University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 7th July 2021 at 9.30 am to 12.30 pm via Microsoft Teams

AGENDA

Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
09:30	**PROCEDURAL ITEMS**					
20 mins	1.	Patient Story	Information	Ms AM Riley	Verbal	
5 mins	2.	Chair's Welcome, Apologies and Confirmation of Quoracy	Information	Mr D Wakefield	Verbal	
	3.	Declarations of Interest	Information	Mr D Wakefield	Verbal	
	4.	A. Minutes of the Meeting held 9th June 2021 B. Minutes of the Extraordinary Meeting held 14th June 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 – June 2021	Information	Mrs T Bullock	Enclosure	**BAF 6**
10:20	**PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES**					
5 mins	7.	Quality Governance Committee Assurance Report (22-06-21)	Assurance	Ms S Belfield	Enclosure	**BAF 1**
10 mins	8.	IPC Board Assurance Framework	Assurance	Ms AM Riley	Enclosure	**BAF 1**
10 mins	9.	CNST Maternity Incentive Scheme	Approval	Ms AM Riley / Ms L Dudley	Enclosure	**BAF 1**
10 mins	10.	Revalidation Annual Update	Assurance	Mr N Coleman	Enclosure	
10:55 – 11:10 : BREAK						
11:10	**ENSURE EFFICIENT USE OF RESOURCES**					
5 mins	11.	Performance & Finance Committee Assurance Report (22-06-21)	Assurance	Mr P Akid	Enclosure	**BAF 9**
11:15	**ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT AND RESEARCH**					
5 mins	12.	Transformation and People Committee Assurance Report (23-06-21)	Assurance	Prof G Crowe	Enclosure	**BAF 2 & 3**
11:20	**ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS**					
40 mins	13.	Integrated Performance Report – Month 2 • Urgent Care Review	Assurance	Ms AM Riley Mrs T Bullock Mrs R Vaughan Mr M Oldham	Enclosure	
12:00	**GOVERNANCE**					
10 mins	14.	Board Development Programme 2021-22	Approval	Miss C Rylands	Enclosure	
12:10	**CLOSING MATTERS**					
10 mins	15.	Review of Meeting Effectiveness and Business Cycle Forward Look	Information	Mr D Wakefield	Enclosure	
	16.	Questions from the Public **Please submit questions in relation to the agenda, by 9.00 am 5th July to nicola.hassall@uhnm.nhs.uk**	Discussion	Mr D Wakefield	Verbal	
12:20	**DATE AND TIME OF NEXT MEETING**					
	17.	**Wednesday 4th August 2021, 9.30 am via Microsoft Teams**				

University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 9th June 2021, 9.30 am to 12.20 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												
Ms T Bowen	TBo	Non-Executive Director												
Mr P Bytheway	PB	Chief Operating Officer												
Mrs T Bullock	TB	Chief Executive												
Prof G Crowe	GC	Non-Executive Director												
Dr L Griffin	LG	Non-Executive Director												
Mr M Oldham	MO	Chief Financial Officer	JT											
Dr J Oxtoby	JO	Medical Director		AW										
Dr K Maddock	KM	Non-Executive Director												
Mr S Purser	SP	Interim Chief Nurse	SP	MR										
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											
Ms S Gohir	SG	Associate Non-Executive Director												
Prof A Hassell	AH	Associate Non-Executive Director												
Mrs L Thomson	LT	Director of Communications												
Miss C Rylands	CR	Associate Director of Corporate Governance												
Mrs L Whitehead	LW	Director of Estates, Facilities & PFI												

In Attendance:		
Mrs N Hassall	NH	Deputy Associate Director of Corporate Governance (minutes)
Mr P Gallagher	PG	Patient (item 1)
Mrs A Grocott	AG	Head of Patient Experience (item 1)

Members of Staff and Public via MS Teams: 5

No.	Agenda Item	Action
1.	**Patient Story**	
086/2021	Mr Gallagher described his story and highlighted the care which he had received at the Trust, when he was admitted with Covid which he had caught while undergoing chemotherapy treatment. He explained that he was put into an induced coma upon admission which was frightening and described the excellent care he received during his stay, by both doctors and nurses on the Intensive Care Unit, and particularly highlighted the care received from Chris Morrallee. It was noted that Mr Gallagher had subsequently nominated Mr Morrallee for a Daisy Award and explained the way in which he had suggested changing Mr Gallagher's treatment pathway which was subsequently discussed and agreed with a doctor, demonstrating the positive culture on the unit. Mr Gallagher	

PROUD TO CARE

	explained that once he was transferred to Ward 113 he felt isolated due to being in a side room, but highlighted the care received by James Haywood, Physiotherapist. He described some issues experienced in terms of his follow up after discharge which he recognised was not the fault of the Trust, but stated that staff should be cognisant of not over promising in terms of timing of discharge nurse visits. Mr Wakefield referred to Mr Gallagher being put into an induced coma and queried whether the reasons for doing so were fully explained. Mr Gallagher explained that he was fully told of the reasons and it was due to the condition he was in. Mr Wakefield queried if Mr Gallagher queried why the doctor had not decided to change his treatment and Mr Gallagher explained that Mr Morrallee was with him for more time than the doctor and therefore he felt that was the reason. Mrs Bullock thanked Mr Gallagher for the story and welcomed the intervention from Mr Morrallee which reflected the expected and positive multidisciplinary team approach within the Intensive Care Unit. Mr Akid queried if Mr Gallagher had noted anything for improvement and Mr Gallagher stated that he saw the same care being given to other patients. He explained that at the start of shifts a nurse was allocated to patients but sometimes this changed during the shift which he was surprised about. Dr Oxtoby expressed his pride and gratitude of the staff in critical care and accepted the point made regarding discharges and over promising in respect of district nursing services, and agreed this should be relayed to staff. Mr Purser thanked Mr Gallagher for sharing his story and the positive comments made. He referred to the nurses changing partway through a shift, and stated that staff were assessed based on skill mix and as acuity changed throughout the hospital, staff were moved as required and that this was done on a risk assessed basis. Mr Wakefield summarised the staff particularly praised by Mr Gallagher; Dr Krueper, Mr Morrallee and James Haywood as well as Lisa Weir who arranged the discharge and Dr Kam. He welcomed the excellent teamwork noted by Mr Gallagher and referred to the importance of being cognisant of patients feeling isolated while in side rooms, as well as considering how improvements could be made when discharging patients in terms of post discharge arrangements and links with community, which was a key issue for the ICS. **The Trust Board noted the story.** Mr Gallagher and Mrs Grocott left the meeting.	
2.	**Chair's Welcome, Apologies & Confirmation of Quoracy**	
087/2021	Mr Wakefield welcomed members of the Board and observers to the meeting and the above apologies were received. It was confirmed that the meeting was quorate. Mr Wakefield welcomed Ms Gohir and Ms Bowen to their first meeting and welcomed Mr Purser who was acting as Interim Chief Nurse. He also welcomed Ms Freeman as an observer.	

3.	**Declarations of Interest**	
088/2021	The standing declarations were noted.	
4.	**Minutes of the Previous Meeting held 5th May 2021**	
089/2021	The minutes of the meeting from 5th May 2021 were approved as an accurate record.	
5.	**Matters Arising from the Post Meeting Action Log**	
090/2021	PB/474 – Mrs Vaughan referred to the additional workforce performance metrics and stated that some had been incorporated into the performance report and this remained work in progress.	
6.	**Chief Executive's Report – May 2021**	
091/2021	Mrs Bullock highlighted a number of areas from her report. Mr Wakefield referred to the introduction of Vocera and welcomed the benefits it had brought. Mr Wakefield referred to the work on the various strategies and queried when the revised Estates strategy was due to be considered. Mrs Bullock stated that the majority of the enabling strategies would be refreshed once the overall Trust and clinical service strategy had been confirmed. Mrs Whitehead confirmed that the intention was to bring back the strategy in the summer, as agreed by the Board in 2020. Mr Wakefield referred to the progress being made on Provider Collaboratives and queried the timeline for considering this further at a Board Seminar. Mrs Bullock explained that she would provide a presentation to a future Board Seminar on this once some initial work had been completed and described the stock take which was to be undertaken, with meetings continuing to take place to make further progress. **The Trust Board received and noted the report and approved EREAFs 7654, 7352, 7721, 7571 and 7569).**	
PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES		
7.	**Quality Governance Committee Assurance Report (27-05-21)**	
092/2021	Ms Belfield highlighted the following from the report: • The Committee welcomed the staff story provided to the Committee which was very humbling and a credit to the Trust • The Committee requested further information in respect of caesarean sections • The Committee had welcomed the assurance provided in respect of falls and the actions taken as a result of the NG Tubes issue Ms Gohir referred to the elective caesarean rates and queried how the Trust compared to national rates. In addition, she queried the waiting times for women waiting for a caesarean section. Ms Belfield stated that this was an area which was discussed more frequently and the team continuously tried to obtain national	

	data to be used for benchmarking. Mr Bytheway stated that a business case had previously been funded which focussed on separating elective and emergency cases which enabled additional sessions so that there was a split between the two. Although he added that there had not been a reduction in emergency caesarean section rates so the reasons for this needed to be explored. Mrs Bullock added that emergency caesarean section rates were previously high, not because of emergencies but because elective cases were being put onto emergency lists which was the reason for the business case. She stated that since the business case was approved, waiting times had reduced but women did inevitably have to wait sometimes due to emergencies. Ms Ashley referred to the business case review which would be undertaken and this would be reported to Quality Governance Committee in due course. Mr Wakefield stated that the main issue was to provide assurance that the required patient safety standards and outcomes were being met. Professor Hassell stated that the Ockenden review referred to vulnerabilities associated with not undertaking enough caesarean section rates, therefore this was one of the reasons for requesting national guidance in terms of what Non-Executive Directors should be seeing in terms of assurance, given the conflicting information. **The Trust Board received and noted the assurance report.**	
8.	**Infection Prevention and Control Board Assurance Framework (BAF)**	
093/2021	Mr Purser highlighted the following from the report: • There had been one decrease in risk score in relation to BAF 3 and a couple of amber actions which required further progress • Progress had been made in terms of mask fit testing, and the Trust had continued to loan the portacount machine with a business case being put forwards to obtain permanent equipment. In addition centralised recording of mask fit testing had been included on the health roster system making the reporting of data more robust Mr Wakefield welcomed the progress made in completing the outstanding actions particularly the progress made on the portacount equipment and progression of the business case. **The Trust Board received and noted the report.**	
9.	**UHNM Quality Account 2020/21**	
094/2021	Mr Purser highlighted that given the changes to timescales, the report provided to Board members remained in draft, given that the deadline for stakeholder comments was not until the end of the month. Mr Wakefield thanked the team for preparing the report in the timescale and referred to the 2021/22 aims and queried the measures for those. Mr Purser stated that a lot of the measures would be driven nationally and he agreed to consider and include.	**SP**

	Ms Gohir referred to complaints and whether the demographic of those complaining represented the demographics of the local population. Mr Purser stated that although that level of detail was not required within the report, it was something which was monitored by the complaints system which demonstrated that it was representative of the demographic. Dr Griffin referred to the aim of continuing to improve the safety and treatment of patients and improving sepsis treatment and queried whether associated targets should be included. He also queried whether the Quality Account should reflect the work being undertaken to reduce health inequalities going forwards. Professor Hassell referred to the section on research and queried whether a section on education should also be included. Mr Purser agreed to consider and include. Professor Crowe requested additional information in terms of the shared governance model. Mr Purser explained that the work tied in with Improving Together, and was a useful tool to empower staff on wards to change things directly associated with patient care or staff wellbeing. He stated that it looked at developing staff leadership skills at all levels to enable them to make changes to their own environment. Mr Wakefield referred to section 3.2 and performance against 2020/21 KPIs and he requested an additional paragraph to be included to explain the reasons for the difference in reporting of c-difficile figures given they were higher in 2019/20. **The Trust Board:** • **Noted the Quality Account 2020/2021 which included the quality priorities for 2021/22 which linked to existing Trust aims and objectives** • **Approved the draft Quality Account pending the above changes, and inclusion of the final Stakeholder comments**	**SP** **SP**
ENSURE EFFICIENT USE OF RESOURCES		
10.	**Performance & Finance Committee Assurance Report (25-05-21)**	
095/2021	Mr Akid highlighted the following from the report: • The Committee discussed the progress made in terms of Project STAR and the recognised the reasons for the shorter timeframe in making a decision for additional works • The Committee welcomed the report from the initial meeting of the Operational Delivery Group and the risk in relation to the histology bottleneck • The Committee noted the rise in emergency attendances and cancer referrals and received a number of positive updates from procurement Mr Oldham clarified that the Trust's £17.1 m forecast deficit for the H2 position was worst case scenario, given that H2 guidance had not yet been received. He confirmed that the H1 forecast was a break even position. **The Trust Board received and noted the assurance report.**	
ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT AND RESEARCH		
11.	**Transformation and People Committee Assurance Report (26-05-21)**	
096/2021	Professor Crowe highlighted the following:	

	• Continued work of the Guardian of Safe Working to address issues raised by staff • The Committee welcomed utilising best practice in taking forward the Staff Voice surveys • In terms of Improving Together a number of approaches had been reinvigorated post pandemic in order to deliver the required transformation and change Mr Wakefield referred to progress made in appointing Nurse Associates and queried if retention rates for nursing associates were monitored, once they had completed their training. Mr Purser stated that given the Nursing Associates were a new role, the figures were not yet available, but it had been agreed going forwards that this would be monitored. He added that he expected a large number of Nursing Associates to subsequently move onto their nurse training which would look like they had 'left' to complete their training so this needed consideration in terms of how the figures were reported. **The Trust Board received and noted the assurance report.**	
ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS		
12.	**Integrated Performance Report – Month 1**	
097/2021	Mr Purser highlighted the following: • Positive improvements had been made in respect friends and family test results, which had been re-established post pandemic. • The harm free care metrics remained above the national average and sepsis screening through emergency portals saw a sustained improvement • Mitigation and improvement plans for falls were being explored, given an increase in the number of falls and a small increase in harm following a fall. This had been discussed at Quality Governance Committee and a deep dive was being undertaken to explore any themes. This had also been challenged as part of performance reviews • Sepsis screening for inpatients had seen an improvement and the Trust was nearing the national target but further work was required Mr Wakefield referred to the review of falls on Ward 228 and queried the findings. Mr Purser stated that Ward 228 had been identified as a particular area for consideration and that the review demonstrated that if the falls risk assessment was completed at the right time, on admission, associated plans could be put in place to support patients. Ms Gohir referred to the serious incident in maternity where the care was rated as 'grade c' which may have contributed to a poorer outcome and queried what that meant. In addition she queried whether the ethnicity of the mother and baby was known. Mr Purser agreed to obtain the information in terms of ethnicity and provide to Ms Gohir and stated that in terms of the incident, this was under review and once complete would be reported to the Quality Governance Committee. Professor Crowe welcomed the review into falls and referred to sepsis screening and not achieving the target, he queried whether this was a manual process and whether automation could help. Mr Purser confirmed that manual recording was taking place, by undertaking snapshot audits and this could be improved by automation. Professor Crowe noted the small sample size but queried the reason why antibiotics were not provided for the one patient and Mr Purser explained that this was due to the patient being transferred to critical care which was critical	**SP**

the patients deteriorating condition.

Mr Bytheway highlighted the following in terms of urgent care performance:

- A non-elective improvement plan was in place looking at addressing flow through portals, flow through wards and how to manage available beds
- Every metric had deteriorated over the course of the last 3 weeks and the reasons for this were being explored. Between 440 to 450 attendances were being seen at Royal Stoke with the same workforce being pulled into a bigger department treating higher numbers. A number of actions were being taken which included short term temporary staffing to improve decision making, a business case based on making longer term productivity and efficiency savings which also took into account the new urgent care standards
- The number of patients in the Emergency Department at 9.00 am had previously improved but more recently had deteriorated which correlated with a reduction in simple discharges and increase in long stay patients
- The discharge lounge continued to see higher number of patients but the 30% discharge target by lunchtime, was not being met, with performance at circa 20%
- Data was being collected in terms of the actions taken to improve triage times, and the Trust continued to work with Vocare to standardise the staffing in place so that patients could be triaged within the 15 minute target

Mr Wakefield referred to the time and money already spent in putting interventions into ED and the reference to a further business case. He queried what had been achieved from the previous investment, interventions and support already provided. Mr Bytheway stated that an additional 10 doctors had been put into the Department which made small improvements. He stated that a transformation plan had also been agreed and developed with the Emergency Care Intensive Support Team (ECIST) as they challenged the staffing model in place, although taking this piece of work forward had been delayed by Covid. He added that in terms of transformation, there had been a fundamental change in the willingness to engage with transformation and addressing staffing was key going forwards. Mr Bytheway also noted that although the 4 hourly performance had deteriorated there were many other improvements that had sustained such as flow through the department, no corridor waits and ambulance waits being an exception.

Dr Griffin referred to the surge in ambulatory presentations and the reference to greater acuity which seemed to be a contradiction. In addition he welcomed the actions taken to improve upon the small numbers streamed to primary care and increase the number of discharges, but queried the actions associated with tackling the increasing number of Medically Fit for Discharge (MFFDs) patients and high emergency readmission rate.

Mr Bytheway stated that in terms of MFFD patients, complex discharges continued to take place and numbers were increasing. He stated that acuity levels and ambulatory patients were linked and two separate work streams were in place to address this. He stated that as the Trust was seeing more ambulances, by default these patients were sicker, but there had also been an increase in walk in patients and the worried well. He stated that the work to improve triage was aimed at assessing patients for an urgent treatment care category to ensure patients were seen in the most appropriate place.

Mr Akid referred to the assistance previously provided by MProve and queried whether actions were in place to ensure delivery of the actions identified in addition to being held accountable for performance. Mr Bytheway referred to the

various work streams in place and commented that there had been an improvement as a result of the interventions identified. Mr Wakefield suggested that some of the points raised could be further discussed at the Performance and Finance Committee.

Mr Bytheway continued:

- There had been an increase in the over 62 day patient tracking list, although the 104 day list was holding. There was concern with regards to the ability to deliver the trajectory going forwards
- The number of referrals had increased in a number of areas, particularly breast, colorectal and urology with an increase in the number of patients being operated on, and patients moving through clinical priorities

Mr Wakefield referred to the change in demand for breast cancer and whether this was a result of Covid and patients waiting longer to see their GP. Mr Bytheway stated that this was part of the reason, particularly for the challenged specialties,

Professor Hassell queried if there had been any change in referral case mix and Mr Bytheway stated that there had been a slight increase in cancer detection rate in March, but this was not significant and the cancer identification rate as a Trust had remained similar to 2020.

Ms Ashley stated that West Midlands Cancer Alliance were experiencing similar numbers and a number of different models were being considered to alleviate the pressure on Acute Trusts, such as the introduction of a breast pain service managed in the community.

Mr Wakefield queried if Mr Bytheway was confident of the ability to achieve the cancer trajectories. Mr Bytheway stated that the trajectories had not been finally confirmed, and were under review given the current position. He stated that there was a significant risk in the ability to achieve the standards for quarter 1 and 2 given the shape of the patient tracking list, but the Trust continued to operate at full capacity to manage the clinical risk for urgent and cancer patients, therefore clinical prioritisation would remain in place.

- Mr Bytheway added that planned care performance was positive overall, and the Trust had over delivered against the national request, but the Trust was getting back to 100% delivery

Mr Wakefield summarised that for sub waiting lists it was hoped that a positive improvement would be seen from August 2021 and at the end of June / July and diagnostic performance was hoped to return to 90%.

Mrs Vaughan highlighted the following in relation to workforce performance:

- There had been an improving picture for workforce indicators, and in month sickness stood at 4.23%, however in the past week there had been an increase in Covid related staff absence which was 8% at the time of writing the report and had presently increased to 12% to 13%
- The Trust had launched its staff mental health and psychological wellbeing hub
- Enhancements continued to be made to the Empactis system, which had been linked to Health Roster, removing the duplication in using different systems
- There had been an improvement in appraisals and work was ongoing to reduce the number of overdue appraisals

	• Actions continued to be taken in respect of statutory and mandatory training in order to improve compliance • Information had been included in terms of turnover and vacancy rates Professor Crowe welcomed the addition of vacancy rates and suggested that the information be analysed via Statistical Process Charts going forwards. He queried what had been done in general terms to monitor the wellbeing of minority groups. Mrs Vaughan stated that the staff survey results and workforce race equality standard provided detail and information in relation to wellbeing and this would continue to be considered at the Transformation and People Committee. She stated that in terms of referrals for support, information was not readily available given the ability to self-refer but actions were ongoing to consider the impact and outcomes of the wellbeing offer going forwards. Mr Oldham highlighted the following in relation to financial performance: • The budget had been split into two halves although the Trust was only aware of the income allocation for the first 6 months, with a break-even position for H1 anticipated. Beyond that period, the Trust was unsure as to the income would be, but to provide certainty to the Divisions, budget had been set for 12 months • The year-end deficit was based on not continuing to receive support for Covid costs etc although this had not yet been confirmed and would be updated once further guidance had been received • Financial performance in month was a surplus of £2.7 m • In terms of the elective recovery fund, the expectation was that in April the Trust would deliver 70% of 2019/20 work, 75% in May, 80% June and 85% July onwards. Initial data demonstrated UHNM delivering £1.8 m activity above the threshold which would be shown in the accounts therefore a further improvement was expected • In terms of financial impact of the elective recovery fund, the system obtained a net position, therefore of the £1.8 m of additional activity, £1.4 m would be taken into the system • The Trust had cash of £55.4 m and a cash flow forecast would be set in order to be able to measure progress, although the submission was not due until later in the month • £1.1 m of the capital programme had been delivered and £4.6 m of the capital allocation was to be finalised and would be reported to Performance and Finance Committee in due course Mr Wakefield summarised that the Trust had performed well for the first two months and recognised the importance of working with system partners to ensure income for the system was maximised. He stated that the H2 deficit was a guesstimate given the lack of guidance, and the cash position and capital position was on track. Ms Ashley referred to figures for Elective Recovery Fund and the that the 5 gateway criteria were not applicable to April, therefore going forwards the Trust needed to achieve the % as well as the gateways. **The Trust Board received and noted the performance report.**	
CLOSING MATTERS		
13.	**Review of Meeting Effectiveness and Business Cycle Forward Look**	

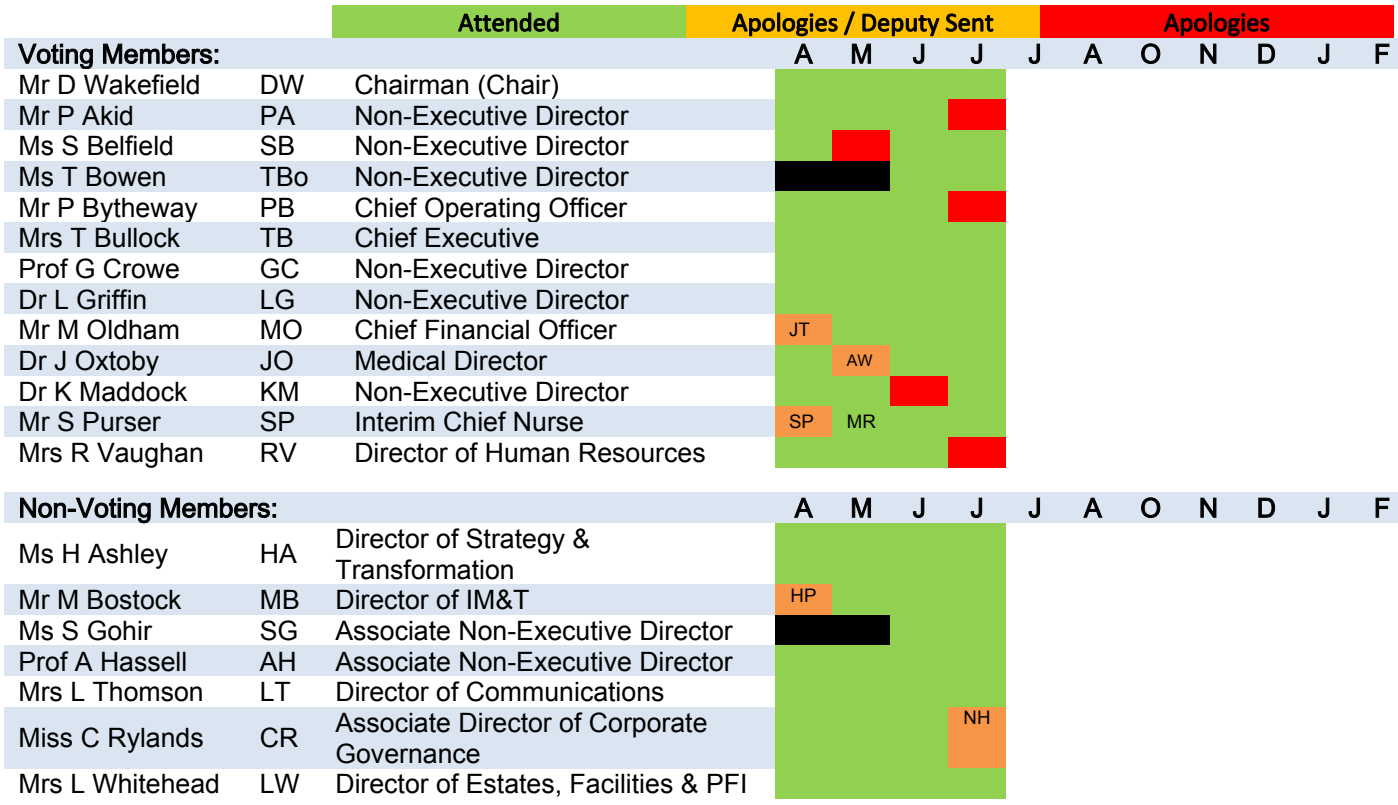
098/2021	No further questions were raised.	
14.	**Questions from the Public**	
099/2021	Mr Syme had raised the following questions prior to the meeting: 1. Triage Urgent Care. Mention had been made of pressures on Urgent Care and specifically of an additional 'intervention which had been required to be made in terms of triage times'. He asked the Board to clarify what the additional intervention regarding triage times was and how it would ensure patient experience of triage times would be improved. It was recognised that Mr Bytheway had answered this question as part of section 12, in terms of the changes to the staffing model, working in conjunction with Vocare. 2. Use of Independent Sector. He queried what the financial impact on UHNM was, in relation to use of the Independent Sector and if the Independent Sector activity was not undertaken in Staffordshire whether there was a financial risk to UHNM and if so what that financial risk equated to. Mr Oldham stated a contract had been agreed with Ramsey and Nuffield Healthcare, whereby charges for activity would be made, with a corresponding income stream therefore having no impact on activity. He stated that the threshold was based on 2019/20 activity and there was no financial risk if Staffordshire patients were treated in the local Independent Sector. He added that if the activity flowed outside of the area there was a risk, but this would be subject to further discussion and approval. 3. Breast Cancer. Mr Syme referred to the 2 week wait standards for Breast Cancer which had been stipulated several times as a main challenge for the Trust. He referred to the Integrated Performance Report which stated that two week wait performance for Breast cancer was 11.8% and that report stipulated that the 'underperformance' was a 'national' issue. He queried the following: • Why is the two week wait breast performance so poor? • What was within the control of UHNM to dramatically improve performance? • When could women referred for suspected Breast Cancer expect to be seen within 2 weeks and thus not be subjected to extended delays? It was noted that the questions had been discussed in part during the meeting, however it was agreed to provide additional information within the minutes to answer the questions in full: In terms of poor performance, it was noted that this was due to the exponential growth in demand, although despite the increase in referrals, the Trust's performance was above national levels. The Trust was aiming to improve performance by instigating a nurse led Breast pain clinic in the community. This had been agreed by the breast cancer team and the logistics were being considered as to how this could be delivered. It was noted that the West Midlands Cancer Alliance was leading on this best practice initiative for the region, and locally the scheme was endorsed by the system at the STP Cancer Board meeting in June. In terms of not subjecting patients to extended delays, patients over 35 who had been referred on a two week wait pathway were not subject to delays and would	

	be appointed within the 14 day target. Waits for patients under 35 were being recovered and performance was not expected to improve for this low risk cohort of patients until August. Communications had have been drafted for GPs and the CCG would help to support the message along with any primary care education initiatives on signs and symptom recognition, to help alleviate pressure on the service. Mrs Bullock highlighted that the meeting was the last for Mr Bostock and thanked him for his time at the Trust. Mr Wakefield reiterated Mrs Bullock's comments and stated his departure would be a loss to the Trust and he thanked him for the support had provided during his time in post.	
DATE AND TIME OF NEXT MEETING		
15.	Wednesday 7th July 2021, 9.30 am, via MS Teams	

Extraordinary Trust Board (Open)

Meeting held on Monday 14th June 2021, 9.00 am to 9.30 am
Via Microsoft Teams

MINUTES OF MEETING



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

Non-Voting Members:		
Ms H Ashley	HA	Director of Strategy & Transformation
Mr M Bostock	MB	Director of IM&T
Ms S Gohir	SG	Associate Non-Executive Director
Prof A Hassell	AH	Associate Non-Executive Director
Mrs L Thomson	LT	Director of Communications
Miss C Rylands	CR	Associate Director of Corporate Governance
Mrs L Whitehead	LW	Director of Estates, Facilities & PFI

In Attendance:

Mrs N Hassall NH Deputy Associate Director of Corporate Governance (minutes)

Members of Staff and Public via MS Teams: 0

No.	Agenda Item	Action
1.	**Chair's Welcome, Apologies and Confirmation of Quoracy**	
100/2021	Mr Wakefield welcomed Board members to the meeting and noted the above apologies. It was confirmed that the meeting was quorate.	
2.	**Declarations of Interest**	
101/2021	There were no declarations of interest noted.	
3.	**Audit Committee Assurance Report (11-06-21)**	
102/2021	Professor Crowe highlighted the following: • 3 internal audit reports had been presented, concluding with partial assurance	

	and improvements required, all of which required elements of follow up. It was noted that the data quality audit reviewed reporting of Emergency Department data and it was noted that a further report was to be provided to the Performance and Finance Committee on this in due course • The Committee supported the Annual Report and Annual Governance Statement for Board approval • The External Audit findings report outlined that a thorough process had been undertaken in terms of completion of the audit and the additional requirements for the audit for 2020/21 were highlighted • In terms of the provisions within the report in relation to the annual leave accrual, the auditors highlighted the allowance may be overstated which was grounds to consider but this was under the level of materiality • The overall Internal Audit Head of Opinion provided an overall good level of assurance which was positive Mr Wakefield stated that Mr Akid had commented that he supported the treatment of the accrual within the accounts and the approach taken. Mr Wakefield referred to the internal audit reports which received partial assurance and queried whether this had any impact on the overall Head of Internal Audit Opinion. Professor Crowe stated that this did not impact on the overall rating, and that when putting forward areas for review, the Trust recognised there were improvements to be made, therefore while the ratings were disappointing to see the rating, it was not surprising. **The Trust Board received and noted the assurance report.**	
4.	**2020/21 Annual Report and Annual Governance Statement**	
103/2021	Mrs Hassall referred to the discussion at the Audit Committee in respect of the Annual Report and highlighted that additional changes had been made to the report to correct some typographical errors, as well as removing Mrs Bullock's pension figures, given that the incorrect figures had been provided for 2019/20 from the Pension Authority. It was noted that this had been discussed by the Audit Committee and it was agreed to adjust the tables within the report to represent the true pension figures, given that Mrs Bullock had left the pension scheme on 31st March 2019. In addition, a note had also been included within the annual report to reflect the reason for the change. Mr Wakefield queried whether the rising staff costs of 10% year on year needed to be commented on and queried whether the use of e-scooters was part of a Government trial. Mrs Whitehead confirmed that use of the scooters at County Hospital was part of a national scheme. Mrs Preston stated that the main increase in staff costs was due to the annual leave provision in addition to the costs of additional staff required during the pandemic. Mr Wakefield agreed to discuss this further with Mr Oldham and Mrs Preston. Mr Wakefield referred to the reference to constitutional targets which identified the issues with A&E and queried whether the rising waiting lists needed to be referred to. Mrs Bullock stated that this had been referred to within the report and agreed to reflect the associated challenge this would pose in 2021/22. Mr Wakefield referred to the issue of the increase in employees earning higher than Executive Directors and requested additional information in terms of the	**NH**

	reason for the increase. Mr Oldham and Mrs Vaughan agreed to explore the reasons for this and provide the information to Mr Wakefield. Dr Oxtoby queried whether his pension details were correct given he had retired and returned and it was agreed to confirm outside of the meeting. **The Trust Board approved the Annual Report and Annual Governance Statement.**	**MO/RV**
5.	**2020/21 Annual Accounts**	
104/2021	Mr Oldham stated that the financial position had not changed since it was reported at the Performance and Finance Committee, and nothing had changed since the draft accounts had been provided to the Audit Committee, stating a surplus of £7.1 m for the year. He stated that the movement to £7.1 m had been driven by a late adjustment in month 12 from the Department of Health and Social Care, for other income streams associated with Covid which had previously been expected for Trusts posting a deficit. Mr Oldham highlighted the following: • a number of technical amendments had been made and he highlighted a prior period adjustment regarding drawings of estate, which had been recognised and adjusted in the accounts and disclosures made to reflect that. • some of the items identified as part of the audit were highlighted, such as unadjusted statements and the stock value of 0 which had been checked, as well as an incorrect journal entry, both of which netted each other off. • In terms of the £5 m annual leave accrual, this had been considered by the auditors and the difference of opinion was due to the associated finance standard not being explicit in terms of expectations. Therefore this had not been adjusted, but a disclosure had been made in order to highlight the difference. • The goods received note and invoice accrual had also been identified by the auditors, in terms of possible overstated position, although some were quite historic. It had been agreed to review this going forwards. • In terms of value for money, the final report was due to be presented to the Audit Committee at the end of July. Substantial work had already been undertaken and no issues had been identified to date. • The signed letter of representation was to be sent to the auditors to provide them with assurance of the robustness of the Trust's approach and a statement had been included regarding the annual leave accrual as well as the additional income which had been received Mr Wakefield referred to the comment on the Royal Infirmary impairment and it was agreed to discuss this further. Mrs Preston agreed to provide the working paper to Mr Wakefield. Mr Wakefield referred to note 22 and other liabilities which referred to additional Public Dividend Capital which had been received (PDC), but no comment had been made on the likely impact on interest payments. Mrs Preston confirmed that this was cost neutral with a possible immaterial gain of £100,000. Mr Wakefield stated that he welcomed the strength of the balance sheet and stated that in terms of underlying operational profit, performance in real terms had broadly improved by £20 m. Professor Crowe referred to the value for money work, and the enhanced assessment of Trusts, and that passing the threshold was particularly positive. Professor Crowe referred to the accrual of annual leave and stated that if Board	**SP**

	members required additional information to make this more transparent, to request it from the team, as it was available. Mr Oldham thanked Mrs Preston and the finance team for the work undertaken to prepare and submit the accounts. **The Trust Board approved the audited annual accounts in readiness for signing and submission to NHSEI.**	
6.	**Date and Time of Next Meeting**	
	Wednesday 7th July 2021, 9.30 am	

Trust Board (Open)

Post meeting action log as at **30 June 2021**

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

Ref	Meeting Date	Agenda Item	Action	Assigned to	Due Date	Done Date	Progress Report	RAG Status
PTB/465	07/04/2021	Midwifery Continuity of Carer Action Plan	To discuss the document further at QGC, in terms of the specific actions to be taken and anticipated dates of delivery for the revised trajectories. In addition, to provide information on peer group comparisons.	Lyn Dudley	30/07/2021		Update to be provided at a future QGC meeting.	GB
PTB/470	05/05/2021	IM&T Strategy Progress Report	To take further information to PAF in relation to bring your own devices and associated safeguards.	Heidi Poole	22/06/2021	22/06/2021	Complete - update provided to June's meeting.	B
PTB/472	05/05/2021	Integrated Performance Report – Month 12	To establish the reasons for the decrease in sepsis screening compliance for children and discuss at QGC.	Scott Purser	23/06/2021	22/06/2021	Discussed at QGC in June.	B
PTB/473	05/05/2021	Integrated Performance Report – Month 12	To provide ongoing monitoring at QGC of Covid screening rates.	Scott Purser	23/06/2021	30/06/2021	Complete and included within the revised IPR.	B
PTB/474	05/05/2021	Integrated Performance Report – Month 12	To consider the workforce dashboard as to whether additional metrics could be included such as wellbeing metrics, vacancy levels etc.	Ro Vaughan	09/06/2021	09/06/2021	Complete - additional metrics included and additional metrics will continue to be considered.	B
PTB/475	05/05/2021	Board Assurance Framework - Q4	To schedule a session at a future Board Seminar to consider the outcome of the clinical service line reviews	Helen Ashley Claire Rylands	14/07/2021	30/06/2021	Complete. Included on Board Seminar Programme	B
PTB/476	09/06/2021	UHNM Quality Account 20/21	To update the account to include; measures for 2021/22 aims/priorities, inclusion of a section regarding education, paragraph explaining the higher numbers of c-difficile reported in 2019/20	Scott Purser	30/06/2021	30/06/2021	Complete and published online.	B
PTB/477	09/06/2021	Integrated Performance Report – Month 1	To obtain the information in terms of ethnicity in relation to the maternity serious incident and provide to Ms Gohir and take the outcome of the investigation to Quality Governance Committee once complete.	Scott Purser	31/07/2021	30/06/2021	Complete. Information provided to MS Gohir.	B
PTB/478	14/06/2021	Annual Report / Annual Governance Statement 2020/21	To include a sentence regarding the impact of waiting lists within the report.	Nicola Hassall	14/06/2021	14/06/2021	Complete - included.	B
PTB/479	14/06/2021	Annual Report / Annual Governance Statement 2020/21	To explore the reasons for the increase in employees earning more than Executive Directors and provide this to Mr Wakefield.	Mark Oldham Ro Vaughan	07/07/2021	30/06/2021	The information relates to senior medical staff undertaking additional duties and bank shifts, particularly but not exclusively linked to medicine specialties. Further discussion to take place with Mr Wakefield	B
PTB/480	14/06/2021	Annual Accounts	To provide the working paper associated with the Royal Infirmary impairment to Mr Wakefield.	Sarah Preston	07/07/2021		Paper to be provided to Mr Wakefield	GB

Chief Executive's Report to the Trust Board

FOR INFORMATION

Part 1: Trust Executive Committee

The Trust Executive Committee met on 30th June 2021. The meeting was held virtually using Microsoft Teams; there was no agenda as the general purpose of the meeting was to provide an opportunity to discuss current issues, key priorities and to hear from Divisions in terms of areas of focus / challenges:

Key highlights were as follows:

- A presentation regarding the plans in place to address with the anticipated surge in admissions to the **Paediatric Intensive Care Unit**
- A proposal to establish a **Centralised Vascular Access Service** whereby it was agreed for this to progress to development of a business case
- The actions being taken to improve and maximise **ward flow** as part of preparing for winter
- The improvements required to the number of calls answered to **Consultant Connect**
- The ongoing actions being taken to complete the **Job Planning** round
- Further guidance awaited in respect of possible changes to **social distancing** as result of potential easing from 19th July 2021
- An update in respect of the **Month 2 Financial Position** and impact of the Elective Recovery Fund
- The expected financial challenges from 2022/2023 impacted the changes brought about by the revised **Single Oversight Framework** affecting future investment decisions
- The significant increase in Covid related **staff absences**
- Enhancements made to the **Empactis Sickness Absence Reporting System,** to include links to Allocate
- The requirement for line managers to consider **Pay Progression** and pay impacting points for their immediate staff on Agenda for Change contracts
- Progress being made with **Project STAR** and the ongoing demolition of the Royal Infirmary site
- Ongoing engagement with staff and stakeholders of the development of **Community Diagnostic Hubs**
- First week of filming had taken place for **999 Critical Condition**
- NHS Thank You Day and the Big Tea Event were due to take place to raise funds for **UHNM Charity**
- An ongoing increase in communications within the **Integrated Care System**
- The launch of free **patient entertainment** which would be able to be accessed from own devices
- An appointment had been made to the position of **Executive Medical Director**
- Ongoing actions to address the issues raised by the LNC/BAPIO Survey with the commencement of an **Independent Review** with the report expected to be received by the end of September
- **Activity plan** for quarter 2 onwards being considered, to support the bed plan in anticipation of a surge in July / August
- Over-performance during April and May for **elective recovery** although some staffing challenges had been identified
- In respect of the **Medical Division**, two issues were escalated in terms of the increasing rise in attendances within the Emergency Department and increase in sickness absence. The Division thanked the Business Intelligence Team for the creation of a triage tracker
- An update from the **Surgical Division** which highlighted challenges associated with availability of beds and removal of beds to adhere to social distancing, in addition to levels of staff sickness.
- The **Specialised Division** had agreed mutual aid to other regional centres, continued working with other Divisions and the Improving Together team
- In relation to **Children's, Women's and Diagnostics**, challenges were noted within Pharmacy in relation to TTOs as was the limited histopathology capacity

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 May to 11th June, 6 contract awards, which met this criteria, were made, as follows:

- **Franking machine postage charges for 2021/2022 (REAF 7450)** supplied by Pitney Bowes at a total cost of £620,000.00, for the period 01/04/21 - 31/03/22, approved on 11/05/21
- **AHP/HSS Master Vendor Contract (REAF 7721)** supplied by Maxximma at a total cost of £4,500,000.00, for the period 07/08/21 - 08/08/24, providing savings of £24,100.00, approved on 10/06/21
- **RS/1510/CAP - MRU Extension & Alterations (REAF 7654)** supplied by Trenton construction Ltd at a total cost of £1,529,590.40, for the period 07/07/21 - 06/07/22, approved on 10/06/21
- **Independent Sector Contract with Ramsay Healthcare (REAF 7571)** supplied by Ramsay Healthcare at a total cost of £3,180,000.00, for the period 01/04/21 - 30/09/21, approved on 10/06/21
- **Independent Sector Contract with Nuffield Healthcare (REAF 7569)** supplied by Nuffield Health at a total cost of £4,980,000.00, for the period 01/04/21 - 30/09/21, approved on 10/06/21
- **Cytotoxic Dose Banded Chemo (REAF 7352)** supplied by various at a total cost of £8,096,209.00, for the period 03/11/20 - 30/06/21, approved on 10/06/21

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

Services of Junior Doctors via Health Education England (eREAF 7698)

Contract Value	£1,616,666.67 incl. VAT
Duration	01/04/21 - 31/08/21
Supplier	St Helens & Knowsley Hospitals Teaching NHS Trust

Clinical Waste Management Services Contract (eREAF 7704) - Amendment

Contract Value	£1,088,186.40 incl. VAT
Duration	16/09/19 - 15/09/22
Supplier	Sharpsmart

Savings - £7,187.13 Negated Inflation

Extension of outsourcing Histopathology specimen processing and reporting (eREAF 7751)

Contract Value	£1,008,000.00 incl. VAT
Duration	1/09/21 - 31/08/23
Supplier	Source Bio-Science

Savings - £23,520.00 Negated Inflation

PWC Clarity Direct Engagement Contract (eREAF 7789)

Contract Value	£764,373.53 incl. VAT
Duration	1/10/21 - 30/09/23
Supplier	IHP Vinci Construction

Savings - £5,865.46 Negated Inflation

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 June 2021:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Divisional Chair – Surgery	Vacancy	Yes	TBC
Consultant in Community Paediatrics	Vacancy	Yes	06/09/2021
Consultant Histopathologist	Vacancy	Yes	01/11/2021

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

Post Title	Reason for advertising	Start Date
Clinical Lead – ENT	Vacancy	01/06/2021
Clinical Director - Specialised Surgery	Vacancy	01/06/2021
Guardian of Safe Working	Vacancy	01/06/2021
Locum Consultant Thoracic Surgeon	Extension	16/06/2021
Consultant Colorectal Surgeon	Retire and Return	09/06/2021
Consultant Cardiothoracic Anaesthetist	Extension	15/06/2021
Locum Consultant Neurosurgeon	Vacancy	28/06/2021

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

Post Title	Closing Date	Note
Locum Consultant Clinical/Medical Oncologist	06/06/2021	No applications
Consultant Microbiologist	14/06/2021	No applications
Consultant Medical Oncologist - Urology & Colorectal (CRC)	16/06/2021	No applications
Consultant Microbiologist	21/06/2021	No applications
Consultant Histopathologist	21/06/2021	No applications

3. Covid 19

Nationally and locally the transmission of the Covid Delta variant is significantly increasing. To date this has not led to a significant increase in admissions to hospital although we have seen slightly more patients admitted to critical care and have had to convert a pod for covid use only. We continue to monitor the situation with our public health and system colleagues but in the meantime our recovery and restoration work continues at pace. However, as a result of the increasing Delta variant we are seeing a sharp rise in staff absence for Covid related issues and this is starting to impact on elective recovery.

4. Bullying and Harassment

Following the recent Local Negotiation Committee (LNC) survey to UHNM medical staff, we have committed to undertake a full review across the Trust in respect of bullying and harassment and importantly action that can be taken. Following research with other NHS organisations and expert advice, we have selected a joint approach with the review being undertaken by brap and Roger Kline. Brap is a charitable organisation which supports organisations, communities, and cities with meaningful approaches to learning, change, research, and engagement and has vast experience in conducting such work in a wide variety of organisations, including the NHS (www.brap.org.uk). Roger Kline is Research Fellow at Middlesex University Business School and authored “The Snowy White Peaks of the NHS” (2014), designed the Workforce Race Equality Standard (WRES) and was then appointed as the joint national director of the WRES team 2015-17. I am delighted that we have been able to secure their skills, expertise and combined experience which we are confident will secure a robust and objective view.

5. Ongoing Closure of the Freestanding Midwifery Birth Unit

The Free Standing Birthing Unit at County Hospital (FMBU), temporarily closed in March 2020, as part of the Trusts response to the Covid pandemic, due to the need to redeploy staff from County Hospital to the Royal Stoke Maternity Unit, due to staff shortages.

The FMBU has remained temporarily closed and although the staffing challenges had begun to ease we are not in a position to reopen the unit as yet due to the impact of the Covid delta variant being very apparent in our region and the impact on staffing. The issue of County FMBU is further compounded by the Ockenden recommendations into safe, maternity care. The opening of the FMBU would not allow either of our units to be compliant.

The Trust remains committed to the provision of maternity care to its entire population, but have sought support for temporary closure for a further 6 months whilst the issues are resolved or alternatives progressed.

6. Integrated Care System: Design Framework (ICS:DF)

On the 1st June 2021 the ICS:DF was published to set out the next steps in developing ICSs and to create the conditions for partnerships to thrive. The publication was circulated to Board members and a Board Seminar will be used to give the appropriate time and attention to understanding the imperatives for the Trust and the system. The Staffordshire and Stoke on Trent System has already submitted its ICS Development Plan which was approved nationally. Significant consideration is now being given to the content of this paper and actions that need to be taken.

The ICS:DF outlines roles, responsibilities, accountabilities and a number of 'must do's'. This is a significant document therefore detail is not provided here but the following headings give insight into the documents coverage:

- Governance and Accountability
  - ICS Partnership
  - ICS NHS Board
  - Oversight
  - Managing the Transition to Statutory ICS
  - Quality Governance
  - Clinical and Professional Leadership
- People and Culture
- Place Based Partnerships
- Provider Collaboratives
  - Primary Care
  - Voluntary, Community and Social Enterprise Partners
  - Independent Sector
  - NHS Trusts and Foundation Trusts
- Integrated commissioning
- Finance
- Data and Digital Requirements

In relation to oversight (Governance and Accountability) a new system oversight framework has just been published which outlines how ICS performance will be judged. Further detail will be discussed at a future Board Seminar however following the consultation in March 2021 it is clear that ICSs will be judged on a range of more than 70 metrics, with performance against these resulting in various levels of support and scrutiny.

The new system oversight framework for 2021-22 confirms that systems, as well as individual organisations, will be put into one of four segments. Those in the fourth segment will be subject to a "recovery support programme", which will replace the label of "special measures". Those in the third segment will also be subject to some mandated support.

Eligibility for a particular segment will be determined, in part, by a system, provider or commissioner's performance within six "oversight themes" quality of care, access and outcomes; preventing ill health and reducing inequalities; people; finance and use of resources; leadership and capability; and local strategic priorities.

- The metrics for elective care do not mention the 18-week standard, but will monitor "patients waiting more than 52 weeks to start consultant-led treatment".
- Primary care include the proportion of the population with access to online GP appointments.
- Workforce measures include the proportion of staff in senior leadership roles who are from minority ethnic backgrounds, and who are women.
- Other metrics include delayed transfers of care per 100,000 population,
- The rate of neonatal deaths,
- The aggregate scores for NHS staff survey questions that measure perception of leadership culture.

The NHS has changed the eligibility for a system, commissioner or provider being put into segment three. The criteria on financial performance are now whether it has an underlying deficit in the bottom quartile nationally, a negative variance against its financial plan, or is not forecasting to meet plan at year end. The March consultation listed both the negative variance against plan and not forecasting to meet a plan at the year's end, but did not include an underlying deficit in the bottom quartile.

7. Provider Collaboratives

From April 2022 all Trusts providing acute, community and/or mental health services are expected to be part of one or more Provider Collaborative.

I was asked by the ICS Chair if I would lead the Provider Collaborative work for the system which I agreed to do once the Covid19 pressures reduced. The system work commenced at the end of May and I am being supported in this work by Helen Ashley and Tom Clowes. Resource has also been made available from the system Transformation and Delivery Unit Provider.

- To date the national self-assessment has been completed
- Discussion with all system leaders regarding expectations has concluded
- A stocktake of current collaborative arrangements is underway
- Discussion regarding governance and reporting requirements is underway whilst draft Terms of Reference have been developed
- Discussion with other Provider Collaborative SROs and executive leads is underway and learning utilised from those more advanced

Next steps:
- Conclude the stocktake
- Complete analytics - Review population demographics, system data to highlight variation e.g. GIRFT, Model Hospital, RightCare etc.
- Agree gaps and use the above data to determine opportunities
- Agree workstreams

Updates on progress will be provided to the system Chief Executive Forum, UHNM Board and Board Seminars and the ICS Board

8. NHS Tea Party

UHNM Charity is taking part in the NHS Big Tea on Monday 5 July focused on encouraging staff and local businesses to raise money specifically for the Trust. Nationally this is being billed as the nation's biggest tea break and UHNM Charity has already signed up five local companies as well as the local Potters Club which is promoting it to all its members including the Paragon Group. On the day the Lord Mayor Councillor Chandra Kanneganti, a senior partner at Goldenhill Medical Centre and councillor for Goldenhill and Sandyford will be promoting the work of UHNM Charity and support the Trust's local events. We would like to officially thank the Lord Mayor for his support and especially for making the UHNM one of his chosen charities.

