University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 10th March 2021 at 9.30 am to 12.00 pm via Microsoft Teams

AGENDA

Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
09:30	**PROCEDURAL ITEMS**					
20 mins	1.	Staff Story	Information	Mrs M Rhodes	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 3rd February 2021	Approval	Mr D Wakefield	Enclosure	
5 mins	5.	Matters Arising via the Post Meeting Action Log	Assurance	Mr D Wakefield	Enclosure	
20 mins	6.	Chief Executive's Report – February 2021 • Covid-19	Information	Mrs T Bullock	Enclosure	**BAF 6**
10:20	**PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES**					
5 mins	7.	Quality Governance Committee Assurance Report (24-02-21)	Assurance	Prof A Hassell	Enclosure	**BAF 1**
5 mins	8.	IPC Board Assurance Framework	Information	Mrs M Rhodes	Enclosure	**BAF 1**
10:30	**ENSURE EFFICIENT USE OF RESOURCES**					
5 mins	9.	Performance & Finance Committee Assurance Report (23-02-21)	Assurance	Mr P Akid	Enclosure	**BAF 9**
10:35	**ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT AND RESEARCH**					
5 mins	10.	Transformation and People Committee Assurance Report (26-02-21)	Assurance	Prof G Crowe	Enclosure	**BAF 2 & 3**
10 mins	11.	Gender Pay Gap Report	Assurance	Mrs R Vaughan	Enclosure	**BAF 2**
10:50 – 11:05: BREAK						
11:05	**ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS**					
50 mins	12.	Integrated Performance Report – Month 10	Assurance	Mrs M Rhodes Mr P Bytheway Mrs R Vaughan Mr M Oldham	Enclosure	
11:55	**CLOSING MATTERS**					
5 mins	13.	Review of Meeting Effectiveness and Business Cycle Forward Look	Information	Mr D Wakefield	Enclosure	
	14.	Questions from the Public **Please submit questions in relation to the agenda, by 12.00 pm 8th March 2021 to nicola.hassall@uhnm.nhs.uk**	Discussion	Mr D Wakefield	Verbal	
12:00	**DATE AND TIME OF NEXT MEETING**					
	15.	**Wednesday 7th April 2021, 9.30 am via Microsoft Teams**				

University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 3rd February 2021, 9.30 am to 12.30 pm
Via Microsoft Teams

MINUTES OF MEETING

Attended	Apologies / Deputy Sent	Apologies

Voting Members:			A	M	J	J	J	A	O	N	D	J	F	M
Mr D Wakefield	DW	Chairman (Chair)												
Mr P Akid	PA	Non-Executive Director												
Ms S Belfield	SB	Non-Executive Director												
Mr P Bytheway	PB	Chief Operating Officer												
Mrs T Bullock	TB	Chief Executive												
Prof G Crowe	GC	Non-Executive Director												
Dr L Griffin	LG	Non-Executive Director												
Mr M Oldham	MO	Chief Financial Officer												
Dr J Oxtoby	JO	Medical Director							AW					
Prof P Owen	PO	Non-Executive Director												
Mrs M Rhodes	MR	Chief Nurse												
Mr I Smith	IS	Non-Executive Director												
Mrs R Vaughan	RV	Director of Human Resources												

Non-Voting Members:			A	M	J	J	J	A	O	N	D	J	F	M
Ms H Ashley	HA	Director of Strategy & Transformation												
Mr M Bostock	MB	Director of IM&T			HP									
Prof A Hassell	AH	Associate Non-Executive Director												
Mrs L Thomson	LT	Director of Communications												
Miss C Rylands	CR	Associate Director of Corporate Governance						Item 7 & 8					NH	
Mrs F Taylor	FT	NeXT Non-Executive Director												
Mrs L Whitehead	LW	Director of Estates, Facilities & PFI												

In Attendance:		
Mrs K Andrews	KA	Patient (item 1)
Mrs A Grocott	AG	Head of Patient Experience (item 1)
Mrs N Hassall	NH	Deputy Associate Director of Corporate Governance (minutes)
Mrs R Pilling	RP	Quality Improvement Facilitator (item 1)
Mrs S Wallis	SW	Head of Midwifery (item 9)

Members of Staff and Public via MS Teams: 8

No.	Agenda Item	Action
1.	**Patient Story**	
017/2021	Mrs Rhodes introduced Mrs Andrews who recalled her positive experience at UHNM, following treatment to remove a breast lump. Subsequently, she was informed she had breast cancer and outlined the professionalism and timeliness of her scans and treatment. She felt that all of her questions were answered, her treatment options and surgery were well explained and she welcomed the thoroughness of her treatment and the caring nature of all staff she encountered. She explained the way in which she was also diagnosed with a lesion on her lung and again felt that everything was explained thoroughly. Mrs Andrews	

PROUD TO CARE

	summarised that during the last 2 years of treatment, she welcomed the care and professionalism of all staff at both County and Royal Stoke and that the care was of the highest standards. Professor Crowe thanked Mrs Andrews for her story, and the heartfelt thanks she provided. Mrs Bullock thanked Mrs Andrews for the story, and welcomed the compliments made regarding the all the staff. Mr Wakefield joined the meeting. Professor Crowe queried if there was anything which Mrs Andrews felt could have been improved. Mrs Andrews stated that there were a couple of occasions where she waited quite some time in clinics without any explanation for the delay due to breakdown in communications. Mrs Bullock apologised for this and agreed with the importance of ensuring patients were kept up to date regarding wait times. Mr Andrews suggested that the oncology garden at County Hospital could be utilised for those waiting for appointments as it would help to reduce crowding in the waiting area. Dr Griffin thanked Mrs Andrews for her story and the acknowledgement of the whole team including radiographers, domestics and porters etc. Mr Wakefield referred to the decision to delay surgery for Mrs Andrew's lung lesion and queried how this impacted on Mrs Andrews. She explained that although it was difficult at first, as she wanted the surgery to remove the cancer carried out as soon as possible, the reasons for the delay from the oncologists, in terms of the importance of continuing with chemotherapy first were well explained, and therefore she was happy with the decision once she was aware of the facts. Dr Oxtoby stated that the Multidisciplinary Team Meetings aimed to add value in providing a broader perspective to help to ensure the right decisions were made, therefore it was inevitable that some decisions needed to be altered although this needed to be balanced in setting the right expectations with patients beforehand. Mr Wakefield thanked Mrs Andrews for her story and summarised that he welcomed to hear how positive her care was and welcomed hearing that she never felt rushed and that the majority of delays were explained. He also welcomed the positivity and comments made about all of the team and the care they provided. He agreed with the suggestion of exploring whether the oncology garden could be utilised for those waiting for appointments as well as addressing the issue in relation to the delays in clinics and mis-communication. He added that in terms of the issue with parking, improved communications were required to highlight the exemptions for those patients receiving cancer care. Mrs Andrews, Mrs Grocott and Mrs Pilling left the meeting. **The Trust Board noted the story.**	
2.	**Chair's Welcome, Apologies & Confirmation of Quoracy**	
018/2021	Mr Wakefield welcomed members of the Board and observers to the meeting and the above apologies were received. It was confirmed that the meeting was quorate.	

	Mr Wakefield welcomed the continued commitment of staff working at the Trust and offered his thanks. He passed his condolences onto those who had passed away due to the virus and extended his sympathies to their families. Mr Wakefield thanked the volunteers from the Armed Forces and the local Council who had provided their support to the Trust during the past few weeks and noted the sad passing of Captain Sir Tom Moore and welcomed the contribution he made in raising money for the NHS. Mr Wakefield welcomed the final confirmation that the Trust had exited Financial Special Measures and highlighted that the meeting was the last for Professor Owen and he thanked her for her contribution and wished her well in her retirement.	
3.	**Declarations of Interest**	
019/2021	The standing declarations were noted. Mr Bostock highlighted that he had been appointed as Non-Executive Consultant for Wi-Fi Spark.	
4.	**Minutes of the Previous Meeting held 6th January 2021**	
020/2021	The minutes of the meeting from 6th January 2021 were approved as an accurate record.	
5.	**Matters Arising from the Post Meeting Action Log**	
021/2021	PB/455 – it was noted that in terms of numbers vaccinated, over 13,000 workers had received the vaccine, although some data was being validated. It was noted that the vaccination had been offered to all priority groups and staff as appropriate and going forwards staff were able to receive the vaccine at other centres. Mrs Rhodes explained that at the request of the system programme the hospital vaccination hub had gone into hibernation until the second doses were due to be provided.	
6.	**Chief Executive's Report – January 2021**	
022/2021	Mrs Bullock highlighted a number of areas from her report. In relation to Covid, she explained that numbers were starting to reduce but critical care capacity remained challenged. Mr Wakefield queried whether it was the right decision from a system point of view, of the vaccination hub going into hibernation. Mrs Bullock stated that the Trust had offered to continue with vaccinations for the system, but it was felt that the capacity within the hospital hub was not required. Mr Wakefield referred to the actions being taken to recruit internationally and queried if the Trust had stopped recruiting from the EU. Mrs Bullock stated that this had not stopped but there were fewer opportunities to appoint from the EU. Dr Griffin welcomed the introduction of staff rest facilities and staff pods following receipt of charity monies and welcomed the stories regarding the way in which staff had been taking time to keep married couples together on wards, during	

	such difficult times. Professor Crowe referred to the Community Rapid Intervention Service (CRIS) and queried if the impact and outcome of this as well as Call 111, could be heard at a future Board meeting. Mrs Bullock agreed to invite representatives to join a future meeting to provide a staff story. Professor Crowe welcomed the efforts made with international recruitment and apprenticeship support to bolster nursing numbers. He referred to the need to continue to support staff during the pandemic, as well as providing them with an opportunity to rest and restore going forwards. Mrs Bullock referred to the actions being taken to provide staff with the opportunity to do so. **The Trust Board received and noted the report and approved EREAFs 7210, 7188, 3402 and 7192.**	**TB**
PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES		
7.	**Quality Governance Committee Assurance Report (20-01-21)**	
023/2021	Mrs Rhodes highlighted that the Committee used the majority of the meeting to consider the Infection Prevention and Control deep dive which was welcomed. Dr Oxtoby drew attention to the discussion regarding mortality reviews, the continued focus on nosocomial infections to ensure lessons were being learnt in order to minimise future infections and the continued focus on duty of candour. It was agreed that the presentation provided to the Quality Governance Committee, would be provided at a future Trust Board Seminar. **The Trust Board received and noted the assurance report.**	**MR**
8.	**Infection Prevention and Control Board Assurance Framework (BAF)**	
024/2021	Mrs Rhodes referred to the deep dive undertaken at the Quality Governance Committee (QGC) and queried whether the document should be provided on a monthly basis, given that not much changes month on month Dr Griffin referred to risks 1 and 6 which referred to the system and queried if this was local or internal. Mrs Rhodes explained that this related to internal systems within the Trust. Professor Crowe referred to the areas which referred to challenges in terms of cleaning and whether these had been addressed. He also queried the confidence in achieving the target risk scores given the target dates and whether these needed to be revised. Mrs Rhodes stated that these were reviewed on a weekly basis and agreed there were some risks where the target scores may not be achieved by the date provided, but this is what the Trust aspired to. She added that if the number of Covid positive patients did not reduce, it would be increasingly difficult to deliver some of the standards, although the majority were in the Trust's own gift to deliver. She stated that should any of the dates need to be revised, these would be confirmed with the QGC in February. Mrs Rhodes referred to the actions being taken in respect of cleaning and noted that some audits had been paused due to Covid but these had recommenced and	

	Matrons were undertaking daily checks on the wards. Mr Wakefield referred to compliance with mask wearing and bare below the elbow and queried how confident the Trust was that the actions required were having the desired effect. Mrs Rhodes stated that there had been improved compliance following walk arounds, and staff were being challenged if they were not wearing their mask correctly. **The Trust Board noted the position against the self-assessment compliance framework with Public Health England and other COVID-19 related infection prevention guidance.**	
9.	**Ockenden Report: Assessment and Assurance Framework and Action Plan**	
025/2021	Mrs Wallis highlighted the following: • A number of immediate actions were required to be undertaken by all Trusts, which were agreed and signed off by the Chief Executive for submission on 21st December • Subsequently, Trusts were asked to complete the assessment and assurance framework • It was noted that a number of audits were to be undertaken in order to provide the assurance and evidence of compliance • The Assessment and Assurance Framework was to be submitted by 15th February Professor Owen referred to some of the areas which seemed to have missing narrative and Mrs Wallis explained that where there was no narrative, it was due to no action being required. Mr Akid requested clarification in terms of who would audit compliance and how independent the audits would be. Mrs Wallis explained that the Division had their own Clinical Auditor who would undertake the audits, and support was also available from the Local Maternity System (LMS) and corporate clinical audit team. She added that the LMS also provide scrutiny in terms of the audits. Mr Wakefield queried the reference to Paid Activities for Consultants and Mrs Wallis stated that the peer review was not funded and a more robust process was required, as this was undertaken by goodwill. Mrs Rhodes agreed to consider whether the internal auditors could assist in providing independent assurance on the action plan and she agreed to discuss this with the internal audit team. Mrs Rhodes added that the assurance framework was also being reviewed to establish if any of the actions needed to be applied elsewhere in the organisation. Dr Griffin referred to the emphasis on the Trust Board hearing the voices of women, and stated that whilst their views were captured he queried if this constituted as 'listening'. He also queried where sepsis screening linked into the document. Mrs Wallis referred to the ongoing work to change the mindset regarding sepsis screening, in that women were provided with the necessary antibiotics and no adverse incidents had been raised related to sepsis in the last year, but an advocate had been put in place which had improving screening. Mrs Wallis referred to videos which had been provided in response to women's questions and information was also provided on monthly activities, in addition to	**MR**

	involving representatives in developing services as well as reading and commenting on leaflets. She added that she aimed to provide a quarterly maternity experience report to the Board going forwards. **The Trust Board noted and supported the action plan from the assessment and assurance framework** Mrs Wallis left the meeting.	
ENSURE EFFICIENT USE OF RESOURCES		
10.	**Performance & Finance Committee Assurance Report (19-01-21)**	
026/2021	Mr Akid highlighted the following from his report: • Concerns regarding critical care capacity were outlined, including the move to 200% in order to support the national effort and patients transferred from the South East. • Continued challenges in terms of urgent care performance and demand for beds which was high • An update was provided in terms of an IT incident and assurance was provided that there were no single points of failure • In terms of the financial outlook, the aim was to reset the budget for 2021-22 with some risks and uncertainties highlighted **The Trust Board received and noted the assurance report.**	
ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT AND RESEARCH		
11.	**Transformation and People Committee Assurance Report (21-01-21)**	
027/2021	Professor Crowe highlighted the following: • A number of areas provided credible assurance in terms of the ways in which the Trust was providing support to staff for their wellbeing and conducting risk assessments • It was agreed not to hold a meeting in March and instead a workshop was to be held, for an informal review of the transformation and Delivering Exceptional Care programme • It was noted that some disciplinary activity was being undertaken • Two areas on the Board Assurance Framework had increased in the risk rating; sustainable workforce and leadership which was to be expected given the current pressures **The Trust Board received and noted the assurance report.**	
ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS		
12.	**Integrated Performance Report – Month 9**	
028/2021	Mrs Rhodes highlighted the following: • The number of nosocomial cases had been included • Additional quality indicator benchmarking had been included where available Mr Wakefield welcomed the additional benchmarking information which had been provided and queried the patient safety incident totals compared to some which were lower and queried if this was due to the Trust not reporting as much or there	

	being fewer incidents. Mrs Rhodes agreed to review the data and provide additional narrative. Mr Wakefield queried if the Trust was assured that there were safe staffing levels given the current challenges and Mrs Rhodes explained that a paper had been provided to members of the Transformation and People Committee with regards to workforce numbers. It was noted that 3 wards had been escalated where there were concerns about staffing and additional staff had been put in place. Mrs Rhodes added that from an establishment perspective, there was enough funding to supply the right number of nurses, but the Trust had not achieved the 1:8 ratio on every shift, every day, in every area. She added that there was some correlation between incidents and areas with lower numbers of staff but this also correlated with ward moves and staff not being familiar with the different ward environment. Mr Smith referred to the position of reaching 100% written duty of candour which should be welcomed and Mr Smith referred to page 24 and the fifth paragraph which read 845.5% and was incorrect and should read 84.5%. Mrs Rhodes agreed to amend. Mr Bytheway highlighted the following: • Urgent care performance continued to be challenged during December, due to the increase in Covid challenges, increases in sickness levels and bed availability being reduced • In the main, challenges related to ambulance holds during the month, although the Urgent Care Board metrics showed an improvement from December to January; triage times and referral to discharge times. It was noted that ambulance holds had reduced in January • In terms of cancer performance, the Trust had continued to aim to treat P1 and P2 patients and during December and January the Patient Tracking List had remained static due to the number of treatments being undertaken. • There had been some change in the number of 104 day patients due to the risk of catching Covid versus having the operation and overall performance remained the same as November, although in January there would be a deterioration in performance due to the challenges in critical care • It was noted that the Trust had achieved 3 standards in December and that that cancer performance was above the national average Mr Wakefield referred to cancer two week wait referrals in month and seeing more than the trajectory, but the number of 31 day patients being below trajectory and queried how the Trust would deal with the problem which was building up. Mr Bytheway stated that the actions focused on ensuring patients were being brought into the Trust, and concentrating on the 28 day standard. He stated that as the 31 day target required access to diagnostics, this was challenging due to operating space but further actions were being considered as part of recovery and restoration. Dr Griffin referred to primary care referrals and whether these were being sustained and Mr Bytheway stated that there was some variation, but overall there had not been a reduction in referrals. Mr Wakefield queried the impact from the increase in GP workloads on referrals and Mr Bytheway stated that whilst the assumption was to stand down routine work, GPs were continuing with triaging patients demonstrating any red flag symptoms.	MR MR

Mr Bytheway referred to planned care and the associated ongoing risks and highlighted the following:

- Increasing size of waiting lists and the number of 52 week patients
- Treatment had continued for P1 and P2 patients but more focus was required on P3 and P4 patients
- Cancer patients were continuing to be treated at the Independent Sector and the Trust was engaging with the contract as part of the national programme to work with the Independent Sector, particularly in terms of getting P3 and P4 patients treated sooner
- Clinical validation of the waiting list had continued and patients were being managed in time order as per national guidance

Mr Wakefield queried the reason for the number of day cases being low and whether the Trust was making full use of the Independent Sector. Mr Bytheway stated that there was not a specific day case theatre at UHNM therefore, when theatre cases were taken down, it impacts day cases. He added that until the end of December, utilisation of the Independent Sector was variable, but from January a more robust process for filling lists had been identified, and in the last week 75% to 80% of the list was being filled.

Mrs Ashley referred to utilisation of the Independent Sector, and referred to the agreement of identifying patients who were appropriate to be transferred to the Independent Sector and since the beginning of January, the Trust had identified 800 patients, 325 of which had accepted the decision.

Dr Griffin referred to the report which referred to 12,000 patients waiting to be contacted regarding their wait for treatment and requested an update in terms of how these patients were being kept under continuous review. Mr Bytheway agreed to provide a further update in terms of these patients. He added that that each patient was allocated a time period and if this was breached, it was flagged to the clinical team so that action could be taken with the Consultant in charge of their care.

PB

Professor Crowe queried if risks associated with the waiting list could be subject to internal audit in order to provide assurance of the processes undertaken.

Mrs Vaughan highlighted the following in relation to workforce performance:

- Sickness absence in month was 6.19% and cumulatively 5.34%. She added that the most recent information highlighted that Covid related absence had reduced to 43% of all absences which was an improvement on previous figures
- The Trust was continuing to focus on staff testing, although numbers had reduced and the Trust had gone live with a self-booking system for staff testing
- A number of wellbeing initiatives continued to be provided which included the provision of rest facilities. A wellbeing plan was in place which included the planned pause to give staff time to recuperate after the pandemic
- The staff recognition programme had commenced which included distributing thank you letters and badges

Mr Smith referred to staff absences due to Covid and the continued fluctuation, and queried if the Trust was aware of the number of long-term Covid absences i.e. those shielding. Mrs Vaughan stated that the Trust was aware of the number of staff who were shielding due to other conditions and these staff had been written to, in order continue to provide them with support. Mrs Vaughan added that detailed information was not necessarily available corporate, for those staff

	with long Covid symptoms, but at a divisional level, teams held this information and were providing support to those with long term absence, and work was in place to provide additional rehabilitation support for these staff members. Mr Wakefield thanked Mrs Vaughan and the team for the continued work being undertaken by the Human Resources team during the pandemic. Mr Oldham highlighted the following: • The Trust had achieved a £2.1m surplus and was ahead of plan. • The plan originally anticipated a £7.2 m deficit but when excluding the £5 m TSA funding, the forecast was £2.2 m deficit. As a result of the surplus the Trust had forecast that it would achieve a break-even position, although as activity steps up, there were some associated risks and opportunities • It was noted that as the Trust was anticipating a surplus, it could negate the risk associated with the carry forward of staff annual leave which would need to be accrued • The Trust continued to underspend on pay, which was associated with the receipt of winter monies, Covid costs and investments which due to staffing shortfalls had not been spent • In terms of income and expenditure for 2021-22, the Trust was continuing to work on this, and was anticipating the planning guidance to be received at the end of March, with a paper to be presented to the Performance and Finance Committee (PAF) in due course • It was noted that for the first quarter of 2021/22, the new regime would not be in place, therefore arrangements for 2020/21 would be in place and a plan was to be submitted for the final 3 quarters by the end of June • In terms of capital, the Trust was behind the programme with £7.3 m under target which was mainly associated with the additional Public Dividend Capital monies which had been received for the works in the Emergency Department and associated decant. It was noted that some profiling issues had been identified with the Linac and Interventional Radiology, and a paper was to be provided to PAF on both the forecast and the plan for 2021/22 capital • The Trust awaited receipt of Covid capital which had been spent so this was risk in terms of managing the year end position **The Trust Board received and noted the performance report.**	
GOVERNANCE		
13.	**Audit Committee Assurance Report (21-01-21)**	
029/2021	Professor Crowe highlighted the following: • A number of internal audit reports were considered which received significant assurance with minor improvements • The Trust had deferred the full asset valuation given the current pandemic and a desktop evaluation would be undertaken • The annual accounts timetable was scheduled and it was expected that the submission may be extended • In terms of incident reporting it was noted that the Trust needed to learn lessons consistently which linked to overall cultural • There had been some drift in policy reviews, due to the pandemic and these were being worked through with teams to identify the completion dates and any requests for extensions • The Financial Reporting Council were to review the external audit from 2019/20 and a report was to be provided to Grant Thornton, with any insights to be shared with the Trust	

	The Trust Board received and noted the assurance report.	
14.	**Board Assurance Framework (BAF) – Quarter 3**	
030/2021	Mrs Hassall presented the updated BAF for Quarter 3 which had been considered by respective Committees in January. It was noted that there were no changes following QGC and the Audit Committee, and additional controls had been added to BAF3 in relation to recruitment, following the TAP meeting. Mrs Hassall stated that 3 risks had increased in their level of risk; BAF 1 in relation to Harm Free Care, BAF 2 in relation to leadership/culture and delivery of Trust values/aspirations and BAF 3 for sustainable workforce, and the rationale for the changes in these risk scores were highlighted. It was noted that BAF 9, financial sustainability had reduced and reached the target risk score, due to the anticipated position of break-even at the year end. Mr Wakefield referred to BAF 6 and implications of the phase 4 letter and whether the Trust had an indication of receipt of a phase 5 letter. Mrs Bullock stated that the Trust was expecting planning guidance in March but was not expecting anything further. Mr Wakefield welcomed the introduction of international recruitment as a control for BAF 3 and queried the impact of the vaccine on staff absence and whether the Trust should plan on reduced absences as a result of the vaccine. Mrs Vaughan stated that whilst it was hoped the vaccine would have a positive impact on reducing staff absences, nationally Trusts had been advised to take a cautionary approach to this. Mr Oldham stated that in terms of the assumptions in the financial plans, it was expected that sickness would reduce and this needed to be considered as part of the planning. Professor Crowe referred to the ratings on the BAF which he supported and stated that some areas were difficult to address and required further consideration in terms of 2021/22 and the Boards appetite for these risks. Mrs Bullock stated that a future Board Seminar was to consider the review of Strategic Risks for 2021/22, taking into account risk appetite as part of that session. **The Board approved the Board Assurance Framework.**	
15.	**Speaking Up Report – Quarter 3 2020-21**	
031/2021	Mrs Vaughan highlighted the following: • During quarter 3, some national and strategic events took place which included working with partners at Keele Medical School • New training materials had been launched and were to be incorporated into mandatory training programmes • 28 contacts were raised during the quarter, half of which related to attitudes and behaviour • Recruitment of an Associate Freedom to Speak Up Guardian was scheduled to take place in addition to recruiting additional Employee Support Advisors to support teams across the organisation in speaking up Mr Wakefield referred to the National Guardian survey which found that most of the Guardians were white and therefore referred to the need of ensuring	

	Guardians matched the ethnicity of the workforce and the environment. In addition, he referred to the index in Appendix 2 which was 75% and one of the lowest. Mrs Vaughan explained that the index was derived from the staff survey and therefore the Trust needed to ensure processes and procedures were well communicated, and staff were supported in raising concerns. Mrs Vaughan highlighted that the Associate Guardian was also Chair of the ethnically diverse network but accepted that more could be done in terms of being more diverse. **The Trust Board noted the speaking up data and themes raised during Quarter 3 and the proposed actions to further encourage and promote a culture of speaking up at UHNM.**	
16.	**Risk Management Policy**	
032/2021	Mrs Hassall explained that the policy had been revised following its 3 yearly review. It was noted that the main changes included the revised Risk Appetite Statement, and reference to the roles of the Executive Assurance Groups. It was noted that the policy had been through consultation with key stakeholders and was approved by the Audit Committee in January. **The Trust Board approved the policy.**	
CLOSING MATTERS		
17.	**Review of Meeting Effectiveness and Business Cycle Forward Look**	
033/2021	No further questions were raised.	
18.	**Questions from the Public**	
034/2021	Mr Syme had provided 3 questions in advance. Mrs Bullock explained that his first question related to item 8, and page 33 of the document which referred to strict adherence to policy regarding patient isolation and cohorting, and that Root Cause Analyses (RCAs) should be completed on any inappropriate patient moves. It was noted that the question had been forwarded to the Freedom of Information team for a response, in terms of the number of RCAs which had been activated and completed as it was not possible to provide that information within the timeframe. Mrs Bullock stated that Mr Syme's second question was in relation to the Integrated Performance Report, whereby page 3 referred to extreme pressures on UHNM and the 'National Ask' for December 2020 was "100% of last year's business as usual and for inpatients 90%". He stated that UHNM actual December 2020 was 84.5% and 68.2% respectively and the "national ask" initially seemed to imply/state penalties for non achievement. He queried if any penalties had been imposed for non achievement and if so what was the total of such penalties accrued to date by UHNM. Mr Oldham stated that the elective incentive scheme letter in December amended the scheme and he referred to the 10% tolerance of the target. He explained that no fines were to be levied in recognition of the pressures, considering that system beds were more than 15% occupied with Covid and there being significant staff	

	absence. He reiterated that the Trust had not been fined and nothing was reflected in the final figures. Mrs Bullock continued with Mr Syme's last question which referred to clinical priorities during Covid and the Clinical Guide to Surgical Prioritisation during the Coronavirus Pandemic document. He stated that the guide gave clear timelines for procedures and asserts that 'prioritisation is when and not by whom'. He queried the most recent numbers of UHNM patients whose clinical priorities placed them within specific categories P1a P1b and P2, queried whether the Trust had been able to adhere to the timelines for patients who come within the categories and queried if there had been extended time intervals before procedures and queried what had been actioned to mitigate against future 'breaches'. Mr Bytheway stated that this question had been more or less responded to under his performance section and noted that P1s in the main related to all non-elective i.e. emergency procedures and a routine clinical triage process had continued for these patients. He added that there had been a small amount of breaches and added that patients continued to be treated based on clinical priority. He stated that in terms of P2s, these clinically urgent and cancer patients were in the main treated in the 4 weeks timeframe and going forwards he hoped to include more granular detail within the Integrated Performance Report.	
DATE AND TIME OF NEXT MEETING		
17.	Wednesday 10th March 2021, 9.30 am, via MS Teams	

Trust Board (Open)

Post meeting action log as at **03 March 2021**

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

Ref	Meeting Date	Agenda Item	Action	Assigned to	Due Date	Done Date	Progress Report	RAG Status
PTB/451	09/12/2020	Patient Story - December	To provide an update of the actions taken in response to the story, to a future Quality Governance Committee.	Michelle Rhodes	24/02/2021	24/02/2021	Updates in the QGC minutes which will be forwarded to members.	B
PTB/454	06/01/2021	Update from the Chief Nurse	To include benchmark information on the number of incidents reported to the Quality Governance Committee.	Michelle Rhodes	24/02/2021	03/02/2021	Completed and included benchmarking summary for indicators and presented in report at February Trust Board and Quality report included QGC agenda for 23/02/2021 agenda.	B
PTB/455	06/01/2021	Update from the Director of Human Resources	To confirm the exact numbers of staff vaccinated in the prioritised groups to Professor Crowe.	Ro Vaughan	03/02/2021	03/02/2021	Update provided at February's meeting.	B
PTB/457	03/02/2021	Chief Executive's Update	To invite representatives from the Community Rapid Intervention Service (CRIS) to a future meeting, to provide a staff story.	Tracy Bullock	06/05/2021		Invited to May's meeting.	GB
PTB/458	03/02/2021	Quality Governance Committee Assurance Report	To provide the IPC presentation provided to the Quality Governance Committee, at a future Trust Board Seminar.	Michelle Rhodes	17/03/2021	10/02/2021	IPC team invited to join the next Trust Board Seminar in March.	B
PTB/459	03/02/2021	Ockenden Report: Assessment and Assurance Framework and Action Plan	To consider whether the internal auditors could assist in providing independent assurance on the action plan	Michelle Rhodes	31/03/2021		Internal audit approached to establish whether a review could be scheduled. Scoping meeting taking place.	GB
PTB/460	03/02/2021	Integrated Performance report Month 9	To review the benchmarking data in relation to patient safety incidents and provide additional narrative.	Michelle Rhodes	10/03/2021	22/02/2021	Benchmarking data for PSIs under further review. Nationally available data is limited. Additional narrative to be provided and included in latest report.	B
PTB/461	03/02/2021	Integrated Performance report Month 9	To amend page 24 and the fifth paragraph which should read 84.5% rather than 845.5% .	Michelle Rhodes	10/03/2021	24/02/2021	Report has been updated and incorrect decimal place corrected.	B
PTB/462	03/02/2021	Integrated Performance report Month 9	To provide a further update in respect of the progress made in contacting 12,000 patients regarding their wait for treatment.	Paul Bytheway	10/03/2021	03/03/2021	Update provided within the narrative of the Trust Board performance report narrative	B

University Hospitals of North Midlands NHS Trust

Chief Executive's Report to the Trust Board

FOR INFORMATION

Part 1: Trust Executive Committee

The Trust Executive Committee met on 3rd March 2021. The meeting was held virtually using Microsoft Teams; there was no agenda or papers as the general purpose of the meeting was to provide an opportunity to discuss the latest position with regard to Covid-19 and to hear from Divisions in relation to next steps, staff wellbeing and any challenges/risks they may have.

However, the meeting in March dedicated time to receiving a presentation from the Organisational Development Team and the Culture and Leadership group. This work was started pre-Covid but then put on hold. Work has now recommenced and the first presentation is being shared widely, including at the Trust Board Seminar on the 17th March.

Part 2: Chief Executive's Highlight Report

1. Contract Awards and Approvals

Department of Health Procurement Transparency Guidance states that contract awards over £25,000 should be published in order that they are accessible to the public. Since 12th January to 11th February, 4 contract awards, which met this criteria, were made, as follows:

- **Nursing Master Vendor Contract (REAF 7210)** supplied by Medacs at a total cost of £3,700,000.00, for the period 01/04/21 – 31/03/22, providing savings of £74,000.00, approved on 03/02/21
- **Patient Monitoring Trust Wide 10 year rolling Replacement (REAF 7192)** supplied by Philips Healthcare Systems at a total cost of £6,609,806.98, providing savings of £1,192,955.88, approved on 03/02/21
- **Medical Locum Temporary Staffing Contract (REAF 7188)** supplied by Miscellaneous at a total cost of £6,078,655.00, for the period 01/04/21 - 31/09/21, providing savings of £60,786.55, approved on 03/02/21
- **CCN for Testing System for Enteric Pathogens into Roche MES (REAF 3402)** supplied by Roche at a total cost of £2,361,785.00, for the period 01/04/21 - 31/03/26, approved on 03/02/21

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

Supply Chain Coordination Limited (SCCL) - Trust wide Annual Expenditure (eREAF 7311)

Contract Value	£14,300,000.00
Duration	01/04/21 – 31/03/22
Supplier	SCCL

Blood Sciences Siemens Managed Service Contract - Year 9 Premium (eREAF 5162)

Contract Value	£4,055,212.40
Duration	01/10/20 – 30/09/21
Supplier	Siemens Healthineers UK

Salary Sacrifice Vehicle Leasing (eREAF 7308)

Contract Value £2,700,605.10
Duration 01/04/21 - 31/03/25
Supplier NHS Fleet Solutions

The Trust Board are asked to approve the above REAFs.

2. Consultant Appointments

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

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Locum Consultant - General Paediatrician	Vacancy	Offered but candidate didn't accept	n/a
Medical Support Worker (B6)	New	TBC	TBC
Locum Consultant Urology	Vacancy	TBC	TBC
Locum Consultant in General Surgery with interest in Colorectal Surgery	Vacancy	Yes	17/05/2021

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

Post Title	Reason for advertising	Start Date
Consultant Cancer Colorectal Surgeon	Vacancy	01/02/2021
Consultant Intensivist	Retire & Return	02/02/2021
Consultant Anaesthetist General x 2	Vacancy	03/02/2021
Consultant in Intensive Care Medicine	New	03/02/2021
Senior Medical Practitioner Haematology x 2	Vacancy	05/02/2021
Deputy Director Research and Innovation	Vacancy	15/02/2021
Locum Musculoskeletal Radiologist	New	15/02/2021
Locum GI Radiologist	Vacancy	15/02/2021
Consultant in Emergency Medicine	Extension	17/02/2021
Locum Consultant Urology	Extension	17/02/2021

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

Post Title	Closing Date	Note
Consultant Intensivist	05/02/2021	No applications
Consultant Intensivist	16/02/2021	No applications

3. Covid-19 & Move from Level 4 to Level 3

We have recently passed the one year anniversary since we accepted and started to treat our first Covid-19 positive patients. Even with all the best planning in place, nothing really could have prepared us mentally and physically for what followed – which included treating more than 4,763 patients, of which more than 3,300 have all been discharged home. There remain high numbers of patients in our hospitals, and pressures related with Covid-19 remain high, particularly in our critical care unit, although we are seeing a gradual decline in the number of patients being admitted with Covid-19.

