University Hospitals of North Midlands NHS Trust

Trust Board (Open)

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

AGENDA

Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
09:30	**PROCEDURAL ITEMS**					
20 mins	1.	Patient Story	Information	Mrs AM Riley	Verbal	
5 mins	2.	Chair's Welcome, Apologies and Confirmation of Quoracy	Information	Mr D Wakefield	Verbal	
	3.	Declarations of Interest	Information	Mr D Wakefield	Verbal	
	4.	Minutes of the Meeting held 5th January 2022	Approval	Mr D Wakefield	Enclosure	
	5.	Matters Arising via the Post Meeting Action Log	Assurance	Mr D Wakefield	Enclosure	
20 mins	6.	Chief Executive's Report – January 2022	Information	Mrs T Bullock	Enclosure	
10:15	**PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES**					
5 mins	7.	Quality Governance Committee Assurance Report (27-01-22)	Assurance	Ms S Belfield	Enclosure	**BAF 1**
5 mins	8.	IPC Board Assurance Framework – January 2022	Assurance	Mrs AM Riley	Enclosure	**BAF 1**
5 mins	9.	Bi-Annual Nurse Staffing Review Update	Information	Mrs AM Riley	Enclosure	
10:30	**ENSURE EFFICIENT USE OF RESOURCES**					
5 mins	10.	Performance & Finance Committee Assurance Report (25-01-22)	Assurance	Dr L Griffin	Enclosure	**BAF 6, 7, 8 & 9**
10:35	**ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT AND RESEARCH**					
5 mins	11.	Transformation and People Committee Assurance Report (26-01-22)	Assurance	Prof G Crowe	Enclosure	**BAF 1, 2, 3, 4 5**
10 mins	12.	Speaking Up Report – Quarter 3	Assurance	Mrs R Vaughan	Enclosure	
10:50 – 11:05: COMFORT BREAK						
11:05	**ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS**					
40 mins	13.	Integrated Performance Report – Month 8	Assurance	Mrs AM Riley Mr P Bytheway Mrs R Vaughan Mr M Oldham	Enclosure	**BAF 1, 2, 3, 6 & 9**
11:45	**GOVERNANCE**					
5 mins	14.	Audit Committee Assurance Report (27-01-22	Assurance	Prof G Crowe	Enclosure	
10 mins	15.	Board Assurance Framework – Quarter 3	Approval	Mrs N Hassall	Enclosure	
12:00	**CLOSING MATTERS**					
5 mins	16.	Review of Meeting Effectiveness and Business Cycle Forward Look	Information	Mr D Wakefield	Enclosure	
	17.	Questions from the Public **Please submit questions in relation to the agenda, by 9.00 am 7th February to nicola.hassall@uhnm.nhs.uk**	Discussion	Mr D Wakefield	Verbal	
12:05	**DATE AND TIME OF NEXT MEETING**					
	18.	**Wednesday 9th March 2022, 9.30 am via Microsoft Teams**				

University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 5th January 2022, 9.30 am to 11.35 am
Via Microsoft Teams

MINUTES OF MEETING

Attended	Apologies / Deputy Sent	Apologies

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

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

In Attendance:	
Mr C Frary	Patient (item 1)
Mrs N Hassall	Deputy Associate Director of Corporate Governance (minutes)
Mrs R Pilling	Senior Sister- Patient Experience (item 1)

Members of Staff and Public via MS Teams: 1

No.	Agenda Item	Action
1.	**Patient Story**	
001/2022	Mr Frary described his story and his experience after he had a hysterectomy. He described the exceptionally positive way in which he was cared for during his initial admission, and how well he was supported in his transgender journey. He explained that after being discharged he was readmitted into the Trust where unfortunately the experience was not as positive. He explained that he was initially admitted into a female bay, which resulted in an insensitive initial reaction from one of the nurses after which time he was taken into a treatment room for 3 hours, before being moved onto a ward into a male bay and commencing treatment. He explained that other members of the clinical team had spoken to him about his procedure in earshot of other patients, which given the nature of the surgery made him feel uncomfortable.	

PROUD TO CARE

	Mr Wakefield apologised to Mr Frary for the experience he received during his unplanned admission and queried whether he felt this was a one off instance. Mr Frary explained that he was unsure as to whether it was a general issue but felt that staff needed to think before they spoke to patients to ensure their dignity and privacy was maintained, or offering to speak in a more private setting rather than conversations in earshot of other patients. Mrs Riley offered to work with Mr Frary on ways to improve communication with transgender patients, and suggested it would be beneficial to focus on this as a patient priority. Dr Lewis agreed to work with Mrs Riley with regards to taking forward the conversations with clinical teams. Dr Griffin referred to the importance of raising education and awareness with staff on communication with transgender people as well as improving public understanding, whereby the Board needed to take a leadership role in in promoting understanding, sharing experiences and stories. Ms Gohir queried whether Mr Frary could suggest how the Trust could encourage other patients to have the confidence and raise any concerns in relation to their experience and Mr Frary explained that as a patient he was regularly asked to provide feedback and stated that it was important to demonstrate to patients that their feedback was taken on board and actioned. Ms Bowen queried whether Mr Frary had been asked about which bay he would have been more comfortable in and he explained that as part of the transgender training programme, the focus was on having specific conversations with patients regarding this, in terms of the pronouns to be used when they were being addressed as well as determining where they felt comfortable. Mr Wakefield thanked Mr Frary for outlining his story and highlighting the exemplary care received during his initial admission at County Hospital which should be recognised. He stated that his experience following his second admission following post-operative complications was unacceptable and he welcomed the comment from Mr Frary about being aware of privacy and dignity when communicating with patients. He welcomed the actions suggested in terms of educating both staff and the public, by sharing the story and broadening understanding. **The Trust Board noted the patient story.** Mr Frary and Mrs Pilling left the meeting.	**AMR**
2.	**Chair's Welcome, Apologies & Confirmation of Quoracy**	
002/2022	Mr Wakefield welcomed members of the Board and observers to the meeting. It was confirmed that the meeting was quorate. Mr Wakefield thanked staff for their continued efforts during 2021 as well as their continued hard work during such pressures. He referred to recent national guidelines received on reducing the administrative burden and stated that the Board would consider how to implement the guidance, in terms of continuing to obtain assurance whilst limiting the time spent in meetings. Mr Wakefield welcomed the receipt of the CQC report and improved scores which reflected well on the contributions of staff over the past 12 months.	

3.	**Declarations of Interest**	
003/2022	The standing declarations were noted.	
4.	**Minutes of the Previous Meeting held 8th December 2021**	
004/2022	The minutes of the meeting from 8th December 2021 were approved as an accurate record.	
5.	**Matters Arising from the Post Meeting Action Log**	
005/2022	PTB/489 – Dr Lewis confirmed that he had discussed the care plan with members of the team including a neurologist, specialist nurse and acute medicine consultants, agreeing a care plan for future presentations which had been shared with the family. PTB/496 – Mrs Vaughan stated that feedback had been provided to the disability staff network which would review the action plan to establish which actions were to be prioritised. PTB/501 – Mrs Riley highlighted that the original timescale for training was January but given the current pressures, a plan was being put in place for February, maximising the use of digital training where possible.	
6.	**Chief Executive's Report – December 2021**	
006/2022	Mrs Bullock highlighted a number of areas from her report and provided an update in relation to Covid and the current pressures impacting on patient flow through the hospital and cancellation of elective surgery. Dr Griffin referred to the number of patients coming into hospital for a different reason and testing positive for Covid and queried if the process for testing patients was impacting on staff absence. Mrs Bullock stated that this was not the case and outlined the flow and segregation of patient with Covid, unknown or without Covid. In addition, she noted that staff continued to wear appropriate PPE depending on the area, given the possibility of asymptomatic patients. Mr Wakefield referred to the CQC report and welcomed the improvement in a number of areas but highlighted that a number of areas were not inspected during this visit and therefore continued with their Requires Improvement rating from 2019. Mr Wakefield therefore noted that the overall Required Improvement rating could not change as a result of this. **The Trust Board received and noted the report and approved EREAFs 8497, 8481 and 8480.**	
STRATEGY		
7.	**Digital Strategy Progress Update**	
007/2022	Mrs Freeman referred to the paper which provided an update on the progress being made in developing the strategy. She stated that a number of the actions had been undertaken and further were underway in preparation for the strategy	

	being presented in March 2022. Ms Bowen welcomed the inclusion of ICS digital stakeholders. Ms Gohir queried whether the strategy would focus on equality and Mrs Freeman confirmed that digital inclusion was a focus. Mr Akid referred to timing of the staff survey and away day and queried whether it would be too late to include items brought up in those forums. Mrs Freeman stated that engagement and consultation had already taken place and therefore she did not consider that issues raised would be fundamentally different things to things which had already been taken into account. **The Trust Board received and noted the update.**	
PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES		
8.	**Quality Governance Committee Assurance Report (16-12-21)**	
008/2022	Ms Belfield highlighted the following from the report: • The meeting considered and discussed the impact of staff shortages and challenges being faced • The additional pressures in maternity were noted • Some challenges associated with needlestick injuries and availability of staff to complete risk assessments were identified • The Committee received a positive update from the Medical Examiner **The Trust Board received and noted the assurance report.**	
9.	**IPC Board Assurance Framework (BAF) – December 2021**	
009/2022	Mrs Riley highlighted the following: • The main changes related to the risk scores reflecting the ongoing actions being taken in relation to the CPE outbreak which had since been closed. It was noted that the most recent NHSIE visit was positive and the Trust had improved from red to amber with a further visit planned in March • It was noted that a new NHSIE template had been provided on the IPC BAF which would be reflected and reported in February Mr Wakefield referred to lessons learned regarding cleaning of beds and queried if any feedback had been provided after this had been raised nationally. Mrs Riley stated that the guidance was to continue as normal and the Trust continued to keep a pragmatic watch on cleaning of beds Professor Maddock referred to the staffing challenges and queried whether the availability of staff would impact on cleaning and the associated score. Mrs Riley stated that this was closely monitored and the score may increase, although the document reflected the position as at the end of December. Professor Hassell referred to mask usage for the prevention of spread of covid and queried the environments where staff were required to wear FFP3 or similar masks. Mrs Riley stated that this had been recently reviewed and enhanced PPE was required in areas with aerosol generating procedures and areas where covid patients were being nursed. In addition, if staff were concerned they had the ability to choose to wear enhanced PPE.	

	The Trust Board received and noted the report.	
ENSURE EFFICIENT USE OF RESOURCES		
10.	**Performance & Finance Committee Assurance Report (14-12-21)**	
010/2022	Mr Akid highlighted the following from the report: • Welcomed the updates provided by the Executive Groups • A positive update was provided on the EPMA system and change in scope. It was noted that due diligence had been undertaken and the Committee approved the change. **The Trust Board received and noted the assurance report.**	
ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT & RESEARCH		
11.	**Transformation and People Committee Assurance Report (15-12-21)**	
011/2022	Professor Crowe highlighted the following from the report: • Some concerns had been raised in respect of staff absences and associated risks and impact on other programmes, accepting that some areas would focus on other priorities • Work remained ongoing in respect of identifying the vaccination status of staff and the Trust was supporting staff in having those discussions • The Committee received a strategic discussion on workforce requirements and would continue to be appraised of how this is being taken forward **The Trust Board received and noted the assurance report.**	
ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS		
12.	**Integrated Performance Report – Month 8**	
012/2022	Mr Wakefield requested updates in relation to the way in which the Trust was managing Covid pressures, given the significant staff absences rather than focusing on November's performance. Mrs Riley highlighted the following: • Staffing was challenging and a staffing hub had been set up which was running daily. • A site safety dashboard had been put in place to enable the drill down of skill mix • Minimum staffing numbers had been determined for each area to deliver fundamental care • Risk assessments had been undertaken based on varying levels of staff absences, and all available resources were being considered in order to mitigate the risk • Given the risk of care being delayed, incidents continued to be monitored closely but there was no evidence of harm at present Mr Wakefield referred to the challenges associated within specialised areas given the skill mix required and difficulties in staff being deployed into those roles. Mrs Riley highlight that in terms of maternity staffing the position was relatively stable and activity was being managed well, but in terms of other specialist areas, risk	

assessments would be undertaken for staff to determine competencies and ensure that staff were not being moved into areas where they did not have the necessary skills or experience.

Dr Lewis raised a concern in terms of the expanding bed capacity with limited nursing and medical resources, and the need to ensure patients were being managed appropriately to ensure they were only admitted into hospital if it was of benefit to them and that they were being discharged once declared m,edically optimised.

Professor Hassell welcomed the setting of minimum staffing numbers for each area to provide fundamental care and queried the action which would be taken if this could not be achieved. Mrs Riley stated that the creation of the hub was crucial in reviewing data in real time in order to make rapid decisions. It was noted that all registrants had been written to, to outline the current position and set out expectations including speaking up if they felt staffing levels were unsafe, which had been well received.

Mr Akid referred to the staff absence figures and queried if vacancies/annual leave were included in the figures. Mrs Riley stated that the figures related to absences which was the main challenge, although recruitment to vacancies continued, including increasing the number of international nurses. Mrs Vaughan added that prioritisation of recruitment to certain posts was being undertaken.

Dr Griffin welcomed the actions taken and queried the position in theatres and critical care given previous challenges. He also queried how staff were being supported whilst being deployed to other areas. Mrs Riley stated that the pressures were not impacting on critical care as much as the previous waves but the position continued to be monitored. She stated that whole system had been impacted by staff absences, and added that there had been difficulties in getting patients discharged to where they need to be due to infection prevention issues. Mrs Riley agreed that staff would feel anxious about being moved to different areas, but they were supported in terms of ensuring they had the right skills for the role.

Ms Bowen referred to the colleagues who were consistently ‘holding the fort’ and whether they were being proactively reached out to, to ensure they were taking time off. Mrs Riley stated that Divisions held those conversations with staff as well as members of the Executive Team undertaking walkarounds to keep the lines of communication open.

Ms Gohir referred to maternity case outlined in the serious incident summary and queried whether the issue was related to staffing. She also welcomed the inclusion of ethnicity breakdown within the report. Mrs Riley explained that the investigation remained ongoing, but clarified that the issue was not due to staffing.

Mr Wakefield summarised that whilst there had been delays to care, the Trust had not determined any harm although it was vital for the Board to be appraised of any changes to this position. He also reflected on the risk posed by Dr Lewis in relation to bed expansion, given the current staffing challenges.

Mr Bytheway highlighted the following:

- A plan was in place for expansion and risk assessments were being undertaken. The main challenge was staffing the areas given the current levels of absence and continued challenges in the system

- A green ward had been stood down over Christmas to deal with the challenges. This area was utilised given that it was already staffed
- Main challenges related to the redeployment of staff when there were Covid outbreaks and the need for staff to work differently
- A critical incident had not yet been declared, although this was expected within the next week or so, at which point other services such as planne diagnostics would have to be stood down
- A workforce bureau had been established, to coordinate staffing and provide oversight, in order to manage the risks by using staff differently
- It was the aim to continue with cancer and clinically urgent work as well as maintaining operating at County theatres for as long as possible
- Divisional and specialty plans continued to be worked through, to ensure wards were covered and engagement with junior medical workforce had continued, given the likelihood that some would need to be redeployed

Mr Wakefield referred to his recent visit to A&E whereby they discussed the staffing challenges and he queried how close the Trust was to calling a critical incident given the absence levels in urgent care. Mr Bytheway stated that urgent care staffing at Royal Stoke was no worse than normal but staffing at County had been compromised; extra beds had been opened at County Hospital and it was noted that more community beds were being opened in the area, in order to reduce the growing number of Medically Fit for Discharge Patients (MFFD).

Dr Griffin welcomed continued operating of theatres at County Hospital and queried if it was possible to be provided with a snapshot of current performance for cancer, diagnostics and long waiters. Mr Bytheway stated that for December the un-validated position was that performance was better than November.

Professor Crowe sought assurance that new ways of working were being implemented based on previous waves, and referred to the use of virtual wards. He queried whether there were other ways the Trust could innovate and generate new ways of working. Mr Bytheway referred to the primary care team at County Hospital which were trying to pull patients into the virtual ward to relieve pressure, and referred to the continuation of outpatient digital reviews. He stated that diagnostics continued to be carried out and the transformational work undertaken as part of the previous waves had become business as usual.

Ms Bowen referred to the modelling data used for the winter plan and the different scenarios and queried if performance was base lining or was outside of the worst case scenario. Mr Bytheway stated that it was outside of the worst case scenario, due to the number of MFFD patients being significantly higher than planned, although attendances were similar to plan. He stated that it was expected that there would be more Covid cases than initial predictions with a peak of 164 being predicted for the middle of January, although numbers had already reached 135 so it was likely that these would increase above the prediction.

Ms Bowen referred to the associated risks with being worse than the worst case scenario and Mr Bytheway stated that the main risks related to the delay in providing care although work was ongoing to ensure clinical staff had the time to provide the fundamentals of clinical care.

Mr Wakefield queried whether the Trust's performance mirrored the national position and Mr Bytheway stated that the Trust was no different to other hospitals. He stated he was optimistic that an appropriate structure was in place to manage the challenges, but this did not negate current performance, delivery of care and

associated risks.

Mrs Bullock stated that NHS Providers were looking at any differences between Trusts, and it was becoming apparent that smaller independent hospitals and rural hospitals were tending to struggle the most.

Mr Wakefield summarised that as covid rates increased, the Trust needed to be clear with staff and patients on what activity and care was possible to deliver.

Ms Bowen referred to communications with patients in terms of highlighting the reasons for the delays and Mr Bytheway stated that staff had received training and advice how to discuss delays with patients and stated that cancer / clinically urgent patients received specific communication. He stated that it was more difficult for those patients on a P3 and P4 pathway as their non urgent nature meant they had already been waiting a long time and there was no ability to provide confirmed dates for future treatment.

Mrs Vaughan highlighted the following in relation managing sickness absence:

- Covid related absence stood at 56% of general absences and these absences continued to be managed
- Escalations for staff testing were in place to ensure PCR tests were undertaken in a timely way enabling appropriate support and intervention to be provided
- National guidance continued to be changed in relation to lateral flow tests, PCR results, and isolation requirements and staff continued to be kept up to date of the changes
- Staff in corporate functions were being identified for redeployment to support clinical areas

Mr Wakefield referred to children returning to school which could impact on the absence position, and queried whether the Trust was forecasting an increase. Mrs Vaughan stated that this was to be expected and therefore the position would continue to be monitored and actions taken to respond to specific challenges.

Professor Crowe queried whether systems were in place to identify any 'hot spots' so that these could be escalated and Mrs Vaughan stated that the Allocate and Empactis systems enabled the opportunity to identify potential red flags, along with our dashboard for nursing staff.

Professor Crowe queried whether actions continued to be taken to support staff and their wellbeing, in terms of basic support packages and Mrs Vaughan stated that this work continued, with engagement with Divisions to ensure timely interventions were provided.

Mr Oldham highlighted the following in relation to financial performance:

- Financial position remained strong with a plan in place for the second half of year to achieve a surplus of £5.1m
- Forecast for month 9 reviewed and anticipating a positive position
- Covid spending had reduced in month and capital was £2.3 m behind plan due to some slippages in schemes, partly due to some issues with the supply chain

Mr Wakefield summarised that the financial position was healthy due to the inability to spend the funds, as the main issue of the operational backlog related to staff absence and availability rather than funding.

	Dr Griffin referred to rising energy costs and queried if there was a potential impact on the Trust. Mr Oldham stated that this had not yet been explored. Ms Bowen referred to the 3 month delay associated with the ICS and queried the impact on the Trust. Mr Oldham stated that guidance had been received but the allocations had not been provided, and added that the main impact would be on the CCGs. **The Trust Board received and noted the performance report.**	
CLOSING MATTERS		
13.	**Review of Meeting Effectiveness and Business Cycle Forward Look**	
013/2022	No further comments were raised.	
14.	**Questions from the Public**	
014/2022	No questions had been received.	
DATE AND TIME OF NEXT MEETING		
15.	Wednesday 9th February 2022, 9.30 am, via MS Teams	

Trust Board (Open)

Post meeting action log as at **02 February 2022**

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

Ref	Meeting Date	Agenda Item	Action	Assigned to	Due Date	Done Date	Progress Report	RAG Status
PTB/488	06/10/2021	Patient Story	To take an update to QGC on the actions taken as a result of the patient story regarding sickle cell.	Ann Marie Riley	27/01/2022	27/01/2022	Complete - update provided to January's QGC meeting.	B
PTB/490	03/11/2021	Research Strategy	To provide a session on the Research Strategy at a future Board Seminar	Matthew Lewis Kam Karunanithi	12/01/2022	11/01/2022	Originally scheduled for January Board Seminar but cancelled due to pressures. To be rescheduled in the seminar programme.	B
PTB/495	03/11/2021	BAF - Q2	To discuss the approach to revising the BAF with Mr Wakefield	Claire Rylands	05/01/2022	11/01/2022	Update provided via email to Mr Wakefield regarding the format of the new BAF.	B
PTB/496	03/11/2021	Workforce Disability Equality Standard Report	To prioritise the actions identified in terms of possible impact	Ro Vaughan	05/01/2022	05/01/2022	Update provided to January's meeting. Discussed with the staff network and action plan being reviewed and prioritised.	B
PTB/497	07/12/2021	Quality Governance Committee Assurance Report (25-11-21)	To take an update to QGC in relation to maternity outcomes and ethnicity.	Ann Marie Riley	27/01/2022	27/01/2022	Complete - report provided to QGC included information on ethnicity.	B
PTB/498	07/12/2021	IPC Board Assurance Framework – November 2021	To obtain the information in relation to timescales and impact of the sink replacement programme	Ann Marie Riley	09/02/2022		**Update to be provided**	GB
PTB/499	07/12/2021	H2 Plan	To further discuss the change in the underlying deficit at PAF.	Mark Oldham	25/01/2022	25/01/2022	Discussion held at PAF.	B
PTB/500	07/12/2021	Integrated Performance Report - Month 7	To take an update to the Quality Governance Committee on the reasons for the increase in pressure ulcers and lapses in care, lessons learned and actions being taken	Ann Marie Riley	25/01/2022	25/01/2022	Verbal update provided to January's meeting and further assurance to be provided to a future meeting in respect of pressure ulcer reporting and in particular deep tissue incidents.	B
PTB/501	07/12/2021	Integrated Performance Report - Month 7	To confirm the timescales expected to be adhered to in terms of training new staff in sepsis awareness	Ann Marie Riley	05/01/2022	05/01/2022	Update provided to January's meeting. Timescale initially aimed at January but given pressures had been moved to February and it was agreed that this would be considered further by QGC.	B
PTB/502	07/12/2021	Integrated Performance Report - Month 7	To take an update to the QGC in terms of covid / nosocomial death reviews	Matthew Lewis	24/03/2022		Action not yet due.	GB
PTB/503	07/12/2021	Integrated Performance Report - Month 7	To confirm the timescale associated with the planned care national pilot	Helen Ashley	09/02/2022		**Update to be provided**	GB
PTB/504	07/12/2021	Integrated Performance Report - Month 7	To provide benchmarking information in relation to vacancy rates.	Ro Vaughan	09/02/2022		**Update to be provided**	GB
PTB/505	07/12/2021	Integrated Performance Report - Month 7	To obtain an update in relation to the timescales associated with completion of the Digital Pathology programme.	Helen Ashley	09/02/2022		**Update to be provided**	GB
PTB/506	07/12/2021	Raising Concerns Report – Quarter 2	To obtain further information in relation to learning associated with the case referring to storage of confidential records.	Ro Vaughan	09/02/2022		**Update to be provided**	GB
PTB/507	05/01/2022	Patient Story	To work with Mr Frary on ways to improve communication with transgender patients, taking forward conversations with clinical teams. To provide an update to QGC on this.	Ann Marie Riley Matthew Lewis	28/02/2022		Action not yet due.	GB

University Hospitals of North Midlands NHS Trust

Chief Executive's Report to the Trust Board

FOR INFORMATION

Part 1: Trust Executive Committee

The Trust Executive Committee met on 2nd February 2022. The meeting was held virtually using Microsoft Teams and members received an update from the CCG on the Clinical and Professional Leadership Framework, an update in respect of County Hospital as well as an opportunity for Divisions to escalate any urgent issues.

- The Committee were advised that the Trust had commissioned a strategic review of the estate at County Hospital to ensure any future work and developments at the site were in line with the clinical services strategy. It was noted that further update would be provided to the Committee in March 2022.
- Dr Rachel Gallyot, CCG Chair presented the Clinical and Professional Leadership Framework for the ICS noting the vision and purpose of ICS was to empower clinical and professional leaders to deliver high-quality care to all. The five principles of the framework were outlined in addition to the expectations and the proposed model. The Committee noted that the aim of the framework looked to identify multi-professional strategic leads which was welcomed and the importance of all partners engaging and contributing to this going forwards was noted.
- The Surgical Division explained that the Division were continuing to deliver over 80% of planned sessions but continued to experience challenges with green capacity and streaming of patients through theatres.
- The Medical Division highlighted the continued high numbers of Medically Fit for Discharge (MFFD) patients impacting on the medicine bed base and noted that there had been little change in ambulance attendances although activity was not significantly increasing.
- The Specialised Division highlighted the their successes and challenges in recovering the elective surgery backlog. Elective orthopaedic work at County Hospital had returned and capacity was continuing to increase which was positive. Critical care recovery had improved and the Committee welcomed the recent work whereby the Trust supported UHB with their neurosurgical cases.
- The Children's, Women's and Diagnostics Division highlighted their main risk in relation to histopathology, due to staffing shortages and increase in complexity, which was causing some backlogs and the Committee noted the recruitment plans in place to address the workforce gaps within the Division and were pleased to note the appointment of two Histopathologists.
- The Committee noted that the Trust had been successful in its bid in relation to an Imaging Academy Hub which was being progressed, and the Committee noted the progress in providing a new pharmacy in the atrium and provision of 4 new linacs
- The Medical Director noted the additional scrutiny for locum doctors for pay beyond escalated rates with the aim of re-setting locum pay rates at a more appropriate level.
- The Committee noted that the planning application had been submitted for Project STAR
- The Trust continued to focus on reducing the number of long wait patients in particular those over 104 weeks and the Committee welcomed the provision of a system wide performance dashboard
- An update was provided on VCOD whereby the Trust was awaiting information on the next steps following the recent decision from the Government
- The Communications Team were continuing with the Trust's targeted recruitment campaign with the aim of increasing the number of applicants for various roles within the Trust
- Divisions were to be issued with communications in respect of the planning process for 2022/23 and the Committee noted the previous challenges of submitting bids for national monies at short notice, with a process being put in place to ensure that comprehensive bids were prepared and submitted going forwards
- The Committee noted the agreement of the system to utilise some surplus monies as part of the Better Care Fund which would help with services which support care out of hospital and support discharges
- The Committee noted the ongoing recruitment to the Shadow ICS whereby an interim Chief Executive had been appointed and adverts were live for a number of Executive positions

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 10th December to 12th January, 8 contract awards, which met this criteria, were made, as follows:

- **Anaesthetic Medical Records** supplied by GE Healthcare at a total cost of £657,345.00, providing savings of £370,000.00, approved on 07/12/21
- **Installation of 2nd VIE plant and medical gas infrastructure works IHP** supplied by IHP Vinci Construction at a total cost of £1,042,992.41, approved on 11/01/22
- **Staff Shuttle Bus Service** supplied by ABC Supreme at a total cost of £1,066,927.00, providing savings of £8,891.00, for the period 01/02/22 – 31/01/24, approved on 11/01/22
- **Link Bus Service** supplied by ABC Supreme at a total cost of £1,071,628.00, providing savings of £8,930.00, for the period 01/02/22 – 31/01/24, approved on 11/01/22
- **Extension - Pacemakers Devices and Loop Recorders** supplied by various at a total cost of £1,093,157.68, providing savings of £7,287.00, for the period 01/12/21 - 30/06/22, approved on 10/12/21
- **Clinical Key Resource Library** supplied by Elsevier at a total cost of £523,003.20, providing savings of £4,358.00, for the period 01/01/22 - 31/12/26, approved on 15/12/21
- **Project STAR – Extension** supplied by IHP Vinci Construction at a total cost of £1,152,080.60, approved on 10/12/21
- **Maintenance of Endoscopes** supplied by SCCL at a total cost of £3,214,593.00, providing savings of £561.00, for the period 01/07/21 - 30/06/26, approved on 10/12/21

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

Home Delivery of Darbepoetin (eREAF 8535)

Contract Value £1,173,208.00 incl. VAT
Duration 01/12/21 - 30/11/22
Supplier Fresenius Medical Care Ltd

No savings - This is a UHNM pass through cost therefore there are no associated savings.

Blood Sciences Siemens Managed Service Contract (MES) - Year 10 (eREAF 8590)

Contract Value £5,146,184.50 incl. VAT
Duration 01/10/21 - 30/09/22
Supplier Siemens Healthineers UK

Savings – No savings, however, on-going VAT reclaim on any 3rd party handling fees which equates to £720,465.83 which is based on a VAT rate of 20% minus the 6% management fee.

Cath Lab Interventional Cardiology Consumables (eREAF 8602)

Contract Value £4,165,056.96 incl. VAT
Duration 01/03/22 - 28/02/24 (with an option to extend for 12 months)
Supplier Various

Savings - £947,000 Incl VAT Cost Avoidance and Negated Inflation savings of £3470.88

M2 Managed Print Solution Service (eREAF 8662)

Contract Value £1,444,036.90 incl. VAT
Duration 01/03/22 - 28/05/25
Supplier SCC

Savings - £802.24 Incl VAT Negated Inflation saving. In addition to this as the contract is a Managed Service (MES), the costs of the VAT can be reclaimed which would equate to £240,672 in reclaimed VAT (20%) costs over the contract duration.

Pharmacy Outsourced Dispensing Service (eREAF 8687)

Contract Value £2,785,893.00 incl. VAT
Duration 01/04/22 - 31/03/25
Supplier Lloyds Pharmacy

Savings - No immediate savings, however, pharmacy savings will be continually monitored throughout the contract term and any savings identified will be recorded accordingly.

Pharmacy Outsourced Dispensing Service - Drug costs (eREAF 8688)

Contract Value £42,000,000.00 incl. VAT
Duration 01/04/22 - 31/03/25
Supplier Lloyds Pharmacy

Savings - No immediate savings, however, pharmacy drugs savings will be continually monitored throughout the contract term and any savings identified will be recorded accordingly.

The Trust Board are asked to approve the above eREAFs.

2. Consultant Appointments

The following table provides a summary of medical staff interviews which have taken place during January 2022:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Clinical Lead for Haematology	Vacancy	Yes	06/01/2022
Clinical Lead for Haematology	Vacancy	Yes	06/01/2022
Locum Consultant Orthopaedic Surgeon	Vacancy	Yes	17/02/2022
Clinical Lead for Acute Oncology	Vacancy	Yes	13/01/2022
Consultant Histopathologist	Vacancy	Yes	TBC
Consultant Microbiologist	Vacancy	No	n/a
Locum Consultant Orthopaedic Surgeon - Fragility Fractures	Vacancy	Yes	02/02/2022
Specialist Grade - Breast Radiology	Vacancy	Yes	14/02/2022
Consultant Histopathologist	Vacancy	Yes	28/02/2022
Locum Consultant Neonatologist	Vacancy	Yes	30/05/2022
Consultant Hepatologist	Vacancy	Yes	12/09/2022

The following table provides a summary of medical staff who have joined the Trust during January 2022:

Post Title	Reason for advertising	Start Date
Locum Consultant Radiologist - Body Radiology	Vacancy	04/01/2022
Locum Consultant Clinical Oncologist - Urology & Gynaecology	Vacancy	31/01/2022
Consultant Chemical Pathologist	Vacancy	31/01/2022
Consultant Neurologist	Extension	04/01/2022
Senior Medical Practitioner Cardiology	Vacancy	01/01/2022

Post Title	Reason for advertising	Start Date
Specialist Doctor in Clinical Haematology	Vacancy	01/01/2022
Specialist Doctor in Clinical Haematology	Vacancy	01/01/2022
Locum Consultant Urology	New	01/01/2022
Clinical Lead for Simulation	Extension	01/01/2022
Locum Consultant obstetrician and Gynaecologist	Vacancy	01/01/2022
Consultant Trauma Anaesthetist	Vacancy	04/01/2022
Consultant Haematologist	Vacancy	05/01/2022
Clinical Lead for Haematology	Vacancy	06/01/2022
Clinical Lead for Haematology	Extension	06/01/2022
Locum Consultant Plastic Surgeon	Vacancy	10/01/2022
Locum Consultant Spinal Surgeon	Vacancy	17/01/2022
Locum Consultant Cardiac Surgeon	Vacancy	17/01/2022
Consultant Histopathologist	Retire & Return	17/01/2022
Locum Consultant Orthopaedic Surgeon	Vacancy	17/01/2022
Clinical Lead for Acute Oncology	Vacancy	13/01/2022
Locum Consultant Spinal Surgeon	Vacancy	18/01/2022
Doctor Bank	COVID	22/01/2022
Consultant Haematologist	Vacancy	24/01/2022
Medical Examiner	New	24/01/2022
Medical Examiner	New	24/01/2022
Medical Examiner	New	24/01/2022
Medical Examiner	New	24/01/2022

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

Post Title	Closing Date	Note
Glaucoma Consultant Ophthalmology	03/01/2022	No suitable applicants
Locum Consultant Radiologist - Body Radiology	05/12/2021	Applicant withdrew
Child Health Clinical Lead for PICU	29/12/2022	Candidate not appointed
Consultant Intensivist	16/01/2022	No suitable applicants
Consultant Haematologist	17/01/2022	No applications
Medical Examiner	17/11/2021	Candidate withdrew
Locum Glaucoma Consultant Ophthalmology	03/01/2022	No suitable applicants
Respiratory Consultant	16/01/2022	No suitable applicants

3. Covid 19 and Trust Pressures

The pressure on our services is continuing and as such, on the 7th January the Trust declared a critical incident for a period of three weeks with a weekly review. The incident was formally stood down on the 24th January after just over two weeks. The Trust felt able to review its position early due to improved absence position and the number of patients with Omicron was no longer rising, this position has now plateaued with numbers slowly dropping and the number of patients in critical care has reduced, and the number of patients medically optimised for discharge continues to slowly reduce. Although the Trust is still very busy and challenged, this is as result of typical January winter pressures and not as a result of Covid-19. As such, some staff remained on deployment until the end of January and we continue to receive support from the Military.

Over the course on February and March we will start to build up the amount of elective and planned work that the Trust is doing, with the aim of getting to 80-90% of pre covid levels of operating by the end of March. We recognise that many patients have been waiting too long for their elective and planned work and we continue to work with our divisions to improve this position as quickly as possible, whilst recognising the backlog will take significant time to clear.

In respect of Vaccination as a Condition of Deployment (VCOD) the Trust conducted extensive work to understand the impact on staff working at UHNM and to implement legislation effective from 1 April 2022. However, on 31st January 2022 the Government announced its decision not to continue with the mandatory vaccination programme, although this decision is subject to Parliamentary process and will require further consultation and a vote to be passed into legislation.

Whilst this has been a significant workload over the course of the last few weeks it has also allowed us to get a more comprehensive picture of the level of Covid-19 vaccination at UHNM. Although we have always known our vaccination levels to be high, until now we did not have a complete picture.

We are waiting for further guidance nationally in respect of next steps.

4. NHSEI Visit to Royal Stoke by the National Clinical Advisor in EPRR

Following our declaration of internal critical incident, we were visited on 11th January 2022 by a team from national NHS England, led by Professor Kevin Fong the National Clinical Advisor in EPRR for NHS England. The team visited Royal Stoke to find out more about the pressures being faced by the Trust whilst also speaking to a number of frontline staff and operational teams. The team gave some very positive feedback about how we were managing the extremely difficult challenges they observed and heard about, and in a follow-up email Professor Fong recognised that, despite our "maximal efforts and agility in dynamic risk assessment and mitigation, the pressures are unsustainable". He said he was inspired with the strength and depth of quality in our workforce, saying “my last visit focussed on the ICU team who have been exemplary but on this visit I was equally impressed with the AMU team and their efforts to innovate and adapt amidst the pressure of the current surge."

5. Section 31 Reporting

In January the Trust was informed by the Deputy Chief Inspector of the CQC that future updates to the CQC in respect of our Section 31 notice would be provided on a monthly basis, instead of weekly) for a period of 3 months.

6. UHNM and Keele University to become an Imaging Academy Hub

In December 2021, the Trust submitted an Expression of Interest (EOI) for UHNM to be a ‘Hub’ in the ‘Hub and Spoke’ Model of the Midlands Imaging Academy. UHNM submitted a collaborative EOI in partnership with Keele University, and the aim that the Hub would operate from both organisations and sites working together to provide the training provision needed. This application was subsequently confirmed as successful in January 2022.

Imaging Training Academies seek to improve the training and development of a sustainable, multidisciplinary diagnostic workforce capable of responding to the demands placed on services and the development of Training Academies is part of Health Education England’s (HEE) wider cancer and diagnostics workforce programme.

The main aims of the Imaging Training Academy are to:

- Increase imaging training capacity across the region
- Provide multi-professional imaging training across the region
- Provide flexible and high quality training environments for clinical radiology, diagnostic radiography and sonography, and imaging support staff. In addition to this it is the intention of HEE Midlands to extend the remit of the Imaging Training Academy to include mammography and medical physics/nuclear medicine.
- Enable immersive training in priority areas to support the rapid development of skills to support and expedite learning trajectory
- Make best use of available teaching faculty
- Ultimately the aim is to increase the numbers of learners and thereby increase the numbers of imaging staff able to enter the workforce

7. Professional Nurse Advocates

The Professional Nurse Advocate (PNA) programme was launched in March 2021 and provides those on the programme with skills to facilitate restorative supervision to their colleagues and teams, in nursing and beyond. The training equips them to listen and to understand challenges and demands of fellow colleagues, and to lead support and deliver quality improvement initiatives in response.

In December, 9 staff successfully completed the PNA programme which means the Trust now has 10 such roles. A further 21 have commenced the programme with a 5 due to start before March.

8. International Nurse Recruitment

I am pleased to report that all of our 91 international nurses have now arrived in the Trust and 80 have now achieved NMC status. We are looking to recruit a further 130 international nurses this year, and are also working with NSHE to support some refugee nurses. In addition, 14 of our nursing assistants who are registered nurses in their own country have also gained registration with the NMC.

9. NHS Midlands' Charter

The Covid-19 pandemic meant some trainees had difficulty accessing their usual medical education and training and were unable to acquire new competencies and maintain existing ones. The Midlands' Charter, first published at the end of 2020, outlined the commitment to prioritise the restoration of postgraduate medical education and training impacted during the Covid-19 pandemic and recognised the determination of providers to restore and reset education and training and to establish the Midlands region as a beacon for postgraduate education. As previously reported to Board, the Midlands Charter won the BMJ's Workforce and Wellbeing Team of 2021.

I am pleased to now report that the Midlands' Charter has recently been updated (January 2022) to showcase the brilliant work that has happened since the last publication over a year ago and is a testament to all involved in the Charter that powerful change has happened to improve the lives of medical trainees. It was great to see UHNM as one of the showcase Trusts for trainee engagement and adopting a co-creative approach to planning service delivery over the pandemic.

Over the next six months the Midlands' Charter team will be looking at how it can further update the Charter to be fit for the post-Covid world, to further embed these principles into the region as part of our ambition to be a beacon of excellence in post-graduate medical education.

10. LGBT+ History Month

February marks LGBT+ history month and throughout the month the Trust will be promoting LGBT+ inclusivity, through a serious of educational and celebratory resources. A calendar has been developed to help support members of the LGBT+ community which includes a mix of past and present webinars as well as reflection exercises, research and information. The calendar also provides links to resources supporting health and well-being, which has been especially relevant during the last two years.

Committee Chair's Highlight Report to Board

Quality Governance Committee
27th January 2022

NHS
University Hospitals of North Midlands
NHS Trust

1. Highlight Report

!	Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
•	Following a deep dive into medicines safety, the Committee noted that the reporting rate of medication incidents remained below the national average of 6 per 1000 bed days, with the Trust rate being 4 per 1000 bed days. The Committee considered the further work which was being undertaken to report on themes and trends in relation to medication incident reporting as well as understanding any blocks to reporting.	• To receive an updated Infection Prevention BAF at the next meeting, reflecting the changes to the national template • It was agreed to refer the response to the Medical Examiner's Correspondence to the Executive Team as well as obtaining advice from the legal team • To receive a further update on readmissions for the areas of focus at a future meeting • To include quarterly updates on the Staffing Assurance Report within the business cycle • To provide further assurance in respect of pressure ulcer reporting in terms of deep tissue incidents • To receive the updated CQC Action Plan at a future meeting • RIDDOR report to be updated
•	The Committee noted the Quality Impact Assessments which had been undertaken in response to opening additional clinical areas for surge capacity, although noting not all areas had been utilised. The Committee raised concern with regards to the continuing pressures and impact on staff wellbeing, and the actions being taken to support staff wellbeing were noted.	
•	Month 9 quality performance remained generally consistent with previous months, although the number of new harms had deteriorated in relation to pressure ulcers and falls. It was noted that 2 never events had been reported in December and the detail was provided to the Committee. The Committee suggested that analysis of patient incidents be undertaken in future reports to determine any which were likely due to staffing	
✓	**Positive Assurances to Provide**	**Decisions Made**
•	An update was provided in terms of Covid and operational pressures, whereby the critical incident had been stood down and the impact from the fourth wave had not impacted upon critical care as per previous waves	
•	In relation to infection prevention, the increase in the number of c-difficile cases in the previous quarter was raised, although it was noted this had since reduced, all cases had been subject to a Root Cause Analysis and there had been no instances of 2 or more cases having the same type	
•	The initial analysis into readmissions during August 2020 and July 2021 was provided which identified a number of areas for future focus including neonatal disorders, musculoskeletal and rheumatological disorders, paediatric medicine and paediatric renal procedures and disorders	
•	The Committee welcomed the update in relation to nursing and midwifery staffing and the expected refinements of future reports, focussing on areas with less an 80% staffing. The Committee were reassured of the actions taken in those areas such as reviewing any flags of potential harm and completion of quality reviews.	
•	The Winter Preparedness Staffing Assurance Report was received and welcomed, which set out expectations in terms of safe staffing. The self-assessment was noted and it was agreed to consider on a quarterly basis.	• The Committee agreed to proceed to response to the Medical Examiner, subject to confirmation from the Executive and Legal Teams • The Committee approved the Q3 Board Assurance Framework
•	A verbal update was provided in relation to the increase in pressure ulcers and lapses in care and the deep dive which had been undertaken and demonstrated that the increase was due to improved reporting. It was noted that overall, cases of moderate harm and above had reduced.	
•	The Committee received an update of the actions taken as a result of the patient story provided to a previous Board meeting in relation to sickle cell. It was confirmed that the care plan for the patient had been addressed in addition to taking forward broader learning in relation to timely medication. It was noted that the new treatment for sickle cell was being explored and once available the Trust hoped to be able to offer this to suitable patients.	
•	The Committee received the final CQC inspection report and noted that the evidence requested in relation to the section 29a notice had been provided at the end of November and a response was awaited.	
•	The Committee welcomed the revisions made to the Q3 BAF and the inclusion of the Assurance Map	
•	The Committee noted the 3 month pause in national reporting of the maternity incentive scheme	
•	It was noted that the FMBU continued to be closed until April due to ongoing pressures	

Comments on the Effectiveness of the Meeting

- The Committee welcomed the approach to take papers as read enabling adequate discussion and questioning from members.

2. Summary Agenda

No.	Agenda Item	BAF Mapping		Purpose	No.	Agenda Item	BAF Mapping		Purpose
		BAF No.	Risk				BAF No.	Risk	
1.	Infection Prevention HAI Report Q3 2021/22	1		Assurance	9.	Update on the Sickle Cell Patient Story (Board Action PTB/488)			Assurance
2.	Infection Prevention Board Assurance Framework	1		Assurance	10.	CQC Inspection Report	1, 2, 3		Assurance
3.	Deep Dive Focus on Medicines Safety – UHNM Overview and Current Position			Assurance	11.	Board Assurance Framework Q3 2021/22	All		Approval
4.	Medical Examiner's Office Correspondence			Approval	12.	Executive Health & Safety Group Assurance Report (Jan-22)			Assurance
5.	HED Readmissions Analysis			Assurance	13.	Quality & Safety Oversight Group Assurance Report (Jan-22)	1		Assurance
6.	Nursing and Midwifery Staffing and Quality Report / Risk and Quality Impact Assessments	1, 3		Assurance	14.	Maternity Incentive Scheme – Pause in Reporting			Information
7.	Update on Pressure Ulcers and Lessons Learned (Board Action PTB/500)	1		Assurance	15.	Freestanding Midwifery Birth Unit Update		13420, 11518, 13419	Information
8.	M9 Quality & Safety Report	1		Assurance					

3. 2021 / 22 Attendance Matrix

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

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

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	9th February 2022
Report Title:	Infection Prevention Board Assurance Framework	**Agenda Item:**	8.
Author:	Helen Bucior, Infection Prevention Lead Nurse Emyr Philips , Associate Chief Nurse Infection Prevention/Deputy DIPC		
Executive Lead:	Mrs Ann-Marie Riley, Chief Nurse/DIPC		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Executive Summary:

Situation

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

Background

Understanding of COVID-19 has developed and is still evolving. Public Health England and related guidance on required Infection Prevention measures has been published, updated and refined to reflect the learning. This continuous self- assessment process will ensure organisations can respond in an evidence based way to maintain the safety and patients, services users and staff. Each criteria had been risk scored and target risk level identified with date for completed. Although work is in progress, the self-assessment sets out what actions, processes and monitoring the Trust already has in place for COVID-19.

Assessment/Risks

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

Progress

- New updates are highlighted in yellow (reflecting the NHS Board assurance framework version 1.8). In addition completed actions have been moved to the relevant control / assurance field rather than being listed separately.
- Following the NHSEi visit on 10th December the Trust moved back to AMBER. Internal risk rating for both criteria 1 and 2 reduced to reflect this
- External company continues to assist with mask fit testing
- Wards are currently receiving reminder calls to prompt COVID screening
- Cleaning Collaborative work stream (multi-disciplinary representation) established and using Improving Together tools and methodologies to work through the actions needed to respond to the cleaning issues in West Building highlighted during the CPE Outbreak
- West Building estates non complaint hand wash sinks replacement work is in progress

Key Recommendations:

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

NHS
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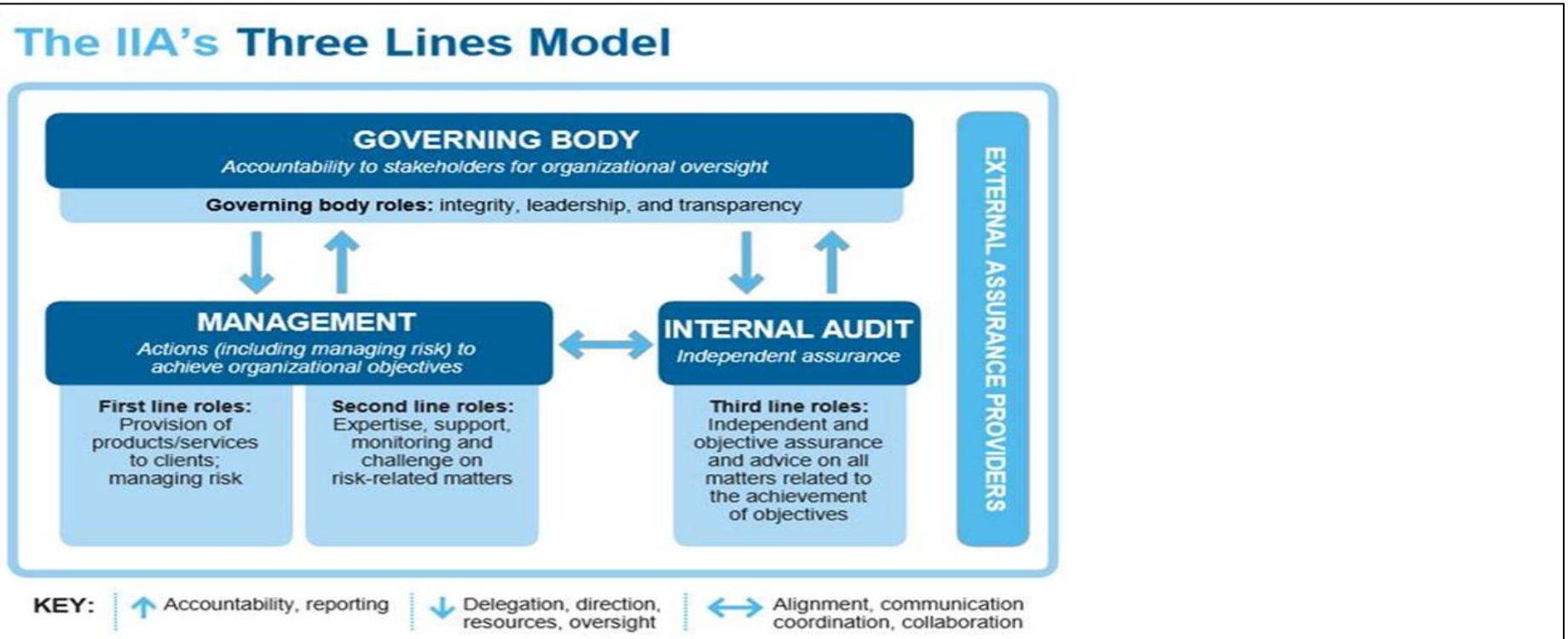
NHS Trust

Infection Prevention and Control Board Assurance Framework

January 2022

Summary Board Assurance Framework

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



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

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

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

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

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

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

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

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

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

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	Linked Key Infection Prevention points – COVID 19 vaccination sites Monitoring of IP practices, ensuring resources are in place to enable compliance with IP practice of staff adherence to hand hygiene? • Staff adherence to hand hygiene • Patients, visitors and staff are able to maintain 2 metre social and physical distancing in all patient care areas, unless staff are providing clinical/personal care and wearing appropriate PPE • Staff social distancing across the workplace • Staff adherence to wearing of fluid resistant surgical face masks a) clinical b) non clinical setting Monitoring of staff compliance with wearing appropriate PPE, within the clinical setting The role of PPE guardians/safety champions to embed and encourage best practice has been considered There are visual reminders displayed communicating the importance of wearing face	• Aerosol generating procedures (AGP's) which require high level PPE agreed at clinical and tactical group • COVID -19 Clinical Group reviews any proposed changes in PPE from the clinical areas • Link to Public Health England donning and doffing posters and videos available on Trust intranet • Chief Nurse PPE video • Extended opening hours supplies Department • Risk assessment for work process or task analysis completed by Health and Safety • 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	have submitted PPE donning an doffing records to the IP team • Donning and Doffing training also held locally in clinical areas • Cascade training records held locally by Divisions • Sodexo and Domestic service training records • IP unannounced assurance visits • Review of UHNM vaccination areas against key infection prevention points COVID -19 • Hand hygiene audits • FFP3 testing records can be added as a skill to Health roster.	

