Day Case and Elective Activity delivered for June 21 and numbers of patients treated rising week on week over 500 elective operations w/e 21st June 21.
- Plan to release more patients to the IS to enable full optimisation of capacity through one off lift and shift of patients, starting with the Nuffield.
- Next Planned Care Cell focus on theatre capacity and productivity given the emergent covid risks and staff isolation rate of attrition.
- Scoping of schemes to support management of referred demand (Referral Hub) and waiting list management (Patient Contact Initiative)

RTT

- The indicative performance for June 21: the total number of Referral To Treatment pathways grew to 63,537 (May 61, 608).
- The Trust has continued to reduce the number of > 52 weeks to 3,322 (May 3,606). Recovery plans have been reviewed.
- RTT performance in June is 61.89% (May 62.06%).

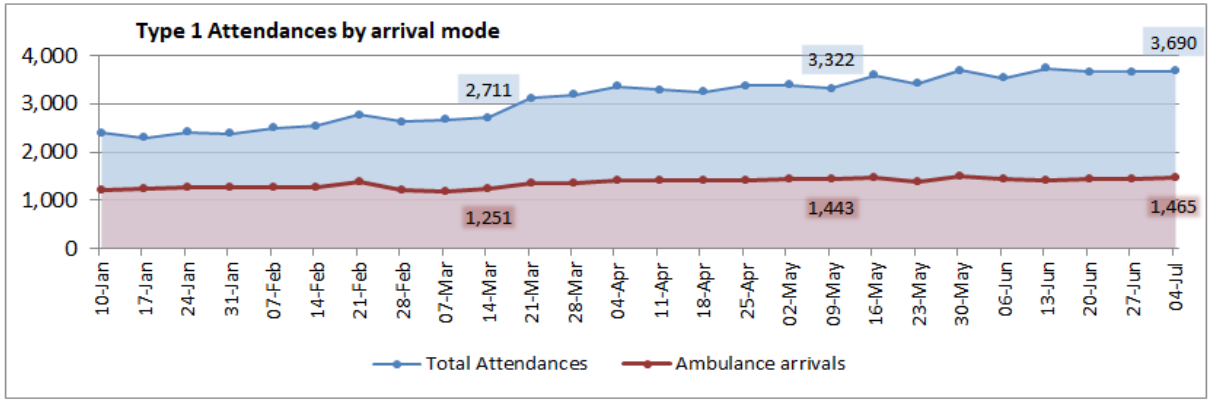
Diagnostics

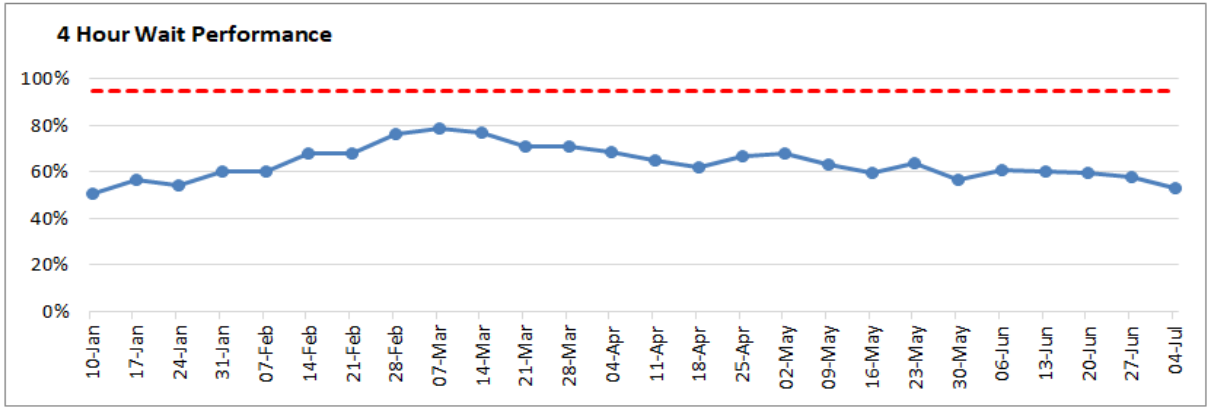
- For DM01 (15 nationally identified Dx tests) however, the waiting list, continues to grow. Although reduction is seen in some modalities i.e. MRI, this has been offset by the increase in Non-obstetric ultrasound.
- The greatest proportion of > 6 week waits are within Non-obstetric ultrasound, which has doubled since Mar-21 and is related to the significant Increase in demand and activity for breast 2ww referrals where the prioritisation over the long waiters, has impacted on performance. A working group is set up comprising of imaging, breast surgery and the cancer to team to review the referral s and total capacity required. There also seems to be more referrals from Primary care for patients under the age 35. Cancer team are engaging with the PCN/CCG regarding referrals, and within radiology effort is being made to put on additional capacity out of hours to clear the backlog with more joint working with surgery.
- The DM01 diagnostic performance for June 21 is provisionally 76.08% (May 79.43%).

Section 1: NON ELECTIVE IMPROVEMENT

The Urgent Care Improvement Programme has a number of projects aimed at improving current performance which in turn improves clinical care and patient experience.

This is set against the context of 4 hour performance and attendances.





Urgent Care – Work stream 1: Front Door

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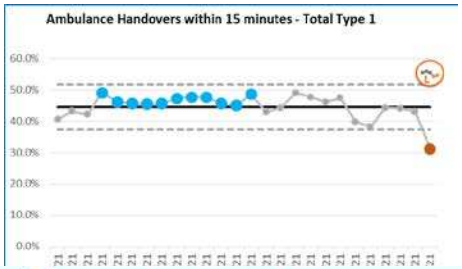

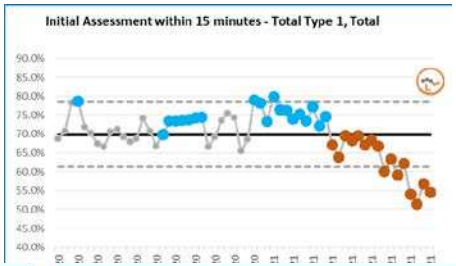

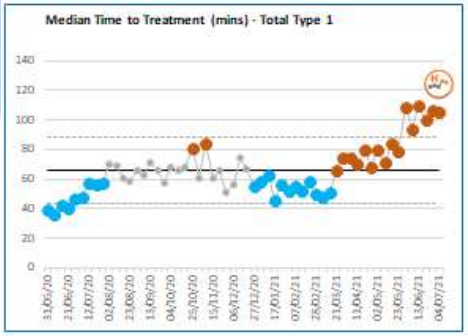

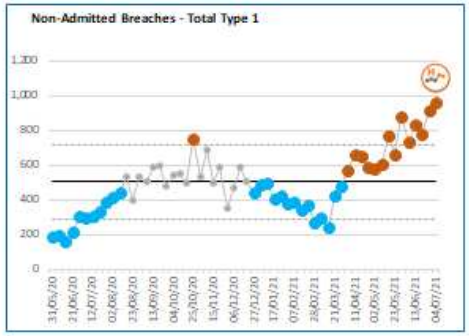

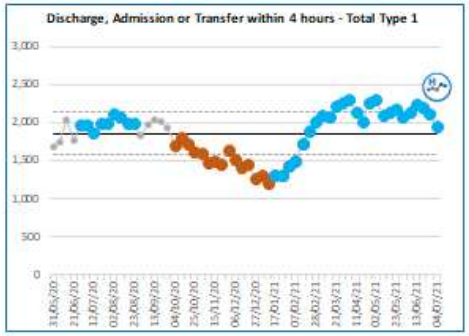

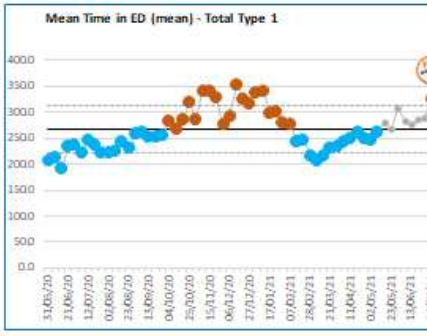

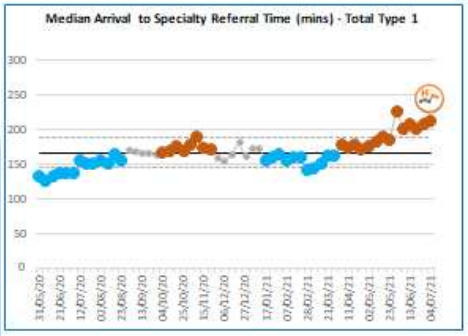

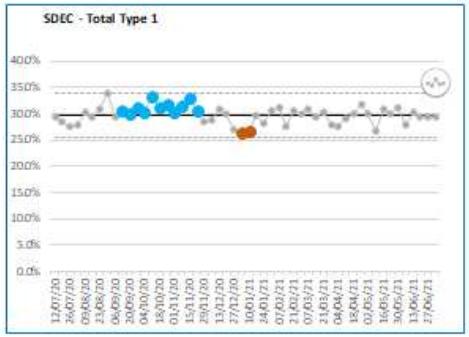

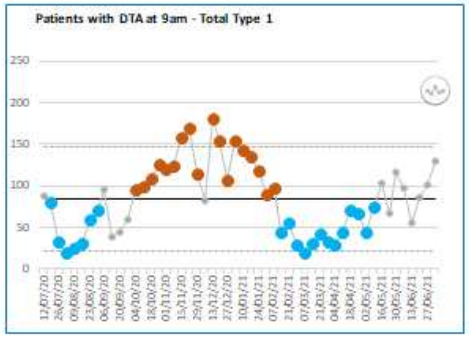

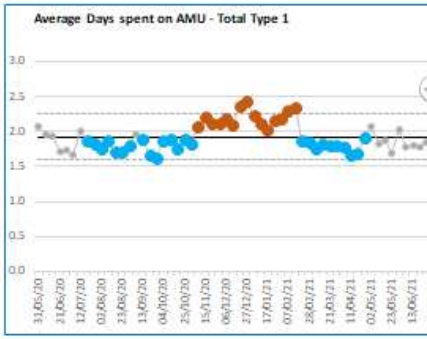

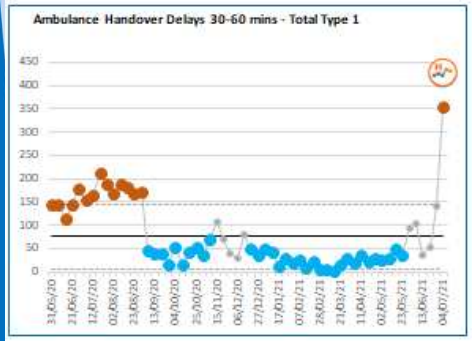

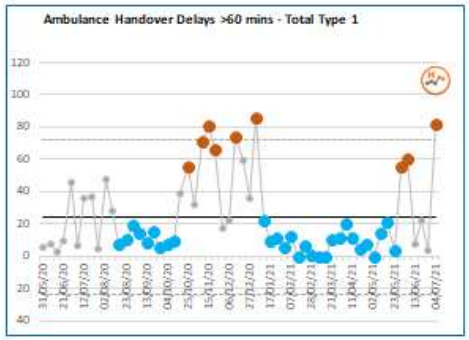

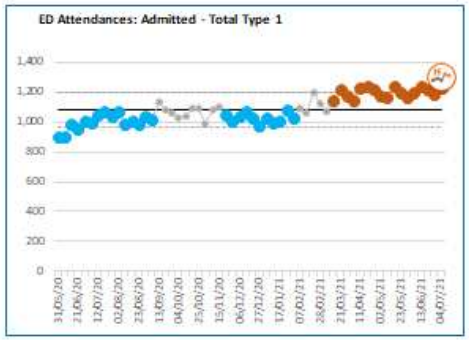

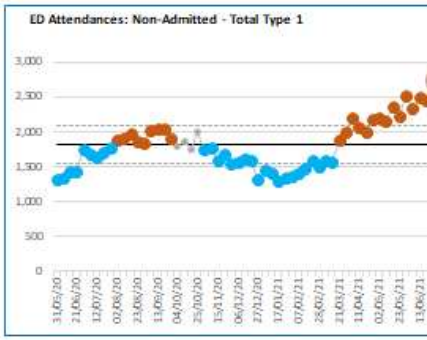

Urgent Care – Work stream 1: Front Door

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SUMMARY

Attendances:

The total rise in attendances is notable, particularly in the non-ambulance pathway. Mostly seen at RS site, with daily average attendances of 386 (a rise of 16/day since previous month) and this is above the levels seen in 2019 which averaged 360/day. There has been an increase of > 40% in attendances at RS since March 2021.

The attendances have continued to rise without an increase in resources to meet this demand. We would therefore expect to see the deterioration that we have in the ED process metrics.

This added to the departments footprint with social distancing that is spread over a larger geographical area adds increasingly to the challenges.

National bundle

- The percentage of ambulance handovers in 15mins is showing early signs of deterioration. However, there is a robust process for patients who are held on ambulances with a navigator at the front door and clinicians who review and check the patients .
- The percentage of patients whose Time to initial Assessment has reduced to around 54% (from c64% in May), this directly correlates to the increase in attendances, particularly in the non-ambulance. Paediatrics has also seen a rise to 96/ day on average. The rise in all non-ambulance attendances is in line with the national picture.
  The rises that impact on performance the most are where there are surges of over 30 attendances within the hour particularly in the evening where staff shortages, particularly decision makers has been a challenge. The department are aiming to maintain the triage time with re-deployment of staff in the department at the time. A business case addressing workforce issues is underway.
- The MEAN time in the department has also risen and again this is in direct correlation to the rise in attendances.
- The number of referral to specialty teams has remained fairly static, however the data is showing an increase in referral to discharge time. Challenges were noted with Trauma.
- The number of patients spending over 12 hours in the department has also risen above the mean.

Performance

System-wide performance is down to 69.8% (May 72.2%), with total type 1 at 58.8%. At Royal Stoke the non-admitted performance fell to 58.2% (May 61.1%) and the admitted performance maintained a performance at 33.6% .

Urgent Care – Work stream 1: Front Door

NHS University Hospitals of North Midlands NHS Trust

ACTIONS

Attendances:

- Economy –wide meeting to discuss and agree action regarding the rise in non-ambulance attendances w/c 5th July
- 'RED' GP reinstated within the UCC 6th July with immediate effect seen.
- Maintaining a focus on initial time to triage – re-deploying staff in the department when required.
- Estates challenges are currently preventing the embedding of a CDU, but this is being reviewed weekly

Non-ambulance footprint:

- Focus on the non-ambulance and non-admitted cohort including a complete review of the ED estate.

National bundle:

- Maintain the 15 minute triage time by re-deployment of staff 'real-time'.
- Review of Test of Change data for new triage pilot at RSUH completed, meeting with CCG/Vocare to discuss this week. Links to staffing availability to be brought to the next NE group meeting
- The electronic referral system introduced has shown some real benefits with a reduction in time spent on the telephone. -Continue to develop plan to expand the roll-out across Specialised and Surgery
- Visible trigger boards in ED
- Specialised division piloting a new metric relating to 'pulling' patients out of ED
- Specialised reviewing the Trauma pathway

Workforce:

- Business case to address workforce issues with clear key metrics to measure improvements. Immediate ToC case supported by Execs and enacted 6th July
- Engage senior clinicians. Re-set department structures.
- Working on A&E internal improvements including roles and responsibilities, huddles and rounding to improve grip, supported by visible improvement and escalation dashboards

Urgent Care – Work stream 2: Flow

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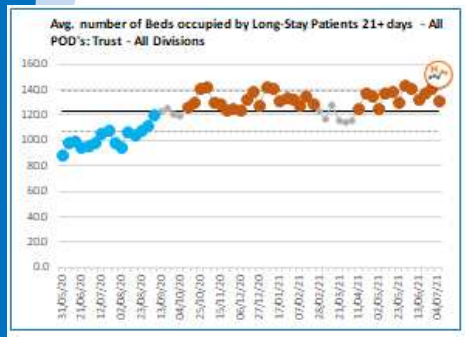
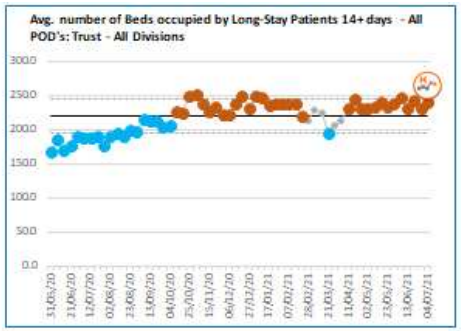
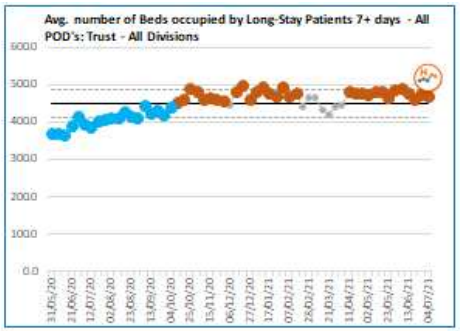
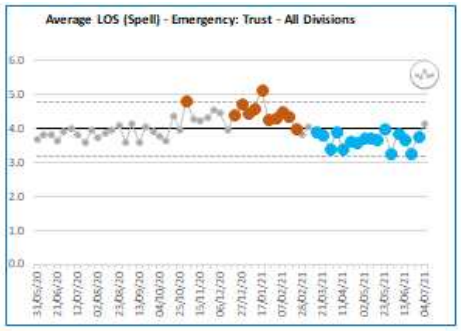
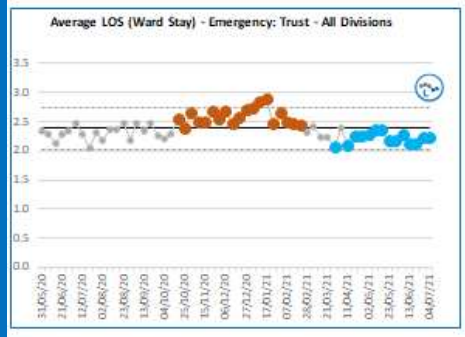
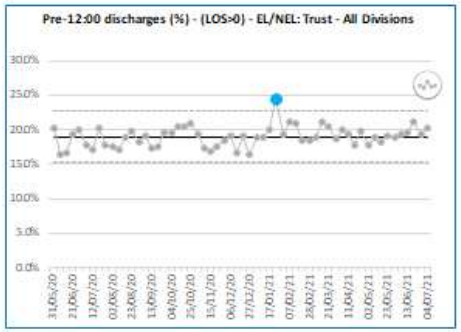


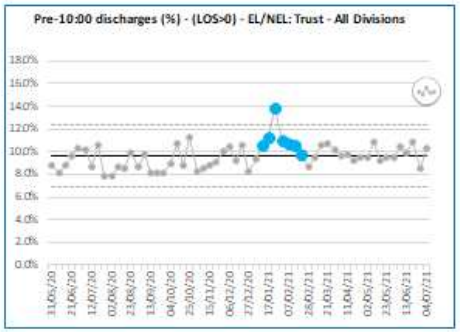


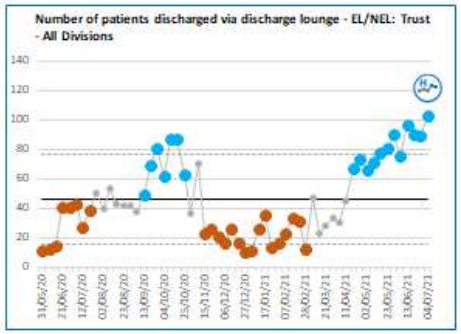


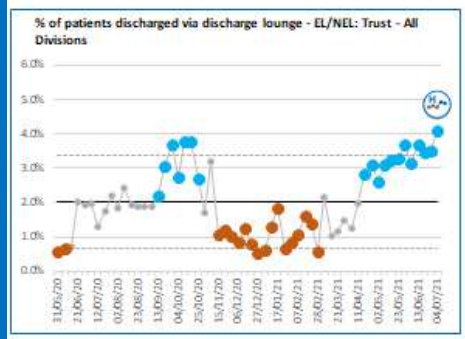


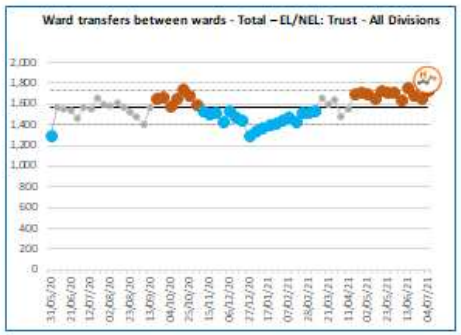


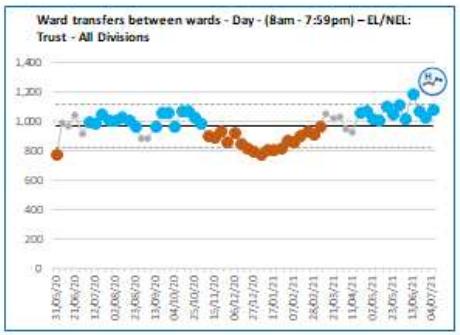


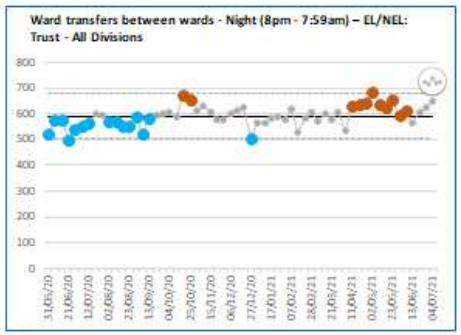












Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Urgent Care – Work stream 2: Flow

SUMMARY

- The number of long staying patients > 21 days, remains high through June however, numbers remain around 40 below 1920 BAU levels.
- MFFD has seen a decrease in numbers after several consecutive months of rises, mostly driven by Medicine and Surgery.
- The pre-noon discharge percentage of 30% was not reached but improvements were seen in Medicine and CWD with an overall steady rate of c20% across all areas. Pre-noon discharges need to be seen jointly with LoS as so me areas have brought forward discharges to the previous afternoon/evening. Average Los for emergency admissions has seen a reduction reaching the lower control limit of 3.2 days compared to 4.6/4.7 days in December and January.
- A significant increase was noted in the number of patients discharged via the discharge lounge, particularly notable in Medicine and Specialised

ACTIONS

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

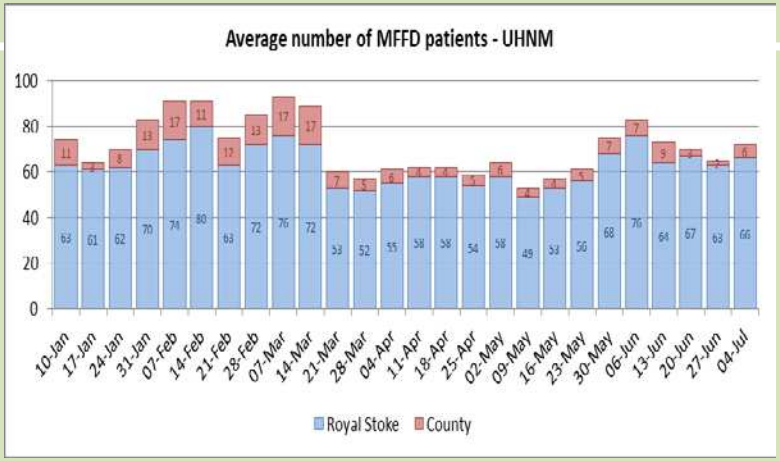
Work stream 3: Clinical Site Management

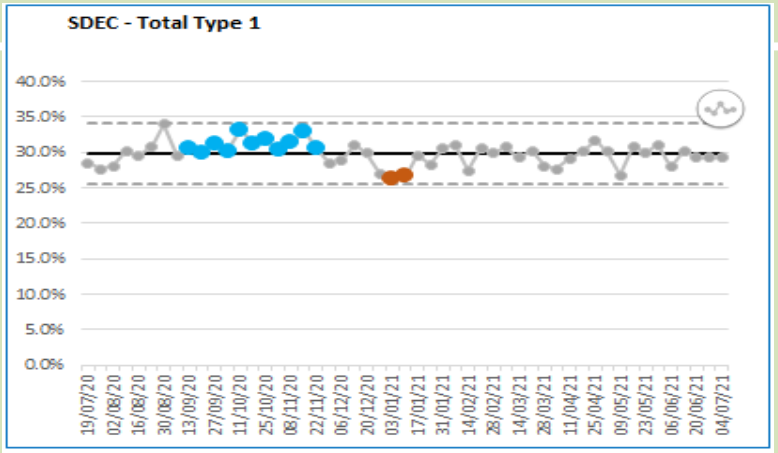
Summary

- With increased demand UHNM saw a rise in the number of patients in the department with a DTA at 9am – over 100 total for the week at the end of May.
- The percentage of patients allocated to SDEC has remained static.
- MFFD numbers have improved slightly through the month

Actions

- The IPS standards for all portals have been submitted through Divisional boards and are for approval at Junes Non-Elective Group. Following which these will be implemented and monitored for compliance.
- Confirm and agree the new 'battle rhythm' for the sites post COVID.
- Agree workforce model that's Deliver clinical oversight.
- Begin to map out ways of working that supports the delivery of the Urgent Care standards. Tracking of patients with pathways of over 12 hours now reported on the site reports.





Section 2: ELECTIVE CARE

Cancer

University Hospitals of North Midlands NHS Trust

Cancer Summary:

- The Trust is currently predicted to achieve the following cancer standards for June 21: 31 day subsequent treatments for Radiotherapy is expected to achieve a high 96% compliance.
- The overall 2ww position has improved in June by and is predicted to achieve in the region of 90%. Specialties with the most 14 day breaches are Breast and Skin.
- The Breast Symptomatic standard (for Breast referrals where cancer is *not* suspected) is predicted to land in the region of 30% in June. This has stayed the same since May 21 as patients referred with suspected cancer are prioritised.
- The Breast 2WW pathway (where cancer *is* suspected) is predicted to achieve 80% against the 14 day standard in June. Patients seen on this pathway are included in the trusts overall 2WW performance. The Breast 80% 2WW suspected cancer position is a big improvement from around 25% compliance in May.
- Performance against the 62 day standard is currently at 65% for June 21. The majority of patients waiting over 62 days are on a Lower GI pathway. See actions on next slide.
- The Trust continues to record a high volume of 2WW 1st appointments in June 21 – an un-validated total of 3159 suspected cancer patients were seen.
- 31 day subsequent surgery is predicted to improve in June to circa 88%, up from 78% in May.
- There are on-going delays in diagnostics, specifically Pathology. The impact of the delays in turn around times are widespread, for example patients are deferred from a MDT discussions due to unreported specimens. This impacts a number of standards; 28 day, 31 day, 62 day.
- Delays in pathology are contributing to a growing backlog of patients waiting over 62 days. However the overall PTL has reduced for the past 3 consecutive weeks.
- In order to manage the backlog of patients waiting for surgery - patients are being dated according to their clinical need rather than their clock start date, resulting in a higher number of patients waiting over 104+ days in June. This clinical prioritisation of patients is continuing into July. Directorates are well engaged and cited on those listed and waiting for surgery, and feedback on any capacity issues through the assurance framework with exec oversight.