9. Fizz Free Schools

UHNM Charity and the Stoke City Community Trust have joined forces to launch a campaign to highlight the damage fizzy drinks and foods with high sugar content are having on the teeth of young people in Staffordshire. Together with the Keep Stoke Smiling Campaign, the aim is to improve the dental health of children, teenagers and young adults across the county. The partnership between the two charities and the Orthodontic Team at the Trust will see more than 5,000 tubes of toothpaste handed out to local schools and community groups. As well as distributing the toothpaste, which was donated by Colgate, the Keep Stoke Smiling team will also raise dental health awareness and promote the benefits of a nice smile, through an interactive PHSE Personal, Social, Health and Economic Education workshop/ lesson. Figures show that Stoke-on-Trent currently sits near the bottom of the UK league table for dental health in children, with a quarter of five-year-olds suffering some form of tooth decay. The average child misses four school days per year due to pain from tooth decay, with five-year-olds consuming their own bodyweight in sugar and a bathtub full of fizzy drinks annually. In total thousands of pupils across the county will benefit from a visit over the coming weeks by the Stoke City Community Trust and UHNM Charity staff with schools being encouraged to sign-up to becoming fizz free. This is an on-going project and we have already held sessions in 20 schools and the majority have signed up to become fizz free.

10. National Expert Panel – NHS Food Review

Jenny Clarke, Estates, Facilities and PFI Matron has been successful in securing a position on the National Expert Panel which was a recommendation of the Government's Food Review, published in October 2020. The Panel will meet until the end of March 2024 and is made up of multi-disciplinary representatives and Jenny is one of three selected across the Country to represent Nursing. The Expert Panel will assist to direct the workload and challenge Exemplar Sites and Subgroups with innovation and ways to reform healthcare food across the seven English regions of the NHS. UHNM is being considered as an exemplar site and this represents a great opportunity to showcase all that is positive about the catering service provided at County site and Royal Stoke.

11. Project SEARCH

On the 14th July a graduation event will be held to celebrate the achievements of our 2020 Project SEARCH students. Project SEARCH is an innovative supported internship programme that provides one year work preparation for young people with learning disabilities and autistic spectrum conditions. It is a true partnership between Estates, Facilities and PFI Division, Sodexo and Newfriars College. Building on the success of the first year's programme six of the ten students have secured employment across our hospital sites. The graduation event will be held at Harecastle Tunnel South where the students from 2019 and 2020 have been working hard, come rain or shine, on a community project to create a nature walk alongside the canal tow path. In 2021 we will be welcoming on board our Supplies and Procurement Department who have offered a placement opportunity within their team. This is great news and a really valuable placement as we look to expand Project SEARCH, beyond Estates, Facilities and PFI Division and maximise the enormous benefits that Project SEARCH delivers for UHNM and for the fabulous young people involved in the programme.

12. High Potential Scheme for Staffordshire and Stoke-on-Trent Shadow ICS

UHNM Executives continue to support future leaders on their career development by providing executive mentoring and delivering virtual sessions to participants on the High Potential Scheme which aims to accelerate the career development of aspiring middle level clinical or non-clinical leaders to senior executive roles. Working in partnership with the National Leadership Academy this is the first national pilot site for the scheme. The first face-to-face workshop, post Covid will take place on 22nd July 2021 and Lorraine Whitehead, Director of Estates, Facilities and PFI, has been invited to share her personal journey and insights. Lorraine herself was a graduate from the Health Education England Advancing Talent Programme for Shropshire and Staffordshire in June 2016 and secured her role as Director of Estates, Facilities and PFI, shortly after completing the programme. This represents a fantastic opportunity for UHNM to inspire future leaders in considering and accelerating their own career pathways, within our system.

13. 999 Critical Condition

Brinkworth Film starting filming the third series of 999:Critical Condition on site at Royal Stoke on 21 June. Both the production company and Channel 5 have embraced our enthusiasm for showcasing services across the wider hospital while also focusing on the care we provide as one of the UK's best Major Trauma Centres. Filming is expected to take four to six months and we look forward to see it begin to air before the end of the year.

14. Patient Entertainment Provision

We are delighted that this month (July) we will be launching our initiative to deliver free entertainment for patients, visitors and staff across both our hospital sites. This has been funded by UHNM Charity and will mean anyone in our hospitals can access free view channels, newspapers and information services on their own devises through a dedicated Wi-Fi solution.

Quality Governance Committee Chair's Highlight Report to Board

June 2021

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The internal audit undertaken into discharge letters concluded with partial assurance with improvements required, with 6 recommendations made which were being taken forward and monitored via a Discharge Summary Working Group • In terms of the month 2 quality and safety report, there had been 2 grade 4 pressure ulcers reported, despite an overall reduction in the number of reported pressure ulcers. It was noted that the patients had since been discharged and lessons from the RCAs had been shared with others in terms of continence management, recognising early stages of categorisation of pressure ulcers, dealing with non-concordance and improving discharge handover. • The Trust was progressing well with a number of elements of the saving babies lives care bundle, although the main challenge was the ability to achieve full training compliance with effective fetal monitoring, although the 90% target had been removed due to the pandemic. In addition the Trust continued to work upon increasing compliance with carbon monoxide monitoring and adhering to the recommendations within the divergence report	• To recirculate the GIRFT gap analysis to members, including the outstanding information from respiratory medicine • To provide assurance to the Performance and Finance Committee in the ability to achieve the timeline from moving from MediSec to Medway • To provide regular updates at future meetings in relation to the progress made in implementation of the recommendations associated with the discharge letters internal audit • A deep dive to be undertaken in relation to sepsis screening and reported to the Committee in due course • To provide assurance at a future meeting in relation to the actions being taken to improve CTG monitoring • To provide an easy read at a glance version of the SBLCB and the areas being achieved, or not
Positive Assurances to Provide	**Decisions Made**
• Work continued to be undertaken to understand events in cardiothoracic and a risk summit had been held with no immediate safety concerns raised, although a number of learning points had been identified which would be fed back to a future meeting • The Quarter 4 Medicines Optimisation report was provided, and it was noted that medicine cold storage was become more complex, dispensing error rates had reduced and were below the benchmark and a risk in relation to a national shortage of human normal immunoglobulin was noted with mitigation being considered in addition to the risk associated with the delay in upgrading the pharmacy computer system with Windows 10 • An update in relation to Get It Right First Time (GIRFT) was provided, and it was noted that 13 national reports had been received, although these were under embargo and the Trust were in the process of considering the recommendations and reviewing associated action plans • A gap analysis had been undertaken to assess the recommendations made within the GIRFT Covid report, which identified that the majority of recommendations had been implemented / adopted with minor improvements identified • In relation to the CQC Insight Report, the Trust awaited the formal removal of financial special measures and noted the actions being taken in respect of outlying areas • The Trust was compliant with all 10 NHS Resolution Maternity Incentive Scheme actions, albeit some areas had an action plan in place to move the Trust into being fully compliant • The Annual Fire Safety report was presented which provided positive assurance in terms of fire safety management across the Trust • A positive update was provided by the Quality and Safety Oversight Group with ongoing actions being taken to improve effectiveness of the meeting and provide greater discussion of the key items	• The Committee agreed to delay the next GIRFT report to October, following the conclusion of the meetings to be held in September • The Committee approved the NHS Resolution Maternity Incentive Scheme action plan which was to be presented to the Trust Board in July • The Committee approved the Standard Operating Procedure and associated process to implement the use of ligature knives within the Trust

Comments on the Effectiveness of the Meeting
• The Committee welcomed the items considered and discussions held

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Q4 Medicines Optimisation	Assurance	7.	M2 Quality & Safety Report	Assurance
2.	Get It Right First Time Update	Assurance	8.	Saving Babies Lives Care Bundle & NHS Resolution Maternity Incentive Scheme	Assurance & Approval
3.	GIRFT COVID Gap Analysis Summary - Update	Assurance	9.	Standard Operating Procedure – Use of Ligature Knives	Approval
4.	Discharge Letters Internal Audit Report Update	Assurance	10.	Annual Report Fire Safety 2020/2021	Assurance
5.	CQC Insight Report	Assurance	11.	Executive Health & Safety Group Highlight Report (June 2021)	Assurance
6.	Cardiothoracic Update	Information	12.	Quality & Safety Oversight Group Highlight Report (June 2021)	Assurance

3. 2020 / 21 Attendance Matrix

Attended	Deputy Sent	Apologies Received

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

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	7th July 2021
Report Title:	Infection Prevention Board Assurance Framework Q1 2020/21	**Agenda Item:**	8.
Author:	Helen Bucior, Infection Prevention Lead Nurse Emyr Philips , Associate Chief Nurse Infection Prevention/Deputy DIPC		
Executive Lead:	Scott Purser ; Deputy Chief Nurse		

Purpose of Report:

Assurance		Approval		Information	✓

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

Executive Summary:

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

- Computer of Wheels : Cleaning the inside of box that contains the hard drive. This has been risk assessed as low risk and will be reviewed again in 6 months or sooner in of outbreak of infection
- Not moving patients until 2 negative COVID screens achieved. For asymptomatic patients this is not always possible, COVID screening frequency increased for inpatients. Step down guidance in place
- There has been 1 change in risk score since previously reported; in relation to BAF 2 risk score has decreased following the computer on wheels risk assessment.

<u>Progress</u>

- Mask fit testing skill is now available on Health Roster. This will enable areas to record model of FFP3 mask and date of mask fit testing electronically and also compile compliance data using this system. The mask fit testing certificate must continue to be completed manually and filed in the staff member personal folder
- BAF shared with ACN's who share with their matrons. BAF highlight sheet produced by one of the Matrons, this has also been shared between divisions.

Key Recommendations:

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

University Hospitals of North Midlands NHS Trust

Infection Prevention and Control Board Assurance Framework

Quarter 1 – 2021/22

Summary Board Assurance Framework as at Quarter 1 2020/21

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

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

Risk Scoring								
Quarter	Q4	Q1	Q2	Q3	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2	2			There are a number of controls in place, however evidence of assurance monitoring has demonstrated some gaps which will be addressed through the action plan	Likelihood:	1	End of Quarter 2
Consequence:	3	3				Consequence:	3	
Risk Level:	6	6				Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
1.1	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 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
		• 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		

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 that test negative are rescreened on days 4, 6, 14 and weekly • Critical care plan with step down decision tree • COVID-19 Divisional pathways • Step down guidance available on COVID 19 intranet page • Barrier and Terminal clean process in place • IP PHE guidance • COVID Q+A available on Trust intranet  covid-19-faq-v6-10-6-2021.docx	• Unannounced visits for clinical areas with clusters or HAI cases of COVID-19 • Review of HCAI COVID cases by IP Team • Datix /adverse incidence reports for inappropriate transfers	• NHSI key point 4 : Patients are not moved until at least two negative test results are obtained, unless clinically justified
1.3	Compliance with the national guidance around discharge or transfer of Covid-19 positive patients.	• Infection prevention step down guidance available on Trust intranet • All patients who are either positive or s are positives are advised to complete self –isolation if discharged or transferred within that time frame	• 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**
		 Patient Information Lealfet - Contact 202  Testing and lifting IP precautions.pdf • All patients are screened 48 hours prior to transfer to care homes • New UHNM ward round guidance October 2020. This also included placement of the extremely vulnerable patient  4th-february-2021-covid-ward-round-guic  guidance-on-screening-and-testing-for-co		
1.4	**All staff (clinical and non-clinical)** are trained in putting on and removing PPE, know what PPE they should wear for each setting and context and have access to the PPE that protects them for the appropriate setting and context as per national guidance. Linked NHSIE Key Action 3: Staff wear the right level of PPE when in clinical settings, including use of face masks in non-clinical settings. Linked Key Infection Prevention points – COVID 19 vaccination sites Monitoring of IP practices, ensuring resources are in place to enable compliance with IP	• Key FFP3 mask fit trainers in place in clinical areas • PPE posters and information available on the Trust COVID -19 page. This provides the what, where and when guide for PPE • Infection Prevention Questions and Answers Manual include donning and doffing information. • Areas that require high level PPE are agreed at clinical and tactical • Aerosol generating procedures (AGP's) which require high level PPE agreed at clinical and tactical group • COVID -19 Clinical Group reviews any proposed changes in PPE from the clinical areas	• Daily stock level of PPE distributed via email and agenda item for discussion at COVID-19 tactical group • IP complete spot check of PPE use if cluster/OB trigger • Records of Donning and Doffing training for staff trained by IP • A number of Clinical areas have submitted PPE donning an doffing records to the IP team • Donning and Doffing training also held locally in clinical areas	• FFP3 Training records further improvement part of health and safety portacount business case

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
	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	• Link to Public Health England donning and doffing posters and videos available on Trust intranet • Chief Nurse PPE video • Extended opening hours supplies Department • Risk assessment for work process or task analysis completed by Health and Safety • PHE announced from 11th June 2020 all staff to wear mask in both clinical and non-clinical health care setting • Matrons walk rounds • Specialised division summarised BAF and circulated to matrons • ACN's to discuss peer review of areas • Poster displayed in entrances and along corridors reinforcing the use of masks social distancing and one way systems • Catch it , bin in, kill it posters in ED waiting rooms • Lessons learnt poster  Lessons learnt - Non Clinical June 2021.pdf  Lessons learnt - Clinical June 2021.pdf  unannounced-ip-visit -template-2020-11.pd  non-clinical-assuranc e-visit-checklist-2020	• Cascade training records held locally by Divisions • Sodexo and Domestic service training records • IP unannounced assurance visits • Review of UHNM vaccination areas against key infection prevention points COVID -19 • Hand hygiene audits	
1.5	National IPC guidance is regularly checked for updates and any changes are effectively	• Notifications from NHS to Chief nurse/CEO • IP team COVID lead checks Public Health	• Clinical Group meeting action log held by	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	communicated to staff in a timely way.	England webpage daily (Monday-Friday) for updates • Changes raised at -19 clinical groups which was held originally twice weekly, reduced to weekly and now increased back to twice weekly due to surge of COVID. • Purpose of the Clinical Group - The Group receive clinical guidance and society guidance which is reviewed and if agreed used to advise clinical teams after approval at Exec COVID -19 meeting which is held twice monthly. • The clinical group initially weekly , now stepped down to Bi weekly • Tactical group – The tactical Group held daily. April 2021 now stepped down. The Group decide and agreed tactical actions Makes recommendations to Gold command • Chief nurse updates • Changes/update to staff are included in weekly Facebook live sessions • COVID -19 intranet page • COVID -19 daily bulletin with updates • IP provide daily support calls to the clinical areas	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	• Meeting Action log held by emergency planning • Trust Executive Group Gold command – Overall decision	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		tactical group. • COVID Gold command , decisions /Assurance reported to Trust Board Via CEO Report/COO	making and escalation • Tactical, Operational Delivery Group - The delivery of the objectives and benefits, and programme communications COVID 19 response and R&R. Co - ordination of resources. Escalation forum for linked Groups and Cells ensuring that the interdependencies are effectively managed, including system. Makes recommendations to Gold Command for key decisions. • Clinical steering Group – Coordinate clinical decision – making to underpin continual service delivery and COVID 19 related care • Workforce Group – Lead the plan and priorities for our people recovery. Health 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 • Visiting /walk round of areas by executive/senor leadership team	• IP risks are agenda item at Infection Prevention and Control committee (IPCC) • Definite Nosocomial COVID 19 case numbers are in included in Quality Performance Report • Nosocomial death review process – paper to Quality and Governance Committee 20th January 2021 • COVID themes report to IPCC • RCA process for all probable and definite COVID 19	

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

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 4 Progress Report	BRAG
1.	1.1	Up- to- date COVID -19 Divisional pathways	ACN's	30/09/2020	Associate Chief Nurse contacted and request made for COVID -19 pathways 28th July 2020. ED pathways in place and also County to Royal transfer of COVID positive patients. Divisional restoration plans in progress	Complete
2	1.1	Revised pathways to include actions for	ACN's	31/10/2020	4th September Chief Nurse DIPC request at senior meeting that	Complete

		extremely vulnerable patients who are admitted into the Trust			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	31/05/2020 31/08/2021	Testing and re testing, Interpretation of swabs and step down of IP precaution process in place at UHNM. Suspected or positive patients are moved on clinical need/assessment and in line with UHNM step down process. For patients who test negative on admission re screening is undertaken. 17th November NHSI guidance recommended that the second test is taken on day 3 after admission and day 5 after admission. Implementation of the new guidance is in place and a manual prompt is provided to the clinical areas. (Days 4 and 6 admission day counted as day 1). Waiting for 2 negatives swabs before moving for patients that are not COVID suspected does not always occur. April 2021 Chief Nurse reminded ACN's of testing guidance June 2021 – Day 14 and weekly COVID testing for patients who test negative and remain an inpatient - in place	Problematic – revised due date
4	1.3	Patient COVID -19 discharge information letter for patient who are discharged but contact of a positive case	IP Team	31/11/2020	Action at COVID weekly meeting was to create an information leaflet for patients and household members on discharge, with information on isolating, symptoms and useful information for informing the local authorities and the test and trace system. 6th November leaflet sent out for comments 22/12/2020 to Clinical Group for approval. Progressed to Outbreak Group and Tactical Group , minor changes made 12th December 2020 Submitted to Gold	Complete
5	1.4	Improving staff FFP3 mask fit staff training data recording and retention of records.	Health and Safety	31/08/2021	Proposed Fit Testing compliance improvement Task and Finish Group. Inaugural meeting took place 29th July 2020. ESR will be up and running for the purpose of recording fit test records as soon as the Trust gives the go ahead to procure Portacount fit test systems, this is a project lead by Health and	On track

					Safety As at 03/02/2021 People O&D have created FFP3 mask “classes” on ESR. Health and Safety are in the process of collating fit test records which were requested at Exec Health and Safety Groups from Divisional H&S Leads. Portacount Business case : Health and Safety Head continues with Business case with target date for completed revised for end of August 2021 <u>10/03/2020</u> Portacount machine obtained (on loan) by Infection Prevention Team via Midlands Coordinator for the FFP3 Mask Project. Plus mask fit tester will be available to test staff using the portacount machine. The portacount is a quantitative test and uses specialised equipment to measure exactly how much air is leaking through the seal of a mask. ACN’S informed and response requested to aid in identifying testing priority. Midlands Coordinator is meeting IP next week to work through plan. Mask fit testing also continues using hood and bitrex (qualitative, relies on taste) Mask fit testing option also added to e rostering to enable areas to identify staff member that have been tested and record mask model. A report can also be produced with compliance using this system. The mask fit testing certificate must also continue to be completed and filed in the staff member personal folder. Updated mask fit strategy to March which includes mask fit re test frequency. <u>May 2021</u> FFP3 cascade mask fit refresher in progress. This refresher	

					includes checking that fitters are aware of e rostering and the need to file test certificate in staff members personal folder June 2021 Portacount Business case - Awaiting decision from Exec Health and Safety Group	
6.	1.4	Divisions to retain current mask fit training records and compliance score for their areas whilst central recording and retention of records process is agreed	ACN'S	30/09/2020	Associate Chief Nurse contacted and request made for assurance with staff mask fit compliance. Compliance also added to Divisional papers for infection Prevention and Control Committee (IPCC). Current process that clinical areas hold their own training records and can also enter basic details on Health Rostering including model of mask staff fitted with. A number of clinical areas have also forwarded training records to the IP Team. IP Team. IP have a list of mask fit testers, this is also available on the Trust COVID intranet page.	Complete
7.	1.8	Re instate admission proud to care documentation, currently emergency admission document in place	Deputy Director of Quality and Safety	30/09/2020	Original proud to care booklet reinstated now	Complete
8.	1.8	To complete an analysis (Advantages and disadvantages) to reinstating MRSA screening as per UHNM policy	Deputy Director Infection Prevention	14/06/2021	MRSA screening had reduced temporarily due to the COVID pandemic but UHNM are still following PHE 2014 guidance. This was an agreed temporary change in UHNM practice. Previously the Trust were screening over and above the 2014 guidance. Due to the COVID pandemic less elective work is taking place therefore less elective screening. High risk areas all still screen on admission. Risk based screening is for lower risk areas. Prior to the 2014 guidance the DIPC at the time (supported by the CCGs) did not want to reduce the screening policy the Trust already had in place. The CCG requested screening policy have to be approved by the CCGs. Discussed at IPCC. DIPC requested a pro's and con's exercise re screening changes due to the COVID pandemic. The Trust has not dropped below national guidance. October 2020 MRSA screening is around 50% of pre COVID screening, laboratory does not have the capacity to process COVID work and level of MRSA screens pre COVID. Paper to	complete

					November IPCC. This continues to be under review during COVID Pandemic. <u>March 2021</u> Screening for elective high risk surgery to resume This action continues to be under review during COVID Pandemic and surveillance of MRSA bacteraemia cases is on-going. <u>20/04/2021</u> Due to wave 2 COVID 19 , paper deferred to May IPCC 2021 <u>May 2020</u> Screening recommenced a pre COVID 19 pandemic. DIPC advised action complete	
9.	1.8	To explore an alternative laboratory for Clostridium difficile ribotying	Kerry Rawlin Laboratory	31/08/2020	Leeds Hospital has agreed to help with ribotyping Clostridium difficile specimens. Await first batch of results to gain assurance that process is working 04/09/2020 we are experiencing problems in receiving ribotyping results back from Leeds. Usually they would arrive electronically. UHNM have contacted Leeds and are awaiting a resolution with their IT team and the PHE reference electronic reporting system. Ribotype now being received from Leeds and added to ICNET patient case	Complete

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

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

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

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

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

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

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		and linen waste holds • Red alginate bags available for infected linen in the clinical areas • Infected linen route		
2.10	Single use items are used where possible and according to single use policy.	• IP question and answers manual • Medical device policy • SOP for Visor decontamination in time of shortage	• IP audits held locally by divisions	
2.11	Reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance.	• IP question and answers manual covers decontamination • Air powered hoods – SOP in place which includes decontamination process for the device • Re usable FFP3 Masks – Sundstrom/ GVS Elipse. SOP's in place which includes the decontamination process • Medical device policy • Availability of high level disinfectant in clinical areas • Sterile services process • Datix process	• 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 assist the dilution of air	• 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 reduction in risk of infection transmission through ventilation	• Estates have planned programme of maintenance • The Authorising Engineer Ventilation will provide external independent specialist advice and support as well as carrying out an annual audit for system compliance.	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		systems. TOR written • The Trust also appointed external authoring Engineers. This is in line with the NHS estates best practise and guidance from Health Technical Memorandum (HTM) namely 03/01 Specialised Ventilation for Healthcare Premises. • Lessons learnt poster which encourage regular opening of windows to allow fresh air  ventilation-air-changes-per-hour-2021-06 •		
	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.	Complete
2	2.4	To address cleaning issues and environmental damage highlighted during NHSI visit	Head of CPM Estates, Facilities & PFI Division	14/12/2020	Feedback from NHSI provided to Sodexo and action plan devised  Action Plan Following NHS England NHS Im  NHSI action plan June 21.docx	Complete
3	2.4	To address dirty nursing equipment and commodes, plus computer on wheels	ACN'S / IP/ Deputy Head of IM&T	31/05/2021 – re: Computers on Wheels	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	Complete

					IT have contacted clinical technology to see if they can provide cleaning service For the air intakes that have dust collection this would require a wipe over Visible parts of COW such as external casing, screen, and keyboard mouse to be cleaned by clinical staff. 18/02/2021 – Feedback from IM&T. They are chasing cost associated with cleaning of COW's 03/03/2021 – Feedback from IM&T cost still awaiting. They are chasing. Outside of COW and parts that can be seen are cleaned by the clinical staff 15/03/2021 Cleaning of internal parts of COW IM&T have raised this to a COW provider and they are providing a cost to clean the devices. In addition reached out to an internal UHNMM cleaning team to gain a cost 16/03/2021 – Costing back from external company for cleaning internal parts of COW, next stage to be agreed 22/04/2021 – 2 costings back for comparison, next stage to be agreed 27/04/2021 Paper/presentation prepared for Chief nurse to present to execs May 2021 Further information send , awaiting decision May 2021 Raised at Local Meeting with other IP Teams , feedback - only outside/touch points of Computer cleaned June 2021 Discussed at the Excecs meeting 08/06/2021 it was agreed that the risk would appear low ,however a risk assessment to be completed , if the outcome of risk assessment is low then the risk will held by the organisation and replace with new style replacement COW over time. June risk assessment completed = low To review risk in 6 months time	
4	2.8	All high touch surfaces and items are decontaminated multiple times every day –	Head of CPM Estates,	30/04/2021	To revisit high touch points protocol to check frequency of clean for area that area not on barrier cleans – computers , mobile	Complete

		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	Facilities & PFI Division IP Team		phones, keyboards Cleaning of communal toilets after each use inpatient areas – Letter -CEM/CMO /2020/043 24TH December 2020. This letter was raised at IPCC 25/01/2021. 16th February Meeting with IP & Facilities colleagues to discuss the NHS/NHSE/PHE facilities cleaning requests in line with COVID 19 – letter CEM/CMO 24th December 2020 Hefma network Responses/Scoping exercise completed Trust position work in progress. Paper to next March IPCC Additional cleaning resource in place for ED Royal Stoke and overnight at County this requirement has been extended for a further 3 months Wheelchair cleaning stations also installed across both sites Clinical areas aware of the need to decontaminate high touch points such as desk top phones and keyboards <u>April 2020</u> Lessons learnt poster uploaded into the Trust intranet, including clinical and non- clinical cleaning high touch points	

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

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

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

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		• Monthly review of antimicrobial consumption undertaken by AMS team. Available online at UHNM	timely reporting on compliance with AMS CQUIN targets. • Wards showing deviation from targets are followed up by targeted AMS team ward reviews generating action plans for ward teams. On hold during COVID19 due to redeployment of duties	
3.2	Mandatory reporting requirements are adhered to and boards continue to maintain oversight. Linked NHSIE Key Action 5: Daily data submissions have been signed off by the Chief Executive, the Medical Director 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. These have restarted in December 2020 as held during COVID-19. Results online. • Results from all AMS audits and targeted ward reviews are reported at the Antimicrobial Stewardship Group and minutes seen by IPCC • CQUIN submissions completed in timely manner and generate action plans for AMS and ward teams to follow up concerns each quarter. Currently suspended.	• Whilst only a snap-shot audit the Trust value the output from these audits. Work is underway Q1 and Q2 20/21 to review potential change in data collection to optimise impact. • IPCC scrutinise results. Divisions held to account for areas of poor performance. Audit outputs will be used as basis of feedback on performance to individual clinical areas going forward. • Trust CQUIN contracts manager holds regular track and update meetings to challenge progress vs AMS CQUINS, Currently suspended.	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 4 Progress Report	BRAG
1.	3.1	Further controls are required to improve compliance	ACN'S	30/04/2021	Antimicrobial audits results discussed at IPCC 27th July 2020. Separate meeting with chief nurse/IP and ACN's to be arranged during August to discussed results and any corrective actions.	Complete

					Feedback meeting completed 4th September 2020. – Senior meeting. To review escalation of areas that are not compliant with antimicrobial guidelines. New point prevalence audits undertaken by AMS pharmacists during December 2020 to provide updated snapshot for ACNs. Results will be discussed at March IPCC meeting 31/03/2021 Following discussion of these results at March 2021 IPCC a meeting has been arranged between Chief Nurse, deputy DIPC, lead AMS pharmacist and lead AMS microbiologist to discuss ways in which divisions can be supported to improve their stewardship performance. Individual clinical areas can be identified from Pharmacy audit data. Meeting date 15.4.21 April 2021 Meeting held between ASG leads, CD Pharmacy, Deputy DIPC and DIPC on 15th April 2022. Action plan in place	
2.	3.1	To review current escalation of areas that are not compliant with antimicrobial guidelines	DIPC	30/04/2021	Raised at September Antimicrobial Pharmacist Group and IPCC. Escalation process to be agreed. Meeting between Antimicrobial Pharmacist and Deputy DIPC undertaken. Escalation process to be discussed at November Antimicrobial Stewardship Group. January 2021 discussed at Trust Board to be discussed at ASG, then to IPCC Following discussions between DIPC and AMS Pharmacist a draft escalation protocol has been produced and was presented at January ASG as the November meeting cancelled (clinical pressures) the group have 2 weeks to review. Will thereafter to be forwards to IPCC for discussion and ratification at the March IPCC meeting. 31/03/2021 The draft escalation protocol was approved at March ASG. It will be shared with Chief Nurse and Deputy DIPC at meeting above (15.4.21) and target wards will be identified. Protocol approved at March 2021 ASG.	Complete

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

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

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		other PPE if they are providing bedside care. We will continue to monitor prevalence and changes in visiting restrictions will be reinstated with immediate effect should it be necessary • The only exceptional circumstances where on visitor , an immediate family member or 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 • EOL visiting guidance in place • March 2021 Visiting guidance inpatient during COVID 19 pandemic: principles discussed at Clinical Group and tactical • Visiting COVID-19 information available on UHNM internet page		
4.2	Areas in which suspected or confirmed Covid-19 patients are being treated are clearly marked with appropriate signage and have restricted access.	• ED colour coded areas are identified by signs • Navigator manned ED entrance • Hospital zoning in place	• Daily Site report for county details COVID and NON COVID capacity	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
4.3	Information and guidance on Covid-19 is available on all trust websites with easy read versions.	• COVID 19 section on intranet with information including posters and videos	• COVID-19 page updated on a regular basis	
4.4	Infection status is communicated to the receiving organisation or department when a possible or confirmed Covid-19 patient needs to be moved.	• Transfer policy C24 in place , expires November 2020 • IP COVID step down process in place	• Datix process	

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.	Complete

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

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
5.1	Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed Covid-19 symptoms and to segregate them from non Covid-19 cases to minimise the risk of cross-infection as per national guidance. Screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases. Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from Non Covid-19 Staff are aware of agreed template for triage	• 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**
	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 June2020 • ED navigator provide masks to individual in ED • Mask stations at hospital entrances • Covid-19 bulletin dated 12th June 2020 • 28th August updated guidance from PHE recommends in patients to also wear surgical masks if tolerated and does not compromise care • IP Assurance visits • Senior walk rounds of clinical areas • Matrons daily visits	• 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 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	• Colour coded areas in ED to separate patients, barriers in place. • Screens in place at main ED receptions • Colour coded routes identified in ED • Social distancing risk assessment in place • Perspex screens agreed through R+R process for other reception area • Social distance barriers in place at main reception areas	• 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
	ventilated.	• Chief Nurse/DIPC visited clinical areas to review social distancing within bays. A number of beds have been removed throughout the Trust.		
5.4	For patients with new-onset symptoms, it is important to achieve isolation and instigation of contact tracing as soon as possible.	• Process for isolation symptom patient in place • Process for cohorting of contacts • Contacting patients who have been discharged from hospital then later found to be a close contact of a COVID-19 positive case , patient to be informed by the clinical area and self- isolation advice provided as per national guidance • https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance/stay-at-home-guidance-for-households-with-possible-coronavirus-covid-19-infection	• If patient found to be positive in the bay and exposing other patient. IP liaise with clinical are, apply bay restrictions. • Patient who tested negative on admission and remain an inpatient are retested for COVID days 4 and 6, day 14 then weekly • Spot check audits	
5.5	Patients with suspected Covid-19 are tested promptly.	• All patients who require overnight stay are screened on admission and patients who develop symptoms – UHNM screening guidance in place	• Adverse incident monitor /Datix	
5.6	Patients who test negative but display or go on to develop symptoms of Covid-19 are segregated and promptly re-tested and contacts traced.	• Screening protocol in place which includes rescreening /re testing. Pathways in place for positive COVID 19 patients • Iportal alert and April 2021 contact alert in place iportal/medway • The IP team have been applying a Covid-19 contact alert within the ICNET system since November 2020 and this continues. • Inpatient contacts are cohorted • COVID 19 positive patients are cared for on	• 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
		blue wards or single rooms or COVID 19 cohort areas on critical care unit		
5.7	Patients who attend for routine appointments and who display symptoms of Covid-19 are managed appropriately.	• Restoration and Recovery plans • Thermal temperature checks in imaging, plan to extent to other hospital entrances • Mask or face coverings for patients attending appointments from Monday 15th June 2020	• Datix process	

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

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

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
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 programme in place • Trust mask fit strategy • SOP and training for reusable FFP3 masks	• 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
		• SOP and training for use of air powered hoods • Critical care - Elipse FFP3 reusable introduced • PPE posters are available in the COVID -19 section of trust intranet page		
6.3	A record of staff training is maintained.	Mask fit strategy in place	• Training records originally held locally by the Clinical areas • Records held on L drive for those trained by the infection prevention team • April 2021,Option now available to enter FFP3 training onto Health Rostering this captures the model of mask and date trained • Test certificate must continue to be filed in personal folder • Health and Safety leading on portacount mask fit business case which has the potential to enhance mask fit training records further as this system is capable of collected data which can be uploaded	
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	• SOP 's available on Trust intranet • Training logs held divisionally for air powered systems • IP training log for air powered systems key trainers and	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		(Sundstrom))	distribution of reusable FFP3 masks (Sundstrum)	
6.5	Any incidents relating to the re-use of PPE are monitored and appropriate action taken.	• PPE standard agenda at COVID Tactical meeting • Datix process • Midlands Region Incident Coordination Centre PPE Supply Cell	• Tactical group action log • Datix process • Incidents reported by procurement to centre PPE supply Cell	
6.6	Adherence to the PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk.	• PPE Audits • PPE volume use discussed at tactical COVID-19 Group	• Spot audits completed by IP team	
6.7	Staff regularly undertake hand hygiene and observe standard infection control precautions. Linked NHSIE Key Action 1: Staff consistently practices good hand hygiene.	• Hand hygiene requirements set out in the infection prevention Questions and Answers manual • Poster for hand hygiene technique displayed at hand wash sinks and stickers on hand soap and alcohol dispensers • Alcohol gel availability at the point of care	• Monthly hand hygiene audits completed by the clinical areas • Infection Prevention hand hygiene audit programme. Overview of results fed into infection Prevention committee • Independent hand hygiene audits completed by IP Senior Health Care	
6.8	Hygiene facilities (IP measures) and messaging are available for all • Hand hygiene facilities including instructional posters • Good respiratory hygiene measures • Staff maintain physical distancing of 2 metres wherever possible in the workplace unless wearing PPE as part of direct care	• Hand washing technique depicted on soap dispensers • Social distance posters displayed throughout the Trust • IP assurance visits • Matrons visits to clinical areas	• Hand hygiene audits • Spot checks in the clinical area • IP assurance visits	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	• Staff maintain social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace • Frequent decontamination of equipment and environment in both clinical and non-clinical areas • clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas • Guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas	• Car sharing question forms part of OB investigation process • Communications reminding staff re car sharing • IP Q+A decontamination section • COVID Q+A • Wearing of mask posters displayed throughout the Trust • Advise and videos' on the Trust internet page • Hand hygiene posters /stickers on dispenser display in public toilets	• Cleanliness audits • IP environmental audits • Quarterly audits conducted and held by the clinical areas	
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	• 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
		uniforms home available for 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 • RCA's are required for all Probable and Definite HAI Covid-19 cases	• Theme report IPCC • RCA review	
6.15	Robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of outbreak meetings.	• ICNet surveillance system • Daily COVID reports of cases	• Outbreak investigation • Outbreak minutes	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	**KLOE**	**Action Required**	**Lead**	**Due Date**	**Quarter 4 Progress Report**	**BRAG**
1.	6.3	Improving staff FFP3 mask fit staff training data recording and retention of records	Health and Safety	31/08/2021	Proposed Fit Testing compliance improvement Task and Finish Group. Inaugural meeting planned for 29th July 2020. ESR will be up and running for the purpose of recording fit test records as soon as the Trust gives the go ahead to procure Portacount fit test system as this is part of the project lead by Health and Safety. December 2020 Health and Safety have agreement to proceed to Business case As at 03/02/2021 People O&D have created FFP3 mask "classes" on ESR. Health and Safety are in the process of collating fit test records which were requested at Exec Health and Safety Groups from Divisional H&S Leads. Business case : Head of Health and Safety's continues with business case with a revised due date end of August 2021 10/03/2020 Portacount machine obtained (on loan) by Infection Prevention Team via Midlands Coordinator for the FFP3 Mask Project. Plus mask fit tester will be available to test staff using the portacount machine. The portacount is a quantitative test and uses specialised equipment to measure exactly how much air is leaking through the seal of a mask. ACN'S informed and response requested to aid in identifying testing priority. Midlands Coordinator is meeting IP next week to work through plan. In additional Mask fit testing also continues using hood and bitrex (qualitative, relies on taste) Mask fit testing option also added to e rostering to enable areas to identify staff member that have been tested. A report can also be produced with compliance using this system. The mask fit	On Track

					testing certificate must also continue to be completed and filed in the staff member personal folder. Updated mask fit strategy to March IPCC which includes re test frequency <u>May 2021</u> FFP3 cascade mask fit refresher in progress. This refresher includes checking that fitters are aware of e rostering and the need to file test certificate in staff members personal folder <u>June 2021</u> Portacount Business case - Awaiting decision from Exec Health and Safety Group	
2	6.2	Spot audits of PPE on wards and Departments	Quality and Safety Team IP	30/04/2021	Audits are required on a weekly basis – ongoing action	Complete

7. Provide or secure adequate isolation facilities

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
7.1	Patients with possible or Covid-19 are isolated in appropriate facilities or designated areas where appropriate. Restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff	• Hospital zoning in place • Recovery and Restoration plans for the Trust – • December 2020 –another increased wave of COVID 19 • COVID prevalence considered when zones identified • Purple wards • Blue COVID wards identified at both sites created during second wave • Green wards for planned screened elective patients • Recovery and Restoration plans • Ward round guidance available on COVID 19 intranet page	• June 2020 IP team to review patients that are found COVID positive and nursed in bay to ascertain compliance with pathway and IP control measures are in place Review pathways and identify themes which are presented at IPCC . • Themes report to IPCC	
7.2	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 Toxin-PCR by building March 2021.c • Patients received from London to critical care unit – screening policy for resistant organisms in place	• RCA process for Clostridium *difficile* • CDI report for January Quality and Safety Committee and IPCC • Outbreak investigations • MRSA bacteramia investigations • Datix reports	

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

8. Secure adequate access to laboratory support as appropriate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
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	• Mask fit strategy in place	• Training records for reusable	• Availability of locally held

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally Staff who carryout fit testing training are trained and competent to do so All staff required to wear an FFP respirator have been fit tested for the model being used and this should be 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	• Mask fit education pack • SOP for reusable face masks and respiratory hoods in place • PHE guidance followed for the use of RPE • PPE poster available on the intranet • Training records held locally • Fit testers throughout the Trust • Complete and issue Qualitative Face Fit Test Certificate	masks • Training records held locally • Mask fit option now available on Health Rostering to record mask type and date	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
	the nationally agreed algorithm and a record kept in staff members personal Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board			
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	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
10.5	Consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas.	• Social distancing tool kit • Staff encouraged to keep to 2 metre rule during breaks • Purpose build rooms for staff breaks in progress	• Social distance monitor walk rounds • Social distance posters identify how many people allowed at one time in each room	
10.6	Staff absence and wellbeing are monitored and staff who are self-isolating are supported and able to access testing.	• Team Prevent available to offer guidance and treatment to staff presenting with onset of symptoms.	• Team prevent monitoring process • Work force bureau	
10.7	Staff who test positive have adequate information and support to aid their recovery and return to work.	• Team Prevent available to offer guidance and treatment to staff presenting with onset of symptoms. • Empactis line will first ask – is the absence related to coronavirus. To which the employee must say yes or no • Once the absence is reported to the employees manger via email, the manager will categorise the absence type specified in the flow chart. • Team prevent complete COVID 19 staff screening • Areas where transmission has occurred are discussed at clinical group and relevant staff screening under an ILOG number is agreed. • Flow charts or staff returning to work available on COVID 19 section 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	31/08/2021	Proposed fit testing compliance improvement task and finish group Inaugural meeting planned for 29th July 2020. ESR will be up and running for the purpose of recording fit test records as soon as the Trust gives the go ahead to procure Portacount mas k fit systems as this is part of the project lead by Health and Safety case As at 03/02/2021 People O&D have created FFP3 mask "classes" on ESR. Health and Safety are in the process of collating fit test records which were requested at Exec Health and Safety Groups from Divisional H&S Leads. Portacount Business case : Health and Safety Head continues with Business case with target date for completed revised for end of August 2021 10/03/2020 Portacount machine obtained (on loan) by Infection Prevention Team via Midlands Coordinator for the FFP3 Mask Project. Plus mask fit tester will be available to test staff using the portacount machine. The portacount is a quantitative test and uses specialised equipment to measure exactly how much air is leaking through the seal of a mask. ACN'S informed and response requested to aid in identifying testing priority. Midlands Coordinator is meeting IP next week to work through plan. In additional m ask fit testing also continues using hood and bitrex (qualitative, relies on taste) Mask fit testing option also added to e rostering to enable areas to identify staff member that have been tested. A report can also be produced with compliance using this system. The mask fit testing certificate must continue to be completed and filed in the staff member personal folder. Updated mask fit strategy to March IPCC with include update on re fit frequency	On Track

					May 2021 FFP3 cascade mask fit refresher in progress. This refresher includes checking that fitters are aware of e rostering and the need to file test certificate in staff members personal folder June 2021 Portacount Business case - Awaiting decision from Exec Health and Safety Group	

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.

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (open)	Date:	7th July 2021
Report Title:	CNST Maternity Incentive Scheme	Agenda Item:	9.
Author:	Donna Brayford, Quality and Risk Manager Lynn Dudley, Interim Head of Midwifery		
Executive Lead:	Tracy Bullock, Chief Executive		

Purpose of Report:

Assurance		Approval	✓	Information	

Alignment to Strategic Objectives:

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

Executive Summary:

This report provides an update on UHNM progress against the Maternity Safety Incentive Scheme.

Maternity safety is an important issue for all Clinical Negligence Scheme for Trusts (CNST) members as obstetric claims represent the scheme's biggest area of spend (c£500m in 2016/17). Of the clinical negligence claims notified to NHS Resolution in 2016/17, obstetric claims represented 10% of the volume and 50% of the value. These figures do not take into account the recent change to the Personal Injury Discount Rate.

In 2019, UHNM was fully compliant with the CNST 10 actions which recouped an initial £600K to the Trust with an additional £300K awarded from NHS Resolution.

On the 26th March 2020, in recognition of the current pressure on the NHS and maternity services in response to COVID-19, the majority of reporting requirements relating to the maternity incentive scheme 10 safety actions were paused until Monday 31 August 2020. Trusts were asked to continue to apply the principles of the 10 safety actions, given that the aim of the maternity incentive scheme is to support the delivery of safer maternity care.

On the 1st October 2020, year 3 was then re-launched. There has been an appreciation that the pandemic continues to place a significant strain on all NHS services, including maternity services. NHS Resolution has continued to work with trusts and key stakeholders to understand how the situation continues to impact on the ability of trust maternity departments to deliver on the maternity incentive scheme ten safety actions.
In March 2021 a revised safety actions document was released

Appendix 1 of this report provides information on compliance and links to supporting evidence

Key Recommendations:

The Trust Board is asked to note that UHNM maternity services confirm compliance against each of the 10 actions (with evidence) specified by NHS Resolution in their revised guidance issued March 2021. In addition, approval is sought, for the Chief Executive to sign the self-declaration for submission to NHS Resolution with this document by 12 noon on 15th July 2021.

In accordance with revised guidance maternity services have developed an action plan against the relevant maternity safety action to ensure compliance where the required standards/process indicators have not been met.

Safety action 4: Safety action Clinical workforce planning
Neonatal nursing workforce. Currently the neonatal nursing workforce has a shortfall of 17.84 WTE
Neonatal services have developed an action plan to include:

- A workforce review and action plan
- The development of a business case
- Quarterly updates of progress to be shared throughout UHNM.

Safety action 6: Implementation of the Saving Babies Lives Care Bundle (5 elements)
Element 1 Reducing Smoking in pregnancy
Whilst maternity services have achieved compliance during COVID 19 with asking women if they smoked at booking and 36 weeks; we have developed an action plan to ensure we achieve compliance against process indicators following the reintroduction of CO monitoring March 2021

Element 2 Risk assessment & surveillance for reduced fetal growth
Compliance standards met

Element 3: Raising awareness of reduced fetal movements
Maternity services have achieved implementation compliance of over 80% of women receiving information regarding reduced fetal movements. The process indicator standard is 95% (current compliance 90%). Maternity services have therefore developed an action plan to ensure we achieve ≥95%

Element 4: Fetal monitoring training
Whilst a comprehensive training package has been offered to all relevant staff groups in accordance with revised guidance; maternity services have developed an action plan to ensure we achieve 90% compliance (currently 71%).

Element 5: Preterm birth
Maternity services are currently 53.6 % compliant against a process indicator score of 85% for singleton live births less than 34+0 weeks receiving a full course of antenatal corticosteroids, within seven days of birth.

A full course = 2 doses of steroids 24 hours apart (12 hours apart in some clinical presentations). Maternity services have developed an action plan to ensure we achieve a process indicator score of ≥85%. A recent regional Neonatal Operational Delivery Network meeting confirmed that UHNM compliance data at 53.6% is higher by comparison to other units in the region.

Safety action 8: Multi-professional maternity emergencies training
90% of all maternity unit staff groups have attended an in-house multi-professional maternity emergencies training session since the launch of MIS year 3 in December 2019.

In accordance with revised guidance maternity services have offered on-line comprehensive multi-professional maternity emergencies training.

Maternity services have developed an action plan to achieve compliance against the 90% standard

- Midwives, anaesthetist and Maternity Support Workers are currently compliant.
- Medical staff and Operating Department Practitioners (ODPs) are currently 50%

Maternity Incentive Scheme – Year Three: Ten Maternity Safety Actions

Introduction

NHS Resolution is operating a third year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support delivery of safer maternity care.

The maternity incentive scheme applies to all acute trusts that deliver maternity services and are members of the CNST. As in year two, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

As in year two, the scheme incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

The deadline for submission of our Trust Board Declaration to NHS Resolution is 15.07.2021.