Control and Assurance Framework

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	• based on the measures as prioritised in the hierarchy of controls including evaluation of the ventilation in the area, operational capacity, and prevalence of the infection/new variant of concern in the local areas • Applied in order and include elimination , substitution , engineering , administration and PPE/RP • Communicated to staff Safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems.	• The Trust has a list of available models of FFP3 masks to use. A number of staff are trained on 2 types of masks but this work is on-going as the priority it to ensure all staff who require FFP3 are tested on a suitable model first then tested on an alternative model	• Local FFP3 records held by the division • Health roster FFP3 records	
1.5	National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way.	• Notifications from NHS to Chief nurse/CEO • IP team COVID lead checks Public Health England webpage daily (Monday-Friday) for updates • Changes raised at -19 clinical groups which was held originally twice weekly, reduced to weekly and now increased back to twice weekly due to surge of COVID. • Purpose of the Clinical Group - The Group receive clinical guidance and society guidance which is reviewed and if agreed used to advise clinical teams after approval at Exec COVID -19 meeting which	• 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
		is held twice monthly. • The clinical group initially weekly , now stepped down to Bi weekly • Tactical group – The tactical Group held daily. April 2021 now stepped down. The Group decide and agreed tactical actions Makes recommendations to Gold command • Chief nurse updates • Changes/update to staff are included in weekly Facebook live sessions • COVID -19 intranet page • COVID -19 daily bulletin with updates • IP provide daily support calls to the clinical areas		
1.6	Changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted.	• Incidence Control Centre (ICC) Governance • Clinical Group, Divisional cells, Workforce Bureau, Recovery cells subgroup feed in to tactical group. • COVID Gold command , decisions /Assurance reported to Trust Board Via CEO Report/COO	• Meeting Action log held by emergency planning • Trust Executive Group Gold command – Overall decision making and escalation • Tactical, Operational Delivery Group - The delivery of the objectives and benefits, and programme communications COVID 19 response and R&R. Co - ordination of resources. Escalation forum for linked Groups and Cells ensuring that the interdependencies	

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 effectively managed, including system. Makes recommendations to Gold Command for key decisions. • Clinical steering Group – Coordinate clinical decision – making to underpin continual service delivery and COVID 19 related care • Workforce Group – Lead the plan and priorities for our people recovery. Health and Wellbeing. Agree significant pipeline changes in working practices. Agree the impact if change made during COVID and priorities to support recovery • Divisional Groups – Agree infection Prevention measures  COVID19RRGOVERNANCE NOV20v1.pptx	
1.7	Risks are reflected in risk registers and the Board Assurance Framework where appropriate. • Linked NHSIE Key Action 5: Daily data submissions have been signed off by the Chief Executive, the Medical Director or the	• 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	• 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	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	Chief Nurse and the Board Assurance Framework is reviewed and evidence of reviews is available. • Trust Board has oversight of on going outbreaks and actions plans • The Trust Chief Executive, the Medical Director or the Chief Nurse has oversight of daily sitrep.in relation to COVID-19, other seasonal respiratory infections, and hospital onset cases • Linked NHSIE Key Action 9: Local Systems must assure themselves, with commissioners that a Trust's infection prevention and control interventions are optimal, the Board Assurance Framework is complete and agreed action plans are being delivered. • There are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas	• Outbreak areas are included in daily tactical meeting • Outbreak areas included in Gold update slides • Outbreak meetings attended by CCG and PHE • Definite Nosocomial COVID 19 case numbers are in included in Quality Performance Report • Nosocomial death review process • Visiting /walk round of areas by executive/senor leadership team SOP bed removal due to social distancir	• 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	
1.8	Robust IPC risk assessment processes and practices are in place for non Covid-19	• IP questions and answers manual • Section in IP questions and answer manual	• MRSA screening compliance • Monthly Sepsis Compliance	

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

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	**KLOE**	**Action Required**	**Lead**	**Due Date**	**Quarter 3 Progress Report**	**BRAG**
3	1.2	NHSI key point 4 : Patients are not moved until at least two negative test results are obtained, unless clinically justified	Microbiologist/ ACN's	31/05/2020 31/08/2021 29/10/2021 31/12/2021 28/02/2022	Testing and re testing, Interpretation of swabs and step down of IP precaution process in place at UHNM. Suspected or positive patients are moved on clinical need/assessment and in line with UHNM step down process. For patients who test negative on admission re screening is undertaken. 17th November NHSI guidance recommended that the second test is taken on day 3 after admission and day 5 after admission. Implementation of the new guidance is in place and a manual prompt is provided to the clinical areas. (Days 4 and 6 admission day counted as day 1). Waiting for 2 negatives swabs before moving for patients that are not COVID suspected does not always occur. September 2021 A COVID themes review paper is presented at IPCC bi monthly and is an agenda item. Investigation of themes and discussions at COVID outbreak meetings provide an opportunity to review not always achieving this standard and whether this has an impact on potential transmission or outbreak. A number of specialised ward strive to isolate admissions into a single room until COVID results are known. November & December 2021 actions continues to remain under surveillance	Action under surveillance

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

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
2.1	Designated nursing/medical teams with appropriate training are assigned to care for and treat patients in Covid-19 isolation or cohort areas.	• Higher risk areas with own teams • Zoning of hospital in place with cleaning teams • UHNM clinical guidance available on the intranet • Trust COVID -19 clinical group established to discuss and agree clinical pathways • Nice Guidance and National Clinical Guidance COVID-19 available on the Trust intranet • Links to PHE guidance on assessing COVID-19 cases available on Trust intranet page • Education videos clinical and non - clinical videos on Trust intranet • Process and designated staff for ED to ensure cleans are completed 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 cleaning teams • PPE education for cleaning teams • Initial meetings held with facilities/estates to discuss and plan COVID-19 requirements IP agenda item • Representatives from the division are attending the daily tactical meetings, and an E,F & PFI daily meeting is taking place which includes our partners • Discussed at March Matrons meeting. To ensure terminal cleans are signed off by the Nurse in Charge	• Clinical teams sign off any terminal cleans requested to say that clean has been completed to the agreed standard. • Spot check assurance audits completed by cleaning supervisors/managers during COVID • Cleanliness complaints or concerns are addressed by completing cleanliness audit walkabouts with clinical teams, and CPM / domestic supervisors • PPE and FFP3 mask fit training records with are held by cleaning services • GREAT training record cards are held centrally by Sodexo for all individual domestics • Key trainers record • Notes from Sodexo Performance Monthly meeting , Sodexo Operational meeting , Divisional IP Meeting and facilities/estates meeting	• Learning from CPE outbreak. We have recognised areas we can strengthen our assurance process on standards of cleanliness
2.3	Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line 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
	A terminal clean /deep clean of inpatient rooms is carried out: • Following resolutions of symptoms and removal of precautions • When vacated following discharge or transfer (this includes removal and disposal /or laundering of all curtains and bed screens) • Following an AGP if room vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air changes within the room)	• High level disinfectant , Virusolve and Tristel in place and used for all decontamination cleans • Dedicated terminal clean teams introduced during the 2/3 wave of COVID for ED, AMU/AMRA/FEAU as well as Lyme Building where main ITU beds are located to ensure that quick , effective decontamination of potentially infected areas could be completed 24/7. • Terminal cleans are requested via IP Team • Terminal clean process included in IP Q+A manual	• Completion of random 10% rooms each week by cleaning supervisors/managers to ensure that all rooms are cleaned to the agreed cleaning standards – Any rooms that are found to be below standard are rectified immediately. • Terminal clean electronic request log • Patient survey feedback is reviewed by joint CPM / Sodexo/EFP group and action plan completed if needed. • IP assurance visits and audits	
2.4	Increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance. A minimal of twice daily cleaning of • Patients isolation rooms • Cohort areas • Donning and doffing areas • Frequently touched surfaces e.g. door/toilet handles, patient call bells over bed tables and bed rails.	• Increased cleaning process (barrier clean) included in Infection Prevention Questions and Answers manual • Process in place for clinical areas with clusters and HAI cases of COVID -19 requiring increased cleaning and /or terminal cleans • Feedback from NHSI provided to cleaning teams and action plan	• Barrier clean request electronic log held by Sodexo and circulated following any updates / removal of barrier cleans to Sodexo and Trust staff including IP Team. • IP spot checks for clinical areas with clusters of COVID -19 or HAI cases of COVID -19 • Disinfectant check	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	Where there may be higher environmental contamination rates including • Toilets/commodes particularly if patient has diarrhoea Increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas	 Action Plan Following NHS England NHS Im devised  NHSI action plan June 21.docx • Increased cleaning process (barrier clean) included in Infection Prevention Questions and Answers manual	completed during IP spot checks • Additional ad-hoc cleaning requests can be requested by clinical teams 24/7 should the environment become contaminated between scheduled cleans. • November 2021 Implementation of IPS audit • C4C audit programme in place	
2.5	Attention to the cleaning of toilets / bathrooms, as Covid-19 has frequently been found to contaminate surface in these areas.	• Cleaning schedules in place • Barrier cleans (increased cleaning frequency) process in place which includes sanitary ware and other frequent touch points • Barrier cleans also requested for other infections /period of increased incidence /outbreaks e.g C.diff , Norovirus	• Cleaning schedules are displayed on each ward • Additional ad-hoc cleaning requests can be requested by clinical teams 24/7 should the environment become contaminated between scheduled cleans.	
2.6	Where patients with respiratory infection are cared for: Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution 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 high level disinfectant used as routine for cleaning/disinfecting environment and non invasive equipment • Virusolve wipes also used during height of pandemic	• Evidence from manufacture that these disinfectants are effective against COVID -19 • Evidence of Virusolve weekly strength checks , held locally at ward /department level • IP checks that disinfectant is available during 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
2.7	Manufacturer's guidance and recommended product 'contact time' must be followed for all cleaning / disinfectant solutions / products.	• Contact times detailed in SOP and cleaning methods statements • Included in mandatory training • Included in IP Q+A • Disinfectant used routinely	• Monthly on-going training is completed with all domestic staff to ensure that core competencies such as cleaning effectively with chemicals is trained out on a frequent basis. • Where outbreaks are identified, regular staff who clean in this area have competency checks to ensure that they are following GREAT card training • Spot checks completed by CPM includes observation of cleaning techniques by the domestic staff.	
2.8	As per national guidance: • 'Frequently touched' surfaces, e.g. door / toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated more than twice daily and when known to be contaminated with secretions, excretions and bodily fluid. • Electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should 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).	• 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	

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

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

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
organisational estates teams and or specialist advice from ventilation group and or the organisations authorised engineer A systematic review of the ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways Where possible air is diluted by natural ventilation by opening windows and doors were appropriate Review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission. Where a clinical space has a very low air changes and it is not possible to increase dilution effectively , alternative technologies are considered with estates/ventilation group When considering screens/partitions in reception /waiting areas , consult with estates/facilitates teams , to ensure that air flow is not affected, and cleaning schedules are in place Ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air Where possible ventilation is maximised by opening windows where possible to assist the dilution of air.	authoring Engineers. This is in line with the NHS estates best practise and guidance from Health Technical Memorandum (HTM) namely 03/01 Specialised Ventilation for Healthcare Premises. • Lessons learnt poster which encourage regular opening of windows to allow fresh air  ventilation-air-changes-per-hour-2021-06 • • IP and estates have worked with areas know to be undertaking aerosol generating procedures and completed the fallow times • IP have nominated point of contact re ventilation advise • January 2022 Estates and IP are exploring the use of air scrubber machine • Review of areas that request Perspex screens to check need and requirement for cleaning/ventilation not affected		

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
2.13	The Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level. The organisation had systems and processes in place to identify and communicate changes in the functionality of area/rooms Ensure cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment Monitor adherence environmental decontamination with actions in place to mitigate any identified risk Monitor adherence to the decontamination of shared equipment	• Cleaning standards meetings in place, review of standards • Cleaning collaborative improvement project now underway • Regular walkabouts of all non-clinical areas are completed, and any actions found are either emailed through to helpdesk to be logged as jobs to be completed or are noted by Sodexo at time of audit – follow-up visits are completed to ensure all jobs have been completed • Quarterly Environmental Audits are completed of all clinical areas by an independent auditor plus input from nursing, cleaning and estates to review environmental standards – reports produced after each visit, and re-audits completed if disciplines fail to achieve agreed %.	• Reports produced after each visit, and re-audits completed if disciplines fail to achieve agreed %. • C4C report presented at IPCC	Cleanliness assurance processes around

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	**KLOE**	**Action Required**	**Lead**	**Due Date**	**Quarter 3 Progress Report**	**BRAG**
6	2.4	West Building long standing Estates issues. Reactive work	Divisions Facilities and Estates	05/11/2021 30/11/2021 End of quarter 1 2022	<u>November 2021</u> Capital funding agreed and allocated c £150k for the replacement of 75 non-compliant wash hand basins including associated IPS panels within the West Building Wards and FEAU.	In progress
7	2.13	Cleaning issues both nursing and cleaning responsibilities highlighted during CPE outbreak west Buildings. Strengthen assurance process on standards of cleanliness	Divisions Facilities/ACN	12/11/2021 31/12/2021 End of quarter 1 2022	<u>November 2021</u> 03/11/2021 terminal clean west building completed Terminal clean briefing sheet designed Terminal clean of all West using steam and HPV Terminal Clean of FEAU and ward 122 using steam and HPV completed 06/11/2021 Cleaning Collaborative work stream (multi-disciplinary representation) established and using Improving Together tools and methodologies to work through the actions needed to respond to the cleaning issues in West Building highlighted during the CPE Outbreak.	In progress

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

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

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

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		• Monthly review of antimicrobial consumption undertaken by AMS team. Available online at UHNM	with AMS CQUIN targets. • Wards showing deviation from targets are followed up by targeted AMS team ward reviews generating action plans for ward teams. On hold during COVID19 due to redeployment of duties • The pharmacy team undertook a trust-wide point prevalence audit using a new electronic data capture tool. Results will be reviewed during January and shared with ACN's and Microbiologist.	
3.2	Mandatory reporting requirements are adhered to and boards continue to maintain oversight. Linked NHSIE Key Action 5: Daily data submissions have been signed off by the Chief Executive, the Medical Director and the Chief Nurse and the Board Assurance Framework is reviewed and evidence of reviews is available. Linked to NHSIE Key Action 10: Local systems must review system performance and data, offer peer support and take steps to intervene as required. Risk assessments and mitigations are in place to avoid unintended consequences from other pathogens	• 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.	

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

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
4.1	Implementation of national guidance on visiting patients in a care setting. Visits from patients relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients , staff and visitors There is clearly displayed , written information available to prompt patients, visitor and staff to comply with hand washing, wearing of facemask /face coverings and physical distancing Restrictive visiting may be considered appropriate during outbreaks within inpatient areas. This is an organisational decision following a risk assessment	• To help protect patients and staff from Covid-19, the NHS suspended all visiting to hospitals. This national suspension has now been lifted and visiting is to be introduced in some areas of our hospitals, subject to certain conditions. From Monday 17 August 2020 visiting will be phased in across some areas and will be allowed in the West Building at Royal Stoke and in Wards 7, 12, 15 at County Hospital. All visiting will have to be pre-booked and relatives will be provided with the correct information and contact details to book in advance. Visitors will be instructed to wear face masks and other PPE if they are providing	• Monitored by clinical areas • PALS complaints/feedback from service users • Outbreak meetings	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
If visitors are attending a care areas with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be a FRSM. Visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reason (e.g. parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible. Visitors are not present during AGPs on infectious patient unless they are considered essential following a risk assessment e.g. care/parent/guardian.	bedside care. We will continue to monitor prevalence and changes in visiting restrictions will be reinstated with immediate effect should it be necessary • The only exceptional circumstances where on visitor , an immediate family member or carer will be permitted to visited are listed below- • The patient is in last days of life- palliative care guidance available on Trust intranet • The birthing partners are able to attend all scans and antenatal appointments induction of labour and post natal appointments • The parent or appropriate adult visiting their child • Other ways of keeping in touch with loved ones e.g. phone calls , video calls are available • EOL visiting guidance in place • Guidance to accommodate visitor if appropriate and necessary to assist a patients communication and/or to meet their health, emotional , religious or spiritual need • A familiar care/parent or guardian/support/personal assistant • Children both parents /guardian where the family bubble can be		

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

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

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

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	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 Screening for COVID -19 is undertaken prior to attendance wherever possible to enable early recognition and to clinically assess patients prior to any patients attending a healthcare environment Patients with respiratory symptoms are assessed in segregated areas, ideally a single room, and away from other patients pending their test result. There is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved	• Hospital zoning/pathways • COVID 19 care pathway • Screening protocol in place		

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	Patients at risk of severe outcomes of respiratory infection receive protective IP measures depending in their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation and risk for their families and carers accompanying them for treatments /procedures must be considered	• Included in COVID 19 care pathway • IP Q+A isolation manual		
5.3	Ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff. Linked NHSIE Key Action 6: Where bays with high numbers of beds are in use, these must be risk assessed, and where 2m can't be achieved, physical segregation of patients must be considered and wards are effectively ventilated. Patient visitors , and staff can maintain 1 metre or greater social and physical distancing in all patient care areas: ideally segregation should be spate spaces , but there is potential to use screens e.g. to protect reception staff	• Colour coded areas in ED to separate patients, barriers in place. • Screens in place at main ED receptions • Colour coded routes identified in ED • Social distancing risk assessment in place • Perspex screens agreed through R+R process for other reception area • Social distance barriers in place at main reception areas • Chief Nurse/DIPC visited clinical areas to review social distancing within bays. A number of beds have been removed throughout the Trust. • January 2022 – 2 metre rule maintained. Risk assessments completed and signed off by DIPC for ward areas need to use closed beds due to social distancing • January 2022 - Risk assessments to be revisited for Out- patient /imaging area that need to reduce distance to 1 metre – this work is in progress	• 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
5.4	For patients with new-onset symptoms, it is important to achieve isolation and instigation of contact tracing as soon as possible.	• Process for isolation symptom patient in place • Process for cohorting of contacts • Contacting patients who have been discharged from hospital then later found to be a close contact of a COVID-19 positive case , patient to be informed by the clinical area and self- isolation advice provided as per national guidance • https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance/stay-at-home-guidance-for-households-with-possible-coronavirus-covid-19-infection	• If patient found to be positive in the bay and exposing other patient. IP liaise with clinical are, apply bay restrictions. • Patient who tested negative on admission and remain an inpatient are retested for COVID days 4 and 6, day 14 then weekly • Spot check audits • Assurance obtained for monitoring of inpatient compliance with wearing face masks via Matrons daily walk round	
5.5	Patients with suspected Covid-19 are tested promptly. There is evidence of compliance with routine testing protocols in line with key actions	• All patients who require overnight stay are screened on admission and patients who develop symptoms – UHNM screening guidance in place • December 2021 – surveillance of Omicron cases in place to monitor number of inpatients with the variant	• Adverse incident monitor /Datix	
5.6	Patients who test negative but display or go on to develop symptoms of Covid-19 are segregated and promptly re-tested and contacts traced. Isolation , testing an instigation of contact tracing is achieved for all patients with new onset symptoms , until proven negative	• 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. Where treatment is not urgent consider delaying this unit resolution of symptoms providing this does not impact negatively on patient outcomes	• Restoration and Recovery plans • Thermal temperature located in a number outpatient areas – with SOP if patient triggers. Script in place for scheduling outpatient/ investigations • Mask or face coverings for patients attending appointments from Monday 15th June 2020 • Process at PREAMMS if patient positive for COVID	• Datix process	

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

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

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

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
6.4	Appropriate arrangements are in place so that any reuse of PPE is in line with the CAS Alert is properly monitored and managed.	• SOP in place for reuse of visors • SOP in place for use of air powered filters systems plus key trainers • SOP in place for the care of reusable FFP3 masks (Sundstrom))	• SOP 's available on Trust intranet • Training logs held divisionally for air powered systems • IP training log for air powered systems key trainers and distribution of reusable FFP3 masks (Sundstrum)	
6.5	Any incidents relating to the re-use of PPE are monitored and appropriate action taken.	• PPE standard agenda at COVID Tactical meeting • Datix process • Midlands Region Incident Coordination Centre PPE Supply Cell	• Tactical group action log • Datix process • Incidents reported by procurement to centre PPE supply Cell	
6.6	Adherence to the PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk.	• PPE Audits • PPE volume use discussed at tactical COVID-19 Group	• Spot audits completed by IP team	
6.7	Staff regularly undertake hand hygiene and observe standard infection control precautions. Linked NHSIE Key Action 1: Staff consistently practices good hand hygiene.	• Hand hygiene requirements set out in the infection prevention Questions and Answers manual • Poster for hand hygiene technique displayed at hand wash sinks and stickers on hand soap and alcohol dispensers • Alcohol gel availability at the point of care	• Monthly hand hygiene audits completed by the clinical areas • Infection Prevention hand hygiene audit programme. Overview of results fed into infection Prevention committee • Independent hand hygiene audits completed by IP Senior Health Care	
6.8	Hygiene facilities (IP measures) and messaging are available for all • Hand hygiene facilities including instructional 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 1 metre or greater wherever possible in the workplace unless wearing PPE as part of direct care • Staff maintain social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace • Frequent decontamination of equipment and environment in both clinical and non-clinical areas • clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas • Staff regularly undertake hand hygiene and observe standard infection prevention precautions • Guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas	displayed throughout the Trust • IP assurance visits • Matrons visits to clinical areas Recommendation that physical distancing should be at least 1 metre, increasing whenever feasible to2 metres across all health and care settings. • Car sharing question forms part of OB investigation process • Communications reminding staff re car sharing • IP Q+A decontamination section • COVID Q+A • Wearing of mask posters displayed throughout the Trust • Advise and videos' on the Trust internet page • Hand hygiene posters /stickers on dispenser display in public toilets	• Cleanliness audits • IP environmental audits • Quarterly audits conducted and held by the clinical areas • Hand hygiene audits	
6.8	The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with	• Paper Towels are available for hand drying in the Clinical	• IP audits to check availability	

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

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

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

7. Provide or secure adequate isolation facilities

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

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
7.1	Patients with possible or Covid-19 are isolated in appropriate facilities or designated areas where appropriate. Restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff Areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas That clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs	• Hospital zoning in place • Recovery and Restoration plans for the Trust – • December 2020 –another increased wave of COVID 19 • COVID prevalence considered when zones identified • Purple wards • Blue COVID wards identified at both sites created during second wave • Green wards for planned screened elective patients • Recovery and Restoration plans • Ward round guidance available on COVID 19 intranet page • Patient are offered and encouraged to wear masks – stickers have been developed to record if patients are unable to	• June 2020 IP team to review patients that are found COVID positive and nursed in bay to ascertain compliance with pathway and IP control measures are in place Review pathways and identify themes which are presented at IPCC . • Themes report to IPCC • Inappropriate patient moves reported via Datix. Daily process Discuss at outbreak meetings as necessary	

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

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

8 Secure adequate access to laboratory support as appropriate.

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

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

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

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

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

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

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

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

9.1	The application of IP practices and monitored and that resources are in place to implement and measures adherence to good IP practice. This must include all care areas and all staff (permanent , agency and external contractors)
	
	Staff are supported in adhering to all IPC policies, including those for other alert organisms.
	
	Safe spaces for staff break areas/changing facilities are provided
		• IP included in mandatory update
		• Infection Prevention Questions and Answers manual with ICON on every desk top for ease of use
		• Infection Prevention triage desk which provides advice and support to clinical areas
		•
		  ◦ Rest pods are in place
		  ◦ Additional rest areas in place
		  ◦ List of changing areas available on the Trust intranet
			• IP audit programme
			• Audits undertaken by clinical areas
			• CEF audits recommenced Sept 2020
			• Proud to care booklet audits recommenced Sept 2020
			• Compliance with correct mask wearing and Doctors complaint with Bare Below the Elbow monitored via senior walk rounds of clinical areas	

9.2	Any changes to the PHE national guidance on PPE are quickly identified and effectively 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	• 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
		• Daily tactical group • Incident control room established where changes are reported through • Chief nurse updates • Changes/update to staff are included in weekly Facebook live sessions • COVID -19 intranet page • COVID -19 daily bulletin with updates		
9.3	All clinical waste and linen/laundry related to confirmed or possible Covid-19 cases is handled, stored and managed in accordance with current national guidance.	• Waste policy in place • Waste stream included in IP mandatory training	The Trust has a Duty of Care to ensure the safe and proper management of waste materials from the point of generation to their final disposal (Cradle to Grave). This includes: • Ensuring the waste is stored safely. • Ensuring the waste is only transferred to an authorised carrier and disposer of the waste. • Transferring a written description of the waste • Using the permitted site code on all documentation. • Ensuring that the waste is disposed of correctly by the disposer. • Carry out external waste audits of waste contractors used by the Trust.	

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

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

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

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	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 A risk assessment is carried for health and social care staff including pregnant and specific ethnic minority groups who may be a high risk of complications from respiratory infection such as influenza and severe illness from COVID -19 ○ A discussion is had with employees who are in the at-risk groups: including those who are pregnant and specific ethnic minority groups; ○ That advice is available to all health and social care staff, including specific advice to those at risk from complications ○ Bank, Agency and locum staff who fall onto these categories should follow the same deployment advice as permanent staff ○ A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff	• PPE donning and doffing videos available on the intranet • PPE posters • IP Q+A manual • Staff risk assessment process already in place at UHNM • Staff risk assessment information available on the Trust intranet page	• IP assurance visits	
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	• 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 for reusable masks • Training records held locally • FFP3 testing records now available on Health Rostering to record mask type and date and divisional mask fit compliance %	

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 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-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	• 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 • For staff groups that use Heather roster FFP3 mask fit	monitored	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	should include a centrally held record of results which is regularly reviewed by the board A fit testing programme is in place for those who may need to wear respiratory protection Staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection prevention precautions, including PPE and outlined in national guidance	testing details can be added as a skill to this system. • Fit testing in place • PPE requirement applicable to all staff , no exemptions for those who have recovered or received vaccination		
10.3	Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the crossover of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance.	• Restore and Restorations plans	• Incidence process/Datix	
10.4	All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas. Health and care settings are COVID 19 secure workplaces as far as practical, that is that any work place risks are mitigated maximally for everyone Linked NHSIE Key Action 2: Staff maintain social distancing in the workplace, when travelling to work (including avoiding car sharing) and to remind staff to follow public health guidance outside of the workplace.	• Social distancing tool kit available on COVID 19 intranet page • Site circulation maps • Keep your distance posters • COVID-19 secure declaration • Social distancing risk assessment guidance for managers presentation 5th June2020 • Meeting room rules • Face masks for all staff commenced 15th June • Visitor face covering • COVID secure risk assessment process in place • November 2020 – Car sharing	• 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
		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. Where there has been a breach in infection prevention procedures staff are reviewed by Occupational Health , who will • Lead on the implementation of system to monitor for illness and absence • Facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the health care workforce • Lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19	• 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 of staff returning to work available on COVID 19 section of intranet	• Via emapactis • Staff queries' through workforce bureau or team prevent	

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:**	9th February 2022
Report Title:	Bi-Annual Nurse Staffing Review Update	**Agenda Item:**	9.
Author:	Helen Inwood – Director of Nursing		
Executive Lead:	Chief Nurse		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Executive Summary:

The bi-annual nurse staffing review was due to be provided to Transformation and People Committee in January 2022 and to the Trust Board in February 2022. However the full review has not been completed due to Covid-19. Therefore this report focuses on actions taken since the last report, ongoing initiatives around workforce development and compliance with e-rostering compliance which supports the effective deployment of staff.

Assurance around staffing and quality is provided in the quarterly reports and the monthly reports of fill rates are reported as part of the quality and safety dashboard.

The report identifies that plans are in place to conduct a non-ward based staffing review and a full establishment review in 6 months.

Key Recommendations

The Trust Board is asked to receive and note the report and note that although the planned review has not been undertaken, additional actions have been taken in relation to ensuring safe, sustainable, and productive staffing levels.

The Trust Board is asked to note that the planned establishment review process is expected to commence in the Spring for both ward and non-ward based areas.

Workforce Assurance Report

January 2022

1. Introduction

The purpose of this report is to update the Trust Board of the safer staffing review in relation to nurse staffing in line with NHS England and NHS Improvement expectations and those of the Care Quality Commission. In January 2018, The National Quality Board (NQB) updated its guidance to provider Trusts, which sets out revised responsibilities and accountabilities for Trust Board for ensuring safe, sustainable, and productive staffing levels. This report includes an update reflecting the nursing, midwifery and AHP staffing initiatives. Recognising there is no formal safer staffing model for non-ward based staffing, this report intends to offer a narrative and assurance of continued monitoring and leadership.

2. Background

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	**Expectation Two**	**Expectation Three**
Right Staff	Right Skills	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. A staffing review for inpatients, as advised by the NQB, was undertaken in both 2019 and 2020. Due to the COVID-19 pandemic during 2021/22, staffing levels and skill mix has needed constant, daily reviews as the challenges of the pandemic continue. Staffing levels, acuity, capacity and demand is monitored using the daily management processes within the teams. Quarterly reports are now prepared to specifically review whether there are any patient harms that can be associated with staffing levels, as well as measures taken to mitigate any identified risks.

3. Progress since the Report in July 2021

As a result of the Covid-19 pandemic a formal mid year safer staffing review has not been commissioned. Daily oversight, and daily huddles within all teams and the use of daily escalation processes, provide a daily assurance of acceptable staffing levels and the actions taken to minimise potential harm to patients when staffing levels have fallen below planned levels. The monthly quality dashboard provides monthly updates and discussion in real time to manage and support clinical teams. Despite the pandemic, the services have continued to review, respond and develop in line with the safer staffing recommendations. This paper will highlight positive changes made since the last review, as well as acknowledging and discussing the challenges.

Recruitment

Work continues in collaboration with HR and the Divisions to support the recruitment and retention strategy, with oversight from TAP. During the last 6 months the following staff have been recruited.

Staff Group	Number
Registered Nurses	147
International nurses	91
Nursing Assistants	142.33 wte

Our international nurse recruitment pipeline has proved successful and will continue to provide a positive and sustainable workforce to compliment the "grow our own" pipeline, which is further supported by an expansion in the number of clinical student placements.

Plans have been submitted to ethically recruit a further 130 international nurses and 3 international midwives. For midwives this will be an opportunity to explore the international market to see if it can provide a future pool for recruitment. The Trust has also been identified as one of 12 Trusts nationally to pilot an initiative to deploy refugee nurses. We will be recruiting 5 refugee nurses from Syria/Lebanon to commence at the Trust in March 2022. This is an exciting opportunity, supported by HEE, and if successful could identify a further recruitment pipeline.

We continue to work with our 81 nursing assistants who have a nursing qualification overseas. In 2021 all identified staff were given the opportunity to undertake supported coaching to enable them to meet the required standard of English to progress to nursing registration. 45 nursing assistants have now attained the required level of English and are working through the OSCE preparation. Eleven have already progressed to become registrants and on-going support is being given to 23 staff to prepare for the English examination. Two of the nursing assistants have elected to go through the Nursing Associate programme as an alternative route to gaining NMC registration.

Student placements have increased for all clinical professions. The impact of this will be an increase in the number of nurses coming through training but the increase number of students on the wards at all levels is an added pressure on nursing staff, in relation to training and supervision, during the current challenges. The table below shows the numbers total number of days nursing and midwifery students were on placement at UHNM.

	Q1	Q2	Q3	Q4	Total
2015-2016 Total	15,545	9,125	9,808	13,663	**48,141**
2016-2017 Total	18,031	8,324	11,711	16,165	**54,231**
2017-2018 Total	18,478	9,027	11,779	16,345	**55,629**
2018-2019 Total	17,919	9,395	12,537	15,125	**54,976**
2019-2020 Total	18,110	12,246	14,492	17,292	**62,140**
2020-2021 Total	*10,275*	*13,535*	15,154	19,245	**58,209**

(2020 – 2021 Q2 & Q2 deployment of 2nd & 3rd year students due to Covid, 1st year students removed)

It is a credit to our leaders that they have managed to maintain their support for students and the placement evaluations reflect that the nurses are having a good experience with feedback being better than average. The table below demonstrates the UHNM student evaluations for nursing and midwifery against the national average in the National Education and Training Survey.

Category	UHNM Score	National Average
Learning environment and culture	78.39%	76.12%
Educational Governance and Leadership	72.17%	69.94%
Supporting and Empowering Learners	75.06%	71.17%
Delivery curricula and assessments	72.09%	66.20%

At the last workforce review in July 2021 a number of areas were identified as having establishments that did not reflect the acuity of patients. This was largely a result of wards moving to a larger template or new national guidelines. The following business cases have been improved in the last 12 months to support nurse staffing levels.

Scheme	Staff identified	Reason
ED Medical Workforce	2 ACPs	Patient numbers/acuity
Acute Medicine Nursing Workforce	32 RN 5.44 NA	To meet nurse:patient ratios and acuity identified in staffing review
Adult Critical Care	2 ACCP 38.5 RN	Increased beds
7th Theatre at County	4.6 Theatre Practitioners 2 NA	Expansion
Ward 222 staffing	13 RN 0.44 Registered Nursing Associate	To meet nurse:patient ratio and acuity identified in staffing review

The Trust has also worked with the HEE to try and eliminate nursing assistant vacancies. A number of large recruitment schemes have been undertaken with “Indeed”. Induction programmes lasting a week have now been developed on a monthly basis to ensure the nursing assistants recruited have the skills and knowledge required. This initiative has been well received by wards, well evaluated by the individuals recruited and we are looking to see if it has a positive impact on retention.

Grow Our Own Staff

We have continued to identify pathways to enable nursing assistant meet their full potential in addition to developing a pipe line for additional nurses

- 8 nursing assistants have commenced a 4 year Registered Nurse Apprenticeship Programme
- 30 Assistant Practitioners/Nursing Associates have been identified for a 18 month Top up Registered Nurse apprenticeship programme
- 30 Nursing assistants are commencing a Nursing associate apprenticeship

Preceptorship

All new registrants are provided with a preceptorship programme. The numbers supported through this programme to December 2021 are

- 42 overseas nurses
- 44 Registered Nursing Associates
- 147 Registered Nurses

Continuing Professional Development (CPD) Money

The Nursing Directorate have reviewed how the CPD money is spent and considered creative ways of utilising the resource to support staff in undertaking ongoing development through internal and external training. More than 400 staff have received funding to undertake external development programmes

Advanced Clinical Practitioners (ACP)

Advanced Clinical Practice is a defined level of practice within clinical professions such as nursing, paramedics, pharmacy and physiotherapy. This level of practice is designed to transform and modernise pathways of care, enabling safe and effective sharing of skills across traditional professional boundaries.

There are currently 160 ACPs across UHNM in a variety of areas. We continue to support staff to develop into this role and there are currently 39 staff studying MSc in Advanced Practice. The table below identifies the anticipated completion.

No.	Completion
11	Early 2022
12	Autumn 2022
04	Early 2023
12	Autumn 2023

UHNM have employed a lead for ACP, and a number of work streams have commenced to support this role within the organisation.

- Inaugural UHNM ACP conference – attended by 160 internal and external multi-professional staff
- UHNM Advanced Practice 3 year strategy
- Implementation of a Trust Steering Group and working Group
- Integration of job plans to support the 4 pillars of advanced practice
- Enhanced governance processes for non-medical prescribers across UHNM
- Standardise the recruitment of future ACPs
- Promote the role of ACPs within the UHNM to support career progression
- Working with HEE and national advanced practice leads to ensure UHNM is at the forefront of the advanced practice national agenda

Professional Nurse Advocate (PNA)

The Professional Nurse Advocate is a new and fundamental leadership and advocacy role designed to deploy restorative supervision. It supports a continuous improvement process that aims to build on the personal and professional clinical leadership for nurses, enhance the quality of care for patients, and support preparedness for appraisal and professional revalidation. The restorative function has been shown to have a positive impact on the physical and emotional wellbeing of staff as it reduces burnout, stress and absences, and improves job satisfaction and patient experience.

This is a new initiative for nursing nationally and internationally and the training programme was launched in March 2021 with the ambition of there being one Professional Nurse Advocate for every 20 Registered Nurse by 2024. This year 34 Registered Nurses have been nominated to undertake this programme (10 of which have now successfully completed the programme) with plans to continue to support staff access the training. The impact of the role will be monitored and evaluated, with reports feeding back into TAP.

Maintaining staffing levels

During the pandemic rosters continue to be designed based on acuity and demand, and fill rates across all inpatients wards are reported on a monthly basis. The number of wards that do not achieve an average of 80% RN fill has increased. Trust services have experienced and continue to experience

the effects of COVID-19 with most wards, at some point, having cared for service users who are both suspected and are actually symptomatic of Covid 19. Multiple areas have also experienced increased staff sickness related to the virus.

Despite staff redeployment on a shift by shift basis there are occasions when staffing levels do not replicate the usual staffing levels and staff are asked to complete “red flags” on these occasions and provide evidence of mitigations put into place. Over the 6 months since the last report the following red flags have been reported (although it is important to note that there is under-reporting of red flags).

Red Flag	Medicine	Specialised	Surgery
Delay in providing pain relief	47	154	12
Less than 2 RN on shift	47	54	16
Missed intentional rounding	82	259	20
More than 50% of RNS being temporary staff	1	1	0
Shortfall in RN time	12	2	1
Shortfall of more than 8 hours or 25% RN time	13	6	1
Unplanned omission in providing medications	32	22	0
Vital signs not assessed or recorded	50	110	3
Total	**290**	**608**	**53**

If patient harm is identified staff are asked to complete a DATIX incident form so a more considered review of staffing issues and mitigations can be identified. The number of DATIX reports are listed below. On review of these a further training need has been identified as the majority of these incidents should have been recorded as red flags as no harm occurred to patients.

Location	July	Aug	Sept	Oct	Nov	Dec
Medicine						
• Wards	9	11	18	12	8	12
• Emergency portals	4	4	1	1	5	6
Surgery						
• Wards	6	3	2	5	6	3
• Theatres	2	2	2	1	14	1
• Critical care	0	3	4	4	2	2
Specialised						
• Wards	3	4	1	4	0	3
CWD						
• Child Health	8	15	2	10	9	0
• Oncology	1	1	1	1	0	1
• Midwifery	21	13	15	10	9	11
Total	**54**	**56**	**46**	**48**	**53**	**39**

Rostering key performance indicators

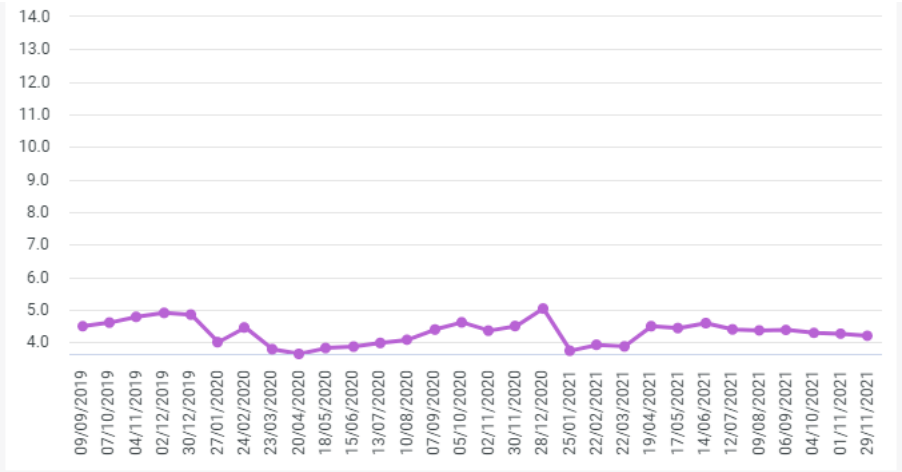
The 3 indicators reviewed were

- Rosters in advance
- Bank/agency usage
- Unavailability

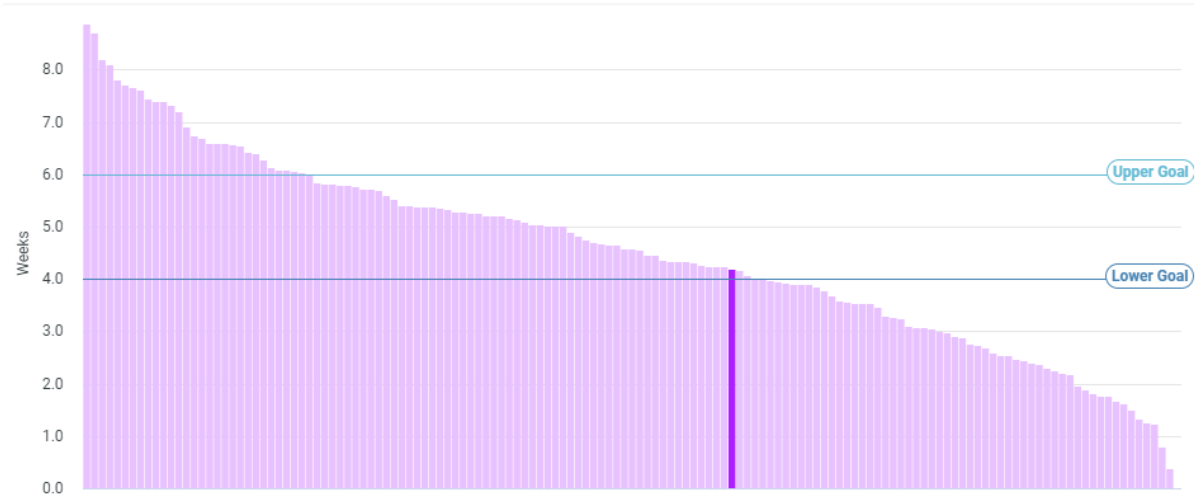
Rosters in advance

Evidence suggests that rosters produced 4 weeks or more before the shifts promotes effective and efficient staff deployment and potentially reduces bank / agency usage. Wards are requested to meet this requirement.

The graph below shows our average lead in time, in weeks, for all nursing rosters on the Allocate system, and do not therefore solely reflect the inpatient wards. The average time in the wards is 4.2 weeks compared with a national average of 2.6 weeks. This does show an improvement on the previous report, at a time where ward managers are having to contend with frequent ward moves and reconfigurations



The graph below shows the compliance within the Trust compared to outher units nationally.

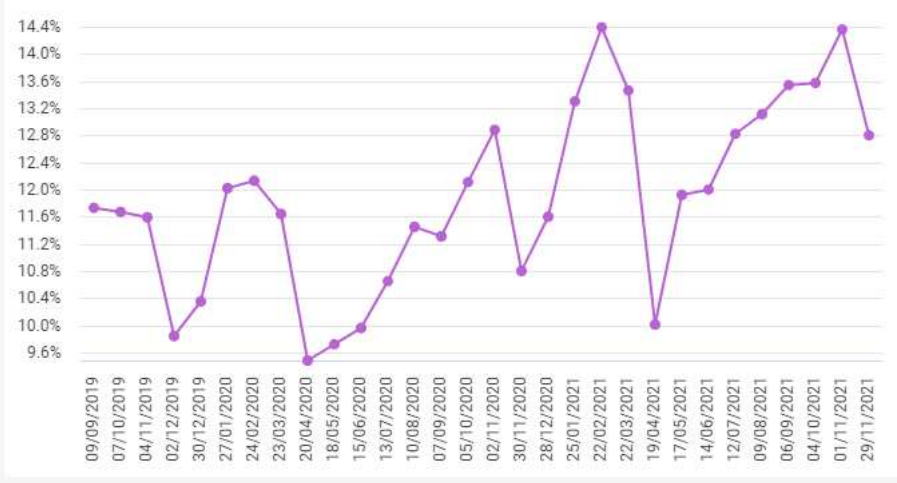


Division	Medicine	Surgery	Specialised	CWD
Rosters in advance	4.42 weeks	2.95 weeks*	5.30 weeks	3.24 weeks

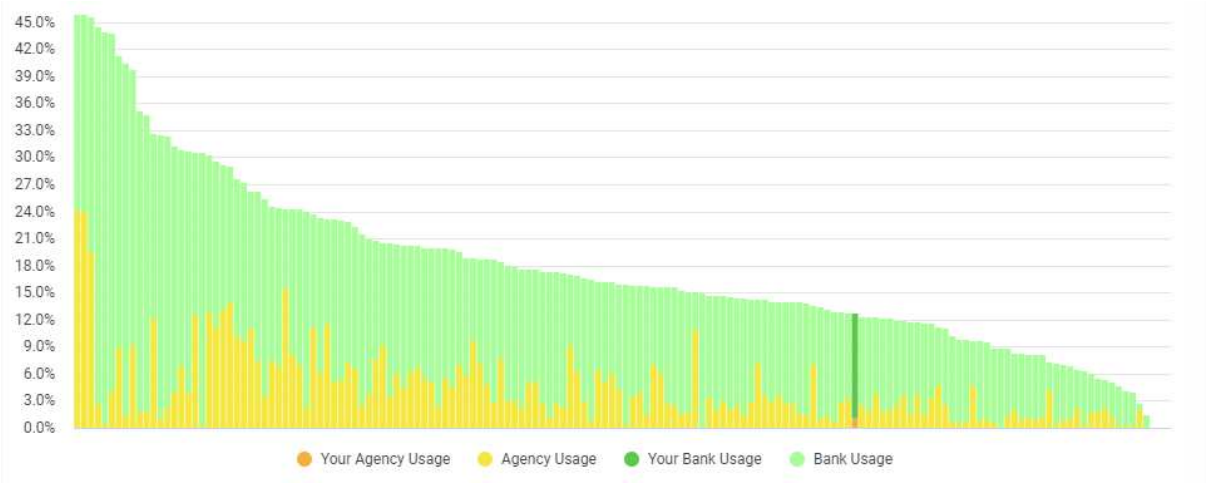
* The figure will include theatres, who due to schedulling publish rosters 2 weeks in advance

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. Through the allocate system we can see our usage for every 4 week rostering period and the graph below demonstrates that during the peaks our use of back and agency staffing has increased.



Against our peers the Trust utilisation is 12.8% (a reduction of 0.8% from the previous 6 months) compared to 18.3% for Acute Trusts. Of the 12.8% usage only 9.9% is comprised of agency usage, which is a slight increase on the previous period. The table below identifies our Trust performance against other Units



Division	Medicine	Surgery	Specialised	CWD
Temporary Staffing	20.54%	10.44%	17.43%	6.26%

Unavailability

Nursing rosters contain 21.5% headroom to accommodate annual leave entitlement, sickness and study leave. Efffective rosters should demonstrate a figure close to 21.5% unavailalibty. 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 the 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 31.3% agianst the national average of 28.5%. this figure is consistent with the previous period. Within this unavaialability, annual leave is between the expected controls,, so the increase is predominantly related to a high sickness and maternity level. With sickness where staff are isolating but working from home this will show as a working day and will be included within the unavailability.

Division	Medicine	Surgery	Specialised	CWD
Unavailability	31.44%	29.85%	30.14%	31.05%

4. Allied Health Professionals

In October 2021 Royal Stoke as an NHS provider organisation (NHS Trust) accepted funding (£62,000) from Health Education England to invest in local interventions that will help the National Health Service (NHS) meet its workforce supply challenges and opportunities. This investment is aimed at helping the NHS achieve its target, as set out in the pre-pandemic NHS People Plan, of having 27,000 additional AHPs by 2024 to meet future AHP workforce demand. This is considered a conservative estimate given the additional workforce demand arising from the 2020 Diagnostics Review (Richards Review). The AHP professional groups for our organisation include: Physiotherapy, Occupational Therapy, Dietetics, Speech and Language Therapy, Radiography (Diagnostic and Therapeutic), Operating Department Practitioners and Orthoptists.

Project Objectives

The project objectives are:

- To provide robust workforce intelligence that facilitates place-based, system-wide and/or regional workforce reform
- Short-term targeted, workforce reform via return to practice (RtP), international recruitment (IR), and retention improvement practices (particularly for newly registered AHPs)
- Longer-term reform via targeted education and placement (practice learning) expansion; and increase in AHP apprenticeship uptake via regional consortia.
- Growth, recognition, and development of the AHP non-registered workforce
- Focused business plans and funding bids for 2022/23.

Progress to Date

An AHP project Lead was assigned to lead on the project in October2021 reportable to the Executive Workforce Assurance Group

An AHP steering group was set up to meet twice a monthly to support achievement of the project objectives.

All 7 of the project domains were given project leads overseen and co-ordinated by the AHP project lead.

The first highlight report was submitted in December 2021 to update on project progress.

5. Conclusions

The current need to review and deploy staff on a daily basis to meet the challenges created by Covid has meant the usual workforce review could not be undertaken and daily meetings have been established to ensure there is executive overview of daily staffing. However work has continued to increase the supply of registered nurses through international recruitment, increasing student numbers and growing our own staff.

Roles such as advanced clinical practitioners and Professional Nurse Advocates provide further opportunity to invest in our staff and create rewarding career opportunities.

Monitoring key performance indicators relating to e-roster enables us to maximise the deployment of staff available.

There are plans in place to commence workforce reviews in the Spring for non-ward areas such as emergency Departments and theatres and all wards.

6. Recommendations

To note the progress since the last review and the planned establishment review process that will commence in the Spring for both ward and non-ward based areas.