As a result from 1st March 2021, we stood down our internal incident Level 4 to Level 3, although critical care will remain on Level 4. While the situation maybe improving we are cautiously taking steps and starting to plan our recovery and will monitor Covid-19 infection rates closely as we do this.

4. Publication of the White Paper

On 12th February 2021, the Department of Health and Social Care (DHSC) formally published a White Paper 'Integration and Innovation: working together to improve health and social car for all', setting out legislative proposals for a Health and Care Bill. These proposals are an evolution of those initially put forward by NHS England and NHS Improvement (NHSE/I) in 2019 and 2020, with some further important additions (e.g. the proposals to give the Secretary of State powers to direct the NHS, move powers between arm's length bodies and intervene in local reconfiguration decisions).

NHSE/I have also published a paper, Legislating for Integrated Care Systems: five recommendations to Government and Parliament, which summarises the feedback received from the Integrating Care engagement exercise, and sets out key legislative proposals in response to this feedback and DHSC has accepted these proposals and incorporated them into the White Paper.

The Trust and system partners are reviewing the content of the white paper to understand the implications for the system and our own organisations. Further discussion will take place at a future board seminar and at the ICS Shadow Board

5. Joint Advisory Group (JAG) Accreditation

I was pleased to receive a letter earlier in the month from Dr Chris Healey, Joint Advisory Group (JAG) on Gastrointestinal Endoscopy accreditation chair, following an inspection at both County Hospital and Royal Stoke, confirming that the Trust had met all the required JAG accreditation standards. JAG accreditation is awarded to high-quality gastrointestinal endoscopy services and in his letter he congratulated the team for "the high standard of achievement and for their hard work during the accreditation process." I know a great deal of work went into achieving this high standard and it recognises the amazing service the team provides to our patients.

6. Thank you to Stoke on Trent Council Volunteers

Earlier in the year, a number of redeployed workers from Stoke City Council services, took on volunteer roles to support Royal Stoke's critical care unit. These volunteers provided welcome support to the Critical Care staff and our patients, during a particularly challenging period and we are extremely grateful for additional resource provided by Stoke City Council and the volunteers themselves.

7. LGBT+ History Month

During February, the Trust proudly celebrated LGBT+ History month to raise awareness of, and combat prejudice against, LGBT+ people and history.

Founded in 1994, LGBT+ History Month explores the heritage of lesbian, gay, bisexual and transgender history, and the history of the gay rights and related civil rights movements. The Trust used the month to share and highlight stories about our LBGT+ staff and how we as an organisation could support them.

Thank you to all those who participated and in particular the UHNM LGBT+ Staff Network which is crucial to helping to create change, promote inclusivity and to allow people to come together and share experiences so that we can understand concerns and improve staff experience.

8. 'Thank You' Cards

In recognition of the extraordinary efforts all staff have demonstrated in 2020, all staff employed by the Trust, and those on site employed by our partners, have been given a Thank You card and badge from the Trust, hand delivered to their ward or department. In addition, staff have been awarded a gift of a Wellbeing Day – to do something positive to support their own health and wellbeing. To date over 11,000 thank you cards and badges have been handed out to staff across UHNM.

9. Digital Aspirant Business Case Funding

I am pleased to highlight that the Trust has recently been successful in receiving £250,000 of financial support from NHSX, in order to create and submit a business case worth £6 m for 2021/22 as part of the Digital Aspirant programme. Work is already underway in writing the business case to seek further funding, in order to support our digital transformation journey.

10. First Public Meeting of ICS Shadow Board

The first Public Board meeting of the ICS was held 18th February. The membership of the Board has been expanded to include both LMC members and PCN Chairs and the Board received a number of stories which included a presentation from the Community Rapid Intervention Service (CRIS) team, real patient stories illustrating the positive impact of this service. In future, UHNM Board stories will be included and a strategy is being developed for the scale and scope of services going forward. The Board had an interesting discussion in relation to health inequalities, and making progress in using population health data to drive what could be collectively delivered for our population and also received a presentation from Peter Axon, Chief Executive of North Staffordshire Combined, on ICPs.

11. Hospital Hub Vaccination Campaign

The Hospital Vaccination Hub reopened on the 25th February to provide second doses of the Pfizer vaccine to those who had received a first vaccination in December and January.

As an update to the Board, as of the 1st February 2021 the numbers vaccinated through the UHNM hub are as follows:

Total vaccines given:	
Total as of 1st February	22,974
1st dose	20,769
2nd dose	2,119
Unable to vaccinate	86

	First dose	Second dose	% of first dose of total vaccinated
Numbers and % Patients > 80s vaccinated	433	239	2%
Numbers and % UHNM (incl Sodexo and Ezec)	11,467	1,434	55%
Numbers and % Care Home staff vaccinated	1,465	139	7%
Numbers and % WMAS staff vaccinated	399	99	2%
Numbers and % MPFT staff vaccinated	298	41	1%
Numbers and % NSC staff vaccinated	949	57	5%
Numbers and % LHA/other NHS staff vaccinated	4,529	8	22%
Numbers and % Patients <80	1229	102	6%

We know that nationally the rate of vaccination for BAME staff is generally much lower and given the impact of Covid-19 on our BAME colleagues it was important that we vaccinated as many as possible.

Unfortunately the true vaccination rate for any groups of our staff can never be fully understood as vaccinations have also been given through other routes such as system vaccination hubs, vaccination centres, GPs and Pharmacies. As a result of Information Governance regulations this information cannot be shared although we have requested information on raw numbers for each staff group.

However, we can assure the Board that all of our staff have been offered a vaccine. To date the UHNM hub has vaccinated 76% of its staff in total and 63% of its BAME staff which is excellent in comparison to the regional/national uptake. We also know that many more of our staff have been vaccinated to date through the other portals.

Quality and Governance Committee Chair's Highlight Report to Board

February 2021

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• 33 Serious Incidents were reported during Quarter 3; 2 of which were de-escalated – all are being reviewed in accordance with Trust policy. • Standards for patient falls were not achieved although a number of mitigating actions have been identified – there are no particular concerns with specific areas. • Maternity sepsis screening was also below target and the team are looking at ways in which this can be improved. • Reporting of medication incidents is lower than the national average (4 compared to 6) and work has been undertaken to address this, along with benchmarked date being included within the report for continued monitoring. In terms of dispensing errors, the Trust is currently just over the national benchmark mean of 19 with 20 errors per 100,000 dispensed items.	• Review of sharps incidents undertaken following an increase in incidents resulting in harm; the deep dive did not give any indication of a singular problem although a number of actions, including quality of reporting and investigation and a proactive gap analysis against regulations have been agreed – the outcome of the gap analysis will be reported back to the Committee • More regular report on Sharps to be presented to the Committee on a regular basis • Review of timeliness of reporting quality and safety indicators to the Committee to be undertaken to ensure the most up to date data is available • Nationally there is a review of definitions for Never Events being undertaken; the outcome of which will be shared with the Committee • The Clinical Audit Department are working closely with the Maternity Team to provide assurance associated with the Ockenden Recommendations
Positive Assurances to Provide	**Decisions Made**
• Reduction in Covid patients being seen in general and acute patients although it was noted that the number is still higher than the peak of the first wave • Likely that a decision will be taken tomorrow to deescalate from Level 4 to Level 3 – heading in the right direction • Sickness rates including Covid related absence is now reducing also although it was noted that there may well be some further absences associated with the second vaccination • Fully compliant with all Perinatal Mortality Standards at Q3 with 100% compliance being seen against a number of standards • Significant progress has been made against the CQC Action Plan • Research and Innovation have begun to reactivate studies that were paused at the beginning of the pandemic with over 40 studies now reactivated • UHNM is the top recruiting Trust in the West Midlands network for recruitment to UPH Covid Trials and the top recruiter for REMAP CAP in the UK • An update was shared with the Committee which provides follow up on issues raised through patient stories reported to the Board	• There were no items requiring decision at this meeting.
Comments on the Effectiveness of the Meeting	
• Very important that the Committee continues to maintain its emphasis on Maternity Services	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Executive Directors Update including Covid-19	Information	10.	Medicines Optimisation report – Focus on Medicines Safety – Overview and UHNM Current Position	Assurance
2.	Q3 Perinatal Report	Assurance	11.	CQC Actions Update	Assurance
3.	UHNM MBRRACE-UK 2018 Perinatal Mortality Data	Assurance	15.	CQC Insight Report Update	Assurance
4.	Quarterly Maternity Dashboard Q3 2020/21	Assurance	16.	Research and Development Update	Assurance
5.	Healthwatch Maternity Action Plan	Assurance	17.	Clinical Audit Progress Report	Assurance
6.	Health and Safety – Sharps Incident Increase Report	Assurance	18.	December Patient Story Update	Assurance
7.	M9 Quality and Safety Report	Assurance	19.	Executive Health & Safety Group Highlight Report	Assurance
8.	Serious Incident Summary Q3 2020/21	Assurance	20.	Quality & Safety Oversight Group Highlight Report	Assurance
9.	Mortality Summary Report	Assurance	21.	Quality Impact Assessment Report	Assurance

3. 2020 / 21 Attendance Matrix

Attended	Apologies & Deputy Sent	Apologies

Members:			A	M	J	J	A	S	O	N	D	J	F	M
Prof A Hassell	AH	Associate Non-Executive Director (Chair)												
Ms S Belfield	SB	Non-Executive Director (Chair)												
Mr P Bytheway	PB	Chief Operating Officer												
Mr J Maxwell	JM	Head of Quality, Safety & Compliance												
Prof P Owen	PO	Non-Executive Director												
Dr J Oxtoby	JO	Medical Director		GH										
Mrs M Rhodes	MR	Chief Nurse				HI								
Miss C Rylands	CR	Associate Director of Corporate Governance						NH	NH					
Mr I Smith	IS	Non-Executive Director												
Mrs R Vaughan	RV	Director of Human Resources												

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	10th March 2021
Report Title:	Infection Prevention Board Assurance Framework Q4 2020/21	**Agenda Item:**	8.
Author:	Helen Bucior, Infection Prevention Lead Nurse Emyr Philips , Associate Chief Nurse Infection Prevention/Deputy DIPC Claire Rylands, Associate Director of Corporate Governance		
Executive Lead:	Michelle Rhodes, Chief Nurse/DIPC		

Purpose of Report:

Assurance		Approval		Information	✓

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

Executive Summary:

Situation

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

Background

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

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

Assessment

- The yellow areas highlighted on the document relate to the additional Key Lines of Enquiry which have been included following additional guidance which was released on 12th February
- There continue to be a number of systems, processes and controls in place, however evidence of assurance monitoring has demonstrated some gaps which will be addressed through the action plans.
- Whilst there has been little change since the document was presented to the Trust board in February, work is ongoing to improve the assurance framework going forwards, to provide more robust assurance on the controls identified.

Key Recommendations:

The Board is asked to note the document for information, and note that work is ongoing to strengthen the assurance framework going forwards, which will be reported to the Board in April 2021.

University Hospitals of North Midlands NHS Trust

Infection Prevention and Control Board Assurance Framework

Quarter 3 – March 2021

2020/21

Summary Board Assurance Framework as at Quarter 1 2020/21

Ref / Page	Requirement / Objective	Risk Score				
		Q1	Q2	Q3	Q4	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.	High 9	High 9	High 9		→
BAF 2 Page 13	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	Mod 6	Low 3	Mod 6		↑
BAF 3 Page 19	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	High 9	High 9	High 9		→
BAF 4 Page 22	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.	Mod 6	Mod 6	Low 6		→
BAF 5 Page 25	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.	High 9	Low 3	Low 3		→
BAF 6 Page 28	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.	High 9	High 9	High 9		→
BAF 7 Page 32	Provide or secure adequate isolation facilities.	Mod 6	Low 3	Mod 6		↑
BAF 8 Page 34	Secure adequate access to laboratory support as appropriate.	Mod 6	Mod 6	Low 3		↓
BAF 9 Page 38	Have and adhere to policies designed for the individuals and provide organisations that will help prevent and control infections.	Mod 6	Low 3	Mod 6		↑
BAF 10 Page 41	Have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	Mod 6	Mod 6	Low 3		↓

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

Risk Scoring								
Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3	3		There are a number of controls in place, however evidence of evidence of assurance monitoring has demonstrated some gaps which will be addressed through the action plan	Likelihood:	1	End of Quarter 4
Consequence:	3	3	3			Consequence:	3	
Risk Level:	9	9	9			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	Infection risk is assessed at the front door and this is documented in patient notes.	• On arrival in ED patients are immediately identified either asymptomatic for COVID -19 and apply infection prevention precautions. • ED navigator in place • Colour coded areas in ED to set out COVID and Non COVID areas. This has been revised in September 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	• 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	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		• When 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 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	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
		• 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)		
1.2	Patients with possible or confirmed Covid-19 are not moved unless this is essential to their care or reduces the risk of transmission. There are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically imperative That on occasions when it is necessary to cohort COVID or non-COVID patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per guidance.	• All patients admitted to the Trust are screened for COVID -19 • All patients are rescreened on days 4-6 • 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	• Unannounced visits for clinical areas with clusters or HAI cases of COVID-19 • Review of HCAI COVID cases by IP Team • Datix /adverse incidence reports for inappropriate transfers	• NHSI key point 4 : Patients are not moved until at least two negative test results are obtained, unless clinically justified
1.3	Compliance with the national guidance around discharge or transfer of Covid-19 positive patients.	• Infection prevention step down guidance available on Trust intranet • All patients who are either positive or s	• Datix/adverse incidence reports	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		are positives are advised to complete self –isolation if discharged or transferred within that time frame  guidance-on-screeni ng-and-testing-for-cc  Patient Information Lealfet - Contact 202 • 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-rounds-g uidance-161020-final		
1.4	**All staff (clinical and non-clinical)** are trained in putting on and removing PPE, know what PPE they should wear for each setting and context and have access to the PPE that protects them for the appropriate setting and context as per national guidance. Linked NHSIE Key Action 3: Staff wear the right level of PPE when in clinical settings, including use of face masks in non-clinical settings. Linked Key Infection Prevention points – COVID 19 vaccination sites	• Key FFP3 mask fit trainers in place in clinical areas • PPE posters and information available on the Trust COVID -19 page. This provides the what, where and when guide for PPE • Infection Prevention Questions and Answers Manual include donning and doffing information. • Areas that require high level PPE are agreed at clinical and tactical • Aerosol generating procedures (AGP's) which require high level PPE agreed at clinical and tactical group	• Daily stock level of PPE distributed via email and agenda item for discussion at COVID-19 tactical group • IP complete spot check of PPE use if cluster/OB trigger • Records of Donning and Doffing training for staff trained by IP • A number of Clinical areas have submitted PPE donning an doffing records to the IP team	• Training completed in areas - records are held locally by clinical areas, these include Divisional donning and doffing training records and Divisional FFP3 mask fit training records • FFP3 Training records require central holding/recording

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
Monitoring of IP practices, ensuring resources are in place to enable compliance with IP practice of staff adherence to hand hygiene? • Staff adherence to hand hygiene • 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 Consider implementing the role of PPE guardians/safety champions to embed and encourage best practice There are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace	• 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 • 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	• Donning and Doffing training also held locally in clinical areas • Cascade training records held locally by Divisions • Sodexo and Domestic service training records • IP assurance visits • Review of UHNM vaccination areas against key infection prevention points COVID -19	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
1.5	National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way.	• Notifications from NHS to Chief nurse/CEO • IP team COVID lead checks Public Health England webpage daily (Monday-Friday) for updates • Changes raised at -19 clinical groups which was held originally twice weekly, reduced to weekly and now increased back to twice weekly due to surge of COVID. • Purpose of the Clinical Group - The Group receive clinical guidance and society guidance which is reviewed and if agreed used to advise clinical teams after approval at Exec COVID -19 meeting which is held twice monthly. • Tactical group – The tactical Group held daily. The Group made decided and agreed tactical actions into the incident. • 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	• Clinical Group meeting action log held by emergency planning	
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.	• Meeting Action log held by emergency planning • Trust Executive Group Gold command – Overall decision making and escalation	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		• COVID Gold command , decisions /Assurance reported to Trust Board Via CEO Report/COO	• Tactical, Operational Delivery Group - The delivery of the objectives and benefits, and programme communications COVID 19 response and R&R. Co - ordination of resources. Escalation forum for linked Groups and Cells ensuring that the interdependencies are effectively managed, including system. Makes recommendations to Gold Command for key decisions. • Clinical steering Group – Coordinate clinical decision – making to underpin continual service delivery and COVID 19 related care • Workforce Group – Lead the plan and priorities for our people recovery . Health 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	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
			infection Prevention measures  COVID19RRGOVERNANCE NOV20v1.pptx	
1.7	Risks are reflected in risk registers and the Board Assurance Framework where appropriate. • Linked NHSIE Key Action 5: Daily data submissions have been signed off by the Chief Executive, the Medical Director or the Chief Nurse and the Board Assurance Framework is reviewed and evidence of reviews is available. • Trust Board has oversight of on going outbreaks and actions plans • Linked NHSIE Key Action 9: Local Systems must assure themselves, with commissioners that a Trust's infection prevention and control interventions are optimal, the Board Assurance Framework 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	• Risk register and governance process • Datix incidents • Board assurance document standing agenda item Trust board and IPCC. • TOR • Outbreak IImarch submissions are copied to Chief Nurse/DIPC and exec Team • Outbreak areas are included in daily tactical meeting • Outbreak areas included in Gold update slides • Outbreak meetings attended by CCG and PHE • Definite Nosocomial COVID 19 case numbers are in included in Quality Performance Report • Nosocomial death review process	• IP risks are agenda item at Infection Prevention and Control committee (IPCC) • Definite Nosocomial COVID 19 case numbers are in included in Quality Performance Report • Nosocomial death review process – paper to Quality and Governance Committee 20th January 2021 • COVID themes report to IPCC	

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

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 4 Progress Report	BRAG
1.	1.1	Up- to- date COVID -19 Divisional pathways	ACN's	30/09/2020	Associate Chief Nurse contacted and request made for COVID -19 pathways 28th July 2020. ED pathways in place and also County to Royal transfer of COVID positive patients. Divisional restoration plans in progress	
2	1.1	Revised pathways to include actions for extremely vulnerable patients who are admitted into the Trust	ACN's	31/10/2020	4th September Chief Nurse DIPC request at senior meeting that extremely vulnerable patients are included in revised pathways. October 2020 Extremely vulnerable patient recommendations included into the COVID ward round guidance document. November 2020 – Confirmation from ED County highly vulnerable patients are admitted into single cubicle. Consultant ED Royal confirms the same process. Children's – highly vulnerable have direct access to ward	
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	13/12/2020 – not achieved. Revised due date to be confirmed.	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 5-7 after admission. Implementation of the new guidance is underway and a manual prompt is provided to the clinical areas. (Days 4 and 6 admission day counted as day 1). Waiting for 2 negative before COVID negative and not suspected patients are moved does not always occur.	
3	1.3	Patient COVID -19 discharge information letter for patient who are discharged but contact of a positive case	IP Team	31/11/2020	Action at COVID weekly meeting was to create an information leaflet for patients and household members on discharge, with information on isolating, symptoms and useful information for informing the local authorities and the test and trace system. 6th November leaflet sent out for comments 22/12/2020 to Clinical Group for approval. Progressed to Outbreak Group and Tactical Group , minor changes made 12th December 2020 Submitted to Gold	
4	1.4	Improving staff FFP3 mask fit staff training data	Health and	31/12/2020 –	Proposed Fit Testing compliance improvement Task and Finish	

		recording and retention of records.	Safety	revised date 31/03/2021	Group. Inaugural meeting took place 29th July 2020. ESR will be up and running for the purpose of recording fit test records as soon as the Trust gives the go ahead to procure Portacount fit test systems, this is a project lead by Health and Safety As at 03/02/2021 People O&D have created FFP3 mask "classes" on ESR. Health and Safety are in the process of collating fit test records which were requested at Exec Health and Safety Groups from Divisional H&S Leads. Business case : Waiting Head of Health and Safety's go-ahead	
5.	1.4	Divisions to retain current mask fit training records and compliance score for their areas whilst central recording and retention of records process is agreed	ACN'S	30/09/2020	Associate Chief Nurse contacted and request made for assurance with staff mask fit compliance. Compliance also added to Divisional papers for infection Prevention and Control Committee (IPCC). Current process that clinical areas hold their own training records and can also enter basic details on OLM. A number of clinical areas have also forwarded training records to the IP Team. IP Team. IP have a list of mask fit testers.	
6.	1.8	Re instate admission proud to care documentation, currently emergency admission document in place	Deputy Director of Quality and Safety	30/09/2020	Original proud to care booklet reinstated now	

7.	1.8	To complete an analysis (Advantages and disadvantages) to reinstating MRSA screening as per UHNM policy	Deputy Director Infection Prevention	31/12/2020 – revised target date 31/03/2021	MRSA screening had reduced temporarily due to the COVID pandemic but UHNM are still following PHE 2014 guidance. This was an agreed temporary change in UHNM practice. Previously the Trust were screening over and above the 2014 guidance. Due to the COVID pandemic less elective work is taking place therefore less elective screening. High risk areas all still screen on admission. Risk based screening is for lower risk areas. Prior to the 2014 guidance the DIPC at the time (supported by the CCGs) did not want to reduce the screening policy the Trust already had in place. The CCG requested screening policy have to be approved by the CCGs. Discussed at IPCC. DIPC requested a pro's and con's exercise re screening changes due to the COVID pandemic. The Trust has not dropped below national guidance. October 2020 MRSA screening is around 50% of pre COVID screening, laboratory does not have the capacity to process COVID work and level of MRSA screens pre COVID. Paper to November IPCC. This continues to be under review during COVID Pandemic.	
6.	1.8	To explore an alternative laboratory for Clostridium difficile ribotying	Kerry Rawlin Laboratory	31/08/2020	Leeds Hospital has agreed to help with ribotyping Clostridium difficile specimens. Await first batch of results to gain assurance that process is working 04/09/2020 we are experiencing problems in receiving ribotyping results back from Leeds. Usually they would arrive electronically. UHNM have contacted Leeds and are awaiting a resolution with their IT team and the PHE reference electronic reporting system. Ribotype now being received from Leeds and added to ICNET patient case	

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

Risk Scoring								
Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2	1	2		Whilst cleaning procedures are in place to ensure the appropriate management of premises further evidence to confirm compliance e.g. c4c audits to be reinstated	Likelihood:	1	End of quarter 4
Consequence:	3	3	3			Consequence:	3	
Risk Level:	6	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 teams with appropriate training are assigned to care for and treat patients in Covid-19 isolation or cohort areas.	• Higher risk areas with own teams • Zoning of hospital in place with cleaning teams • UHNM clinical guidance available on the intranet • Trust COVID -19 clinical group established to discuss and agree clinical pathways • Nice Guidance and National Clinical Guidance COVID-19 available on the Trust intranet • Links to PHE guidance on assessing COVID-19 cases available on Trust intranet page • Education videos clinical and non - clinical videos on Trust intranet • Process and designated staff for ED to ensure cleans are completed timely	• Clinical Group action log • PPE training records which are held locally	

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

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

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
			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). Linked NHSIE Key Action 1: All high touch surfaces and items are decontaminated multiple times every day – once or twice a day is insufficient.	• Cleaning of frequently touch points included in Barrier clean process • Offices and back offices also supplied with disinfectant wipes to keep work stations clean. • Non- invasive medical equipment must be decontaminated after each use. IP Q+A manual	• IP checks • Barrier clean request log • Terminal clean request log • Additional ad-hoc cleaning requests can be requested by clinical teams 24/7 should the environment become contaminated between scheduled / barrier cleans. • Non-clinical areas are cleaned at regular frequencies through the day especially sanitary ware, and if additional cleans are required between scheduled cleaning, these can be requested via the helpdesk.	• To check protocol for none barrier clean areas and also electronic equipment
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	• IP audits held locally by divisions • Datix reports/adverse	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		linen bag displayed in clinical areas and linen waste holds • Red alginate bags available for infected linen in the clinical areas • Infected linen route	incidents	
2.10	Single use items are used where possible and according to single use policy.	• IP question and answers manual • Medical device policy • SOP for Visor decontamination in time of shortage	• IP audits held locally by divisions	
2.11	Reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance.	• 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/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	• IP audits held locally by divisions • Datix reports/adverse incident reports	
2.12	Review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission. Ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to	• HTM hospital ventilation • UHNM has established a Ventilation Safety Group as recommended by the Specialised Ventilation for Healthcare Society in order to provide assurance to the Trust Board on the safe operation and	• Estates have planned programme of maintenance • The Authorising Engineer Ventilation will provide external independent specialist advice and support as well as carrying	

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

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	**KLOE**	**Action Required**	**Lead**	**Due Date**	**Quarter 4 Progress Report**	**BRAG**
1.	2.3	To re instate C4C cleanliness audits and patients survey	Head of CPM Estates, Facilities & PFI Division	30/09/2020	Soft FM cleaning services and Sodexo recovery plan in place which includes the process for reinstating the monitoring process and patient surveys which have commenced 6th July 2020. 04/09/2020 The C4C audits programme are now covering all areas but are not fully multi-disciplinary audit team e.g. only CPM on them due to social distancing. (yet to invite Sodexo, Nurse)We are likely to expand this out during October 2020 December 2020 – email confirmation from Sodexo and retained that C4C audits are in place 01/10/20 – Fully disciplinary team are now invited to C4C audits with strict social distancing in place at all times. Audits remain fluid to allow maximum access during the 3rd wave of Covid.	
2	2.4	To address cleaning issues and environmental damage highlighted during NHSI visit	Head of CPM Estates, Facilities & PFI Division	14/12/2020	Feedback from NHSI provided to Sodexo and action plan devised  Action Plan Following NHS England NHS Im  NHSI action plan Feb 2021.docx	
3	2.4	To address dirty nursing equipment and commodes, plus computer on wheels	ACN'S / IP/ Deputy Head of IM&T	30/12/2020 – revised target date for Computers on Wheels 31/03/2021	Dirty nursing equipment and commodes found during NHSI Visit. These were address at time. Action for IM&T re computer. Terminal clean check list to be revisited to set out roles and responsibilities for cleaning. Full ward terminal clean check list agreed by IP , Sodexo /retained and County. IT have reviewed a number of computers on wheels and confirmed high level of dust. The computer is housed is a box and would require to be unlocked and vacuum, IT have identified that there is a danger that the cables can be disturbed during this process. The two companies used by UHNM Ergotron and Parity do not offer a cleaning service IT have contacted clinical technology to see if they can provide	

					cleaning service For the air intakes that have dust collection this would require a wipe over 18/02/2021 – Feedback from IM&T. They are chasing cost associated with cleaning of COW's	
4	2.8	All high touch surfaces and items are decontaminated multiple times every day – once or twice a day is insufficient. • Electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily. • Cleaning of communal toilets after each use inpatient areas – Letter -CEM/CMO /2020/043 24TH December 2020	Head of CPM Estates, Facilities & PFI Division IP Team	31/03/2021	To revisit high touch points protocol to check frequency of clean for area that area not on barrier cleans – computers , mobile phones, keyboards Cleaning of communal toilets after each use inpatient areas – Letter -CEM/CMO /2020/043 24TH December 2020. This letter was raised at IPCC 25/01/2021. 16th February Meeting with IP & Facilities colleagues to discuss the NHS/NHSE/PHE facilities cleaning requests in line with COVID 19 - Hefma network Responses/Scoping exercise in progress Trust position work in progress Paper to next IPCC	

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

Risk Scoring								
Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3	3		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 4
Consequence:	3	3	3			Consequence:	3	
Risk Level:	9	9	9			Risk Level:	6	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
3.1	Arrangements around antimicrobial stewardship are maintained.	• Regular, planned Antimicrobial stewardship (AMS) ward rounds • Trust antimicrobial guidelines available 24/7 via intranet and mobile device App • Clostridium *difficile* Period of increased incidence and outbreaks are reviewed by member of AMS team and actions generated cascaded to ward teams • Regional and National networking to ensure AMS activities are optimal • AMS CQUIN further mandates key AMS principles to be adhered to • Monthly review of antimicrobial consumption undertaken by AMS team.	• Same day escalation to microbiologist if concerns • 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 with AMS CQUIN targets. • Wards showing deviation from targets are followed up by targeted AMS team ward reviews	• Further controls required due to elements of non - compliance with audits • Gap in control identified as there is no current escalation of areas not complying with antimicrobial guidelines.

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
			generating action plans for ward teams	
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 of the Chief Nurse and the Board Assurance Framework is reviewed and evidence of reviews is available. Linked to NHSIE Key Action 10: Local systems must review system performance and data, offer peer support and take steps to intervene as required.	• Quarterly point prevalence audits maintained by AMS team at UHNM despite many regional Trusts not undertaking any more. • Results from all AMS audits and targeted ward reviews are reported at the Antimicrobial Stewardship Group and minutes seen by IPCC • CQUIN submissions completed in timely manner and generate action plans for AMS and ward teams to follow up concerns each quarter.	• Whilst only a snap-shot audit the Trust value the output from these audits. Work is underway Q1 and Q2 20/21 to review potential change in data collection to optimise impact. • IPCC scrutinise results. Divisions held to account for areas of poor performance. • Trust CQUIN contracts manager holds regular track and update meetings to challenge progress vs AMS CQUINS	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 4 Progress Report	BRAG
1.	3.1	Further controls are required to improve compliance	ACN'S	31/12/2020 - revised target date 31/03/2021	Antimicrobial audits results discussed at IPCC 27th July 2020. Separate meeting with chief nurse/IP and ACN's to be arranged during August to discussed results and any corrective actions. Feedback meeting completed 4th September 2020. – Senior meeting. To review escalation of areas that are not compliant with antimicrobial guidelines. New point prevalence audits undertaken by AMS pharmacists during December 2020 to provide updated snapshot for ACNs. Results will be discussed at March IPCC meeting	
2.	3.1	To review current escalation of areas that are not compliant with antimicrobial guidelines	DIPC	31/10/2020 - revised target date	Raised at September Antimicrobial Pharmacist Group and IPCC. Escalation process to be agreed. Meeting between Antimicrobial Pharmacist and Deputy DIPC undertaken. Escalation process to	

				31/12/2021	be discussed at November Antimicrobial Stewardship Group. January 2021 discussed at Trust Board to be discussed at ASG, then to IPCC Following discussions between DIPC and AMS Pharmacist a draft escalation protocol has been produced and was presented at January ASG as the November meeting cancelled (clinical pressures) the group have 2 weeks to review. Will thereafter to be forwards to IPCC for discussion and ratification at the March IPCC meeting.	