Safety Action Number	Safety Action	Progress	Supporting information	Leads	Evidence to support
1. Are you using the National Perinatal Mortality review Tool to review perinatal deaths to the required standard?					
Required standard	**a) (i)** Were all perinatal deaths eligible notified to MBRRACE-UK from the 11 January 2021 onwards to MBRRACE–UK within 7 working days and the surveillance information where required completed within four months of each death? **a) (ii)** A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from Friday 20 December 2019 to 15 March 2021 will have been started before 15 July		• Monthly MDT review meetings established to review perinatal deaths with additional dates scheduled as required	Perinatal Case Review leads for Maternity & Neonatology	• Perinatal Mortality Review Tool (PMRT) submitted to MBBRACE i) Perinatal surveillance information available on MBRRACE-UK portal ii) Perinatal surveillance available on MBRRACE-UK portal
Required standard	**b) At least 50%** of all deaths who were born and dies at your trust (including home births that died) from Friday 20th December 2019 to Monday, 15th March 2021 will have been reviewed by a MDT with each review completed to the point that a draft report has been generated by the tool before 15th July 2021		• Fully compliant; see above	Perinatal Case Review leads for Maternity & Neonatology	• PMRT contains names and roles of the MDT in attendance • Date draft report commenced registered in the MBRRACE-UK portal
Required standard	**c) In 95%** of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Friday 20 December 2019, the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought.		• Letter formatted for use across maternity and neonatology to ensure parent's perspective is included • Widening support by bereavement midwives to include parents who have had a baby die on the NNU	Bereavement Midwives Neonatologist Matron	• Perinatal Mortality Review Tool contains this information • Letters to parents
Required standard	**d)** Quarterly reports have been submitted to the Trust Board from 1 October 2020 that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety champion.		• Established governance process for reports received through the Directorate, Division, QSOG, QGC and Trust boards	Quality & Risk Manager	• Quarterly reports and action plans • Agenda & minutes of meetings

Safety Action Number	Safety Action	Progress	Supporting information	Leads	Evidence to support
2.	**Are you submitting data to the Maternity Services Data Set to the required standard?**				
Required standard	This relates to the quality, completeness of the submission to the Maternity Services Data Set (MSDS) and readiness for implementing the next version of the dataset (MSDSv2). All 13 criteria are mandatory		• K2 electronic maternity system enables full compliance with MSDS submission	Data analysts K2 Digital Midwife	• NHS Digital compliance reports
Required standard	**1.** Was your Trust compliant with all 13 criteria in either the December 2020 or the January 2021's submission?		• Fully compliant	Data analysts K2 Digital Midwife	• As above
Required standard	**2**. Has the Trust Board confirmed that they have fully conformed with the MSDSv2 Information Standards Notice, DCB1513 And 10/2018, which was expected for April 2019 data, or that a locally funded plan is in place to do this, and agreed with the maternity safety champion and the LMS. This should include submission of the relevant clinical coding in MSDSv2 in SNOMED-CT		• Fully compliant	Data analysts K2 Digital Midwife	• Executive summary submitted to Trust Board
3.	**Can you demonstrate that you have TC services to support the Avoiding Term Admissions (ATTAIN) Programme into the Neonatal Unit?**				
Required Standard	**Standards a, b and c have been removed** **d)** A data recording process for transitional care is established, in order to produce commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2.		• Fully compliant	Data analyst	• NHS Digital report
Required Standard	**e)** Has a review of term admissions to the neonatal unit and to TC during the Covid-19 period (Sunday 1 March 2020 – Monday 31 August 2020) undertaken to identify the impact of: - closures or reduced capacity of TC - changes to parental access - staff redeployment - changes to postnatal visits leading to an increase in admissions including those for jaundice, weight loss and poor feeding		• Monthly review completed of all Term Admissions to the Neonatal Unit • UHNM has the lowest term admission rate in the West Midlands • Recognised as an exemplar site for good practice across the region	Neonatal lead consultant for ATAIN	• Executive report presented to Quality Assurance Committee and Local Maternity System

Safety Action Number	Safety Action	Progress	Supporting information	Leads	Evidence to support
Required Standard	**f)** An action plan to address local findings from ATAIN reviews, including those identified through the COVID 19 period as in point e) above has been agreed with the maternity and neonatal safety champions and Board level champion		• Audit - Monthly review of all Term Admissions to the Neonatal Unit • Report and Action Plan completed	Neonatal lead consultant for ATAIN	• Action plan • Minutes meetings
Required standard	**g)** Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board Safety champions.		• Action plan	Neonatal lead consultant for ATAIN Maternity Safety Champions	• Action plan • Minutes
4. Can you demonstrate an effective system of workforce planning to the required standard?					
Required Standard	**Anaesthetic medical workforce** An action plan is in place and agreed at Board level to meet Anaesthesia Clinical Services Accreditation (ACSA) standards 1.7.2.5, 1.7.2.1 and 1.7.2.6		• Fully compliant with anaesthetic cover for maternity	Obstetric Anaesthetic Consultant lead	• Confirmation received from Anaesthetic clinical lead
Required standard	**Neonatal medical workforce** The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing		• Fully compliant with the BAPM national standards	Neonatal Clinical Director	• Confirmation received from Neonatology clinical lead
Required standard	**Neonatal Nursing workforce** The neonatal unit meets the service specification for neonatal nursing standards. If these are not met, an action plan is in place and agreed at board level to meet these recommendations.		• Currently the registered nursing workforce within the Neonatal Unit has a deficit of 17.84 WTE • Action Plan and Business Case in place	Neonatal Matron	• Action Plan • Agenda and Minutes
5. Can you demonstrate an effective system of midwifery workforce planning to the required standard?					
Required Standard	**a)** A systematic, evidence-based process to calculate midwifery staffing establishment has been done.		• 2018/19 Birthrate plus evaluation conducted • Further review due 2020/2021 • Monthly dashboard completed to include midwife to birth rate ratio. Presented throughout the Trust and LMNS	Head of Midwifery	• Birthrate plus data • Monthly workforce information maternity dashboard • Agenda and minutes

Safety Action Number	Safety Action	Progress	Supporting information	Leads	Evidence to support
Required Standard	**b)** The obstetric unit midwifery labour ward coordinator has supernumerary status (defined as having no caseload of their own during that shift) to enable oversight of all birth activity in the service		• Protected role of co-ordinator to ensure oversight on every shift	Head of Midwifery	• Escalation policy • Birth rate plus acuity tool • Introduction of Flo-Co Co-ordinator Role
Required Standard	**c)** Women receive one-to-one care in labour (this is the minimum standard that BirthRate+ is based on)		• 100% of women have one to one care in labour • Process for escalation to ensure that this is protected	Head of Midwifery	• Birthrate plus report • Incident reporting: 'red flag'
Required Standard	**d)** Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board at least once a year, during the maternity incentive scheme year three reporting period (December 2019 – July 2021) Percentage of specialist MW employed & mitigation to cover any inconsistencies. BirthRate+ accounts for 9% of establishment which are not included in clinical numbers		• Bi annual workforce challenge with the Chief Nurse	Head of Midwifery	• Birth rate plus report • Midwifery staffing report and action plan • Midwife/Birth Ratio • Minutes
6. Can you demonstrate compliance with all five elements of the Saving Babies lives Care Bundle?					
Required Standard	**1.** Board level consideration of the Saving Babies' Lives Care Bundle (SBLCB Version 2) published April 2019) in a way that supports the delivery of safer maternity services. **2**. Each element of the SBL care bundle implemented or an alternative intervention in place to deliver against element(s). **3**. The quarterly care bundle survey should be completed until the provider trust has fully implemented the SBLCBV2 including the data submission requirements. **Element One: Reducing smoking** **a)** Recording of carbon monoxide reading for each pregnant woman on Maternity Information System (MIS) and inclusion of these data in the providers' Maternity Services Data Set (MSDS) submission to NHS Digital.		UHNM collaborate with the LMNS Towards the implementation of the interventions of the SBLCB SBLCB report SBLCB action plan **a)** During COVID 19 CO measurements were suspended; organisations were asked to report compliance against the percentage of women asked	Quality and Risk manager Directorate Clinical auditor Head of Midwifery SBLCB lead Midwife LMNS	• Minutes from Directorate, Division, Board and LMNS meetings • SBLCB survey submissions • SBLCB report • SBLCB action plan • Training resources **Element One Reducing smoking** a) MSDS submission

Safety Action Number	Safety Action	Progress	Supporting information	Leads	Evidence to support
	Has standard a) been successfully implemented (80%) or more? **b)** Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded. Has standard b) been successfully implemented (80%) or more? **c)** Percentage of women where CO measurement at 36 weeks is recorded. Has standard c) been successfully implemented (80 %) or more?		if they smoked **b)** During COVID 19 CO measurements were suspended; organisations were asked to report compliance against the percentage of women asked if they smoked at booking. UHNM audit revealed 97% compliance 01/03/21 UHNM reintroduced CO monitoring and have an action plan to increase compliance from 26.6% monitoring (May) **c)** During COVID 19 CO measurements were suspended; organisations were asked to report compliance against the percentage of women asked if they smoked at 36 weeks. UHNM audit revealed 100% compliance.		**b)** Maternity services action plan to achieve 80% compliance. Weekly audit being commenced **c)** Audit
	Element 2: Risk assessment & surveillance for reduced fetal growth Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified Has standard a) been successfully implemented (80%) or more? Do you have evidence that the Trust Board has specifically confirmed that all the following 3 standards are in place within the investigation:		• Yes • Yes	SBLCB lead Midwife Directorate Clinical Auditor Fetal medicine specialist	• K2 customised growth chart • Training programme for Symphysis fundal height (SFH) measurement/ FGR/Small Gestational Age Charts • Audit

Safety Action Number	Safety Action	Progress	Supporting information	Leads	Evidence to support
	a) Women with a BMI >35 KG/M2 are offered ultrasound assessment of growth from 32 weeks gestation onwards **b)** In pregnancies identified as high risk at booking uterine artery Doppler flow velocity is performed by 24 completed weeks gestation **c)** There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks gestation				**a)** Clinical guideline and pathway in place **b)** Divergence report agreed for uterine artery Doppler flow **c)** Audit data
	Element 3: Raising awareness of reduced fetal movements **a)** Percentage of women booked for antenatal care who had received leaflet/ information by 28+0 weeks of pregnancy Has standard a) been successfully implemented (80%) or more? **b)** Percentage of women who attend with RFM who have a computerised CTG Has standard a) been successfully implemented (80%) or more?		**a)** No, 90%, action plan developed **b)** Yes 100%	Quality and Risk manager Outpatient Matron Directorate Clinical auditor Head of Midwifery SBLCB lead Midwife LMNS	**a)** K2 maternity records Audit Kicks Count Information (available in different languages **b)** K2 maternity records Audit
	4. Element 4: Effective fetal monitoring in labour **a)** Percentage of staff who have received training on intrapartum fetal monitoring in line with the requirements of Safety Action eight, including: intermittent auscultation, electronic fetal monitoring, human factors and situational awareness.		For the current training year CNST require that training is offered to all staff. UHNM are compliant with this action. Trust are required to have an action plan in place for achieving >95% **a)** Compliance not achieved, currently 71% Action Plan implemented	Fetal Monitoring Lead Midwife and Consultant, SBLCB lead Midwife	• Training database for the completion of 3 mandatory K2 training modules (85% pass rate of each module) • Training database for the mandatory attendance of one MDT workshop with focus on human factors • Training agenda • Training resources

Safety Action Number	Safety Action	Progress	Supporting information	Leads	Evidence to support
	b) Percentage of staff who have successfully completed mandatory annual competency assessment. A threshold score of 80% compliance should be used to confirm successful implementation. If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.		b) Compliance not achieved, currently 71% Action Plan implemented • K2 CTG Training package with target for successful completion of each module operational (license purchased) • Training has been offered to all staff groups		
	Element 5: Reducing Preterm Birth **a)** Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth. Process indicator score of less than 85% requires an action plan. **b)** Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth. **c)** Percentage of women who give birth in an appropriate care setting for gestation Process indicator score of less than 85% for all above measurements requires an action plan.		**a)** Currently not compliant 53.6 % action plan developed **b)** 100 % compliant **c)** 100% compliant	Quality and Risk manager Directorate Clinical auditor Head of Midwifery SBLCB lead Midwife Lead Consultant Pre-term birth LMNS	**a)** Audit and action Plan **b)** Audit **c)** Audit
7. Can you demonstrate that you have a patient feedback mechanism for maternity services that you regularly act on feedback?					
Required Standard	Evidence should include: • Terms of Reference for your Maternity Voices Partnership (MVP) • A minimum of one set of minutes of MVP meetings demonstrating explicitly how feedback is obtained and the consistent involvement of Trust staff in coproducing service developments based on this		• Terms of Reference. • Leaflets and guidelines co-produced by the MVP • Ethnic Minority Task and Finish Group develop by the LMNS	Head of Midwifery LMNS Professional Midwifery Advocate (PMA)	• MVP feedback • Maternity survey action plan • MVP Minutes

Safety Action Number	Safety Action	Progress	Supporting information	Leads	Evidence to support
	feedback • Evidence of service developments resulting from coproduction with service users • Written confirmation from the service user chair that they are being remunerated for their work and that they and other service user members of the Committee are able to claim out of pocket expenses • Evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation				
8. Can you evidence that 90% of each maternity unit staff group have attended an "in house" multi-professional maternity emergencies training session within the last training year?					
Required standard	Maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year. Any shortfall in reaching the 90 % threshold should be identified and commit to addressing this as soon as possible		For the current training year CNST require that training is offered to all staff. UHNM are compliant with this action. Trust are required to have an action plan in place for achieving >90% of all staff groups • Midwives, anaesthetist and Maternity Support Workers are compliant. • Medical staff and ODP's are below compliance, currently 50% • Trajectory and action plan developed E-learning training content delivered digitally including local: ○ COVID19 Personal protective equipment	Lead Midwife Education & Development Training co-ordinator Consultant Obstetric Training Lead	• Training report summary • Compliance trajectory and evidence plan

Safety Action Number	Safety Action	Progress	Supporting information	Leads	Evidence to support
			(PPE) ○ PRactical Obstetric Multi-Professional Training (PROMPT) training presentations used (as developed in line with MIS) ○ Human factors		
9.	**Can you demonstrate that the trust safety champions (obstetrician and Midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?**				
Required Standard	**a)** A pathway has been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence from floor to Board and through the local maternity system (LMS) and MatNeoSIP Patient Safety Networks.		• Pathway developed	Chief Nurse Medical Director	• Pathway document
Required Standard	**b)** The Board level safety champions have implemented a feedback session every other month for maternity and neonatal staff to raise concerns relating to relevant safety issues.		• Monthly meetings with Head of Midwifery (HoM) and Chief Nurse • Bi monthly meetings between HoM, Obstetric lead and Medical Director • Monthly safety meetings with Chief Nurse and Medical Director established • Executive and non-executive walkabouts through maternity	Chief Nurse Medical Director	• Safety dashboard/ equivalent visible to staff • Monthly report by Quality & Risk newsletter • Safety concerns raised by staff reflected in minutes board meetings & include updates on progress, impact & outcomes
Required Standard	**c)** The Board level safety champions have taken steps to address named safety concerns and that progress with actioning these are visible to staff. Continuity of Carer Action Plan		• As above	Chief Nurse Medical Director	• As above
Required Standard	**d)** Together with their frontline safety champions, the Board safety champion has reviewed local outcomes in relation to national documents focusing on Covid-19.		• Report and action plan shared with Board Safety Champion	Head of Midwifery	• Board Safety Champion feedback

Safety Action Number	Safety Action	Progress	Supporting information	Leads	Evidence to support
	e) The Board Level Safety Champion is actively supporting capacity (and capability) building for all staff to be actively involved in the following areas: quality and safety improvement activity within the Trust, including that determined in response to Covid-19 safety concerns. Specific national improvement work and testing lead by MatNeoSIP that the Trust is directly involved with		• Monthly meetings with HoM and chief nurse • Bi monthly meetings between HoM, obstetric lead and medical Director • Monthly safety meetings with CN/ MD established • Exec and non-executive walkabouts through maternity	Head of Midwifery, Safety Champions	• Engagement with networks & collaborative local learning systems including: ○ Local Maternity and Neonatal System ○ Health Safety Investigation Branch ○ NHSI ○ Preventing cerebral palsy in preterm babies (PReCePT) ○ Getting it Right First Time (GiRFT) ○ Saving Babies Lives Care Bundle
10. Have you reported 100% of qualifying 2018/2019 incidents under NHS Resolution Early Notification Scheme?					
Required standard	**a)** Reporting of all qualifying incidents that occurred in the 2019 to 2020 to NHS resolution under the Early Notification Scheme reporting criteria **b)** Reporting of all qualifying cases to the Healthcare Safety Investigation Branch (HSIB) for 2020/21. **c)** For qualifying cases which have occurred during the period 1 October 2020 to 31 March 2021 the Trust Board are assured that: **1.** The family have received information on the role of HSIB and the EN scheme; and **2.** There has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.		▪ Fully compliant	Quality & Risk Manager UHNM Legal team	• Early Notification form submission • Letters to parents

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	7th July 2021
Report Title:	Revalidation Report 2021	**Agenda Item:**	10.
Author:	Nick Coleman, Responsible Officer		
Executive Lead:	John Oxtoby, Medical Director		

Purpose of Report:

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

Impact on Strategic Objectives:

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

Executive Summary:

- The COVID 19 pandemic necessitated that medical appraisal was stopped for the first half of the appraisal year.
- Once restarted, the focus of the process was on the health and wellbeing of doctors and their professional development with a reduction in the burden of documentation.
- Despite this 90% of doctors with a prescribed connection to UHNM completed an appraisal for the year 2020/21
- Feedback from doctors has been that the changes are a positive step in developing appraisal for the future.
- All Revalidation recommendations have been made on time.

Key Recommendations:

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

Effect of Covid on Appraisal and Revalidation

June 2021

In March 2020 the NHS Medical Director wrote to all Responsible Officers strongly recommending that appraisals were suspended until further notice unless there were exceptional circumstances. This was in order to increase capacity in the workforce by allowing appraisers to return to clinical practice. Responsible Officers (ROs) were asked to classify appraisals which were affected as 'approved missed' appraisals, and affected appraisals were to be regarded as cancelled, not postponed.

As appraisal is managed and delivered locally, the NHS agreed that the approach taken by each designated body towards restarting appraisal would vary according to local pressures. All doctors at UHNM were advised in September that appraisals should resume, but that in accordance with new GMC guidance appraisals would be rebalanced to reduce the documentary burden for pre-appraisal documentation. The new process emphasises the importance of appraisal in supporting the personal and professional development of doctors and concentrates on how doctors have maintained their health and wellbeing during the COVID-19 pandemic, and any support they might need.

The GMC issued guidance that doctors who were due to revalidate before the end of September 2020 were to have their revalidation date deferred for one year to give doctors more time to reschedule and complete appraisals, and to avoid the need for ROs to make revalidation recommendations during this time. This has led to a reduction in recommendations for the year 2020/21 and a significant increase in doctors who will require a recommendation during the following year.

Appraisal

The number of doctors with a prescribed connection to UHNM varies through the year, but the annual performance figures submitted centrally through the compulsory Annual Organisational Audit (AoA) and used for the purposes of appraisal performance assessment are based on doctors connected on 31st March 2021.

The total number of doctors on the GMC Connect system for that date was 861.

Consultants

There are 523 consultants with a prescribed connection to UHNM and 94% completed an appraisal

Staff Grade, Associate Specialist, Specialty doctors and short term contract holders

There are 338 doctors in this group of which 83% completed an appraisal

The overall appraisal rate at UHNM was 90%.

Quality Assurance (external)

UHNM has not had an external QA visit for the year 20/21 and it is very unlikely that there will be one during the year.

Quality Assurance (Internal)

There will be a limited QA process that involves sampling of the new appraisal summaries from the Allocate system in accordance with GMC guidance. The results of the this will be available by the end of July.

Allocate

The Allocate system continues to function well and colleagues are becoming more familiar with it and this has improved appraisal compliance. The system allows ongoing audit of the process to improve compliance.

Revalidation

Due to the pandemic the number of recommendations due for the year was considerably reduced and I have made only 52 recommendations to the GMC regarding revalidation in the appraisal year. There were no deferrals in this group.

There was 1 notice of non-engagement made to a doctor by the GMC due to the doctor refusing to disclose private practice information when asked to do so after concerns were raised elsewhere. This matter has since been resolved after the doctor agreed to share the relevant information.

The number of recommendations due in the forthcoming year will be considerably increased due to the backlog.

Conclusions

Appraisal rates have remained steady during the last year despite the pandemic.

Revalidation recommendations have been made on time.

Nick Coleman
Responsible Officer
June 2021

Performance and Finance Chair's Highlight Report to Board

22nd June 2021

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The Committee noted the future financial risk associated with the car parking business case but recognised the main risk was the inability to identify a strategic solution to the car parking provision should the case not proceed as planned • The Committee noted that the delay with the LIMs go live was due to delays with the product and discussions were ongoing with the supplier to mitigate the risk and put in place contingency plans • The Committee noted the risks associated with histology and increased pressure on non-obstetric ultrasound which were highlighted by the Operational Delivery Group • The Committee requested clarification for the planning of winter care beds based and in particular the assumptions made for flu and Covid, and it was noted there was a risk associated with the deficit of flexible beds due to the difficulties in managing flu and Covid positive patients • The Committee noted the challenges associated with urgent care performance due to increased attendances and managing the larger footprint of the department within the current staffing model, which required addressing. It was noted however that the quality of care had improved as there was no corridor care and flow had also improved but this was not translating into improved 4 hour performance • The challenges associated with breast cancer referrals were highlighted, with actions being taken within the community to treat low risk patients. In terms of 62 day cancer performance this was being effected by diagnostic processing power with particular challenges in some specialties, although improvement plans were in place	• To provide a presentation to the Committee at the next meeting in terms of urgent care performance and the associated challenges and successes over the past 2 years, and the actions being taken to address • To identify whether acuity of patients could be identified alongside 4 hour performance, to determine the acuity of patients who were waiting over 4 hours • To outline the difference between the underspend on nursing and links with establishment in order to understand the true position
Positive Assurances to Provide	**Decisions Made**
• The Committee welcomed the update from the Executive Infrastructure Group and in particular the development of the Medical Devices Strategy although noted the challenges in ensuring divisional engagement • The Committee noted an updated position in relation to Data Security and Protection training, which was nearing the 95% target with updates provided in relation to the ongoing actions and reports being considered by the Data Security and Protection Group • The Committee received an update in terms of the safeguards being put in place for Bring Your Own Devices, which included a cloud based monitoring solution, progress of which would be monitored by the IM&T Programme Group • The Committee queried whether there was a risk in relation to forecast winter plan budget and whether this covered the resources required to deal with increased attendances. It was noted that the overall amount budgeted for winter funding would need to utilised, but given the Trust had not traditionally spent all of its winter monies previously, this was a small risk. • The year to date financial position was a £7 m surplus, mainly driven by the elective recovery fund due to activity being undertaken above the set threshold, and the Trust held a strong position in relation to its revenue. Capital was £1 m behind plan and a paper regarding the capital programme was to be provided to the Committee in July • The Committee received an update in relation to the payroll partnership with Royal Wolverhampton and the progress made to date in developing the service agreement	• The Committee approved the refreshed Market Testing Variation Business Case which would be taken to the Trust Board for approval • The Committee approved the business case in relation to the Multi Story Car Park build of associated early capital spend • The Committee approved the following EREAFs; 7783, 7698, 7649, 7704, 7832, 7751, 7789

Comments on the Effectiveness of the Meeting

- No comments were made in respect of effectiveness of the meeting.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Business Case Approvals: • BC-0359A Refreshed Sodexo Market Testing Variation Business Case	Approval	6.	Operational Delivery Group Highlight Report	Assurance
2.	Project STAR Multi Story Car Park Funding	Approval	7.	Month 2 Performance Report	Assurance
3.	Authorisation of New Contract Awards and Contract Extensions	Approval	8.	Month 2 Finance Report	Assurance
4.	Executive Infrastructure Group Highlight Report (June 2021)	Assurance	9.	Royal Wolverhampton NHS Trust Payroll Partnership Agreement	Assurance
5.	Executive Data Security & Protection Group Highlight Report (June 2021) • Bring Your Own Device Scheme and Associated Safeguards	Assurance			

3. 2021 / 22 Attendance Matrix

Attended | Apologies & Deputy Sent | Apologies

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

Transformation and People Committee Chair's Highlight Report to Board

June 2021

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Although compliant for medical staffing, the Trust was not compliant with the British Association of Perinatal Medicine (BAPM) 2010 service standards, for nurse staffing with a deficit of 17.84 WTE. The challenges associated with neonatal staffing were articulated and it was noted that actions were being taken to address the shortfall, which in the main would be addressed by development of a business case which was going through due process. • The Trust was noting a continued increase in Covid related staff absences with additional actions being taken to provide staff testing	• To further explore the issue in relation to neonatal nurse staffing at the Quality Governance Committee • To develop the neonatal business case in conjunction with discussing with the Executive Team • To provide an update to Committee members on essential to role training compliance • To provide additional information in terms of how many staff were accessing the Staff Psychological and Wellbeing Hub • To strengthen the Research Strategy in relation to aims, associated timelines and tracking, baseline and benchmarking performance, as well as links to the ICS and working with Academic Health Sciences Network
Positive Assurances to Provide	**Decisions Made**
• The Committee noted the activities being undertaken to obtain more regular feedback from staff in relation to their wellbeing, via regular staff pulse check surveys. Actions continued to be taken to undertake overdue appraisals and improve compliance with Performance Development Reviews, with a positive continuing improvement noted in relation to statutory and mandatory training completion. • The Committee noted that the second meeting of the Culture Review Committee had been held and an organisation had been commissioned to undertake an independent review, with Terms of Reference drafted • The Committee received a presentation in relation to the Children's Hospital Strategy which was welcomed by the Committee and it was noted that this was to be formally launched in September 2021 • The Committee noted that the work plan associated with Improving Together was on track and a positive update was provided in terms of how the programme was working in practice to enable change and improvement • The Executive Workforce Assurance Group had considered its effectiveness and subsequently changed their way of working in order to help improve divisional engagement. The Committee noted the areas escalated and the actions being taken in respect of possible increase in staff retirement, gaps in Medical Divisional Management Team, ongoing actions to improve staff resilience and wellbeing and close monitoring of Covid related absence	• The Committee supported the core elements of the Research Strategy and it was agreed that once the additional enhancements had been made as noted above, that it would be brought back to the Committee prior to taking to the Trust Board for approval in August
Comments on the Effectiveness of the Meeting	
• The Committee welcomed the presentations received in relation to the Children's Hospital and Research Strategy • The Committee reflected on the increased membership and the impact on lengthened discussions and that going forwards additional information should be provided to newer members outside of the meeting, to enhance current knowledge	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Neonatal Workforce CNST	Assurance	5.	Improving Together Highlight Report	Assurance
2.	M2 Workforce Report	Assurance	6.	Executive Workforce Assurance Group Highlight Report (June 2021)	Assurance
3.	Staffordshire Children's Hospital at Royal Stoke Clinical Strategy 2020-2025	Approval	7.	Executive Research & Innovation Group Highlight Report (June 2021)	Assurance
4.	Research Strategy	Approval			

3. 2021 / 22 Attendance Matrix

			Attended			Apologies & Deputy Sent								
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												
Ms T Bowen	TB	Non-Executive Director												
Mrs T Bullock	TB	Chief Executive												
Mr P Bytheway	PB	Chief Operating Officer												
Dr L Griffin	LG	Non-Executive Director												
Ms S Gohir	SG	Associate Non-Executive Director												
Dr K Maddock	KM	Non-Executive Director												
Mr S Purser	SP	Interim Chief Nurse	MR											
Miss C Rylands	CR	Associate Director of Corporate Governance			NH									
Mrs R Vaughan	RV	Director of Human Resources												

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	7th July 2021
Report Title:	Integrated Performance Report, month 2 2021/22	**Agenda Item:**	13.
Author:	Quality & Safety: Jamie Maxwell, Head of Quality & safety; Operational Performance: Karan Allman, Deputy Head of Performance; Matt Hadfield, Deputy Associate Director of Performance & Information. Workforce: Claire Soper; Finance: Tringham, Jonathan		
Executive Lead:	Scott Purser: Interim Chief Nurse Paul Bytheway: Chief Operating Officer Ro Vaughan: Director of Workforce Mark Oldham: Director of Finance		

Purpose of Report:

Assurance	✓	Approval		Information	

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

Executive Summary:

Situation

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

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

Assessment

1. Quality & Safety:

The Trust achieved the following standards in May 2021:

- Friend & Family (inpatients)96.6% and improvement from previous months and exceed 95% target
- Harm Free Care 96.5% and 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 99.1% (via Safety Express audit)
- Zero avoidable MRSA Bacteraemia cases reported

- There have been no Category 2, 3 or 4 Pressure Ulcers attributable to lapses in care during May 2021. However, there were 2 Category 4 PUs initially reported in February 2021 which were then investigated and reviewed at Tissue Viability Panel in May 2021 where it was agreed that there were lapses in care attributable to UHNM. Both these were subsequently reported as Serious Incidents
- Sepsis Screening compliance in Emergency Portals exceeded the target 90% with 94.8%
- Inpatients IVAB within 1 hour achieved 100% for audited patients
- Emergency Portals IVAB in 1 hour improved to 92.3% and exceeded the 90% target
- Maternity IVAB within an hour was 100% for audited patients
- Zero Never Events
- There were 0 Nosocomial COVID Infections reported

The Trust did not achieve the set standards for:

- Friend & Family Test for A&E 75.5% and below 85% target
- Friends & Family Test for Maternity not returned data. The Midwifery team have been reminded that National reporting of the FFT has resumed and escalated to Head of Midwifery
- Falls rate was 6.0 per 1000 bed days but is below the average rate per 1000 bed days during COVID-19 pandemic
- 93.3% Duty of Candour 10 day letter performance following formal verbal notification. 1 case awaiting confirmation of letter being sent out.
- C Diff YTD figures are above trajectory with 10 against a target of 8
- Inpatient Sepsis Screening compliance (adult Inpatients) 78.9% and below the target of 90%
- Children's Sepsis Screening compliance 87.1% below the 90% target
- Maternity Sepsis Screening recorded 75%

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

- The rate of complaints per 10,000 spells is 22.58 is below (positive) the target of 35 and is within normal variation.
- Total number of Patient Safety Incidents 45.89 in May but the rate per 1000 bed days was relatively stable. Rate is below the NRLS mean 50.7
- Patient Safety Incidents with moderate harm or above and the rate of these incidents have increased during recent months but still within normal variation.
- Rate of falls reported that have resulted in harm to patients has remained relatively stable but currently at 1.8 in May 2021. The rate of patient falls with harm continues to be within the control limits and normal variation
- Medication related incidents rate per 1000 bed days has increased to 4.2. Current national NRLS published mean rate is 6 (April 2019 –March 2020)
- Zero COVID-19 deaths falling in to the 'Definite' category (according to the National definition of Nosocomial deaths)
- 15 Serious Incidents reported in May 2021 with falls the largest category of incidents and all incidents were reported on STEIS within the 2 working date target

2. Operational Performance:

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

- Continued rise in attendances: Mostly seen at RS site, with daily average attendances of 369 (a rise of 20/day since previous month and brings this in line with attendances seen in May 19 (371/day). The rise continues in ambulatory care particularly and in children's, which has risen to 84/day on average (up from 68/day in April. This was predicted and is in line with numbers seen pre-covid and the number of children's admissions haven't risen, however the demand for side rooms has impacted on wait times.
- Ambulance arrivals have risen slightly to a daily average of 172.
- The most challenged area was in relation to the conversions and the flow of patients out of ED (see slide 5).
- System-wide performance is down to 72.2%, with total type 1 at 60.68%. At Royal Stoke the non-admitted maintained a performance similar to April at 61.1% but the admitted performance fell to 34.7% from 46.6% in April.

- The department had continued days with sub 60% performance
- After a challenged start to May , Towards the end we have seen improvements through Work Stream 2 consistent with improved flow with a reduction in the number of DTAs in ED at 09.00 ;reduction on speciality to discharge times and a reduction of those patients waiting over 12 hours in ED

The Trust is predicted to achieve the following three cancer standards for May 21: 31 day subsequent treatments for anti-cancer drugs and radiotherapy, the 28day FDS standard. The 2ww position in May is predicted to land at 81% which is an improvement on April (76.7%) despite the challenges. The sites that most influence this performance are Breast with the continued demand where performance is low at 27% but is an improvement 0n April (11.8%). This breast underperformance is a national issue and UHNM is working closely with the West Midlands Alliance, CCGs and GP representatives to mitigate.

62 day performance is predicted at this point to achieve 64.6% and continues with one of the lowest backlogs regionally. This position will change as more treatments are recorded. In addition, the number of patients waiting over 104 days at the end of May was 31, with 8 having a diagnosis of Cancer.

Benchmarking nationally, the Trust is 1 of only 12 STPs with a 62 day backlog lower than 200 patients, which is a good position, but this is at risk due to the fast rate of growth in patients waiting on the PTL - the number of patients waiting between 34-62 days has increased by 45.5% in the past 4 weeks.

The National ask for elective care has been revisited and an activity plan has been developed against the National Planning and Guidance trajectories for 2021/22 set at 70%, rising by 5 percentage points in subsequent months to 85% from July 21. The threshold level is set against a baseline value of all elective activity delivered in 2019/20, allowing for available funding, workforce recovery and negative productivity impacts of the pandemic through 2021/22.

For total inpatient activity, the actual against the national ask for April 21 was 74.8% (Inpatient 71.7% and Day Case 75.2%). For April the total outpatient actuals against BAU for outpatients was 93.0%. This is higher in Follow ups than new (84% New, 102% follow up). Both 1st new appointments and Follow ups are on track to be above the national ask for May.

Theatre capacity at UHNM has been released from 29th March 2021 (24 theatres) with enhanced lists at County. The new Independent Sector contract has been drafted but sees another change to pathways and case-mix of activity with UHNM holding the contract and the Independent Sector doing the activity on our behalf. The volume of patients transferred is subject to clinical release and patient acceptance of movement.

The RTT performance for May 21: the total number of Referral To Treatment pathways grew to 61,608(April 59,645). The Trust has reduced the number of > 52 weeks to 3,606 (April 4,094). Recovery plans have been reviewed. RTT performance in May achieved 62.06% (April 61.08%).

For DM01 (15 nationally identified Dx tests) the waiting list, which had shown significant growth seems to have plateaued off with a reduction in MRI, CT and Non-obstetric ultrasound. The greatest proportion of > 6 week waits are within Non-obstetric ultrasound related to the significant Increase in demand and activity for breast 2ww referrals which due to the prioritisation over the long waiters, has impacted on performance. A working group is set up comprising of imaging, breast surgery and the cancer to team to review the referral s and total capacity required. There also seems to be more referrals from Primary care for patients under the age 35. Cancer team are engaging with the PCN/CCG regarding referrals, and within radiology effort is being made to put on additional capacity out of hours to clear the backlog with more joint working with surgery.

The current DM01 diagnostic performance for May 21 is 79.43% (April 78.72).

3. Workforce:

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

Partnership working with the ICS continues on a range of Recruitment and Retention initiatives. System-wide processes are agreed for mutual aid and redeployment of staff to areas of need.

Sickness and covid-related absences continue to be monitored daily. Staff showing symptoms, or with household members showing symptoms, are tested and results returned within 24-48 hours.

As of 9th June 2021, covid-related open absences numbered 81, which was 13.46% of all absences (8.32% at 11th May 2021).

The key performance issues are that the sickness rate remains above target and that compliance with PDR requirements is below target.

- Overdue PDRs are required to be scheduled from Q2 and the compliance rate has improved over the last 3 months.
- Actions towards improving sickness rates are being developed through the Improving Together Programme and A3 process. Divisional Teams are developing specific actions to address sickness and improve compliance with completing call backs and return to work interviews.

Sickness:
The in-month sickness rate was 4.55% (4.23% reported at 30/04/21). The 12 month cumulative rate reduced to 5.05% (5.21% at 30/04/21).

Appraisals:
The Non-Medical PDR compliance rate was 80.61% (77.42% at 30 April 2021).

Statutory and Mandatory Training:
The Statutory and Mandatory training rate at 31 May 2021 was 94.62% (94.19% at 30 April 2021), At 31 May 2021, 90.86% of staff had completed all 6 Core for All modules (90.32% at 30/04/21).

4. Finance:

The Trust has delivered a surplus of £4.3m in month against a planned break even position. The position in month is driven by underspends against the COVID-19 allocation, underspends on clinical supplies as activity levels remain below 2019/20 planned levels, underspends on pay (primarily qualified nursing) and slippage against reserves held by the Trust.

ERF for the year to date has been accounted for in month with £2.9m of income recognised against a planned figure of £2.6m. Based on activity plans £8.8m of income is forecast for H1 with additional costs approved of £0.6m to support the delivery of the activity plans.

The Trust incurred £0.8m of costs relating to COVID-19 in month which is a reduction in comparison with Month 1's figure of £1.1m primarily in non-pay due to a reduction in testing costs. This remains within the Trust's fixed allocation with £0.2m being chargeable on top of this allocation for COVID-19 testing costs.

Capital expenditure for the year to date stands at £2.6m which is £1m behind the plan mainly due to an underspend within the medical equipment sub group and the Lower Trent wards scheme.

The cash balance at Month 2 of £48.2m shows a reduction of £7.6m from the beginning of the year. This reduction is in line with expectations for Month 2 due to the anticipated reduction in both capital and general creditors from the year end position.

Key Recommendations:

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

NHS
University Hospitals of North Midlands
NHS Trust

Integrated Performance Report

Month 2 2021/22

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Contents

A note on **SPC**

University Hospitals of North Midlands NHS Trust

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

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

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

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

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

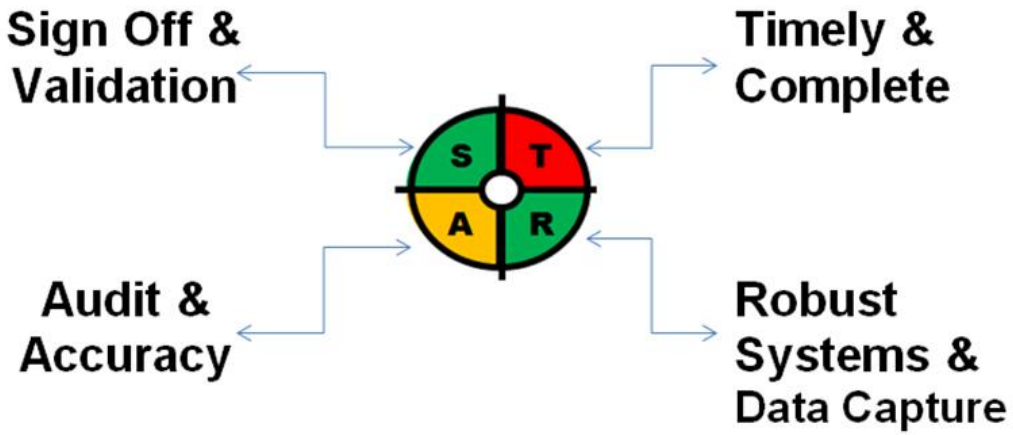
Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

A note on **Data Quality**

University Hospitals of North Midlands NHS Trust

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



Explaining each domain

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

RAG rating key

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

Quality

Caring and Safety

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

Quality Spotlight Report

NHS
University Hospitals of North Midlands
NHS Trust

Key messages

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

Quality Dashboard

NHS University Hospitals of North Midlands NHS Trust

Metric	Target	Latest	Variation	Assurance
Patient Safety Incidents	N/A	1680		
Patient Safety Incidents per 1000 bed days	N/A	45.89		
Patient Safety Incidents per 1000 bed days with no harm	N/A	30.70		
Patient Safety Incidents per 1000 bed days with low harm	N/A	12.59		
Patient Safety Incidents per 1000 bed days reported as Near Miss	N/A	1.78		
Patient Safety Incidents with moderate harm +	N/A	25		
Patient Safety Incidents with moderate harm + per 1000 bed days	N/A	0.68		
Harm Free Care (New Harms)	95%	96.5%		
Patient Falls per 1000 bed days	5.6	6.0		
Patient Falls with harm per 1000 bed days	1.5	1.8		
Medication Incidents per 1000 bed days	N/A	4.2		
Medication Incidents % with moderate harm or above	TBC	1.31%		
Patient Medication Incidents per 1000 bed days	N/A	4.1		
Patient Medication Incidents % with moderate harm or above	TBC	1.32%		

Metric	Target	Latest	Variation	Assurance
Serious Incidents reported per month	N/A	15		
Serious Incidents Rate per 1000 bed days	N/A	0.41		
Never Events reported per month	0	0		
Duty of Candour - Verbal/Formal Notification	100%	100%		
Duty of Candour - Written	100%	93.3%		
All Pressure ulcers developed under UHNM Care	TBC	55		
All Pressure ulcers developed under UHNM Care per 1000 bed days	N/A	1.50		
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 | Operational | Workforce | Finance

Quality Dashboard

NHS University Hospitals of North Midlands NHS Trust

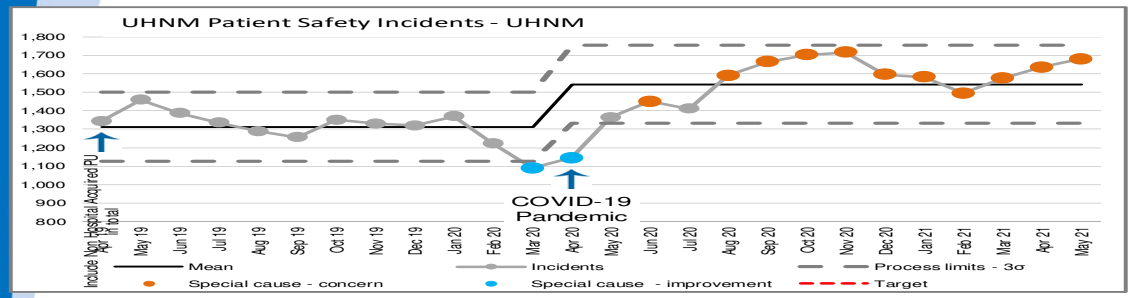
Metric	Target	Latest	Variation	Assurance
Friends & Family Test - A&E	N/A	75.5%	H	?
Friends & Family Test - Inpatient	N/A	96.6%	L	P
Friends & Family Test - Maternity	N/A	N/A	H	?
Written Complaints per 10,000 spells	35	22.58		?
Rolling 12 Month HSMR (3 month time lag)	100	97.87	H	P
Rolling 12 Month SHMI (4 month time lag)	100	103.93	H	P
Nosocomial COVID-19 Deaths (Positive Sample 15+ days after admission)	N/A	0	H	
VTE Risk Assessment Compliance	95%	99.1%	H	?
Emergency C Section rate % of total births	15%	19.59%	H	?
Reported C Diff Cases per month	8	10		?
Avoidable MRSA Bacteraemia Cases per month	0	0		P
HAI E. Coli Bacteraemia Cases per month	N/A	16	H	
Nosocomial "Definite" HAI COVID Cases - UHNM	0	0		

Metric	Target	Latest	Variation	Assurance
Inpatient Sepsis Screening Compliance (Contracted)	90%	78.9%		?
Inpatient IVAB within 1hr (Contracted)	90%	100.0%	H	?
Children Sepsis Screening Compliance (All)	90%	87.1%		?
Children IVAB within 1hr (All)	90%	N/A	H	F
Emergency Portals Sepsis Screening Compliance (Contracted)	90%	94.8%	H	?
Emergency Portals IVAB within 1 hr (Contracted)	90%	92.3%		?
Maternity Sepsis Screening (All)	90%	75.0%	H	F
Maternity IVAB within 1 hr (All)	90%	100.0%	H	F

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Reported Patient Safety Incidents

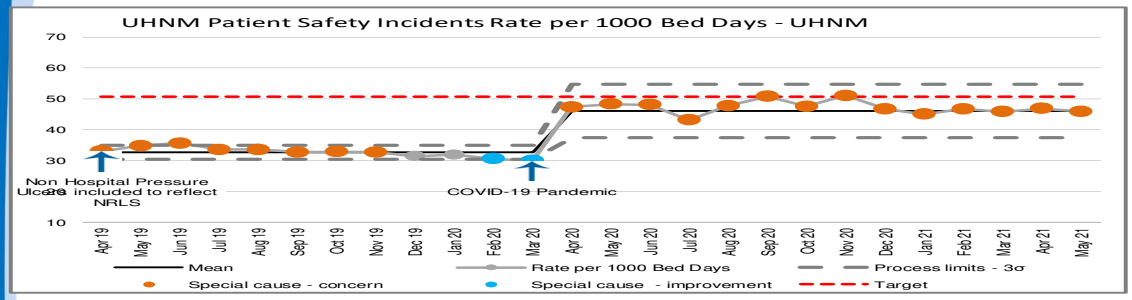


Variation	Assurance
	

Target	Mar 21	Apr 21	May 21
N/A	1575	1635	1680

Background

Total Reported patient safety incidents



Variation	Assurance
	

NRLS Mean	Mar 21	Apr 21	May 21
50.70	45.85	46.85	45.89

What is the data telling us:

The above data relates to **all** reported Patient Safety Incidents (PSIs) across the Trust. The May 2021 total remains within variation limits but is consistently above the mean rate and approaching upper limit. However, the reporting of incidents and near misses should continue to be encouraged and promoted and increasing rates and numbers of total incidents is not necessarily to be viewed as concern. It is important to review the different levels of harm within the overall totals.

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

- Patient related Slip/Trip/Fall - 223 (202)
- Clinical assessment (Including diagnosis, images and lab tests) – 80 (79)
- Patient flow incl. access, discharge & transfer - 125 (125)
- Documentation – 53 (58)
- Treatment/Procedure - 75 (66)
- Medication incidents - 156 (122)
- Infection Prevention – 52 (44)
- PU developed under UHNM Care - 52

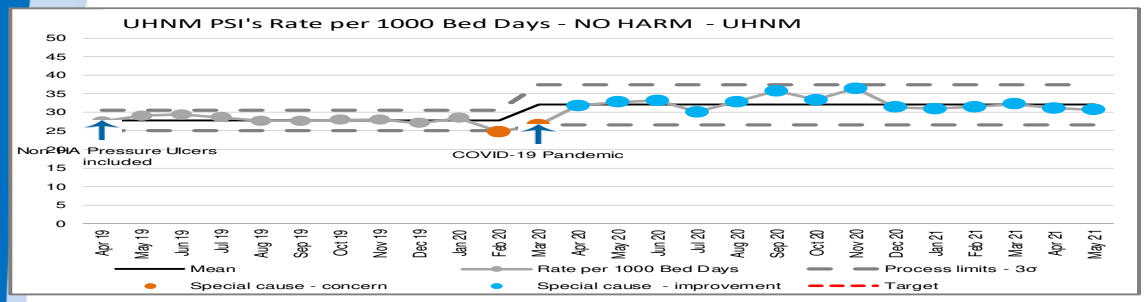
There have been increases in Falls, Medication, Treatment and Infection Prevention related incidents compared to April 2021 totals (in brackets). Reductions in number of Documentation related incidents.
PSIs are reviewed and analysis undertaken on locations and themes.

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

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

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

University Hospitals of North Midlands NHS Trust

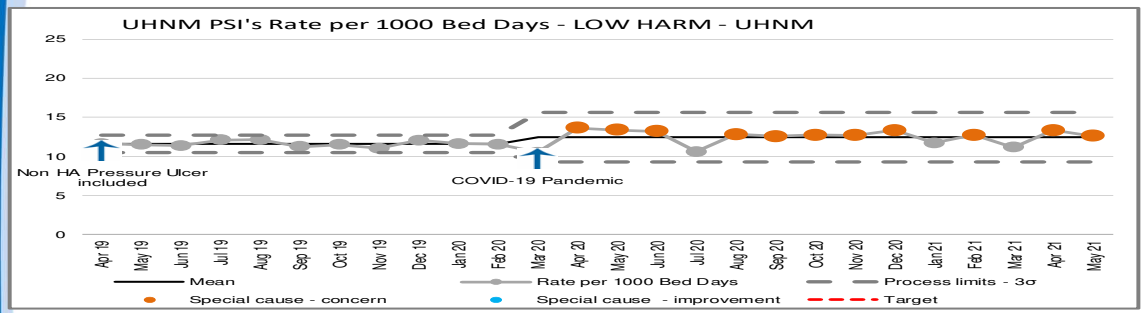


Variation	Assurance

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

Background

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

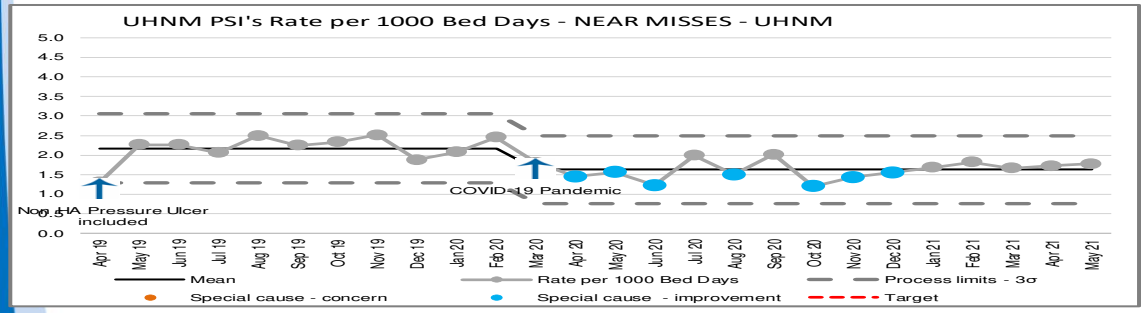


Variation	Assurance

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

Background

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



Variation	Assurance

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

Background

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

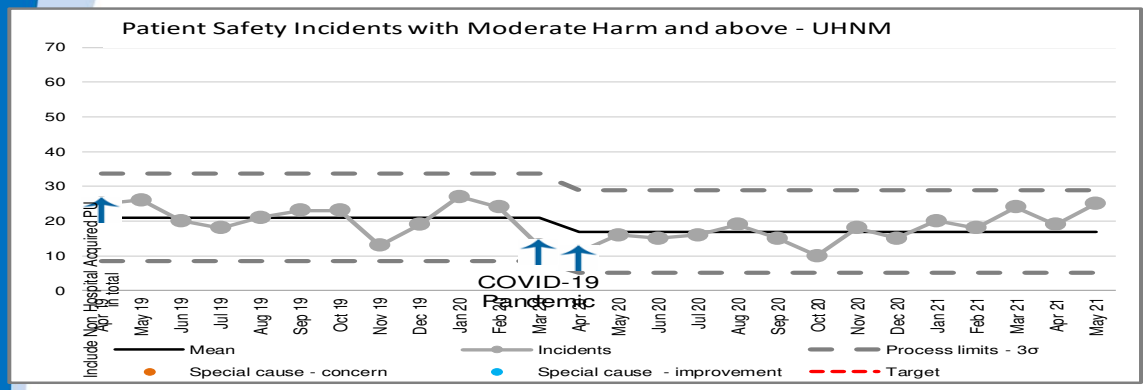
What is the data telling us:

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

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

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

Reported Patient Safety Incidents with Moderate Harm or above

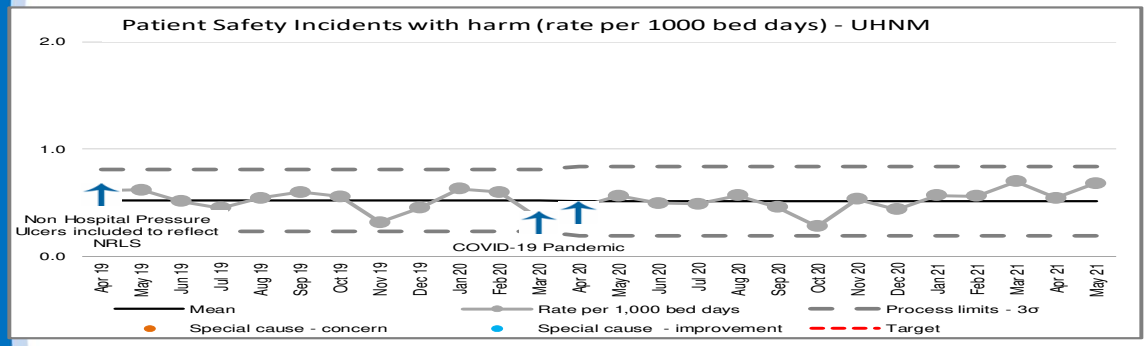


Variation	Assurance

Target	Mar 21	Apr 21	May 21
N/A	24	19	25

Background

Patient safety incidents with reported moderate harm and above



Variation	Assurance

Target	Mar 21	Apr 21	May 21
N/A	0.70	0.54	0.68

What is the data telling us:

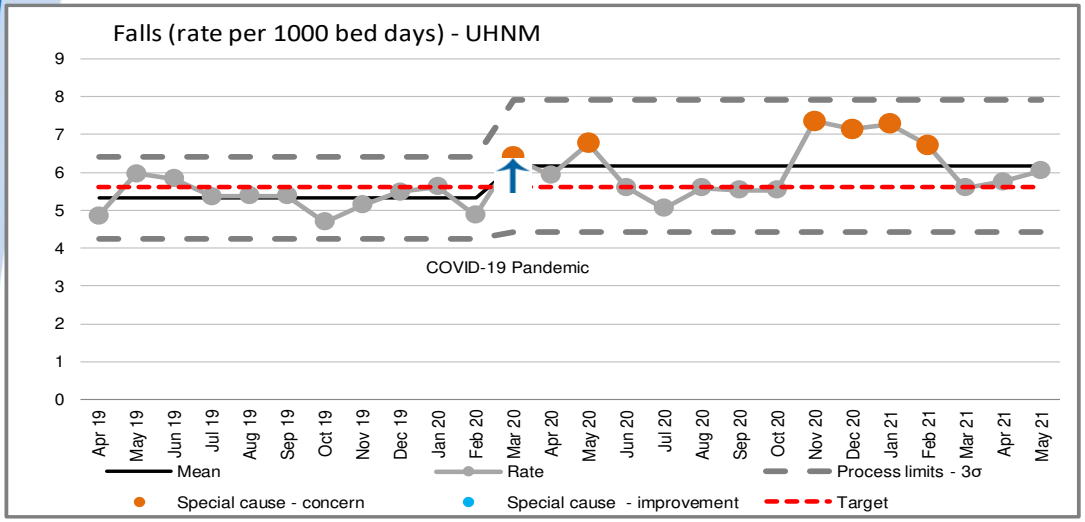
The variation noted in charts above for moderate harm or above total and rate per 1000 bed days is within normal variation and special cause noted. However the last 5 months have seen overall increase above the mean total and rate since the start of COVID-19 pandemic.

