University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 9th June 2021 at 9.30 am to 12.15 pm via Microsoft Teams

AGENDA

Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
09:30	**PROCEDURAL ITEMS**					
20 mins	1.	Patient Story	Information	Mr S Purser	Verbal	
5 mins	2.	Chair's Welcome, Apologies and Confirmation of Quoracy	Information	Mr D Wakefield	Verbal	
	3.	Declarations of Interest	Information	Mr D Wakefield	Verbal	
	4.	Minutes of the Meeting held 5th May 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 – May 2021	Information	Mrs T Bullock	Enclosure	**BAF 6**
10:20	**PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES**					
10 mins	7.	Quality Governance Committee Assurance Report (27-05-21)	Assurance	Ms S Belfield	Enclosure	**BAF 1**
10 mins	8.	IPC Board Assurance Framework	Assurance	Mr S Purser	Enclosure	**BAF 1**
10 mins	9.	UHNM Quality Account 2020/21	Approval	Mr S Purser	Enclosure	**BAF 1**
10:50	**ENSURE EFFICIENT USE OF RESOURCES**					
10 mins	10.	Performance & Finance Committee Assurance Report (25-05-21)	Assurance	Mr P Akid	Enclosure	**BAF 9**
11:00 – 11:15 : BREAK						
11:15	**ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT AND RESEARCH**					
10 mins	11.	Transformation and People Committee Assurance Report (26-05-21)	Assurance	Prof G Crowe	Enclosure	**BAF 2 & 3**
11:25	**ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS**					
40 mins	12.	Integrated Performance Report – Month 1	Assurance	Mr S Purser Mr P Bytheway Mrs R Vaughan Mr M Oldham	Enclosure	
12:05	**CLOSING MATTERS**					
10 mins	13.	Review of Meeting Effectiveness and Business Cycle Forward Look	Information	Mr D Wakefield	Enclosure	
	14.	Questions from the Public **Please submit questions in relation to the agenda, by 9.00 am 7th June to nicola.hassall@uhnm.nhs.uk**	Discussion	Mr D Wakefield	Verbal	
12:15	**DATE AND TIME OF NEXT MEETING**					
	15.	**Wednesday 7th July 2021, 9.30 am via Microsoft Teams**				

University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 5th May 2021, 9.30 am to 12.35 pm
Via Microsoft Teams

MINUTES OF MEETING

			Attended	Apologies / Deputy Sent	Apologies

Voting Members:			A	M	J	J	J	A	O	N	D	J	F	M
Mr D Wakefield	DW	Chairman (Chair)												
Mr P Akid	PA	Non-Executive Director												
Ms S Belfield	SB	Non-Executive Director												
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												
Mrs M Rhodes	MR	Chief Nurse	SP											
Mrs R Vaughan	RV	Director of Human Resources												

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

In Attendance:		
Mrs N Hassall	NH	Deputy Associate Director of Corporate Governance (minutes)
Mrs L Roberts	LR	CRIS (item 1)
Mrs S Wallis	SW	Head of Midwifery (item 8)

Members of Staff and Public via MS Teams: 8

No.	Agenda Item	Action
1.	**Staff Story – Community Rapid Intervention Service (CRIS) Team**	
066/2021	Mrs Roberts provided a presentation to Board members and highlighted the following: • That the service provided the opportunity to identify alternative pathways for patients by working with partners • The team provided support to Care Homes, engaged with the West Midlands Ambulance Service, and had recently been included as an option available through the Think 111 service • Patient stories reflecting the positive patient feedback received, due to the way in which the CRIS team had enabled patient wishes to be adhered to, in terms of avoiding unnecessary hospital admissions	

PROUD TO CARE

	Professor Hassell queried the size and skill mix of the team and what a typical patient journey consisted of. Mrs Roberts stated that there were 18 practitioners within the team, whose experience included community care, critical care, paramedics and physiotherapy. She added that the team were looking to expand to include a mental health practitioner, in particular to help with dementia patients and that the skill mix was to be expanded to include staff who could take bloods and recheck clinical observations in care homes. Mrs Roberts stated that in terms of a typical patient journey, after the referral, the patient would be immediately triaged at source to identify any red flags and if they were identified for the team to see them, they would receive a visit within 2 hours and a medical management plan would be put in place. She added that Home First colleagues in the community would also be utilised with the aim of supporting patients for the sub-acute period before passing back to core services. Miss Walsh commented on the service which had made a significant difference in how healthcare was delivered, in a short space of time, and added that Consultant medical input into the service needed to increase. She welcomed the change in culture in terms of Care Homes ringing the CRIS team rather than 999, which was a major step forward. Mr Akid referred to the logistics in taking pressure off other parts of the hospital and queried whether there had been a reduction in A&E numbers as a result, and if so whether that capacity would be back filled by something else. Mr Bytheway stated that the impact was difficult to measure, given the pandemic, but stated that the impact would slow the rate of increases in attendances going forwards. Mr Wakefield welcomed the way in which the service had the potential to reduce attendances in addition to providing support to GPs. He thanked Mrs Roberts and the team for the service provided. **The Trust Board noted the story.** Mrs Roberts left the meeting.	
2.	**Chair's Welcome, Apologies & Confirmation of Quoracy**	
067/2021	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 Freeman to the meeting as an observer, who was to join the Trust later in the year as the new Director of Digital Transformation. Mr Wakefield reflected on the situation in India and thanked staff again for the efforts undertaken during the past 12 months. Mr Wakefield highlighted that new Non-Executive and Associate Non-Executive Directors had been appointed and an announcement would be made in due course. Mr Wakefield stated that it was Mrs Rhodes' last Board meeting and expressed how she had been a great role model for staff, that she would be missed, and thanked her for her time at the Trust and wished her the best in her new role.	
3.	**Declarations of Interest**	

068/2021	The standing declarations were noted.	
4.	**Minutes of the Previous Meeting held 7th April 2021**	
069/2021	The minutes of the meeting from 7th April 2021 were approved as an accurate record.	
5.	**Matters Arising from the Post Meeting Action Log**	
070/2021	No further updates were provided.	
6.	**Chief Executive's Report – April 2021**	
071/2021	Mrs Bullock highlighted a number of areas from her report and reflected on the situation in India and the response provided; she stated that the response was being coordinated nationally, whereby the Department of Health and Social Care were providing equipment and medicines, whilst NHS England / Improvements Chief People Officer, Prerans Issa, was leading a Clinical Advisory Group. A Chair from a neighbouring Trust was working with the South Asian Heritage NHS Leaders Network and South Asian Health Foundation, holding webinars and seeking donations etc. In terms of the national response, India had been asked what was required, whereby it had been noted that peer to peer support was required and that additional staffing was not required. Over 200 ventilators had already been sent and 496 oxygen concentrators. Mrs Bullock stated that individual Trusts had been asked not to send anything individually as India felt this would be too difficult to coordinate multiple donations and they preferred the centralised approach from nations. It was noted that main action for the Trust was to support its own staff and colleagues who had friends and family in India, highlighting the support in place for staff. In addition the Black and Minority Ethnic staff network had been contacted to establish what support was required. Furthermore, a number of Indian nurses were due to join the Trust in May, but given that flights had ceased and many of them wanting to stay in India to support family, they would not join the Trust until later in the year. Dr Griffin queried the impact from long Covid on staff sickness absence and the quantum of this. Mrs Bullock stated that staff were being provided with support in terms of managing their condition and Mrs Vaughan added that a rehabilitation programme had been provided via Occupational Health, and an associated referral pathway, with good initial take up of the support. Mrs Bullock highlighted that Dr Oxtoby was due to retire in September and therefore the Trust had gone out to advert for a substantive Medical Director. She stated that she had been pleased with the initial interest in the post. **The Trust Board received and noted the update and approved EREAFs 7575, 7502, 7474, 7255 and 7576.**	
PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES		
7.	**Quality Governance Committee Assurance Report (23-04-21)**	
072/2021	Professor Hassell highlighted the following from the report:	

	• A number of areas had been identified for escalation, in terms of issues with infusion pumps and NG tubes, 1 unavoidable MRSA bacteraemia having been reported and consideration of the impact of flu and norovirus in winter 2021 • In addition, the Committee noted that a number of patient safety standards had not been achieved including written duty of candour Mr Wakefield referred to the suggestion of giving everyone over 50 the flu and Covid booster at the same time and whether this had been confirmed and if so whether there would be any impact on the Trust. Mrs Rhodes stated that no confirmation had been received but the teams had already started to consider how the booster jab could be provided to staff, depending on the guidance. **The Trust Board received and noted the assurance report.**	
8.	**Maternity New Serious Incident Report Summary**	
073/2021	Mrs Wallis joined the meeting. Mrs Wallis highlighted the following from her report: • For April, 1 serious incident had been declared. The baby was doing well but the long term impact was not yet known and the incident would be investigated • Additional information had been provided in terms of the minimum evidence required in terms of meeting the Ockenden recommendations, and the frequency of reporting Serious Incident reports to the Board had been changed, to quarterly, therefore this would be reflected accordingly Mr Wakefield agreed with the move to providing the reports on a quarterly basis and stated that more frequent monitoring of overall Serious Incidents would continue to be provided to the Quality Governance Committee (QGC). **The Trust Board received and noted the action plan.** Mrs Wallis left the meeting.	
9.	**Infection Prevention and Control Board Assurance Framework (BAF)**	
074/2021	Mrs Rhodes highlighted the following: • There had been a change in risk score in relation to BAF 10 regarding fit testing of masks. She stated that an over cautious approach had been provided in terms of increasing the score, but fit testing had started to be included on E Roster • Actions remained ongoing in respect of fit testing and additional equipment had been made available to assist with this • Personal Protective Equipment (PPE) requirements had been reviewed over the past few weeks and the Trust had changed its advice regarding use of goggles, which were not required for those staff who did not have much patient contact Mr Wakefield referred to BAF 3 and compliance with audits and Mrs Rhodes stated that this referred to action regarding antimicrobial stewardship and an issue whereby Pharmacists had been redeployed during Covid. She stated that these Pharmacists had since stepped back into their usual roles and would therefore be undertaking more work in relation to antimicrobial stewardship.	

	Mr Wakefield referred to BAF 8 and access to lab support and queried the progress in terms of MRSA screening. Mrs Rhodes stated that the Trust had continued to adhere to national guidance, and added that the additional screening was over and above the national requirements. She stated that this was being considered as to whether the Trust could go back to providing that service and added that lab capacity was not an issue. Mr Wakefield summarised that 3 risks related to portacount fit testing and queried whether there would be enough equipment to do so. Mrs Rhodes stated that once the testing had been complete it would not be required for another year, therefore the equipment on loan was sufficient for the interim. **The Trust Board received and noted the document, and noted the ongoing work to strengthen the assurance framework going forwards, building upon the recommendations made by the Internal Auditors.**	
ENSURE EFFICIENT USE OF RESOURCES		
10.	**Performance & Finance Committee Assurance Report (20-04-21)**	
075/2021	Mr Akid highlighted the following from the report: • There had been an improvement in urgent care performance which was welcomed • 3 / 8 cancer targets had been achieved and it was noted that the 52 week wait standard would be challenging going forwards given the numbers • In terms of the financial plan, there remained some uncertainty for 2021/22 given the outstanding guidance for last 6 months of the year • A number of positive assurances were provided to the Committee, in relation to data security and protection, the update from the cancer team in terms of actions taken to treat patients according to clinical priority and the positive year-end financial performance • The Committee welcomed the delivery of the capital programme for the year given the large schedule Professor Crowe endorsed the approach to identify future trajectories for monitoring at future meetings. **The Trust Board received and noted the assurance report.**	
11.	**IM&T Strategy Progress Report**	
076/2021	Mr Bostock highlighted the following from the report: • Despite the challenges of Covid, it had also provided an opportunity to fast track some IM&T developments • Some delays had been incurred in terms of Windows 10 upgrade, County phone system replacement, laboratory information management system (LIMS) replacement, electronic patient letters, and EPMA projects but none of the delays had increased the risk to the Trust or exceeded budget • Opportunities included home working, voice over IP, video conferencing, patient electronic consultations, patient booking apps, virtual clinics and the provision of additional iPads and laptops to staff • The Trust was awaiting the go live of a patient entertainment package and the Trust had also started to enable staff to bring in their own device • He highlighted the opportunities going forwards and thanked the staff for their	

	work over the past year and the way in which they had supported the Trust during the pandemic Mr Wakefield echoed the comments made about the IM&T staff and the volume of work undertaken during the year. Professor Crowe welcomed the work undertaken to provide staff with additional equipment, as this was something which could be overlooked. He also welcomed the opportunity going forwards to look at enabling further transformational activities and thanked Mr Bostock for the work undertaken to date. Professor Crowe referred to the slippage associated with EPMA project and queried whether there were any concerns over the delay. Mr Bostock explained that the Trust's development partner, System C, had a good record in terms of their implementation of systems in the NHS. He stated that EPMA would therefore be developed around the Trust and its needs with the main differential being the slower implementation of the roll out. Mr Wakefield referred to bring your own devices and queried what the aim was. He requested additional information to be provided to the Performance and Finance (PAF) Committee in terms of how the scheme worked and associated safeguards. Mr Wakefield referred to the integrated care record and queried the timescales for connecting with the Integrated Care System and enabling the sharing of data. Mr Bostock stated that the record was live and data was being shared with primary care and health and social care providers. He stated that in terms of the next phase, access would be provided to patients supporting personal and population health agendas. **The Trust Board received and noted the update.**	**MB**
ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT AND RESEARCH		
12.	**Transformation and People Committee Assurance Report (21-04-21)**	
077/2021	Professor Crowe highlighted the following: • The Committee welcomed the update from the AMU team and the response provided by the team during the pandemic • The Improving Together programme had continued to progress, alongside the development of the Quality Improvement Academy • Staff wellbeing initiatives had continued • Staff were being supported by introducing agile working and flexible contracts, aimed at helping to address some of the retention challenges • Following a gap analysis of the disciplinary policy, the Trust's policy stood up well when compared with the best practice from Imperial College • Some gaps had been identified in terms of obtaining data to confirm how many staff had been vaccinated, as previously discussed, and this remained a risk in terms of the inability to establish the numbers of staff vaccinated, whilst at the same time supporting those staff who had some hesitancy in having the vaccine, and helping them to make an informed choice Mr Wakefield queried whether it was possible to ask individuals to confirm whether they had been vaccinated or not. Mrs Bullock stated that she hoped a national solution would be provided, and Mrs Vaughan stated that the main challenge was that the NHS had not mandated the vaccine for staff, therefore	

	they do not have to inform the Trust if they have received the vaccine or not. She stated that line managers continued to have discussions with staff as part of their risk assessment process, taking vaccination status into consideration. In addition it was noted that the various national systems were not necessarily joined up and if a GP had provided the vaccination to a member of staff, the Trust would not have permission to see the information being held as this would be classed as patient information. **The Trust Board received and noted the assurance report.**	
13.	**Speaking Up Report – Quarter 4 and Annual Report 2020/21**	
078/2021	Mrs Vaughan highlighted the following: • 31 speaking up contacts had been made during the quarter, of which a significant number related to attitudes and behaviour. There had been a reduction in relation to quality and safety concerns • 2 cases remained open since the previous quarter, demonstrating timeliness of closing cases, with feedback provided when possible in addition to demonstrating any learning • Staff survey feedback had been included and considered • Information had been provided from the national guardians office and additional guidance was expected to be provided during the quarter • Benchmarking information had been included for information • Recommendations had been made in terms of the launch of training and incorporating this into statutory and mandatory training packages Professor Hassell welcomed that the Trust had better than average response in relation to reporting errors, near misses and taking associated action to avoid it from happening again. He referred to the 4 cases reported in terms of recruitment issues and whether there was any commonality with these cases. Mrs Vaughan agreed to request the information from Mrs Lees. Mr Wakefield referred to the incident whereby a doctor wrote to the Guardian in relation to care of patients on the ward and the actions taken. Miss Walsh stated that she expected that this would have been a doctor visiting a patient. Mr Wakefield referred to the benchmarking data and queried what it demonstrated. Mrs Vaughan stated that benchmarking was difficult due to differences in reporting, but given that reporting was be provided through the National Guardian's Office, it had become easier to identify generic themes. **The Trust Board noted the speaking up data and themes raised during Quarter 4 and throughout 2020-21 and the actions proposed to further encourage and promote a culture of speaking up at UHNM.**	RV
ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS		
14.	**Integrated Performance Report – Month 12**	
079/2021	Mrs Rhodes highlighted the following: • There had been some concern raised regarding an increase in the number of patient falls during the pandemic, although these had started to decrease which was positive. She stated that the main areas affected were AMU and FEAU and continued actions were in place to address this, considering the associated the environment	

- The nosocomial rate for March for Stoke was above the national average, but less Covid positive patients were being seen. A number of issues had been identified in relation to routine testing of patients and more scrutiny had been put in place to ensure wards were testing patients on admission as well as on days 4 and 6
- There had been one nosocomial outbreak on Ward 124, none of which were identified as definite and all were being looked after appropriately

Mr Wakefield referred to sepsis screening compliance for children and queried the reasons for the deteriorated performance in March. Mrs Rhodes stated that additional training had been provided to the department and escalated to ward management. Mrs Rhodes agreed to establish the reasons behind the decrease in performance and provide this to the QGC. **MR**

Professor Crowe referred to Covid screening rates and inconsistencies and queried if this was tracked and reported on. Mrs Rhodes stated that this would be taken to QGC for monitoring going forwards. **MR**

Mr Bytheway highlighted the following in terms of urgent care performance:
- Time to triage, time in the Emergency Department and referral to discharge performance had been maintained during March.
- The main challenge was bed occupancy which continued to rise, particularly in the specialised service, major trauma and surgical specialties
- Continued actions were being taken to ensure efficient ward based processes remained in place
- Continued work was being undertaken with primary care to consider the reasons for the rise in ambulatory patients which was in turn affecting performance

Mr Wakefield referred to page 27 and the increase in attendances from the beginning of March, and 4 hour performance worsening since that time and queried whether the workforce was flexible enough to meet demand on a daily basis in order to sustain performance. Mr Bytheway referred to the ECIST review which identified that the workforce was not sufficient to keep up with the pace and this was being considered by a business case. He stated that the Trust had made it clear that if the investment was to be supported, the case needed to clarify the benefits.

Professor Hassell queried the case mix of increased attendances i.e. whether this was due to the return of schools. Mr Bytheway stated that the significant increase was within major trauma and in the main no real theme had been identified, but attendances were related to illness rather than injury.

Mr Bytheway continued:
- MProve ceased work on 30th April and a review was to be undertaken to establish what the support provided in terms of results
- The Trust had not achieved the two week wait standard
- The number of treatments provided in month had increased in line with increased theatre capacity
- The size of overall 62 day backlog and 104 day backlog had reduced, but it was not expected that performance would increase over the next few months due to the aim of treating those patients on the backlog

Mr Wakefield referred to the number of long wait patients and whether these would move into P1/P2 categories. Mr Bytheway stated that only a small amount of patients would not be treated and contact was maintained with those patients

to ensure there had been no change in symptoms. Mr Wakefield welcomed the progress made in terms of cancer performance.

Mr Bytheway referred to planned care and theatre usage which was pushing towards 100% and demonstrated a significant increase in operating capability. In terms of patients outside of the P2 category, the Trust was looking to demonstrate the numbers overdue, in terms of establishing a trajectory to treating those patients. It was noted that the Trust had continued to use the Independent Sector as additional mitigation, as well as increasing the utilisation of County Hospital, with plans being considered to utilise County Hospital 7 days a week. It was noted that the 52 week trajectory was to be provided to the PAF Committee in due course.

Dr Griffin referred to the continuing increase in number of RTT patients and diagnostics performance, and queried whether it was anticipated that numbers would peak, and establish the baseline for trajectories. Mr Bytheway stated that he expected there to be a number of late presenters with cancer and acute illness and it was known that in some cases their condition would be more severe. He added that he did not think the Trust had reached the peak, but he hoped that the trajectories could plan for that.

Mr Bytheway stated that in terms of diagnostics, all modalities were performing well in terms of supporting delivery of DM01, and he was confident that the Trust would return to mid 90% performance once the backlog had been addressed.

Mr Wakefield referred to the number of discharges before midday which were at 19% and queried the actions being taken. Mr Bytheway stated that a high target had been set and although there were days when the Trust reached 26-27 discharges, at a weekend this was more challenged and was part of a specific workstream to improve.

Mrs Vaughan highlighted the following in relation to workforce performance:

- In terms of absence levels these had continued to reduce and performance for March was 4.4%
- Covid related absence had reduced to 9% which was encouraging
- Work had continued on reducing all staff absences and providing staff with the support required to return to the workplace
- Continued support was being provided to staff who required counselling. In addition, group therapy sessions were being put in place, recognising the continued impact of Covid
- Work in relation to recognising domestic abuse was being undertaken
- Staff wellbeing programmes continued to be in place in addition to supporting staff with stress and mental health issues
- There had been an improvement in appraisal performance during March, emphasising conversations and being clear that the previous pause had been lifted
- The Trust had achieved 93.9% in relation to statutory and mandatory training

Professor Crowe reflected on the dashboard and given the key aspects of workforce, whether additional metrics could be included such as wellbeing metrics, vacancy levels etc. Mrs Vaughan agreed to consider this further with Professor Crowe. RV

Mr Oldham highlighted the following in relation to financial performance:

- The Trust delivered £7.9 m surplus at the end of the year, which was subject to change as NHSIE were reviewing some allocations, although it was not

	anticipated that there would be any changes • The Trust had previously forecast a break even position which had moved to surplus driven by a drop in other income which had been recognised and funded centrally • The Trust had spent £1.8 m in month 12 in relation to Covid, which was within the allocation and slightly reduced from month 11 • Additional pension contributions made by employers had been recognised in the accounts with the centre providing the income, in addition, the Trust had received £16.9 m costs associated with the provision of PPE • A small gain had been accounted for in terms of stock which also helped the position • In terms of capital spend, the Trust had spent nearly £67 m investment in the year, with a significant number of schemes delivered which was testament to the capital team and those spending the money • In terms of capital schemes, good progress had been made on the demolition of the Royal Infirmary site and reducing the associated risk, significant IT investment had been made with a number of other purchases to support developments • The cash position remained positive and the balance sheet looked healthy when compared to beginning of 2020/21 **The Trust Board received and noted the performance report.**	
GOVERNANCE		
15.	**Audit Committee Assurance Report (22-04-21)**	
080/2021	Professor Crowe highlighted the following from the report: • The Committee approved a number of policies and supported the outline Internal Audit Plan for 2021/22 • Positive assurance was provided in relation to the preliminary Head of Internal Audit Opinion • A number of reports where significant assurance with minor improvements identified were received, with actions identified to address any gaps • An update from external audit was provided in respect of their audit • The Committee welcomed the strong assurance provided in terms of Committee Effectiveness and the actions being taken to keep the Committees running effectively. It was noted that the Committee was to consider further, who to provide effective cross Committee assurance **The Trust Board received and noted the assurance report.**	
16.	**Board Assurance Framework Q4**	
081/2021	Miss Rylands highlighted a number of areas from her report. Mr Wakefield referred to the actions identified in respect of the development of the Trust wide strategy and queried when this may be concluded. Ms Ashley stated that some of the language used in the Trust's overall 2025Vision was being refreshed and updated in line with some of the conversations held as part of Improving Together. In addition, underneath the overall strategy the clinical strategy would be identified. She stated that in respect of this, a set of dates had been agreed with Divisions to present their clinical service line reviews, with the aim of presenting these to the Board Seminar in July.	**HA/CR**

	Mr Wakefield referred to BAF 6 and BAF 8 and links to the Risk Register which had a mix of scores, with the overall score being higher. He queried why those strategic risks were scored higher than corporately and Miss Rylands stated that work continued to be undertaken with Divisions in terms of reviewing their risk registers to bring them into alignment. Mr Wakefield referred to the action regarding recruitment of overseas nurses which had been identified as complete, but may be impacted due to the delay of recruitment of nurses from India. Professor Crowe referred to the gap between target appetite and current scores and queried the process for refresh and consideration going forwards. Miss Rylands stated that she was to work on this with the Executive Team individually and collectively, to assess individual risk assessments and target risk scores and added that a future Board Seminar was to focus on risk appetite. **The Trust Board scrutinised and approved the Board Assurance Framework.**	
17.	**Committee Effectiveness and Revised Rules of Procedure**	
082/2021	Miss Rylands highlighted the following from the report: • A summary had been provided of the effectiveness reviews which demonstrated a clear broad consensus that the Committees had been effective, despite different ways of working which was positive • Interim terms of reference had been put in place due to the pandemic and the Board needed to formally stand those down and reinstate the formal terms of reference • Due to the overall positivity of the findings, there had been few actions identified for improvement • The Rules of Procedure excluded the Trustee Committee Terms of Reference, as these were to be considered further following discussion at the next Trust Board Seminar Dr Griffin stated that it would be useful to consider any elements of changed ways of working which the Trust would wish to continue i.e. virtual engagement. Miss Rylands referred to the actions being undertaken to look at new ways of working and agree what would continue and the Trust moved towards the 'new normal'. Mr Wakefield referred to the roadmap to normal and if stated that if the Trust moved to mixed physical and virtual meetings, it would need to consider making technological improvements in the Boardroom. It was noted that improvements had already been made to the equipment used in the Trust Boardroom. **The Trust Board noted the outcomes of the self-assessment process, that the annual reports for each Committee had been considered by the respective Committees and that revised Committee Governance Packs had been approved by each Committee, and incorporated within the Rules of Procedure for 2021/22** **The Trust Board approved the revised Rules of Procedure for 2021/22, incorporating the Trust Board Business Cycle and Committee Governance Packs and agreed to reinstate the usual terms of reference.**	
18.	**G6 and FT4 Self-Certification**	
083/2021	Miss Rylands highlighted the following from the report:	

	• The context had been updated to reference the significant change in terms of exiting Financial Special Measures and removal of one of the Care Quality Commission Section 31 notices in relation to the Mental Health Act • The Board needed to consider whether it confirmed or not against each element of the self-certification • The Trust Board had previously confirmed with the statements, other than point 4 of FT4 and not confirmed with G6, on the basis of the Trust's financial position and performance against constitutional targets Mr Wakefield suggested that for FT4 elements 1, 2, 3, 5 and 6 were confirmed. He stated that the Board should not confirmed element 4 of FT4 nor G6, due to the size of the waiting lists and operational performance. The above was agreed, given that the major risks were long waiting lists, that although financial performance had improved, there remained an underlying deficit and system with a huge deficit, in addition to an outstanding Section 31 notice. The Board recognised that it was well governed and there were systems and processes in place. **The Trust Board confirmed with elements 1, 2, 3, 5 and 6 of FT4 Self-Certification. It did not confirm with element 4 of the FT4 document and did not confirm with element 1 of the G6 document.**	
CLOSING MATTERS		
19.	**Review of Meeting Effectiveness and Business Cycle Forward Look**	
084/2021	No further questions were raised.	
20.	**Questions from the Public**	
085/2021	There were no questions raised in advance of the meeting.	
DATE AND TIME OF NEXT MEETING		
21.	Wednesday 9th June 2021, 9.30 am, via MS Teams	

Trust Board (Open)

Post meeting action log as at **28 May 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.	Sharon Wallis	23/06/2021		Action not yet due.	GB
PTB/467	07/04/2021	Infection Prevention and Control Board Assurance Framework (BAF)	To confirm whether actions had been taken to address the issues raised by NHSI in terms of cleaning mobile computers and equipment	Lorraine Whitehead Michelle Rhodes	05/05/2021	28/05/2021	Issue raised with IM&T and nursing team. Further actions identified and reflected within the BAF.	B
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.	Mark Bostock	22/06/2021		Action not yet due.	GB
PTB/471	05/05/2021	Speaking Up Report – Quarter 4 and Annual Report 2020/21	To provide further information to Professor Hassell with regards to the 4 cases which referred to recruitment issues and whether there was any commonality.	Ro Vaughan	17/05/2021	05/05/2021	Complete - information provided to Professor Hassell.	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.	Michelle Rhodes	23/06/2021		Action not yet due.	GB
PTB/473	05/05/2021	Integrated Performance Report – Month 12	To provide ongoing monitoring at QGC of Covid screening rates.	Michelle Rhodes	23/06/2021		Action not yet due.	GB
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		Action not yet due.	GB
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		Action not yet due.	GB

University Hospitals of North Midlands NHS Trust

Chief Executive's Report to the Trust Board

FOR INFORMATION

Part 1: Trust Executive Committee

The Trust Executive Committee met on 2nd 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:

- **Children's Hospital Strategy** draft for comment was presented by the Child Health team relating to the long term future of **Children's and Young People's Services** locally and regionally
- Pockets of **Covid-19** prevalent in local areas and staff were reminded to maintain focus
- **Care Quality Commission** Inspection expected imminently
- **Surplus financial position** achieved at the end of the 2020/21 year
- Regarding the **Independent Sector** contract, there is capacity available and clinicians were encouraged to review waiting lists and identify patients that can be moved across.
- The staff **Health and Wellbeing Plan** has now been finalised
- **HR/OD Plan** for 2021/22 has been issued
- National **OD and People Review** remains on-going
- **Project STAR** and **Market Testing** business cases currently being refreshed and the demolition of the **Royal Infirmary** Site continues at pace
- Work continues on decant solutions for the **Trent Building**
- **iPortal** is being migrated onto new **infrastructure** in June which will improve performance significantly
- **Robotic automation** is being implemented in the Trust with some positive opportunities arising
- A monthly **Staff Voice** tool has been launched to allow staff to provide feedback
- The Trust will be holding a **NHS Tea Party** event on **5th July** through **NHS and UHNM Charities** to raise funds.
- Early stage work has commenced on **Provider Collaboratives**

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 April to 11th May, 5 contract awards, which met this criteria, were made, as follows:

- **Trust High Cost Tariff Devices (REAF 7576)** supplied by NHS SC at a total cost of £14,490,291.08, for the period 01/04/21 - 31/03/22,approved on 05/05/21
- **Elective Hip and Knee (REAF 7575)** supplied by Smith & Nephew at a total cost of £6,419,008.64, for the period 01/04/21 - 31/03/25, providing savings of £501,458.35, approved on 05/05/21
- **LIMS Contract to Shrewsbury and Telford Hospital (SaTH) (REAF 7502)** supplied by Clinisys at a total cost of £3,088,201.00, for the period 01/12/19 - 30/09/29, providing savings of £855,350.00, approved on 05/05/21
- **National Blood Service (REAF 7474)** supplied by NHS Blood and Transplant Service at a total cost of £3,450,000.00, for the period 01/04/21 - 31/03/22, approved on 05/05/21
- **Digital Pathology Sectra MSC (REAF 7255)** supplied by Sectra at a total cost of £3,388,707.00, approved on 05/05/21

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

MRU (Medical Research Unit) Alterations - (eREAF 7654)

Contract Value £1,529,590.40 incl. VAT
Duration Capital Purchase
Supplier Trenton Construction Ltd

Savings - No savings

Cytotoxic Dose Banded - Chemo, Immunotherapy and Mono Medicines - (eREAF 7352)

Contract Value £8,096,209.00 incl. VAT
Duration 03/11/20 - 30/06/21
Supplier Various

Savings - £36,402.07 Negated Inflation

AHP/HSS Master Vendor Contract - (eREAF 7721)

Contract Value £4,500,000.00 incl. VAT
Duration 07/08/21 – 08/08/24
Supplier MAXXIMMA

Savings - £241,000.00 incl. VAT

Independent Sector Contract with Ramsay Healthcare – (eREAF 7571)

Contract Value £3,180,000.00
Duration 01/04/021 - 30/09/21
Supplier Ramsay Healthcare

Savings – No savings

Independent Sector Contract with Nuffield Health – (eREAF 7569)

Contract Value £4,980,000.00 incl. VAT
Duration 01/04/021 - 30/09/21
Supplier Nuffield Health

Savings – No savings

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 May 2021:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Clinical Lead Specialised – Plastic Surgery	Vacancy	Yes	07/05/2021
Clinical Lead Specialised – Plastic Surgery	Vacancy	Yes	07/05/2021
Clinical Lead Specialised – OMF	Vacancy	Yes	24/05/2021
Clinical Lead Specialised – ENT	Vacancy	Yes	01/06/2021
Clinical Lead Specialised – Ophthalmology	Vacancy	Yes	01/05/2021
Clinical Lead Specialised – Restorative Dentistry	Vacancy	Yes	30/04/2021
Clinical Lead Specialised – Dermatology	Vacancy	Yes	04/05/2021
Clinical Lead Specialised – Orthodontics	Vacancy	Yes	06/05/2021
Guardian of Safe Working	Vacancy	Yes	01/06/2021
Locum Consultant Neurosurgeon	Vacancy	Yes	28/06/2021
General Paediatric Consultant	Vacancy	Yes	TBC
General Paediatric Consultant	Vacancy	Yes	TBC

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

Post Title	Reason for advertising	Start Date
Clinical Lead Specialised – Plastic Surgery	Vacancy	07/05/2021
Clinical Lead Specialised – Plastic Surgery	Vacancy	07/05/2021
Clinical Lead Specialised – OMF	Vacancy	24/05/2021
Clinical Lead Specialised – Ophthalmology	Vacancy	01/05/2021
Clinical Lead Specialised – Restorative Dentistry	Vacancy	30/04/2021
Clinical Lead Specialised – Dermatology	Vacancy	04/05/2021
Clinical Lead Specialised – Orthodontics	Vacancy	06/05/2021
Acting Up Consultant Gastroenterologist	Vacancy	01/05/2021
Locum Orthodontic Consultant	Retire and Return	03/05/2021
Locum Consultant Neurologist	Extension	11/05/2021
Locum Consultant in General Surgery with interest in Colorectal Surgery	Vacancy	17/05/2021
MOD Consultant in Emergency Medicine	Vacancy	17/05/2021

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

Post Title	Closing Date	Note
Locum Consultant Clinical/Medical Oncologist	11/05/2021	No applications
Consultant Microbiologist	20/05/2021	No applications

3. Covid 19

As we ease out of lockdown we increase our focus on recovering our elective services. Thanks to all of our staff and their hard work we are doing extremely well and we were particularly praised by NHSE/I Regional team during our system planning meeting on the 1st June 2021. UHNM was described as 'punching above our weight' and although pleased with our progress we have a shared concern around maintaining progress throughout winter and our plans around urgent care were discussed in detail. Whilst acknowledging we are making good progress we are by no means complacent and recognise that we still have a lot to do to get our waiting lists near pre-Covid levels. Our priority will be to ensure our patients are seen as soon as possible and to support this we are looking at how we can maximise the use of County Hospital by increasing the clinical services which are delivered at Stafford and by continuing the very many of the services we moved to Stafford during Covid-19.

4. International Recognition

Our very own radiology cardiac CT team have been commended internationally for quickly reducing the number of people waiting for scans delayed due to the pandemic. Heart Care Company 'HeartFlow, Inc.' have been working in partnership with clinicians at UHNM to provide the potentially life-saving diagnostic tool HeartFlow Analysis. The company singled out our teams and commended them for their dedication and commitment. They are one of many teams working at UHNM going above and beyond to tackle the backlog of patients waiting as a result of the pandemic.

Additionally, we are using technology (robots) and working differently to help patients book X-ray appointments. This pioneering automated process enables our patients to select their own X-ray appointments with the robot mimicking human actions and sending a short text message to the patient's mobile phone with a unique web browser link where they can select their preferred imaging location and date and time for an appointment.

5. Quarterly System Review

On the 13th May 2021 we had our routine quarterly system review meeting with NHS England / Improvement. This was a positive meeting whilst recognising some of the challenges that lay ahead:

- The meeting was opened by acknowledging the good 14 months we have had in terms of managing Covid19 well.
- They were especially pleased with the mutual aid we provided to other Trusts in relation to critical care, neurosurgery, complex spinal and thoracic surgery.
- They acknowledged that our system vaccination programme had been managed really well
- The CCG vote had successfully concluded,
- The ICS had been approved and was up and running

Some of the challenges we discussed were:

- Workforce and well-being of staff
- Urgent care, the significant increase in ED attendances and how we maintain flow over winter along with the elective recovery
- The on-going closure of FMBU at County Hospital
- Refining our financial long term plan

6. Our Thanks to Leisure Centre Staff

We were able to take time out to thank the extraordinary people from Stoke City Council who volunteered selflessly to work in our Critical Care Unit earlier this year. A few of us attended a small event to present volunteers with much deserved certificates and honorary UHNM family Covid-19 badges. Their offer of support and remarkable work ethic provided not just extra hands but demonstrated solidarity, partnership and compassion for both our patients and our own teams at a time when it was really needed. It was great

to hear from some of them about how welcome they had been made to feel and that it was a period in their life they would never forget.

7. World Facilities Management (FM) Day

Our Estates, Facilities and PFI Division were invited to participate on an expert panel for a Global Event to celebrate World Facilities Management (FM) Day and encourage improved gender balance and attracting more women into FM roles. The webinar, held on 12th May 2021, was attended by 100s of people from around the world.

This year's theme for World FM Day was 'Celebrating FM: standing tall beyond the pandemic'. A tribute to a sector that became highly visible due to its crucial role in controlling the pandemic. Staff from UHNM's FM services went above and beyond in so many ways during the pandemic to ensure we could continue to provide high quality safe patient care, whether that is the cleaners, the porters or the estates staff. There are too many staff groups to mention but all did an amazing job and World FM Day was a great way to recognise this.

8. Strategy Development

The executive team is also now beginning to address the long term use and development of our hospital services and we are talking more about strategy and where we want to be in the future. In particular, the Children's Hospital of Royal Stoke was officially launched at the very start of the pandemic but all future plans were delayed as a result of Covid. Therefore it was great to have the Children's Hospital strategy presented to our Executive meeting before it goes to our Trust Executive Committee and Board and we all look forward to seeing how these exciting plans develop. Next will be the diagnostics and adult critical care strategies and I will ensure you get to hear more about all the plans over the coming months.

9. Chief Executive's Awards

One of the highlights of my job is being able to present my personal award to staff members who have gone above and beyond. Therefore, I was delighted to present the Chief Executive's Award to Brijesh Patel, Consultant in Emergency Medicine and Michelle Le'Queux, Business Manager for their role in delivering the roll out of a vital communications system – Vocera, in the Emergency Department. The kit was funded from the grant to UHNM Charity from the Denise Coates Foundation and my award was given for their work in setting the system up and training staff to improve efficiencies in the way the department delivers patient care, improve staff morale and most importantly, provide safer patient care. I was delighted to see it in action and get to use the technology and I am very keen to see what the possibilities are for its wider use in our hospitals. My thanks again go to the Denise Coates Foundation for their very generous donation that has made this initiative possible.

I was also able to present newly qualified scrub nurse Riya Muthu-Kandathil with an award for her contribution and help to support the upcoming delegation of international nurses. Riya, originally from Kerala, India has volunteered her own time to take part in videos which will help recruits prepare for their OSCEs (Objective Structured Clinical Examinations). I had seen her films but it was great to meet her, hear her story and personally thank her for her efforts. Whilst due to the events in India, the arrival of some of our Indian Nurses has been delayed but none of Riya's efforts will have been wasted.

10. Celebrating our Staff

We have celebrated a number of groups of staff such as our nursing teams and ODP's in national awareness days and it was lovely to be part of some of these celebrations and to see our staff get into the spirit also. All of our staff deserve to be recognised, appreciated and valued and this is another reason why I am excited about the roll out of our quality improvement programme 'Improving Together'. Patients can only be made our number one priority if we focus on our staff and ensure that they feel valued and developed and the launch of our programme is all about those things. I was pleased to be able to join two

QI training sessions, one with the first cohort of clinical areas and the second with managers and it was great to hear the enthusiasm from those who are passionate about putting our patients first.