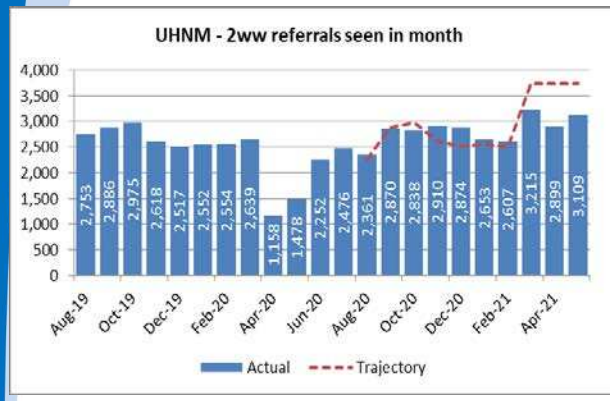
Cancer

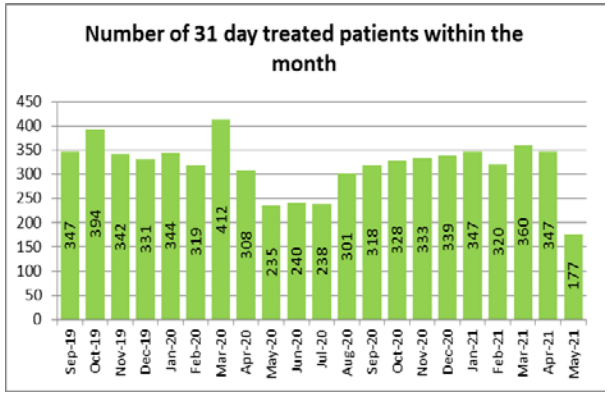
NHS
University Hospitals of North Midlands
NHS Trust

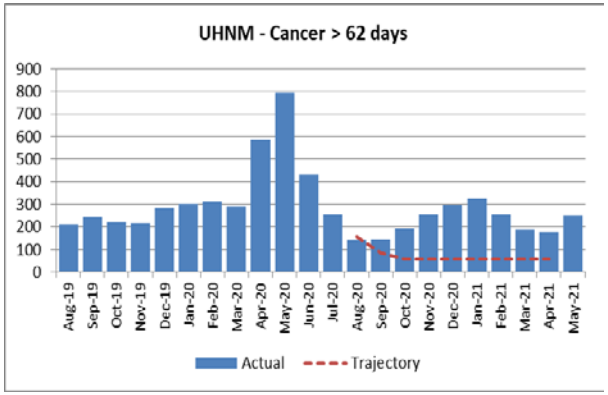
Actions:

- Lower GI improvement actions: The new 'Rapid Diagnostic Centre' LGI Pathway is planed to go live on 2nd August. This will see FIT requested as part of the 2WW referral into the LGI suspected cancer service. An updated blood test order set on ICE for NG12 will include FIT to make it easier for GPs to request the test. The CCG are supporting the pathway and are configuring the referral form into EMIS that will be circulated to primary care. It will be a soft launch – FIT not yet required as prerequisite to 2WW referral but ERS will be monitored to target education to practises who are not yet requesting FIT.
- New Vague Symptoms Service Actions: The new 'Rapid Diagnostic Centre' Vague Symptoms service is on track to go live in September. This pathway will deliver better access to a cancer specialist when patients present in primary care with non-specific symptoms and don't fit a traditional 2WW pathway, but where there is an underlying suspicion of cancer. A new Nurse Practitioner has commenced post and is continuing the progress already made in setting up the pathway. The service is hosted by Oncology and has built a strong network of links across the hospital to provide a broad assessment of symptoms and quick onward referral to the most appropriate clinicians, to enable faster diagnosis of cancer.
- The Cancer team held successful planning sessions to support directorates to incorporate cancer trajectories into capacity and demand modelling tools. The Skin team are reviewing extra clinics and have outlined a proposal to instigate spot clinics in the community for patients who are most likely to be discharged at 1st OPA. Clinics backfilled by a middle grade in the hospital enable this model to increase capacity to accommodate the rising volume of 2WW referrals. The scheme has been put forward for investment from the cancer alliance.
- A trust training programme has enabled Robotic Assisted Laparoscopic Prostatectomy (RALP) capacity to increase. This increased capacity will support the trust in managing the growing wait list of RALPs that are currently being scheduled outside of target.
- In June the Cancer team completed the trust annual quality surveillance process with excellent representation and high quality responses from each of the MDTs. Self declarations have been submitted by each of the services, which describe compliance or risk against the NHSEI quality indicators. Updated operational policies have also been submitted which illustrate innovative practices and highlight areas of best practice in cancer services across trust. A summary report will be provided to go through governance.
- Discussions are on-going with neighbouring trust Shrewsbury and Telford Hospital to understand how UHNM can provide mutual aid and support new partnerships, particularly in H&N services.

Cancer







Core Standard	Target	Trust Actu	Clock Stop	Breaches	Breaches Over	Needed Treatme
TWW Standard	93%	89.9%	3159	318	97	1384
TWW Breast Symptomatic	93%	29.9%	87	61	55	785
31 Day First	96%	93.0%	299	21	10	227
31 Day Subsequent Anti Cancer Drug	98%	97.0%	33	1	1	18
31 Day Subsequent Surgery	94%	88.1%	42	5	3	42
31 Day Subsequent Radiotherapy	94%	96.6%	88	3	Achieved!	Achieved!
62 Day Standard	85%	64.5%	160.5	57	33	220.5
Rare Cancers - 31 Day RTT pathway	85%	-	0	0	1	1
62 Day Screening	90%	74.1%	27	7	5	44
28 Day FDS Standard	75%	71.0%	2458	713	99	395
62 Day Consultant Upgrade	93%	83.0%	94	16	10	135
Closed Pathways > 104 Day			14			

Planned care - *Inpatients*

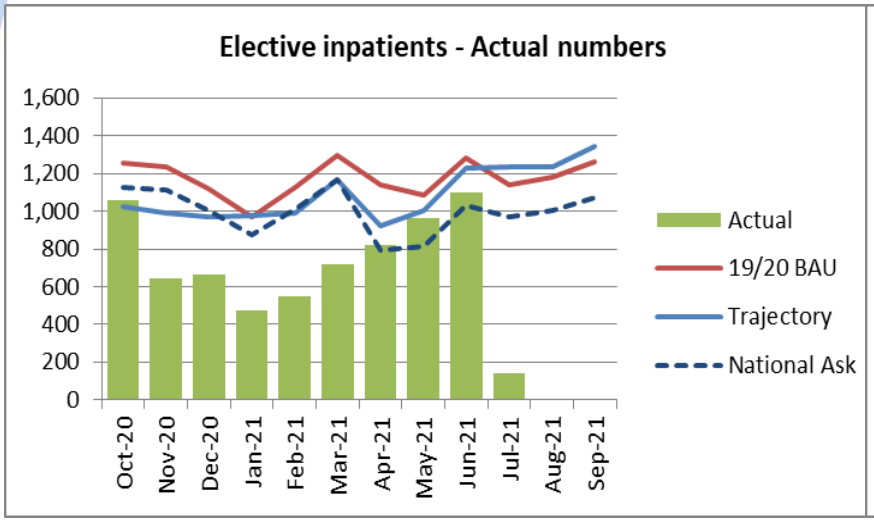
Elective inpatients Summary

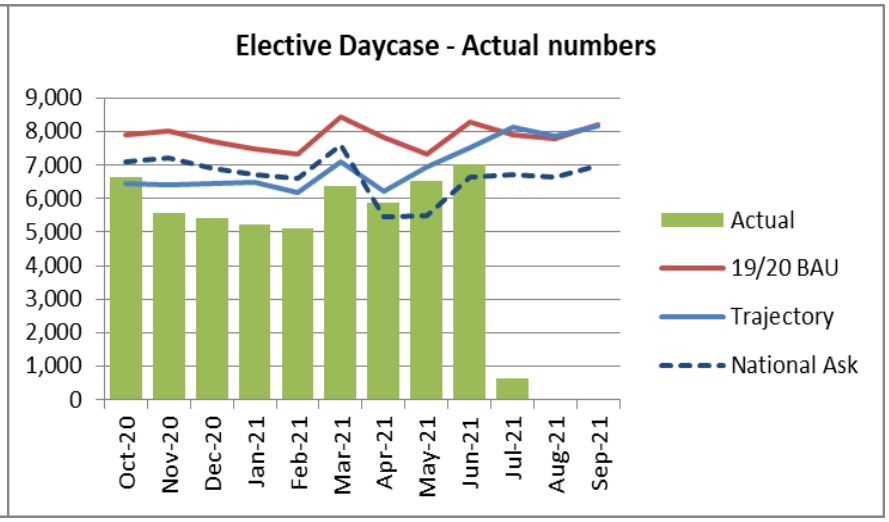
- For June the total inpatient actuals against BAU was 84.9%. This is higher in Inpatients than Day case (85.4% IP, 84.9% DC).
- The number of elective operations for UHNM (inpatients and day cases) reached 8,134 in June. However, progress with further Elective and Day-case theatre capacity continues to demonstrate week on week increase in activity.
- The Planned Care Cell continues and reports directly to the Operational Delivery Group .The focus of activities has been as follows:
- **GIRFT:** pathways ENT, Ophthalmology, T&O and General Surgery with links to the Midlands Elective Recovery Programme.
- **AUGMENTED CAPACITY:** IS contract review with the handover of a cohort of patients to ensure optimised fill of all available capacity with backfill cases in the IS gift to deploy.
- **INVESTMENT INITIATIVES:** Scoping of initiatives that need extra support to enable 3 schemes by ISP – Referrals Management Hub and Pt contact initiative.
- **BAU PROCESSES:** PTL management including hub and spoke validation with Divisions and RTT Training new staff and where RCA have shown non compliance against policy. P2 surveillance for clinical oversight continues. D/Q audit planned in 2 weeks.

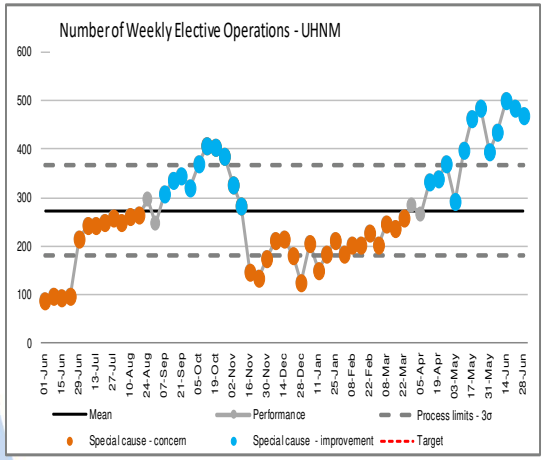
Actions

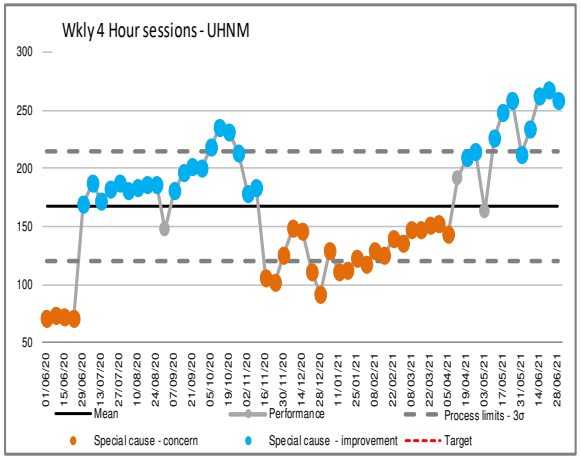
- Enact revised IS pathway initiative 9 (circa 2,500 patients handover to Nuffield as one off traunch in addition to the sub contract). Same proposal in work up for Ramsay.
- Scope Patient Contact Initiative with Gen Surgery and Endoscopy and work up bids.
- Scope Referral Management Hub proposal with In Sourcing Company (local request for volunteers not forthcoming).
- Continued oversight P2 clinical notation to Medway for assurance of clinical review of P2 pts.
- Risk assess theatre activity plans in light of rising covid numbers and staffing attrition rates – PCC focus 15/7 on theatres/productivity.

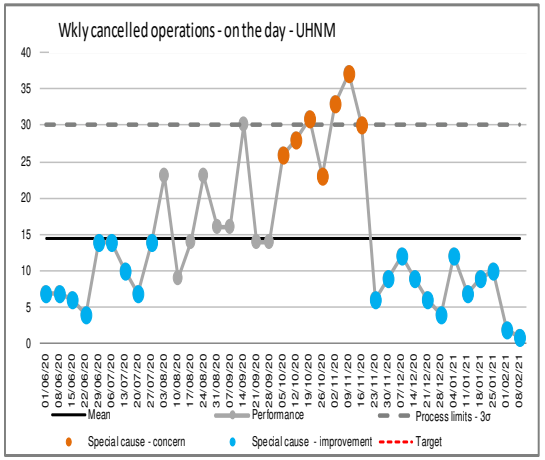
Planned care – *Inpatient Activity*











Planned care - *Outpatients*

NHS University Hospitals of North Midlands NHS Trust

Summary

- For June the total outpatient actuals against BAU for outpatients was 99.4%. This is higher in Follow ups than new (87% New, 108% follow up).
- June 21 numbers recorded to date were 73,263. However this may increase further as the outstanding outcomes are completed.

Outpatients

- 3 Key work streams are Divisional recovery and waiting list position, outpatient transformation (patient initiated follow-ups and enhanced advice & guidance); demand management; productivity & utilisation.
- For outpatient appointments (appointment type) the Trust delivered **68.3%** F2F and **31.7%** non F2F(Telephone & Video). For New appointment types the proportion of F2F was **70.3%** with non F2F **29.7%** & Follow Ups F2F **67.2%** with non F2f **32.8%**.
- June's performance for ASIs position only fractionally decreased by 0.2% to 87.6% within 3 days (from 87.8% in May).

RTT

- The overall Referral To Treatment (RTT) Waiting list continues to rise. For June the number of Incomplete pathways has risen to 63,537 (May 61,625).
- The number of patients > 18 weeks has risen to a level of 24,216 (May 23,375).
- The numbers of 52 week waits in June is continuing to decline with a reported 3,322 (May 3,606, April 4,094).
- However, there are now patients who have reached 104 weeks. At the end of June the numbers reported were 53. The Planned Care group is monitoring progress against treatment plans for these patients.
- Performance however, has fallen slightly to 61.89% (May 62.06%).
- June NFTF consistently above 30% vs.. 25%, comparing favourably vs.. peers against both measures.
- Follow up backlog increased by 20,000 to 70,000 due to move to using Review Date.
- 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 12,000 (half of increase attributable to use of Review Date).

Planned care - *Outpatients*

University Hospitals of North Midlands NHS Trust

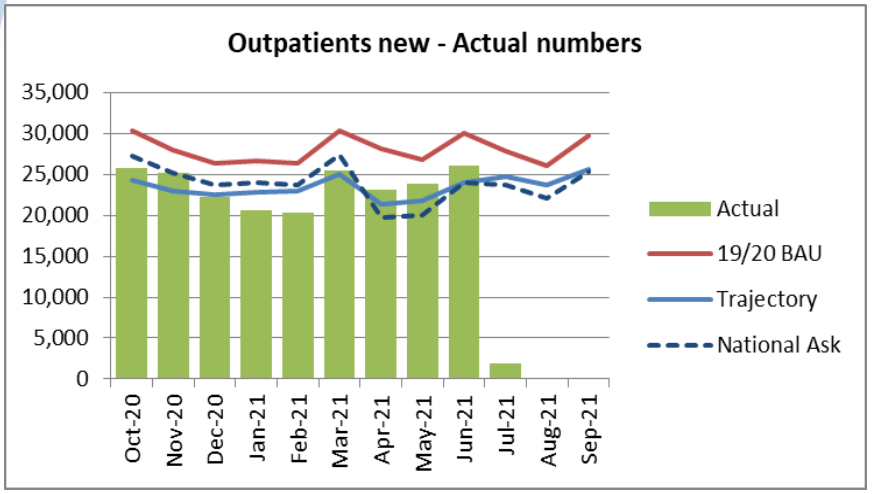
Actions

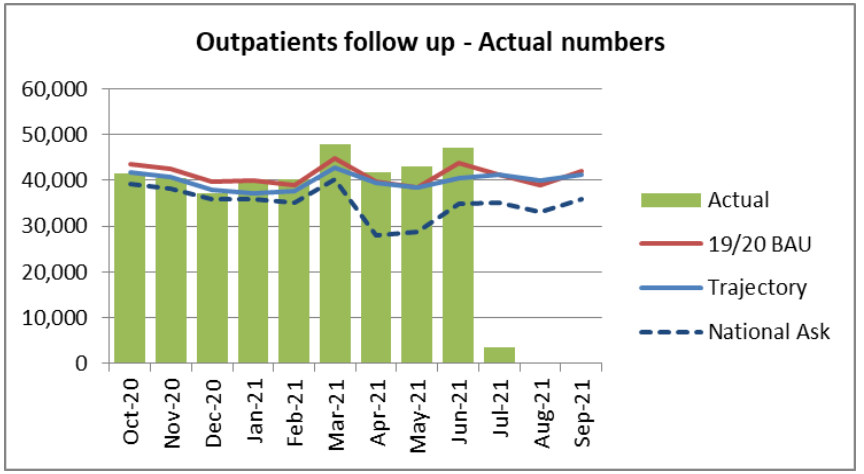
- Key actions identified around Divisional Waiting List Management with a focus on validation, data quality and >52weeks patients.
- ASI performance / unoutcomed activity monitoring in place; assurances around triage processes and clinical prioritisation of new patients provided from Divisions.
- Outpatient Service Delivery & Performance workstream delivering vs. plans for Partial Booking Rollout, Netcall Rollout, CAF Issues Action Plan, and OP Clinic Process vs. Maturity model. Real time Room utilisation feedback to be trialled. Session flags to be updated to support utilisation monitoring,. Review Date training to be prioritised with support of DQ guides and floor walking.
- Enhanced Advice & Guidance sub workstream rationalising specialties for rollout, linking with system, and PIFU sub-workstream rolling out vs. plan on track to begin in July (respiratory).

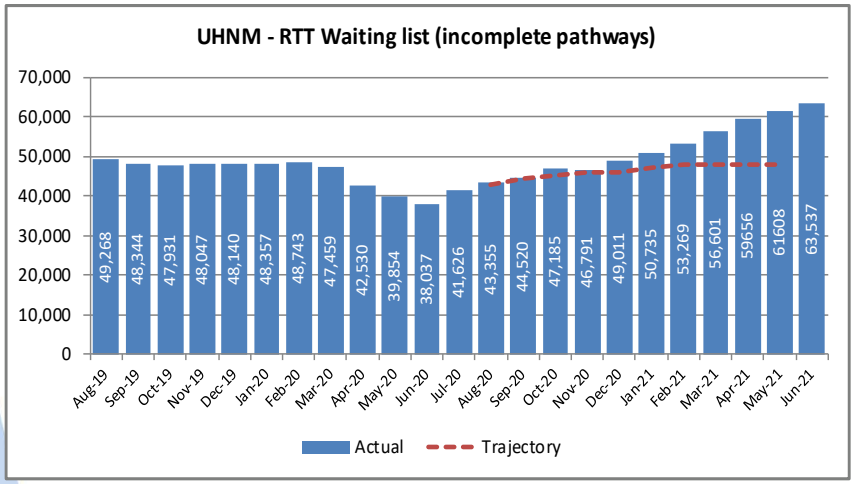
Risks:

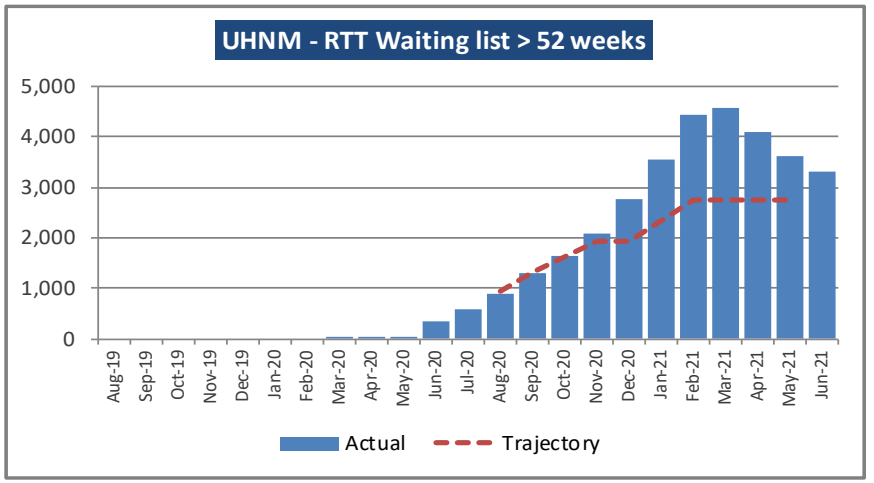
- Deteriorated waiting list position vs. pre-covid; volume of patients requiring DQ and clinical validation very challenging, raised on Divisional Risk Registers.
- FTF activity limitations for ENT, Oral & Eyes in non-shared OP areas; looking at other specialty subject to confirmation.
- iportal intermittent performance issues affecting timely completion of virtual outcome forms; update pending in July.

Planned care – *Outpatient activity & RTT*

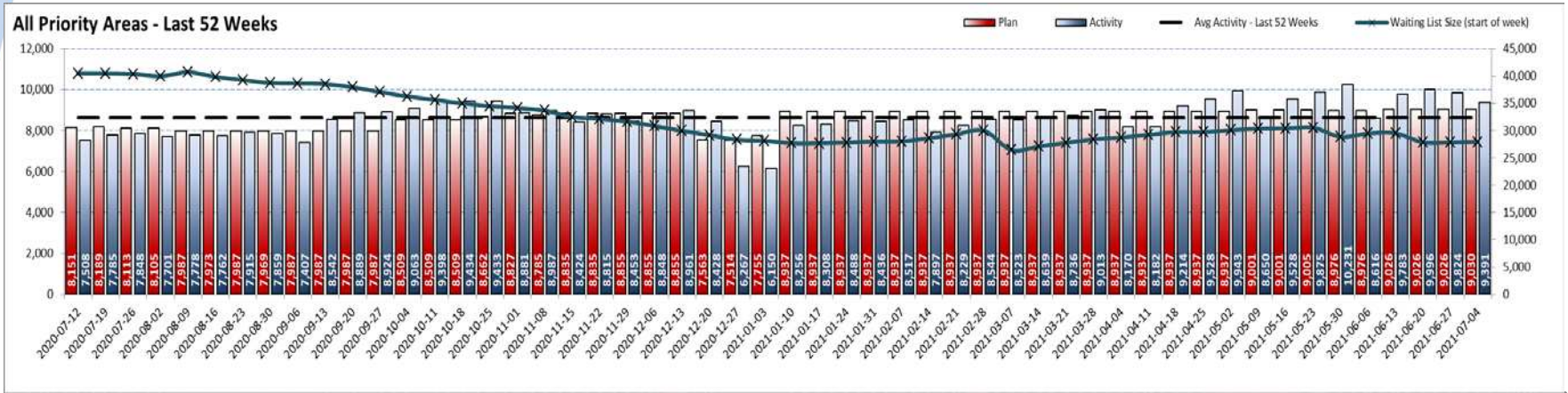








Diagnostic Activity



Summary

- Diagnostic performance for all tests is monitored through the Diagnostic Cell. June saw a rise in activity for all areas and in June overall activity rose to 97% of pre-covid business as usual.
- Capacity and Demand work is being planned in the next quarter and is reliant on transformation and corporate support
- For DM01 (15 nationally identified Dx tests) however, the waiting list, continues to grow. Although reduction is seen in some modalities i.e. MRI, this has been offset by the increase in Non-obstetric ultrasound.
- The greatest proportion of > 6 week waits are within Non-obstetric ultrasound, which has doubled since Mar-21 and is related to the significant increase in demand. The non-obstetric ultrasound waiting list has risen from 3,680 in Jan 21 to 8,631 at the end of June 21 against a workforce that is at full capacity. A request for additional investment in workforce is being finalised, however sonographers are hard to recruit.
- A working group is set up comprising of imaging, breast surgery and the cancer to team to review the increase in breast referral s and total capacity required. There also seems to be more referrals from Primary care for patients under the age 35. Cancer team are engaging with the PCN/CCG regarding referrals, and within radiology effort is being made to put on additional capacity out of hours to clear the backlog with more joint working with surgery.
- The current DM01 diagnostic performance for June 21 is 76.08% (May 79.43%). Endoscopy and non obstetric ultrasound are the areas of concern with CWD delivering a recovery plan to the July 0DG.
- Imaging – average demand over last 6mths was 9,000 patient requests per week, with activity in June peaking at c9,500 patients scanned per week

Diagnostic Activity

University Hospitals of North Midlands NHS Trust

Areas of Concern:

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

Impact :

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

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

Increase in outsourcing and locum costs

Increasing staff sickness due to workplace pressures

Mitigation:

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

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

Impact:

Increase in waiting times and backlog for non urgent scans

Inability to meet DM0-1 standards

Increased stress for current staff

Poor patient experience

Mitigation:

Paper for approval for additional staffing resource to July ODG.

Attempting to source locum sonographers

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

Impact:

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

Mitigation:

- Use of the Independent sector has been prioritised for P3 classification patients where suitable (DM01) to date 320 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 circa 165

APPENDIX 1

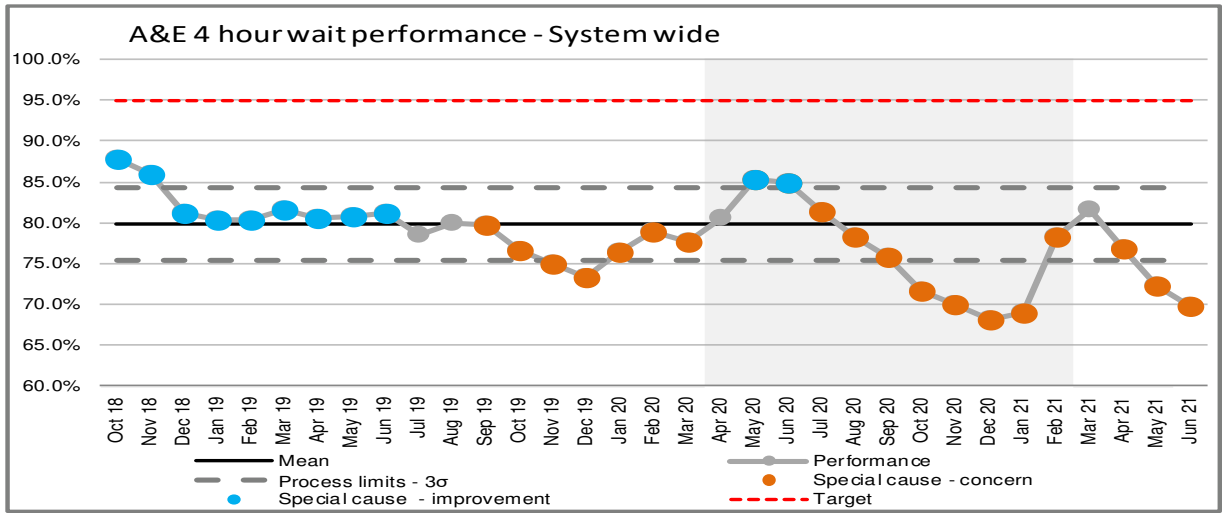
Operational Performance

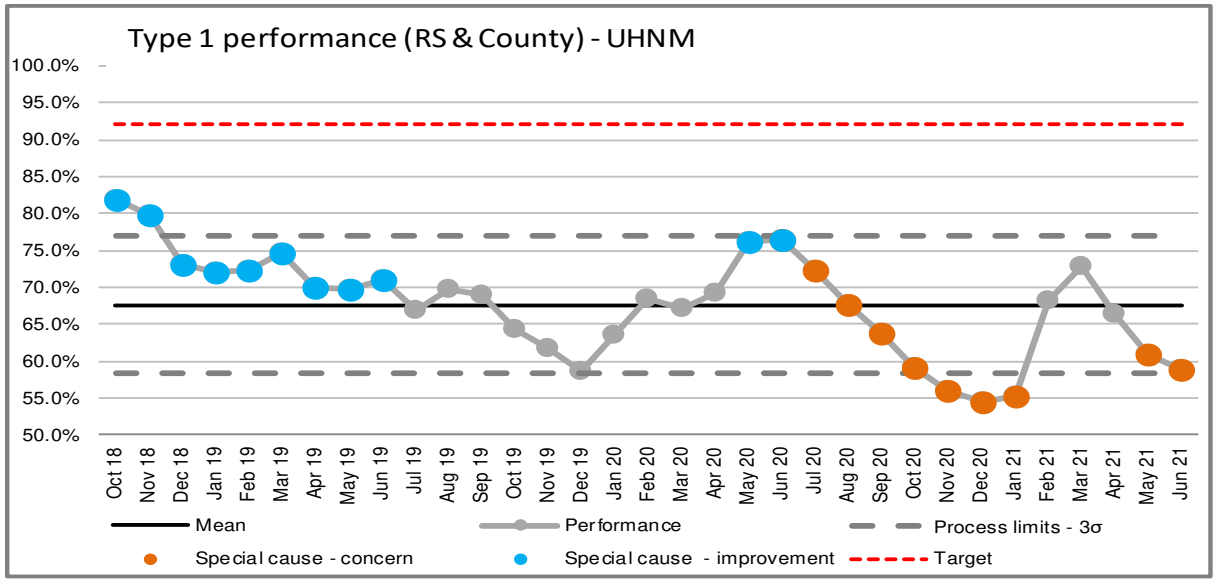
Constitutional standards

	Metric	Target	Latest	Variation	Assurance	DQAI
A&E	A&E 4 hour wait Performance	95%	69.80%	L	F	
	12 Hour Trolley waits	0	2		?	
Cancer Care	Cancer Rapid Access (2 week wait)	93%	90.85%		?	
	Cancer 62 GP ref	85%	60.85%		?	
	Cancer 62 day Screening	90%	74.07%		?	
	31 day First Treatment	96%	92.46%		?	
Elective waits	RTT incomplete performance	92%	61.89%	L	F	
	RTT 52+ week waits	0	3322	H	F	
	Diagnostics	99%	76.08%	L	F	

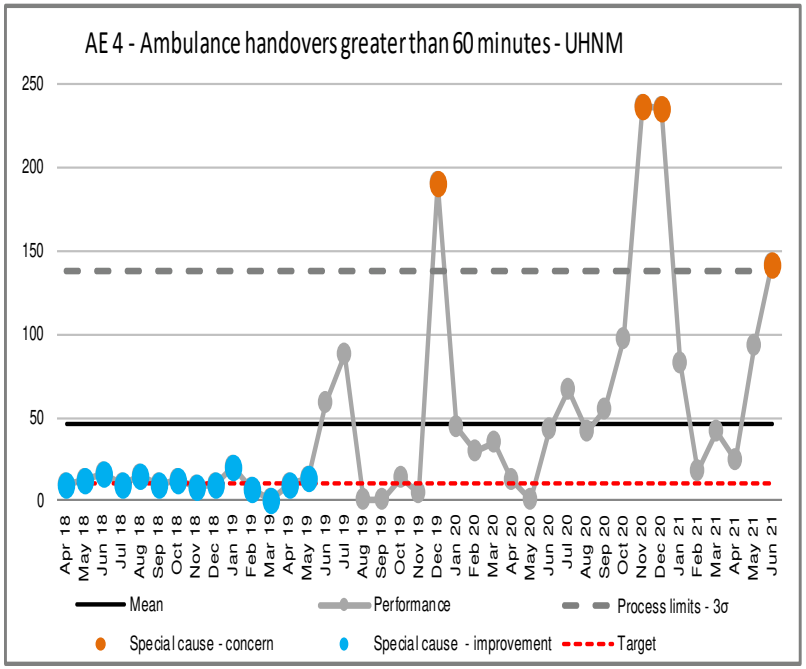
	Metric	Target	Latest	Variation	Assurance	DQAI
Use of Resources	DNA rate	7%	7.3%		?	
	Cancelled Ops	150	136	L	?	
	Theatre Utilisation	85%	76.0%			
Inpatient / Discharge	Same Day Emergency Care	30%	30.1%	H	?	
	Super Stranded	183	150	L	P	
	DToC	3.5%	1.60%	L	?	
	Discharges before Midday	30%	19.6%		F	
	Emergency Readmission rate	8%	11.8%	L	F	
	Ambulance Handover delays in excess of 60 minutes	10	142	H	?	