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	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2	2	2		There is a substantial amount of information available to provide to patients this requires continuous update as national guidelines change	Likelihood:	1	End of Quarter 3
Consequence:	3	3	3			Consequence:	3	
Risk Level:	6	6	3			Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
4.1	Implementation of national guidance on visiting patients in a care setting.	• To help protect patients and staff from Covid-19, the NHS suspended all visiting to hospitals. This national suspension has now been lifted and visiting is to be introduced in some areas of our hospitals, subject to certain conditions. From Monday 17 August 2020 visiting will be phased in across some areas and will be allowed in the West Building at Royal Stoke and in Wards 7, 12, 15 at County Hospital. All visiting will have to be pre-booked and relatives will be provided with the correct information and contact details to book in advance. Visitors will be instructed to wear face masks and other PPE if they are providing	• Monitored by clinical areas • PALS complaints/feedback from service users	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		bedside care. We will continue to monitor prevalence and changes in visiting restrictions will be reinstated with immediate effect should it be necessary • The only exceptional circumstances where on visitor , an immediate family member or care 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 partner accompany a women in established labour • 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 • COVID-19 information available on UHNM internet page		
4.2	Areas in which suspected or confirmed Covid-19 patients are being treated are clearly marked with appropriate signage and have restricted access.	• ED colour coded areas are identified by signs • Navigator manned ED entrance • Hospital zoning in place • Isolation signs for doors	• 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	• Transfer policy C24 in place , expires	• Datix process	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	organisation or department when a possible or confirmed Covid-19 patient needs to be moved.	November 2020 • IP COVID step down process in place		

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

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	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	1	1		Whilst arrangements are in place ensure the screening of all patients , there is a small number of patients who appear to have a delay in admission screening	Likelihood:	1	End of quarter Q2
Consequence:	3	3	3			Consequence:	3	
Risk Level:	9	3	3			Risk Level:	3	

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	Staff are aware of agreed template for triage questions to ask Triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible			
5.2	Mask usage is emphasized for suspected individuals. Face masks are available for all patients and they are always advised to wear them 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 Monitoring of Inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so)	• Use of mask for patients included in IP COVID -19 • question and answers manual • All staff and visitors to wear masks from Monday15th June • 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	• Hospital entrances Mask dispensers and hand gel available	• Face mask leaflet produced for patients, awaiting approval • CAN/Matrons to monitor/process to monitor
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	• 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	• 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**
	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.	• 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.		
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	
5.5	Patients with suspected Covid-19 are tested promptly.	• All patients who require overnight stay are screened on admission. All patients that test negative for COVID 19 are retested on day 4 and 6	• Adverse incident monitor /Datix	
5.6	Patients who test negative but display or go on to develop symptoms of Covid-19 are segregated and promptly re-tested and contacts traced.	• Screening protocol discussed at Clinical group which includes re testing • Inpatient contacts are cohorted • COVID 19 positive patients are cared for on blue wards or single rooms or COVID 19 cohort areas on critical care unit	• Datix process • IP reviews	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
5.7	Patients who attend for routine appointments and who display symptoms of Covid-19 are managed appropriately.	• Restoration and Recovery plans • Thermal temperature checks in imaging, plan to extent to other hospital entrances • Patient temperature checks in outpatient department • Mask or face coverings for patients attending appointments from Monday 15th June	• Datix process	

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

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	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3	3		Whilst information and communication/controls are in place to ensure staff are aware of their responsibilities spot audits undertaken have demonstrated some gaps in compliance	Likelihood:	1	End of Q4
Consequence:	3	3	3			Consequence:	3	
Risk Level:	9	9	9			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:				
	Separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas	• To be confirmed	• To be confirmed	
6.1	All staff (clinical and non-clinical) have appropriate training, in line with the latest PHE and other guidance, to ensure their personal safety and working environment is safe.	• 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	• Tactical group action log • Divisional training records • Mandatory training records	
6.2	All staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation, and on how to safely don and doff it.	• PPE and standard precautions part of the infection prevention Questions and Answers manual. • FFP3 train the trainer	• Training records • IP spot checks	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		programme in place • Trust mask fit strategy • SOP and training for reusable FFP3 masks • SOP and training for use of air powered hoods • Critical care - Elipse FFP3 reusable introduced • PPE posters are available in the COVID -19 section of trust intranet page		
6.3	A record of staff training is maintained.	Mask fit strategy in place	• FFP3 training records entered onto OLM and held on L drive for those trained by the infection prevention team • Training records held locally by the Clinical areas	• FFP3 Mask Training records held locally by divisions for training completed by key trainers in the clinical areas • OLM captures that staff member attended IP training session but not the outcome e.g. passed or failed mask fit training
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 (Sundstrum))	• 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	• Tactical group action log • Datix process • Incidents reported by procurement to centre PPE	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		Coordination Centre PPE Supply Cell	supply Cell	
6.6	Adherence to the PHE national guidance on the use of PPE is regularly audited withactions in place to mitigate any identified risk.	• PPE Audits • PPE volume use discussed at tactical COVID-19 Group	• Spot audits completed by IP team	
6.7	Staff regularly undertake hand hygiene and observe standard infection control precautions. Linked NHSIE Key Action 1: Staff consistently practices good hand hygiene.	• Hand hygiene requirements set out in the infection prevention Questions and Answers manual • Poster for hand hygiene technique displayed at hand wash sinks and stickers on hand soap and alcohol dispensers • Alcohol gel availability at the point of care	• Monthly hand hygiene audits completed by the clinical areas • Infection Prevention hand hygiene audit programme. Overview of results fed into infection Prevention committee • Independent hand hygiene audits completed by IP Senior Health Care	
6.8	Hygiene facilities (IP measures) and messaging are available for all • Hand hygiene facilities including instructional posters • Good respiratory hygiene measures • Staff maintain physical distancing of 2 metres 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	• Hand washing technique depicted on soap dispensers • Wearing of mask posters displayed throughout the Trust • Social distance posters displayed throughout the Trust • Communications reminding staff re car sharing • Car sharing question forms part of OB investigation process • Hand hygiene posters display in public toilets	• Hand hygiene audits • Spot checks in the clinical area	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	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 Guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas			
6.8	The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance Guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas	• Paper Towels are available for hand drying in the Clinical areas	• IP audits to check availability	
6.9	Staff understand the requirements for uniform laundering where this is not provided on site.	• Instruction for staff laundering available on the Trust COVID - 19 section of intranet • Dissolvable bags to transport uniforms home available for	• Clinical areas to monitor • Reports of member of public reporting sighting of staff in uniform	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		staff • Communications /daily bulletin to remind staff not to travel to and from work in uniforms		
6.10	All staff understand the symptoms of Covid-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household displays any of the symptoms.	• For any new absences employee should open and close their usual absence via Empactis system • Symptom Advice available on Trust intranet	• Cluster /outbreak investigations	
6.11	All staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE and other national guidance if they or a member of their household display any of the symptoms	• Communication /documents • Reminders on COVID bulletins Trust intranet • Staff Lateral flow testing	• Cluster /outbreak investigations	
6.12	A rapid and continued response through on- going surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patient/individuals)	• ICNET surveillance system • Reports • Trust wide daily COVID Dashboard/report • COVID -19 Tactical daily 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	• Theme report IPCC • RCA review on selected cases	
6.15	Robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of outbreak meetings.	• ICNet surveillance system • Daily COVID reports of cases	• Outbreak investigation • Outbreak minutes	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 4 Progress Report	BRAG
1.	6.3	Improving staff FFP3 mask fit staff training data recording and retention of records	Health and Safety	31/12/2020 - revised target date 31/03/2021	Proposed Fit Testing compliance improvement Task and Finish Group. Inaugural meeting planned for 29th July 2020. ESR will be up and running for the purpose of recording fit test records as soon as the Trust gives the go ahead to procure Portacount fit test system as this is part of the project lead by Health and Safety. December 2020 Health and Safety have agreement to proceed to Business case As at 03/02/2021 People O&D have created FFP3 mask "classes" on ESR. Health and Safety are in the process of collating fit test records which were requested at Exec Health and Safety Groups from Divisional H&S Leads. Business case : Waiting Head of Health and Safety's go-ahead	
2	6.2	Spot audits of PPE on wards and Departments	Quality and Safety Team IP	ongoing	Audits are required on a weekly basis	

7. Provide or secure adequate isolation facilities.

Risk Scoring								
Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2	1	2		Isolation facilities are available and hospital zoning in place. Further work is currently being undertaken during next wave of COVID to identify next blue ward	Likelihood:	1	Quarter 4
Consequence:	3	3	3			Consequence:	3	
Risk Level:	6	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:				
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	• Hospital zoning in place • Recovery and Restoration plans for the Trust – December 2020 – no in 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	• 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	
7.2	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.	• Areas agreed at COVID-19 tactical Group • Restoration and Recovery plans	• Action log and papers submitted to COVID-19 tactical and Clinical Group	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
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 C diff report 2021.docx • Patients received from London to critical care unit – screening policy for resistant organisms in place	• RCA process for Clostridium *difficile* • CDI report for January Quality and Safety Committee and IPCC • Outbreak investigations • MRSA bacteramia investigations • Datix reports	

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

8. Secure adequate access to laboratory support as appropriate.

Risk Scoring								
Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2	2	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 is currently in progress to improve COVID-19 swab screening for clinical staff to improve the risk of false COVID-19 negative results.	Likelihood:	1	End of Q4
Consequence:	3	3	3			Consequence:	3	
Risk Level:	6	6	3			Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
8.1	Testing is undertaken by competent and trained individuals. • Regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	• How to take a COVID screen information available on Trust intranet. This has been updated in November 2020 • Laboratory services for UHNM are located in the purpose built Pathology Laboratory on-site at RSUH. The Laboratory is United Kingdom Accreditation Service (UKAS) accredited. • Turnaround times included in tactical slides	• Review of practice when patient tests positive after initial negative results	• Key trainers for COVID screening technique to reduce risk of false COVID-19 negative results for clinical staff
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 • Screening process in place for elective surgery and some procedures e.g. upper	• Empactis reporting • Team Prevent systems • Datix/adverse incidence reporting • Cluster /outbreak investigation procedures	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
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. 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. d) All patients must be tested 48 hours prior to discharge directly to a care home and must only be discharged when the test result is available. Care home patients testing positive can only be discharged to CQC designated facilities. Care homes must not accept discharged patients unless they have that persons test result	endoscopy • Process in place for staff screening via empactis system and Team Prevent • Patients who test negative are retested after 5 days. • Patient who develop COVID symptoms are tested • Staff screening instigated in outbreak areas • November 2020 - Lateral flow device staff screening to be implemented to allow twice weekly. Staff are asked to submit results via text. Jan 2021 Recent communications on COVID bulletin to remind staff to submit results • Questions and answers available on the COVID 19 page Trust intranet re lateral flow including actions to take for reporting both a negative or positive result • All patient discharged to care setting as screened 48 hours prior to transfer/discharge • Designated care setting in place for positive patients requiring care facilities on discharge – Trentham Park		

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	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 evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control and testing document • That sites with high nosocomial rates should consider testing COVID negative patients daily. • That those being discharged to a care facility within their 14 day isolation period should be discharged to a designated care setting, where they should complete their remaining isolation.			
8.3	Screening for other potential infections takes place.	• Screening policy in place, included in the Infection Prevention Questions and Answers Manual	• MRSA screening compliance • Prompt to Protect audits completed by IP • Spot check for CPE screening	• Blanket screening for MRS A paused due to COVID -19

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 2 Progress Report	BRAG
1.	8.1	Champions COVID-19 swabbing technique in	Deputy Director	on-going	Training package and recording system to be devised. Work to	

		clinical areas	if infection Prevention		commence. 1st September swabbing video recorded, minor changes to be completed week commencing 14th September then video will be circulated to key people for preview and comments. Child positioning included in video Screening video now complete and uploaded on to Trust intranet November 2020. A number of areas have identified swabbing Champions, request sent to ACN's. Implementation of champions in progress.	
2	8.2	NHSIE Key Action - Those who test negative upon admission must have a second test 3 days after admission and a third test 5-7 days post admission	Microbiologist/IP Team	07/12/2020	Following NHSI new guidance Those who test negative for COVID on admission are to be retested on day 4 and day 6, with admission day counted as day one. Implementation of this is underway and prompt is provided to clinical areas	
3	8.2	Those who test negative upon admission must have a second test 3 days after admission and a third test 5 days post admission	Deputy Chief Nurse	07/12/2020	Report received by Deputy Chief Nurse on a daily basis with list of patients that are due for re screen. Clinical areas then contacted and prompt to re screen.	
4.	8.3	To complete an analysis (Advantages and disadvantages) to reinstating pre COVID 19 UHNM screening policy	Deputy Director if infection Prevention	31/12/2020 -revised target date 31/03/2021	MRSA screening had reduced temporarily due to the COVID pandemic but UHNM are still following PHE 2014 guidance. This was an agreed temporary change in UHNM practice. Previously the Trust were screening over and above the 2014 guidance. Due to the COVID pandemic less elective work is taking place therefore less elective screening. High risk areas all still screen on admission. Risk based screening is for lower risk areas. Prior to the 2014 guidance the DIPC at the time (supported by the CCGs) did not want to reduce the screening policy the Trust already had in place. The CCG requested screening policy have to be approved by the CCGs. Discussed at IPCC. DIPC requested a pro's and con's exercise re screening changes due to the COVID pandemic. The Trust has not dropped below national guidance. October MRSA screening is around 50% of pre COVID screening; laboratory does not have the capacity to process COVID work and level of MRSA screens pre COVID. Paper to November IPCC. This continues to be under review during COVID Pandemic.	

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

Risk Scoring								
Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2	1	2		There is a range of information, procedures , pathways available along with mechanism to monitor however, some of these mechanisms were paused and need to be re -instated	Likelihood:	1	Q4
Consequence:	3	3	3			Consequence:	3	
Risk Level:	6	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:				
9.1	Staff are supported in adhering to all IPC policies, including those for other alert organisms.	• IP included in mandatory update • Infection Prevention Questions and Answers manual with ICON on every desk top for ease of use • Infection Prevention triage desk which provides advice and support to clinical areas	• IP audit programme • Audits undertaken by clinical areas • CEF audits • Proud to care booklet audits	• NHSI visit highlighted a number of staff none compliant to wearing of masks , and Doctor non compliant with Bare below the elbow
9.2	Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff.	• Notifications from NHS to Chief nurse/CEO • IP team COVID lead checks Public Health England webpage daily (Monday-Friday) for updates • Changes raised at COVID clinical group which is held twice weekly • Daily tactical group • Incident control room established where changes are reported through • Chief nurse updates	• Clinical Group meeting action log held by emergency planning	

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

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

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 2 Progress Report	BRAG
1.	9.1	CEF Audits to recommence	Deputy Director of Quality and Safety	30/09/2020	Review of tool kit with Chief Nurse planned, aiming to trial during August and reinstate audits fully during September 2020. CEF audits reinstated.	
2.	9.1	Proud to care booklet audits paused. Plan for recommencing	Deputy Director of Quality and Safety	30/9/2020	Original proud to care booklets reinstated	
3.	9.1	Compliance with correct mask wearing and Doctors complaint with Bare Below the Elbow	Deputy DICP/Medical Director/ ACN's	on-going	NHSI Action plan devised	

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

Risk Scoring								
Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2	2	2		There are clear control in place for management of occupational needs of staff through team prevent to date	Likelihood:	1	End of Quarter 4
Consequence:	3	3	3			Consequence:	3	
Risk Level:	6	6	6		Adhere to social distancing gaps in adherence	Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
10.1	Staff in 'at risk' groups are identified and managed appropriately, including ensuring their physical and psychological wellbeing is supported. That risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic and pregnant staff	• All managers carry our risk assessment • Process available on the COVID 19 Trust intranet page • BAME risk assessment • Young persons risk assessment • Pregnant workers risk assessment • Risk assessment to identify vulnerable workers	• Risk assessment and temporary risk mitigation will be reported to the workforce bureau. To protect confidentiality individual risk assessments will not be requested as these should be kept in the employees personal file • Managers required to complete , review and update risk assessments for vulnerable persons	
10.2	Staff required to wear FFP3 reusable respirators undergo training that is compliant with PHE	• Mask fit strategy in place • Mask fit education pack	• Training records for reusable masks	• Availability of locally held training records.

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
national guidance and a record of this training is maintained and held centrally Staff who carryout fit testing training are trained and competent to do so All staff required to wear an FFP respirator have been fit tested for the model being used and this should be 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	• SOP for reusable face masks and respiratory hoods in place • PHE guidance followed for the use of RPE • PPE poster available on the intranet • Training records held locally • Fit testers throughout the Trust • Complete and issue Qualitative Face Fit Test Certificate	• Training records held locally	• Lack of central holding of FFP3 records

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	kept in staff members personal Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board			
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. 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 – Care sharing instructions added to COVID Bulletin	• Social distance monitor walk round introduced Friday 5th June • Social distance department risk assessments • COVID-19 secure declarations	
10.5	Consideration is given to staggering staff breaks	• Social distancing tool kit	• Social distance monitor walk	

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 limit the density of healthcare workers in specific areas.	• Staff encouraged to keep to 2 metre rule during breaks • Purpose build rooms for staff breaks in progress	rounds • Social distance posters identify how many people allowed at one time in each room	
10.6	Staff absence and wellbeing are monitored and staff who are self-isolating are supported and able to access testing.	• Team Prevent available to offer guidance and treatment to staff presenting with onset of symptoms.	• Team prevent monitoring process • Work force bureau	
10.7	Staff who test positive have adequate information and support to aid their recovery and return to work.	• Team Prevent available to offer guidance and treatment to staff presenting with onset of symptoms. • Empactis line will first ask – is the absence related to coronavirus. To which the employee must say yes or no • Once the absence is reported to the employees manger via email, the manager will categorise the absence type specified in the flow chart. • Team prevent complete COVID 19 staff screening • Areas where transmission has occurred are discussed at clinical group and relevant staff screening under an ILOG number is agreed. • Flow charts or staff returning to work available on COVID 19 section of intranet	• Via emapactis • Staff queries' through workforce bureau or team prevent	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 4 Progress Report	BRAG

1.	10.2	Improving Staff FFP3 mask fit recording and retention of records	Health and Safety	31/12/2020 – revised target date 31/03/2021	Proposed fit testing compliance improvement task and finish group Inaugural meeting planned for 29th July 2020. ESR will be up and running for the purpose of recording fit test records as soon as the Trust gives the go ahead to procure Portacount mas k fit systems as this is part of the project lead by Health and Safety case As at 03/02/2021 People O&D have created FFP3 mask "classes" on ESR. Health and Safety are in the process of collating fit test records which were requested at Exec Health and Safety Groups from Divisional H&S Leads. Business case : Waiting Head of Health and Safety's go-ahead	

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

Performance and Finance Chair's Highlight Report to Board

February 2021

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• There had been an expected reduction in cancer performance for January and February although the total size of the Patient Tracking List had remained the same. There had been continued delays associated with the Covid level 4 incident plan across endoscopy, pathology and availability of theatre capacity. • The impact of the annual leave accrual was yet to be determined, and how this would be funded. • In terms of the capital programme, this was £4.6 m behind plan with the main slippage associated with the Linac and IR2 with ongoing discussions as to catching up before the end of March	• To continue to report on performance associated with the new urgent and emergency care standards • In terms of actual financial performance to consider how reporting could be simplified to factor in risks and opportunities • To clarify the bridge for 2021/22 • To discuss the extension of the current UHNM LIMS contract to Shrewsbury and Telford Hospital (SaTH) (eREAF 7444) at the next Trust Board meeting • Savings baked into the budget – system there but not always aware of seeing CIP report and cashable savings
Positive Assurances to Provide	**Decisions Made**
• Vaccine second doses to commence on 25th February, with the aim of completing the round of vaccinations within the next 6 weeks • The number of Covid patients in general beds was slowly reducing and Covid related sickness absence had also reduced • In terms of operational performance, incremental improvements were being seen in urgent care performance and the Medical Division were taking forward a number of projects to improve patient flow and overall performance • It was noted that in order to move away from level 4 this would be determined by bed capacity, available workforce and critical care capacity • In terms of financial performance, the Trust continued with positive performance and delivered a surplus of £1.9 m. In terms of the income and expenditure position, a break-even forecast had been submitted. • An update on the high level financial outlook for 2021/22 was provided, whereby it was noted that additional guidance was required in order to accurately inform the position • In terms of the quarterly procurement update, a number of positive developments were highlighted • An update from the Data Security and Protection Group identified ongoing actions to meet the requirements of the toolkit, including statutory and mandatory training, personal data requests, cyber security and Brexit	• The Committee approved the draft capital programme for 2021/22 • The Committee supported the proposed service agreement to continue with a RWT payroll service agreement from 1st April 2021. • The Committee approved the following EREAFs: Supply Chain Coordination Limited (SCCL) - Trust wide Annual Expenditure (eREAF 7311) Blood Sciences Siemens Managed Service Contract - Year 9 Premium (eREAF 5162) Salary Sacrifice Sodexo Childcare voucher monies (eREAF 3670) Salary Sacrifice Vehicle Leasing (eREAF 7308)
Comments on the Effectiveness of the Meeting	
• The Committee felt that all areas of the agenda were covered well with significant discussion	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Executive Directors Update including Covid-19	Information	11.	Capital Programme 2021/22	Approval
2.	Month 10 Performance Report	Assurance	12.	Royal Wolverhampton NHS Trust Payroll Partnership Agreement	Assurance
3.	Proposed Urgent and Emergency Care Standards	Information	13.	Quarterly Procurement Update Report	Assurance
4.	Month 10 Finance Report	Assurance	14.	Authorisation of New Contract Awards and Contract Extensions	Approval
5.	High Level Financial Outlook 2021/22	Assurance	15.	Executive Data Security & Protection Group Highlight Report	Assurance

3. 2019 / 20 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												
Mrs T Bullock	TB	Chief Executive												
Mr P Bytheway	PB	Chief Operating Officer												
Dr L Griffin	LG	Non-Executive Director												
Mr M Oldham	MO	Chief Finance Officer												
Mrs S Preston	SP	Strategic Director of Finance												
Mrs M Ridout	MR	Director of PMO												
Miss C Rylands	CR	Associate Director of Corporate Governance		NH			NH	NH	NH	NH		NH	NH	
Mr J Tringham	JT	Director of Operational Finance												

Transformation and People Committee Chair's Highlight Report to Board

February 2021

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The Committee recognised that despite the continued assurance provided in terms of actions being taken to support staff, there was some way to go in order to get staff back into good health and wellbeing due to the effects of the pandemic and this was reflected in the increased risk scores provided to the two associated risks on the Board Assurance Framework.	• To focus on the Delivering Exceptional Care Programme at the meeting in March and to invite the Quality Improvement team to the session • To consider the revised Research and Innovation Strategy at a future meeting and to consider the timing of future updates • To consider the scheduling and timing of bringing an update to the Committee of the full staff survey results
Positive Assurances to Provide	**Decisions Made**
• In general, the numbers of Covid patients were slowly reducing and the numbers had reached a point where they were below the peak in the first surge. There had also been a slow reduction in the number of critical care patients. • An update was provided in terms of transformation, whereby the team were continuing to support the EPRR team during the pandemic as well as working on the vaccination hub and working with the Workforce Bureau to assist with staff redeployment • An update was provided from the Research and Innovation Director in terms of the progress made to appoint to the new team, the ongoing review and update of the strategy, and continued working with partners to take forward the research and innovation agenda • In terms of medical appraisals and revalidation, the pandemic had forced some changes in terms of revalidation whereby revalidation had been deferred, allowing appraisals to be missed and lengthening the time the Revalidation Officer could make any recommendations • In terms of workforce development, there had been a positive improvement in the reduction of sickness absence and in particular Covid related absences. There had been a continued focus on staff wellbeing and supporting staff to have the time to pause and reflect after the pandemic. • An improving picture was expected in terms of the vaccination programme and numbers vaccinated although a concern was noted in terms of ensuring the Trust was able to monitor the numbers of staff vaccinated elsewhere • 95% of Covid risk assessments had been completed, and the risk assessment had been updated to reflect population health factors • A presentation was provided to members in terms of the actions being taken in respect of nursing recruitment, which included overseas recruitment, and expanding the skills of those in existing roles • A verbal update was provided in respect of the initial feedback from the staff survey • In terms of gender pay gap reporting, the main challenge related to fewer women being in medical and dental posts and in the upper pay quartile, with a number of actions identified to address the gaps • The Committee requested an update on the provision of a Junior Doctors Forum as highlighted with the Guardian of Safe Working report, and a number of actions were outlined as to how this was being taken forward	• The Committee agreed to highlight to the Audit Committee the issue of not being able to complete a full cycle of business however noting that nothing had slipped which could not be caught up in the next cycle. In addition, to highlight that sub-group reports were not being provided at the present time.

Comments on the Effectiveness of the Meeting

- Members felt the meeting progressed well and in good time, allowing for sufficient time for discussion
- The Chair reflected that there had been a period whereby reports had been allowed to go outside of the standard approach given the pandemic, therefore going forwards this needed to improve and adhere to the usual standards.
- The Committee welcomed the various updates on activities and progress of workforce and transformation and welcomed the positive progress on nursing recruitment

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Executive Directors Update including Covid-19	Information	7.	Nursing Recruitment Vacancy Progress	Assurance
2.	Q3 Transformation Programme Update	Assurance	8.	Staff Survey Verbal Update	Information
3.	Delivering Exceptional Care Highlight Report	Assurance	9.	Gender Pay Gap Report	Information
4.	R&I Strategy Refresh Update	Assurance	10.	Guardian of Safe Working Report Q3	Assurance
5.	Revalidation Update	Assurance	11.	National Student Survey & Action Plan	Assurance
6.	M10 Workforce Report	Assurance	12.		

3. 2019 / 20 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												
Mr P Bytheway	PB	Chief Operating Officer												
Dr L Griffin	LG	Non-Executive Director												
Mr M Oldham	MO	Chief Finance Officer												
Prof P Owen	PO	Non-Executive Director												
Mrs M Rhodes	MR	Chief Nurse			HI									
Miss C Rylands	CR	Associate Director of Corporate Governance	NH					NH	NH				NH	
Mrs R Vaughan	RV	Director of Human Resources												

INFORMAL MEETING

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	10th March 2021
Report Title:	Gender Pay Gap Report	**Agenda Item:**	11
Author:	Assistant Director of HR/Head of HR Governance and Workforce Information Workforce Equality Manager		
Executive Lead:	Director of Human Resources		

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

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

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

Situation

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

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

Background

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

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

Assessment

This 2020 Gender Pay Gap shows a mixed position, with a deterioration in the median pay gap but improvement in the median bonus pay gap (the difference between the mid points in the ranges of hourly earnings of men and women), however the mean gender pay gap is static and the mean bonus gap has increased (the difference between the average hourly earnings of women compared to men).

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

Key Recommendations:

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

University Hospitals of North Midlands NHS Trust

Gender Pay Gap Report

Employers with more than 250 employees must calculate figures comparing men and women's average pay across the organisation. This is known as the gender pay gap and is calculated as the percentage difference between average hourly earnings for men and women.

Equal pay and gender pay

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

UHNM's pay approach supports the fair treatment and reward of all staff irrespective of gender. This is in line with our equality and diversity statement that was launched in May 2016. Remuneration to all staff, regardless of gender, is made in accordance with National Terms and Conditions.

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

Our Gender Pay Gap Data

The data is a snapshot of pay taken on 31st March 2020:

Based on Hourly Pay	At 31st March 2018	At 31st March 2019	At 31st March 2020	What this means
Median Pay Gap				
The median gender pay gap shows the difference in the midpoints of the ranges of hourly rates of pay for men and women. The individual hourly rates of pay are ordered from lowest to highest and the middle value is compared	10.3%	8.8%	12.6%	There has been a small decrease in the percentage of women, and a small increase in the percentage of men in the upper pay quartiles while at the same time there has also been a small increase in the percentage of women, and decrease in the percentage of men in the lower pay quartiles which has resulted in the median pay gap increasing.
Average (Mean) Pay Gap				
The mean gender pay gap is the difference in the average hourly rates of pay that male and female employees receive. The hourly rates of all male or female full-pay are added, and then divided by the number of male or female employees. The gap is calculated by subtracting the results for females from results for males and dividing by the mean hourly rate for males. This number is multiplied by 100 to give a percentage.	28.1%	27.6%	27.7%	

	We are confident that our gender pay gap is a result of the workforce distribution, rather than an equal pay issue. This is because we adhere to the Agenda for Change system, national terms and conditions of service (TCS) for Medical staff and, for very senior managers (VSMs), there is a specific VSM pay framework. The Trust also has a robust job evaluation process in place.

Bonus Pay Gap	At 31st March 2018	At 31st March 2019	At 31st March 2020	What this means
Median Bonus Pay Gap				
The median gender bonus gap is calculated by arranging the bonus payments of all male or female employees from highest to lowest and find the point that is in the middle of the range	1.2%	29.2%	20.5%	The number of consultants (both male and female), in receipt of a Clinical Excellence Awards has reduced, however it is positive that the median pay gap has decreased. With only a very small proportion of employees receiving clinical excellence awards any fluctuation in the profile can impact on the pay gap.
Average (Mean) Bonus Pay Gap				
The mean gender bonus gap is the difference in the average bonus payment that male and female employees receive. Bonus payments (*see below) for all male or female employees are added, then divided by the number of male or female employees. The gap is calculated by subtracting the results for females from results for men and dividing by the mean hourly rate for men. This number is multiplied by 100 to give a percentage	1.5%	11.0%	19.1%	

	*Bonus payments relates only to Clinical Excellence Award (CEA) payments made to eligible Medical Consultant Staff. Clinical Excellence Awards recognise and reward NHS consultant medical staff who perform 'over and above' the standard expected of their role and who can demonstrate achievements in developing and delivering high quality care, and commitment to the continuous improvement of the NHS. There are two award types - Local and National. Both have eligibility criteria which means that not all consultants can apply (the criteria is explained in our Clinical Excellence Award Policy HR47). The local scheme changed in 2018 to a 3 year non pensionable award programme, each year the total number of applicants has decreased year on year. Due to the current pandemic the scheme has changed to an automatic allocation of the award which is to be paid to all eligible consultants in March 2021, as a result this is likely to see no change to the pay gap associated to this group.

The proportion of male and female workforce in each pay quartile was as follows at 31st March 2020:

	Female	Male
% of employees in the lower pay quartile	81.5%	18.5%
% of employees in the lower middle pay quartile	80.6%	19.4%
% of employees in the upper middle pay quartile	83.4%	16.6%
% of employees in the upper pay quartile	65.2%	34.8%
Number of employees receiving bonus pay (i.e. a Clinical Excellence Award)	44 (0.48% of all female employees)	176 (6.48% of all male employees)

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

Supporting Gender Equality at UHNM:

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

Progress from our previous Gender Pay Gap Report:

- Our Flexible Working Policy was reviewed in October 2020 to further enhance the family friendly workplace offering available, with the policy now including the right to request flexible working from the first day and flexible working as a reasonable adjustment to support employees with disabilities. Managers receive training on applying the policy in our Gateway to Management programme.
- The Trust ran a high profile awareness campaign on menopause and the workplace 'Let's Talk About Menopause' which promoted the support and adjustments available for workers experiencing menopausal symptoms when at work
- During 2020 the Staffordshire High Potential Scheme was launched. The HPS is a fully funded 24-month career development scheme to help high potential, aspiring middle level clinical or non-clinical NHS leaders accelerate their career to senior executive roles at a faster pace. There has been particular emphasis on encouraging applications from protected groups including females and it is extremely positive that 50% of UHNM representatives on the scheme are women
- Revised the nomination process for our Connects Leadership Development programmes to a self-nomination system designed to increase diversity of applications

- Launched an Agile working review across the organisation
- Participated in a Staffordshire Integrated Care System Winter Inclusion School event 'Women Through the Leadership Lens' held on 25th January 2021 with the keynote speaker being UHNM Chief Executive Tracy Bullock

Proposed Actions to reduce the Gender Pay Gap:

We will build upon the flexible working changes that are emerging though Covid-19 and respond to the NHS People Plan aspirations of making flexible working a reality for our workforce, and also to the recommendations from Mend the Gap: The Independent Review into the Gender Pay Gap in Medicine by progressing the following actions:

Action / Recommendation	Timescale
1. Promoting flexible working, with jobs advertised as flexible unless there is a strong justification not to, helping to improve work–life balance	Q1 2021/22
2. Introduce an Agile Working Policy	Q1 2021/22
3. Review our annual PDR process so that it includes wellbeing conversations about flexible working	Q3 2021/22
4. Continue to make effective use of e-rostering systems	Ongoing
5. Focus on raising awareness of and improving flexible working in the medical profession – supporting doctors in training that are working flexibly and attracting and retaining doctors wishing to work less than full time. Action to include undertaking a survey of doctors in training views of flexible working opportunities in the organisation	Q1 2021/22
6. Support our staff with caring responsibilities through the introduction of a Carer's Passport	Q4 2021/22
7. Continue to actively promote our personal and leadership development to all and ensure that applications are reflective of the diversity of our workforce	Ongoing

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

Appendix 1

Notes and Explanations

1 Explaining the Gender Pay gap:

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

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

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

An example of how a Gender Pay Gap can come about

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

2 Explaining the Data

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

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

It is important to note that the gender pay gap may vary by occupation, age group and even working patterns.

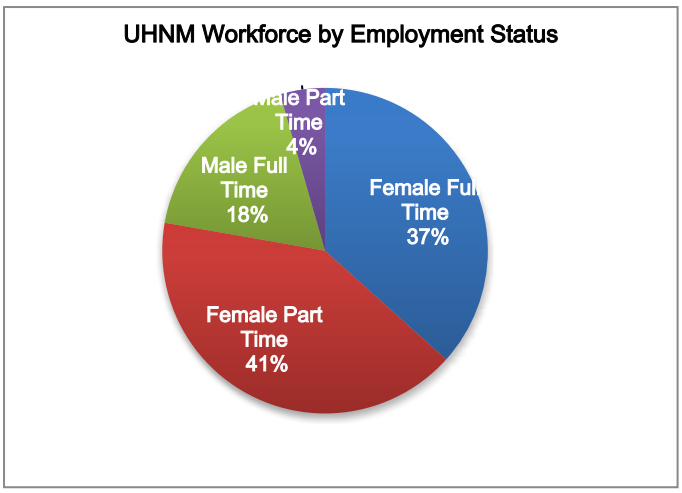
Note: The Trust does use agency workers who are not included in the data because they are part of the headcount of the agency company that provides them

3 How our workforce was made up (as at 31st March 2020)

UHNM is typical of any NHS Trust in that it has a higher number of females than males in its workforce. From a total headcount of 10,939 78% were female compared to 22% men.

Staff Group	Female	Male
Add Prof Scientific and Technic	77%	23%
Additional Clinical Services	85%	15%
Administrative and Clerical	82%	18%
Allied Health Professionals	79%	21%
Estates and Ancillary	52%	48%
Healthcare Scientists	63%	37%
Medical and Dental	37%	63%
Nursing and Midwifery Registered	92%	8%
Grand Total	**78%**	**22%**

Agenda for Change Pay Band	Female	Male
Apprenticeship	79%	21%
Band 1	91%	9%
Band 2	81%	19%
Band 3	85%	15%
Band 4	82%	18%
Band 5	87%	13%
Band 6	86%	14%
Band 7	81%	19%
Band 8a	77%	23%
Band 8b	66%	34%
Band 8c	63%	38%
Band 8d	47%	53%



UHNM Gender Pay Gap Summary

		Year 4 2020	Year 3 2019	Year 2 2018	Year 1 2017
Mean Gender Pay Gap		27.7%	27.6%	28.1%	2.1%
Median Gender Pay Gap		12.6%	8.8%	10.3%	10.1%
Mean Gender Bonus Gap		19%	11%	1.5%	4.4%
Median Gender Bonus Gap		20.5%	29.2%	1.2%	0%
Proportion of males and females receiving a bonus payment	Women	0.5%	0.6%	0.5%	0.5%
	Men	6.5%	6.7%	6.7%	6.4%
% of employees in the upper pay quartile	Women	65.2%	65.8%	66.4%	65.9%
	Men	34.8%	34.2%	33.6%	34.1%
% of employees in the upper middle pay quartile	Women	83.4%	84.2%	84.2%	84.4%
	Men	16.6%	15.8%	15.8%	15.6%
% of employees in the lower middle pay quartile	Women	80.6%	80%	80.2%	80.9%
	Men	19.4%	20%	19.8%	19.1%
% of employees in the lower pay quartile	Women	81.5%	81%	80.9%	79.3%
	Men	18.5%	19%	19.1%	20.7%

How do we compare with other similar organisations?

We can compare our gender pay performance against our Model Hospital recommended peers using the gender pay gap data from the last report (31st March 2019 snapshot), which is available from the Government Gender Pay Gap Service website.

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

Trust	Median Pay Gap	Mean Pay Gap	Median Bonus Pay Gap	Mean Bonus Pay Gap	% of Women & Men in receipt of a bonus	% of Women in the highest paid roles
UHNM	**8.8%**	**27.6%**	**29.2%**	**11.0%**	**0.6% Women** **6.7% Men**	**65.8%**
Derby Teaching Hospitals NHS Foundation Trust	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported
Gateshead Health NHS Foundation Trust	16.3%	29.8%	53.9%	44.5%	0.9% Women 7.7% Men	70.5%
Nottingham University Hospitals NHS Trust	8.8%	24.6%	33.3%	38.7%	0.9% Women 5.9% Men	78.8%
Royal Wolverhampton NHS Trust	16.5%	29%	12.9%	19.5%	0.6% Women 5.4% Men	64.2%
Sheffield Teaching Hospitals NHS Foundation Trust	10.4%	21.7%	92.5%	76.5%	3.9% Women 9.5% Men	64.1%
University Hospitals Southampton NHS Foundation Trust	10.6%	26.6%	34.6%	34.4%	1.5% Women 8.5% Men	62.6%
University Hospitals Birmingham NHS Foundation Trust	12.5%	28.3%	66.7%	47.9%	0.9% Women 6.9% Men	57.6%
University Hospitals Coventry and Warwickshire NHS Trust	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	10th March 2021
Report Title:	Integrated Performance Report, month 10 2020/21	**Agenda Item:**	12.
Author:	Performance Team		
Executive Lead:	Helen Ashley: Director of Strategy and Transformation /Deputy Chief Executive		

Purpose of Report:

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

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

Executive Summary:

Situation

The 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

The Trust continued to experience significant operational pressures in January-21. Critical care managed a high number of Covid-19 positive patients alongside side those that needed elective procedures. From Thursday 7th January 21 the Trusts incident level was raised to Level 4 for the whole of the organisation. Critical care was treating more covid positive patients than ever with 210% occupancy at the peak. The wards had more Covid-19 patients than anytime previously and critical care unit also treated more patients than ever before with colleagues in the Paediatric Intensive Care Unit stepping in to provide adult care

All Trusts received instructions to increase capacity to support the health care systems in London and the South East and in response the Trust doubled the intensive care capacity and at one point the ITU was caring for 8 patients that were out of the area.