11. Recognition of all Staff by Newcastle-under-Lyme Borough Council

We were thrilled to receive news that all of our amazing staff have been recognised for their dedication and tireless efforts during the pandemic by being granted the Freedom of the Borough by Newcastle-under-Lyme Borough Council. During the last 18 months our council colleagues, all our local NHS partners and our local communities have offered support and been so generous to our UHNM family and we are of course truly grateful to receive this honour on behalf of everyone.

In addition the work of our UHNM Charity has been recognised with the newly appointed Lord Mayor for the city of Stoke-on-Trent, Councillor Chandra Kanneganti, a senior partner at Goldenhill Medical Centre and councillor for Goldenhill and Sandyford, choosing us as one of his chosen charities. We are looking forward to working with the Lord Mayor over the coming year.

12. Learning and Development

To support learning and development of our staff, with our local NHS partners, we have joined the West Midlands Employers Coaching and Mentoring Pool and as part of International Coaching Week, staff will be able to access a coach or mentor, providing a unique opportunity to focus on development goals within a professional and confidential setting.

13. Staff Wellbeing

The safety and wellbeing of our staff and teams is a key priority for us and during the month, with our NHS and local authority partners in Staffordshire and Stoke-on-Trent we launched the Staff Psychological and Wellbeing Hub, providing essential health and support to all staff system wide. This is about the offer that we provide to our UHNM family direct and the additional support given by our Chaplaincy, Pastoral and Spiritual Team.

14. Goodbye to Michelle Rhodes, Chief Nurse

I was extremely saddened to see Michelle Rhodes, Chief Nurse, leave us this month and would like to acknowledge the fantastic work she has done for UHNM in her brief time with our family. Her 17 years' experience as a director, her dedication, professionalism and her unfailing humour have made a huge difference to all we do at Royal Stoke and County Hospitals and she will be missed greatly.

Scott Purser, our Deputy Chief Nurse will be the interim Chief Nurse until Ann-Marie Riley joins us on 1st July and I know that we will be safe in his hands.

We also continue with our plans to recruit to the Medical Director role in readiness for John Oxtoby leaving us in September. The vacancy is currently out to advert and this closed at the end of May with an excellent field of candidates. The recruitment process continues and will conclude with interviews on 25th June.

15. Financial Special Measures

Whilst somewhat delayed due to the pandemic, I was delighted to finally receive formal notification from NHS England / Improvement that we are no longer subject to Financial Special Measures. Whilst we have been aware of this new for some time, it was great to see it in black and white and it gave me another opportunity to thank our staff for all of their hard work and commitment in delivering this.

16. Captain Sir Tom Legacy 100 Challenge

Thank you to everyone who joined the Captain Sir Tom Legacy 100 challenge. Many of our staff took on challenges to raise money for our UHNM Charity, from counting steps to cycling. The Executive Team and I all took part in the challenge by squeezing 100 visits to teams and departments across both hospitals during the week which we all thoroughly enjoyed. I spent some time in the head and neck department during an outpatients clinic and was delighted to join a surgeon, clinical oncologist, plastic surgeons, nurse specialists and the prosthetics team and to witness their passion and enthusiasm for providing the best care to our patients. In particular, it was fascinating to see the remarkable things the prosthetics team were doing to preserve the features of the face to support surgeons undertaking radical and major surgery.

17. Staffordshire University Arts Project

The month also saw the launch of a unique arts project in partnership with the Staffordshire University. We asked students to capture a snapshot of the old Royal Infirmary heritage that supports a positive memory for staff, patients, visitors and local residents alike and one which is underpinned by a sustainable theme celebrating the rich history of the hospital and its contributions to the region. Demolition works of the site commenced early last year and prior to that, Staffordshire University Archaeological team completed a digital, laser-mapped, 3D photographic model of the site prior to works commencing for future record and use, which was made available for the students. The students formed three teams and throughout the week took time to talk to staff and research into our long and impressive heritage. The judges faced a difficult decision but after much deliberation chose the winning team who came up with the idea of creating a walkway onsite which combines both our history and the future. We are now looking forward to working with the winning students on making this a reality for our staff, patients and visitors to enjoy.

Quality and Governance Committee Chair's Highlight Report to Board

27th May 2021

1. Highlight Report

Matters of Concern or Key Risks to Escalate

- Concern raised that there was investment into Maternity Services which had anticipated improvements in **Caesarean Section** performance although this had not been seen and the dashboard demonstrated a rise with electives surpassing emergencies; an explanation was given although the Committee will continue to monitor
- Gap Analysis into **Sharps Regulations** has identified some gaps in compliance; the Head of Health & Safety is working with the Procurement team to introduce safer sharps where possible and is ensuring that up to date risk assessments are in place where appropriate
- HSE Gap Analysis has identified some gaps in terms of risk assessment documentation and cleaning and hygiene in non-clinical areas; an action plan is in place to address these gaps
- Investigation into the use of Cytotoxic Drugs undertaken. It was noted that a 'closed system' had now been implemented and a number of steps were being taken to ensure sustained improvements with the risk assessment process.
- There will be a 9 month delay with the implementation of **Electronic Prescribing and Medicines Administration System**
- An investigation into incidents identified within the Cardiothoracic Department has been undertaken and RCA investigations continue, and a risk summit is planned.
- Grade 4 **Pressure Ulcer** has been reported and further information will be included in the next report
- There were 44 **Serious Incidents** reported during Quarter 4 – these were summarised

Major Actions Commissioned / Work Underway

- Advice was sought by the Non-Executive Directors in terms of the questions they should be asking in relation to **Caesarean Sections**; it was noted that this was subject to national discussion and was recognised that patient outcomes were likely to be a more appropriate measure of patient safety
- Committee sought clarification on the varying roles of **MBRACE / NHSR** etc.as detailed within the Maternity Reports – a breakdown was agreed to be circulated
- **HSE Gap Analysis** to be updated / monitored on a monthly basis and presented to the Executive Health & Safety Committee
- Further assurance associated with the Health and Safety **Risk Assessment** process to be provided to the Committee on a regular basis
- HSIB have issued a number of findings and recommendations associated with **NG Tube placement** – an action plan has been developed and is being worked through, this also takes into account actions identified by the Coroner in a Regulation 28 Letter following a recent inquest – noted that due dates / progress needs to be included in future updates along with audit findings
- Deep Dive being undertaken into slight increased observed in relation to **patient falls**
- Update on progress with surgical division review of **mortality rates** to be shared with the Committee at the next meeting
- **Care Quality Commission** action plans remain under review to ensure effective implementation
- Effectiveness Review of the **Quality and Safety Oversight Group** is being planned

Positive Assurances to Provide

- Positive **staff story** shared with Committee regarding a member of staff and her experience of using the RITA system with a patient suffering with extreme anxiety having received some bad news; the Committee were pleased to hear the positive impact on the patient
- In Quarter 4, there were 6 **perinatal case reviews** and 100% compliance was achieved against all 4 standards
- Maternity Services taking steps to ensure that all of their **patient information** is accessible in a variety of languages
- Further analysis into **sharps Incidents** has identified that there were no themes and numbers of incidents have now started to reduce with the majority of cases resulting in Low Harm

Decisions Made

- Approval of the **Clinical Audit Programme** for 2021 / 2011
- Approval of the draft **Quality Account** although it was recognised that it would be further developed ahead of Board approval

- A number of actions including comprehensive **Risk Assessment** have been undertaken associated with BD Pumps; there have been no microbiology incidents reported and the Committee were assured that the matter is now close to resolution
- **Research activity** has been reviewed, re-organised and restarted following a Covid related pause
- **Family Liaison Service** has been extremely valuable to patients during Covid with positive feedback highlighted within the Patient Experience Report

Comments on the Effectiveness of the Meeting

- Really full agenda although agreed that there was sufficient time to discuss all of the key issues
- Agreed to give the Research and Innovation item more time at the next meeting

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Executive Directors Update including Covid-19	Information	11.	M1 Quality and Safety Report	Assurance
2.	Staff Story – RITA	Information	12.	Serious Incident Summary (Quarter 4 2020/21)	Assurance
3.	Q4 Maternity Dashboard	Assurance	13.	Electronic Prescribing and Medicines Administration Project Update and Next Steps	Information
4.	Perinatal Mortality Report	Assurance	14.	Research and Innovation Update	Assurance
5.	Sharps Incidents Update	Assurance	15.	Clinical Audit Programme 2021/22	Approval
6.	HSE Gap Analysis	Assurance	16.	Care Quality Commission Inspection / Actions Update	Assurance
7.	Cytotoxic Investigation Outcome	Assurance	17.	Q4 Patient Experience Report 2020/21	Assurance
8.	BD Pump Consumables Update	Assurance	18.	Draft Quality Account	Assurance
9.	Cardiothoracic Incidents Update	Assurance	19.	Executive Health & Safety Group Highlight Report and Quality and Safety Oversight Group Highlight Report	Assurance
10.	NG Tubes Update / Action Plan	Assurance	20.	Review of Meeting Effectiveness, Business Cycle and Items for Escalation to Trust Board / Audit Committee	Information

3. 2021 / 22 Attendance Matrix

			Attended	Apologies & Deputy Sent	Apologies

Members:			A	M	J	J	A	S	O	N	D	J	F	M
Prof A Hassell	AH	Associate Non-Executive Director												
Ms S Belfield	SB	Non-Executive Director (Chair)												
Mr P Bytheway	PB	Chief Operating Officer												
Mr J Maxwell	JM	Head of Quality, Safety & Compliance												
Dr K Maddock	KM	Non-Executive Director												
Dr J Oxtoby	JO	Medical Director		MP										
Mrs M Rhodes	MR	Chief Nurse		SP										

Miss C Rylands	CR	Associate Director of Corporate Governance	
Mrs R Vaughan	RV	Director of Human Resources	

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	9th June 2021
Report Title:	Infection Prevention Board Assurance Framework	**Agenda Item:**	8
Author:	Helen Bucior, Infection Prevention Lead Nurse Emyr Philips , Associate Chief Nurse Infection Prevention/Deputy DIPC Claire Rylands, Associate Director of Corporate Governance		
Executive Lead:	Scott Purser, Interim 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

- There continue to be a number of systems, processes and controls in place; however evidence of assurance monitoring has demonstrated some gaps which will be addressed through the action plans.
- Amber Action :Computer of Wheels : Cleaning the inside of box that contains the hard drive, awaiting exec decision
- Amber Action : 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 two changes in risk score since previously reported; in relation to BAF 3 and BAF 10, these risk scores have decreased.

Progress

- Portacount fit test systems; Portacount machine and mask fit tester (on loan for 3 months) obtained by Infection Prevention Team via DHSC National test support team. The portacount is a quantitative test and uses specialised equipment to measure exactly how much air is leaking through the seal of a FFP3 mask. This will enable testing of staff who have been unable to taste Bitrex solution and therefore not able to be fitted using the current hood system. The tester is also providing extra support to areas to switch from 3m FFP3 masks.
- Head of Health and Safety Head continue with Portacount business case. Portacount also has the capability of collecting mask fit test information
- 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
- Appropriate antimicrobial use : escalation protocol now in place
- 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 forwards, building upon the recommendations made by the Internal Auditors.

NHS
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	Mod 6			→
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 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	• 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		
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 practice of staff adherence to hand hygiene?	• 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 • Link to Public Health England donning and	• 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 • Cascade training records	• 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**
	• 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	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 - Clinical (2).pdf	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 communicated to staff in a timely way.	• Notifications from NHS to Chief nurse/CEO • IP team COVID lead checks Public Health England webpage daily (Monday-Friday) for updates • Changes raised at -19 clinical groups which was held originally twice weekly,	• 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**
		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 meet weekly • Tactical group – The tactical Group held daily. April 2021 now stepped down. The Group decide and agreed tactical actions Makes recommendations to Gold command • Chief nurse updates • Changes/update to staff are included in weekly Facebook live sessions • COVID -19 intranet page • COVID -19 daily bulletin with updates • IP provide daily support calls to the clinical areas		
1.6	Changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted.	• Incidence Control Centre (ICC) Governance • Clinical Group, Divisional cells, Workforce Bureau, Recovery cells subgroup feed in to tactical group. • COVID Gold command , decisions /Assurance reported to Trust Board Via CEO Report/COO	• Meeting Action log held by emergency planning • Trust Executive Group Gold command – Overall decision making and escalation • Tactical, Operational Delivery Group - The delivery of the objectives and benefits, and	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
			programme 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 infection Prevention measures  COVID19RRGOVERNANCE NOV20v1.pptx	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
1.7	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	
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	• MRSA screening compliance • Monthly Sepsis Compliance audits. Screening compliance for sepsis and time to antibiotics for Red	

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 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	flag patients • IP audits • Infection Prevention Health care associated infection report, including submitted to monthly to Quality and Safety. • Submission of Infection figures to Public Health England. Clostridium difficile, MRSA blood stream infections (bacteraemia) and Gram Negative blood stream infections • Seasonal influenza reporting • Audit programme for proud to care booklets	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 4 Progress Report	BRAG
1.	1.1	Up- to- date COVID -19 Divisional pathways	ACN's	30/09/2020	Associate Chief Nurse contacted and request made for COVID -19 pathways 28th July 2020. ED pathways in place and also County to Royal transfer of COVID positive patients. Divisional restoration plans in progress	Complete
2	1.1	Revised pathways to include actions for extremely vulnerable patients who are admitted into the Trust	ACN's	31/10/2020	4th September Chief Nurse DIPC request at senior meeting that extremely vulnerable patients are included in revised pathways. October 2020 Extremely vulnerable patient recommendations included into the COVID ward round guidance document. November 2020 – Confirmation from ED County highly vulnerable patients are admitted into single cubicle.	Complete

					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	Testing and re testing, Interpretation of swabs and step down of IP precaution process in place at UHNM. Suspected or positive patients are moved on clinical need/assessment and in line with UHNM step down process. For patients who test negative on admission re screening is undertaken. 17th November NHSI guidance recommended that the second test is taken on day 3 after admission and day 5-7 after admission. Implementation of the new guidance is underway and a manual prompt is provided to the clinical areas. (Days 4 and 6 admission day counted as day 1). Waiting for 2 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 May 2021 Day 15 and weekly rescreens introduced	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 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.	On track

					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	
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	Complete

					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.	
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 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>	complete

					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	2			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	6				Risk Level:	3	

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
2.2	Designated cleaning teams with appropriate training in required techniques and use of PPE are assigned to Covid-19 isolation or cohort areas. Assurance processes are in place for monitoring and sign off terminal cleans as part of outbreak management	• SOP and cleaning method statements for domestic teams/Sodexo • PPE education for Domestic /Sodexo staff • Initial meetings held with facilities/estates to discuss and plan COVID-19 requirements IP agenda item • Representatives from the division are attending the daily tactical meetings, and an E,F & PFI daily meeting is taking place which includes our partners • 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		
	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 Feb 2021.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	Problematic – revised target date

					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 chief nurse to present to execs Further information send , awaiting Exec decision	
4	2.8	All high touch surfaces and items are decontaminated multiple times every day – once or twice a day is insufficient. • Electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily. • Cleaning of communal toilets after each use inpatient areas – Letter -CEM/CMO /2020/043 24TH December 2020	Head of CPM Estates, Facilities & PFI Division IP Team	30/04/2021	To revisit high touch points protocol to check frequency of clean for area that area not on barrier cleans – computers , mobile phones, keyboards Cleaning of communal toilets after each use inpatient areas – Letter -CEM/CMO /2020/043 24TH December 2020. This letter was raised at IPCC 25/01/2021. 16th February Meeting with IP & Facilities colleagues to discuss the NHS/NHSE/PHE facilities cleaning requests in line with COVID 19 – letter CEM/CMO 24th December 2020 Hefma network Responses/Scoping exercise completed Trust position work in progress. Paper to next March IPCC Additional cleaning resource in place for ED Royal Stoke and overnight at County this requirement has been extended for a further 3 months	Complete

					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	• 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)	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		• 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 • Monthly review of antimicrobial consumption undertaken by AMS team. Available online at UHNM	• Meeting minutes reviewed and actions followed up • Real time discussions / requests for support / advice enabled via regional and national social media accounts. National (incl. PHE) thought leaders members • Trust and commissioners require timely reporting on compliance with AMS CQUIN targets. • Wards showing deviation from targets are followed up by targeted AMS team ward reviews 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	• 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	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		follow up concerns each quarter. Currently suspended.	vs AMS CQUINS, Currently suspended.	

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

					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.	

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	
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 blue wards or single rooms or COVID 19	• 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
		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 • SOP and training for use of air	• 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
		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 (Sundstrom))	• SOP 's available on Trust intranet • Training logs held divisionally for air powered systems • IP training log for air powered systems key trainers and distribution of reusable FFP3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
			masks (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 withactions in place to mitigate any identified risk.	• PPE Audits • PPE volume use discussed at tactical COVID-19 Group	• Spot audits completed by IP team	
6.7	Staff regularly undertake hand hygiene and observe standard infection control precautions. Linked NHSIE Key Action 1: Staff consistently practices good hand hygiene.	• Hand hygiene requirements set out in the infection prevention Questions and Answers manual • Poster for hand hygiene technique displayed at hand wash sinks and stickers on hand soap and alcohol dispensers • Alcohol gel availability at the point of care	• Monthly hand hygiene audits completed by the clinical areas • Infection Prevention hand hygiene audit programme. Overview of results fed into infection Prevention committee • Independent hand hygiene audits completed by IP Senior Health Care	
6.8	Hygiene facilities (IP measures) and messaging are available for all • Hand hygiene facilities including instructional posters • Good respiratory hygiene measures • Staff maintain physical distancing of 2 metres wherever possible in the workplace unless wearing PPE as part of direct care	• 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 uniforms home available for	• Clinical areas to monitor • Reports of member of public reporting sighting of staff in uniform	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		staff • Communications /daily bulletin to remind staff not to travel to and from work in uniforms		
6.10	All staff understand the symptoms of Covid-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household displays any of the symptoms.	• For any new absences employee should open and close their usual absence via Empactis system • Symptom Advice available on Trust intranet	• Cluster /outbreak investigations	
6.11	All staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE and other national guidance if they or a member of their household display any of the symptoms	• Communication /documents • Reminders on COVID bulletins Trust intranet • Staff Lateral flow testing	• Cluster /outbreak investigations	
6.12	A rapid and continued response through on- going surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patient/individuals)	• ICNET surveillance system • Reports • Trust wide daily COVID Dashboard/report • COVID -19 Tactical daily • briefing	• COVID Dashboard • COVID -19 Tactical daily briefing • COVID 19 Gold update slides	
6.13	Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	• ICNet surveillance system • Reports • 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 testing certificate must also continue to be completed and filed	On Track

					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	
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	2			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
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	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
10.2	Staff required to wear FFP3 reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally Staff who carryout fit testing training are trained and competent to do so All staff required to wear an FFP respirator have been fit tested for the model being used and this should be 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	• Mask fit strategy in place • Mask fit education pack • SOP for reusable face masks and respiratory hoods in place • PHE guidance followed for the use of RPE • PPE poster available on the intranet • Training records held locally • Fit testers throughout the Trust • Complete and issue Qualitative Face Fit Test Certificate	• Training records for reusable masks • Training records held locally • Mask fit option now available on Health Rostering to record mask type and date	• Availability of locally held training records.

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board			
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	• 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
		Bulletin		
10.5	Consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas.	• Social distancing tool kit • Staff encouraged to keep to 2 metre rule during breaks • Purpose build rooms for staff breaks in progress	• Social distance monitor walk rounds • Social distance posters identify how many people allowed at one time in each room	
10.6	Staff absence and wellbeing are monitored and staff who are self-isolating are supported and able to access testing.	• Team Prevent available to offer guidance and treatment to staff presenting with onset of symptoms.	• Team prevent monitoring process • Work force bureau	
10.7	Staff who test positive have adequate information and support to aid their recovery and return to work.	• Team Prevent available to offer guidance and treatment to staff presenting with onset of symptoms. • Empactis line will first ask – is the absence related to coronavirus. To which the employee must say yes or no • Once the absence is reported to the employees manger via email, the manager will categorise the absence type specified in the flow chart. • Team prevent complete COVID 19 staff screening • Areas where transmission has occurred are discussed at clinical group and relevant staff screening under an ILOG number is agreed. • Flow charts or staff returning to work available on COVID 19 section 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	On Track

					re fit frequency <u>May 2021</u> FFP3 cascade mask fit refresher in progress. This refresher includes checking that fitters are aware of e rostering and the need to file test certificate in staff members personal folder	

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:	9th June 2021
Report Title:	UHNM Quality Account 2020/2021	Agenda Item:	9
Author:	Head of Quality, Safety & Compliance Department		
Executive Lead:	Chief Nurse		

Purpose of Report:					
Assurance		Approval	✓	Information	

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

Summary of other meetings presented to and outcome of discussion:

Quality Governance Committee – approved the draft Quality Account pending final agreement at Trust Board and inclusion of External Stakeholder comments to be received by 28th June 2021 prior to inclusion for final publication on 30th June 2021.

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

The attached is the latest version Trust's annual Quality Account. The Quality Account summarises activity during 2020/21. The content of the Quality Account is defined by the Quality Accounts letter 2019/20 issued by NHS Improvement and the NHS Quality Accounts Guidance which continues to apply. Noted NHS providers are no longer expected to obtain assurance from their external auditor on their Quality Account for 2020/21.

The Quality Governance Committee reviewed and approved the draft account and priorities on 27th May 2021. Trusts were notified on 30th April 2021 that the DHSC had decided that the changes in publication dates for the 2019/20 Quality Accounts as result of the COVID-19 pandemic were not being extended for 2020/2021.

The Quality Account has been shared with external stakeholders for completion and return of the final Stakeholder comments by 28th June 2021, from Clinical Commissioning Groups, Overview & Scrutiny Committees of both Stoke-on-Trent City Council and Staffordshire County Council and Healthwatch. The final account including the stakeholder comments will be published by 30th June 2021.

Part A of the Quality Account provides summary of Strategic Objectives, Quality Priorities and Objectives for 2020/21 and how these will be measured and monitored, participation in clinical audit programmes, clinical research participation, data quality results and Information Governance Toolkit attainment levels.

Our overall goal is to support our staff to get it right first time, every time for our patients.

The identified priorities for 2021/22, and agreed at Trust Executive level, are:

To continue to improve safe care and treatment to patients

How will we do this:

- Improve sepsis treatment and recognition of deteriorating patients
- To evaluate and reduce long waiters following the COVID-19 pandemic
- To support the Recovery & Restoration Plan across the health economy
- Ensure that services follow appropriate infection prevention guidance and continue to be COVID secure
- Aim to reduce harm from patient falls and hospital acquired pressure damage by further 10% from 2019/2020 baseline
- Evaluate and introduce new technologies and techniques for treating patients.
- Improve the number of reported medication errors
- Delivering the Improving Together Programme

To improve staff engagement and well being following COVID-19 pandemic

How will we do this:

- To support the introduction of the Trust's Wellbeing Programme and activities that focus on staff wellbeing and empowerment
- Ensure that staff are working within COVID secure environments and support provided to staff
- Support staff and services in providing care in 'new ways' following COVID
- Promote mental health wellbeing and support
- Delivering the Improving Together Programme
- Introduction of Shared Governance

To improve patient experience

How will we do this:

- Utilise patient and visitor feedback
- Seek wider engagement with 'harder to reach' patient groups
- Review patients experiences during COVID and identify positive changes to adapt service provisions
- Review the different ways that patient experience and views are gathered and acted upon within UHNM

Part B of the account reviews the Trust's Quality Performance for 2020/21 against the priorities that were identified last year. These include both local and national results and how the indicators compare against the initial targets that had been set at the start of 2020/21.

Part C is currently awaiting completion as the stakeholder comments and will not be ready for inclusion until after 28th June 2021 due to stakeholders having 30 days consultation period.

Key Recommendations:

The Trust Board is asked to:

- To note the latest Quality Account 2020/2021 along with the quality priorities for 2021/22 and links to existing Trust aims and objectives
- To recommend approval prior to final Stakeholder comments being included
- To recommend final publication by 30th June 2021

NHS
University Hospitals of North Midlands
NHS Trust

Quality Account

2020 / 2021

CONTENTS

Part A: Statement on Quality

OVERVIEW

1. Introduction to UHNM

Welcome to the Quality Account for the University Hospitals of North Midlands NHS Trust (UHNM) for 2020/21. As we review the last 12 months and consider our priorities for the year ahead, we reflect on the impact the COVID-19 pandemic has had on our hospitals, our staff and our patients. This will be long lasting and will require a fundamental shift in how we provide care.

During the last year we did all we could to continue care for all our patients, including transferring planned surgery and treatments to other providers and private hospitals less impacted by COVID-19; transforming our outpatient appointments into telephone and video consultations and introducing a family support service to help provide essential communication between families and patients while visiting restrictions were in place. Despite the challenges we have faced, we have made great progress in improving our services for our patients and local communities, while making every effort to keep them safe and receive the best possible experience.

Our staff have adapted and shown resilience under extreme pressure and acted with compassion and professionalism and it is hoped this report serves as an open and honest account of where we have moved forward both as a result of and despite the pandemic and where we still have further improvements to make.

We are committed to providing safe, high quality care to our communities and we continue to focus on delivering quality improvement in all we do.

University Hospitals of North Midlands NHS Trust was formed in November 2014 following the integration of University Hospital of North Staffordshire NHS Trust and Mid Staffordshire NHS Foundation Trust. We have two hospitals, Royal Stoke University Hospital and County Hospital, and we are very proud of both.

We are a large, modern Trust in Staffordshire, providing services in state of the art facilities. We provide a full range of general hospital services for approximately 900,000 people locally in Staffordshire, South Cheshire and Shropshire. We employ around 11,000 members of staff and we provide specialised services for a population of three

million, including neighbouring counties and North Wales.

We are one of the largest hospitals in the West Midlands and have one of the busiest Emergency Departments in the country, with an average of nearly 15,000 patients attending each month across both of our sites. Many emergency patients are brought to us from a wide area by both helicopter and land ambulance because of our Major Trauma Centre status; as we are the specialist centre for the North Midlands and North Wales.

As a University Hospital, we work very closely with our partners at Keele and Staffordshire University and we are particularly proud of our medical school, which has an excellent reputation. We also have strong links with local schools and colleges. As a major teaching Trust, we hold a large portfolio of commercial research, which provides us with a source of income. Our research profile also enables us to attract and retain high quality staff.

Our specialised services include cancer diagnosis and treatment, cardiothoracic surgery, neurosurgery, renal and dialysis services, neonatal intensive care, paediatric intensive care, trauma, respiratory conditions, spinal surgery, upper gastro-intestinal surgery, complex orthopaedic surgery and laparoscopic surgery.

Royal Stoke University Hospital

The County Hospital (Stafford)

We are a key player in the Staffordshire Sustainability and Transformation Partnership (STP) and take an active part in the planning and discussions. The health economy plan remains focused on minimising admissions to and discharging as soon as possible from the major acute site at Royal Stoke University's Hospital (RSUH), with as much care as possible is being delivered in community settings or at County Hospital (CH).

We benefit from being able to attract and retain high quality staff. In order to do this we need to continue to maintain and expand our tertiary capabilities to service the populations of the north west Midlands, Derbyshire, Wales, south Manchester and the northern suburbs of Birmingham.

2. Statement on Quality

We are proud to say that University Hospital of North Midlands NHS Trust continues to show commitment of our staff to improve the quality, safety and experience of patients in our care. We will continue to achieve this by our staff understanding their role and empowering and equipping them towards delivering excellence every day resulting in improved patient outcomes, staff morale, productivity and efficiency.

COVID-19 has clearly dominated 2020/2021, however, throughout the year we also continued to transform the way we deliver services and we have been overwhelmed with the professionalism, flexibility and positive attitudes from our staff. Our staff are most definitely our greatest asset and have served our Trust and more so our patients, exceptionally well during extraordinary times. Therefore, caring for staff wellbeing remained our number one priority during this time and I know staff managed to take part in some the extensive wellbeing packages on offer since the start of the Pandemic, whether that be free car parking, new rest pods and cabins, 24 hour counselling and psychological support and a wellbeing day to name but a few.

Whilst we have progressed and transformed during 2020/2021 we sadly had to delay the roll out of our Quality Improvement Programme for the Trust, although we did successfully recruit to the Quality Academy. We are wholly committed to restarting this programme in 2021/2022 and have the resources in place to support and sustain this. We are personally excited by this as we introduce a program that develops, rewards, values and empowers our staff to be the best they can be.

Despite the obvious challenges, 2020/21 was also a year of significant achievements for UHNM; many of which are highlighted within this report. In October 2020 the Trust exited Financial Special Measures, a regime that the Trust had been in since 2017. This was as a result of tireless efforts in identifying and delivering efficiencies whilst maintaining quality.

During 2020/2021 much of our elective and planned care reduced significantly meaning that many of our patients were waiting far longer than we would wish although we went to considerable lengths to continue to provide surgery and treatments to our sickest and most vulnerable patients and were particularly successful in continuing to deliver care for our cancer patients. The challenges for our COVID-19 wards and our Critical Care Unit were as never seen before and at one stage we increased our critical care capacity by over 200%! This allowed us to support our own population and that of other struggling regions such as London. The challenges of urgent care diminished in volume but increased in complexity as we developed pathways and routes through our hospital that segregated COVID-19 positive and non COVID-19 positive patients; with blue, purple and green wards and zones.

Whilst addressing the complexities as outlined above we continued to transform urgent care for our patients and during February/March 2021 we started to see the fruits of our Urgent Care Improvement Programme which saw patients consistently spending less time in our Emergency Department and receiving care much more quickly.

Going forward into 2021/2022 one of our most significant challenges will be to address the capacity and demand mismatch that we have as a result of loss of productivity due to infection Prevention requirements, donning and doffing of additional Personal Protective Equipment and social distancing. This is against a backdrop of significantly increased waits for elective and planned work. We are all keen to resume such activity and are committed to working with our partners to ensure we maximise our collective resource to reduce those waits as quickly and safely as possible.

We are grateful to our partners within the system and beyond, for the support that they gave us to secure the capacity we needed to allow us to effectively respond to the constant surges of patients with COVID-19. We are particularly grateful to Stoke City Council for providing volunteers to support our staff in Critical Care and to North Staffordshire Combined NHS Trust for providing the much needed psychological support for our staff.

Our workforce is our greatest asset as without them, we would not be able to provide the care we do for our patients and it would be remiss not to acknowledge the tremendous sacrifice our staff have made. Our staff came to work day in and day out in the face of an unknown and highly infectious disease. Many of us lost friends, family and colleagues. Going forward we will continue to reflect and remember the ultimate sacrifice that some of our staff made to support their colleagues and to serve our patients

We recognise that our patients expect and deserve the highest standards of care from the services we provide and this is why we continually strive to set challenging targets and place quality at the heart of everything we do, ensuring we absolutely put the interests of our patients ahead of individual or organisational ambition. Listening to the community we serve remains a priority. Through engaging with our local and wider population we can understand better and respond to their concerns and needs. We believe that by doing this we are promoting a contribution from our patients and the public to the success of the Trust and therefore achieving our ambition together.

We made strong progress against many of the quality and safety priorities identified in last year's account, including:

- 87% and 63% reduction respectively in Category 2 and Category 3 Hospital Acquired Pressure Ulcers with 'lapses in care' in 2020/21 compared to 2019/20 totals
- Continued improvement in sepsis Intravenous Antibiotics (IVAB) in 1 hour results for 2020/21
- Exceeding the 95% National Target for Harm Free Care (New Harms) throughout 2020/21
- Reduction in total patient falls during 2020/21 compared to 2019/20
- UHNM continues to compare well against peers during 2020/21 and remains within expected ranges for both HSMR and SHMI mortality indicators

We are proud of our achievements, however we recognise that there are also areas where we need to make further improvement, for example:

- Emergency Department 4 hour target performance
- Continued improvement in Sepsis screening compliance and pathway
- To reduce harm from falls
- To reduce Category 4 Hospital acquired pressure ulcers

It has been an incredibly challenging year for all of us but it is also one that has made us very proud to be Chairman and Chief Executive of UHNM. Undoubtedly there will be further challenges ahead for us throughout 2021/22 and beyond but given we have seen what our UHNM family can do in extremis we are more than ever more confident that together, we will come through and we look forward to seeing how the 'new NHS' evolves. We hope you enjoy reading this Quality Account.

The Directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011 and 2013 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Account (which incorporate the above legal requirements).

In preparing the Quality Account, Directors are required to take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the Trust's performance over the period covered;
- The performance information reported in the Quality Account is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- The Quality Account has been prepared in accordance with Department of Health guidance.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

David Wakefield
Chairman

Tracy Bullock
Chief Executive Officer

2.2 Strategic Objectives

Our '2025Vision' was developed to set a clear direction for the Organisation to become a world class centre of clinical and academic achievement and care. One in which our staff all work together with a common purpose to ensure patients receive the highest standard of care and the place in which the best people want to work.

To achieve the 2025 Vision we must respond to the changing requirements of the NHS as they emerge and operate in ever more challenging times. This means that we have to think further than the here and now and continue to look beyond the boundaries of our organization for inspiration. Out involvement in the STP is crucial in enabling us to move towards our vision and to become a sustainable provider of healthcare services.

Our Strategic Objectives

Our Vision is underpinned by 5 key Strategic Objectives (SO):

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**

Our Values

We continue to encourage a compassionate culture through our values, which identify the attitude and behavioural expectations of our staff.

Together	• We are a team • We are appreciative • We are inclusive
Compassion	• We are supportive • We are respectful • We are friendly
Safe	• We communicate well • We are organised • We speak up
Improving	• We listen • We learn • We take responsibility

Our full 2025 Vision is available via our website: www.uhnm.nhs.uk .

Priorities for Improvement

3.1 Our Quality Priorities and Objectives for 2021/22

Our core vision continues to be a leading centre in healthcare, driven by excellence in patient experience, research, teaching and education. Our overall ambition is to become one of the top University Teaching Hospitals in the UK by 2025.

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We want everyone who works at UHNM to share this vision and place quality at the heart of everything we do by embracing and demonstrating the following Trust values of Compassion, Safety, Improving and Together. The Trust is supporting this vision through a number of initiatives

Improving Together

During the early months 2020/21, we began our new exciting quality improvement journey with the introduction of our Improving Together programme. Improving Together will help us become and world-class centre of clinical and academic achievement where staff work together to deliver high standards of care – delivering exceptional care with exceptional people. Due to the need to focus activities in the Trust on the COVID-19 second wave response, this programme was paused until March 2021. The implementation is moving ahead and will be a focus for the next few years.

The Improving Together programme has a number of components:

- The establishment of a Quality Improvement Academy team to build greater capacity and support for all of our staff to use established quality improvement methodologies and lead in local and organizational quality improvement projects and sustain the culture change into the future

- Developing our Executive Team as 'Lean' leaders with behaviours and skills that will cascade through the organisation, supporting all staff to lead quality improvement at whatever level and role they perform
- Introduction of a Strategic Deployment Framework – which focuses improvement activity on key priorities identified from the data on Trust performance
- Introduction of an Operational Improvement System – a new set of skills, routines and behaviours which enables all staff to contribute to small changes each day that will improve the care we provide to our patients in line with the Trust's identified priorities – the whole being greater than the sum of its parts
- A structured and prioritised approach to 'Step-Change' quality improvement projects, to deliver a consistent, focused and evidence based approach to improvement work across the Trust and into the wider system

Shared Governance

Shared Governance is a leadership model used to empower and develop frontline staff. This model encourages clinical staff to innovate and take ownership of the quality of care that they provide, identifying them as the experts in their area. Shared Governance is new to UHNM and we are excited to be able to implement this across our hospitals to support staff development and high quality patient care. The model works through voluntary participation of staff to join a Council that meets on a monthly basis, with the support of the Chief Nurse and other partners across the hospital. The aims of Shared Governance are:

- To improve patient experience and outcomes
- To improve staff satisfaction
- Increase the moral of the team
- Develop the right leaders for our future NHS
- A culture of safety; challenging poor practice and innovating for improvements
- Working in partnership with patient representatives to ensure high quality service innovation
- Improve recruitment and retention
- Create strong inter professional relationships for improved patient outcomes

Prioritising our quality improvement areas

We have continued our focus on quality aligned to our Strategic Objectives and 2025Vision.

Our aim is to provide safe, clean and effective person-centred care to every patient, every time. To achieve this we recognize that we must continue to:

- Build stronger clinical leadership
- Provide valid, reliable and meaningful information as a basis for measurement and improvement
- Build greater capacity and capability of or staff to interpret the information and implement sustainable change.

Our Overall Goal for 2021/22 is:

To support our staff to get it right first time every time for our patients

Aims

To continue to improve safe care and treatment to patients

How will we do this:

- Improve sepsis treatment and recognition of deteriorating patients
- To evaluate and reduce long waiters following the COVID-19 pandemic
- To support the Recovery & Restoration Plan across the health economy
- Ensure that services follow appropriate infection prevention guidance and continue to be COVID secure
- Aim to reduce harm from patient falls and hospital acquired pressure damage by further 10% from 2019/2020 baseline
- Evaluate and introduce new technologies and techniques for treating patients.
- Improve the number of reported medication errors
- Delivering the Improving Together Programme

Measure this through:

- Quality Performance Report
- Harm Free Care
- Serious Incidents analysis
- Legal claims
- Mortality reviews and outcomes
- Clinical Audits
- Wards Performance Boards as part of Delivering Exceptional Care

To improve staff engagement and well being following COVID-19 pandemic

How will we do this:

- To support the introduction of the Trust's Wellbeing Programme and activities that focus on staff wellbeing and empowerment
- Ensure that staff are working within COVID secure environments and support provided to staff
- Support staff and services in providing care in 'new ways' following COVID
- Promote mental health wellbeing and support
- Delivering the Improving Together Programme
- Introduction of Shared Governance

Measure this through:

- Staff survey
- Pulse Check
- Chief Executive Briefings
- Freedom to Speak up report

To improve patient experience

How will we do this:

- Utilise patient and visitor feedback
- Seek wider engagement with 'harder to reach' patient groups
- Review patients experiences during COVID and identify positive changes to adapt service provisions
- Review the different ways that patient experience and views are gathered and acted upon within UHNM

Measure this through:

- Inpatient and Outpatient survey
- Complaints & PALS themes
- Patient Stories

3.2 How we have performed against Quality KPIs during 2020/21

Quality Indicator	Previous Period		Current Period	
The value of the Summary Hospital level Mortality Indicator (SHMI)	**March 2019 – February 2020** 0.98 (Band 2)		**January 2020 – December 2020** 1.03 (Band 2)	
The percentage of deaths with palliative care coded at either diagnosis and/or specialty level	-%		2.3%	
Patient Reported Outcome Measures scores* *(National Average)* Groin hernia surgery Varicose Vein Surgery Hip Replacement Primary Surgery Knee Replacement Primary Surgery **EQ-5D scores finalised data release*	**Participation Rate 2018/19** - - 57.7% *(66.4%)* 66.3% *(73.7%)*	**Adjusted Health Gain 2018/19** - - 0.447 *(0.465)* 0.327 *(0.338)*	**Participation Rate 2019/20** - - 57.2% *(65.5%)* 54.1% *(63.5%)*	**Adjusted Health Gain 2019/20** - - 0.436 *(0.453)* 0.334 *(0.334)*
Percentage of patients aged 0 to 15; and 16 and over Readmitted to a hospital which forms part of the Trust within 28 days of being discharged from hospital	**No new data publication available from NHS Digital portal**		**No new data publication available from NHS Digital portal**	
The Trust's responsiveness to the personal needs of its patients	**2019/20 Survey** **66.0** *(England average 67.1)*		**2020/21 Survey** **TBC** **TBC**	
Percentage of staff employed by the Trust who would recommend the trust as a provider of care to their friends and family (Agree / Strongly Agree)	**2019** **74%** *(England Average Acute Trusts 71%)*		**2020** **76%** *(England Average Acute Trusts 73%)*	
Percentage of patients who were admitted to hospital and who were risk assessed for Venous Thromboembolism (Acute Trusts) *(National Average)*	**2019/20** Q1 93.79% (95.56%) Q2 93.99% (95.47%) Q3 93.29% (95.33%) Q4 TBC % (TBC%)		**2020/21** **No new data publication available from NHS Digital portal**	
The rate per 100,000 bed days of Clostridium Difficile infection reported within the Trust amongst patients aged two or over [1] (Trust apportioned)	**2018/19** 29.1 *(England Average 22.1)*		**2019/20** 39.8 *(England Average 29.7)*	
The number and rate of patient safety incidents reported within the trust - Acute trusts (non specialist)	*6332 (Oct 2018 – March 2019)* *27.3 per 1000 bed days*		*9368 (Oct 2019 – March 2020)* *40.2 per 1000 bed days*	
The number and rate of such patient safety incidents that resulted in severe harm or death— acute (non specialist)	*28 (Oct 2018 – March 2019)* 0.12		*22 (Oct 2018 – March 2019)* 0.1	

[1] All NHS Trusts are required to report the data published via NHS Digital's national Quality Account portal. There is a difference in the Clostridium Difficile rates reported via NHS Digital portal and the rates reported in Trust's Integrated Performance Report because of a difference between the Public Health England figures and the NHS Digital's figures. This difference is due to different methodologies used by these national databases for calculating bed day rates. The Integrated Performance Report data uses the data from Public Health England.