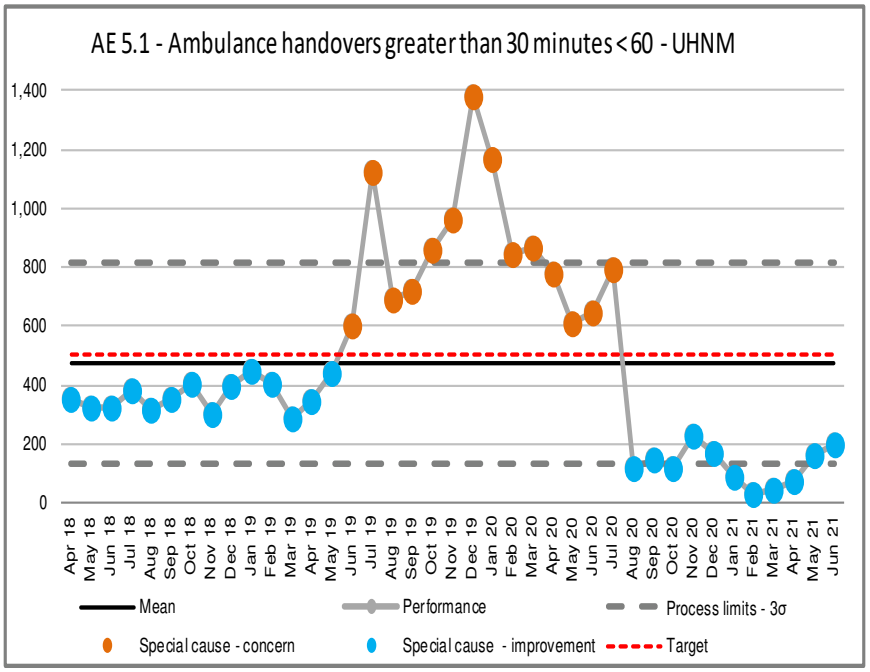
URGENT CARE – 4 hour access performance





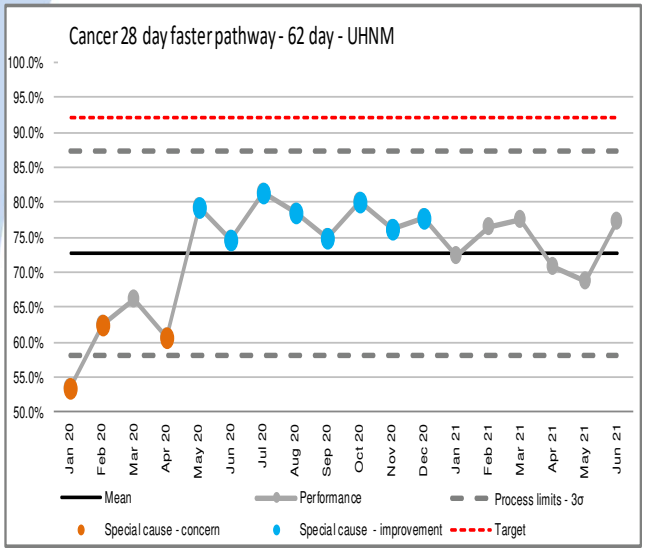
URGENT CARE – 4 hour access – ambulance handovers

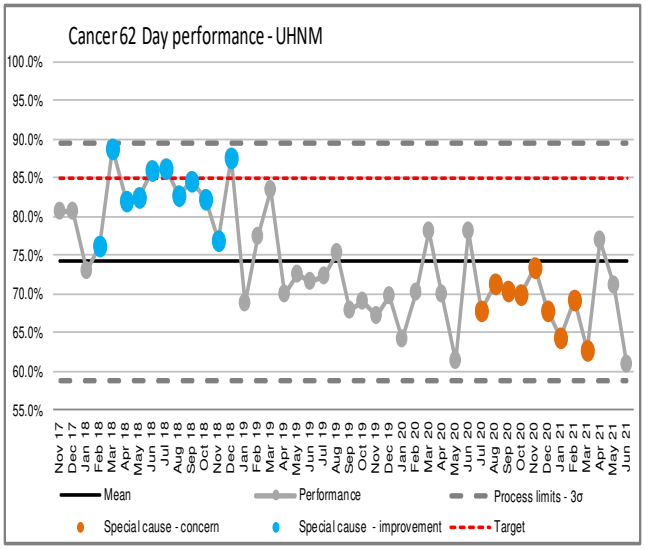




From August – internal validation of > 30 minutes

Cancer – 62 Day





Variation	Assurance

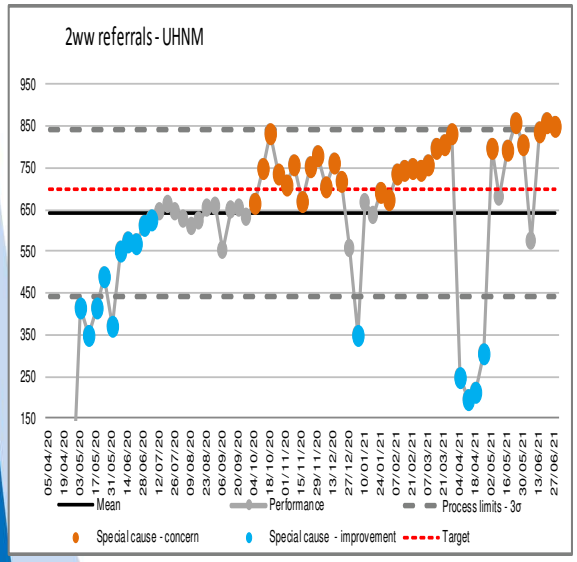
Target	Apr 21	May 21	Jun 21
85%	77.1%	71.1%	60.9%

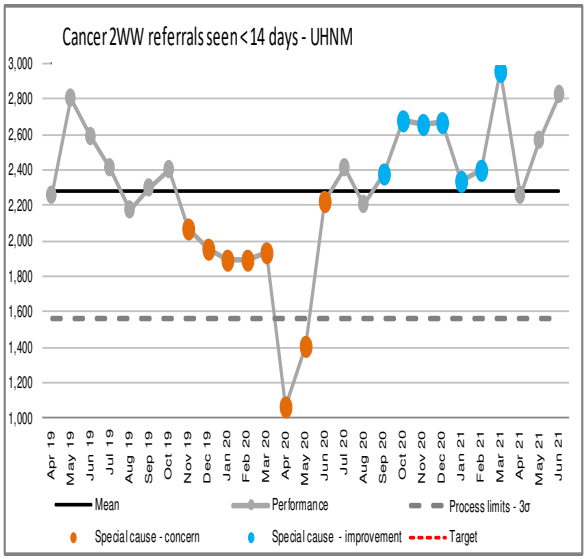
Background

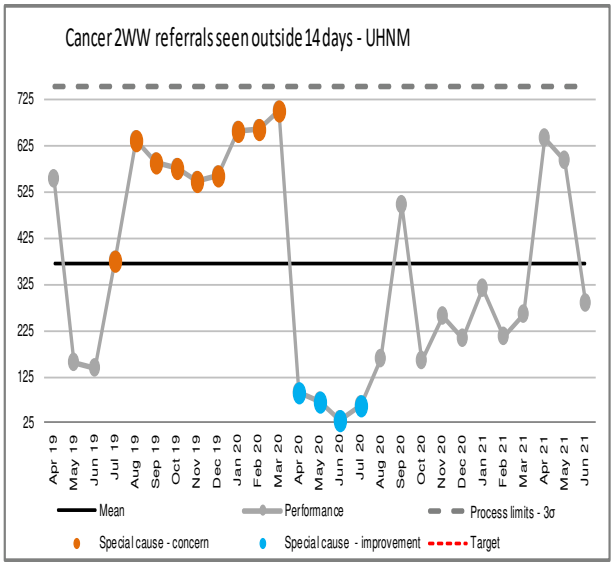
% patients beginning their treatment for cancer within 62 days following an urgent GP referral for suspected cancer

What is the data telling us?

Apart from two occasions the standard has been below the mean since Sept-19. In March the standard fell to the lower control limit.

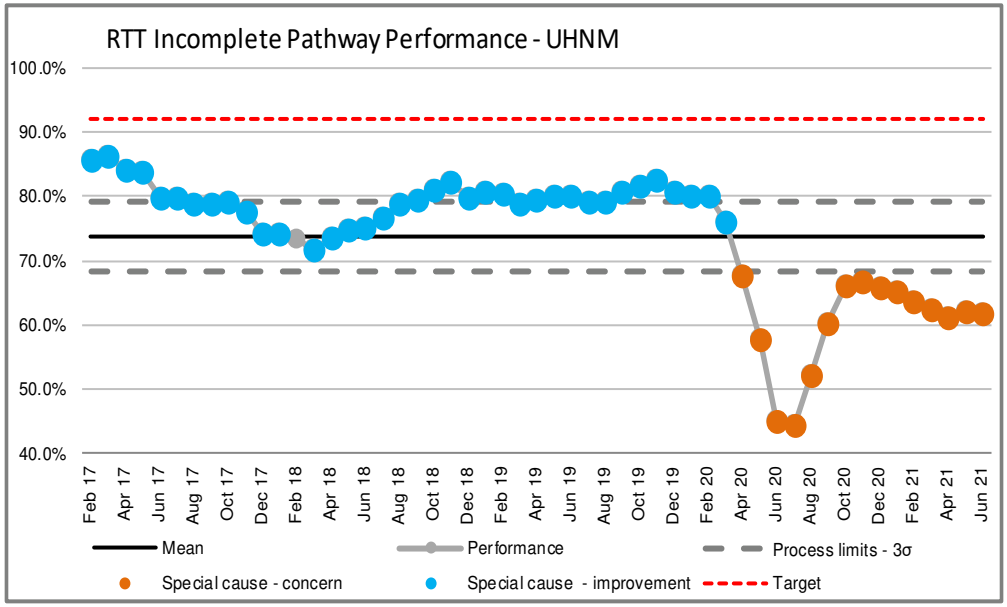






Quality | Operational | Workforce | Finance

Referral To Treatment



Variation	Assurance

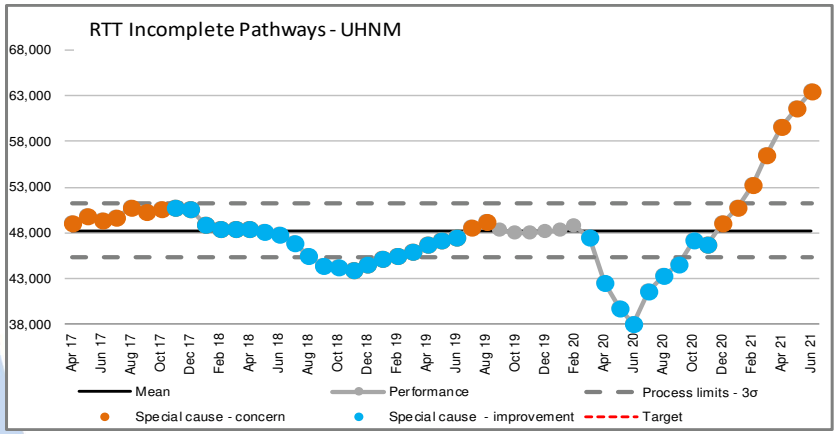
Target	Apr 21	May 21	Jun 21
92%	61.1%	62.1%	61.9%

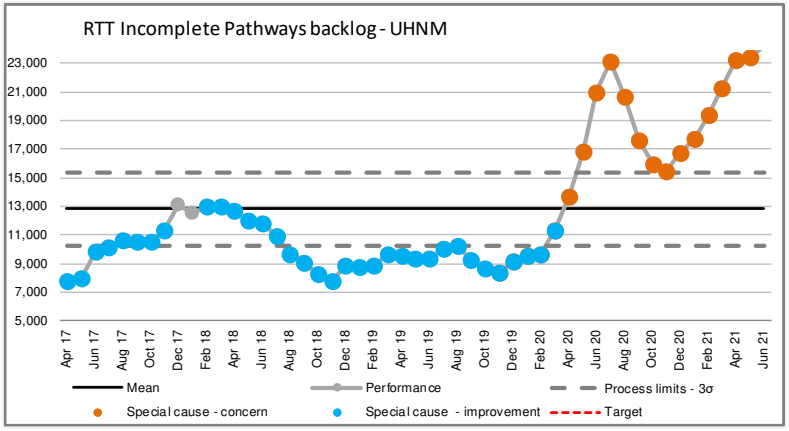
Background

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

What is the data telling us?

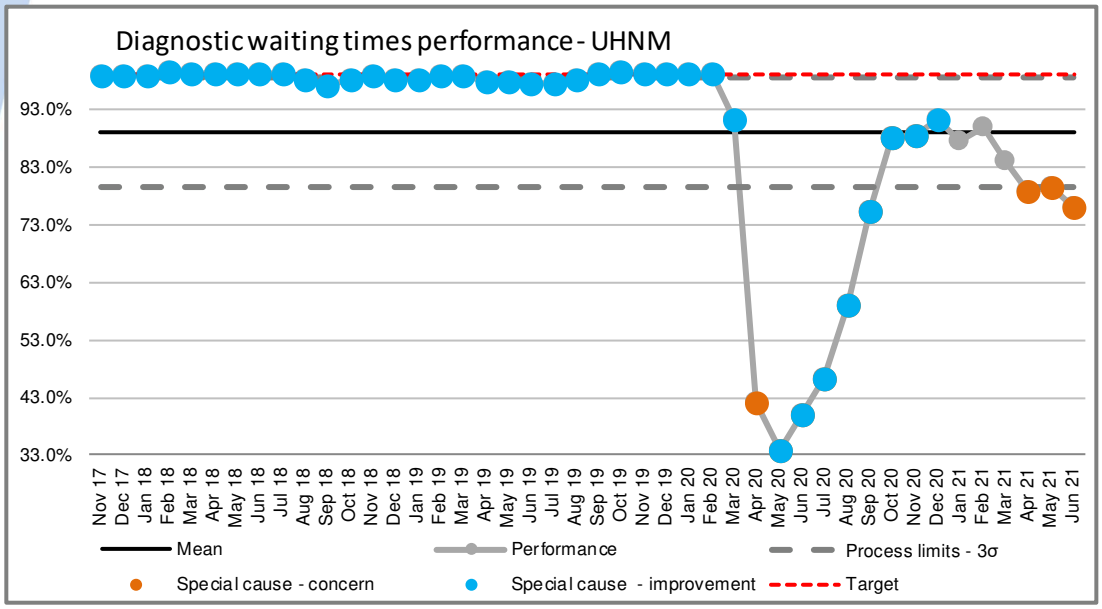
Recovery of RTT performance was seen from July until a steady deterioration was seen with the second wave of the pandemic. This apears to have plateaued.





Quality | Operational | Workforce | Finance

Diagnostic Standards



Variation	Assurance
	

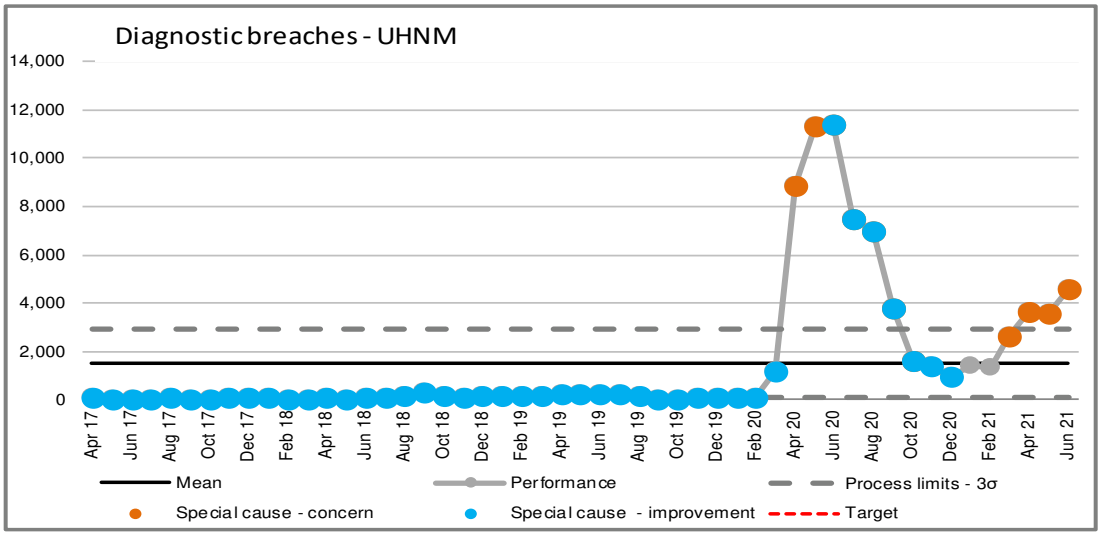
Target	Apr 21	May 21	Jun 21
99%	78.7%	79.4%	76.1%

Background

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

What is the data telling us?

The diagnostic performance has shown normal variation up until March 2020. Special cause variation occurred from March (COVID-19). Recovery has been evident since June 20



Quality | Operational | Workforce | Finance

APPENDIX 2

UEC Standards - National proposal
March 2021

Introduction

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

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

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

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

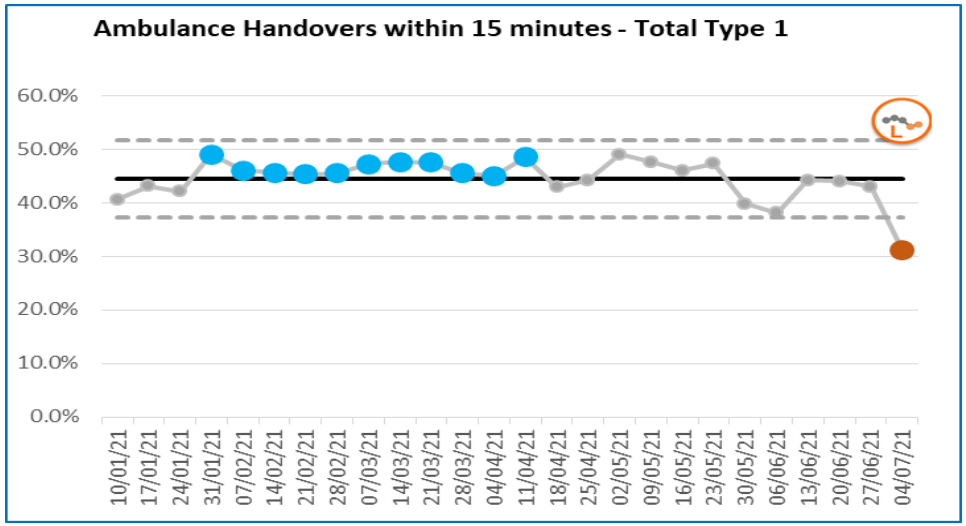
Governance

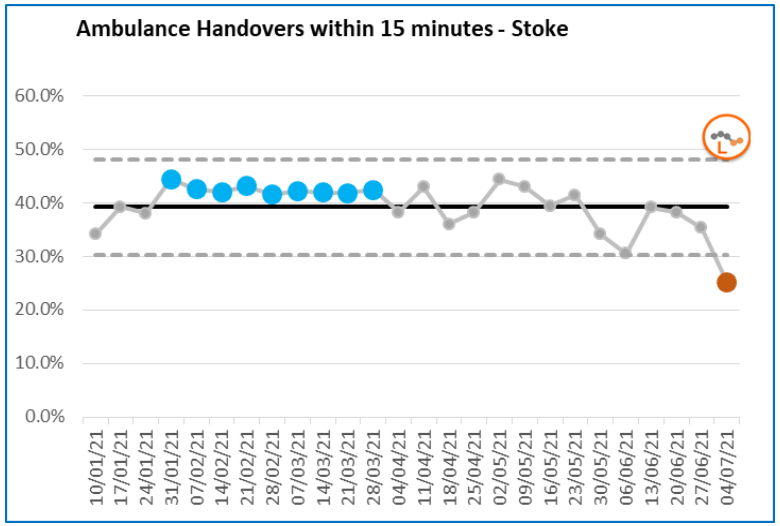
The newly proposed UEC standards will be monitored through both ED performance review and Medicine Divisional board meetings. Organisationally oversight will be through the Urgent Care Programme Board in addition to relevant trust committees

Assessment

Ambulance Handover Times	March remains **positive** with consistent performance above 40% with little variation. Little change
Initial Assessment within 15 minutes	The proportion of patients waiting under 15 minutes for their initial assessment fell towards the end of March to **under 70%.** This has continued into April. This was more notable in the non-ambulance assessments.
Mean time in the department	Both Admitted and non admitted mean times in department increased through April, more notable in Non-admitted.
Patients spending more than 12 hours in department	The number of patients spending over 12 hours in the department has remained steady and below the mean.

2. Percentage of Ambulance Handovers within 15 minutes

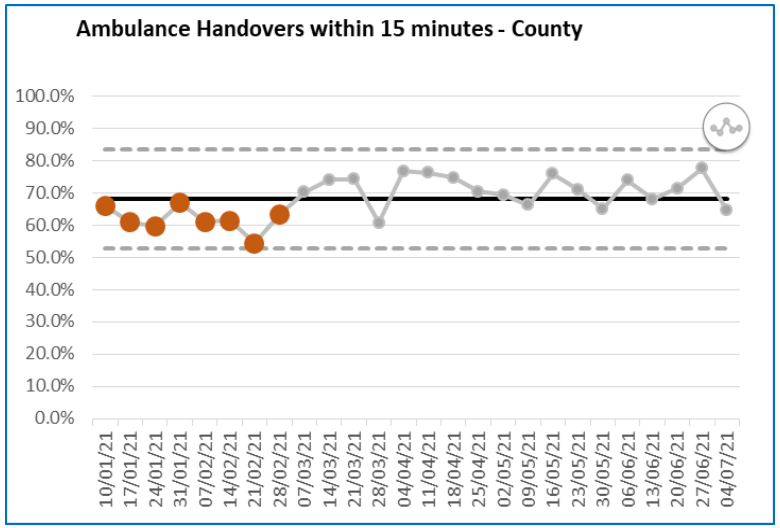




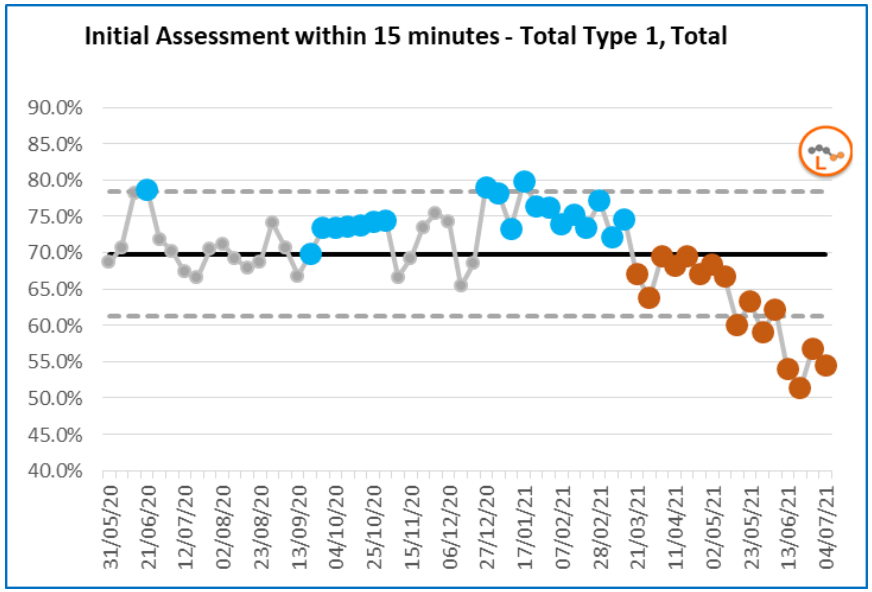
Internal collection of data for Ambulance handovers within 15 minutes began at the beginning of January 21. This is the time taken for the ambulance service to hand over the care to the ED.
N.B. this is un-validated performance and also includes handover time related to direct ambulance conveyance to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

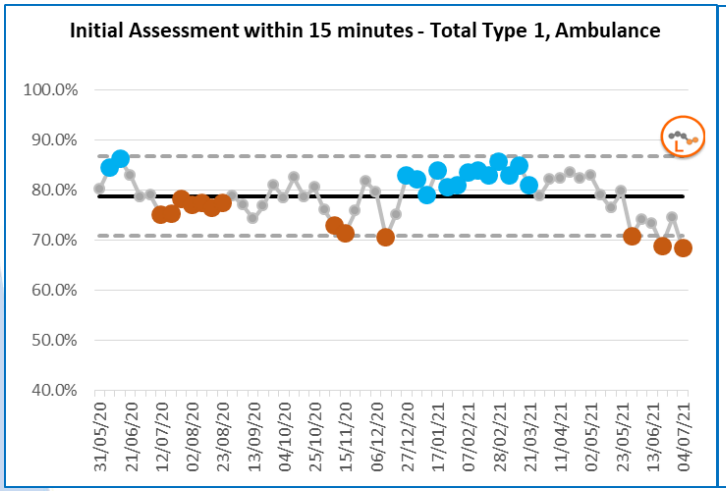
For total ambulance handovers at UHNM in June, the percentage within 15 minutes averaged 40% with a dip seen in the last week to 31%. A local UHNM target of 48% has been set as the goal to improve to as part of the NEL Improvement programme.