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

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

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

Patient Falls Rate per 1000 bed days



Variation	Assurance

Target	Mar 21	Apr 21	May 21
5.6	5.6	5.8	6.0

Background

The number of falls per 1000 occupied bed days

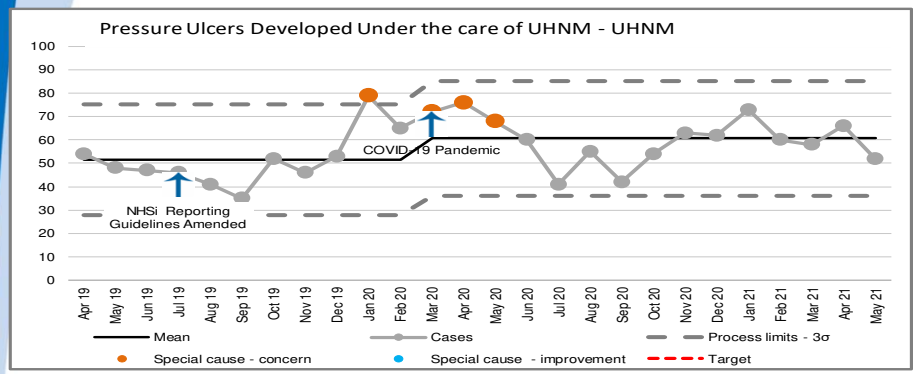
What is the date telling us:

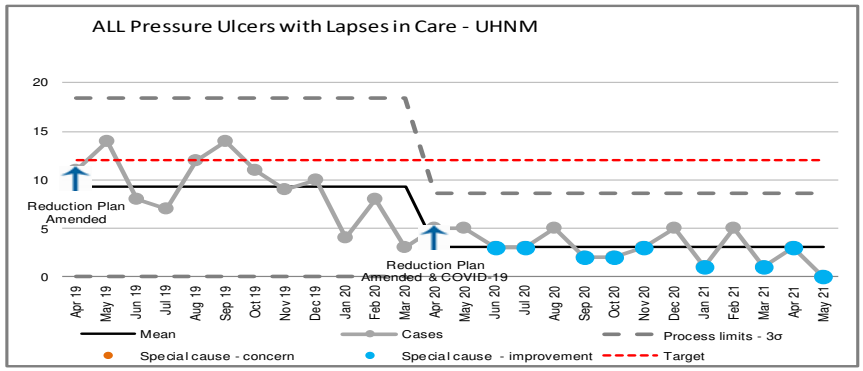
The data shows the Trust's rate of reported patient falls per 1000 bed days. Using the rate makes allowance for changes in activity/increased patient numbers. The Trust set a target rate, based on the Royal College of Physicians National Falls Audit published rate for acute hospitals, of 5.6 patient falls per 1000 bed days. May 2021 shows 6 and remains below the current Trust mean rate.
The Top areas for total falls in May 2021 were:
Royal Stoke AMU, Royal ED, Ward 223 - Cardiothoracic Surgery, Ward 228 – Neurosurgery, Ward 113 - Respiratory Medicine

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

- Education session on falls are being delivered by the QIF (Falls) to staff on AMU. A trial of sensors is continuing with educational support from Medline
- A visit to ward 228 and ARTU was completed in late May. Assurance was gained from ward 228 that robust staff education on falls awareness takes place and many preventative steps are taken to ensure patients safety. At the time of the visit ARTU were relocated due to maintenance. One concern was a lake of re-assessment particularly in re-completion of the multifactorial assessment for long stay patients. Staff were however, very visible within the ward and it was obvious that many steps were being taken to prevent falls. All findings were fed back the Specialised ACN at the time.
- Ward 233 have featured in the top falling area chart but on analysis of the data it was noted that 5 out of 10 falls were for the same patient. This patient remains an inpatient and the senior team have been alerted and asked to review his documentation and to ensure adequate falls prevention is provided.
- Support has been given to ward 113. A visit and review of their documentation provided assurance that staff were knowledgeable about falls prevention. Cohorting and 1:1 supervision was in place. The ward were provided with larger falls symbols to help highlight patients at risk in side rooms where the doors need to be closed due to IP precautions.

Total Pressure Ulcers developed under care of UHNM





Variation	Assurance

Target	Mar 21	Apr 21	May 21
N/A	58	66	52

Background

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

Variation	Assurance

Target	Mar 21	Apr 21	May 21
12	1	0	0

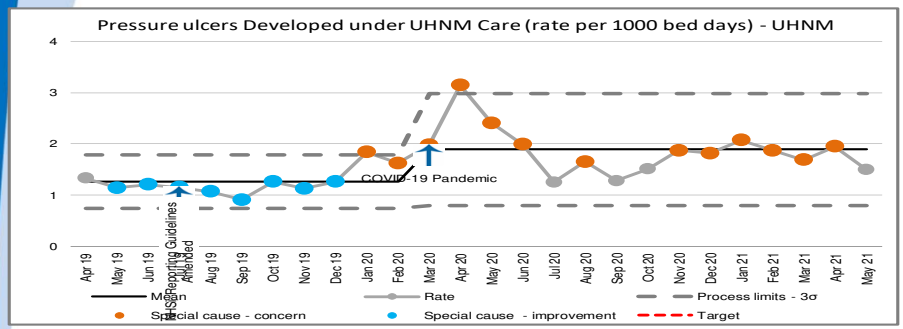
Background

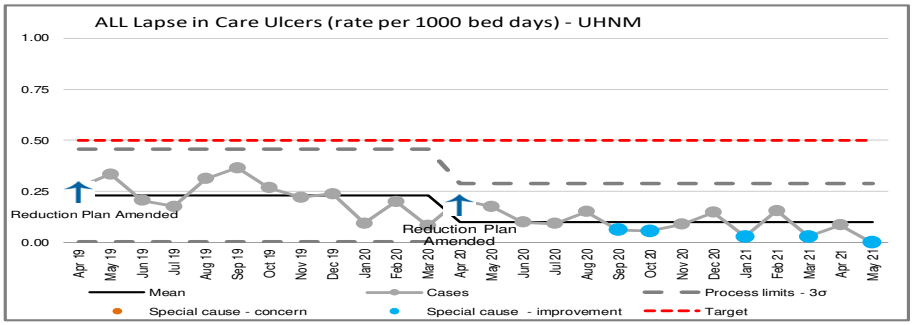
ALL pressure ulcers which developed whilst under the care of UHNM which had lapses of care associated

During May 2021 the 52 reported pressure ulcer related incidents were split between the following categories:

	Total (May 2021)
Category 1	12
Category 2	27
Category 3	5
Category 4	0
Unstageable	8
Total	52

Pressure Ulcers developed under care of UHNM per 1000 bed days





Variation	Assurance

Target	Mar 21	Apr 21	May 21
N/A	1.69	1.95	1.50

Background

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

Variation	Assurance

Target	Mar 21	Apr 21	May 21
0.5	0.03	0.09	0.00

Background

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

What the data is telling us

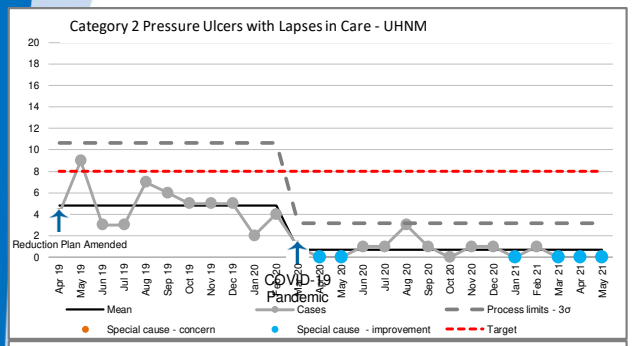
Chart one shows that in May 2021 the rate of hospital acquired pressure ulcers are now below the mean and predicted to be returning to pre-COVID-19 numbers as UHNM exits the second wave of COVID 19. However, the number includes three Category 4 pressure ulcers. The development of these have all been thoroughly investigated at MDT RCA panel. The two incidents that occurred in February 2021 were identified as being due to lapses in care and feature on the second chart. The first of these occurred on Ward 225 due to a failure to manage the patients' incontinence. This was exacerbated by a failure to provide a bariatric bed and alternating air mattress in a timely manner to facilitate repositioning and reduce the impact of pressure when the patient was on bed rest. The second incident occurred on Ward 218 where a patient who is believed to have mild pressure damage on admission was transferred to the care of another hospital without the appropriate communication on the condition of this skin which subsequently broke down to a deep category 4 pressure ulcer.

The third incident which occurred in March 2021 was not found to be due to lapses in care. This pressure ulcer developed as a Deep Tissue Injury during emergency surgery that meant the patient could not be moved to reduce pressure intra-operatively. The injury then quickly broke down, over a large cavity where large sections of bowel, had been removed due to the patients extremely serious clinical condition and has required surgical management to promote healing. All three of the Category 4 pressure ulcers incidents were externally reported as Serious incidents.

Actions

- The learning from all the Category 4 incidents has been shared Trustwide through the quality nurses group and via divisional hot topics newsletters.
- The wards involved in the incidents with lapses in care have developed thorough action plans to ensure learning from these incidents to improve pressure ulcer preventative care going forward. They will return to a MDT panel to present evidence of their completed Actions in July.
- As mis-classification of pressure ulcers, particularly at the Deep Tissue Injury stage has emerged as a theme, though not a root cause of incidents investigated during the last six months and again was a feature in both the Category 4 incidents there is currently a focus on classification. This includes work with the quality nurses to cascade updates and the inclusion of categorization pictures in the Skin Health booklet due for launch in July 2021. Work is currently underway to determine if the capability of Vitalpack can be optimized to allow the use of QR codes to provide more extensive reference points for staff on a number of different aspects including categorization, management pathways, dressing selection.

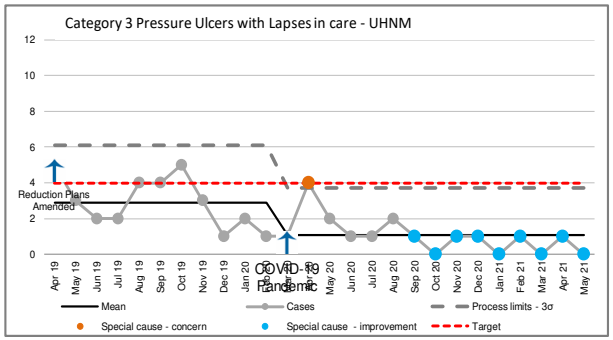
Pressure Ulcers with lapses in care



Variation	Assurance
L	P

Target	Mar 21	Apr 21	May 21
8	0	0	0

Background

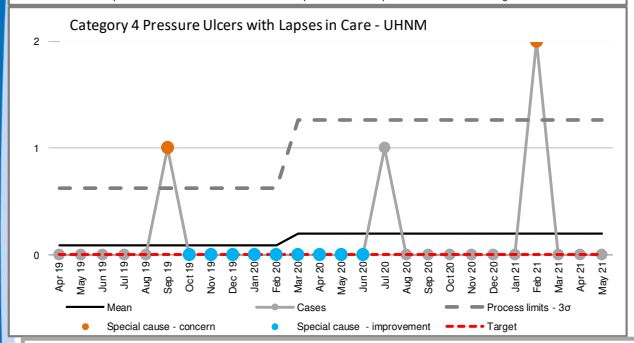


Variation	Assurance
L	P

Target	Mar 21	Apr 21	May 21
4	0	1	0

Background

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

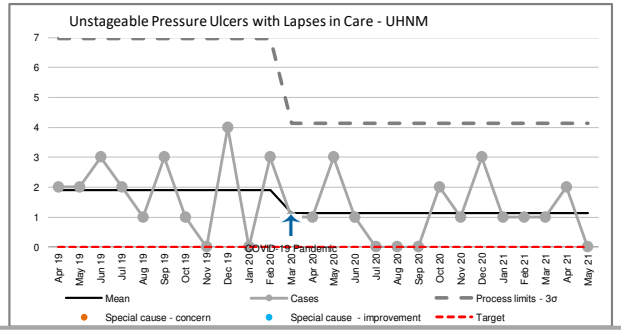


Variation	Assurance
	?

Target	Mar 21	Apr 21	May 21
0	0	0	0

Background

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



Variation	Assurance
	?

Target	Mar 21	Apr 21	May 21
0	1	2	0

Background

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

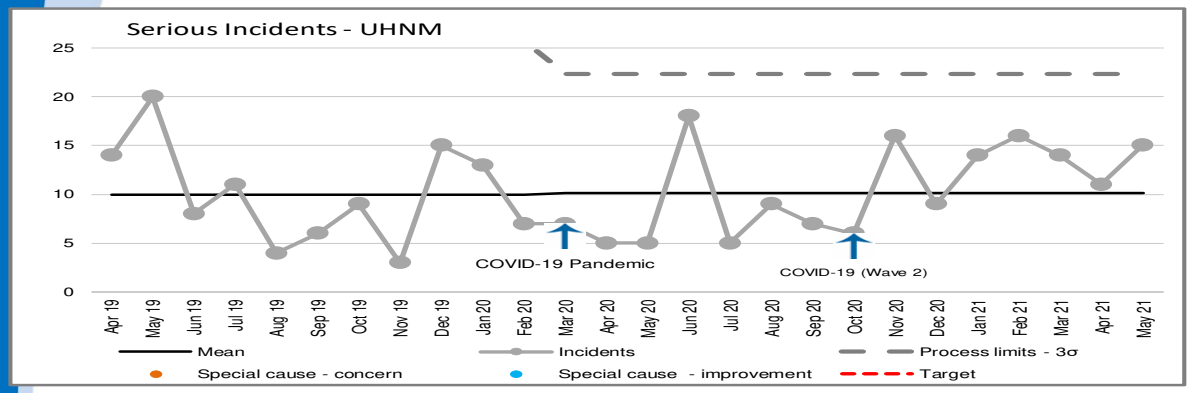
What is the data telling us:

The data above shows that there have been no Pressure Ulcers with lapses in care in May 2021. However, it should be noted that there are 6 RCAs scheduled for presentation to panel and therefore these numbers may change. Chart two highlights the aforementioned two Category 4 pressure ulcers that developed due to lapses in care on Wards 218 and 225 in February 2021, following RCA presentation at MDT panel in May 2021.

Actions:

- In response to the Category 4 pressure ulcer that developed Ward 218 in February and other near miss incidents connected to communication on discharge, Ward 218, the Tissue Viability Team and the Quality & Safety Team are collaborating via a Task and Finish Group. This group aim to review and consider improvements to current practices, including discharge letters, nurse to nurse communication and information to patients on discharge. This will feed into a larger Trustwide focus on discharge processes that commenced in May 2021.
- In response to the Category 4 pressure ulcer that developed on Ward 225, who are the highest reporting area for pressure ulcer incidents with lapses in care at UHNM and who have struggled to sustain improvements, a new Pressure Ulcer Prevention (PUP) Champion has been appointed for the ward who alongside feeding back on the lapses identified is completing weekly assurance audits and highlighting good or improved practice to ensure improvements are both made and sustained.
- Pressure Ulcer Prevention (PUP) Champions training will re-commence in July following a re-launch of Tissue Viability Link roles at a large introductory event to be held in June.

Serious Incidents per month

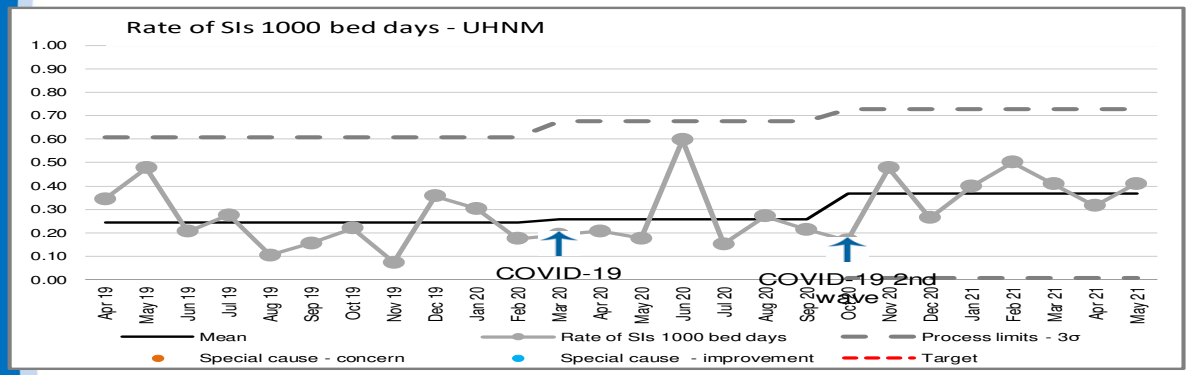


Variation	Assurance

Threshold	Mar 21	Apr 21	May 21
N/A	14	11	15

Background

The number of reported Serious Incidents per month



Variation	Assurance

Target	Mar 21	Apr 21	May 21
N/A	0.41	0.32	0.41

Background

The rate of Serious Incidents Reported per 1000 bed days

What is the data telling us:

May 2021* saw 15 incidents reported with:

- 9 Falls related incidents
- 1 Maternity (baby only)
- 2 Diagnostic related
- 2 Pressure Ulcer
- 1 Related to patient body after death

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

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

Serious Incidents Summary

University Hospitals of North Midlands NHS Trust

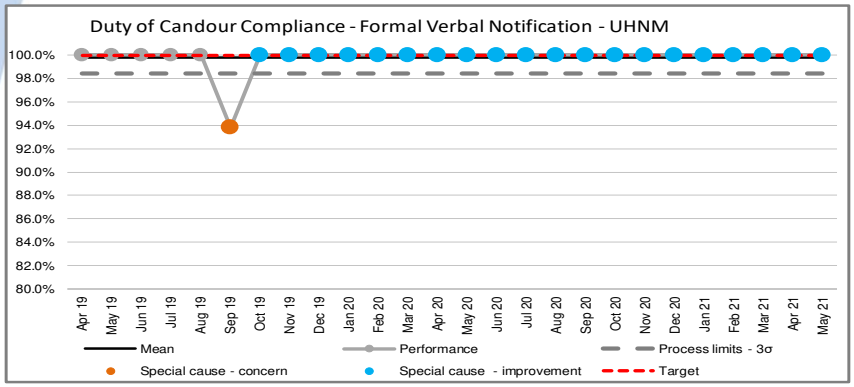
Summary of new Maternity Serious Incidents

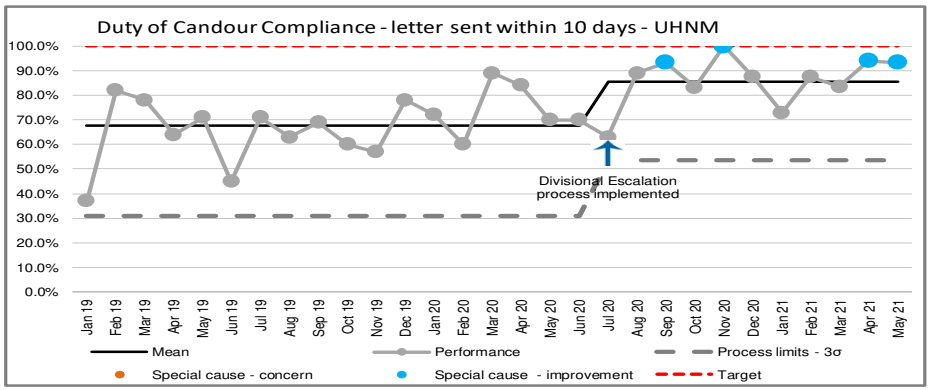
Following the formal recommendations in the Ockenden Report, below is an outline of the Maternity related serious incidents reported during March 2021. The new recommendation requires the Trust Board to receive summary on the new Maternity related Serious Incidents along with previously reported summary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

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

STEIS Ref. No.	Target Completion Date	SI Category	Incident Synopsis
2021/9749	02/08/2021	Maternity/Obstetric incident meeting SI criteria: baby only (this includes foetus, neonate and infant)	The baby required transfer to the NNU for therapeutic cooling. All cooled baby related incidents have been agreed to proactively report as SIs whilst HSIB investigation completed.

Duty of Candour Compliance





Variation	Assurance
H	?

Target	Mar 21	Apr 21	May 21
100%	100.0%	100.0%	100.0%

Background

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

Variation	Assurance
H	?

Target	Mar 21	Apr 21	May 21
100%	83.5%	94.1%	93.3%

Background

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

What is the data telling us:

During May 2021 there were 15 incidents reported and identified that have formally triggered the Duty of Candour. All of these cases have been formally notified of the incident.

Confirmed Follow up Written Duty of Candour compliance (i.e. receiving the letter within 10 working days of verbal notification) during May 2021 is 14 cases out of 15. There is 1 case awaiting confirmation of letter being sent out.

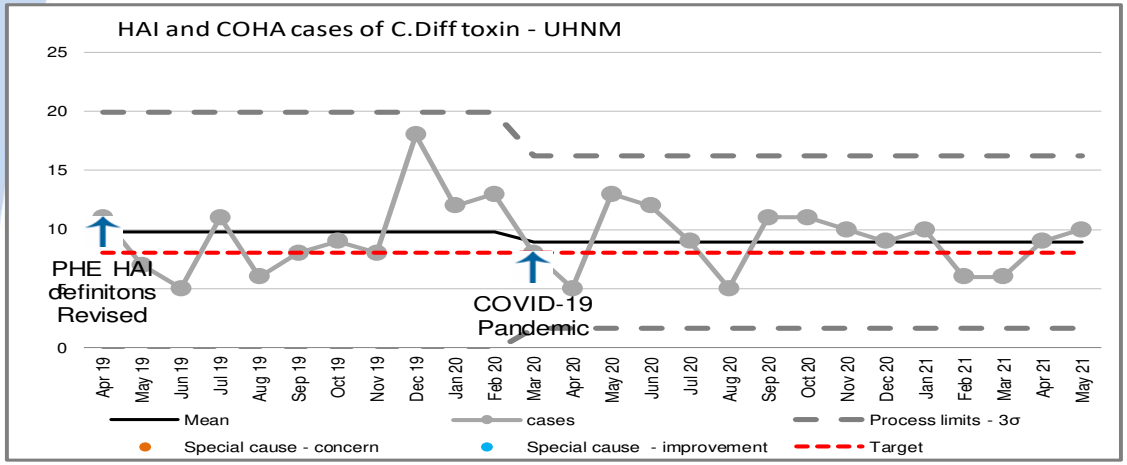
Since the new escalation process was introduced within the Divisions there has been an improvements in performance with smaller confidence intervals and performance above the mean.

Actions taken:

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

Compliance is included in Divisional reports for discussion and action.

Reported C Diff Cases per month



Variation	Assurance

Target	Mar 21	Apr 21	May 21
8	6	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 predominantly above the Trust mean for monthly cases but within SPC limits since the change in healthcare associated infections definition by PHE in April 2019.

There have been 10 reported C diff cases in May which is above monthly trajectory 10 versus a target of 8

7 of these were Hospital Associated Infection (HAI) cases and 3 Community Onset Healthcare Associated (COHA) cases.

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

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

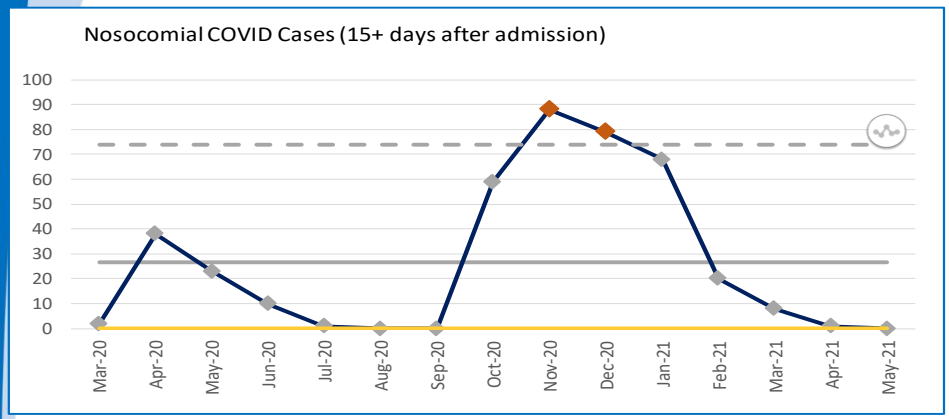
There has been one clinical area , ward 201 that has had more that one case of C diff toxin to report within a 28 day period

1x COHA toxin reported in April, 1 x toxin reported in May, the ribotypes were different which would indicate **no** person to person transmission

Actions:

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

HAI Nosocomial COVID Cases per Month



What do these results tell us?

- The data shows an in month decrease in definite Healthcare Acquired COVID - 19 cases with zero in May 2021

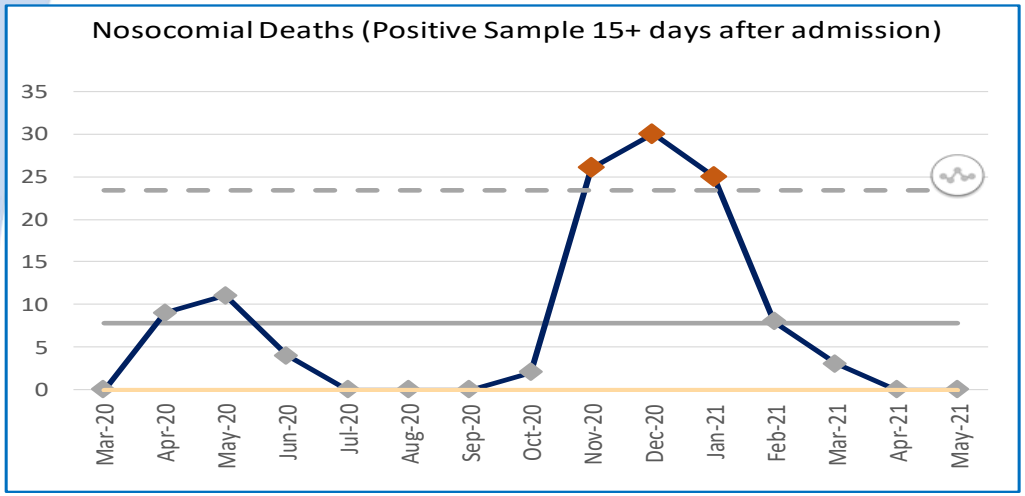
Actions :

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

	Community COVID-19 rate per 100,000 population (as at month end)				UHNM		
	England	W Mids	Staffs	Stoke	Total Admissions	COVID cases	
						Prob	Def
Oct 20	232.1	273.7	352.2	373.3	17006	63	59
Nov 20	152.2	188.0	206.0	350.3	14956	109	88
Dec 20	526.0	404.1	370.2	318.7	14701	107	79
Jan 21	283.0	328.0	296.0	239.5	14255	128	68
Feb 21	86.60	113.2	104.6	125.2	14101	31	20
Mar 21	56.0	61.6	56.2	76.8	17105	12	8
Apr 21	24.1	23.6	17.7	35.1	16554	3	1
May-21	36.0	tbc	tbc	tbc	17273	0	0

Percentage breakdown of COVID Cases per onset category per month				
Month	Community Onset	Indeterminate	Probable	Definite
Mar-20	89.4%	6.8%	2.5%	1.2%
Apr-20	73.5%	9.5%	9.7%	7.2%
May-20	65.6%	10.7%	14.6%	9.1%
Jun-20	67.2%	10.3%	13.8%	8.6%
Jul-20	92.3%	3.8%	0.0%	3.8%
Aug-20	78.6%	21.4%	0.0%	0.0%
Sep-20	100.0%	0.0%	0.0%	0.0%
Oct-20	66.7%	8.7%	12.7%	11.9%
Nov-20	67.7%	13.0%	10.7%	8.6%
Dec-20	68.5%	11.4%	11.5%	8.5%
Jan-21	66.8%	13.1%	13.2%	7.0%
Feb-21	70.8%	13.9%	9.3%	6.0%
Mar-21	73.8%	9.8%	9.8%	6.6%
Apr-21	82.9%	5.7%	8.6%	2.9%
May-21	90.0%	10.0%	0.0%	0.0%
Grand Total	69.7%	11.3%	11.1%	7.8%

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



What do these results tell us?

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

- Total 119 hospital acquired COVID-19 deaths with 1st positive results 15 days or more following admission recorded since March 2020.
- The mean number of deaths per month since March 2020 is 8

Actions :

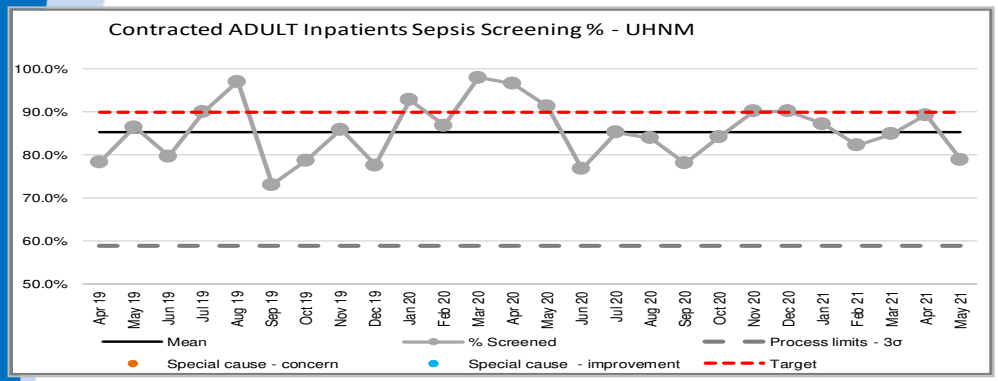
Ongoing work to identify the ward outbreaks and cross reference with patients involved is being undertaken with support from the Infection prevention Team to support the review of the nosocomial deaths.

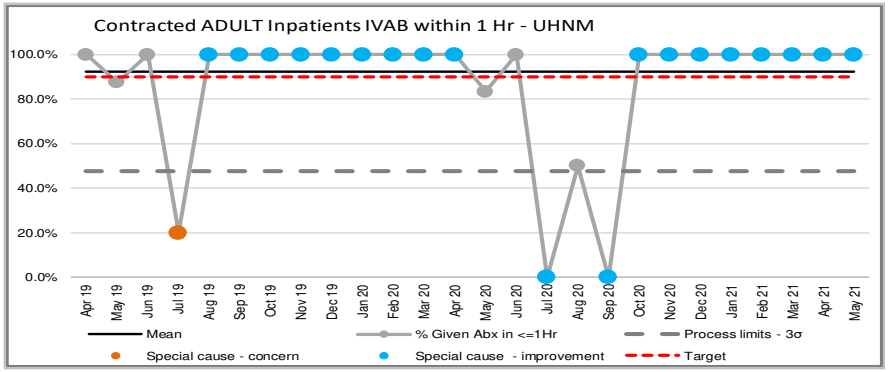
The online SJR form has been adapted to include specific COVID related questions following pilot review by Deputy Medical Director.

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

Sepsis Screening Compliance (Inpatients Contract)

University Hospitals of North Midlands NHS Trust





Variation	Assurance

Target	Mar 21	Apr 21	May 21
90%	85.0%	89.4%	78.9%

Background

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

Variation	Assurance

Target	Mar 21	Apr 21	May 21
90%	100.0%	100.0%	100.0%

Background

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

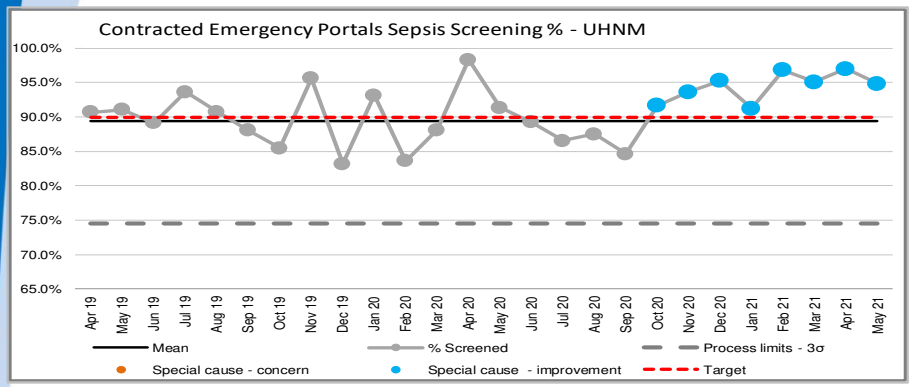
What is the data telling us:

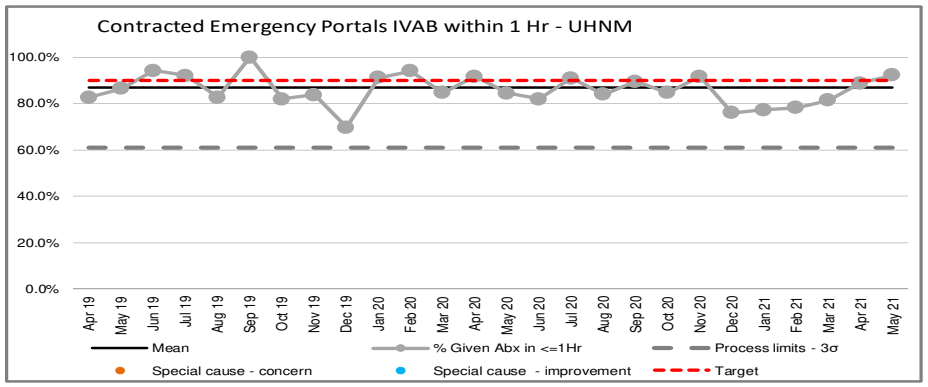
Inpatients May results now show a significant drop from 89.4% to 78.9% for screening and maintain 100% compliance for IVAB within an hour. Of the 95 Inpatients that triggered a sepsis screen, 78 had sepsis red flags present, 1 of these patients were given IVAB within hour and of the remaining 77 patients, 45 had alternative diagnosis that were deemed as not sepsis related and IVAB were not indicated. The remaining 32 patients were already receiving IVAB prior to the identified red flag trigger. Surgery division screening compliance has fallen to 55% while both Medicine & Specialised achieved between 82%-89% screening compliance.

Actions:

- The sepsis team have continued to provide sepsis re-enforcement, kiosks, visiting ward areas to update clinical staff and promote awareness around sepsis whilst answering any queries they may have
- The Sepsis team regularly identify areas of poor compliance and prioritise those areas for more focused re-enforcement and sepsis kiosks each month
- The team now offer 30 minutes drop in sessions for particular areas of UHNM. Some medicine, surgery and specialised wards have benefited from these in recent months and we have planned similar events for the rest of the clinical areas including County; on-going
- The Sepsis Team continue to work closely with the VitalPacs team in order to address issues such as staff access levels, sepsis alerts not showing and training needs.
- The Sepsis Team continue to provide unannounced ward visits out of hours to deliver reinforcement to those staff who work regular nights. The Sepsis Clinical Lead and Sepsis Team have continued to deliver yearly sepsis training to all level of clinicians via Microsoft Teams; on-going
- The Sepsis team have organised Sepsis Champion Day (5 hour CPD) to all levels of clinical staff which will include simulation & workshop for July 2021.

Sepsis Screening Compliance (Emergency Portals Contract)





Variation	Assurance
H	?

Target	Mar 21	Apr 21	May 21
90%	95%	97%	95%

Background

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

Variation	Assurance
	?

Target	Feb 21	Mar 21	Apr 21
90%	78%	81%	89%

Background

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

What is the data telling us:

Adult Emergency Portals screening in April 2021 achieved 97% for the 67 patients audited.

The performance for IVAB within 1hr continues to improve significantly to 88.9%. There were 57 red flag sepsis patients identified from the 67 patients audited in the screening sample. Out of the 57 red flag patients, 24 received IVAB within an hour whilst 16 were already on IVAB and 14 had an alternative diagnosis.

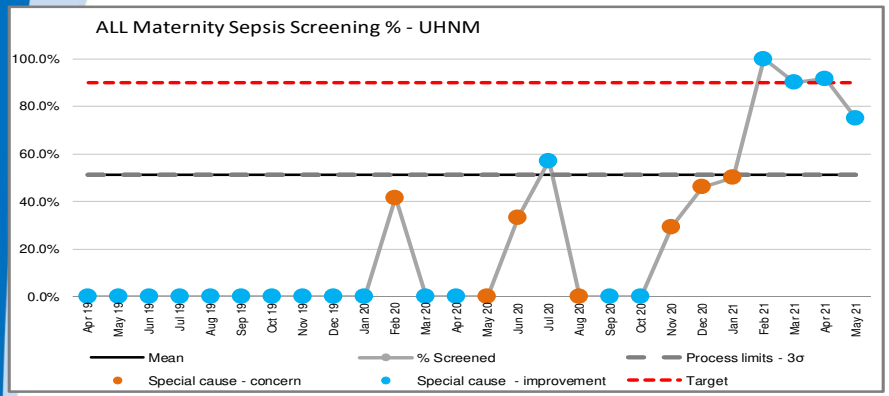
There were 3 late IVAB, 3 of which were administered within 2 hours. This have been escalated to the respective areas' senior teams.

Actions:

- The Sepsis Team continue to closely monitor the compliance by visiting the A&E regularly and offering department based sepsis reinforcement when staffing and acuity allows
- The A&E Education Team and A&E Sepsis doctor will continue to provide sepsis virtual education for both A&E sites as required.
- The Sepsis Team is working collaboratively with the A&E Quality nurses, senior staff and A&E Sepsis clinical lead for providing solutions to late IVAB incidents although it is anticipated that as the covid-19 cases ease there will be fewer incidents of late IVAB given within 2hrs. The late IVAB have been addressed through escalation and training for individual staff involved.
- The Sepsis Team have invited the sepsis champions in this department to attend the 5 hour CPD Sepsis training arranged for July 2021.

Sepsis Screening Compliance ALL Maternity

University Hospitals of North Midlands NHS Trust

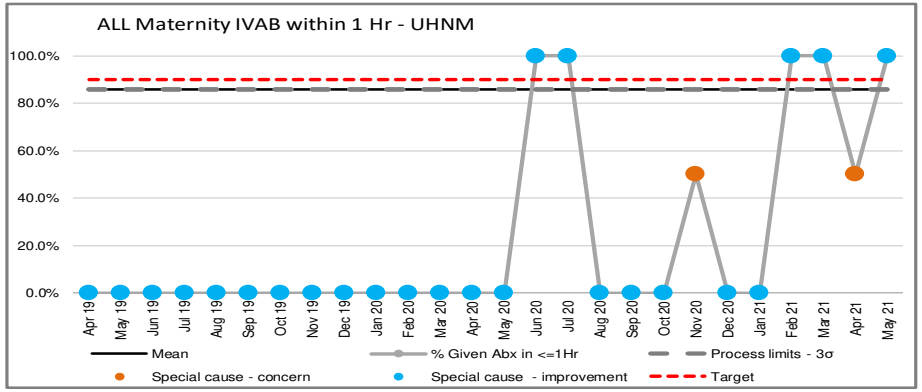


Variation	Assurance
H	F

Target	Mar 21	Apr 21	May 21
90%	90.0%	91.7%	75.0%

Background

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



Variation	Assurance
H	F

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

Background

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

What is the data telling us:

Maternity Inpatients and Emergency portal (MAU) audited by the Sepsis Team in May 2021 shows that 75% of patients that trigger with MEOWS >4 were audited and screens completed via newly launch sepsis tool in K2 electronic system. This result was taken from 8 patients audited with two missed screen from the emergency portal (MAU).

100% compliance was achieved for IVAB within an hour from the 2 cases audited in MAU and Inpatient wards.

Actions:

- The Maternity Senior Team have continued to work collaboratively with the sepsis team to ensure patient safety. The Sepsis Team provided training to all maternity staff in February up to present and had an excellent uptake.
- The new electronic version of maternity sepsis screening tool was launched from the 12th May 2021. The Sepsis Team have provided further support and training during the same week to enhance staff awareness and understanding, hence it was anticipated to see some initial problem during the 1st week of launch.
- The sepsis team will continue to audit Maternity comprehensively to ensure the maintenance of high standard of sepsis practice and compliance.
- Two missed screening has been escalated to the Maternity senior team for learning and action, whilst IVAB within hour compliance has improved.

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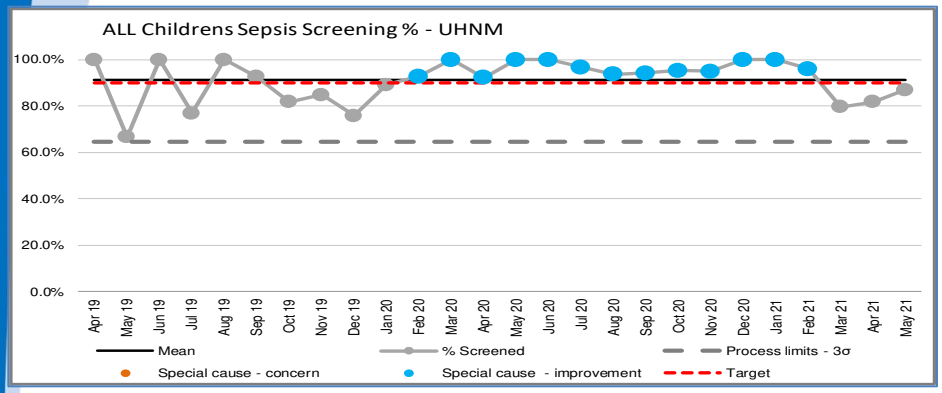
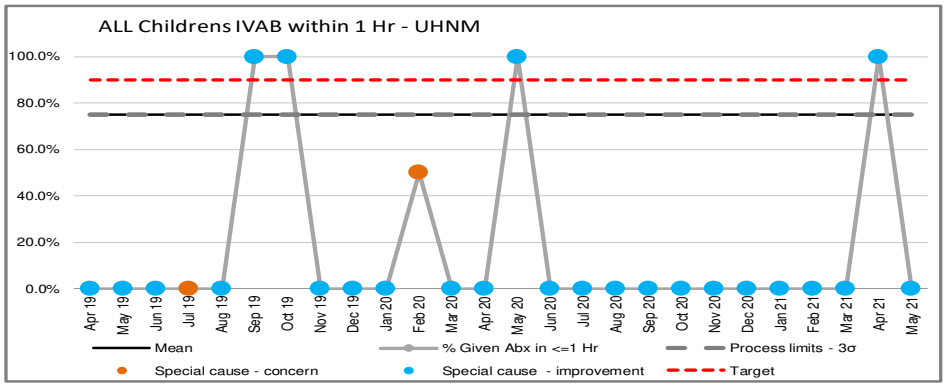
Sepsis Screening Compliance ALL Children

NHS University Hospitals of North Midlands NHS Trust





Variation	Assurance
	?

Target	Mar 21	Apr 21	May 21
90%	79.6%	81.8%	87.1%

Background

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

Variation	Assurance
H	F

Target	Mar 21	Apr 21	May 21
90%	N/A	100.0%	N/A

Background

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

What is the data telling us:

The charts above show improvement in sepsis compliance for May 2021, with a result of 87.1%.

Whilst CAU continued to sustain and maintain compliance of > 90% there has been a significant drop for Children A&E since March & April but started to pick up from May with four missed screens resulting in a screening compliance of 85%. Inpatients ward 216 and ward 217 have no PEWS 5> triggers during randomised audits. Missed screens has been escalated to the senior team in Children A&E. Most Paediatric patients are already on oral antibiotics or IV antibiotics prior to trigger of PEWS >5 (this is both of moderate and high risks).

Actions:

- In the absence of formal training and sepsis champion days, the Sepsis Team will continue to deliver re-enforcement and kiosks to specific areas when falls in compliance are identified. Ward managers and seniors teams are encouraged to forward concerns and ad hoc training is offered to all areas when required. The subsequent audits suggest that the poor result for Children A&E is an isolated incident and we are hopeful of better results in the coming month.
- The Sepsis Team have adjusted the audit process to take smaller samples over a wider range of dates to give a more comprehensive perspective.
- Formal training is planned and arranged for July 2021 tentatively.

Operational Performance

2025 Vision "Achieve NHS Constitutional patient access standards"

Spotlight Report from Chief Operating Officer

University Hospitals of North Midlands NHS Trust

Emergency Care

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

- Continued rise in attendances: Mostly seen at RS site, with daily average attendances of 369 (a rise of 20/day since previous month and brings this in line with attendances seen in May 19 (371/day). The rise continues in ambulatory care particularly and in children's, which has risen to 84/day on average (up from 68/day in April) however the conversion to in patients has not increased over the expected norm. The ambulatory numbers are impacting on performance due to surge (some days 30 plus Type 1 per hour over 3 or more hours that puts the site in escalation) – peaks 12:00 – 15:00 and 17:00 – 20:00 . WMAS reporting daily call volumes on a par with new year's evening volumes.
- Ambulance arrivals have risen slightly to a daily average of 172.
- The most challenged area was in relation to the conversions and the flow of patients out of ED (see slide 5).
- System-wide performance is down to 72.2%, with total type 1 at 60.68%. At Royal Stoke the non-admitted maintained a performance similar to April at 61.1% but the admitted performance fell to 34.7% from 46.6% in April.
- The department had continued days with sub 60% performance with most of the front door metrics challenged , despite this the NEL metrics have seen slight improvements.

Cancer

- The Trust is predicted to achieve the following three cancer standards for May 21: 31 day subsequent treatments for anti-cancer drugs and radiotherapy, the 28day FDS standard. The 2ww position in May is predicted to land at 81% which is an improvement on April (76.7%) despite the challenges. The sites that most influence this performance are Breast with the continued demand where performance is low at 27% but is an improvement 0n April (11.8%). Breast demand is a reported national pressure. Local mitigation plans in progress with WMCA looking at the Nottingham Community Clinic Model and UHNM have introduced an < 35 clinic to triage low threshold referrals.

- 62 day performance is predicted at this point to achieve 64.6% and continues with one of the lowest backlogs regionally. This position will change as more treatments are recorded. In addition, the number of patients waiting over 104 days at the end of May was 31, with 8 having a diagnosis of Cancer.

- Benchmarking nationally, the Trust is 1 of only 12 STPs with a 62 day backlog lower than 200 patients, which is a good position, but this is at risk due to the fast rate of growth in patients waiting on the PTL - the number of patients waiting between 34-62 days has increased by 45.5% in the past 4 weeks due to patients coming off surveillance pathways or diagnostic outcomes being published to inform next stage treatment.

Spotlight Report from Chief Operating Officer

NHS
University Hospitals of North Midlands
NHS Trust

Planned Care

- The Planned Care Cell has been convened twice since the Operational Delivery Group Governance model commenced on 19th April 2021. The focus of activities has been as follows:
- Mapping of waiting list priorities to available acute and independent sector capacity for assurance of May 21 trajectory together with tactical capacity management of 9 specialty urgent P2 challenge underway.
- Data Quality Re-Audit of the Waiting List P2 patients to be enacted 1st week of June 21.
- Refinement enacted of the P2 tracker that will enable weekly monitoring of treatments by Grade.
- Weekly monitoring of progress with the increasing capacity national framework contract with the independent sector and referral of UHNM patients. Proposals for expedited transfer of patients in progress with the IS and CCG stakeholders.
- RTT Training and floor walking recommenced following Clinician engagement and championing of pathways and PTL ownership.
- Weekly cancer diagnostic and treatment escalations to the Senior Team and oversight as to treatment plans and outcomes at the Performance Assurance Meeting for escalation to the Planned Care Cell if in week actions fail to deliver right outcome.
- Waiting list analytic outcomes indicate 9 challenged specialties based on weeks worth of activity held compared to reference standard and P2 clearance. This will inform how to allocate resources to get traction on increasing treatment capacity for both RTT and Cancer.

RTT

- The indicative performance for May 21: the total number of Referral To Treatment pathways grew to 61, 608 (April 59,645). The Trust has reduced the number of > 52 weeks to 3606 (April 4,094). Recovery plans have been reviewed. RTT performance in May is 62.06% (April achieved 61.08%).

Diagnostics

- For DM01 (15 nationally identified Dx tests) the waiting list, which had shown significant growth seems to have plateaued off with a reduction in MRI, CT and Non-obstetric ultrasound. The greatest proportion of > 6 week waits are within Non-obstetric ultrasound related to the significant Increase in demand and activity for breast 2ww referrals which due to the prioritisation over the long waiters, has impacted on performance. A working group is set up comprising of imaging, breast surgery and the cancer to team to review the referral s and total capacity required. There also seems to be more referrals from Primary care for patients under the age 35. Cancer team are engaging with the PCN/CCG regarding referrals, and within radiology effort is being made to put on additional capacity out of hours to clear the backlog with more joint working with surgery.
- The current DM01 diagnostic performance for May 21 is 79.43% (April 78.72).

Urgent Care - Summary

University Hospitals of North Midlands NHS Trust

- Attendances to ED have continued to increase and are back to pre COVID levels. At RS the increase is around 20 patients per day compared to the last reporting period (daily average of 369). Both ambulance and self-presenting pathways are demonstrating increases with the most challenging being within the self-presenting ambulatory group. Ambulance arrivals rose by a daily average of 172/day (a rise of 4/day). Presentations involving children are also increasing, notably respiratory conditions which was predicted due to relaxation of covid restrictions. The numbers and conversions however are in line with attendances seen pre-covid. The challenges have been in regards to the demand for level 1, HDU beds and surge in ambulatory attends for which teams have to reallocate ED staff to support.
- Overall there was increased periods when the level of hourly presentations was over and above the processing capacity within the ED and key metrics within the ED quality framework started to move outside of the required timescale e.g. triage time (reduced to below the mean of 70% within 15 mins) and waiting times (time to treatment has increased to 80 mins). Arrival to triage times have been constantly difficult to manage but a reconfiguration of the Minors Area has enabled 6 triage rooms to be created and improvements are expected from June.