The wards continued to have more covid positive patients than anytime previously and the number peaked at 349 and has plateaued at this high level, averaging 37 new patients/ day. The number of patients who were discharged reached 2,925. Added to this the number of bed restrictions/ closures continued, the

MEAN number of closures across the month was 41.

Quality & Safety:

The Trust achieved following standards in January 2021:

- Harm Free Care 95.7% continues to be above the national 95% target
- Trust rolling 12 month HSMR and SHMI continue to be below and within expected ranges respectively
- 100% of patients/family informed verbally of incidents that are reported as meeting duty of candour threshold
- VTE Risk Assessment continues to exceed 95% target with 99.4% (via Safety Express audit)
- Zero avoidable MRSA Bacteraemia cases reported
- There has been zero Category 2, 3 and 4 pressure ulcers due to lapses in care in January but, it should be noted, there are pressure ulcers awaiting investigation and so this data may change.
- Sepsis Screening Compliance in Emergency Portals decreased to 91% but remains above the target 90%
- Children's sepsis Screening Compliance 100.0%
- Inpatients IVAB within 1 hour achieved 100% for audited patients
- Zero Never Events

The Trust did not achieve the set standards for:

- Patient Falls rate per 1000 bed days higher than target in January 2021 at 7.3 falls per 1000 bed days
- Inpatient Sepsis Screening compliance (adult Inpatients) decreased to 87.2% and below the target of 90%
- C Diff target above trajectory target of 8 during January 2021 with 10 cases reported. YTD figures are 95 against trajectory of 78
- Emergency Portals IVAB in 1 hour improved to 77% but still below the 90% target
- Maternity Sepsis Screening remains below target, although Sepsis Screening did improve to 50% and continuing action plan in place

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

- The rate of complaints per 10,000 spells has increased to 28.2 but is below (positive) the target of 35 but is within normal variation.
- Total number of Patient Safety Incidents decreased along with the rate per 1000 bed days but are higher than January 2020 total and rate
- Patient Safety Incidents with moderate harm or above and rate of incidents with moderate harm or above per 1000 bed days has remained low and around the long term average. National comparison taken from latest CQC Insight Report is that 26.1% of reported patient safety incidents to NRLS resulted in harm. UHNM latest results are 22.8%. UHNM is lower that national average (September 2019 – August 2020)
- Rate of falls reported that have resulted in harm to patients has decreased during January 2021 compared to previous month. The rate of patient falls with harm continues to be within the control limits and normal variation
- The number and rate of pressure ulcers that have developed under our care continue to show a decreasing trend and is currently below the organisational mean.
- Medication related incidents rate per 1000 bed days has remained relatively stable. Current national NRLS published mean rate in 6 (April 2019 –March 2020)
- Nosocomial COVID Infections have reported decrease during January 2021 with 68 compared to December 2020 with 79 reported cases and 88 in November 2020
- Definite Nosocomial COVID-19 deaths decreased to 25 and total of 107 since March 2020

Operational Performance:

The impact on operational performance continued. The Trust system wide 4hour performance achieved 69%, (December 68.2%) and for UHNM Type 1 this was 55.5% (December 55%). In January 21 the number of 12 hour trolley waits reduced to 33 (64 in December) there have been zero breaches since 12th January. There was however some improvements noted across some of the quality metrics with Urgent

Care.

The trust is predicted to underperform in January-21 on all Cancer standards. Covid impact, choice, capacity and workforce attrition are the main factors affecting treatment ratios. The 104+ day backlog remains at 51 for January-21 and the 62 day backlog continues to rise and at the end of January was 324 (December 296).

2WW referrals in December were exponentially high when compared to the same period last year and as a consequence more patients were appointed/ seen in January-21. Increased demand is being matched by extra activity put on by specialties where necessary. Despite the increase in 2ww referrals and internal capacity challenges, the 2ww PTL has been managed down to circa 2800 patients, the same volume as in June 2020, when referrals were at their lowest due to the pandemic.

Discussions with the IS are continuing for March lists - to optimise theatre capacity available. Managed through the assurance framework. Directorates are currently reviewing the surgical wait list to identify patients suitable for March lists.

The National ask for January-21 was for total Outpatients to be at 100% of last year's business as usual and for Inpatients 90%. The trajectories for January were set 89.9% (Outpatients) and 88.1% (Inpatients) of BAU for last year. The actuals for January, against BAU, was outpatients 88.4% and inpatients 66.6%. This demonstrates the efforts to maintain outpatient capacity even if the inpatient work has fallen due to the requirement for workforce staffing to support the 200% critical care mutual aid support to London.

RTT performance for January 21: the total number of Referral To Treatment pathways grew to 50,735(December 49,054). This is above the forecast 46,100. The Trust has 3,538 over 52 week breaches (December 2,773) as a consequence of standing down elective work. This was over the forecasted position. Recovery plans for recovery of the long waiting patients are being reviewed. RTT performance in January is 65.20% (December 65.73%).

January saw a fall in performance (DM01), mainly due to the rise of > 6 week patients in Imaging. The performance for January is 87.57% (December 91.2%). The waiting list size has reduced to 11, 594 (December 11,668) The Diagnostic cell will re-start in February to oversee recovery.

The strategic focus of our People Plan remains on supporting recruitment, workforce deployment, staff wellbeing, absence management and staff testing. The focus of the Workforce Bureau remains on risk assessments, staff wellbeing, staff testing, staff deployment and supporting the vaccination programme.
The daily sickness sitrep highlights wards and areas with high numbers of staff calling in as absent, which then triggers mitigating actions set out in business continuity plans. Redeployment processes are place to support areas of need and volunteer placements, including Military personnel and volunteers from local councils, are offering support. A system-led workforce demand and supply process is in place to manage redeployment of staff where required.

Workforce:

The strategic focus of our People Plan remains on supporting recruitment, workforce deployment, staff wellbeing, absence management and staff testing.
The focus of the Workforce Bureau remains on risk assessments, staff wellbeing, staff testing, staff deployment and supporting the vaccination programme:

- From 9th December 2020, all staff and those working in the Trust were offered the vaccination. Additionally, the Trust offered the vaccination to partner organisations as well as other health and social care workers, some local authority workers and patients. The focus in the coming weeks will be on further promoting the vaccine for our BAME employees. UHNM was stood down as a hospital hub with effect from 31st January 2021 when the vaccination programme moved to the 34 community hubs. Staff are still able to access the vaccination at one of these community vaccination centres. Plans are in place to commence roll out the second dose of the vaccination from 25th February. Around 76% of UHNM employees have received a first does of the vaccine
- Between 31st March 2020 and 12th February 2021 we have carried out 8,579 PCR tests, excluding staff

outbreak screening.

- As at 12th February, 95.07% of all permanent and fixed term staff have completed a covid-related risk assessment
- As of 12th February 2021, covid-related open absences numbered 303, which was 39% of all absences (48.94% at 4th January 2021)

The key performance issues remain compliance with the sickness rate being above target and with PDR requirements although an Executive decision was taken to suspend PDR's unless there is capacity to continue to undertake them.

Sickness
The in-month sickness rate was 5.71% (6.19% reported at 31/12/20). The 12 month cumulative rate increased to 5.42% (5.34% at 31/12/20).Over the course of the next few months, the wellbeing plan is being developed to support and signpost staff to a range of wellbeing offers depending on staff needs at this time, including psychological support

Appraisals
The Non-Medical PDR compliance rate was 74.65% (76.26% at 31st December 2020)

Statutory and Mandatory Training
The Statutory and Mandatory training rate at 31st January 2021 was 93.41% (93.93% at 31st December 2020). At 31st January 2021, 89.17% of staff had completed all 6 Core for All modules (89.86% at 31/12/20)

For Finance, the key messages are:

- The Trust has received confirmation that it will receive £12.4m additional funding for M7-12 relating to the TSA agreement, NHSI have only factored £7.4m of this into the plan which remains at £7.2m deficit however the remaining £5m is factored into the forecast of £2.2m.
- The Trust has delivered a surplus of £1.9m in Month 10 against a planned deficit of £1.3m which is driven by additional DHSC funding relating to the TSA agreement, additional NHSE income in respect of mechanical thrombectomy and continued slippage against the original COVID-19 allocation and winter plan.
- Activity delivered in Month 10 is significantly lower than plan although NHS income levels from patient activities have been maintained due to the temporary funding arrangements. The Trust estimates the impact of the Elective Incentive Scheme (EIS) to be a £0.9m reduction to income in Month 10 which is not reflected in the financial position in line with guidance from NHSI/E.
- The Pathology Network went live on 1 December with the financial impact included in the financial position and whilst there is a negligible impact on the bottom line, this is causing variances between the reporting categories (i.e. other income, pay and non-pay)
- The Trust incurred £2.4m of costs relating to COVID-19 which is a substantial increase on month 9 (£1.6m) due to expanding NHS workforce/additional shifts and testing as a result of the second wave. This remains within funded run rate with £1.9m in allocation and 0.5m chargeable outside the notified envelope.
- Capital expenditure for the year to date stands at £41.7m which is £4.6m behind plan with the main driver being slippage on the PDC funded RI site demolition and phasing of Linac and IR2 bi-plane.
- The month end cash balance is £90.2m which is £9.3m more than plan.

Key Recommendations:

To note performance.

NHS
University Hospitals of North Midlands
NHS Trust

Integrated Performance Report

Month 10 2020/21

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Contents

A note on **SPC**

University Hospitals of North Midlands NHS Trust

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

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

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

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

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

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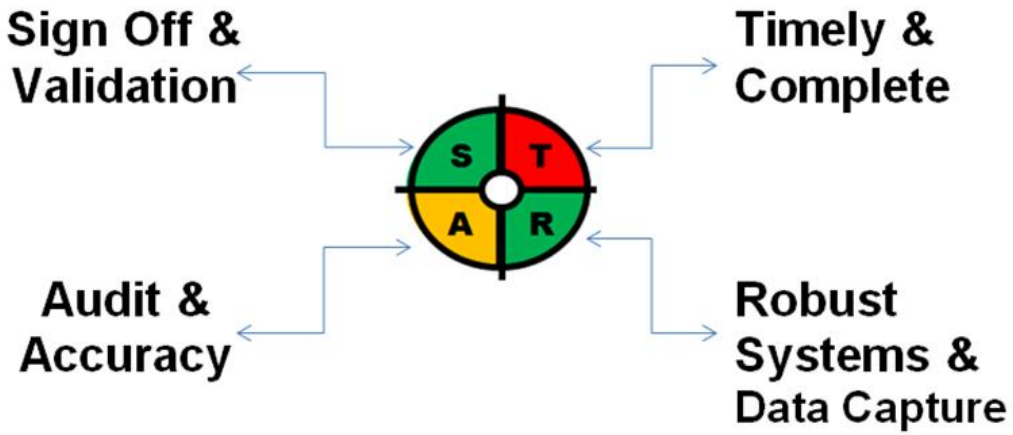
A note on **Data Quality**

University Hospitals of North Midlands NHS Trust

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



Explaining each domain

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

RAG rating key

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

Quality

Caring and Safety

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

Quality Spotlight Report

NHS University Hospitals of North Midlands NHS Trust

Key messages

The Trust achieved following standards in January 2021:

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Quality Dashboard

NHS University Hospitals of North Midlands NHS Trust

Metric	Target	Latest	Variation	Assurance
Patient Safety Incidents	N/A	1524		
Patient Safety Incidents per 1000 bed days	N/A	43.37		
Patient Safety Incidents per 1000 bed days with no harm	N/A	29.96		
Patient Safety Incidents per 1000 bed days with low harm	N/A	11.04		
Patient Safety Incidents per 1000 bed days reported as Near Miss	N/A	1.59		
Patient Safety Incidents with moderate harm +	N/A	25		
Patient Safety Incidents with moderate harm + per 1000 bed days	N/A	0.71		
Harm Free Care (New Harms)	95%	96%		
Patient Falls per 1000 bed days	5.6	7.3		
Patient Falls with harm per 1000 bed days	1.5	1.5		
Medication Incidents per 1000 bed days	N/A	4		
Medication Incidents % with moderate harm or above	TBC	1.9%		
Patient Medication Incidents per 1000 bed days	N/A	3.0		
Patient Medication Incidents % with moderate harm or above	TBC	2.9%		

Metric	Target	Latest	Variation	Assurance
Serious Incidents reported per month	N/A	14		
Serious Incidents Rate per 1000 bed days	N/A	0.40		
Never Events reported per month	0	0		
Duty of Candour - Verbal/Formal Notification	100%	100%		
Duty of Candour - Written	100%	73%		
All Pressure ulcers developed under UHNM Care	TBC	59		
All Pressure ulcers developed under UHNM Care per 1000 bed days	N/A	1.68		
All Pressure ulcers developed under UHNM Care lapses in care	12	0		
All Pressure ulcers developed under UHNM Care lapses in care per 1000 bed days	0.5	0.00		
Category 2 Pressure Ulcers with lapses in Care	8	0		
Category 3 Pressure Ulcers with lapse in care	4	0		
Category 4 Pressure Ulcers with lapses in care	0	0		
Unstageable Pressure Ulcers with lapses in care	0	0		

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Quality Dashboard

NHS University Hospitals of North Midlands NHS Trust

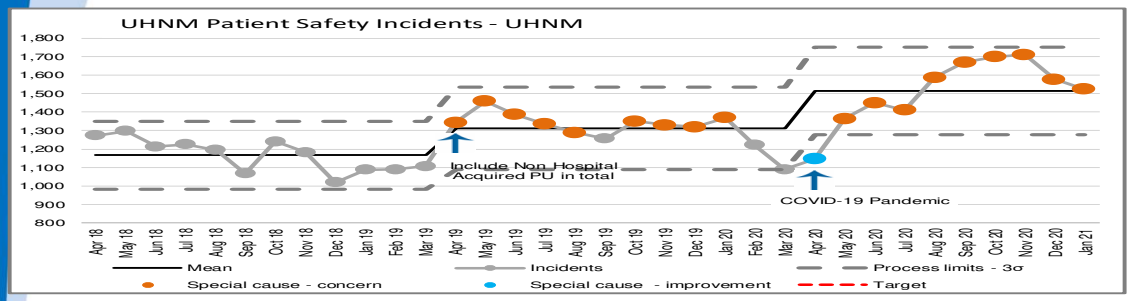
Metric	Target	Latest	Variation	Assurance
Friends & Family Test - A&E	N/A	N/A		
Friends & Family Test - Inpatient	N/A	98.0%		
Friends & Family Test - Maternity	N/A	N/A		
Written Complaints per 10,000 spells	35	28.19		
Rolling 12 Month HSMR (3 month time lag)	100	94.64		
Rolling 12 Month SHMI (4 month time lag)	100	102.91		
Nosocomial "Definite" COVID-19 Deaths	N/A	25		
VTE Risk Assessment Compliance	95%	99.4%		
Emergency C Section rate % of total births	15%	18.6%		
Reported C Diff Cases per month	8	10		
Avoidable MRSA Bacteraemia Cases per month	0	0		
HAI E. Coli Bacteraemia Cases per month	N/A	5		
Nosocomial "Definite" HAI COVID Cases - UHNM	0	68		

Metric	Target	Latest	Variation	Assurance
Inpatient Sepsis Screening Compliance (Contracted)	90%	87.2%		
Inpatient IVAB within 1hr (Contracted)	90%	100.0%		
Children Sepsis Screening Compliance (All)	90%	100.0%		
Children IVAB within 1hr (All)	90%	N/A		
Emergency Portals Sepsis Screening Compliance (Cor	90%	91.2%		
Emergency Portals IVAB within 1 hr (Contracted)	90%	77.3%		
Maternity Sepsis Screening (All)	90%	50.0%		
Maternity IVAB within 1 hr (All)	90%	N/A		

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Reported Patient Safety Incidents

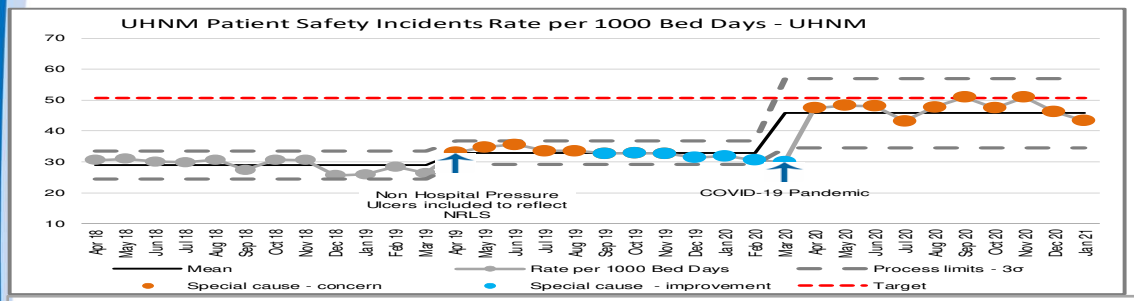


Variation	Assurance
	

Target	Nov 20	Dec 20	Jan 21
N/A	1711	1578	1524

Background

Total Reported patient safety incidents



Variation	Assurance
	

NRLS Mean	Nov 20	Dec 20	Jan 21
50.70	50.97	46.22	43.37

What is the data telling us:

The above data relates to **all** reported Patient Safety Incidents (PSIs) across the Trust. January 2021 has seen a decrease in total number of reported PSIs and is within variation limits. The reporting of incidents and near misses should continue to be encouraged and promoted.

The largest categories for reported patient safety incidents excluding Non Hospital acquired Pressure Ulcers are:

- Patient related Slip/Trip/Fall - 257 (243),
- Clinical assessment (Including diagnosis, images and lab tests) – 93 (60)
- Patient flow incl. access, discharge & transfer - 69 (82)
- Documentation – 36 (51)
- Treatment/Procedure - 64 (64)
- Medication incidents - 106 (99)
- Infection Prevention - 52

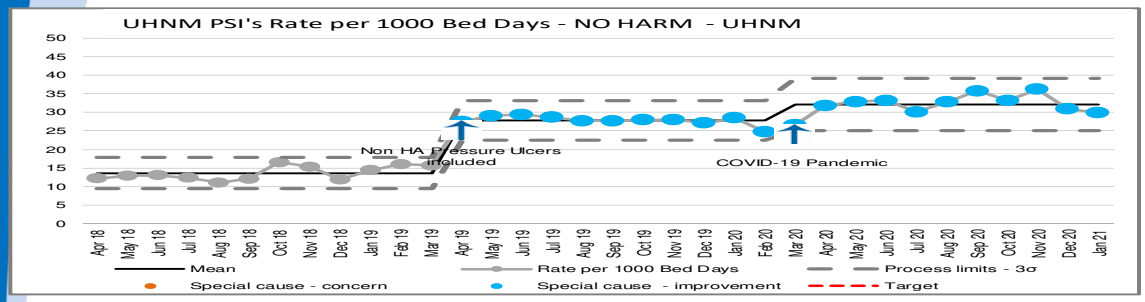
There have been decreases in Patient Flow and Documentation incidents compared to December 2020 totals (in brackets). However, there have been increased incidents in relation to Falls, Clinical assessment and Medication incidents whilst there has been no change in Treatment/Procedure incidents reported. Patient Safety Incidents are reviewed and analysis undertaken on locations and themes.

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

The rate of reported patient safety incidents per 1000 bed days has decreased compared to December 2020 and is lower than previous 5 months and below the mean rate during the COVID-19 pandemic. The current published NRLS Acute (non specialist) data has mean rate is 50.7 (October 2019 – March 2020). UHNM have seen increases recently which brings Trust rate to similar level as national mean rate taken from NRLS.

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

University Hospitals of North Midlands NHS Trust

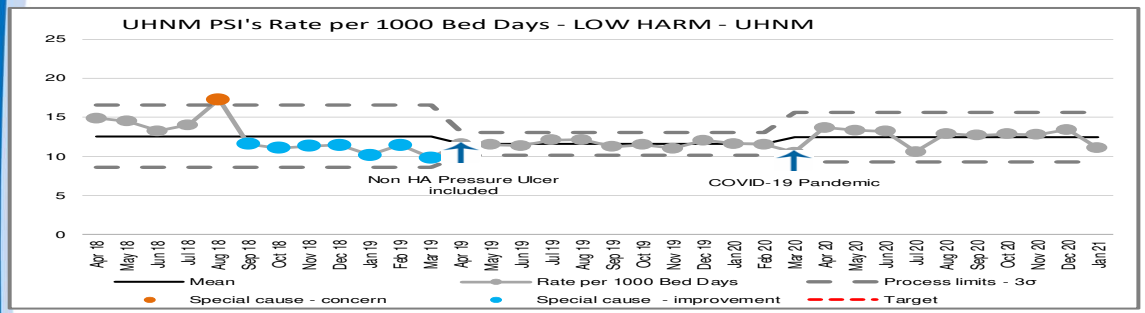


Variation	Assurance

Target	Nov 20	Dec 20	Jan 21
N/A	36.22	30.84	29.97

Background

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

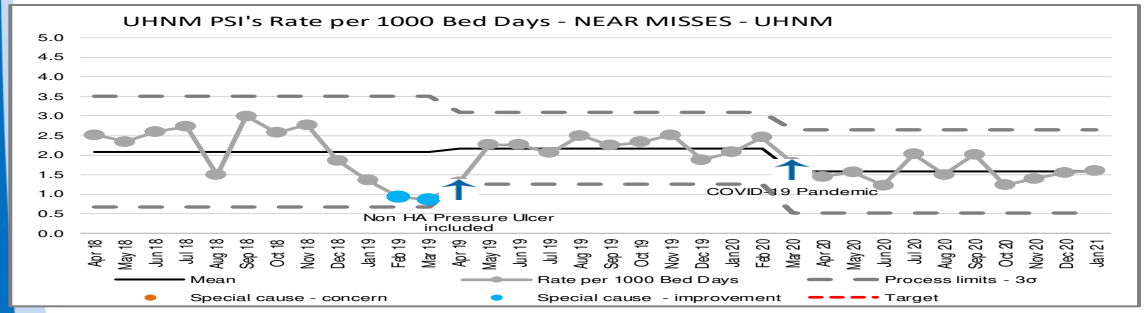


Variation	Assurance

Target	Nov 20	Dec 20	Jan 21
N/A	12.78	13.42	11.04

Background

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



Variation	Assurance

Target	Nov 20	Dec 20	Jan 21
N/A	1.40	1.55	1.59

Background

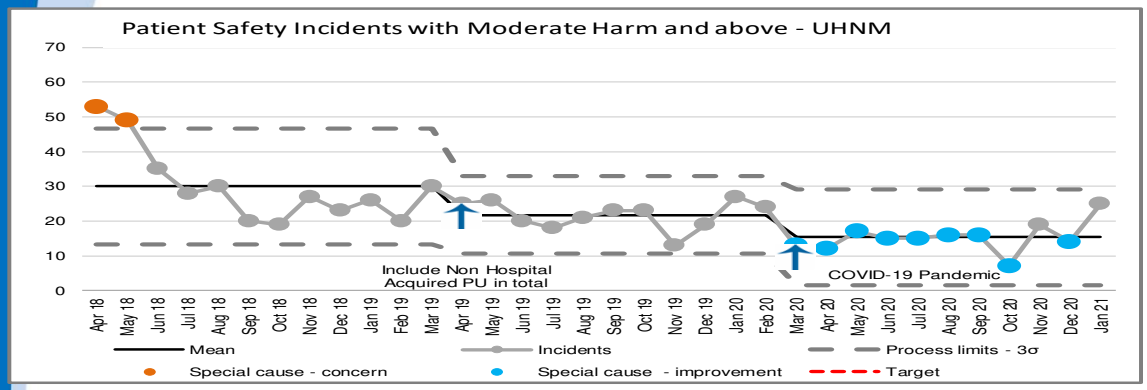
The rate of Patient safety Incidents per 1000 bed days that are reported as NEAR MISS

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. The rate of incidents reported resulting in no harm is continuing the trend to increase and should be encouraged as reporting these incidents allows for actions and learning to be identified via potential trends of incidents.

Low harm rate has similar profile and is higher than pre pandemic although returned to long term organisational mean. Near misses rates had increased during earlier months of pandemic and have seen return to similar rates pre COVID.

Reported Patient Safety Incidents with Moderate Harm or above

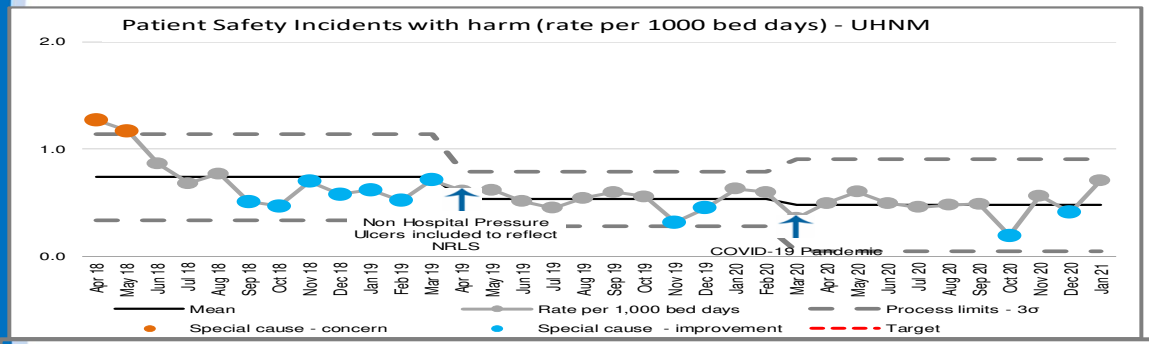


Variation	Assurance

Target	Nov 20	Dec 20	Jan 21
N/A	19	14	25

Background

Patient safety incidents with reported moderate harm and above



Variation	Assurance

Target	Nov 20	Dec 20	Jan 21
N/A	0.57	0.41	0.71

What is the data telling us:

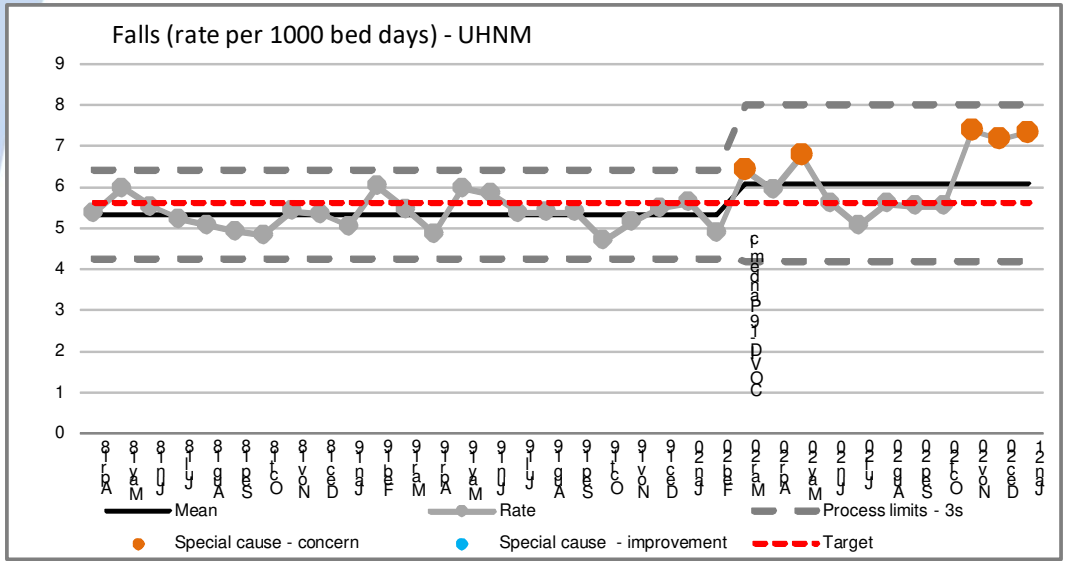
The chart show that during January 2021 there has been increase of PSIs with moderate harm or above (at time of report 10/02/2021). The number of PSIs with moderate harm or above continues to be below the pre COVID mean. The second chart, shows the rate of PSIs with moderate harm or above per 1000 bed days and there are continued positive trends with reductions from pre COVID period. The data illustrates the positive outcomes from the incidents being reported as there are lower rates of harm despite rate of reporting increasing. This is an indicator of a potentially positive reporting culture and staff are willing and able to report incidents and near misses.

The top category of incidents resulting in moderate harm reflect the largest reporting categories with Slips/Trips/Falls being the largest category.

The second largest category is Treatment/Procedure (3 of these are unintended injury during procedure (bleeding), 1 treatment delay, 1 complication of treatment, 1 delay in recognising complication, 1 delay in monitoring and 1 extravasation injury)

National Comparison taken from latest CQC Insight Report is that 26.1% of reported patient safety incidents to NRLS resulted in harm. UHNM latest results are 22.8% . UHNM is lower that national average (September 2019 – August 2020)

Patient Falls Rate per 1000 bed days



Variation	Assurance
H	?

Target	Nov 20	Dec 20	Jan 21
5.6	7.4	7.1	7.3

Background

The number of falls per 1000 occupied bed days

What is the date telling us:

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

The chart shows the average rate since April 2018 is below the target. The rate in January remains above 7.

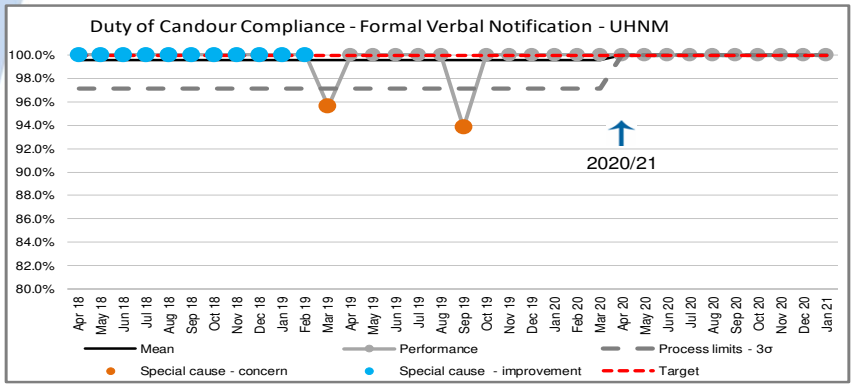
The Top areas for total falls in January were:

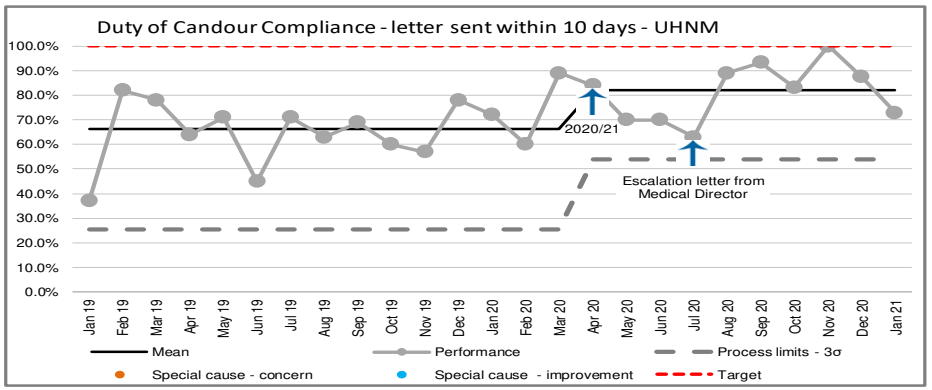
231/230 (AMU), 100/101, FEAU, 127, 226, 121

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

- 16 new RITA packages have arrived and been delivered to many clinical areas across the trust. Training is being provided by My Improvement.
- All areas are being encouraged to use the STOP 5 hot debrief tool to identify immediate actions to prevent further falls.
- Quality improvement facilitator support to wards with falls prevention is at times limited due to being required to work clinically. Every effort is made to contact wards with increase numbers of falls.

Duty of Candour Compliance





Variation	Assurance
	P

Target	Nov 20	Dec 20	Jan 21
100%	100.0%	100.0%	100.0%

Background

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

Variation	Assurance
	?

Target	Nov 20	Dec 20	Jan 21
100%	100.0%	87.5%	73.0%

Background

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

What is the data telling us:

Formal Verbal Notification Duty of Candour has been recorded in 100% of all patient related incidents that have formally triggered meeting the threshold during January 2021. There were 11 incidents reported with 10 in the Medicine Division and 1 Surgery Division

Follow up Written Duty of Candour Compliance for receiving the letter within 10 working days of verbal notification during January 2021 was 73% with 8 cases within 10 working days target and 3 cases having letter sent out between 12 and 15 days following formal notification.

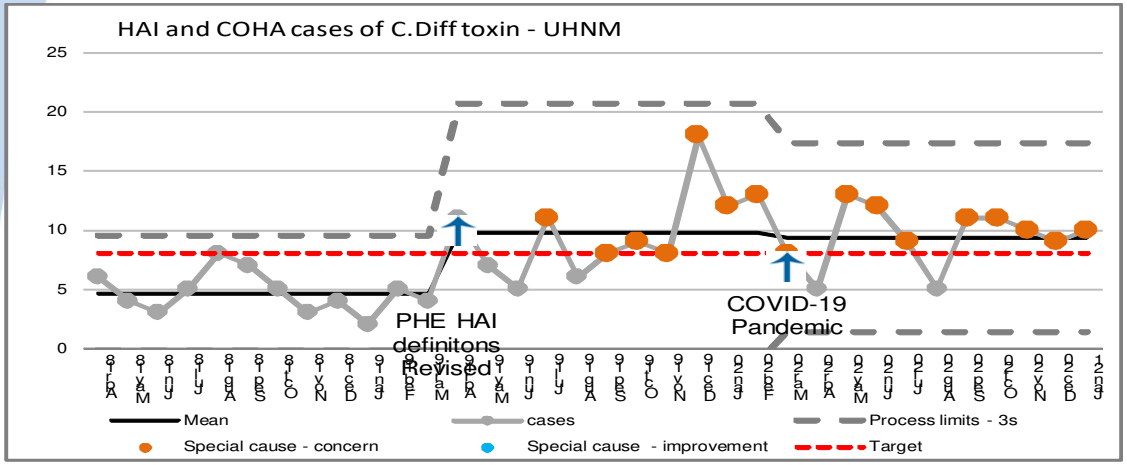
Actions taken:

The escalation and follow up on incidents which formally trigger duty of candour continues to be escalated within the Divisions to support the improvement in meeting the 10 working day target. Escalations on outstanding letters are provided to relevant directorates and divisions via the Divisional Governance & Quality Managers.