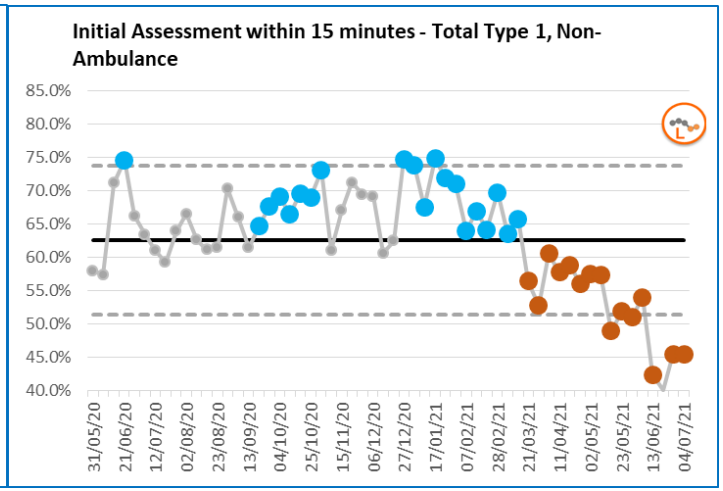
County have maintained a much higher percentage than Royal Stoke albeit with much smaller numbers.



3. Time To Initial Assessment – percentage within 15 minutes







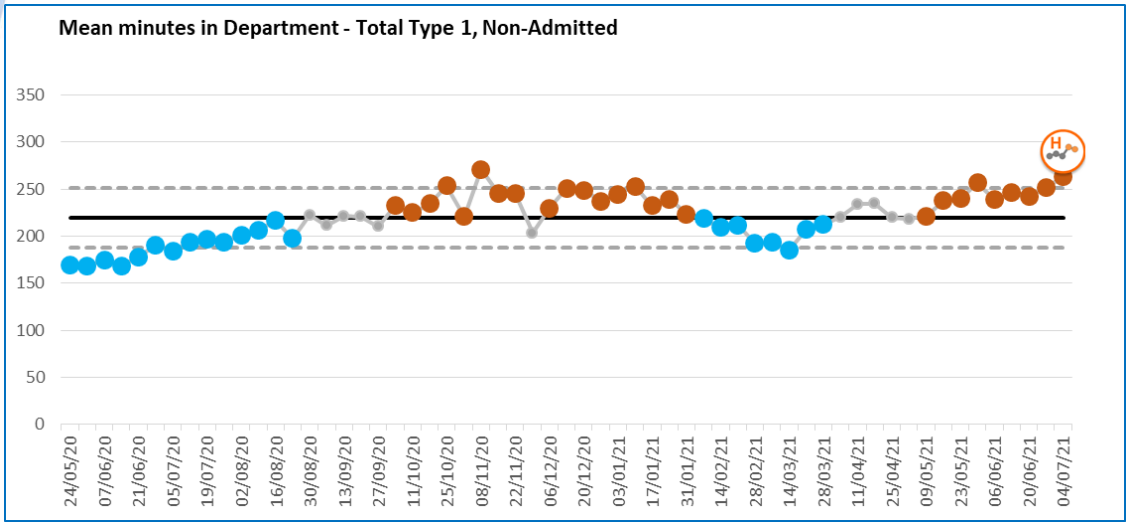
Time to Initial assessment is the time from arrival to when the patient is first triaged.

The proportion of patients waiting under 15 minutes for their initial assessment fell to around **55%.**

This was more notable in the non ambulance assessments.

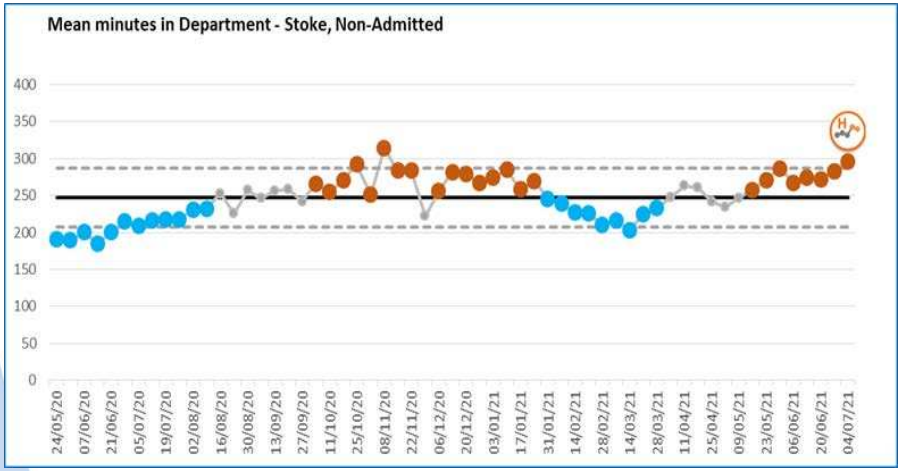
A local UHNM improvement target of 85% has been set.

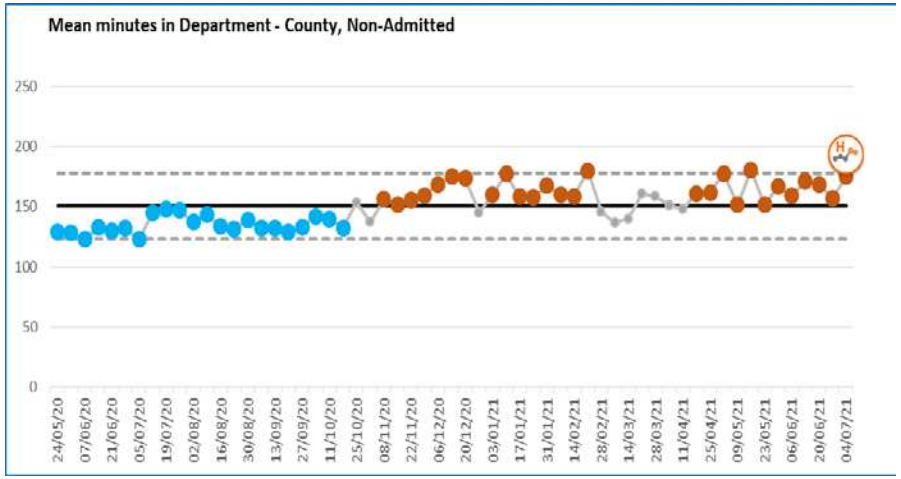
4. Average (mean) time in Department – non admitted patients



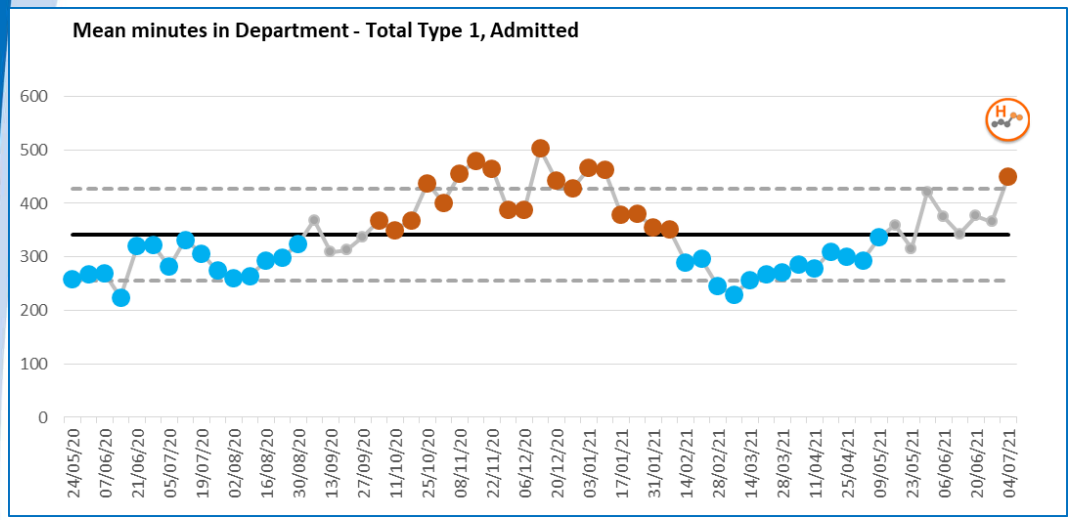
The mean time in the department through June has risen and was reported as reaching 287 minutes at the end of the month.
The rise was more notable at Royal Stoke.

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





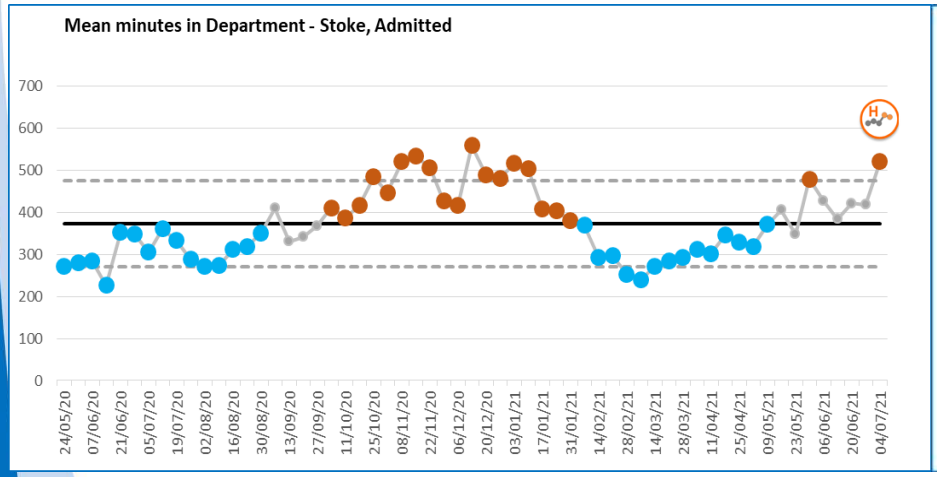
5. Average (mean) time in Department – admitted patients

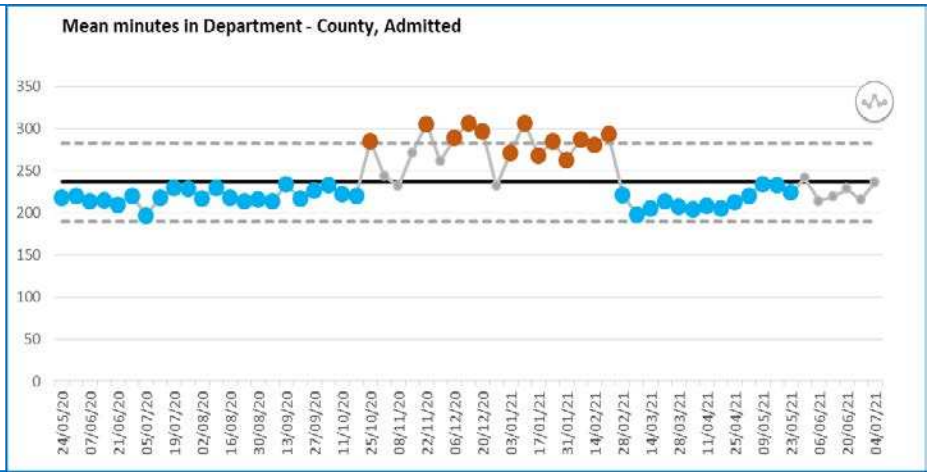


The mean time in the department for admitted patients rose in June and reached a point at the end of June to 450 mins.

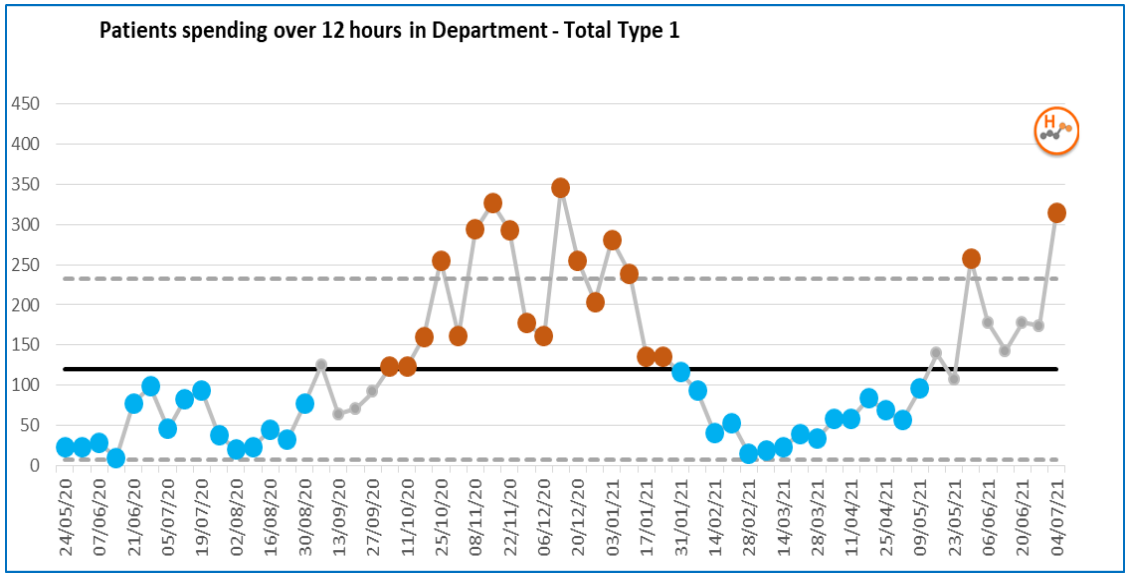
This was notable at Royal Stoke..

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

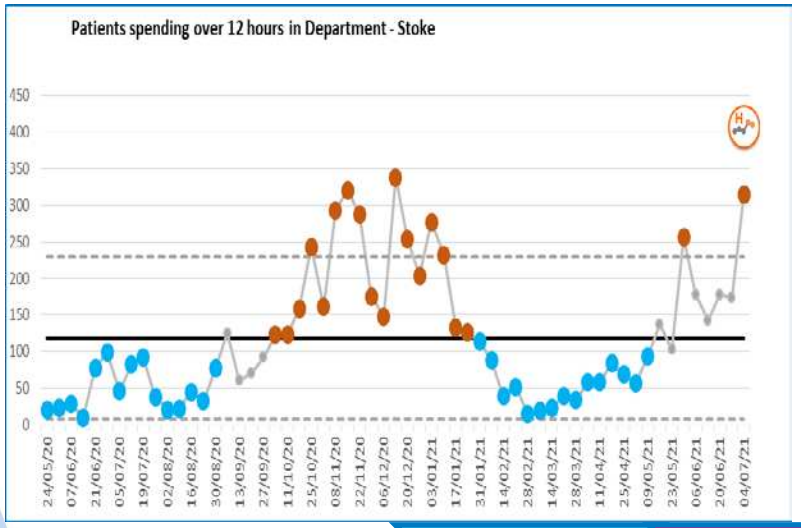


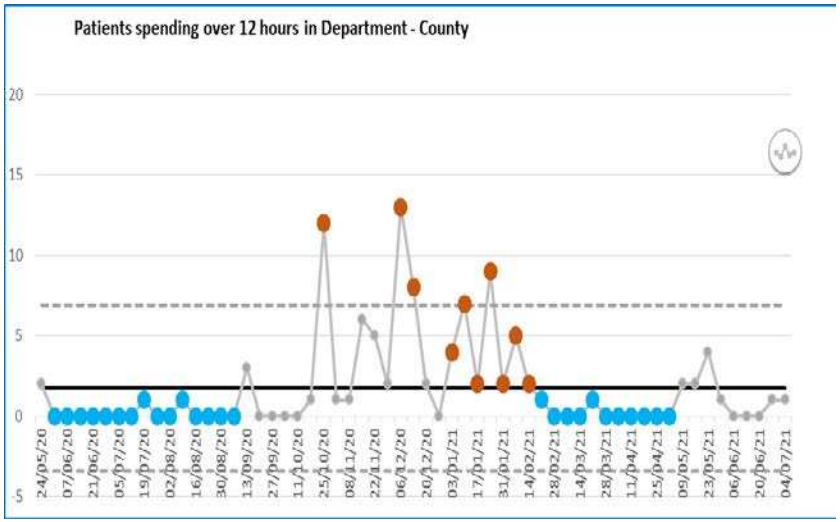


6. Patients spending more than 12 hours in the department



The number of patients spending over 12 hours in the department rose in June. This was notable at Royal Stoke.





Workforce

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

Workforce Spotlight Report

Key messages

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

Statutory and Mandatory Training

At 94.97%, rounded to 95%, the Statutory and Mandatory Training rate has achieved the Trust target for the core training modules . At 30 June 2021, 91.16% of staff had completed all 6 Core for All modules (90.86% at 31/05/21)

The key performance issues are:

Sickness

The sickness rate remains above target. The in-month sickness rate was 4.86% (4.55% reported at 31/05/21). The 12 month cumulative rate reduced to 5.02% (5.05% at 31/05/21)

Covid-related absences have been increasing since mid-June, albeit at a slower rate than other sickness absences. As of 9th July 2021, covid-related open absences* numbered 226, which was 27.10% of all absences (13.46% at 9th June 2021)

[**includes absences resulting from staff adhering to isolation requirements*].

- Sickness and covid-related absences continue to be monitored daily. Staff showing symptoms, or with household members showing symptoms, are tested and results returned within 24-48 hours.
- Actions towards improving sickness rates are being developed through the Improving Together Programme and A3 process. Divisional Teams are developing specific actions to address sickness and improve compliance with completing call backs and return to work interviews.
- Stress-related sickness absence increased as a proportion of all sickness absences in June and communications have been issued reminding staff of the importance for rest; recovery; health and wellbeing. Managers and team members have been asked to plan annual leave so that time off is shared equitably and evenly distributed throughout the annual leave year

Appraisals

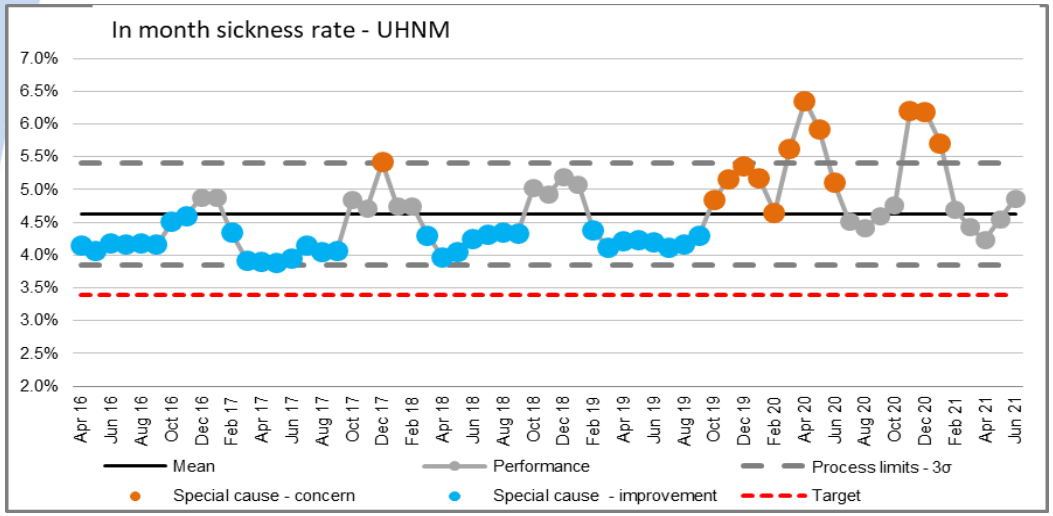
The Non-Medical PDR compliance rate was 81.03% (80.61% at 31 May 2021) and compliance remains below target.

- Overdue PDRs are required to be scheduled from Q2 onwards and the compliance rate has improved over each of the last 4months.

Workforce Dashboard

Metric	Target	Latest	Variation	Assurance
Staff Sickness	3.4%	4.86%		
Staff Turnover	11%	10.00%		
Statutory and Mandatory Training rate	95%	94.97%		
Appraisal rate	95%	81.03%		
Agency Cost	N/A	3.19%		

Sickness Absence



Variation	Assurance
	F

Target	Apr 21	May 21	Jun 21
3.4%	4.2%	4.6%	4.9%

Background

Percentage of days lost to staff sickness

What is the data telling us?

Sickness rate is consistently above the target of 3.4%.

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

Summary

The in-month sickness rate was 4.86% (4.55% reported at 31/05/21). The 12 month cumulative rate reduced to 5.02% (5.05% at 31/05/21)

As of 9th July 2021, covid-related open absences* numbered 226, which was 27.10% of all absences (13.46% at 9th June 2021) [**includes absences resulting from adhering to isolation requirements*].

Covid related absences have been increasing since mid-June, although at a slower rate than other sickness absences.

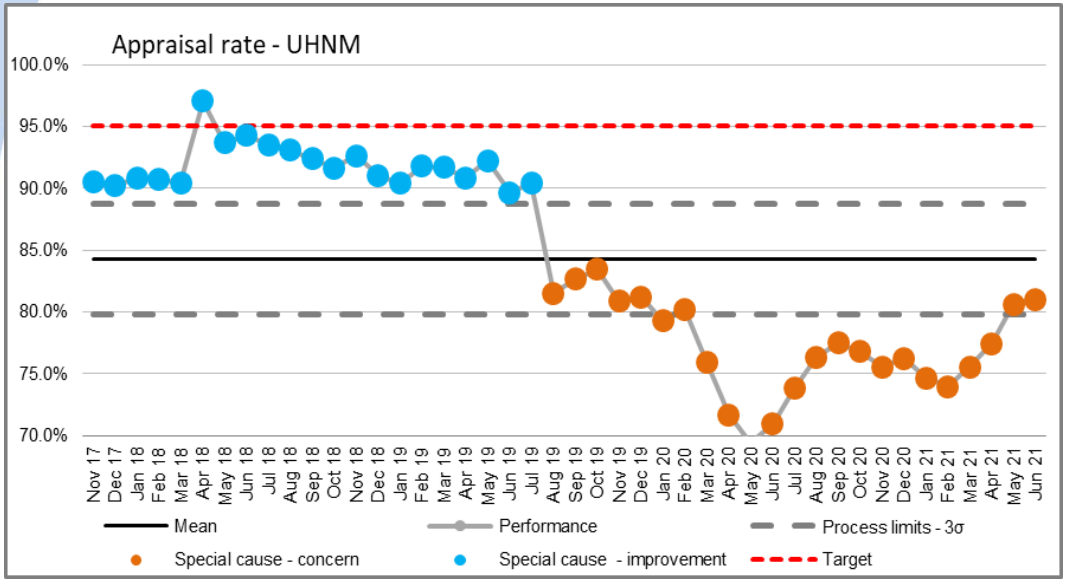
Towards addressing stress related absence, the Wellbeing Ambassador programme will commence in quarter 2. In July, Wellbeing workshops, part of the 'Stop Stressing Start Coping' Wellbeing Support Package, commenced and Wellbeing Courses for July and August were promoted. These cover:

- Taming Anxiety - a toolkit to enable staff to meet anxiety head on.
- A Manager's Response to Stress in the Workplace

Actions

- Actions towards improving sickness rates are being developed through the Improving Together Programme and A3 process
- Regular communications are issued to update staff as regards PCR and lateral flow testing, isolation guidance, wearing of PPE, and location of community vaccination centres.
- Communications have been issued reminding staff of the importance for rest; recovery; health and wellbeing. Managers and team members have been asked to plan annual leave so that time off is shared equitably and evenly distributed throughout your annual leave year
- Project Wingman will re-visit both Royal stoke and County Hospital sites in September 2021.

Appraisal (PDR)



Variation	Assurance
L	F

Target	Apr 21	May 21	Jun 21
95.0%	77.4%	80.6%	81.0%

Background

Percentage of Staff who have had a documented appraisal within the last 12 months.

What is the data telling us?

The appraisal rate is consistently below the target of 95%.

The PDR rate has improved month-on-month since February 2021

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

Summary

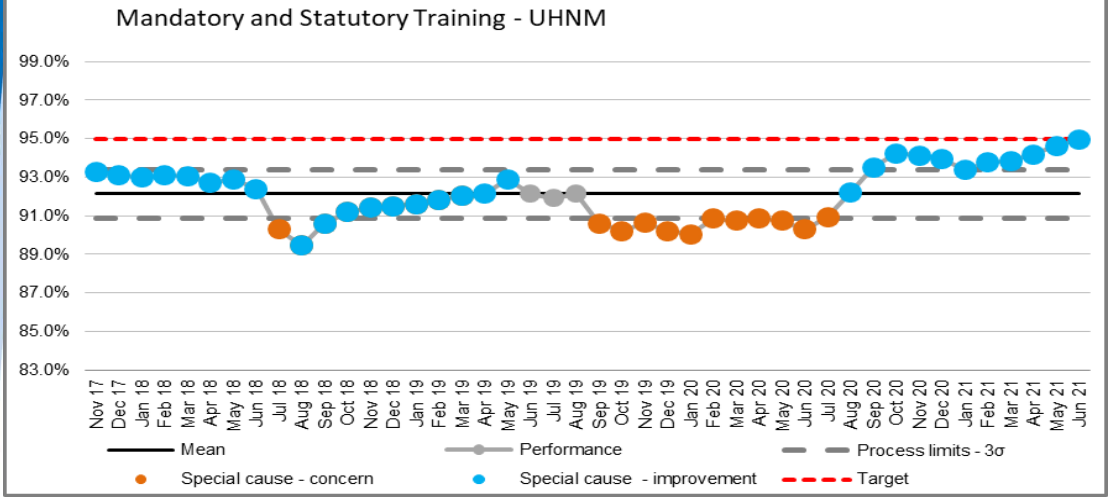
The Non-Medical PDR compliance rate was 81.03% (80.61% at 31 May 2021).

Overdue PDRs are expected to be scheduled from Q2 and improvement since the previous month has demonstrated that progress is being made

Actions

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

Statutory and Mandatory Training



Variation	Assurance
H	F

Target	Apr 21	May 21	Jun 21
95.0%	94.2%	94.6%	95.0%

Background

Training compliance

What is the data telling us?

At 94.97%, rounded to 95%, the Statutory and Mandatory Training rate has achieved the Trust target for the core training modules

Summary

The Statutory and Mandatory training rate at 30 June 2021 was 94.97% (94.62% at 31 May 2021). At 30 June 2021, 91.16% of staff had completed all 6 Core for All modules (90.86% at 31/05/21)

Competence Name	Assignment Count	Required	Achieved	Compliance %
205|MAND|Security Awareness - 3 Years|	10732	10732	10193	94.98%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	10732	10732	10233	95.35%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	10732	10732	10142	94.50%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	10732	10732	10175	94.81%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	10732	10732	10161	94.68%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	10732	10732	10248	95.49%

Compliance rates for the Annual competence requirements were as follows:

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 1 Year|	10732	10732	9330	86.94%
NHS|CSTF|Information Governance and Data Security - 1 Year|	10732	10732	9723	90.60%

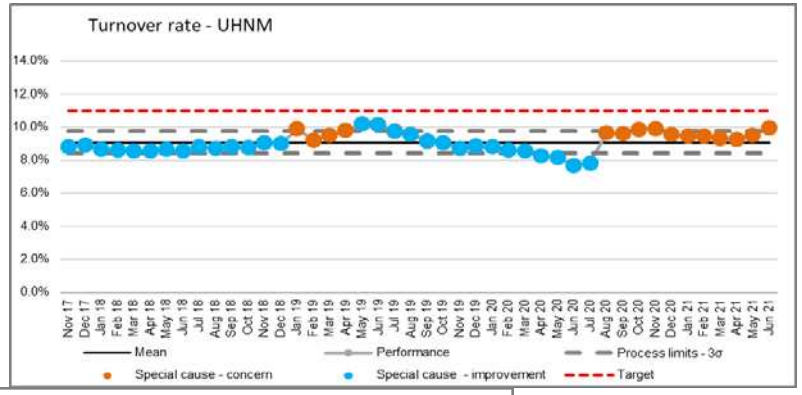
Note: The figures reported elsewhere to Board in respect of Information Governance and Data Security Training, have been adjusted for a 6 month extension due to COVID19. The figures reported in this report are unadjusted.