- The most notable change in May was the admitted pathways. Whilst the number of referrals to specialties had not significantly increased the referral to discharge time had deteriorated, particularly during the second half of the month to a daily average of 230 mins (up from a daily average of 166 mins in April). With performance for all specialties down to 26%. This was mainly seen in referrals to AMU where the daily average referral to discharge time rose to a daily average of 322mins and the number of breaches due to 'awaiting medical bed' rose from a daily average of 22 to 30 in May. This is due to the number of factors: AMU has returned to its pre Covid bed base capacity as Medicine shrank back to its own footprint, reducing AMU from 65 beds to 58. As a result the AMU team start each day with a full ward and minimal empty beds. In May AMRA has increasingly been used overnight reducing the early pull capacity from AMU to maximise flow out of ED; increasing numbers and complexity of patients in the main Medical bed pool; increasing number of MFFD patients resulting in reduced capacity for onward transfer; the number of discharges per day in April was 65 -70 a day and additional surge bed base was open. At the end of April medicine completed the return to normal bed base and the number of discharges per day reduce to 50 – 55 (this links directly to the acuity of the admitted patients and the complexity of needs .

- Physical Ambulatory footprint with capacity to treat and green pathways remained difficult to manage with current workforce. A CDU has now been reintroduced for the ambulatory pathways (01.06.21) so improvement is expected moving forward.

- Consequently, the 4hr performance has deteriorated in May, with system wide performance at 72.2% (April 76.8%). Royal Stoke was challenged throughout the month with performances below 60% & 50% and a final position of 51.4%. County type 1 achieved 87.4%.

- There was zero reported 12 hour trolley waits.

Urgent Care Improvement Programme

University Hospitals of North Midlands NHS Trust

Work stream 1 - Acute Front Door

- A streamlined referral process from ED to Acute Medicine is now complete and phase 2 include AMU to the medical wards
- Establish task and finish group to support quality improvement and the implementation of the new Urgent Care standards
- Share and consult on the revised Acute Medicine Model
- Deliver the Business case for the Acute Medicine Nursing Model following the findings from the Nursing review
- Deliver an ED specific set of metrics to support flow through the department
- Maintain progress with 111 First and expedite inclusion of UHNM in the 111 Kiosks to support patient presentation at ED culture / awareness of alternative pathways

1. Weekly Urgent Care Meetings within ED and Acute Medicine consolidated to reinvigorate the urgent care actions and support sustained improvement in a context of returning to BAU.
2. Weekly Acute Front Door meetings featuring ED and Acute Medicine actions runs weekly with support from MProve
3. Workforce business case is being consulted on it requires additional input from the divisional team and finance division for June Medicine Board.
4. Electronic Referral from ED to Acute Medicine, AMRA and AEC drafted. Acute Medicine Dashboard ready and being tested for go live .

Work stream 2 - Patient Flow

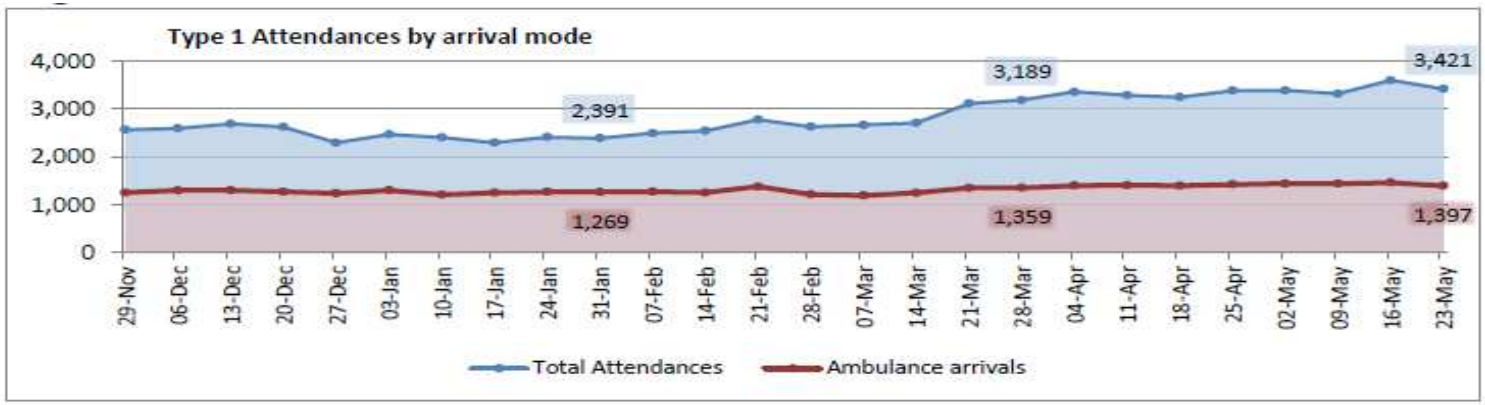
- Maintain focus of discharges before midday through improvement workshops
- Maintain focus on the use and future opportunities for the UHNM discharge Lounge
- Support length of stay by using directorate Teams – support improvements seen
- Importance of young persons rehab Unit working with MPFT
- Set up Task and Finish Groups with each division to support sustained improvements

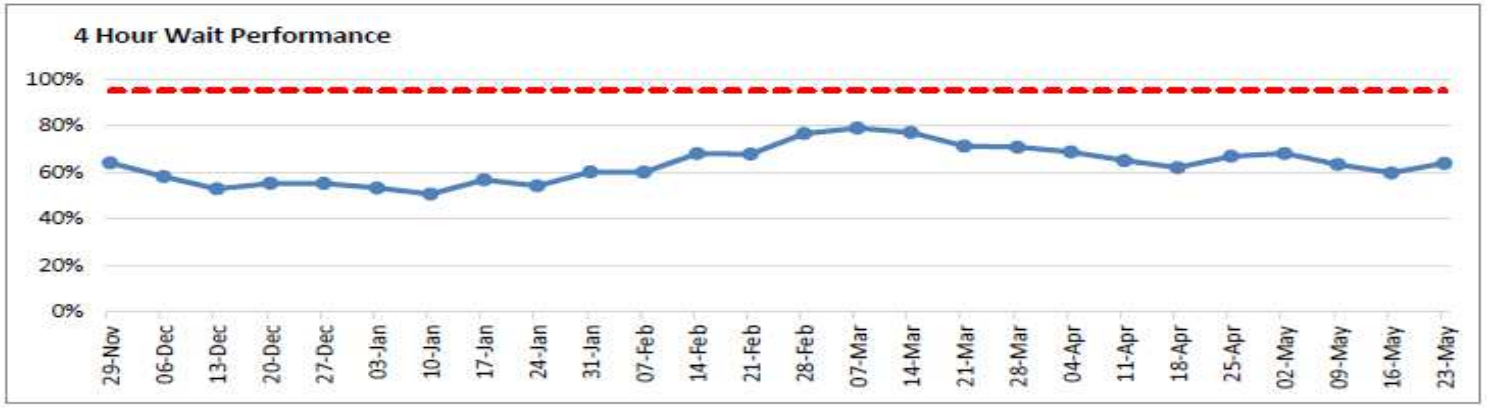
Work stream 3 -Clinical Site Management

- 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

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

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





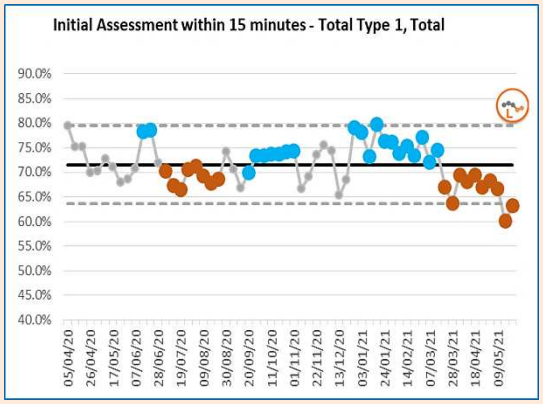
The Urgent Care Improvement Programme has a number of projects aimed at improving current performance.

University Hospitals of North Midlands NHS Trust

Work stream 1: Front Door – timing metrics

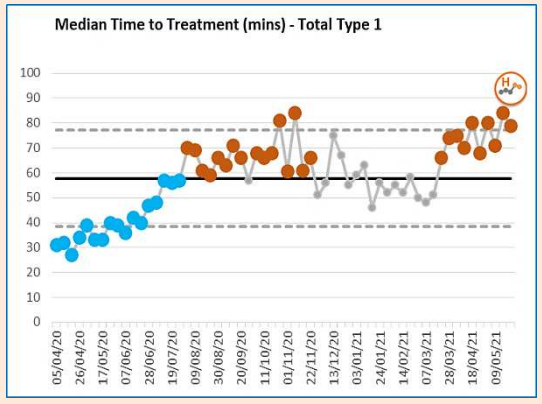
Time To triage – improve the time taken to triage patients so that patients are directed to appropriate care as quickly as possible. The aim is for 95% of patients triaged within 15 minutes.

The chart below shows that the time to initial assessment is cause for concern and for May has remained below the Mean of 70%. The performance for ambulance triage times was maintained at 80%, whereas for non-ambulance the percentage fell to around 55%.



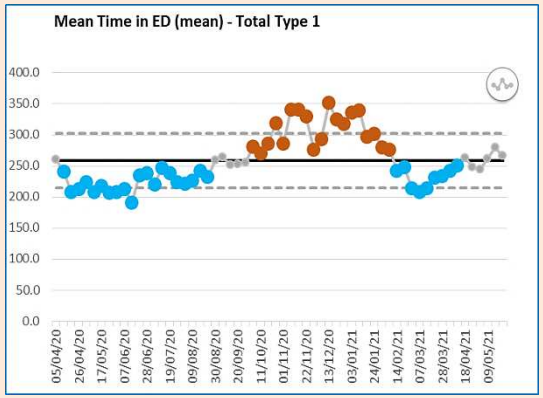
The median time to treatment - set at 60 minutes to ensure patients treated quickly and for those requiring referrals to other specialties are done so in optimum time.

May is showing cause for concern as the Median time in the department is rising. This is seen at both RS and County sites. The median time to treatment rose to, on average, 80 minutes.



The Mean time in the ED – The median time is set at 240 minutes as per national 4hour standard.

The mean time in the ED began to deteriorate, going above the Mean of 280 minutes towards the end of May. This is more noticeable in the non-admitted patients.



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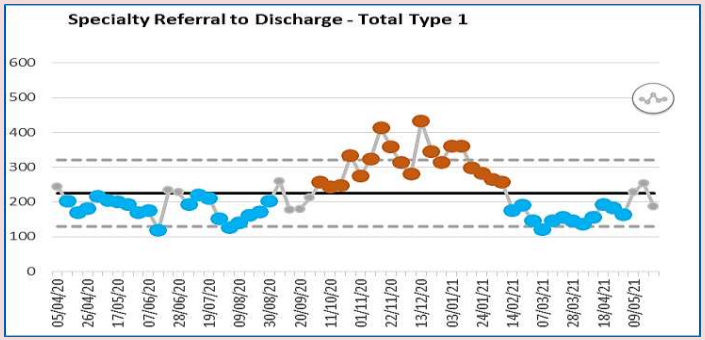
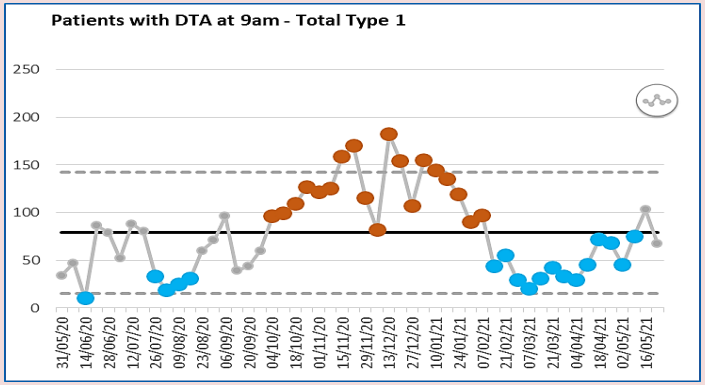
Work stream 2: Flow



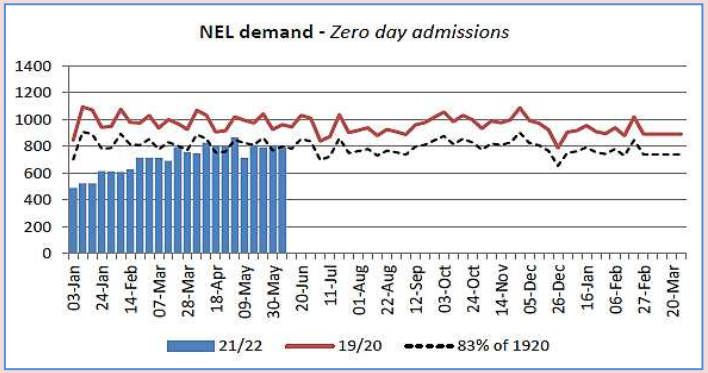
Referral to Discharge Time – improve the time taken from referral to specialties to discharge from ED either as admission or discharge home.

The specialty referral to discharge time is showing normal variation although there has been some improvements towards the end of May.



The number of patients who have a decision to admit at 9am

The number of patients with a DTA at 9am is showing normal variation of c75. There has been some improvements towards the end of May.



Emergency admissions: the number of Zero day Non Elective admissions

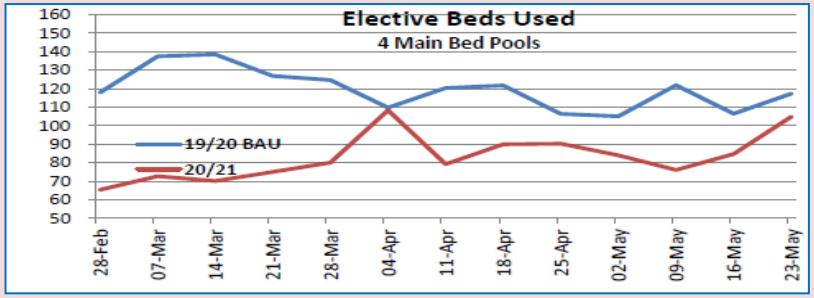
NEL Demand (admissions requiring an overnight bed) is at 95% of 201920 Business as usual level.

Surgical admissions requiring an overnight bed have been at c180 for the last 8 weeks fluctuating from 160 to 190.

Last week Specialised saw a rise to 206 - close to the peak of 210 in April.

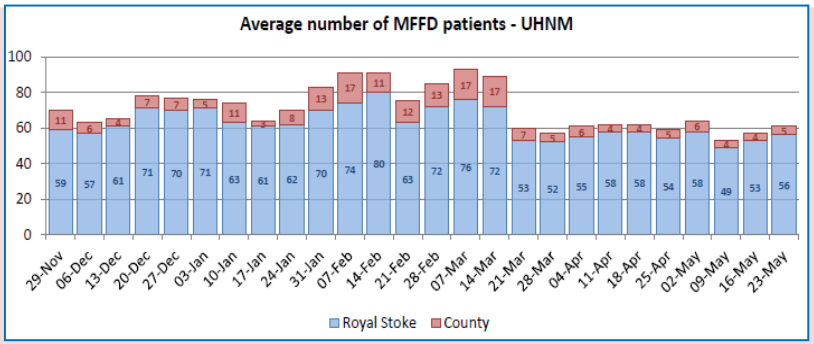
Same day admissions have seen an increase through the year but recently this has steadied at around 83% of 1920 BAU.

Work stream 2: Flow cont.



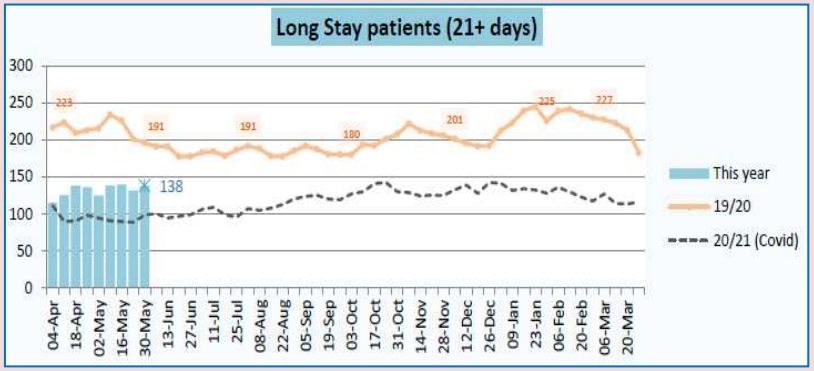
Elective beds:

The elective beds used across the four main bed pools has been rising steadily in line with our increased elective activity.



MFFD.

The MFFD numbers remain low at County and slow growth seen at Royal Stoke. Medicine has seen a growth towards the end of May.



Super Stranded patients: Reduce the number of patients with an extended stay over 21 days.

The number of patients in beds with a length of stay over over 21 days remains fairly static throughout May.

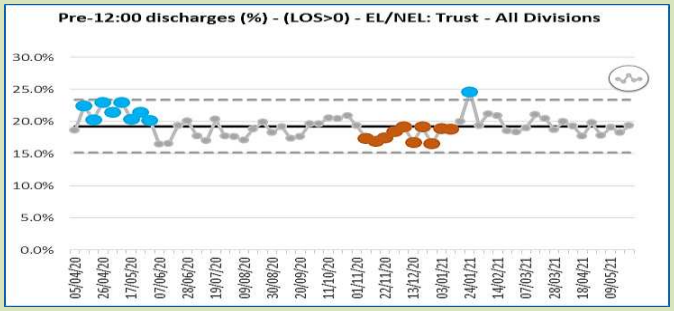
Work stream 3: Clinical Site Management

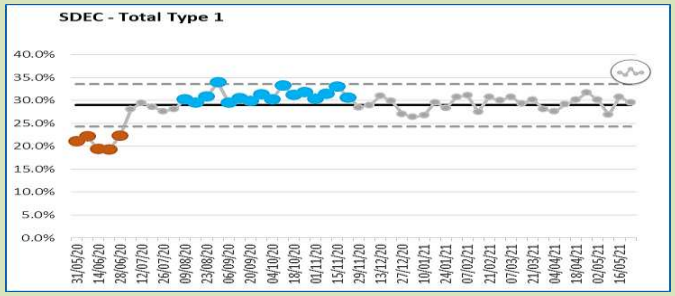
Pre-noon Discharges:
Maintain focus on the number of patients discharged from a hospital bed pre-noon to increase available capacity for admissions earlier in the day.

- The percentage of pre-noon discharges has remained static with normal variation.
- All division mandated to validate next day EDD's by 5pm for overnight workup of patients to support early morning discharge to support the KPI (30% before noon) to create capacity and flow for the next day.
- Site admin are having training with the transport team for a more dynamic communication link between the site, wards and patient flow.

Same Day emergency Care (SDEC):
Improve allocation of patients to most clinically appropriate clinical areas and clinical pathways.

- The percentage of patients allocated to SDEC has remained static.
- The IPS standards for all portals have been submitted through Divisional boards and are for approval at Junes Non-Elective Group. Following which these will be implemented and monitored for compliance.





Cancer

NHS
University Hospitals of North Midlands
NHS Trust

Summary:

- The 2ww position has improved in May and is predicted to achieve 81%. Specialties with the most 14 day breaches are Breast and Skin, due to a large increase in referrals since last month. 62 day performance is currently at 64.6% for May21.
- The Trust is currently predicted to achieve the following cancer standards for May 21: 31 day subsequent treatments for Anti cancer drugs and Radiotherapy; 28 Day Standard.
- The Trust continues to record a high volume of 2WW 1st appointments in May 21 – a total of 3109 suspected cancer patients were seen in May. 2WW performance will remain challenged in specialties such as Breast , until the backlog is cleared – the specialty are booking 1st appointments at day 21. This is a nationally recognised trend – in response, the west midlands cancer alliance have set up a regional task and finish group to combine efforts to mitigate locally.
- There are on-going delays in Pathology. The impact of the delays in turn around times are widespread, for example 41 patients were deferred from a Breast MDT discussion last week due to unreported specimens – this is mirrored among other specialties which is also contributing to PTL growth. Any concerns have been reported thorough the appropriate channels.
- In order to manage the backlog of patients waiting for surgery - patients are being dated according to their clinical need rather than their clock start date, resulting in the lower performance at 70.8% for 31 day subsequent surgery. This clinical prioritisation of patients is continuing into June which will be detrimental to cancer performance, which will not recover until the surgical backlog has been cleared.
- 62 day performance is predicted at this point to achieve 64.6% and continues with one of the lowest backlogs regionally. This position will change as more treatments are recorded. In addition, the number of patients waiting over 104 days at the end of May was 31, with 8 having a diagnosis of Cancer.
- The number of patients waiting over 104 days at the end of May was 31.

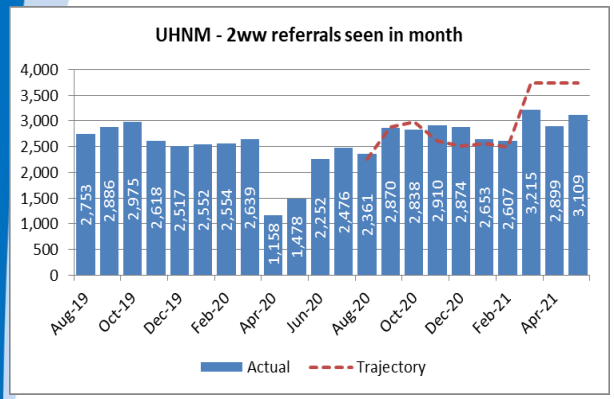
Cancer

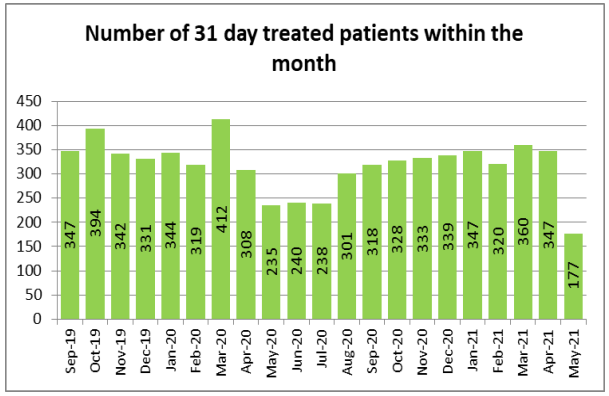
University Hospitals of North Midlands NHS Trust

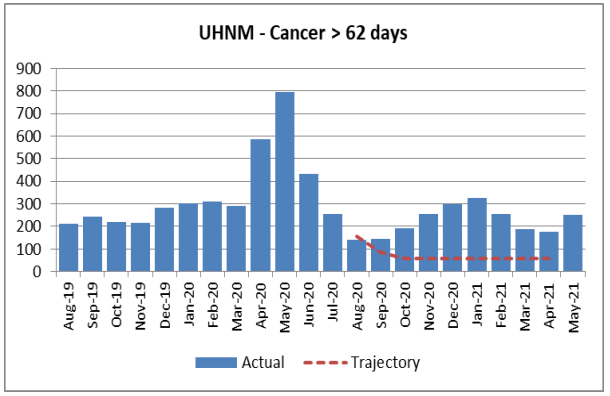
Actions:

- Cancer trajectories have been built using the NSHEI predicted demand (which aligned closely with internal predictions, factoring in the gap analysis of the previous year). Trajectories were presented to directorates at the Trust assurance meeting for feedback.
- Figures from the trajectories have been fed into capacity and demand modelling tools, which enable specialties to match clinics to predictions, and build services around calculations from credible data. The corporate cancer team will support with drop in or bespoke sessions for specialties to understand the tools and how to use them effectively.
- The Endoscopy department are involved in a Cytosponge pilot, and have begun to identify patients on the OGD waiting list who are suitable for this new diagnostic technique, that identifies pre-cancerous cells – contributing to the earlier and faster diagnosis of cancer.
- Breast continue to implement solutions from other geographies such as; breast pain clinics, exploring ANPs in the community, referral analysis by age range – to inform idea of a fire break clinic that excluded imaging for under 35s, referral demand analysis by CCG breakdown, audit of Breast referrals with new forms sent to practices using old forms, using the capacity and demand modelling tool support service configuration.
- Some Urology patients experiencing delays of more than 8 weeks for surgery – this will impact future 104 day position. Action: The theatre recovery plan is ahead of schedule with more capacity than anticipated coming online.
- Deep dive into pathology data is on –going. Pathology dashboard is in development that will provide an understanding of the trusts true cancer pathology demand. Delays have been escalated to the network to seek mutual aid from partner organisations.
- The cancer staging data COSD had maintained a steady 30% for the past three years against an optimal performance of 90+%. This is being addressed through a tactical Data Quality work stream and as a result collection of Performance status, CNS and Stage metrics for the COSD audit have all increased since last month.

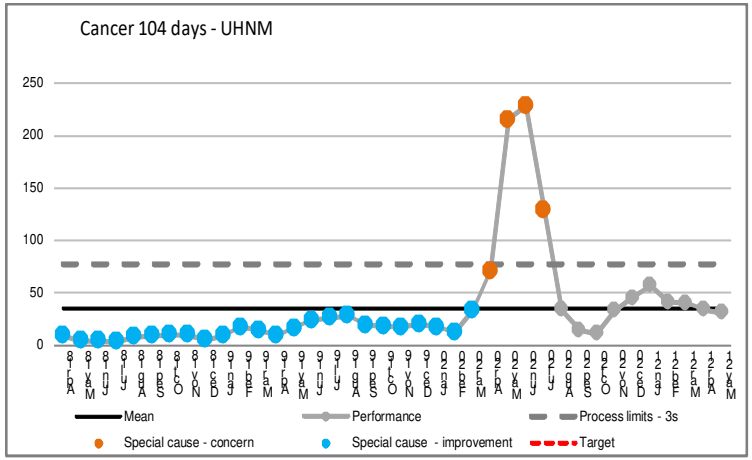
Cancer







May Provisional	Target	Trust Actual	Clock Stops	Breaches	Breaches Over	Needed Treatments
TWW Standard	93%	81.0%	3109	590	373	5320
TWW Breast Symptomatic	93%	27.4%	73	53	48	685
31 Day First	96%	92.7%	177	13	6	149
31 Day Subsequent Anti Cancer Drugs (inc Chemo)	98%	100.0%	18	0	Achieved!	Achieved!
31 Day Subsequent Surgery	94%	70.8%	24	7	6	93
31 Day Subsequent Radiotherapy	94%	100.0%	51	0	Achieved!	Achieved!
62 Day Standard	85%	64.6%	97.5	34.5	20	133.5
Rare Cancers - 31 Day RTT pathway	85%		0	0	1	1
62 Day Screening	90%	78.9%	19	4	3	22
28 Day FDS Standard	75%	75.0%	1731	432	Achieved!	Achieved!
62 Day Consultant Upgrade	93%	80.4%	56	11	8	102
Closed Pathways > 104 Day			9.5			



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Planned care - *Inpatients*

University Hospitals of North Midlands NHS Trust

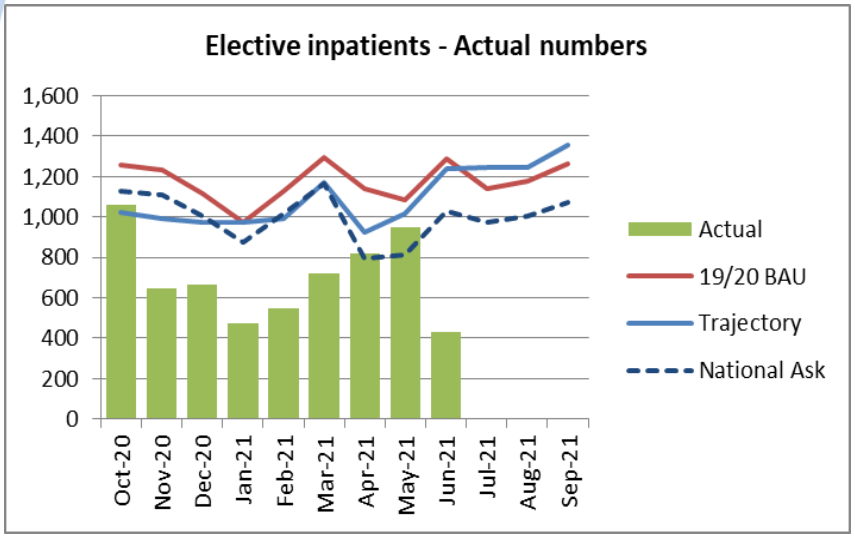
Elective inpatients Summary

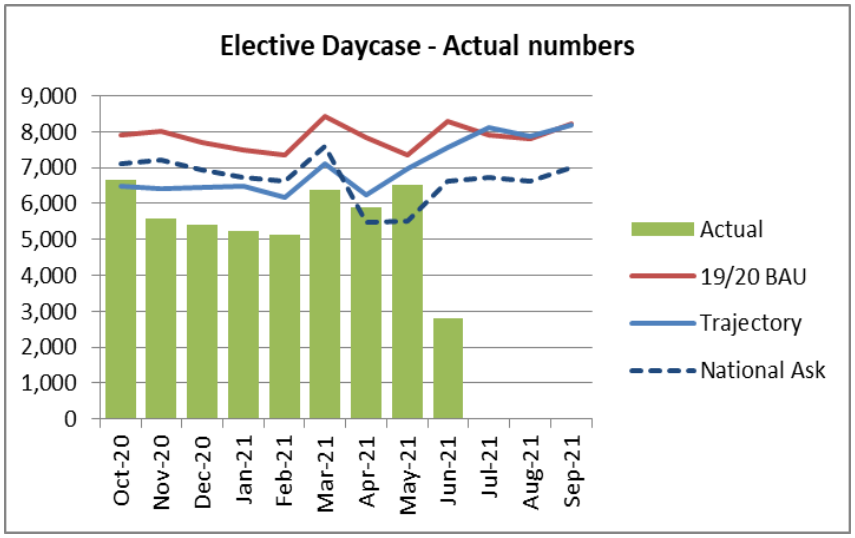
- For May the total inpatient actuals against BAU was 88.6%. This is higher in Day case than Inpatients (87% IP, 88% DC).
- The number of elective operations for UHNM (inpatients and day cases) reached 5739 in May. However, progress with further Elective and Day-case theatre capacity continues to demonstrate week on week increase in activity – w/c 24th May tracked 485 procedures (>80% of same week 2019)
- Previous constraints to capacity resultant or IPC pathways have now been mitigated in agreement with Trust Clinical Sub-Group seeing the return of Theatre 29 as a functional operating theatre rather than recovery area.
- The Planned Care Cell continues and reports directly to the Operational Delivery Group .The focus of activities has been as follows:
    - Continued validation of patients to send to the Independent Sector.
    - Continued Clinical validation of the P2 patients and other urgent long wait patients.
    - Work up of the patient contact initiative with the CCG to deliver a robust questionnaire for teams to deploy.
    - Weekly monitoring of progress with the increasing capacity national framework contract with the independent sector and referral of UHNM patients.
    - RTT Training and floor walking and confirmation of a hub and spoke model of validation between the central and Divisional Teams.
    - Modelling of short, medium and long term theatre capacity at RSUH and County.
    - Test of change plan specialised to understand quantum of theatres/beds required for NEL demand to right size capacity for County electives.
    - Test of change plan in surgery to focus on capacity skew to support challenged cancer specialties (urology and gastroenterology) to enable expedited clearance.
    - Development of P2 tracker that gives visibility to tactical clearance of P2 activity based on swap out of capacity then holding to the 28 day clearance.

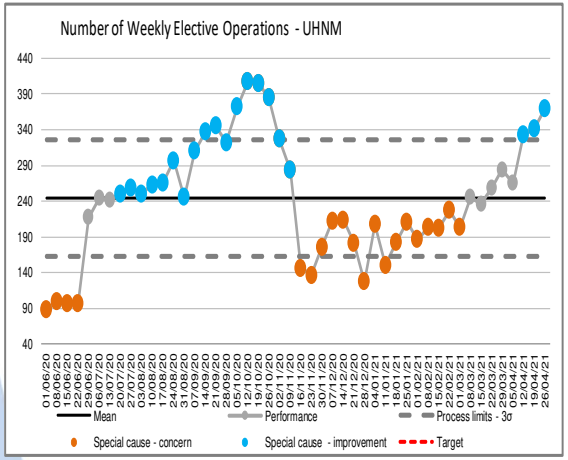
Actions

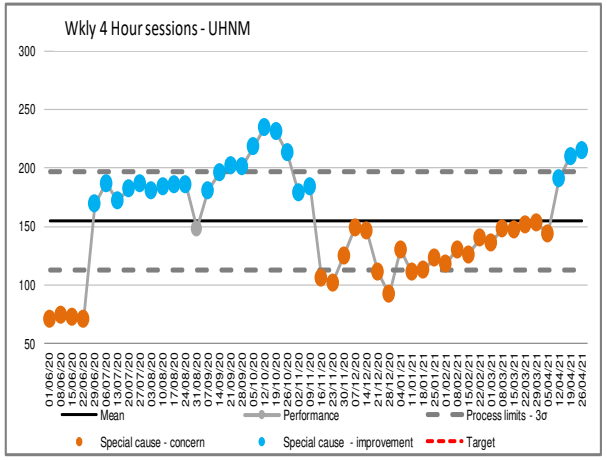
- Monitor the Test of Change Plan in specialised.
- Monitor the P2 Tracker clearance plan against additional theatre capacity on line.
- Review outputs of theatre modelling.
- Confirm elective tracker dashboard to support NEL and EL performance metrics.
- Receive outputs of training plans.
- Confirm final patient contact letter correspondence and source resource for phone contact pilot.
- Theatre timetable representing 100% pre-Covid capacity published end of May to commence 5th July subject to staff cover.

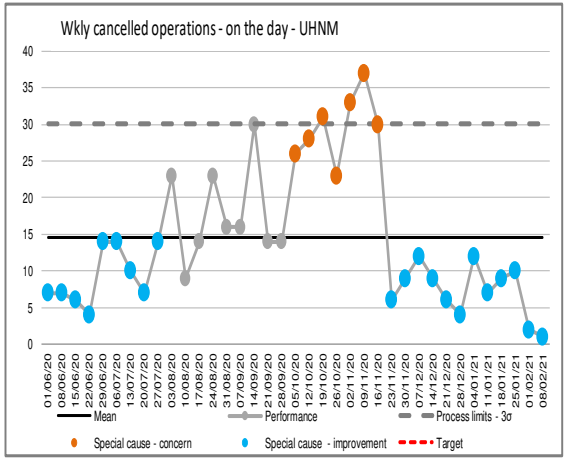
Planned care – *Inpatient Activity*











Planned care - *Outpatients*

University Hospitals of North Midlands NHS Trust

Summary

- For May the total outpatient actuals against BAU for outpatients was 76.3%. This is higher in Follow ups than new (67% New, 83% follow up).
- May 21 numbers recorded to date were 49,687. However this may increase further as the outstanding outcomes are completed.
- The overall Referral To Treatment (RTT) Waiting list continues to rise. For May the number of Incomplete pathways has risen to 61,625 (April 59,645).
- The number of patients > 18 weeks has remained fairly static for the first time at a level of 23,375 (April 23,214).
- The numbers of 52 week waits in May is continuing to decline with a reported 3,606 compared to April 4,094 & March 4,563.
- However, there are now patients who have reached 104 weeks. At the end of May the numbers reported were 38, however these are being validated. The Planned Care group is monitoring progress against treatment plans for these patients.
- This in turn has resulted in an improved performance to 62.06%
- For outpatient appointments (appointment type) the Trust delivered **68.3%** F2F and **31.7%** non F2F(Telephone & Video). For New appointment types the proportion of F2F was **70.3%** with non F2F **29.7%** & Follow Ups F2F **67.2%** with non F2f **32.8%**. The Media Type field in Medway is now mandatory which has now eliminated the 'Not Set' cohort.
- May's performance for ASIs position only fractionally decreased by 0.2% to 87.8% within 3 days (from 88% in April).

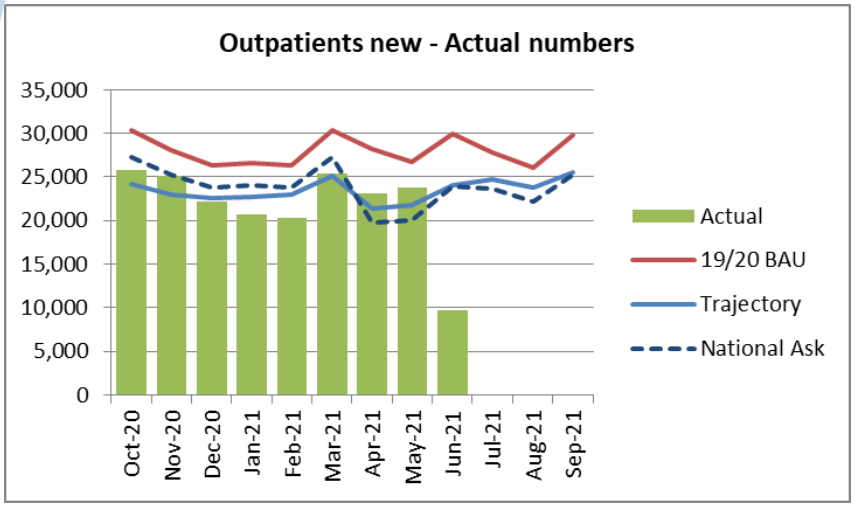
Actions

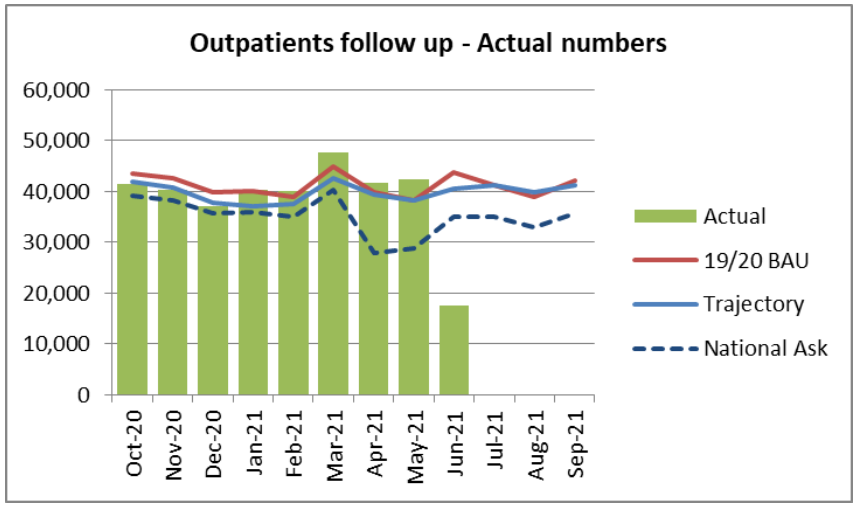
- Work is required on template reconfiguration based on Divisional assumptions - this needs to be aligned to the in patient and diagnostics plans for the purpose of substantive job planning.
- Revised 52 ww trajectory to be drafted once all cell plans confirmed to reduce the end of March 2021 delivery.
- 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.

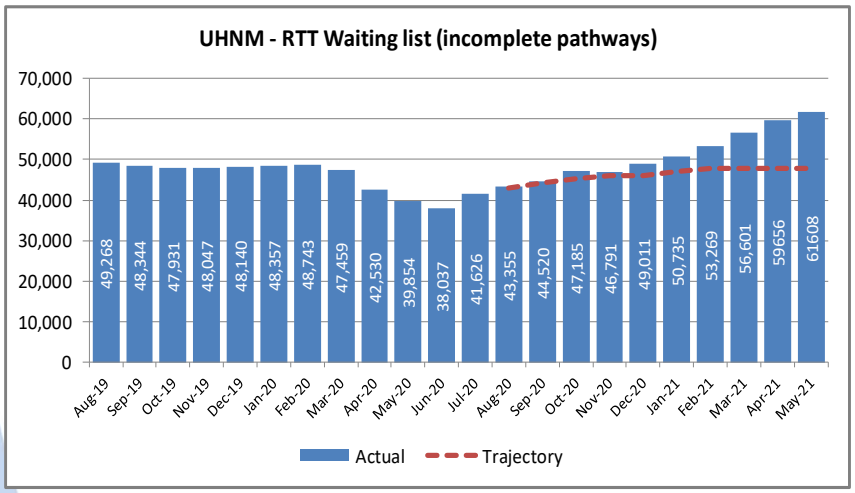
Risks:

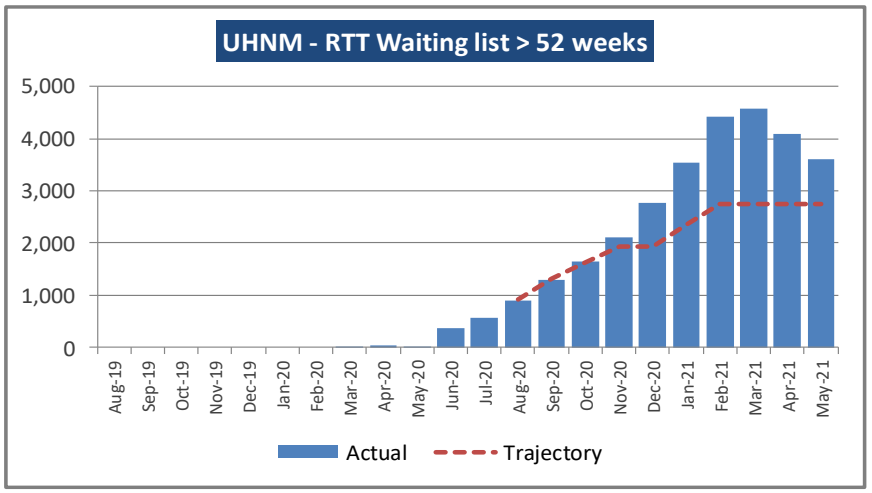
- Impact of stopping FTF activity in some areas to release staff to support frontline being monitored.

Planned care – *Outpatient activity & RTT*









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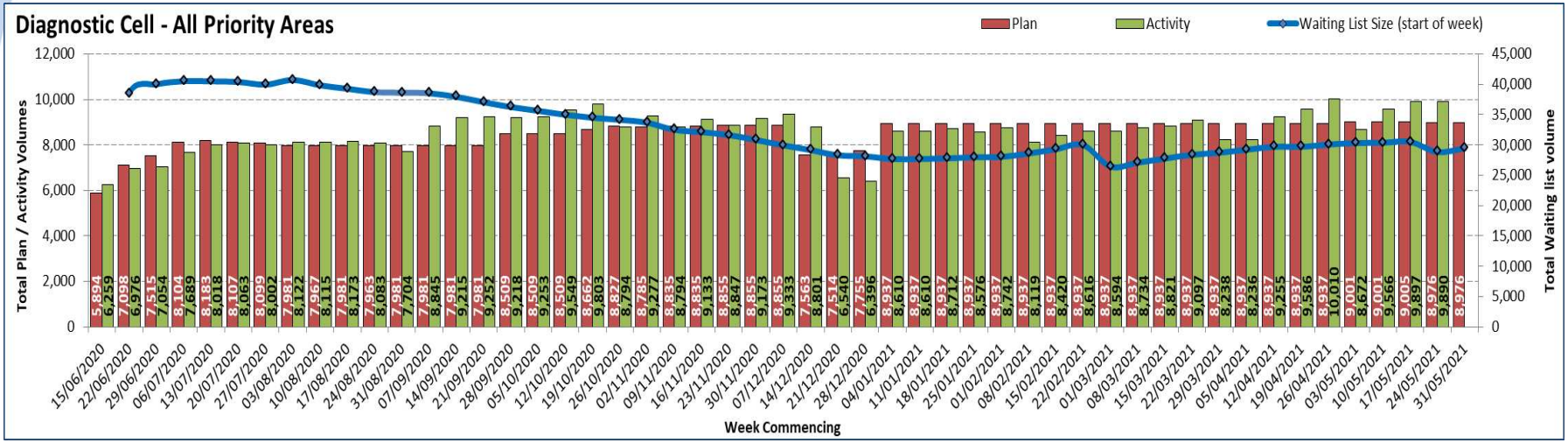
Diagnostic Activity



Summary

- Diagnostic performance is monitored through the Diagnostic cell. All priority areas have been identified and May saw arise in activity for these tests and towards the end of May this rose to 90% of pre-covid business as usual.
- For DM01 (15 nationally identified Dx tests) however, the waiting list, which had shown significant growth seems to have plateaued off with a reduction in MRI, CT and Non-obstetric ultrasound.
- The greatest proportion of > 6 week waits are within Non-obstetric ultrasound related to the significant Increase in demand and activity for breast 2ww referrals which due to the prioritisation over the long waiters, has impacted on performance. A working group is set up comprising of imaging, breast surgery and the cancer to team to review the referral s and total capacity required. There also seems to be more referrals from Primary care for patients under the age 35. Cancer team are engaging with the PCN/CCG regarding referrals, and within radiology effort is being made to put on additional capacity out of hours to clear the backlog with more joint working with surgery.
- The current DM01 diagnostic performance for May 21 is 79.43% (April 78.72).
- Capacity and Demand work is being planned in the next quarter
- Histology turnaround times remain a concern due to the increase in demand and the deficits in consultant workforce – a remedial plan is being developed with Network partners – this is on-going.

APPENDIX 1

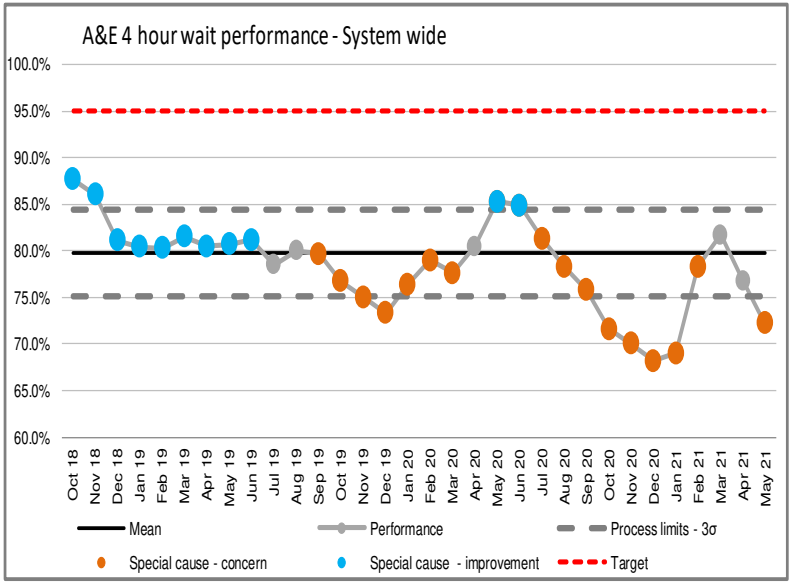
Operational Performance

Constitutional standards

	Metric	Target	Latest	Variation	Assurance	DQAI
A&E	A&E 4 hour wait Performance	95%	72.20%	L	F	
	12 Hour Trolley waits	0	0		?	
Cancer Care	Cancer Rapid Access (2 week wait)	93%	81.02%	L	?	
	Cancer 62 GP ref	85%	64.62%		?	
	Cancer 62 day Screening	90%	78.98%		?	
	31 day First Treatment	96%	92.66%		?	
Elective waits	RTT incomplete performance	92%	62.01%	L	F	
	RTT 52+ week waits	0	3606	H	F	
	Diagnostics	99%	76.00%	L	F	

	Metric	Target	Latest	Variation	Assurance	DQAI
Use of Resources	DNA rate	7%	7.3%		?	
	Cancelled Ops	150	69	L	?	
	Theatre Utilisation	85%	76.0%			
Inpatient / Discharge	Same Day Emergency Care	30%	30.1%	H	?	
	Super Stranded	183	150	L	P	
	DToC	3.5%	1.80%	L	?	
	Discharges before Midday	30%	18.9%		F	
	Emergency Readmission rate	8%	14.1%	L	F	
	Ambulance Handover delays in excess of 60 minutes	10	93		?	

URGENT CARE – 4 hour access performance



Variation	Assurance
	

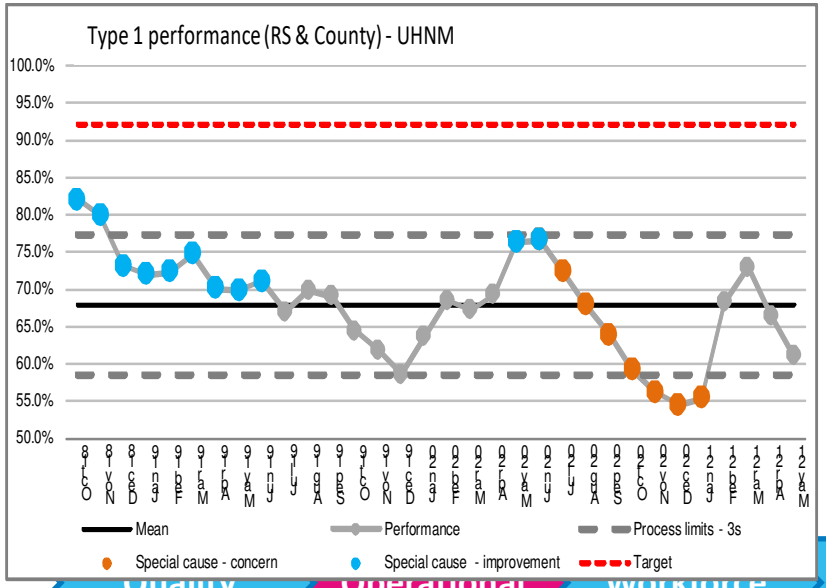
Target	Mar 21	Apr 21	May 21
95%	81.7%	76.8%	72.2%

Background

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

What is the data telling us?

Performance for the previous 3 months has fallen between the control limits with the month below the lower control limit.