Commissioning for Quality and Innovation (CQUIN) Indicators for 2020/21

During 2020/21, due to the national NHS response to the COVID-19 pandemic the funding for all acute Trusts changed to a block payment which included funding for CQUINs.

As a result of this there were no national or local CQUINs which were required to be agreed or to be achieved during 2020/21. Therefore UHNM were automatically paid for CQUINs at 100% even though there were no indicators set to be achieved.

4. Patient Story

I am writing to express thanks and gratitude on behalf of my wife and I. On 8th April 2020 our baby daughter, Mya Lily, was born in the delivery suite of Royal Stoke hospital. After having a couple of trips to the Maternity Birthing Centre we were finally admitted in the early morning of 8th April 2020 and were treated with professionalism, great care and utmost compassion by the whole team. In particular, we wish to mention the care and support of Annabel Norman who delivered Mya at 09:35am.

We feel that Annabel is a credit to the department, her friendly nature, calm attitude, encouragement, motivation and general support was invaluable. One minute making a cup of tea, the next suturing a tear after delivery. Her ability to inform us, calm us as well as progress the labour was astounding.

At a time that must be incredibly difficult for all NHS workers, and their families we wanted to express how thankful and impressed we were with our experience, from the phone calls we made to the Maternity Birthing Centre from home to the moment we walked out of the maternity building with Mya, the whole team went above and beyond the expectations of two first time parents".

Just a few words to thank all staff who supported us and my mum up until she sadly passed away. It was an enormous comfort to us all that we were able to use the face time service to see and talk to mum. I can't imagine how she would have felt without them as she said on several occasions that she felt abandoned. We realise that the current situation dictates these strange times we are living in but without your valuable service it would have been even more distressing. Our thanks to you all again, With kind regards

I have just had contact with the NHS services following a routine blood test. The blood test indicated the need for further investigation into my prostate readings. The blood results were reported to my GP on Friday morning and I was seen and examined that afternoon.
The hospital contacted me to arrange a triage telephone call and as a result arranged an MRI scan.
Following this I received a telephone report on the outcome. The whole process took less than a fortnight.
Every member of staff I either spoke to or met was wonderful and treated me as though I was a family member. I cannot express my admiration and thanks to all the people I encountered.
Their professionalism and dedication was exemplary.
Please pass on my thanks to all concerned.
This is my NHS and I am proud of it.

My last admission was again to Critical Care on the 7th July 2020. I hold staff at the hospital in complete admiration for the way they have managed the Coronavirus crisis. I was not admitted due to Coronavirus but I was very impressed as to how A&E Resus & Ward 222 organised themselves. Not once did I feel unsafe whilst there. I was then transferred to Pod 4 where the staff were outstanding. I truly hope the Board of Directors know what an amazing team of doctors & nurses they have there. They are amazing people. I cannot praise them highly enough. They kept me going through a very dark period in which I really wasn't sure I would live. To maintain that standard of care I find hard to comprehend. To be there for patients who are frightened & alone because they cannot receive visitors takes an ability rare to most people. When I asked nurses how they coped with the COVID-19 patients & weren't they afraid of contracting the disease? They all said it was their job & it wasn't something they thought about & the majority said that what had affected them the most that they couldn't give dying patients a hug, offer sympathy & comfort to frightened people who knew or believed they were dying. These are remarkable people.

5. Statement of Assurances

5.1 Review of Services

Care Quality Commission

The Trust was last inspected in June 2019; the inspection followed the new regime for inspection. The CQC inspected 5 services provided at the Royal site. This included:

- Urgent and Emergency Care at Royal Stoke University Hospital and County Hospital
- Medical Care
- Outpatients at Royal Stoke University Hospital and County Hospital
- Children's Services
- Maternity Services at Royal Stoke University Hospital and County Hospital

The final report was published on 14th February 2020. The overall rating for the Trust stayed the same. The CQC rated UHNM as **requires improvement** because:

- The CQC had concerns regarding the care and treatment of patients in the Emergency Department at Royal Stoke Hospital
- They also raised concerns in relation to the care and treatment of patients with mental health needs and patients who lacked mental capacity to make decisions
- Governance systems although embedded were over complicated and unreliable. The CQC acknowledged that the newly appointed CEO was undertaking extensive work to improve these systems
- In rating the Trust, the CQC took into account the current ratings of services not inspected this time
- Immediate actions have been taken to address the issues identified with regard to the care of patients with mental health needs
- Improvements to the triage system and process were implemented immediately and the Board subsequently agreed significant investment for nurse staffing

The inspection did not include surgical care or critical care and therefore the ratings awarded to these core services in 2017 remain the same. The CQC rated UHNM's Critical Care as an Outstanding Service.

Section 31 Notices

On 19th June 2019 the Trust were served notice under Section 31 of the Health and Social Care Act 2008, imposing specific conditions in relation to the Emergency Department at Royal Stoke and Medical Care (compliance with Mental Health Act Code of Practice) at Royal Stoke.

A weekly report was developed, which set out the specific detail of conditions imposed along with an Assurance Framework that detailed the immediate actions taken in response along with monitoring arrangements, ongoing assurance mechanisms and supporting evidence available.

Following an application by the Trust to remove the conditions, the CQC wrote to the Trust on 24th September 2020 confirming that they were removing the conditions in relation to the Mental Health Act code of practice but confirmed that they refuse to remove the conditions relating to the Emergency department because:

- We had not yet achieved 95% compliance with assessing patients within 15 minutes of arrival in emergency department at Royal Stoke University Hospital.

- Audits undertaken did not provide the CQC with full assurance of the systems in place to ensure that patients are assessed within 15 minutes of attending the department by suitably qualified and trained staff in line with national guidance.
- CQC were not assured that the action you are currently taking is enough to assure the inspectors that the system is implemented and effective.

In response to the letter received, the weekly report has been amended and enhanced in order to provide the CQC with additional assurance.

The table below shows the rating by the 5 key domains and compares results to the 2017 inspections:

Domain	October 17 Ratings	June 2019 Ratings	
Are services safe?	Requires Improvement	Requires Improvement	🟡
Are services effective?	Good	Requires Improvement	🟡
Are services caring?	Outstanding	Good	🟢
Are services responsive?	Requires Improvement	Requires Improvement	🟡
Are services well led?	Good	Requires Improvement	🟢
Overall	Requires Improvement	Requires Improvement	🟡

Care Excellence Framework

The Care Excellence Framework (CEF) is a unique, integrated tool of measurement, clinical observations, patient and staff interviews, benchmarking and improvement. It reflects CQC standards and provides assurance around the CQC domains of:

- Safety
- Effectiveness
- Responsive
- Caring
- Well led

The CEF is delivered in a supportive style fostering a culture of learning, sharing and improving, and reward and recognition for achievement. Each domain consists of clinical observations, documentation reviews, patient interviews and feedback from staff forums.

The framework provides an award system for each domain and an overall award for the ward/department based on evidence. The awards range through bronze, silver, gold and platinum and are displayed in each clinical area. The clinical area is supported to develop and deliver a bespoke improvement plan and spread good practice.
Areas with a bronze award are supported to make improvements by the Quality and Safety team and areas rated platinum are encouraged to share their good practices via the CEF Steering Group.

During the past 12 months as a result of the COVID19 pandemic planned CEF reviews were suspended. During the COVID-19 pandemic, safety reviews were conducted to provide assurance about the standards of care delivered to our patients. The programme has recommenced in April 2021 and will be reported in the Quality Account 2021/22.

PLACE Inspection

It was agreed that UHNM would undertake the PLACE-Lite desk top review, in accordance with National guidance as a result of the on-site visual inspection process being unable to be undertaken due to Covid19. The PLACE-Lite desk top exercise reviewed existing sources of data from formal Trust audits/surveys in the absence of an on-site visual inspection. This paper provides the results of the review which concluded that the PLACE scores achieved in 2019 are likely to have remained broadly similar should a PLACE inspection have occurred in 2020.

Adapted process during the COVID-19 Pandemic

A Working Group was established to undertake the PLACE Lite Desktop review and this consisted of members of the Estates, Facilities and PFI Divisional Team, including the EFP Matron, Contract Performance Manager, Head of Governance & Compliance, Deputy Head of Governance & Compliance. They completed the data gathering and validation exercise from the broad range of data from the four audits/surveys over the twelve month period.

It became apparent that not all of the wards inspected during PLACE 2019 were inspected during 2020 via one of the above audit/survey mechanisms. This is because Environmental Audits and Clinical Excellence Framework (CEF) audits were unable to proceed with their routine programme of audits due to COVID 19 restrictions.

The month of September 2020 was chosen regarding the data sources for the patient satisfaction and meal time observation audits, reflecting the time of the year that PLACE is normally undertaken. Environmental audit dates were randomly chosen for 2020 when inspections had been able to proceed and at least one of the above sources of data was available for each of the areas included within the last PLACE inspection. This was used to give an indication of whether the last PLACE scores achieved would likely have been upheld.

Findings of PLACE Lite Desktop Review

Environmental Audits

All areas bar one achieved a score of 90% or above (pass) and a significant number (17 areas) achieved 98% or above (excellent). The only exception to this was County Ultrasound where 86.6% was achieved for the estates domain as a result of problems identified with floor seal repairs at an audit undertaken on 25th November 2020. The area was re-audited on 24th February 2021 and four of the five issues had been resolved with the remaining repair planned to be undertaken shortly.

Patient Satisfaction Surveys

A good level of patient satisfaction was indicated with overall scores of 79% being achieved for the Royal Stoke site and 78% for the County site.

Meal observation Audits

The majority of areas achieved 80% or above. The learning identified was that the Saffron system was not used in all areas to support the meal ordering process on the day of the audit. All areas have been reminded to utuilise the Saffron system

5.2 Participation in Clinical Audit

Clinical Audit is an evaluation of the quality of care provided against agreed standards and is a key component of quality improvement. The aim of any Clinical Audit is to provide assurance and to identify improvement opportunities. The Trust has an agreed yearly programme of Clinical Audits which includes:

- National audit where specialities/Directorates are asked to be involved
- Corporate and Divisional audits
- Local audits which clinical teams and specialties determine and reflect their local priorities and interests

As part of the Clinical Audit Policy any clinical audit carried out within the Trust should be registered with the Trust's Clinical Audit Team, the team has a database which monitors the progress.

The National Clinical Audits and NCEPOD enquiries that the Trust participated in, and for which data collection was completed during 2020/21 alongside the number of cases submitted, are referred to in the tables below:

A process is in place to ensure that leads are identified for all the relevant National Audits and NCEPOD.
The lead will be responsible for ensuring full participation in the audit.

National Confidential Enquiries
Following receipt of the reports, we undertake review of the recommendations and implement an improvement plan.

NCEPOD Study	UHNM Registered	Completed
Out of Hospital Cardiac Arrest	Yes	Trust was not included in national data collection
Dysphagia in People with Parkinson's	Yes	Awaiting report
Transition from Child Health to Adult Services	Yes	Pilot
Alcoholic Liver Disease	Yes	Data Collection
Epilepsy	Yes	Data Collection

All published reports are received by the Trust and reviewed locally. A steering group is convened for each enquiry and local action plans are developed where necessary to ensure all relevant recommendations from NCEPOD are implemented. Implementation of the action plans is monitored centrally at the Trust's NICE and External Publications Implementation Group, chaired by the Associate Medical Director (Governance, Safety and Compliance), to ensure full completion.

5.3 National Clinical Audits

These audits indicate our level of compliance with national standards and provide us with benchmark information on to which to compare practice. The results of the audits inform the development of local action plans to improve patient care.

National Clinical Audit National Audit	UHNM Registered	% of cases Submitted
Antenatal and Newborn National Audit Protocol 2019 to 2022	Yes	100%
BAUS – Renal Colic	Yes	100%
BAUS – Female Stress Urinary Incontinence Audit	Yes	100%
BAUS – Cytoredutive Radical Nephrectomy Audit	Yes	100%
British Spine Registry	Yes	100%
Case Mix Programme (CMP)	Yes	100%
Cleft Registry and Audit Network (CRANE)	Yes	Postponed
Elective surgery (National PROMs Programme)	Yes	100%
Emergency Medicine – Fractured Neck of Femur	Yes	100%
Emergency Medicine – Pain in Children	Yes	100%
Emergency Medicine – Infection Control (topic changed due to covid)	Yes	100%
Falls and Fragility Fractures Audit Programme (FFFAP) – Audit of Inpatient Falls	Yes	100%
Falls and Fragility Fractures Audit Programme (FFFAP) – Hip Fracture Database	Yes	100%
Falls and Fragility Fracture Audit Programme (FFFAP) – Fracture Liaison Database	Yes	100%
Inflammatory Bowel Disease (IBD) Registry – Service Standards	Yes	100%*
Inflammatory Bowel Disease (IBD) Registry – Biological Therapies Audit	Yes	100%*
Learning Disabilities Mortality Review Programme (LeDeR)	Yes	100%
Mandatory Surveillance of HCAI	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	100%
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP)	Yes	100%
National Audit of Breast Cancer in Older People (NABCOP)	Yes	100%
National Audit of Cardiac Rehabilitation (NACR)	Yes	100%
National Audit of Care at End of Life (NACEL)	Yes	Postponed
National Audit of Dementia (Care in general hospitals)	Yes	Postponed
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes	100%
National Bariatric Surgery Registry (NBSR)	Yes	100%
National Cardiac Arrest Audit (NCAA)	No	0%
National Cardiac Audit Programme	Yes	100%

National Comparative Audit of Blood Transfusion Programme – 2020 Audit of the management of perioperative paediatric anaemia	Yes	Postponed
National Diabetes Audit - Adults	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	100%
National Gastric-Intestinal Cancer Programme	Yes	100%
National Joint Registry (NJR)	Yes	100%
National Lung Cancer Audit (NLCA)	Yes	100%
National Maternity and Perinatal Audit (NMPA)	Yes	100%
National Neonatal Audit Programme - Neonatal and Special Care (NNAP)	Yes	100%
National Ophthalmology Audit	Yes	100%
National Paediatric Diabetes Audit (NPDA)	Yes	100%
National Prostate Cancer Audit	Yes	100%
National Vascular Registry	Yes	100%
Neurosurgical National Audit Programme	Yes	100%
NHS Provider interventions with suspected / confirmed carbapenemase producing gram negative colonisations / infections	Yes	Cancelled
Paediatric Intensive Care Audit Network (PICANet)	Yes	100%
Perioperative Quality Improvement Programme (PQIP)	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
Serious Hazards of Transfusion: UK National Haemovigilance Scheme	Yes	100%
Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	100%
Surgical Site Infection Surveillance Service	Yes	100%
The Trauma Audit and Research Network (TARN)	Yes	100%
UK Cystic Fibrosis Registry	Yes	100%
UK Registry of Endocrine and Thyroid Surgery	Yes	100%
UK Renal Registry National Acute Kidney Injury Programme	Yes	100%

* Only data up to end of quarter 3 was used for reporting due to COVID-19, as per the National Audit website

Corporate and Local Clinical Audits

A total of 64 clinical audit projects were completed by Clinical Audit Staff and a further 595 clinician led audit projects were registered during 2020/21. These audits help us to ensure that we are using the most up to date practices and identify areas where we can make further improvements. An example of improvements made in response to the audit results is:

Audit of the Baseline Characteristics of Hydroxycarbarnide Use in Sickle Cell Disease

Action	Co-ordinator	Action to be complete by
To ensure that all relevant staff are aware of the results of the audit, the report was shared with: a) The Lead Consultants b) The Directorate Governance meeting	Audit Lead	Complete
To ensure that patients' Sickle Cell Diagnosis is communicated effectively in both primary and secondary care settings, the Hydroxycarbarnide status is recorded on all patient clinic letters	Audit Lead	Complete
To improve patient / carer knowledge about Hydroxycarbarnide a patient information leaflet has been developed in conjunction with the Trust Hospital User Group	Audit Lead	Complete
To improve the management and care of patients prescribed Hydroxycarbarnide a prescribing and monitoring protocol has been developed and is now in use.	Audit Lead	Complete
To determine if improvements in practice have taken place a re-audit will be undertaken as part of the 2021/22 Clinical Audit programme	Clinical Audit Department	March 2022

5.4 Participation in Clinical Research

UHNM participates in clinical trials across the healthcare sector from novel interventions and drugs to device innovations which aim to improve quality of life and outcomes for our patients. Research Practitioners and Midwives work alongside clinical teams and support services to identify and consent potential research participants, discussing trials with patients and providing care throughout the studies. During the pandemic UHNM has been contributing to the delivery of national Urgent Public Health Studies in response to COVID-19. The trials have provided important information on the epidemiology of the virus as well as potential treatment options for those affected by COVID-19

There are several other key reasons why UHNM should participate in research. Being research active:

- is associated with better clinical outcomes
- brings a range of finance benefits, including savings on medicines and staff time
- improves UHNM's reputation
- enhances recruitment & retention of high quality staff
- improves staff knowledge & skills
- is key to our academic partnerships
- enhances patient experience

Furthermore, the Care Quality Commission (CQC) are increasingly recognising the value of research and it has been identified that research active organisations fare better in CQC inspections. A key development has been the recent agreement by CQC to include, for the first time, a question about research opportunities offered to patients in the CQC Annual Survey of Inpatient Experience.

Strategic Aims

1. Culture: To develop a Trust-wide culture of research and innovation.
2. Capacity: To grow the Trust's capacity to support research and innovation.
3. Finance: To develop a robust, sustainable and transparent financial model for research and innovation.
4. Governance: To support and enhance research and innovation through provision of a robust governance framework.

Research and Innovation highlights from 2020/2021

- We recruited more than 6000 participants to COVID-19 research studies, this contributed to UHNM being the second highest recruiter for the West Midlands.
- We were on of the top 3 recruiting sites in the country for REMAP-CAP, this intensive care based study, looks at patients with Community Acquired Pneumonia and identifies the effect of a range of interventions to improve outcome.
- We have successfully opened and recruited 250 participants to the SIREN study, which looked at whether prior infection of SARS-CoV2 protects against future infection of the same virus.
- We continue to support home-grown research, this included setting up and opening the COVAC-IC study in less than 3 months. This study looks at the immune response to COVID-19 vaccines in immunocompromised patients with haematological disorders.
- We are sponsoring a medical device trial led by one of our UHNM Paediatric consultants in collaboration with an international company. The trial which will look at performance and adherence in children and young people whilst using asthma devices.
- We continued to support the management and evaluation of the £1.2m Innovate UK Heart Failure Test Bed which uses digital technology to improve early detection of deteriorating health in heart failure.
- A small grant of £14,000 was awarded by the North Staffordshire Medical Institute to a UHNM Dietician with support from the academic team. This pilot/feasibility study will look at whether using coloured crockery with older people improves their dietary intake.

- One of our cardiology consultants has been awarded a Clinical Research Network West Midlands Academic Research Scholarship. This will enable him to develop his research portfolio and strengthen links with Keele CTU.
- A Speech and Language therapist has been successfully awarded a Clinical Research Network West Midlands personal development award to support them to develop their research skills and portfolio.
- UHNM has acquired RED-CAP, which is a system that enables better data management and also enables virtual consenting of patients taking part in research.
- The COVID pandemic has helped the research department to explore different ways to run research trials; it has helped to streamline processes and facilitated the progress of remote consent and remote monitoring of studies.

5.5 Data Quality

The Data Quality Strategic Plans and Data Quality Assurance Group have been re-aligned during 2020/21 to fall under the auspices of the Executive Business Intelligence Group, led by the Chief Financial Officer. The corporate Data Quality team continued to provide assurance throughout the last year to support the improvement of Data Quality and the provision of excellent services to patients and other customers.

- The DQ team continued to support UHNM staff, answering and resolving thousands of queries and helping to support teams undertaking unfamiliar roles in the Trust's response to the COVID-19 pandemic.
- Support for IT projects was also continued with testing, validation and systems expertise provided by the team.
- The DQ Strategy has been revised and the terms of reference for the DQ Assurance group has been updated to reflect DQ obligations to Data Security & Protection Assurance Framework.
- The Data Quality Assurance Indicator has been partially implemented for the Integrated Performance Report discussed at Trust Board level.

2020/21 has been another productive year for the data quality team and we aim to build on this throughout 2021/22, supporting the strategic aims of the Trust.

5.6 NHS Number & General Medical Practice Code Validity

University Hospitals of North Midlands NHS Trust submitted records to the Secondary Uses System (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data. This is a single source of comprehensive data which enables a range of reporting an analysis in the UK. The figures below are for the period April 2020 to March2021 which reflect a marginal improvement in NHS Number validation compared to last year.

The percentage of UHNM records in the published data which included the patient's valid **NHS number** was:

- 99.8% for admitted patient care; national performance is 99.5%
- 99.9% for outpatient care; national performance is 99.7%
- 99.1% for accident & emergency care; national performance is 98.0%

Valid **General Medical Practice Code** performance is:

- 100% for admitted patient care; national performance is 99.8%
- 100% for outpatient care; national performance is 99.7%
- 99.7% for accident & emergency care; national performance is 97.9%

Trust performance for GMP Code remains higher than the national average.

5.7 Clinical Coding Accuracy Rate

The annual internal Data Security & Protection Toolkit (DSPT) clinical coding audit took place during 2020/21, achieving an overall 'mandatory' rating in all areas of the audit and 'advisory' in 1 of the 4 areas audited. Percentage accuracy has improved in three out of the four areas since last year. All recommendations from the 2019/20 audit have been actioned. The Trust's Clinical Coding auditors carried out this year's audit.

The Trust was not subject to an external Payment by Results (PbR) audit in 2020/21.

The internal Staff Audit Programme continues for all coding staff and has been updated for 2021/22.

The Trust has a qualified Clinical Coding Trainer who has established a 2 year training programme for trainee coders and in-house workshops for existing staff. In addition, they provide all mandatory national training, ensuring all coders are compliant with training requirements.

U-codes (no associated income due to missing information) have remained low throughout 2020/21, reporting a monthly average of 3.5%.

5.8 Data, Security & Protection (DSP) Toolkit Attainment Levels

This year is the third iteration of the new data security and protection toolkit (and the second since the COVID pandemic lockdown started) and it should be noted that it is still being refined. This is a self-assessment tool which the Trust must complete and it is usually submitted to NHS Digital on the 31st March every year.

However due to the ongoing COVID-19 pandemic, Trusts have been advised that it is not required to submit the DSP Toolkit until 30 June 2021. This extension includes the timeframe for completion of the mandatory Data Security & Protection training which was also been extended to 30th June 2021. The toolkit was revised to embrace the National Data Guardian's 10 data security standards. (The National Data Guardian. 2016 National Data Guardian for Health and Care Review of Data Security, Consent and Opt-Outs Crown Copyright) although the emphasis is more on Cyber Security measures rather than the traditional data protection requirements of previous toolkits. The toolkit submission for 2020/2021 requires all 40 assertions to be completed.

The Trust will be submitting its self-assessment, using the extension to ensure all 40 assertions have been addressed. An action plan is in place, incorporating feedback from the internal auditors, with the key focus on the percentage of staff successfully completing the level 1 data security awareness training. The Trust's Executive Data Security & Protection Group monitors progress and provides assurance to the Trust Board, via the Finance & Performance Committee. The Trust's submission has been rated by Internal Auditors as providing 'Significant Assurance with minor improvements' however, if the Trust does not achieve the training target, the Trust's rating will be classified as 'Standards not fully met (plan agreed).' An improvement plan will be submitted to NHS Digital for their approval, following which the Executive Data, Security & protection Group will monitor progress in line with agreed timescales for implementation

5.9 Seven Day Services

The seven day services programme is designed to ensure patients that are admitted as an emergency, receive high quality consistent care, whatever day they enter hospital. There were 10 clinical standards for seven day services in hospitals developed and four of the ten were identified as priorities on the basis of their potential to positively affect patient outcomes.

These are:

- Standard 2 – Time to first consultant review
- Standard 5 – Access to diagnostic tests
- Standard 6 – Access to consultant-directed interventions
- Standard 8 – Ongoing review by consultant twice daily if high dependency patients, daily for others

Achieving the 4 high priority clinical standards for 7 day working, remains a Critical Success Factor (CSF) under Strategic Objective 1: Provide safe, effective, caring and responsive services.

In response to UHNM's consistent compliance with the standards, an assurance framework was developed which moved away from large scale audits to a more focussed review process. The framework consists of a programme of specialty level audits which facilitate a process of continual monitoring and allows improvements to be driven and owned at a local level. The reporting structure is a quarterly progress update to the Trust Board giving the Board oversight of UHNM's level of compliance. Whilst the vast majority of audit activity was postponed during 2020/2021 due to the COVID-19 pandemic, case note reviews have now been completed for Paediatric Medicine and ENT and re-audits scheduled during 2021/2022. In addition, the review of Respiratory Medicine is now underway.

Part B: Review of Quality Performance

6. Quality Priorities 2019/20

In 2020/21, in partnership with our stakeholders we identified 3 specific priorities to focus on:

To continue to improve safe care and treatment to patients

To improve staff engagement and well being

To improve patient experience

Details of our performance against these priorities are provided in the following pages.

Priority 1:
To continue to improve safe care and treatment to patients

Quality, safety and patient experience remains our number 1 priority and our strategy confirms our relentless commitment to the elimination of error, to systematic promotion of safety, embracing wholeheartedly learning from our mistakes and those of others, changing our clinical services to improve the outcomes for patients and the delivery of excellent clinical results.

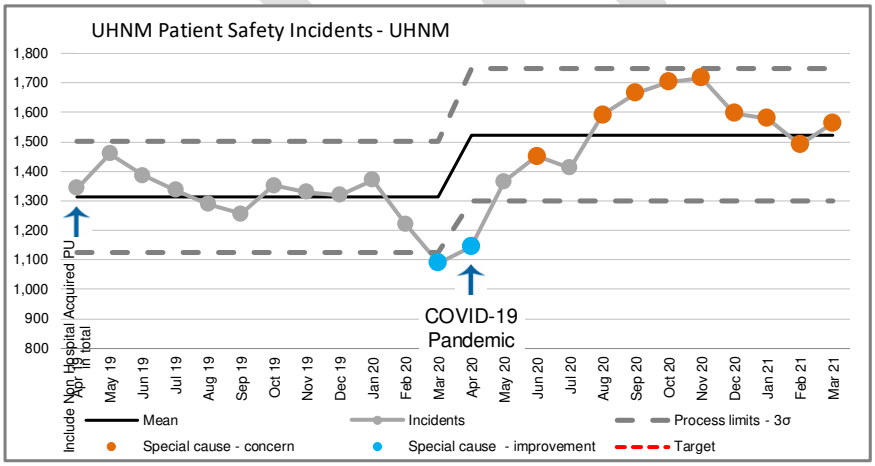
We said we would achieve this by

- Improve sepsis treatment and recognition of deteriorating patients
- To evaluate and reduce long waiters following the COVID-19 pandemic
- To support the Recovery & Restoration Plan across the health economy
- Ensure that services follow appropriate infection prevention guidance, are COVID secure and social distancing continues.
- Aim to reduce harm from patient falls and hospital acquired pressure damage by further 10%
- Evaluate and introduce new technologies and techniques for treating patients.
- Improve the number of reported medication errors and implementation of new ePMA system
- Delivering Exceptional Care

Performance against this priority and its aims has been monitored during 2020/21 using a range of key indicators. The following section provides a summary of the performance for these indicators and what these results mean for our patients.

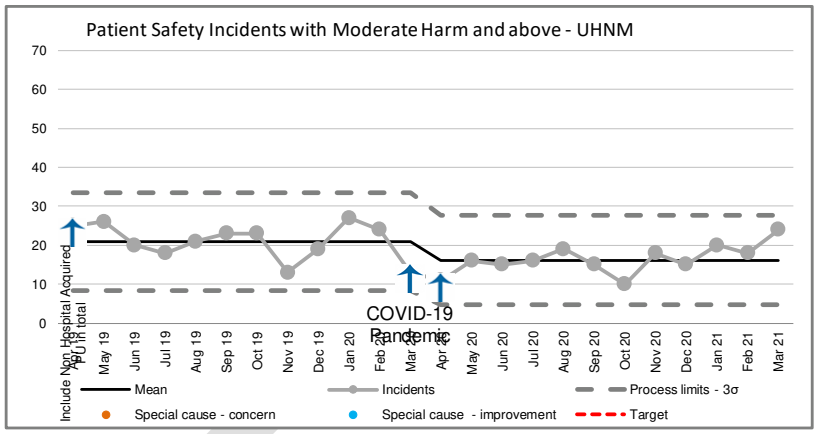
Patient Safety Incidents

We continue to aim to reduce harm to our patients. A key indicator of this is the number of patient safety incidents* reported and the rate per 1000 bed days and the number and rate of patient safety incidents with moderate harm or above. The charts below illustrate the monthly totals for these indicators.

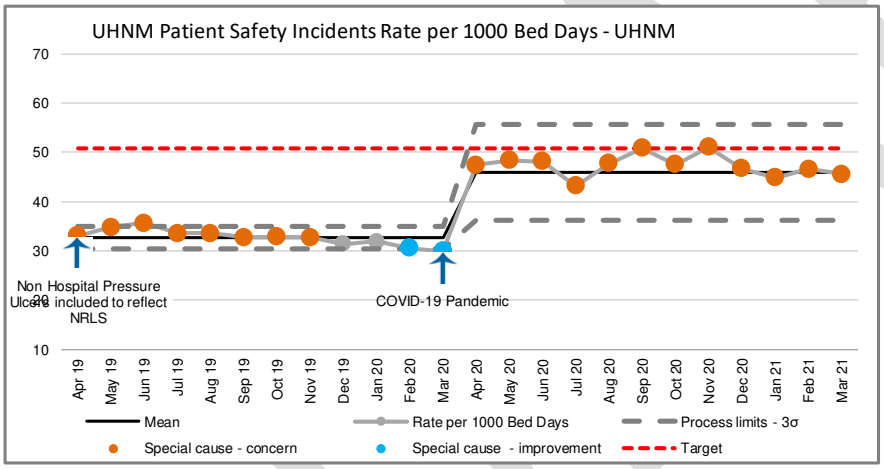


16% increase in total reported Patient Safety Incidents from 2019/20 to 2020/2021. Increased reporting is an indication of an open and improved reporting culture

22% reduction in total reported Patient Safety Incidents with harm 2019/20 to 2020/2021

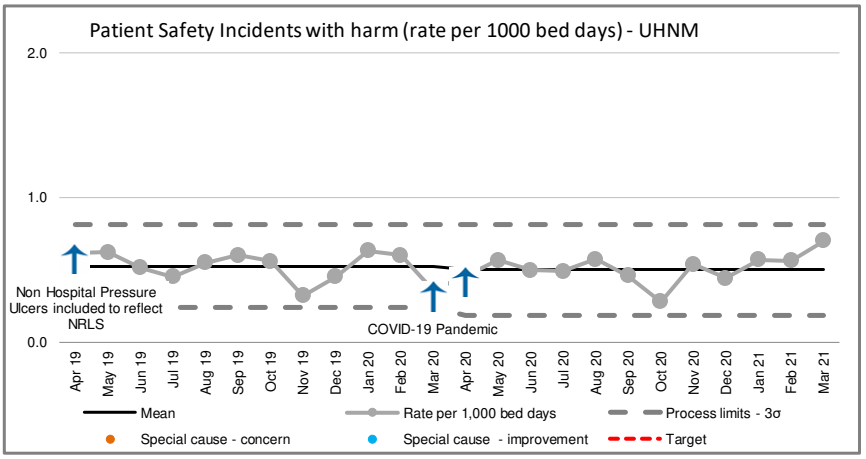


Total reported patient safety incidents have increased during 2020/21 compared to 2019/20 as the Trust has continued to promote positive reporting of adverse incidents. The rate of reported incidents has increased by a greater percentage than the total numbers. This is a result of the lower activity caused by the COVID-19 pandemic. However, there have been reducing numbers of patient safety incidents reported as resulting on moderate harm or above during 2020/21. This is important as the increased reporting of patient safety incidents are related to low or no harm. Reporting of low and no harm incidents is indicator of positive reporting culture and staff awareness of need and benefits of reporting incidents to see improvements and reductions in the level of harm.



44% increase in rate of reported Patient Safety Incidents per 1000 bed days from 2019/20 to 2020/21

Rate of reported Patient Safety Incidents with moderate harm per 1000 bed days in 2020/21 has same mean rate (0.5) as 2019/20



Never Events

UHNM has introduced strong systems to allow for the reporting of adverse incidents to ensure lessons are learnt whenever possible. During 2020/21, we have reported 1 Never Event which compares to 6 reported in 2019/20. The following provides a summary of the reported Never Events together identified learning to prevent recurrence.

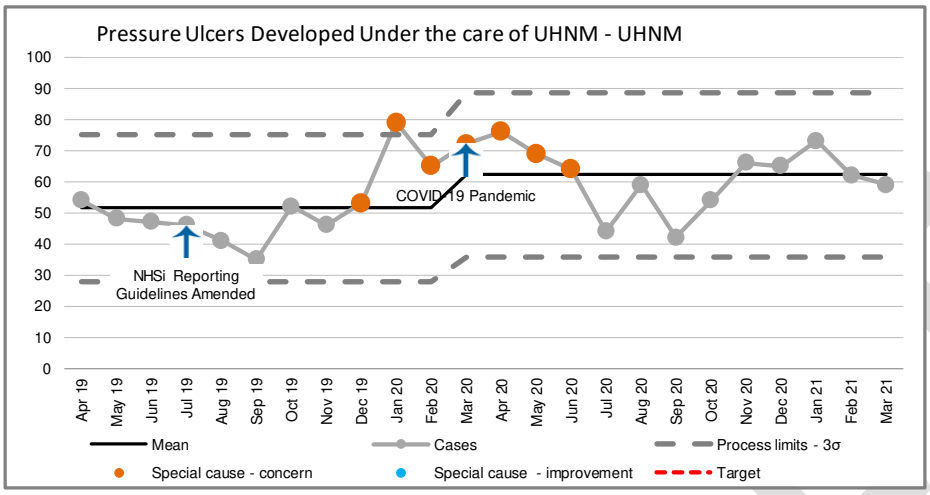
1 reported Never Events during 2020/21

2020/15667 Wrong intraocular lens implant

Never Event Incident interdepartmental Workshops were held to map pathway critical failure points from TCI to post surgery (including: Theatres, Ophthalmology clinicians, Ophthalmology nursing team, Ward staff)
Human Factors Training undertaken across Ophthalmology, Theatres and Surgical Wards
WHO checklist has been amended to include 'Additional Device Placements' which is to take prosthesis number (lens strength for Ophthalmology purposes)
6 month Audit to completed once all actions are in place for assurance

Pressure Ulcers developed under UHNM Care

We have seen an increase in Pressure Ulcers developed whilst under the care of UHNM. During 2020/21 there were 733 reported pressure ulcers developed at UHNM compared to 638 in 2019/20. This equates to 14.9% rise in identified pressure ulcers.

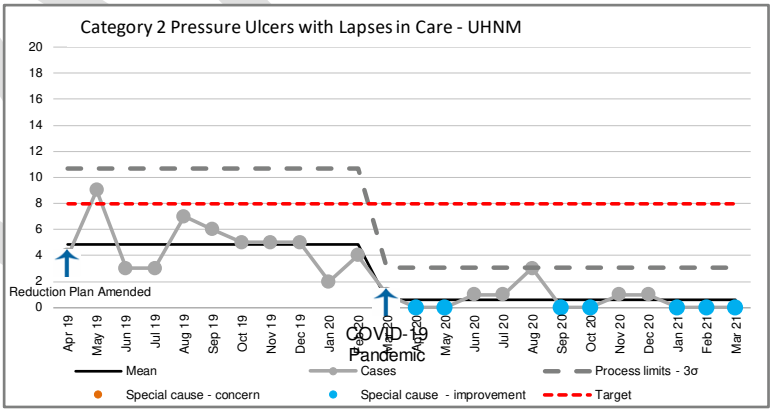


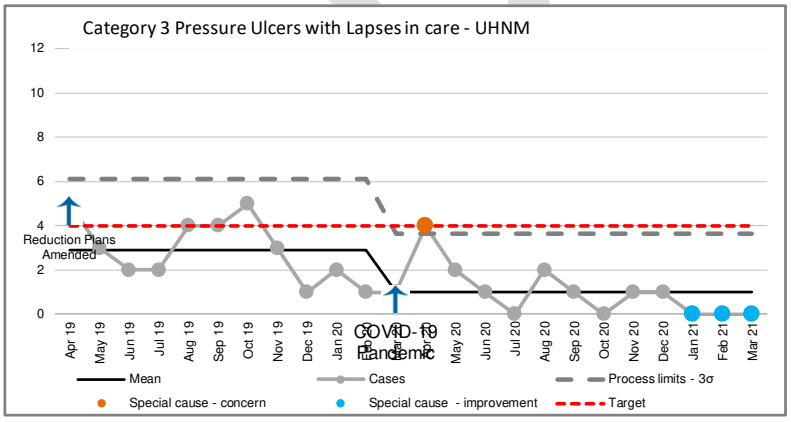
14.9% increase in reported Pressure Ulcers Developed whilst under care of UHNM

2 Category 4 Hospital Acquired Pressure Ulcer with lapse in care identified during 2020/21

However, there have been reductions in Categories of Pressure Ulcers which have had lapses in care identified during 2020/21, due to the high standard of care provided.