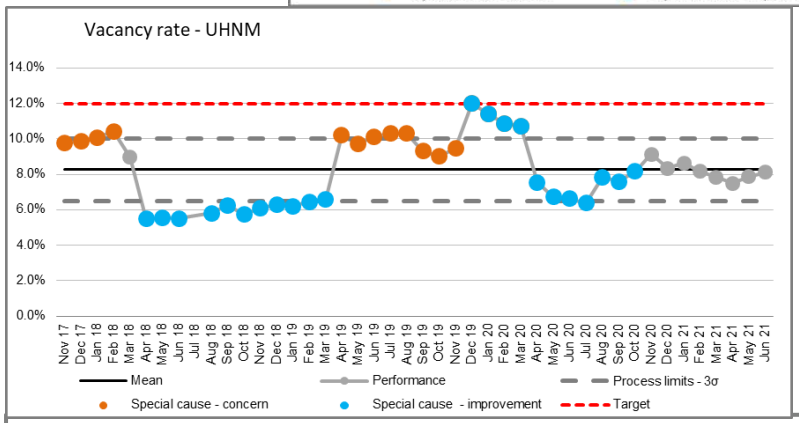
Actions

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

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

Workforce Turnover





Variation	Assurance
H	P

Target	Apr 21	May 21	Jun 21
11.0%	9.3%	9.5%	10.0%

Background

Turnover rate

What is the data telling us?

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

Summary

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

The overall Trust vacancy rate, calculated as Budgeted Establishment less staff in post, was 8.12% and remains consistent with previous months.

Vacancies at 30 June 2021	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous month %
Medical and Dental	1,415.93	1,258.96	156.97	11.09%	10.28%
Registered Nursing	3,272.11	2,914.38	357.73	10.93%	10.57%
All other Staff Groups	6,275.94	5,900.39	375.55	5.98%	6.05%
Total	10,963.98	10,073.73	890.25	8.12%	7.94%

- Medical & Dental +11.4 vacancies
- Registered Nursing + 12.03 vacancies and
- A reduction of 3.99 vacancies across all other staff group vacancies

Both Medical and Nursing had more voluntary resignations and retirements in June than in May

Actions

At 30 June 21, four Consultant vacancies had been advertised more than twice and all are progressing through the recruitment process.

The first cohort of overseas nurses has joined the Trust and are undertaking the required isolation period prior to induction.

Applications for Trainee Nursing Associate Apprenticeships has opened for UHNM employees. This two year apprenticeship development programme combines clinical, academic study and learning on and off the job. The programme should be a source of supply for future nursing need

Finance

2025 Vision "Ensure efficient use of resources"

Finance Spotlight Report

NHS University Hospitals of North Midlands NHS Trust

Key messages

- The Trust has delivered a surplus of £1.3m in month against a planned surplus of £3.3m. The position in month is driven by overspends against clinical supplies due to a stock adjustment in respect of DHSC issued PPE and because of a reduction of the planned ERF expenditure reserve on the back of the planning resubmission.
- ERF income recognised for the year to date is £5.4m against a revised planned figure of £3.3m. Based on activity plans, £8.8m of income is forecast for H1 with additional costs approved of £0.6m to support the delivery of the activity plans. Revised thresh holds for receiving ERF funding have been recently announced for Q2 which will reduce the income earned by the Trust; the full impact of this will be reported to the Committee in August.
- The Trust incurred £1.0m of costs relating to COVID-19 in month which is an increase in comparison with Month 2's figure primarily due to an increase in testing costs. This remains within the Trust's fixed allocation with £0.5m being chargeable on top of this allocation for COVID-19 testing costs.
- A high level forecast for the year suggest that the Trust may have a surplus in excess of its plan for the year of £3.8m if no corrective action is taken; a full forecast is being carried out and will be reported to the Committee in August.
- Capital expenditure for the year to date stands at £4.8m which is £1.2m behind the plan mainly due to an underspend within the medical equipment sub group, commitments brought forward from 2020/21 and the lower Trent wards scheme.
- The cash balance at Month 3 of £63.3m shows an increase of £8.5m from the beginning of the year. This increase reflects the revenue surplus at Month 3.

Finance Dashboard

	Metric	Target	Latest	Variation	Assurance
I&E	TOTAL Income	variable	80.1		
	Expenditure - Pay	variable	44.4	H	?
	Expenditure - Non Pay	variable	30.0		P
Activity	Daycase/Elective Activity	variable	8,118	L	?
	Non Elective Activity	variable	10,009	L	?
	Outpatients 1st	variable	25,914	L	?
	Outpatients Follow Up	variable	46,788		?

Income & Expenditure

Income & Expenditure Summary Month 03 2021/22	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Income From Patient Activities	816.1	71.9	73.1	1.2	216.2	214.4	(1.8)
Other Operating Income	94.5	7.2	7.0	(0.2)	21.5	21.1	(0.4)
Total Income	910.6	79.2	80.1	1.0	237.7	235.5	(2.2)
Pay Expenditure	(540.8)	(45.0)	(44.4)	0.6	(135.6)	(132.6)	3.0
Non Pay Expenditure	(330.4)	(26.4)	(30.0)	(3.6)	(85.4)	(81.4)	4.1
Total Operational Costs	(871.2)	(71.4)	(74.4)	(3.0)	(221.0)	(213.9)	7.1
EBITDA	39.5	7.8	5.7	(2.1)	16.7	21.6	4.9
Depreciation & Amortisation	(29.9)	(2.5)	(2.5)	(0.0)	(7.6)	(7.5)	0.1
Interest Receivable	0.3	0.0	0.0	(0.0)	0.1	0.0	(0.1)
PDC	(7.6)	(0.6)	(0.6)	0.0	(1.9)	(1.9)	0.0
Finance Cost	(16.1)	(1.3)	(1.3)	0.1	(4.0)	(3.9)	0.1
Other Gains or Losses	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Surplus / (Deficit)	(13.8)	3.3	1.3	(2.0)	3.3	8.3	5.0
Financial Recovery Fund	5.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	(8.8)	3.3	1.3	(2.0)	3.3	8.3	5.0

The Trust delivered a £1.3m surplus for Month 3 and a year to date surplus position of £8.3m against a planned surplus position of £3.3m both in month and year to date; this surplus is measured against the Trust's financial plan which was re-submitted in June 2021 to take into account the full impact of the ERF. The main variances in month are:

- Income from patient activities has over performed in month due to £1.6m higher than plan income in respect of the ERF funding. This over performance relates to an adjustment in Month 3 for ERF income relating to Months 1 and 2 (see additional table below). This over performance is offset by Independent Sector (IS) under performance of £0.6m (which is offset by a corresponding underspend in non-pay).
- Pay is underspent in month by £0.6m which is driven by underspends across registered nursing and NHS infrastructure support. This is further driven by COVID-19 funding underutilised in month.
- Non-pay is overspent in month largely due to the amendment of the ERF expenditure reserve as part of the plan re-submission in month and an overspend on supplies and services - clinical driven by stock adjustments for both DHSC PPE consumed in the first quarter of 2021/22 and Interventional Radiology stock count.

Capital Spend

University Hospitals of North Midlands NHS Trust

Capital Expenditure as at Month 3 2021/22 £m	Total approved scheme cost	2021/22	In Month			Year to Date		
	Plan	Plan	Budget	Actual	Variance	Budget	Actual	Variance
PFI & finance lease liability repayment	-	(9.2)	(0.8)	(0.8)	-	(2.3)	(2.3)	-
Pre-committed items	-	(9.2)	(0.8)	(0.8)	-	(2.3)	(2.3)	-
PFI lifecycle and equipment replacement	-	(5.3)	(0.2)	(0.2)	-	(0.5)	(0.5)	-
PFI enabling cost	-	(0.8)	-	-	-	-	-	-
PFI related costs	-	(6.1)	(0.2)	(0.2)	-	(0.5)	(0.5)	
Emergency PDC - RI demolition	(7.0)	(2.4)	(0.1)	(0.1)	-	(0.3)	(0.2)	0.1
Emergency PDC - MRU decant	(2.4)	(1.1)	(0.4)	(0.3)	0.0	(0.6)	(0.6)	0.0
Wave 4b funding - lower Trent Wards	(9.1)	(6.5)	(0.4)	(0.1)	0.4	(0.7)	(0.1)	0.5
Diagnostic Funding	-	(0.4)	-	-	-	-	-	-
PDC funded capital schemes	(18.5)	(10.4)	(0.9)	(0.5)	0.4	(1.6)	(1.0)	0.6
LIMS (Laboratory Information Management System	(2.7)	(0.6)	(0.1)	(0.1)	0.0	(0.2)	(0.2)	0.0
EPMA (Electronic Prescribing)	(4.7)	(0.5)	(0.0)	(0.0)	(0.0)	(0.1)	(0.1)	(0.0)
Completion of RSUH ED doors	(0.4)	(0.2)	(0.1)	(0.0)	0.1	(0.2)	(0.0)	0.1
Pathology integration	(0.2)	(0.1)	-	-	-	-	-	-
Medical devices fleet replacement	(4.9)	(0.7)	-	-	-	-	-	-
Schemes with costs in more than 1 financial year	(12.9)	(2.2)	(0.2)	(0.1)	0.1	(0.4)	(0.3)	0.2
2021/22 schemes	-	(10.6)	(0.4)	(0.6)	(0.1)	(1.3)	(0.8)	0.4
Central contingency and risk	-	(0.5)	-	-	-	-	-	-
Depreciation funded balance to be allocated	-	(2.3)	-	-	-	-	-	-
Trust cash funded balance to be allocated	-	(2.3)	-	-	-	-	-	-
Funds to be allocated to schemes	-	(5.1)	-	-	-	-	-	-
Donated/Charitable funds expenditure	-	(0.2)	(0.0)	(0.0)	-	(0.2)	(0.2)	-
Charity funded expenditure	-	(0.2)	(0.0)	(0.0)	-	(0.2)	(0.2)	-
Overall capital expenditure	(31.4)	(43.5)	(2.5)	(2.2)	0.3	(6.0)	(4.8)	1.2

The Lower Trent scheme is £0.5m behind plan. The profile of expenditure on the lower Trent wards is currently being reviewed by the Estates team and this may result in a request to DHSC to re-profile the PDC drawdown for this scheme.

Within 2021/22 schemes Medical equipment is £0.2m behind plan due to delays in equipment being delivered with Commitments brought forward from 2020/21 showing an underspend of £0.2m which again is mainly due to delivery delays.

The plan shown in the table above includes funds yet to be allocated including £2.3m of Trust funded depreciation and £2.3m relating to the overall STP capital allocation, however the latter would need to be funded by the use of the Trust cash balance. The Executive team has considered a detailed report setting out the impact of the STP funding. The paper highlighted the considerations to be made around the allocation of the additional capital and the risks highlighted by the Capital Sub Groups specifically in relation to their current funding and pressures.

Balance sheet

Balance sheet as at Month 3	31/03/2021	30/06/2021			
	Actual £m	Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment	531.2	531.1	529.8	(1.3)	Note 1
Intangible Assets	22.8	19.5	19.3	(0.1)	
Other Non Current Assets	-	-		-	
Trade and other Receivables	0.5	0.5	0.5	-	
Total Non Current Assets	554.5	551.0	549.5	(1.5)	
Inventories	15.0	15.0	14.6	(0.4)	
Trade and other Receivables	47.4	47.2	51.2	4.0	Note 2
Cash and Cash Equivalents	55.8	54.8	63.3	8.5	Note 3
Total Current Assets	118.2	117.1	129.1	12.0	
Trade and other payables	(98.5)	(96.1)	(98.3)	(2.2)	Note 4
Borrowings	(8.3)	(8.3)	(8.3)	(0.0)	
Provisions	(3.6)	(3.6)	(3.6)	0.0	
Total Current Liabilities	(110.4)	(108.0)	(110.2)	(2.2)	
Borrowings	(268.5)	(266.3)	(266.3)	0.0	
Provisions	(2.2)	(2.2)	(2.2)	0.0	
Total Non Current Liabilities	(270.7)	(268.5)	(268.5)	0.1	
Total Assets Employed	291.5	291.5	300.0	8.4	
Financed By:				-	
Public Dividend Capital	637.9	637.9	637.9	0.0	
Retained Earnings	(465.3)	(465.3)	(457.0)	8.3	Note 5
Revaluation Reserve	118.9	118.9	119.1	0.2	
Total Taxpayers Equity	291.5	291.5	300.0	8.4	

The balance sheet plan reflects the impact on the balance sheet of the 2021/22 revenue plan submitted to NHSIE on 22 June 2021. Variances to the plan at Month 3 are explained below:

- Property, Plant and Equipment is £1.3m lower than plan and reflects the underspend in the capital plan to Month 3 which is due to lower than planned expenditure on medical equipment replacement, commitments brought forward from 2020/21 and the lower Trent wards scheme.
- Trade and other receivables are £4m higher than plan and reflect increased accruals in relation to the recovery of COVID-19 testing costs (£1.2m) and the Elective Recovery Fund (£2.8m).
- Cash is £8.5m higher than plan which reflects the current revenue surplus of £8.3m. Capital accruals have reduced since the year end by £4m however this is partly offset by reduced payments to NHS Supply Chain early in 2021/22.
- Trade and other payables are £2.2m higher than plan which reflects the reduction in capital creditors from the 31 March 2021 offset by an increase in the payables balance with NHS Supply Chain, mainly due to changes in the invoicing for high cost devices from 1 April 2021.
- Retained earnings shows a variance of £8.3m from plan which reflects the year to date revenue underspend at Month 3.

Expenditure - Pay and Non Pay

Pay Summary Month 03 2021/22	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Medical	(160.8)	(13.3)	(13.7)	(0.3)	(40.2)	(40.8)	(0.6)
Registered Nursing	(160.5)	(13.3)	(12.7)	0.6	(40.1)	(37.9)	2.1
Scientific Therapeutic & Technical	(66.0)	(5.5)	(5.4)	0.2	(16.6)	(16.1)	0.5
Support to Clinical	(71.3)	(5.9)	(6.1)	(0.2)	(18.0)	(18.2)	(0.2)
Nhs Infrastructure Support	(82.1)	(6.9)	(6.5)	0.4	(20.6)	(19.5)	1.1
Total Pay	(540.8)	(45.0)	(44.4)	0.6	(135.6)	(132.6)	3.0

Pay –Key variances:

Overspend on medical staffing largely due to additional premium (agency) spend on trainee grades against vacancies (primarily in Medicine) and also as a result of increased treatment initiatives undertaken in month driven by Medicine (respiratory and gastro) and CWD (Radiology backlog reporting and Histology staffing shortages).

Underspend on registered nursing remains in line with the prior year trend as a result of the number of vacancies across the trust. This run rate is expected to increase marginally once overseas nurses are able to join the trust and newly qualified nurses commence in post in September.

Non Pay Summary Month 03 2021/22	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Tariff Excluded Drugs Expenditure	(78.2)	(6.8)	(6.9)	(0.1)	(19.0)	(19.5)	(0.5)
Other Drugs	(22.5)	(1.9)	(2.1)	(0.2)	(5.6)	(5.6)	0.0
Supplies & Services - Clinical	(87.9)	(7.2)	(8.9)	(1.7)	(21.7)	(20.7)	0.9
Supplies & Services - General	(7.5)	(0.6)	(0.5)	0.1	(1.9)	(1.5)	0.3
Purchase of Healthcare from other Bodies	(25.9)	(3.0)	(2.3)	0.6	(8.8)	(6.0)	2.8
Consultancy Costs	(1.7)	(0.1)	(0.2)	(0.1)	(0.4)	(0.6)	(0.2)
Clinical Negligence	(25.4)	(2.2)	(2.2)	(0.0)	(6.6)	(6.6)	0.0
Premises	(33.8)	(2.9)	(2.9)	0.1	(8.8)	(8.7)	0.1
PFI Operating Costs	(35.5)	(2.9)	(2.9)	0.0	(8.8)	(8.9)	(0.0)
Other	(12.1)	1.3	(1.0)	(2.3)	(3.8)	(3.3)	0.6
Total Non Pay	(330.4)	(26.4)	(30.0)	(3.6)	(85.4)	(81.4)	4.1

Non Pay key variances:

Overspend on supplies and services clinical is mainly driven by a £0.8m adjustment for stock usage in respect of PPE issued by the DHSC in 2020/21 and non recurrent costs arising from Quarter 1 Stocktakes.

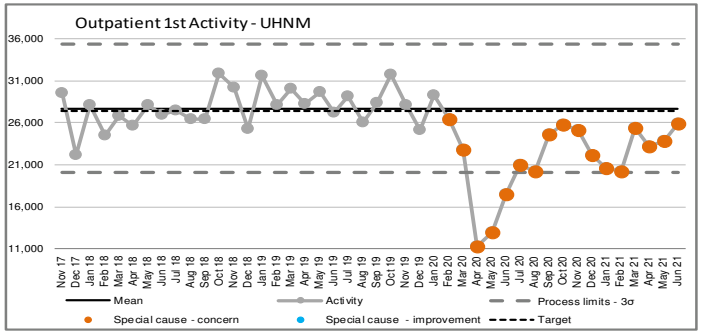
Purchase of healthcare from other bodies is underspent in month largely as a result of the IS contract as the Trust had planned a £1.4m cost in month against an actual cost of £0.8m (year to date variance of £2.2m).

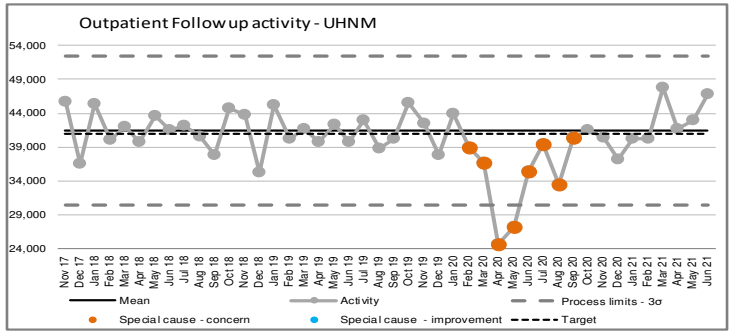
The “Other” category budget for Month 3 includes an adjustment of £2.7m in respect of the year to date reduction in the ERF expenditure reserve in line with the re-submission of the plan in Month 3; hence this is showing as an overspend in month.

Activity

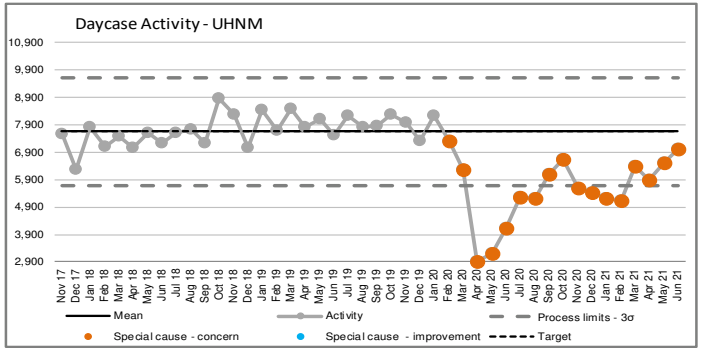
NHS University Hospitals of North Midlands NHS Trust

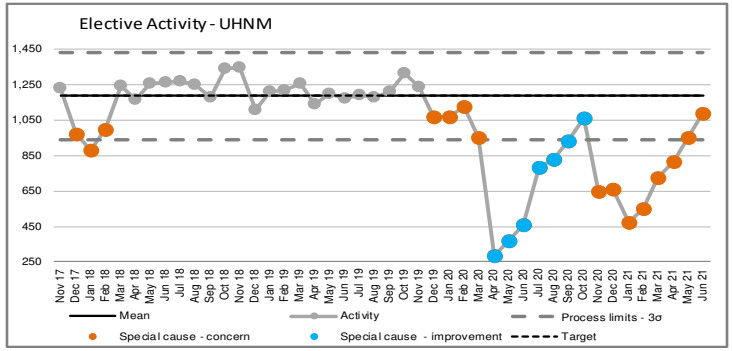
Planned care Outpatient



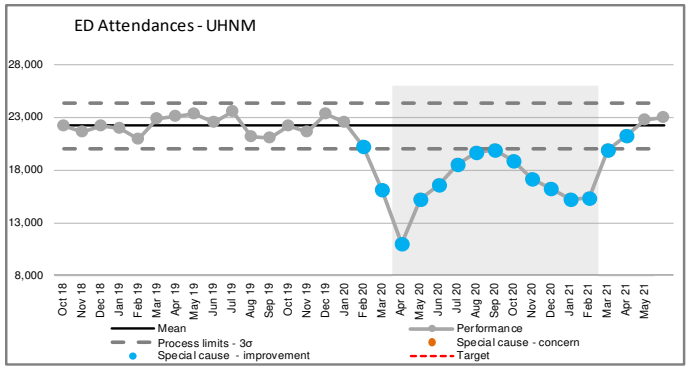


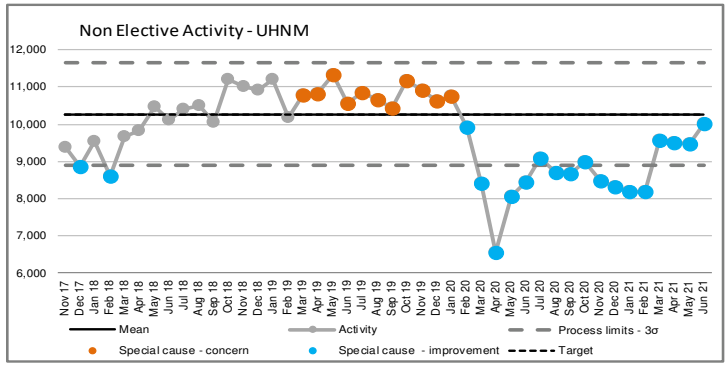
Planned care Inpatient





Urgent Care





Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Audit Committee Chair's Highlight Report to Board

28th July 2021

1. Highlight Report

Matters of Concern or Key Risks to Escalate

- Internal Audit Recommendations: one recommendation has exceeded the 6 month timeframe in (relating to emergency department escalation procedure) – assurance was given that this had been completed although was awaiting sign off
- External Auditor's Report: two improvement recommendations made in respect of financial sustainability made; specifically in relation to planning for the medium term and working up and delivering cost improvements
- Losses and Special Payments: losses and special payments for the period April to June 2021 amount to £167, 828; Divisional Performance Reviews now include a standard agenda item for review of these indicators
- Single Tender Waivers: there were two single tender waivers exceeding £50, 000 during quarter 1 21/22
- SFI breaches: 11 SFI breaches exceeding £20, 000 were reported in quarter 1

Major Actions Commissioned / Work Underway

- Declarations of Interest: ABPI (pharmaceutical industry) data has recently been issued and the corporate governance team will work with auditors in ensuring that the data cross references correctly with declarations of interest held
- Board Assurance Framework: Further work to be undertaken around the Board Assurance Framework, ensuring that gaps are well understood with actions to address them
- External Audit Opinion: some further context to be included with regard to system working
- Local Counter Fraud Report: the current counter fraud training package has been reviewed and updated, the package includes two modules and staff have to complete both before a 'pass' is given

Positive Assurances to Provide

- Internal Audit review of Ockenden: has concluded with Significant Assurance with Minor Improvement opportunities
- Internal Audit Review of External Investigations / Reporting Framework: has concluded with 'reasonable assurance' with some issues to be addressed (positive – 'above the line' rating concluded by new auditors)
- Declarations of Interest: 100% compliance with declarations for 2020/21 confirmed – auditors confirmed that this is very rare when compared with other organisations
- Value for Money Audit Opinion: work has now been concluded and no significant weaknesses have been identified – audit certificate issued

Decisions Made

- Board Assurance Framework: Some key changes to the BAF which were supported by the Committee, however, some further reflection needed around the scoring which would be done ahead of the Q2 report.
- Clinical Audit Programme 21/22: approved by the Committee; assurance against delivery is through the Quality Account and quarterly reports to the Quality Governance Committee
- Extension of External Audit Contract: approved by the Committee to support an extension from 1 April 2021 to 31 March 2022, on the basis of a clear rationale being provided around working relationships and retention of valuable knowledge and experience

Comments on the Effectiveness of the Meeting

- Managing to conduct meetings effectively online, would look to factor 'teams' meetings into the business cycle as matters normalise

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Internal Audit Annual Report: Ockenden Review	Assurance	8.	Auditors Annual Report	Assurance
2.	Internal Audit Progress Report: External Investigations / Reporting Framework	Assurance	9.	Audit Findings Report – Follow Up	Assurance
3.	Internal Audit Recommendation Tracker	Assurance	10.	Counter Fraud Progress Report	Assurance
4.	Corporate Governance Report	Assurance	11.	Losses and Special Payments Q1 21/22	Assurance
5.	Board Assurance Framework Quarter 1	Approval	12.	SFI Breaches and Single Tender Waivers Q1 21/22	Assurance
6.	Issues for Escalation from Committees	Information	13.	Review of Meeting Effectiveness, Business Cycle	Information
7.	Clinical Audit Programme 2021/22	Approval	14.	Items for Escalation	Approval

3. 2021 / 22 Attendance Matrix

Attended | Apologies & Deputy Sent | Apologies

Members:		Apr	Jun	Jul	Oct	Jan
Prof G Crowe	Non-Executive Director (Chair)					
Mr P Akid	Non-Executive Director					
Ms S Belfield	Non-Executive Director					

Attendees:		Apr	Jun	Jul	Oct	Jan
Ms N Coombe	External Audit					
Mr G Patterson	External Audit					
Mr A Bostock	Internal Audit - KPMG					
Ms A Khela	Internal Audit - KPMG					
Mr S Stanyer	LCFS - KPMG					
Mr M Gennard	Internal Audit - RSM					
Mr A Hussain	Internal Audit - RSM					
Ms A Deegan	LCFS - RSM					
Mrs N Hassall	Deputy Associate Director of Corporate Governance			JD		
Mr M Oldham	Chief Finance Officer					
Mrs S Preston	Strategic Director of Finance					
Miss C Rylands	Associate Director of Corporate Governance					

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	4th August 2021
Report Title:	Speaking Up Report – Quarter 1 2021-22	**Agenda Item:**	16
Author:	Raising Concerns & Workforce Equality Manager		
Executive Lead:	Director of HR		

Purpose of Report:

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

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

Executive Summary:

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

Background - this quarterly Speaking Up Report provides an update to Trust Board on progress in relation to developing our speaking up culture, relevant national speaking up guidance published, and a summary of concerns raised at UHNM for the Quarter 1 period of April – June 2021.

Assessment – during the quarter 43 speaking up contacts were received. 35 concerns were recorded on the speaking up tracker, which includes concerns raised with the Freedom to Speak Up Guardians and those raised to the Chief Executive's Office, within a division, or via CQC/other routes that have then been notified to the FTSU Guardian for inclusion on the speaking up tracker. One of the concerns was raised anonymously. 8 contacts were made to our Employee Support Advisors, and are included in our reportable speaking up data.

Key Recommendations:

Trust Board is asked to note:

- The speaking up data and themes raised during Quarter 1 2021-22
- The actions proposed to further encourage and promote a culture of speaking up at UHNM.

Speaking Up
Quarter 1 2021-22

1. Introduction

This Quarter 43 speaking up contacts have been made via the UHNM speaking up routes, which include 35 concerns recorded on the speaking up tracker which records issues raised with the Freedom to Speak Up Guardians; the Chief Executive's Office; within a division or via CQC/other routes that have then been notified to the FTSU Guardian for inclusion on the speaking up tracker. One of these concerns was raised anonymously. 8 contacts have also been made to our Employee Support Advisors, who act as speaking up champions across the Trust.

2. National Guardians Office (NGO) Update

National Guardian

Dr Henrietta Hughes OBE has announced that she will be standing down as National Guardian for the NHS, after five years in the role. The Care Quality Commission will now lead the open competitive recruitment process for the next National Guardian for the NHS, in association with the co-sponsors NHS England/Improvement.

Speaking Up National Policy

NHSE/I is expected to confirm shortly if it will be updating the national FTSU policy this year.