Continued support is being provided during increased COVID-19 pressures with the drafting of the 10 day notification letters for clinicians by the Divisional Governance & Quality team.

Compliance being included in Divisional reports for discussion and action.

Reported C Diff Cases per month



Variation	Assurance
	

Target	Nov 20	Dec 20	Jan 21
8	10	9	10

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 all 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 10 reported C Diff cases in January. 3 of these were Hospital Associated Infection (HAI) cases and 7 Community Onset Hospital Associated (COHA) cases.

Two clinical areas have reported 2 cases Clostridium *difficile* toxin cases within a 28 day period, awaiting ribotype results

For January 2021, UHNM is above trajectory for the year to date 2020/21 , 95 cases versus a year to date target of 78

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

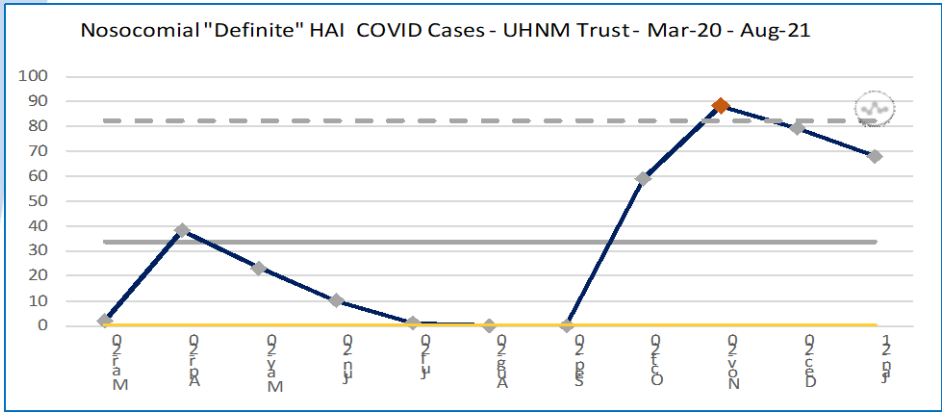
RCA's reviews with the CCG are paused due to COVID 19.

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 to review the CDI deep dive report with was presented at IPCC.

HAI Nosocomial COVID Cases per Month



	Metric Name	Latest Value	Lower process limit	Upper Process limit	Mean
1	Nosocomial "Definite" HAI COVID Cases - UHNM Trust	68	-15.0	81.9	33.5

What do these results tell us?

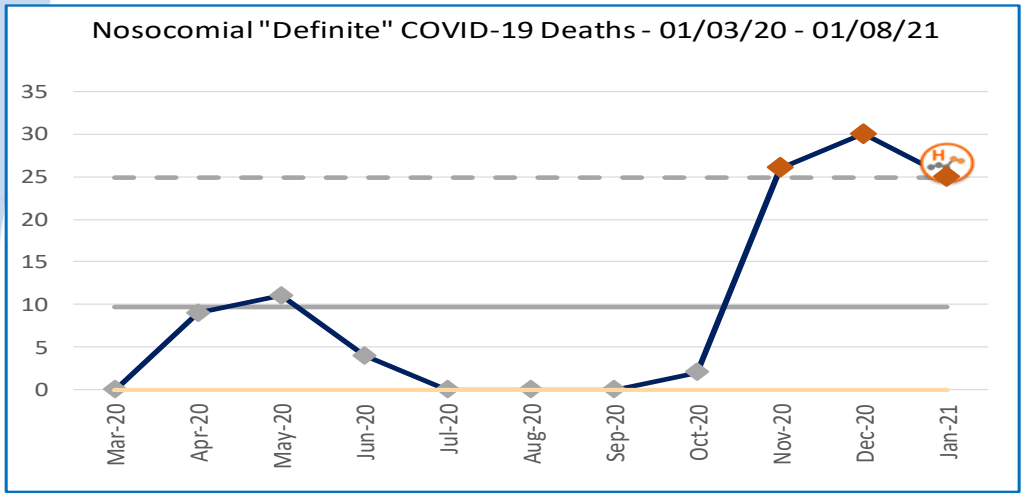
- The data shows an Increase in definite Healthcare Acquired COVID -19 cases. This increase started during the second wave of the COVID -19 pandemic and January 2021 saw a slight reduction compared to December and November 2020.
- A number of COVID ward outbreaks were reported during January 2021
- Ward 106&107 /Ward 108/ Ward 81/ Ward 76a/ Ward 110/ Ward 7/ Haemodialysis Unit/ Ward 226/ Ward 225/ Ward 201/ Ward 120 , Ward 100& 101
- All the outbreaks have now been closed and restrictions removed.

Definite healthcare acquired infection (HAI) | **SARS-CoV-2 detected ≥ 15 days into admission**

Actions :

- All Emergency patients screened for COVID 19 on admission to UHNM, screening programme in place for planned surgery/procedures.
- All inpatients who have received a negative COVID screen have a repeat COVID screen on day 4 and 6 as per NHS key actions
- COVID 19 themes report 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 contact of positive case via ICNet system
- Process in place for outbreak management and reporting
- Swabbing champions rolled out in a number of areas

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.

- The data shows a decrease in definite Healthcare Acquired COVID -19 deaths during January 2021 compared to November and December 2020.
- Total 107 hospital acquired COVID-19 deaths with 1st positive results 15 days or more following admission recorded since March 2020.
- Total recorded definite hospital onset COVID-19 deaths is 30 during December
- 2 recorded at County Hospital, 23 recorded at RSUH
- The mean number of deaths per month since March 2020 is 9.7, however following the in month reduction in January 2021 the monthly total is returning to the upper control limit.

Actions :

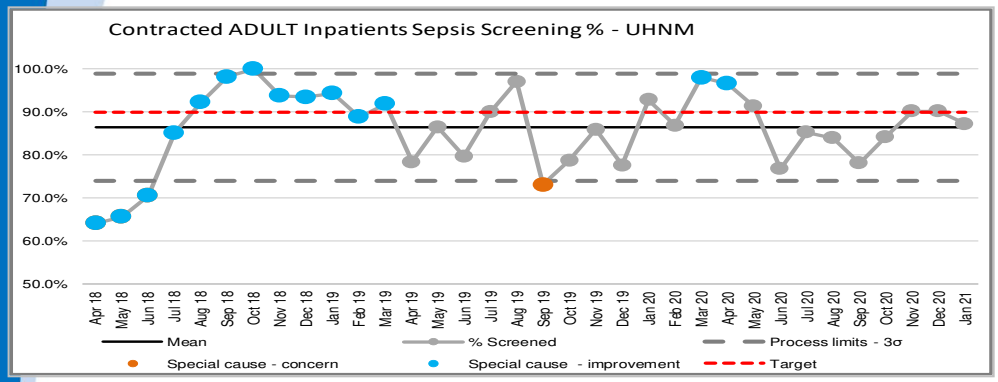
Agreed to establish corporate review panel for definite hospital onset COVID-19 deaths to assess the quality of care provided and managed appropriately in relation to COVID-19 with ward moves and appropriate infection prevention procedures.

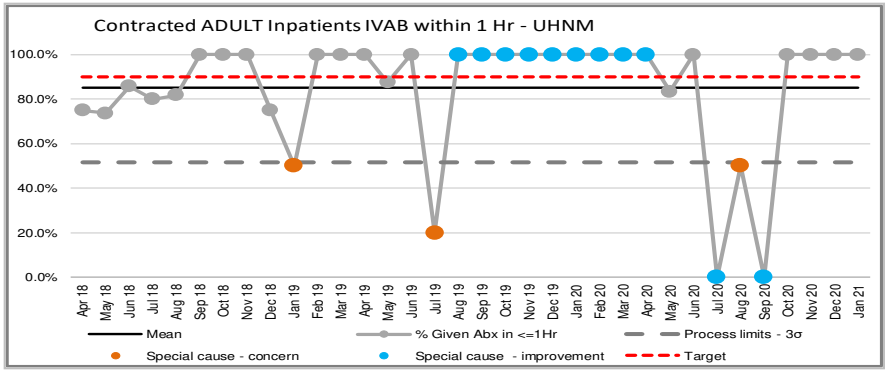
Review Panel to comprise of Deputy Medical Directors and senior clinicians from Clinical Divisions and will commence during end of Quarter 4 2020/21. Senior Clinicians have been identified by Divisional Chairs

Online SJR form is to be adapted to include specific COVID related questions following pilot review by Deputy Medical Director.

Sepsis Screening Compliance (Inpatients Contract)

University Hospitals of North Midlands NHS Trust





Variation	Assurance
	

Target	Nov 20	Dec 20	Jan 21
90%	90.2%	90.2%	87.2%

Background

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

Variation	Assurance
	

Target	Nov 20	Dec 20	Jan 21
90%	100.0%	100.0%	100.0%

Background

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

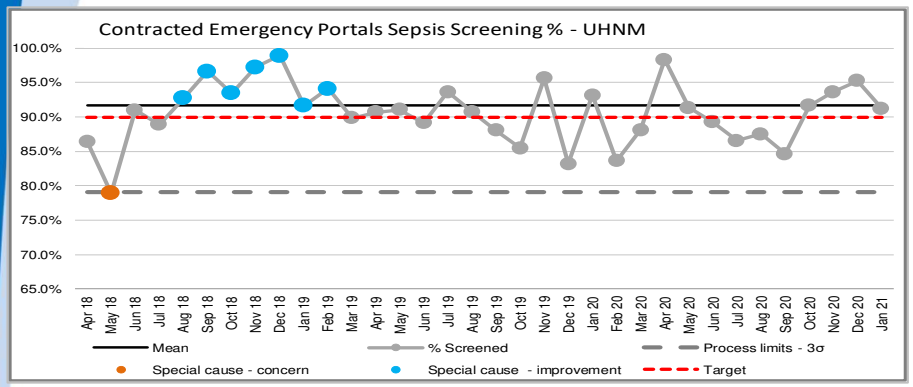
What is the data telling us:

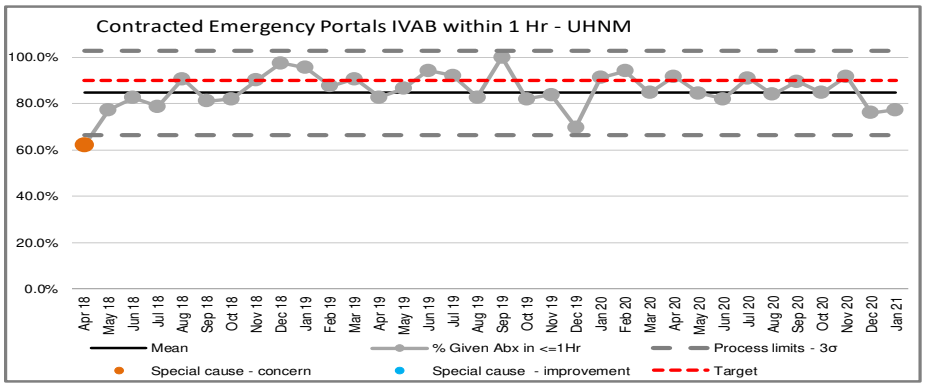
January results now at 87.2% which shows drop from the previous 2 months. Inpatient areas also achieved 100% for IVAB within an hour, Of the 94 Inpatients that triggered a sepsis screen, 38 were not red flags sepsis and 56 patients with red flags (4 of these patients were given IVAB within hour and the remaining 52 patients, 27 had alternative diagnosis that were deemed as not sepsis related and IVAB were not indicated. The remaining 25 patients were already received treatment for sepsis and administration of IVAB initiated prior to the identified red flag trigger).

Actions:

- In the absence of formal practical training due to COVID-19 restrictions, the sepsis team have continued to provide sepsis re-enforcement which consists of visiting ward areas to update clinical staff and promote awareness around sepsis whilst answering any queries they may have as well as sepsis kiosks a 15-20 minutes drop in session (commenced already in prioritised areas, like older adults wards & other medicine areas , few areas from Surgery, Specialised & CWD).
- The sepsis team now input data weekly rather than monthly in order to identify Inpatient areas with poor compliance and prioritise those areas for sepsis re-enforcement/ kiosks- drop in session; on-going
- The sepsis team continue to work closely with the VitalPacs team in order to address issues with staff access levels. This remain as one of the priorities to continue/ monitor closely to help improve this system; on-going
- The missed screens for this month were the on-going problems with staff access levels for sepsis Vitals, lack of communications between HCA's and qualified staff and night shifts having higher occurrences. Therefore, the sepsis team had provided unannounced ward visits out of hours to deliver reinforcement to those staff who worked regular nights; this is done on an adhoc basis and we hope to see improvement as a result; on-going
- Yearly consultants and all levels of clinicians departmental sepsis training already commenced via Microsoft Teams from Surgery division & Maternity Department. Specialised & Renal department already arranged in March and hopefully Haematology/Oncology & Respiratory department will follow.

Sepsis Screening Compliance (Emergency Portals Contract)





Variation	Assurance
	

Target	Nov 20	Dec 20	Jan 21
90%	94%	95%	91%

Background

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

Variation	Assurance
	

Target	Nov 20	Dec 20	Jan 21
90%	92%	76%	77%

Background

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

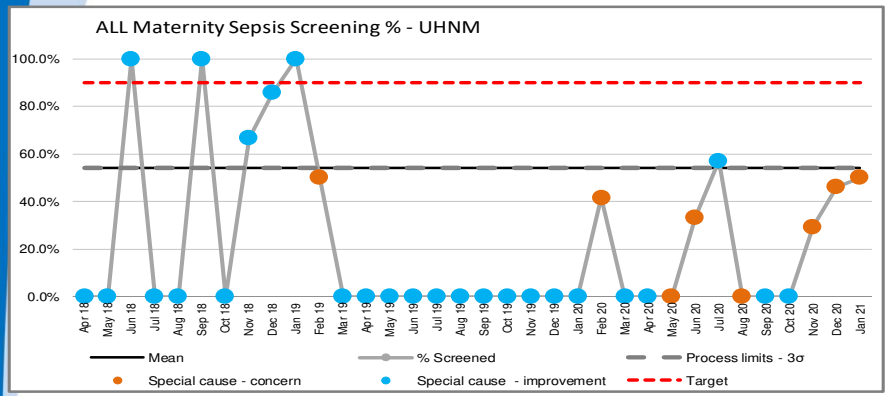
What is the data telling us:

Adult screening in January 2021 achieved 91% for the 57 patients audited whilst IVAB within 1 hour increased to 77% for the 55 red flag sepsis patients identified during the audit & 2 moderate risks sepsis triggers. Although out of the 55 red flags, only 22 required IVAB within an hour as (17 given within hour & 5 late IVAB). 16 had alternative diagnosis and were deemed as not sepsis related /IVAB were not indicated and 17 already on IVAB. This indicator currently relates to all Emergency Portals that had been audited (A&E Royal & County, AMU Royal & County, SAU, FEAU)

Actions:

- The sepsis team continued to closely monitor the compliance by visiting the department regularly and provided immediate sepsis reinforcement when required
- The A&E education team and A&E sepsis doctor will continue to provided sepsis virtual education for both A&E sites as required. Sepsis talk via Microsoft teams will also commence from the 3rd week of March 2021, this will be available trust wide and will be advertised via comms
- The delayed IVAB and missed screening already escalated and lesson learned discussed with A&E team, currently the sepsis team is working collaboratively with the A&E Quality nurses, senior staff and A&E sepsis clinician lead for providing sepsis reinforcement to all level of staff and doctors; still on-going action
- Sepsis team will work collaboratively with A&E department regarding management of patients with sepsis triggers whilst held in the ambulance due to capacity pressures this winter

Sepsis Screening Compliance ALL Maternity

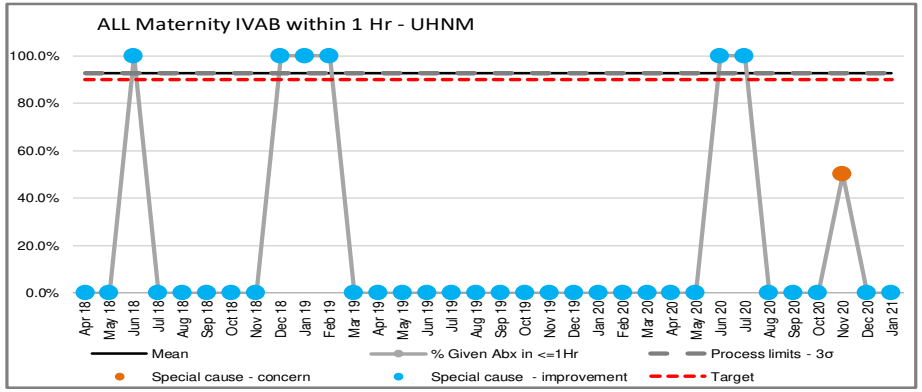


Variation	Assurance
L	F

Target	Nov 20	Dec 20	Jan 21
90%	29.4%	46.2%	50.0%

Background

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



Variation	Assurance
H	P

Target	Nov 20	Dec 20	Jan 21
90%	50%	N/A	N/A

Background

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

What is the data telling us:

Maternity Inpatients and Emergency portal (MAU) audited by the Sepsis Team in December 2020. All patients that trigger with MEOWS >4 were audited via the Maternity K2 system. The Inpatient wards screening compliance scored 50% (5 missed screening from a sample size of 10 patients) and MAU with 33% (only 1 missed screening from a small sample size of 3 patients) and overall total score of 46%. We have no red flags from MAU and Inpatients areas therefore it will be scored as N/A. However, few of the patients audited already received IVAB due to moderate risks triggers.

Actions:

The Maternity senior team have been working collaboratively with the sepsis team and have created an action plan to resolve/improve both screening and IVAB compliance: this was presented in the IPCC meeting. Currently the Sepsis Team is providing sepsis reinforcement or training as well as creating further awareness to ensure staff are aware of the process for attaching completed screening tools to the K2 system. Mainly, the maternity documentation and notes are all completed electronically except for the sepsis screening tool and prescription chart hence the issue of missing paper documentation. The new electronic version of maternity sepsis screening tool will be ready for trialling very soon, and hopefully become available in their K2 Athena system; aim to improve screening compliance. Furthermore, Sepsis training via Microsoft team is currently available and aim to provide to all levels of clinicians and midwives from Feb-March 2021, already commenced and still on-going.

Quality Indicator Peer Benchmarking

Indicator YTD (Sept 2020)	Date / Period	Target	University Hospitals of North Midlands	Nottingham University Hospitals	University Hospitals of Derby & Burton	University Hospitals of Leicester	Oxford University Hospitals	University Hospital Southampton	University Hospitals of Birmingham *
Clostridium Difficile (Hospital Acquired)	April - September 2020	Local []	55	86	50	39	60	39	78 *
MRSA bacteraemia (Hospital Acquired)	April - September 2020	0	0	2	1	0	3	0	0 *
Hospital Acquired Inpatient COVID-19 Infections (15+ days)	March - September 2020		74	Not reported	Not reported	Not reported	Not reported	65	Not reported
Patient Safety Incidents per 1000 bed days	April - September 2020		47.7	Not reported	68.74	Not reported	Not reported	Not reported	Not reported
NRLS Patient Safety Incident rate per 1000 bed days	October 2019 - March 2020		40.2	49.4	40	47.9	53.9	34.5	49.1
NRLS Patient Safety Incident Total (YTD)	April - September 2020		6316	12216	7867	11586	4705	6161	16337
NRLS Patient Safety Incident Total (month)	September 2020		1353	2490	1353	2467	1156	475	1389
Serious Incidents	April - September 2020		49	Not reported	54	Not reported	21	32	21 *
Never Events	April - November 2020	0	1	0	0	3	1	1	6
Falls per 1000 bed days	April - September 2020	5.6	5.7	Not reported	6.29	4.6	Not reported	Not reported	7.38 *
Falls with Moderate + harm per 1000 bed days	April - September 2020		0.12			0.07	Not reported	Not reported	Not reported
VTE Risk Assesment Completion	April - September 2020	95%	98.9%	92.7%	93.8%	98.8%	98.5%	Not reported	Not reported
Complaints Received	April - September 2020		264	286	Not reported	Not reported	317	Not reported	547
HSMR	September 2019 - October 2020	100	94.64	114.90	107.91	106.06	88.00	79.65	104
SHMI		1.00	0.99	1.02	0.90	0.97	0.91		1.00

* August Data

The benchmarking data is collated from various sources and is designed to allow the Trust Board and organisation to compare against peers. The availability of data for the various indicators used by UHNM with peer Trusts is variable. There is also limited nationally published benchmarking data readily available.

UHNM is noted as reporting lower rate of Patient Safety Incidents than some peers in NRLS data. This is being reviewed to identify potential reasons.

Data sources:
www.england.nhs.uk/statistics/statistical -work-areas
Public Board Reports

Operational Performance

2025 Vision "Achieve NHS Constitutional patient access standards"

Contents

A note on **SPC**

NHS University Hospitals of North Midlands NHS Trust

In some areas of the following report, statistical process control (SPC) methods are used 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;

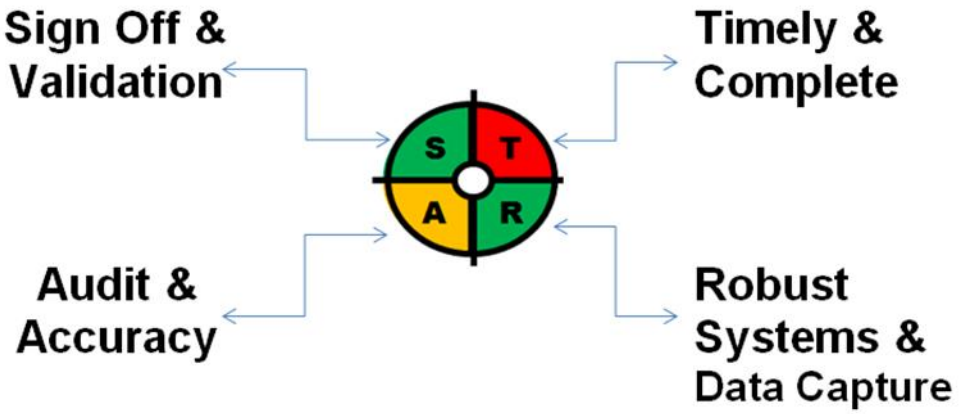
Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling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

ORANGE indicates **special cause variation** of particular concern and needing action
BLUE is where improvements are seen
GREY indicates no significant change (common cause variation)

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**

Restoration and Recovery

Spotlight Report from Chief Operating Officer

NHS
University Hospitals of North Midlands
NHS Trust

Emergency Care

The Trust continued to experience significant operational pressures in January-21. Critical care managed a high number of Covid-19 positive patients alongside side those that needed elective procedures. From Thursday 7th January 21 the Trusts incident level was raised to Level 4 for the whole of the organisation. . Critical care were treating more covid positive patients than ever with 210% occupancy at the peak. The wards had more Covid-19 patients than anytime previously and critical care unit also treated more patients than ever before with colleagues in the Paediatric Intensive Care Unit stepping in to provide adult care

All Trusts received instructions to increase capacity to support the health care systems in London and the South East and in response the Trust doubled the intensive care capacity and at one point the ITU was caring for 8 patients that were out of the area.

The wards continued to have more covid positive patients than anytime previously and the number peaked at 349 and has plateaued at this high level, averaging 37 new patients/ day. The number of patients who were discharged reached 2,925. Added to this the number of bed restrictions/ closures continued, the MEAN number of closures across the month was 41.

The impact on operational performance continued. The Trust system wide 4hour performance achieved 69%, (December 68.2%) and for UHNM Type 1 this was 55.5% (December 55%). In January 21 the number of 12 hour trolley waits reduced to 33 (64 in December) there have been zero breaches since 12th January. There were however some improvements noted across some of the quality metrics with Urgent Care as shown in the document.

Cancer

The trust is predicted to underperform in January-21 on all standards. Covid impact, choice, capacity and workforce attrition are the main factors affecting treatment ratios.

The 104+ day backlog remains at 51 for January-21 and the 62 day backlog continues to rise and at the end of January was 324 (December 296).

2WW referrals in December were exponentially high when compared to the same period last year and as a consequence more patients were appointed/ seen in January-21. Increased demand is being matched by extra activity put on by specialties where necessary. Despite the increase in 2ww referrals and internal capacity challenges, the 2ww PTL has been managed down to circa 2800 patients, the same volume as in June 2020, when referrals were at their lowest due to the pandemic.

Discussions with the IS are continuing for March lists - to optimise theatre capacity available. Managed through the assurance framework. Directorates are currently reviewing the surgical wait list to identify patients suitable for March lists.

Planned Care

The National ask for January-21 was for total Outpatients to be at 100% of last years business as usual and for Inpatients 90%. The trajectories for January were set 89.9% (Outpatients) and 88.1% (Inpatients) of BAU for last year. The actuals for January, against BAU, was outpatients 88.4% and inpatients 66.6%. This demonstrates the efforts to maintain out patient capacity even if the in patient work has fallen due to the requirement for workforce staffing to support the 200% critical care mutual aid support to London.

RTT

The performance for January 21: the total number of Referral To Treatment pathways grew to 50,735(December 49,054). This is above the forecast 46,100. The Trust has 3,538 over 52 week breaches (December 2,773) as a consequence of standing down elective work. This was over the forecasted position. Recovery plans for recovery of the long waiting patients are being reviewed. RTT performance in January is 65.20% (December 65.73%).

Diagnostics

January saw a fall in performance (DM01), mainly due to the rise of > 6 week patients in Imaging. The performance for January is 87.57% (December 91.2%). The waiting list size has risen slightly to 11, 594 (December 11,668) The Diagnostic cell will re-start in February to oversee recovery.

Urgent Care - Summary

NHS
University Hospitals of North Midlands
NHS Trust

Summary

- System-wide attendances in January-21 have continued with the steadily fall in numbers and are far outside the ranges seen pre-covid (70%) The decline in attendance numbers is seen at both Type 1 sites Royal Stoke and County with both seeing demand close to 70% of Jan-20.
- However, ambulance conveyances to Royal Stoke remain high and are at 90% of those in Jan-20 with a daily average of 149 which as a proportion of all attendances remains high at 58% (compared to c48% pre-covid).
- NHS-111 continued and numbers have remained consistent with a daily average of 31.
- 47% of attendances are referred to specialties (compared to 36% pre-covid) with the majority referred to Medicine. The daily average number of patients referred to Medicine is 15/ day higher than the same time last year. Trauma capacity was limited at times, likely to be in response to the severe weather conditions.
- Conversion rate is increasing month on month and expected to continue. The conversion rate for January at RS rose to 44.9% (December 42.7%).
- Within the main bed pools, the number of patients in medical beds continues to rise: the daily average for January was 525 compared to Dec which was 447/day - An increase of 78 beds in use.
- 91 escalation beds were opened through January.
- There was an average of 35 new covid cases per day reaching a max of 348 pts. In beds at the Trust with the number plateauing at that high level.
- The bed restrictions for Infection Prevention have continued and remained high with an average of 40 beds restricted/ closed on a daily basis further impacting on available capacity.
- MFFDs, Stranded and Super stranded patients all saw an increase as a result the average LoS ,1+ days for NEL medical patients has continued to rise to an average of 8.4 days (this rise is in line with the previous year).
- At the front door, improvements have been seen with both time to initial assessment and time to treatment in ED seeing reductions
- Discharges before noon have also seen a dramatic improvement in January with the rate recovering back to just above the two year mean.
- Overall staff absence has remained high through out January however the proportion of absence due to covid is now reducing .

Urgent Care - Actions

During the Pandemic the Urgent Care work has continued. February will continue to see a number of areas of work continue, which has been directed by the three work streams and the Urgent Care plan.

Acute Front Door

- Embed and sustain the changes seen in January through engagement with the team
- Complete business case for ED workforce to support the flow through the Department
- Establish task and finish group to support quality improvement and the implementation of the new Urgent Care standards.

1. Weekly Urgent Care Meetings within ED and Acute Medicine to reinvigorate the acute care actions and support post covid recovery
2. CQC Triage times paper submitted to Urgent Care Board for approval in order to protect the nursing staff within ED to support this process.
3. Electronic Referral from ED to Acute Medicine, AMRA and AEC

Lastly, implementation of the 5 national asks around urgent care.

Patient Flow

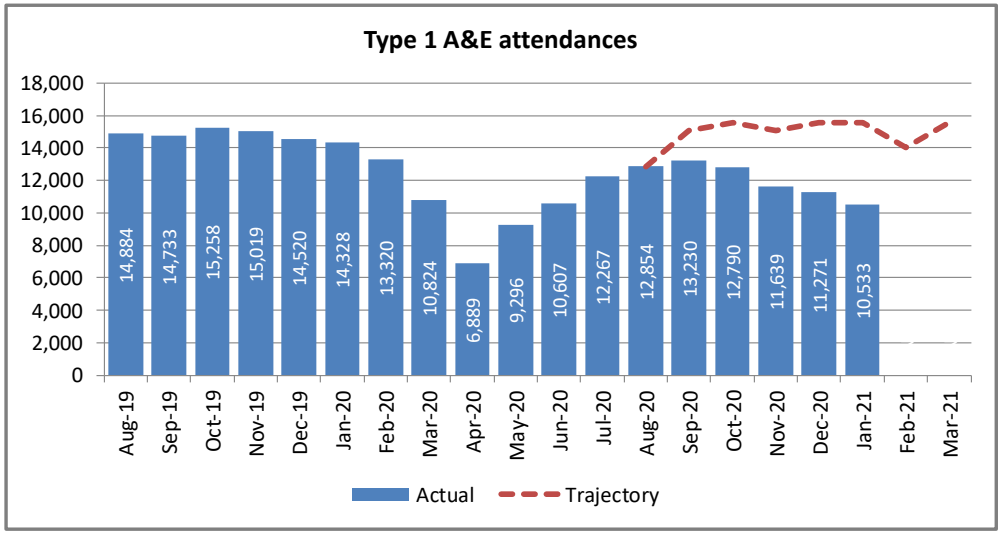
- Maintain focus of discharges before midday through improvement workshops
- Support length of stay by using directorate Teams – support improvements seen
- Review need for COVID discharge lounge to support earlier flow
- Importance of young persons rehab Unit working with MPFT
- Confirm In reach model with GP Federation that Support earlier step down
- Set up Task and Finish Groups with each division to support sustained improvements

Clinical Site Management

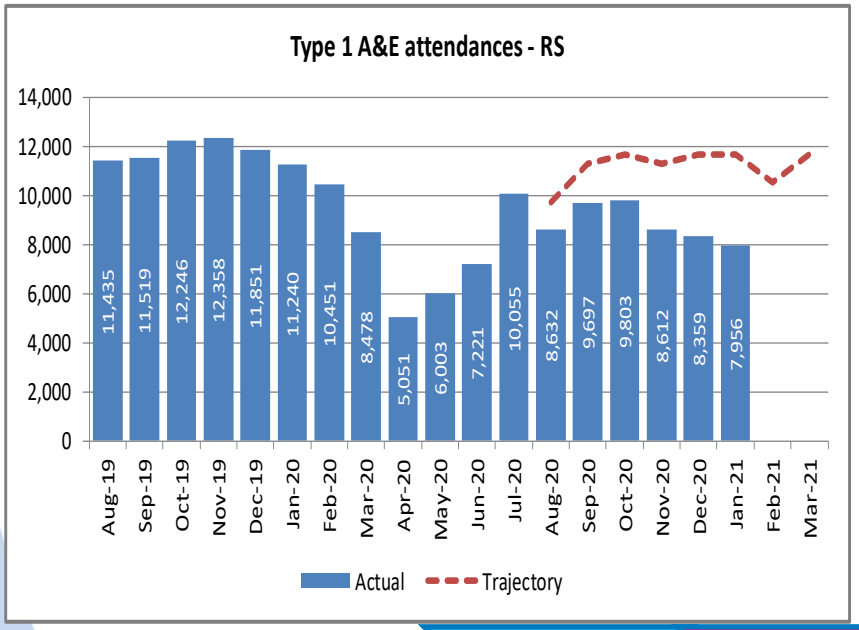
- Confirm and agree the new 'battle rhythm' for the sites post COVID
- Agree workforce model that's Deliver clinical oversight
- Begin to map out ways of working that supports the delivery of the Urgent Care standards

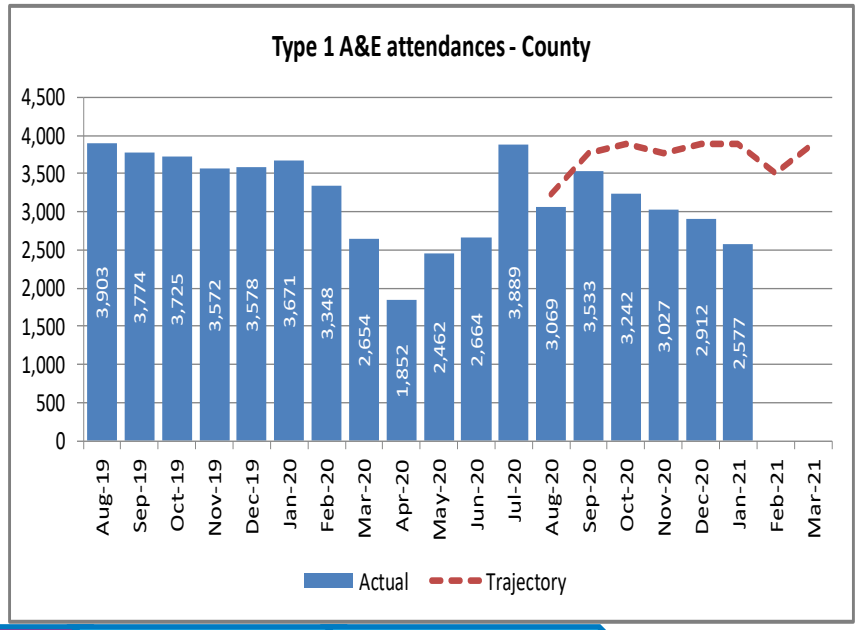
Urgent Care *(attendances)*

University Hospitals of North Midlands NHS Trust

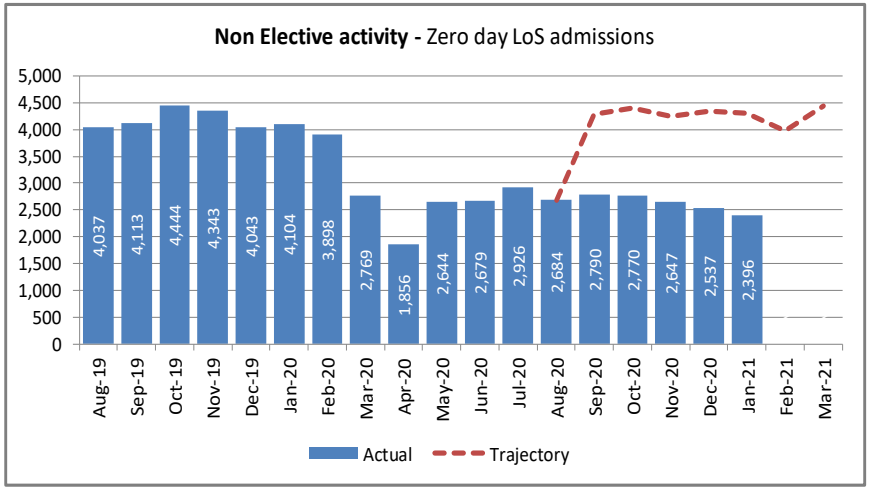


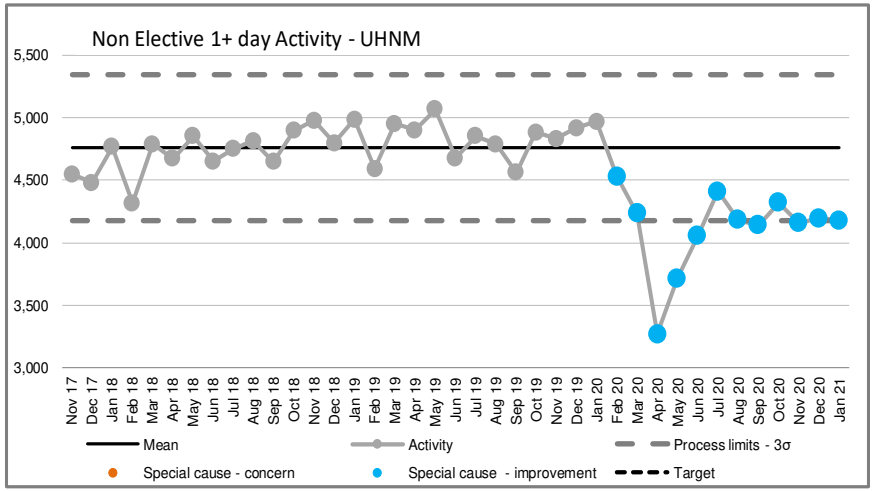
	% attendances vs. Jan 20
Type 1	73.5%
RS	70.8%
County	70.2%





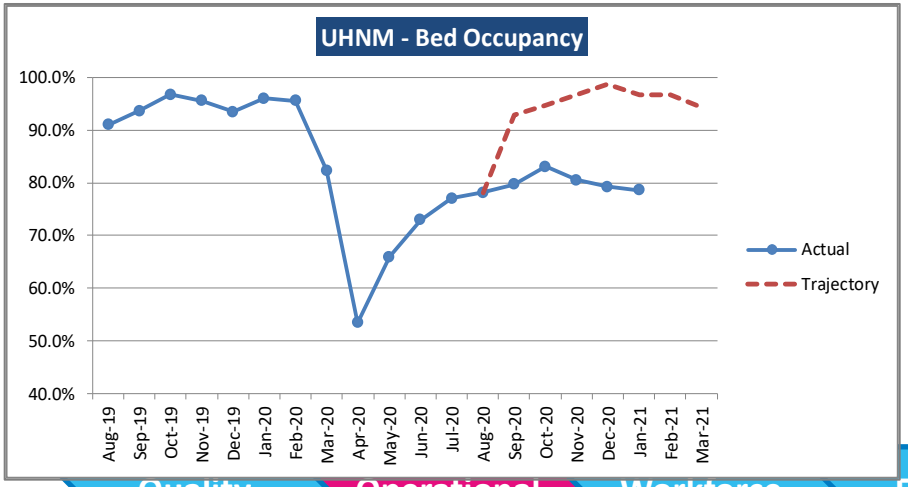
Urgent Care - *(admissions)*





	Nov 20	Dec 20	Jan 21
Previous year	4,343	4,043	4,104
2020 Actual	2,647	2,537	2,396
% of BAU	61%	63%	58%

	Nov 20	Dec 20	Jan 21
Previous year	4,831	4,918	4,969
2020 Actual	4,159	4,196	4,178
% of BAU	86%	85%	84%



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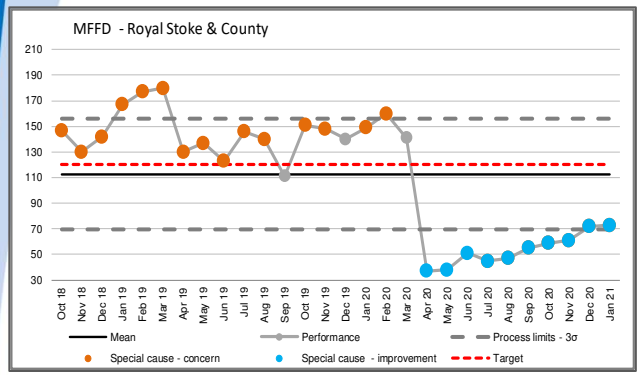
URGENT CARE – *(Discharges)*



Variation	Assurance
H	?