87% reduction in Category 2 Pressure Ulcers with 'lapses in care' in 2020/21 compared to 2019/20

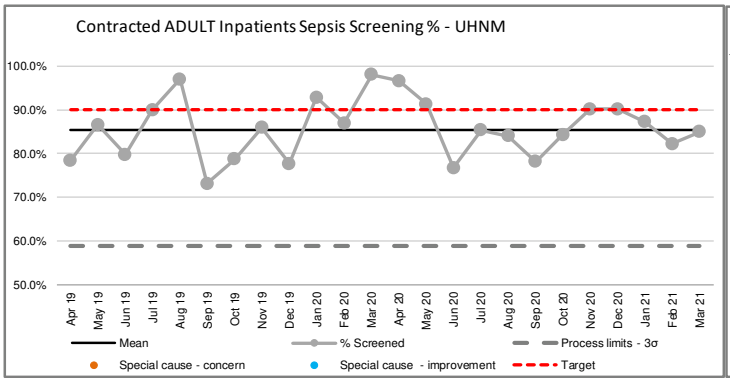


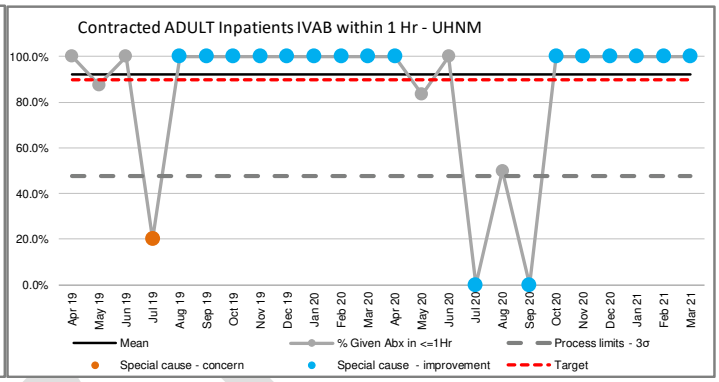


63% reduction in Category 3 Pressure Ulcers with 'lapses in care' in 2020/21 compared to 2019/20

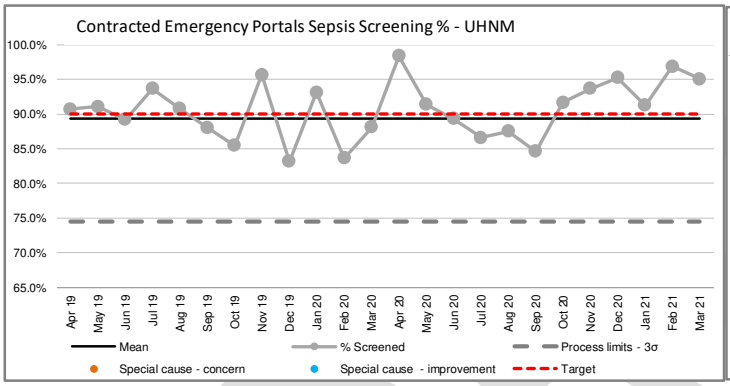
Sepsis Recognition and Treatment

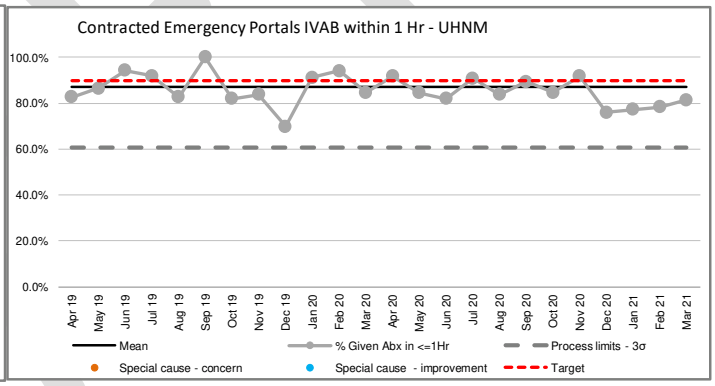
Inpatient areas have seen improvements in both screening and Intravenous Antibiotics (IVAB) in 1 hour during 2020/21. Sepsis screening improved from 85.4% in 2019/20 to 85.9% in 2020/21. Likewise the IVAB in 1 hour has improved from 92.3% to 93.3%.





Emergency Portals have seen improvements in screening but reductions in IVAB in 1 hour during 2020/21. Sepsis screening increased from 89.4% in 2019/20 to 91.8% in 2020/21. However, the IVAB in 1 hour has reduced from 87% to 84.3%.



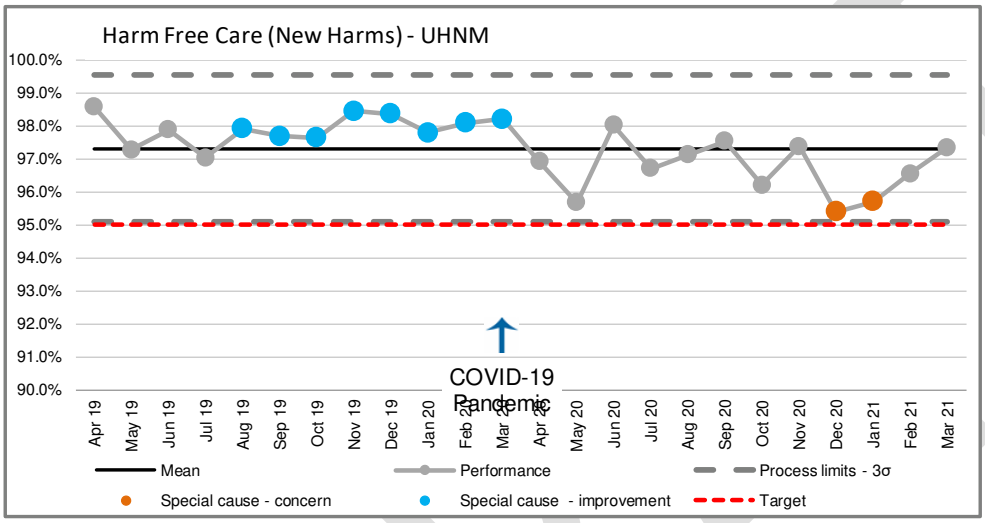


The UHNM Sepsis Team has continued to support and raise awareness to all levels of clinical/medical staff in emergency portals and in-patient areas at both sites to continue to embed the sepsis pathway and improve sepsis screening and antibiotic timeliness.

Harm Free Care (New Harms)

The national target for Harm Free Care (New Harms) is 95% and UHNM have continually exceeded this target and during 2020/21 and the COVID-19 pandemic the final overall average rate is 96.7% (refer to chart below). The results are gathered during the monthly Safety Thermometer assessments where all UHNM Inpatients are reviewed on 1 day of the month to assess whether they have experienced harm from a fall, pressure ulcer, pulmonary embolism/deep vein thrombosis or catheter associated urinary tract infection during their current inpatient admission. These results are reported nationally on monthly basis.

The mean rate for 2020/21 has varied and there have been decreases compared to 2019/20 but this year includes the extreme challenges of the COIVID-19 pandemic and the Trust has continued to exceed the national target despite these challenges.



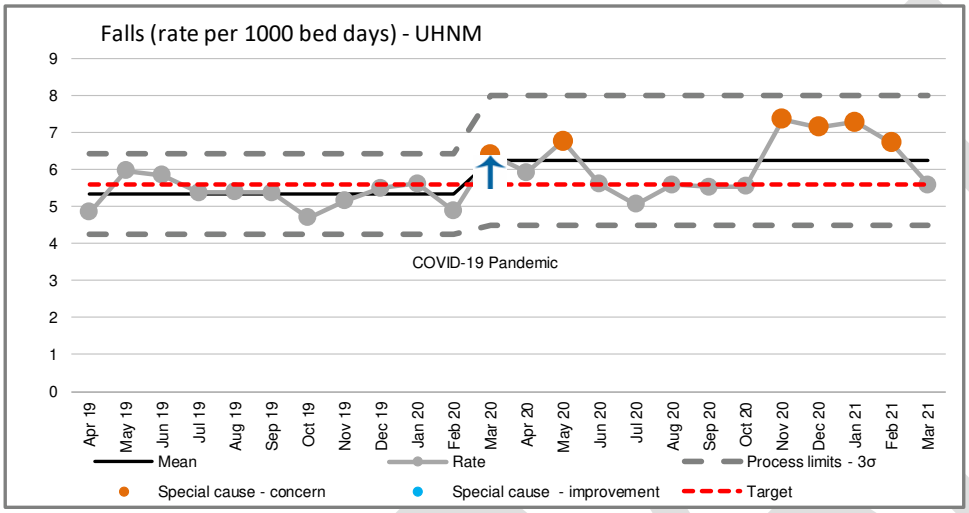
Exceeding the 95% National Target for Harm Free Care (New Harms) throughout 2020/21

Average Rate 96.7

Patient Falls

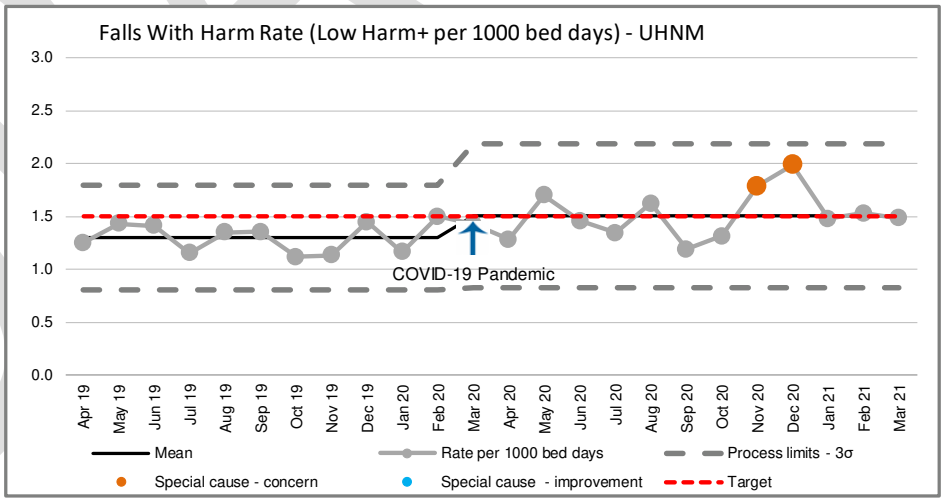
Patient Falls have reduced in total numbers in 2020/21 compared to 2019/20 with 2387 and 2603 respectively. This equates to 8.3% reduction. In order to be able to account for changes in activity the Trust uses the patient falls rate per 1000 bed days. During 2020/21 the overall rate was 6.2 compared to 5.4 in 2019/20. During COVID-19 pandemic there have continued to be challenges and there has been reductions in activity. The reductions in activity have resulted in increase in rate as the total numbers of falls has reduced.

The Royal College of Physicians national average for acute NHS Trusts from previous national audit report is 5.6 falls per 1000 bed days.



14.8% increase in rate of reported patient falls in 2020/21 compared to 2019/20.

15% increase in rate of harm to patients as result of falls per 1000 bed days in 2020/21 with 1.5 compared to 1.3 in 2019/20

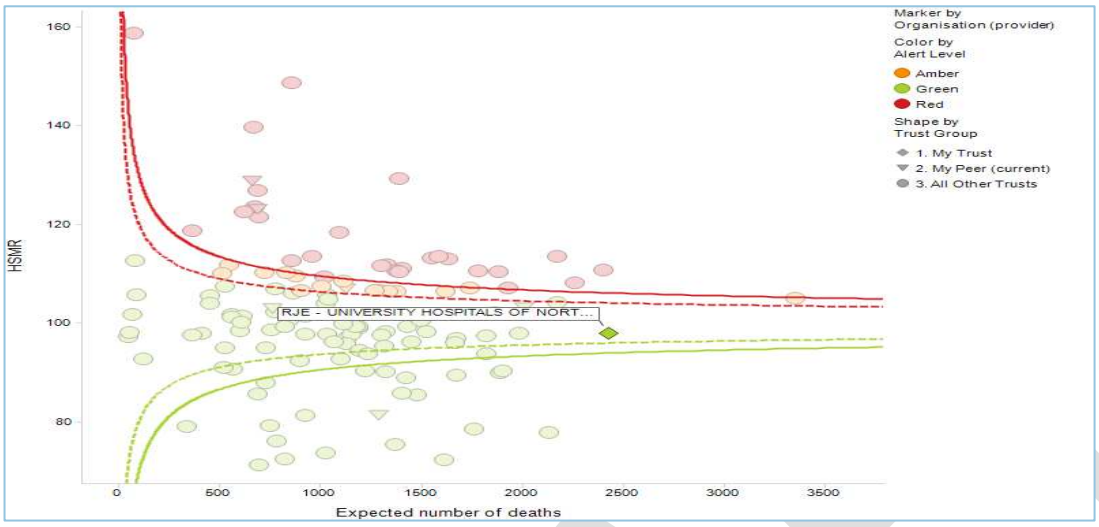


There have been increases in both the total numbers and rate of patient falls that have resulted in harm. This is important as the aim was to reduce harm from falls by 10% whilst encouraging incidents to be reported.

Total falls with harm have increased by 6%, with 669 in 2020/21 compared to 631 in 2019/20. This has also seen the rate of falls with harm increase by 15%.

Mortality

Our mortality rate with current HSMR for 2020/21 (March 2020 – February 2021) is 97.87. This means that UHNM's number of in hospital deaths is less than expected range based on the type of patients that have been treated. This compares to 92.68 for 2019/20.



UHNM continues to compare well against peers during 2020/21 and is better than expected based on standardized casemix

To calculate mortality we use a system called Hospital Standardised Mortality ratio (HSMR). HSMR is a system which compares a hospital's actual number of deaths with their predicted number of deaths. The prediction calculation takes account of factors such as the age and sex of patients, their diagnosis, whether the admission was planned or an emergency. If the Trust has a HSMR of 100, this means that the number of patients who died is exactly as predicted. If the HSMR is above 100 this means that more people died than would be expected, a HSMR below 100 means that fewer than expected died.

The Summary Hospital-level Mortality Indicator (SHMI) is a measure of mortality, developed by the Department of Health, like HSMR this measure compares actual number of deaths with our predicted number of deaths.

Like HSMR the prediction takes into account factors such as age and sex of patients and their diagnosis. The current SHMI value for the Trust is 1.03. This is a rolling 12 month measure and covers the period November 2019 – October 2020

Why are the two measure different?

Although similar the measures are not exactly the same, one of the reasons that the SHMI is different is because unlike HSMR it looks at patients who die within 30 days of leaving hospital.

Learning from Deaths Mortality Reviews

During 2020/21, we continued to use our online Mortality Review Proforma to allow in hospital deaths to be electronically reported following review of the patient death and included the outcomes of these reviews within Mortality Summary Report presented at the Trust's Quality Governance Committee and reported to the Trust Board.

Of 3997 inpatient deaths during 2020/21 2586 patients have been reviewed (65%)

Overall number of reviews submitted during 2020/21 is 3519

These reviews required reviewing clinicians to assess the care provided prior to death using the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) A-E categories. In addition, from December 2017, we adopted a more detailed review proforma based on the Royal College of Physicians Structured Joint Review form.

During April 2020 – March 2021, the Trust have completed 2586 online proformas for hospital deaths recorded during 2020/21 (65%). Each one of these deaths is assessed to classify the level of care the patient received. The overall number of mortality reviews submitted during 2020/21 is 3519. Completio of the reviews has been impacted by COVID-19 pandemic and during 2021/22 there will be further reviews undertaken of hospital onset COVID-19 related deaths.

It should be noted that the mortality reviews are currently ongoing and these figures relate to deaths in 2020/21 that have also had completed reviews submitted by 31st March 2021. There are deaths that are still being reviewed as part of the Trust's local Mortality & Morbidity Review meetings but whilst the deaths may have occurred in 2020/21 the review will be completed in 2021/22.

	2020/21 Total		Q1		Q2		Q3		Q4	
Total Number of Deaths in reporting period	3997		962		694		1252		1089	
Total Number of Deaths in reporting period subject to review (% of total deaths)	2586	65%	747	78%	574	83%	791	63%	474	44%
Total Number of reviewed deaths with suboptimal care identified – NCEPOD grade E (% of reviews)	1	0.04%	1	0.13%	0	0%	0	0%	0	0%

* The Royal College of Physicians removed the scoring system on preventability following a national pilot. UHNM continue to use the NCEPOD classification system:
A: Good practice - a standard that you accept for yourself
B: Room for improvement - regarding clinical care
C: Room for improvement - regarding organisational care
D: Room for improvement - regarding clinical & organisational care
E: Less than satisfactory - several aspect of all of the above

A summary of the learning identified from the completed mortality reviews is provided below and does not just relate to those deaths where suboptimal care has been identified. The learning relates to where improvements can be made but did not directly contribute to a patient's death.

The following provides summary of issues identified during the Structured Judgement Review process that could be improved.

- Main failure is that patient was not transferred as explicitly requested by neurology consultant. Since then a better system for escalating transfer of such cases has come into place
- Importance of recognising when patients are End of Life and a palliative approach is more appropriate
- Importance of optimal resuscitation to be discussed in departmental audit meeting
- Could be improved recognition and treatment of sepsis
- There could be an improvement of communication between different teams, including effective handovers and a time frame set to when patients should be reviewed
- Importance of clear documentation of agreed Do Not Attempt Cardio Pulmonary Resuscitation decisions to allow delivery of agreed care
- Importance of timely observations and checking of medication as prescribed
- Requirement for further training for ED staff Re ECG interpretation triage of chest pain
- Changes need to be made to ensure that inpatient records do not go missing - an important intervention will be the introduction of digital note making and electronic prescribing
- Notes need to kept in better order, including clarity and legibility of documentation
- Need to check for the consultant report on scans reports as the consultant may need to have amended these from the original
- Importance of completing screening and assessment tools to identify medical needs
- Identified need for renal replacement training on the equipment set up and commencement to ensure timely set up of renal replacement therapy when patient requires it
- Identified need for better management of hypoglycaemia
- Need to avoid transferring acutely unwell patients to avoid negative impact of multiple ward moves on patients and their relatives
- Ensuring there is a more timely referral to ITU
- Need to consider ruptured AAA as a cause for low blood pressure in older patients
- In the case of sigmoid volvulus the abdomen should be checked on the day of a planned procedure to check whether this has resolved
- Need to ensure pre-operative tests are carried out
- Regular review of medications to ensure appropriate as patients' conditions change.

Hospital Acquired Infections

The Trust continues to strive to reduce the number of avoidable hospital associated infections. Two of the key infection associated indicators that are used are Methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium Difficile (C Diff). During 2020/21, we have seen decreases in like for like numbers compared to 2019/20 for Clostridium Difficile.

Indicator	2020/21 Target	2019/20	2020/21
To reduce C Difficile infections	96	116	107
To reduce MRSA infections	0	0	0

Priority 2:
To improve staff engagement and well being

We said we would do this by:

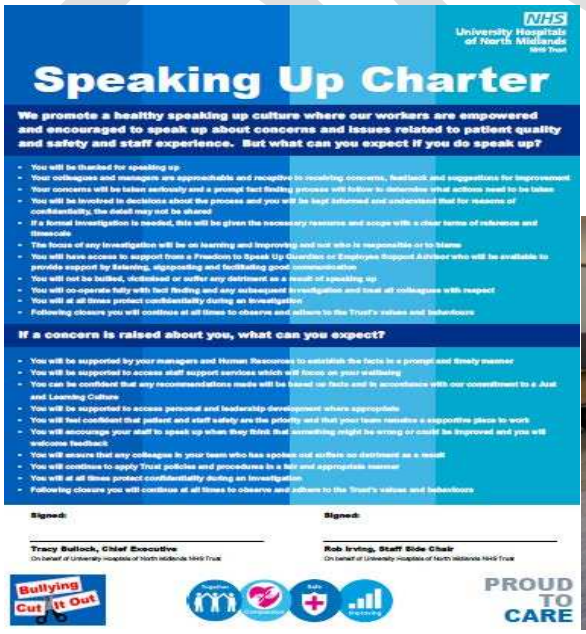
- To support the introduction of the Trust's Wellbeing Programme and activities that focus on staff wellbeing and empowerment
- Ensure that staff are working within COVID secure environments and support provided to staff
- Support staff and services in providing care in 'new ways' following COVID
- To introduce the Trust's new Quality Improvement Methodology during 2020/21 and the cultural change programme
- Promote mental health wellbeing and support
- Delivering Exceptional Care

Performance against this priority and its aims has been monitored during 2019/20. The following section provides a summary of the performance for these indicators and what these results mean for our patients.

Freedom to Speak Up

The Trust has continued to promote our speaking up routes and support available from our Freedom to Speak Up Guardians. There are regular reports provided to the Transformation and People Committee and Trust Board on speaking up themes raised and actions taken.
Actions taken in 2020/21:

- Launched our Speaking Up Charter – The Charter has been designed to demonstrate our commitment to supporting staff to speak up.



Tracy Bullock, Chief Executive pictured with Rob Irving, Chair of Staff Side and Ro Vaughan, Executive Lead for Speaking Up and Charlotte Lees, FTSU Guardian after signing the Charter in August 2020

- An audit of our speaking up arrangements by the Trusts Internal Auditors KPMG was undertaken during 2020. The Audit provided an assessment of 'significant assurance with minor improvement opportunities'
- Our Speaking Up Index score improved from 74% in 2019 to 75.5% in 2020.
- A new question was introduced to the 2020 NHS Staff Survey specifically relating to a speaking up culture:

Question	Average for Acute Trusts	UHNM 2020 Result
I feel safe to speak up about anything that concerns me in this organisation	65.0%	63.6%

- The other 2020 Staff Survey indictors relating to speaking up demonstrate that we have improved against all of the safety culture indicators, and the gap narrowed between UHNM and the average for acute trusts.

Question	Average for Acute Trusts	UHNM 2020 Result	UHNM 2019 Result	UHNM 2018 Result	UHNM 2017 Result
My organisation treats staff who are involved in an error, near miss or incident fairly	61.4%	58.7%	57.4%	55.9%	52.3%
My organisation encourages us to report errors, near misses or incidents	88.2%	86.2%	84.5%	82.4%	83.4%
If you were concerned about unsafe clinical practice, would you know how to report it?	94.6%	93.4%	92.7%	93.4%	93.3%
I would feel secure raising concerns about unsafe clinical practice	71.8%	69.8%	67.8%	65.6%	65.9%

- Other safety culture indicators in the Staff Survey not included in the Speaking Up Index:

Question	Average for Acute Trusts	UHNM 2020 Result	UHNM 2019 Result	UHNM 2018 Result	UHNM 2017 Result
I am confident that my organisation would address my concern	59.1%	56.7%	56.1%	52.7%	52.7%
When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again	72.7%	73.1%	69.9%	67.6%	68.2%
We are given feedback about changes made in response to reported errors, near misses and incidents	61.9%	60.0%	58.9%	57.7%	53.9%

- During 2020-21 over 120 individuals raised issues through our speaking up routes
- Our Speaking Up Policy is reviewed annually and was updated during 2020,
- The Trust's intranet has a Speaking Up page on the Staff Room section, with guidance for workers and managers.
- The Raising Concerns and Workforce Equality Manager is the Trust Freedom To Speak Up (FTSU) Guardian, supported by Associate Guardian roles and a network of Employee Support Advisors who are representative of our workforce.
- The FTSU Guardians have ready access to senior leaders and others to enable rapid escalation of issues, maintaining confidentiality as appropriate.
- Promoted during 2020 safe speaking up channels available to those staff whose voices are not so often heard. During Speaking Up Month 2020 the Trust Freedom to Speak Up Guardians attended three system wide events for Black, Asian and Minority Ethnic, Disability and Long Term Conditions and LGBT+ staff network groups to

raise awareness of speaking up, the role of freedom to speak up guardians and employee support advisors and the safe channels available for staff to raise issues.

- Our Ethnic Diversity Staff Network Chair is also an Associate Freedom to Speak Up Guardian.
- The Trust has named Executive and Non-Executive Leads for speaking up
- The FTSU Guardian reports quarterly in person to the Transformation and People Committee, and through this to Trust Board.
- UHNM has outlined its vision and strategy for speaking up in its Speaking Up Plan
- The Trust Board had a board development session on Speaking Up delivered by NHS England & Improvement in January 2020 and speaking up training is part of our Gateway To Management programme for staff with line manager responsibility.
- Updated our Disciplinary Policy and Grievance Policies to include the Just and Learning framework and recommendations from National Guardian Office Case Reviews

2020 NHS Staff Survey – The National Context and Trust Outcomes

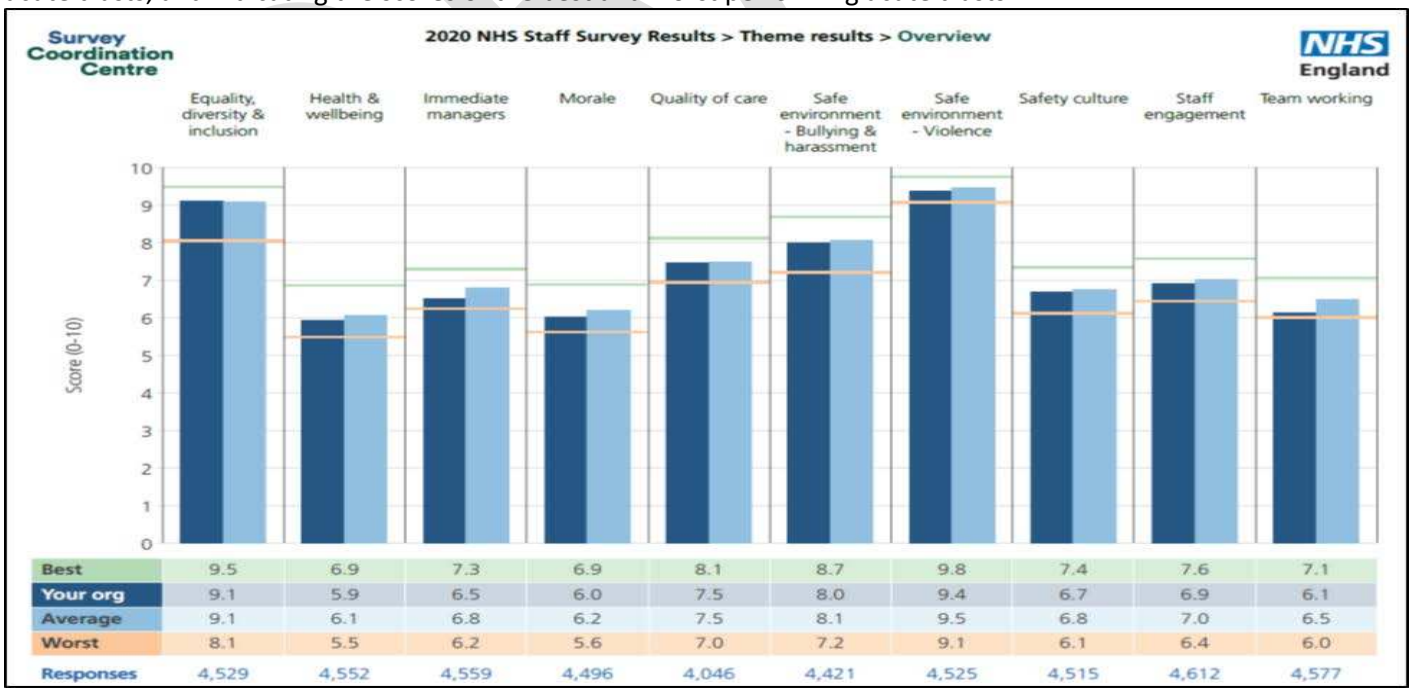
The 2019 NHS Annual Staff Survey was carried out between September and December 2020 and the Trust response rate was 44%. The national response rate was 45% and there were 128 organisations in the acute benchmarking group.

It should be noted that the published Staff Survey report is based on a sample population of 1250, regardless of the number of staff surveyed. Also, data in the national results is weighted to reflect the distribution of staff according to staff group.

There were two statistically significant improvements in the 2020 scores when compared to the previous year's data.

- Health and Wellbeing
- Safe Environment – Bullying and Harassment

The following table presents an overview of the 10 themes, comparing this Trust's results to the national average for acute trusts, and indicating the scores of the best and worst performing acute trusts.



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	6.9	7.3	6.9	8.1	8.7	9.8	7.4	7.6	7.1
Your org	9.1	5.9	6.5	6.0	7.5	8.0	9.4	6.7	6.9	6.1
Average	9.1	6.1	6.8	6.2	7.5	8.1	9.5	6.8	7.0	6.5
Worst	8.1	5.5	6.2	5.6	7.0	7.2	9.1	6.1	6.4	6.0
Responses	4,529	4,552	4,559	4,496	4,046	4,421	4,525	4,515	4,612	4,577

The chart shows that the main themes where this Trust scores lower than national average are:

1. **Health and wellbeing** – all aspects of this theme improved. Positively, staff perceptions on opportunities for flexible working improved from 48.1% to 51.6% and the organisation taking positive action on health and wellbeing improved from 24.5% to 27.9%.
   Fewer staff said they had experienced Musculoskeletal problems (reduced from 27% to 26.4%) and fewer staff said they had come to work despite not feeling well enough (reduced from 59.1% to 49.4%)
   However, there was an increase in the percentage of staff saying they had felt unwell as a result of work related stress.
2. **Immediate Managers –**There was an improvement in staff saying their immediate manager took a positive interest in their health and safety (from 65.3% to 65.6%, but fewer staff said their immediate manager valued their work (reduced from 68.9% to 67.3%). Staff perceptions were also reduced as regards:
   - The support they get from their immediate manager (from 66.4% to 64.9%)
   - Their manager gives clear feedback (from 57.0% to 55.6%)
   - Their immediate manager asks for staff opinion before making decisions affecting their work (from 49.9% to 48.7%)

   Encouragingly, there has been a slight improvement in staff feeling that communication with senior management is effective and that senior managers act on staff feedback.
3. **Morale –** Staff say they have unrealistic time pressures, that they are not involved in decisions on changes affecting their work areas and that they do not receive the respect they deserve from colleagues at work. The have less choice in deciding how to do their work, relationships are strained and their immediate manager does not encourage them. This is of course in the context of the Trust operational pressures in managing the impact of the covid pandemic, where staff have worked in different environments, with different teams and under challenging conditions.
   Although the percentage of staff who said they are thinking of leaving reduced, the percentage who are looking for other jobs, and who would leave as soon as they got another job increased.
4. **Safe Environment – Violence –** There was a small increase in staff saying they experienced physical violence from patients, relatives or other members of the public (16.5% up to 16.6%). Experience of physical violence from other colleagues also increased from 1.4% to 1.7%. Both of these aspects are above the national average.
   Staff experience of violence at work from a manager reduced from 0.7% to 0.6%.
5. **Safety Culture –** Continuing the improvement seen on 2019, and reflecting the implementation of Just and Learning Culture, there were further improvements in every aspect of this theme:
   - The percentage of staff saying those involved in an error, near miss or incident are treated fairly improved from 57.4% to 58.7%
   - That the organisation takes action to ensure errors or incidents don't happen again improved from 69.9% to 73.1%
   - Staff saying they receive feedback staff in response to reported incidents improved from 58.9% to 60%
   - Staff feeling secure about raising unsafe clinical practice improved from 67.8% to 69.8
   - Staff confidence that the organisation would address their concerns increased from 56.1% to 56.7%, and
   - Staff saying the Trust acts on concerns raised improved from 71.4% to 72.8%
6. **Team Working** – Perhaps reflecting operational pressures over the last 12 months, fewer staff said their teams have shared objectives (down from 69.1% to 68.3%) and teams have been meeting less to discuss effectiveness (from 50.9% to 48.7%)
7. **Staff engagement –** At 6.9, the staff engagement score remains just below the acute trust average of 7.0. This is unchanged from the previous year.
   Staff morale was impacted in 2020, with fewer staff saying they looked forward to coming to work and staff saying they were less enthusiastic about their job. There was also a reduction in staff saying time passed quickly for them at work.

Staff also said they felt less able to contribute to improvements in 2020, which is probably a reflection of the operational changes implemented to manage the COVID-19 pandemic

COVID-19 Questions

Staff were asked four classification questions relating to their experience during the COVID-19 pandemic:

- Have you worked on a COVID-19 specific ward or area at any time?
- Have you been redeployed due to the COVID-19 pandemic at any time?
- Have you been required to work remotely/from home due to the COVID-19 pandemic at any time?
- Have you been shielding?

Overall, there was little distinction between the results of those staff whose method of working has been impacted most by COVID-19 and the "All Staff results. The main areas of distinction are:

- Staff working on covid wards and those redeployed have greater concerns for their health and wellbeing
- Staff shielding for a household member report lower morale
- Staff required to work from home/remotely have reported a greater perception of bullying and harassment
- Staff working on covid wards have reported a greater instance of violence

Next Steps

The improvement activities set out below follow on from the 2019 Staff Survey, when we set out our key areas of corporate focus planned for 2020/21. The overall vision is that we want to be a Trust that is seen positively by our staff in all aspects of staff engagement, with the goal of being above average as a Trust overall by the next survey (2021) and in the top 20% of Trusts by 2023

Priority 3:
To improve patient experience

We said we would do this by:

- Utilise patient and visitor feedback
- Seek wider engagement with 'harder to reach' patient groups
- Ensure patients are fully informed of COVID-19 requirements and Trust continues to provide the best possible communication with patients/relatives by working with other key stakeholders and groups
- To introduce the Trust's new Quality Improvement Methodology during 2020/21 and the cultural change programme
- Review patients experiences during COVID and identify positive changes to adapt service provisions
- Review the different ways that patient experience and views are gathered and acted upon within UHNM

Performance against this priority and its aims has been monitored during 2019/20. The following section provides a summary of the performance for these indicators and what these results mean for our patients

University Hospitals of North Midlands aspires to achieve a culture where the voice of our patients, their carers and families is at the heart of all that we do and we believe that patients can be equal partners in creating positive changes through identifying where barriers and challenges exist in our systems.

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The Trust has also worked in partnership with stakeholders on quality improvement activities including:

- Hospital User Group – has continued to meet virtually during the COVID 19 pandemic
- Clinical Quality Review Group
- Healthwatch – close relationship with Healthwatch maintained through membership of the HUG. Healthwatch have been invaluable for collecting and sharing feedback from our patients during the pandemic
- Overview and Scrutiny Committee
- Quality review visits of the patient pathway which are Director led with Clinical Commissioning Group and GP involvement
- Complaint Peer Review Workshops – on hold due to the pandemic
- Patient Information Leaflet Ratification Workshops – continued virtually throughout the pandemic.
- PLACE inspections
- Assist, dDeaflinks and Capita have continued to provide interpretation services throughout the pandemic. The majority of foreign language interpretation now takes plave via video or telephone with good effect.
- Learning Disability Service User Group – has continued to meet virtually
- The Sustainable Transformation Programme has worked with UHNM, MPFT, CCG, WMAS and Derbyshire Trust to introduce "111First" to direct patients to the most appropriate service and admission into emergency portals as appropriate

- UHNM membership of the CCG Community & Engagement Group to provide consistent messaging to the general public and hard to reach groups throughout Staffordshire
- Working with MPFT, Combined Health and the CCG to agree a consistent approach and Peer review of local Equality Delivery System objectives

Annual Inpatient Survey

The 2020 Inpatient Survey has been delayed as a result of COVID 19. Patients who were in hospital either November or December 2020 are currently being surveyed but no results yet.

The way we communicate with our patients continues to have a significant effect on their overall experience of our Trust. We know we need to improve the way we share information to support patients to feel more involved in decisions that affect their care and treatment.

Improvement initiatives include:

- "It's OK to ask" campaign: to encourage patients to ask the questions about their care and treatment that matter to them. This campaign has been extended in the community to prepare patients for their GP Consultation and hospital visit and support Shared Decision Making. The Health Literacy training was put on hold but is now being rolled out to other areas in the Trust.
- Redesign of patient information leaflets to promote patient awareness and development of an electronic Patient Information library to support staff to have easy access to patient information leaflets
- Measurement of effectiveness of initiatives with patient surveys to inform the Clinical Excellence Framework audit programme
- Triangulation of quality and safety data through an internally designed Quality Management System data base to identify themes.
- Production of a Food and Hydration strategy which pays close attention to the end quality of food and drink served so that everyone received meals they enjoy.
- There continues to be a firm focus on patient experience at Trust induction on line only
- Purple Bow initiative established to provide additional support for relatives of end of life patients. RESPECT document introduced (palliative care will help if you need more info re this)
- Proactive recruitment of volunteers to assist with the improvement of service delivery and the patient experience.

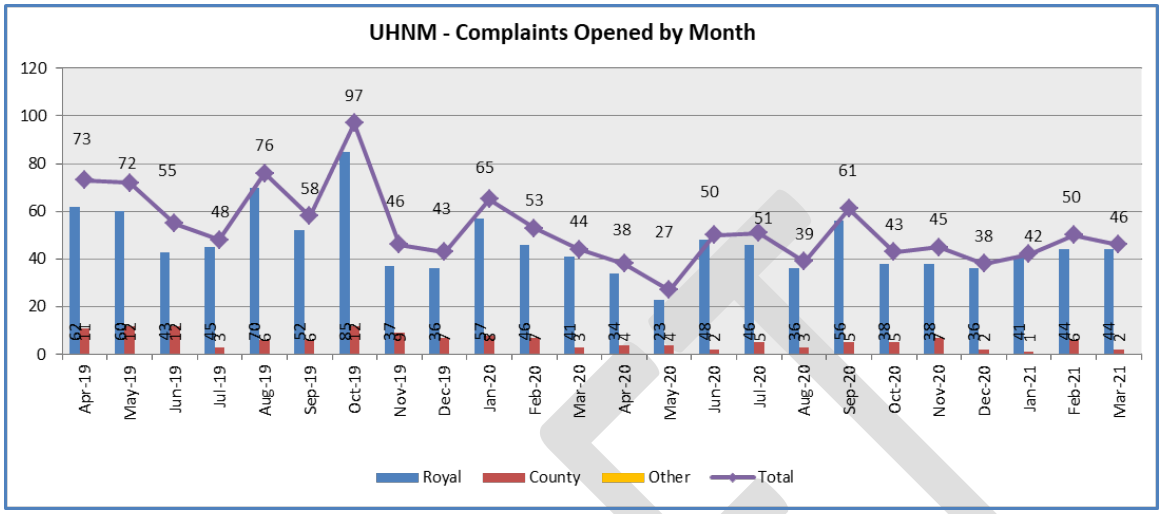
Complaints

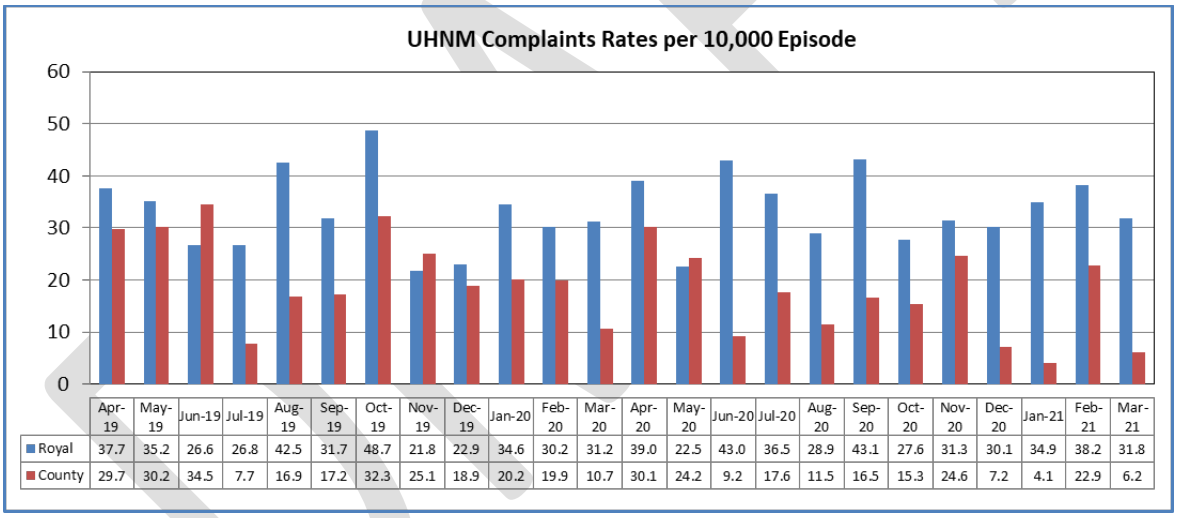
The total number of complaints opened at Royal Stoke University Hospital during 2020/21 is 484 which is 21% lower than the previous 3 year average of 616.
The total number of complaints opened at County Hospital was 46 in 2020/21, which is 59% lower than the previous 3 year average of 112.