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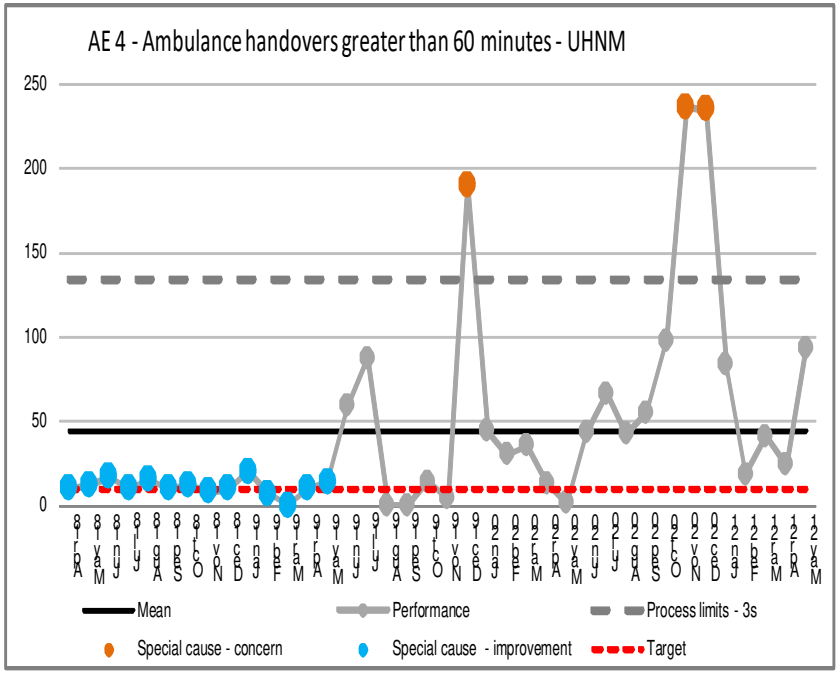
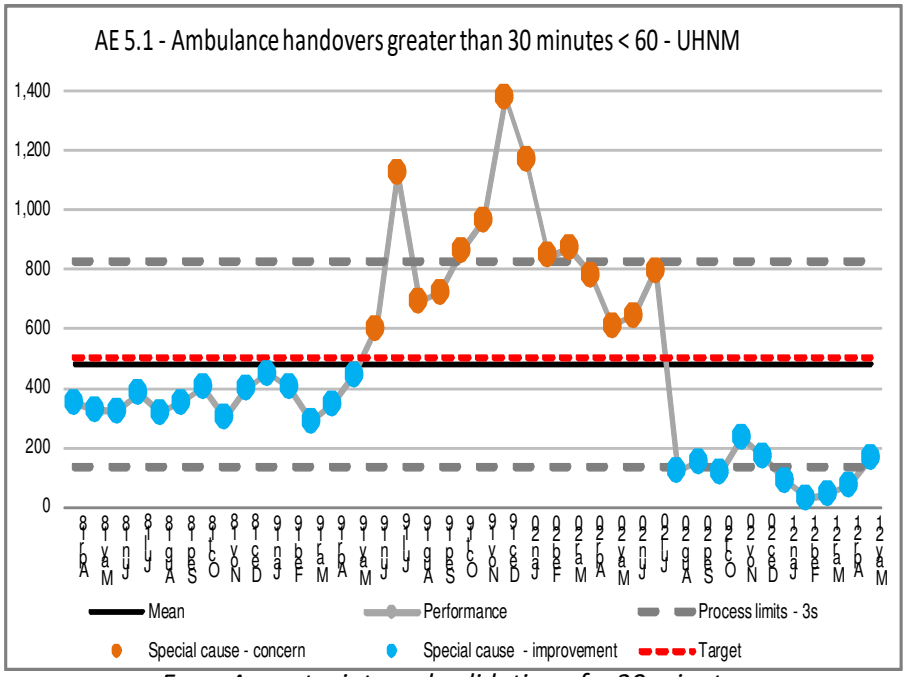
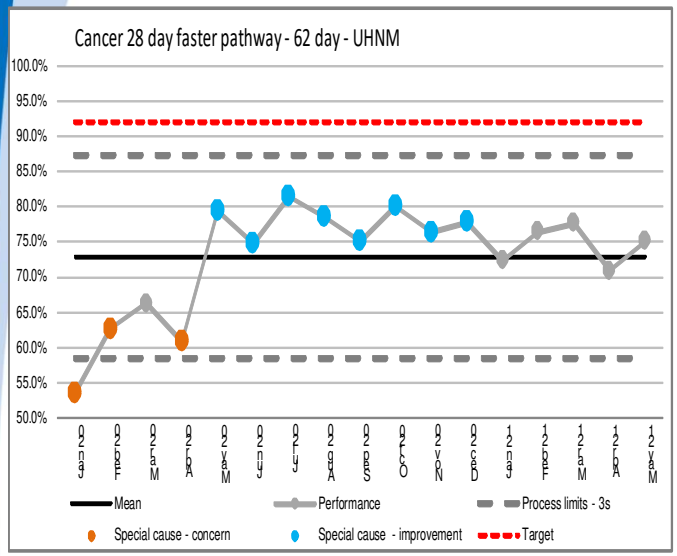
URGENT CARE – 4 hour access – ambulance handovers

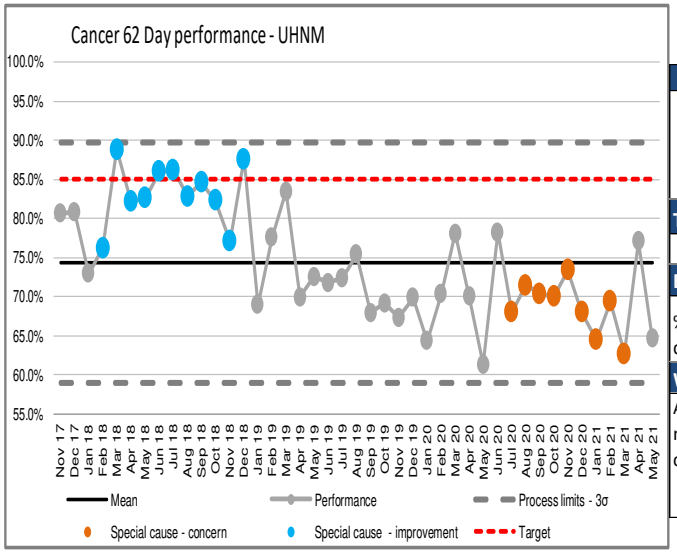




From August – internal validation of > 30 minutes

Cancer – 62 Day





Variation	Assurance

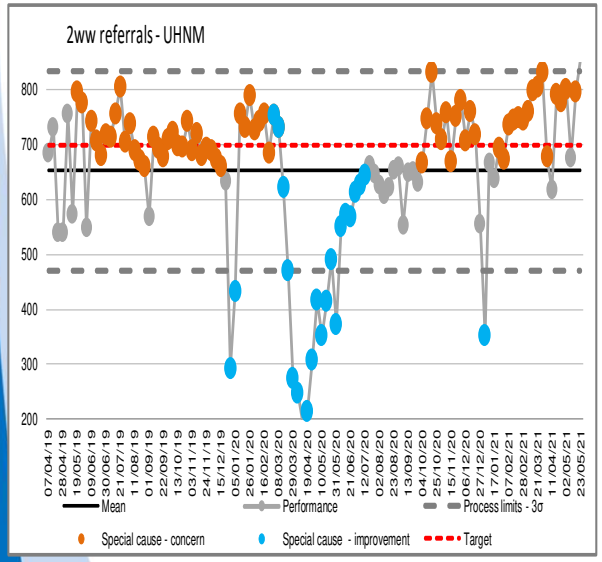
Target	Mar 21	Apr 21	May 21
85%	62.7%	77.1%	64.6%

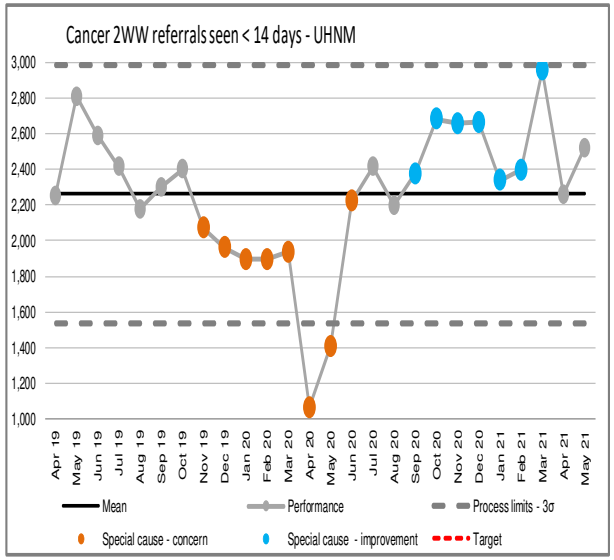
Background

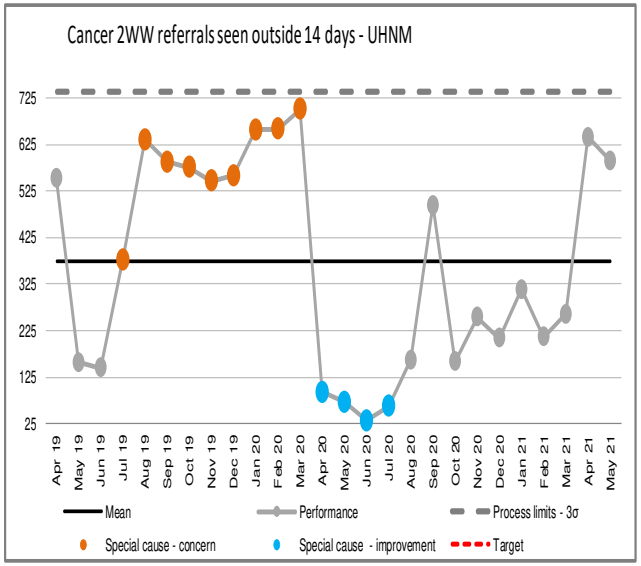
% patients beginning their treatment for cancer within 62 days following an urgent GP referral for suspected cancer

What is the data telling us?

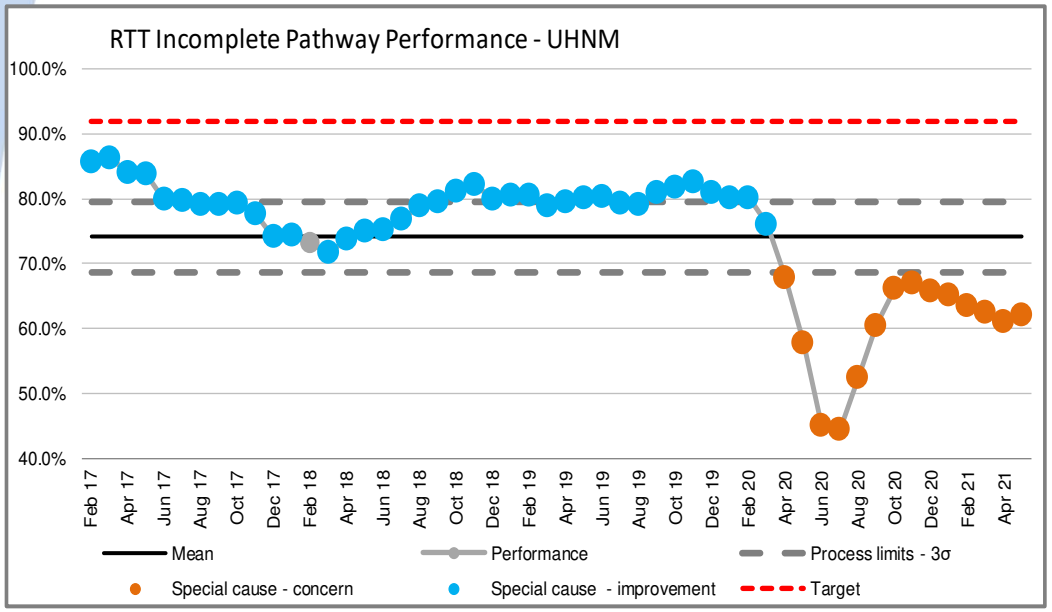
Apart from two occasions the standard has been below the mean since Sept-19. In March the standard fell to the lower control limit.







Referral To Treatment



Variation	Assurance
	

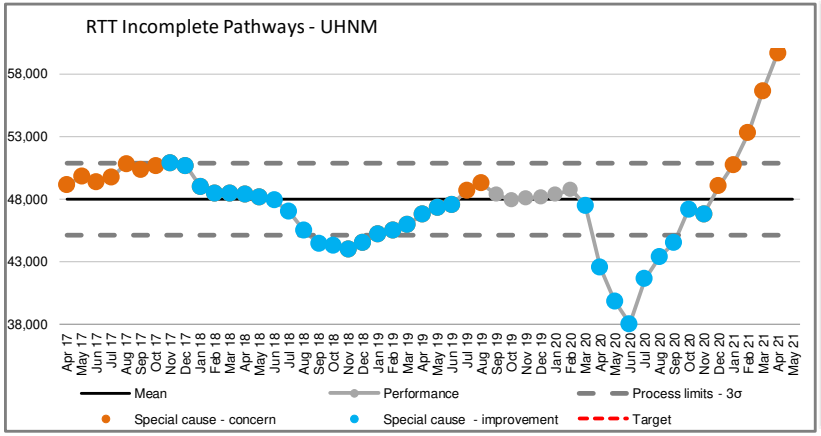
Target	Mar 21	Apr 21	May 21
92%	62.5%	61.1%	62.1%

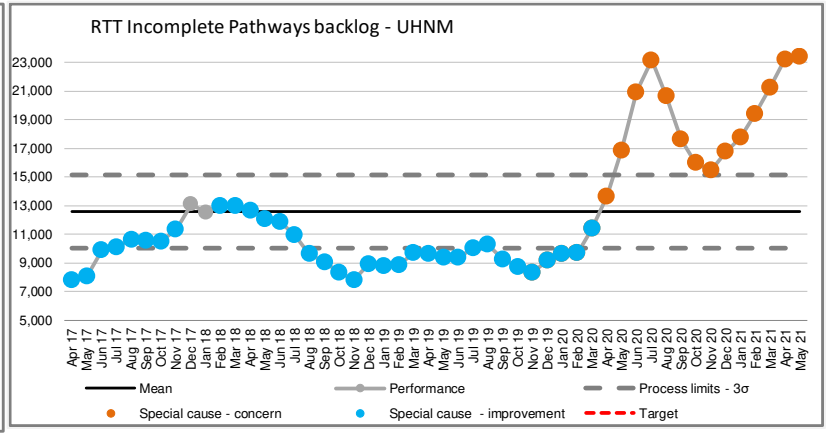
Background

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

What is the data telling us?

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





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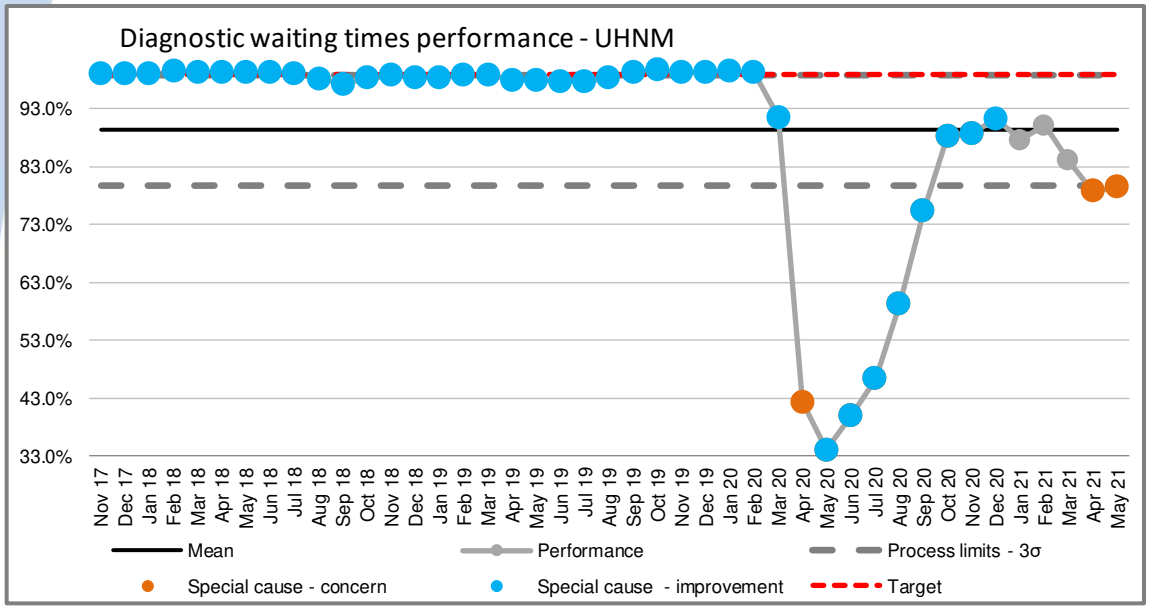
Diagnostic Standards



Variation	Assurance
	

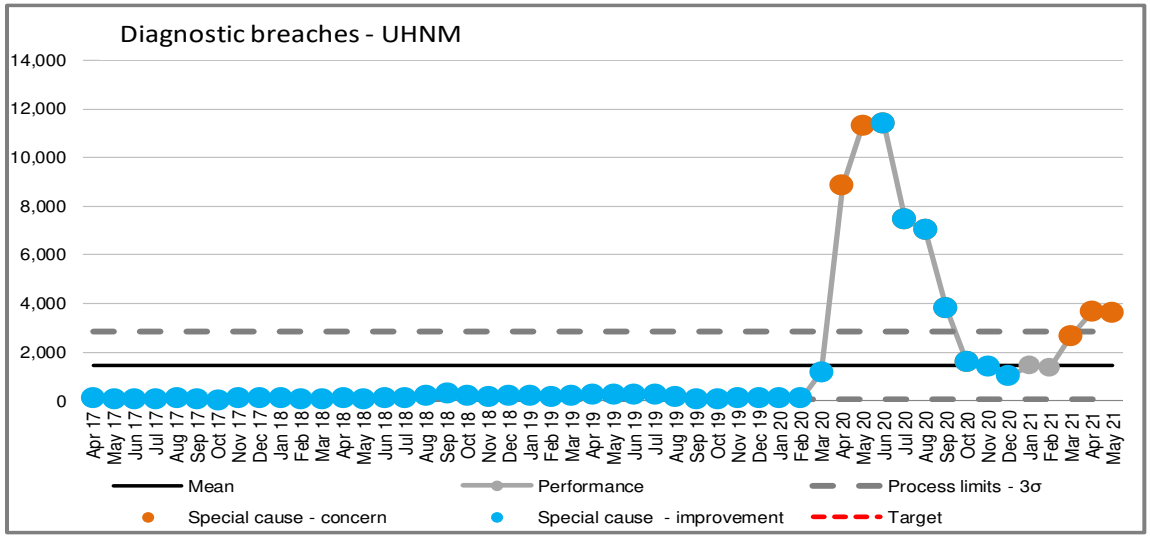
Target	Mar 21	Apr 21	May 21
99%	84.1%	78.7%	79.4%

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.



Together Compassion Safe Improving

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APPENDIX 2

UEC Standards - National proposal
March 2021

Introduction

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

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

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

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

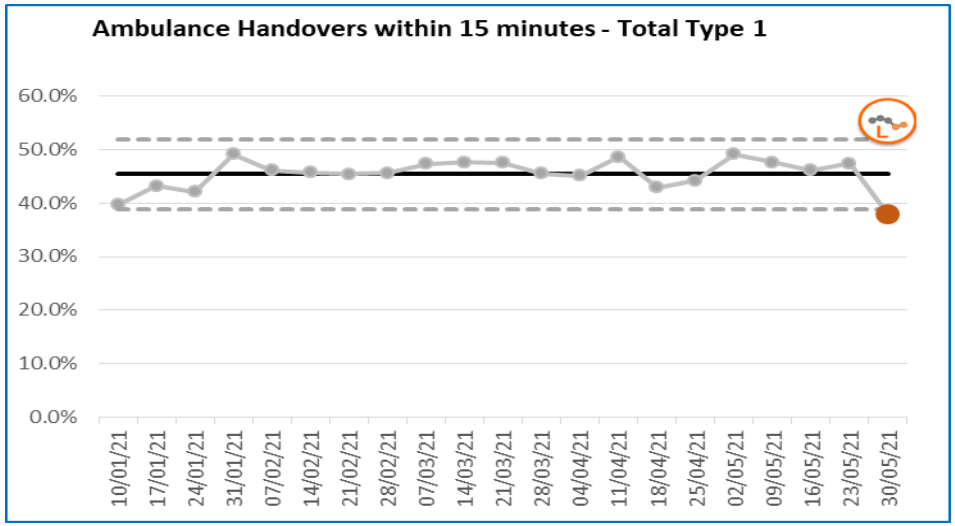
Governance

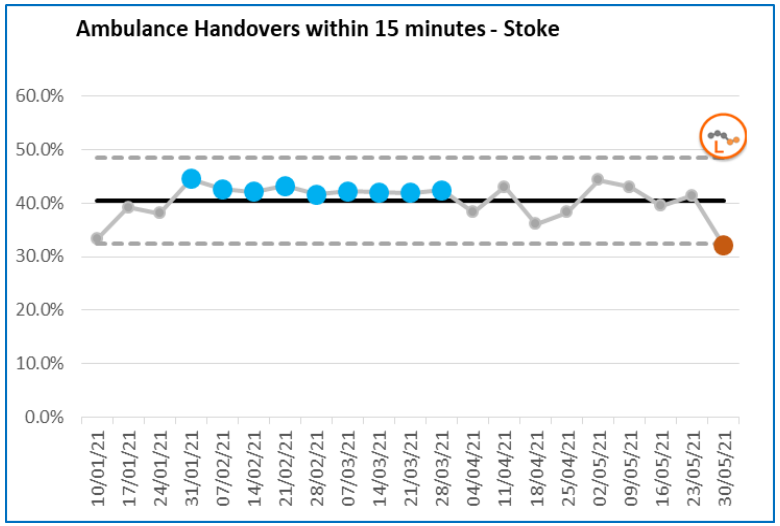
The newly proposed UEC standards will be monitored through both ED performance review and Medicine Divisional board meetings. Organisationally oversight will be through the Urgent Care Programme Board in addition to relevant trust committees

Assessment

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

2. Percentage of Ambulance Handovers within 15 minutes

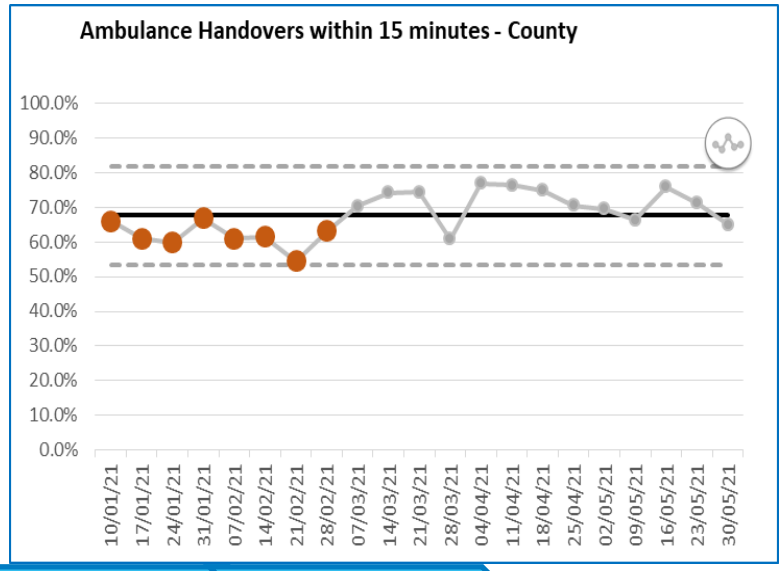




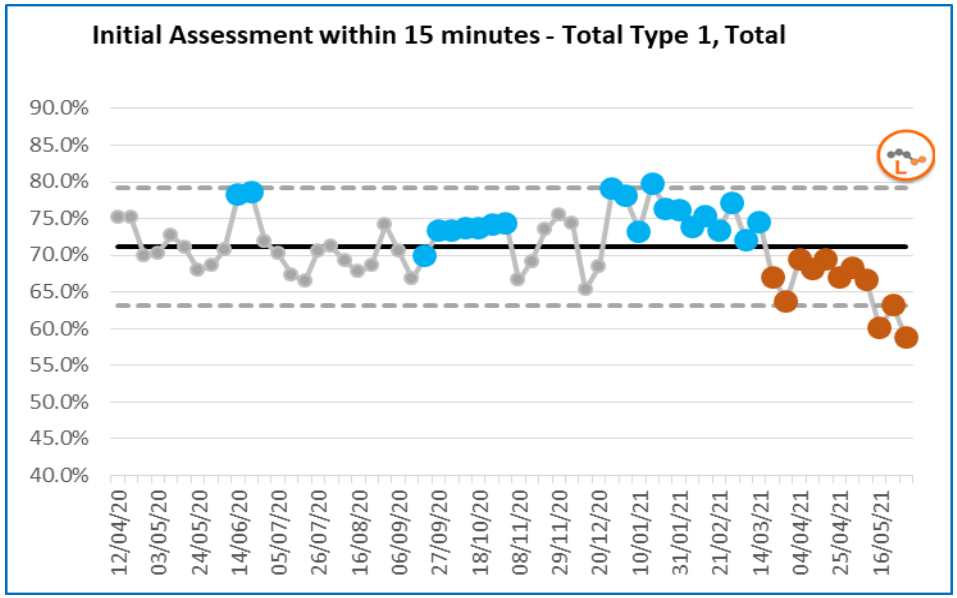
Internal collection of data for Ambulance handovers within 15 minutes began at the beginning of January 21. This is the time taken for the ambulance service to hand over the care to the ED.
N.B. this is un-validated performance and also includes handover time related to direct ambulance conveyance to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

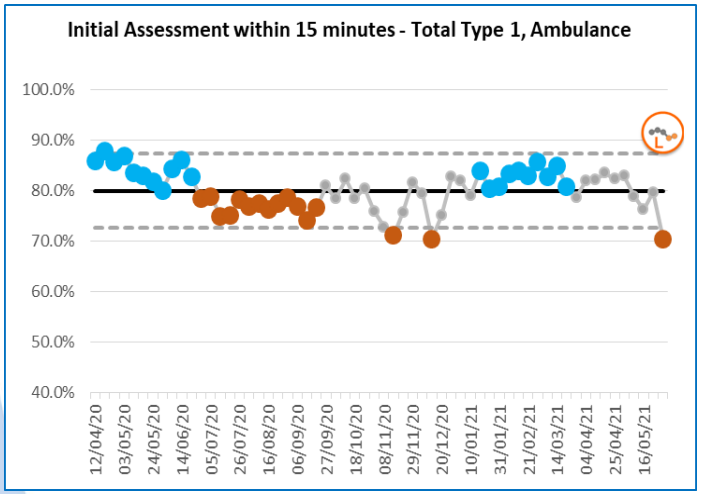
For total ambulance handovers at UHNM in May, the percentage within 15 minutes had reduced to 38% from 53.8% in April. A local UHNM target of 48% has been set as the goal to improve to as part of the NEL Improvement programme.

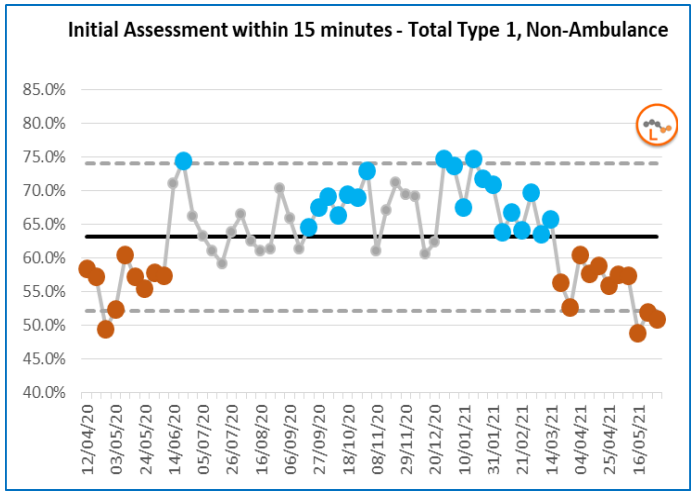
County have maintained a much higher percentage than Royal Stoke albeit with much smaller numbers.



3. Time To Initial Assessment – percentage within 15 minutes







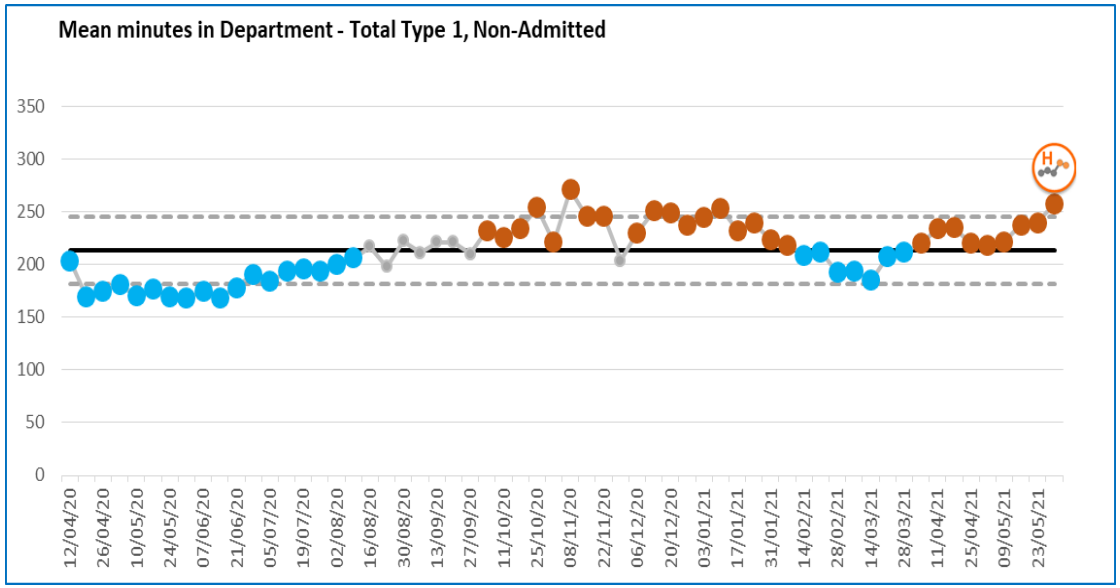
Time to Initial assessment is the time from arrival to when the patient is first triaged.

The proportion of patients waiting under 15 minutes for their initial assessment fell towards the end of May to **60%.**

This was more notable in the ambulance assessments.

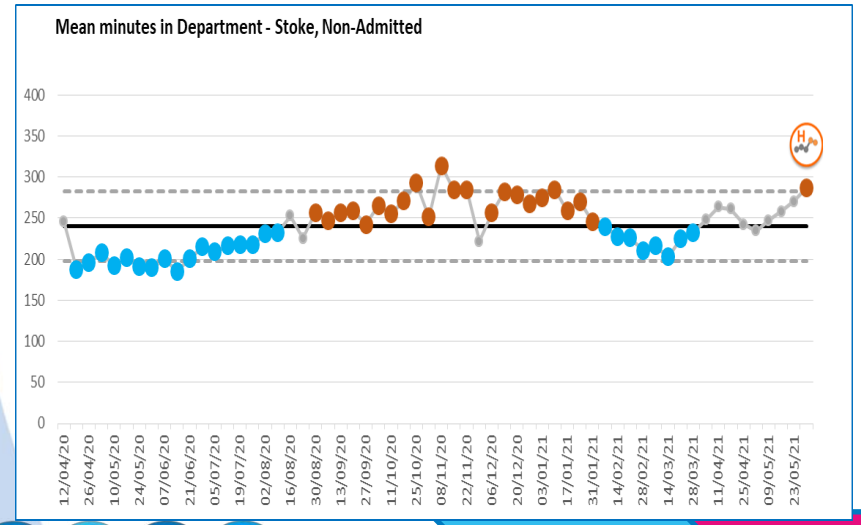
A local UHNM improvement target of 85% has been set.

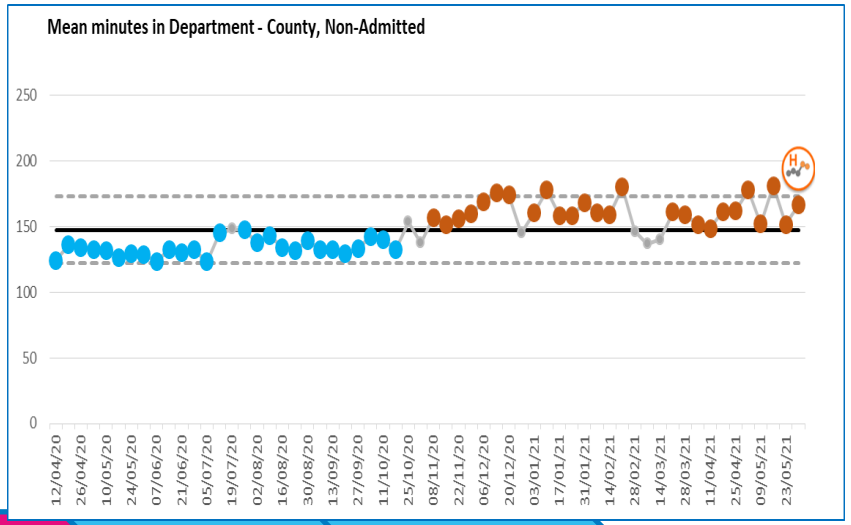
4. Average (mean) time in Department – non admitted patients



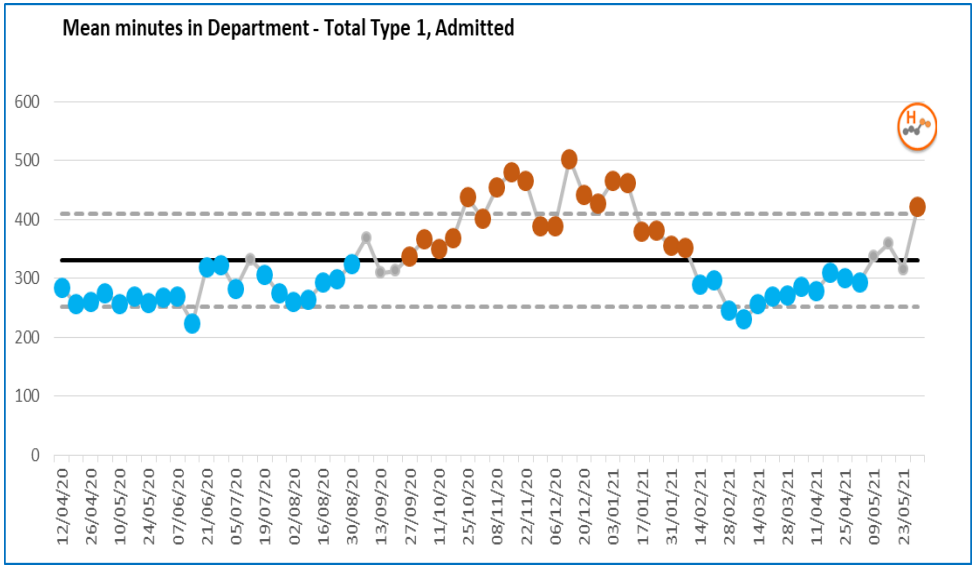
The mean time in the department through May had risen and was reported as reaching 240 minutes at the end of the month.
This was more notable at Royal Stoke whereas County maintained normal variation.

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





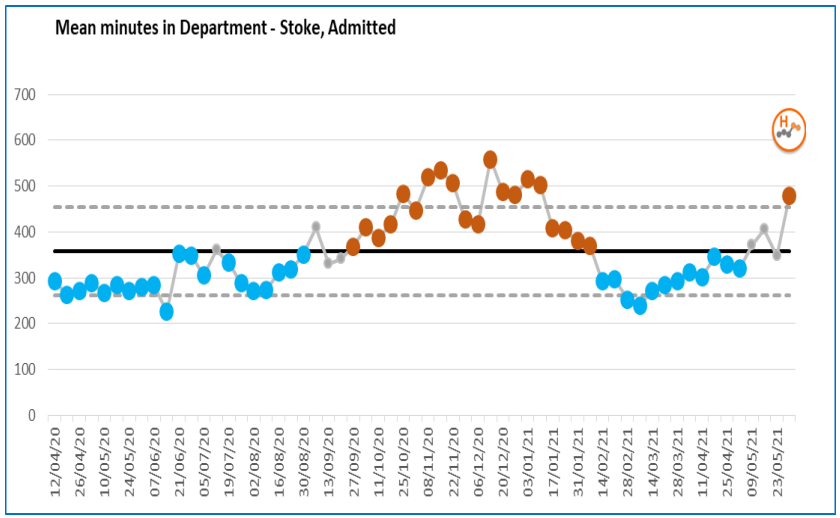
5. Average (mean) time in Department – admitted patients

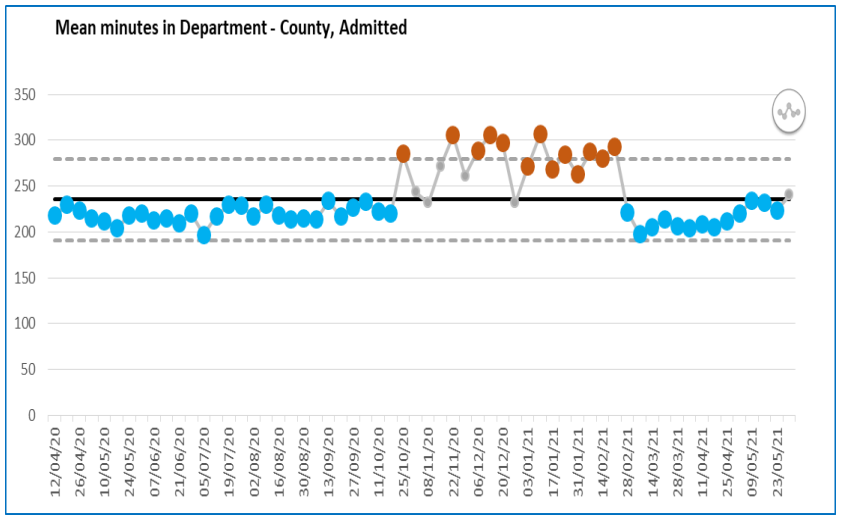


The mean time in the department for admitted patients rose in May and reached a point at the end of May to 400mins.

This was notable at Royal Stoke..

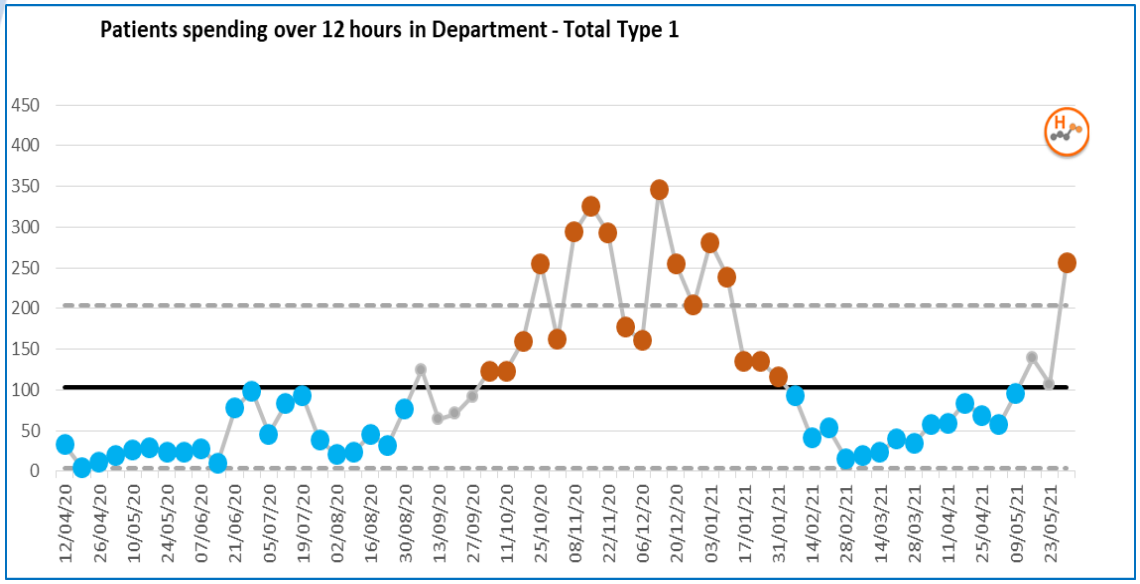
An improvement target for UHNM has been set at 240 minutes.



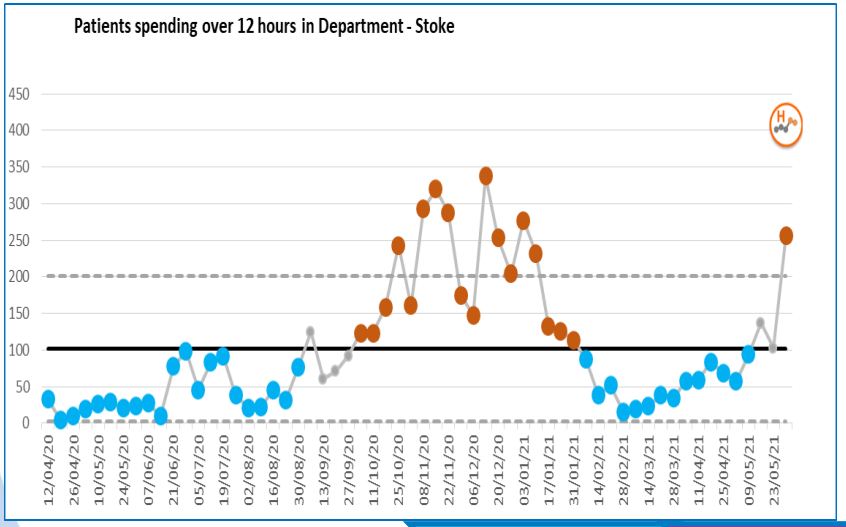


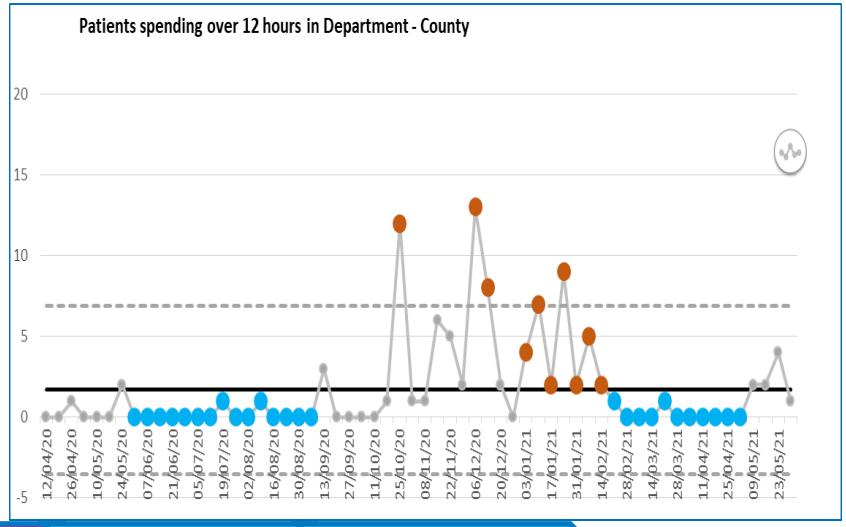
Quality | Operational | Workforce | Finance

6. Patients spending more than 12 hours in the department



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





Workforce

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

Workforce Spotlight Report

Key messages

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

Partnership working with the ICS continues on a range of Recruitment and Retention initiatives. System-wide processes are agreed for mutual aid and redeployment of staff to areas of need

Sickness and covid-related absences continue to be monitored daily. Staff showing symptoms, or with household members showing symptoms, are tested and results returned within 24-48 hours.

As of 9th June 2021, covid-related open absences numbered 81, which was 13.46% of all absences (8.32% at 11th May 2021)

The key performance issues are that the sickness rate remains above target and that compliance with PDR requirements is below target.

- Overdue PDRs are required to be scheduled from Q2 and the compliance rate has improved over the last 3 months.
- Actions towards improving sickness rates are being developed through the Improving Together Programme and A3 process. Divisional Teams are developing specific actions to address sickness and improve compliance with completing call backs and return to work interviews.

Sickness

The in-month sickness rate was 4.55% (4.23% reported at 30/04/21). The 12 month cumulative rate reduced to 5.05% (5.21% at 30/04/21)

Appraisals

The Non-Medical PDR compliance rate was 80.61% (77.42% at 30 April 2021).

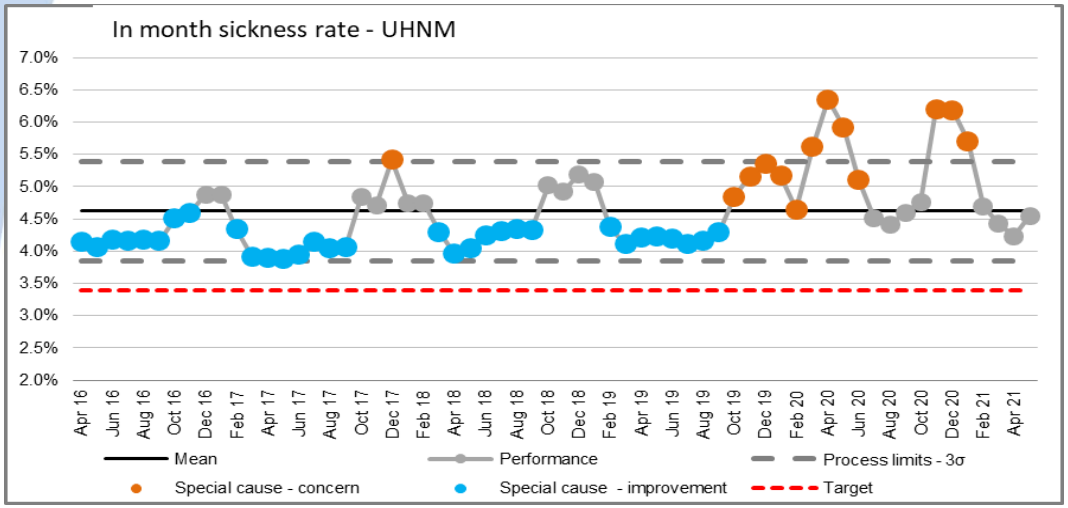
Statutory and Mandatory Training

The Statutory and Mandatory training rate at 31 May 2021 was 94.62% (94.19% at 30 April 2021), At 31 May 2021, 90.86% of staff had completed all 6 Core for All modules (90.32% at 30/04/21)

Workforce Dashboard

Metric	Target	Latest	Variation	Assurance
Staff Sickness	3.4%	4.55%		
Staff Turnover	11%	9.51%		
Statutory and Mandatory Training rate	95%	94.62%		
Appraisal rate	95%	80.61%		
Agency Cost	N/A	2.75%		

Sickness Absence



Variation	Assurance
	F

Target	Mar 21	Apr 21	May 21
3.4%	4.4%	4.2%	4.6%

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 4.55% (4.23% reported at 30/04/21). The 12 month cumulative rate reduced to 5.05% (5.21% at 30/04/21)

As of 9th June 2021, covid-related open absences numbered 81, which was 13.46% of all absences (8.32% at 11th May 2021)

Actions towards improving sickness rates are being developed through the Improving Together Programme and A3 process. Divisional Teams are developing their own A3's with their specific actions to address sickness and improve compliance with completing call backs and return to work interviews via the Empactis System.

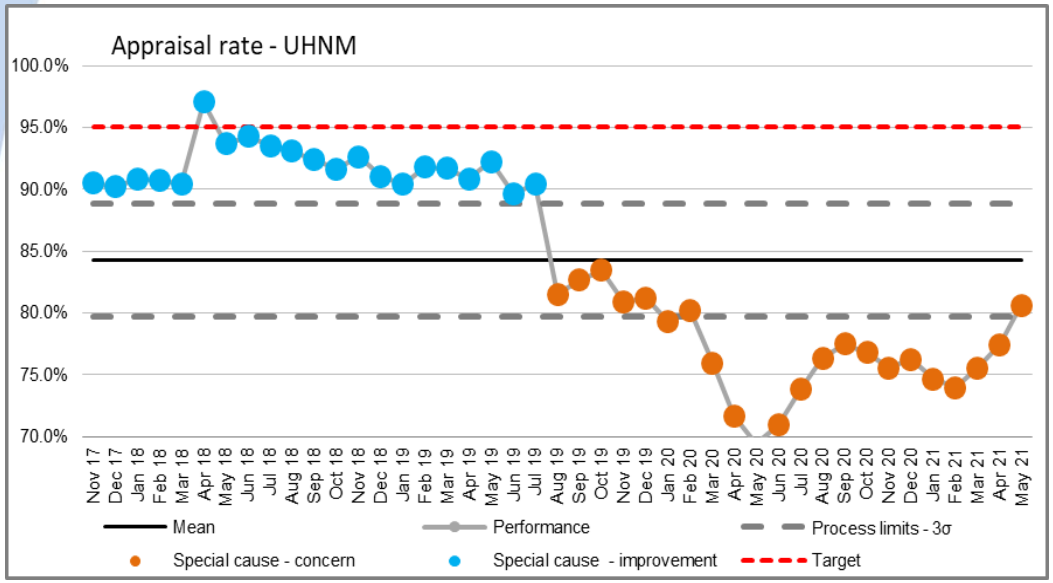
The focus of the Wellbeing Plan is on ensuring staff psychological wellbeing. Listening support sessions will continue until June and over 20 Teams have accessed this intervention to date. The Staff Psychological and Wellbeing Hub opened on 14th May 2021. Suicide Awareness for Professionals will be launched in June with PALS and Outpatient staff attending the pilot.

To support in reducing covid infection, Lateral-Flow asymptomatic testing of frontline staff and staff PCR testing continues be offered. Vaccinations are available via the Community Hubs. Covid Risk assessments are in place and continue to be reviewed.