Committee Chair's Highlight Report to Board

Performance and Finance Committee
25th January 2022

NHS
University Hospitals of North Midlands
NHS Trust

1. Highlight Report

!	Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
	• Continuing high number of cancer referrals were noted and although there was an increase in treatments in December, there remained challenges with 2 week wait in certain specialties, colorectal, skin and breast cancer. Performance was not expected to improve in January/February but the number of treatments was expected to increase • In terms of planned care performance, theatre activity was anticipating to reach 70% by mid-February followed by 80-90% in March with further improvements thereafter. It was noted that the main risk to elective recovery was workforce pressures and not financial. • Ultrasound continued to be the biggest challenge in terms of diagnostics performance • The Q3 data security and protection (DSP) report demonstrated that training stood at 88%, and an ICO notice had been received in relation to an FOI breach in timescales, but no further action was to be taken.	• To incorporate the questions raised by the Committee into the final primary care business case • To clarify the contract issues associated with urology demand • To update the BAF to reflect the comments made in relation to providing additional information in respect of the medical physics risk (BAF1), strengthening the rationale behind the increased risk score of BAF6, updating the gaps in control associated with the winter plan (BAF6) and considering an additional action for BAF3 in relation to the piece of work being undertaken with Divisions • To provide further information and assurance with regards to the actions taken to address the Log4j cyber IT vulnerability
✓	**Positive Assurances to Provide**	**Decisions Made**
	• The critical incident was stood down on 24th January due slight improvements in sickness absence, reduction in MFFDs and Covid numbers remaining static. Although still challenged, the pressures were more akin to usual winter pressures rather than Covid related. Also, the additional support for staffing from the army remains in place within ED, Critical Care and Infectious Diseases. • Month 9 performance urgent care indicators demonstrated an improved position towards the end of December, although further work was being undertaken to establish the reasons for ambulance handovers not improving. • A progress update on red rated service developments was provided and the Committee considered the changes to the schemes which had moved from amber to red, and the related clinical risks • The Committee welcomed the improvement in the DSP toolkit standards • Month 9 financial performance continued to be ahead of plan with a year to date surplus of £15.6m. The Trust had submitted its forecast position with best, worst and most likely scenarios and these were described to the Committee. It was noted that the capital programme was slightly behind schedule.	• The Committee agreed with the direction of travel for the proposal to develop an Enhanced Primary Care Streaming Model and agreed to receive the full business case in February • The Committee approved the following business cases; BC-0448 Overseas Nursing, BC-0437 Secondary Care Dental Services NHSE Funded Restoration and Recovery, BC-0442 Urology Nephrectomy Demand and BC-0446 Additional Pharmacy Staffing Resource and Input to the Adult Cancer Care • The Committee approved the following EREAFs: Occupational Health Services Contract (eREAF 8449), Shoulder Arthroplasty and Extremities (eREAF 8489), Home Delivery of Darbepoetin (eREAF 8535, Blood Sciences Siemens Managed Service Y10 (eREAF 8590), Cath Lab Interventional Cardiology Consumables (eREAF 8602), Blood Sciences Managed Service Contract Y9 (eREAF 8643), M2 Managed print solution Contract (eREAF 8662), Pharmacy Outsourced Dispensing Service (eREAF 8687) and Pharmacy Outsourced Dispensing Service - Drug costs (eREAF 8688) • The Committee approved the Q3 BAF • The Committee approved the Budget Setting Framework for 2022/23

Comments on the Effectiveness of the Meeting
• The Committee welcomed the approach to taking the papers as read in order to enable time for questions and discussion on the papers.

2. Summary Agenda

No.	Agenda Item	BAF Mapping		Purpose	No.	Agenda Item	BAF Mapping		Purpose
		BAF No.	Risk				BAF No.	Risk	
1.	Month 9 Performance Report • Development of Enhanced Primary Care Streaming Model	1 & 6	16636/ 16643/ 8542 / 19463	Assurance	8.	Board Assurance Framework Q3 2021/22	All	Various	Approval
2.	Progress Update on Red Rated Service Developments		NA	Assurance	9.	Q3 Data Security & Protection Update	7	NA	Assurance
3.	BC-0448 Overseas Nursing	1 & 3	NA	Approval	10.	Executive Data Security & Protection Group Assurance Reports: December 21 & January 22	7	NA	Assurance
4.	BC-0437 Secondary Care Dental Services NHSE Funded Restoration and Recovery		NA	Approval	11.	Budget Setting Framework 2022/23	9	21694	Approval
5.	BC-0442 Urology Nephrectomy Demand		NA	Approval	12.	Month 9 Finance Report	9	21694	Assurance
6.	BC-0446 Additional Pharmacy Staffing Resource and Input to the Adult Cancer Care	1 & 3	NA	Approval	13.	Operational Excellence: Improving Together - 6 Months Post Implementation Update		NA	Information
7.	Authorisation of New Contract Awards and Contract Extensions		NA	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										Chair		
Mr M Oldham	MO	Chief Finance Officer												
Mrs S Preston	SP	Strategic Director of Finance												
Miss C Rylands	CR	Associate Director of Corporate Governance	NH	NH	NH	NH	NH	NH	NH	NH	NH	NH		
Mr J Tringham	JT	Director of Operational Finance												

In addition Amy Freeman, Director of Digital Transformation was in attendance.

Committee Chair's Highlight Report to Board

Transformation and People Committee
26th January 2022

NHS
University Hospitals of North Midlands
NHS Trust

1. Highlight Report

!	Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
	• The nurse establishment review had not been completed as planned, instead an evaluation had been undertaken to establish the progress made since the previous review. The aim of moving towards a full workforce review including nursing, midwifery and AHPs over the course of the next few years was also noted. • The delays to the culture programme were noted, in part due to the inability to engage with staff due to the current pressures. It was noted that once the programmes had recommenced, further updates would be provided to the Committee in terms of linkages with the overarching HR plan. • The Committee noted that the average time to conclude non-complex disciplinary cases was 41 days against the ambition of 28 days and the Committee requested assurance of the actions being taken to achieve this. • An update from the Improving Together Programme was provided and it was noted that training had been paused due to the critical incident and a dip in terms of adoption of tools was also expected. The Committee welcomed the continued work within SAU, AMU and County Hospital theatres in respect of routines and huddles, although it was noted that overall a number of deliverables were off track due to the current pressures.	• To ensure the next report regarding the establishment review included the timeline for reviewing and considering AHP workforce etc. • To confirm any implications of not undertaking the establishment review as planned, within the AGS whilst noting the alternative work which had been undertaken • To update the BAF in relation to BAF3 and ensuring the scoring reflected the rationale for BAF1 (i.e. Ext 20) and in terms of BAF 4 and 5, it was agreed that going forwards an update in relation to system work streams would be provided to the Committee. It was agreed to consider the challenges associated with discharges and MFFDs within BAF 6
✓	**Positive Assurances to Provide**	**Decisions Made**
	• 35 speaking up concerns had been raised during the quarter, with the overriding themes relating to attitudes and behaviours and policies and processes. The Committee noted that the gap analysis would be reviewed in light of new NGO guidance and queried the ability to close down concerns in a timely manner, although no issues were raised in respect of concluding reviews. The Committee received assurance that the Senior Independent Director had reviewed the process undertaken in relation to an investigation, following feedback from the individual who had raised the initial concern, and the positive outcome of the review was to be shared with the individual. • In terms of equality, diversity and inclusion, the focus during the quarter was on disability awareness whereby the disability network group had prioritised a number of key drivers as well as taking forward disability training and identifying disability champions. The Committee noted the development of the Equality, Diversity and Inclusion Strategy which was due to be ratified in due course and the Committee welcomed the pace and progress being made in this area. • An update was provided in terms of mandatory covid vaccination, whereby vaccination status for a number of staff was outstanding, although responses were coming in daily and reducing further. The risks to business continuity were highlighted and the Committee noted the actions being taken to discuss and consider next steps with line managers and employees. • The Committee noted the progress being made to correlate information in relation to staff engagement metrics from both local and national surveys and noted that appraisal compliance had improved in month. • The Committee welcomed the update in relation to the future of HR and OD and noted that a further update was to be provided in April. Assurance was provided in respect of system working, with the aim of sharing resources and enabling staff to move throughout the system.	• The Committee approved the Board Assurance Framework

Comments on the Effectiveness of the Meeting
• The Committee noted that it was broadly on track to consider the majority of items within the business cycle, as planned

2. Summary Agenda

No.	Agenda Item	BAF Mapping		Purpose	No.	Agenda Item	BAF Mapping		Purpose
		BAF No.	Risk				BAF No.	Risk	
1.	Workforce Assurance Report	1, 2, 3		Assurance	6.	Future of HR and OD			Information
2.	Speaking Up Report Q3 2021/22	2		Assurance	7.	Improving Together Highlight Report			Assurance
3.	Equality, Diversity & Inclusion Progress Report	2		Assurance	8.	Board Assurance Framework Q3 2021/22	All		Approval
4.	Formal Disciplinary Activity Q3 2021/22	2		Assurance	9.	Nursing and Midwifery Staffing and Quality Report / Risk and Quality Impact Assessments	1, 3		Assurance
5.	M9 Workforce Report	1, 2, 3		Assurance					

3. 2021 / 22 Attendance Matrix

Attended	Apologies & Deputy Sent	Apologies

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

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	9th February 2022
Report Title:	Speaking Up Report – Quarter 3	**Agenda Item:**	12.
Author:	Raising Concerns & Workforce Equality Manager		
Executive Lead:	Director of Human Resources		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

Executive Summary

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

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

Assessment – during the quarter 35 speaking up contacts were received. 32 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. Four of the concerns were raised anonymously. 3 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 3 2021-22.
- The actions proposed to further encourage and promote a culture of speaking up at UHNM.

Speaking Up
Quarter 3 2021-22

1. Introduction

This Quarter 35 speaking up contacts have been made via the UHNM speaking up routes, which include 32 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. 3 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

Case Review Gap Analysis Tool

The NGO undertakes case reviews where it has found that good speaking up practice has not been followed, and recommends remedial action. Reviews seek to identify learning, support improvement and celebrate innovation. The ultimate aim is to improve the experience of workers and patients.

These case reviews are a useful tool to reflect upon our own speaking up arrangements. The reports and recommendations have helped us to identify opportunities for improvements in our own processes and procedures.

The NGO has now collated together recommendations from the nine case review reports which have been published and grouped them thematically. To help with gap analysis, the NGO has included a tool, published in December which Freedom to Speak Up Guardians and others responsible for speaking up in their organisations can use to review arrangements and develop plans and actions for improvement. Using this and other guidance published by the NGO as a self-review tool, organisations can identify and improve gaps in their speaking up arrangements.

The tool will be completed and shared in the next speaking up report.

West Suffolk NHS Foundation Trust Independent Review

NHS E/I has published the report of the independent investigation undertaken to review raising concerns at West Suffolk NHS Foundation Trust. The findings of the review illustrate what happens when speaking up is viewed as a threat, when those who speak up are the focus, rather than the matters raised. The report can be read here

Impact of Ethnicity on Speaking Up

The NGO commissioned research looking into peoples experiences of accessing their Freedom to Speak Up Guardian, and whether ethnicity has an impact.

The research found that Black and minority ethnic respondents were six times more likely than White respondents to say that they were more likely to raise a concern with a Guardian of the same ethnicity as themselves.

Compared to their White colleagues, discrimination was far more likely to feature in issues experienced by Black and minority ethnic workers involved in the research. There was an assumption that a Black or minority ethnic Guardian would understand and take seriously issues around bias and discrimination, which was reflected in their preference to speak up to a Freedom to Speak Up Guardian of the same ethnicity. The research also noted that the perceptions of ethnic minority workers may be impacted by a range of factors, including the wider organisational culture and the support for Freedom to Speak Up Guardians from managers and leaders in their organisation.

Despite these reservations, the research found that Black and minority ethnic workers who did speak up had comparable experiences to White workers. Black and minority ethnic workers who had spoken up also reported that they thought Freedom to Speak Up Guardians had a good understanding of discrimination and bias, were empathetic and had good listening skills.

The research also found awareness among Freedom to Speak Up Guardians of the potential impact of characteristics, and details some examples of the work they were carrying out to improve the speaking up culture for all workers. This national report will be discussed with our Ethnic Diversity Network.

The UHNM FTSUGuardian function currently has one Guardian from an ethnically diverse background, who is also the Trusts WRES (Workforce Race Equality Standard) Expert. There is also diversity within our Employee Support Advisors, which will hopefully be further enhanced through a recruitment drive for additional ESA's from amongst our Diversity Staff Network membership.

3. Supporting a Speaking Up Culture

UHNM Speaking Up Training Update

The new UHNM mandatory speaking up e-learning was launched during October's Speaking Up Month and is based on the resources released by the NGO and Health Education England. The Speak Up, Listen Up training 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. At the time of writing, 859 UHNM staff have undertaken the training, with an additional 101 staff having selected to undertake the Core speaking up training programme provided by E-Learning for Health.

These packages are also pre-requisite training for the UHNM Gateway to Management programme and work is continuing on incorporating the training in the corporate induction package.

The next phase of the NGO training will be a Trust Board awareness package, the release of which is expected imminently.

Speaking Up Policy - Update

The Speaking Up Policy HR30 has been updated to reflect a recommendation from the most recent NGO Case Review regarding the development of terms of reference. Our Policy now states that reporters of concerns and issues will have input into the terms of reference for any investigation that is to be undertaken. The updated Policy is to be considered at the January TJNCC meeting prior to formal ratification.

Work in Confidence System

During the quarter the Lead FTSU Guardian has undertaken conversations with other NHS organisations that use the Work in Confidence system to understand the impact and benefits of the system. A paper is being finalised to include an options appraisal.

Lead Freedom to Speak Up Guardian Recruitment

Recruitment is currently underway for the Lead Freedom to Speak Up Guardian position, and an update will be provided in the next report. Positively, the hours for this position have been increased from 0.6WTE to full time.

4. Quarterly Speaking Up Cases – Quarter 3 – October – December 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
October	12	3	6	0
November	12	0	6	0
December	8	1	2	0
Total	**32**	**4**	**14**	**0**

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

Theme	Number
Attitudes and behaviours	13
Equipment and maintenance	0
Staffing levels	0
Policies, procedures and processes	11
Quality and safety	5
Patient experience	0
Performance capability	0
Service Changes	0
Other	3
Total	**32**

Summary of speaking up contacts recorded on the Speaking Up Tracker during Quarter 3 October - December 2021:

No.	Theme	Summary	Status
1.	Policies, Processes & Procedures	Reporter raised issues about rota allocation in their area.	Reporter supported to raise issues with next level manager and action agreed. Reporter satisfied with action taken.
2.	Policies, Processes & Procedures	Reporter raised concerns about how their own and other staff with disabilities are treated in their department, the support for recommended reasonable adjustments, and the culture and leadership in the department.	Reporter supported to raise concerns with next level manager. Grievance process initiated.
3.	Attitudes & Behaviours	Anonymous letter received in CEO office relating to leadership and behaviours on ward location.	Open sessions held with staff, data reviewed and CEF visit arranged. Supportive package in place.

No.	Theme	Summary	Status
4.	Attitudes & Behaviours	Second anonymous letter received in CEO office relating to leadership and behaviours on ward location (as above).	Open sessions held with staff, data reviewed and CEF visit arranged. Supportive package in place.
5.	Attitudes & Behaviours	Reporter raised issues about attitudes and behaviours in their team, and the support made available for training.	Support provided for reporter to raise issues with line manager.
6.	Policies, Processes & Procedures	Reporter concerned about how their long term health condition is being managed.	Advice and support provided. Reporter satisfied with action taken.
7.	Attitudes & Behaviours	Formal grievance submitted regarding quality and safety concerns and culture within department.	Grievance process underway; speaking up review being undertaken by division – active.
8.	Attitudes & Behaviours	Anonymous speaking up form received from outgoing member of department, about line manager behaviour.	Escalated to next level manager. Range of support and development in place.
9.	Policies, Processes & Procedures	Concerns raised about application of employee relations process and outcome, and management of health condition.	Speaking Up investigation underway – active.
10.	Attitudes & Behaviours	Ongoing issues in a team with multiple concerns raised.	Speaking Up investigation underway – active.
11.	Attitudes & Behaviours	Ongoing issues in a team with multiple concerns raised (linked to 10, above).	Speaking Up investigation underway – active.
12.	Attitudes & Behaviours	Ongoing issues in a team with multiple concerns raised (linked to 10, 11, above).	Speaking Up investigation underway – active.
13.	Attitudes & Behaviours	Reporter raised issues relating to dignity at work.	Managed under dignity at work policy. Reporter satisfied with action taken.
14.	Quality & Safety	Multiple reporters raised issues about management and quality within their department.	Speaking Up Review underway – active.
15.	Quality & Safety	Multiple reporters raised issues about management and quality within their department.	Speaking Up Review underway – active.
16.	Quality & Safety	Multiple reporters raised issues about management and quality within their department.	Speaking Up Review underway – active.
17.	Attitudes & Behaviours	Reporter concerned about attitudes and behaviour of manager during sickness management process.	Supported reporter to raise with next level manager and informal resolution undertaken.
18.	Other	Request for support at a conduct meeting received.	Signposted to appropriate support and advocacy. Reporter satisfied with outcome.
19.	Policies, Processes & Procedures	Reporter being managed under Sickness Policy. Concerns raised about disability discrimination and dignity at work.	Guidance provided. Grievance submitted and investigated. Partially upheld.
20.	Policies, Processes & Procedures	Reporter concerned about how sickness policy is being applied and the support for reasonable adjustments in their place of work.	Advice and guidance provided. Reporter satisfied with action taken.
21.	Other	Support for a colleague sought. Reporter left the work area due to way treated and feels that colleague is isolated and being discriminated against.	Contact made to arrange meeting – active.

No.	Theme	Summary	Status
22.	Quality & Safety	Reporter raised patient and staff quality and safety concerns including staffing levels, clinical incidents, sickness levels and staff welfare, and previous management response to concerns raised.	Division Review underway – active.
23.	Policies, Processes & Procedures	Reporter raised concerns about the potential national mandate for covid-19 vaccination status for patient facing NHS staff.	Supportive conversation held with senior manager. Enhanced information shared through Trust Communications. Reporter satisfied with outcome.
24.	Policies, Processes & Procedures	Reporter raised concerns about the process and communication for the collection of pension arrears, with some staff having unexpected payments deducted from their November pay, relating to the pay award.	Escalated to senior finance manager. Response provided to reporter with guidance on appeals process. Closed.
25.	Attitudes & Behaviours	Reporter raised concerns about organisation culture and bullying.	Response provided by Trust Medical Director of actions being undertaken in the organisation, including BRAP review.
26.	Policies, Processes & Procedures	Reporter concerned about management decision about work location and impact on their disability.	Advice and support provided. Grievance process underway – active.
27.	Quality & Safety	Concerns raised about quality and safety and culture within their department (linked to 22 above).	Division Review currently underway – active.
28.	Policies, Processes & Procedures	Reporter raised concerns about discrimination and Covid 19 vaccination status.	Supported to raise informal grievance and escalate to next level manager - active.
29.	Other	Anonymous speaking up form received raising issues about lack of quiet dedicated space for junior doctors to work on wards to write up notes/TTO's and speak to relatives etc. As reporter stated the previous room had been taken off the junior doctors.	Division fact find confirmed that the doctors room was changed to a smaller room which was not covid secure. The room does have space with dedicated PC. There is a PC on the nursing station for doctors, and nursing room can be utilised and each bay has a computer on wheels. There is a regular forum with the junior doctors to listen to their concerns and this will be discussed at the next meeting. Also raised with Deputy Medical Director and Lead for doctors in training for awareness.
30.	Policies, Processes & Procedures	Reporter raised concerns that an employee had continued working despite testing positive for Covid-19.	Fact finding currently being undertaken.
31.	Attitudes & Behaviours	Letter received in CEO Office raising concerns about the culture in a department and treatment of a team member.	Review commissioned – active.
32.	Attitudes & Behaviours	Anonymous concern from a group of staff about workplace experiences following MOC to new work location.	Review commissioned – active.

Learning from Speaking Up Cases

During the quarter there has been an increase in the number of contacts through Speaking Up routes about the management of workers with a disability or long term condition. This may well have corresponded with the Trusts increased promotion of Disability awareness throughout Disability History Month held during November and December.

The themes from speaking up routes are similar to those raised by our Disability & Long Term Conditions Staff Network, and in collaboration with our Trust EDI team, and Trust Communications team the Network has helped to shape a Disability Management Toolkit. This aims to inform and support managers on the appropriate and compassionate management of staff with long term health conditions, and improve the experiences of staff in the workplace.

Open Speaking Up Cases from Previous Quarters

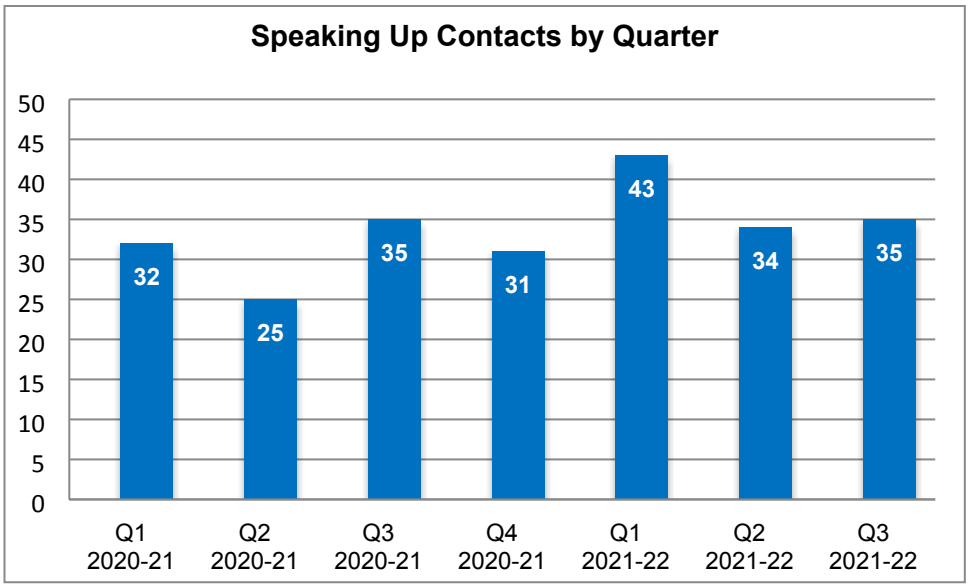
Theme	Summary	Month Case Raised	Status
Attitudes & Behaviours	Multiple grievances submitted with reporter dissatisfied with process.	June 2020	External active investigation, additional grievances raised.
Quality & Safety / Attitudes & Behaviours	Concerns raised with Chief Nurse about quality and safety and behaviours. Actions identified and communicated to reporters.	May 2021	Ongoing communication with reporters on status of actions. Additional processes currently active.
Quality & Safety	Concerns raised with Medical Director about quality and safety, workload, communication and behaviours	September 2021	Additional related concerns received. Division undertaking a review.

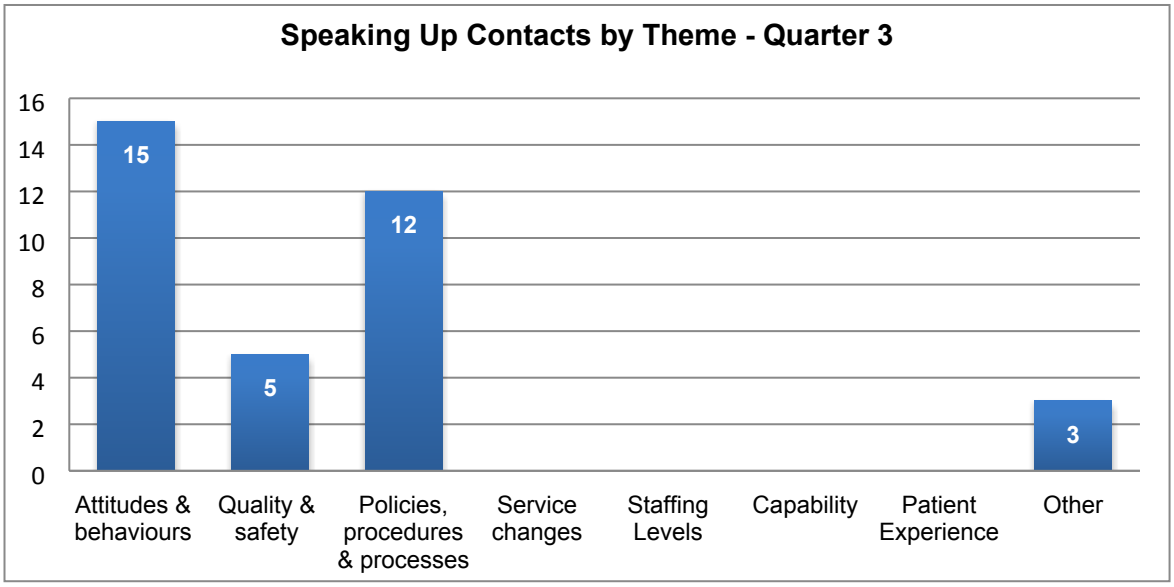
Issues Raised with our Employee Support Advisors

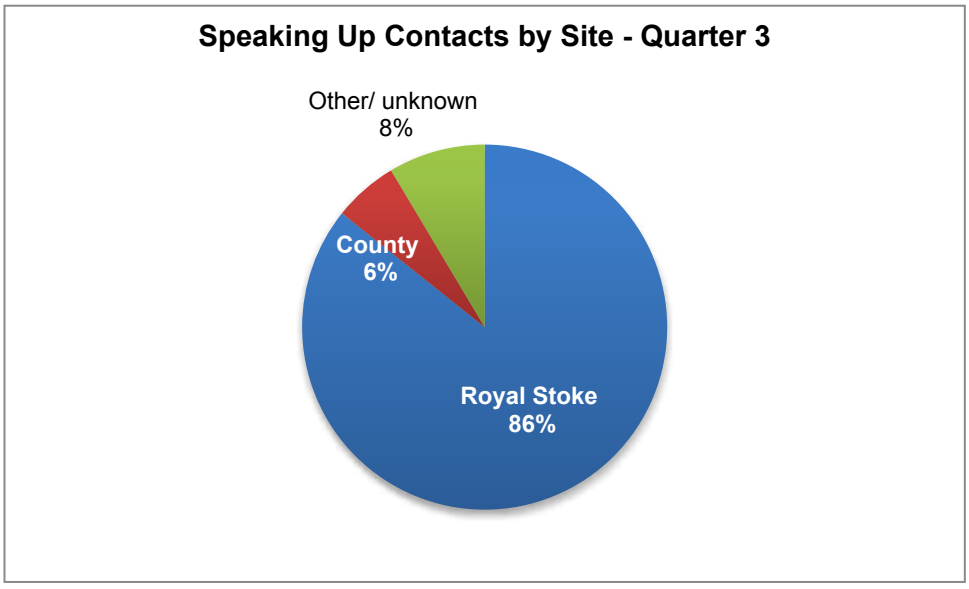
The NGO requests on a quarterly basis the number of issues raised through freedom to speak up channels (i.e. Freedom to Speak Up Guardians and champions). Our Employee Support Advisors act as speaking up champions and therefore their activity is included in NGO data submissions. During the quarter our ESA's have received 3 contacts relating to the following themes:

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

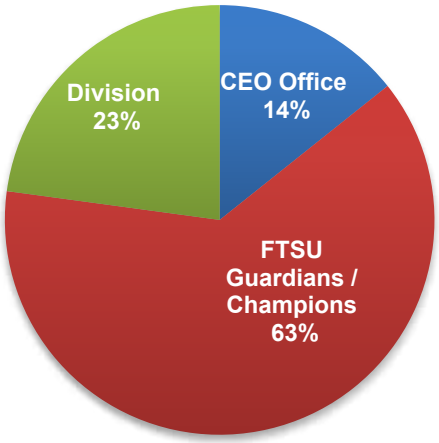
Quarter 3 Data Summary of All Speaking Up Contacts:



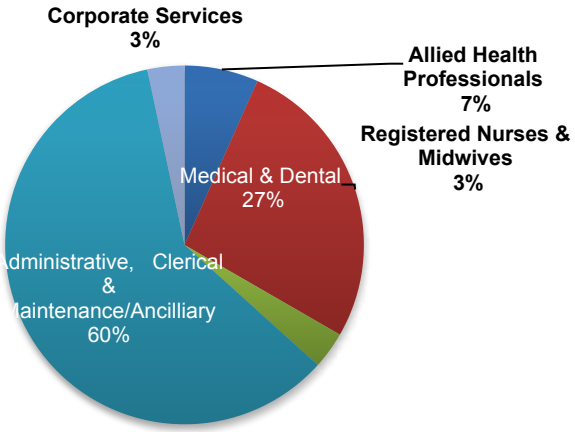




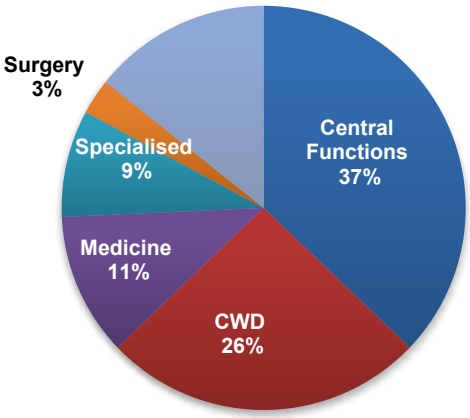
Speaking Up Contacts by Route - Quarter 3

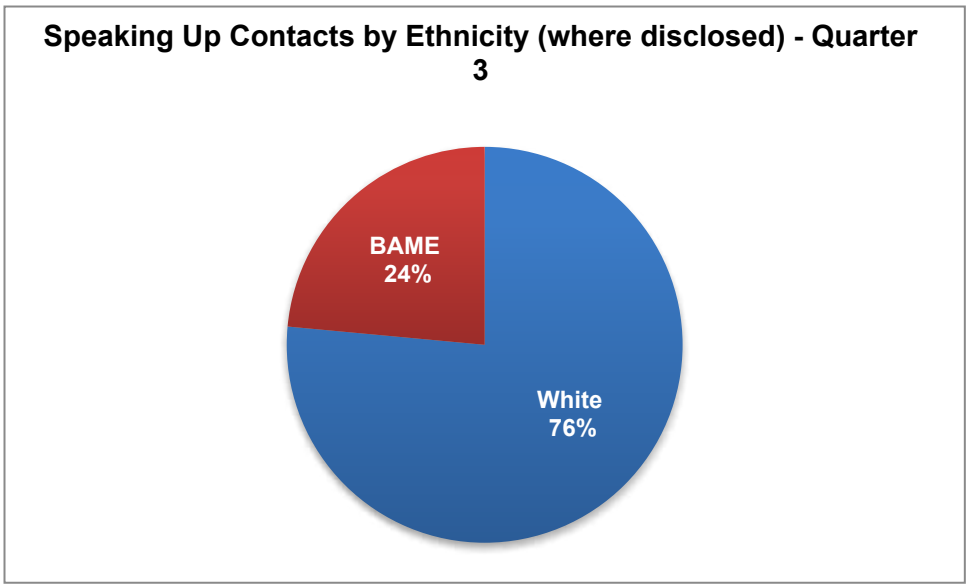


Speaking Up Contacts by Professional Group (where known) Quarter 3



Speaking Up Contacts by Division - Quarter 3





5. Recommendations

Trust Board is asked to note the activity and actions relating to speaking up undertaken in the Quarter 3 of 2021-22, and the focus going forward over the next quarter, which will be:

- Submit the updated Speaking Up Self Review Tool and UHNM Speaking Up Strategy
- Progress the recruitment of Lead FTSU Guardian
- Submit the options appraisal for the Work in Confidence reporting system
- Report back on the review of speaking up champion network arrangements against the NGO Guidelines undertaken in partnership with our Employee Support Advisors
- Complete the NGO Case Review Gap Analysis Tool and include as an appendix in the Quarter 4 Report

Executive Summary

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

Purpose of Report

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

Alignment with our Strategic Priorities

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

Risk Register Mapping

Executive Summary

Situation

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

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

Assessment

Quality & Safety

The Trust achieved the following standards in November 2021:

- Friend & Family (Inpatients) 98.6% and exceeds 95% target.
- Friends & Family Test for Maternity returned 100%.
- Harm Free Care continues to be above the national 95% target with 96.6%
- Trust rolling 12 month HSMR continues to be below expected range.
- C Diff YTD figures below trajectory with 5 against a target of 8.
- VTE Risk Assessment completed during admission continues to exceed 95% target with 99.0% (point prevalence audit via Safety Thermometer).
- Zero avoidable MRSA Bacteraemia cases reported.
- There have been no Category 4 Pressure Ulcers attributable to lapses in care during November 2021.
- Sepsis Screening compliance in Emergency Portals exceeded the target 90% with 93.0%.

- Inpatient Sepsis IVAB within 1 hour achieved 97.8% and exceeded 90% target rate
- Maternity Sepsis Screening compliance 91.7% against 90% target
- Zero Never Events.

The Trust did not achieve the set standards for:
- Friend & Family Test for A&E 69.2% and below 85% target.
- Falls rate was 5.8 per 1000 bed days but is below the average rate per 1000 bed days during COVID-19 pandemic
- There were 20 Pressure ulcers including Deep Tissue Injury identified with lapses in care during November 2021.
- 81.3% Duty of Candour 10 working day letter performance following formal verbal notification.
- Inpatients Sepsis Screening 88.6% below 90% target rate
- Emergency Portals IVAB in 1 hour improved to 86% but is below the 90% target for audited patients
- Children's Sepsis Screening compliance 85.7% and below the 90% target.
- Maternity Sepsis IVAB in 1 hour compliance at 50% and below the targets
- Emergency C Section rate is above 15% target at 19.51%.

Operational Performance

Emergency Care
- Attendances reduced in December from previous months and flow was optimised in ED and across the Acute floor aided by the decreased attendances and the Home for Christmas planning in medicine.
- Ambulance handover delays for 30-60mins reduced slightly and the > 60 mins also decreased in December. The percentage of handovers within 15 minutes increased to 66% .
- Time to initial assessment improved and the total type 1 performance for the last week of December was 68% within the 15 minutes
- The number of patients in the department for > 12 hours is of significance again in December although slightly lower than seen in October and November. There were 609 validated, 12 hour (DTA) trolley waits in December.

Cancer
- The Trust is provisionally predicted to achieve the 31 Day Subsequent Anti-Cancer Drugs, 31 Day Subsequent Radiotherapy, and Rare Cancer standards for December 21.
- The overall 2WW position for December is predicted to achieve in the region of 55%. This is an improvement on last month's position. Specialties with the most 14 day breaches are Breast, Skin and Upper GI. Performance against the 62 day standard is currently at 47% for December 21. This is an un-validated position that is expected to change as histology confirms a cancer or non-cancer diagnostic for patients treated.
- Theatre, Oncology, Diagnostic and Surgical workforces have been impacted, resulting in breaches. The position is being managed through the reinstated daily clinical prioritisation meetings and a robust planned care assurance framework. 2WW and 62 day position is significantly challenged, and will be validated prior to upload.
- After a focus on reducing the number of patients waiting to be appointed, the volumes in the RAS have reduced. Although still high, significant improvements have been made in Skin, Colorectal & Breast, and the Breast team are now booking within 14 days.
- The Trust continues to conduct a high number of 1st appointments, with 3011 patients being seen in December.

Planned Care
- Day Case and Elective Activity delivered 84.1% for December 21 against the national ask of 95%. This is lower in Inpatients than Day case (76% IP, 86% DC).
- In month Planned Care Cell focuses on elective recovery based on 10 high impact changes in accordance with the elective plan.
- Modelling of Q4 theatre capacity required to enable validation of H2 plan delivery offset against covid surge demand planning.
- CCG Commissioned Deloitte review is ongoing and UHNM are sense checking any outputs that will improve treatment capacity in the IS.
- CCG have an interim commissioning manager who is supporting elective opportunities in Tier 2 sector/regionally around mutual aid.

- Referral Hub – awaiting specification from 18 week source group and reviewing use of electronic ERS to manage referrals.
- Some work has already taken place at specialty level with respect to patient contact. This is being coordinated and consolidated to inform corporate next step and avoid duplication. Quotes now received for additional support to this project.

RTT

- The overall Referral To Treatment (RTT) Waiting list continues to rise. For December the indicative number of Incomplete pathways has risen to 70,951 (November 69,204).
- The number of patients > 18 weeks has risen to a level of 31,599 (November 29,072).
- The numbers of 52 week waits in December has increased with a reported 4,393 (November 4,046) this figure is below trajectory.
- At the end of December the numbers of > 104 weeks reported were 399. The Planned Care group is monitoring progress against treatment plans for these patients.
- Performance however, has slightly increased at 55.76% (November 55.26%).
- Work plans around long wait patient validation and treatment tracking are in progress

Diagnostics

- For DM01 (15 nationally identified Dx tests) the un-validated position for total waiting list has increased in December from 20,134 to 20,669. The Non-obstetric ultrasound waiting list reduced slightly from 9,935 to 9,901. Due to the challenges in Non-Obstetric Ultrasound this has adversely affected performance. The current DM01 diagnostic performance for December 21 is at 68% (November 69 %).
- The greatest proportions of > 6 week waits are within Non-obstetric ultrasound and endoscopy. The ultrasound position is related to an increase in demand alongside workforce shortfalls. The waiting list is growing significantly by c250 per week against a limited workforce that is at full capacity. The independent sector has now been commissioned to provide additional capacity. For endoscopy (colonoscopy and gastroscopy). This is related to an on-going increase in demand. Improvement actions are being developed and implemented.

Workforce

The strategic focus of our People Plan remains on supporting recruitment, staff wellbeing, absence management and implementing the new mandatory vaccination regulations.

Sickness

- The in-month sickness rate was 6.23% (5.57% reported at 30/11/21). The 12 month cumulative rate reduced to 5.25% (5.27% at 30/11/21). The daily sickness sitreps showed a steady rise in sickness rates during December 2021, with surge from 26th December.

Appraisals

- The Non-Medical PDR compliance rate was 76.18%, which is a slight improvement from the position at 30 November 2021 (75.80%) although performance remains below target. Completion of PDRs has been suspended while the Trust is at Critical Incident level

Statutory and Mandatory Training

- The Statutory and Mandatory training rate at 31st December 2021 was 95.50% (95.47% at 30 November 2021). This compliance rate is for the 6 ‘Core for All’ subjects only. At 31st December 2021, 91.50% of staff had completed all 6 Core for All modules (91.39% at 30/11/21)

Vacancies

- The overall Trust vacancy rate was 10.5% as a result of a small uplift in budgeted establishment to account for Winter planning.
- In accordance with the requirements set out in the NHSEI letter ‘Planning for Winter’, dated 13/12/21, the Trust is working to accelerate recruitment plans where possible, including for healthcare support workers.

Finance

Key messages

- The Trust set a plan at the start of the year with a H1 surplus of £8.3m and a full year deficit of £8.8m. The guidance for H2 was reviewed and the Trust set a revised breakeven plan for the financial year ending 31 March 2022. At both a National and System level an agreement was reached that the Trust was to carry forward the surplus of £14.5m delivered in H1 and therefore the planned position for H2 was a £14.5m deficit to achieve a breakeven plan for the year. Since then, the Trust has worked through the submitted activity plans and calculated an expected income of £5.1m against the Elective Recovery Fund. Therefore in November 2021, the Trust formally submitted a revised annual plan of a £5.1m surplus for the financial year ending 31 March 2022.
- The Trust has delivered an actual deficit of £0.8m in month against an in month planned deficit of £2.5m and a year to date surplus of £15.6m resulting in a favourable variance of £8.5m against the year to date plan. The positive position against plan in month is primarily driven by underspends against non-recurrent investment funds.
- A full year forecast has been undertaken at Month 9 which presents a £5.2m surplus. This includes material movements expected in Q4 including no ERF income and a release of part of the prior year annual leave accrual.
- The Trust incurred £1.1m of costs relating to COVID-19 in month which is an increase of £0.1m compared with Month 8's figure. This remains within the Trust's fixed allocation with £0.7m being chargeable on top of this allocation for COVID-19 testing costs.
- Capital expenditure for the year to date stands at £17.9m which is £2.8m behind the plan mainly due to an underspend relating to digital pathology and estates infrastructure.
- The cash balance at Month 9 is £83m which is £5m higher than plan, the main reason being lower than forecast capital payments which reflects the overall slippage against the capital plan.

Key Recommendations

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

NHS
University Hospitals of North Midlands
NHS Trust

Integrated Performance Report

Month 9 2021/22

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Contents

A note on **SPC**

University Hospitals of North Midlands NHS Trust

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

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

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

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

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

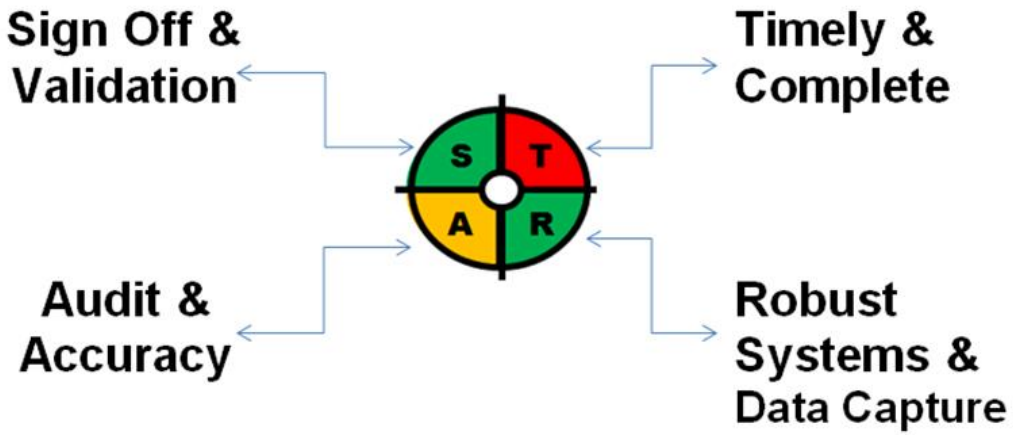
Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

A note on **Data Quality**

University Hospitals of North Midlands NHS Trust

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



Explaining each domain

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

RAG rating key

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

Quality

Caring and Safety

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

Quality Spotlight Report

NHS University Hospitals of North Midlands NHS Trust

Key messages

The Trust achieved the following standards in December 2021:

- Friend & Family (Inpatients) 98.3% and exceeds 95% target.
- Friends & Family Test for Maternity returned 100%
- Trust rolling 12 month HSMR continue to be below expected range.
- VTE Risk Assessment completed during admission continues to exceed 95% target with 98.9% (point prevalence audit via Safety Thermometer).
- Zero avoidable MRSA Bacteraemia cases reported.
- There have been no Category 4 Pressure Ulcers attributable to lapses in care during December 2021.
- Sepsis Screening compliance in Emergency Portals exceeded the target 90% with 96%.
- Inpatients Sepsis Screening 96.6% above 90% target rate and Inpatient Sepsis IVAB within 1 hour achieved 100% and exceeded 90% target rate
- Children's Sepsis Screening compliance 92.9% and above the 90% target.
- Maternity Sepsis Screening compliance 100% against 90% target and Maternity Sepsis IVAB in 1 hour compliance also at 100%

The Trust did not achieve the set standards for:

- Friend & Family Test for A&E has improved to 73.3% but is below 85% target.
- Harm Free Care dropped below national 95% target rate at 94.1%
- Falls rate was 5.9 per 1000 bed days but is below the average rate per 1000 bed days during COVID-19 pandemic
- There were 34 Pressure ulcers including Deep Tissue Injury identified with lapses in care during December 2021.
- 80% Duty of Candour 10 working day letter performance following formal verbal notification. All patients have received written notification but 2 cases were over 10 day target.
- 2 Never Events reported
- C Diff YTD figures above trajectory with 9 against a target of 8.
- Emergency Portals Sepsis IVAB in 1 hour improved to 88% but is below the 90% target for audited patients
- Emergency C Section rate is above 15% target at 20.8%.

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

- The rate of complaints per 10,000 spells is 26.37 and is below (positive) the target of 35 and within normal variation. Majority of complaints in December 2021 relate to clinical treatment.
- Total number of Patient Safety Incidents decreased in month (1715) and the rate per 1000 bed days has also decreased at 44.79 and both measures are within normal variation.
- Total incidents with moderate harm or above and the rate of these incidents have decreased but is normal monthly variation. December 2021 has seen decrease compared to previous month increase and November's higher totals.
- Increase in total reported incidents relating to staffing shortages and lack of appropriate staff on wards/departments during December 2021. 74 in total although 30 were coded as patient related, the remaining 44 were reported as staff related incidents.
- Rate of falls reported that have resulted in harm to patients currently at 1.6 per 1000 bed days in December 2021. The rate of patient falls with harm continues to be within the control limits and normal variation and is around the mean rate which indicates there may be improvement in reducing harm from falls.
- Medication related incidents rate per 1000 bed days is 3.8 and patient related 3.2 which are decreases compared to previous months. The monthly variation is within the normal expected variation and consistent with Trust mean rates. However whilst it is below the previously published NRLS national mean rate of 6.0 the arte is nearer to the this national mean rate.
- Pressure Ulcers developed under UHNM care has seen an increase during December 2021 along with an in number with lapses in care.
- 23 Definite Hospital Onset / Nosocomial COVID-19 cases reported in December 2021.
- 1 COVID-19 death falling in to the 'Definite' category (according to the National definition of Nosocomial deaths of first positive result 15 days or more after admission to hospital).
- 16 Serious Incidents reported in December 2021. All the serious incidents were reported on STEIS within the 2 working date target following confirmation of SI criteria.

Quality Dashboard

NHS
University Hospitals of North Midlands
NHS Trust

Metric	Target	Latest	Variation	Assurance
Patient Safety Incidents	N/A	1715	H	
Patient Safety Incidents per 1000 bed days	N/A	44.79	H	
Patient Safety Incidents per 1000 bed days with no harm	N/A	28.91		
Patient Safety Incidents per 1000 bed days with low harm	N/A	13.95	H	
Patient Safety Incidents per 1000 bed days reported as Near Miss	N/A	1.59		
Patient Safety Incidents with moderate harm +	N/A	13		
Patient Safety Incidents with moderate harm + per 1000 bed days	N/A	0.31		
Harm Free Care (New Harms)	95%	96.6%	L	?
Patient Falls per 1000 bed days	5.6	5.9	L	?
Patient Falls with harm per 1000 bed days	1.5	1.0		?
Medication Incidents per 1000 bed days	6	3.9		?
Medication Incidents % with moderate harm or above	0.50%	1.36%		?
Patient Medication Incidents per 1000 bed days	6	3.2		F
Patient Medication Incidents % with moderate harm or above	0.50%	1.63%		?

Metric	Target	Latest	Variation	Assurance
Serious Incidents reported per month	0	16		F
Serious Incidents Rate per 1000 bed days	0	0.42		?
Never Events reported per month	0	2		?
Duty of Candour - Verbal/Formal Notification	100%	100%		?
Duty of Candour - Written	100%	80.0%		?
All Pressure ulcers developed under UHNM Care	TBC	0	L	
All Pressure ulcers developed under UHNM Care per 1000 bed days	N/A	2.40	H	
All Pressure ulcers developed under UHNM Care lapses in care	12	34	H	?
All Pressure ulcers developed under UHNM Care lapses in care per 1000 bed days	0.5	0.84	H	?
Category 2 Pressure Ulcers with lapses in Care	8	5		?
Category 3 Pressure Ulcers with lapse in care	4	2		?
Deep Tissue Injury with lapses in care	0	20	H	
Unstageable Pressure Ulcers with lapses in care	0	7	H	?

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Quality Dashboard

NHS
University Hospitals of North Midlands
NHS Trust

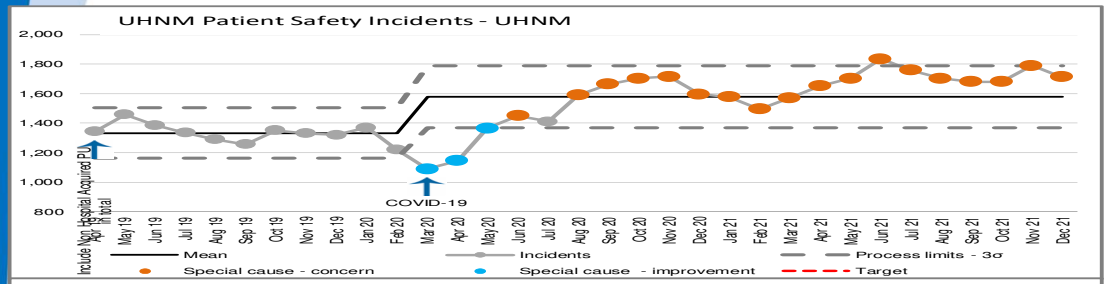
Metric	Target	Latest	Variation	Assurance
Friends & Family Test - A&E	85%	73.3%		
Friends & Family Test - Inpatient	95%	98.6%		
Friends & Family Test - Maternity	95%	100.0%		
Written Complaints per 10,000 spells	35	24.90		
Rolling 12 Month HSMR (3 month time lag)	100	97.33		
Rolling 12 Month SHMI (4 month time lag)	100	101.79		
Nosocomial COVID-19 Deaths (Positive Sample 15+ days after admission)	N/A	1		
VTE Risk Assessment Compliance	95%	98.9%		
Emergency C Section rate % of total births	15%	20.80%		
Reported C Diff Cases per month	8	9		
Avoidable MRSA Bacteraemia Cases per month	0	0		
HAI E. Coli Bacteraemia Cases per month	8	10		
Nosocomial "Definite" HAI COVID Cases - UHNM	0	23		

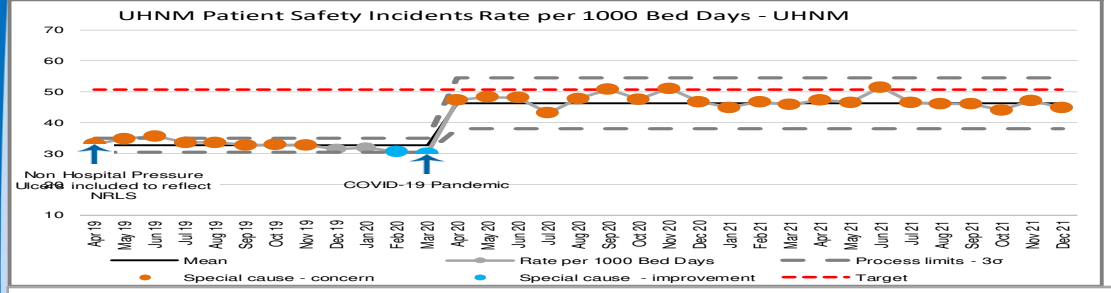
Metric	Target	Latest	Variation	Assurance
Inpatient Sepsis Screening Compliance (Contracted)	90%	96.6%		
Inpatient IVAB within 1hr (Contracted)	90%	100.0%		
Children Sepsis Screening Compliance (All)	90%	92.9%		
Children IVAB within 1hr (All)	90%	N/A		
Emergency Portals Sepsis Screening Compliance (Contracted)	90%	96.0%		
Emergency Portals IVAB within 1 hr (Contracted)	90%	87.9%		
Maternity Sepsis Screening (All)	90%	100.0%		
Maternity IVAB within 1 hr (All)	90%	100.0%		

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Reported Patient Safety Incidents





Variation	Assurance
	

Target	Oct 21	Nov 21	Dec 21
N/A	1681	1791	1715

Background

Total Reported patient safety incidents

Variation	Assurance
	

NRLS Mean	Oct 21	Nov 21	Dec 21
50.70	44.10	47.16	44.79

What is the data telling us:

The above data relates to **all** reported Patient Safety Incidents (PSIs) across the Trust. The December 2021 total remains above the mean total since COVID-19 started. However, the reporting of incidents and near misses should continue to be encouraged and promoted and increasing rates and numbers of total incidents is not necessarily to be viewed as concern. It is important to review the different levels of harm within the overall totals.