During 2020/21, the Complaints Team have achieved the following:

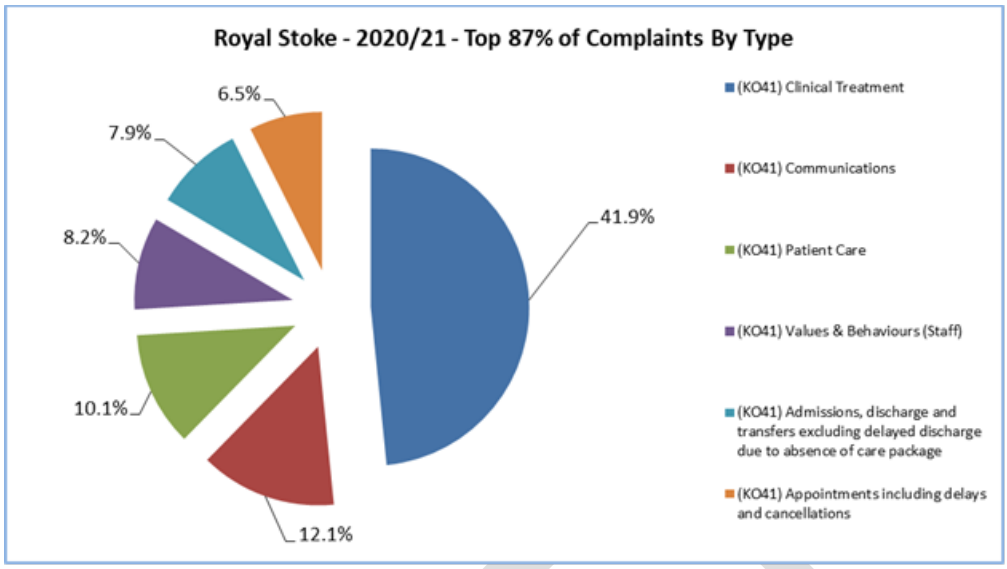
- Complaints are categorised to assist in analysing their trends and themes.
- On-going review of the current process to facilitate an improvement in the timeliness of responses from receipt of complaint to final response
- A set of Golden rules has been agreed to improve consistency and quality of responses

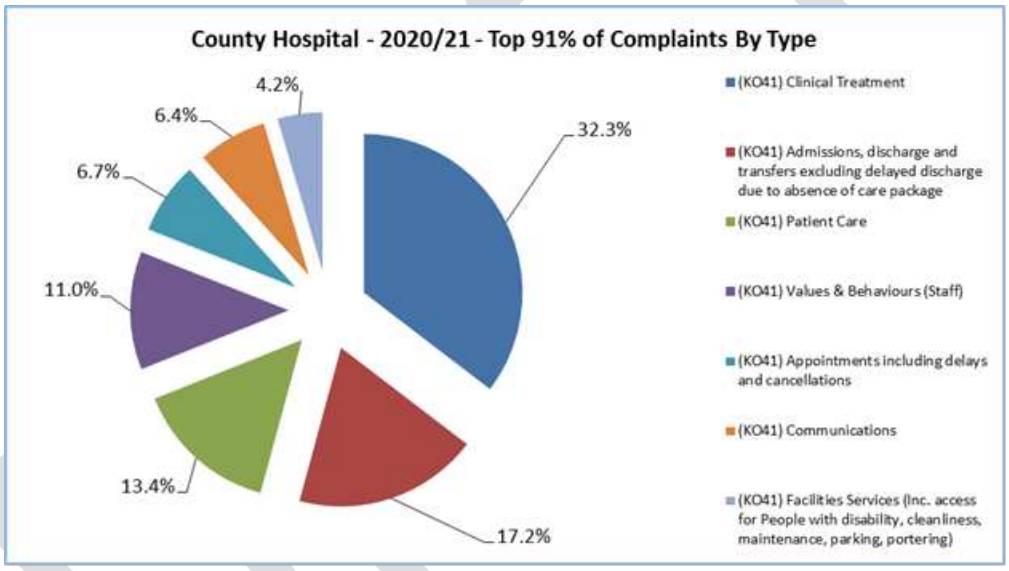
- Complaints closed during 2020/21 had been open for an average of 83 days compared to the previous 3 year average of 50 days. During COVID-19 Pandemic holding letters were sent to every complainant explaining there would be delay in responding to concerns raised whilst the Trust were managing the pandemic.





	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Royal	37.7	35.2	26.6	26.8	42.5	31.7	48.7	21.8	22.9	34.6	30.2	31.2	39.0	22.5	43.0	36.5	28.9	43.1	27.6	31.3	30.1	34.9	38.2	31.8
County	29.7	30.2	34.5	7.7	16.9	17.2	32.3	25.1	18.9	20.2	19.9	10.7	30.1	24.2	9.2	17.6	11.5	16.5	15.3	24.6	7.2	4.1	22.9	6.2





Learning from Complaints

One of the most important aspects of the complaints process for the Trust is to learn lessons and make changes to enhance the experience for our patients, carers and relatives. The section below describes some of the improvements made as a direct result of complaint investigations.

You said: When you attended the ED with your daughter, your daughter's temperature was taken but yours was not which raised a concern for you.
We Did: All A&E staff have been informed of the change in process, following a discussion with the Infection Prevention team. Now anyone accompanying a patient to A&E shall also have their temperature taken.

You said: Your relative was discharged inappropriately following an overdose. Family were not informed of her discharge and she was sent home unsupervised in a taxi.

We did: Ensured there are other phone numbers available for internal staff to contact families including a phone in each doctor's office. Call Centre team instructed that external callers should be directed to the AMU reception and staff phones.

You said: You are unhappy that your details had been shared without consent and was a breach of GDPR (36068)
We did: Stroke Pathway Document has been amended to add a section regarding consent for details to be passed to the Crewe Stroke Recovery Service which must be completed by the therapist responsible for the patient's discharge

You said: During your brother's inpatient stay, you highlighted to the nursing teams that he had learning disabilities and would require encouragement to comply with treatment, this did not happen.
We did: Discuss with staff that when a learning disability is disclosed that a referral is made to the Learning Disability Nurse and a 'This is Me' document completed.

You said: That communication with the ward when your wife had to re-attend post discharge was poor and led to unnecessary distress for your wife
We Did: The Obstetrics and Gynaecology Directorate have introduced an evening consultant ward round/ handover for the Junior Doctor's

You said: That an interpreter was not booked for your friend who was to be given bad news at their clinic appointment
We did: All administration staff will be reminded of the importance of ensuring that something is done when the dialogue box appears when booking an appointment and an interpreter needs to be booked.

Part C: Statements from our key stakeholders

NHS
Stoke-on-Trent
Clinical Commissioning Group

NHS
North Staffordshire
Clinical Commissioning Group

NHS
Stafford and Surrounds
Clinical Commissioning Group

City of
Stoke-on-Trent

Performance and Finance Chair's Highlight Report to Board

25th May 2021

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The Committee noted that Chairs approval had been previously provided to place an order for additional works to mitigate Project STAR programme risks and secure savings. The Committee recognised the challenges associated with requesting approval and challenged the reasoning for the short timescales which resulted in the need to seek approval before the Committee meeting. Assurance was provided to the Committee in terms of the actions taken to consider and agree the approach, and recognised the importance of making an earlier decision in order to mitigate the associated risks. • The Committee welcomed the initial meeting of the Operational Delivery Group; a number of areas of concern were highlighted, in terms of the histology 'bottleneck', the number of P2 patients and the anticipated surge in paediatrics from August 2021 to March 2022 • In terms of urgent care performance, there had been an increase in surgical and specialised admissions which was impacting upon bed occupancy and the main deterioration in performance was due to increased ambulatory patients. In addition an intervention had also been required to be made in terms of triage times • In terms of cancer performance, rising referrals had created competing demands between cancer and clinically urgent patients, although clinical prioritisation and validation continued. It was noted that one of the main areas of challenge related to 2 week waits for breast cancer • The Committee raised concern regarding the financial impact in relation to use of the Independent Sector (IS), although it was noted that the Trust had control over what activity was undertaken by the IS and as long as the work was undertaken in Staffordshire, it would count towards the Trust's baseline.	• To bring an update to a future meeting in terms of investment decisions and applicable sources of funding • A verbal update to be provided to the Committee in relation to progress being made in reducing the Endoscopy backlog • To provide an updated paper at the next Committee in relation to confirmed trajectories
Positive Assurances to Provide	**Decisions Made**
• An update was provided in terms of progress with the key procurement workstreams including savings, collaborative procurement partnerships and new a Service Level Agreement • A positive update was provided by the Business Intelligence Group which continued to build upon its work programme • The Committee queried the financial impact of returning to previous activity levels and noted the ongoing work being undertaken in respect of applying and delivering the national guidance and determining the associated income stream • In terms of planned care, theatre operating had increased up to 102%, therefore work was ongoing to assess what could be done in addition, to make an impact on reducing the patient tracking list • In relation to diagnostics, the waiting list was relatively steady • In terms of financial performance, a break-even plan had been determined for H1 with the key assumption being that expenditure levels would return to pre-Covid levels, and in month 1 the Trust had delivered a surplus of £2.7 m driven by a number of non-recurrent benefits	• The Committee approved the 6 month extension for the Endoscopy Insourced Service • The Committee approved the following E-REAFs: o RS/1510/CAP - MRU (Medical Research Unit) alterations - (eREAF 7654) o Cytotoxic Dose Banded - Chemo, Immunotherapy and Monoclonal Medicines - (eREAF 7352) o AHP/HSS Master Vendor contract - (eREAF 7721) o Independent Sector contract with Ramsay Healthcare – (eREAF 7571) o Independent Sector contract with Nuffield Health – (eREAF 7569) o Franking Machine postage charges for 2021/2022 – (eREAF 7450)
Comments on the Effectiveness of the Meeting	
• Committee members felt the meeting ran well with significant discussion on key items	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Executive Directors Update including Covid-19	Information	6.	Executive Business Intelligence Group Highlight Report	Assurance
2.	BC-0411 Endoscopy Insourced Service – 6 Month Extension	Approval	7.	Operational Delivery Group Highlight Report	Assurance
3.	Authorisation of New Contract Awards and Contract Extensions	Approval	8.	Month 1 Performance Report • Activity Planning Update	Assurance
4.	Quarterly Procurement Update Report	Assurance	9.	Minutes from Non-Elective Improvement Group	Information
5.	Project STAR Cost Pressure	Information	10.	Month 1 Finance Report	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												
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										
Mr J Tringham	JT	Director of Operational Finance												

Transformation and People Committee Chair's Highlight Report to Board

May 2021

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Guardian of Safe Working closely with teams within the Surgical Division to work through some of the concerns identified ; noted that concerns raised more generally by Junior Doctors are being addressed • Medical Education Highlight Report demonstrated that the pandemic had a significant impact on medical trainees and steps to mitigate this impact were made but requires ongoing review • 409 medical students completed the NETS survey which concluded with an overall score of 73.54% which was below the benchmark of 76.36% • 42 overseas nurses who have been recruited are delayed due to the crisis in India • There are time critical activities associated with the Improving Together were highlighted in terms of completion of A3's – deadlines have been set and are on track	• Implementation of the HR Delivery Plan and the Wellbeing Plan • Work on updating the Junior Doctors 'Mess' has progressed well and is expected to be completed by August 2021 • 49 overeas nurses have been recruited and are being taken through the process with their expected arrival planned for early June – arrangements are underway in terms of their induction programme • A further overseas recruitment process is underway with a further 50 individuals recruited • Nursing Associates – 20 completed training in March, 20 due to complete early spring and a further 20 due to complete by September. A business Case has been prepared for a further 30 to be introduced into the workforce • Improving Together Programme progressing well with the final individual recruited to the team (nursing). Training sessions are well underway with good engagement. • Assurance Map associated with Improving Together developed; Highlight Report to include progress with Delivery Plan, Training, Improvement Projects in the future • Progress with refresh of the Strategic Objectives and a Strategy Development Template are under development
Positive Assurances to Provide	**Decisions Made**
• Performance in completing PDR's and Statutory and Mandatory Training compliance continue to improve with Statutory and Mandatory Training just marginally below the target at 94.19% although PDR compliance requires further improvement (at 77.42%) • Sickness absence continues to reduce with Covid related absence reducing to 8.32% of all absences • Staff Voice Survey Tool due to be launched in June • Development of HR Delivery Plan which takes into account national, regional and local priorities • Refreshed Wellbeing Plan which focuses on the key Wellbeing Priorities for the coming year • RESPOND Training has been delivered to over 400 staff with external partners also interested in adopting the model • Working in partnership with Combined Healthcare and Sodexo applications for the Connects Leadership Programme have been extremely positive in terms of interest • Despite appraisals being stood down during the pandemic, the number of medics who were revalidated remained high which was pleasing to note	• Approval of the minutes of the previous meeting • Approval of the HR Delivery Plan • Approval of the Welllbeing Plan, with support from the Wellbeing Guardian

Comments on the Effectiveness of the Meeting
• Positive focus on People aspects of the agenda, busy agenda with lots to oversee • Consideration to a further Deep Dive to be given for a future meeting • Really good papers presented

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Executive Directors Update including Covid-19	Information	9.	Postgraduate Medical and Dental Education Report	Assurance
2.	Month 1 Workforce Report	Assurance	10.	Quarterly Nurse Vacancy Progress Report	Assurance
3.	HR Delivery Plan 2021/22	Assurance	11.	Improving Together Highlight Report	Assurance
4.	Health and Wellbeing Plan 2021 – 2023	Assurance	12.	Executive Workforce Assurance Group Highlight Report	Assurance
5.	Organisational Development Culture Update	Assurance	13.	Executive Strategy and Transformation Highlight Report	Assurance
6.	Q4 Guardian of Safe Working Report	Assurance	14.	Review of Meeting Effectiveness	Information
7.	Q4 Revalidation Report	Assurance	15.	Review of Business Cycle	Information
8.	National Education and Training Survey	Assurance	16.	Items for Escalation	Approval

3. 2019 / 20 Attendance Matrix

Attended | Apologies & Deputy Sent | Apologies

Members:			A	M	J	J	A	S	O	N	D	J	F	M
Prof G Crowe	GC	Non-Executive Director (Chair)												
Ms H Ashley	HA	Director of Strategy and Transformation												
Ms S Belfield	SB	Non-Executive Director												
Mr P Bytheway	PB	Chief Operating Officer												
Dr L Griffin	LG	Non-Executive Director												
Mr M Oldham	MO	Chief Finance Officer												
Dr K Maddock	KM	Non-Executive Director												
Mrs M Rhodes	MR	Chief Nurse												
Miss C Rylands	CR	Associate Director of Corporate Governance												
Mrs R Vaughan	RV	Director of Human Resources												

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	9th June 2021
Report Title:	Integrated Performance Report, month 1 2021/22	**Agenda Item:**	12
Author:	Quality & Safety: Jamie Maxwell, Head of Quality & safety; Operational Performance: Karan Allman, Deputy Head of Performance; Matt Hadfield, Deputy Associate Director of Performance & Information. Workforce: Claire Soper; Finance: Tringham, Jonathan		
Executive Lead:	Scott Purser: Interim Chief Nurse Paul Bytheway: Chief Operating Officer Ro Vaughan: Director of Workforce Mark Oldham: Director of Finance		

Purpose of Report:

Assurance	✓	Approval		Information	

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

Executive Summary:

Situation

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

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

Assessment

Quality & Safety:

The Trust achieved the following standards in April 2021:

- Friend & family (inpatients) 98.5% and improvement from previous months and exceed 95% target
- Harm Free Care 96.3% 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 99.5% (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. However, there are 8 incidents under review, so this figure may change.
- Sepsis Screening compliance in Emergency Portals exceeded the target 90% with 97% which continues the steady improvement recorded since October 2020
- Inpatients IVAB within 1 hour achieved 100% for audited patients
- Children's IVAB in 1 hour was 100%
- Maternity Sepsis Screening recorded 91.7%
- Zero Never Events

The Trust did not achieve the set standards for:
- Friend & Family Test for A&E 79.7% and below 85% target
- Falls rate was 5.8 per 1000 bed days but is below the average rate per 1000 bed days during COVID-19 pandemic
- 94.1% Duty of Candour 10 day letter performance following formal verbal notification. 1 case awaiting confirmation of letter.
- C Diff YTD figures are above trajectory with 9 against a target of 8
- Inpatient Sepsis Screening compliance (adult Inpatients) increased to 89.4% but below the target of 90%
- Children's Sepsis Screening compliance 81.8% below the 90% target
- Emergency Portals IVAB in 1 hour improved to 89% but still below the 90% target
- Maternity IVAB within an hour was 50% for audited patients

During April 2021, the following quality highlights are to be noted:
- The rate of complaints per 10,000 spells is 32.59 is below (positive) the target of 35 and is within normal variation despite in month increase.
- Total number of Patient Safety Incidents increased in April but the rate per 1000 bed days was relatively stable with 0.03 increase from March. Rate (45.59) is below the NRLS mean 50.7
- Patient Safety Incidents with moderate harm or above and the rate of these incidents have decreased slightly in April but are within normal variation. The total number and rate for April 2021 remains above the long term average. Rate of Low and No Harm incidents increased
- Rate of falls reported that have resulted in harm to patients has remained relatively stable at 1.6 compared to 1.5 in previous month. 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 decreased to 3.4. Current national NRLS published mean rate is 6 (April 2019 –March 2020)
- There was 1 Nosocomial COVID Infections reported during April 2021.
- Zero COVID-19 deaths falling in to the 'Definite' category (according to the National definition of Nosocomial deaths) in April
- 11 Serious reported in April 2021 with falls the largest category of incidents and all incidents were reported on STEIS within the 2 working date target

Operational Performance:

The decline in the number of covid-19 patients attending and being admitted continued in April. Inpatients numbers were reduced again by half from the previous month, with <30 (from a peak in Jan of 349). The number of beds restricted for infection prevention also continued to reduce and for most days were < 5 and on some days zero. As these numbers continue to decline the Trust saw the number of 'blue' areas reducing and as a result the last Covid-19 ward was closed. However, going forward there is an underlying number of patients with Covid-19 or recovering that are still acutely ill, requiring side rooms and are not yet medically fit for discharge.. Consequently, this has the potential to reduce available capacity for admissions.
Operational performance system wide was 76.8%, with Royal Stoke site at 56.9%.
The improvement trajectory is marked by some challenged days of performance attributed to high volume ambulatory attends and compounded by workforce challenges. There was a continued increase in sub 60 and sub 50 performance days in April, with clear evidence in the acute front door pathway metrics of ambulatory, non-admitted attends. This is being addressed with an audit of those attends to frame

discussions with the system about GP, walk in centre and 111 First / SDEC pathways and management of unheralded patients. This is being addressed through the acute front door improvement work stream.

The Trust is predicted to achieve the following three cancer standards for April21: 31 day subsequent treatments for radiotherapy, the rare cancers standard and the 28day FDS standard. The 2ww position in April is predicted to land at 76.7%. The sites that most influence this performance are Breast is at 11.8%; skin 88.9% and Upper GI at 75.7% - all are large volume sites and have seen rises in demand (particularly breast). The increase in demand has put significant pressure on outpatient capacity. Additional clinics are being resourced to meet demand. Additional fewer than 35 clinics where radiology support may not be required are also being set up. 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 has recovered and is predicted at this point to achieve 75.6%., with one of the lowest backlogs regionally. In addition, the number of patients waiting over 104 days has reduced to 28, a reduction of almost half since last month.
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 indicative performance for April 21: the total number of Referral To Treatment pathways grew to 59,645 (March 56,601). The Trust has reduced the number of > 52 weeks to 4,094 (March 4,563) as a consequence of standing down elective work. This was over the forecasted position. Recovery plans for recovery of the long waiting patients are being reviewed. RTT performance in April achieved 61.08% (March 62.5%).

The diagnostic performance for April is 78.72% (March 84.1%). The waiting list size is 17,169 (March 16,514), with the greatest growth mainly seen in MRI, CT and non-obstetric Ultrasound. The proportion of the patients waiting that have waited under 6 weeks is decreasing. 73% are under 6 weeks. Non Obstetric ultrasound see the largest deterioration (-5%). This relates to the increased activity of the 2ww and urgent. Recovery plans are now being transacted and monitored via the Diagnostic Cell to end of March 2021, with investment requests approved for DMO1 modalities to support this recovery timescale.

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 11th May 2021, covid-related open absences numbered 45, which was 8.32% of all absences (16.8% at 7th April 2021). The Trust has commissioned covid rehabilitation courses from our Occupational Health provider to support staff suffering from long-covid

The staff health and wellbeing offer has developed incrementally during the pandemic with a combination of UHNM created as well as nationally available support and interventions. The wellbeing offer is updated weekly and includes

- The Staff Psychological and Wellbeing Hub opened on 14th May.
- Listening support sessions continuing until June
- Suicide Awareness for Professionals will be launched in June
- A further CISM practitioners course was delivered in May

Staff across the Trust accessed 255 Staff Support and Counselling sessions throughout April in comparison to 119 in the same period last year.

The key performance issues are that the sickness rate remains above target and that compliance with PDR requirements is below target. The expectation that overdue PDRs are scheduled from Q2 has been communicated and the compliance rate has improved over the last 3 months.

Sickness

The in-month sickness rate was 4.23% (4.42% reported at 31/03/21). The 12 month cumulative rate reduced to 5.21% (5.37% at 31/03/21)

Appraisals

The Non-Medical PDR compliance rate was 77.42% at 30 April 2021 (75.56% at 31st March 2021).

Statutory and Mandatory Training

The Statutory and Mandatory training rate at 30 April 2021 was 94.19% (93.85% at 31 March 2021). At 30 April 2021, 90.32% of staff had completed all 6 Core for All modules (90.19% at 31/03/21)

For Finance, the key messages are:

The continuation of funding arrangements from the second half of 2020/21 into the first half of 2021/22 ("H1") have enabled the Trust to set a breakeven budget for the first half of the year (which is in agreement with System wide plans). The arrangements for the second half of the year ("H2") are not known; based on a high level assessment of income the trust is forecasting a £17.1m deficit for H2.

The Trust has delivered a surplus of £2.7m 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 levels, underspends on pay (primarily qualified nursing) and slippage against reserves held by the Trust.

The Trust incurred £1.1m of costs relating to COVID-19 in month which is a reduction in comparison with Month 12's figure of £1.8m primarily in pay due to reduced demands on additional shifts or backfill for sickness absence. This remains within the Trust's fixed allocation with £0.6m being chargeable on top of this allocation for COVID-19 testing costs.

Capital expenditure for the year to date stands at £1.1m which is in line with the plan.

The cash balance at Month 1 of £55.4m shows a reduction of £0.4m from the year end and is in line with expectations for Month 1. A cash plan will be prepared in line with the re-submission of the revenue plan to NHS England and NHS Improvement on 26 May and be reported against from Month 2 onwards.

Key Recommendations:

To note performance.

NHS
University Hospitals of North Midlands
NHS Trust

Integrated Performance Report

Month 1 2021/22

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Contents

A note on **SPC**

University Hospitals of North Midlands NHS Trust

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

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

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

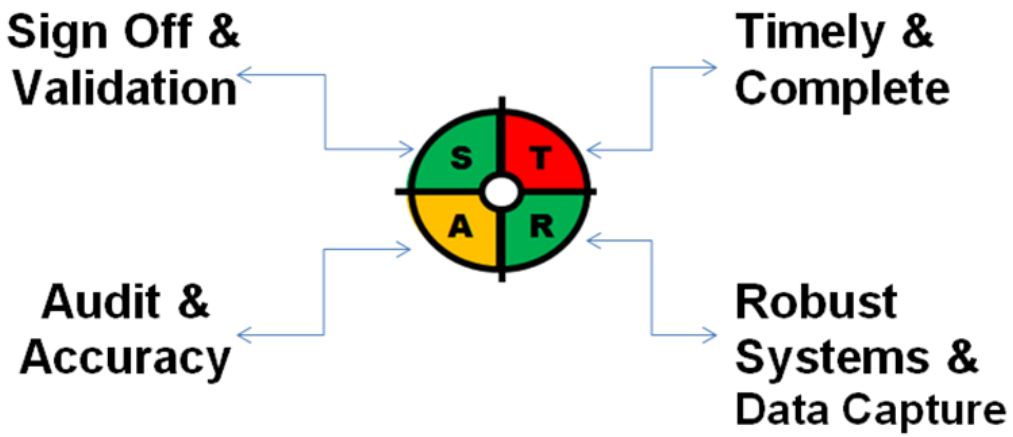
The below key and icons are used to describe what the data is telling us;

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

A note on **Data Quality**

NHS
University Hospitals of North Midlands
NHS Trust

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



Explaining each domain

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

RAG rating key

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

Quality

Caring and Safety

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

Quality Spotlight Report

NHS University Hospitals of North Midlands NHS Trust

Key messages

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Quality Dashboard

Metric	Target	Latest	Variation	Assurance
Patient Safety Incidents	N/A	1592		
Patient Safety Incidents per 1000 bed days	N/A	45.60		
Patient Safety Incidents per 1000 bed days with no harm	N/A	29.93		
Patient Safety Incidents per 1000 bed days with low harm	N/A	13.09		
Patient Safety Incidents per 1000 bed days reported as Near Miss	N/A	1.80		
Patient Safety Incidents with moderate harm +	N/A	20		
Patient Safety Incidents with moderate harm + per 1000 bed days	N/A	0.57		
Harm Free Care (New Harms)	95%	96.3%		
Patient Falls per 1000 bed days	5.6	5.8		
Patient Falls with harm per 1000 bed days	1.5	1.6		
Medication Incidents per 1000 bed days	N/A	3.4		
Medication Incidents % with moderate harm or above	TBC	0.00%		
Patient Medication Incidents per 1000 bed days	N/A	3.4		
Patient Medication Incidents % with moderate harm or above	TBC	0.00%		

Metric	Target	Latest	Variation	Assurance
Serious Incidents reported per month	N/A	11		
Serious Incidents Rate per 1000 bed days	N/A	0.32		
Never Events reported per month	0	0		
Duty of Candour - Verbal/Formal Notification	100%	100%		
Duty of Candour - Written	100%	94.1%		
All Pressure ulcers developed under UHNM Care	TBC	68		
All Pressure ulcers developed under UHNM Care per 1000 bed days	N/A	1.95		
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		

Quality Dashboard

NHS University Hospitals of North Midlands NHS Trust

Metric	Target	Latest	Variation	Assurance
Friends & Family Test - A&E	N/A	86.1%	H	?
Friends & Family Test - Inpatient	N/A	98.5%		P
Friends & Family Test - Maternity	N/A	N/A	H	?
Written Complaints per 10,000 spells	35	32.58		?
Rolling 12 Month HSMR (3 month time lag)	100	97.96	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%	99.5%	H	?
Emergency C Section rate % of total births	15%	15.61%	H	?
Reported C Diff Cases per month	8	9		?
Avoidable MRSA Bacteraemia Cases per month	0	0		P
HAI E. Coli Bacteraemia Cases per month	N/A	9		
Nosocomial "Definite" HAI COVID Cases - UHNM	0	1		

Metric	Target	Latest	Variation	Assurance
Inpatient Sepsis Screening Compliance (Contracted)	90%	89.4%		?
Inpatient IVAB within 1hr (Contracted)	90%	100.0%	H	?
Children Sepsis Screening Compliance (All)	90%	81.8%		?
Children IVAB within 1hr (All)	90%	100.0%	H	F
Emergency Portals Sepsis Screening Compliance (Contracted)	90%	97.0%	H	?
Emergency Portals IVAB within 1 hr (Contracted)	90%	88.9%		?
Maternity Sepsis Screening (All)	90%	91.7%	H	F
Maternity IVAB within 1 hr (All)	90%	50.0%	L	F

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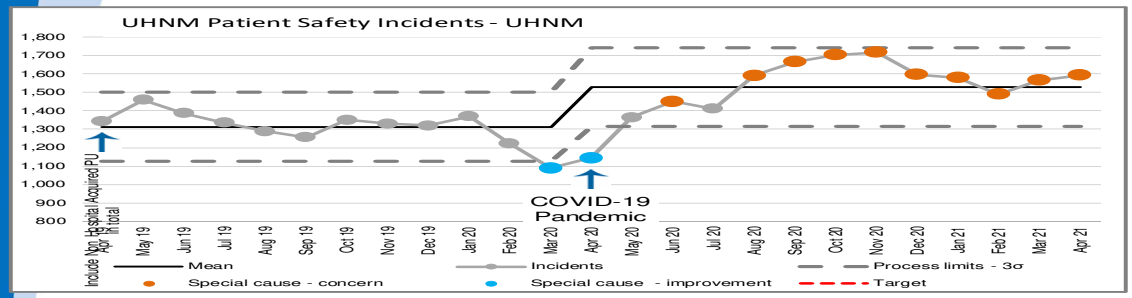
Quality | Operational | Workforce | Finance

Reported Patient Safety Incidents

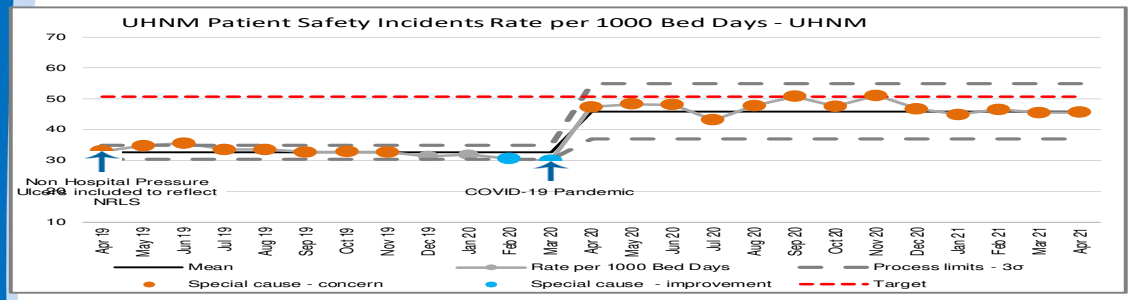


Variation	Assurance
	

Target	Feb 21	Mar 21	Apr 21
N/A	1490	1565	1592

Background

Total Reported patient safety incidents



Variation	Assurance
	

NRLS Mean	Feb 21	Mar 21	Apr 21
50.70	46.59	45.56	45.60

What is the data telling us:

The above data relates to **all** reported Patient Safety Incidents (PSIs) across the Trust. April 2021 has seen a slight increase in total number of reported PSIs compare to previous month and is also significantly higher than April 2020 and start of the COVID-19 pandemic period. The April 2021 total remains within variation limits. The reporting of incidents and near misses should continue to be encouraged and promoted.

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

- Patient related Slip/Trip/Fall - 202 (192)
- Clinical assessment (Including diagnosis, images and lab tests) – 79 (57)
- Patient flow incl. access, discharge & transfer - 125 (122)
- Documentation – 58 (56)
- Treatment/Procedure - 66 (70)
- Medication incidents - 122 (134)
- Infection Prevention – 44 (52)

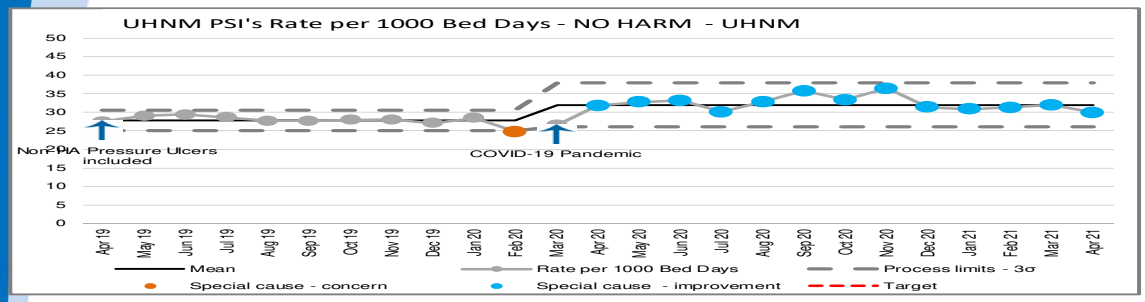
There have been increases in Falls, Clinical assessment, Patient Flow and Documentation related incidents compared to March 2021 totals (in brackets). Reductions in number of Treatment, Medication and Infection Prevention related incidents.
PSIs are reviewed and analysis undertaken on locations and themes.

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 increased slightly compared to March 2021 but is lower than April 2020. UHNM have seen increases in the rate of PSIs from the start of the COVID-19 pandemic as result of increased reported PSI numbers and reduced activity. Recent rates have started to stabilise as more non COVID-19 activity increases.

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

University Hospitals of North Midlands NHS Trust

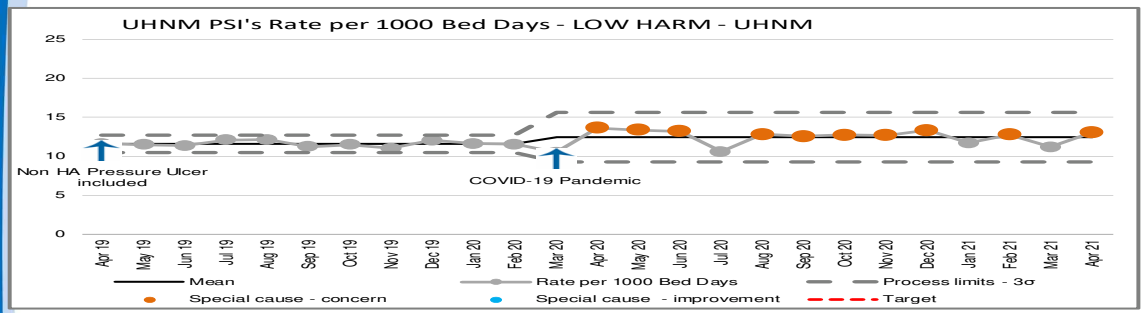


Variation	Assurance

Target	Feb 21	Mar 21	Apr 21
N/A	31.33	31.96	29.93

Background

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

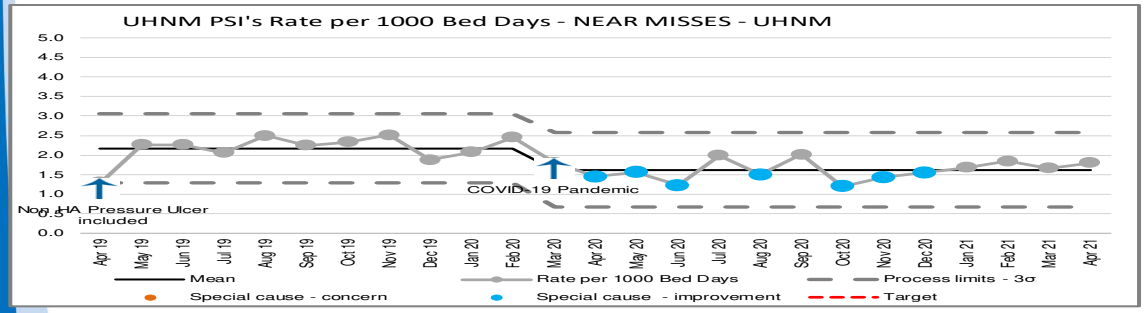


Variation	Assurance

Target	Feb 21	Mar 21	Apr 21
N/A	12.79	11.18	13.09

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	Feb 21	Mar 21	Apr 21
N/A	1.84	1.66	1.80

Background

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

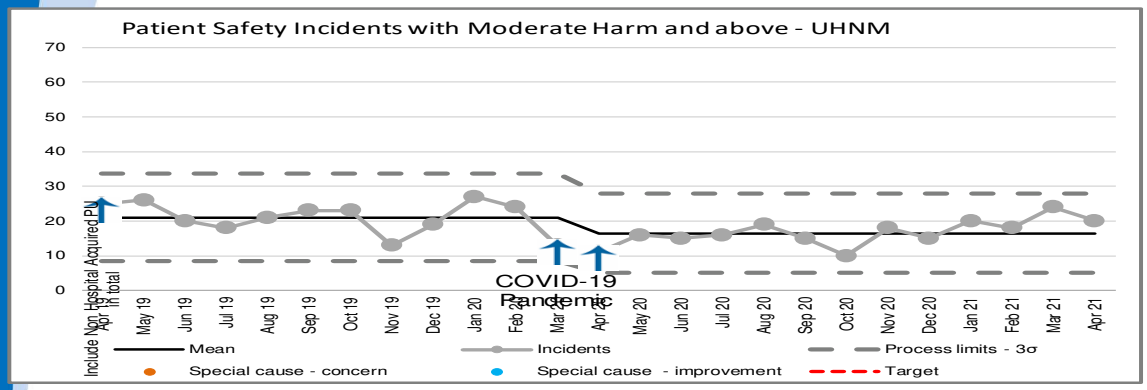
What is the data telling us:

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

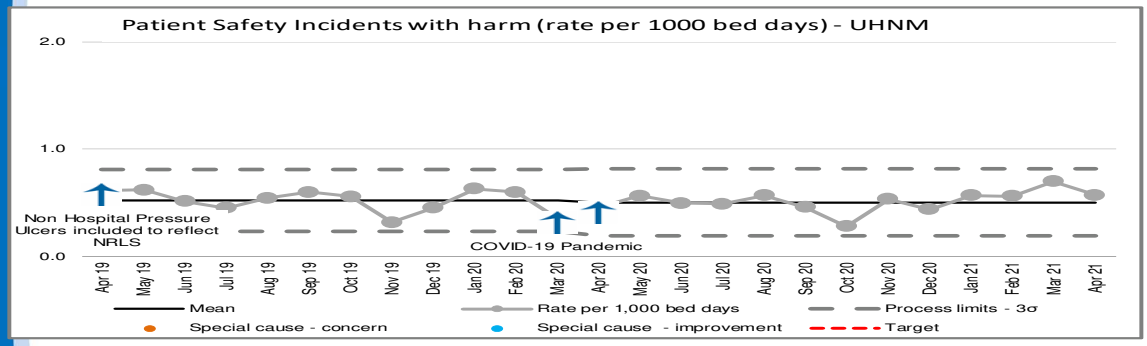


Variation	Assurance

Target	Feb 21	Mar 21	Apr 21
N/A	18	24	20

Background

Patient safety incidents with reported moderate harm and above



Variation	Assurance

Target	Feb 21	Mar 21	Apr 21
N/A	0.56	0.70	0.57

What is the data telling us:

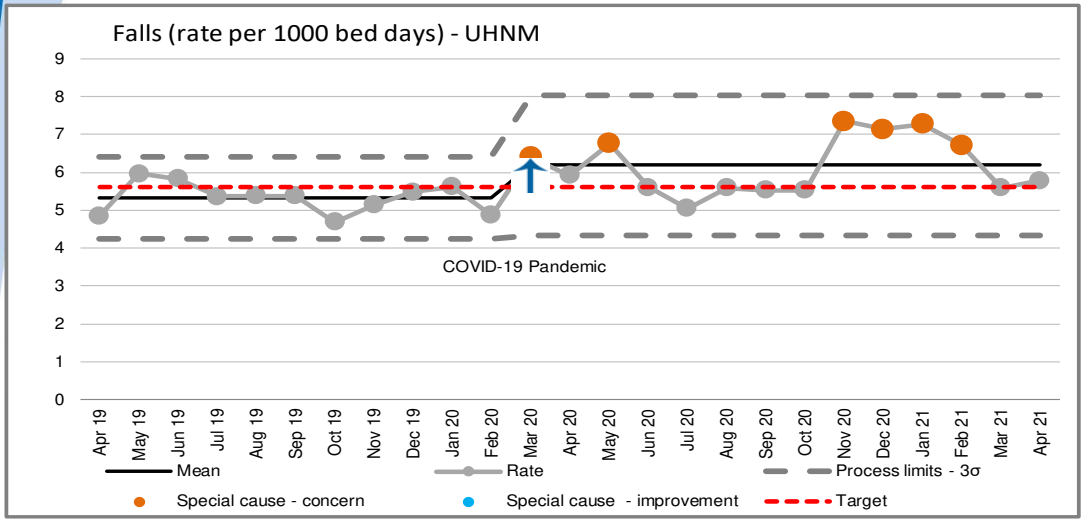
The long term trend for Patient Safety Incidents reported with moderate harm or higher is reducing. April 2021 rate per 1000 bed days above the COVID-19 period mean rate but is within control limits indicating normal variation.