Actions

- Listening support sessions will continue until June and over 20 Teams have accessed this intervention to date
- Suicide Awareness for Professionals will be launched in June with PALS and Outpatient staff attending the pilot
- In May further a further CISM practitioners course will be delivered, with 14 places booked to date
- Actions towards improving sickness rates are being developed through the Improving Together Programme and A3 process

Appraisal (PDR)



Variation	Assurance

Target	Mar 21	Apr 21	May 21
95.0%	75.6%	77.4%	80.6%

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

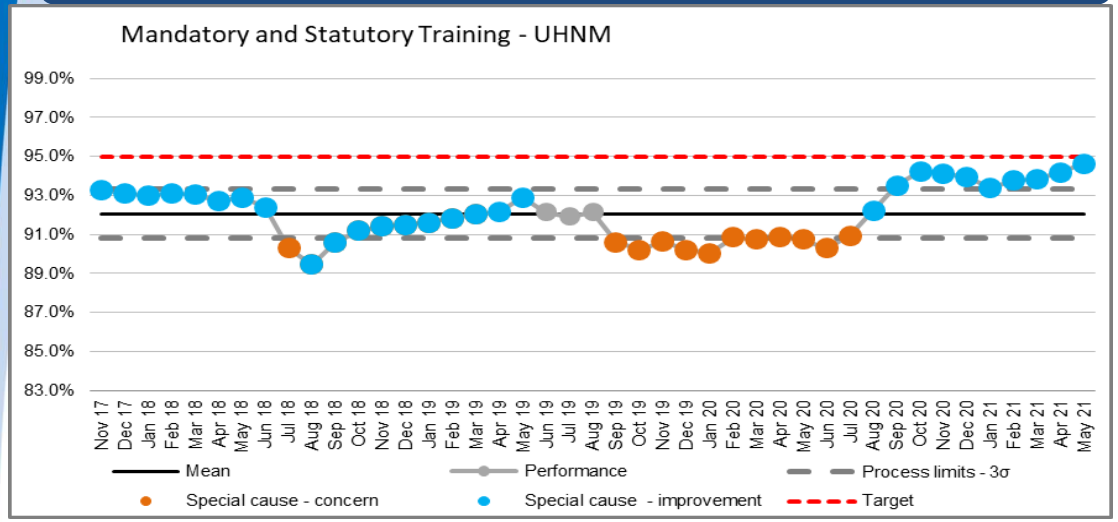
The Non-Medical PDR compliance rate was 80.61% (77.42% at 30 April 2021).

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

Actions

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

Statutory and Mandatory Training



Variation	Assurance
H	F

Target	Mar 21	Apr 21	May 21
95.0%	93.9%	94.2%	94.6%

Background

Training compliance

What is the data telling us?

The Training rate is just below the 95% target for the core training modules

Summary

The Statutory and Mandatory training rate at 31 May 2021 was 94.62% (94.19% at 30 April 2021), At 31 May 2021, 90.86% of staff had completed all 6 Core for All modules (90.32% at 30/04/21)

Competence Name	Assignment Count	Required	Achieved	Compliance %
205|MAND|Security Awareness - 3 Years|	10595	10595	10032	94.69%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	10595	10595	10048	94.84%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	10595	10595	9972	94.12%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	10595	10595	10000	94.38%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	10595	10595	9994	94.33%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	10595	10595	10101	95.34%

Compliance rates for the Annual competence requirements were as follows:

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 1 Year|	10595	10595	9165	86.50%
NHS|CSTF|Information Governance and Data Security - 1 Year|	10595	10595	9620	90.80%

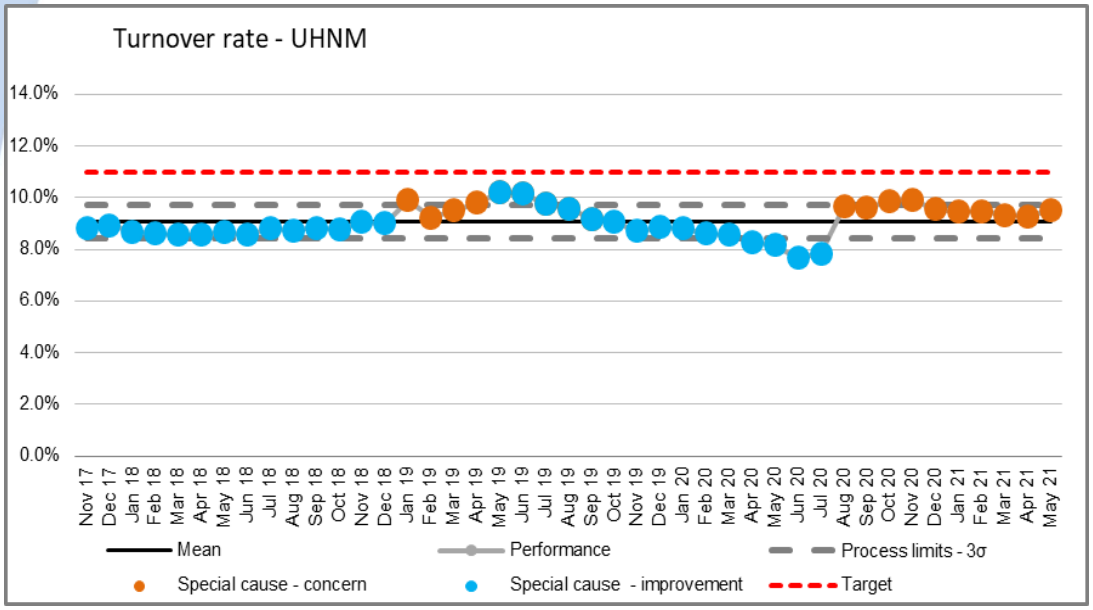
Note: The figures reported elsewhere to Board in respect of Information Governance and Data Security Training, have been adjusted for a 6 month extension due to COVID19. The figures reported in this report are unadjusted.

Actions

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

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

Workforce Turnover



Variation	Assurance
H	P

Target	Mar 21	Apr 21	May 21
11.0%	9.3%	9.3%	9.5%

Background

Turnover rate

What is the data telling us?

The special cause variation from August 2020 was a result of the B3 Student Nurses, who had supported the Trust throughout the first wave of covid-19, returning to University

The 12m rolling turnover rate remains below the target 11%

Summary

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

The overall Trust vacancy rate, calculated as Budgeted Establishment less staff in post, was 7.86% and remains consistent with previous months.

*An SPC chart is being developed to reflect the vacancy rate

Vacancies at 31 May 2021	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous month %
Medical and Dental - May 21	1,413.11	1,270.36	142.75	10.10%	9.85%
Registered Nursing - May 21	3,271.31	2,926.40	344.91	10.54%	10.17%
All other Staff Groups - May 21	6,269.18	5,896.40	372.78	5.95%	5.56%
Total - May 21	10,953.60	10,093.16	860.44	7.86%	7.49%

For all 3 groupings, the vacancy rate increased due to an increase in budgeted establishment which was greater than the increase in staff in post

Actions

At 31 May 21, there were two Consultant Vacancies which had been advertised more than twice. Both are progressing through the recruitment process.

The first 11 overseas nurses will arrive with the Trust on the 28th June and a further 50 are due later in the year.

Recruitment is progressing to reduce Healthcare Support Worker vacancies towards zero.

Finance

2025 Vision "Ensure efficient use of resources"

Finance Spotlight Report

NHS University Hospitals of North Midlands NHS Trust

Key messages

- The Trust has delivered a surplus of £4.3m in month against a planned break even position. The position in month is driven by underspends against the COVID-19 allocation, underspends on clinical supplies as activity levels remain below 2019/20 planned levels, underspends on pay (primarily qualified nursing) and slippage against reserves held by the Trust.
- ERF for the year to date has been accounted for in month with £2.9m of income recognised against a planned figure of £2.6m. Based on activity plans £8.8m of income is forecast for H1 with additional costs approved of £0.6m to support the delivery of the activity plans.
- The Trust incurred £0.8m of costs relating to COVID-19 in month which is a reduction in comparison with Month 1's figure of £1.1m primarily in non-pay due to a reduction in testing costs. This remains within the Trust's fixed allocation with £0.2m being chargeable on top of this allocation for COVID-19 testing costs.
- Capital expenditure for the year to date stands at £2.6m which is £1m behind the plan mainly due to an underspend within the medical equipment sub group and the Lower Trent wards scheme.
- The cash balance at Month 2 of £48.2m shows a reduction of £7.6m from the beginning of the year. This reduction is in line with expectations for Month 2 due to the anticipated reduction in both capital and general creditors from the year end position.

Finance Dashboard

	Metric	Target	Latest	Variation	Assurance
I&E	TOTAL Income	variable	129.7		
	Expenditure - Pay	variable	44.2		
	Expenditure - Non Pay	variable	26.1		
Activity	Daycase/Elective Activity	variable	7,449		
	Non Elective Activity	variable	9,515		
	Outpatients 1st	variable	23,296		
	Outpatients Follow Up	variable	41,260		

Income & Expenditure

Income & Expenditure Summary Month 2 2021/22	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Income From Patient Activities	812.6	73.3	71.9	(1.4)	144.3	141.3	(3.0)
Other Operating Income	94.2	7.4	7.0	(0.4)	14.3	14.1	(0.1)
Total Income	906.8	80.7	78.9	(1.8)	158.5	155.4	(3.1)
Pay Expenditure	(540.0)	(45.5)	(44.2)	1.3	(90.6)	(88.1)	2.4
Non Pay Expenditure	(335.6)	(30.8)	(26.1)	4.7	(59.0)	(51.4)	7.6
Total Operational Costs	(875.5)	(76.3)	(70.3)	6.0	(149.6)	(139.5)	10.1
EBITDA	31.3	4.4	8.6	4.2	9.0	15.9	6.9
Depreciation & Amortisation	(30.0)	(2.5)	(2.4)	0.1	(5.0)	(5.0)	0.1
Interest Receivable	0.3	0.0	0.0	(0.0)	0.0	0.0	(0.0)
PDC	(7.6)	(0.6)	(0.6)	0.0	(1.3)	(1.3)	0.0
Finance Cost	(16.1)	(1.3)	(1.3)	0.0	(2.7)	(2.7)	0.0
Surplus / (Deficit)	(22.1)	(0.0)	4.3	4.3	(0.0)	7.0	7.0
Financial Recovery Fund	5.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	(17.1)	(0.0)	4.3	4.3	(0.0)	7.0	7.0

The Trust delivered a £4.3m surplus for Month 2 and a year to date surplus position of £7m both against a planned break even position; this surplus is measured against the Trust's financial plan submitted at the beginning of the financial year. The main variances in month are:

- Income from patient activities has underperformed in month due to £0.7m lower than plan income in respect of the Independent Sector (IS) activity and £0.3m under performance on pass through device income; both of which are offset by corresponding underspends in non-pay. There has also been an adjustment in month of £1m relating to a Month 1 restatement of pass through drug income. This is offset by additional ERF funding above plan of £0.3m in month which relates to Month 1 and 2 (see additional table below).
- Pay is underspent in month by £1.3m which is driven by underspends across most staffing categories. This is further driven by reserves and COVID funding not used in month.
- Non-pay is underspent in month largely due to reserves and COVID-19 funds not being fully utilised in month. Supplies and services - clinical spend is also below budget as although elective activity has started to recover it is not yet at planned levels and as a result of the IS and pass through device comments noted above.

Capital Spend

NHS University Hospitals of North Midlands NHS Trust

Capital Expenditure as at Month 2 2021/22 £m	Total approved scheme cost - schemes > 1 yr (excl PFI)	2021/22	In Month			Year to Date			Notes
	Plan	Plan	Budget	Actual	Variance	Budget	Actual	Variance	
PFI & finance lease liability repayment	-	(9.2)	(0.8)	(0.8)	-	(1.5)	(1.5)	-	
Pre-committed items	-	(9.2)	(0.8)	(0.8)	-	(1.5)	(1.5)	-	
PFI lifecycle and equipment replacement	-	(5.3)	(0.2)	(0.2)	-	(0.3)	(0.3)	-	
PFI enabling cost	-	(0.8)	-	-	-	-	-	-	
PFI related costs	-	(6.1)	(0.2)	(0.2)	-	(0.3)	(0.3)		
Emergency PDC - RI demolition	(7.0)	(2.4)	(0.1)	(0.1)	0.1	(0.2)	(0.1)	0.1	
Emergency PDC - MRU decant	(2.4)	(1.1)	(0.3)	(0.3)	-	(0.3)	(0.3)	-	
Wave 4b funding - lower Trent Wards	(9.1)	(6.5)	(0.2)	(0.0)	0.2	(0.2)	(0.0)	0.2	Approved scheme costs include £0.7m funded from ED and RI.
Diagnostic Funding	-	(0.4)	-	-	-	-	-	-	From overall STP allocation
PDC funded capital schemes	(18.5)	(10.4)	(0.6)	(0.3)	0.2	(0.7)	(0.4)	0.2	
LIMS (Laboratory Information Management System)	(2.7)	(0.6)	(0.1)	(0.1)	(0.0)	(0.1)	(0.1)	0.0	Approved cost takes into account prior year budget revisions
EPMA (Electronic Prescribing)	(4.7)	(0.5)	(0.0)	(0.0)	0.0	(0.1)	(0.1)	0.0	
Completion of RSUH ED doors	(0.4)	(0.2)	-	-	-	-	-	-	
Pathology integration	(0.2)	(0.1)	-	-	-	-	-	-	
Medical devices fleet replacement	(4.9)	(0.7)	-	-	-	-	-	-	Fleet replacement costs to 31.3.25 only
Schemes with costs in more than 1 financial year	(12.9)	(2.2)	(0.1)	(0.1)	(0.0)	(0.2)	(0.1)	0.0	
ICT Infrastructure	-	(0.6)	(0.0)	(0.0)	0.0	(0.1)	(0.0)	0.0	
Estates Infrastructure	-	(2.9)	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0	
Medical Equipment Replacement	-	(2.0)	(0.6)	-	0.6	(0.6)	(0.1)	0.5	
Health & Safety Compliance	-	(0.2)	(0.0)	-	0.0	(0.0)	-	0.0	
Beds, mattresses and hoists	-	(0.1)	-	-	-	-	-	-	
Critical Risk Infrastructure	-	(0.3)	-	-	-	-	-	-	
4th Linear Accelerator Replacement	-	(2.3)	-	-	-	-	-	-	
West building doctors accommodation	-	(0.1)	-	-	-	-	-	-	
Sodexo accommodation	-	(0.1)	-	-	-	-	-	-	
Commitments b/f from 2020/21	-	(0.3)	(0.1)	(0.1)	0.0	(0.2)	(0.1)	0.1	
Lloyds dispensary footprint	-	(0.6)	-	-	-	-	-	-	
Digital Pathology (MES)	-	(0.7)	-	-	-	-	-	-	
Investment schemes	-	(0.5)	-	-	-	-	-	-	
2021/22 schemes	-	(10.6)	(0.8)	(0.1)	0.7	(0.9)	(0.2)	0.7	
Central contingency and risk	-	(0.5)	-	-	-	-	-	-	
Depreciation funded balance to be allocated	-	(2.3)	-	-	-	-	-	-	Funding available from revision of depreciation
Trust cash funded balance to be allocated	-	(2.3)	-	-	-	-	-	-	Funding available from total STP CDEL allocation
Funds to be allocated to schemes	-	(5.1)	-	-	-	-	-	-	
Donated/Charitable funds expenditure	-	(0.2)	(0.2)	(0.2)	-	(0.2)	(0.2)	-	Budget will be matched to expenditure as incurred
Charity funded expenditure	-	(0.2)	(0.2)	(0.2)	-	(0.2)	(0.2)	-	
Overall capital expenditure	(31.4)	(43.5)	(2.4)	(1.5)	0.9	(3.6)	(2.6)	1.0	

Medical equipment is £0.5m behind plan mainly due to delays in the delivery of 6 operating tables (£0.4m); this expenditure is only expected to slip by 1 month with delivery to take place in Month 3.

The plan includes funds yet to be allocated including £2.3m of Trust funded depreciation and £2.3m relating to the overall STP capital allocation; however the latter would need to be funded by the use of the Trust cash balance.

The Executive team has considered a detailed report setting out the impact of the STP funding. The paper highlighted the considerations to be made around the allocation of the additional capital and the risks highlighted by the Capital Sub Groups specifically in relation to their current funding and pressures.

It was recognised that there may be a requirement to use these unallocated funds to contribute towards the business cases requesting national funding – Car Parking and Digital Aspirant, and this needs to be considered alongside the potential allocation to internally funded developments and sub group requests.

Balance sheet

Balance sheet as at Month 2	31/03/2021	31/05/2021			
	Actual £m	Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment	531.2	531.2	530.2	(1.0)	Note 1
Intangible Assets	22.8	19.9	19.9	(0.0)	
Other Non Current Assets	-	-	-	-	
Trade and other Receivables	0.5	0.5	0.5	-	
Total Non Current Assets	554.5	551.6	550.5	(1.0)	
Inventories	15.0	15.0	15.5	0.5	Note 2
Trade and other Receivables	47.4	49.9	49.6	(0.3)	
Cash and Cash Equivalents	55.8	47.8	48.2	0.4	
Total Current Assets	118.2	112.7	113.2	0.6	
Trade and other payables	(98.5)	(91.5)	(84.2)	7.4	Note 3
Borrowings	(8.3)	(8.3)	(8.3)	(0.0)	
Provisions	(3.6)	(3.6)	(3.6)	0.0	
Total Current Liabilities	(110.4)	(103.4)	(96.1)	7.4	
Borrowings	(268.5)	(267.0)	(267.1)	(0.0)	
Provisions	(2.2)	(2.2)	(2.2)	0.0	
Total Non Current Liabilities	(270.7)	(269.2)	(269.2)	(0.0)	
Total Assets Employed	291.5	291.5	298.5	7.0	
Financed By:				-	
Public Dividend Capital	637.9	637.9	637.9	0.0	
Retained Earnings	(465.3)	(465.3)	(458.3)	7.0	Note 4
Revaluation Reserve	118.9	118.9	118.9	-	
Total Taxpayers Equity	291.5	291.5	298.5	7.0	

The balance sheet plan reflects the impact on the balance sheet of the 2021/22 revenue plan submitted to NHSIE on 26 May 2021. A further plan submission will take place on 22 June 2021 and any updates will be reflected at Month 3. Variances to the plan at Month 2 are explained below:

- Property, Plant and Equipment is £1m lower than plan and reflects the underspend in the capital plan to Month 2 which is due to lower than planned expenditure on medical equipment replacement and the Lower Trent wards scheme.
- Inventory is higher than plan at Month 2 and reflects the value of high cost devices held mainly in relation to the pacemakers inventory stock count.
- Payables are £7.4m lower than plan which reflects the revenue underspend of £7m and also the lower than planned capital expenditure.
- Retained earnings show a variance of £7m from plan which reflects the year to date revenue underspend at Month 2.

Expenditure - Pay and Non Pay

Pay Summary (£m)	Annual Plan	In Month			YTD		
		Plan	Actual	Variance	Plan	Actual	Variance
Medical	(160.4)	(13.4)	(13.5)	(0.0)	(26.9)	(27.2)	(0.3)
Registered Nursing	(160.5)	(13.5)	(12.8)	0.7	(26.8)	(25.2)	1.6
Scientific Therapeutic & Technical	(66.0)	(5.6)	(5.4)	0.2	(11.1)	(10.7)	0.4
Support to Clinical	(71.4)	(6.0)	(6.1)	(0.1)	(12.1)	(12.1)	0.0
Nhs Infrastructure Support	(81.8)	(7.0)	(6.5)	0.5	(13.7)	(13.0)	0.8
Total Pay	(540.0)	(45.5)	(44.2)	1.3	(90.6)	(88.1)	2.4

Pay –Key variances:

The underspend on registered nursing remains in line with the prior year trend as a result of the number of vacancies across the trust. This run rate is expected to increase marginally once overseas nurses are able to join the trust.

Within the above budget for Month 2 is £1.1m of reserves which have not been spent (split across numerous expenditure headings) with the main elements being £0.6m on the COVID-19 reserve driven by the reduction in costs compared to the prior quarter and £0.5m on the non-recurrent investment reserve.

Non Pay Summary (£m)	Annual Plan	In Month			YTD		
		Plan	Actual	Variance	Plan	Actual	Variance
Tariff Excluded Drugs Expenditure	(78.2)	(5.9)	(6.2)	(0.3)	(12.1)	(12.5)	(0.4)
Other Drugs	(22.5)	(1.9)	(1.7)	0.2	(3.7)	(3.5)	0.2
Supplies & Services - Clinical	(87.8)	(7.2)	(6.1)	1.1	(14.5)	(11.8)	2.6
Supplies & Services - General	(7.5)	(0.6)	(0.5)	0.1	(1.2)	(1.0)	0.3
Purchase of Healthcare from other Bodies	(25.7)	(3.1)	(2.0)	1.0	(5.8)	(3.7)	2.1
Consultancy Costs	(1.7)	(0.1)	(0.2)	(0.1)	(0.3)	(0.4)	(0.1)
Clinical Negligence	(25.6)	(2.2)	(2.2)	(0.0)	(4.4)	(4.4)	0.0
Premises	(33.3)	(3.0)	(2.8)	0.1	(5.9)	(5.8)	0.0
PFI Operating Costs	(35.5)	(3.1)	(3.1)	(0.0)	(5.9)	(5.9)	(0.0)
Other	(17.8)	(3.8)	(1.1)	2.7	(5.1)	(2.3)	2.9
Total Non Pay	(335.6)	(30.8)	(26.1)	4.7	(59.0)	(51.4)	7.6

Non Pay key variances:

The underspend on supplies and services clinical is made up of £0.3m underspend on pass through devices (£1m year to date) and £0.8m general underspend driven by activity levels still being below plan (£1.6m year to date).

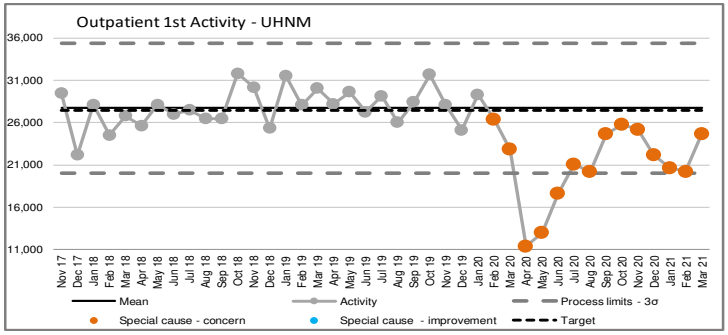
Purchase of healthcare from other bodies is underspent in month largely as a result of the IS contract as we had planned a £1.4m cost in month against an actual cost of £0.6m (year to date variance of £1.7m).

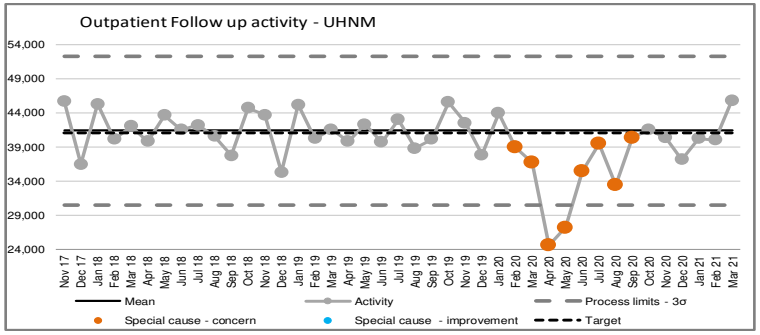
The "Other" category for Month 2 includes £2.6m relating to the Elective Recovery Fund which has been calculated based on activity trajectories submitted by the Divisional teams. At present no spend has been incurred against this although the Divisions have drawn up additional cost for recovery totalling £0.6m for H1 which will be reflected from Month 3 onwards.

Activity

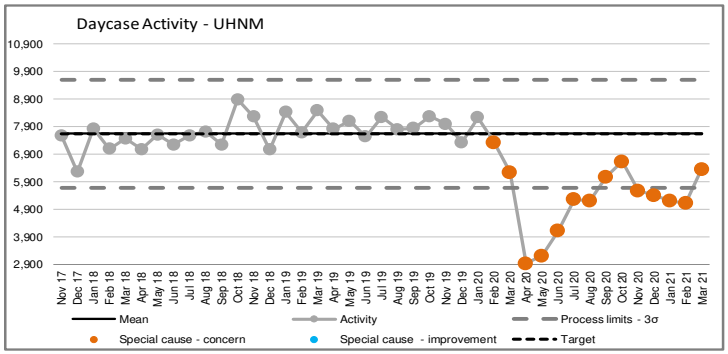
NHS University Hospitals of North Midlands NHS Trust

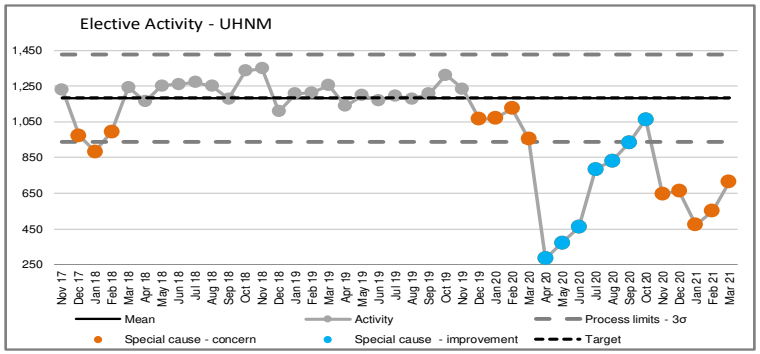
Planned care Outpatient



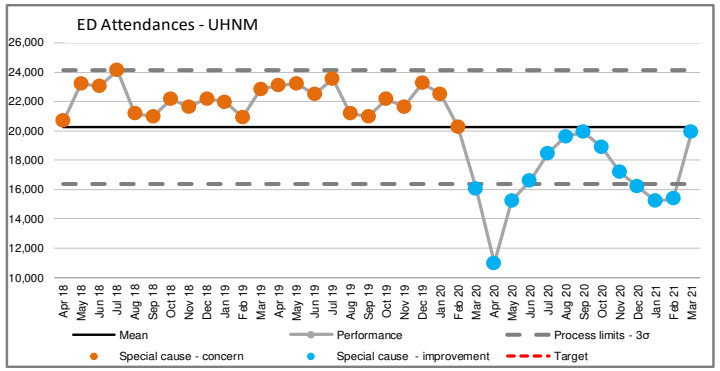


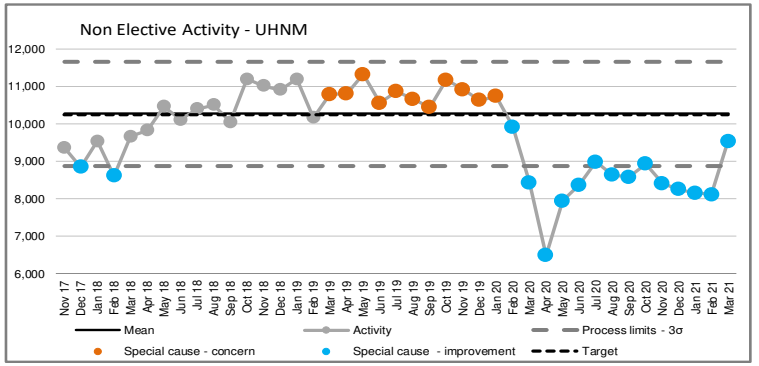
Planned care Inpatient





Urgent Care





Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

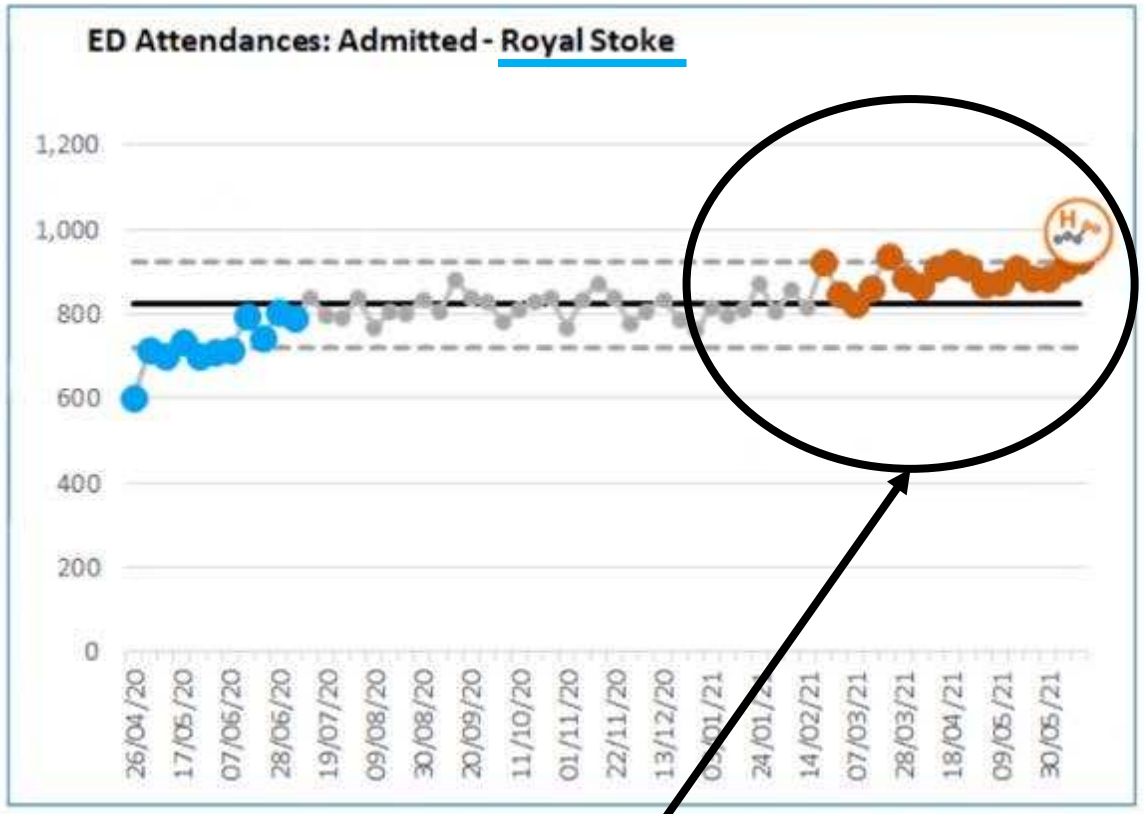
ED Performance UHNM

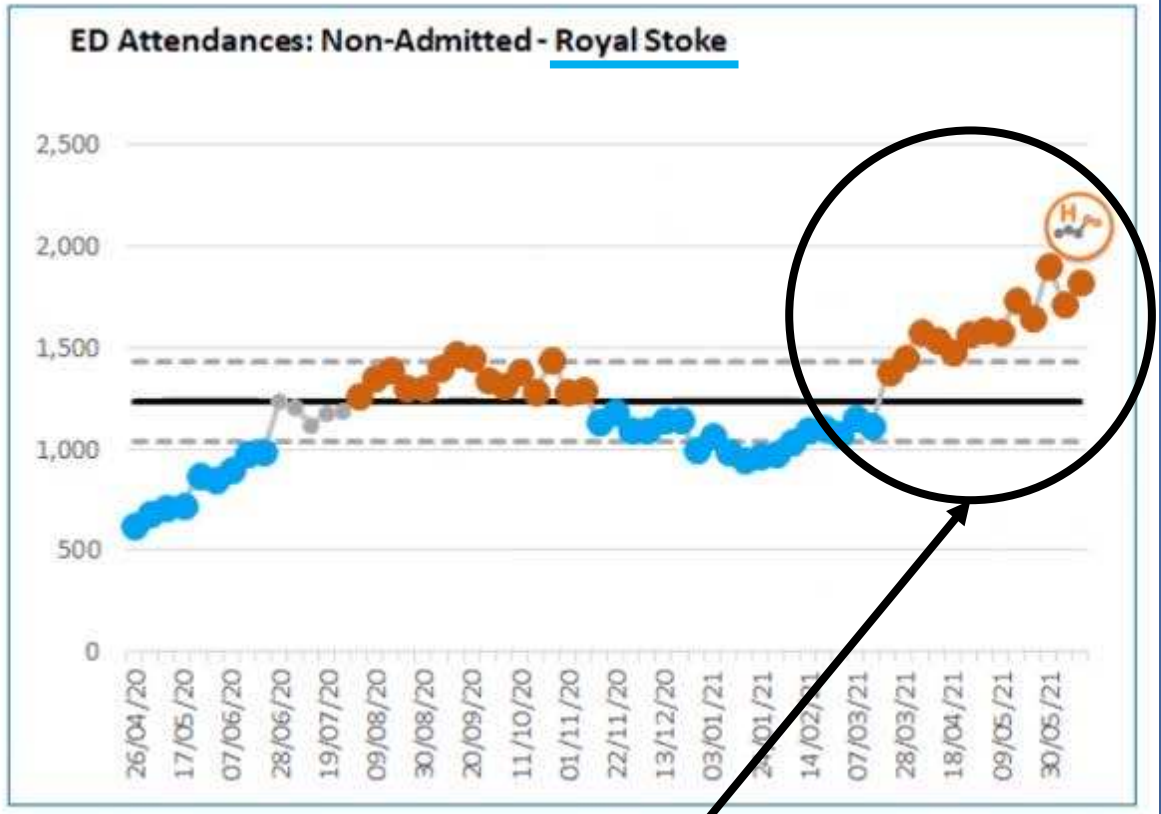
Neil Storey

Revolutionise Ltd

July 2021

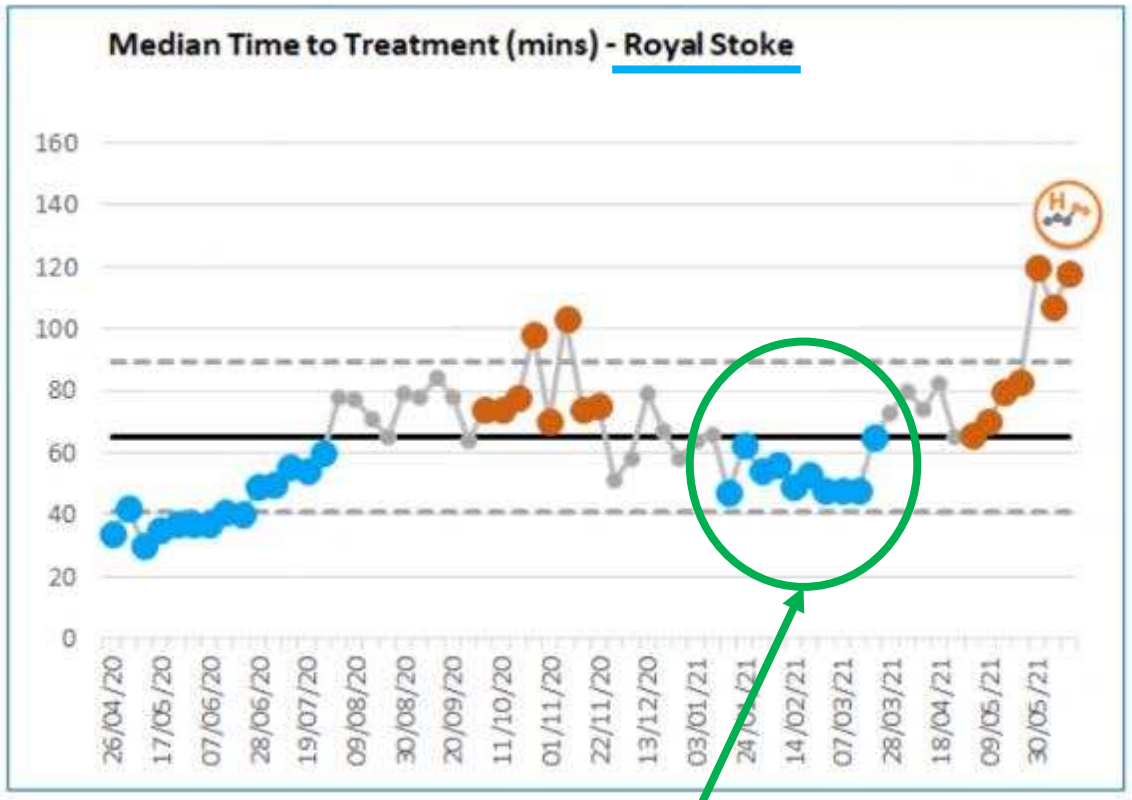
43% Increase in Attendances

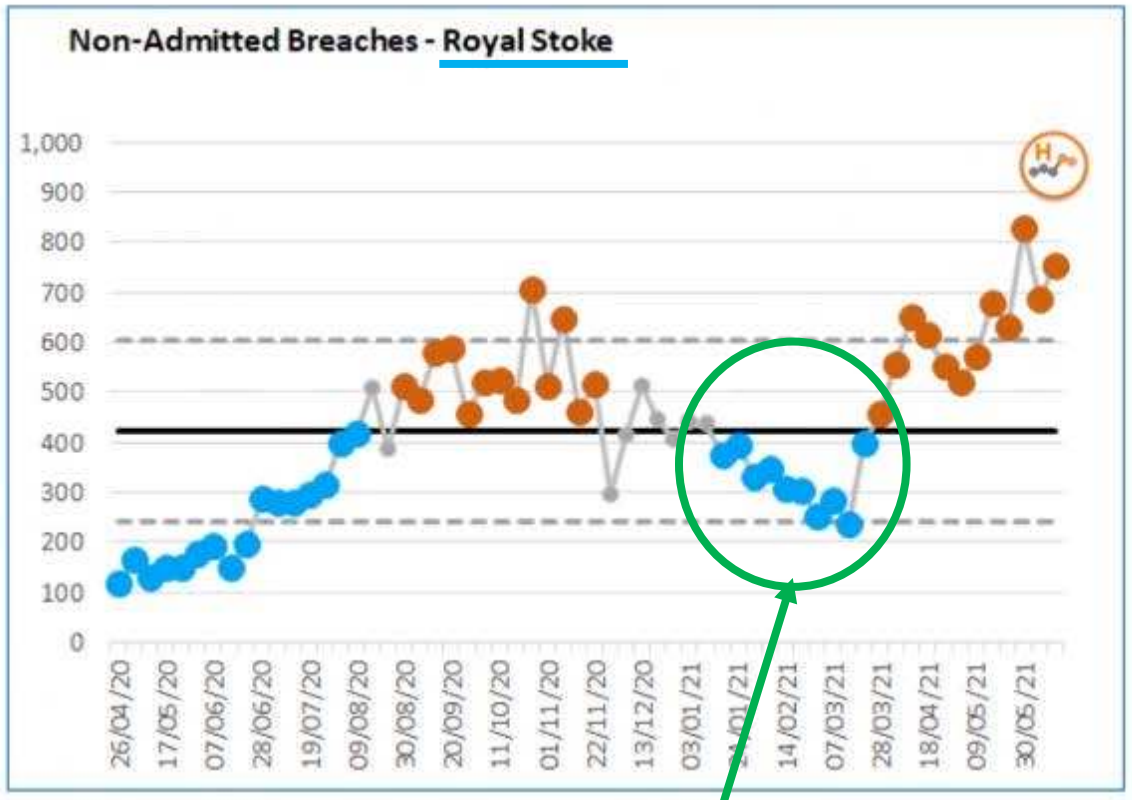




Admitted attendance has increased from around 800 patients per week to 900 per week since mid March. That equates to around 100 extra patients per week or 15 per day.

Increase in non-admitted attendance of around 1000 patients per week since mid March. That equates to around 140 extra patients per day.

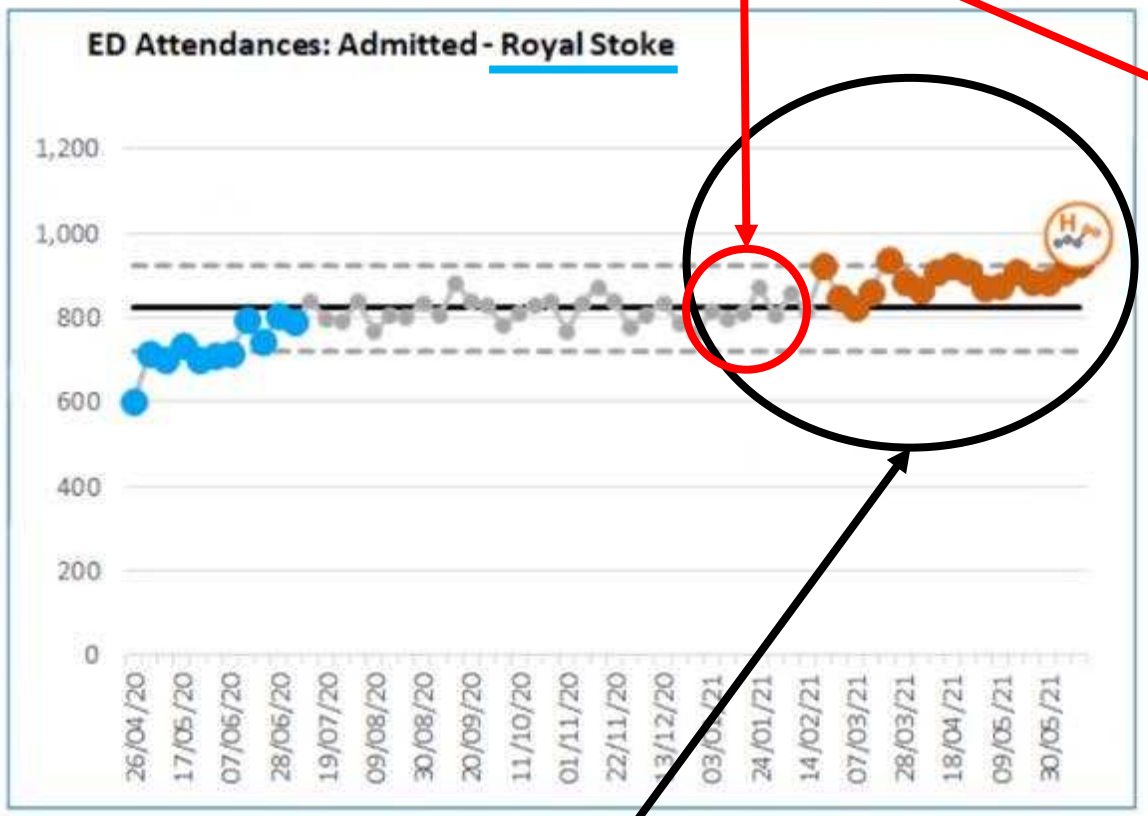


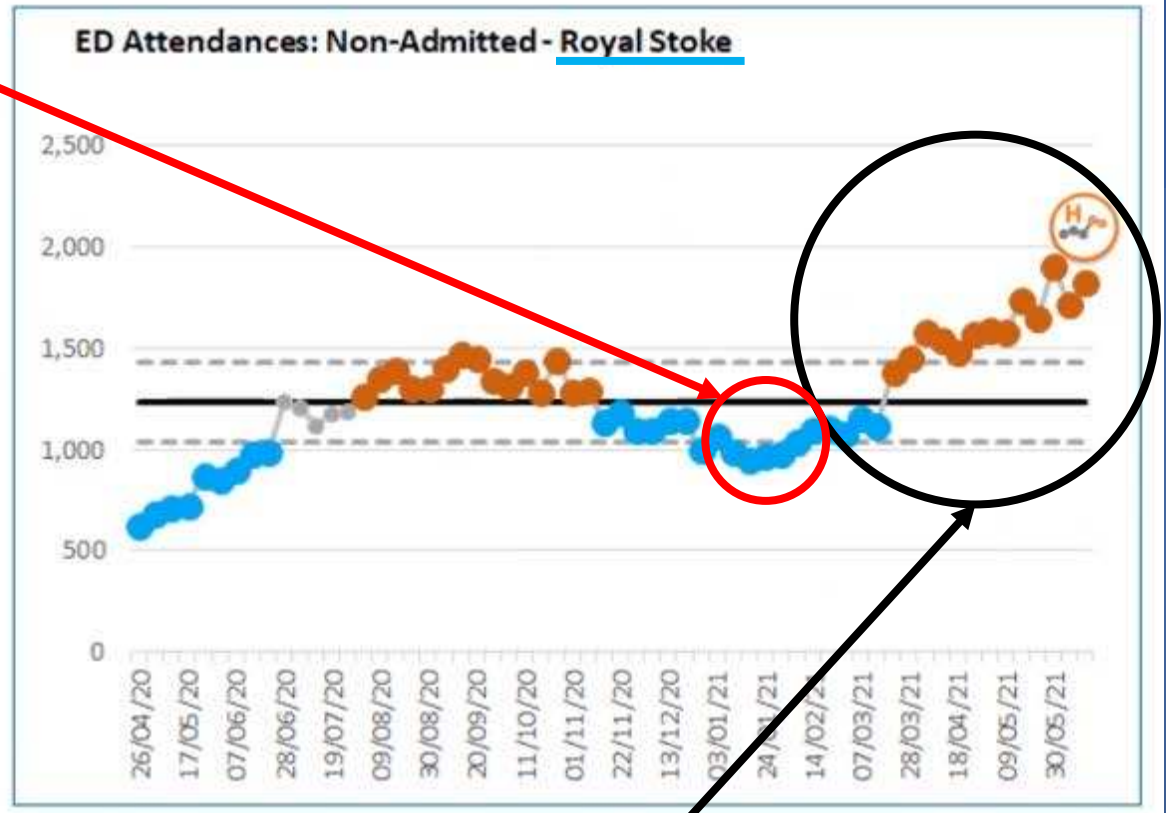


Time to treatment (wait to be seen) was consistently under 60 minutes between 10th Jan 21 and 14th March 21.
This correlates with a combined weekly attendance of c1700 patients per week or 242 per day. The current ED Clinician rota is staffed to manage 277 patients per day.