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

- Patient related Slip/Trip/Fall - 227 (222)
- Clinical assessment (Including diagnosis, images and lab tests) – 76 (90)
- Patient flow incl. access, discharge & transfer - 91 (100)
- Documentation – 37 (49)
- Pressure Ulcers (Hospital acquired) – 92 (81)
- Treatment/Procedure - 78 (79)
- Medication incidents - 126 (173)
- Infection Prevention – 54 (32)
- Staffing – 30 (30)

There has been increase in the number of staffing related incidents submitted during December with 74 (60 in November and 61 in October) incidents reported. 30 of these were under patient related and the remaining 44 were reported as staff related. All of these incidents were relating to lack of suitable trained staff. Individual incidents may relate to lack of different staff groups and during December 2021 the following were reported:

69 – insufficient professional healthcare staff

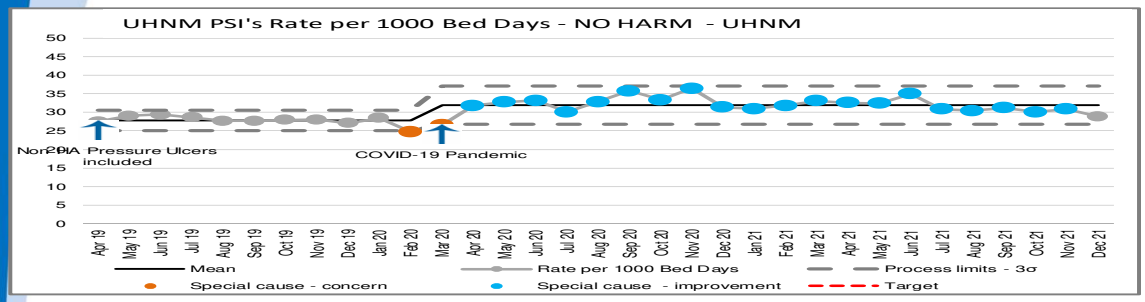
7 – insufficient non professional healthcare staff (6 of these were reported at County Hospital Ward 1)

6 – insufficient support staff

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

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

University Hospitals of North Midlands NHS Trust

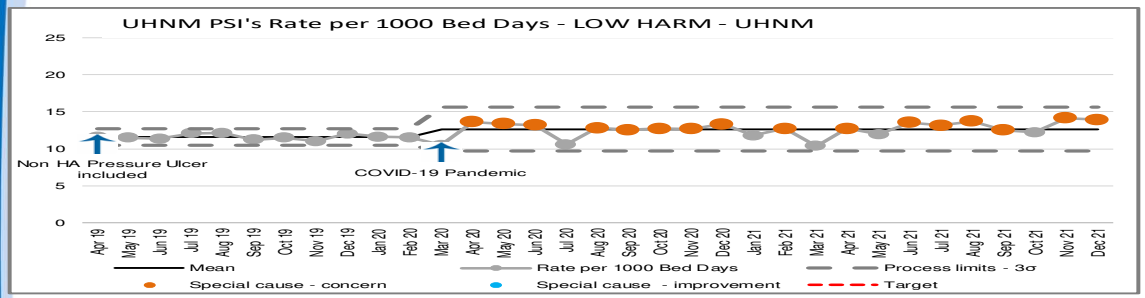


Variation	Assurance

Target	Oct 21	Nov 21	Dec 21
N/A	30.12	30.91	28.91

Background

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

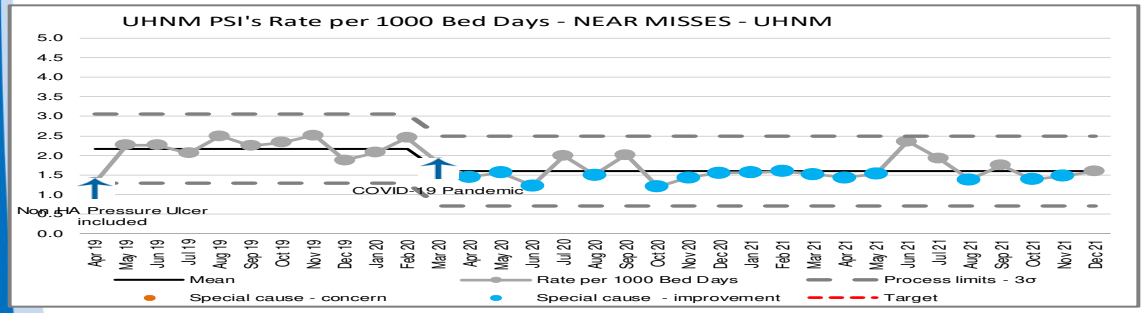


Variation	Assurance

Target	Oct 21	Nov 21	Dec 21
N/A	12.20	14.14	13.95

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	Oct 21	Nov 21	Dec 21
N/A	1.39	1.47	1.59

Background

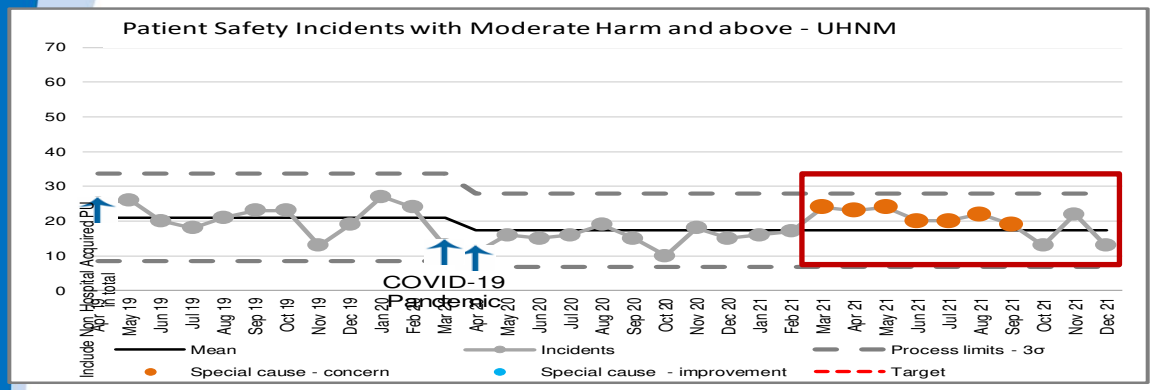
The rate of Patient safety Incidents per 1000 bed days that are reported as NEAR MISS

What is the data telling us:

The Rate of Patient Safety Incidents per 1000 bed days with no harm or low harm are showing consistent trends. Although Low harm has seen increase in recent months but still within normal variations. 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

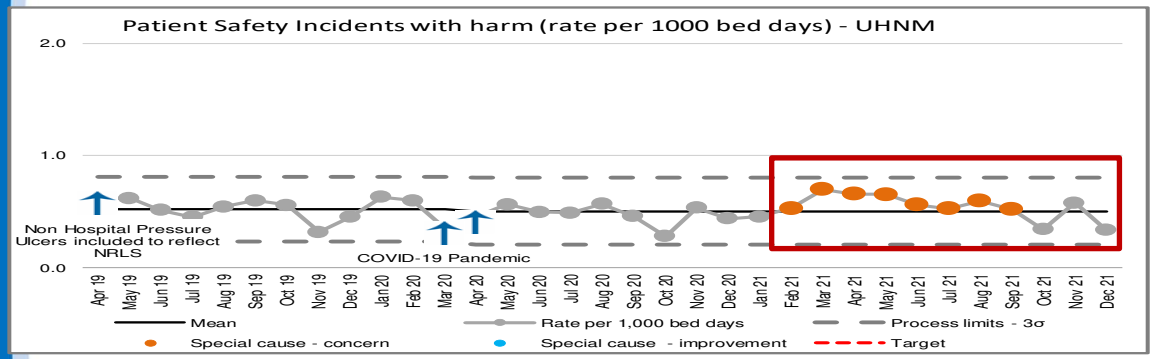


Variation	Assurance

Target	Oct 21	Nov 21	Dec 21
N/A	13	22	13

Background

Patient safety incidents with reported moderate harm and above



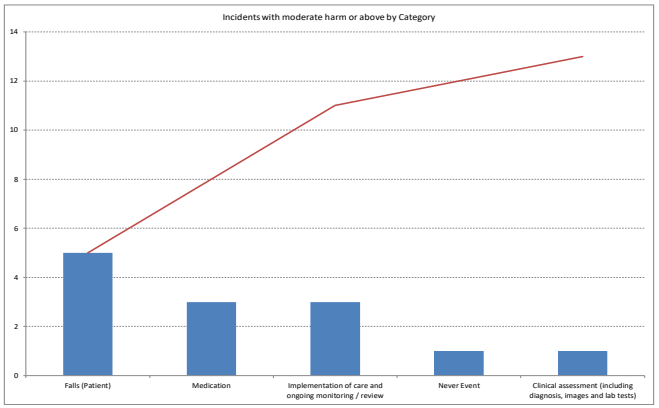
Variation	Assurance

Target	Oct 21	Nov 21	Dec 21
N/A	0.34	0.58	0.34

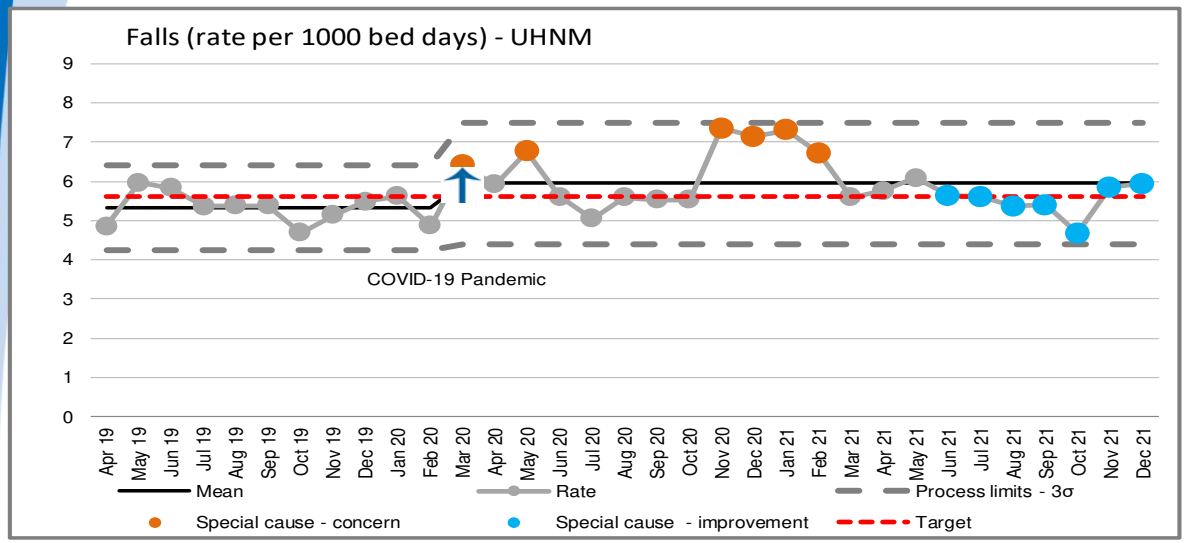
What is the data telling us:

The variation noted in charts above for moderate harm or above total and rate per 1000 bed days is within normal variation and no special cause noted. Whilst noted that not statistically significant yet the previous months were showing reductions in the number and rate of incidents with moderate harm or above. December has seen a decrease from November and remains in normal variation. It appears that the increase in November 2021 was outlier in recent trend from April 2021.

The top category of incidents resulting in moderate harm reflect the largest reporting categories with 5 Falls, 3 medication and 3 Implementation of care related being top 4 categories.
National Comparison taken from latest CQC Insight Report is that 26.1% of reported patient safety incidents to NRLS resulted in harm. UHNM latest results are 22.8% .



Patient Falls Rate per 1000 bed days



Variation	Assurance
L	?

Target	Oct 21	Nov 21	Dec 21
5.6	4.7	5.8	5.9

Background

The number of falls per 1000 occupied bed days

What is the data telling us:

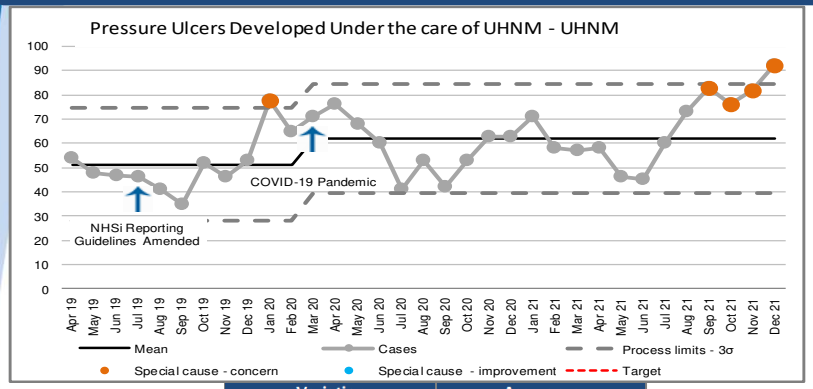
The chart shows the Trust's rate of reported patient falls per 1000 bed days is currently not showing any significant change. The Trust adopted the average rate of 5.6 patient falls per 1000 bed days from the Royal College of Physicians National Falls Audit report (2015) as a target rate.

The areas reporting the highest numbers of falls in December 2021 were:
Royal ED Royal Stoke AMU Ward 112 – Orthopaedics Ward 121 (Diabetes, Endocrinology and Gen Med) Ward 126 (Respiratory) Ward 110 – Vascular (County) Ward 14 Ward 201

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

- Ward 112 - Spot checks have been completed by the corporate nursing team and issues have been fed back to the ward team.
- The falls risk alert symbol for use in ED for transfers to AMU has encountered some challenges, alternative have been discussed and a plan is being made to move forward. Discussion also continues around the doors in majors that restrict visibility.
- Ward 201 – discussions around multiple fallers and safe use of bed rails have taken place. Staff are engaged and have shared learning identified.
- Ward 14 - Staff had been asked to continue to talk about falls at safety huddles to ensure falls awareness and prevention is considered.
- Ward 121, 126 and 110 have all been supported with bed rail spot check audits and general falls awareness / prevention advice has been shared with the teams

Total Pressure Ulcers developed under care of UHNM

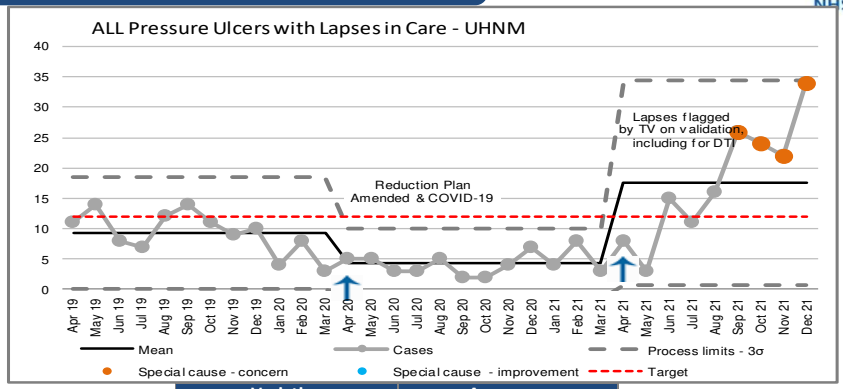


Variation	Assurance
	

Target	Oct 21	Nov 21	Dec 21
N/A	76	82	92

Background

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



Variation	Assurance
	

Target	Oct 21	Nov 21	Dec 21
12	24	22	34

Background

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

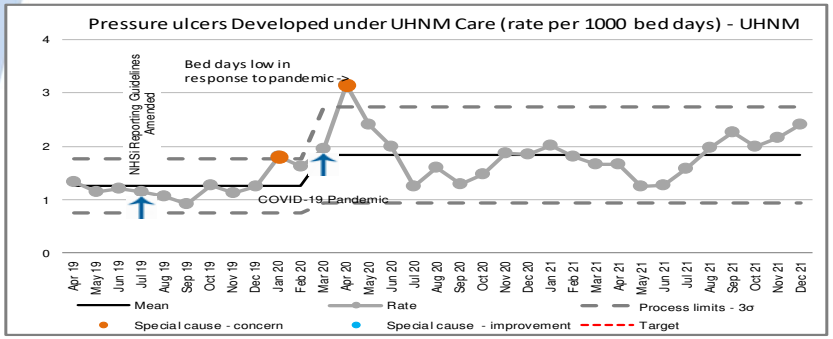
The tables below show breakdowns of the pressure ulcers reported in December 2021.

Category	Total (Dec 2021)
DTI	45
Category 2	30
Category 3	6
Category 4	1
Unstageable	10
Total	**92**

Top Body Locations	Total (Dec 2021)
Heel	31
Buttock	14
Sacrum	12
Mouth	5
Leg	5

The number of pressure ulcers reported as developing under the care of UHNM in December is significantly above average. This is primarily due to numbers of DTI's (45), compared to a 2-year monthly average of 24, though the average number of Category 2's reported also remains higher than that seen before November 2020. Number within other categories are stable.

Pressure Ulcers developed under care of UHNM per 1000 bed days

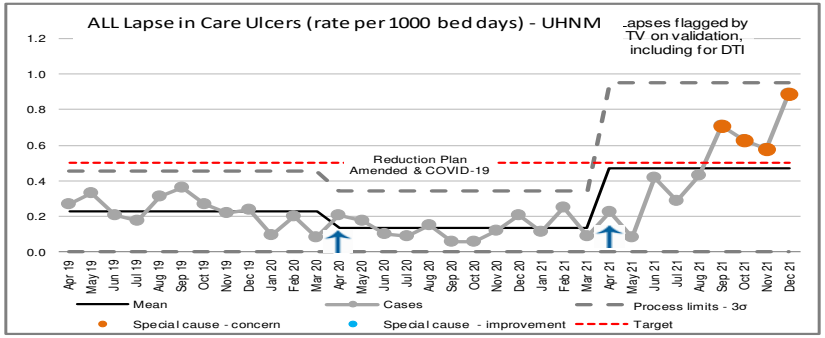


Variation	Assurance
	

Target	Oct 21	Nov 21	Dec 21
N/A	1.99	2.16	2.40

Background

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



Variation	Assurance
	

Target	Oct 21	Nov 21	Dec 21
0.5	0.63	0.58	0.89

Background

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

What the data is telling us

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

The chart above right shows the rate of pressure ulcers with lapses in care identified was significantly higher between September – December than in previous months (see detail on previous slide). All lapses in care are fully investigated with individualised action plans to support quality improvement. Spot audits are also presented at this panel to provide assurance that actions and learning from RCAs have resulted in actual improvements in preventative practice.

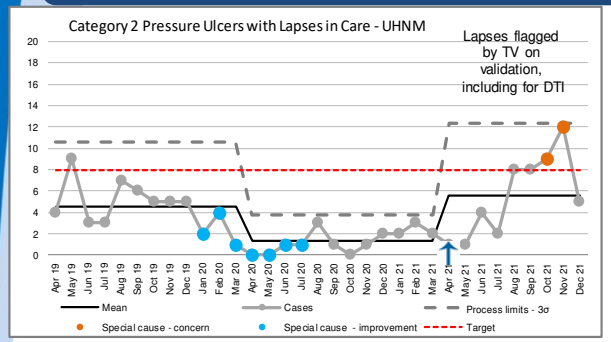
High reporting areas will be presenting all incidents at bespoke RCA panels, to allow identification of trends, and establish their improvement and educational focus. The Tissue Viability team and Corporate Nursing Quality & Safety Teams will support with this.

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

Actions

- Themes and incidents are under constant review by the Quality & Safety team to identify and discuss any emerging themes.
- Documentation is under constant review to reduce identified lapses
- Pressure Ulcer Prevention (PUP) education is now delivered on multiple platforms including the Nursing Assistant, adaptation nurse and Preceptorship induction programme , new starters in ED and child health, and ward champions . Education and support can also be requested as required.
- Alerts of themes will be sent to wards for awareness to encourage improvement initiatives.
- The Quality & Safety team are engaged in supporting clinical areas who are focusing on pressure ulcers as a driver or watch metric . Surgery Division have identified Pressure Ulcers reduction as a driver metric.
- Seating audits are being completed across the trust and a proposal for new chairs has been submitted for the Royal Stoke site. Care of the elderly received their new chairs last week with funds supported by PHE. The County site will be due for their 2 yearly audit next month.
- Review of surfaces in ED to enhance Pressure ulcer prevention, 15 Stryker trollies with high quality pressure relieving mattresses have been purchased.

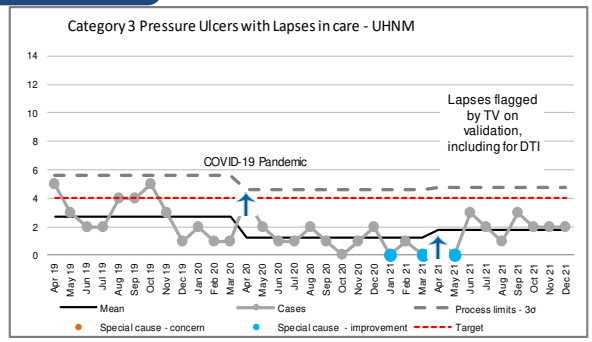
Pressure Ulcers with lapses in care



Variation	Assurance
	

Target	Oct 21	Nov 21	Dec 21
8	9	12	5

Background

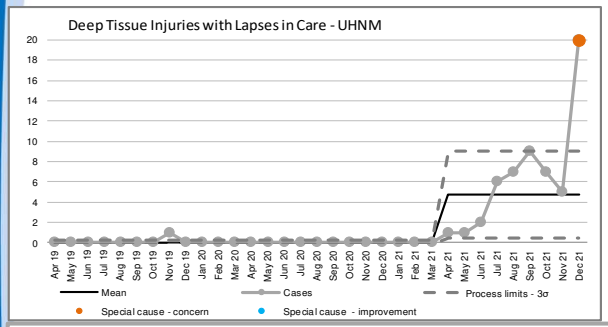


Variation	Assurance
	

Target	Oct 21	Nov 21	Dec 21
4	2	2	2

Background

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

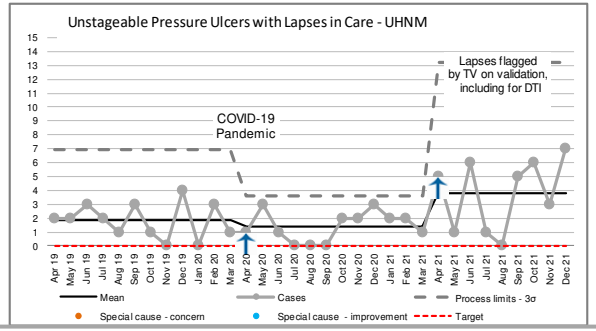


Variation	Assurance
	

Target	Oct 21	Nov 21	Dec 21
N/A	7	5	20

Background

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



Variation	Assurance
	

Target	Oct 21	Nov 21	Dec 21
0	6	3	7

Background

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

What is the data telling us:

The charts above show that the Pressure Ulcers with lapses in care reported in December 2021 included a range of categories, though like the total numbers, the number of DTI's is particularly high. Further analysis is being undertaken to assess the potential causes for increased pressure ulcers with lapses in care and whether this is result of the current operational pressures across the Trust.

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

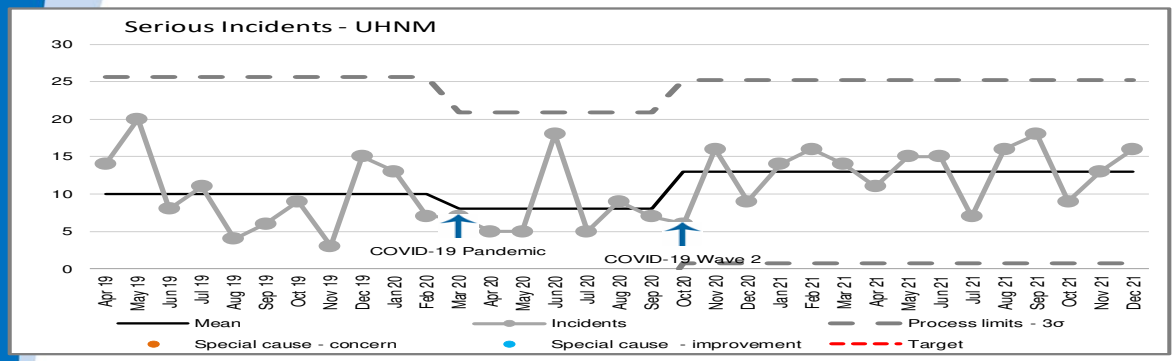
Locations with more than 1 lapse in December were:
(County) Ward 1 (4), AMU Stoke (4), W 113 (Respiratory) (3), W 81 (2), W 201 (2), (County) Ward 12 (2), (County) Ward 14 (2), Emergency Care Centre (2).

Root Cause(s) of damage - Lapses - Dec 2021	Total
Management of heel offloading	18
Management of repositioning	13
Management of device	3
Management of non-concordance	2
Clinical condition	1
Management of continence	1

Actions:

- High reporting wards will be sent notification, with Hot Debriefs taking place on the wards
- Education continues on high reporting areas from TV Team and Corporate team
- The Tissue Viability Team and Corporate Nursing Team are supporting high reporting areas following panel
- presentation, to gain assurance around actions. Feedback is then provided to the ward managers.
- Pressure Ulcer Prevention (PUP) Champions training is in process planning for next year and focuses on learning from incidents.
- Engage house keepers to support wards with ensuring adequate equipment is available for heel offloading.

Serious Incidents per month

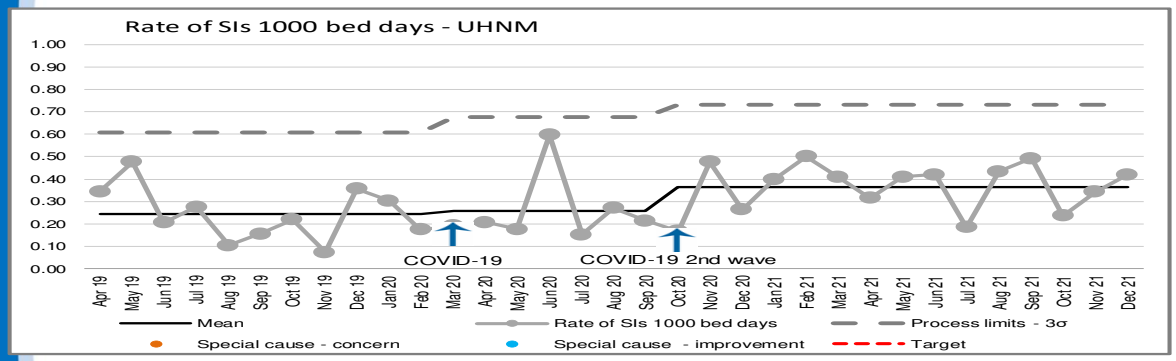


Variation	Assurance
	F

Threshold	Oct 21	Nov 21	Dec 21
0	9	13	16

Background

The number of reported Serious Incidents per month



Variation	Assurance
	?

Target	Oct 21	Nov 21	Dec 21
0	0.24	0.34	0.42

Background

The rate of Serious Incidents Reported per 1000 bed days

What is the data telling us:

December 2021* saw 16 incidents reported with 13 at RSUH and 3 at County Hospital (which were all patient falls):

- 6 Falls related incidents
- 3 Treatment delay related incidents
- 2 Surgical/invasive procedure related incidents
- 1 Diagnostic related incidents
- 1 Medication related incidents
- 1 Maternity/Obstetric (mother only)
- 1 Maternity/Obstetric (baby only)

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

There are currently 71 incidents open on STEIS for UHNM as at 31st December 2021.

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

Serious Incidents Summary

University Hospitals of North Midlands NHS Trust

Summary of new Maternity Serious Incidents

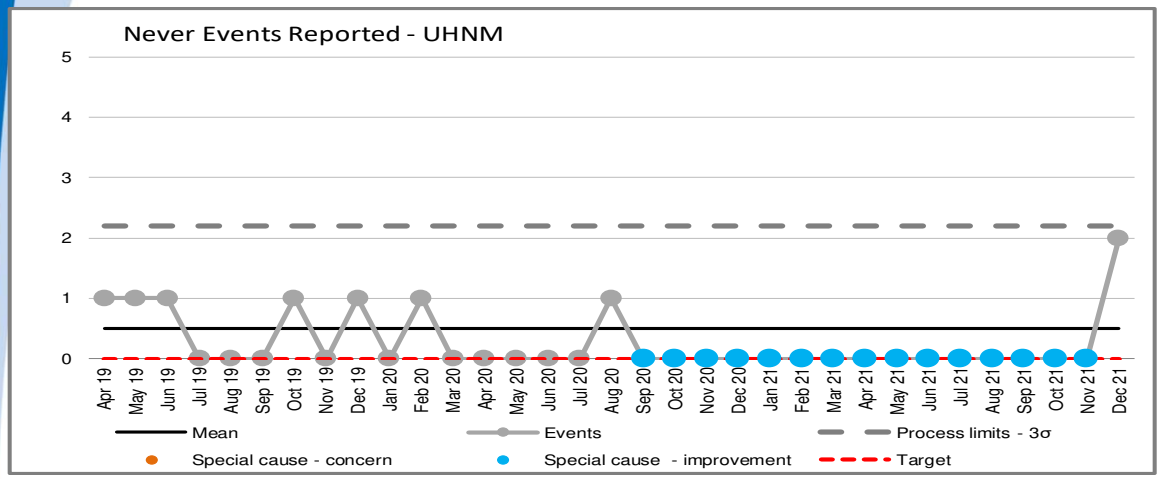
Following the formal recommendations in the Ockenden Report, below is an outline of the Maternity related serious incidents reported during December 2021. The new recommendation requires the Trust Board to receive summary on the new Maternity related Serious Incidents along with previously reported summary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

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

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

Log No	Patient Ethnic Group:	Type of Incident	Target Completion date	Description of what happened:
2021/24634	White- British	Obstetric/Maternity related (Baby only)	28/02/2022	The Serious Incident report is based on the grading of care following a PMRT review which was completed as per MBRRACE guidance. Neonatal death following baby being brought in by ambulance after born at home at 23+1 weeks of pregnancy. Missed opportunity to commence inotropes peripherally whilst attempting to gain central line access. Missed opportunity to change ventilator support following blood gas
2021/23613	White- British	Obstetric/Maternity related (Mother only)	28/02/2022	Maternal Death reported 61 days post-partum. Mother reported COVID-19 positive. Elective Caesarean Section undertaken 23/09/2021. attended Emergency Department 07/11/2021 and admitted to Critical Care.

Never Events



Variation	Assurance

Target	Oct 21	Nov 21	Dec 21
0	0	0	2

Background

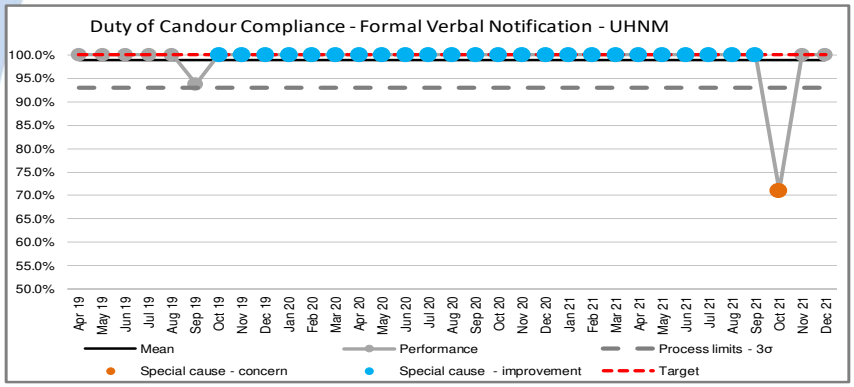
Defined as Serious Incidents that are wholly preventable, as strong systemic protective barriers should be in place

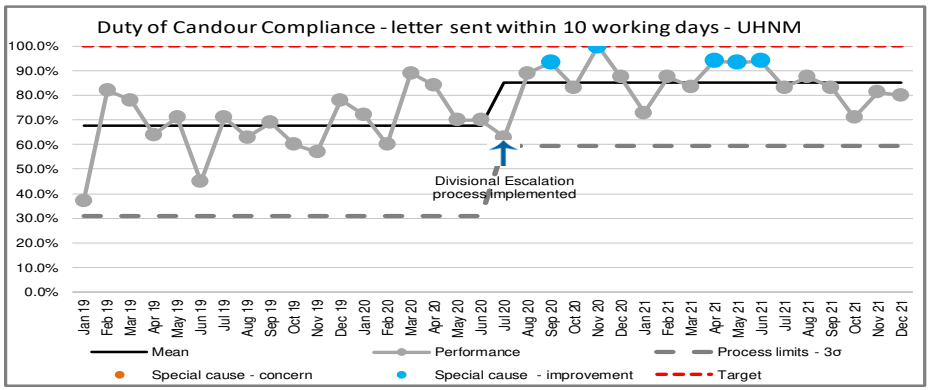
There have been 2 reported in December 2021and 2 in total for year to date 2021/22. The target is to have 0 Never Events.

Prior to December 2020, there had been sustained good performance against the target of zero Never events with no events recorded for 15 months.

Log No.	STEIS Category	Description	Target Completion date
2021/25872	Surgical invasive procedure incident	Punch biopsy lesion on right anterior nostril performed. At the end of the procedure when patient was in CTS, the patient made staff aware that the incorrect lesion had been removed and it was actually on the skin outside. Patient was reviewed by surgeon and consultant and apologies provided. Patient was resubmitted for surgery the same day to remove the correct lesion. A punch biopsy lesion skin right soft triangle area of nose was successfully performed, removing the correct lesion.	18/03/2022
2021/25043	Surgical invasive procedure incident	A small swab went missing during the last/final count in a Robotic Anterior Resection with right inguinal hernia repair using mesh at Theatre 26 on 03 December 2021 at around 14:00 to 14:20. a discrepancy was noted in the final swab count. Surgeons were immediately informed. An xray was ordered and swab was seen on the xray image so surgeon performed immediate removal procedure.	07/03/2022

Duty of Candour Compliance





Variation	Assurance

Target	Oct 21	Nov 21	Dec 21
100%	71.0%	100.0%	100.0%

Background

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

Variation	Assurance

Target	Oct 21	Nov 21	Dec 21
100%	71.0%	81.3%	80.0%

Background

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

What is the data telling us:

During December there were 10 incidents reported and identified that have formally triggered the Duty of Candour. All 10 of these cases (100%) have recorded that the patient/relatives been formally notified of the incident in Datix.

Confirmed Follow up Written Duty of Candour compliance (i.e. receiving the letter within 10 working days of verbal notification) during December 2021 is 80%.

Whilst there were 2 cases that had not received the letter within 10 days, all letters had subsequently been circulated .

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

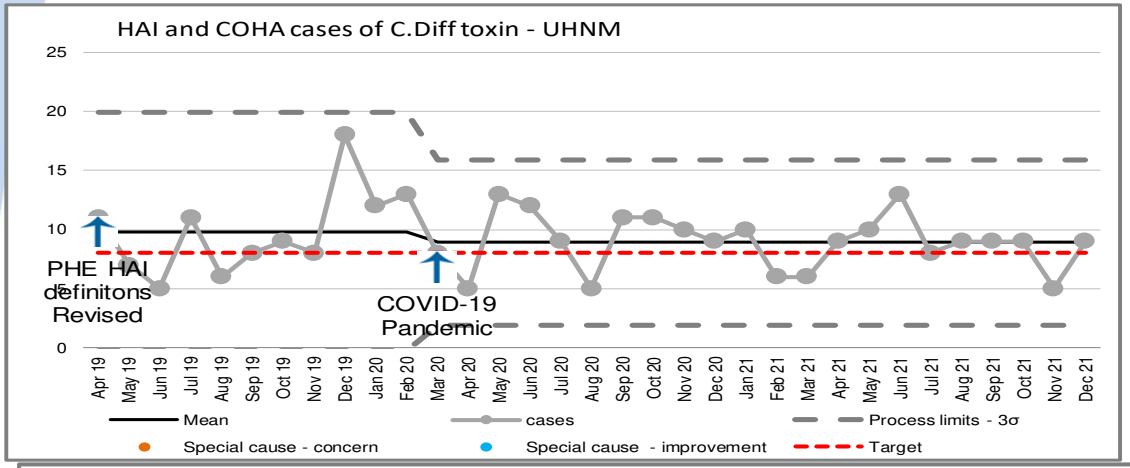
Actions taken:

Current decline in performance has been escalated with Divisions via Quality & Safety Oversight Group and support is being provided to facilitate the completion of the written notifications during the increased pressures and staffing shortages.

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	Oct 21	Nov 21	Dec 21
8	9	5	9

Background

Number of HAI + COHA cases reported by month

What do these results tell us?

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

There have been 9 reported C diff cases in December with 8 being Hospital Associated Infection (HAI) cases and 1 COHA case.

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

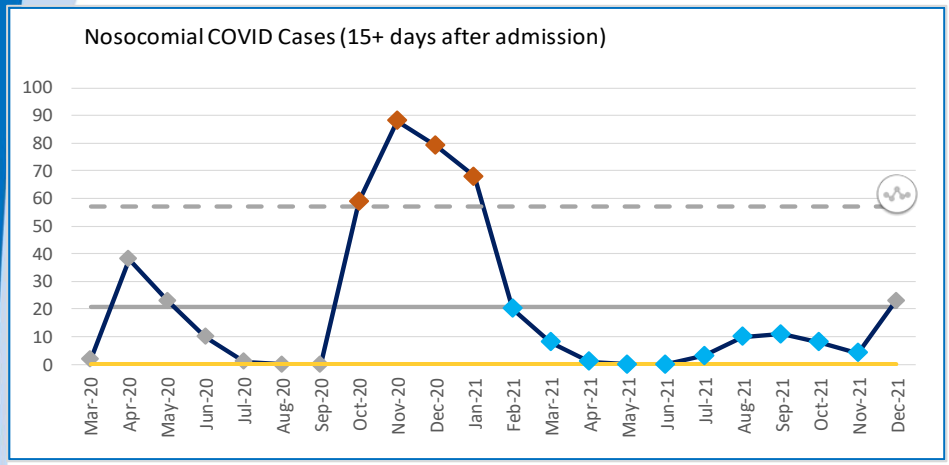
There have been two clinical areas that have had more than one Clostridium *difficile* case in a 28 day period.

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

Actions:

- Continue surveillance for HAI C diff with continued immediate implementation of control measures to prevent transmission
- In all cases control measures are instigated immediately
- 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?

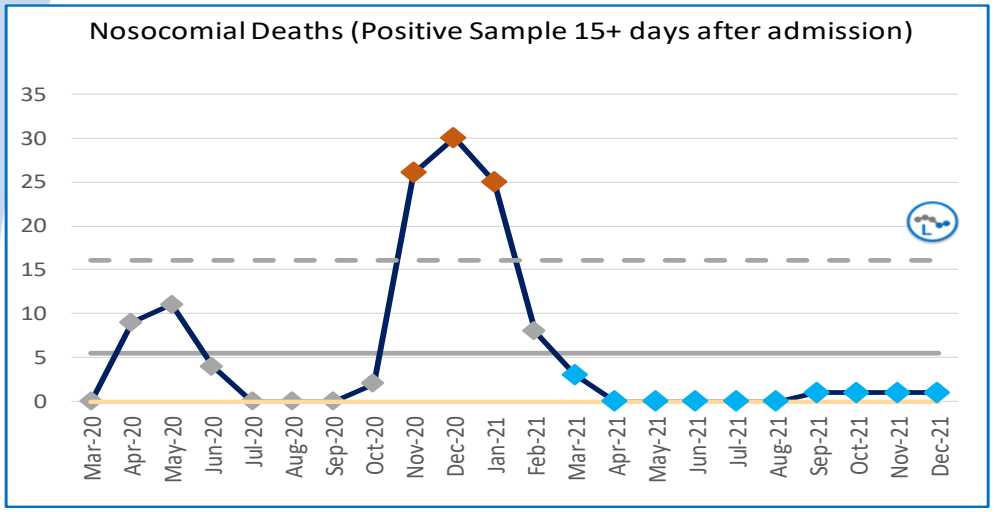
- The data shows an in month increase in definite Healthcare Acquired COVID -19 cases with 23 in December 2021.
- Local, Regional and National community COVID-19 rates significantly increased in December 2021 (see table opposite) compared to November 2021 and the rates from same period in 2020.
- December has seen increase in Probable and definite Hospital Onset COVID but is below Wave 2 figures and December 2020 figures.

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

Actions :

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

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



What do these results tell us?

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

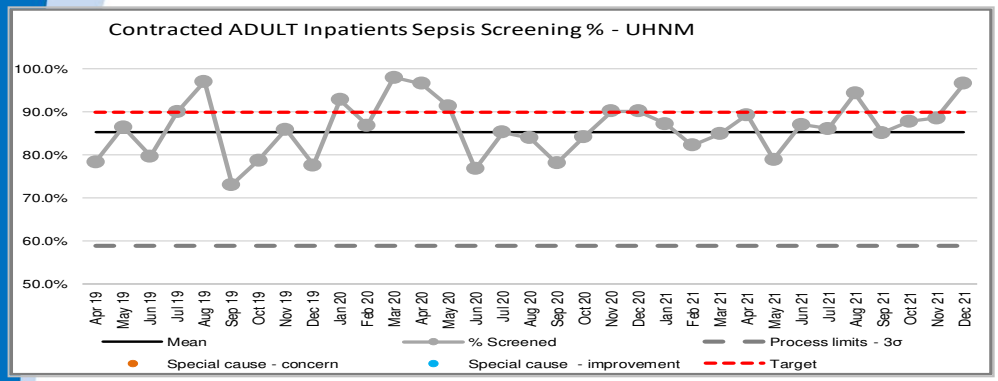
- There have been 1 recorded definite hospital onset COVID-19 deaths during December 2021
- Total 126 hospital acquired COVID-19 deaths with 1st positive results 15 days or more following admission recorded since 1st March 2020 up to 31st December 2021.
- The mean number of deaths per month since March 2020 is 6.

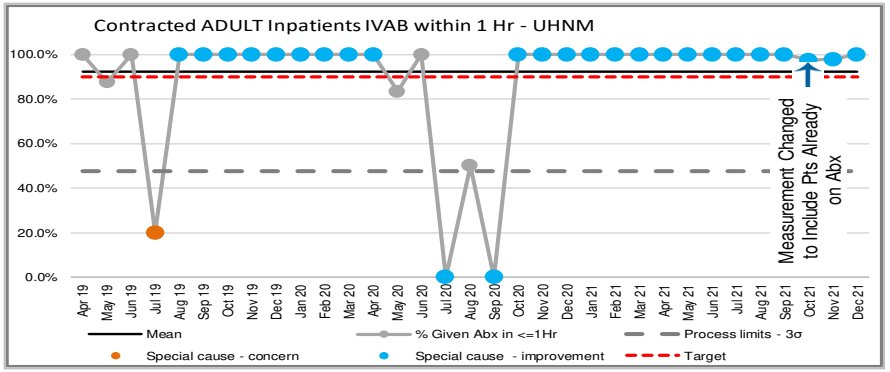
Actions :

Review Panels continued to be held during December 2021 and the definite hospital onset / nosocomial deaths will have completed reviews by end of January 2022
Summary report on outcomes of the reviews to be drafted and reported in February 2022 at Mortality Review Group

Sepsis Screening Compliance (Inpatients Contract)

University Hospitals of North Midlands NHS Trust





Variation	Assurance

Target	Oct 21	Nov 21	Dec 21
90%	87.9%	88.6%	96.6%

Background

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

Variation	Assurance

Target	Oct 21	Nov 21	Dec 21
90%	97.5%	97.8%	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:

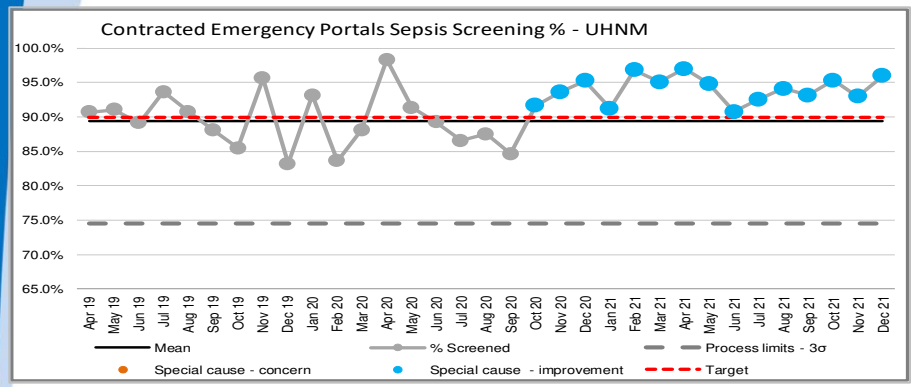
December 2021 Inpatients results show significant improvement in screening compliance to 96.6%. Compliance for IVAB within an hour achieved 100%.

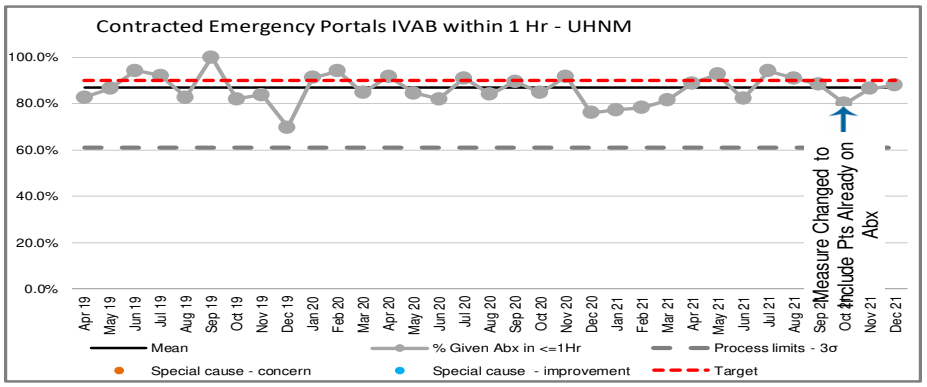
Of the 117 Inpatients that triggered a sepsis screen in the audit, 84 had sepsis red flags present, 2 of these patients were newly identified sepsis and given IVAB within hour. For the remaining 82 patients, 45 had alternative diagnosis that were deemed as not sepsis related . The remaining 37 patients were already receiving IVAB prior to the identified red flag trigger. Screening compliance from the four divisions all achieved >95% which is overall an excellent achievement.

Actions:

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

Sepsis Screening Compliance (Emergency Portals Contract)





Variation	Assurance
H	?

Target	Oct 21	Nov 21	Dec 21
90%	95%	93%	96%

Background

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

Variation	Assurance
	?

Target	Oct 21	Nov 21	Dec 21
90%	80%	86%	88%

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 December 2021 achieved 96% for the 99 patients audited.

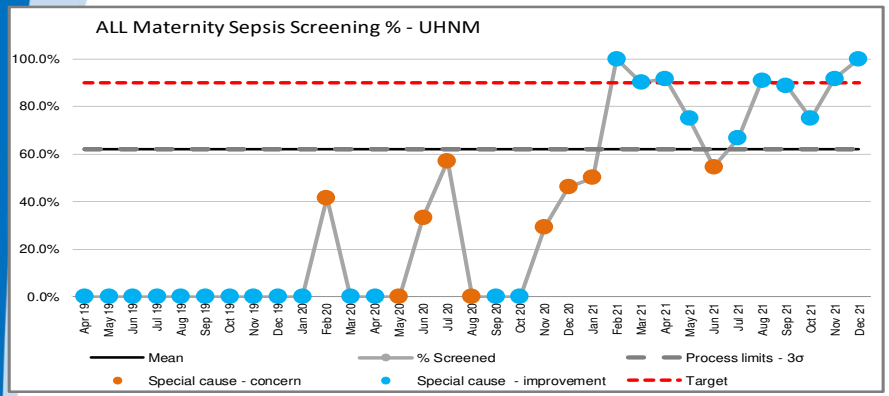
The performance for IVAB within 1hr has further improved to 88% in December. There were 85 red flag sepsis patients identified from the 99 patients audited in the screening sample. Out of the 85 red flag patients, 58 were true red flags, 33 received IVAB within an hour , 7 delayed IVAB and 18 patients were already on IVAB. The Remaining 27 had an alternative diagnosis. All delayed IVAB were from A&E Royal Stoke site (6) and A&E County (1) in which 6 were administered within 2 hours and 1 administered > 2 hours. This has been escalated to both A&E Royal & County senior teams.

Actions:

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

Sepsis Screening Compliance ALL Maternity

University Hospitals of North Midlands NHS Trust

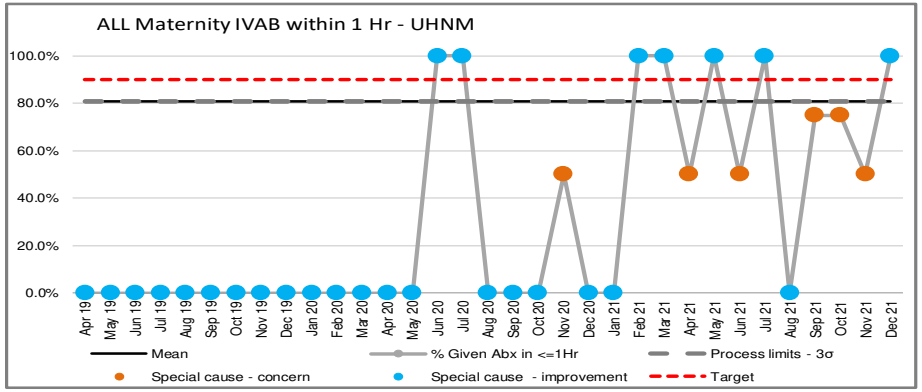


Variation	Assurance
H	F

Target	Oct 21	Nov 21	Dec 21
90%	75.0%	91.7%	100.0%

Background

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



Variation	Assurance
H	F

Target	Oct 21	Nov 21	Dec 21
90%	75%	50%	100%

Background

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

What is the data telling us:

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

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

Actions:

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

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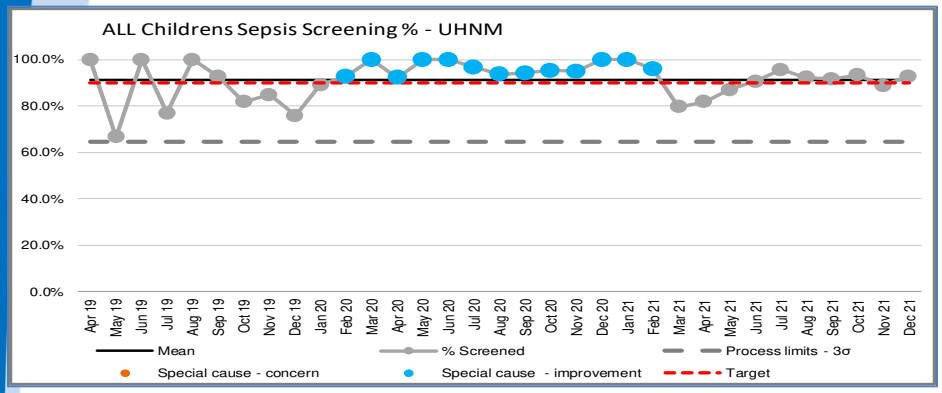
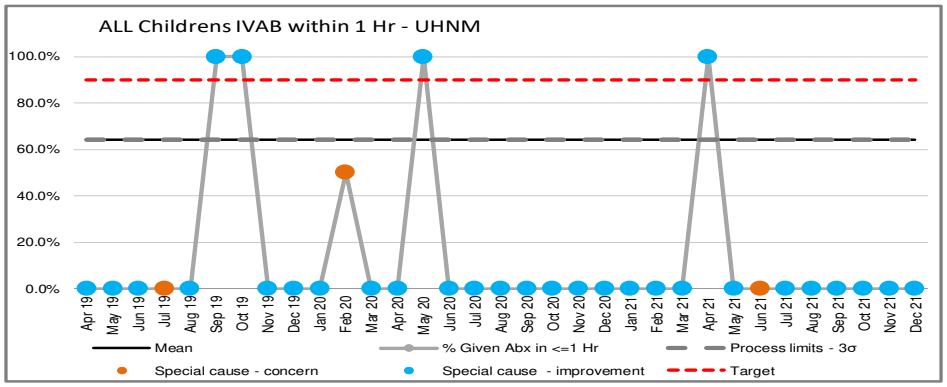
Sepsis Screening Compliance ALL Children

NHS University Hospitals of North Midlands NHS Trust





Variation	Assurance
	?