The top category of incidents resulting in moderate harm reflect the largest reporting categories with Slips/Trips/Falls being the largest category with 6.
The second largest category is Treatment/Procedure with 4 (2 patients reported pneumothorax following lung biopsy, 2 were delay in treatment for jaundiced baby and readmitted following review by Community Midwives due to missed appointment for initial review)

Infection Prevention (1 was COVID +ve swab on ward 124) and Clinical Assessment related categories had 3 each.

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	Feb 21	Mar 21	Apr 21
5.6	6.7	5.6	5.8

Background

The number of falls per 1000 occupied bed days

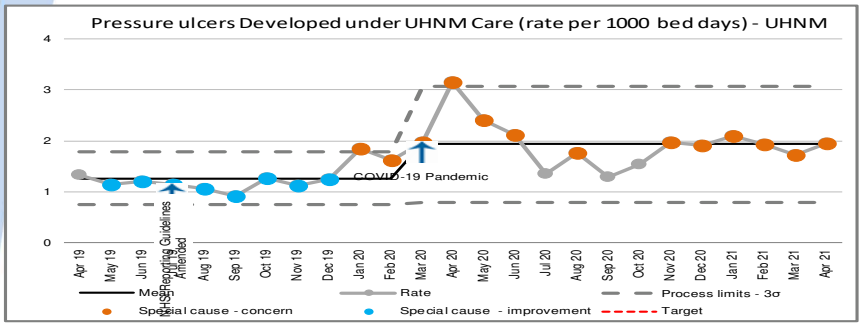
What is the date telling us:

The date shows the Trust's rate of reported patient falls per 1000 bed days. Using the rate makes allowance for changes in activity/increased patient numbers. The Trust set a target rate, based on the Royal College of Physicians National Falls Audit published rate for acute hospitals, of 5.6 patient falls per 1000 bed days. April shows 5.8 and below the current Trust mean rate.
The Top areas for total falls in April 2021 were:
AMU (Stoke), Ward 228, ARTU, Ward 233 (SSU), Ward 127 (Stroke)

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

- Numbers of total falls have improved since the Covid 19 pressures have started to ease.
- AMU (Stoke) remains the top falling area. Plans continue for a trial of assistive technology and the ward is relocating which will reduce the number of side rooms. Further falls prevention training has been built into their training plan for June.
- Ward 228 are showing a slight increase in usual numbers. Deputy Matron is aware and we have agreed to monitor numbers closely.
- ARTU again a slight increase in expected numbers has been seen April. As the ward has a new manager we will keep monitoring numbers
- Falls awareness is high on the agenda on SSU. There have been a number of actions from recent RCA hearings but also lots of evidence of good practice being emended. We will continue to keep in touch with the quality and education team and hopefully start to see an improvement in numbers.
- 1:1 and small group falls prevention training is being delivered and contact is being maintained with all falls champions to keep staff talking about falls.
- A new falls champions day has been delivered to increase the numbers of champions as County site.
- Errors in the patient risk assessment book have been highlighted to Harlow and staff have been made aware.

Pressure Ulcers developed under care of UHNM per 1000 bed days

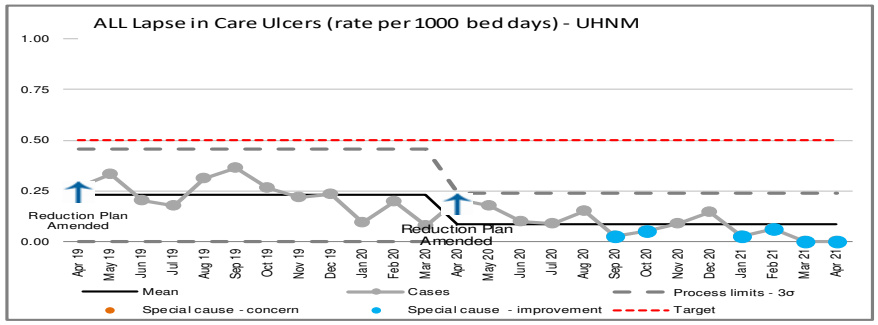


Variation	Assurance
H	

Target	Feb 21	Mar 21	Apr 21
N/A	1.94	1.72	1.95

Background

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



Variation	Assurance
L	P

Target	Feb 21	Mar 21	Apr 21
0.5	0.06	0.00	0.00

Background

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

What the data is telling us

Chart one shows that in April 2021 the rate of hospital acquired pressure ulcers remains on the mean as UHNM exits the second wave of COVID19.

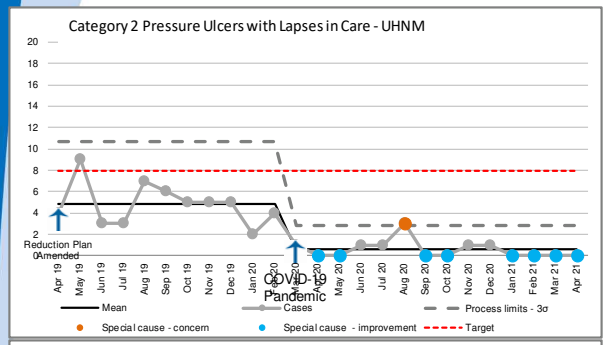
Throughout the second wave, the number of incidents have remained on or below the mean and did not peak as in this period last year. This is a reflection of changes in patient management and preventative measures, in response to the learning from incidents during the first wave.

The second chart confirms that there has been no rise in pressure ulcers that have developed due to lapses in care. This supports the observation the first chart is a reflection of the acuity and underlying condition of the patients during this period rather than any deterioration in the standards of preventative measures across the clinical areas. However, it should be noted that there are on going RCA investigations into incidents during April and therefore it is possible this number may change.

Actions

- To improve learning from incidents Trustwide, there has been a launch of an improved pressure ulcer incident investigative process on April 1st. This new process moves the investigative focus from identifying what the lapses were, towards a focus around analyzing how/why these specific lapses occurred. As a consequence, clinical areas are enabled to identify specific and sustainable actions to drive improvements to practice/processes in a more sustainable and timely manner. The expectation will be that when the incident is presented to the Quality & Safety team, the clinical area will have already completed the feedback stages of actions, be in the process of any more detailed actions identified and be able to evidence immediate improvements in practice.
- As mis-classification of pressure ulcers has emerged as a theme, though not a root cause of incidents investigated during the last six months, there will be an educational focus on categorization beginning May 2021. This will include returning the categorization page to the risk assessment booklet for staff reference when completing the body map and cascade training led by the Pressure Ulcer Prevention champions.
- Work continues to improve identification of pressure ulcers as the earliest possible stage i.e. Category 1 in patients with darker skin tones via the provision of new more inclusive images within the risk assessment booklet , a nationally developed education video and a staff awareness program within the Pressure Ulcer Champions training.

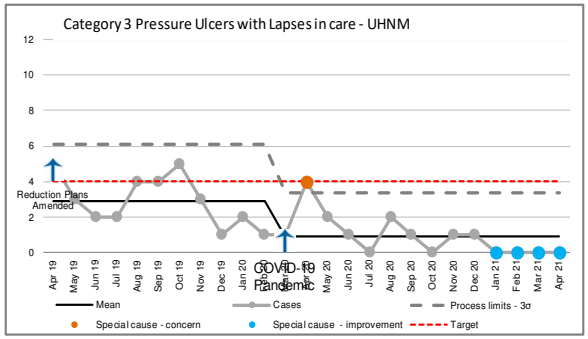
Pressure Ulcers with lapses in care



Variation	Assurance

Target	Feb 21	Mar 21	Apr 21
8	0	0	0

Background

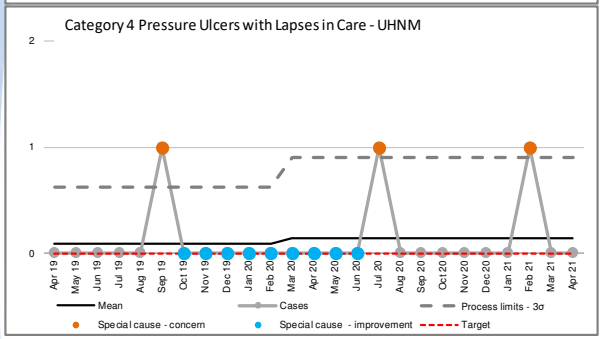


Variation	Assurance

Target	Feb 21	Mar 21	Apr 21
4	0	0	0

Background

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

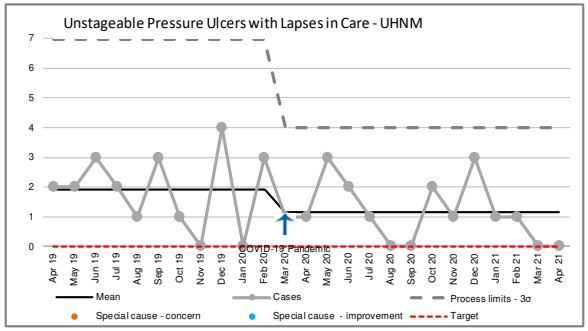


Variation	Assurance

Target	Feb 21	Mar 21	Apr 21
0	1	0	0

Background

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



Variation	Assurance

Target	Feb 21	Mar 21	Apr 21
0	1	0	0

Background

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

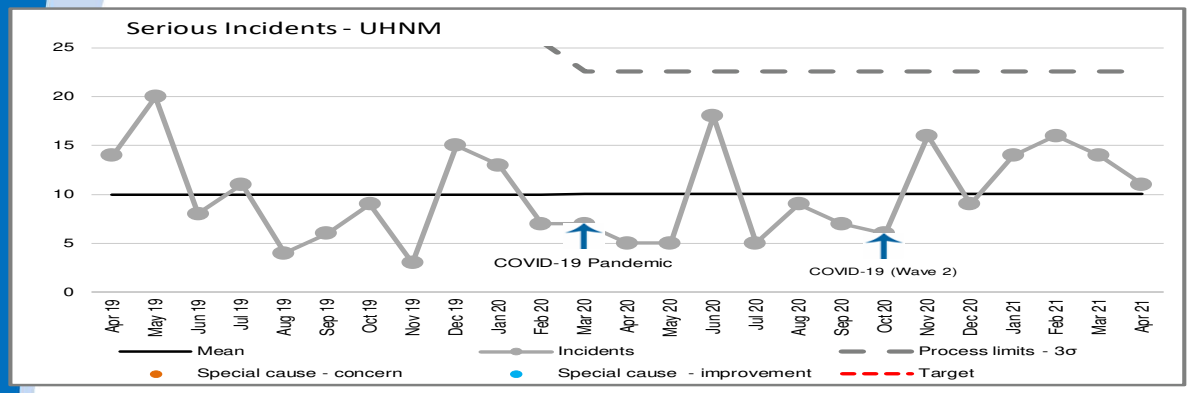
What is the data telling us:

The data above shows that there have been no Pressure Ulcers with lapses in care in March and April 2021. However, it should be noted that there are 8 RCAs scheduled for presentation to panel and therefore these numbers may change.

Actions:

- In response to a serious incident on Ward 218 in February and other near miss incidents connected to communication on discharge, a Task and Finish Group has been launched to review 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 due to commence in May 2021.
- Ward 225, who are the highest reporting areas for incidents with lapses and who have struggled to sustain improvements following incidents with lapses in care, are re-focusing on the themes from incidents over the last year. They have appointed a new Pressure Ulcer Prevention (PUP) Champion who alongside feedback, is completing weekly assurance audits 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

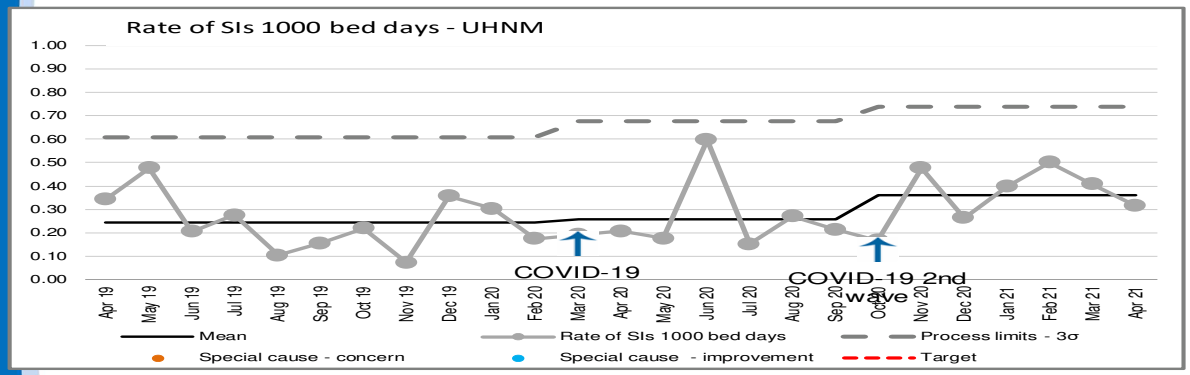


Variation	Assurance

Threshold	Feb 21	Mar 21	Apr 21
N/A	16	14	11

Background

The number of reported Serious Incidents per month



Variation	Assurance

Target	Feb 21	Mar 21	Apr 21
N/A	0.50	0.41	0.32

Background

The rate of Serious Incidents Reported per 1000 bed days

What is the data telling us:

April 2021 saw 11 incidents reported with 8 at RSUH and 3 at County Hospital:

- 7 Falls related incidents
- 1 Maternity (baby only)
- 1 Diagnostic related
- 1 Pressure Ulcer
- 1 Medication related

100% of the reported Serious Incidents during April 2021 were reported on STEIS within the agreed 2 working timeframe from identification/confirmation the incident met the serious incident reporting criteria. The rate of SIs per 1000 bed days for April 2021 is 0.32 which compares to organizational average rate of 0.306.

Serious Incidents Summary

University Hospitals of North Midlands NHS Trust

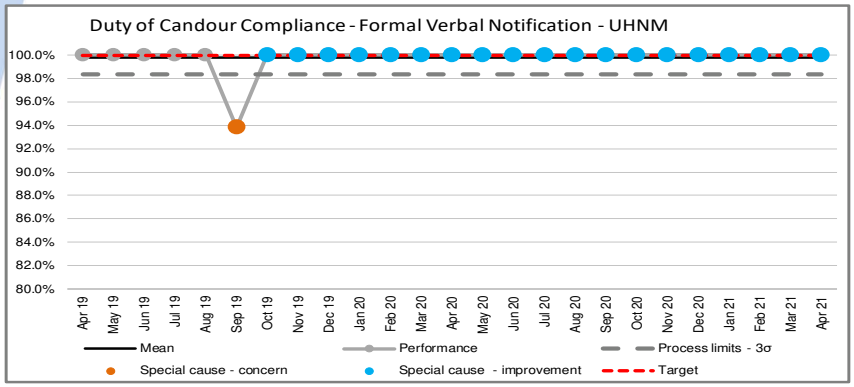
Summary of new Maternity Serious Incidents

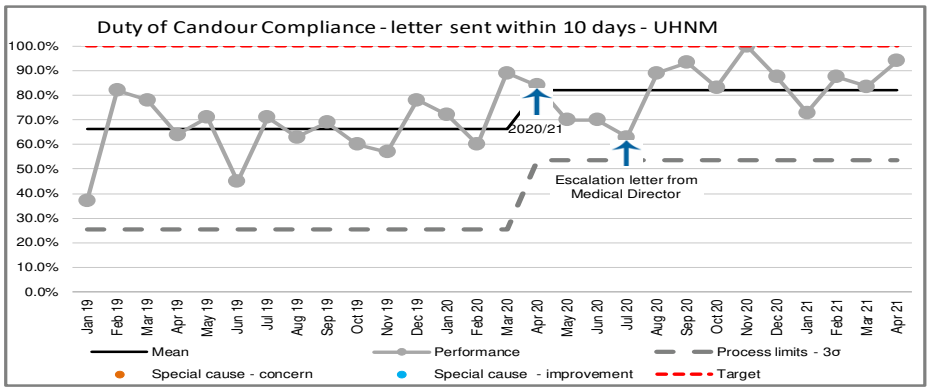
Following the formal recommendations in the Ockenden Report, below is an outline of the Maternity related serious incidents reported during March 2021. The new recommendation requires the Trust Board to receive summary on the new Maternity related Serious Incidents along with previously reported summary 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
2021/7394	01/07/2021	Maternity/Obstetric incident meeting SI criteria: baby only (this includes foetus, neonate and infant)	Baby born at 26+1 week gestation on 01/12/2020. Deteriorated unexpectedly on 07/12/2020 requiring full neonatal resuscitation. Sadly passed away 07/12/2020. Blood cultures revealed gram negative bacilli indicating overwhelming infection. Grading of care of baby from birth up to death of baby was graded a C, the review group identified care issues they considered may have made a difference to the outcome of the baby.

Duty of Candour Compliance





Variation	Assurance
H	?

Target	Feb 21	Mar 21	Apr 21
100%	100.0%	100.0%	100.0%

Background

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

Variation	Assurance
	?

Target	Feb 21	Mar 21	Apr 21
100%	87.5%	83.5%	94.1%

Background

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

What is the data telling us:

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

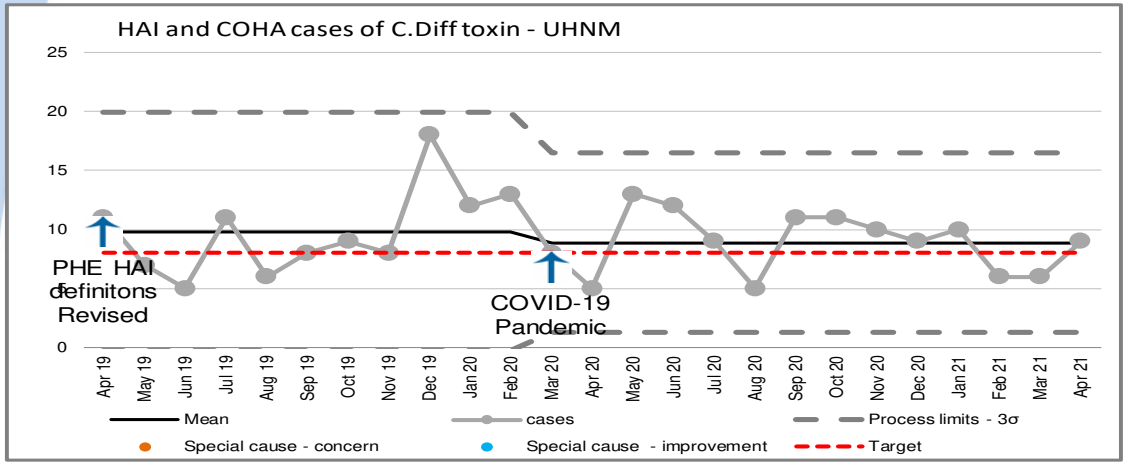
Confirmed Follow up Written Duty of Candour compliance (i.e. receiving the letter within 10 working days of verbal notification) during April 2021 is 16 cases out of 17. There is 1 case under review and 10 working day deadline not yet reached following completion of the verbal notification.

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

Compliance included in Divisional reports for discussion and action.

Reported C Diff Cases per month



Variation	Assurance

Target	Feb 21	Mar 21	Apr 21
8	6	6	9

Background

Number of HAI + COHA cases reported by month

What do these results tell us?

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

There have been 9 reported C diff cases in April which is above monthly trajectory 9 versus a target of 8

2 of these were Hospital Associated Infection (HAI) cases and 7 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 have been two clinical areas that have had more that once case of C diff toxin to report within a 28 day period in April:

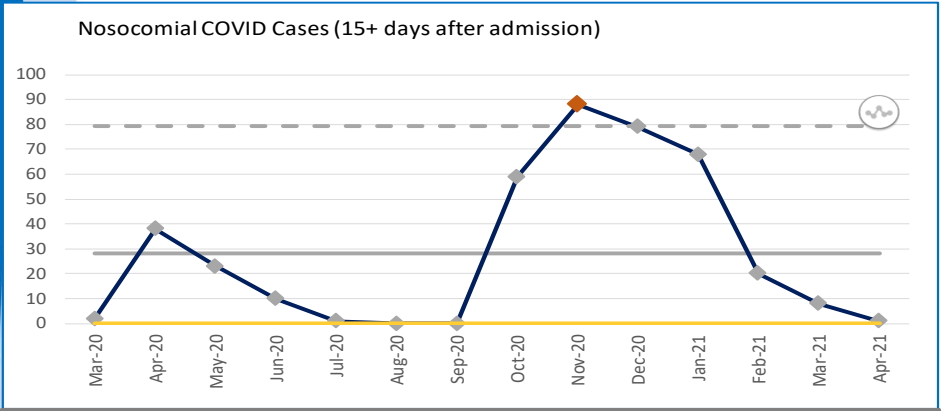
Ward 81 2x COHA

Ward 124 1x HAI and 1x COHA

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 are paused due to COVID 19.
- Each in-patient is reviewed by the C *difficile* nurse at least 3 times a week, and forms part of a multi-disciplinary review.
- Routine ribotyping of samples is now being undertaken at Leeds hospital. This will help determine if cases can be linked
- A Clostridium *difficile* task and finish Group in progress

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. The UHNM case numbers continue to reflect the changes in community rates on national, regional and local levels. It should be noted that Stoke community rate remains above the regional and national rate.
- COVID ward outbreaks were reported during March 2021 on:
  Ward 124
- The ward is now open to admission and the outbreak moved to 28 days surveillance on 5th 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
- COVID 19 themes report provided to IPCC
- UHNM Guidance on Testing and re-testing for COVID 19 plus step down of suspected/positive cases
- Isolate suspected patients on identification of symptoms
- Process for patients identified as contact of positive case via ICNet system
- Process in place for outbreak management and reporting
- Swabbing champions rolled out in a number of areas

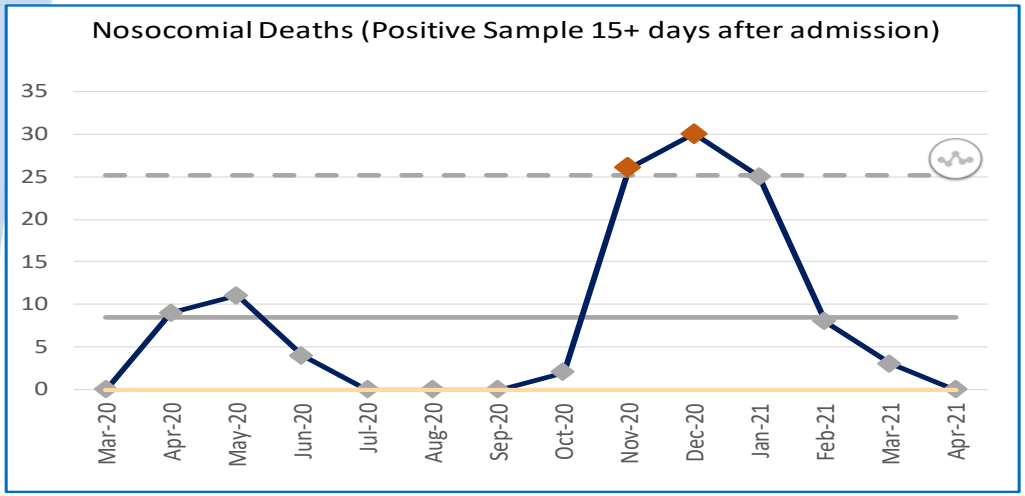
	Community COVID-19 rate per 100,000 population (as at month end)				UHNM		
	England	W Mids	Staffs	Stoke	Total Admissions	COVID cases	
						Prob	Def
Oct 20	232.1	273.7	352.2	373.3	17006	63	59
Nov 20	152.2	188.0	206.0	350.3	14956	109	88
Dec 20	526.0	404.1	370.2	318.7	14701	107	79
Jan 21	283.0	328.0	296.0	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	16571	3	1

Prob = Probable Hospital onset COVID (1st positive sample 8-14 days after admission)
Def = Definite Hospital onset COVID (1st positive sample 15+ days after admission)

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%
Grand Total	69.7%	11.3%	11.1%	7.9%

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



What do these results tell us?

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

- There have been zero recorded definite hospital onset COVID-19 deaths during April 2021
- Total 118 hospital acquired COVID-19 deaths with 1st positive results 15 days or more following admission recorded since March 2020.
- The mean number of deaths per month since March 2020 is 9, however following the in month reduction in March 2021 the monthly total is below the overall mean.

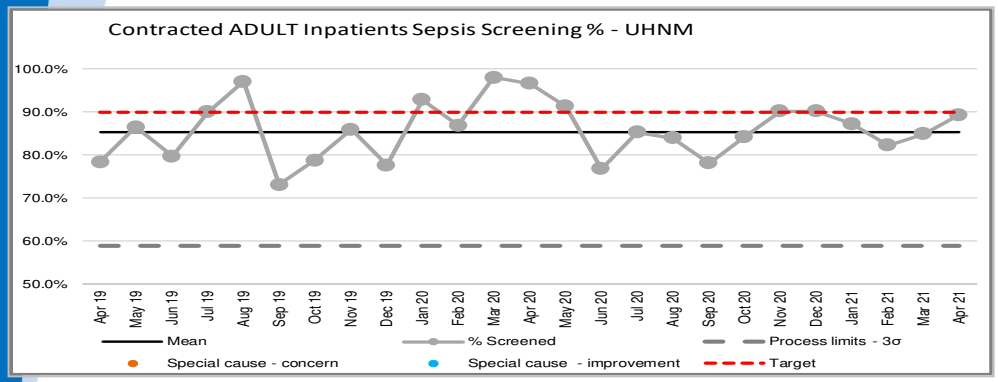
Actions :

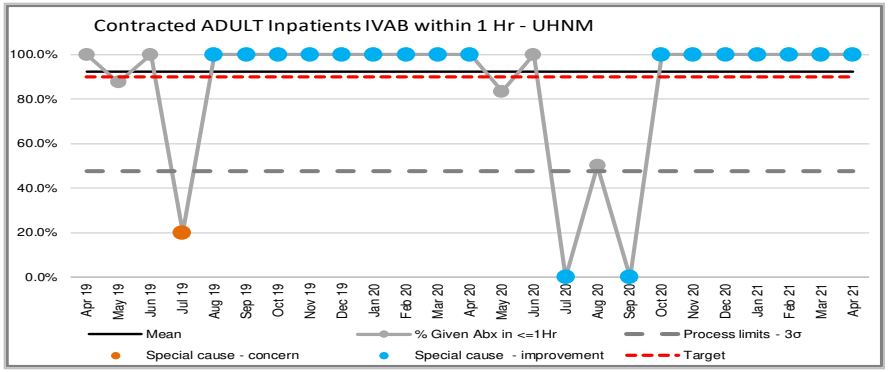
Ongoing work to identify the ward outbreaks and cross reference with patients involved is being undertaken with support from the Infection prevention Team to support the review of the nosocomial deaths.

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)





Variation	Assurance

Target	Feb 21	Mar 21	Apr 21
90%	82.2%	85.0%	89.4%

Background

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

Variation	Assurance

Target	Feb 21	Mar 21	Apr 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:

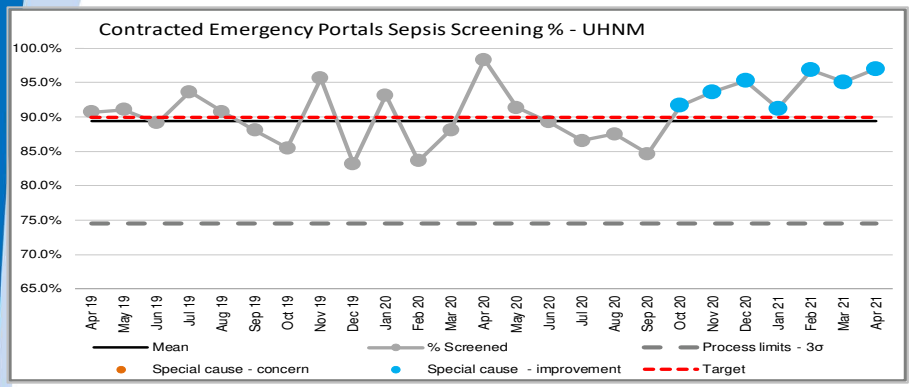
Inpatients April results now show 89.4% for screening and maintain 100% compliance for IVAB within an hour. Of the 113 Inpatients that triggered a sepsis screen, 89 had sepsis red flags present, 2 of these patients were given IVAB within hour and of the remaining 87 patients, 43 had alternative diagnosis that were deemed as not sepsis related and IVAB were not indicated. The remaining 44 patients were already receiving IVAB prior to the identified red flag trigger.

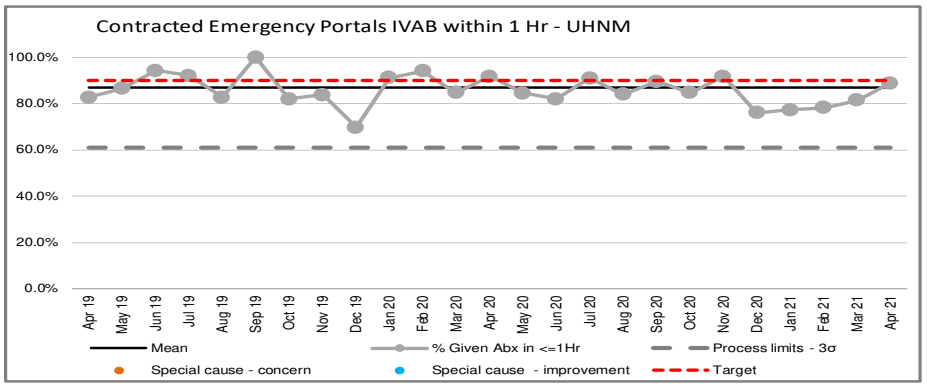
Actions:

- In the absence of formal practical training due to COVID-19 restrictions, the sepsis team have continued to provide sepsis re-enforcement, 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 each month
- The team now offer 30 minute drop in sessions for particular areas of UHNM. The West building and Lyme building have benefitted from these in recent months and we have planned similar events for the Specialised areas and County in April and May.
- 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
- The Sepsis team have organised Sepsis Champion Day (5 hour CPD) to all levels of clinical staff which will include simulation & workshop in July 2021

Sepsis Screening Compliance (Emergency Portals Contract)

NHS University Hospitals of North Midlands NHS Trust





Variation	Assurance
H	?

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

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.

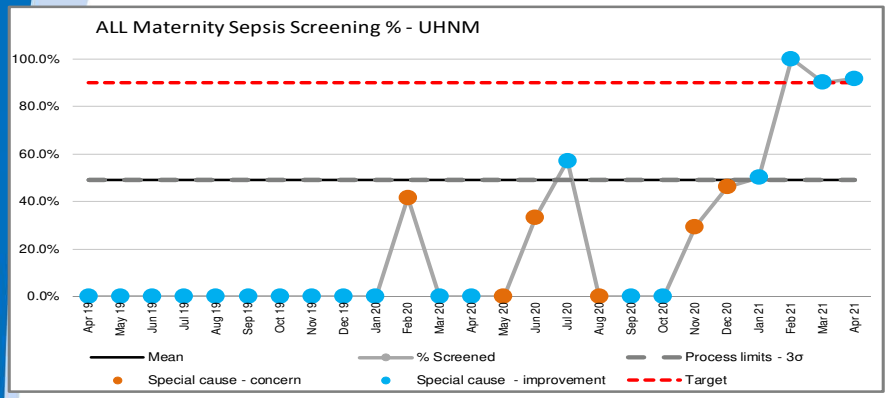
The performance for IVAB within 1hr continues to improve significantly to 88.9%. There were 57 red flag sepsis patients identified from the 67 patients audited in the screening sample. Out of the 57 red flag patients, 24 received IVAB within an hour whilst 16 were already on IVAB and 14 had an alternative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

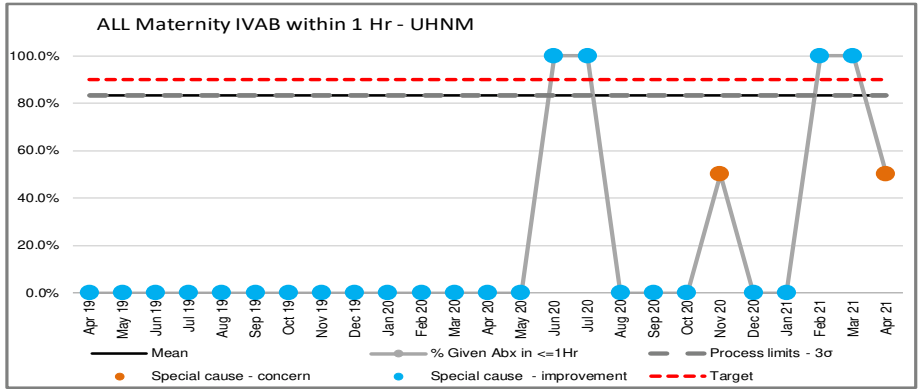
There were 3 late IVAB, 3 of which were administered within 2 hours. This have been escalated to the respective areas' senior teams.

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





Variation	Assurance
H	F

Target	Feb 21	Mar 21	Apr 21
90%	100.0%	90.0%	91.7%

Background

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

Variation	Assurance
L	F

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

Background

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

What is the data telling us:

Maternity Inpatients and Emergency portal (MAU) audited by the Sepsis Team in April 2021 shows that 91.7% of patients that trigger with MEOWS >4 were audited and screens uploaded to the Maternity K2 system. This result was taken from 12 patients audited with a single missed screen from one of the Inpatient ward areas.

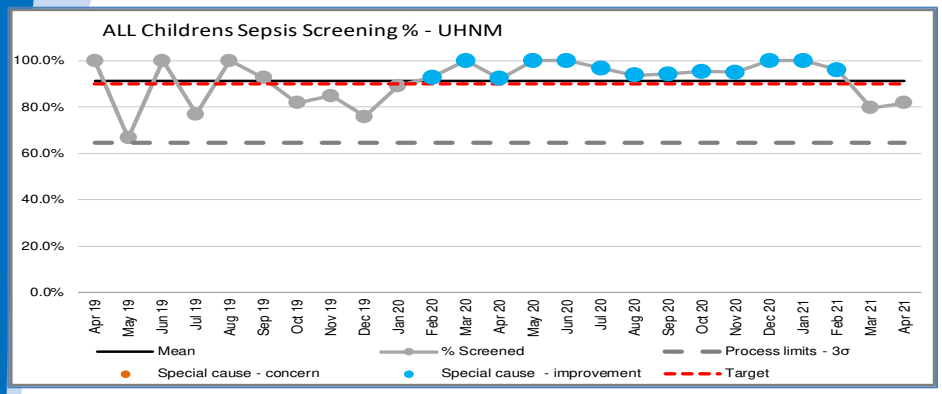
50% compliance was achieved for IVAB within an hour from the 2 cases audited in one of the Inpatient wards.

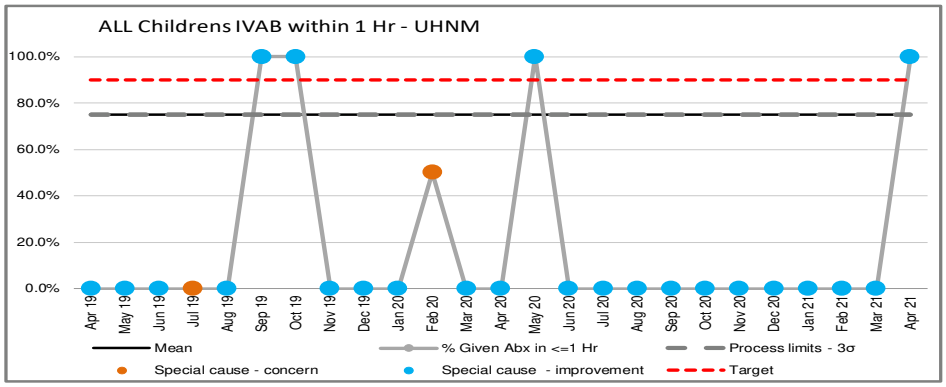
Actions:

- The Maternity Senior Team have been working collaboratively with the sepsis team and following the creation an action plan and great improvements have been seen for the third consecutive month. The Sepsis Team provided training to all maternity staff in February up to present and had an excellent uptake. The issue of attaching completed screening tools to the K2 system has been addressed internally and this is now standard practice.
- The new electronic version of maternity sepsis screening tool due to go live on 12th May 2021 and the Sepsis Team will provide further training during the same week to enhance staff awareness and understanding.
- The sepsis team will continue to audit Maternity comprehensively to ensure the maintenance of this newly achieved high standard of sepsis compliance.
- Delayed IVAB within 2 hours has been escalated to the Maternity senior team for learning and action.

Sepsis Screening Compliance ALL Children

University Hospitals of North Midlands NHS Trust





Variation	Assurance

Target	Feb 21	Mar 21	Apr 21
90%	96.0%	79.6%	81.8%

Background

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

Variation	Assurance

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

Background

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

What is the data telling us:

The charts above show an uncharacteristic drop in sepsis compliance for April 2021, with a result of 81.8%.

Whilst CAU continued to sustain and maintain compliance of > 90% there has been a significant drop for Children A&E for April with seven missed screens resulting in a screening compliance of 77% for that area. Inpatient ward 216 also missed 1 screening in which resulted to 0% compliance. These missed screens has been escalated to the senior team in CHW. Both Paediatric Inpatient wards have minimal admissions and patients mostly did not trigger PEWS >5.

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 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 planned and date arranged in July 2021.

Operational Performance

2025 Vision "Achieve NHS Constitutional patient access standards"

Spotlight Report from Chief Operating Officer

NHS University Hospitals of North Midlands NHS Trust

Emergency Care

The decline in the number of covid-19 patients attending and being admitted continued in April. Inpatients numbers were reduced again by half from the previous month, with <30 (from a peak in Jan of 349). The number of beds restricted for infection prevention also continued to reduce and for most days were < 5 and on some days zero. As these numbers continue to decline the Trust saw the number of 'blue' areas reducing and as a result the last Covid-19 ward was closed. However, going forward there is an underlying number of patients with Covid-19 or recovering that are still acutely ill, requiring side rooms and are not yet medically fit for discharge.. Consequently, this has the potential to reduce available capacity for admissions

Operational performance system wide was 76.8% , with Royal Stoke site at 56.9%.

The improvement trajectory is marked by some challenged days of performance attributed to high volume ambulatory attends and compounded by workforce challenges. There was a continued increase in sub 60 and sub 50 performance days in April, with clear evidence in the acute front door pathway metrics of ambulatory, non admitted attends. This is being addressed with an audit of those attends to frame discussions with the system about GP, walk in centre and 111 First / SDEC pathways and management of unheralded patients. This is being addressed through the acute front door improvement work stream.