Organisations are encouraged to use the NGO's new policy assessment template to help assess how our organisation's policy encourages workers to speak up and overcome some of the barriers that policies can present. The template has been completed, and two areas for improvement were identified:

- Ensuring that all workers including workers who may be harder to reach than others, such as contract staff, those who work mainly off-site, and those who do not have ready access to an organisation's intranet are aware of the Speaking Up Policy
- Capturing worker feedback on the effectiveness of the policy to help shape reviews of the policy

Guidance on Freedom to Speak Up Champions and Ambassadors

This new guidance sets out principles for the development and support of Freedom to Speak Up Champion/Ambassador networks. Its aim is to inform the work these networks do in partnership with your organisation to consider the needs of workers and how to meet them. The NGO understands that these principles may not align with all guardians' existing arrangements and there will be a 12-month window to 31 March 2022 to consider the implementation of this guidance at a local level.

This guidance is intended to underpin the ongoing need for assurance that arrangements are meeting the needs of workers and does not necessarily spell a full scale refresh of an existing network where assurance about effectiveness is able to be demonstrated.

UHNM's lead FTSU Guardian will be working with our Employee Support Advisors to review the guidance, and to update the role description before undertaking a recruitment campaign to increase our

network of ESA's who also champion speaking up. A development day, with training for new recruits and refresher training for our existing ESA's will form part of this exercise.

3. 2021 Freedom to Speak Up Index

The 2021 Freedom to Speak Up Index Report has been published. UHNM has improved its rating compared to the previous year:

Year	UHNM Index Score	% of staff "agreeing" or "strongly agreeing" that they would feel safe to speak up about anything that concerns them in their organisation
2021	76.8%	63.6% (new question in the 2020 staff survey)
2020	75.5%	
2019	74%	

2021 National Averages:

FTSU Index	79.2%
Midlands Region	79.6%
Acute and Acute & Community Trusts	79.0%

The FTSU Index seeks to allow trusts to see how an aspect of their FTSU culture compares with other organisations so learning can be shared, and improvements made. This is the third year of the Index, and this year's results show the national average for the FTSU Index has continued to rise and once again showed a positive correlation between higher index scores and ratings received by the Care Quality Commission (CQC). Trusts with higher index scores were more likely to be rated 'good' or 'outstanding' by the CQC.

The FTSU index is calculated as the mean average of responses to the following four questions from the 2020 NHS Staff Survey:

- % of staff "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss or incident fairly (question 16a)
- % of staff "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents (question 16b)
- % of staff "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice, they would know how to report it (question 17a)
- % of staff "agreeing" or "strongly agreeing" that they would feel secure raising concerns about unsafe clinical practice (question 17b)

The report acknowledges that the four questions used in the FTSU Index are clinical and incident centric and may not have the same applicability to all staff groups and trust types. Moreover, while they give an indication of FTSU culture, a healthy speaking up culture is about more than these issues and includes making improvement suggestions.

Therefore there was an additional question included in the 2020 NHS Staff Survey which focused on workers feeling safe to speak up more generally:

- % of staff 'agreeing' or 'strongly agreeing' that they would feel safe to speak up about anything that concerns them in their organisation (question 18f)

This question was not included in this year's FTSU Index – to allow for comparability to previous years – but has been analysed alongside the index score.

Organisations are encouraged to use this question, which is not clinically focused as an additional measure of their speaking up culture.

The Index has identified that there are variations in responses to the questions used in the FTSU Index by personal characteristic such as ethnicity and gender. The NGO will be publishing a further report this year on the potential impact of personal characteristics on speaking up, with further analysis of results from the 2020 staff survey.

We know that workers from protected groups can experience greater barriers to speaking up. We have analysed the UHNM responses to question 18F (based on the raw staff survey data) broken down by gender, ethnicity and disability:

Question 18F	Male	Female	White	BAME	Not Disabled	Disabled
% of staff 'agreeing' or 'strongly agreeing' that they feel safe to speak up about anything that concerns me in this organisation	64.8%	64.6%	63.9%	64.1%	66.4%	53.4%

This indicates that whilst there is no significant variation in responses to this question by gender or ethnicity (although there was a range in the responses between the different ethnic backgrounds); there is a notable gap between disabled staff responses compared to staff who do not have a disability. We will continue to work closely with our Staff Networks to raise awareness of the safe channels for speaking up within and external to the Trust and identify barriers and actions needed to address these.

The FTSU Index is also available on the Model Health System. Using the Model Health System, trusts can access data on their culture and engagement, including their FTSU Index and data from their Freedom to Speak Up Guardian on speaking up cases raised to them. This helps to build a comprehensive picture of our organisational culture and identify opportunities to improve, which will inform our FTSU Action Plan.

4. Independent Review into Bullying and Harassment

Following a recent survey carried out by the Medical Staff Committee (MSC) to UHNM medical staff, the Trust has responded with a commitment to undertake a full review of all staff groups to understand the extent of bullying and harassment in the organisation and importantly action that can be taken. A joint approach has been selected, with the review being undertaken by Brap and Roger Kline.

Brap is a charitable organisation which supports organisations, communities, and cities with meaningful approaches to learning, change, research, and engagement and has vast experience in conducting such work in a wide variety of organisations, including the NHS. Roger Kline is Research Fellow at Middlesex University Business School and authored "The Snowy White Peaks of the NHS" (2014), designed the Workforce Race Equality Standard (WRES) and was then appointed as the joint national director of the WRES team 2015-17.

Actions and recommendations arising from the review will be in addition to our existing Speaking Up Index action plan, which will be updated to reflect learning from the 2021 Index Report and presented within the next quarterly update.

5. Supporting a Speaking Up Culture and progress on FTSU Index Actions

UHNM Speaking Up Training Update

The new UHNM mandatory speaking up e-learning will be launched in August 2021, based on the resources released by the NGO and Health Education England 'Speaking Up' and 'Listen Up' will give all staff and understanding of the importance of speaking up and how to speak up, whilst the listen up elements equip line managers with the skills to respond effectively when issues are raised to them.

These packages are pre-requisite training for the UHNM Gateway to Management programme and will also be available for any member of staff to access via ESR to increase their awareness of a speaking up culture.

The next phase of the NGO training is a Trust Board awareness package, which is anticipated later this year.

Demonstrating Learning from Speaking Up

We have introduced a 'You Said/We Did' section on the Intranet to demonstrate actions and learning from speaking up cases, whilst maintaining confidentiality. This section will be continuously updated with new information reflecting speaking up cases brought through our speaking up routes.

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

One of the actions from the KPMG audit of the UHNM freedom to speak up arrangements was for the Associate Freedom to Speak Up Guardians to access the NGO training as soon as it becomes available again (it had been paused due to Covid-19). Both individuals have now undertaken the training and are registered with the National Guardians Office.

The NGO has also recommended that the Trust do not use the term Associate FTSU Guardian, and that this role is termed FTSU Guardian, with a Lead FTSU Guardian who is responsible for the governance arrangements. The role description is being revised to reflect this prior to advertising for replacement FTSU Guardians.

7. Quarterly Speaking Up Cases – Quarter 1 – April – June 2021

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

Month	No. of contacts in the Quarter	Of which were raised anonymously	Of Which are Closed	Reports of detriment/ victimisation as a result of speaking up
April	7	0	4	1
May	19	1	12	0
June	9	0	3	0
Total	**35**	**1**	**19**	**1**

One case was reported anonymously to the CEO office. A signal of a healthy speaking up culture is that staff feel able to raise issues and concerns openly, as opposed to anonymously.

Theme	Number
Attitudes and behaviours	19
Equipment and maintenance	0
Staffing levels	1
Policies, procedures and processes	9
Quality and safety	1
Patient experience	1
Performance capability	0
Service Changes	1
Other	3
Total	**35**

Summary of speaking up contacts recorded on the Speaking Up Tracker during Quarter 1 April - June 2021:

No.	Theme	Summary	Status
1.	Patient Experience	Anonymous concerns raised to CQC regarding patient and staff experience.	Full response provided and review of data undertaken where relevant. Processes followed appropriately.
2.	Quality & safety	Concerns raised about clinical policy change communication, workload pressures and culture in a department.	Action plan in place monitored by Deputy Chief Nurse.
3.	Attitudes & behaviours	Concerns raised by worker about behaviours within their team.	Action plan in place led by Executive Director.
4.	Attitudes & behaviours	Concerns raised by worker about behaviours in their team.	As above.
5.	Attitudes & behaviours	Manager raised issues about undermining behaviours by a colleague.	Advice provided and plan agreed. Closed.
6.	Policies, processes & procedures	Worker raised issues about how flexible working request had been handled.	Supported to raise with line manager. Closed.
7.	Attitudes & behaviours	Concerns raised by worker about behaviours in their team.	Action plan in place led by Executive Director.
8.	Attitudes & behaviours	Concerns about manager behaviours in work area.	Meeting held to discuss issues and action plan in place. Closed.
9.	Attitudes & behaviours	Concerns raised by worker about behaviours in their team.	Action plan in place led by Executive Director.
10.	Attitudes & behaviours	Issues raised about lack of support from team about an individual's disability.	Advice given, signposted to coaching and personal development. Closed.
11.	Attitudes & behaviours	Concerns raised by worker about behaviours in their team.	Action plan in place led by Executive Director.
12.	Service Changes	Worker concerned that agreed reasonable adjustments relating to their disability were not being taken into account during MOC process.	Concerns addressed. Learning that reasonable adjustments need to be clear when relating to flexible working. Closed
13.	Attitudes & behaviours	Worker raised issues relating to behaviours, support to new starters and quality and safety in their work area.	Supported reporter to raise concerns with Divisional ACN – investigation underway.
14.	Other	Contact made requesting support for emotional distress.	Supported to access wellbeing support and referral to occupational health. Closed.
15.	Attitudes & behaviours	Anonymous concerns raised about split sited service and working relationships between department leads.	Action plan in place which includes mediation, additional support in place with oversight by Matron. Closed.
16.	Policies, procedures & processes	Reporter raised concerns about fairness of training support.	Reporter supported to raise directly with next level manager. Support put in place. Closed.
17.	Attitudes & behaviours	Reporter raised concerns about behaviour of colleague on themselves and others in the team.	Investigation underway.
18.	Other	Support sought by individual involved in a speaking up issue.	Support provided on process and signposted to wellbeing support.
19.	Attitudes & behaviours	Worker raised concerns about behaviours of line manager.	Supported worker to raise issues with next level manager – actions agreed

20.	Policies, procedures and processes	Concerns raised by worker about how disability has been managed.	Discussed options of how to raise concerns with manager. Tailored Adjustment Plan completed with Occupational Health advice and support plan in place
21.	Attitudes & behaviours	Worker raised concerns about behaviours and career progression in their department.	FTSUG escalated to senior manager on workers behalf – action involving mediation referral agreed.
22.	Attitudes & behaviours	Concerns raised about bullying behaviours in team.	FTSUG responded, awaiting response on proposed meeting date – open.
23.	Attitudes & behaviours	Contact made regarding bullying and harassment within a team.	Contact made by FTSUG, awaiting response.
24.	Attitudes & behaviours	Contact from worker for support at meeting with managers.	Trade Union representation secured.
25.	Attitudes & behaviours	Line manager raised concerns of staff regarding behaviour of another team member.	Investigation underway.
26.	Policy, procedures & processes	FTSUG contacted for advice on escalation process for raising concerns.	Advice provided as per Speaking Up Policy. Closed.
27.	Staffing Levels	Letter received in CEO office from Society of Radiographers regarding concerns about staffing levels.	Full and comprehensive response provided about the potential risks highlighted due to staff shortages and how these have managed and mitigated with appropriate measures.
28.	Attitudes & behaviours	Individual having difficulties with worker and feeling undermined.	Supported to escalate to next level manager. Closed.
29.	Other	Concerns raised about fair allocation of study leave.	Supported to raise issues with line manager. Further feedback provided about basis for study leave allocation. Closed.
30.	Policies, processes & procedures	Issues raised about fairness of recruitment process.	Open.
31.	Policies, processes and procedures	Reporter raised issues about how a job vacancy had been designed.	Post not filled and job description reviewed and updated prior to being re-advertised. Closed.
32.	Policies, processes and procedures	Support sought about processes related to management of change.	Information provided and process explained. No further action required. Closed.
33.	Attitudes & behaviours	Cultural education expertise sought about how to manage a situation relating to behaviours.	Advice provided. Open.
34.	Policies, processes & procedures	Concerns raised about clinical process on a ward area and behaviours in the team.	Supported to escalate to Matron and support with policy and process in place and awareness of just and learning culture. Closed.
35.	Policies, processes & procedures	Concerns raised over the fair application of retire and return process.	Issue escalated to clinical leadership for review of process.

Open Speaking Up Cases from Previous Quarters

Theme	Summary	Month Case Raised	Status

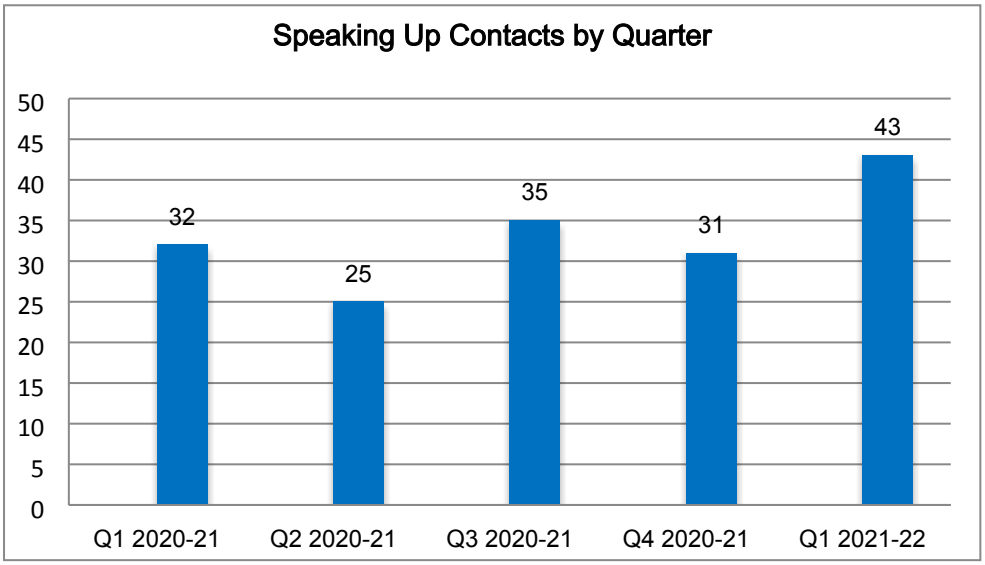
Attitudes & Behaviours	Concerns raised about how a grievance is being managed.	June 2020	External Investigation into grievances agreed as way forward. Objection from the reporter to the proposed Investigating Officer, alternative sought and secured. Active investigation.
Attitudes & Behaviours	Grievances submitted relating to behaviours	November 2020	Grievance investigation active.

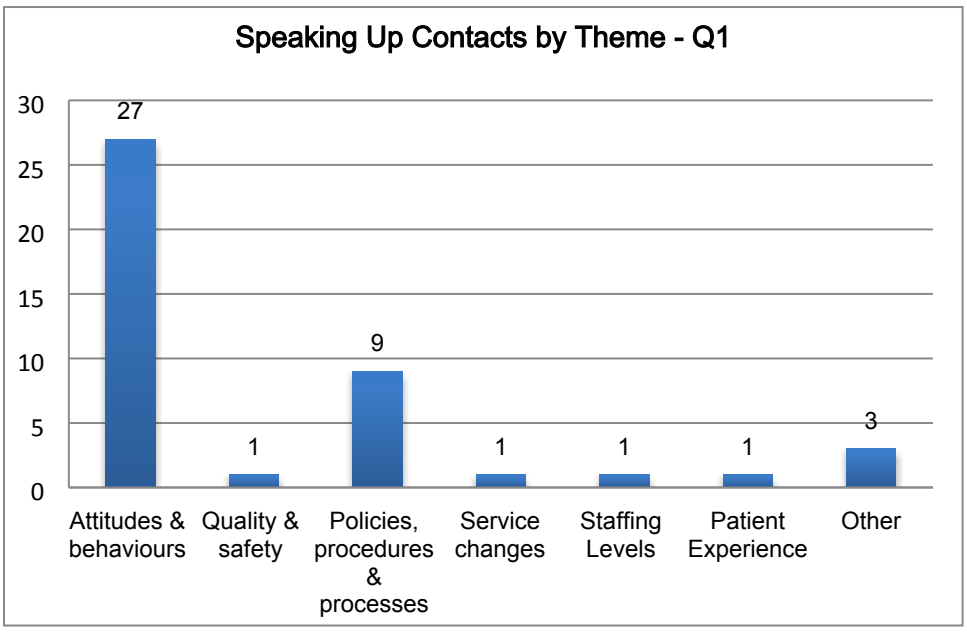
Issues Raised with our Employee Support Advisors

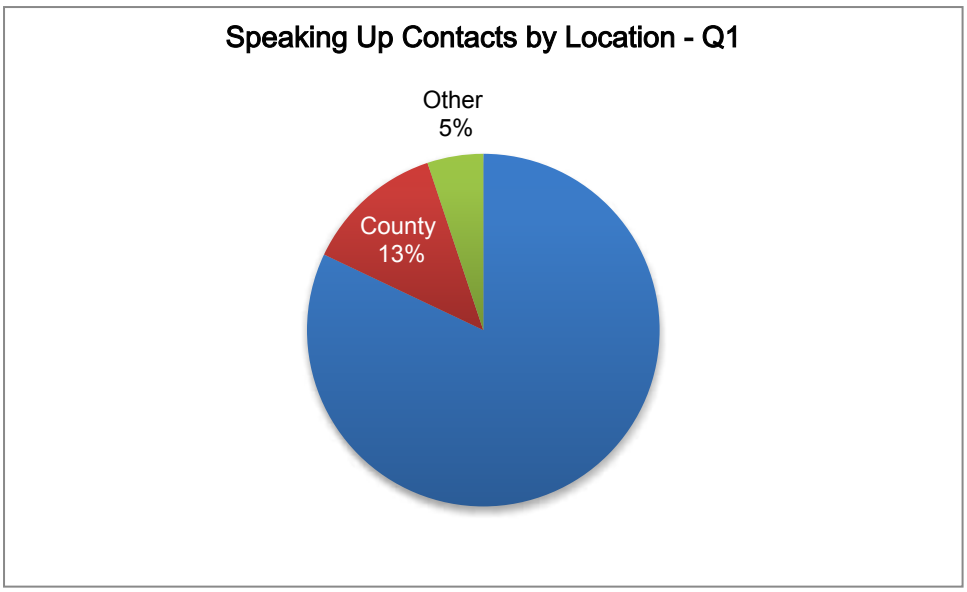
The NGO requests on a quarterly basis the number of concerns raised through freedom to speak up channels (i.e. Freedom to Speak Up Guardians and champions). Our Employee Support Advisors act as speaking up champions and therefore their activity is included in NGO data submissions. During the quarter our ESA's have received 8 contacts relating to the following themes:

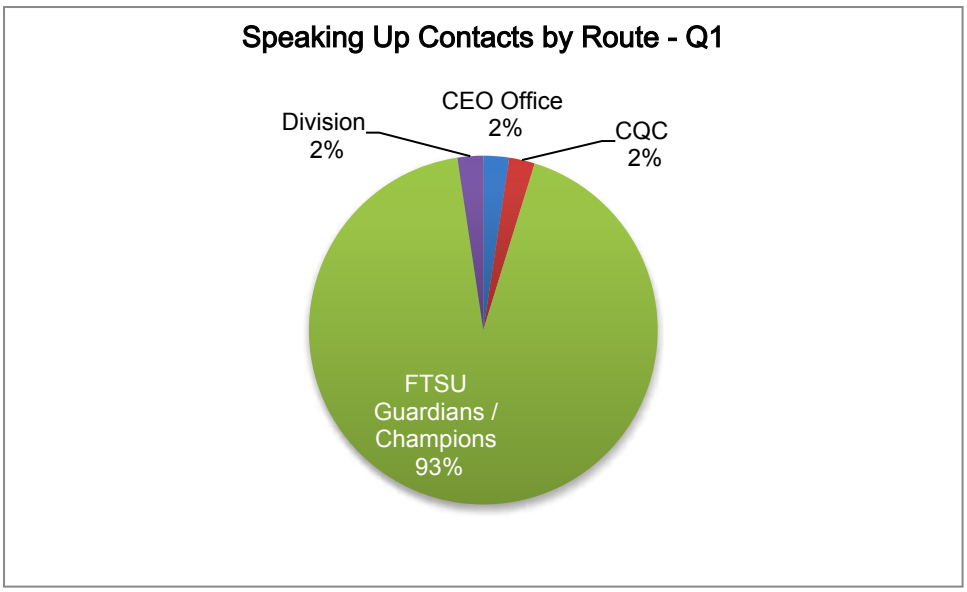
Theme	Number
Attitudes and behaviours	8
Equipment and maintenance	-
Staffing levels	-
Policies, procedures and processes	-
Quality and safety	-
Patient experience	-
Performance capability	-
Service Changes	-
Other	-
Total	**8**

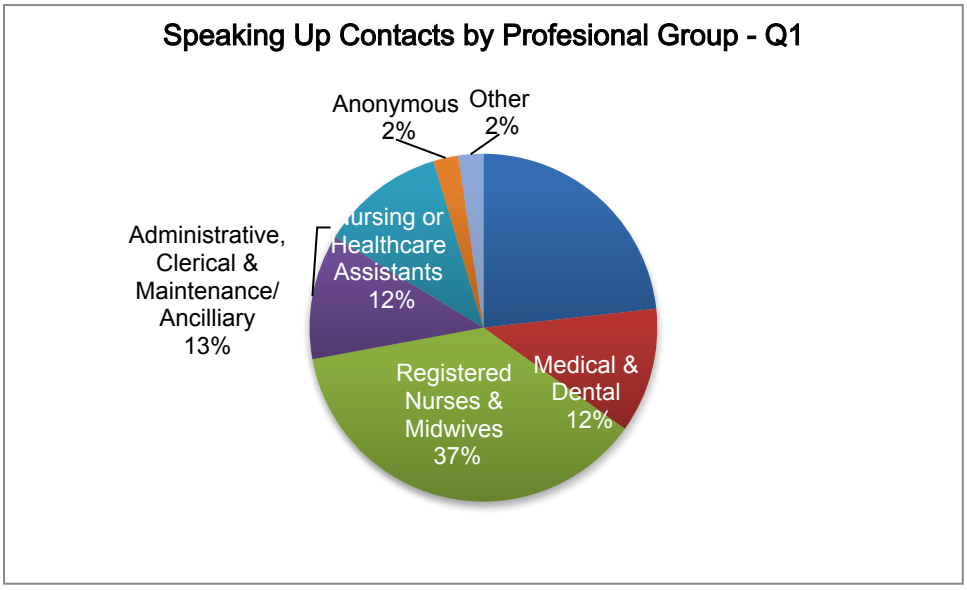
Quarter 1 Data Summary of All Speaking Up Contacts:

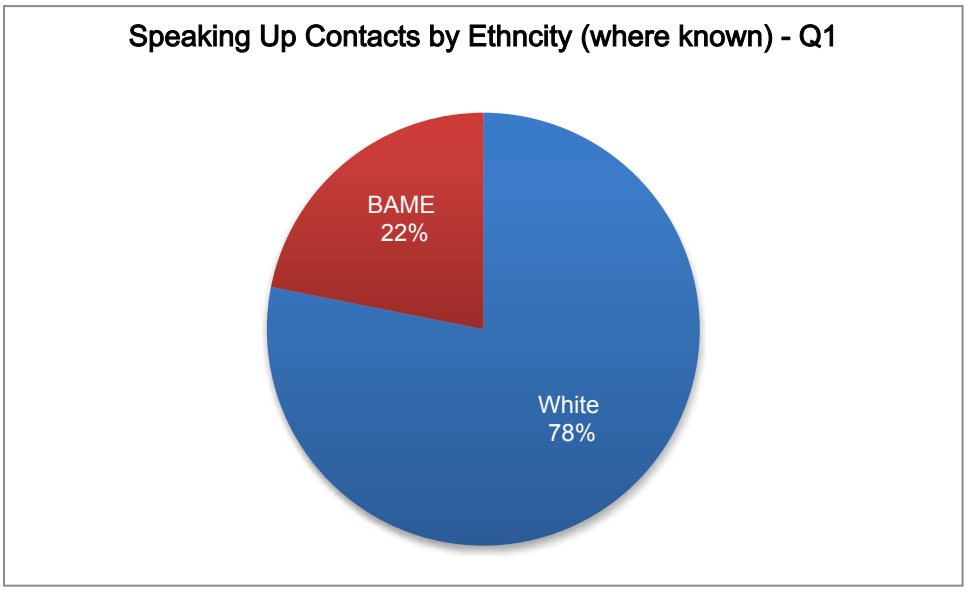



Speaking Up Contacts by Theme - Q1
30
25
20
15
10
5
0
27
1
9
1
1
1
3
Attitudes & behaviours
Quality & safety
Policies, procedures & processes
Service changes
Staffing Levels
Patient Experience
Other


Speaking Up Contacts by Location - Q1
Other 5%
County 13%


Speaking Up Contacts by Route - Q1
Division 2%
CEO Office 2%
CQC 2%
FTSU Guardians / Champions 93%





8. Learning from cases

One of the cases during the quarter related to concerns raised by some members of the midwifery service. Issues raised related to quality and safety in particular about policies and how changes to protocols are communicated effectively to ensure that all staff are aware of critical changes impacting on patient care. Issues were also raised about risks relating to midwifery capacity in reviewing scans and blood results. Action taken as a result of these issues being raised include a review of the Hypertension Policy in view of its complexity and results of an audit and new process of ensuring policy changes are communicated. Blood book results are also now monitored by a midwife with protected time each day. Ongoing work is also in place regarding staff wellbeing and staff engagement.

9. Recommendations

Trust Board is asked to note the activity and actions relating to speaking up undertaken in the Quarter 1 of 2021-22, and the focus going forward over the next quarter, which will be:

- Update FTSU Action Plan following 2021 Index Report and recommendations from Independent Review
- The launch in August 2021 of the UHNM mandatory Speaking Up training package with associated trust wide communications

- Introduce an additional question to the FTSU contact survey to actively seek feedback from workers about the effectiveness of our Speaking Up Policy to help continuously review and improve our policy
- Progress plans for replacement FTSU Guardians
- Continue with the development plan for the Work in Confidence reporting system
- Undertake a review of speaking up champion network arrangements against the NGO Guidelines in partnership with our Employee Support Advisors

Appendix 1: Benchmarking Data

Freedom to Speak Up - National Guardian Reporting Data Q1, 2, 3 and 4 2020-21 - Model Hospital Group

	UHNM	Derby Teaching Hospitals	Gateshead Health	Nottingham University Hospitals	Royal Wolverhampton	Sheffield Teaching Hospitals	University Hospitals Southampton	University Hospitals Birmingham	University Hospitals Coventry and Warwickshire	Average quarterly
Total Concerns Reported										
Q1	29	95	11	No data	22	10	19	10	10	25.8
Q2	18	126	12	No data	35	3	18	19	11	30.3
Q3	28	112	11	32	29	10	45	No data	7	15
Q4	34	118	9	16	27	3	21	33	8	29.9
Number raised anonymously										
Q1	0	5	6	No data	1	1	2	2	0	2.1
Q2	0	21	1	No data	1	0	1	0	1	3.1
Q3	0	18	0	2	3	0	3	No data	0	3.3
Q4	1	77	3	2	3	0	2	1	0	9.9
Element of quality or safety										
Q1	11	3	2	No data	4	0	4	0	1	3.1
Q2	1	11	1	No data	4	0	3	2	1	2.9
Q3	6	13	1	1	5	1	6	No data	0	4.1
Q4	4	7	4	3	6	0	4	3	0	3.4
Element of bullying and harassment										
Q1	15	42	9	No data	16	2	5	7	1	12.1
Q2	6	45	10	No data	28	1	7	10	3	13.8
Q3	15	44	10	0	21	2	34	No data	0	15.8
Q4	22	43	5	5	20	1	8	19	2	13.9
Reporting detriment										
Q1	0	2	0	No data	2	0	1	2	0	0.9
Q2	0	2	0	No data	4	0	1	4	0	1.4
Q3	1	1	0	1	2	0	2	No data	0	0.9
Q4	0	0	0	4	4	0	1	1	2	1.3
FTSU Index Score (2021)	**76.8%**	**77.7%**	**81.4%**	**79.9%**	**78.4%**	**79.7%**	**80.9%**	**75.9%**	**79.6%**	**Average Index Score: 78.2%**

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	4th August 2021
Report Title:	Q1 Board Assurance Framework 21/22	**Agenda Item:**	17
Author:	Claire Rylands, Associate Director of Corporate Governance		
Executive Lead:	Tracy Bullock, Chief Executive		

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

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

Executive Summary:

Situation

The Quarter 1 Board Assurance Framework (BAF) is being presented to the Trust Board in accordance with the annual business cycle. Board members are asked to consider the content of the BAF, which has been scrutinised by each Committee during July.