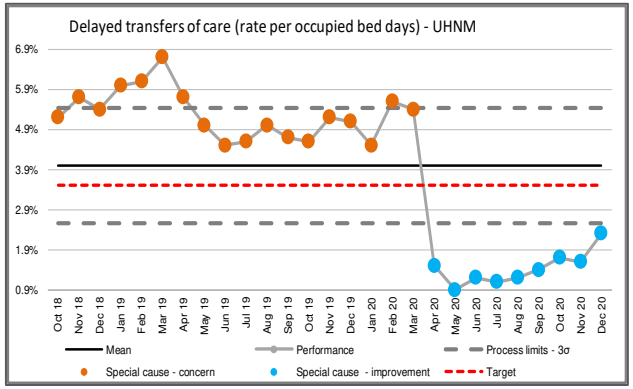
Target	Nov 20	Dec 20	Jan 21
120	61	72	73

Background

The average daily number of patients Medically fit for discharge from an acute bed yet to be discharged.

What is the data telling us?

There has be a series of data points indicating a sustained redduction in the number of MFFDs.



Variation	Assurance
L	?

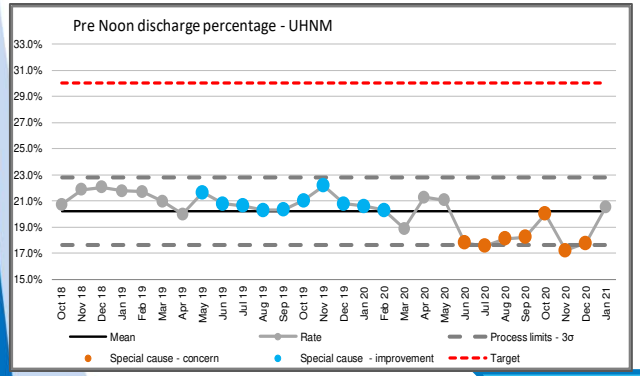
Target	Oct 20	Nov 20	Dec 20
3.5%	1.7%	1.6%	2.3%

Background

The Percentage of bed days occupied by delayed transfers of care. (1 month in arreas)

What is the data telling us?

The delayed transfers of care have been influenced by the actions taken in regards to Covid-19. There was a significant reduction from March when patients were discharged. To date the % remains below the national standard of 3.5%.



Variation	Assurance
	F

Target	Nov 20	Dec 20	Jan 21
30%	17.2%	17.8%	20.5%

Background

The percentage of discharges complete before 12 noon.

What is the data telling us?

The Trust saw a reduction in the number of pre-noon discharges with an upturn seen in September.

Medically fit for discharge (MFFD):

In the complex caseload, the number of patients MFFD has shown a steady increase since Apr-20 with January having on average 64/ day at RS (Apr – 37), both stranded and super stranded patients similarly rising, suggesting challenges in providing care outside the acute setting.

The data is showing that the MFFD numbers are still in improvement i.e. the numbers are low. On average, the daily number of patients MFFD for RS & County is 73/ day.

Work streams are in place to reduce this again including

- an escalated emphasis on ward level management of discharges
- Seven day multi organisational management support in track and triage
- Robust daily challenge of patients waiting 1 day plus
- Strengthened working relationship with ezec
- Introduction of MPFT tracking post to reduce failed discharge due to TTO process delays

Delayed Transfers of Care (DToC) – I month in arrears

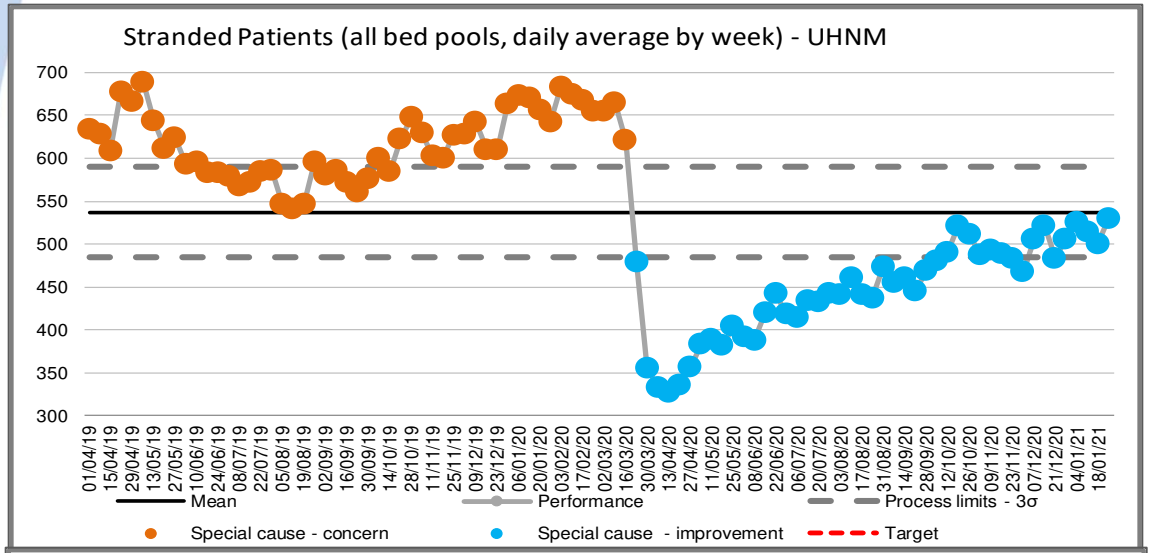
Again, whilst the data shows that for DToC the variation is low and this is still improvement, there are some early indications that percentages are rising. Although still well below the 3.5% national ambition.

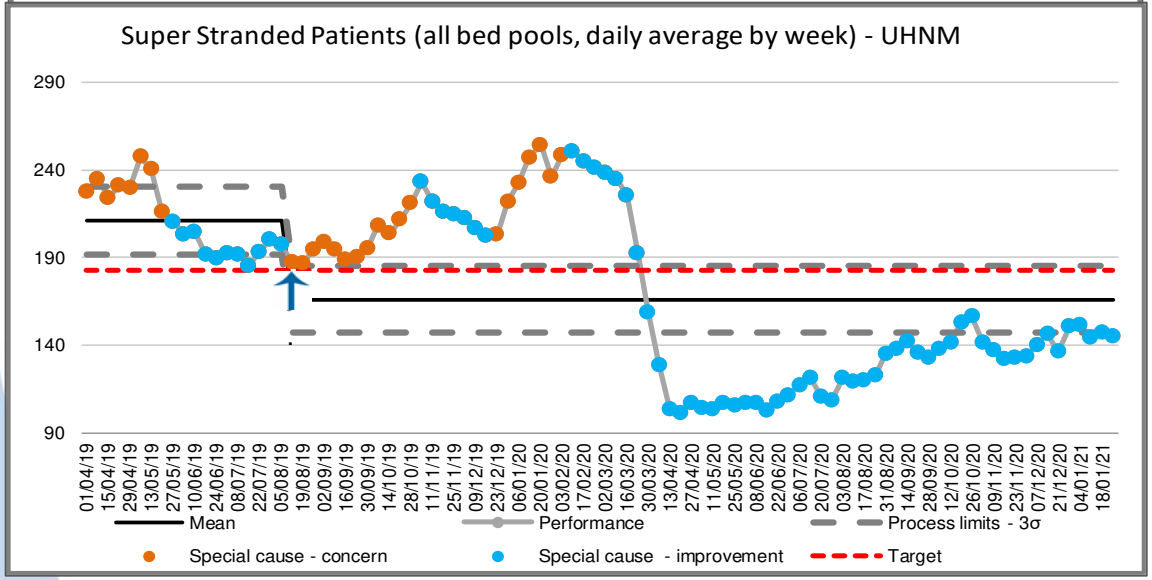
Although the Covid-19 pandemic has resulted in less beds occupied at the Trust , this measure shows that proportionately fewer occupied beds are patients waiting for transfer of care.

Discharges before midday

There is some early indications of improvements in the pre-noon discharges towards the end of January.

URGENT CARE – *(Discharges)*





Summary

- There is evidence that the rolling weekly average for the complex caseload is increasing but are well below the numbers seen pre-covid
- Stranded patients across all bed pools continues to steadily rise.
- Super Stranded patient numbers have seen normal variation. Circa 25% of these are on COVID-19 wards. Discharge of COVID +ve patients can be delayed due to an inability to isolate in the follow on setting.

Actions

LOS reviews commissioned across all wards to check acuity and progress around discharge actions to support reduction of Stranded and Super Stranded, MFFD reduction plans being supported by cross system clinical MDTs to reduce delays.

Cancer

NHS
University Hospitals of North Midlands
NHS Trust

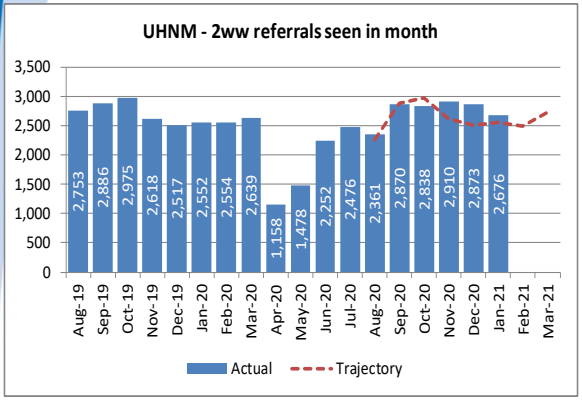
Summary:

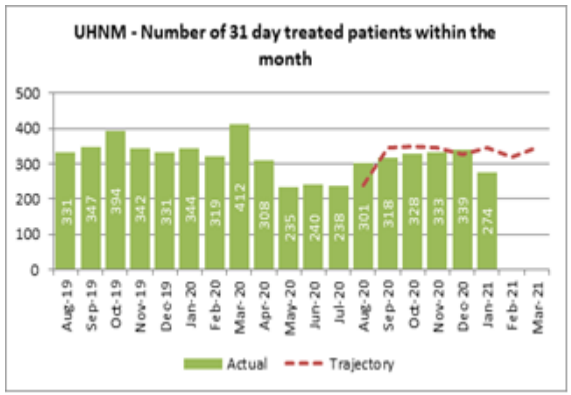
- For January, the trust is predicting to align to national performance for all cancer standards, all of which are expected to underperform.
- The trust saw a high demand of 2ww Referrals in December-20 and as a consequence, in January 2020, the trust appointed 2676 2ww referrals, which was an increase of 124 compared with the same month the previous year.
- Performance against the 2ww standard has been challenged as referrals continue to increase, particularly in Breast. In December 2020 the Breast team received 613 2ww referrals, which is an increase of 116 compared with the same month last year. The specialty continues to review capacity and demand modelling, and put on extra sessions.
- The heightened demand has been escalated to the CCG to try and improve referral completeness – to include breast pain diaries where necessary and mandate physical examination prior to referral. A collaborative operational group between primary and secondary care is in planning to improve partnership working between the two.
- Cancer surgery is being prioritised within the Trust and independent sector.
- Delays are multifaceted including capacity in Endoscopy, Pathology and reduced theatre capacity. The new assurance framework highlights surgical category timeframes and ensures that patients are dated according to clinical priority.
- Despite trust pressures the 104+ day backlog remains steady at 51. This cohort is still being monitored daily and escalated for clinical validation and mitigating actions where necessary.

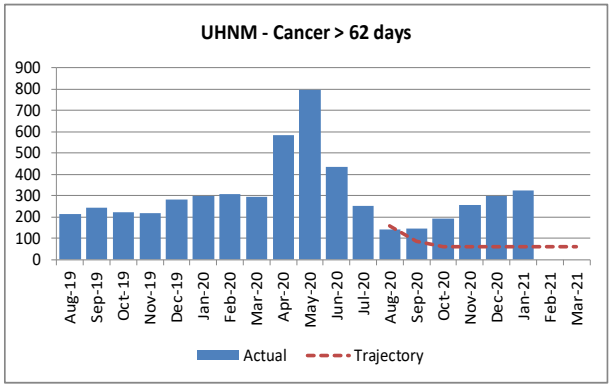
Actions:

- The corporate cancer team have engaged a new GP lead for Cancer who is committed to driving progress of the new Vague Symptoms service – a pathway that will reduce health inequalities and aid faster and earlier diagnosis. Now that all stakeholders have been identified and engaged, the first delivery group will meet in March to begin to set the service up.
- Other specialties are working closely with the cancer bureau to quickly match extra sessions with incoming demand, and continue to review trend analysis to understand and plan substantive clinics in a sustainable way in future months. It has been recognised through weekly assurance calls with the West Midlands Cancer Alliance that UHNM is managing 2ww demand extremely well within the region.
- Action plans to address bottlenecks in Endoscopy and Pathology have been drafted and will contribute to an improved position in month 12 onwards.
- The Histology turnaround time report will be redefined to provide visibility and support a better understanding of flow through the labs.

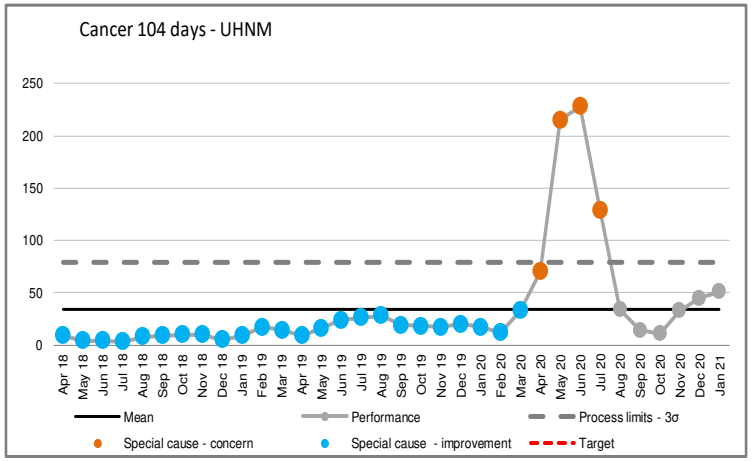
Cancer







	Target	Trust Actual	Clock Stops	Breaches	Breaches Over	Needed Treatments
TWW Standard	93%	87.4%	2697	340	152	2161
TWW Breast Symptomatic	93%	73.2%	41	11	9	117
31 Day First	96%	86.9%	426	56	39	975
31 Day Subsequent Chemotherapy	98%	93.1%	29	2	2	71
31 Day Subsequent Surgery	94%	-	0	0	1	1
31 Day Subsequent Radiotherapy	94%	91.6%	83	7	3	34
62 Day Standard	85%	62.9%	176.5	65.5	40	260.5
Rare Cancers - 31 Day RTT pathway	85%	-	0	0	1	1
62 Day Screening	90%	77.8%	18	4	3	23
28 Day FDS Standard	75%	71.7%	1610	456	54	215
62 Day Consultant Upgrade	86%	55.2%	67	30	21	148
Closed Pathways > 104 Day			20.5			



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Planned care - *Inpatients*

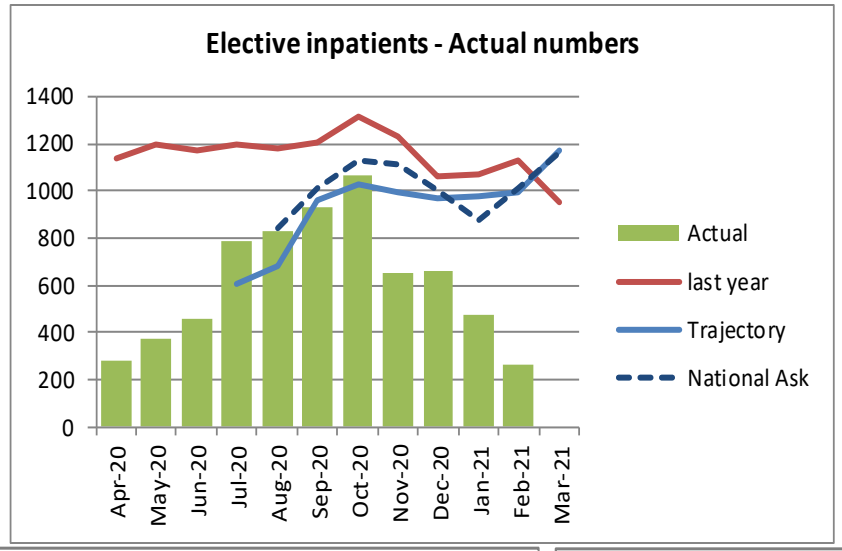
Elective inpatients Summary

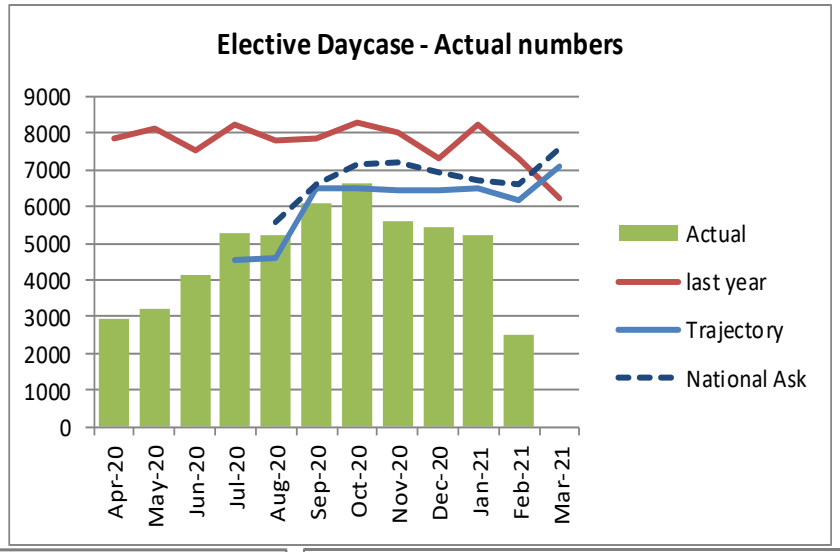
- The effects of Covid were seen on the R&R activity plans. Elective/Daycase activity combined had seen a steady rise since April 20 in line with restoration plans until November when special cause occurred (second wave Covid-19). Following the initial fall in November, activity has remained at around 67% - 69% of BAU. The trajectory for January was set at 88.1% of BAU.
- Covid19 Surge is starting to decline and the Trust is now reviewing its step down criteria from Level 4 incident with some restoration of services (accepting that Critical Care remains @ 178% occupancy so will require a couple more weeks for this to decongest).
- The number of elective operations for UHNM are below the numbers seen pre-covid, although since Nov-20 the numbers are below the Mean and are of normal variation. For RS & County, Elective operations were 884 (compared to November 918). Cancellations on the day continued to show low numbers. These are being driven by a number of factors but can all relate back to the second surge in COVID cases i.e. patients testing positive, no SSCU/critical care beds, patients changing their minds about surgery. Backfilling short notice cancellations is very difficult due to the COVID secure pathways (patients requiring swabs and isolation).
- Insourcing contracts in discussion for Q1 in respect to 60+ week long waiters. Business case deadlines have been advised to all DMs considering insourcing for Q1.
- The reduction in beds in the surgical bed base due to COVID outbreaks in Medicine resulting in further zoning of capacity and of course the growing dependency in CC meaning that staff deployment from other specialities and disciples are now caring for critical care patients.
- NHSEI have advised that there will be some funding release to support treatment pathways for patient to the year end.
- NHSEI have funded Independent sector transfers for Q4, UHNM have outsourced c. 800 patients so far which have included some cancers, cat p1/p2 and long waiters. Transfer will continue until end of March and we expect to see a decrease in long waiters at UHNM.

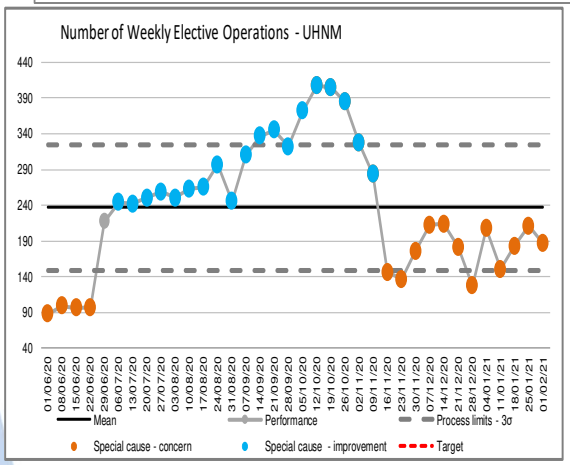
Actions

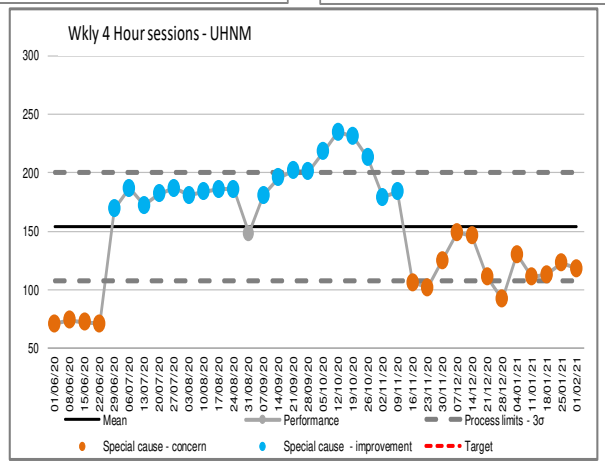
- Categories P5 for covid related delays and P6 for non covid related delays introduced. Surgery have linked with information services to develop a report to support the identification & prioritisation of urgent electives, and will keep Outpatient Cell informed of potential impact on OP activity.
- Long waiters governance assurance paper now complete. Weekly RCA/Clinical harm review meetings have been set up and have taken place from mid-January and will continue.
- Weekly assurance meeting to monitor long waits and specialty plans for the over 52 week patients have now taken place from mid-January and will continue. This is also supported by a clinical harm review process.
- The Surgical Division have been asked to review patient lists for County with a view to relaxing P2 criteria in an effort to optimise all capacity.
- Insourcing for endoscopy through 18 week source group and SHS commenced in mid-December. Insourcing group provided a team of health cares, nurses, scrub nurses, surgeons, anaesthetists in collaboration with a booking team and receptionist. They will run theatre sessions at UHNM over the weekends to reduce theatre backlog, first theatre session commenced 07/12/20.

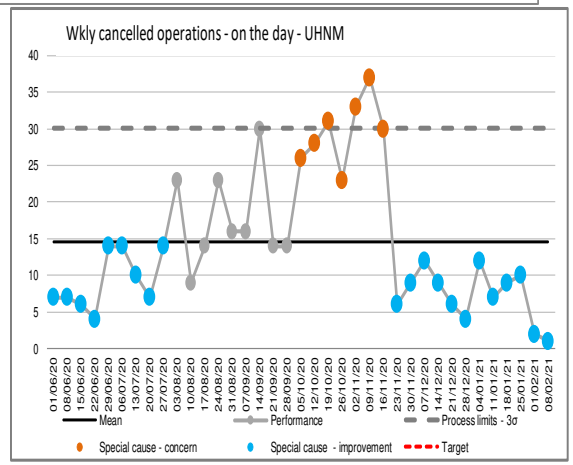
Planned care – *Inpatient Activity*











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Planned care - *Outpatients*

University Hospitals of North Midlands NHS Trust

Summary

- The effects of Covid were seen on the R&R activity plans. Outpatient activity showed a similar picture to that seen for inpatients.
- Activity for outpatients in January 21, the Trust delivered 88.4% vs. BAU and the trajectory set at 89.9%.
- January 21 numbers recorded were 59,968, however this may increase as the outstanding outcomes are completed.
- The overall Referral To Treatment (RTT) Waiting list continues to rise. For January the number of Incomplete pathways as risen to 50,834 (December saw 49,054). The Trust trajectory has been developed based on the assumption that referrals will return to 100% of last year demand (Phase 3 ask). The numbers of RTT pathways has exceeded the trajectory for the last 4 months suggesting more demand from General Practitioners/ clock starts following outpatient attendance, however it is too early to say if this is a trend likely to continue. We are however, at a level seen pre-covid.
- The RTT waiting list shape has changed with the number of patients > 18 weeks remaining at a high level of 17,656 (Dec-20 16,770)).
- The numbers of 52 week waits in January has risen to 3,538 (December is 2,773: November were 2,100). These are expected to grow further through the year and the Trust trajectory of 2756 for March 2021 has already been exceeded. Further reviews are to be undertaken to support the reduction.
- For outpatient appointments (appointment type) the Trust delivered 52.8% F2F and 32.3% non F2F(Telephone & Video) which are both slightly lower than December. There were 14.8% of appointments not set (for new appointment types F2F was 56% & non F2F 28% & follow ups F2F 51% & non F2f 34%). Work is underway to make the Media Type field in Medway mandatory which will eliminate 'Not Set'.
- January's performance for ASIs improved position to 87.3% within 3 days (from 84.7% in December) despite Covid pressures.

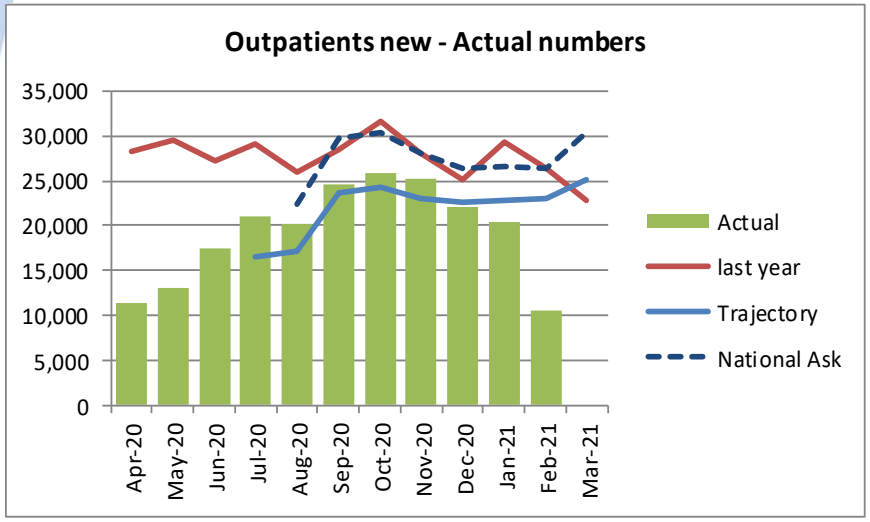
Actions

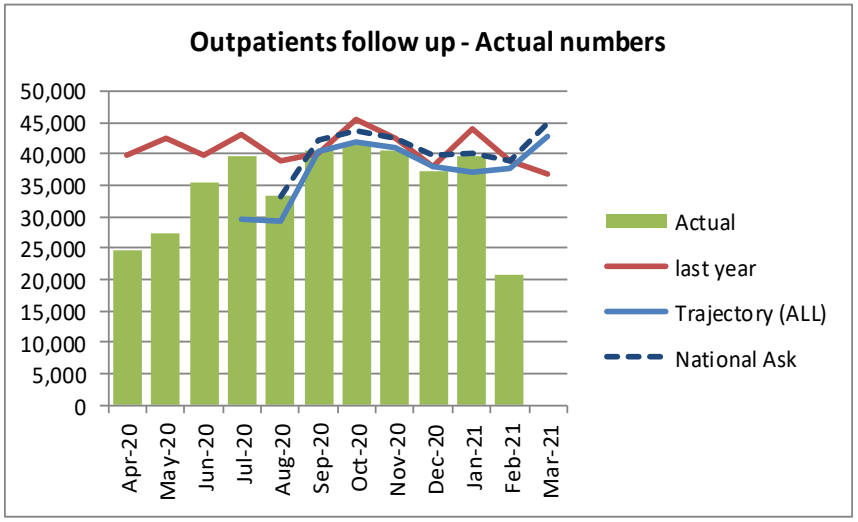
- Work is required on template reconfiguration based on Divisional assumptions - this needs to be aligned to the in patient and diagnostics plans for the purpose of substantive job planning.
- Revised 52 ww trajectory to be drafted once all cell plans confirmed to reduce the end of March 2021 delivery.
- 40+ week waiters are being planned with a combination of IS in/outsourcing and hospital capacity targeting categories 1, 1a, 2 and long waiters.
- UHNM is launching a centralised GP Advice Bureau utilising existing systems (Consultant Connect) and resources (the Outpatient Team). The Bureau will be a single point of access for GP's to access urgent administrative queries . UHNM's GP advice bureau will form part of the Trusts overarching vision to provide a front facing, single point of access to GP's with a specific focus on building, improving and sustaining mutually beneficial partnership working arrangements to ensure the safe, effective and sustainable delivery of services to our local population.