Cancer

The Trust is predicted to achieve the following three cancer standards for April21: 31 day subsequent treatments for radiotherapy, the rare cancers standard and the 28day FDS standard. The 2ww position in April is predicted to land at 76.7%. The sites that most influence this performance are Breast is at 11.8% ; skin 88.9% and Upper GI at 75.7% - all are large volume sites and have seen rises in demand (particularly breast).. The increase in demand has put significant pressure on outpatient capacity . Additional clinics are being resourced to meet demand. Additional under 35 clinic where radiology support may not be required are also being set up. 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 has recovered and is predicted at this point to achieve 75.6%., with one of the lowest backlogs regionally. In addition, the number of patients waiting over 104 days has reduced to 28, a reduction of almost half since last month.

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.

Spotlight Report from Chief Operating Officer

NHS University Hospitals of North Midlands NHS Trust

Planned Care

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.

RTT

The indicative performance for April 21: the total number of Referral To Treatment pathways grew to 59,656 (March 56,601). The Trust has reduced the number of > 52 weeks to 4,083 (March 4,563) as a consequence of standing down elective work. This was over the forecasted position. Recovery plans for recovery of the long waiting patients are being reviewed. RTT performance in April achieved 61.10% (March 62.5%).

Diagnostics

The diagnostic performance for April is 78.72% (March 84.1%). The waiting list size is 17,169 (March 16,514), with the greatest growth mainly seen in MRI, CT and non-obstetric Ultrasound. The proportion of the patients waiting that have waited under 6 weeks is decreasing. 73% are under 6 weeks . Non Obstetric ultrasound see the largest deterioration (-5%). This relates to the increased activity of the 2ww and urgent. Recovery plans are now being transacted and monitored via the Diagnostic Cell to end of March 2021, with investment requests approved for DMO1 modalities to support this recovery timescale.

Urgent Care - Summary

- The 4hr performance deteriorated in April, with system wide performance at 76.8% (March 81.7%). Royal Stoke was challenged throughout the month with performances below 60% & 50% and a final position of 56.9%. County type 1 achieved 92.5%.
- Attendances to ED have increased back to pre COVID levels. At RS the increase is around 35 patients per day compared to the last reporting period. Both ambulance and self-presenting pathways are demonstrating increases with the most challenging being within the self-presenting ambulatory group. Presentations involving children are also increasing. This is resulting in increased periods when the level of hourly presentation is over and above the processing capacity within the ED and key metrics within the ED quality framework such as triage time (reduced to 60% within 15 mins) and waiting time to be seen (time to treatment has increased to 73 mins) start to move outside of the required timescale.
- The majority of metrics remain reasonably stable. Primary increase in attendances particularly from around 17:30. This feature is expected to continue into May
- Ambulances arrivals rose by to daily average of 168/day (a rise of 12/day). However as a proportion of all attendances this fell to 48%. The daily average is more than seen pre-covid.
- The initiatives that are designed to offer alternative pathways to patients other than ED, such as NHS 111 will take time to embed (daily average of 40 patients). It is hoped that the relaxation of total triage within primary care will allow patients to access their GP and reduce some of the default attendance to ED.
- Flow out of the ED into urgent care portals has been effective due to capacity being available across the bed base and portals. There are early signs of this trend slowing down, this will be an area of scrutiny in May to ensure the improvements in ward processes experienced earlier in April can be sustained as business as usual.
- There was zero reported 12 hour trolley waits.
- The majority of metrics remain reasonably stable attendances by both Ambulance and self presentation continue to rise. Primary increase particularly from around 17:30. This feature is expected to continue into May
- Alternative pathways for patients continue to be developed within the Urgent Care Improvement Programme however it will take time for these pathways to embed and become the pathway of choice for patients.

- The number of patients treated with Covid-19 had significantly reduced during the last three weeks of April and from the 20th April there were **no** patients with Covid-19 in Critical Care and just six inpatients at Royal Stoke.
- However, the number of patients within the Medical bed pool remained static with a daily average of 416 patients. This with the increased number of stranded patients suggests that patients are still being cared for within UHNM restricting flow.
- After a period of where consistently 50% of staff absences were due to covid, the proportion is decreasing.

Urgent Care Improvement Programme

NHS
University Hospitals of North Midlands

Work stream 1 - Acute Front Door

- Embed and sustain the changes seen in January and February through engagement with the team and recognising areas of challenge
- Complete business case for ED workforce to support the flow through the Department
- Implement streamlined referral process and review flow from ED to Acute Medicine and to wards
- Establish task and finish group to support quality improvement and the implementation of the new Urgent Care standards
- Redesign the Acute Medicine Model
- Acute Medicine Nursing Model review
- Deliver an ED specific set of metrics to support flow through the department
- Maintain progress with 111 First

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 reducing covid capacity and de-escalation of winter capacity. Weekly Acute Front Door meetings featuring ED and Acute Medicine actions runs weekly with support from MProve
2. First draft workforce business case completed, requires additional input from finance, directorate and division for April submission to Medicine Board.
3. 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

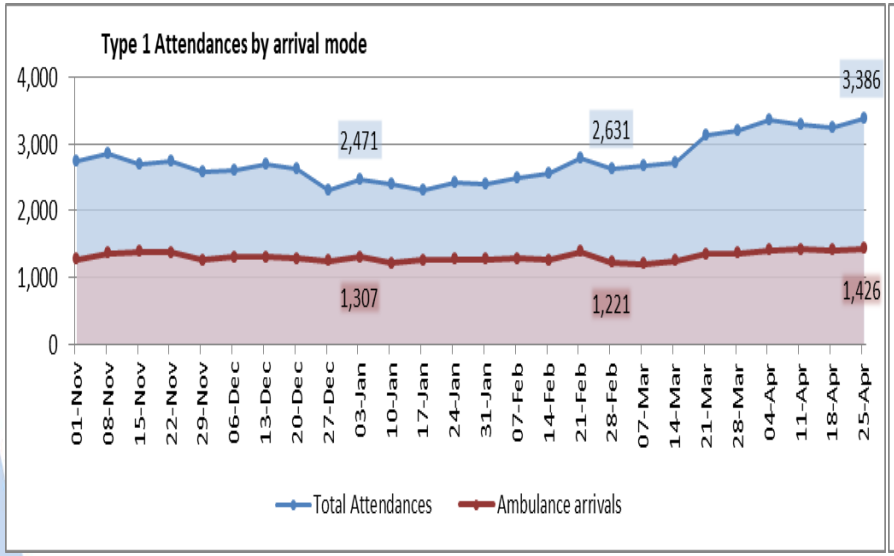
- Maintain focus of discharges before midday through improvement workshops
- Support length of stay by using directorate Teams – support improvements seen
- Review need for COVID discharge lounge to support earlier flow
- Importance of young persons rehab Unit working with MPFT
- Confirm In reach model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

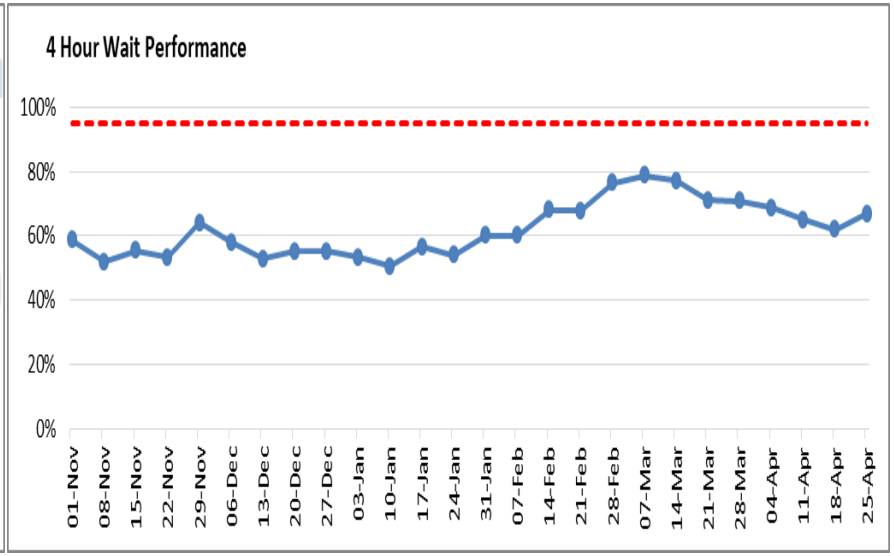
Work stream 3 -Clinical Site Management

- 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.





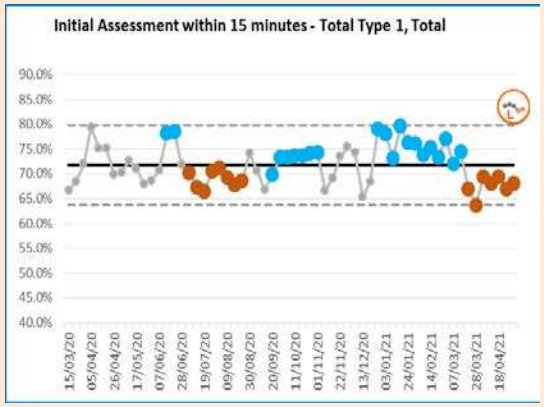
The Urgent Care Improvement Programme has a number of projects aimed at improving current performance.

University Hospitals of North Midlands NHS Trust

Work stream 1: Front Door – timing metrics

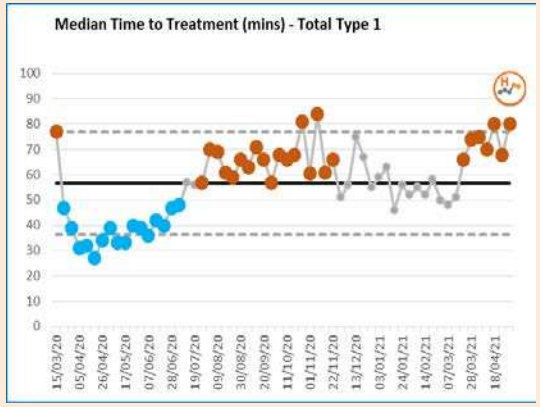
Time To triage – improve the time taken to triage patients so that patients are directed to appropriate care as quickly as possible. The aim is for 95% of patients triaged within 15 minutes.

The chart below shows that for April, the percentage of patients triaged within 15 minutes reduced to less than 70%. This was mainly seen in the non-ambulance arrivals. There has been a sustained increase in self presenting patients particularly in the evening which has challenged triage capacity



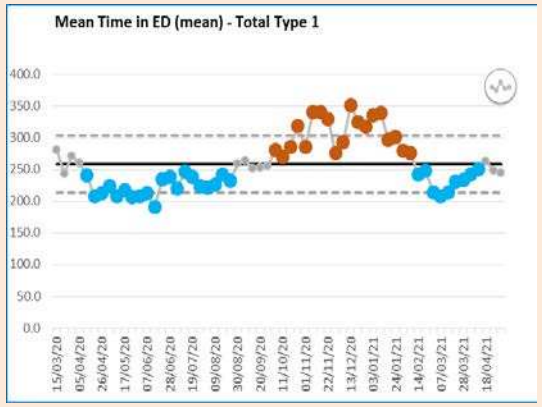
The median time to treatment - set at 60 minutes to ensure patients treated quickly and for those requiring referrals to other specialties are done so in optimum time.

- From mid-January total type 1median time reduced to below the target of 60mins. From the latter half of March to end of April this has risen with the average for the month at 73mins.

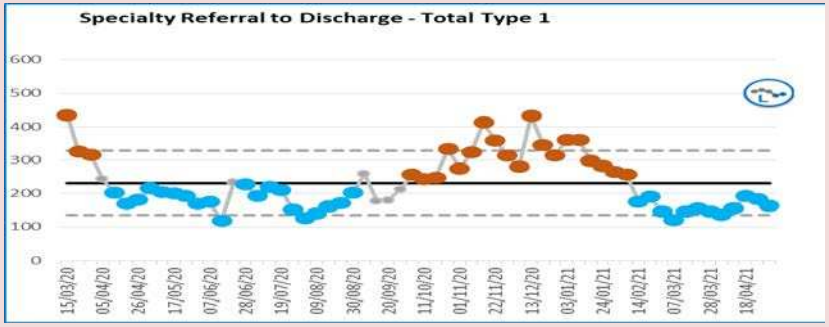


The Mean time in the ED – The median time is set at 240 minutes as per national 4hour standard.

The mean time in the ED has maintained an improvement. This is more noticeable in the admitted patients. Continuing the work with speciality portals and SDEC pathways will assist in sustaining this measure and support delivery of the new ED measure of total time in department

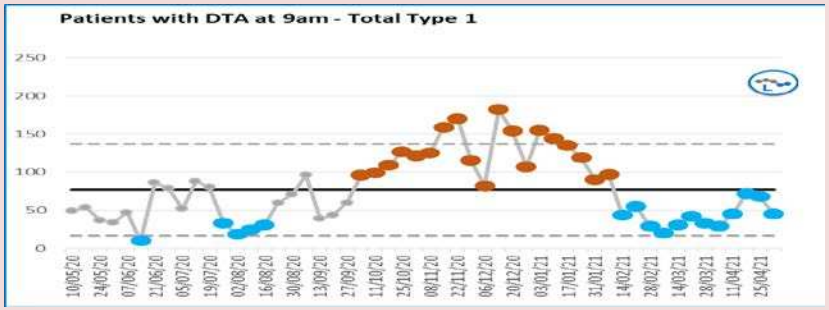


Work stream 2: Flow



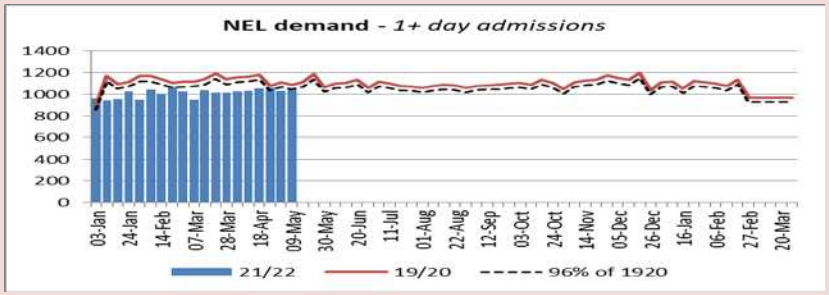
Referral to Discharge Time – improve the time taken from referral to specialties to discharge from ED either as admission or discharge home.

The reduction in time evidenced in February has been maintained, this is a statistically significant improvement in spite of demand not decreasing.



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

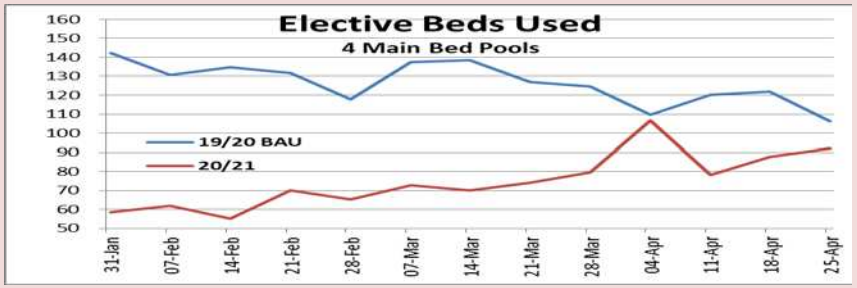
The number of patients with a DTA at 9am has remained below the mean since the middle of February. A rise was seen in April but there are early indications this has reduced.



Emergency admissions: the number of Non Elective admissions requiring a bed overnight (1+day LoS)

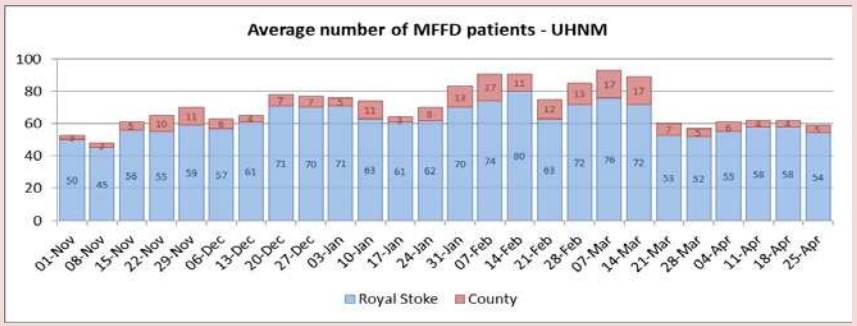
Non-elective activity has seen a rise in admissions over the over the past few months. Zero Day NEL has been rising since January and at the end of April is at 85% of 2019/20. 1 or more days LoS was at 95% of 2019/20 in April. It has been assumed that we will be at 100% of BAU in May and will continue to track along 19/20 BAU level for the rest of the year.

Work stream 2: Flow cont.



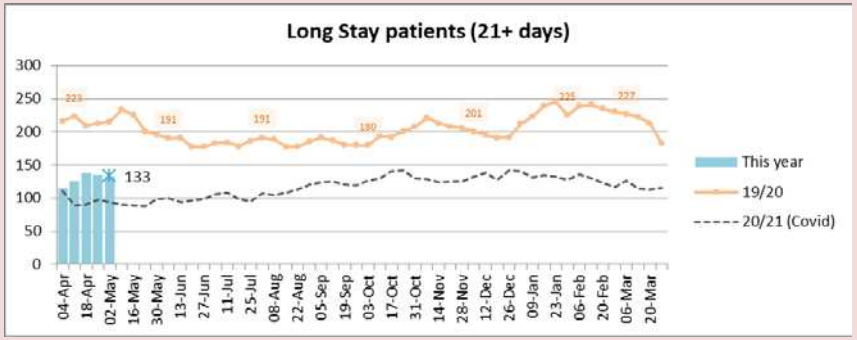
Elective beds:

The elective beds used across the four main bed pools has risen steadily through March and April 21.



MFFD.

After a period of increase in the numbers of Medically Fit For Discharge through January, February, and March, April has seen a reduction to below 60.



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 has remained fairly static in April but early indications for May has seen a rise, mainly in Specialised Division.

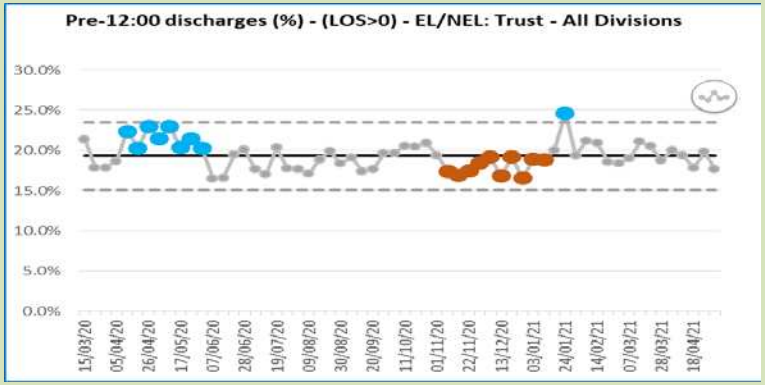
Work stream 3: Clinical Site Management

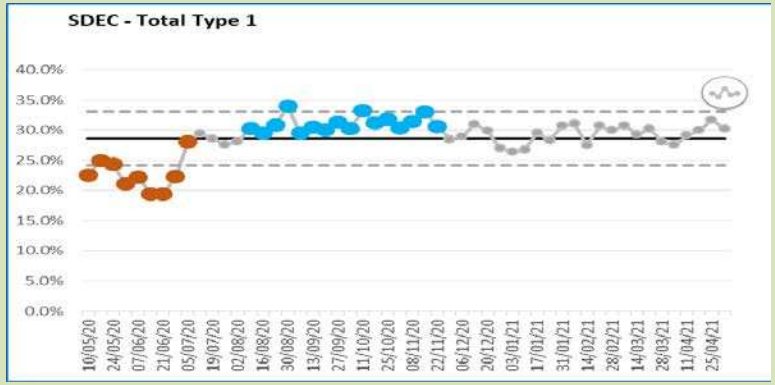
Pre-noon Discharges:
Maintain focus on the number of patients discharged from a hospital bed pre-noon to increase available capacity for admissions earlier in the day.

The percentage of pre-noon discharges has remained static although some early indications in May has shown a slight improvement.
Medicine division will reassess its approach to EDD validation and expediting definite discharges

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.





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Cancer

NHS
University Hospitals of North Midlands
NHS Trust

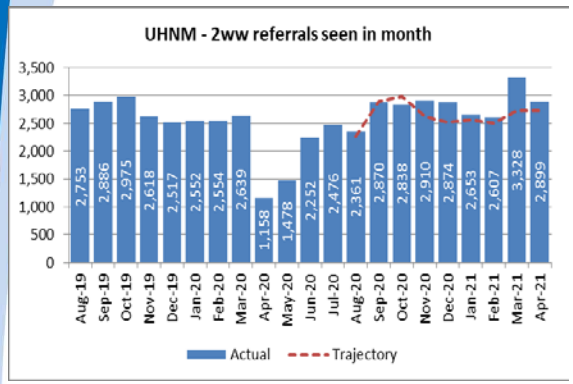
Summary:

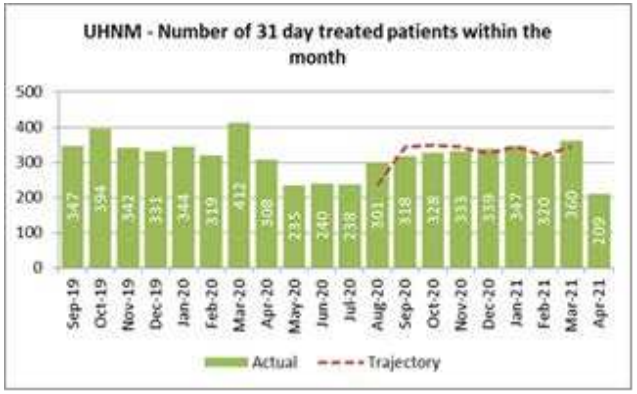
- The Trust is predicted to achieve the following cancer standards for April 21: 31 day subsequent treatments for radiotherapy, the rare cancers standard and the 28day FDS standard. The 2ww position in April is predicted to land at 76.7%.The sites that most influence this performance are Breast is at 11.8% ; skin 88.9% and Upper GI at 75.7% - all are large volume sites and have seen rises in demand (particularly breast).. This breast underperformance is a national issue and UHNM is working closely with the West Midlands Alliance, CCGs and GP representatives to mitigate.
- The Trust continues to record a high volume of 2WW 1st appointments in April21. Demand remains exceptionally high in some specialties such as Breast who are booking 1st appointments at day 21. This is a national trend – the west midlands cancer alliance have set up a regional task and finish group to combine efforts to mitigate locally. Actions below.
- 62 day performance has recovered and is predicted at this point to achieve 75.6%., with one of the lowest backlogs regionally.
- For the 31 Day subsequent surgery, due to reduced theatre capacity, patients are being dated according to their clinical need rather than their clock start date, resulting in the lower performance. This clinical prioritisation of patients is continuing into May 21 and this is expected to be detrimental to performance which will not recover until the surgical backlog has been cleared. Current performance is at 75%.
- The number of patients waiting over 104 days has reduced to 28, a reduction of almost half since last month.
- Benchmarking nationally, we are 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.

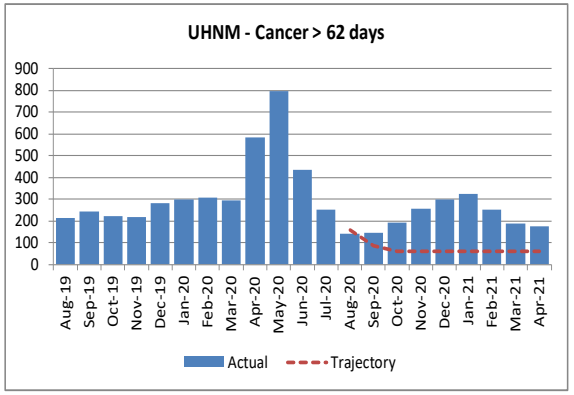
Actions:

- Supporting Breast to implement solutions from other geographies such as; breast pain clinics, 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, capacity and demand modelling tool support.
- Breast & Urology patients experiencing delays of up to 6 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 – specialties still to be allocated.
- FIT requested in tandem to a 2WW referral was endorsed by GPs at the ICP Northern Clinical Assembly – this will improve the patient pathway by risk stratifying patients who go on to have further investigations and prioritise those most at risk of having cancer.
- Vague symptoms pathway delivery group convened with excellent clinical engagement and follow on actions confirmed to create a non specific symptom service for suspected cancer patients. This pathway was endorsed by GPs at the ICP Northern Clinical Assembly.
- Deep dive into pathology data is on –going. Weekly meetings in place to keep pace of actions. Pathology dashboard is in development that will provide an understanding of the trusts true cancer pathology demand.
- 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

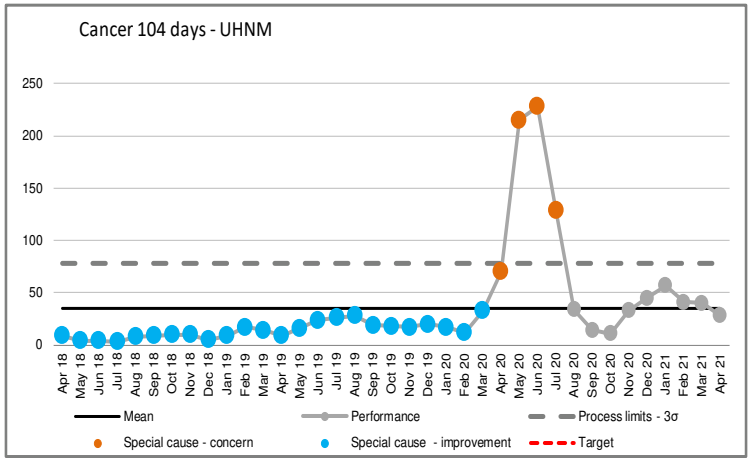






Summary draft achievement position for **Apr-21**

	Target	Trust Actual	Clock Stops	Breaches	Breaches Over	Needed Treatments
TWW Standard	93%	76.8%	2970	690	483	6888
TWW Breast Symptomatic	93%	17.0%	88	73	67	955
31 Day First	96%	94.3%	456	26	8	194
31 Day Subsequent Chemotherapy	98%	94.4%	36	2	2	64
31 Day Subsequent Surgery	94%		0	0	1	1
31 Day Subsequent Radiotherapy	94%	95.6%	91	4	Achieved!	Achieved!
62 Day Standard	85%	76.5%	162	38	14	92
Rare Cancers - 31 Day RTT pathway	85%		0	0	1	1
62 Day Screening	90%	76.5%	17	4	3	24
28 Day FDS Standard	75%	75.0%	1819	455	1	2
62 Day Consultant Upgrade	86%	71.4%	87.5	25	13	91.5
Closed Pathways > 104 Day			10.5			



Planned care - *Inpatients*

NHS
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NHS Trust

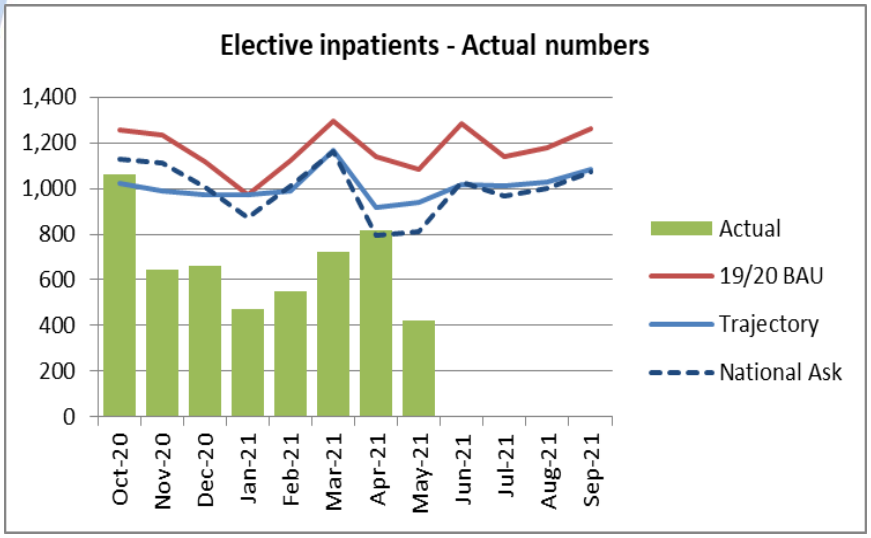
Elective inpatients Summary

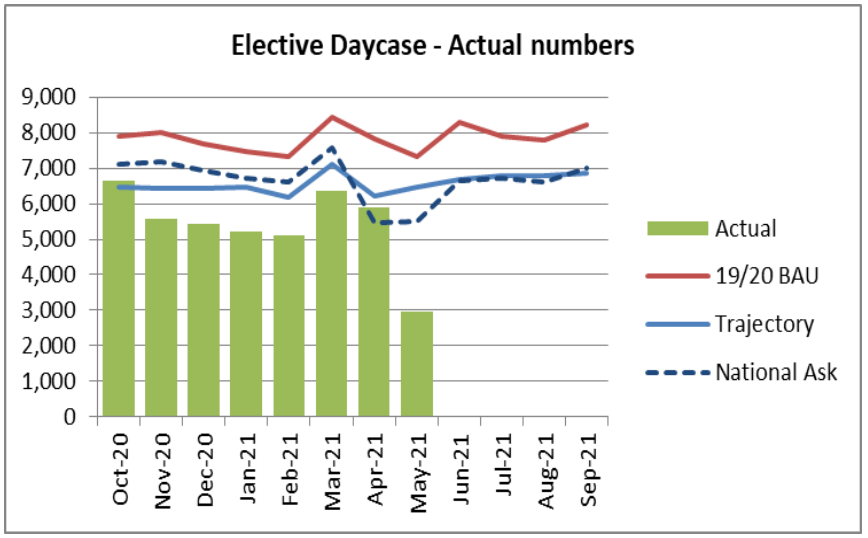
- The National ask for elective care has been revisited and an activity plan has been developed against the National Planning and Guidance trajectories for 2021/22 set at 70%, rising by 5 percentage points in subsequent months to 85% from July 21.
- For total inpatient activity, the actual against the national ask for April 21 was 74.8% (Inpatient 71.7% and Day Case 75.2%)
- The number of elective operations for UHNM (inpatients and day cases) has been steadily increasing reaching 6700 in April 21.
- 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
- Conclusion of the Data Quality Audit of the Waiting List to evaluate P2 management and the refinement of the procedure tracker that will enable weekly monitoring of treatments by Grade.
- Endorsement of the updated Trust Access Policy that covers off Covid -19specific actions around pathway management.
- 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 scale up 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.
- Waiting list analysis completion that details 9 most challenged specialties together with total weeks worth of activity held compared to reference standard for use in application of tactical theatre capacity management.

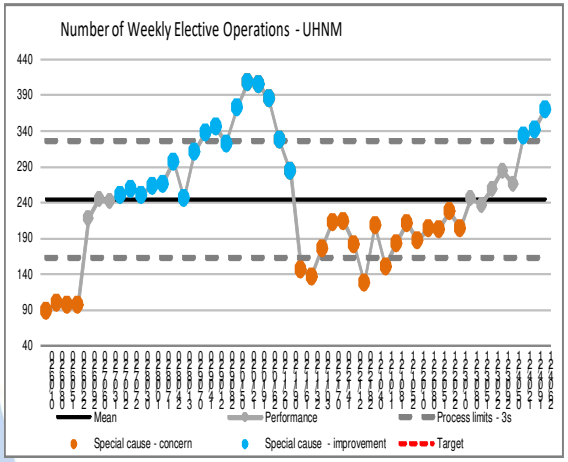
Actions

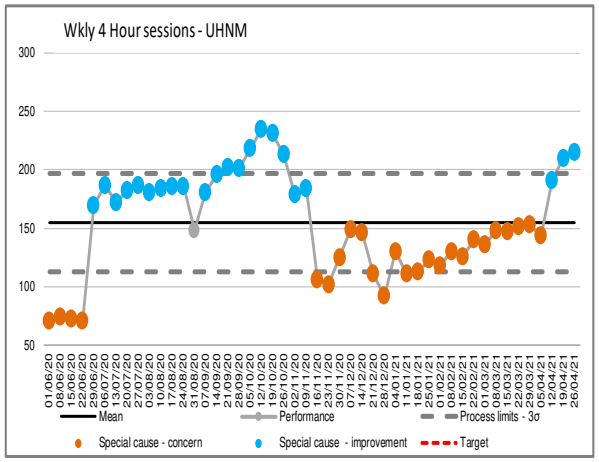
- Conclusion and decision around theatre capacity option that will provide optimal capacity to the 9 challenged specialties in the clearance of urgent/P2 patients and the maintenance of monthly additions.
- Review of the DQ P2 waiting list audit for action by specialties.
- Confirm requirements for any Non ICF treatments at the independent sector and work up activity/contracts to support.
- RTT Validation Team to draft tactical validation plans with the specialty teams and enact to ensure optimised validation across the in patient waiting list.
- Implementation of the Trust Access Policy by all Divisions to support scaling up of activity plans.
- Working up of final draft of Communication briefing to patients on the in patient waiting list with CCG colleagues as part of the QSRM plan for the oversight and proactive management of patients through consultation and action.

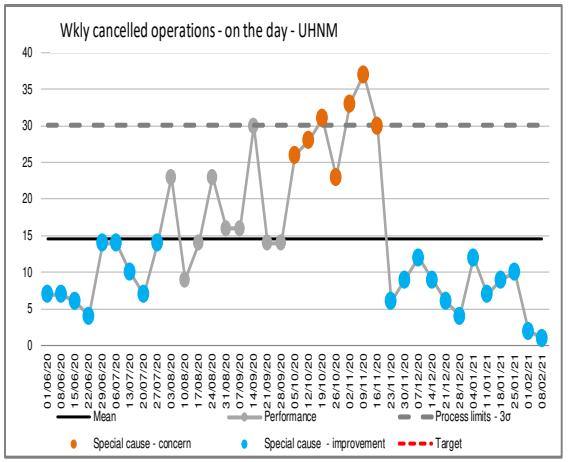
Planned care – *Inpatient Activity*











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Planned care - *Outpatients*

NHS University Hospitals of North Midlands NHS Trust

Summary

- The National ask for Outpatients along with Elective inpatients has been revisited and an activity plan has been developed. For April 2021 it will be set at 70%, rising by 5 percentage points in subsequent months to 85% from July.
- 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).
- April 21 numbers recorded were 62,282. However this may increase further as the outstanding outcomes are completed.
- The overall Referral To Treatment (RTT) Waiting list continues to rise. For April the number of Incomplete pathways has risen to 59,656 (March 56,601).
- The RTT waiting list shape has changed with the number of patients > 18 weeks remaining at a high level of 23,207 (March 21,216).
- The numbers of 52 week waits in April is showing a decline for the first time since the previous year to 4,083 (March 4,563). However this is partly due to having very few referrals 12 months ago.
- For outpatient appointments (appointment type) the Trust delivered **64.5%** F2F and **29.3%** non F2F(Telephone & Video). There were **6.2%** of appointments not set which is an improvement on last month (for new appointment types F2F was **68.6%** & non F2F **25.8%** & follow ups F2F **62.3%** & non F2f **29.3%**). The Media Type field in Medway is now mandatory which will eliminate 'Not Set' by next Month's figures.
- April's performance for ASIs position improved by 4.5% to 88.1% within 3 days (from 83.6% in March).

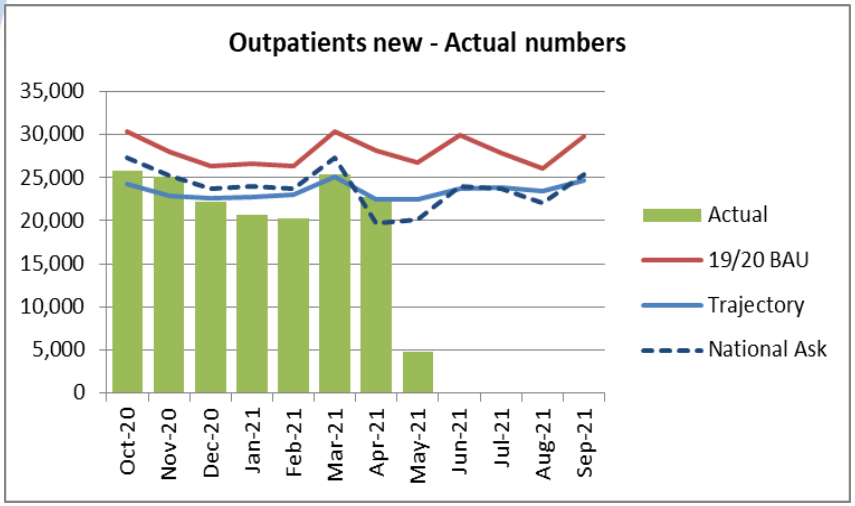
Actions

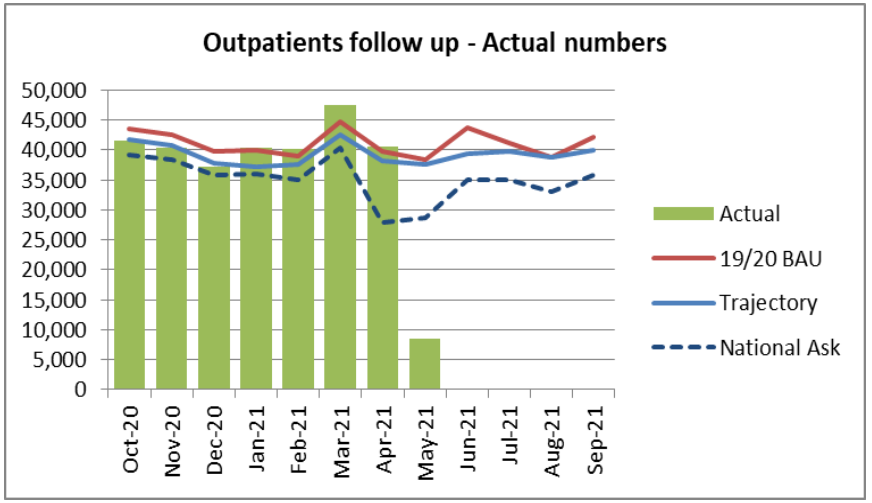
- Work is required on template reconfiguration based on Divisional assumptions - this needs to be aligned to the in patient and diagnostics plans for the purpose of substantive job planning.
- Revised 52 ww trajectory to be drafted once all cell plans confirmed to reduce the end of March 2021 delivery.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

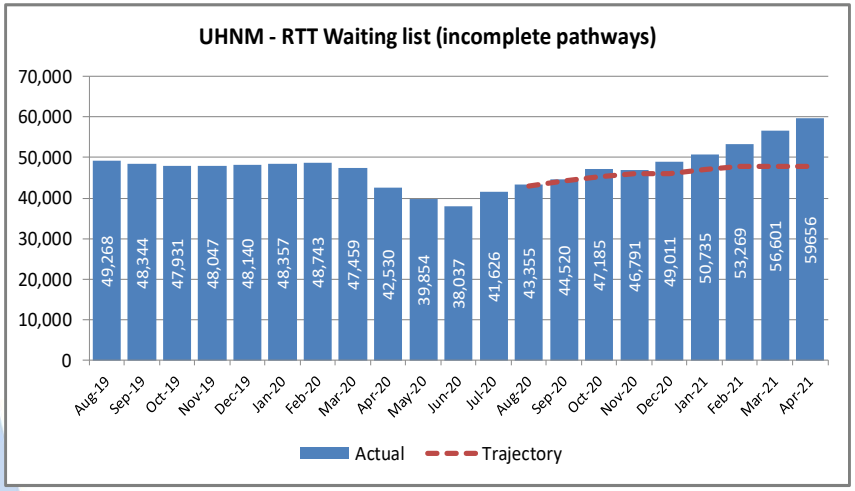
Risks:

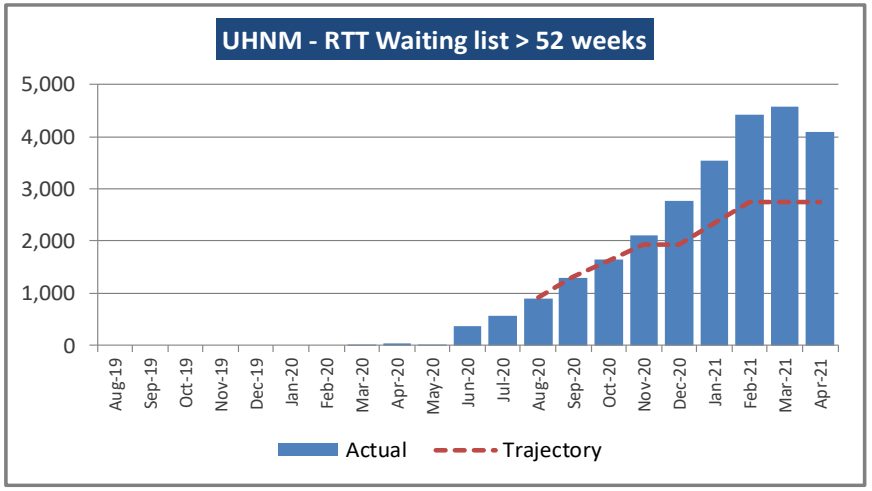
- Impact of stopping FTF activity in some areas to release staff to support frontline being monitored.