Background

The BAF is updated on a quarterly basis by the Executive Team. The structure and content of the BAF is reviewed on an annual basis; the risks contained within the enclosed were agreed by the Executive Team and subsequently the Board, in early 2021. In addition, a number of changes have been made to the style and format of the BAF, which will continue to develop over the coming year.

The BAF has been approved by all the Committees and comments/changes will be incorporated into the next iteration at Q2.

Key Recommendations:

1) The Trust Board is asked to scrutinise the BAF, taking the following considerations into account:

- *Are the levels of risk assigned to each risk appropriate, in particular when compared to other risks within the BAF?*
- *To what extent are the key controls (i.e. existing controls) effective?*
- *What are the gaps in the controls, how significant are they in relation to the current risk score?*
- *What internal assurances and independent external assurances are in place? Are they sufficient / adequate and are there any gaps? Are additional assurances required?*
- *Are there any areas where assurance is duplicated, repeated or excessive when compared to the activity undertaken?*
- *What actions are there in place to further mitigate the risk to the agreed tolerated level? Are they current and active? Are they adequate? Does more need to be done?*
- *Has the impact of Covid-19 been sufficiently drawn into the strategic risks identified?*

2) The Trust Board is asked to approve the Board Assurance Framework.

NHS
University Hospitals of North Midlands
NHS Trust

Board Assurance Framework (BAF)

Quarter 1 2021/22

1. Introduction

Situation

The Board Assurance Framework (BAF) provides a structure and process that enables a focus for the Board on the key risks which might compromise the achievement of the organisation's Strategic Objectives. The BAF maps out the key controls which are in place to support delivery of those objectives and to mitigate risk and provide a framework of assurance which the Board can draw upon when considering the effectiveness of those controls. These controls and assurances have been set out in line with the '3 lines of defence' model (appendix 2), aiding the identification of areas of weakness.

Background

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

Assessment

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

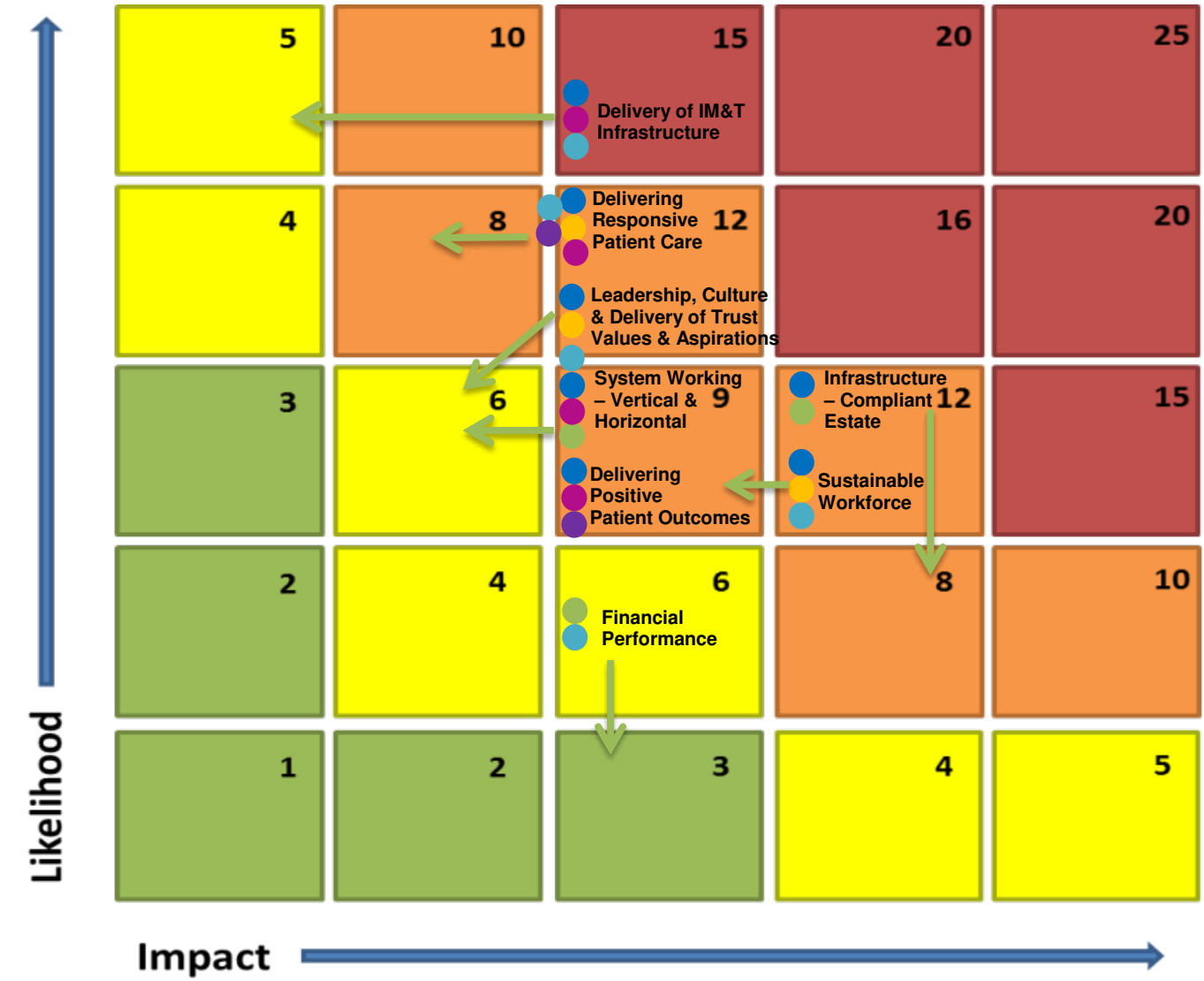
Further changes have been made to the style and format of the BAF for 2021/22, taking into account the findings of our most recent Internal Audit through the inclusion of an indicator of whether the risks identified are 'internally or externally driven'. In addition, the Risk Appetite Matrix has been included; this is used to determine the target levels of risk which have been identified for each Strategic Risk and a specific session has been included on the Board Development Programme to provide an opportunity for Board members to scrutinise this further.

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

2. Summary Board Assurance Framework 21/22

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

3. Strategic Risk Heat Map



The Strategic Heat Map above illustrates where our strategic risks sit at Quarter 1 2021/22 with green arrows to identify the target level of risk in accordance with our Risk Appetite Statement (appendix 1).

4. Board Assurance Framework 2021 / 22

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

Risk Description

Cause	Event	Effect
If there is a deterioration in the delivery of patient safety and quality of patient care	**Then** we may not be able to provide harm free care including the inability to reduce the number of nosocomial infections, pressure ulcers, falls and VTE	**Resulting in** avoidable patient harm, higher than expected mortality and poor patient experience and satisfaction.

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

Strategic Objectives and Risk Register

Impact on Strategic Objectives:	**High Quality**	✓	**Improving and Innovating**	✓	
	Responsive	✓	**Systems and Partners**		
	People		**Resources**		
Links to Risk Register	ID 8877 Risk of Avoidable Hospital Acquired Infections			**High 12**	

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3				**Likelihood:**	2	31/12/21
Consequence:	3				**Consequence:**	2	
Risk Level:	**High 9**				**Risk Level:**	**Mod 4**	
Rationale for Risk Level:	The risk remains above target as work is ongoing with nosocomial reviews and noted increases during Wave 2 of Covid. Increase in reported Serious Incidents during Covid with larges category relating to falls although Q1 saw improvements, still high risk due to ongoing pressures.						

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Senior leadership team in place for each ward and department, with overarching accountability for delivering quality and minimising hospital acquired harm • Falls Champion role in each Ward/Department. • Tissue Viability Link Nurses in each Ward/Department • Corporate Quality & Safety Team co-ordinate Improvement Programmes for Pressure Ulcers, Falls and VTE • Specific governance	• Validation of pressure ulcers undertaken by Corporate Tissue Viability Team • Validation of infections undertaken by Infection Prevention/Microbiology Teams • Datix and Root Cause Analysis (RCA) training available to ensure accurate reporting and investigation of patient harm. Bespoke sessions arranged within Divisions. • Root Cause Analysis (RCA) Scrutiny Panels in place for Serious Incidents, Pressure	• Annual External Audit of Quality Account • CQC Inspection Programme • Process in place with Commissioners to undertake Clinical Quality Review Meetings (CQRM) • NHSEI scrutiny of COVID-19 cases/Nosocomial infections/Trust implementation of Social distancing, Patient/Staff screening and PPE Guidance • Trust 6 nominated Patient Safety Specialists participating with development programme by NHSI as part of national

	arrangements in place for Maternity Services, including compliance with CNST requirements. • Infection Prevention Team co-ordinate Improvement Programmes for infections, including Sepsis and Nosocomial COVID-19 infections • Training Programmes in place for all key harms. • Patient experience team in place • Crude Mortality rates - monitoring and notification from Medical Examiner • Monthly Directorate Mortality and Morbidity meetings (M&M) are held to review deaths and discuss cases.	Ulcers, Patient Falls, Venous Thromboembolism (VTE) and Infections • Agreed reduction trajectories in place for each patient harm • Collaborative working in place with CCG representatives regarding harm reduction • Care Excellence Framework in place, with an identified schedule of annual visits to each Ward/Department, or more frequently if indicated • COVID-19 deaths have been included in the Trust's SJR process to allow for review of care provided to patients and identify any potential areas for improvement/learning • Mortality Review Panel for Definite Nosocomial COVID-19 deaths established by Deputy Medical Director to identify learning and good practice. Review commenced to identify ward status for inclusion in mortality reviews. • Nosocomial COVID-19 Infections will be subject to RCA and reported to the Infection Prevention Committee • A strengthened clinical governance framework including revised Terms of Reference for the Quality and Safety Oversight Group (QSOG) and Quality Governance Committee (QGC) remains in place • "High Quality" identified as a Key Priority Domain for the UHNM Improving Together Programme	NHS Patient Safety Strategy. Induction / Training • Full compliance for years 1 & 2 against CNST 10 Standards
Assurances:	• Quality dashboard available on Intranet • Quality dashboard and Patient Experience dashboard in place and included nosocomial infections during Q1 • Monthly Patient Safety Reports from Ward to Board • Improved timeliness of reporting monthly data agreed during June 2021 • Training Records available at Ward and Corporate level • Care Excellence Framework Visit Reports shared with Ward and Divisional Teams • Mortality report to Mortality Review Group includes analysis of rates and outcomes from mortality reviews. • Monthly highlight reports from Trust Risk Management Panel to Patient Safety Group and QSOG	• Scrutiny of level of Patient Harm and Patient Experience within Executive-Led Divisional Performance Reviews on a monthly basis • Outcome letters as a result of Falls and Pressure Ulcer RCA Panels sent to Senior Sisters/Charge Nurses, Matrons and Associate Chief Nurses • Audit programme to monitor compliance with relevant Trust policies • UHNM Quality Account developed and published according to NHSEI Guidance on 30th June 2021 • Patient stories reported to the Trust Board on a monthly basis • Friends and family test results are reported and monitored on a regular basis • Internal Audit undertaken to review Trust's Incident Reporting and investigation processes. Final report received in Q4 with significant	

	• Presentation of annual M&M activity by Directorate Mortality leads at Mortality Review Group • Infection Prevention Board Assurance Framework – COVID-19 developed with regular reports to QSOG and QGC provided • Updated COVID-19 Mortality report provided in February 2021 to Mortality Review Group and QSOG. Quarter 1 update to be provided to Mortality review Group in July 2021 • Quality Performance Report enhanced to include peer benchmarking where possible for quality indicators including nosocomial COVID-19 reporting	assurance and minor improvement opportunities • Maternity Services Board Assurance Framework in place.	

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

No.	Action Required	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	Quality and Safety Improvement Strategy to be finalised.	Chief Nurse & Medical Director	30/09/2021	Action delayed and target date revised. Draft strategy has been developed pending review / comments.	
2.	To develop Trust Patient Safety Incident Review Plan (PSIRP) and engagement of Patient Safety Partners to support review and patient involvement in Trust quality meetings.	Chief Nurse & Medical Director	30/09/2021	National PSIRF guidance has been updated following Covid with amended dates and learning from early adopters. This is under review and inclusion in UHNM PSIRP.	

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

Risk Description

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

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

Strategic Objectives and Risk Register

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

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

Risk Scoring

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

Rationale for Risk Level:

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

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Annual NHS Staff Survey • Staff Voice pulse check survey implemented from June 2021 • National Quarterly Pulse Survey implemented from July 2021 • Divisional Staff Engagement Plans set out the tailored actions to improve staff experience • Improving Together programme – Staff engagement A3 is developed	• People Strategy and supporting HR Delivery Plan, with performance reported to Transformation and People Committee. The HR Delivery Plan has been updated to take account of the actions required to support the NHS People Plan and ensure alignment of objectives • Partnership working with the STP is in place to introduce a range of Recruitment and Retention initiatives	• The 2020 Staff Survey results showed there were two statistically significant improvements in the 2020 scores when compared to the previous year's data concerning Health and Wellbeing and Safe Environment – Bullying and Harassment. There was no statistically significant change in the remaining 8 themes. ○ At 6.9, the staff

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

		interviews via the Empactis System. • The turnover rate was 9.50% and the overall Trust vacancy rate, calculated as Budgeted Establishment less staff in post, was 7.86%, both of which remain consistent with previous months	understand the extent of bullying and harassment and importantly action that can be taken

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

No.	Action Required	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	Resume the Trust-wide cultural analysis	Director of Human Resources	30/06/2021	***The programme was suspended during the Covid-19 pandemic*** The first stage of the programme was completed, with feedback shared with the Executive Team in January 21. This will inform the OD plans going forwards. The programme has now recommenced	
2.	Implement a UHNM plan relating to the launch of the "Leadership Compact" document within the NHS People Plan	Director of Human Resources	TBC once the national Leadership Compact is released	Development of the Leadership Compact will commence on completion of the Culture analysis, which was ***suspended during the Covid-19 pandemic*** The Leadership Compact has not yet been released nationally	
3.	Leadership and Management Development offer: Internal and External offer focus on managers across the Trust to ensure a competency level is embedded	Director of Human Resources	31/03/2022	Leadership and Management Development is in progress and will be on-going throughout 2021/22 • Plans include for all new managers into the Trust to complete GTM/GTL within 3 months of commencing. • Following the staff survey results regarding middle manager competencies, a business case has been developed to provide for resources to ensure existing managers are developed and is awaiting approval.	
4.	Work with members of the Quality Improvement Academy to deliver "Improving Together to Deliver Exceptional Care" and lead on those aspects linked to leadership behaviours and cultural change	Director of Human Resources	31/03/23	Coaching sessions continue with the Executive Team and an External coach has been confirmed for next session on 28th June. The **Positive & Inclusive Culture A3** continues through the development process, where the drive metric will be the staff engagement rate	
5.	Implement Ministerial ask for quarterly morale tracker from Q1 2021/22	Director of Human Resources	31/07/21	The Trust has signed up to the National People Pulse Survey, which will be implemented from July 2021	

BAF 3: Sustainable Workforce

Internally Driven	✓
Externally Driven	✓

Risk Description

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

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

Strategic Objectives and Risk Register

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

Links to Risk Register	ID 8580: Medical staffing for the Emergency Department (both sites)	**Ext 20**
	ID17977: Reduced staffing in Cancer Centre Pharmacy	**Ext 16**
	ID 10868: T&O Junior Doctor Staffing Gaps	**High12**
	ID 18093: Nurse Staffing within the NNU	**High 12**

Risk Scoring

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

Rationale for Risk Level:

- The Staff Survey showed an improvement in staff recommending the Trust as a place to work (from 60.4% to 64.3%) and in recommending the organisation as place to receive care (from 73.8% to 76.2%).
- At 6.9, the staff engagement score remains just below the acute trust average of 7.0. This is unchanged from the previous year
- Staff sickness rates remain high, but stable. There has been no deterioration in staff engagement or other staff survey indicators. Turnover and vacancy rates remain stable.
- The first 11 overseas nurses will arrive with the Trust on the 28th June and a further 50 are due later in the year.

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Workforce planning process ensures alignment with activity and financial plans • Actions to improve staff experience are detailed in Divisional Staff Engagement Plans • Ongoing recruitment processes • Rotas and rota coordinators management of roster processes • Directorate and divisional management teams monitor	• The Trust's People Strategy is supported by an HR Delivery Plan, with improvement activities cascaded via Divisional People Plans. With the release of the NHS People Plan in July 2020, the HR Delivery Plan has been reviewed and updated to ensure alignment of objectives. The HR Delivery Plan sets out what we aim to deliver to support the national 'People Plan' 4 pillars of activity, which outlines	• The workforce planning process ensures alignment of workforce with activity and financial plans. A Phase 3 Restoration and Recovery Workforce Plan has been produced in line with NHSi requirements. The Plan was amalgamated with those of other system

	staffing levels • Chief Nurse staffing reviews • Annual NHS Staff Survey • The first UHNM Staff Voice has been released. This is a monthly staff survey designed to help understand key issues important to staff about wellbeing, making improvements to where they work and the way they provide patient care • National Quarterly Pulse Survey implemented from July 2021 •	what people can expect from the NHS, from their leaders and each other. • A consistent and cost effective approach to deploying medical workforce across the Trust and support improvements in medical productivity is in place (Medic On Duty, Medic Online, Activity Manager) • System-wide processes are agreed for mutual aid and redeployment of staff to areas of need. • There is a System Recruitment and Retention group in place to look at system-wide recruitment initiatives and the Trust continues to progress its own recruitment plans as well. • We work closely with our education partners and continue to implement our Apprenticeship Strategy and Widening Participation initiatives in recognition of the need for clear educational pathways from schools and colleges into the NHS for clinical support, healthcare scientists, administration and nursing assistant roles. • We have well-established Banks for Medical Staffing, Nursing, Nursing support and Admin and Clerical staff • The Trust is supporting 30 of our Assistant Practitioners through a 2 year apprenticeship to become Registered Nurses and a further 10 nursing assistants on a 4 year apprenticeship to become Registered Nurses.	partners and submitted to NHSi as a system plan. For UHNM, this incorporates the resource required for the Winter Plan. • The *COVID-19 Staff Shortage Contingency Arrangements*, a sub-plan to the Trust's Business Continuity Plan, is in place. This specific Business Continuity plan details the processes that will be put in place within the operational settings of each Division to manage a disruption of service delivery as a result of staff shortages and is supplemented by the *Disruptive Incident Staffing Plan and Operational Workforce Plan*. The plan has been noted as a specific source of assurance on the Board Assurance Framework • Internal redeployment and volunteer process are place to offer support to areas of need and partnership working with the STP continues with system-wide processes for mutual aid and redeployment of staff where possible. • The 2020 Staff Survey results showed there were two statistically significant improvements in the 2020 scores when compared to the previous year's data concerning Health and Wellbeing and Safe Environment – Bullying and Harassment. There was no statistically significant change in the remaining 8 themes. ○ At 6.9, the staff engagement score remains just below the acute trust average of 7.0. This is unchanged from the previous year ○ There was improvement in staff recommending the Trust as a place to work (from 60.4% to 64.3%) and in recommending the organisation as place to receive care (from 73.8% to 76.2%). To address the findings
Assurances :	• HRBPs report actual performance to Divisional Boards and Divisions are held to account via Performance Reviews • Chief Nurse regular reports on Staffing Levels and use of the safe staffing tools	• Monthly reports to Transformation and People Committee cover hard to recruit posts and long term agency and Agency costs are reported in the monthly Finance Report to Performance and Finance Committee • We have implemented a ***Just & Learning Culture*** approach promoting a culture of fairness openness and learning where staff feel confident to speak up supporting staff when things go wrong so errors can be prevented from being repeated • The wellbeing governance structure is led by an Executive Director who oversees delivery of the wellbeing plan at corporate and local level. The Wellbeing Plan has been refreshed and updated. • The Empactis Absence Management System supports the delivery of a consistent approach to managing the key processes associated with health, absence and engagement. • From April 2021, the Workforce Bureau is operating a "virtual workforce bureau" through the respective HR leads rather than meeting formally as a group. • Sickness and covid-related absences continue to be monitored daily. Staff showing symptoms, or	

		with household members showing symptoms, are tested and results returned within 24-48 hours • Risk assessment processes remain in place and all ethnically diverse staff and Category C risk assessments will continue to be reviewed and updated if necessary. • The daily sickness sitrep highlights wards and areas with high numbers of staff calling in as absent. This can then trigger the mitigating actions set out in the *COVID-19 Staff Shortage Contingency Arrangements*, and the *Disruptive Incident Staffing Plan and Operational Workforce Plan.* E-rostering systems are also used to identify areas where workforce capacity is a risk. • The System-led workforce demand and supply process remains in place and will continue to manage redeployment of staff where required • There is a System Recruitment and Retention group in place to look at system-wide recruitment initiatives and the Trust continues to progress its own recruitment plans as well. • The first 11 overseas nurses will arrive with the Trust on the 28th June and a further 50 are due later in the year. • Recruitment is progressing to reduce Healthcare Support Worker vacancies to zero. • Analysis of data and historic trends, reported in monthly performance reports to TAP and Trust Board show that, as at 31 May 21, • The in-month sickness rate was 4.55% (4.23% reported at 30/04/21). The 12 month cumulative rate reduced to 5.05% (5.21% at 30/04/21). Sickness and covid-related absences continue to be monitored daily. Staff showing symptoms, or with household members showing symptoms, are tested and results returned within 24-48 hours. As of 9th June 2021, covid-related open absences numbered 81, which was 13.46% of all absences (8.32% at 11th May 2021) • Actions towards improving sickness rates are being developed through the Improving Together Programme and A3 process. Divisional Teams are developing their own A3's with their specific actions to address sickness and improve compliance with completing call backs and return to work interviews via the Empactis System. • The turnover rate was 9.50% and the overall Trust vacancy rate, calculated as Budgeted Establishment less staff in post, was 7.86%, both of which remain consistent with previous months	of the Staff Survey, corporate priorities planned for 2021/22 are aimed at continuing the improvements in organisational culture and maximising the potential of our people to improve patient outcomes • A new National quarterly 'morale checker' survey is being introduced from July 2021 • Workforce risks are reported via Datix and are monitored to ensure Divisional action and review.

Further Actions (to reduce Likelihood / Consequence of risk to achieve 'Target Risk Level') in line with Risk Appetite					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarterly Progress Report**	**BRAG**
1.	Proactive medical recruitment plans aligned to business planning process/ supply and demand. Consideration to redesigning of roles and recruitment initiatives	Director of Human Resources	31/03/2021	The new Specialist Associate Contract has been implemented to introduce a new role below the level of Consultant and which is likely to be more attractive for potential recruits who do not wish to progress to Consultant level Recruitment of medical staffing is aligned to the business planning process and approval of business cases	
2.	Partnership working with the STP for Recruitment and Retention initiatives	Director of Human Resources	31/03/2021	Recruitment and attraction documentation has been updated. Joint working with System Partners on recruitment and retention, paused during covid, has been re-established	
3.	Nursing recruitment plans to be put this in place to address shortfalls following Chief Nurse establishment review	Director of Human Resources	31/03/2021	Following approval of the Business Case for international recruitment of Nurses, overseas nurses are being welcomed to the Trust from July 2021. The Trust has actively recruited Health Care Support Workers to reduce vacancies towards zero. This was a funded programme with assurance provided to NHSE&I of the workforce pipeline and associated future employment of HCSWs	
4.	Maintain links with / working with ICS workforce leads to develop system wide workforce supply plans and competency based workforce modelling and planning	Director of Human Resources	30/06/21	The NHS '*Priorities and Operational Planning Guidance 21/22*' required the Trust to return a summary workforce plan by 3 June, using the templates issued and covering a number of the key actions. The Workforce Plan forms part of the overall System response to the NHS Priorities and Operational Planning Guidance 21/22 The Workforce Plan was based on budgeted establishment for 2021/22 and staff in post projections and was submitted to the ICS for incorporation into one System Plan to demonstrate partnership working across the STP/ICS, with clear and transparent triangulation between commissioner and provider activity and finance plans. The accompanying narrative focussed on actions being taken to support the health and wellbeing of staff and action on recruitment and retention • The 'staff in post' element of the workforce plan was only required to be planned to 30 September 2021 and shows an increase in staff in post, across all staff groups, of 120.84 fte from the 31st March 2021 baseline. • At the time of the submission, the overseas recruitment of nurses from India had been suspended and as such, these numbers have not been included in the plan. • Business cases are not reflected in the workforce plan until they are approved and finance is released. • Bank and Agency is planned to reduce between 1st April and 30th September 2021, although will likely increase after that to account for Winter Pressures. • As the plan concludes at 30th September, and staffing for Winter Pressures has not been included. • The plan assumes there is no third wave of covid-19 Progress against plan is monitored by NHSE&I via a monthly return	

5.	Provide support and development to line managers to enable them to develop their approach to line management which includes leading agile workers	Director of Human Resources	31/03/22	To support the Staff Survey improvement activity: *Improving Leadership and Management Development and Visibility* • The UHNM Staff Voice has been released. This is a monthly staff survey designed to help management understand key issues important to staff about wellbeing, making improvements to where they work and the way they provide patient care • In July, management development sessions are being offered around managing/leading agile teams and managers/leaders can introduce any topic relating to leading and managing teams at UHNM.	GA

BAF 4: System Working - Vertical

Internally Driven	
Externally Driven	✓

Risk Description

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

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

Strategic Objectives and Risk Register

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

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3				**Likelihood:**	2	31 March 2022
Consequence:	3				**Consequence:**	3	
Risk Level:	**High 9**				**Risk Level:**	**Mod 6**	
Rationale for Risk Level:	• Although a new Chair has been appointed, the substantive Executive Lead still remains uncertain. • The Integrated Care System: Design Framework was published and a plan is being put into place to respond. • An Integrated Care System Strategy that is recognised by all still needs to be designed. • System working is much improved but not all partners are equally engaged.						