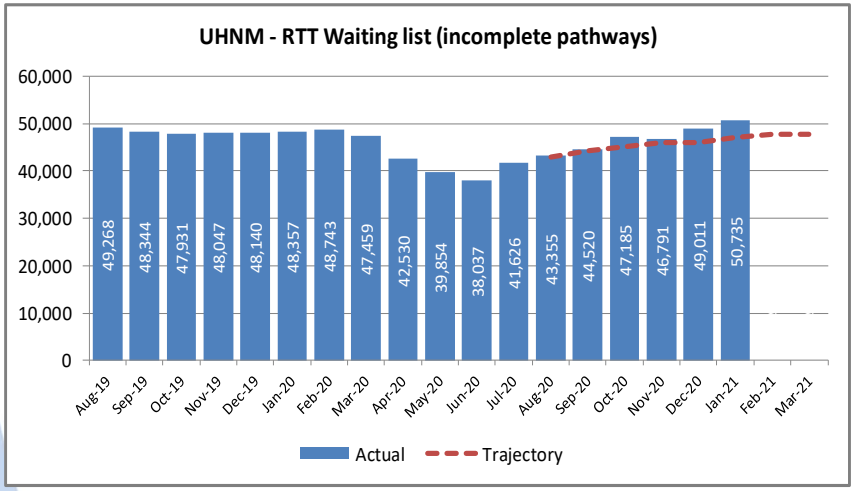
Risks:

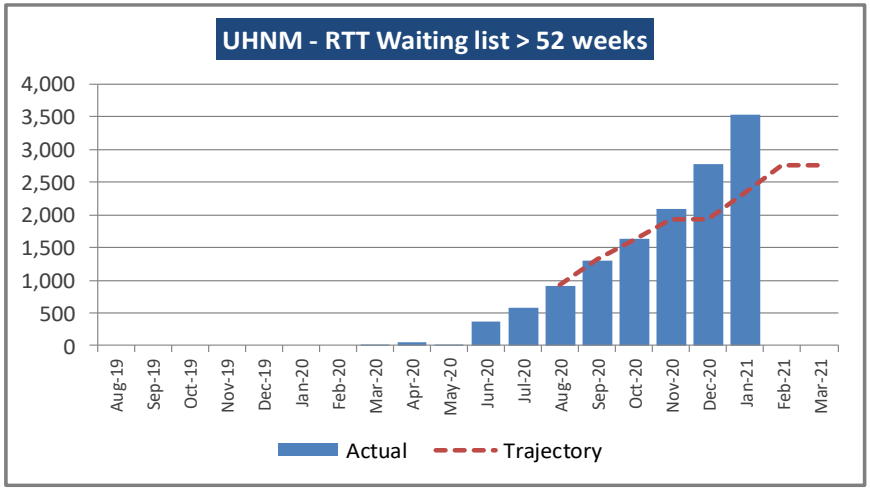
- Impact of stopping FTF activity in some areas to release staff to support frontline being monitored.

Planned care – *Outpatient activity & RTT*

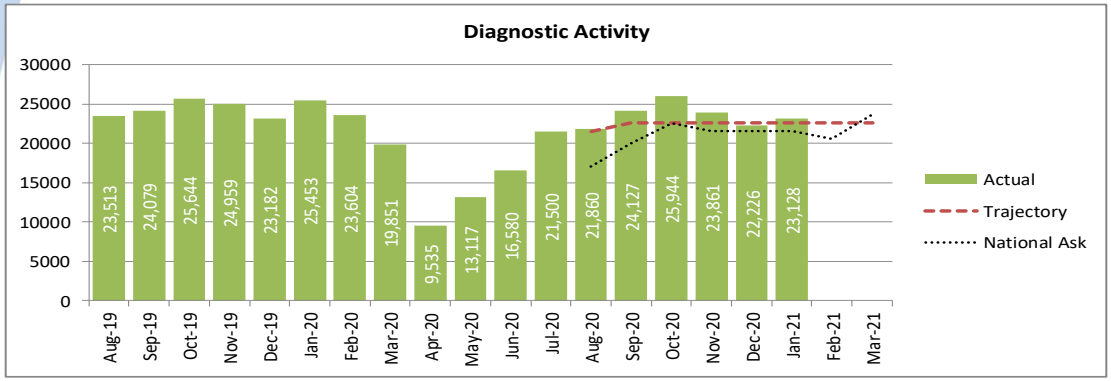








Diagnostic Activity



	Nov 20	Dec 20	Jan 21
Trajectory	22,608	22,608	22,608
Actual	23,861	22,226	23,128
Varience	**1,253**	-382	**520**
Background			
Activity for the 6 key DM01 tests			

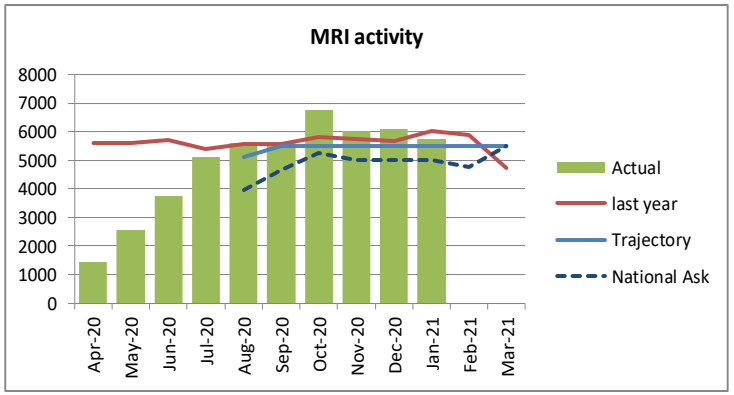
Summary

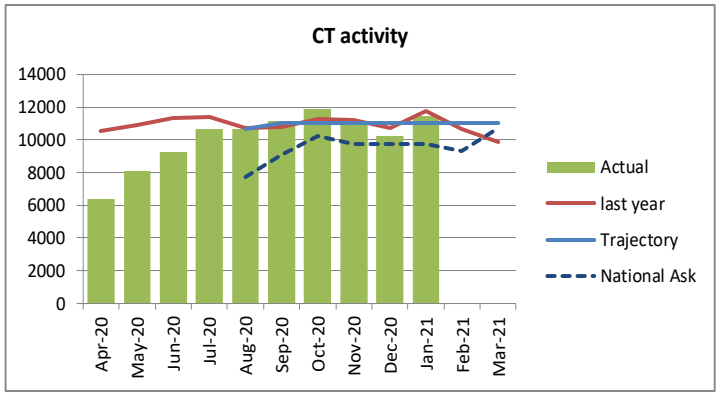
- For the 6 key diagnostic tests in phase 3, January saw an increase in activity which appears to be normal variation (as is for all the DM01 tests). The trust trajectory for activity has consistently met the national ask and would be on trajectory to deliver to the year end. This was before the impact the new variant of Covid-19, the easing of restrictions over the Christmas period and the usual winter pressures which has shown some early indications of having an impact on performance and the size of the waiting list. The indicative diagnostic performance for January 21 is currently 85.74%. The waiting list size is 11, 841 (December 11,668) Recovery plans are now being transacted and monitored via the Diagnostic Cell to end of March 2021, with investment requests approved for DMO1 modalities to support this recovery timescale.

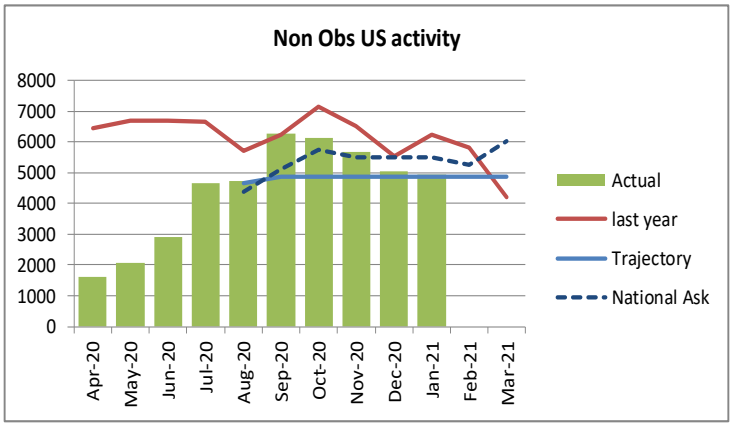
Actions

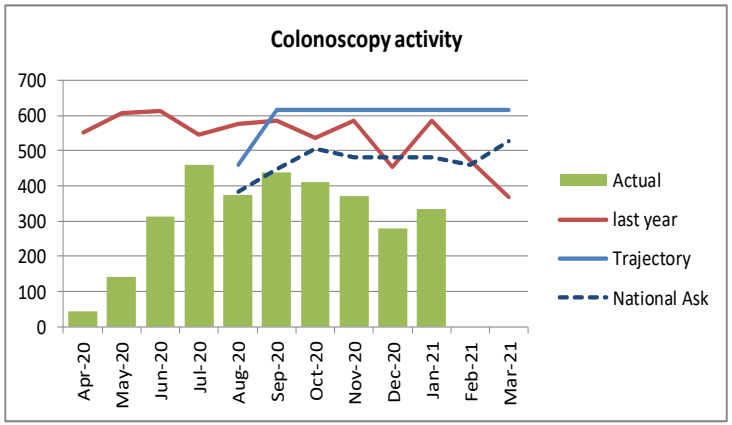
- The diagnostic work streams have made significant improvements and are working towards more initiatives to improve systems and processes.
    - Patient Connect is fully operational for pathology services and a scoping exercise underway to see if this can be transferred to other areas
    - Robotic Process Automation project is in train – to support with the auto scheduling of plain film imaging appointments that were previously 'walk in' but due to social distancing need to be booked – ongoing
- The Diagnostic cell continues to monitor plans and activity against trajectory.
- Mobile MRI to continue to end of March 21.
- Investment papers have been submitted to continue recovery and restoration.

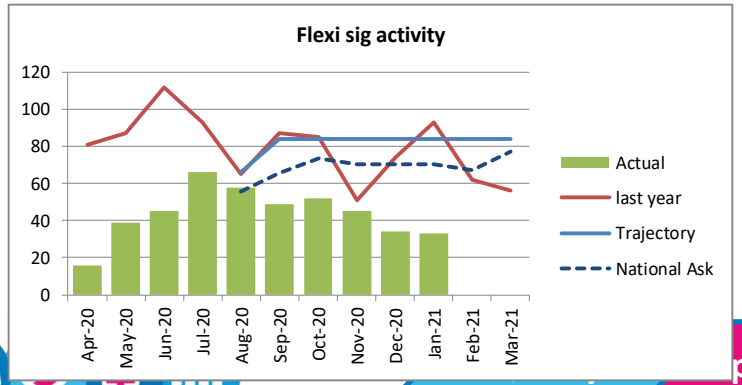
Diagnostics

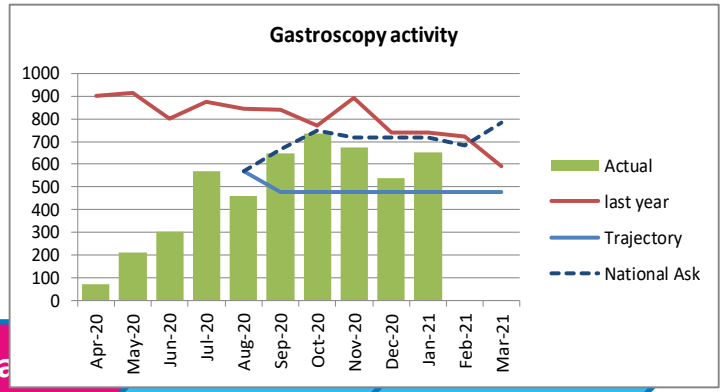












APPENDIX 1

Operational Performance

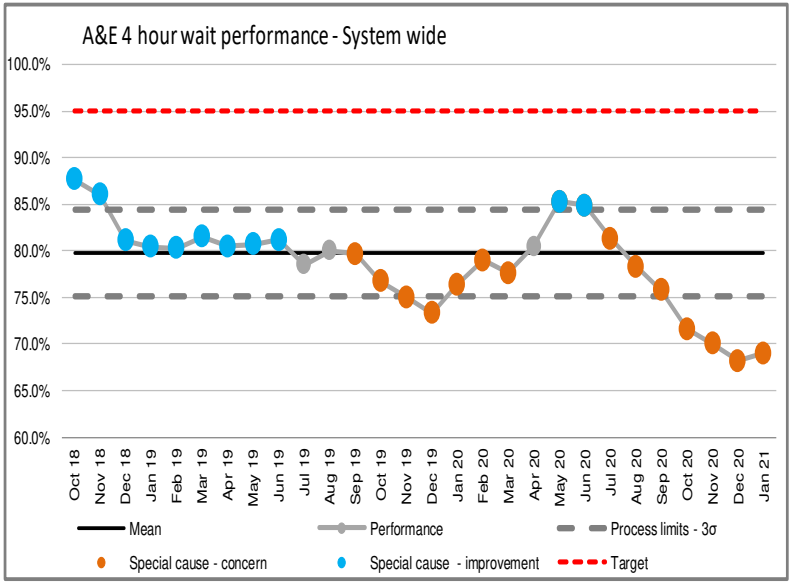
Constitutional standards

	Metric	Target	Latest	Variation	Assurance	DQAI
A&E	A&E 4 hour wait Performance	95%	69.00%	L	F	
	12 Hour Trolley waits	0	33		?	
Cancer Care	Cancer Rapid Access (2 week wait)	93%	87.33%		?	
	Cancer 62 GP ref	85%	62.71%	L	?	
	Cancer 62 day Screening	90%	80.00%		?	
	31 day First Treatment	96%	92.70%		?	
Elective waits	RTT incomplete performance	92%	65.20%	L	F	
	RTT 52+ week waits	0	3538	H	F	
	Diagnostics	99%	87.57%		?	

	Metric	Target	Latest	Variation	Assurance	DQAI
Use of Resources	DNA rate	7%	8.2%		?	
	Cancelled Ops	150	53	L	?	
	Theatre Utilisation	85%	76.0%			
Inpatient / Discharge	Same Day Emergency Care	30%	28.5%		?	
	Super Stranded	183	145	L	?	
	DToC	3.5%	2.30%	L	?	
	Discharges before Midday	30%	20.5%		F	
	Emergency Readmission rate	8%	12.2%	L	F	
	Ambulance Handover delays in excess of 60 minutes	10	83		?	

URGENT CARE – 4 hour access performance

University Hospitals of North Midlands NHS Trust



Variation	Assurance
L	F

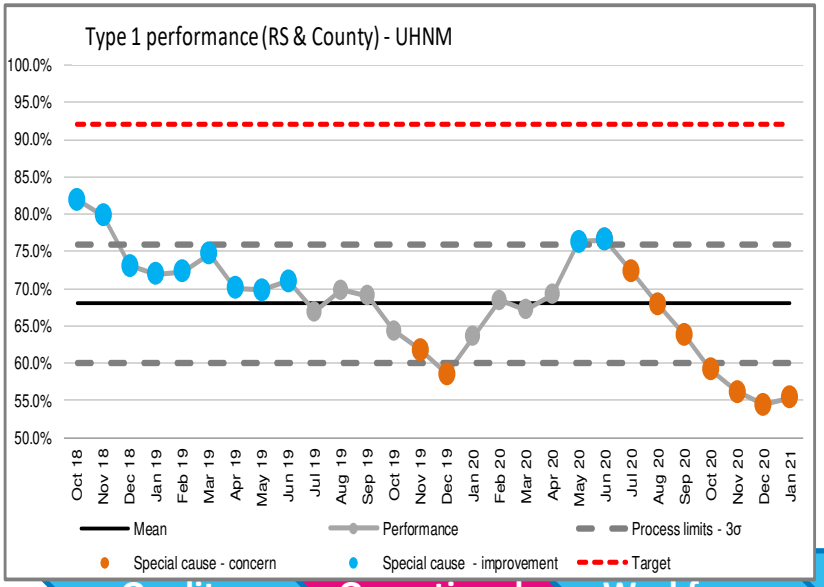
Target	Nov 20	Dec 20	Jan 21
95%	70.0%	68.2%	69.0%

Background

The percentage of patients admitted,transferred or discharged with in 4 hours of arrival at A&E

What is the data telling us?

The improvemnets seen in May and June have not been sustained and performance is showing special cause concern. Performance has been below the lower control limit for 4 months.



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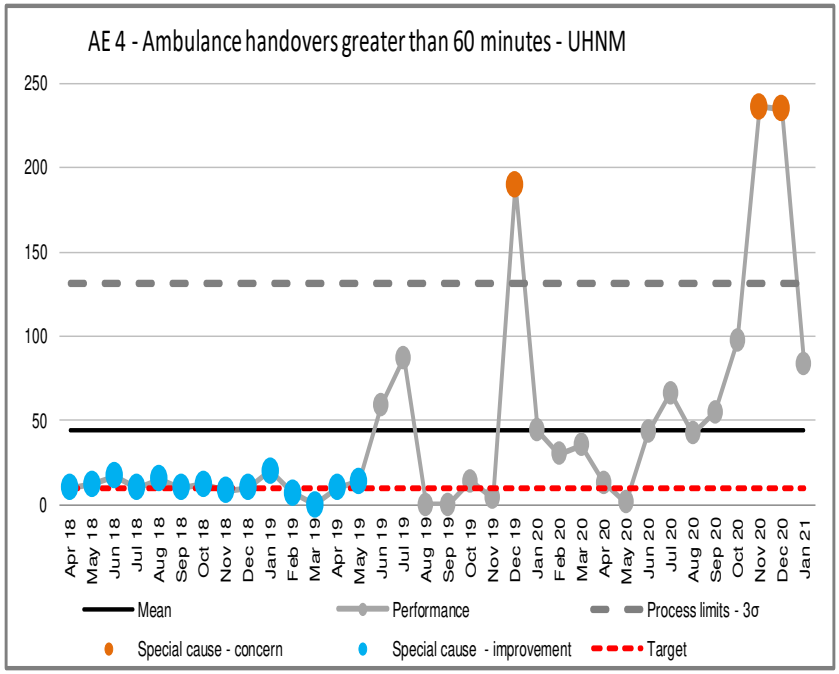
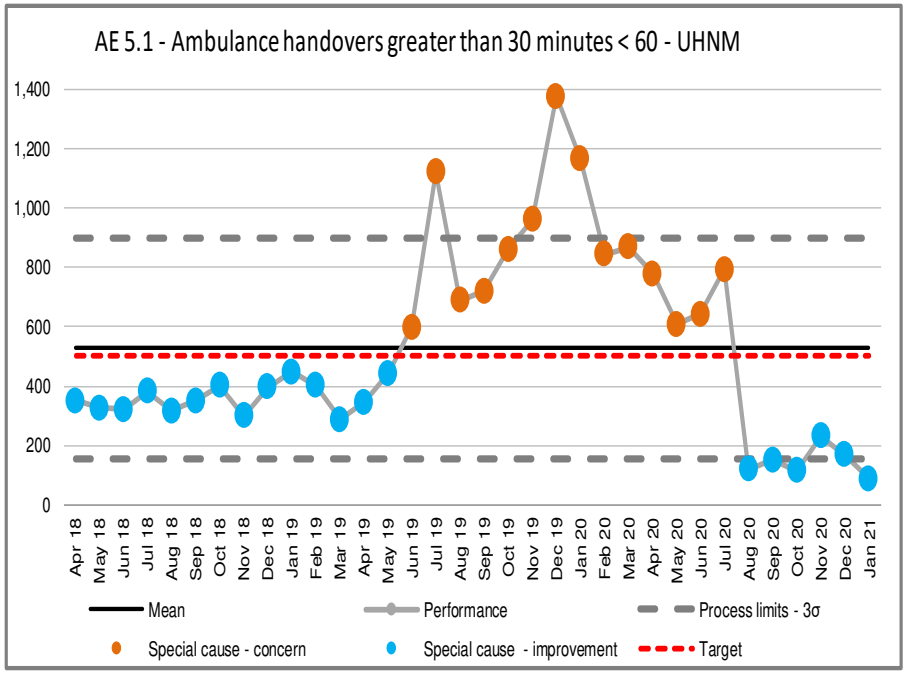
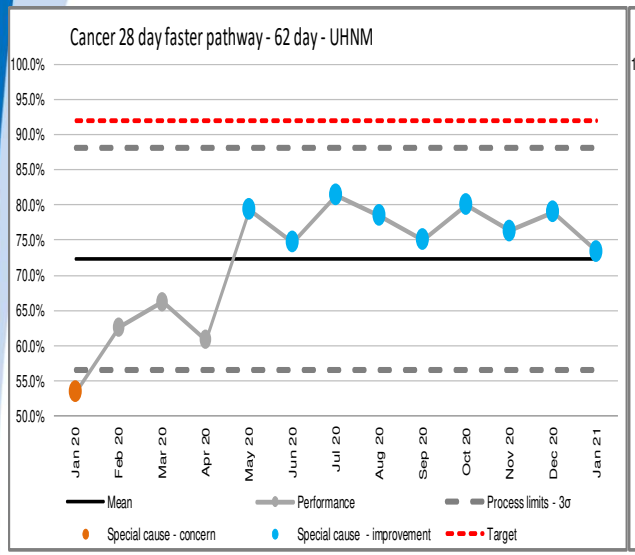
URGENT CARE – 4 hour access – ambulance handovers

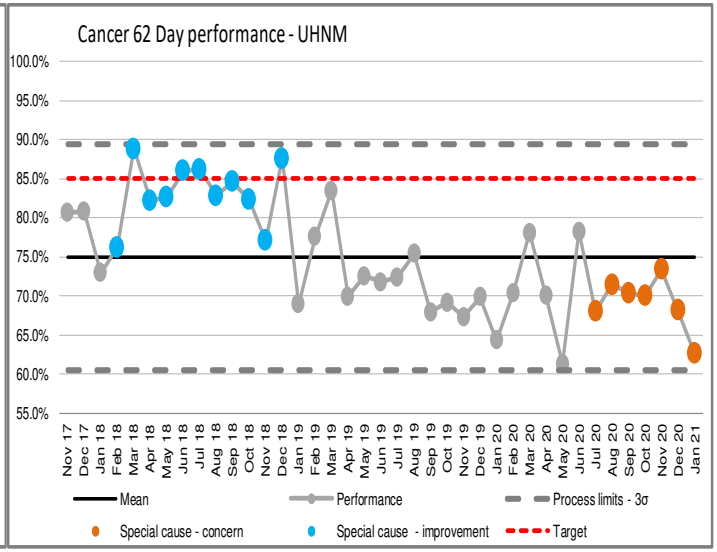




From August – internal validation of > 30 minutes

Cancer – 62 Day





Variation	Assurance
	

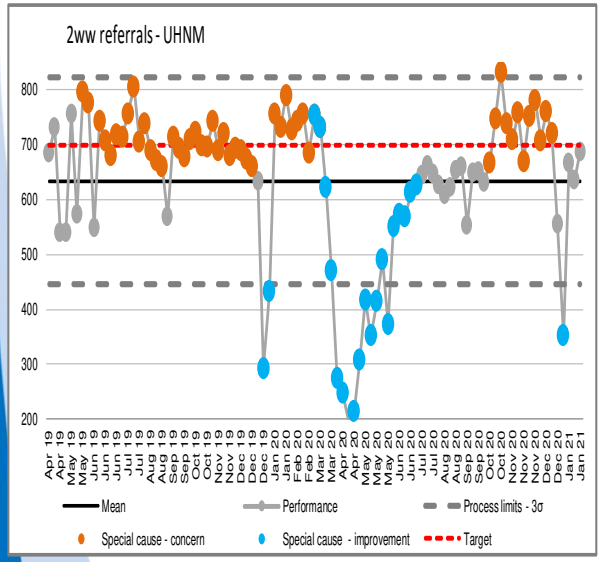
Target	Nov 20	Dec 20	Jan 21
85%	73.4%	68.1%	62.7%

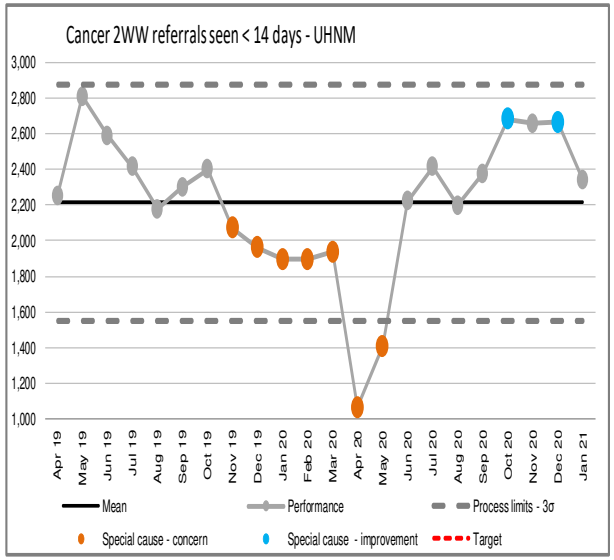
Background

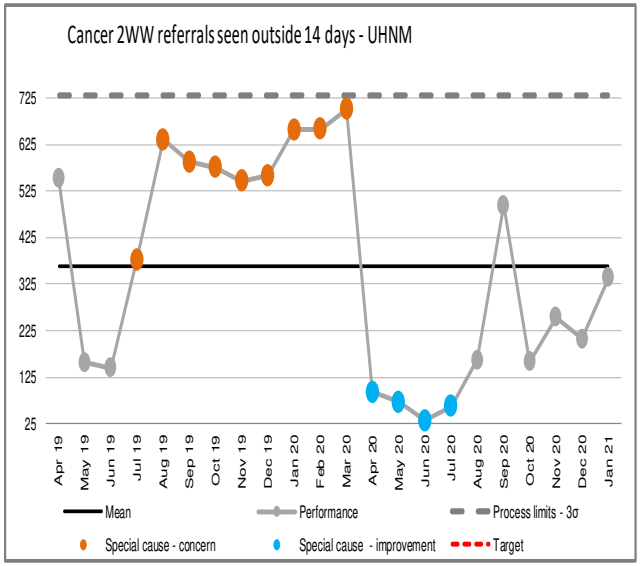
% patients beginning their treatment for cancer within 62 days following an urgent GP referral for suspected cancer

What is the data telling us?

Performance shows normal comon cause variation. However this has been consistently below the mean since April 2019 (with just two data points above the mean). This indicates that the target is unlikely to be met.







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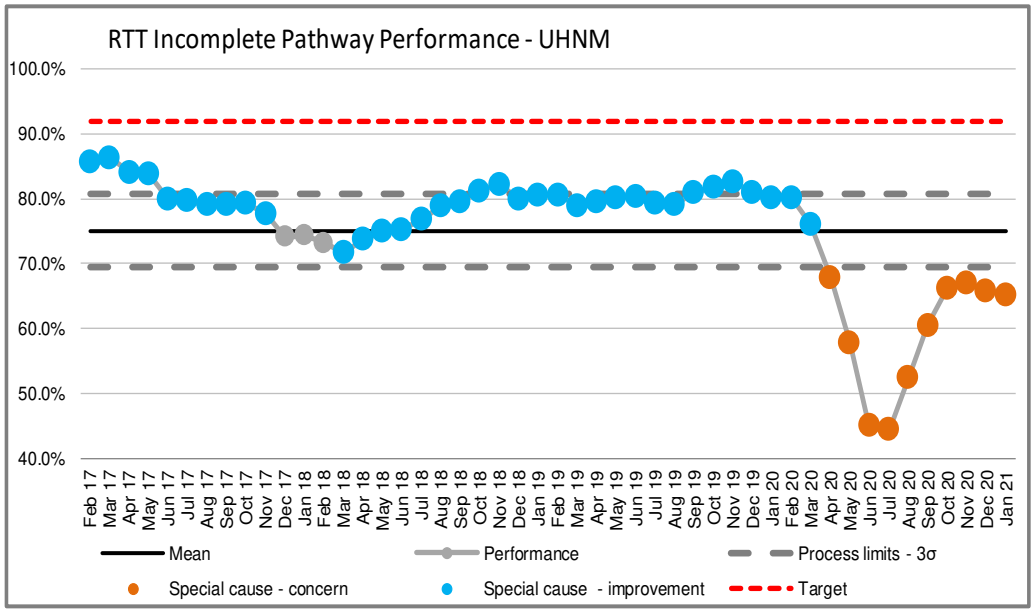
Referral To Treatment



Variation	Assurance
	

Target	Nov 20	Dec 20	Jan 21
92%	67.0%	65.8%	65.2%

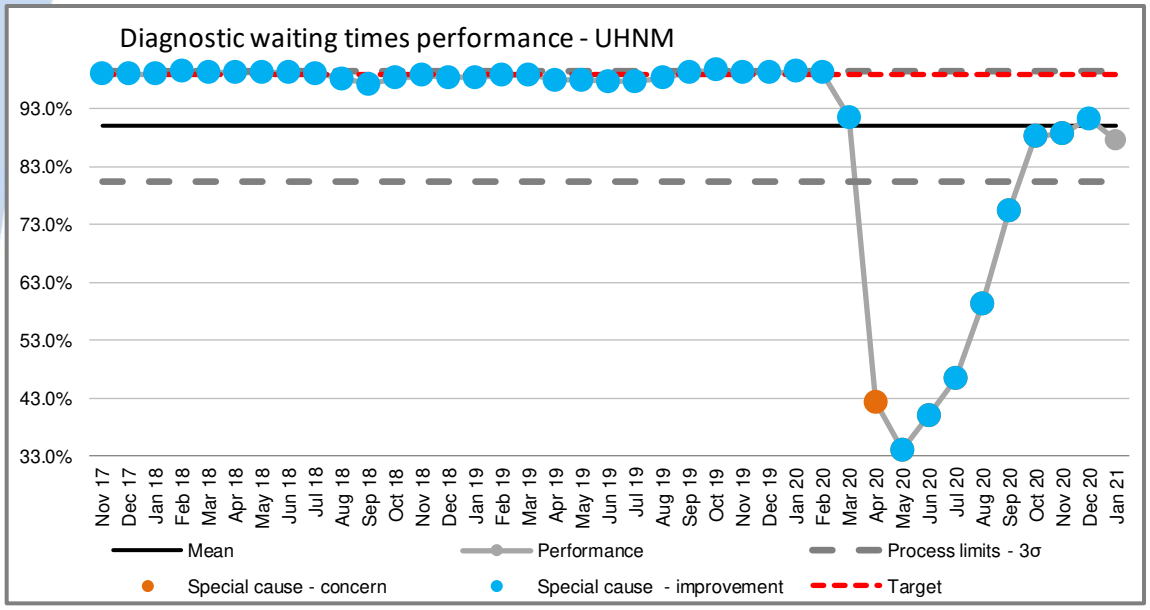
Background

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

What is the data telling us?

The RTT performance deteriorated from March 2020 with the onset of Covid-19. There is some early indication that performance is beginning to increase.

Diagnostic Standards



Variation	Assurance
	

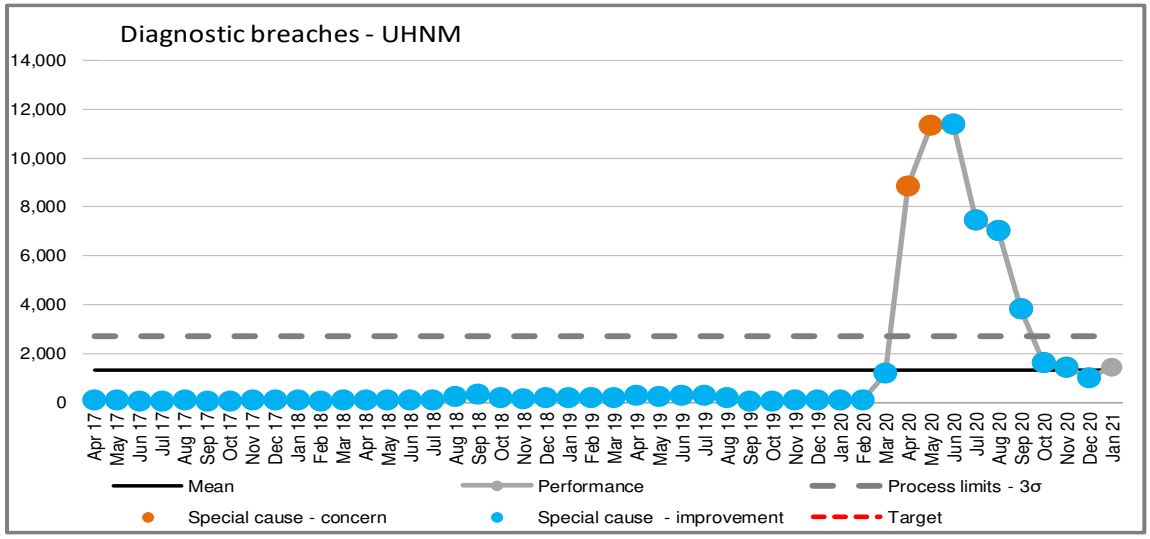
Target	Nov 20	Dec 20	Jan 21
99%	88.6%	91.2%	87.6%

Background

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

What is the data telling us?

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



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Workforce

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

Workforce Spotlight Report

Key messages

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

The focus of the Workforce Bureau remains on risk assessments, staff wellbeing, staff testing, staff deployment and supporting the vaccination programme.

- From 9th December 2020., all staff and those working in the Trust were offered the vaccination. Additionally, the Trust offered the vaccination to partner organisations as well as other health and social care workers, some local authority workers and patients. The focus in the coming weeks will be on further promoting the vaccine for our BAME employees. UHNM was stood down as a hospital hub with effect from 31st January 2021 when the vaccination programme moved to the 34 community hubs. Staff are still able to access the vaccination at one of these community vaccination centres. Plans are in place to commence roll out the second dose of the vaccination from 25th February. Around 76% of UHNM employees have received a first does of the vaccine
- Between 31st March 2020 and 12th February 2021 we have carried out 8,579 PCR tests, excluding staff outbreak screening.
- As at 12th February, 95.07% of all permanent and fixed term staff have completed a covid-related risk assessment
- As of 12th February 2021, covid-related open absences numbered 303, which was 39% of all absences (48.94% at 4th January 2021)

The key performance issues remain compliance with the sickness rate being above target and with PDR requirements although an Executive decision was taken to suspend PDR's unless there is capacity to continue to undertake them.

Sickness

The in-month sickness rate was 5.71% (6.19% reported at 31/12/20). The 12 month cumulative rate increased to 5.42% (5.34% at 31/12/20).Over the course of the next few months, the wellbeing plan is being developed to support and signpost staff to a range of wellbeing offers depending on staff needs at this time, including psychological support

Appraisals

The Non-Medical PDR compliance rate was 74.65% (76.26% at 31st December 2020)

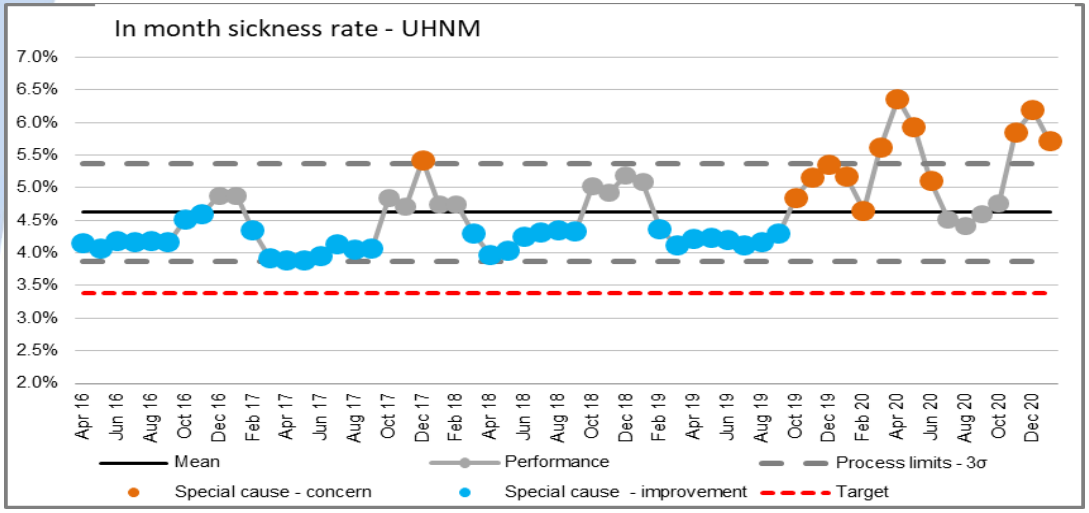
Statutory and Mandatory Training

The Statutory and Mandatory training rate at 31st January 2021 was 93.41% (93.93% at 31st December 2020). At 31st January 2021, 89.17% of staff had completed all 6 Core for All modules (89.86% at 31/12/20)

Workforce Dashboard

Metric	Target	Latest	Variation	Assurance
Staff Sickness	3.4%	5.71%		
Staff Turnover	11%	9.45%		
Statutory and Mandatory Training rate	95%	93.41%		
Appraisal rate	95%	74.65%		
Agency Cost	N/A	3.43%		

Sickness Absence



Variation	Assurance
H	F

Target	Nov 20	Dec 20	Jan 21
3.4%	5.9%	6.2%	5.7%

Background

Percentage of days lost to staff sickness

What is the data telling us?