Target	Oct 21	Nov 21	Dec 21
90%	93.3%	88.9%	92.9%

Background

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

Variation	Assurance
H	F

Target	Oct 21	Nov 21	Dec 21
90%	N/A	N/A	N/A

Background

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

What is the data telling us:

The charts above show good improvement in sepsis compliance compared to November 2021, with a result of 92.9%, which is above the target rate. CAU screening compliance has dropped by achieving 78% (with only 2 missed screening, 7/9) and Children A&E has also achieved 100%. IVAB within hour compliance for CAU & Children A&E are not applicable or no red flags trigger. Children Inpatient ward 216 has no PEWS 5> triggers during randomised audits and Ward 217 screening compliance achieved 100%. Most inpatients Paediatrics are already on oral antibiotics or IV antibiotics prior to trigger of PEWS >5 (this is both of moderate and high risks).

Actions:

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

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Operational Performance

2025 Vision "Achieve NHS Constitutional patient access standards"

Spotlight Report from Chief Operating Officer

NHS University Hospitals of North Midlands NHS Trust

Emergency Care

- Attendances reduced in December from previous months and flow was optimised in ED and across the Acute floor aided by the decreased attendances and the Home for Christmas planning in medicine.
- Ambulance handover delays for 30-60mins reduced slightly and the > 60 mins also decreased in December. The percentage of handovers within 15 minutes increased to 66% .
- Time to initial assessment improved and the total type 1 performance for the last week of December was 68% within the 15 minutes
- The number of patients in the department for > 12 hours is of significance again in December although slightly lower than seen in October and November. There were 609 validated, 12 hour (DTA) trolley waits in December.

Cancer

- The Trust is provisionally predicted to achieve the 31 Day Subsequent Anti Cancer Drugs, 31 Day Subsequent Radiotherapy, and Rare Cancer standards for December 21.
- The overall 2WW position for December is predicted to achieve in the region of 55%. This is an improvement on last months position. Specialties with the most 14 day breaches are Breast, Skin and Upper GI. Performance against the 62 day standard is currently at 47% for December 21. This is an un-validated position that is expected to change as histology confirms a cancer or non cancer diagnostic for patients treated.
- Theatre, Oncology, Diagnostic and Surgical workforces have been impacted, resulting in breaches. The position is being managed through the reinstated daily clinical prioritisation meetings and a robust planned care assurance framework. 2WW and 62 day position is significantly challenged, and will be validated prior to upload.
- After a focus on reducing the number of patients waiting to be appointed, the volumes in the RAS have reduced. Although still high, significant improvements have been made in Skin, Colorectal & Breast, and the Breast team are now booking within 14 days.
- The Trust continues to conduct a high number of 1st appointments, with 3011 patients being seen in December.

Spotlight Report from Chief Operating Officer

NHS University Hospitals of North Midlands NHS Trust

Planned Care

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

- Day Case and Elective Activity delivered 84.1% for December 21 against the national ask of 95%. This is lower in Inpatients than Day case (76% IP, 86% DC).
- In month Planned Care Cell focus on elective recovery based on 10 high impact changes in accordance with the elective plan.
- Modelling of Q4 theatre capacity required to enable validation of H2 plan delivery offset against covid surge demand planning.
- CCG Commissioned Deloitte review is ongoing and UHNM are sense checking any outputs that will improve treatment capacity in the IS.
- CCG have an interim commissioning manager who is supporting elective opportunities in Tier 2 sector/regionally around mutual aid.
- Referral Hub – awaiting specification from 18 week source group and reviewing use of electronic ERS to manage referrals.
- Some work has already taken place at specialty level with respect to patient contact. This is being coordinated and consolidated to inform corporate next step and avoid duplication. Quotes now received for additional support to this project.

RTT

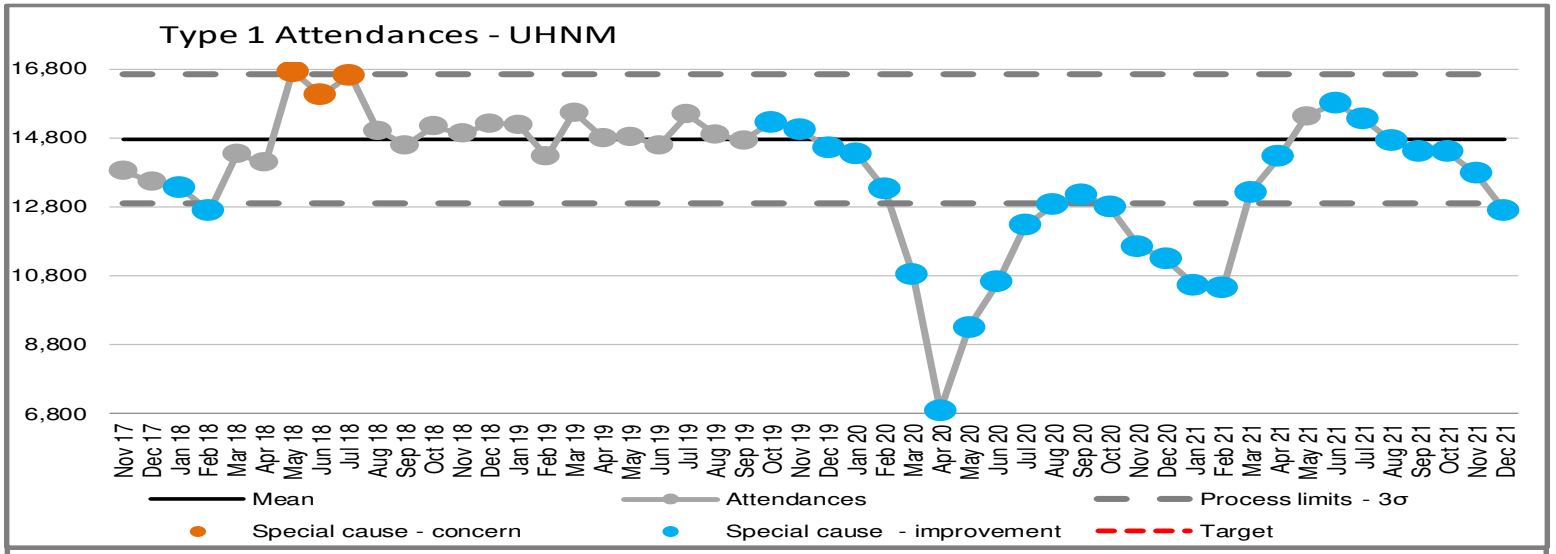
- The overall Referral To Treatment (RTT) Waiting list continues to rise. For December the indicative number of Incomplete pathways has risen to 70,951 (November 69,204).
- The number of patients > 18 weeks has risen to a level of 31,599 (November 29,072).
- The numbers of 52 week waits in December has increased with a reported 4,393 (November 4,046) this figure is below trajectory.
- At the end of December the numbers of > 104 weeks reported were 399. The Planned Care group is monitoring progress against treatment plans for these patients.
- Performance however, has slightly increased at 55.76% (November 55.26%).
- Work plans around long wait patient validation and treatment tracking are in progress

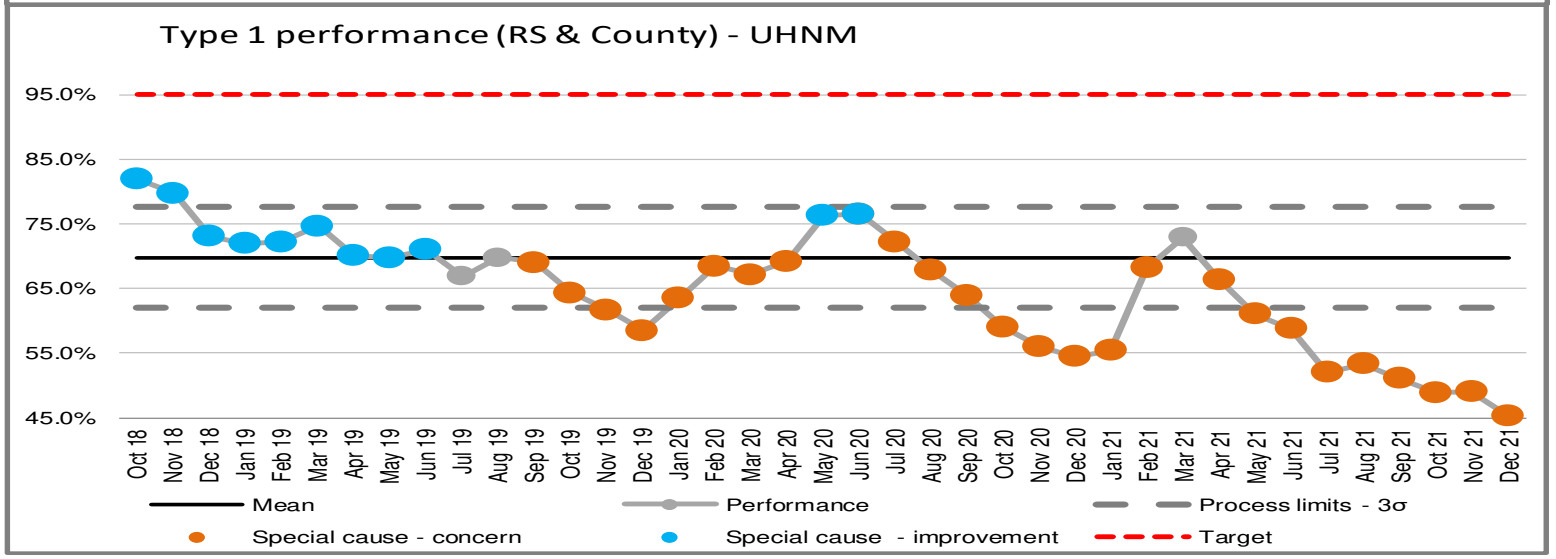
Diagnostics

- For DM01 (15 nationally identified Dx tests) the un-validated position for total waiting list has increased in December from 20,134 to 20,669. The Non-obstetric ultrasound waiting list reduced slightly from 9,935 to 9,901. Due to the challenges in Non-Obstetric Ultrasound this has adversely affected performance. The current DM01 diagnostic performance for December 21 is at 68% (November 69 %).
- The greatest proportion of > 6 week waits are within Non-obstetric ultrasound and endoscopy. The ultrasound position is related to an increase in demand alongside workforce shortfalls. The waiting list is growing significantly by c250 per week against a limited workforce that is at full capacity. The independent sector have now been commissioned to provide additional capacity. For endoscopy (colonoscopy and gastroscopy). This is related to an on-going increase in demand. Improvement actions are being developed and implemented.

Section 1: NON ELECTIVE IMPROVEMENT

Urgent Care – Attendances and 4 hour performance





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Urgent Care – In Month Performance Summary

NHS
University Hospitals of North Midlands
NHS Trust

SUMMARY

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

Triage; Initial assessment within 15 minutes increased in December to 68% with particular improvement seen in the last week of the month when attendances dropped. Performance is influenced most where there are surges of over 30 attendances within the hour, particularly in the evening. This can be where staff shortages, particularly decision makers has been a challenge. The department are aiming to stop the decline in triage time with re-deployment of staff in the department at the time and are looking at tiered rotas in line with RCEM guidance. A business case addressing workforce challenges was approved in early October and staff are being recruited to as per the planning timescale in that case, with staff starting to come on line from December 2021.

Ambulance; The percentage of ambulance handovers within 15mins at RSUH site increased. Ambulance handover delays for 30-60mins decreased as did the >60 mins. This improvement is in line with reduced ambulance attendances for December 2021. Longer delays occurred during peak ambulance arrival times in early evening, when multiple Crews arrive on site in succession.

Long waits; The number of patients in the department for > 12 hours is of significance again in December although slightly lower than seen in October and November. There were 609 validated, 12 hour trolley waits in December.

Admissions; The number of patients attending and admitted with Covid-19 continued to increase again with admissions to wards and critical care proving challenging (23 new hospitalisations a day by the end of December). 1+ LoS spell are at around 92% of 1920 BAU. Discharges pre-noon remained much the same as previous months and remains above the 12 month average.

Performance; In December the 4 hour performance fell to 45.3% from 49% seen in November. With the increase in spells over 1 day LoS the number of stranded, and long stay patients rose. The time from referral to admission increased from 339 to 371 causing admitted performance to reduce, achieving 19% (reduction of 1%). Non-admitted performance also fell from 50.3% to 48.9%

Improvement Overview and Focus

University Hospitals of North Midlands NHS Trust

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

Acute Front Door

STREAMING & DEFLECTION REDESIGN:

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

COMPLEX TRIAGE:

- 15 min triage standard review
- Ambulance handover processes SOP review

MEASURED BY

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

Acute Front Door

WORKFORCE REVIEW & RECRUITMENT:

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

MEASURED BY

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

Ward based Principles

REDUCING CONGESTION:

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

MEASURED BY

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

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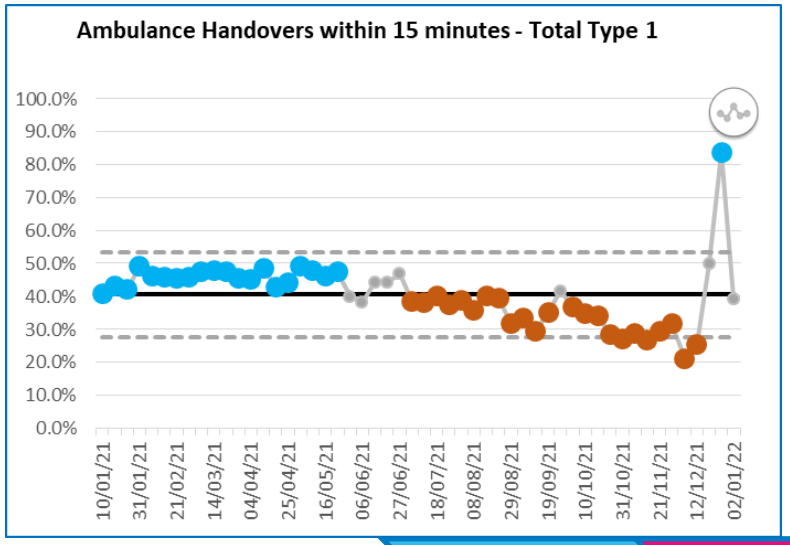
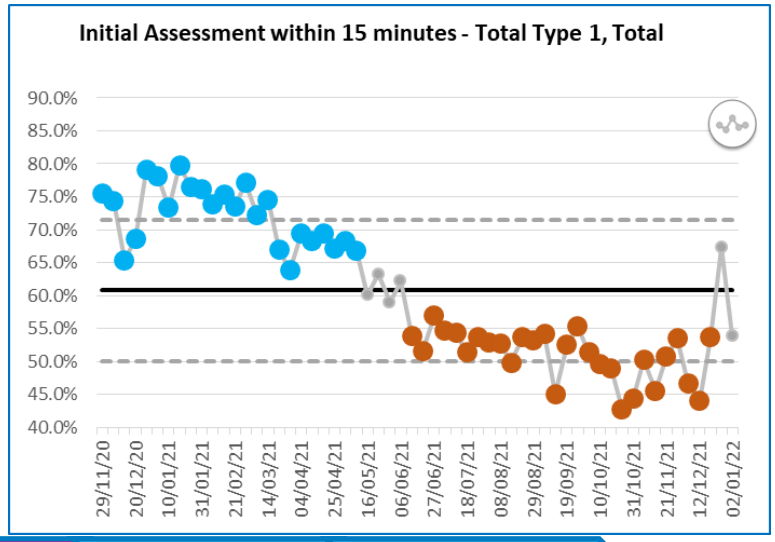
TIME FOCUSED METRICS / UEC Standard

Front Door - Attendance Management

RECENT AND IMMINENT ACTIONS

- Test of change commenced for Navigator at the front door to support redirection to alternative places of care including portals (if attending with GP letter) and primary care services from December. Initial data suggests that patients being directed with GP letters to portals increased from an average of 1.0 per day to 2.4 and the numbers deflected to Urgent Care from the Navigator increased from 4.6 per day to 10.2 per day.
- Internal UHNM – UCC model group commenced reporting to COO with a view of delivering 'UCC like' model from April 1st, initial intention paper to ask for support to proceed being drafted for submission first week of January 2022.
- Working closely with WMAS to effect earlier handover against 'rapid handover' policy should it be implemented by WMAS
- 'RED' GP reinstated and capacity increased - daily monitoring of referrals demonstrates that Vocare are currently seeing on average 23 Children (increase from 17) and 31 adults per day (decrease from 38).
- Use of GP referral hub and consultant connect to prevent GP walk in directed to ED
- Regular social media campaigns to highlight alternative services on offer in the community and use of 111First
- 111 Kiosks - early review of the data available indicates that only 4% of patients are being redirected to alternative pathways
- Separate hot and cold ambulance arrival areas to segregate COVID and non COVID ambulance arrivals in continued use; for review for 2022





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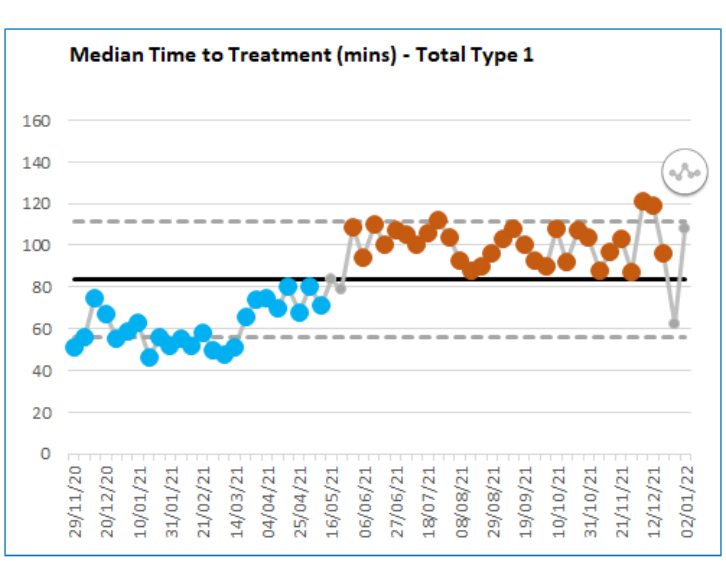
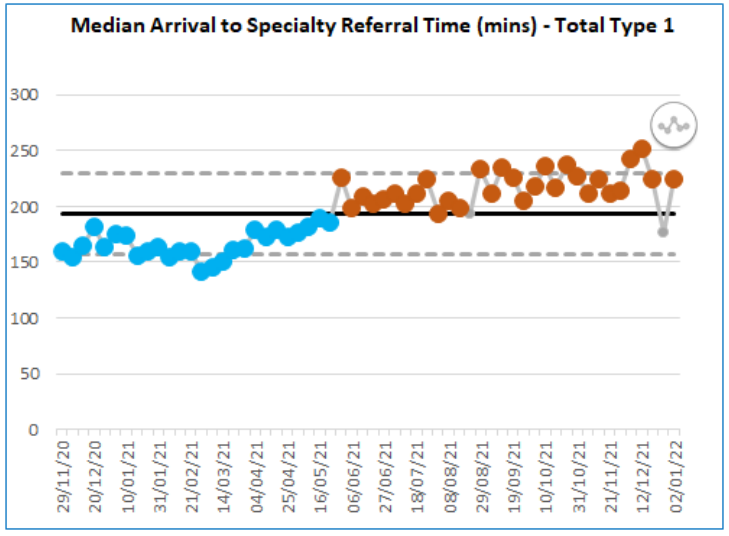
Front Door - Prompt Decisions

RECENT AND IMMINENT ACTIONS

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





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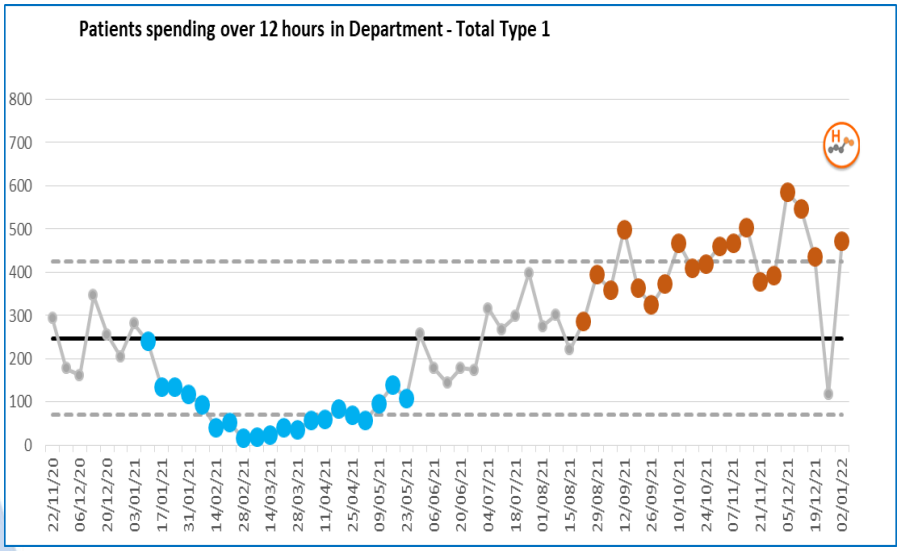
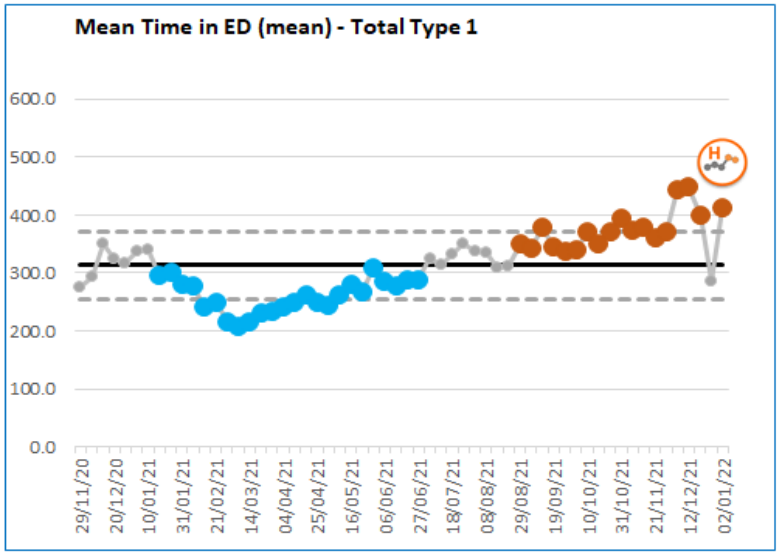
Ward based Principles - Early Egress for Admissions

RECENT AND IMMINENT ACTIONS

- Medicine division piloting new approach to EDD management to define true capacity/demand at start of the day and to drive behaviours at ward level
- From mid December, discharges earlier in the day to be supported through the Transitional Discharge Lounge hub now live on Ward 218.
- Application of MFFD and possible transition to Medically Optimised for Transfer (MOFT) to be reviewed and wards instructed on use
- Continued LOS work on stranded patients – great success seen in 21+ day waits.





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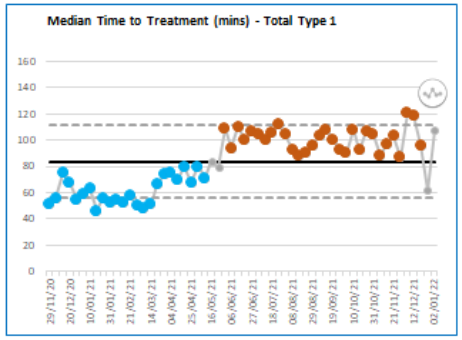
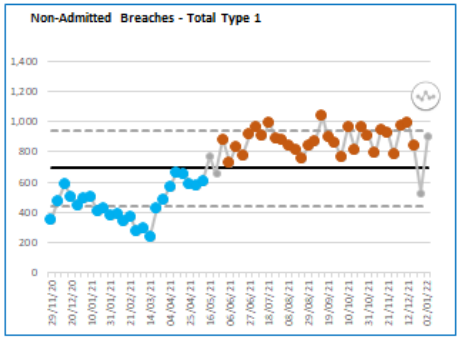
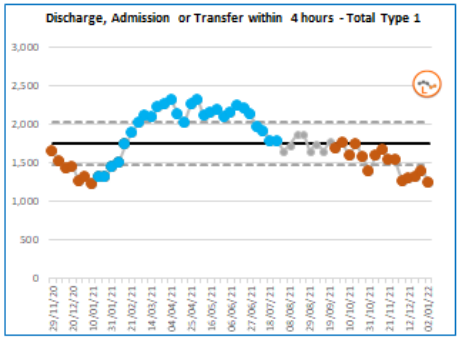
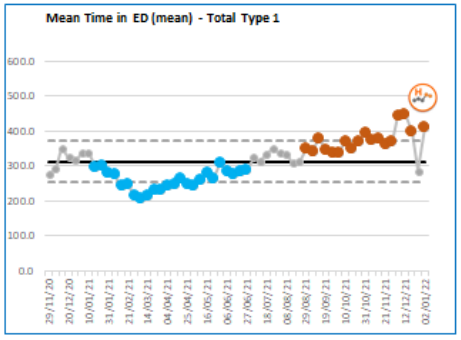
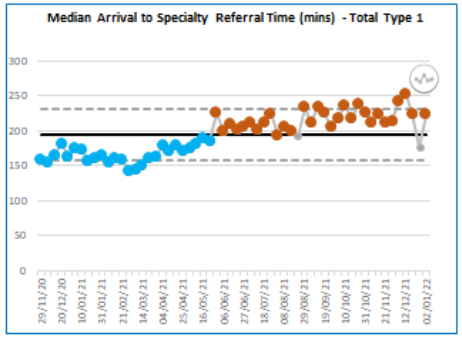
Front door

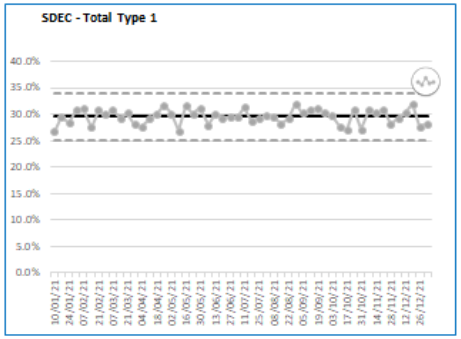


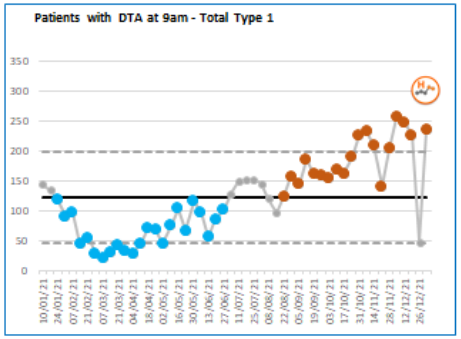


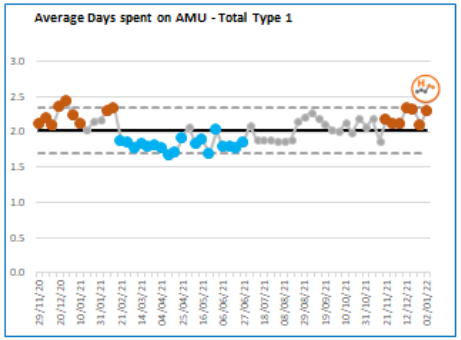


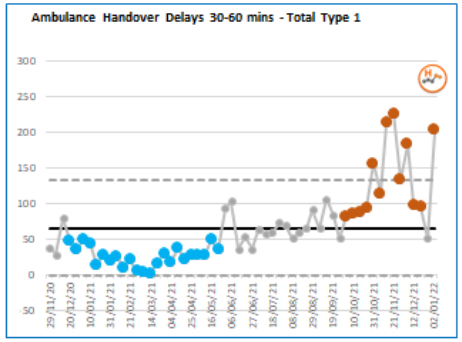


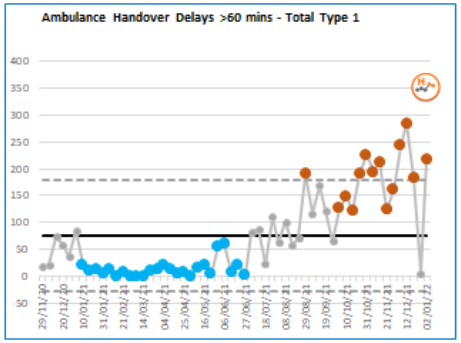


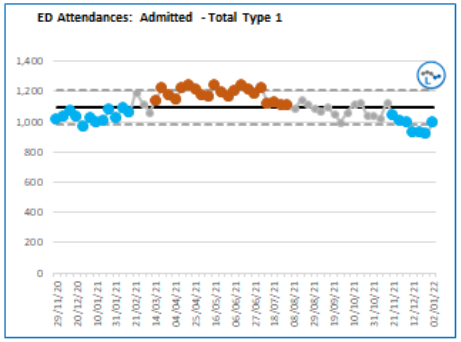


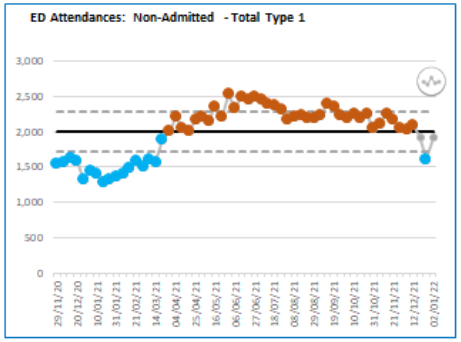








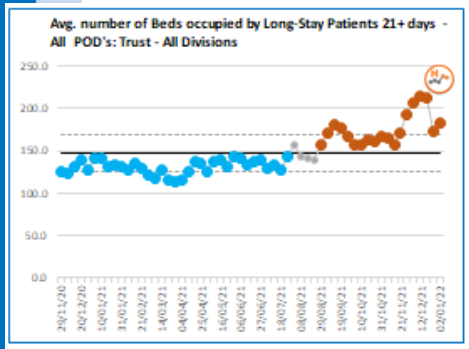


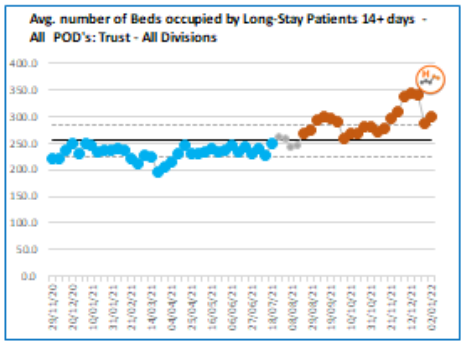


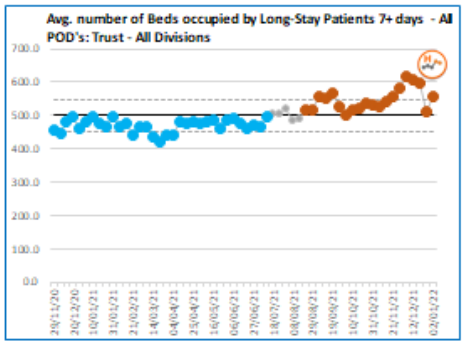
Together Compassion Safe Improving

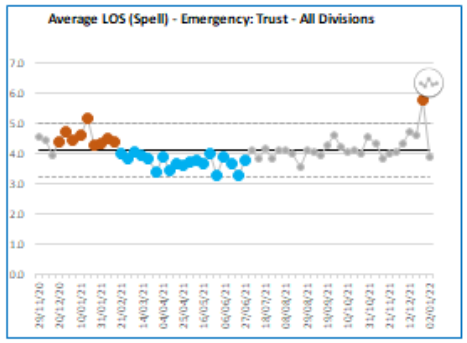
Quality | Operational | Workforce | Finance

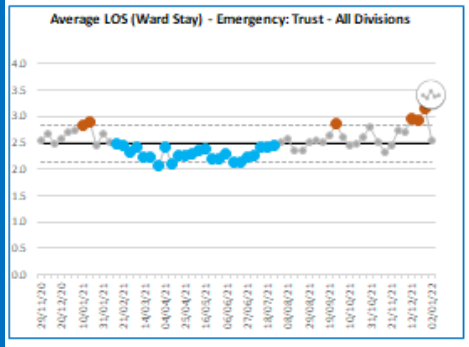
Flow

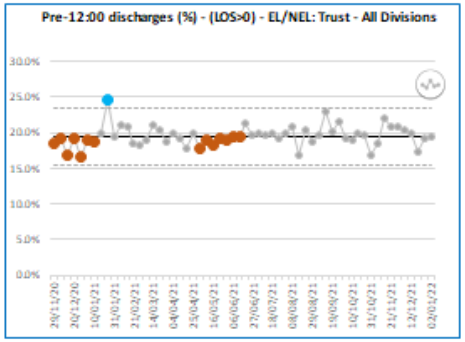

Avg. number of Beds occupied by Long-Stay Patients 21+ days - All POD's: Trust - All Divisions

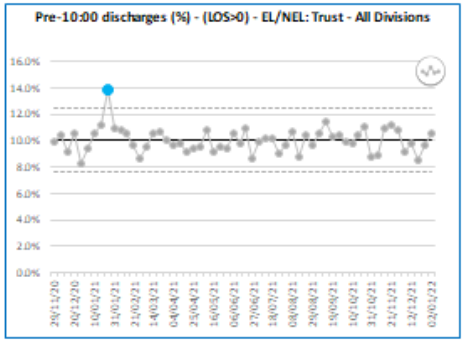

Avg. number of Beds occupied by Long-Stay Patients 14+ days - All POD's: Trust - All Divisions

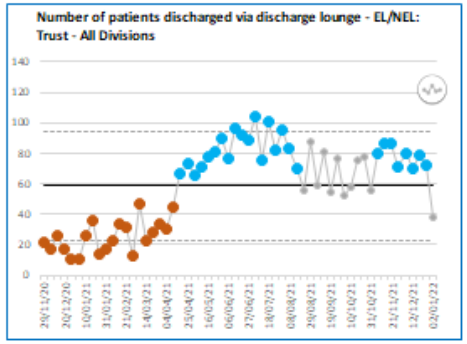

Avg. number of Beds occupied by Long-Stay Patients 7+ days - All POD's: Trust - All Divisions

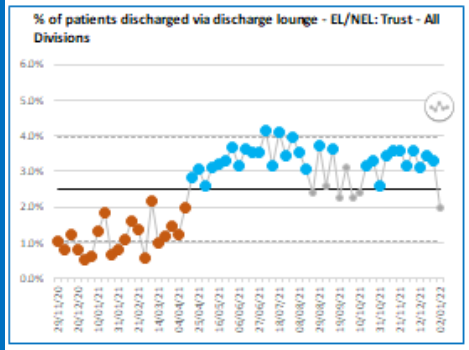

Average LOS (Spell) - Emergency: Trust - All Divisions

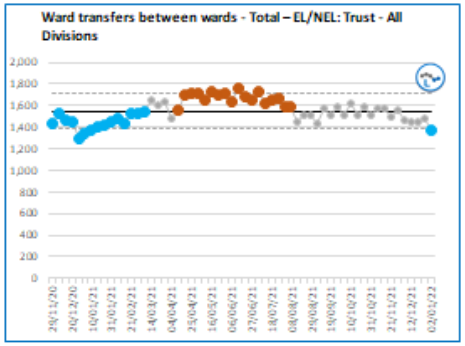

Average LOS (Ward Stay) - Emergency: Trust - All Divisions

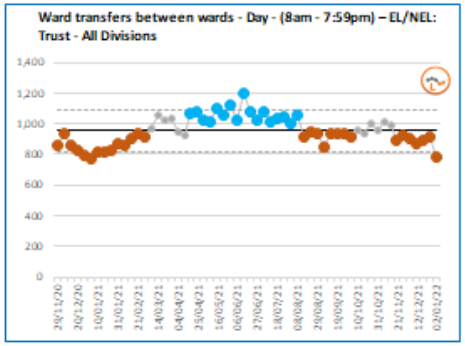

Pre-12:00 discharges (%) - (LOS>0) - EL/NEL: Trust - All Divisions

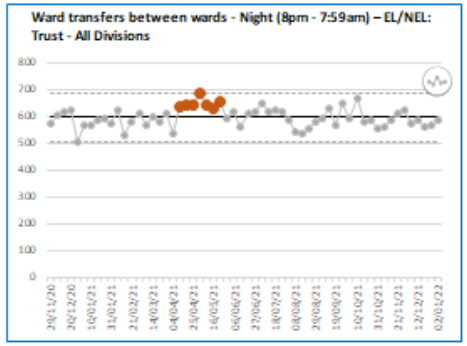

Pre-10:00 discharges (%) - (LOS>0) - EL/NEL: Trust - All Divisions


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


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


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


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


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

Section 2: ELECTIVE CARE

Cancer

University Hospitals of North Midlands NHS Trust

Challenges:

- High number of patients waiting in the RAS to be appointed (although this number has halved since last month)
- There are 510 as of 12.01.21. Of these, 127 are Skin, 164 are Colorectal, and 150 are Breast.
- 2WW performance significantly challenged in Breast, Skin, UGI – predicted performance at 55% for December which will significantly impact future months for 28 day, 62 day performance. Provisional 62 Day performance predicted at 47% in December- this is due to capacity / workforce challenges in specialty and diagnostic services (Pathology, Endoscopy) impacting cancer pathways.
- Widespread workforce shortages impacting on the 2WW back log and wider cancer pathways in a number of different ways e.g. admin booking of investigations / MDT discussion quoracy / pathway tracking processes.

Actions:

- After a corporate focus on reducing number of patients waiting to be appointed, the volumes in the RAS has reduced. Although still high, significant improvements have been made in Skin, Colorectal & Breast.
- The CCG are facilitating targeted GP comms to increase the uptake in FIT given this is one of the pareto pathways contributing to current sub optimal performance.
- Clinical Director for Cancer is attending the COVID clinical group meeting to feed into discussions on cancer treatment capacity.
- On-going talks between cancer services and 18 Weeks to implement Colorectal and Breast pathway support – this will include triage functions as well as investigation requesting and review – up to discharge if necessary.
- The Skin team have trialled a clinical photography pathway to support triage decisions and facilitate 28 Day FDS by sending eligible patients straight to minor ops. By taking photographs of lesions, high volume triage clinics can be done by consultants remotely, and is a better patient experience as patients are given a non cancer diagnosis earlier. The team have also endorsed a Skin Analytics proposal, which uses AI to categorise high risk and low risk lesions, in order to release in house capacity for most at risk patients.
- Targeted Lung Health Checks – the team are expanding the offer to the 'About Better Care' PCN. The programme has already demonstrated a high proportion of Lung cancer diagnosed and treated at an earlier stage. A patient story is being put together that will showcase the achievements of the service.
- Trust is aiming to improve completeness against the 28 Day FDS dataset. All communication with patients that cancer has been excluded or diagnosed should be clearly documented in patient notes. Feedback on processes implemented will be brought by divisions to 1:1 assurance meetings.
- The Breast Pain Community Clinics – go live has been pushed back to Feb in order to allow for Breast pain diary timescales and to tackle current 2WW demand in house. The Breast team are now booking within 14 days.
- The Cancer Services training outreach continues to be a success – with staff from across the trust actively approaching cancer services for support and specific training requirements.
- Lead Nurse has successfully identified funding from Macmillan for the refurbishment of the County Cancer Information Centre.
- The WMCA is taking part in the Galleri Trail – a blood test that returns a signal if there is indication there may be cancer present, which will trigger secondary care investigation. CCG and UHNM Cancer Services are working through logistics of how these patients will be received, monitored and investigated.

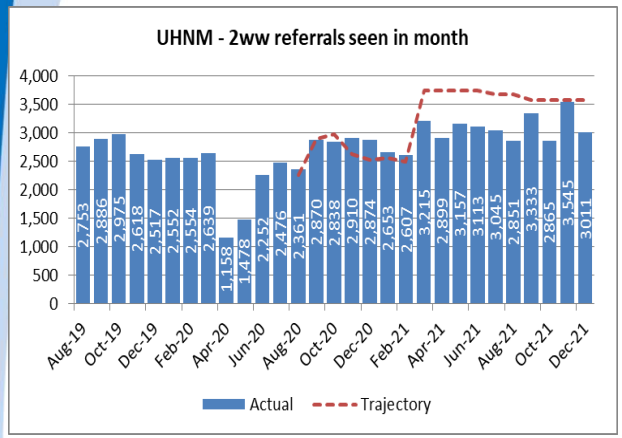
Cancer

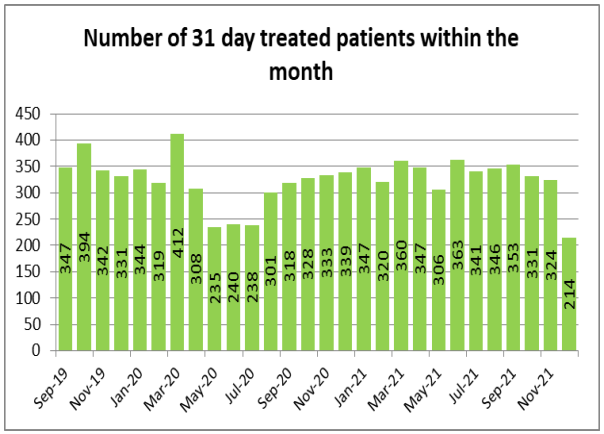
NHS University Hospitals of North Midlands NHS Trust

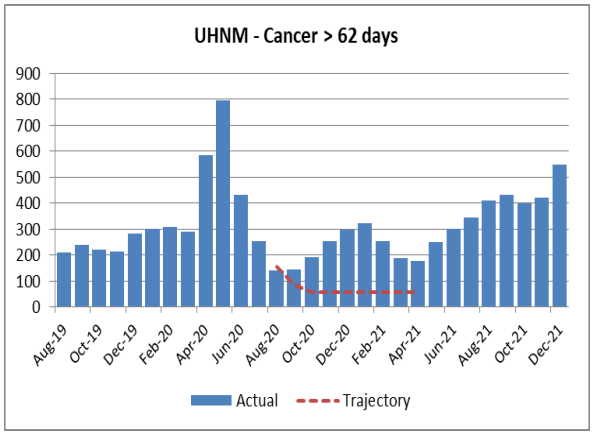
- Trajectories have been agreed and are being tracked against the actual positions. Most recent published data is for October:
  - 14 Day Trajectory October: 86.5%. Actual 64.4%. Actual Seen. 2865. Actual Breaches 1019. The trust is below the set trajectory on this standard.
  - 31 Day Trajectory October: 94.6%. Actual 87.3%. Actual Treated 331. Actual Breaches 42. The trust is below the set trajectory on this standard.
  - 62 Day Trajectory October: 79.6%. Actual 58.3%. Actual Treated 168.0. Actual Breaches 70.0. The trust is below the set trajectory on this standard.

Trust			Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
14 Day Standard 93% *(suspected cancer, excluding breast symptom)*	TRAJECTORY	First Seen	3745	3745	3745	3666	3666	3566	3566	3566	3566	3566	3566	3566
		Breaches	809	769	699	961	901	641	481	366	306	246	186	166
		Performance	78.3%	79.4%	81.3%	73.7%	75.4%	82.0%	86.5%	89.7%	91.4%	93.1%	94.7%	95.3%
	ACTUALS	First Seen	2899	3157	3113	3045	2851	3333	2865	3545	3011	1541	0	0
		Breaches	640	593	318	665	961	1042	1019	1927	1338	1208	0	0
		Performance	77.9%	81.2%	89.7%	78.1%	66.2%	68.7%	64.4%	45.6%	55.5%	21.6%		
		Variation	-0.4%	1.8%	8.4%	4.4%	-9.2%	-13.3%	-22.1%	-44.1%	-35.9%	-71.5%		
		Regional (Midlands)	81.7%	85.0%	81.1%	83.4%	84.0%	81.4%	79.9%					
		National	85.4%	87.5%	84.9%	85.6%	84.7%	84.1%	81.3%					
31 Day First Treatment Standard 96%	TRAJECTORY	Treatment	463	463	463	463	463	463	463	463	463	463	463	463
		Breaches	49	46	43	38	34	29	25	23	22	20	19	18
		Performance	89.4%	90.0%	90.7%	91.7%	92.6%	93.7%	94.6%	95.0%	95.2%	95.6%	95.8%	96.1%
	ACTUALS	Treatment	347	306	363	341	346	353	331	324	214	18	0	0
		Breaches	23	19	22	22	29	46	42	46	16	5	0	0
		Performance	93.3%	93.7%	93.9%	93.5%	91.6%	86.9%	87.3%	85.8%	92.5%	72.2%		
		Variation	3.9%	3.7%	3.2%	1.8%	-1.0%	-6.9%	-7.4%	-9.3%	-2.7%	-23.4%		
		Regional (Midlands)	91.9%	92.5%	91.9%	91.9%	90.2%	88.7%	90.2%					
		National	94.2%	95.1%	94.6%	94.7%	93.7%	92.6%	93.5%					
62 Day (2ww) Standard 85%	TRAJECTORY	Treatment	246.0	246.0	246.0	246.0	246.0	246.0	246.0	246.0	246.0	246.0	246.0	246.0
		Breaches	75.5	71.5	67.5	62.5	59.5	57.5	50.0	44.0	38.0	32.0	32.0	32.0
		Performance	69.3%	70.9%	72.5%	74.5%	75.8%	76.6%	79.6%	82.1%	84.5%	86.9%	86.9%	86.9%
	ACTUALS	Treatment	181.0	166.5	198.0	186.5	187.5	199.0	168.0	178.0	124.0	12.5	0.0	0.0
		Breaches	42.0	48.5	59.0	64.0	69.5	84.0	70.0	87.0	65.0	9.5	0.0	0.0
		Performance	76.7%	70.8%	70.2%	65.6%	62.9%	57.7%	58.3%	51.1%	47.5%	24.0%		
		Variation	7.4%	-0.1%	-2.3%	-8.9%	-12.9%	-18.9%	-21.3%	-31.0%	-37.0%	-62.9%		
		Regional (Midlands)	69.9%	66.4%	66.4%	63.3%	61.6%	58.3%	57.3%					
		National	75.4%	73.0%	73.3%	72.1%	70.7%	68.0%	67.8%					

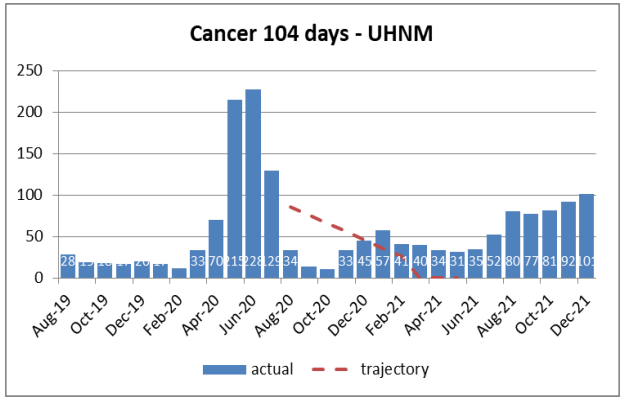
Cancer







December Provisional	Target	Trust Actual	Clock Stops	Breaches	Breaches Over	Needed Treatments
TWW Standard	93%	55.6%	3011	1338	1128	16104
TWW Breast Symptomatic	93%	4.7%	85	81	76	1073
31 Day First	96%	92.5%	214	16	8	187
31 Day Subsequent Anti Cancer Drug	98%	100.0%	21	0	Achieved!	Achieved!
31 Day Subsequent Surgery	94%	91.7%	24	2	1	10
31 Day Subsequent Radiotherapy	94%	97.1%	102	3	Achieved!	Achieved!
62 Day Standard	85%	47.6%	124	65	47	310
Rare Cancers - 31 Day RTT pathway	85%	100.0%	1	0	Achieved!	Achieved!
62 Day Screening	90%	63.0%	27	10	8	74
28 Day FDS Standard	75%	55.5%	1899	846	372	1486
62 Day Consultant Upgrade	93%	83.6%	55	9	6	74
Closed Pathways > 104 Day			24			



Projected to secure 3 standards in month (pending validation). 2ww and 62 day performance impacted by capacity available as workforce used to support Covid surge based on workforce attrition of front line services. Clinicians asked to focus on cancer pathway review > 62 days and focus on 104 day decisions and outcomes to reduce these volumes and ensure appropriate clinical validation of next step pathways.