The number of non-admitted breaches is halved from 400 to 200 per week in the corresponding period of lower demand and improved time to be seen

Time to be seen consistently less than 60 minutes





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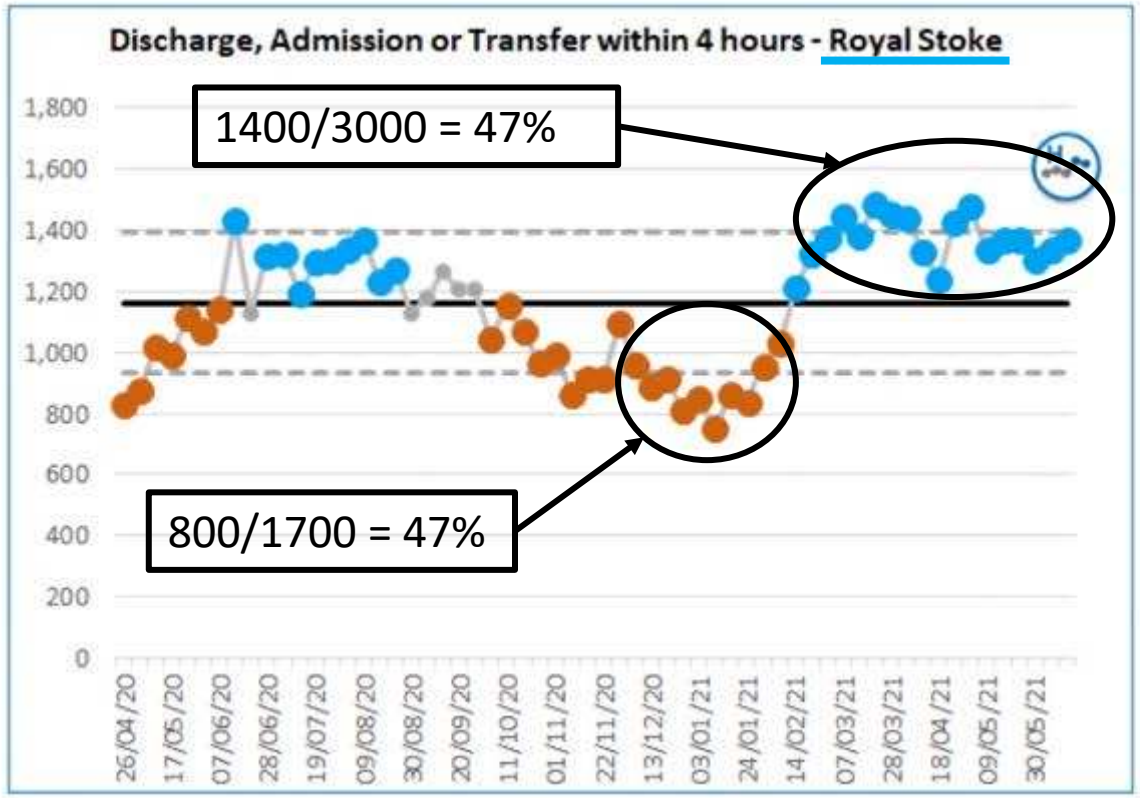
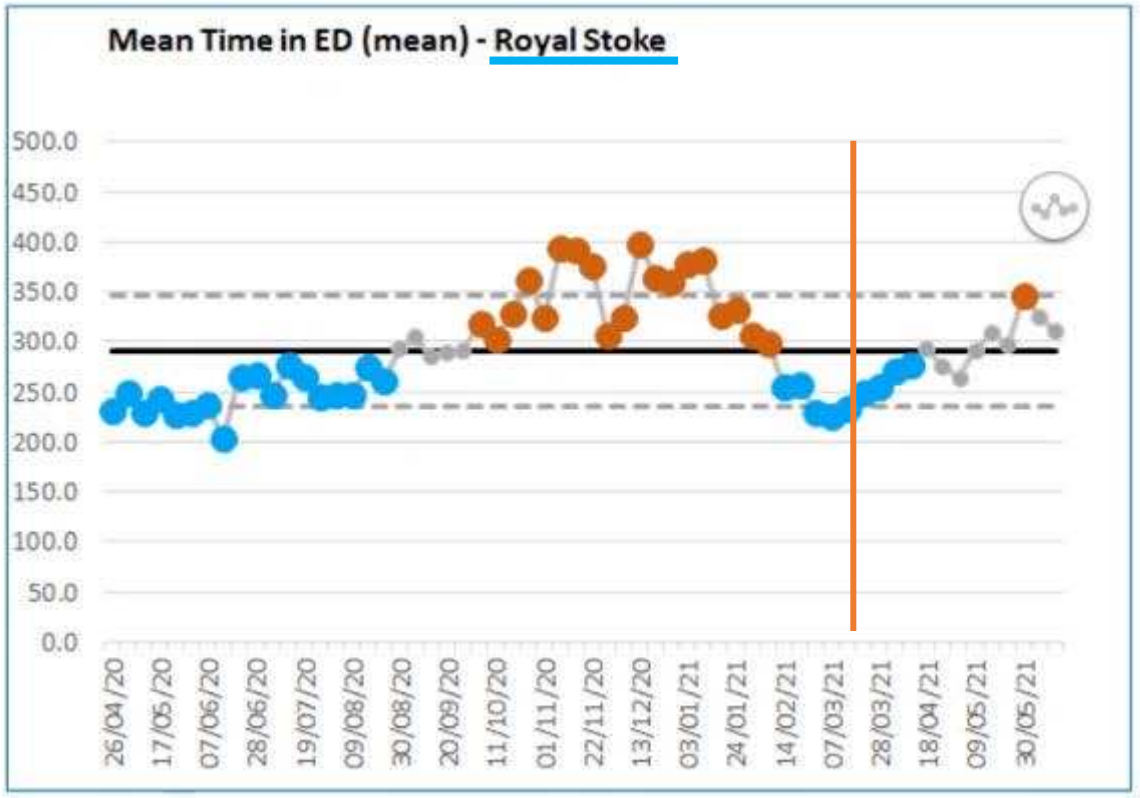
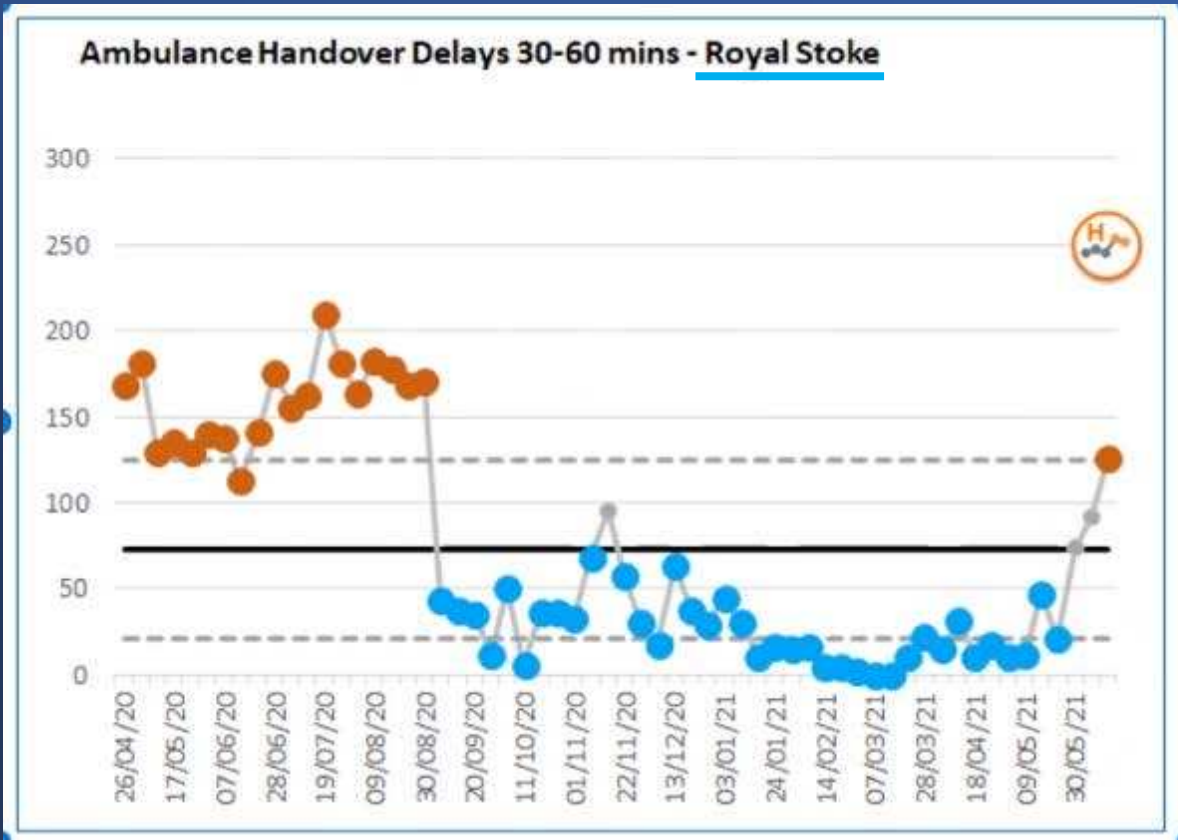
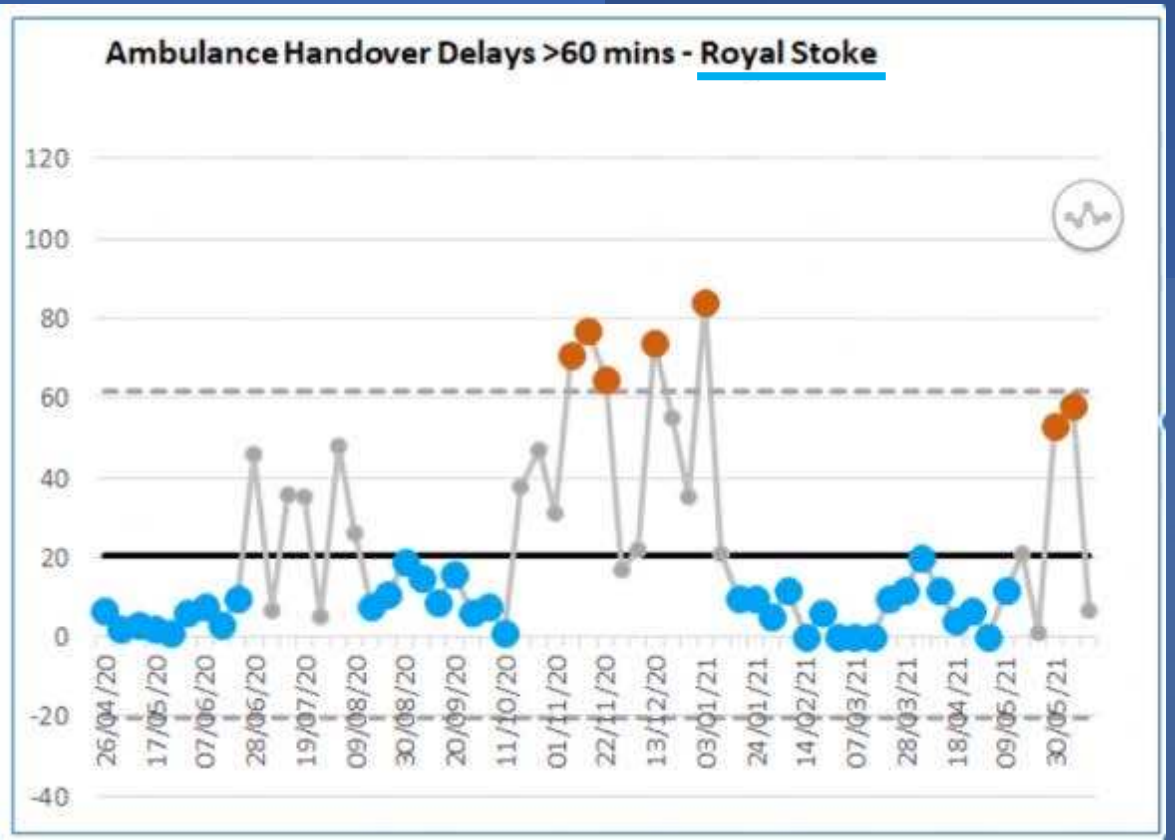




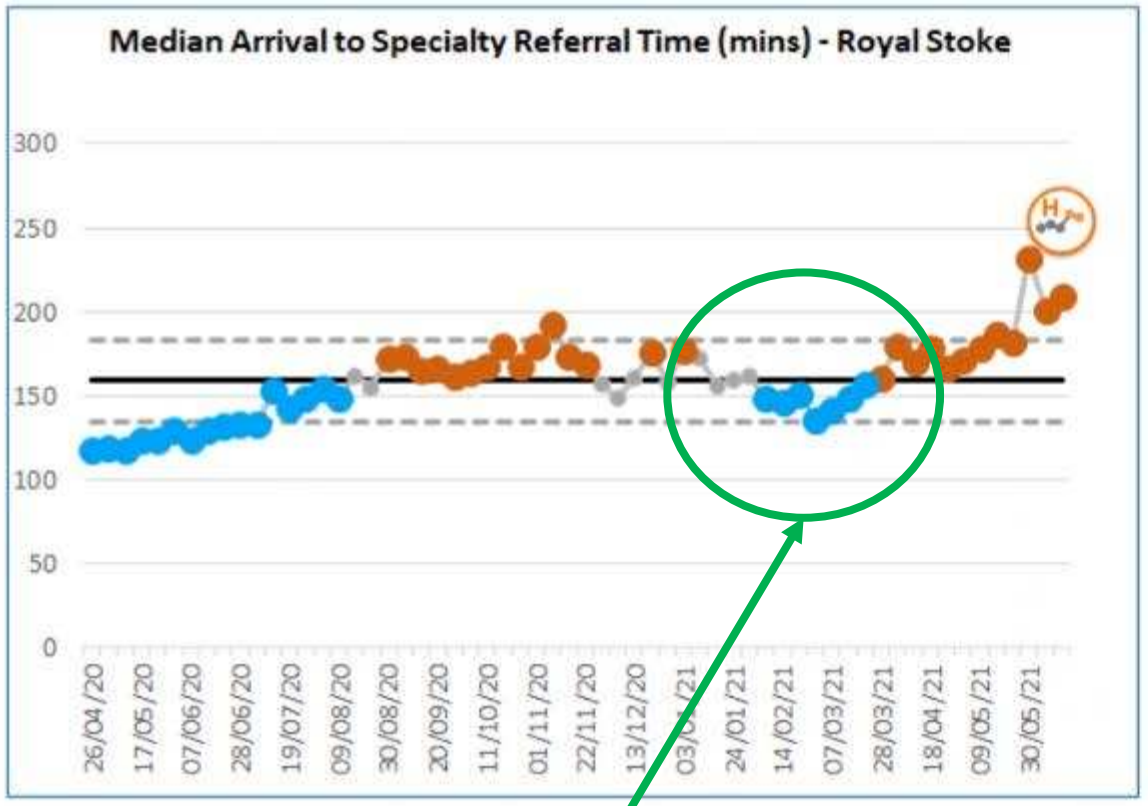
The number of patients being managed within 4 hours has increased by around 600 per week. Due to the change in attendance figures the 4-hour performance has remained the same.

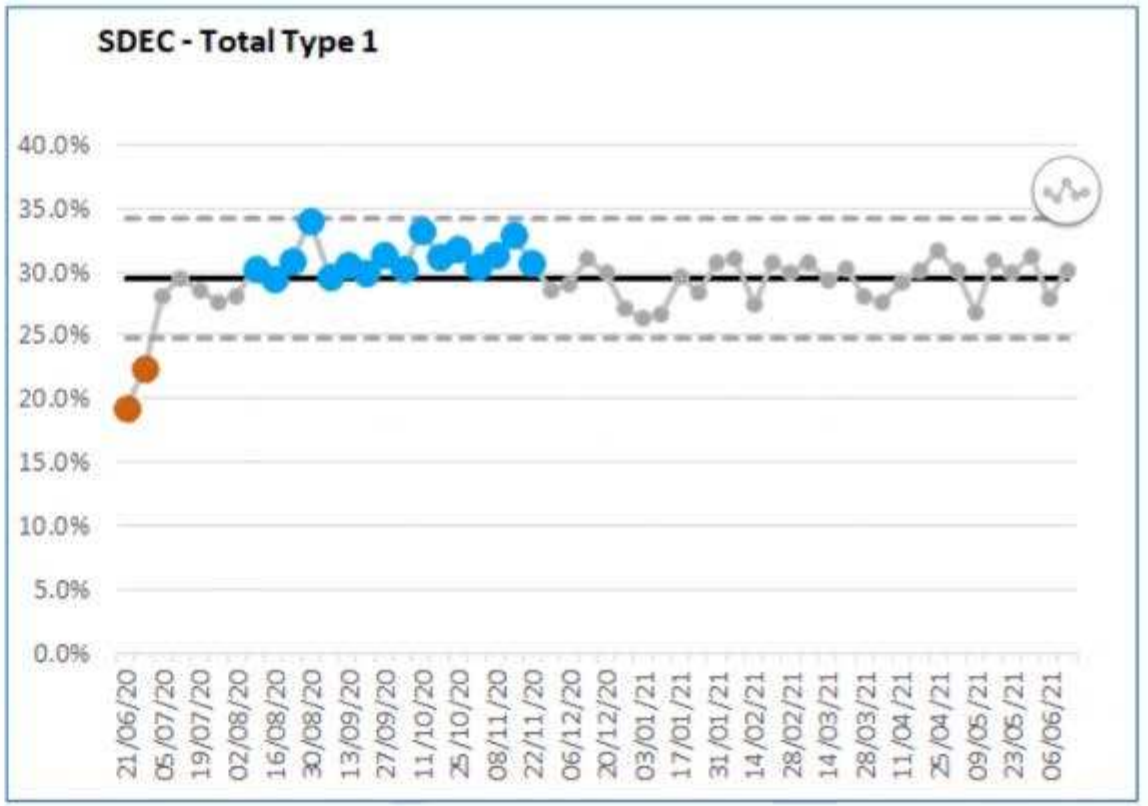
Mean time in ED improves in line with other metrics but begins to deteriorate from around 14th March as activity begins to rise.





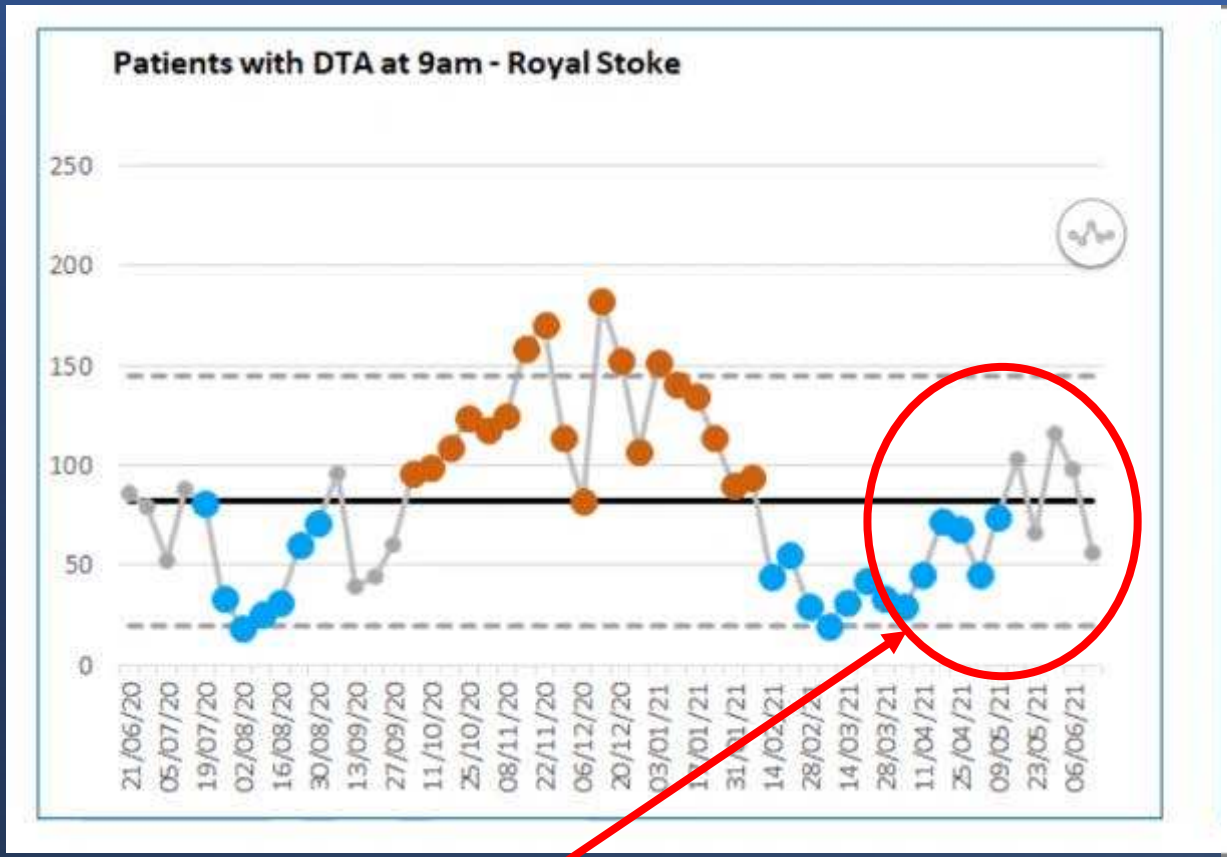
With the exception of the end of May, handover times are relatively constant across this period

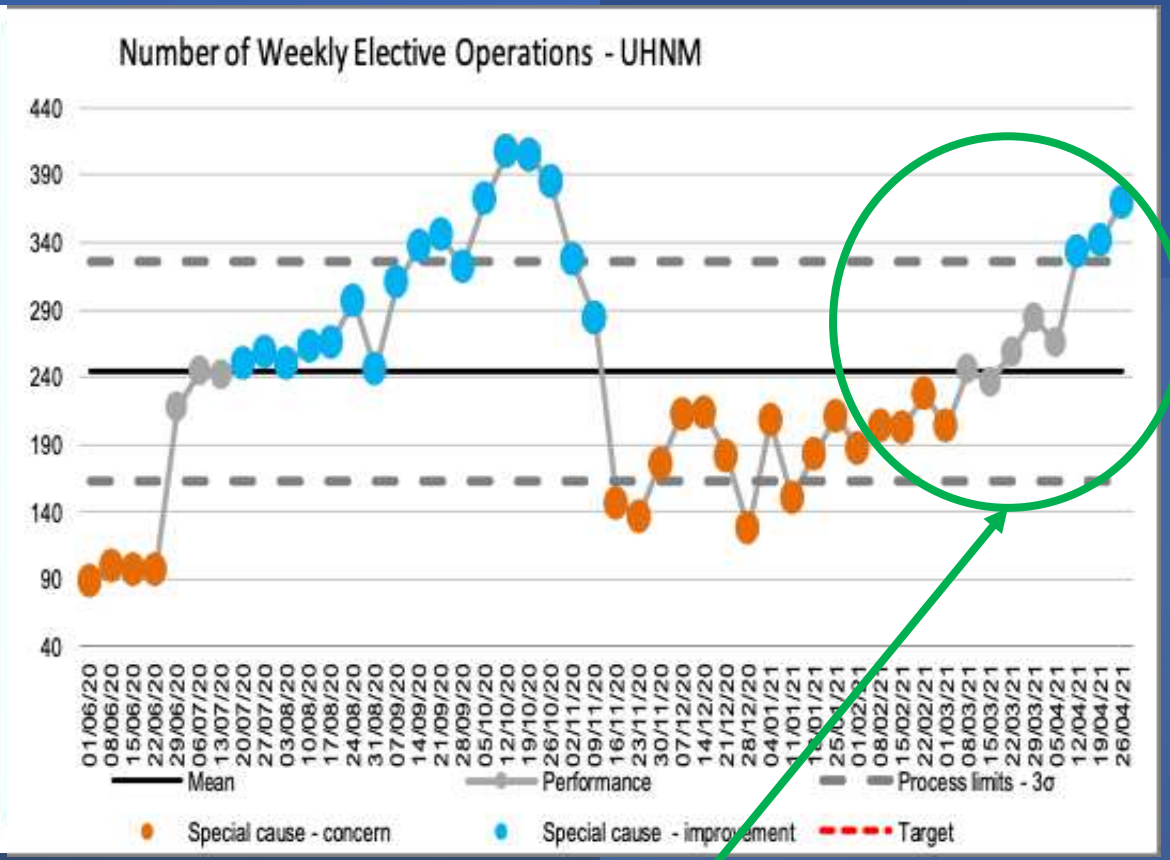




Improvements in Time to Specialty Referral also correlate with the improved resource to activity ratios from Mid Jan to end of March.

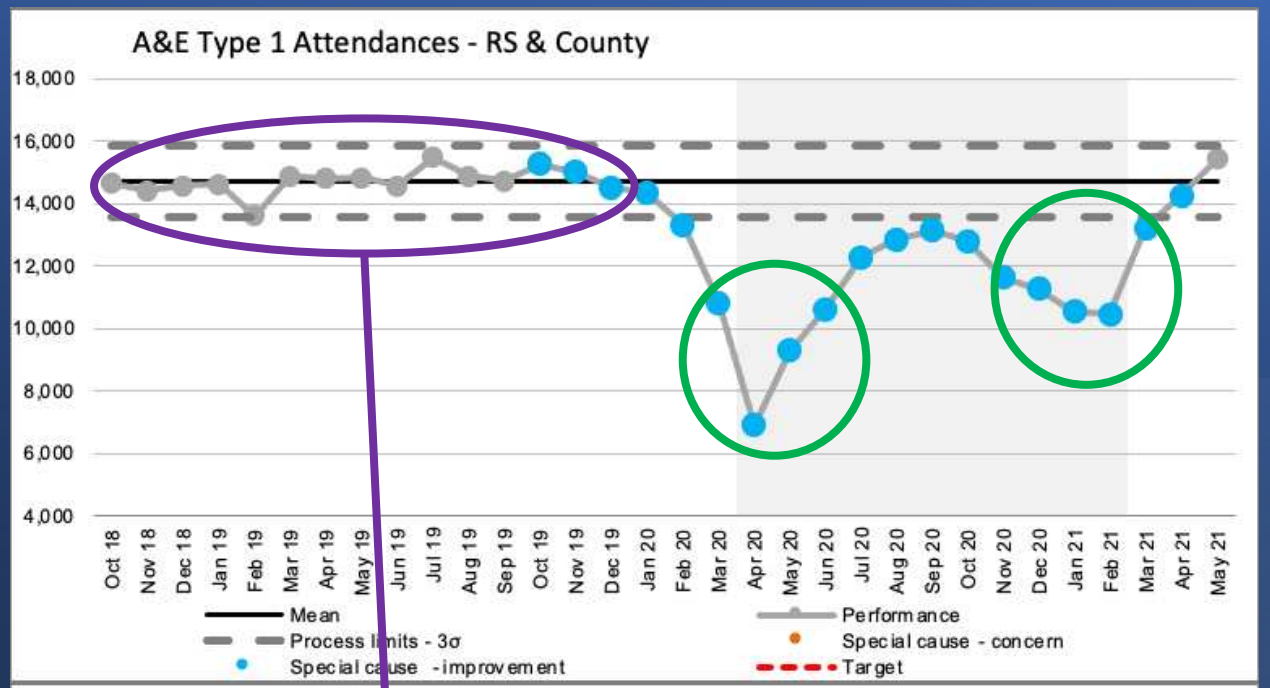
SDEC utilisation has not substantially changed throughout this entire period and could be an area for further exploration to improve the management of the non-admitted patients.

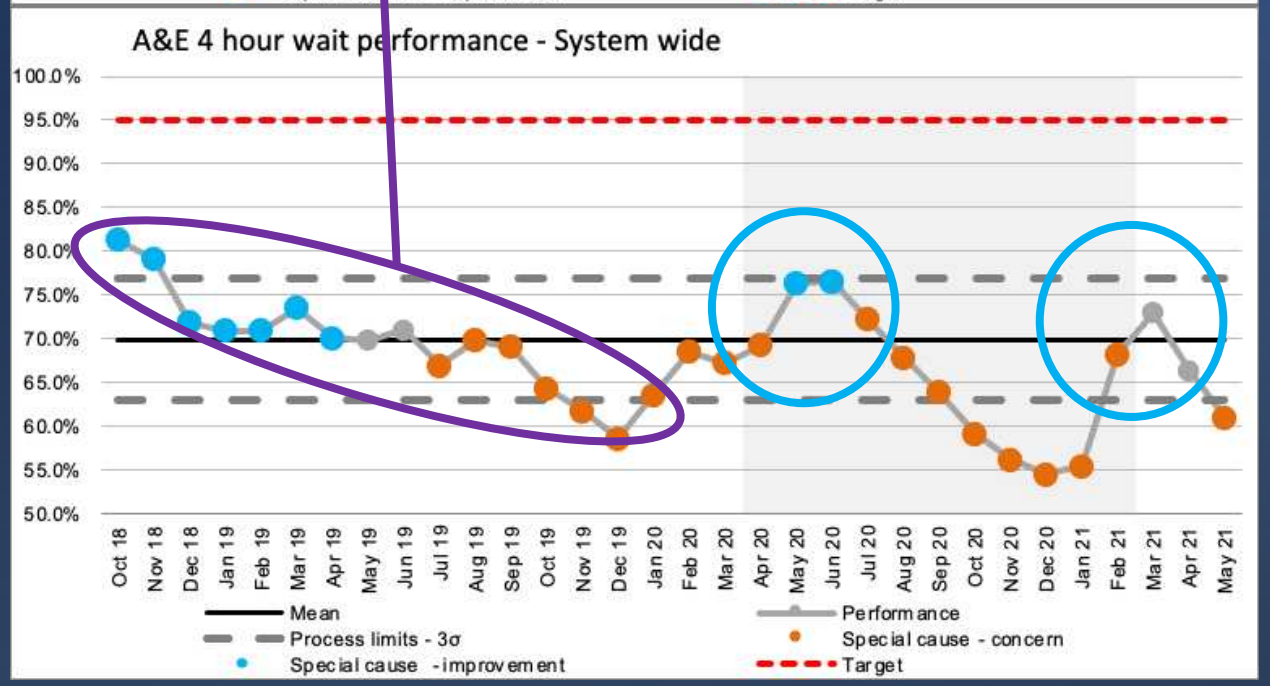




The number of DTAs in ED at 9am each day is also showing a worsening position from early April

Significant increase in Elective workload during the same period almost doubling weekly operations





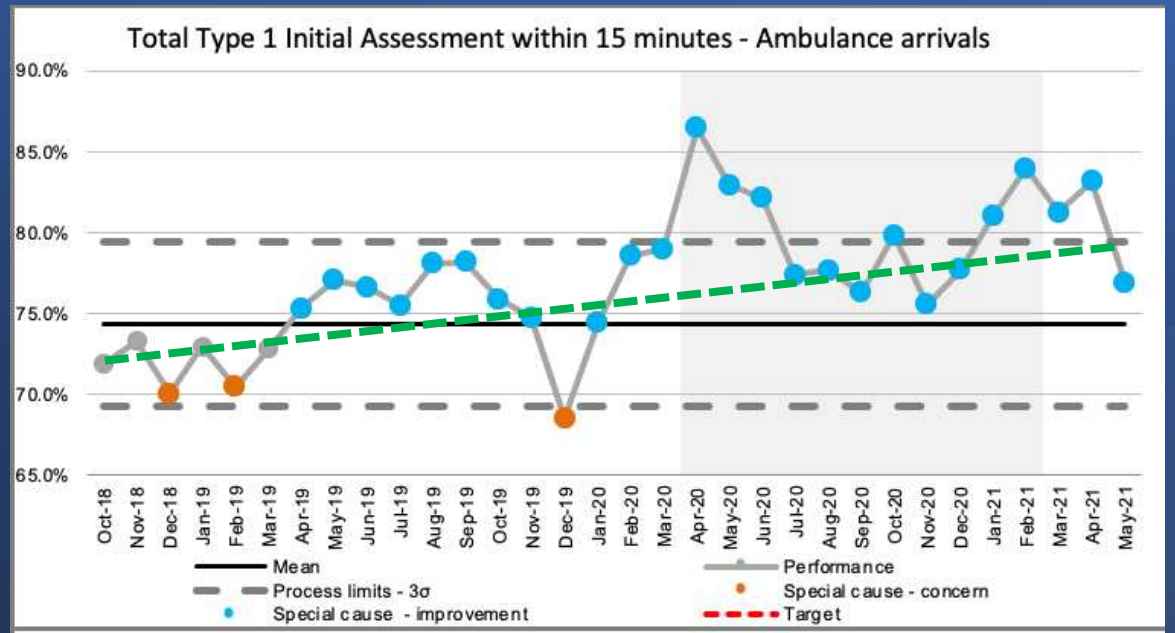
Performance against the 4-hour standard is directly correlated to the emergency activity. Sustained high activity from October 18 to Jan 20 causes a steady decline in performance.

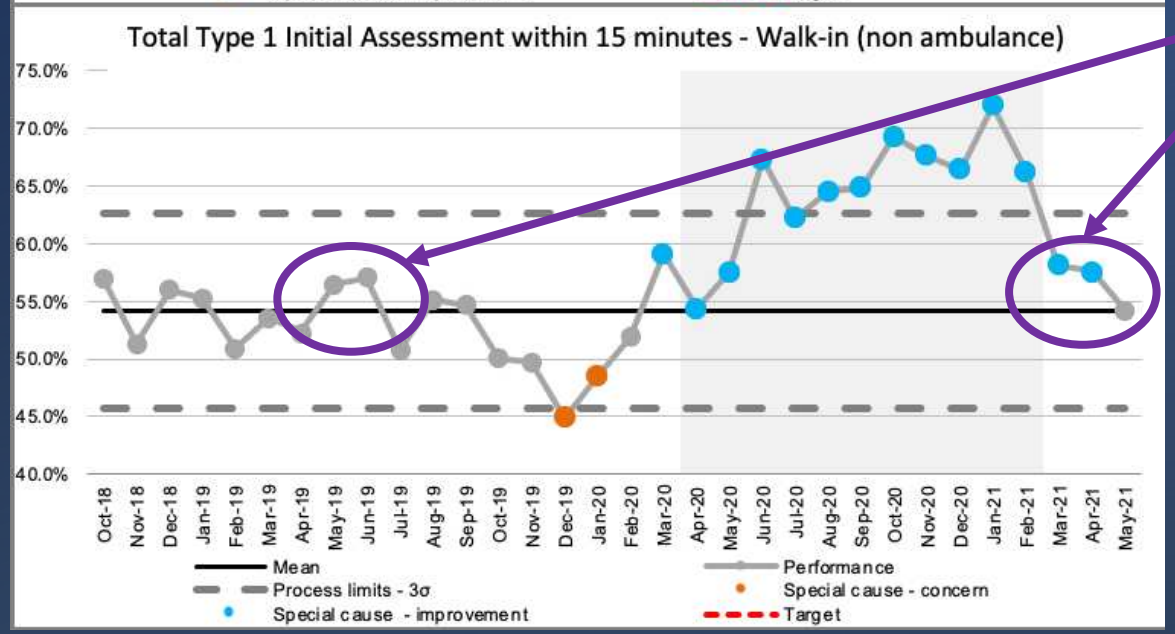
Performance recovers as a result of activity drop due to Covid, but as attendances rise above 10000 per month performance falls again.

= reduced activity and improved performance

= increased activity and reduced performance

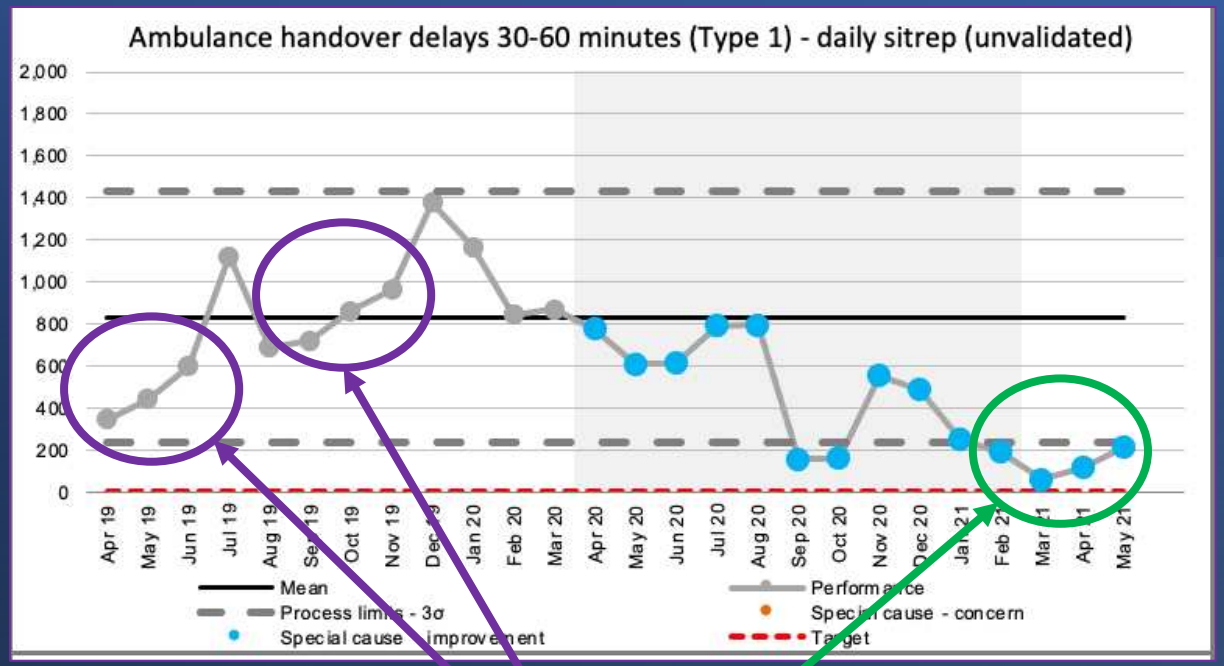
May 2021 saw an increase of around 1000 patients per month compared to the pre-Covid position of May 2019.

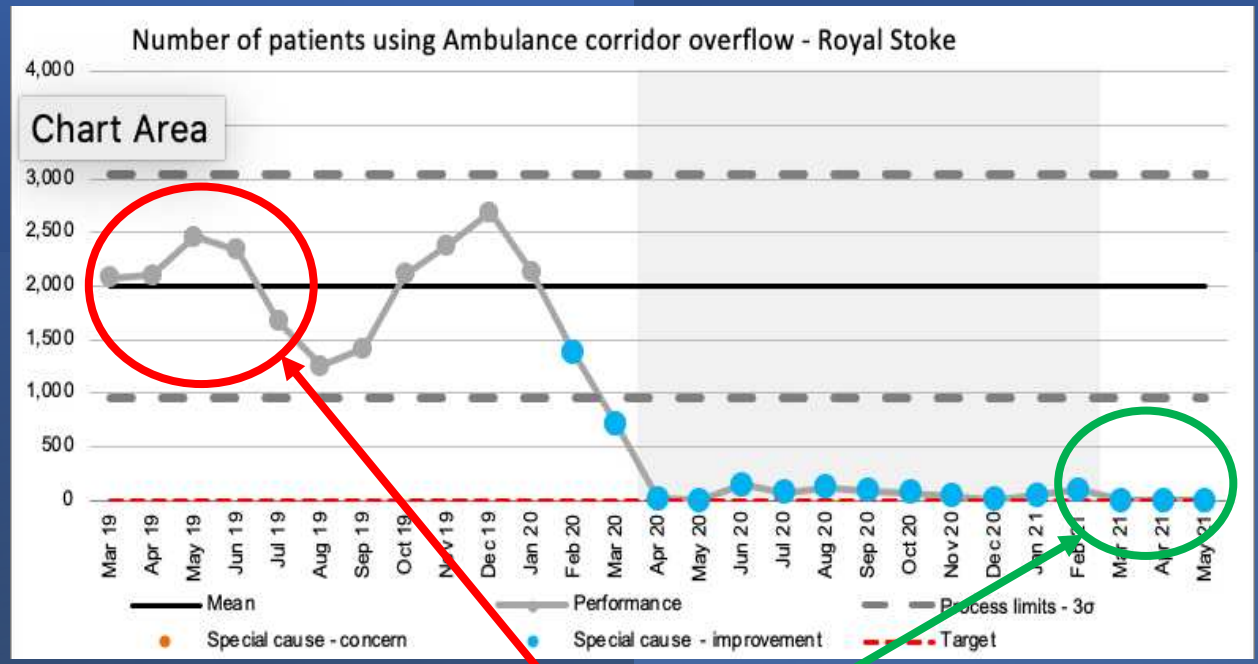




Initial assessment initiatives such as RAT and SiFT have achieved consistent improvements in Initial Assessment Times despite the changes in activity throughout the period.

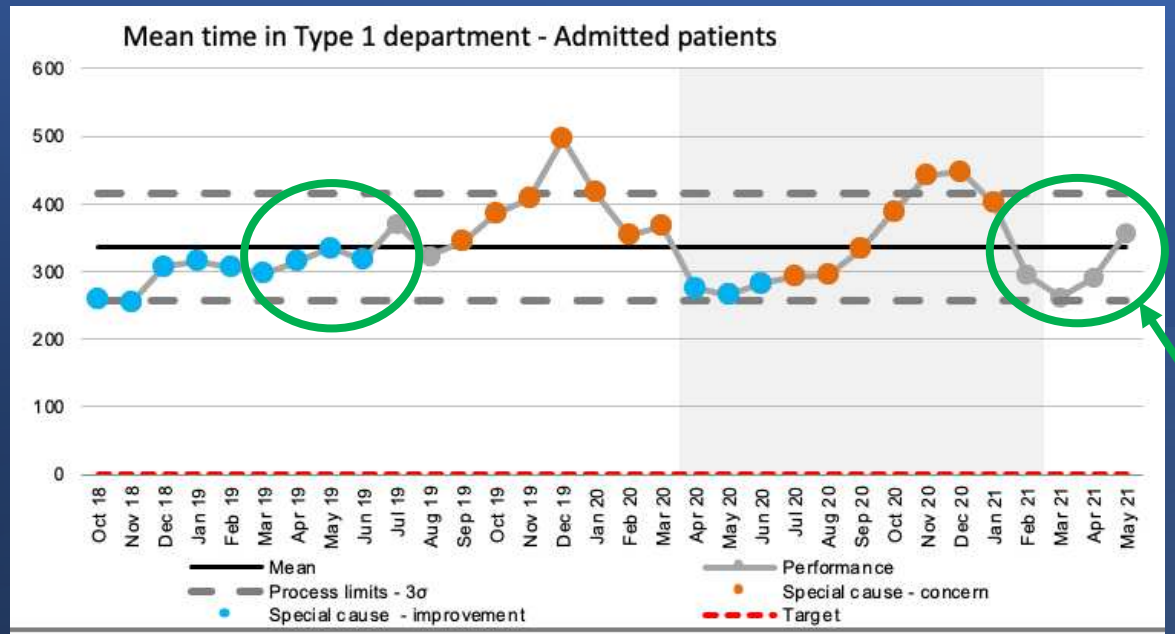
Time to Initial Assessment for walk-in patients in May 21 is almost the same as May 19 with similar activity levels

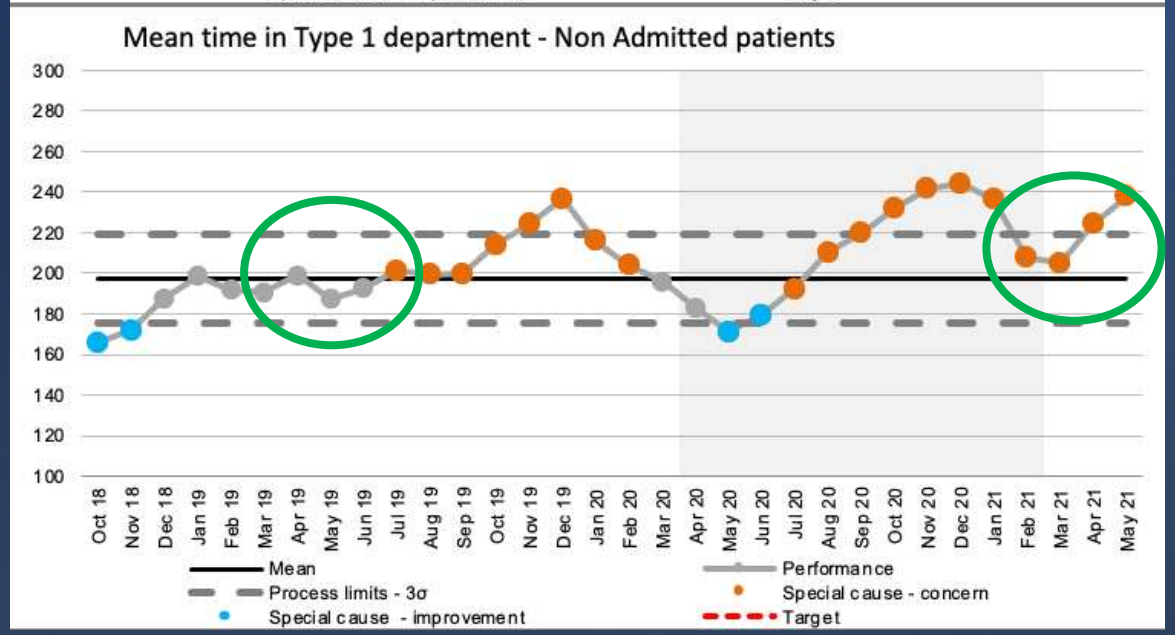




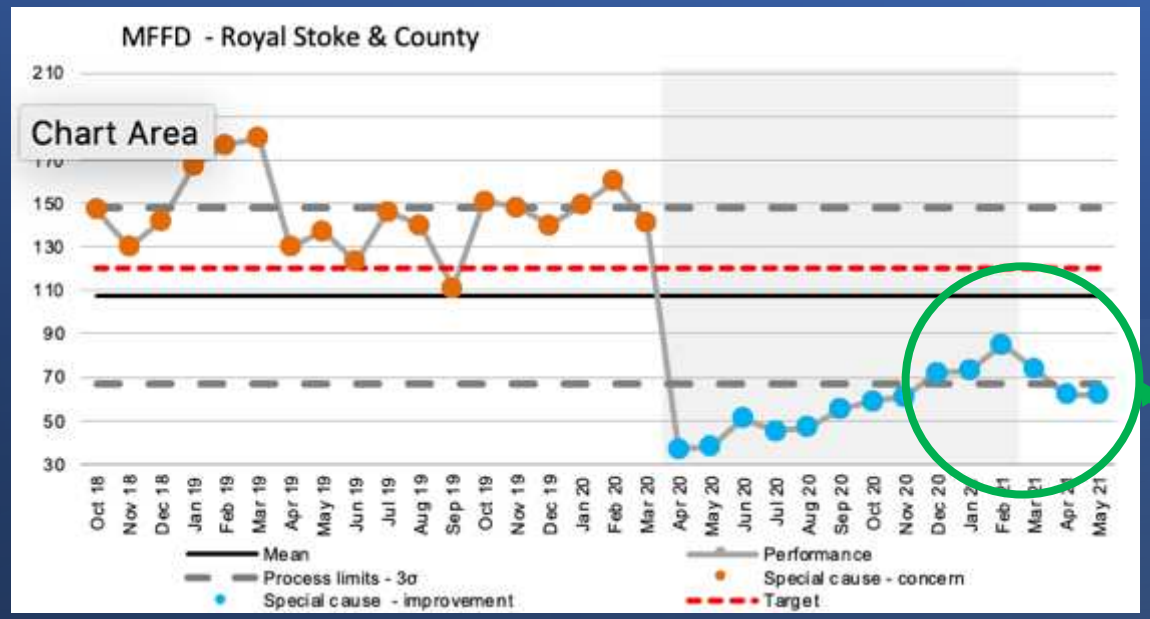
Ambulance handover delays have halved since May 2019 and have fallen by 75% since October 19 (pre pandemic)

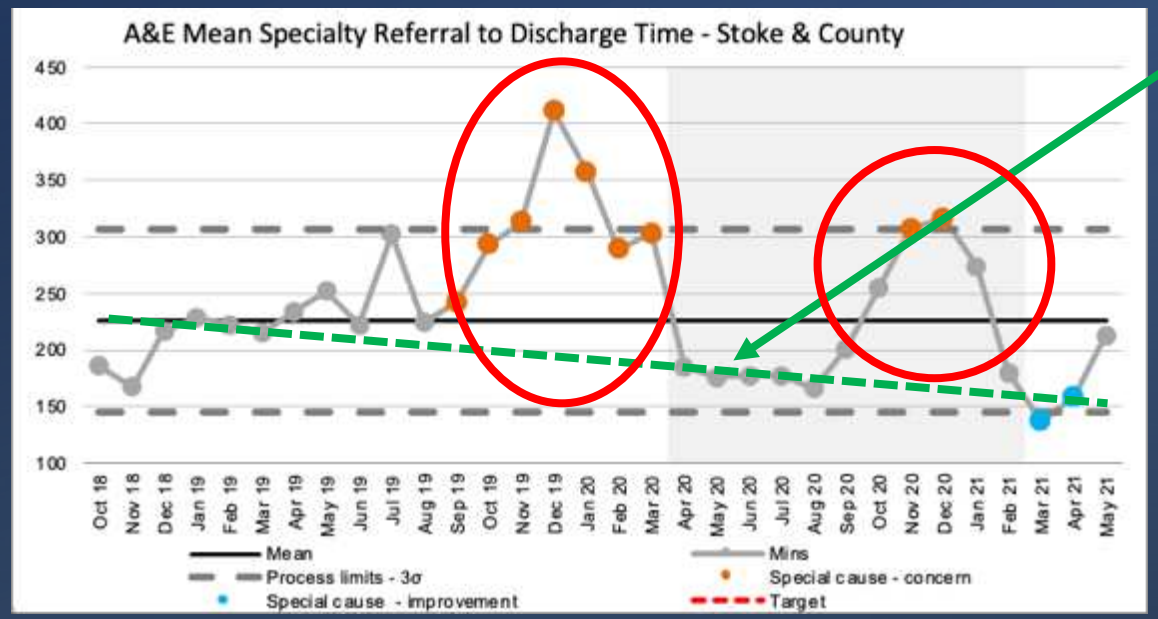
The improvement in corridor care for patients is remarkable. May 19 saw around 2500 patients managed in corridors compared to 0 in May 21 for a similar attendance figure.





Mean Time in Department correlates with activity levels and staffing ratios. Current processing times are similar for both admitted and non-admitted patients compared to May 19 with similar activity levels.





Improvements in flow have created capacity within the Trust to be able to accommodate demand without constantly using escalation and overflow areas.

- The number of patients Medically Fit for Discharge has more than halved since pre-pandemic.
- The time from Specialty Referral to discharge from ED has fallen consistently from the end of 2018 with the exception of the Covid impacts (highlighted)

Summary and Actions

- ED attendances have increased over 40% since early March
- The majority of this increase has been in the non-admitted patient cohort
- ED process times consistently achieved when Clinician to demand ratio is met
- Time to be seen, Mean time in Department, Time to Specialty referral and Non-admitted breaches all improved when activity was around 1700-1800 patients per week (242 – 257 ppd). Current rotas provide for around 272 patients per day and TTBS was consistently below 60 minutes at this time.
- No additional resource has been added to manage this demand increase. ENP workforce has moved to WIC for minor injuries.
- Improvements in flow have enabled the Trust to manage increased activity without the use of escalation and overflow areas
- Elective activity has increased significantly in the same time period
- Current activity has exceeded pre pandemic levels compared to May 2019

Actions

- Focus on non-admitted pathway including complete review of ED estate. Review of CDU impact. Review of current workforce alignment to non-admitted activity
- Time to Initial Assessment pilot – evaluate against data and agree future model asap
- Engage senior clinical workforce to ensure buy-in to and suggest improvements
- Reset department structure, incl R&Rs and expectations
- Visible trigger boards in ED to support the EPIC/NIC in managing the department

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	Date:	7th July 2021
Report Title:	Board Development Programme	Agenda Item:	14.
Author:	Claire Rylands, Associate Director of Corporate Governance		
Executive Lead:	Tracy Bullock, Chief Executive		

Purpose of Report:

Assurance		Approval	✓	Information	

Alignment to Strategic Objectives:

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

Executive Summary:

Situation

The enclosed report sets out the proposed Board Seminar schedule for 2021/22.

Background

The 2020/21 Board Seminar Programme was approved by the Board in March 2020. Previously, a comprehensive plan was developed which underpins the Programme more broadly, and brought together areas of development identified by the Board and the outputs of self-assessment and the supportive developmental review. This plan is due to be updated and developed during 2021, particularly taking into account any findings and recommendations from the forthcoming well-led self-assessment.

Assessment

It should be noted that for the 2020/21 programme, given the associated Covid restrictions, there was limited scope for Board Development sessions, therefore a shorter programme of work was delivered, utilising MS Teams. Therefore, the areas not covered during 2020/21 were considered when developing the programme for 2021/22.

The programme for 2021/22 has been developed through discussions with the Executive Team and takes into account a number of 'must dos', emerging developments and strategic challenges, aligned to the Trust's Strategic Priorities. The programme also identifies whether the topics relate to Board development or whether the focus in providing an update on relevant areas of business, in addition to the inclusion of the purpose, in order to clarify expectations.

Suggested timings have been proposed within the programme, taking into account the dedicated Board Seminar sessions, as well as utilising time allocated to Closed Board meetings, switching into 'seminar mode' after procedural items of business have been covered. Timing for a number of the items are yet to be confirmed, and these will be incorporated into the programme as required.

Key Recommendations:

The Board is asked to approve the Board Development Programme of activities for 2021/22 with the caveat that timings may be flexed / re-prioritised, in addition to inclusion of other items, as required.

Board Development Programme

2021 / 2022 Timetable

NHS
University Hospitals of North Midlands
NHS Trust

Strategic Priority	Topic	Development (D) or Business (B)	Purpose / Outcome	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
					12th		14th		15th		9th / 10th		12th		16th
Resources	UHNM Charity	D	Understanding of Charity Governance and future direction												
Systems & Partners	Draft System Plan	B	Understanding and agreement of the core elements of the System Plan submission, including key risks			Closed Board 9th									
Improving & Innovating	Digital Transformation	D	Session provided by NHS Providers.												
Resources	Clinical Strategy	B	Contribute to and / approve the revised Clinical Strategy.					Closed Board 4th							
Improving & Innovating	Well Led Assessment	B	To self-assess against the Well Led Framework, identifying any gaps to be addressed					Closed Board 4th							
Improving & Innovating	Improving Together	D	Understanding of programme progress to date, key risks, Board / Committee assurance and next steps.												
Systems & Partners	Provider Collaboratives	D & B	Understanding the work undertaken to date and any key issues to be addressed.												
People	Culture Review	B	Report from Independent Review into bullying and harassment – October Trust response and actions taken – November							Closed Board 6th	Time Out				
Systems & Partners	The White Paper	D & B	Session to be provided by Browne Jacobson								Time Out				
Systems & Partners	ICS Development	D & B	Understanding progress made with the Integrated Care System (ICS) and any key issues to be addressed.								Time Out				
Responsive	'State of the Nation'	D	External Speaker to be confirmed												
Improving & Innovating	Risk Appetite	B	Understanding of the revised Risk Appetite Statement and how this should be applied to the BAF.												
Improving & Innovating	Strategic Risks – BAF	B	Agreement of the Strategic Risks for the Board Assurance Framework (BAF) for 2022/23.												

Together Compassion Safe Improving

PROUD TO CARE

Strategic Priority	Topic	Development (D) or Business (B)	Purpose / Outcome	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
					12th		14th		15th		9th / 10th		12th		16th
Resources	System Oversight Framework	D	Understanding of the new SOF and key issues/ implications for NHS Trusts												
Resources	New Financial Regime	D & B	Understanding of, and key issues/implications for NHS Trusts												
People	Executive & Senior Leadership	D	Content and timing to be confirmed												

Trust Board

2021/22 BUSINESS CYCLE

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

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

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