Sickness rate is consistently above the target of 3.4%. The special cause variation seen from March through to July was a result of covid-19. Covid related absences reduced in January following the rollout of the lateral flow tests and vaccinations

Summary

The in-month sickness rate was 5.71% (6.19% reported at 31/12/20). The 12 month cumulative rate increased to 5.42% (5.34% at 31/12/20)

Absence episodes increased significantly during November with the second covid wave and have been reducing since 1st December which may be a result of the rollout of the lateral flow tests and the vaccination programme

The Trust commenced its Vaccination Programme on 9th December 2020. All staff and those working in the Trust have been offered the vaccination. The vaccination programme has seen 76% of UHNM employees receive a first dose. The Trust has also vaccinated many agency, contracted workers, students and volunteers, as well as staff from partner and other organisations. The rollout of the second dose vaccination is planned to commence in February

As of 12th February 2021, covid-related open absences numbered 303, which was 39% of all absences (48.94% at 4th January 2021)

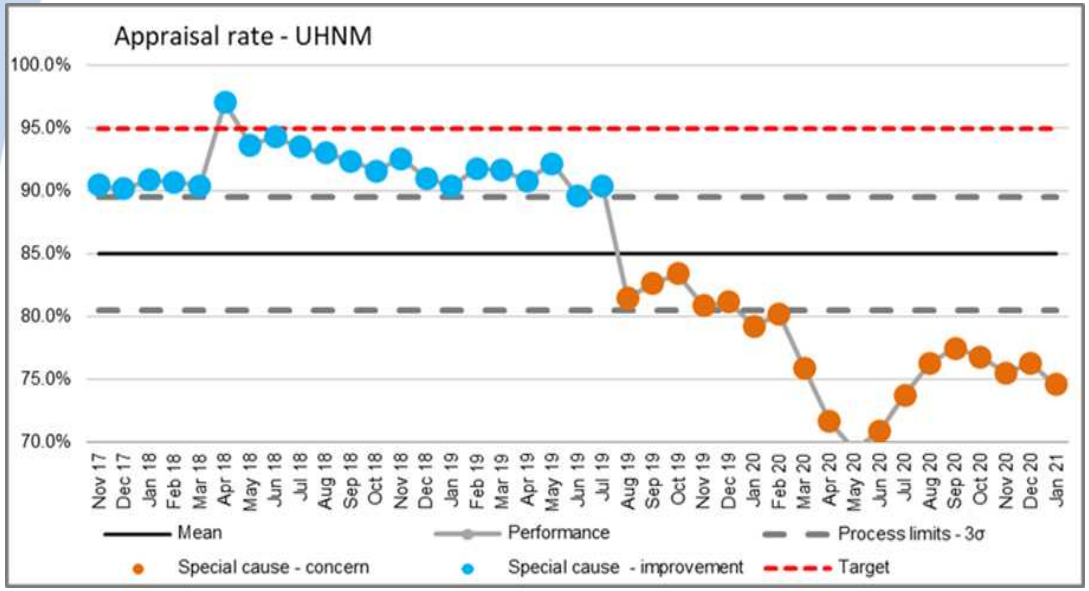
Actions

In February we will be providing Leader Listening Spaces. These will be pilot sessions to support leaders on topics/challenges that are current during the pandemic

The annual staff survey report will be published on 11th March 2021, which will provide insight into staff feelings and perceptions of working at the Trust over the last year.

Over the course of the next few months, the wellbeing plan is being developed to support and signpost staff to a range of wellbeing offers depending on staff needs at this time, including psychological support.

Appraisal (PDR)



Variation	Assurance
L	F

Target	Nov 20	Dec 20	Jan 21
95.0%	75.6%	76.3%	74.7%

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%. More recently the rate shows special cause variation. There has been a drop below the lower control limit since August 2019.

Summary

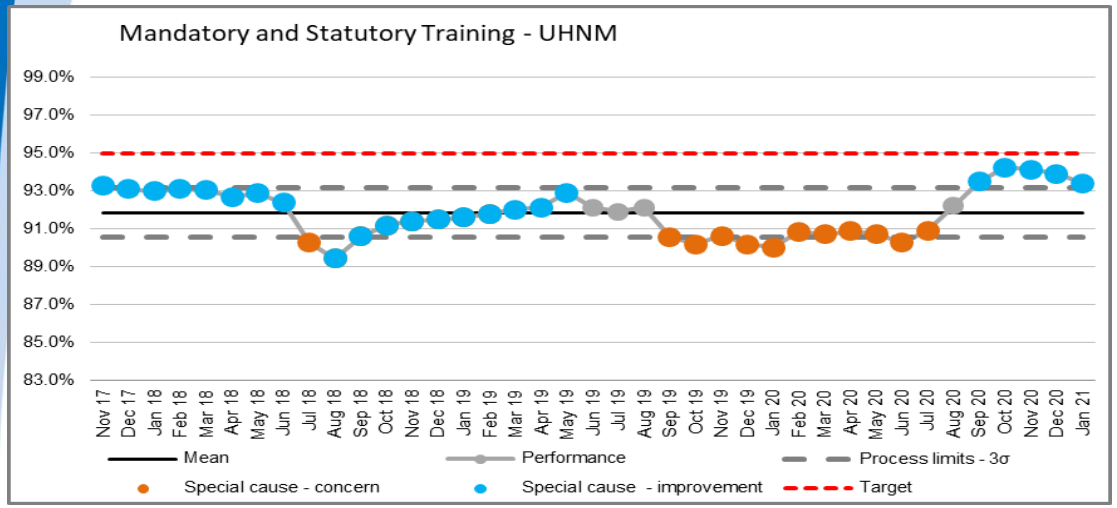
The Non-Medical PDR compliance rate was 74.65% (76.26% at 31st December 2020).

Performance against the improvement trajectories produced by all Divisions is managed via the performance review meetings. It is recognised that this time of year becomes more challenging to timetable PDR discussions due to operational pressures across the Trust.

Actions

Due to the surge in covid, an Executive decision was taken to suspend PDR's unless there is capacity to continue to undertake them..

Statutory and Mandatory Training



Variation	Assurance
H	F

Target	Nov 20	Dec 20	Jan 21
95.0%	94.1%	93.9%	93.4%

Background

Training compliance

What is the data telling us?

The Training rate is consistently below the 95% target. The special cause variation from September 2019 was the point at which local recording systems were no longer used.

Summary

The Statutory and Mandatory training rate at 31st January 2021 was 93.41% (93.93% at 31st December 2020). At 31st January 2021, 89.17% of staff had completed all 6 Core for All modules (89.86% at 31/12/20)

Competence Name	Assignment Count	Required	Achieved	Compliance %
205|MAND|Security Awareness - 3 Years|	10885	10885	10175	93.48%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	10885	10885	10200	93.71%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	10885	10885	10052	92.35%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	10885	10885	10137	93.13%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	10885	10885	10175	93.48%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	10885	10885	10264	94.29%

Compliance with the annual elements of the Statutory and Mandatory Training requirements are as follows:

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 1 Year|	10885	10885	8956	82.28%
NHS|CSTF|Information Governance and Data Security - 1 Year|	10885	10885	9554	87.77%

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

Actions

Finance

2025 Vision "Ensure efficient use of resources"

Finance Spotlight Report

University Hospitals of North Midlands NHS Trust

Key messages

- The Trust has received confirmation that it will receive £12.4m additional funding for M7-12 relating to the TSA agreement, NHSI have only factored £7.4m of this into the plan which remains at £7.2m deficit however the remaining £5m is factored into the forecast of £2.2m.
- The Trust has delivered a surplus of £1.9m in Month 10 against a planned deficit of £1.3m which is driven by additional DHSC funding relating to the TSA agreement, additional NHSE income in respect of mechanical thrombectomy and continued slippage against the original COVID-19 allocation and winter plan.
- Activity delivered in Month 10 is significantly lower than plan although NHS income levels from patient activities have been maintained due to the temporary funding arrangements. The Trust estimates the impact of the Elective Incentive Scheme (EIS) to be a £0.9m reduction to income in Month 10 which is not reflected in the financial position in line with guidance from NHSI/E.
- The Pathology Network went live on 1 December with the financial impact included in the financial position and whilst there is a negligible impact on the bottom line, this is causing variances between the reporting categories (i.e. other income, pay and non-pay)
- The Trust incurred £2.4m of costs relating to COVID-19 which is a substantial increase on month 9 (£1.6m) due to expanding NHS workforce/additional shifts and testing as a result of the second wave. This remains within funded run rate with £1.9m in allocation and 0.5m chargeable outside the notified envelope.
- Capital expenditure for the year to date stands at £41.7m which is £4.6m behind plan with the main driver being slippage on the PDC funded RI site demolition and phasing of Linac and IR2 bi-plane.
- The month end cash balance is £90.2m which is £9.3m more than plan.

Finance Dashboard

	Metric	Target	Latest	Variation	Assurance
I&E	TOTAL Income	variable	74.2		
	Expenditure - Pay	variable	44.8	H	?
	Expenditure - Non Pay	variable	23.4		P
Activity	Daycase/Elective Activity	variable	5,684	L	?
	Non Elective Activity	variable	8,190	L	?
	Outpatients 1st	variable	20,013	L	?
	Outpatients Follow Up	variable	38,955		?

Income & Expenditure

Income & Expenditure Summary Month 10 2020/21	Annual Plan £m	In Month			Year to Date		
		Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Income From Patient Activities	777.6	65.1	66.5	1.4	647.3	651.8	4.5
Other Operating Income	55.8	5.2	7.8	2.6	45.3	52.7	7.4
Total Income	833.3	70.3	74.2	3.9	692.6	704.5	11.9
Pay Expenditure	(522.0)	(45.0)	(44.8)	0.2	(432.1)	(428.5)	3.6
Non Pay Expenditure	(266.7)	(22.5)	(23.4)	(0.9)	(221.4)	(228.6)	(7.2)
Total Operational Costs	(788.7)	(67.5)	(68.2)	(0.8)	(653.5)	(657.1)	(3.6)
EBITDA	44.6	2.8	6.0	3.2	39.1	47.4	8.3
Depreciation & Amortisation	(29.2)	(2.4)	(2.4)	(0.0)	(24.2)	(24.2)	(0.0)
Interest Receivable	0.1	0.0	0.0	0.0	0.1	0.1	0.0
PDC	(5.7)	(0.3)	(0.3)	0.0	(5.1)	(5.0)	0.0
Finance Cost	(17.1)	(1.4)	(1.4)	(0.0)	(14.3)	(14.3)	(0.0)
Other Gains or Losses	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Surplus / (Deficit)	(7.2)	(1.3)	1.9	3.2	(4.3)	4.0	8.3
MRET central funding	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Financial Recovery Fund	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	(7.2)	(1.3)	1.9	3.2	(4.3)	4.0	8.3

At Month 10 the Trust has reviewed its performance against its revised plan and is £3.2m better than this plan in month and £8.3m better than plan year to date. This is summarised in the table below; key points to note are:

- Income from patient activities is better than plan in month by £1.4m of which £0.7m relates to additional pass through drug income within CWD and Specialised and £0.5m income for COVID-19 expenditure relating to those costs incurred in month 10 which were incurred on top of the original COVID-19 allocation of £11.8m.
- The Month 10 position includes £2.0m of income relating to the TSA agreement; £1.2m received from Stafford and Surrounds CCG and £0.8m directly from the DHSC; this is accounted for as other operating income. Only £0.8m of this is being reported as a variance as the revised plan figure has been adjusted for the funding received via the CCG (i.e. the planned deficit of £14.6m has been improved by £7.4m to reach the revised plan of a £7.2m deficit) with the Trust expected to better this plan by the £5m.
- The impact of the Pathology Network in month is additional operating income of £1.4m, additional pay expenditure of £0.8m and additional non pay expenditure of £0.3m.

Capital Spend

University Hospitals of North Midlands NHS Trust

Capital Expenditure as at Month 10 2020/21 £m	Revised Annual	In Month			Year to Date		
	Plan	Revised Budget	Actual	Variance	Revised Budget	Actual	Variance
PFI & finance lease liability repayment	(11.6)	(1.0)	(1.0)	-	(9.6)	(9.6)	-
Pre-ccommitted items	(11.6)	(1.0)	(1.0)	-	(9.6)	(9.6)	-
ICT Infrastructure	(2.9)	(0.5)	(1.6)	(1.0)	(1.7)	(2.1)	(0.4)
Estates Infrastructure	(2.5)	(0.0)	(0.1)	(0.1)	(2.2)	(2.1)	0.0
Medical Equipment	(2.3)	-	(0.2)	(0.2)	(1.4)	(1.3)	0.0
PFI lifecycle and equipment	(2.0)	(0.2)	(0.2)	-	(1.6)	(1.6)	-
Health & Safety Compliance	(0.2)	-	-	-	(0.1)	(0.1)	(0.0)
Other Central schemes	(0.3)	-	(0.2)	(0.2)	(0.0)	(0.3)	(0.3)
Project Star	(0.9)	-	(0.1)	(0.1)	(0.9)	(0.8)	0.1
Investment schemes	(0.1)	-	0.0	0.0	-	(0.1)	(0.1)
COVID-19 Trust funded	(0.8)	-	-	-	(0.8)	(0.8)	0.0
Linac	(2.2)	-	(0.1)	(0.1)	(1.9)	(0.1)	1.8
IR2 Bi Plane	(1.4)	-	(0.0)	(0.0)	(1.0)	(0.1)	0.9
LIMS	(0.8)	(0.1)	(0.1)	(0.1)	(0.7)	(0.4)	0.3
EPMA	(0.8)	(0.0)	(0.0)	0.0	(0.4)	(0.4)	0.0
Pathology schemes	(1.1)	-	(0.1)	(0.1)	(0.6)	(0.7)	(0.0)
Trust funded capital programme	(18.4)	(0.8)	(2.6)	(1.8)	(13.3)	(10.8)	2.5
Royal Infirmary Site demolition	(5.2)	(0.9)	(0.6)	0.2	(4.1)	(3.2)	0.9
ED & RI Decant Accomodation Medical Records	(0.6)	-	(0.1)	(0.1)	(0.3)	(0.1)	0.2
COVID-19 PDC (approved)	(1.3)	-	-	-	(1.3)	(1.3)	-
PDC award for HSLI	(1.2)	-	-	-	(1.2)	(1.1)	0.1
Wave 4b funding - modular wards	(9.1)	-	-	-	(9.1)	(9.1)	-
Critical Risk Infrastructure	(3.2)	(0.4)	(0.2)	0.2	(0.7)	(0.9)	(0.2)
Emergency Department Schemes	(2.8)	-	(0.8)	(0.8)	(2.8)	(2.3)	0.5
ED Decant accomodation - Russell building	(0.7)	-	-	-	(0.7)	-	0.7
ED Decant accomodation - Trent scheme	(0.5)	-	(0.0)	(0.0)	(0.5)	(0.0)	0.5
Adapt & Adopt	(0.3)	-	(0.1)	(0.1)	(0.1)	(0.1)	-
Critical Care Resilience	(0.4)	-	-	-	-	-	-
Purchase of Grindley Hill Court	(5.4)	-	-	-	-	-	
Other PDC funding	(0.5)	-	(0.4)	(0.4)	-	(0.5)	(0.5)
PDC funded capital schemes	(31.1)	(1.3)	(2.2)	(0.9)	(20.7)	(18.6)	2.1
Charitable funds expenditure	-	(2.3)	(2.3)	-	(2.7)	(2.7)	-
Charity funded expenditure	-	(2.3)	(2.3)	-	(2.7)	(2.7)	-
Overall capital expenditure	(61.0)	(5.4)	(8.1)	(2.7)	(46.3)	(41.7)	4.6

At Month 10 the capital programme is £2.5m behind the revised plan on Trust funded schemes, mainly due to the phasing of the plan figures for the Linac and IR2 bi-plane. PDC funded schemes are £2.1m behind plan which is mainly due to the underspend in relation to the phasing of expenditure included in the Emergency Department scheme Memorandum of Understanding (MOU) and the RI demolition works.

A forecast of the likely capital funding and expenditure position gives a balance of available funding of £1.312m; additional schemes are been reviewed to minimise the level of underspend for the year.

Cash flow

Cash Summary at Month 9 2020/21		In Month			Year to date		
	Revised Budget £m	Revised Plan £m	Actual £m	Variance £m	Revised Plan £m	Actual £m	Variance £m
Opening balance	26.7	90.6	82.7	(7.9)	26.7	26.7	-
Block mandate payments (to 31st October 2020)	760.0	63.3	76.2	12.9	631.2	634.5	3.3
Contract income 2019/20	(7.4)	-	-	-	(7.4)	(7.4)	-
Other Income (including other NHS)	63.3	5.5	6.2	0.7	59.5	60.1	0.6
Health Education England Training Income	22.5	-	-	-	14.2	14.0	(0.2)
PSF/FRF - 2019/20 Q4	9.7	-	-	-	9.7	9.7	-
Capital funding (PDC capital)	26.4	1.4	-	(1.4)	12.1	9.1	(3.0)
Total Receipts	874.5	70.2	82.4	12.2	719.3	719.9	0.7
Payroll (excluding agency)	(492.5)	(40.7)	(41.4)	(0.7)	(365.4)	(366.0)	(0.6)
Accounts payable	(347.7)	(31.6)	(33.8)	(2.2)	(263.2)	(264.8)	(1.6)
PDC Dividend	(5.0)	-	-	-	(3.2)	(3.2)	-
Capital payments	(42.4)	(3.1)	(3.8)	(0.7)	(28.8)	(26.5)	2.2
Total Payments	(887.5)	(75.4)	(79.0)	(3.6)	(660.6)	(660.6)	0.0
Closing Balance	13.7	85.4	86.1	0.7	85.4	86.1	0.7

The cash flow budget above has been revised following the submission of the plan for the second half of the financial year on 22 October. The year-end forecast cash balance of £13.7m reflects the year end revenue deficit forecast of £14.7m in this plan and the assumption that the block contract cash received in advance during the financial year will be recovered in March 2021 this has not yet been confirmed by NHSI. This forecast does not include additional cash expected to be received from NHSI/E and DHSC in relation to transitional income.

At the end of December the cash balance of £86.1m is £0.7m higher than plan. In Month 9 the Trust has received the cash in relation to the validated Month 6 top-up of £7.9m. The Month 9 cash received for the block mandates is also higher than plan in month due to receiving the Trust 2 months of the top up COVID-19 block funding in Month 9. The year to date position is £3.3m higher than plan due elements of this being paid in advance, which was not anticipated in the cash plan figure.

Capital funding is £3m behind plan as it was expected that the Trust would have been able to draw down PDC funding in relation to COVID-19 capital and RI demolition works by Month 9.

Accounts payable in month and year to date are slightly higher than plan. The Trust is complying with Treasury guidance for the prompt payment of suppliers and is continuing to pay invoices as they are approved.

Balance sheet

Balance sheet as at Month 10	31/03/2020	31/01/2021			
	Actual £m	Revised Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment	483.0	489.7	490.3	0.6	
Intangible Assets	24.5	20.2	20.3	0.1	
Other Non Current Assets	-	-	-	-	
Trade and other Receivables	0.4	0.4	0.4	-	
Total Non Current Assets	507.9	510.3	511.0	0.7	
Inventories	13.3	13.1	13.8	0.7	
Trade and other Receivables	49.6	32.6	52.7	20.1	Note 1
Cash and Cash Equivalents	26.7	80.8	90.2	9.4	Note 2
Total Current Assets	89.6	126.5	156.7	30.2	
Trade and other payables	(74.8)	(128.4)	(144.6)	(16.2)	Note 3
Borrowings	(208.0)	(10.6)	(10.7)	(0.1)	
Provisions	(6.7)	(6.7)	(6.7)	(0.0)	
Total Current Liabilities	(289.5)	(145.7)	(162.0)	(16.3)	
Borrowings	(276.6)	(266.9)	(267.0)	(0.1)	
Provisions	(1.2)	(1.2)	(1.2)	-	
Total Non Current Liabilities	(277.7)	(268.0)	(268.1)	(0.1)	
Total Assets Employed	30.3	223.0	237.6	14.6	
Financed By:				-	
Public Dividend Capital	409.7	614.9	614.9	-	
Retained Earnings	(476.2)	(488.8)	(474.2)	14.6	Note 4
Revaluation Reserve	96.9	96.9	96.9	-	
Total Taxpayers Equity	30.3	223.0	237.6	14.6	

The revised balance sheet plan reflects the plan submitted to NHSI/E on 22 October which is based on the Month 6 balance sheet and expected movements for the remainder of the financial year. Variances to the revised plan at Month 10 are explained below:

- Note 1 – This figure includes £4.9m transitional funding in relation to the Mid Staffs integration. The variance is also due to receivables including a £8.3m accrual in relation to specialised commissioners pass through funded drugs.
- Note 2 - This is mainly due to the £7.4m cash received from Stafford and Surrounds CCG relating to the Month 7-12 transitional funding and the receipt in advance of COVID-19 top up payments relating to Month 11.
- Note 3 - The payables balance reflects the receipt in advance of £68.4m for February block income received on the 15th January as part of the national COVID-19 response, of this £7.5m is higher than the plan figure due to additional COVID-19 funding also being received a month in advance. The remaining variance to plan is due to an increase in the level of accruals and capital creditors of £7.1m reflecting the level of capital spend in January.
- Note 4 – This variance reflects the better than plan revenue position compared to the original plan(*) prior to confirmation of the transitional funding and a £1m difference between the cash received for Donated Assets and the amount of depreciation charged for Donated Assets.

*The balance sheet plan has not been updated by NHSI to reflect the additional TSA funding of £7.4m and therefore shows an I&E deficit position of £9.3m at Month 10 rather than the £0.2m year to date planned I&E surplus.

Expenditure - Pay and Non Pay

Pay Summary (£m)	Annual Plan	In Month			YTD		
		Plan	Actual	Variance	Plan	Actual	Variance
Medical	(160.5)	(13.9)	(14.0)	(0.1)	(132.6)	(132.4)	0.2
Registered Nursing	(155.3)	(13.5)	(12.9)	0.7	(128.2)	(125.1)	3.1
Scientific Therapeutic & Technical	(58.4)	(5.0)	(5.3)	(0.3)	(48.4)	(48.7)	(0.3)
Support to Clinical	(71.1)	(6.0)	(6.1)	(0.1)	(59.0)	(58.5)	0.5
Nhs Infrastructure Support	(76.8)	(6.5)	(6.5)	(0.1)	(63.8)	(63.8)	0.0
Total Pay	(522.0)	(45.0)	(44.8)	0.2	(432.1)	(428.5)	3.6

Pay - As in the prior month the Trust is now reporting pay spend for the staff who have TUPE'd as part of the Pathology Network arrangements which in month amounted to £0.8m. However, the pay still remains underspent in month and YTD primarily as a result of the Winter slippage referenced above which was £0.5m in month. Whilst the COVID-19 spend has increased overall in month and is above the original plan (see section 2.3) the pay element of the COVID-19 plan was underspent in month by £0.7m.

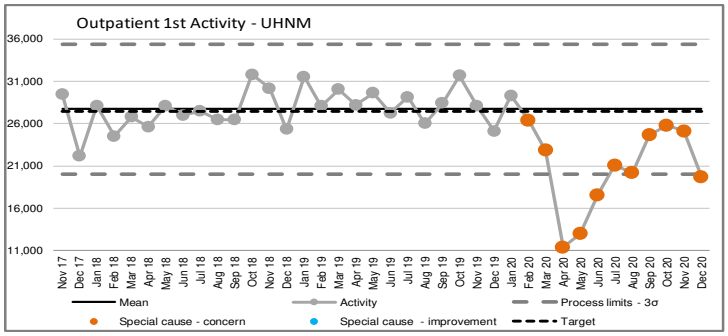
Non Pay Summary (£m)	Annual Plan	In Month			YTD		
		Plan	Actual	Variance	Plan	Actual	Variance
Tariff Excluded Drugs Expenditure	(67.5)	(5.4)	(6.3)	(0.9)	(56.1)	(60.7)	(4.6)
Other Drugs	(19.8)	(1.7)	(1.8)	(0.1)	(16.4)	(17.3)	(0.9)
Supplies & Services - Clinical	(55.8)	(4.6)	(5.0)	(0.4)	(46.3)	(50.0)	(3.7)
Supplies & Services - General	(6.9)	(0.5)	(0.5)	0.0	(5.8)	(6.0)	(0.2)
Purchase of Healthcare from other Bodies	(16.3)	(1.7)	(1.3)	0.4	(12.7)	(10.1)	2.6
Consultancy Costs	(1.4)	(0.0)	(0.0)	(0.0)	(1.0)	(1.0)	0.0
Clinical Negligence	(22.3)	(1.9)	(1.9)	0.0	(19.2)	(19.2)	0.0
Premises	(29.4)	(2.6)	(2.7)	(0.1)	(24.9)	(25.2)	(0.4)
PFI Operating Costs	(34.7)	(2.9)	(2.9)	(0.0)	(28.9)	(29.1)	(0.1)
Other	(12.6)	(1.2)	(1.0)	0.2	(10.1)	(10.0)	0.1
Total Non Pay	(266.7)	(22.5)	(23.4)	(0.9)	(221.4)	(228.6)	(7.2)

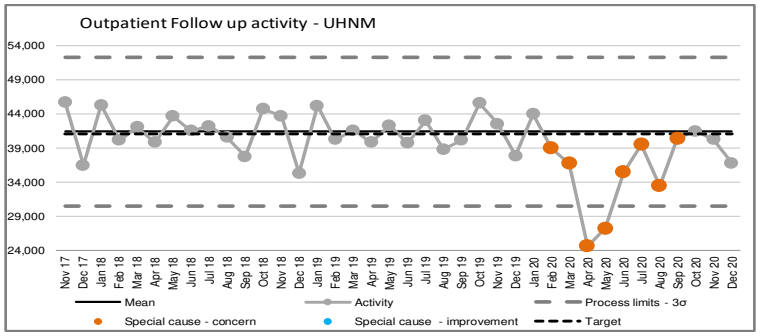
Non-pay Non-pay expenditure is overspent by £0.9m in Month 10. This is primarily driven by pass through drug expenditure but there have also been higher than planned spend clinical supplies which is driven by increased COVID-19 testing costs and the Pathology Network costs (although some has been offset by reduced spend against elective procedure costs). Both of these have limited impact on the bottom line due to the additional income arrangements for those costs outside of the original COVID-19 allocation and the billing arrangements across the Pathology Network.

Activity

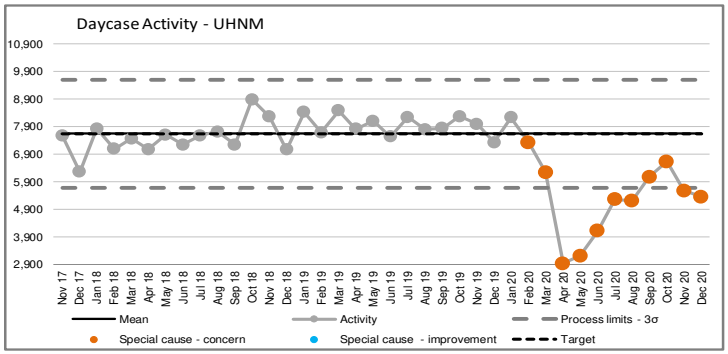
University Hospitals of North Midlands NHS Trust

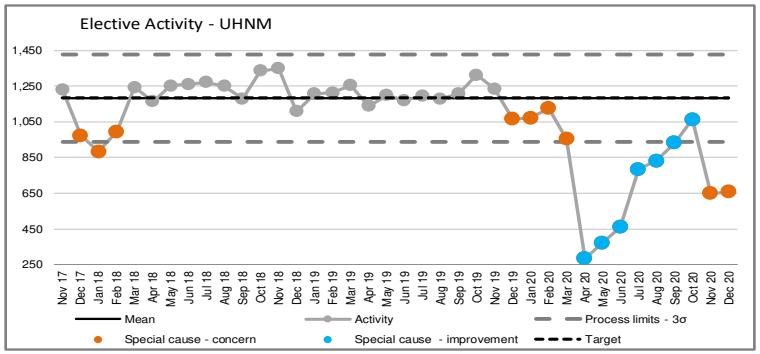
Planned care Outpatient



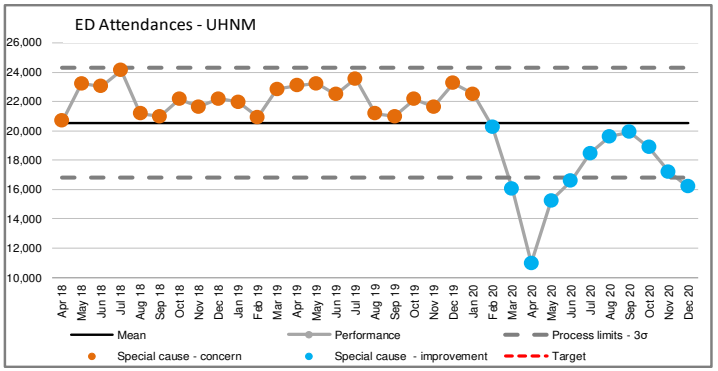


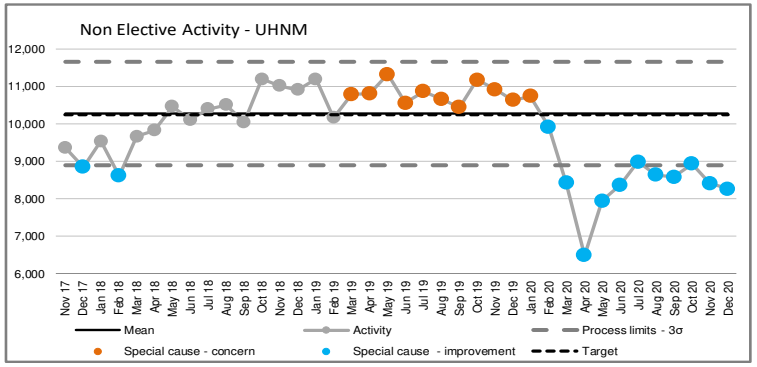
Planned care Inpatient





Urgent Care





Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Trust Board
2020/21 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 8	May 6	Jun 10	Jul 8	Aug 5	Sep 16	Oct 7	Nov 4	Dec 9	Jan 6	Feb 3	Mar 10	Notes
PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES														
Chief Executives Report	Chief Executive													
Patient Story	Chief Nurse													Public Trust Board meetings did not take place in April - June due to social distancing
Quality Governance Committee Assurance Report	Associate Director of Corporate Governance													
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer					→								Delayed due to Covid. Considered in December.
Care Quality Commission Action Plan	Chief Nurse													Divisions are continuing to monitor their action plans, however, due to time lapse since the CQC inspection in June 2019, some actions relating to Emergency Department at Royal Stoke are outdated and no longer relevant due to new ways of working. A meeting is scheduled with CQC relationship manager to discuss how can provide ongoing assurance of the actions being taken as well as seeking guidance on the new standards. Update to be provided in Q1 2021/22
Bi Annual Nurse Staffing Assurance Report	Chief Nurse							→						Discussed at TAP in September 20, and agreed changes required prior to presentation to the Board.. Further report to be provided to the Board once TAP have discussed further. Update to be provided in Q1 2021/22
Quality Account	Chief Nurse													Timing moved due to changes in national requirements regarding submission
7 Day Services Board Assurance Report	Medical Director													Timing TBC due to national changes
NHS Resolution Maternity Incentive Scheme	Chief Nurse													Timing TBC due to national changes
Winter Plan	Chief Operating Officer													
PLACE Inspection Findings and Action Plan	Director of Estates, Facilities & PFI													Timing TBC due to national changes
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													

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Notes
		8	6	10	8	5	16	7	4	9	6	3	10	
People Strategy Progress Report	Director of Human Resources													Deferred to August's meeting due to Covid
Revalidation	Medical Director													Timing TBC due to national changes.
Workforce Disability Equality Report	Director of Human Resources													
Workforce Race Equality Standards Report	Director of Human Resources													
Staff Survey Report	Director of Human Resources													
LEAD STRATEGIC CHANGE WITHIN STAFFORDSHIRE AND BEYOND														
System Working Update	Chief Executive / Director of Strategy													
ENSURE EFFICIENT USE OF RESOURCES														
Performance and Finance Committee Assurance Report	Associate Director of Corporate Governance													
Revenue Business Cases / Capital Investment / Non-Pay Expenditure £1,000,001 and above	Director of Strategy													
IM&T Strategy Progress Report	Director of IM&T													
Going Concern	Chief Finance Officer													
Estates Strategy Progress Report	Director of Estates, Facilities & PFI													Deferred due to Covid-19 Jan: Schemes update circulated to Board members on 4th November 2020.
Annual Plan 2020/21	Director of Strategy													Deferred due to Covid-19
Financial Plan 2021/22	Chief Finance Officer													Delayed due to delay in receiving national guidance regarding planning for 2021/22.
Capital Programme 2021/22	Chief Finance Officer													Delayed due to delay in receiving national guidance regarding planning for 2021/22.
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		Covid Assurance Framework included in CEO Report May 20
Raising Concerns Report	Director of Human Resources		Q4			Q1			Q2			Q3		
Annual Evaluation of the Board and its Committees	Associate Director of Corporate Governance													Deferred due to Covid-19
Annual Review of the Rules of Procedure	Associate Director of Corporate Governance													
G6 Self-Certification	Chief Executive													Deferred to June's meeting
FT4 Self-Certification	Chief Executive													
Board Development Programme	Associate Director of Corporate Governance													Following discussion in August, number of next steps agreed, however given Covid restrictions, limited scope for Board Development sessions via MS Teams.