Planned care - *Inpatients*

University Hospitals of North Midlands NHS Trust

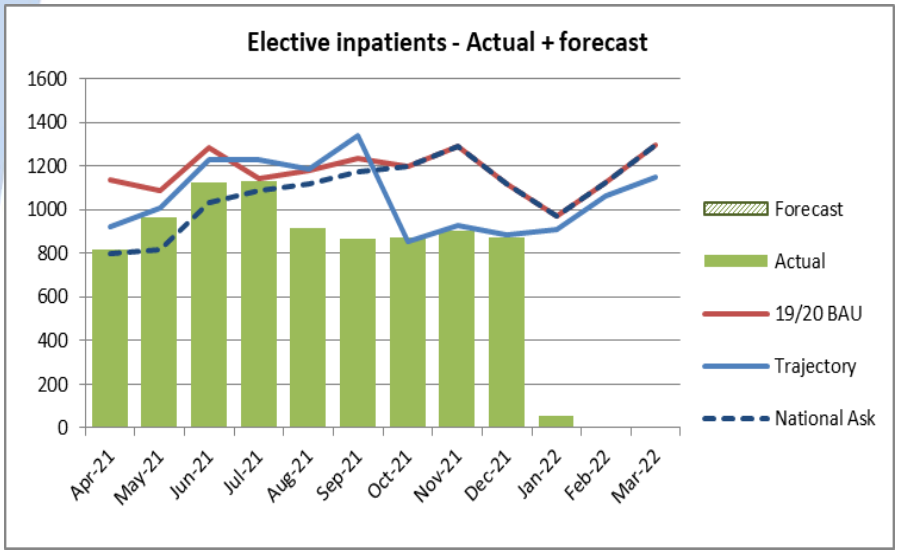
Elective inpatients Summary

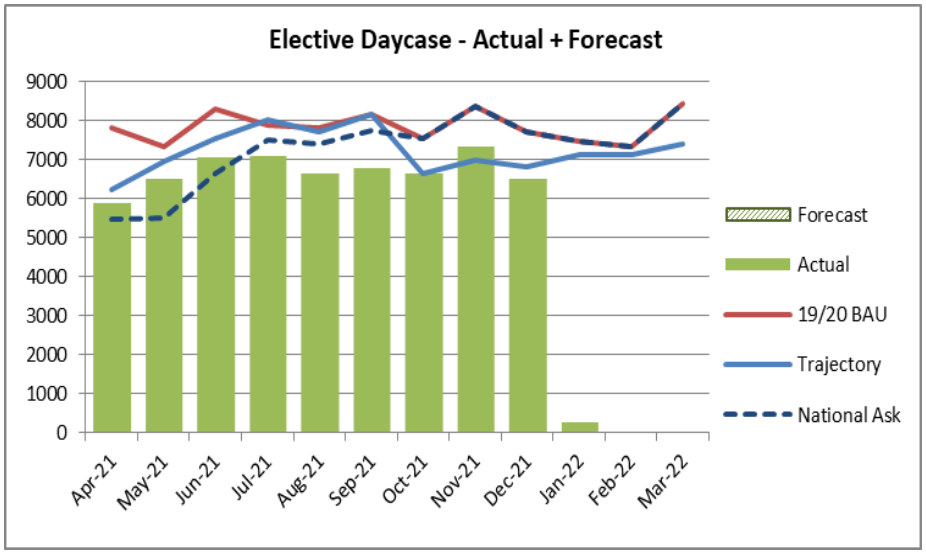
- For December the total inpatient actuals against BAU was %. This is lower in Inpatients than Day case (78% IP, 85% DC).
- In sourcing arrangements at week ends continue and have been bolstered to provide more weekend capacity in T&O starting Feb.
- CCG offer of Spire for additional capacity being reviewed and patients going via CCG Choose and Book Service.
- Nuffield have now reached capacity for T&O until mid-April. No further patients to be sent until 2022/23 contracting arrangement confirmed.
- Ramsay continue to treat patients to contact but again their admin processes are impacting on our numbers reported.
- Ramsay have improved somewhat in returning Endoscopy reports although this is not at as fast a pace as required yet. CCG supporting with difficult conversations.
- Referral Hub has been scoped and further developed to encompass triage functions as well as investigation requesting and review and discharge if necessary or handover to internal team.
- Work with Deloitte to understand capacity across the region completed. 30 Hernia patients, 275 simple hand/foot patients and 100 cataract patients to be IPT to IS capacity at various providers.

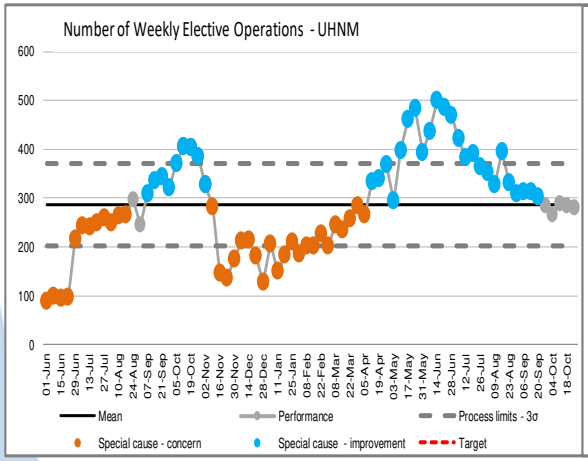
Actions

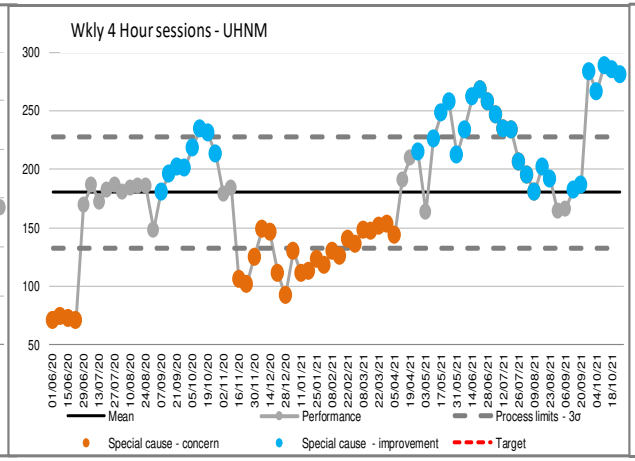
- Progressing resource plan to support increased validation and contacting patients for Q4.
- Progressing with transferring additional patients to the IS on the back of Deloitte or own internal reviews of capacity.
- Elective Storyboard and Slide set being finalised that covers off internal and external performance measures for assurance of a consistent approach to tracking activity linked to performance.
- Corporate validation plan to be rewritten alongside external validation support to ensure a clean PTL and highlight areas for targeted training.
- Theatres drafting their Q4 capacity plans for Divisions to be able to book patients into – this is to be balance against NHSEI request to prepare for a further covid surge.
- Training continues on RTT for new staff and where post validation has found incorrect actioning of pathway for staff to be retrained.

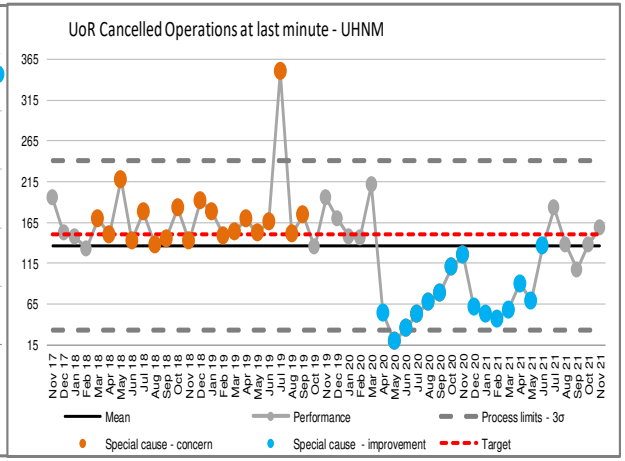
Planned care – *Inpatient Activity*











Planned care - *Outpatients*

NHS University Hospitals of North Midlands NHS Trust

Summary

- For December (as at 10/01) , the total outpatient actuals against BAU for outpatients was 94.3%. This is higher in follow ups than new (83.7% New, 101.3% follow up). Whilst just short of the 95% target, this was impacted by Covid pressures during December.
- December update - For outpatient appointments (appointment type) the Trust delivered **71.5%** F2F and **28.5%** non F2F(Telephone & Video). For new appointment types F2F was **73.3%** & non F2F **26.7%** & follow ups F2F **70.5%** & non F2f **29.5%**
- OP Cell A3 work has helped to define current overall waiting list position by category; vs pre covid increase of 15,000 (6.5%) to 250,000, and increase in those >52 weeks (vs Review Date) by 7,800 (200%) to c.12,000 (half of increase attributable to use of Review Date). As at 02/01/2021, total WL has increased further to 262,000. Recent increases in the waiting list attributed to 3 categories; New (both 18 weeks & Non-18 weeks) & Follow Up Backlog.
- Reduction from 11,631 (end of June) to 10,010 (25th July) in >52 week patients (14%). Further reduction to 9,184 as at 5th September (21% vs end of June). Up to 10,049 as at 2nd January; has been at a similar level for several weeks.

RTT

- The overall Referral To Treatment (RTT) Waiting list continues to rise. For December the indicative number of Incomplete pathways has risen to 70,951 (November 69,204).
- The number of patients > 18 weeks has risen to a level of 31,599 (November 29,072).
- The numbers of 52 week waits in December has increased with a reported 4,393 (November 4,046) this figure is below trajectory.
- At the end of December the numbers of > 104 weeks reported were 399. The Planned Care group is monitoring progress against treatment plans for these patients.
- Performance however, has slightly increased at 55.76% (November 55.26%).
- Work plans around long wait patient validation and treatment tracking are in progress

Planned care - *Outpatients*

NHS University Hospitals of North Midlands NHS Trust

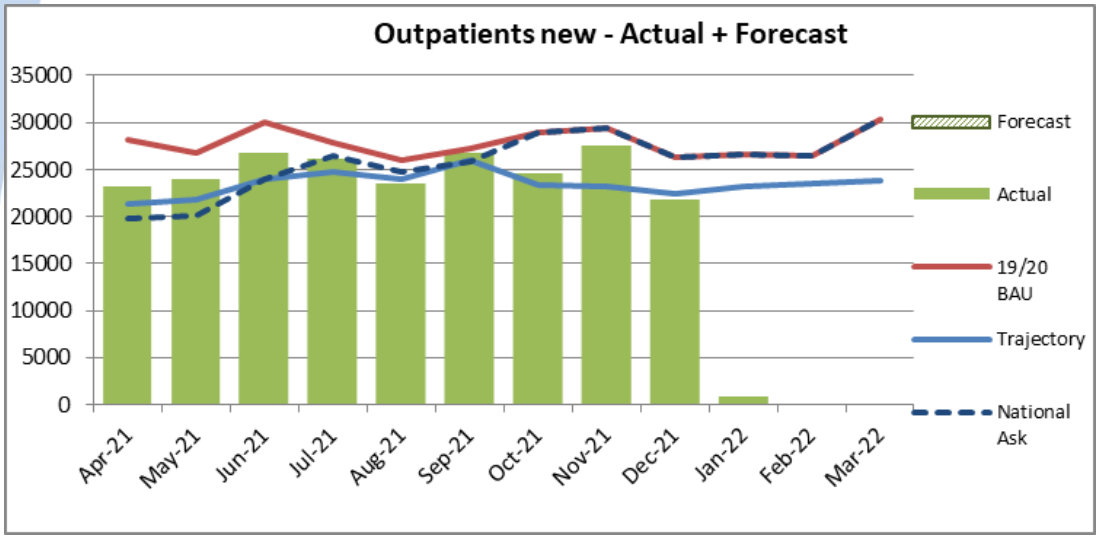
Actions

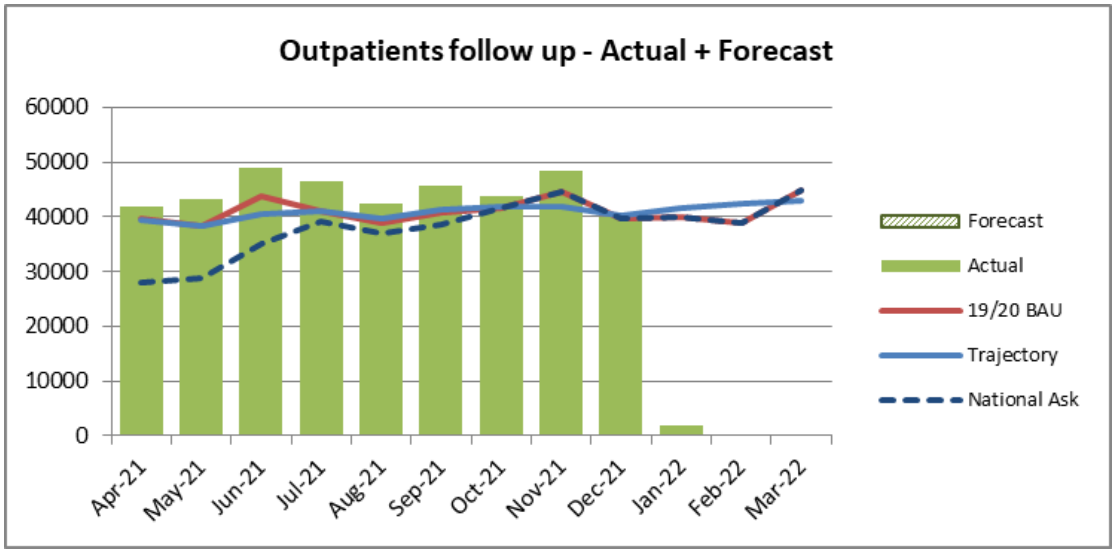
- Key actions identified around Divisional Waiting List Management with a focus on validation, data quality and >52 weeks patients. Clear reporting now in place to support this approach. Divisions have fed back details of their plans relating to OP New Waits >16 weeks & >52 week patients.
- ASI performance reports actively monitored (with live reporting now available); assurances around triage processes and clinical prioritisation of new patients provided from Divisions.
- Outpatient Service Delivery & Performance workstream delivering vs. plans for Partial Booking Rollout, Netcall Rollout, CAF Issues Action Plan, and OP Clinic Process vs. Maturity model. Review Date training prioritised; DQ Alert circulated & Quick Reference Guides created, plus floor walking support. Wider training plan being developed with Ongoing input into Trust training considerations (systems & processes), and links to DQ group.
- Enhanced Advice & Guidance sub workstream (linking with system). Task & Finish Groups now underway for Urology, Neurology, Respiratory and Gastroenterology to take actions forward to increase A&G, develop pathways FAQs. Work commenced to directly contact 21 GP practices not using A&G and a further 32 practices with a high volume of referrals and less than 12% A&G usage. CCG developing training cohorts for PLT to include A&G and liaising directly with practice managers to increase awareness/uncover barriers etc.
- PIFU sub-workstream rolling out vs plan. Regular meetings with live specialties pain, respiratory, cardiology (plus dermatology & gastro went live in December) around process assurance & increasing uptake; meetings ongoing with additional specialties; plastics, ENT & neurology (&T&O) to discuss specific pathways & work through checklist. Benchmarking / watch & wait report used to identify potential target areas for PIFU. Positive links maintained with NHSE.
- Submissions to Elective Recovery Fund in place for A&G & PIFU. Consultant Connect data is included and confirmed, community RAS data now included and backdated. Method of recording of PIFU removals/conversions still to be determined; testing option of PIFU flag for recording activity.
- Virtual Care 25%; SUS submission 'fix' implemented from Nov 2021 (with BI) whilst longer term alignment of clinic booking and media type outcome continues.

Risks:

- Deteriorated waiting list position vs pre-covid; volume of patients requiring DQ and clinical validation very challenging, on Divisional Risk Registers.
- Need to increase FTF activity in some OP areas, restricted by social distancing, 1m+ plans discussed, subject to approval.
- PIFU H2 end target of 2% of all outpatient activity moved or discharged to PIFU (1.5% by December). Whilst achieving rollout to initial specialties in low volumes, shortfall projected currently against this target (nationally an issue); but actions identified to extend rollout and close the gap as outlined above.
- H2 planning guidance has confirmed a target of at least 12% A&G requests (achieving 16.2% Nov) when compared to new referrals by March 2022. Challenge of level 4 pressures during September & October at organisation & system level and recent further challenges during December from Covid pressures.

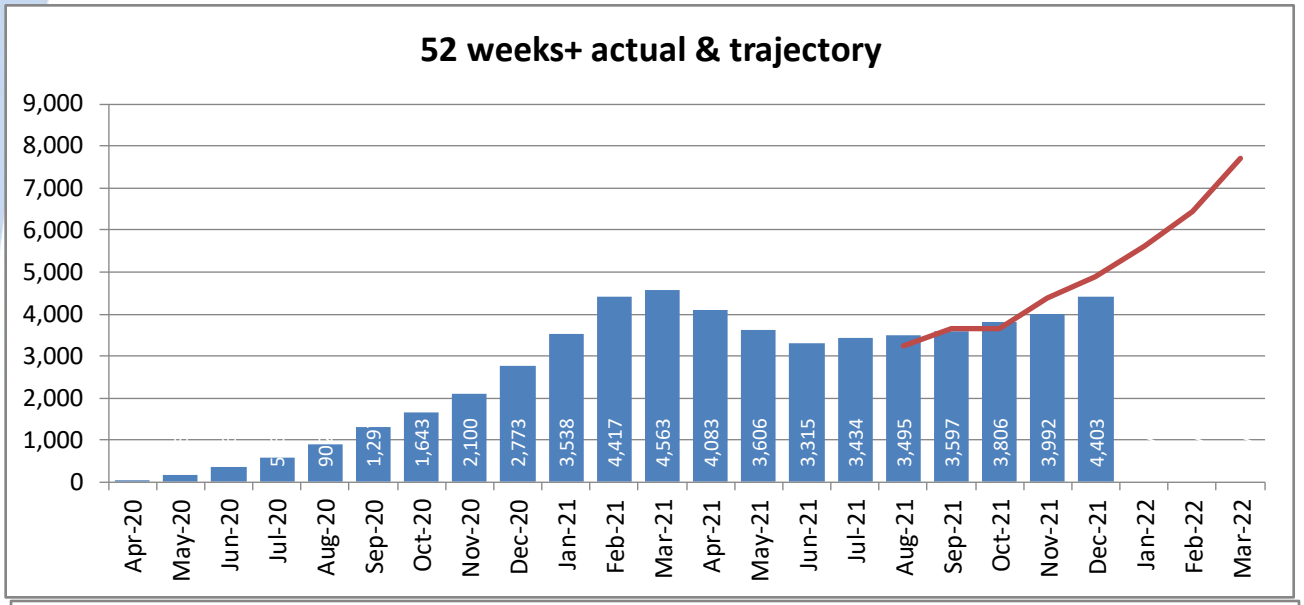
Planned care – *Outpatient activity & RTT*





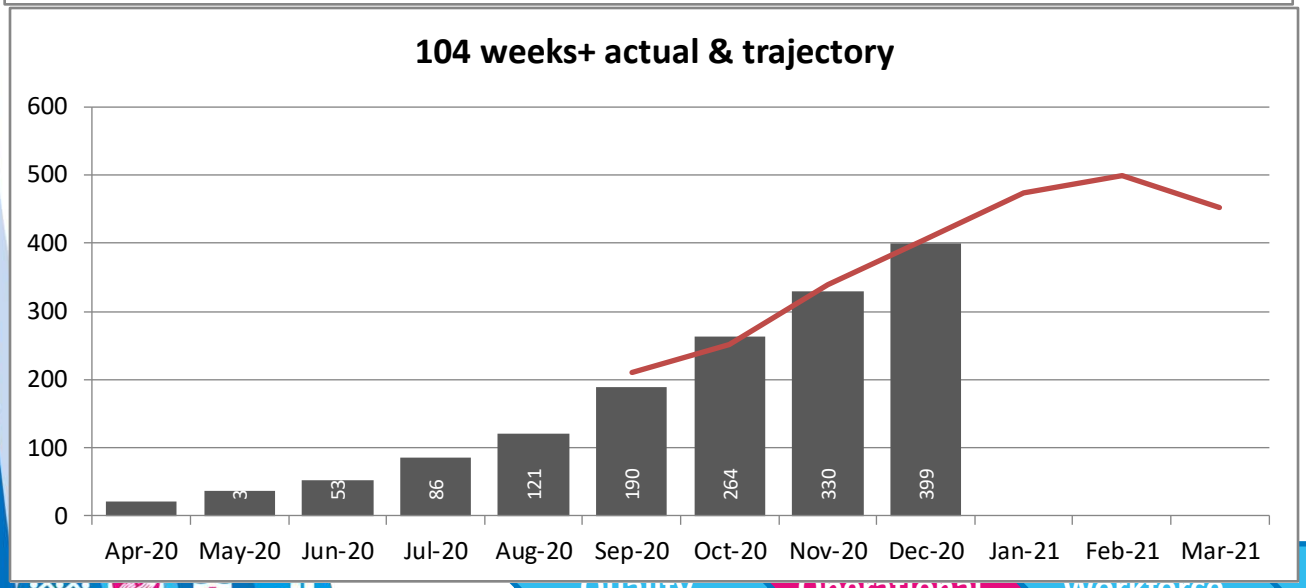
Quality | Operational | Workforce | Finance

Planned care – *RTT Trajectories*



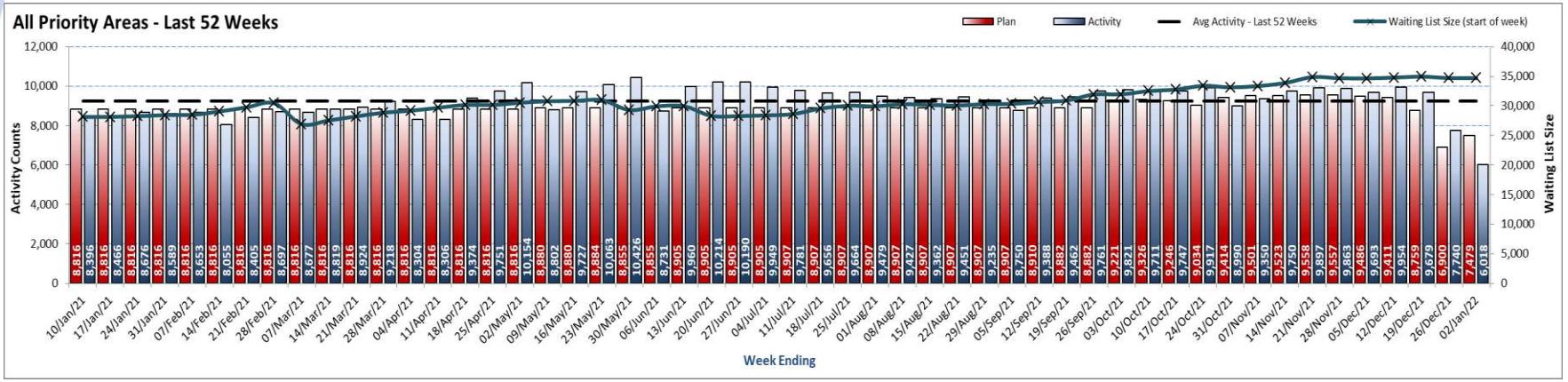
52 Week Waits are expected to increase over the next 3 months with a total of 7,721 at the end of March.

The Trust is currently ahead of trajectory.



104 Week Waits are also expected to increase. Rising to a total of 452 end of March.

Diagnostic Activity



Summary

- For DM01 (15 nationally identified Dx tests) the unvalidated position for total waiting list has increased in December from 20,134 to 20,669. The Non-obstetric ultrasound waiting list reduced slightly from 9,935 to 9,901. Due to the challenges in Non-Obstetric Ultrasound this has adversely affected performance. The current DM01 diagnostic performance for December 21 is at 68% (November 69 %).
- The greatest proportion of > 6 week waits are within Non-obstetric ultrasound and endoscopy. The ultrasound position is related to an increase in demand alongside workforce shortfalls, a number of actions are in place and Non obstetric ultrasound performance is a Driver Metric for CWD and has specific focus for improvement.
- DM01 performance excluding non obs ultrasound would be c90%.
- Capacity and Demand work is being planned in the next quarter and is reliant on Information services capacity.
- Histology and Endoscopy remain high risk areas both have plans for improvement. Histology turnaround times are showing some initial signs of improvement.
- Neurophysiology service has experienced a deterioration in DM01 performance in late Dec / early January due the unexpected sickness in the team and planned annual leave (with a team of only 2 consultants). This has so far resulted in 98 breaches. Skill mix is being utilised where safe to do so and locum agencies and outsourcing companies have been contacted but this has not so far been successful. Risk management is being undertaken, an update on impact will be provided next month.

Diagnostic Activity

Areas of Concern:

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

Impact :

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

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

Increase in outsourcing and locum costs

Increasing staff sickness due to workplace pressures

Mitigation:

- A remedial plan has been developed with Transformation team and Network partners. Improvements are evident – work in progress
- There are 6 Histology trainees who will qualify in the next 12 months (3 in Spring / 3 in Autumn) – recruitment timelines are being progressed

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

Impact:

Increase in waiting times and backlog for non urgent scans

Inability to meet DM0-1 standards

Increased stress for current staff, Poor patient experience

Delays in the scanning and return of patient reports from the Independent Sector provider

Mitigation:

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

Continuing to try to source locum sonographers

Reviewing workforce plans and AFC banding in line with other Trusts

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

Impact:

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

Mitigation:

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

Diagnostic Trajectory

DM01 Modality	Nov	Dec	Jan	Feb	Mar
Gastroscopy (Endoscopy)	60%	65%	75%	80%	85%
Respiratory Physiology (Sleep)	100%	100%	100%	100%	100%
401 Clinical Neurophysiology	100%	100%	100%	100%	100%
Urodynamics	100%	100%	100%	100%	100%
Magnetic Resonance Imaging	97%	97%	97%	97%	97%
Computed Tomography	99%	99%	99%	99%	99%
Non-obstetric ultrasound	60%	75%	85%	95%	97%
Cardiology – Echocardiography	To be confirmed by mid Dec				
Cardiology – Electrophysiology	To be confirmed by mid Dec				
Flexible sigmoidoscopy	To be confirmed by mid Dec				
Cystoscopy	To be confirmed by mid Dec				

- DM01 trajectory based on modality

APPENDIX 1

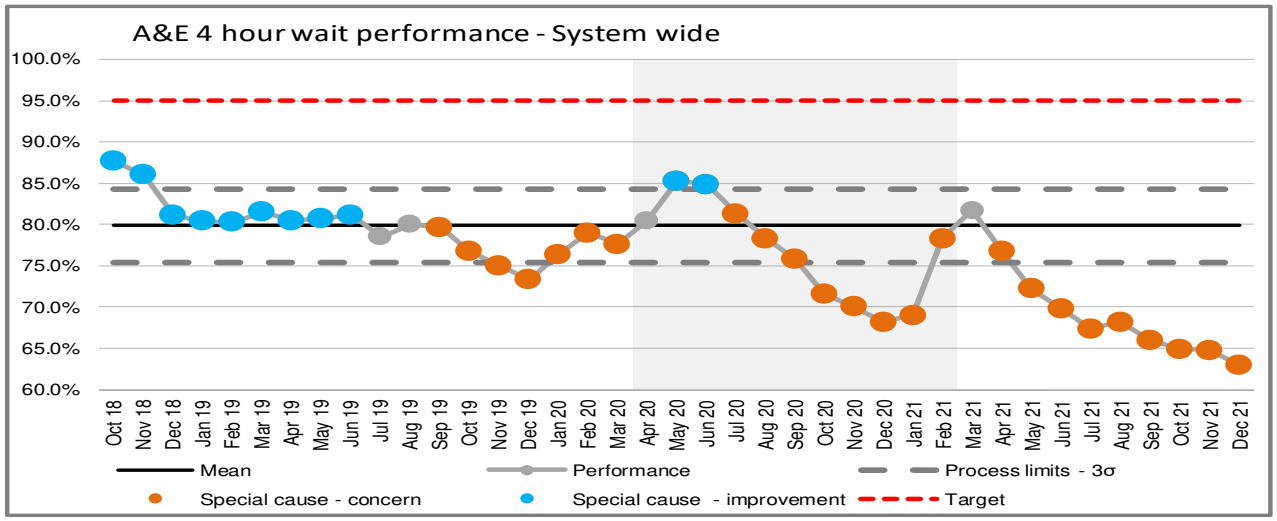
Operational Performance

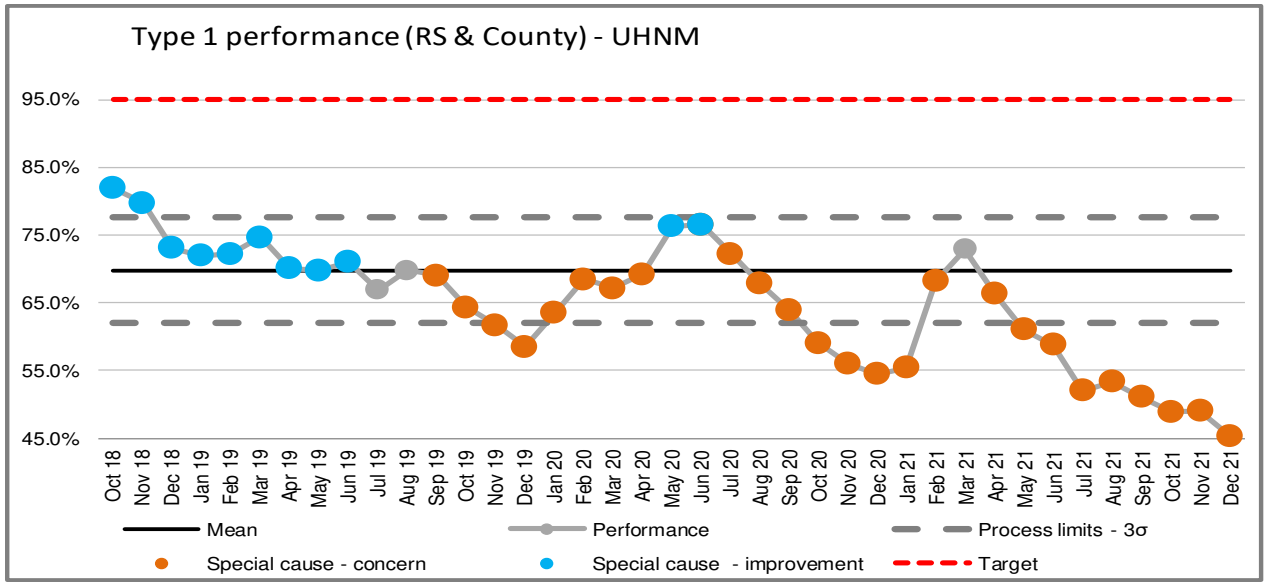
Constitutional standards

	Metric	Target	Latest	Variation	Assurance	DQAI
A&E	A&E 4 hour wait Performance	95%	63.00%	L	F	
	12 Hour Trolley waits	0	372	H	?	
Cancer Care	Cancer Rapid Access (2 week wait)	93%	47.18%	L	?	
	Cancer 62 GP ref	85%	47.58%	L	?	
	Cancer 62 day Screening	90%	61.90%		?	
	31 day First Treatment	96%	85.26%	L	?	
Elective waits	RTT incomplete performance	92%	55.76%	L	F	
	RTT 52+ week waits	0	4403	H	F	
	Diagnostics	99%	68.70%	L	F	

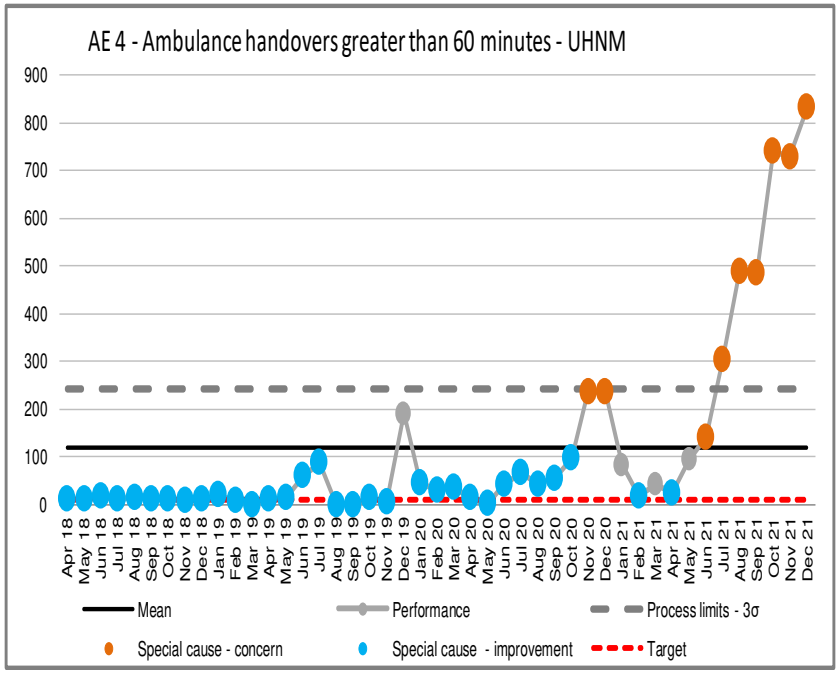
	Metric	Target	Latest	Variation	Assurance	DQAI
Use of Resources	DNA rate	7%	7.3%		?	
	Cancelled Ops	150	158		?	
	Theatre Utilisation	85%	76.0%			
Inpatient / Discharge	Same Day Emergency Care	30%	30.1%	H	?	
	Super Stranded	183	205	H	P	
	DToC	3.5%	3.40%		?	
	Discharges before Midday	30%	20.2%		F	
	Emergency Readmission rate	8%	11.8%	L	F	
	Ambulance Handover delays in excess of 60 minutes	10	833	H	?	

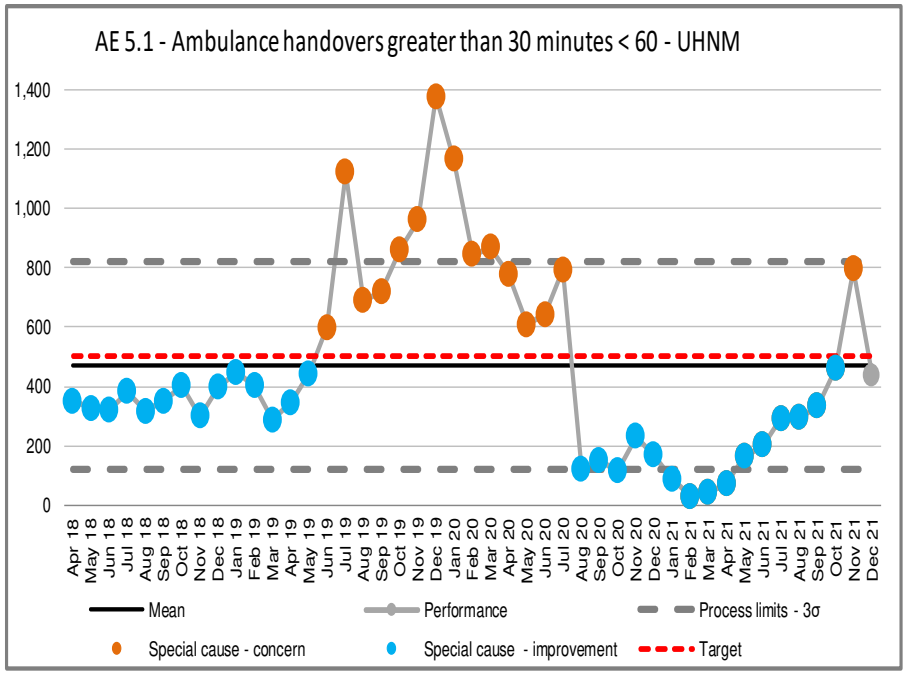
URGENT CARE – 4 hour access performance





URGENT CARE – 4 hour access – ambulance handovers

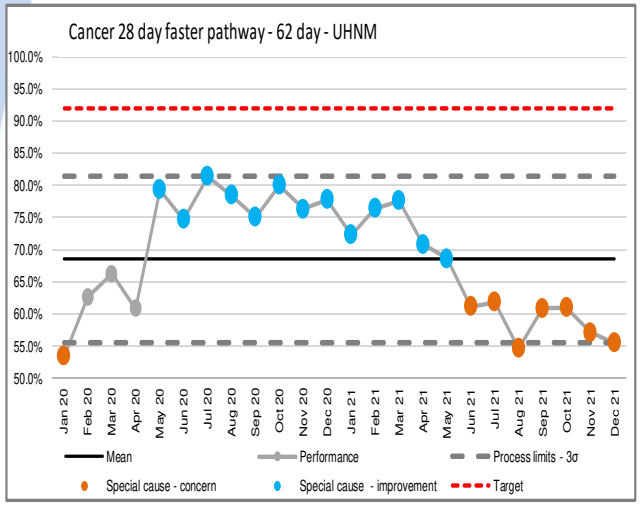


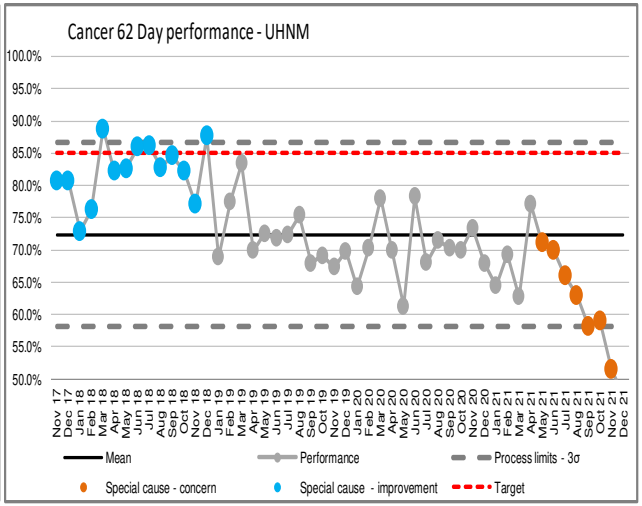


From August – internal validation of > 30 minutes

Quality | Operational | Workforce | Finance

Cancer – 62 Day





Variation	Assurance

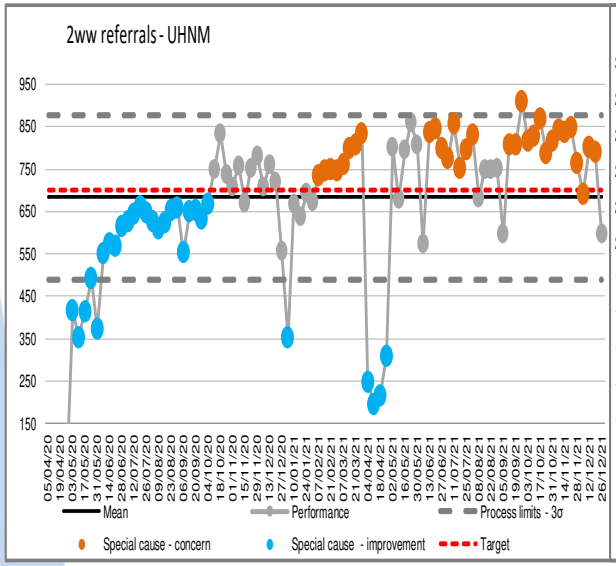
Target	Oct 21	Nov 21	Dec 21
85%	59.1%	51.4%	47.6%

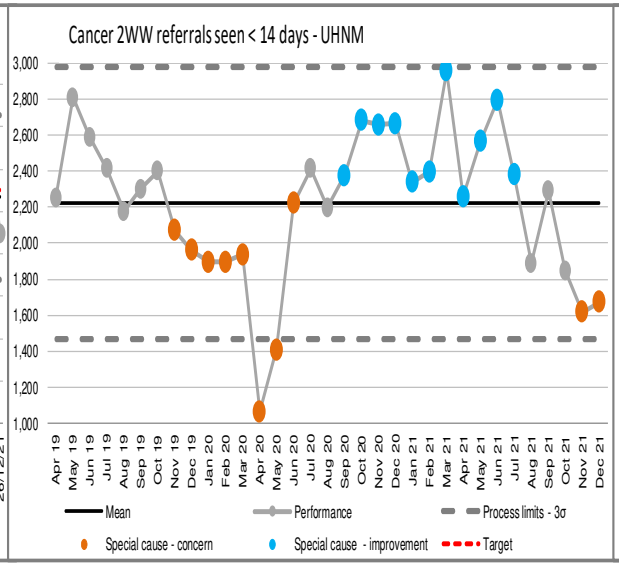
Background

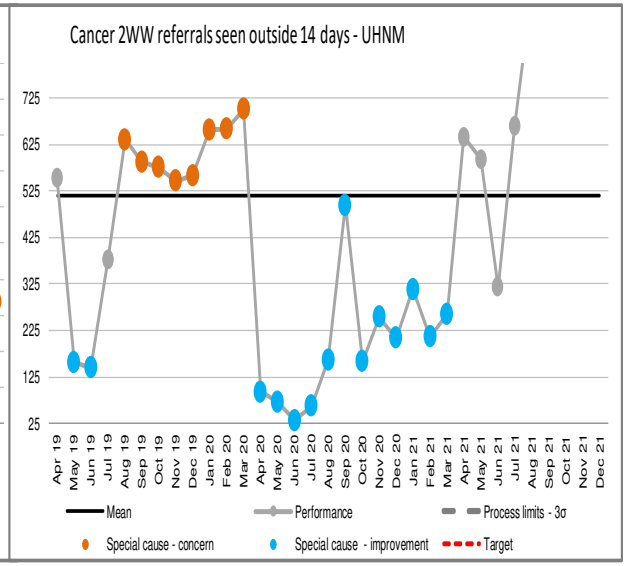
% patients beginning their treatment for cancer within 62 days following an urgent GP referral for suspected cancer

What is the data telling us?

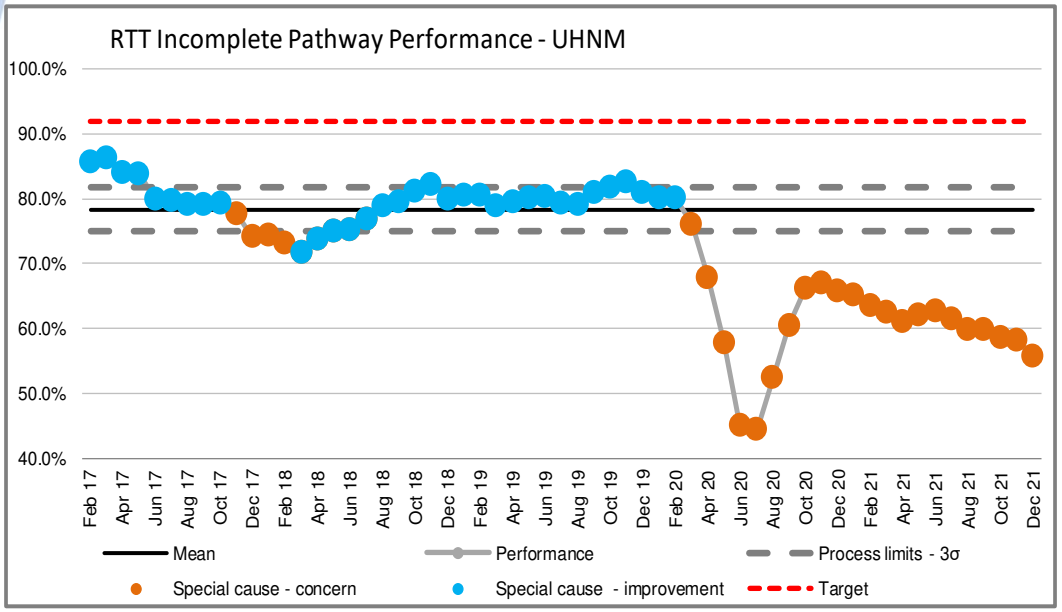
Apart from three occasions the standard has been below the mean since Sept-19.







Referral To Treatment



Variation	Assurance
	

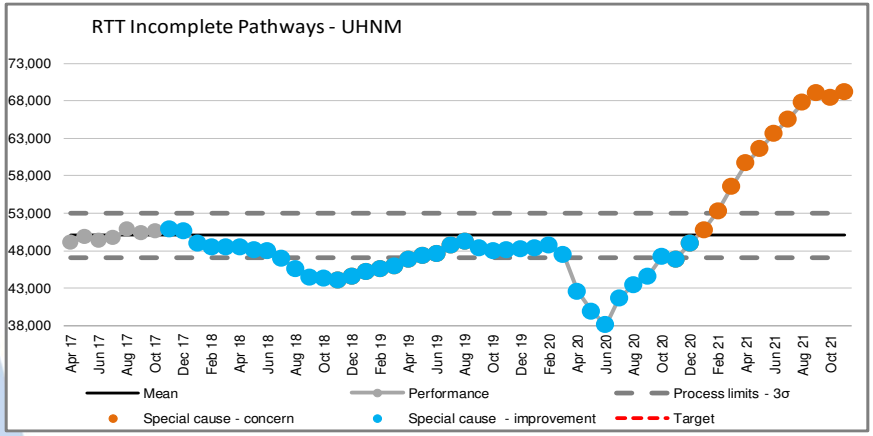
Target	Oct 21	Nov 21	Dec 21
92%	58.6%	58.2%	55.8%

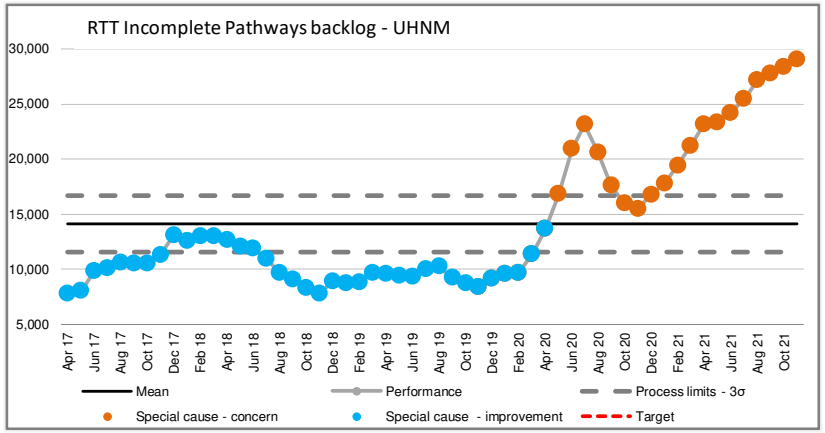
Background

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

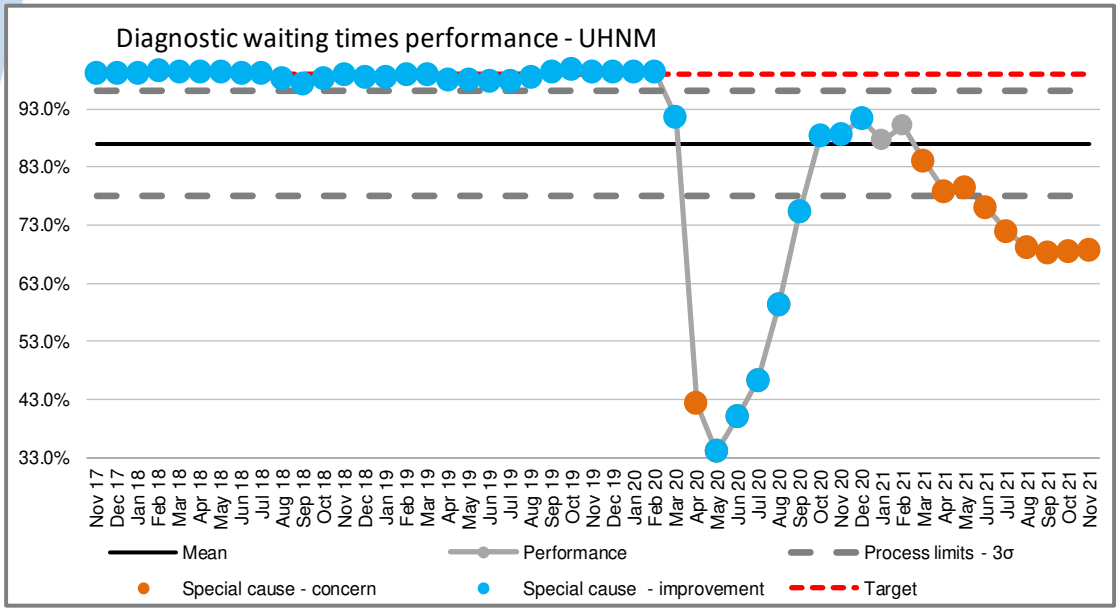
What is the data telling us?

Steady decline in performance since the pandemic began.





Diagnostic Standards



Variation	Assurance
	

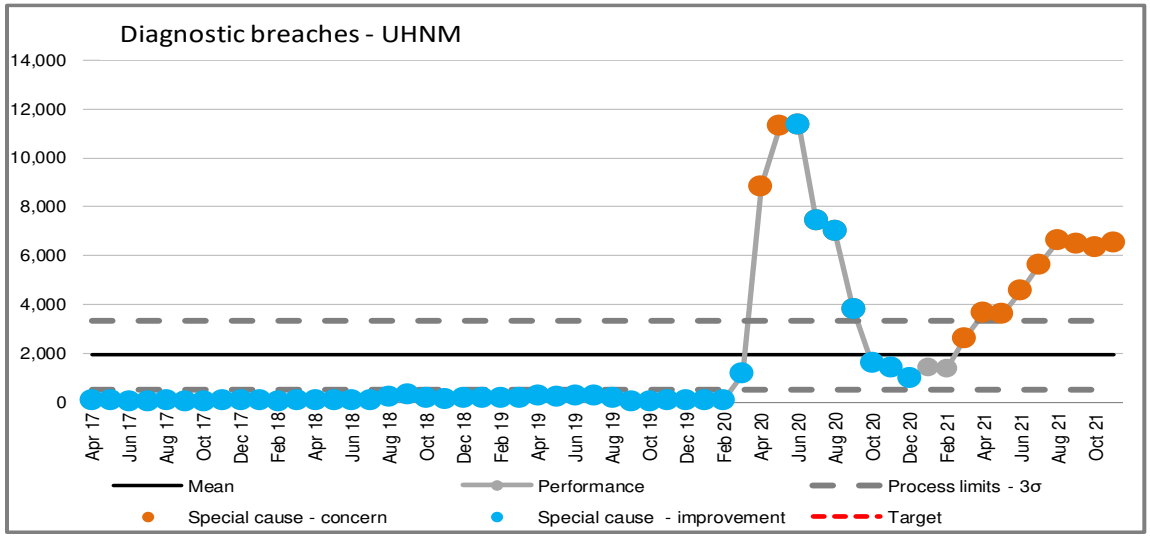
Target	Sep 21	Oct 21	Nov 21
99%	68.1%	68.5%	68.7%

Background

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

What is the data telling us?

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



Quality | Operational | Workforce | Finance

Workforce

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

Workforce Spotlight Report

University Hospitals of North Midlands NHS Trust

Key messages

The strategic focus of our People Plan remains on supporting recruitment, staff wellbeing, absence management and implementing the new mandatory vaccination regulations.

The new regulations were approved as legislation on 6th January 2022, come into force on 1 April 2022, and require that all patient-facing health and social care workers in England are double-vaccinated. Those staff who are unvaccinated will need to have had a first dose by 3 February 2022. A Task and Finish Group has been put in place to implement the NHS England guidance "Vaccination as a Condition of Deployment (VCOD) for Healthcare Workers and work is on-going to identify roles "in scope" as well as other affected workers in the Trust. A data collection exercise is underway to obtain evidence of vaccination or exemption where data held by the Trust is uncertain.