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• ICS Shadow Board in place • ICS Development Plan in place, approved by NHSE/I, with workstream and leads in place • ICS Director in post • System wide Executive Forum, • System Performance, Finance & Strategy Group • System workforce group • System quality group being re-established • Three system Places • Provider Collaborative Workstream now on line, • Self Assessment completed • Back Office Workstream in	• Transformation and Delivery Unit • ICS Workstreams • ICS Development Plan in place and approved by NHSE/I • Three Places developed with OD programme in place • CCG merger approved	• ICS designation plan approved by NHSIE

	place		
Assurances:	• UHNM Chair, Chief Executive and Director of Strategy are members of relevant system groups / meetings • CFO/COO & DoS are members of Finance, Strategy & Operations system group • MD Chairs system wide Clinical Senate • System working regular UHNM Board agenda	• Regular reports from TDU to Exec Forum in place but to be reviewed • UHNM internal reporting of system working in place but under review • Provider Collaborative workstream being led by UHNM CEO	

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

No.	Action Required	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	Appoint ICS Executive Lead	NSC Director of Human Resources	01/10/21	Timeline to be agreed by ICS Chair	**GA**
2.	Develop a revised Integrated Strategy for Health and Social Care	STP Director / Chief Executive	30/06/2021	Strategy development delayed due to Covid-19	**D**
3.	PLACE to develop a clear, agreed, strategic approach to population health management	STP Director / Chief Executive	System Action – Timeframe to be confirmed	Framework for use of Population Health Data in place but evidence of use to determine strategy is limited	**GA**
4.	To revise workstreams in light of new planning guidance and ICS designation plan	STP Director / Chief Executive	30/07/21	Development plan in place and approved by regulators. Design Framework under review / discussion. Workplans to be reviewed as a result.	**GA**
5.	Provider Collaborative stocktake to be completed Presented to Performance, Strategy and Finance Group, Exec Forum ICS Board Variation and population health data to be collated and workstreams to be decided	UHNM Chief Executive	30/08/21	Stock take underway, to be concluded before the end of July. Data analytics under review in terms of expertise. In discussion with other systems and CSU as well as regulators to determine where the most appropriate expertise is.	**GA**
6.	Back Office Functions Workstreams to be agreed	CCG Chief Finance Officer	31/07/21	Workstreams agreed – action complete. HR, IT and Estates. Currently seeking representation/ leads and scoping will be undertaken to understand the art of the possible.	**B**

BAF 5: System Working - Horizontal

Internally Driven	
Externally Driven	✓

Risk Description

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

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

Strategic Objectives and Risk Register

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

Risk Scoring

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

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Designated Lead for UHNM - Director of Strategy • Exec : Exec meetings - need to be formalised with SaTH • DoS represents Trust on Spec Com discussions in respect of network development for Midlands • UHNM CEO leading system Provider Collaborative and self-assessment undertaken	• Transformation & People Committee • Strategy and Transformation Group to be established to oversee Strategic Partnerships • Informal Exec to Exec discussions to be re-established post COVID with SaTH	• N8 Pathology collaborative completed successfully
Assurances:	• Re-launch / development of governance and programmes of work will be reported through TAP with escalations to Trust Board • Trust clinical strategy development will be	• System working updates to the Board each month through the Chief Executive demonstrate that progress is in early stages of development. • Now a standing item on the	

	inclusive of strategic developments with other partners and the outcome of the Provider collaborative and Back Office Review	Executive Directors meeting • Provider collaborative to report to system Finance, Performance and Strategy, Executive Forum and ICS Board	

Further Actions (to reduce Likelihood / Consequence of risk to achieve 'Target Risk Level') in line with Risk Appetite					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarterly Progress Report**	**BRAG**
1.	Exec: Exec discussion with MCHFT to establish joint status of the Stronger Together Programme.	Director of Strategy	Post Covid	Discussion concluded. MCHFT focus is on Place / vertical integration. The arrangement we will have going forward will be contract / SLA monitoring only. There is no plan to change the current partnership arrangements and should other opportunity arise, MCHFT will consider all horizontal options. **Action complete.**	**A**
2.	Develop formal governance for a collaborative programme with SaTH	Director of Strategy	Post Covid	Update July 2021 – Joint meeting of Directors of Strategy and COOs. HA development partnership agreement	**A**
3.	Utilise the Recovery & Restoration programme to develop improved relationships with Specialist Commissioners. Review of current network arrangements for Specialised Services to be completed by Specialised Commissioners.	Chief Executive / Director of Strategy	30/06/2020	Chief Executive is now part of the NHS Midlands Clinical Strategy Group which is largely related to specialist services and has agreed to be part of a Task and Finish Group in respect of specialist cancer services. Therefore ensuring UHNM is contributing to and influencing developments.	**B**
4.	Refresh / development and agreement of UHNM Trust wide Strategy.	Director of Strategy	30/09/2021	Strategy development recommenced	**A**
5.	Strategies for each Trust to be reviewed to ensure that strategic developments between UHNM / MCHFT and UHNM / SATH are taken into account.	Director of Strategy	Post Covid	Discussions concluded with MCHFT and recommenced with SaTH**. Action Complete** as will be picked up under number 2	**A**
6.	Ensure that Restoration and Recovery is taken into account in development of UHNM Strategy.	Director of Strategy	Post Covid	Good progress to date with R&R although not yet incorporated into strategy due to delay. R&R plans robust and delivering. **Action closed**	**GA**
7.	Review and interpretation of national operational planning guidance for 21/22.	Director of Strategy	31/05/2021	As guidance is released this is factored into strategy. Still awaiting financial guidance. **Action closed**	**GA**
8.	Review of current network arrangements for Specialised Services to be completed by Specialised Commissioners.	Chief Executive / Director of Strategy	30/06/2021	No progress made in quarter. Some meetings with Spec Comm have taken place but little action as yet. To continue into 21/22	**GA**

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

Risk Description

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

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

Strategic Objectives and Risk Register

Impact on Strategic Objectives:	**High Quality**	✓	**Improving and Innovating**	
	Responsive	✓	**Systems and Partners**	✓
	People	✓	**Resources**	✓
Links to Risk Register	Elective Planned Care Recovery			
	Covid Surge – Paediatrics and Adults			

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	4				**Likelihood:**	2	
Consequence:	3				**Consequence:**	3	
Risk Level:	**High 12**				**Risk Level:**	**Mod 6**	
Rationale for Risk Level:	• Governance and operational delivery model commissioned to support Planned Care Recovery and traction on delivery evidenced to end of June 21. • Covid related workforce isolation/sickness attrition since beginning of July 21 now impacting on elective capacity to deliver OPD, Diagnostics and Theatre elective recovery plans at the pace needed to scale up capacity to clear backlogs • Third Covid Surge planning now enacted in response to PHE and NHSEI mandates re: Paediatric (August 21) and Adult covid volumes rising – system in surge currently for non elective demand with predictions of higher rates of flu and winter infections (NoroVirus etc)						

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	Revised contract with Independent Sector to transfer a higher volume of patients to ensure timely treatment and reduced waiting list to enable focus on more complex P2 patient clearance	Commissioning of In sourcing provision to increase workforce cover to reduce loss of theatre capacity and enable traction on list continuity. 7th Theatre at county being commissioned to sustain electives during winter.	Winter bed and financial planning under way for early enactment of surge. Includes proposals for additional PODs to help with IPC management and options around MFFD management to protect acute bed capacity.
Assurances:	Contract enacted with patient transfers by August 21 for both IS providers.	Investment cases prepared for review. Oral surgery model already approved.	Winter finance budgets approved with recruitment commenced. Winter bed model draft completed for system discussions.

Further Actions (to reduce Likelihood / Consequence of risk to achieve 'Target Risk Level') in line with Risk Appetite					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarterly Progress Report**	**BRAG**
1	System Urgent Care Plan enablers to understand any mitigations to reduce NEL demand impacts on diagnostics/surgery to re-provide for elective recovery	Chief Operating Officer	August 21	Non Elective Improvement Group	
2	Confirmation of Elective Recovery Fund investment to support Planned Care Enabler initiatives to manage referred demand and increase capacity/waiting list management	Director of Strategy and Transformation	August 21	ODG	

BAF 7:	Delivery of IM&T Infrastructure	Internally Driven	✓
		Externally Driven	

Risk Description

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

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

Strategic Objectives and Risk Register

Impact on Strategic Objectives:	**High Quality**	✓	**Improving and Innovating**		
	Responsive	✓	**Systems and Partners**		
	People		**Resources**	✓	
Links to Risk Register	ID 20032: Pharmacy Windows 10 Compliance			**Ext 15**	
	ID 13595: KCOM Cyber Security Compliance			High 12	

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3				**Likelihood:**	1	31/03/22
Consequence:	5				**Consequence:**	5	
Risk Level:	**Ext 15**				**Risk Level:**	**Mod 5**	
Rationale for Risk Level:	The likelihood of the risk continues to remain static whilst actions progress within the IM&T Cyber Action Plan. If the organisations infrastructure and clinical systems are not adequately protected from either targeted or indirect cyber attack this could compromise the operation and delivery of care within the hospital. Cyber Security remains a real and relevant threat to the NHS.						

Control and Assurance Framework – 3 Lines of Defence

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

	stealth attacks inside the network — in real time. • IT Health dashboard implemented to provide real-time visibility and overview of the network and systems, identifying any potential cyber security issues that warrant attention and assurance on the cyber security environment • Implementation of ORDR at County Hospital to monitor network activity of medical devices and Internet of Things (IoT) devices • Implementation of National Cyber Security Centre recommendations on passwords		*significant assurance with minor improvement opportunities*
Assurances :	• Policies and procedures in place for data, security and protection • DSP statutory and mandatory training • IT Health Dashboard real monitoring of activity • DarkTrace real time monitoring with action taken where appropriate • DMARC real time monitoring with action taken where appropriate	• DSP training report • DSP report presented to PAF on a quarterly basis • DSP assurance reports to the Executive DSP Group: o Asset Management o Registration Authority o Information Security o Cyber Security o Data Quality o Records Management (includes Freedom of Information and Subject Access Requests) o Learning and Assurance Report • DSP Newsletter (which includes monthly reminders on cyber security) • Quarterly DSP Incident newsletter to share learning and best practice • Records management and confidentiality audits	

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

No.	Action Required	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	Deployment of Windows 10 with improved in built security and based on National Cyber Security Centre and Microsoft best practice	Director of IM&T	30/04/2021	This project is 95% with just 338 devices remaining The due date is now the end of April. The extended due date is as a consequence of access issues in critical areas brought about by the Coronavirus pandemic. – Simon will need to provide an update	
2.	Continue work towards the toolkit Cyber Essentials and ISO27001 compliance.	Director of IM&T	31/03/2022	Improvement plan developed and will be monitored via the Executive DSP Group	
3.	Implement IT Health dashboard to provide real-time visibility and overview of the network and systems, identifying any potential cyber security issues that warrant attention and assurance on the cyber security environment	Director of IM&T	30/03/2021	Solution procured via NHS Digital funding with an implementation due date of the 30th March	
4.	Implementation of network segregation	Director of IM&T	31/03/22	Task and finish group to be established to scope and develop action plan	GB
5.	Implementation of ORDR at Royal Stoke	Director of IM&T	31/03/22	Discussions underway to agree timescales for implementation	GB
6.	BYOD implementation	Director of IM&T	31/12/2021	Currently migrating licences to the cloud with plans to register devices on the cloud.	GB

	BAF 8:	Infrastructure to Deliver Compliant Estate Services	Internally Driven	✓
			Externally Driven	

Risk Description

Cause	Event	Effect
If we are unable to sufficiently invest and develop our retained clinical and non-clinical estate	**Then** we may be unable to provide services in a fit for purpose healthcare environment	**Resulting in** the inability to provide high quality services in a safe, secure and compliant environment

Lead Director / s:	Director of Estates, Facilities and PFI	**Supported by:**	Director of Digital Transformation and Chief Finance Officer
Lead Committee:	Performance and Finance Committee	**Executive Group:**	Infrastructure Group

Strategic Objectives and Risk Register

Impact on Strategic Objectives:	**High Quality**	✓	**Improving and Innovating**	
	Responsive		**Systems and Partners**	✓
	People		**Resources**	
	ID 12720: Absence of side rooms in modular wards		**High 12**	
	ID 19633: Ward 120 Ward Environment		**High 12**	

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3				**Likelihood:**	2	31 March 2022
Consequence:	4				**Consequence:**	4	
Risk Level:	**High 12**				**Risk Level:**	**High 8**	
Rationale for Risk Level:	• **Infirmary Site (Project STAR):** Small number of building remain with Trust (EF&PFI building, ICT building, Windsor House) including car parks. IHP increased security to reflect increased possession. Phased handover to IHP – Phases 1, 2, 3 & 4 (asbestos removal) completed. Phases 5 (asbestos removal) underway and within program. • **Estate Condition:** Key risks are funding constraints and physical access. PFI Statutory Maintenance programme underway but facing access difficulty in some areas due to high levels of bed occupation and activity. This will be mitigated by compressing the works in some areas such as theatres, which will attract additional costs. • **Estate configuration / utilisation / optimisation / adjacencies:** Lowe Trent, which is phase 2 of a £17.6m capital funding additional ward scheme, stalled due to decant but is now developing a reworked decant solution. This will entail keeping the building at the infirmary (currently occupied by E&F and IM&T) until Spring of 2022. • **Clinical Service Strategy:** work starting to inform further changes						

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	Infirmary Site (Project STAR): • Emergency capital bids produced; fire Risk assessments completed, manned 24/7 security. Condition of the estate: • PPM; competent estates staff/APs; estates KPI's monitored through CEF/	Infirmary Site (Project STAR): • NHSEI provided capital for site remediation and GHC acquisition • FBC approved by Trust Board and currently with NHSEI. Condition of the Estate • Estates Capital bids submitted to Trust Capital Investment Group	• NHSEI Review of Progress on Project STAR • Regulatory inspection/validation programmes including: CQC, PLACE, PAM and ERIC

	Environmental Audits. • Maintenance Operational Board; Operational policies; Service Specifications PFI. COVID-19 Impact: • Capital schemes; social distancing methodology; zoning proposals agreed through ET & R&R. Estate configuration/optimisation/adjacencies • Clinical Service Strategy Review to conclude and inform changes to Estate Strategy/DCP. Fire / Security • Fire Safety/ Security Policies; Protocols; Guidelines; patrolling; CCTV; FRA's in place.	(CIG) from 7 facet findings, investment prioritised. COVID-19 Impact • Appropriate control of all schemes – ET & R&R. Estate configuration/optimisation/adjacencies • Prioritised clinical service developments, as identified by Clinical Divisions, used to inform Estate Strategy. Fire/Security • 'On the spot' fire improvement notices by Fire Officers. • Fire Safety KPIs & ad-hoc audits/inspections. • LSMS close working with local Police and visibility on site	• External audits including those undertaken by the Fire and Police Service and external audit i.e. KPMG • Authorising Engineers Audits, appointed to provide external audit and assurance (governance) of building services and associated maintenance regimes. • Participation in National Programme hosted jointly by Cabinet Office & HM Treasury, showcasing the most successful Private/Public Sector Strategic Partnerships.
Assurances :	Project STAR: • Project Team, PRINCE principles applied. Condition of the estate • Estate-code 7 facet property appraisals conducted; Maintenance Operational Board; estates maintenance/validation audits; PFI performance against Service Spec; Divisional Board review. COVID-19 Impact • Updates ET & R&R Fire / Security • FRAs; ad-hoc inspections; improvement notices; progress monitored FSG and EH&SG.	Project STAR • Regular updates to internal/external key stakeholders Condition of the estate • Estate Strategy, informed by Estate-code 7 facet property appraisal, Trust Strategy & clinical developments. • Regular reporting to CIG, H&S, QGC, EIG, IPC, TJNCC and LNC. • Strategic partnership - reviewed at Liaison Comm and EIG. COVID-19 Impact: • Regular updates on progress on Risk Assessments/R&R Fire / Security: • FRAs monitored through Trust Fire Committee; Divisional Management Board and Divisional H&S Meetings.	

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

No.	Action Required	Executive Lead	Due Date	Quarterly Progress Report	BRAG
1.	RI Site - Asbestos removal/demolition	Director of E,F & PFI	2022	Asbestos removal Phase 1 - 5 handed over to the principle contractor IHP. Phases 1-4, completed removal	GA
2.	RI/COPD - Create car parking solution	Director of E, F&PFI	2023	FBC approved by Trust Board. NHSEI funded demolition and GHC acquisition, now awaiting approval of car parking construction funding from NHSEI.	GA
3.	RI/COPD - Release land for land sale	Director of E,F& PFI	2023	Will be dependent on funding being made available from NHSEI to construct the new car park.	GA
4.	Trent Business Case	Director of E,F&PFI	2023	Alternative decant solution identified and revised programme currently being worked up.	GA
6.	Sodexo Market Testing BC	Director of E,F&PFI	Oct. 2021	BC approved Trust Board. Approval now being sort from NHSI/E and PFU. Variation being worked up with Project Co with a view to completing by October 2021.	GA
7.	PFI Statutory maintenance	Director of E,F&PFI	Jan 2021	Program underway, significant challenges bed occupation/activity, mitigated by compressing the programme in some areas, which has attracted additional costs.	GA
9.	Strategic Supplier Programme	Director of E,F & PFI	2022	Programme continues, some schemes now nearing completion, refresh of the Business Plan in October 2021.	GA
10.	Estates Workforce Reviews	Director of E,F & PFI	Aug. 2021	Capital completed and being reviewed by Execs. Ops near completion to be completed in August.	GA

BAF 9: Financial Performance

Internally Driven	
Externally Driven	✓

Risk Description

Cause	Event	Effect
If we, or system partners, are unable to operate within available resources	**Then** the system financial plan for 2021/22 may not be delivered	**Resulting in** increasing Cost Improvement Programmes, and a lack of ability to invest in the development of future services

Lead Director / s:	Chief Finance Officer	**Supported by:**	Chief Operating Officer
Lead Committee:	Performance and Finance Committee	**Executive Group:**	Executive Infrastructure Group

Strategic Objectives and Risk Register

Impact on Strategic Objectives:	**High Quality**		**Improving and Innovating**		
	Responsive		**Systems and Partners**	✓	
	People		**Resources**	✓	
Links to Risk Register	VAT recovery on car park development			**High 12**	
	Costs of recovery outstrip revenue from elective recovery fund going forward			**High 12**	

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2				**Likelihood:**	1	31/03/22
Consequence:	3				**Consequence:**	3	
Risk Level:	**Mod 6**				**Risk Level:**	**Low 3**	
Rationale for Risk Level:	Current financial regime for first half gives a good income allocation with performance at month 3 showing an £8m surplus. Second half of the year allocations are yet to be finalised. Expectation that existing block arrangements continue but doubt about level of efficiency creates a risk from October onwards. In addition, the change in guidance on the Elective Recovery Fund significantly reduces the income receiveable to support delivery of additional activity. There is therefore a risk that the costs of ongoing recovery outstrip income and deteriorate the current strong position. This in itself is unlikely however to undermine the delivery of the strategic objective and hence the lower risk.						

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Performance Management meetings in place with Divisions • Financial codes and procedures • Restoration and recovery group scrutiny • Exec Team approval of additional investment up to £250k • STP Finance Director meeting established to consider system position • Ongoing discussions with NHSIE on underlying position to inform improvement trajectories	• Finance report in place to performance and Finance Committee with associated scrutiny; enhanced to include run rate performance and analysis of additional COVID related expenditure • Standing Financial Instructions	• Consideration of Internal audit programme to reflect changing risks on COVID • STP Capital Programme in place in Line with Capital Resource Limit (CRL) • External audit programme in place • NHSE/I allocations confirmed
Assurances:	•	• Performance at Month 3 ahead of plan	

		• System partners agreed allocations across STP for both income and capital	

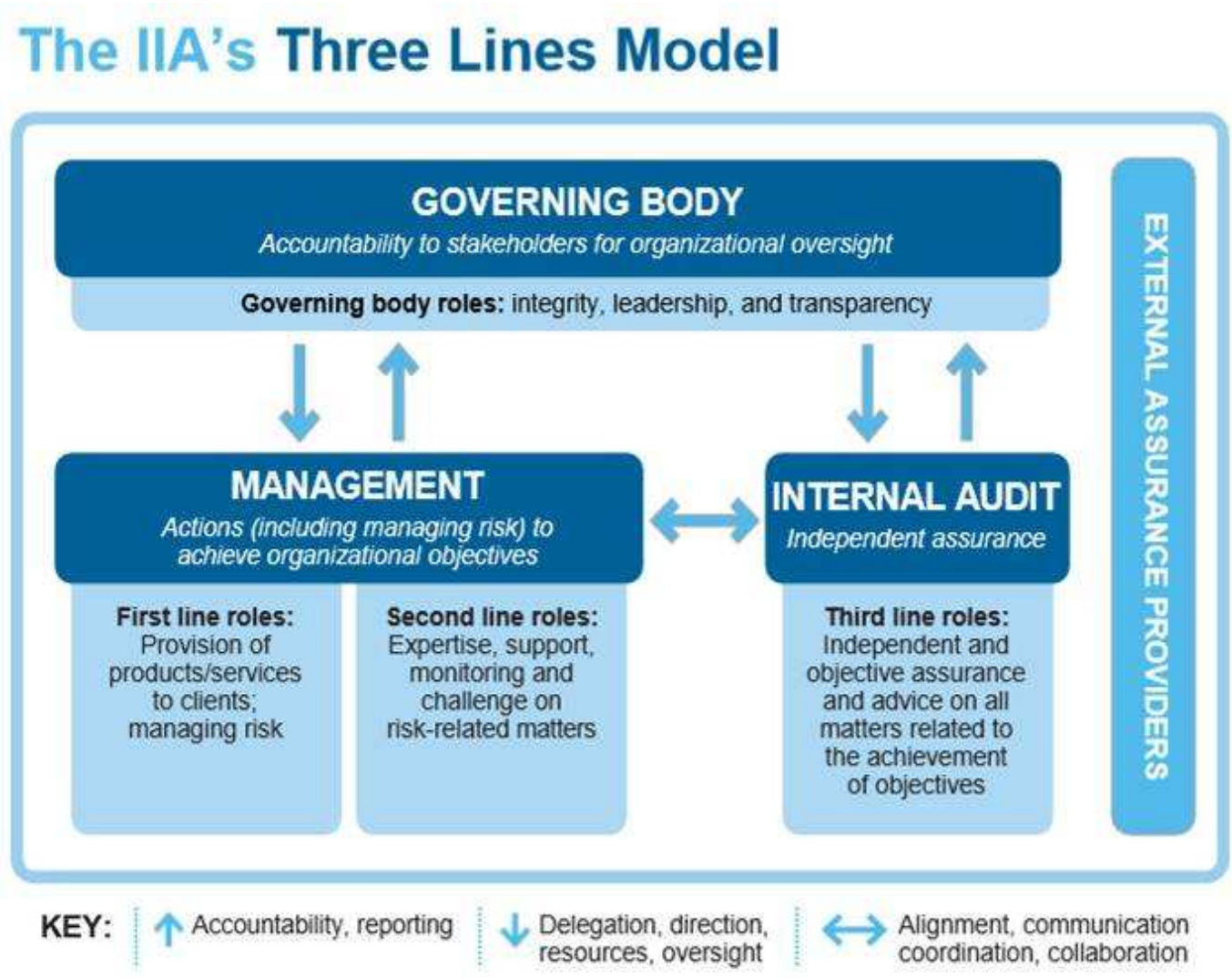
Further Actions (to reduce Likelihood / Consequence of risk to achieve 'Target Risk Level') in line with Risk Appetite					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarterly Progress Report**	**BRAG**
1.	Clarity in respect of Funding regime	MO	**30/09/21**	National guidance still awaited, now expected end of September.	**A**
2.	Investment Assurance report to PAF	MO	**31/07/21**	Positive assurance report presented at Performance and Finance Committee in July.	**B**

Appendix 1: Risk Appetite Matrix

Sub Category of Risk		Risk Appetite	Risk Score Tolerance
Impact on Quality	Patient Safety (e.g. patient harm, infection control, pressure sores, learning lessons)	Cautious	Mod 4 – Mod 6
	Effectiveness (e.g. outcomes, delays, cancellations or operational targets and performance)	Open	High 8 – High 12
	Service User and Carer Experience and the ability to manage quality (e.g. complaints, audit, surveys, clinical governance and internal systems)	Open	High 8 – High 12
Impact on Regulation & Compliance	Statutory Regulation and Requirements (e.g. Information Commissioner, Care Quality Commission, Health and Safety Executive, Professional Regulatory Bodies such as General Medical Council, Nursing & Midwifery Council, external certifications such as JAG and ISO).	Cautious	Mod 4 – Mod 6
	National Guidance and Best Practice (e.g. National Institute for Health and Care Excellence, GIRFT)	Open	High 8 – High 12
Impact on Reputation	Day to day activity (e.g. standards of conduct, ethics and professionalism and delivery of services)	Cautious	Mod 4 – Mod 6
	Risk as a result of protecting and improving the safety of patients	Seek	Ext 15 – Ext 25
Impact on Workforce	Staff recruitment (e.g. compliance with regulations such as visa requirements, Equal Opportunities and Diversity, that ensure staff are recruited fairly and competent to deliver services)	Cautious	Mod 4 – Mod 6
	Employment practice	Cautious	Mod 4 – Mod 6
	Staff retention (e.g. attractiveness of Trust as an employer of choice)	Open	High 8 – High 12
Impact on Infrastructure	Estates Infrastructure	Cautious	Mod 4 – Mod 6
	Security (e.g. access and permissions to systems and networks)	Cautious	Mod 4 – Mod 6
	Control of Assets (e.g. purchase, movement and disposal of ICT equipment)	Cautious	Mod 4 – Mod 6
	Business continuity (e.g. cyber-attack, maintenance of networks, alternative solutions)	Cautious	Mod 4 – Mod 6
	Data (e.g. integrity, availability, confidentiality and security, unintended release)	Cautious	Mod 4 – Mod 6
Impact on Finance & Efficiency	Value for money and sustainability (including cost saving)	Cautious	Mod 4 – Mod 6
	Standing Financial Instructions (SFI's) and financial control	Cautious	Mod 4 – Mod 6
	Fraud and negligent conduct	Minimal	Low 1 – Low 3
	Contracting	Seek	Ext 15 – Ext 25
Impact on Partnerships / Collaboration	Partnerships	Open	High 8 – High 12
Impact on Innovation	Innovation (e.g. new ways of working, new products, new and realigned services, new models of staffing and realignment of services, international recruitment, new ICT systems and improvements)	Seek	Ext 15 – Ext 25
	Financial Innovation (e.g. new ways of working, new products, new and realigned services)	Open	High 8 – High 12

LEVELS OF RISK APPETITE	
Avoid **Risk Score Tolerance 0**	We are not prepared to accept any risk.
Minimal **Risk Score Tolerance 1 – 3**	We accept that risks will not be able to be eliminated, therefore these should be reduced to the lowest levels, with ultra-safe delivery options, recognising that these may have little or no potential for reward/return.
Cautious **Risk Score Tolerance 4 – 6**	We are willing to accept some low levels of risk, while maintaining overall performance of safe delivery options, recognising that these may have restricted potential for reward/return.
Open **Risk Score Tolerance 8 – 12**	We are willing to accept all potential delivery options, recognising that these may provide an acceptable level of reward.
Seek **Risk Score Tolerance 15 - 25**	We are eager to be innovative, choosing options with the potential to offer higher business rewards.

Appendix 2: Three Lines of Defence



Trust Board

2021/22 BUSINESS CYCLE

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

Title of Paper	Executive Lead	Apr 7	May 5	Jun 9	Jul 7	Aug 4	Sep 8	Oct 6	Nov 3	Dec 8	Jan 5	Feb 9	Mar 9	Notes
PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES														
Chief Executives Report	Chief Executive													
Patient Story	Chief Nurse													
Quality Governance Committee Assurance Report	Associate Director of Corporate Governance													
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer													Timing TBC
Care Quality Commission Action Plan	Chief Nurse													Highlighted as part of QGC Assurance Summary
Bi Annual Nurse Staffing Assurance Report	Chief Nurse													Deferred - awaiting presentation at TAP prior to bringing to Board.
Quality Account	Chief Nurse													
7 Day Services Board Assurance Report	Medical Director													Timing TBC
NHS Resolution Maternity Incentive Scheme	Chief Nurse													
Maternity Serious Incident Report	Chief Nurse													
Winter Plan	Chief Operating Officer													
PLACE Inspection Findings and Action Plan	Director of Estates, Facilities & PFI													Timing TBC
Infection Prevention Board Assurance Framework	Chief Nurse													
ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS STANDARDS														
Integrated Performance Report	Various													
ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT & RESEARCH														
Transformation and People Committee Assurance Report	Associate Director of Corporate Governance													
Gender Pay Gap Report	Director of Human Resources													
People Strategy Progress Report	Director of Human Resources													
Revalidation	Medical Director													
Workforce Disability Equality Report	Director of Human Resources													
Workforce Race Equality Standards Report	Director of Human Resources													
Staff Survey Report	Director of Human Resources													
LEAD STRATEGIC CHANGE WITHIN STAFFORDSHIRE AND BEYOND														
System Working Update	Chief Executive / Director of Strategy													
ENSURE EFFICIENT USE OF RESOURCES														
Performance and Finance Committee Assurance Report	Associate Director of Corporate Governance													
Revenue Business Cases / Capital Investment / Non-Pay Expenditure £1,000,001 and above	Director of Strategy													
IM&T Strategy Progress Report	Director of IM&T													Deferred to May due to annual leave
Going Concern	Chief Finance Officer													
Estates Strategy Progress Report	Director of Estates, Facilities & PFI													Timing TBC - waiting to refresh once the clinical strategy has been determined
Annual Plan 2020/21	Director of Strategy													
Financial Plan 2021/22	Chief Finance Officer													
Capital Programme 2021/22	Chief Finance Officer													
GOVERNANCE														
Nomination and Remuneration Committee Assurance Report	Associate Director of Corporate Governance													

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