The aim of Trust Policy will be to redeploy affected staff into non-clinical/regulated areas. However, as an employer, UHNM is making efforts to support staff to receive the vaccine. UHNM will look at redeployment options away from direct face-to-face roles. Where redeployment is not possible, there may be no choice but to end employment for those employees who decline the vaccine, without an allowable exemption, by 1 April 2022. The extent of risk to the Trust will be assessed following completion of the data collection exercise.

Sickness - The in-month sickness rate was 6.23% (5.57% reported at 30/11/21). The 12 month cumulative rate reduced to 5.25% (5.27% at 30/11/21). The daily sickness sitreps showed a steady rise in sickness rates during December 2021, with surge from 26th December.

As of 14th January 2022, covid-related open absences* numbered 482, which was 46.17% of all absences (20.29% at 3rd December 2021) [**includes absences resulting from adhering to isolation requirements*]

- The Workforce Bureau has been stepped back up and is working with Nursing and Medical Bureaus to manage staff deployment
- Daily Sitreps on staff absence are produced which inform decisions on redeployment of staff
- Winter wellbeing plans are in place

Appraisals The Non-Medical PDR compliance rate was 76.18%, which is a slight improvement from the position at 30 November 2021 (75.80%) although performance remains below target. Completion of PDRs has been suspended while the Trust is at Critical Incident level

Statutory and Mandatory Training - The Statutory and Mandatory training rate at 31st December 2021 was 95.50% (95.47% at 30 November 2021). This compliance rate is for the 6 'Core for All' subjects only. At 31st December 2021, 91.50% of staff had completed all 6 Core for All modules (91.39% at 30/11/21)

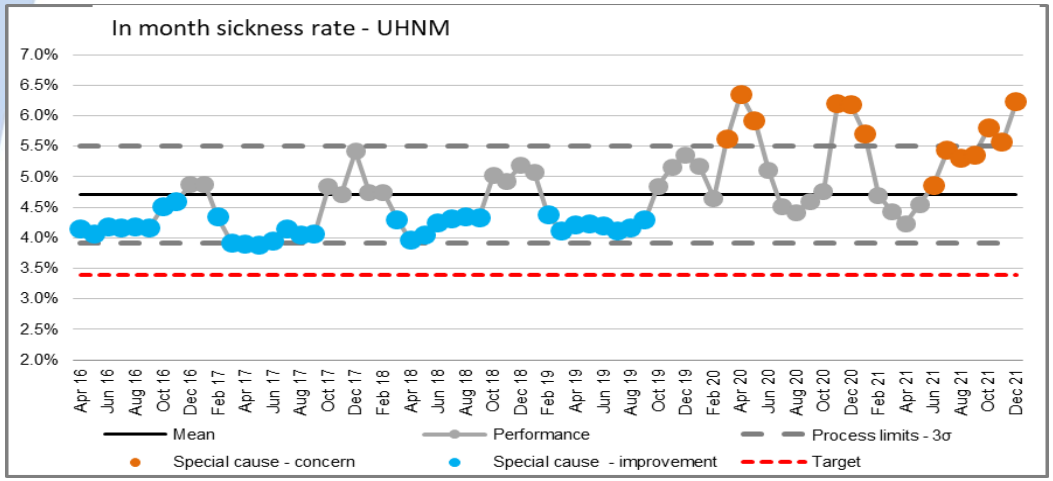
Vacancies - The overall Trust vacancy rate was 10.5% as a result of a small uplift in budgeted establishment to account for Winter planning.

In accordance with the requirements et out in the NHSEI letter 'Planning for Winter', dated 13/12/21, the Trust is working to accelerate recruitment plans where possible, including for healthcare support workers.

Workforce Dashboard

Metric	Target	Latest	Variation	Assurance
Staff Sickness	3.4%	6.23%		
Staff Turnover	11%	9.67%		
Statutory and Mandatory Training rate	95%	95.50%		
Appraisal rate	95%	76.18%		
Agency Cost	N/A	3.63%		

Sickness Absence



Variation	Assurance
H	F

Target	Oct 21	Nov 21	Dec 21
3.4%	5.8%	5.6%	6.2%

Background

Percentage of days lost to staff sickness

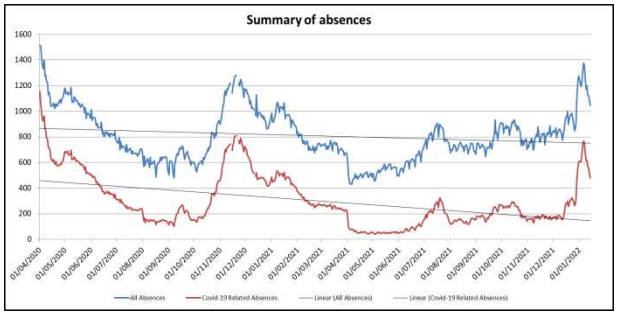
What is the data telling us?

Sickness rate is consistently above the target of 3.4%.

Summary

The in-month sickness rate was 6.23% (5.57% reported at 30/11/21). The 12 month cumulative rate reduced to 5.25% (5.27% at 30/11/21). The daily sickness sitreps showed a steady rise in sickness rates during December 2021, with a surge from 26th December

As of 14th January 2022, covid-related open absences* numbered 482, which was 46.17% of all absences (20.29% at 3rd December 2021) [**includes absences resulting from adhering to isolation requirements*]

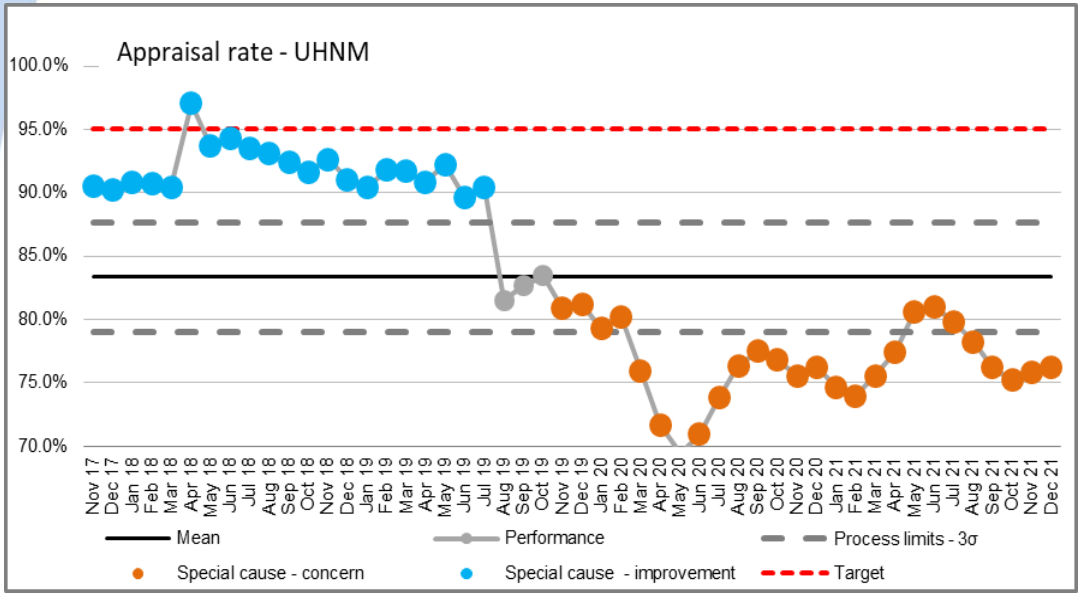


In line with Government policy we are now working with colleagues across to the Trust to implement the mandated vaccination programme for all staff who work in clinical areas

Actions

- Winter Wellbeing Plans are being implemented
- The Workforce Bureau has been stepped back up and is working with Nursing and Medical Bureaus to manage staff deployment
- Level 4 Incident response plans seek to maintain core non elective and Diagnostics/screening services and identify workforce capacity that can be released to support critical services
- Volunteers from across the Trust are being sought to support wards and departments with basic non clinical tasks
- Daily Sitreps on staff absence are produced which inform decisions on redeployment of staff
- Three clinical divisions have identified sickness as a driver metric and are undertaking deep dives into reasons for stress related absence to help target actions for support.

Appraisal (PDR)



Variation	Assurance
L	F

Target	Oct 21	Nov 21	Dec 21
95.0%	75.2%	75.8%	76.2%

Background

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

What is the data telling us?

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

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

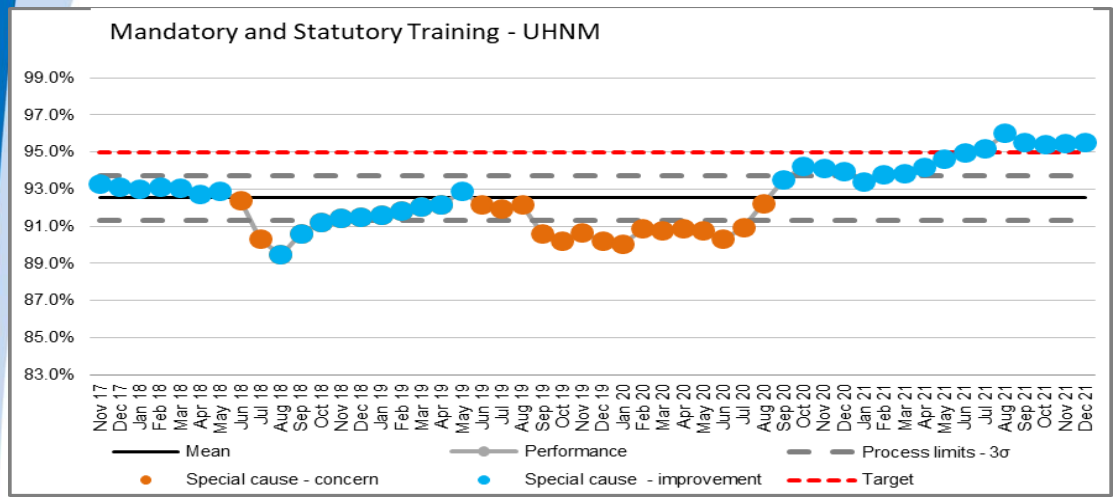
Summary

The Non-Medical PDR compliance rate was 76.18%, which is a slight improvement from the position at 30 November 2021 (75.80%) although performance remains below target.

Actions

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

Statutory and Mandatory Training



Variation	Assurance
H	F

Target	Oct 21	Nov 21	Dec 21
95.0%	95.4%	95.5%	95.5%

Background

Training compliance

What is the data telling us?

At 95.47%, the Statutory and Mandatory Training rate is better than the Trust target for the core training modules

Summary

The Statutory and Mandatory training rate at 31st December 2021 was 95.50% (95.47% at 30 November 2021. This compliance rate is for the 6 'Core for All' subjects only.

At 31st December 2021, 91.50% of staff had completed all 6 Core for All modules (91.39% at 30/11/21)

Competence Name	Assignment Count	Required	Achieved	Compliance %
205|MAND|Security Awareness - 3 Years|	10565	10565	10049	95.12%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	10565	10565	10102	95.62%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	10565	10565	10055	95.17%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	10565	10565	10085	95.46%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	10565	10565	10090	95.50%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	10565	10565	10159	96.16%

Compliance rates for the Annual competence requirements were as follows:

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 1 Year|	10565	10565	9100	86.13%
NHS|CSTF|Information Governance and Data Security - 1 Year|	10565	10565	9434	89.29%

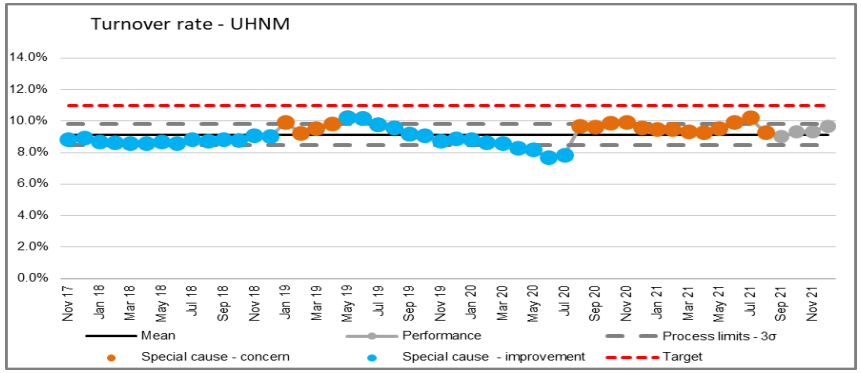
Actions

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

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

Workforce Turnover

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



Variation	Assurance

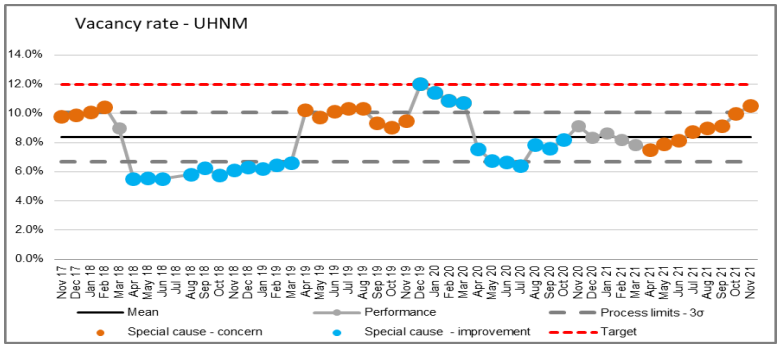
Target	Oct 21	Nov 21	Dec 21
11.0%	9.3%	9.3%	9.7%

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%



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

Summary

The 12m Turnover rate was 9.67% (9.33% at 30/11/21) and the overall Trust vacancy rate was 10.78% as a result of a slight uplift in budgeted establishment. Staff in Post increased in month.

Vacancies at 31 Dec 2021	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous month %
Medical and Dental	1,465.30	1,261.78	203.52	13.89%	13.87%
Registered Nursing	3355.55	2924.91	430.64	12.83%	12.74%
All other Staff Groups	6389.32	5814.92	574.40	8.99%	8.57%
Total	11,210.17	10,001.61	1,208.56	10.78%	10.50%

Although staff in post increased in December 2021, this was offset by an increase in budgeted establishment which meant the vacancy position increased by 36.63fte

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

Actions

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

The corporate risks have been reviewed and reassessed in light of the mandatory covid vaccine, the potential impact of the omicron variant and workforce supply issues. This has resulted in additional actions being added to the Board Assurance framework

Finance

2025 Vision "Ensure efficient use of resources"

Finance Spotlight Report

NHS University Hospitals of North Midlands NHS Trust

Key messages

- The Trust set a plan at the start of the year with a H1 surplus of £8.3m and a full year deficit of £8.8m. The guidance for H2 was reviewed and the Trust set a revised breakeven plan for the financial year ending 31 March 2022. At both a National and System level an agreement was reached that the Trust was to carry forward the surplus of £14.5m delivered in H1 and therefore the planned position for H2 was a £14.5m deficit to achieve a breakeven plan for the year. Since then, the Trust has worked through the submitted activity plans and calculated an expected income of £5.1m against the Elective Recovery Fund. Therefore in November 2021, the Trust formally submitted a revised annual plan of a £5.1m surplus for the financial year ending 31 March 2022.
- The Trust has delivered an actual deficit of £0.8m in month against an in month planned deficit of £2.5m and a year to date surplus of £15.6m resulting in a favourable variance of £8.5m against the year to date plan. The positive position against plan in month is primarily driven by underspends against non-recurrent investment funds.
- A full year forecast has been undertaken at Month 9 which presents a £5.2m surplus. This includes material movements expected in Q4 including no ERF income and a release of part of the prior year annual leave accrual.
- The Trust incurred £1.1m of costs relating to COVID-19 in month which is an increase of £0.1m compared with Month 8's figure. This remains within the Trust's fixed allocation with £0.7m being chargeable on top of this allocation for COVID-19 testing costs.
- Capital expenditure for the year to date stands at £17.9m which is £2.8m behind the plan mainly due to an underspend relating to digital pathology and estates infrastructure.
- The cash balance at Month 9 is £83m which is £5m higher than plan, the main reason being lower than forecast capital payments which reflects the overall slippage against the capital plan.

Finance Dashboard

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

Income & Expenditure

Income & Expenditure Summary Month 09 2021/22	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Income From Patient Activities	868.6	70.9	70.9	0.0	651.4	651.3	(0.0)
Other Operating Income	89.5	8.3	8.4	0.0	66.5	66.2	(0.3)
Total Income	958.1	79.2	79.2	0.1	717.8	717.5	(0.3)
Pay Expenditure	(561.4)	(48.0)	(45.8)	2.1	(416.4)	(408.9)	7.5
Non Pay Expenditure	(338.0)	(29.3)	(29.7)	(0.5)	(254.2)	(252.8)	1.4
Total Operational Costs	(899.5)	(77.2)	(75.5)	1.7	(670.5)	(661.6)	8.9
EBITDA	58.7	1.9	3.7	1.8	47.3	55.9	8.6
Depreciation & Amortisation	(29.9)	(2.5)	(2.5)	(0.0)	(22.5)	(22.6)	(0.1)
Interest Receivable	0.1	0.0	0.0	(0.0)	0.1	0.0	(0.1)
PDC	(7.6)	(0.6)	(0.6)	0.0	(5.8)	(5.8)	0.0
Finance Cost	(16.1)	(1.3)	(1.3)	0.0	(12.1)	(12.0)	0.0
Other Gains or Losses	0.0	0.0	0.0	0.0	0.0	0.0	(0.0)
Surplus / (Deficit)	5.1	(2.5)	(0.8)	1.7	7.1	15.6	8.5
Financial Recovery Fund	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	5.1	(2.5)	(0.8)	1.7	7.1	15.6	8.5

The Trust delivered a £0.8m deficit for Month 9 against a planned deficit of £2.5m and a year to date surplus position of £15.6m against a planned surplus position of £7.1m; the main variances in month are:

- Pay is underspent in month by £2.1m which is primarily driven by underspends across registered nursing and NHS infrastructure (see Winter detail below) and non-recurrent funding underutilised in month for the System Elective Recovery fund and COVID-19.
- Non-pay is overspent against plan in month by £0.5m primarily due to continued spend above budget in respect of drugs and above budget spend on pass-through devices for which we have received additional income. Within non pay the Trust also has non-recurrent funding which has again been underutilised in month.
- In month £0.6m has been spent against the planned Winter figure of £1m and year date £1.2m has been spent against the planned Winter figure of £1.9m. This is primarily due to the on-going staffing shortages both from a recruitment and sickness perspective. This slippage is expected to continue until 31 March 2022 and has been factored into the forecast position presented below.

Capital Spend

Capital Expenditure as at Month 9 2021/22 £m	Total approved scheme cost - schemes > 1 yr (excl PFI)	Revised 2021/22 Plan	2021/22 year end forecast	In Month			Year to Date		
	Plan	Plan	Actual	Budget	Actual	Variance	Budget	Actual	Variance
PFI & finance lease liability repayment	-	(9.2)	(9.2)	(0.8)	(0.8)	-	(6.8)	(6.8)	-
Pre-committed items	-	(9.2)	(9.2)	(0.8)	(0.8)	-	(6.8)	(6.8)	-
PFI lifecycle and equipment replacement	-	(5.3)	(5.3)	(0.2)	(0.2)	-	(1.5)	(1.5)	-
PFI enabling cost	-	(0.8)	-	-	-	-	-	-	-
PFI related costs	-	(6.1)	(5.3)	(0.2)	(0.2)	-	(1.5)	(1.5)	
RI demolition	(7.4)	(0.9)	(1.2)	(0.2)	(0.0)	0.1	(1.3)	(0.8)	0.5
Project STAR multi-storey car park	(1.5)	(1.2)	(1.2)	-	(0.2)	(0.2)	(0.2)	(0.7)	(0.6)
Thornburrow decant office accommodation	(2.4)	(1.9)	(2.0)	-	(0.1)	(0.1)	(1.9)	(2.0)	(0.1)
Wave 4b Funding - Lower Trent Wards	(9.5)	(2.2)	(2.2)	(0.4)	(0.2)	0.2	(1.6)	(1.3)	0.4
CT7 scanner enabling cost	-	(1.2)	(0.1)	-	-	-	-	-	-
STP diagnostic Funding and Cancer funding CT7	-	(1.0)	(1.0)	-	-	-	-	-	-
PDC funding - elective recovery (critical care) TIF	-	(0.3)	-	-	-	-	-	-	-
PDC funding - elective recovery (CTS/theatre) TIF	-	(1.5)	-	-	-	-	-	-	-
PDC funding Cyber Security/Home working TIF	-	(0.3)	-	-	-	-	-	-	-
PDC funding - Unified Tech funding	-	(1.6)	(1.6)	-	-	-	-	-	-
PDC funding - Digital Maternity Tech funding	-	(0.4)	(0.4)	-	-	-	-	-	-
PDC funding - Imaging Academy	-	(0.4)	(0.4)	-	-	-	-	-	-
Schemes funded by PDC and Trust funding	(20.8)	(12.9)	(10.2)	(0.6)	(0.5)	0.1	(4.9)	(4.7)	0.2
LIMS (Laboratory Information Management System	(2.7)	(0.6)	(0.7)	(0.1)	(0.0)	0.1	(0.6)	(0.4)	0.2
EPMA (Electronic Prescribing)	(4.7)	(0.5)	(0.5)	(0.0)	(0.0)	0.0	(0.3)	(0.3)	(0.0)
Completion of RSUH ED doors	(0.4)	(0.2)	(0.2)	-	-	-	(0.2)	(0.2)	0.0
Pathology integration	(0.4)	(0.3)	(0.3)	-	-	-	-	(0.1)	(0.1)
Medical devices fleet replacement	(4.9)	(0.7)	(0.7)	-	-	-	-	-	-
Schemes with costs in more than 1 financial year	(13.0)	(2.3)	(2.5)	(0.1)	(0.0)	0.1	(1.1)	(1.0)	0.1
2021/22 schemes	-	(14.9)	(15.8)	(0.9)	(0.6)	0.3	(6.3)	(3.9)	2.5
Balance to be allocated in updated Plan	-	(0.5)	(0.8)	-	-	-	-	-	-
Funds to be allocated to schemes	-	(0.5)	(0.8)	-	-	-	-	-	-
Donated/Charitable funds expenditure	-	(0.6)	(0.6)	(0.2)	(0.2)	-	(0.6)	(0.6)	-
Charity funded expenditure	-	(0.6)	(0.6)	(0.2)	(0.2)	-	(0.6)	(0.6)	-
Overall capital expenditure	(33.8)	(45.8)	(43.7)	(2.5)	(2.0)	0.5	(20.7)	(17.9)	2.8

The main variances are explained below.

- Works on the demolition of the RI site are £0.5m behind plan due to the identification of additional asbestos; the demolition will be completed slightly later than planned and with an increase to the budget.
- Project Star multi storey car park costs are £0.6m higher than plan due to costs being incurred earlier than expected, by the year end it will be in line with plan.
- Estates infrastructure expenditure is £0.8m behind plan mainly due to delays in the Lyme building chiller replacement project, ward 122 refurbishment and the theatre lighting scheme. The re-prioritisation of other schemes means that expenditure is expected to be in line with plan by the year end.
- The Digital Pathology scheme is £0.7m behind plan; this scheme is a finance lease asset as part of the managed equipment scheme and will be brought on when the relevant equipment is provided to the Trust.
- The scheme to increase the footprint of the pharmacy dispensary area is £0.6m behind plan due to delays in the legal agreement with Project Co for the changes to the building. This scheme is expected to be complete by the year end.

The year-end forecast expenditure of £43.7m is £2.1m lower than the plan of £45.8m. The variance from plan is due to the Trust currently not forecasting to incur £2.1m of expenditure in 2021/22 in relation to the TIF schemes for critical care, County CTS and theatres and digital. At present there is no agreement to be able to carry forward the TIF funding to 2022/23 and scheme leads are continuing to progress the projects. The forecast includes a remaining balance of £0.8m to be allocated in Q4 with a number of statements of need in relation to medical devices and pathology being prepared for CIG in January.

Balance sheet

Balance sheet as at Month 9	31/03/2021	31/12/2021			
	Actual £m	Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment	531.2	526.2	524.0	(2.1)	Note 1
Intangible Assets	22.8	18.2	18.2	(0.0)	
Other Non Current Assets	-	-	-	-	
Trade and other Receivables	0.5	0.5	0.5	-	
Total Non Current Assets	554.5	544.8	542.7	(2.2)	
Inventories	15.0	16.0	17.4	1.4	Note 2
Trade and other Receivables	47.4	43.0	48.2	5.2	Note 3
Cash and Cash Equivalents	55.8	78.0	83.0	5.0	Note 4
Total Current Assets	118.2	137.0	148.6	11.6	
Trade and other payables	(98.5)	(107.4)	(108.8)	(1.4)	Note 5
Borrowings	(8.3)	(8.3)	(8.3)	(0.0)	
Provisions	(3.6)	(3.6)	(3.5)	0.1	
Total Current Liabilities	(110.4)	(119.4)	(120.6)	(1.3)	
Borrowings	(268.5)	(261.7)	(261.8)	(0.1)	
Provisions	(2.2)	(2.2)	(2.1)	0.1	
Total Non Current Liabilities	(270.7)	(263.9)	(263.9)	(0.0)	
Total Assets Employed	291.5	298.6	306.7	8.1	
Financed By:				-	
Public Dividend Capital	637.9	637.9	637.9	0.0	
Retained Earnings	(465.3)	(458.2)	(449.8)	8.4	Note 6
Revaluation Reserve	118.9	118.9	118.7	(0.2)	
Total Taxpayers Equity	291.5	298.6	306.8	8.2	

Variances to the plan at Month 9 are explained below:

- Property, Plant and Equipment is £2.1m lower than plan and reflects the underspend in the capital plan to Month 9. The main areas of underspend are the Digital pathology scheme £0.7m, estates infrastructure £0.8m and the expansion of the pharmacy dispensary area £0.6m. This is partly offset by lower than forecast depreciation and upward revaluations to Wilfred Place and the crèche at County to reflect the sale of the land.
- Inventories are £1.4m higher than plan. This is due to an increased balance in a number of stock areas due to the Christmas and New Year period. The main increases relate to pharmacy £0.4m and pacemakers £0.5m due to a recent purchase of ICD devices. There have been smaller increases in microbiology, theatres and interventional radiology inventory levels.
- Trade and other receivables are £5.2m higher than plan. The main reasons for the variance are accrued income balances in respect of the Annual leave provision at 31 March 2021, DHSC transitional support income for 2021/22 and Out of envelope costs not yet reimbursed. The increases are partly offset by a credit note provision for the Specialised Services block payments in relation to high cost devices where activity has not matched the income received.
- Cash is £5m higher than plan at Month 9, this is mainly due to higher than planned other income and lower than planned capital payments due to slippage in the capital programme.
- Trade and other payables are £1.4m higher than plan. This is mainly due to higher than plan levels of deferred income which is partly offset by lower than planned capital creditors due to slippage in the capital programme. The deferred income relates to cancer transformation funding received from NHS Stoke on Trent CCG.
- Retained earnings show a variance of £8.4m from plan which reflects the revenue surplus year to date.

Expenditure - Pay and Non Pay

Pay Summary Month 09 2021/22	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Medical	(170.1)	(14.2)	(14.1)	0.1	(126.8)	(125.8)	1.0
Registered Nursing	(163.5)	(14.3)	(13.2)	1.1	(120.3)	(116.8)	3.4
Scientific Therapeutic & Technical	(68.2)	(5.9)	(5.5)	0.4	(50.7)	(49.4)	1.2
Support to Clinical	(75.3)	(6.3)	(6.2)	0.1	(56.5)	(56.3)	0.2
Nhs Infrastructure Support	(84.3)	(7.2)	(6.8)	0.4	(62.2)	(60.5)	1.7
Total Pay	(561.4)	(48.0)	(45.8)	2.1	(416.4)	(408.9)	7.5

Pay –Key variances

Within the above budget for Month 9 is £1.2m of reserves which have not been spent (split across numerous expenditure headings) with the main elements being £0.5m for the non-recurrent investment reserve primarily relating to System Elective recovery, £0.4m in respect of Specialised Commissioners and £0.3m against COVID-19.

The underspend on registered nursing remains in line with the prior year trend as a result of the number of vacancies across the trust. Within the Month 9 budget there is £0.5m of underutilised budget in reserves (part of the £1.2m noted above) and within the Month 9 actual were total premium costs (bank and agency) of £1.5m covering existing workforce vacancies and absences.

Non Pay Summary Month 09 2021/22	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Tariff Excluded Drugs Expenditure	(79.8)	(6.5)	(6.7)	(0.2)	(60.7)	(61.9)	(1.1)
Other Drugs	(24.4)	(2.7)	(3.0)	(0.3)	(18.3)	(18.3)	(0.1)
Supplies & Services - Clinical	(89.0)	(7.2)	(8.1)	(0.9)	(66.0)	(67.1)	(1.1)
Supplies & Services - General	(7.0)	(0.5)	(0.8)	(0.3)	(5.1)	(5.6)	(0.5)
Purchase of Healthcare from other Bodies	(24.6)	(2.3)	(1.8)	0.5	(18.5)	(17.1)	1.4
Consultancy Costs	(1.9)	(0.1)	(0.1)	0.0	(1.6)	(1.6)	(0.0)
Clinical Negligence	(25.4)	(2.2)	(2.2)	0.0	(19.7)	(19.7)	0.0
Premises	(31.9)	(2.7)	(3.0)	(0.3)	(24.4)	(24.9)	(0.5)
PFI Operating Costs	(35.5)	(2.9)	(3.0)	(0.0)	(26.6)	(26.6)	(0.0)
Other	(18.5)	(2.1)	(1.1)	1.0	(13.3)	(9.9)	3.3
Total Non Pay	(338.0)	(29.3)	(29.7)	(0.5)	(254.2)	(252.8)	1.4

Non Pay key variances:

Supplies & Services – Clinical is overspent in month in part due to the transaction of an Orthopaedic procurement CIP in month of which £0.3m is a reduction in budget relating to prior periods. In month there has also been a theatres stock write off (£0.1m), overspend on pass-through devices (£0.1m for which we receive additional income), and additional spend in Pathology.

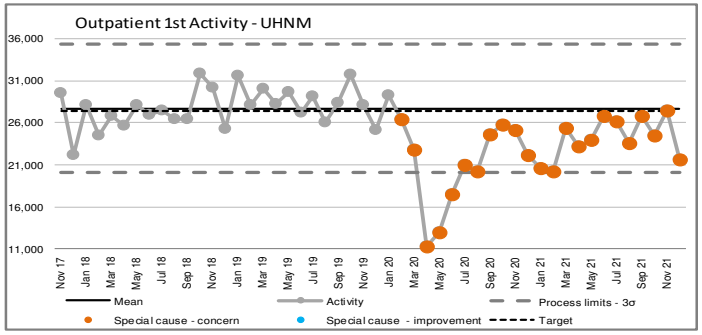
Purchase of Healthcare from other Bodies is reporting a variance of £0.5m as a result of an underspend against the System Elective Funding which has been allocated for SHS elective work (£0.3m) due to on-going staff absences.

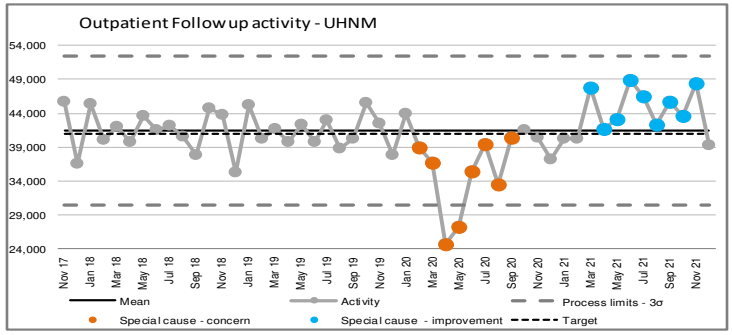
Other expenditure shows an underspend in month of £1m which is driven by underspends against reserves of which £0.4m is against the inflation reserve, £0.2m is against the non-recurrent H2 System Elective monies and £0.2m is against the COVID reserve.

Activity

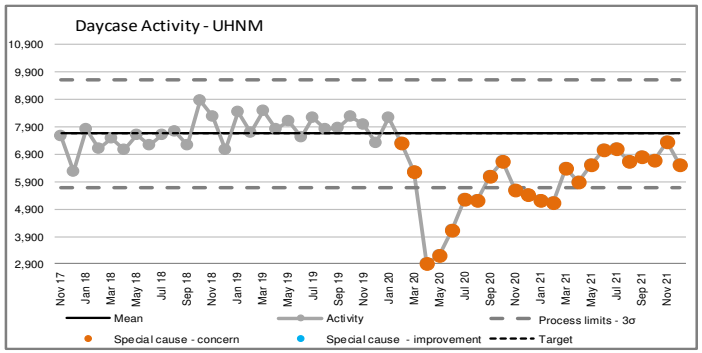
NHS University Hospitals of North Midlands NHS Trust

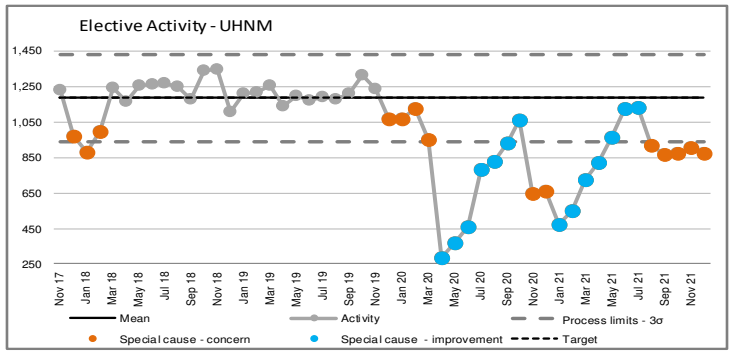
Planned care Outpatient



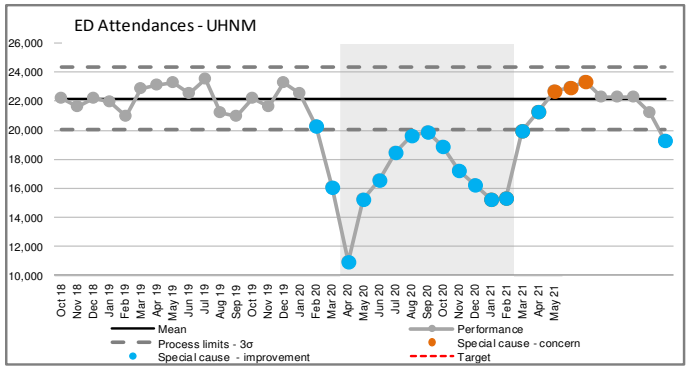


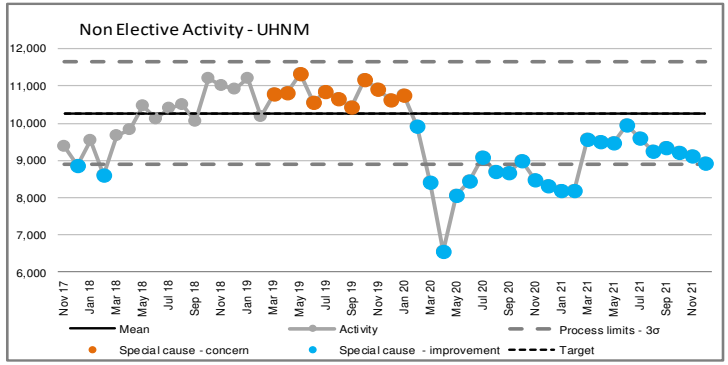
Planned care Inpatient





Urgent Care





Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Committee Chair's Highlight Report to Board

Audit Committee
27th January 2022

NHS
University Hospitals of North Midlands
NHS Trust

1. Highlight Report

!	Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
	• The Committee received the final internal audit report into 18 weeks referral to treatment deep dive which received a partial assurance rating. • The Committee noted the challenges in obtaining updates in respect of the progress with internal audit recommendations, policy reviews and declaration of interests, due to ongoing staffing pressures, although the aim was to provide a more complete update at the next meeting.	• To circulate the draft 2022/23 internal audit plan to members prior to being finalised by the Committee in April • To further enhance discussion of the BAF, by supporting chairs in addressing any gaps in assurance. • To provide an update in relation to the annual leave accrual summarising the assessments made and further detail to enable appropriate consideration of the accounts • To revise the Audit Committee dates in April and June to align with the annual report and accounts submission timescale
✓	**Positive Assurances to Provide**	**Decisions Made**
	• The Committee received the final internal audit reports into Covid-19 Pandemic Business Continuity Planning which received a reasonable assurance rating, key financial systems which received a split assurance rating of substantial and reasonable assurance and payroll which received a substantial assurance rating. • The Committee welcomed the progress in completing the internal audit programme and continued positive working relationships with Internal Audit • The Committee welcomed the change in approach to including an Assurance Map within the Q3 BAF and noted changes to be made to the BAF following discussions by other Committees. The Committee noted the gap between current risk scores and the ability to achieve the target risk scores by the given deadline. It was agreed to discuss and consider this further at the Board Seminar in March. • The Committee received the external audit progress report which included indicative audit risks, and noted the anticipated key areas of focus being the risk of improper revenue recognition, risk of manipulation of expenditure recognition, the risk of management override, the valuation of the Trust's land and buildings as well as the consideration of accounting estimates. The Committee welcomed the approach taken. • The Committee received an update in relation to the Financial Reporting Council annual report which demonstrated positive findings in relation to the quality of external audits undertaken by Grant Thornton • The fieldwork which had been undertaken in relation to fraud and bribery was noted, whereby no concerns had been raised and the Committee noted that a number of actions had already commenced to address the recommendations made within the Fraud Risk Assessment. The Committee welcomed the enhanced engagement with staff as part of fraud awareness week and the ongoing reactive referrals and associated themes were noted, in particular working while sick • £192,966 losses and special payments were made during the quarter and issues in relation to stock control were highlighted, noting the ongoing actions being taken to improve this going forwards • 139 SFI breaches were highlighted, in relation to late Purchase Orders 28 of which were over £20,000 and 5 STWs were noted. The Committee welcomed the approach being taken to track divisional performance in relation to STWs and SFI breaches. • The Committee welcomed the work undertaken to reduce salary overpayments and in particular the work on recovering overpayments • The Committee held a verbal discussion to consider the effectiveness of the internal and external auditors and welcomed the robustness of approaches taken	• The Committee approved the LCFS work plan for 2022/23

Comments on the Effectiveness of the Meeting
• Committee members welcomed the discussion held

2. Summary Agenda

No.	Agenda Item	BAF Mapping		Purpose	No.	Agenda Item	BAF Mapping		Purpose
		BAF No.	Risk				BAF No.	Risk	
1.	Internal Audit Progress Report: • COVID-19 Pandemic - Business Continuity Planning (BCP) Framework • 18 Weeks Referral to Treatment (RTT) Deep Dive Review • Key Financial Systems • Payroll	3, 6 1, 4 9 9		Assurance	8.	Local Counter Fraud Specialist Draft Workplan 2022/23			Approval
2.	Internal Audit Recommendation Tracker			Assurance	9.	Losses and Special Payments Q3 2021/22	9		Assurance
3.	Corporate Governance Report			Assurance	10.	SFI Breaches and Single Tender Waivers Q3 2021/22	9		Assurance
4.	Board Assurance Framework Q3	All		Approval	11.	International Financial Reporting Standard 16 (IFRS 16) Implementation Update	9		Assurance
5.	Issues for Escalation from Committees			Assurance	12.	Update on Accounting Policies, Critical Judgements and Estimation Uncertainty 2021/22	9		Assurance
6.	External Audit Progress Report / Indicative Audit Risks			Assurance	13.	Annual Accounts Timetable			Information
7.	Local Counter Fraud Specialist Progress Report			Assurance					

3. 2021 / 22 Attendance Matrix

Attended	Apologies & Deputy Sent	Apologies

Members:			Apr	Jun	Jul	Oct	Jan
Prof G Crowe	GC	Non-Executive Director (Chair)					
Mr P Akid	PA	Non-Executive Director					
Ms S Belfield	SB	Non-Executive Director					
Attendees:							
Ms N Coombe	NC	External Audit					
Mr G Patterson	GP	External Audit					
Mr M Gennard	MG	Internal Audit - RSM					
Mr A Hussain	AH	Internal Audit - RSM					
Ms A Deegan	AD	LCFS - RSM					SC
Mrs N Hassall	NH	Deputy Associate Director of Corporate Governance					
Mr M Oldham	MO	Chief Finance Officer					
Mrs S Preston	SP	Strategic Director of Finance					
Miss C Rylands	CR	Associate Director of Corporate Governance					NH

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	9th February 2022
Report Title:	Quarter 3 Board Assurance Framework	**Agenda Item:**	15.
Author:	Nicola Hassall, Deputy Associate Director of Corporate Governance		
Executive Lead:	*Various*		

Purpose of Report

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

Alignment with our Strategic Priorities

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

Executive Summary:

Situation

The Board Assurance Framework (BAF) provides a structure and process to enable the Board to focus on the key risks might compromise the achievement of our Strategic Priorities. The BAF has been updated for Quarter 3 21/22 and was presented to the Committees of the Board during January for scrutiny and approval.

Background

The Strategic Risks identified within the BAF were refreshed by the Executive Team and endorsed by the Board at the start of 21/22. As part of our Risk Management Improvement Programme, the BAF is continuously refined in order to ensure that it meets the needs of the Board. This is tested by our Internal Auditors on an annual basis and the findings of their review form the basis of our ongoing improvement programme.

Assessment

There are a number of changes to the format BAF for Q3 and these are detailed within the report; to summarise:

- Addition of an Assurance Map, demonstrating the sources of assurance received by Committees, including reference to whether these received positive assurance from the Committee or were highlighted as an area for escalation
- Updates to the BAF are identified in blue text for ease of identification
- Updates to the BAF to reflect the discussion held by each Committee; a summary of changes is listed below:
  - Links to the risk register updated to reflect current mitigation
  - Update to the rationale for the increased risk score of BAF6
  - Updated gaps in control to reflect the implementation of the winter plan (BAF6)
  - Update to the score of BAF3 to Ext 20 reflecting the increased risk score for BAF1 in terms of staffing
  - Additional action identified for BAF4 and BAF5, in respect of providing additional assurance on system work streams to the Transformation and People the Committee.
- In addition, it is recognised that the Board will further discuss Risk Appetite at a future Board Seminar, given the gap between current and target risk scores, and perceived achievability by the given deadline

Key Conclusions:

- A review of risk scores at Quarter 3 has demonstrated an increase in some risk scores, which are reflective of current operational and workforce challenges. The most significant risks are in relation to 1) Delivering Positive Patient Outcomes, 2) Sustainable Workforce and 3) Delivering Responsive Patient Care – all of which are now scored as Extreme 20.
- The Strategic Risk Heat Map identifies our Strategic Priorities for 'High Quality' and 'Responsive' are currently under the most significant threat to achievement.

Key Recommendations:

- The Trust Board is asked to consider the Quarter 3 BAF and confirm whether it is satisfied that the risk scores are an accurate representation of our current position, and whether there is sufficient action being taken to mitigate these risks.
- The Trust Board is asked to approve the Q3 BAF

University Hospitals of North Midlands NHS Trust

Board Assurance Framework (BAF)

Quarter 3 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 1), 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. However, we continue to improve the format and function of the BAF and will do this on an ongoing basis in order to optimise its effectiveness.

At Quarter 1, we took into account recommendations made by our most recent Internal Audit Review, including an indicators of whether the risks identified are 'internally or externally driven'. We also included the Risk Appetite Matrix (appendix 2) as a reference point; this is used to determine the target levels of risk.

Key Changes to the BAF at Quarter 3

1) Significant changes have been made to refine the BAF as at Quarter 3, which in the main relate to the articulation of assurances. The BAF now contains an Assurance Map, providing a direct link to the assurances received by Committees during the quarter, as well as longer assurances which have previously been presented to Committees in year. Where a risk or matter of concern for escalation has been identified by the Committee in their Committee Highlight Report, against a particular source of assurance, this is indicated by a red exclamation mark in the BAF. Similarly, a green tick indicates that the Committee had noted positive assurance.

This change ensures the assurances documented within the BAF are actual sources of assurances which Committees fully recognise, and have scrutinised, whilst also providing an opportunity for the Board to consider whether the assurances being received by the Committee(s) are sufficient.

2) Key changes since the Quarter 2 BAF was presented have been displayed in blue text.

3) When updating the BAF for Quarter 3, further consideration has been given to the scoring of risk. This has resulted in 3 risks having increased in risk score, reflecting the position in relation to staffing absences as a result of Covid. 2 risks have decreased in risk score with the remainder staying the same. Our 3 most significant risks are as follows:

- BAF 1 Delivering Positive Patient Outcomes – increase in risk score from Extreme 16 to Extreme 20
- BAF3 Sustainable Workforce – the risk score has increased from Extreme 16 to Extreme 20
- BAF 6 Delivering Responsive Patient Care – increase in risk score from Extreme 16 to Extreme 20

Further information is captured within the BAF in the 'rationale for risk score' sections.

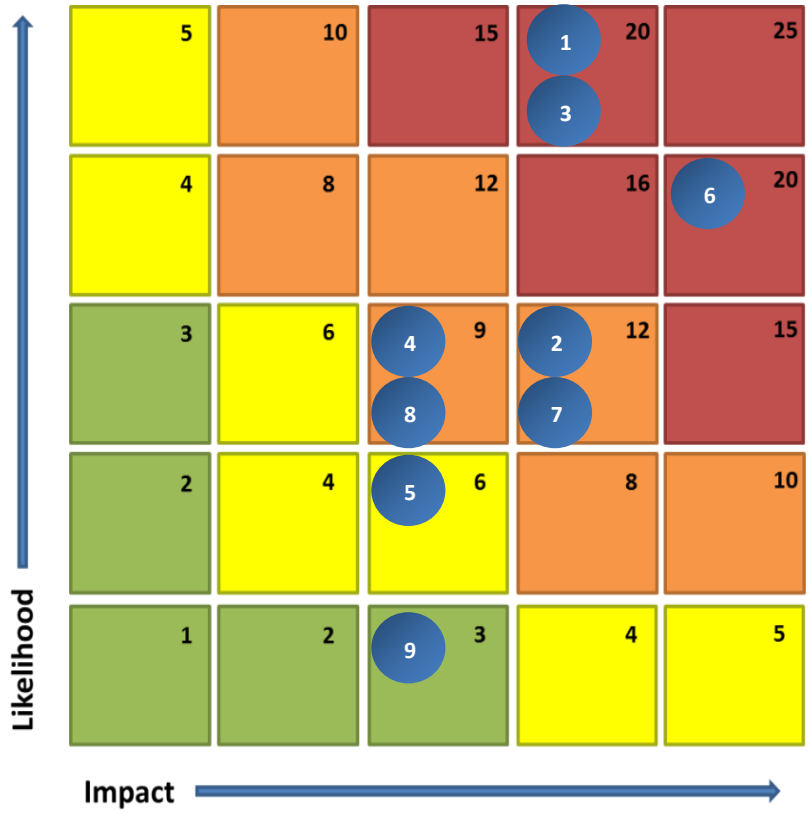
Key to 'BRAG' Ratings

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

2. Summary Board Assurance Framework

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 Responsive People Improving System Resources	● ● ● 	3	3	High 9	4	4	Ext 16	5	4	Ext 20				3	2	Mod 6	↑
BAF 2	Leadership, Culture & Delivery of Values / Aspirations	Quality Responsive People Improving System Resources	● ● 	3	4	High 12	3	4	High 12	3	4	High 12				2	3	Mod 6	→
BAF 3	Sustainable Workforce	Quality Responsive People Improving System Resources	● ● ● ●	3	4	High 12	4	4	Ext 16	5	4	Ext 20				3	3	High 9	↑
BAF 4	System Working – Vertical	Quality Responsive People Improving System Resources	● ● ● 	3	3	High 9	3	3	High 9	3	3	High 9				2	3	Mod 6	→
BAF 5	System Working – Horizontal	Quality Responsive People Improving System Resources	● ● ● ●	3	3	High 9	3	3	High 9	2	3	Mod 6				2	3	Mod 6	↓
BAF 6	Delivering Responsive Patient Care	Quality Responsive People Improving System Resources	● ● ● ● ●	4	3	High 12	4	4	Ext 16	4	5	Ext 20				4	3	High 12	↑
BAF 7	Delivery of IM&T Infrastructure	Quality Responsive People Improving System Resources	● ● ●	3	5	Ext 15	3	4	High 12	3	4	High 12				1	5	Mod 5	→
BAF 8	Infrastructure to Deliver Compliant Estate Services	Quality Responsive People Improving System Resources	● ● ● ●	3	4	High 12	3	3	High 9	3	3	High 9				2	4	High 8	→
BAF 9	Financial Performance	Quality Responsive People Improving System Resources	 ● ●	2	3	Mod 6	2	3	Mod 6	1	3	Low 3				1	3	Low 3	↓

3. Strategic Risk Heat Map



No.	Risk Title	Strategic Priorities
BAF 1	Delivering Positive Patient Outcomes	
BAF 2	Leadership, Culture and Delivery of Trust Values	
BAF 3	Sustainable Workforce	
BAF 4	System Working – Vertical	
BAF 5	System Working – Horizontal	
BAF 6	Delivering Responsive Patient Care	
BAF 7	Delivery of IM&T Infrastructure	
BAF 8	Infrastructure to Deliver Compliant Estates Services	
BAF 9	Financial Performance	

What does the Strategic Risk Heat Map tell us?

The Strategic Risk Heat Map is designed to identify the level of threat posed to our Strategic Priorities. It demonstrates the following:

- **'High Quality'** is the most threatened of our strategic priorities, with 8 out of 9 strategic risks posing a threat to it, 3 of which are scored at Extreme 20.
- **'Responsive'** is the second most threatened of our strategic priorities, with 7 out of 9 strategic risks posing a threat to it, again 3 of which are scored at Extreme 20.
- **'System and Partners'** is the third most threatened of our strategic priorities, with is 5 out of 9 strategic risks posing a threat, however only one of those risks (BAF 6), is classed as Extreme 20.
- For **'People'**, whilst only 3 strategic risks have been identified as posing a threat to it, 2 of those 3 have been classed as Extreme.

4. Board Assurance Framework 2021 / 22

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

Risk Description

Cause	Event	Effect
If we are unable to achieve agreed safe staffing requirements for nursing, medical and AHPs	**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/s:	Quality Governance Committee / Transformation & People 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**	

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	4	5		**Likelihood:**	3	31/03/2022
Consequence:	3	4	4		**Consequence:**	2	
Risk Level:	**High 9**	**Ext 16**	**Ext 20**		**Risk Level:**	**Mod 6**	
Rationale for Risk Level:	Risk score has increased given current nurse staffing absence of 30%. Risk score aligns to Staffing Shortages Risk Assessment. Ward 120 opened at risk given nursing absence of 32%. Increases in lapses in care relating to management of pressure ulcers. Increase in time to triage, ambulance delays and long waits for surgical procedures.						

Links to Risk Register (>12)				
ID11294 NMCPS Pathology Histology Medical Reporting Capacity (achieving TAT)	**Ext 20**	ID21433 Adult Critical Care Consultant Workforce	**Ext 16**
ID21661 Child Health Nursing Workforce during Extremis paediatric pressures	**Ext 16**	ID13419 Midwifery safe staffing	**Ext 16**
ID21721 Nuclear Medicine Physics Service Staff Vacancies	**Ext 15**	ID16432 Covid Compliance with CNST Maternity Safety Actions	**Ext 15**
ID11518 Midwifery Continuity of Carer model	**Ext 15**	ID8451 Trauma Directorate Nursing Workforce	**High 12**
ID10868 T&O Junior Doctor Staffing gaps	**High 12**	ID8615 Radiotherapy Radiographer Staffing Levels	**High 12**
ID21503 General Paediatric Consultant Rota	**High 12**	ID18093 Nurse Staffing within the NNU	**High 12**
ID21706 Safer Care Nursing Resource availability Specialised Decision Unit	**High 12**	ID21634 & ID21660 Staff absences relating to COVID-19 at RSUH and County	**High 12**
ID21867 Antenatal Ultrasound Staffing	**High 12**		

Position Statement

What progress has been made during the last quarter?

Separate risk assessment undertaken identifying existing and additional controls required, dependent upon percentage of absence. Additional actions to obtain better oversight include the development of the site safety dashboard with regular updates provided to tactical and gold meetings and the creation of the staffing hub which is in place 7 days a week, which is also responsible for frequent monitoring of Datix incidents and identifying levels of harm. Additional Matron of the Day support has been put in place to assist in decision making and staff are being redeployed into areas as required. Quality Impact Assessments have been undertaken for 'super surge' areas. In addition to the nurse staffing actions, regular discussions are taking place with Divisional Chairs and continued liaison with the Postgraduate Medical Education lead, Health Education England and LNC, regarding the

redistribution of FY1 grades to support increasing bed pressures in Medicine. A brief of the current position and actions being taken, continues to be provided to the CCG, NHSIE and the CQC.

Key Controls Framework – 3 Lines of Defence	
1st Line of Defence	• Daily nurse staffing meetings to identify requirements and appropriate escalation of gaps and required support • Safer Staffing Tool completion twice daily by Ward staff • Local processes in place for medical and AHP staff to assess requirements and establishments • International Recruitment commenced and approval for c.70 nurses. • Development of Site Safety Dashboard • Development of Safe Staffing hub (8.00 am – 8.00 pm 7 days a week) • Quality Impact Assessments undertaken for change in services regarding additional capacity areas and changes in establishments • 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 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.
2nd Line of Defence	• 6th monthly nurse staffing establishment reviews to ensure established nursing numbers match acuity • Birth rate plus staffing assessment for midwifery services • 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 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 • 52 week / 104 day Harm Review Panel process in place with CCG representation • Agreed policies and procedures for the management of patients with mental health conditions and / or Mental Health Act including Standard Operating Procedure for Use of Ligature Knives and Trust Wide Corporate Ligature Risk Assessment • Policies and Procedures for the Management and care of patients with mental health conditions reviewed and actions completed and responded to in relation to the CQC Section 29a notice
3rd Line of Defence	• Registered and regulated by CQC • Process in place with Commissioners to undertake Clinical Quality Review Meetings (CQRM) • 6 nominated Patient Safety Specialists participating with development programme by NHSI as part of national NHS Patient Safety Strategy. Induction / Training • NHSEI scrutiny of COVID-19 cases/Nosocomial infections/Trust implementation of Social distancing, Patient/Staff screening and PPE Guidance

Assurance Map

Committee Assurances (assurances received by the Committee/s during this quarter)

1st Line (Divisional)		2nd Line (Corporate)		3rd Line (External)	
Q2 Saving Babies Lives Care Bundle	!	Month 6, 7, 8 Quality and Safety Reports	✓!	NHSE Visit to West Building – Update	✓
Q2 Maternity Serious Incident Report	!	Q2 Serious Incident Report	✓		
Q2 Maternity Dashboard	✓	Q2 Infection Prevention Report	!		
Q2 Maternity Services Self-assessment BAF	✓	Q2 Mortality Report (including Covid Mortality Benchmarking)	✓		
Q2 Perinatal Mortality Review Tool	✓	Q2 Patient Experience Report	!		
Maternity Family Experience Report	✓	Q2 IPC Board Assurance Framework	✓!		
Sepsis Review	✓	Q2 Nurse Vacancy Progress Report	✓		
County Serious Incident Update	!	Q2 Nursing Staffing Quality Report	✓		
Emergency Department Medical Workforce Business Case	✓	Emergency Department Assurance Report	✓!		
Anaesthetic Workforce Business Case	✓	Ockenden Report: Assessment and Assurance Framework / Action Plan	✓		
AMU Nursing Workforce Business Case	✓				
Adult Critical Care Expansion	✓				
NIV CCU Ward 222 Nursing Establishment Business Case	✓				

Other Assurances (assurances received by the Committee annually / bi-annually / ad hoc)

Annual Medical Examiners Report	✓	2020/21 Annual Quality Account	✓	CQC Inspection Update	✓!
Clostridium Difficile Update		Bi-Annual Mental Health and Learning Disability Update	✓	CQC Insights Report	✓
Pressure Ulcer Prevention RCA Update	✓	Bi-annual Nursing Establishment Review	!	NHS Resolution Maternity Incentive Scheme	✓
Neonatal Workforce CNST	!	Perfect Ward Update	✓	IPC Board Assurance Framework Internal Audit	✓
Midwifery Workforce Review	!			Ockenden Review Internal Audit	✓

Gaps in Control or Assurance

What are the gaps to be addressed in order to achieve the target risk score?

- CQC Regulatory Actions to be addressed
- UHNM Policies and Procedures for management of patients under Mental Health Act require review following CQC inspection
- Further work required to seek assurance from the 52 week / 104 day Harm Review process

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.	Business case for further 130 international nurses to be developed	Chief Nurse	31/01/2022	Aiming to be taken to Performance and Finance Committee in January 2022.	
2.	Meeting to be held with regards to reducing MFFD patients, with Regional NHS Team	Medical Director	31/01/2022		
3.	Update to be provided to the Regional Risk Group regarding actions being taken for admission avoidance and monitoring of 7 key actions	Chief Nurse	31/01/2022		
4.	To implement Perfect Ward audit system and app	Chief Nurse	31/03/2022	Perfect Ward project has been approved and shared with Executives and NEDs. Project Plan under development.	
5.	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	30/06/2022	National PSIRF guidance has been updated following COVID-19 with amended dates and learning from early adopters. This is under review and inclusion in UHNM PSIRP. National timescale is to implement in 2023	

	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**		

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3	3		**Likelihood:**	3	31/03/2022
Consequence:	4	4	4		**Consequence:**	2	
Risk Level:	**High 12**	**High 12**	**High 12**		**Risk Level:**	**Mod 6**	

Rationale for Risk Level:	• Based on the National Staff Survey, a methodology to calculate a more frequent staff engagement rate is being trialled. This uses the results of the Staff Voice Survey in a consistent and meaningful way to produce a local staff engagement score. As a baseline calculation, based on the Staff Voice Survey results for December 2021, this methodology produced a staff engagement score of 5.9 out of 10. • Leadership and management development offers continue to be promoted. The 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 does remain challenging in the delivery of both leadership and development training • Sickness levels increased from the end of December 2021 and into January. Wellbeing Plans are in place with our Occupational Health and Staff Support and Counselling Providers contributing to the range of offers.
Links to Risk Register	N/A

Position Statement

What progress has been made during the last quarter?

Staff Engagement

- The NHS annual Staff Survey commenced on 4th October 2021. Reminders were issued throughout the survey period and communications took place to encourage staff to respond. The survey closed on 26th November 2021 and the final benchmarked results will be published in February/March 2022. The Trust has received the raw survey data which is being analysed in order to prepare feedback to staff [the staff survey results are under embargo until the national publication date]
- The BRAP survey took place between 20th October and 28th November and the results are awaited.

Staff Wellbeing

- In September, a 'new' masterclass, aimed at reducing conflict situations, was piloted. Designed in collaboration with Staff Support Services, the overall aim of the masterclass was to understand the sequence of conflict, the impact of conflict and to develop the skills and knowledge to respond more effectively in order to re-harmonise relationships in the workplace and prevent further escalation of difference or challenge. Once pilot feedback is reviewed this masterclass title will be available via our Silver Connects award.

Key Controls Framework – 3 Lines of Defence

1st Line of Defence	• Divisional Staff Engagement Plans set out the tailored actions to improve staff experience • Improving Together programme – Staff engagement A3 is developed
2nd Line of Defence	• Staff Voice pulse check survey implemented from June 2021 although was paused while the BRAP and Staff Surveys survey took place. "You said, we did" response to the matters raised in the Staff Voice Survey communicated to staff • New Connects Masterclass; Our NHS People has been promoted for staff who want to gain an

	understanding of the NHS People Plan, what an inclusive workplace looks like, what inclusion is and why it matters • 'Silver' CONNECTS training and 'RESPOND' training • 'Stepping Up' (equivalent) programme open to colleagues from UHNM and across the Integrated Care System (ICS) who identify as having black, Asian and/or minority ethnic heritage/as people of colour and are employed currently in AFC band 5-7 roles (or equivalent). • 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 Trust has set targets for staff engagement rates; sickness and turnover. Actual performance is monitored on against target. • One to one wellbeing coaching support available for BAME colleagues, to help colleagues process experiences faced, to develop coping skills and practical strategies to manage situations and to maintain their health and wellbeing. • Suicide Awareness training provided, targeted at anyone who would like to understand how they can make a difference whether they have a direct or indirect role in suicide prevention.
3rd Line of Defence	• National Quarterly Pulse Survey implemented from July 2021 • 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, the Trust wellbeing plan has been refreshed and updated • The Winter Wellbeing Plan put into place and Wellbeing Focus Groups were set up to • 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 in addition TP Health provided face to face 'Wellbeing Checks' across both sites throughout October. • 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 understand the extent of bullying and harassment and importantly action that can be take • 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. • The system has submitted a bid to take part in a pilot programme called 'Scope for Growth – Career Conversations'. The aim is to create a framework for a structured career development conversation between an individual and their line manager. This will be supported by the Trust should the bid be successful. • The Trust has signed up to the National People Pulse Survey from July 2021.

Assurance Map

Committee Assurances (assurances received by the Committee/s during this quarter)

1st Line (Divisional)		2nd Line (Corporate)		3rd Line (External)	
Improving Together Highlight Report	✓	Q2 Organisational Development / Culture Update	✓		
		M6,7,8 Workforce Performance Report	✓!		
		Health & Wellbeing Plan Progress Report	✓		
		Workforce Disability Equality Standard	!		
		Workforce Race Equality Standard	!		
		Equality, Diversity and Inclusion Progress Report	✓		
		Q2 Speaking Up Report	✓		
Other Assurances (assurances received by the Committee annually / bi-annually / ad hoc)					
		People Plan Annual Report	✓!	Staff Survey Report	✓!
		Human Resources Delivery Plan	✓		
		Learning, Education and Widening Participation Progress Report	✓		

Gaps in Control or Assurance

What are the gaps to be addressed in order to achieve the target risk score?

- The 2021 staff survey has been completed and the published results will be available in February / March 2022. In the meantime, work has commenced to analyse and understand the raw data.

- Through Improving Together, there is a process to improve sickness absence although performance in this area is yet to be reported
- The independent review commissioned to investigate the concerns raised by medical staff regarding bullying and harassment is underway – the risk score may be revised once the outcome of this review is known

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	31/03/2022	Following suspension during the pandemic, the programme has recommenced. The second phase is working towards its conclusion with a Strategy and Delivery plan to be produced for the final Delivery phase. The Delivery plan will go to the TAP Committee early in the new year.	
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	In the processing of developing a leadership behavioural framework which will be co-created with our leaders as part of the Middle Management Programme development process	
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	• The Connects Silver Award is available to all leaders within the Trust. A prerequisite for the Award is completion of the Gateway to Leadership qualification. • The design of an essential programme for middle managers is in progress. This will support their development in maintaining positive, compassionate and inclusive behaviours. The programme will include; civility, just and learning cultures, compassionate leadership. • FY1/2 doctors are undertaking their Silver Award in leadership with the 7 master classes being delivered across their timetable. • A campaign focused on 'Civility & Respect' will be rolled out and a range of initiatives such as a behavioural framework, training sessions with teams, engagement with staff networks etc. • Following a process of co-design an executive and senior divisional leadership development programme will be delivered next year.	
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	31/03/2022	The Positive & Inclusive Culture A3 has been developed, where the driver metric is the staff engagement rate. Focussed negotiations have been in progress with Divisions who are now developing their own A3's to secure improvements in this area.	
5	Produce and action plan to address the findings of the BRAP Survey	Director of Human Resources	31/03/2022	The BRAP Survey has closed and the findings will be reported in due course	
6	To provide a current measure, the Staff Voice Survey should be adjusted to include a local staff engagement indicator	Director of Human Resources	31/03/2022	A methodology is being trialled, based on the National Staff Survey methodology, which uses the results of the Staff Voice Survey in a consistent and meaningful way to produce a local staff engagement score.	
7	Implement the next quarterly People Pulse Survey	Director of Human Resources	31/03/2022	The quarterly People Pulse Survey will next open from January 2022 for staff to share their views about their working experience. The responses will be used to shape a range of support, both locally and nationally	

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**	✓	

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	4	5		**Likelihood:**	3	31/03/2022
Consequence:	4	4	4		**Consequence:**	3	
Risk Level:	**High 12**	**Ext 16**	**Ext 20**		**Risk Level:**	**High 9**	

Rationale for Risk Level:

The level of risk (likelihood) is based on some of the workforce and staffing challenges the Trust is now experiencing. Although there are good plans in place to mitigate risks, with additional recruitment taking place, the need to open additional capacity through winter and the on-going staffing pressures, due to sickness levels and vacancies, is currently playing against the plans.

This level of risk also reflects:

a) The potential impacts arising from Legislation which makes Covid-19 vaccination mandatory for all patient-facing health and social care workers in England from 1st April 2022. These impacts will be mitigated by Trust Policy which will aim to redeploy affected staff into non-clinical/regulated areas. However, as an employer, UHNM is making efforts to support staff to receive the vaccine and look at redeployment options away from direct face-to-face roles. Where this is not possible, we may have no choice but to end employment for those employees who decline the vaccine, without an allowable exemption, by 1 April 2022 and this may impact on staffing available in clinical areas, where there are already vacancies and high levels of sickness absence, ultimately impacting on patient care.

b) The effect of the omicron variant on sickness levels and workforce supply issues is impacting on workforce availability. Sickness levels are monitored on a daily basis and operational contingency plans are in place. Redeployment of staff is being managed via the Medical, Nursing and workforce bureaus and processes are in place to escalate requests for support to the wider System.

Links to Risk Register (>12)

ID11294 NMCPS Pathology Histology Medical Reporting Capacity (achieving TAT)	**Ext 20**	ID20809 NMCPS Histology Admin Capacity	**Ext 16**
ID13419 Midwifery safe staffing	**Ext 16**	ID21157 Haematology Service at MCHT Leighton	**Ext 16**
ID20439 Modality workforce in Renal	**Ext 16**	ID17977 Reduced staffing in Cancer Centre Pharmacy	**Ext 16**
ID21661 Child Health Nursing Workforce during Extremis paediatric pressures	**Ext 16**	ID21433 Adult Critical Care Consultant Workforce	**Ext 16**
ID21481 Reduced Breast service (Imaging), due to vacancy within Breast Radiologist workforce	**Ext 16**	ID11518 Midwifery Continuity of Carer model	**Ext 15**
ID21721 Nuclear Medicine Physics Service Staff Vacancies	**Ext 15**	ID21867 Antenatal ultrasound staffing	**High 12**
ID11002 Consultant Medical Staff Recruitment	**High 12**	ID20626 Low staffing levels for Phlebotomy at Cheshire Sites	**High 12**
ID21595 Technical staffing in Microbiology	**High 12**	ID21719 Medicine Safety Officer Vacancy	**High 12**
ID8451 Trauma Directorate Nursing	**High**	ID8615 Radiotherapy Radiographer	**High**

	Workforce	**12**	Staffing Levels	**12**
	ID10868 T&O Junior Doctor Staffing gaps	**High 12**	ID18093 Nurse Staffing within the NNU	**High 12**
	ID21503 General Paediatric Consultant Rota	**High 12**	ID21634 & ID21660 Staff absences relating to COVID-19 at RSUH and County	**High 12**
	ID21706 Safer Care Nursing Resource availability Specialised Decision Unit	**High 12**		

Position Statement

What progress has been made during the last quarter?

Level 4 Incident response plans have been prepared which seek to maintain core non elective and Diagnostics/screening services based on high level Divisional Plans. These plans also identify workforce capacity that can be released to support critical services. The Trust produces Daily Sitreps on staff absence. This feeds into the tactical Covid Dashboard and informs decisions on redeployment of staff. Three of the clinical divisions have identified sickness as a driver metric under the Improving Together programme and are undertaking deep dives into reasons for stress related absence to help target actions for support.

A Mandatory Covid Vaccine task and finish group has been established to provide assurance through to the Workforce Assurance Group on the actions being taken to implement the statutory requirement for individuals interacting with patients or service users, to have been fully vaccinated against Covid 19. Work commenced with Divisions to assess the apprenticeships required over the next 1, 3, 5 years. This will then help to streamline the engagement offers and promotions used to connect with our communities and to target future workforce effectively

Key Controls Framework – 3 Lines of Defence

1st Line of Defence	• 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 • Medical rotas are reviewed, vacant shifts covered where possible from doctor bank and agency, adverts out for Trust grades where applicable. Locums are used / recruited to fill gaps where necessary • Directorate and divisional management teams monitor staffing levels • Chief Nurse staffing reviews • 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 **Digital Agenda:** The draft People Digital Strategy for the NHS was released in September 2021 and sets out draft commitments for the next 3 years. The Digital Agenda is a system-led work programme initially covering the roll out of a Digital Staff Passport to hold staff 'verified employment and training credentials'.
2nd Line of Defence	• 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 what people can expect from the NHS, from their leaders and each other. • The system led workforce demand and supply process remains in place and will continue to manage redeployment of staff where required, as well as system wide recruitment initiatives. The Trust continues to progress its own recruitment plans as well. • The Workforce Bureau has been reconstituted to manage the upsurge in workforce risks and issues and to manage staff deployment. • Staffing for the Winter plan is out to advert and / or in process of being recruited to • We have an Established Bank – including Nursing, Medics and other staff groups • Business cases approved to address staffing in ED, Anaesthetics and Critical Care and other hotspots • Weekly meetings take place with Medical Staffing to review rotas, gaps and progress against recruitment • Processes are in place to request mutual aid from across the System • General recruitment drives are on-going and there is an element of head hunting via informal networks • Golden Handshakes and handcuffs can be used for new starters **Digital Agenda:** The Trust has volunteered to participate in a trial of the digital staff passport. This will involve identifying doctors training who are due to rotate in the Spring/Summer of 2022. As confirmation of acceptance on to the pilot has not yet been received, no actions are arising at this time.

3rd Line of Defence	• 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 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. • 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 • A new National quarterly 'People Pulse survey has been implemented from July 2021 • Workforce risks are reported via Datix and are monitored to ensure Divisional action and review. Divisions have recently reported increased staffing challenges due to operational pressures and the opening of additional capacity, combined with high sickness rates and vacancy levels

Assurance Map

Committee Assurances (assurances received by the Committee/s during this quarter)

1st Line (Divisional)		2nd Line (Corporate)		3rd Line (External)	
Emergency Department Medical Workforce Business Case	✓	Q2 Nurse Vacancy Progress Report	✓		
Anaesthetic Workforce Business Case	✓	M6, 7, 8 Workforce Performance Report	✓!		
AMU Nursing Workforce	✓	Q2 Nursing Staffing and Quality Report	✓		
Adult Critical Care Expansion	✓	Outline Content of the Strategic Workforce Plan	✓		
NIV CCU Ward 222 Nursing Establishment Business Case	✓	Improving Together Highlight Report	✓		

Other Assurances (assurances received by the Committee annually / bi-annually / ad hoc)

Midwifery Workforce Review	!	People Plan Annual Report	✓!	Staff Survey Report	✓!
Neonatal Workforce CNST	!	Human Resources Delivery Plan	✓	STP/ICS Workforce Development Fund Annual Report for 2020/21	✓
		Bi-annual Nursing Establishment Review	!	E-rostering Internal Audit	!
		Winter Plan	✓!	Job Planning Internal Audit	✓
		Apprenticeship Levy Progress Report	!		
		Learning, Education and Widening Participation Progress Report	✓		

Gaps in Control or Assurance

What are the gaps to be addressed in order to achieve the target risk score?

- The 2021 staff survey has been completed and the results will be available in February / March 2022. In the meantime, work has commenced to analyse and understand the raw data.
- Based on the National Staff Survey, a methodology to calculate a more frequent staff engagement rate is being trialled. This uses the results of the Staff Voice Survey in a consistent and meaningful way to produce a local staff engagement score. As a baseline calculation, based on the Staff Voice Survey results for December 2021, this methodology produced a staff engagement score of 5.9 out of 10.
- To improve visibility of workforce demand, vacancy levels and workforce supply pipeline, additional information has been incorporated into the monthly workforce report to the Transformation and People Committee (from month 6)
- A piece of work is to be carried out with the Divisions to obtain a clear overview of their operational workforce demand and supply concerns, together with details on how they are proposing to close the gap (action 3 below)

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.	Provide support and development to line managers to enable them to develop their approach to management which includes leading agile	Director of Human Resources	31/03/2022	To support the Staff Survey improvement activity: Improving Leadership and Management Development and Visibility • The Leadership and Management Development programme has recommenced and will be on-going	

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**
	workers.			throughout 2021/22 • Management development sessions have been offered around managing/leading agile teams • An Agile Working Policy has been put in place Based on the National Staff Survey, a methodology to calculate a more frequent staff engagement rate is being trialled using the results of the Staff Voice Survey. As a baseline calculation, based on the Staff Voice Survey results for December 2021, this methodology produced a staff engagement score of 5.9 out of 10.	
2.	Implement the legislation requiring all patient-facing health and social care workers in England have been double-vaccinated from 1st April 2022.	Director of Human Resources	31/03/2022	• A Task and Finish Group is in place to implement the requirements of the legislation • A Data Protection Impact Assessment has been completed to ensure the ongoing protection of sensitive personal staff vaccination data • A draft Equality Impact Assessment has been prepared and is under consultation. • The aim of Trust Policy will be to redeploy affected staff into non-clinical/regulated areas. However, as an employer, UHNM is making efforts to support staff to receive the vaccine and look at redeployment options away from direct face-to-face roles, where this is not possible, we may have no choice but to end employment for those employees who decline the vaccine, without an allowable exemption, by 1 April 2022.	
3.	Manage deployment of staff to support areas with high absences as a result of sickness and the omicron variant	Director of Human Resources	31/01/2022	• The Workforce Bureau has been stepped back up and will work in conjunction with Nursing and Medical Bureaus to manage staff deployment • Level 4 Incident response plans have been prepared which seek to maintain core non elective and Diagnostics/screening services based on high level Divisional Plans. These Plans also identify workforce capacity that can be released to support critical services • Volunteers from across the Trust are being sought to move into wards and depts to support with basic non clinical tasks • The Trust produces Daily Sitreps on staff absence. This feeds into the tactical Covid Dashboard and informs decisions on redeployment of staff • Three of the clinical divisions have identified sickness as a driver metric under the Improving Together programme and are undertaking deep dives into reasons for stress related absence to help target actions for support.	

	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**		

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3	3		**Likelihood:**	2	31/03/2022
Consequence:	3	3	3		**Consequence:**	3	
Risk Level:	**High 9**	**High 9**	**High 9**		**Risk Level:**	**Mod 6**	
Rationale for Risk Level:	Covid overall has impacted on system working to progress the ICS with the Omicron impact resulting in routine meetings being cancelled. Substantive ICS CEO not appointed therefore interim arrangements have been put in place. The national deadline for implementation of the ICS has been extended to the 1st July						
Links to Risk Register	N/A						

Position Statement

What progress has been made during the last quarter?

No substantive appointment made to the ICS Chief Executive – interim arrangements put in place for 1 year.

Key Controls Framework – 3 Lines of Defence

1st Line of Defence	• ICS Shadow Board in place • ICS Development Plan in place, approved by NHSE/I, with workstream and leads in place • ICS Interim Chief Executive in post • System wide Executive Forum • System Performance, Finance & Strategy Group • System workforce group • System quality group being re-established • Three system Place Based Partnerships • Provider Collaborative Workstream now on line led by UHNM CEO • Self-Assessment completed • Back Office Workstream in place • UHNM Chair, Chief Executive & Director of Strategy are members of relevant system groups / meetings • CFO/COO & DoS are members of Finance, Strategy & Operations system group • MD member of system wide Clinical Senate • System working discussed weekly at UHNM Executive Meetings
2nd Line of Defence	• Transformation and Delivery Unit (TDU) in place • ICS Workstreams underway but require review • ICS Development Plan in place and approved by NHSE/I • Three Places developed with OD programme in place • CCG merger approved • Design Framework under review / discussion
3rd Line of Defence	• ICS designation plan approved by NHSIE • System Quarterly Performance Review Meetings (outcomes shared with the Board

Assurance Map

Committee Assurances (assurances received by the Committee/s during this quarter)

1st Line (Divisional)		2nd Line (Corporate)		3rd Line (External)	
		Strategy and Transformation Group Highlight Report	✓		
		System Working Update	✓!		

Other Assurances (assurances received by the Committee annually / bi-annually / ad hoc)

				Quarterly System Performance Review Meeting	

Gaps in Control or Assurance

What are the gaps to be addressed in order to achieve the target risk score?

- No substantive ICS Chief Executive
- Revised governance and infrastructure not yet complete for transition into system wide ICP and NHS Board. National delay until 1st July 2022
- Absence of system wide strategy
- Consideration being given to the reorganisation of the NHS infrastructure

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.	Develop a revised Integrated Strategy for Health and Social Care	ICS Chief Executive	System Action – Timeframe to be confirmed	Strategy development delayed due to Covid-19	D
2.	PLACE to develop a clear, agreed, strategic approach to population health management	ICS Chief Executive	System Action – Timeframe to be confirmed	Framework for use of Population Health Data in place. CCG developing system population health data, timeline was end of September but not available as yet. Outputs from this are not yet embedded into decision making.	GA
3.	Update on ICS workstreams to be provided to future Transformation and People Committee	Director of Strategy	February / March 2022		GB

	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**	✓	

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3	2		**Likelihood:**	2	31/03/2022
Consequence:	3	3	3		**Consequence:**	3	
Risk Level:	**High 9**	**High 9**	**Mod 6**		**Risk Level:**	**Mod 6**	
Rationale for Risk Level:	Risk score reduced based on KPMG now supporting data analytics to support the Provide Collaborative Board. Two strands of work underway, 1, Governance, 2, variation and population health analytics. Analytics to be presented at a workshop at the end of February and the first PC Board to take place in March						
Links to Risk Register	N/A						

Position Statement

What progress has been made during the last quarter?

KPMG Commissioned to support the PC workstream. Terms of Reference developed and approved by system Exec Forum. Formal agreement that back office workstream will report to PC.

Key Controls Framework – 3 Lines of Defence

1st Line of Defence	• Designated Lead for UHNM - Director of Strategy • Exec to Exec meetings - formalised with SaTH • Director of Strategy represents Trust on Spec Com discussions in respect of network development for Midlands • UHNM CEO leading system Provider Collaborative and self-assessment undertaken • Strategies for each Trust to be reviewed to ensure that strategic developments between UHNM / MCHFT and UHNM / SATH are taken into account • Restoration and Recovery Plans robust and delivering • Plan for inaugural Provider Collaborative meeting for March 2022 • Membership and Terms of Reference agreed for Provider Collaborative Board
2nd Line of Defence	• Transformation & People Committee • Strategy and Transformation Group established to oversee Strategic Partnerships • Informal Exec to Exec discussions to be re-established post COVID with SaTH • Chief Executive is 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. • Chief Executive and Director of Strategy part of Midlands and West Midlands Provider Collaborative Networks
3rd Line of Defence	• N8 Pathology collaborative completed successfully

Assurance Map

Committee Assurances (assurances received by the Committee/s during this quarter)

1st Line (Divisional)		2nd Line (Corporate)		3rd Line (External)	
		Strategy and Transformation Group Highlight Report	✓		
		System Working Update	✓!		

Other Assurances (assurances received by the Committee annually / bi-annually / ad hoc)

		Draft Clinical Strategy 2021-2026	✓		

Gaps in Control or Assurance

What are the gaps to be addressed in order to achieve the target risk score?

- Variation data and population health management data required for the Provider Collaborative, still not yet available
- Provider Collaborative Committee not yet established
- Place Based Partnerships established but not still running effectively

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.	Develop formal governance for a collaborative programme with SaTH	Director of Strategy	30/06/2022	Significant work underway on joint Adult Critical Care and Pathology collaboratives. No formal planned approach to strategic partnerships is yet in place.	
2.	Refresh / development and agreement of UHNM Trust wide Strategy.	Director of Strategy	31/03/2022	Strategic Framework identifying revised objectives and enabling strategies approved by the Board. Strategy development recommenced with the Clinical Strategy discussed at TAP and being further developed prior to presentation to the Board.	
3.	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	Chief Executive	31/03/2022	Stocktake complete. Paper presented to ICS Shadow Board in October 2021. KPMG supporting analytics and to be presented to a PC workshop at the end of February 2022. Outputs from the workshop, including draft ToR and governance arrangements for the PC to be presented to the inaugural meeting in March.	
4.	Update on ICS workstreams to be provided to future Transformation and People Committee	Director of Strategy	February / March 2022		

	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**	✓

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	4	4	4		**Likelihood:**	4	31/03/2022
Consequence:	3	4	5		**Consequence:**	3	
Risk Level:	**High 12**	**Ext 16**	**Ext 20**		**Risk Level:**	**High 12**	
Rationale for Risk Level:	Risk score increased due to the continuing challenges associated with the Covid pandemic, the increase in sickness absence and increase in waiting lists. In addition, continuing challenges with number of medically fit for discharge patients and subsequent delays in discharge.						

Links to Risk Register				
ID10342 Delivery of constitutional cancer quality standards	**Ext 16**	ID21101 Waiting Times	**Ext 16**
ID18664 Gynaecology 52 Week Wait Patient Numbers	**High 12**	ID16650 Bed Capacity	**High 12**
ID15788 Delivery of RTT Performance - Diagnostic Capacity Covid	**High 12**	ID20739 Endoscopy planned patients waiting list	**High 12**
ID9910 Patients waiting extreme time periods for follow up appointments	**High 12**	ID9227 UHNM Winter Plan - Elective Activity Cancellations	**High 12**

Position Statement

What progress has been made during the last quarter?

Approval of 5 business cases supporting staffing, expansion and sustainability of services.

Key Controls Framework – 3 Lines of Defence

1st Line of Defence	• Reviewed theatre timetable to support critical care demand and focus on P1 and P2 patients • 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
2nd Line of Defence	• 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 but full capacity is likely to be January 2022. • UHNM winter plan to support non-elective and elective pathways including implementation of 'winter ready' schemes to solve UHNM capacity • UHNM bed portal reviewed to ensure appropriate allocation of nursing and medical resources
3rd Line of Defence	• System wide winter plan agreed • Bids prepared to support enablers for urgent care demand reduction across the system • Independent Sector and Insourcing Teams engaged for work during winter 21/22. • Bids submitted to support elective recovery through increased throughput of critical care capacity

Assurance Map

Committee Assurances (assurances received by the Committee/s during this quarter)

1st Line (Divisional)		2nd Line (Corporate)		3rd Line (External)	
CT7 Business Case	✓	M6, 7, 8 Operational Performance Report	✓!		
7TH Theatre at County Hospital Business Case	✓	Operational Delivery Group Highlight Report	✓ !		
Adult Critical Care Expansion Business Case	✓	H2 Operational Plan	✓!		
Emergency Department Medical Workforce Business Case	✓				
Sustainability of Spinal Services Business Case	✓				

Other Assurances (assurances received by the Committee annually / bi-annually / ad hoc)

Planned Care Safety Briefing / Cancer Services Gap Analysis	✓	Winter Plan	✓!		
Paediatric Surge Planning	!				
Colorectal Cancer Pathway Business Case	✓				
Extension of Mobile MRI Rental Business Case	✓				
Endoscopy Insourced Service Business Case	✓				

Gaps in Control or Assurance

What are the gaps to be addressed in order to achieve the target risk score?

- Capacity available to ease management of non-elective / elective demand through winter
- Increase in critical care capacity to ensure available resources for anticipated demand
- Challenges associated with the implementation of the winter plan and achieving the required reduction in occupancy

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.	Increase capacity of UHNM footprint through the development of County Hospital as an elective care centre	Chief Operating Officer	31/03/2022		
2.	Implement the critical care business case which supports an increase in capacity and staffing which allows the protection of our theatre teams	Chief Operating Officer	31/03/2022		
3.	Review of theatre timetable for Q4 to maximise throughput of patients	Chief Operating Officer	31/03/2022		
4.	Monitor the long wait position for the those patients waiting over 52 and 104 weeks as part of performance management	Chief Operating Officer	31/03/2022		
5.	Implement business case that supports elective recovery through Q4 including the development of County as an elective hub ready for the delivery in Q1	Chief Operating Officer	31/03/2022		
6.	Implement business cases that support non-elective programme of work ready for the new urgent care standards	Chief Operating Officer	31/03/2022		
7.	Review independent sector contract as part of annual planning 2022/23	Chief Operating Officer	31/03/2022		

	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**	✓	

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3	3		**Likelihood:**	1	31/03/2022
Consequence:	5	4	4		**Consequence:**	5	
Risk Level:	**Ext 15**	**High 12**	**High 12**		**Risk Level:**	**Mod 5**	
Rationale for Risk Level:	Temporary contract in place with i3 Secure to provide security support services while the Head of Cyber Post is recruited to and the Cyber Lead commences employment with the Trust.						

Links to Risk Register (>12)	ID22938 Log4j Vulnerability	**Ext 15**	ID9036 Vulnerability to Cyber Attack	**Ext 15**
	ID21784 Confidentiality, Integrity and Availability of Trust Information	**High 12**	ID22094 Lack of devices for windows 7 replacement project	**High 12**

Position Statement

What progress has been made during the last quarter?

Darktrace business case has been drafted and approved cycle commenced. Recruitment to the Head of Cyber has commenced and Trust awarded funds for Digital Aspirant for cloud backup services. Cyber bid submitted to NHSX and awaiting outcome

Key Controls Framework – 3 Lines of Defence

1st Line of Defence	• 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, 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
2nd Line of Defence	• 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 • New Digital and 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
3rd Line of Defence	• 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)*

Assurance Map

Committee Assurances (assurances received by the Committee/s during this quarter)

1st Line (Divisional)		2nd Line (Corporate)		3rd Line (External)	
		Q2 Data Security and Protection Update	✓!		
		IM&T Strategy Progress Report	✓		

Other Assurances (assurances received by the Committee annually / bi-annually / ad hoc)

Bring Your Own Device Scheme and Associated Safeguards	✓			Network Security Internal Audit Report	✓
				Data Security and Protection Toolkit Internal Audit Report	✓
				General IT Controls Internal Audit	✓

Gaps in Control or Assurance

What are the gaps to be addressed in order to achieve the target risk score?

- Network segregation of devices is required; actions are in place to address this
- ORDR (or equivalent) for monitoring of clinical technology devices at RSUH; options being explored at network segregation group)
- Immutable back-ups on site solution being implemented with a view to moving this to the cloud
- Delivery and resource plan for ISO27001
- Cloud back up and security services to be established
- Internet logs last for 20 days. Replacement devices and audit log servers to be procured and implemented.
- Log4J action plan to be completed

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 Digital Transformation	31/03/2022	This project is 98%. 102 of the original devices still require upgrade and plans are in place for each one.	
2.	Continue work towards the toolkit Cyber Essentials and ISO27001 compliance.	Director of Digital Transformation	31/03/2022	Improvement plan developed and will be monitored via the Executive DSP Group. However unlikely to achieve the March deadline.	
3.	Implementation of network segregation	Director of Digital Transformation	31/03/2022	Task and finish group to be established to scope and develop action plan	
4.	Implementation of ORDR at Royal Stoke	Director of Digital Transformation	31/03/2022	Discussions underway to agree timescales for implementation	
5.	BYOD implementation	Director of Digital Transformation	31/03/2022	Communications and process drafted	

	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**	✓	

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3	3		**Likelihood:**	2	31/03/2022
Consequence:	4	3	3		**Consequence:**	4	
Risk Level:	**High 12**	**High 9**	**High 9**		**Risk Level:**	**High 8**	

Rationale for Risk Level:

- Project STAR (Demolition) - Buildings remain (EF&PFI, Windsor House, Main Entrance) & car parks
- Estate Condition: Compressed programme, to mitigate access issues due to high levels of bed occupation/ activity. Backlog schemes being delivered consistent with capital programme.
- Estate configuration/utilisation/optimisation/adjacencies - Independent review of County estate undertaken, will inform refresh of Estate Strategy, similar review anticipated for Royal Stoke site.
- West Building – physical estates works progressed to improve compliance, alongside refresh of service standards and monitoring arrangements to ensure cleaning standards improved and sustained.
- Sustainability/Net Carbon Zero (NCZ) – Gap analysis currently being completed against compliance with NHS Standard Contract NCZ Requirements.

Links to Risk Register (>12)				
	ID12720 Absence of Siderooms in Ward 126/127	**High 12**	ID21742 Lack of a clean utility room to dispense medications safely within CED	**High 12**
	ID20315 Interventional Room 5 does not meet Ventilation Building Regulations	**High 12**		

Position Statement

What progress has been made during the last quarter?

- Project STAR - Completed public/key stakeholder consultation; demolition progressing well; meetings held with GHC residents; progressed activities to support submission of planning application for new car park on 17.1.2022, consistent with programme.
- Estate Condition – significant works completed against backlog maintenance; statutory maintenance and progression of capital schemes (including Lower Trent) all of which support in reducing risks associated with condition of the estate.
- Estate Strategy/Clinical Service Strategy – independent review of estate at County to inform refreshed Estates Strategy.
- Sodexo Market Testing Business Case – secured NHSIE/DH Private Finance Unit approval to formal variation of the PFI contract.
- West Building – Re-inspection of West Building by NHSIE, very positive feedback received on transformation achieved.
- Sustainability/NCZ – Feasibilities approved for Heat Decarbonisation, LED Lighting and backlog maintenance aligned to NCZ.

Key Controls Framework – 3 Lines of Defence

1st Line of Defence	• Infirmary Site (Project STAR) – Approved Business Case. • Estate Condition: PPM; competent estates staff/APs; KPI's monitored through CEF/ Environmental Audits • Maintenance Operational Board; Operational policies; Service Specifications PFI, 7 Facet Survey. • Fire Safety/ Security Policies; Protocols; Guidelines; patrolling; CCTV; FRA's in place. • Sustainable Development Steering Group and Sustainable Development Management Plan
2nd Line of Defence	• Infirmary Site (Project STAR): NHSEI provided capital to deliver business case • Estate Condition - Capital bids prioritised against Estate 7 Facet Findings and approved at CIG. • Estate Strategy – Clinical Strategy and independent review used to inform refreshed Estate Strategy.

	• Fire/Security: 'On the spot' fire improvement notices, Fire Safety KPIs & ad-hoc audits/inspections • LSMS close working with local Police and visibility on site
3rd Line of Defence	• NHSEI review on Project STAR, Lower Trent project, Market Testing Business Case & West Building • PFI Statutory maintenance programme • Regulatory inspection/validation programmes including: CQC, PLACE, PAM and ERIC • External audits including Fire and Police Service and external audit i.e. KPMG • Authorising Engineers Audits of building services and associated maintenance regimes. • Participation in National Programme (SSRM) hosted by Cabinet Office & HM Treasury

Assurance Map

Committee Assurances (assurances received by the Committee/s during this quarter)

1st Line (Divisional)		2nd Line (Corporate)		3rd Line (External)	
		Project STAR Update			
Other Assurances (assurances received by the Committee annually / bi-annually / ad hoc)					
PLACE Inspection Findings & Action Plan	✓	Multi Story Car Park Business Case	✓		
		Capital Programme 2021/22	✓!		
		Fire Annual Report	✓		
		Security Annual Report	✓		
		Update on Car Parking Strategy	✓		

Gaps in Control or Assurance

What are the gaps to be addressed in order to achieve the target risk score?

- Project STAR; capital schemes, statutory maintenance &West Building – continue to progress consistent with agreed programmes.

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 demolition	Director of E,F & PFI	01/02/2022	Phases 1-4 completed, Phase 5 underway and on programme.	
2.	Car parking solution	Director of E, F&PFI	31/05/2022	Secure planning approval and vacant possession of site to allow construction to commence.	
3.	RI/COPD - Release land for land sale	Director of E,F& PFI	2024/2025	Will be released upon completion of construction and new car park at GHC.	
4.	Lower Trent Business Case	Director of E,F&PFI	31/01/2023	Conclude decant and complete refurbishment consistent with revised programme.	
5.	Sodexo Market Testing BC	Director of E,F&PFI	31/01/2022	Formalise variation of PFI (Deed of Variation) with Project Co, Sodexo and PFI Funders.	
6.	Estate condition	Director of E,F&PFI	31/03/2022	Delivery statutory maintenance & capital schemes in accordance with programmes.	
7.	Strategic Supplier Programme	Director of E,F & PFI	31/03/2022	Refresh current programme and identify additional schemes for delivery 2023.	
8.	Estates Workforce Reviews	Director of E,F & PFI	31/03/2022	Capital team review completed and focus now on operations review	
9.	Cleaning Collaborative	Director of E,F & PFI	31/03/2022	Sustain improvements seen in West Building and progress all agreed activities to plan.	
10.	Net Carbon Zero	Director of E,F & PFI	31/03/2022	Gap analysis to be produced against requirements of NHS NCZ targets to inform refreshed Sustainable Development Plan.	

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:**	Infrastructure Group

Strategic Objectives and Risk Register

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

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2	2	1		**Likelihood:**	1	31/03/2022
Consequence:	3	3	3		**Consequence:**	3	
Risk Level:	**Mod 6**	**Mod 6**	**Low 3**		**Risk Level:**	**Low 3**	
Rationale for Risk Level:	Month 9 actual performance demonstrated a surplus of circa £16 m against a year end forecast of £5.1 m						
Links to Risk Register	N/A						

Position Statement

What progress has been made during the last quarter?

Clarification of H2 allocations and continued underspend against plan

Key Controls Framework – 3 Lines of Defence

1st Line of Defence	• 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
2nd Line of Defence	• 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 Instruction
3rd Line of Defence	• 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

Assurance Map

Committee Assurances (assurances received by the Committee/s during this quarter)

1st Line (Divisional)		2nd Line (Corporate)		3rd Line (External)	
		M6, 7, 8 Finance Report	✓		
		H2 Financial Plan	✓		
		Investment Assurance Report	!		

		Budget Setting 2021/22	✓	NHS System Oversight Framework Segmentation	!
		H1 Financial Plan	✓		

Gaps in Control or Assurance

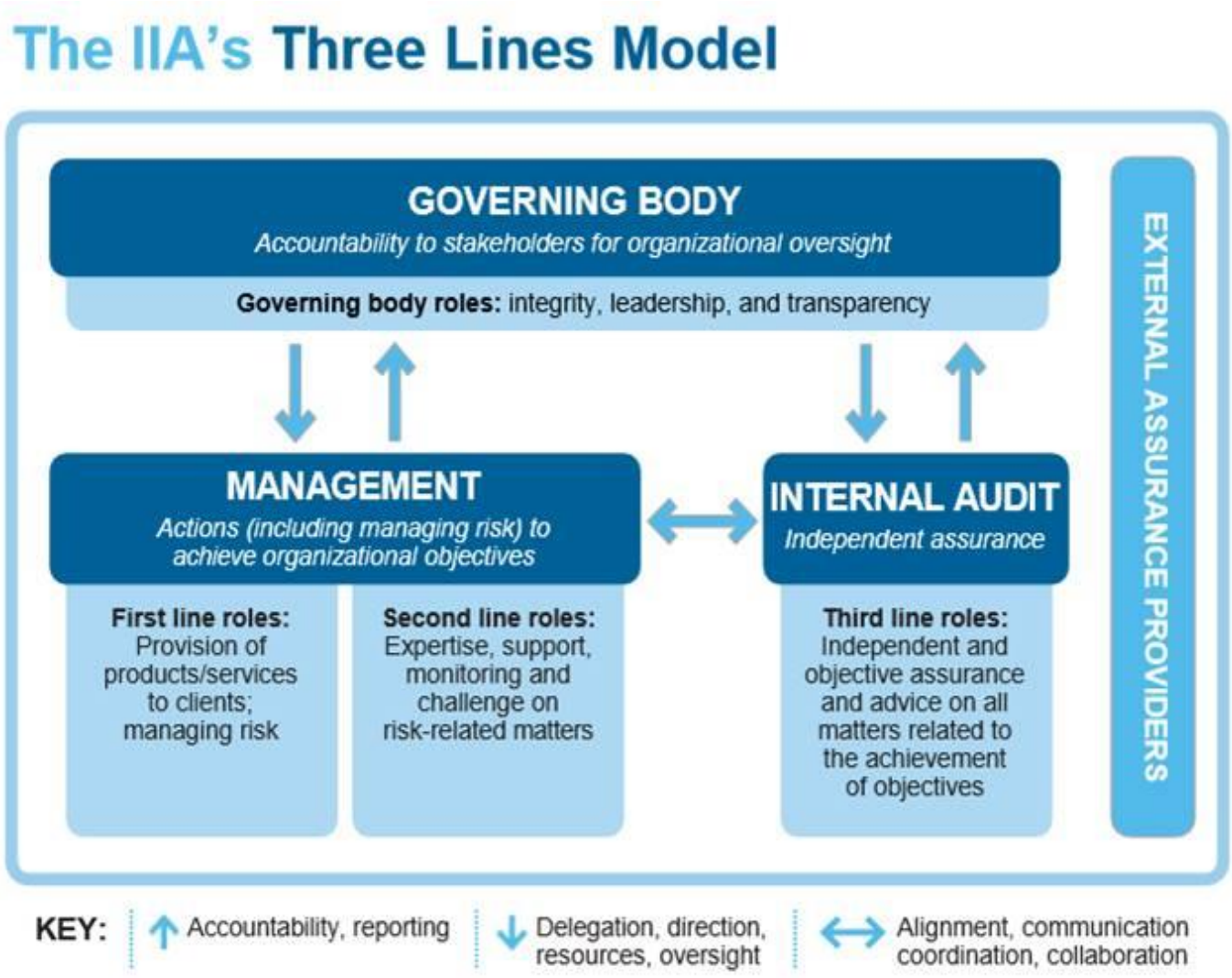
What are the gaps to be addressed in order to achieve the target risk score?

- 2022/23 Financial modelling to be completed to fully understand financial challenge

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.	To develop CIP plans for 2022/23	Chief Finance Officer	31/03/2022		

Appendix 1: Three Lines of Defence



Appendix 2: 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.

Trust Board

2021/22 BUSINESS CYCLE

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

Title of Paper	Executive Lead	Apr 7	May 5	Jun 9	Jul 7	Aug 4	Sep 8	Oct 6	Nov 3	Dec 8	Jan 5	Feb 9	Mar 9	Notes
PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES														
Chief Executives Report	Chief Executive													
Patient Story	Chief Nurse													
Quality Governance Committee Assurance Report	Associate Director of Corporate Governance													
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer													
Care Quality Commission Action Plan	Chief Nurse													Highlighted as part of QGC Assurance Summary. Not provided to December as awaiting finalised CQC Inspection report and updated action plan for 2022.
Bi Annual Nurse Staffing Assurance Report	Chief Nurse													Deferred to February although full bi-annual report not undertaken.
Quality Account	Chief Nurse													
7 Day Services Board Assurance Report	Medical Director													Timing TBC
NHS Resolution Maternity Incentive Scheme	Chief Nurse													
Maternity Serious Incident Report	Chief Nurse													
Winter Plan	Chief Operating Officer													
PLACE Inspection Findings and Action Plan	Director of Estates, Facilities & PFI													Timing TBC
Infection Prevention Board Assurance Framework	Chief Nurse													
ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS STANDARDS														
Integrated Performance Report	Various													
ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT & RESEARCH														
Transformation and People Committee Assurance Report	Associate Director of Corporate Governance													
Gender Pay Gap Report	Director of Human Resources													
People Strategy Progress Report	Director of Human Resources													
Revalidation	Medical Director													
Workforce Disability Equality Report	Director of Human Resources													
Workforce Race Equality Standards Report	Director of Human Resources													
Research Strategy	Medical Director													
Staff Survey Report	Director of Human Resources													
LEAD STRATEGIC CHANGE WITHIN STAFFORDSHIRE AND BEYOND														
System Working Update	Chief Executive / Director of Strategy													
ENSURE EFFICIENT USE OF RESOURCES														
Performance and Finance Committee Assurance Report	Associate Director of Corporate Governance													
Revenue Business Cases / Capital Investment / Non-Pay Expenditure £1,000,001 and above	Director of Strategy													
IM&T Strategy Progress Report	Director of IM&T													Deferred to May due to annual leave
Going Concern	Chief Finance Officer													

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	
Estates Strategy Progress Report	Director of Estates, Facilities & PFI													Timing TBC - waiting to refresh once the clinical strategy has been determined
H2 Plan	Chief Finance Officer													
Annual Plan	Chief Finance Officer													
Capital Programme 2021/22	Chief Finance Officer													
GOVERNANCE														
Nomination and Remuneration Committee Assurance Report	Associate Director of Corporate Governance													
Audit Committee Assurance Report	Associate Director of Corporate Governance													
Board Assurance Framework	Associate Director of Corporate Governance		Q4			Q1			Q2			Q3		
Raising Concerns Report	Director of Human Resources		Q4			Q1			Q2			Q3		
Annual Evaluation of the Board and its Committees	Associate Director of Corporate Governance													
Annual Review of the Rules of Procedure	Associate Director of Corporate Governance													
G6 Self-Certification	Chief Executive													
FT4 Self-Certification	Chief Executive													
Board Development Programme	Associate Director of Corporate Governance													Deferred to July's meeting to allow discussion with Executive Team prior to being presented to the Trust Board.