Planned care – *Outpatient activity & RTT*

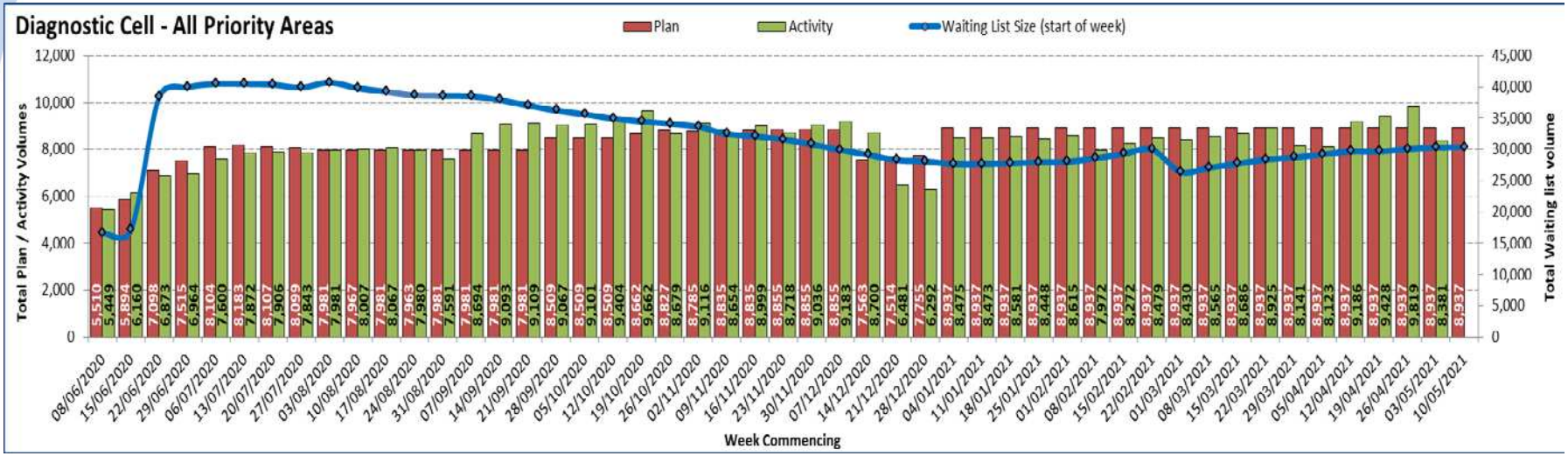








Diagnostic Activity



Summary

- Diagnostic performance is monitored through the Diagnostic cell. All priority areas have been identified and April saw arise in activity for these tests. Revised trajectories have been developed.
- For DM01 (15 nationally identified Dx tests) however, the waiting list is growing month on month with an increase in demand in some significant areas (breast: Non Obs Ultrasound). The DM01 diagnostic performance for April 21 is 78.72 (March 84.1%).
- The waiting list size is 17,169 (March 16,514) and is growing week on week with the greatest growth mainly seen in MRI, CT and non-obstetric Ultrasound. The proportion of the patients waiting that have waited under 6 weeks is decreasing. 73% are under 6 weeks . Non Obstetric ultrasound see the largest deterioration (-5%). This relates to the increased activity of the 2ww and urgent.
- There has been a significant Increase in 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.
- 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

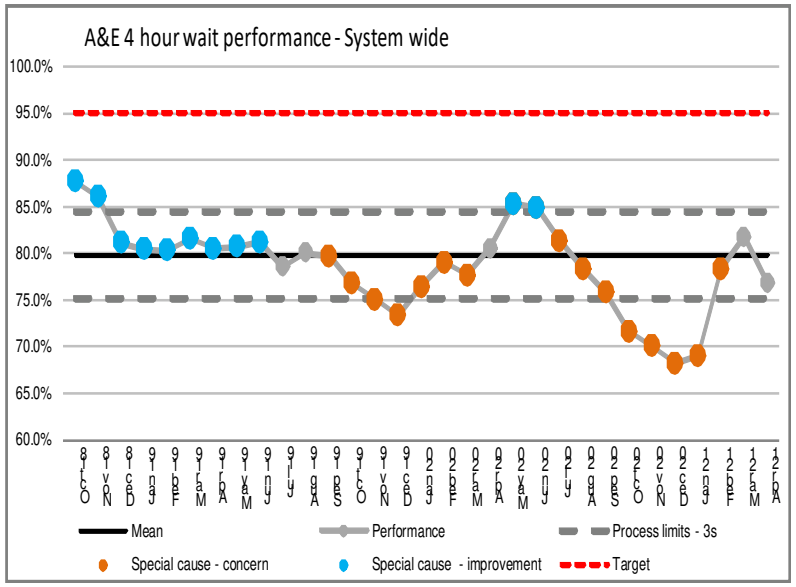
Operational Performance

Constitutional standards

	Metric	Target	Latest	Variation	Assurance	DQAI
A&E	A&E 4 hour wait Performance	95%	76.80%		F	
	12 Hour Trolley waits	0	0		?	
Cancer Care	Cancer Rapid Access (2 week wait)	93%	75.09%	L	?	
	Cancer 62 GP ref	85%	75.60%		?	
	Cancer 62 day Screening	90%	70.00%		?	
	31 day First Treatment	96%	93.30%		?	
Elective waits	RTT incomplete performance	92%	61.10%	L	F	
	RTT 52+ week waits	0	4083	H	F	
	Diagnostics	99%	78.72%	L	?	

	Metric	Target	Latest	Variation	Assurance	DQAI
Use of Resources	DNA rate	7%	7.3%		?	
	Cancelled Ops	150	90	L	?	
	Theatre Utilisation	85%	76.0%			
Inpatient / Discharge	Same Day Emergency Care	30%	30.1%	H	?	
	Super Stranded	183	145	L	P	
	DToC	3.5%	2.60%	L	?	
	Discharges before Midday	30%	19.1%		F	
	Emergency Readmission rate	8%	13.4%		F	
	Ambulance Handover delays in excess of 60 minutes	10	24		?	

URGENT CARE – 4 hour access performance



Variation	Assurance
	F

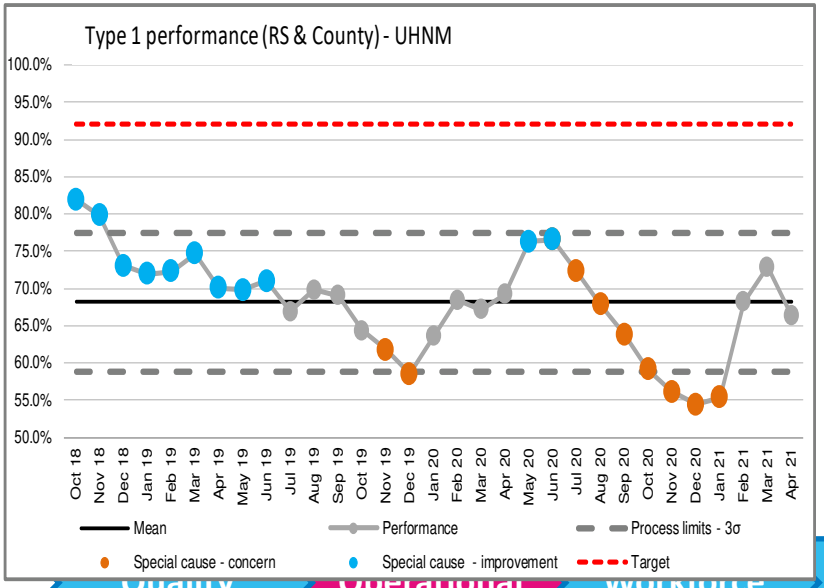
Target	Feb 21	Mar 21	Apr 21
95%	78.3%	81.7%	76.8%

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 last 3 months has fallen bewteen the control limits with the latest being below the mean.



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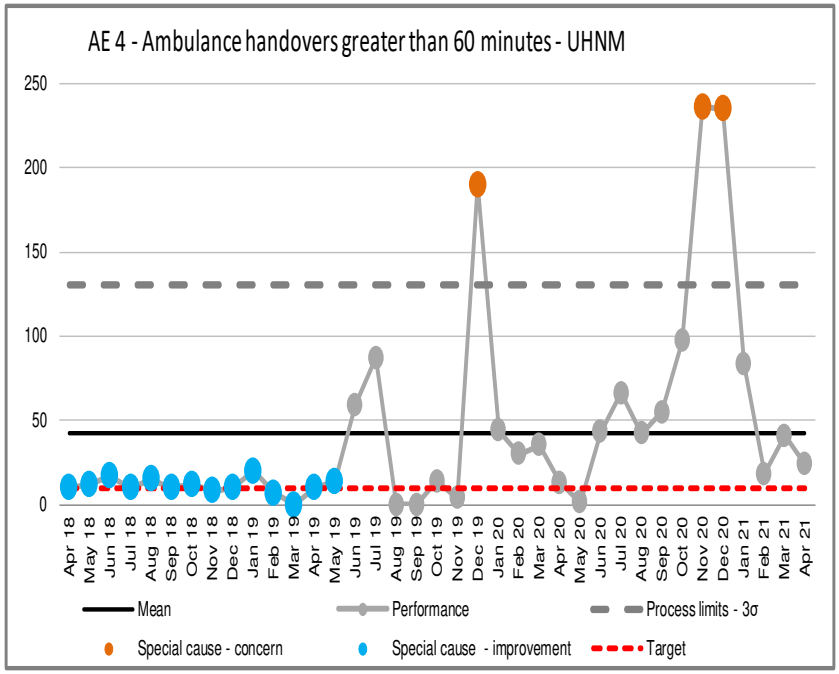
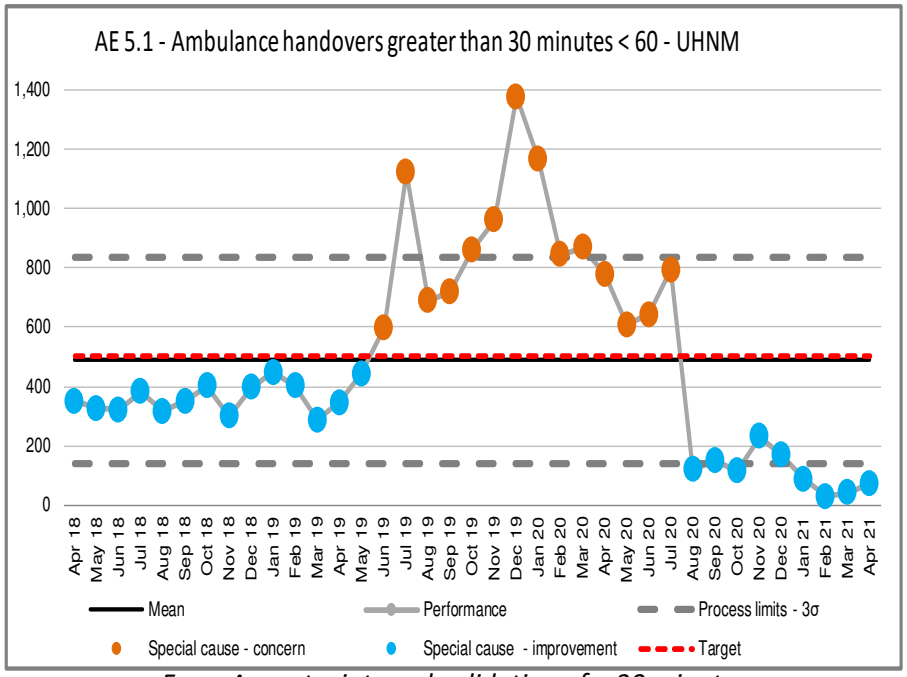
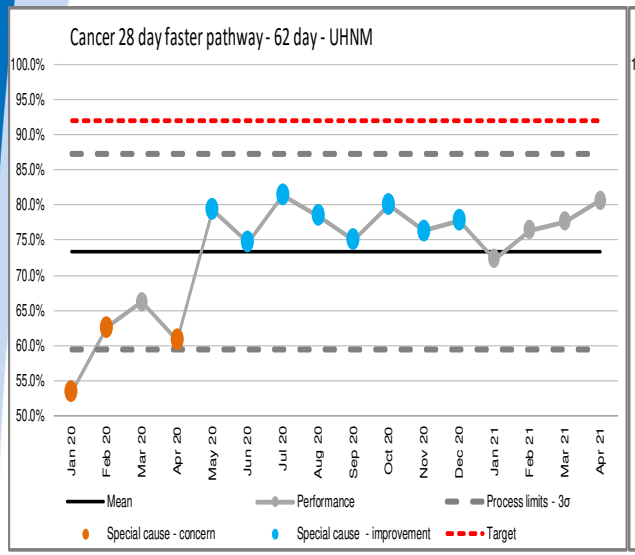
URGENT CARE – 4 hour access – ambulance handovers

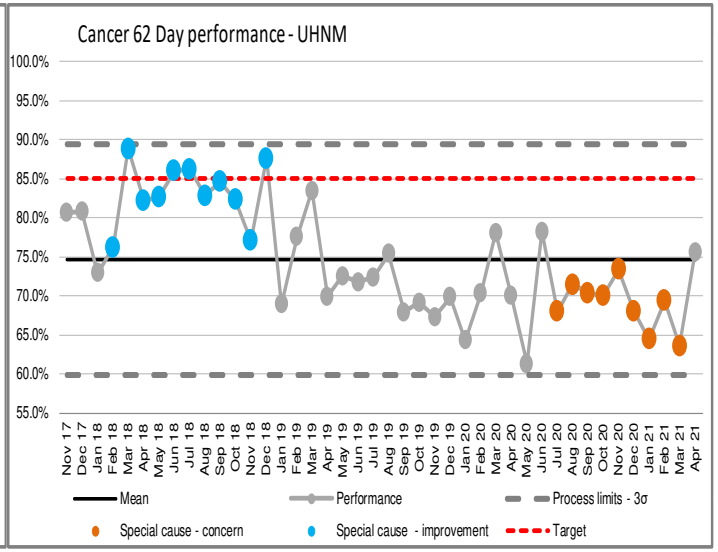




From August – internal validation of > 30 minutes

Cancer – 62 Day





Variation	Assurance

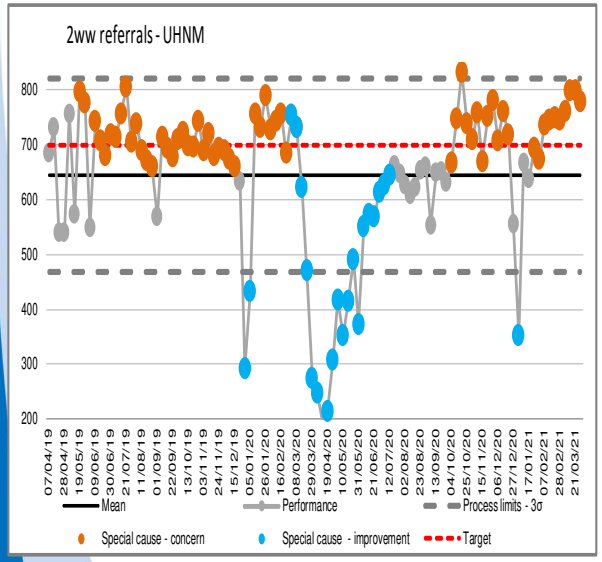
Target	Feb 21	Mar 21	Apr 21
85%	69.3%	63.6%	75.6%

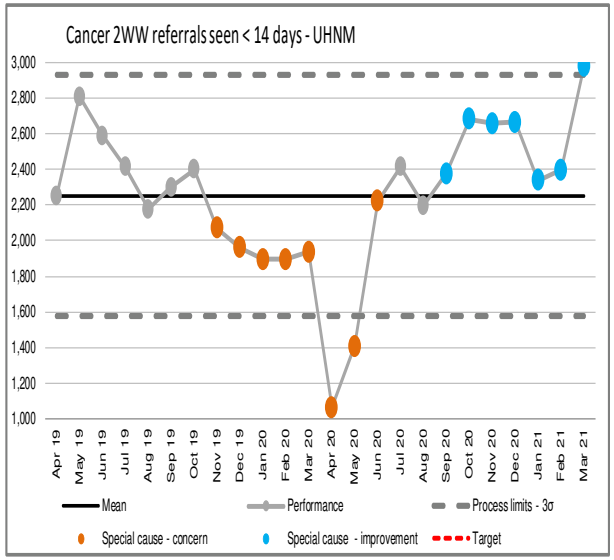
Background

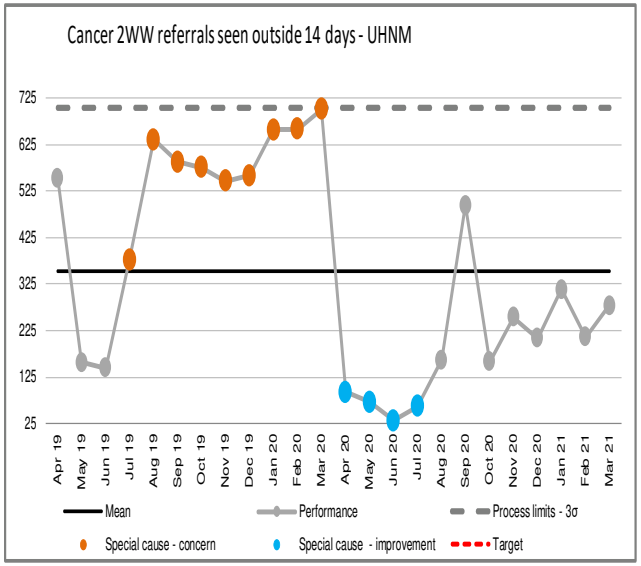
% patients beginning their treatment for cancer within 62 days following an urgent GP referral for suspected cancer

What is the data telling us?

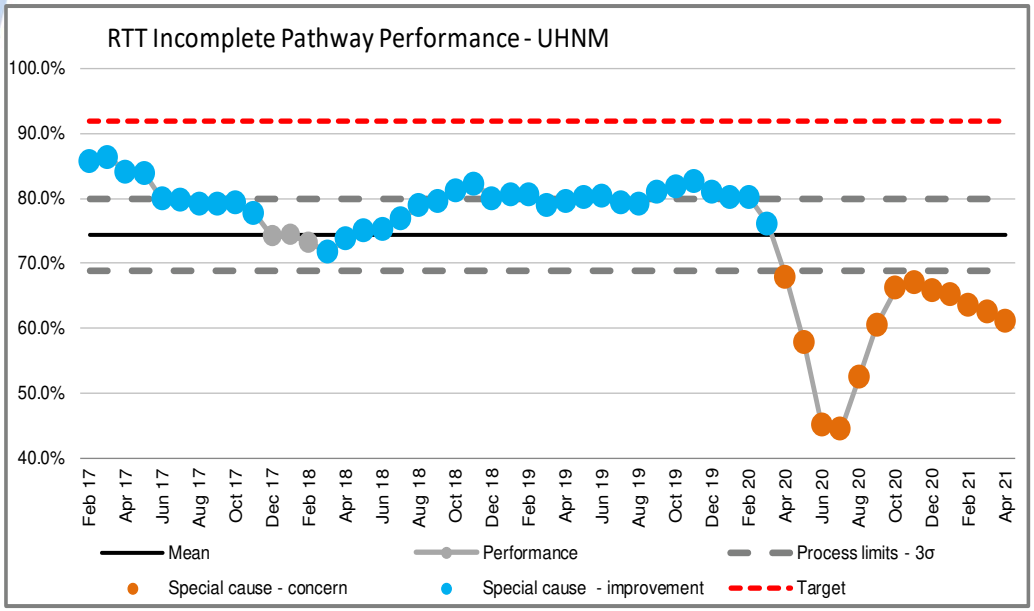
Apart from two occasions the standard has been below the mean since Sept-19. In March the standard fell to the lower control limit.







Referral To Treatment



Variation	Assurance
	

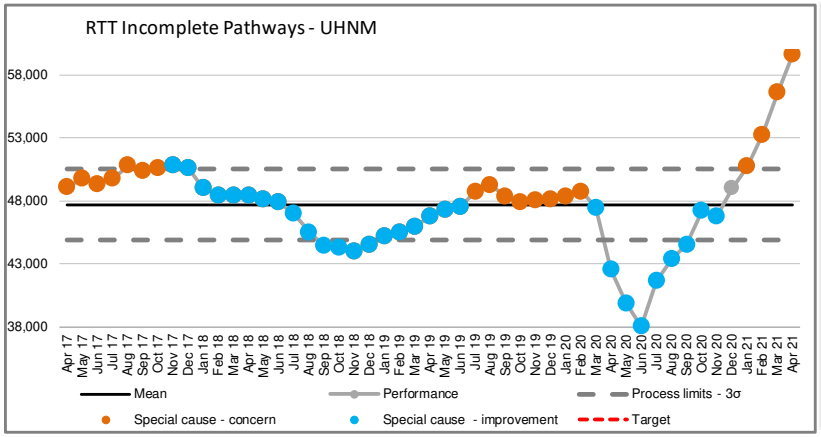
Target	Feb 21	Mar 21	Apr 21
92%	63.6%	62.5%	61.1%

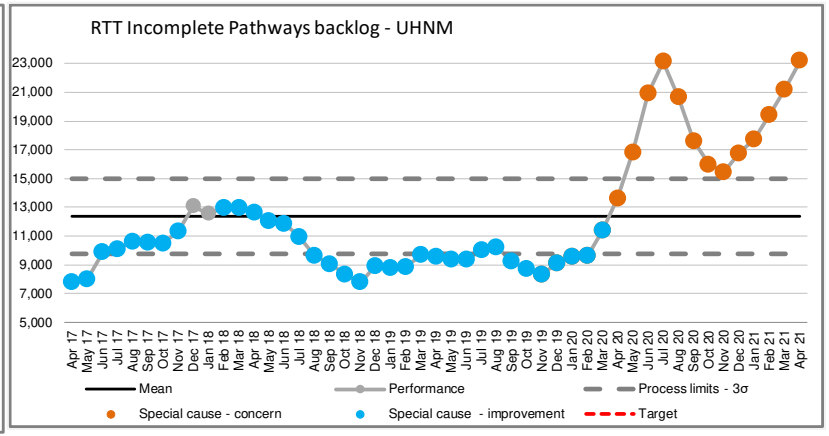
Background

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

What is the data telling us?

The RTT performance deteriorated from March 2020 with the onset of Covid-19. Recovery was seen from July but until the second wave of the pandemic and the reduced capacity to treat patients.





Together Compassion Safe Improving

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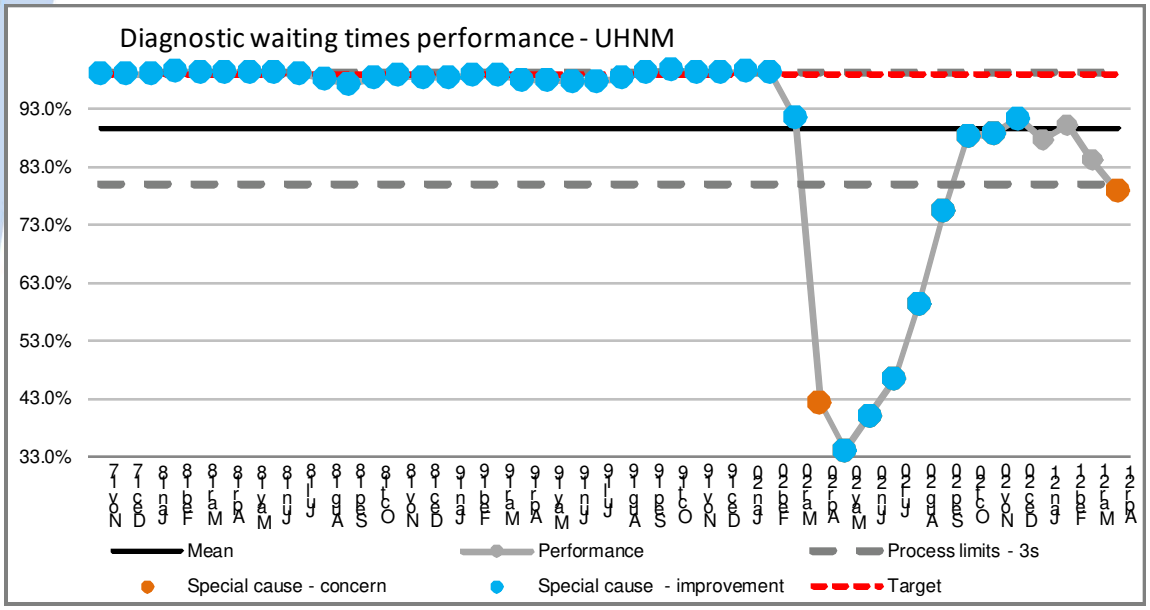
Diagnostic Standards



Variation	Assurance
	

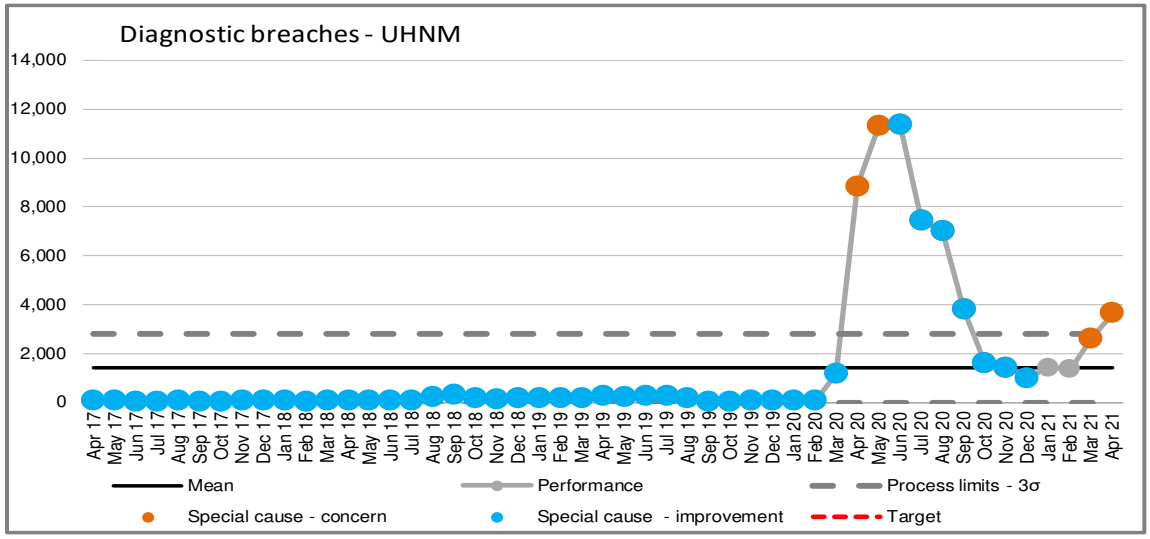
Target	Feb 21	Mar 21	Apr 21
99%	90.1%	84.1%	78.7%

Background

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

What is the data telling us?

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



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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.

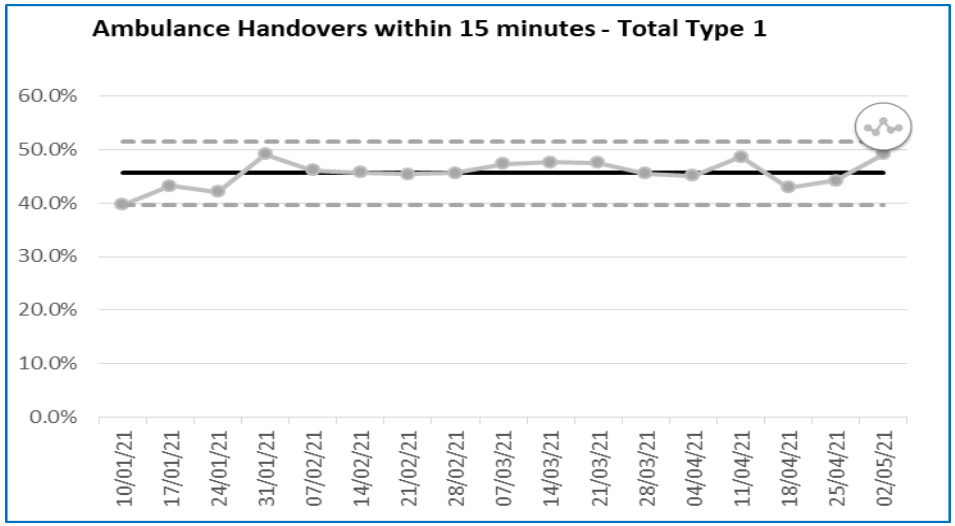
Governance

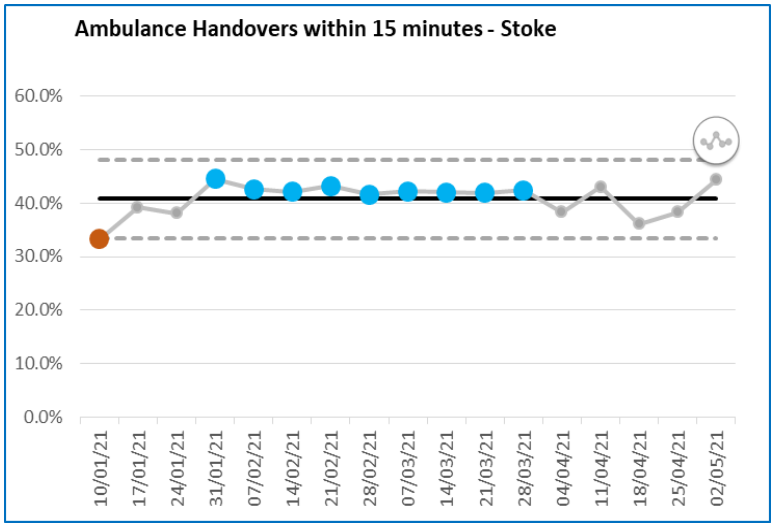
The newly proposed UEC standards will be monitored through both ED performance review and Medicine Divisional board meetings. Organisationally oversight will be through the Urgent Care Programme Board in addition to relevant trust committees

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



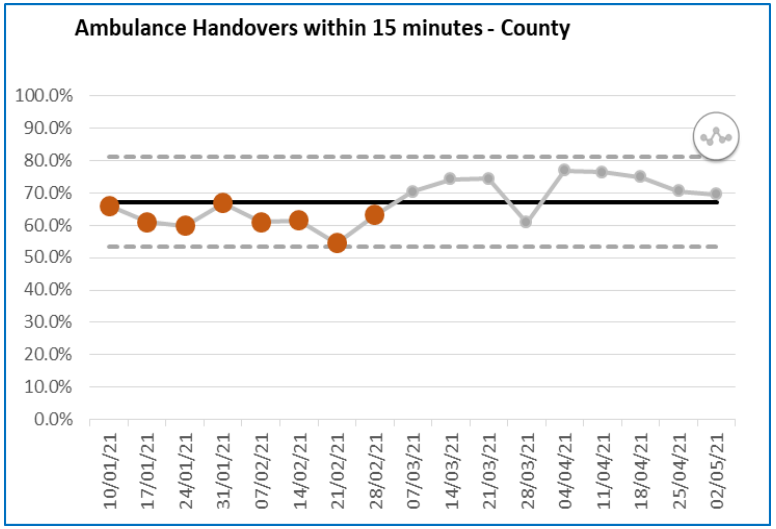


Internal collection of data for Ambulance handovers within 15 minutes began at the beginning of January 21. This is the time taken for the ambulance service to hand over the care to the ED.
N.B. this is un-validated performance and also includes handover time related to direct ambulance conveyance to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

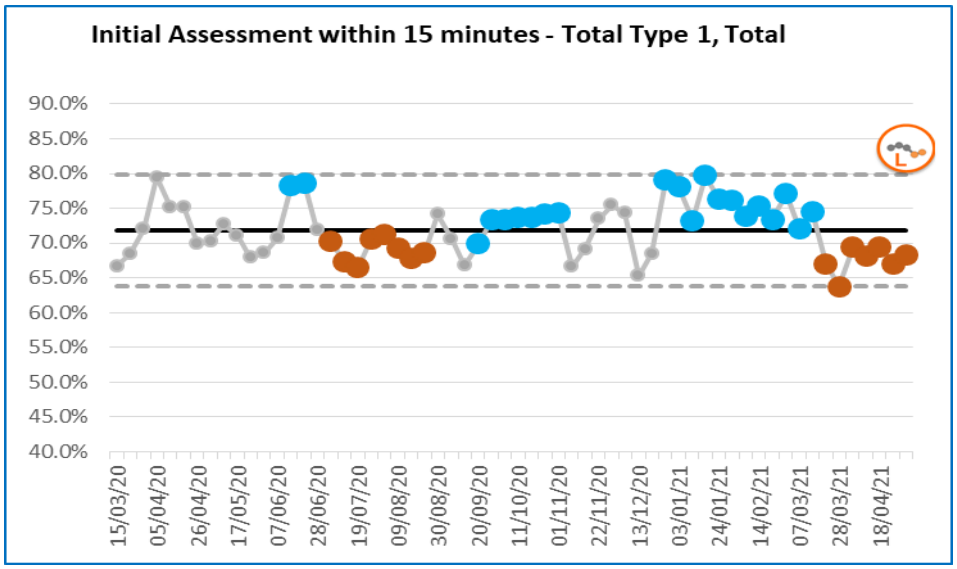
For total ambulance handovers at UHNM in April, the percentage within 15 minutes had increased to 53.8% from 47% in March. A local UHNM target of 48% has been set as the goal to improve to as part of the NEL Improvement programme.

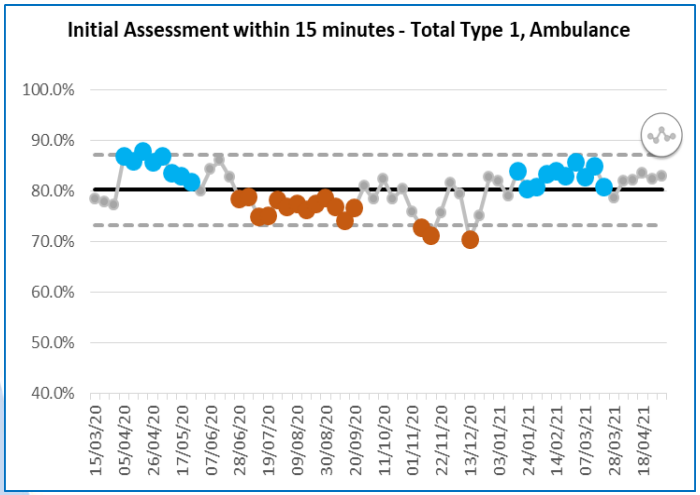
County have maintained a much higher percentage than Royal Stoke albeit with much smaller numbers.

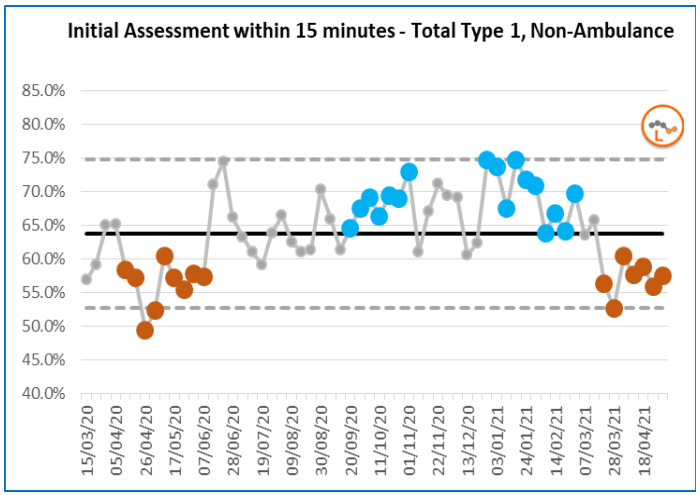
April has seen normal variation continue from last month.



3. Time To Initial Assessment – percentage within 15 minutes







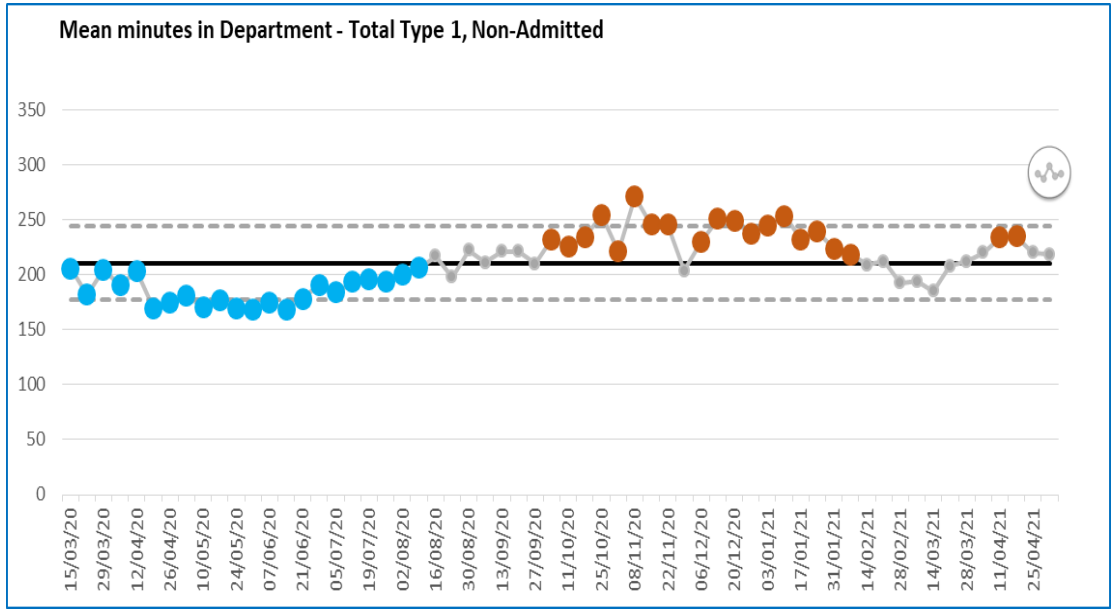
Time to Initial assessment is the time from arrival to when the patient is first triaged.

The proportion of patients waiting under 15 minutes for their initial assessment fell towards the end of April to **68%.**

This was more notable in the non-ambulance assessments which may be accounted for with the increase in attendances in this area.

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

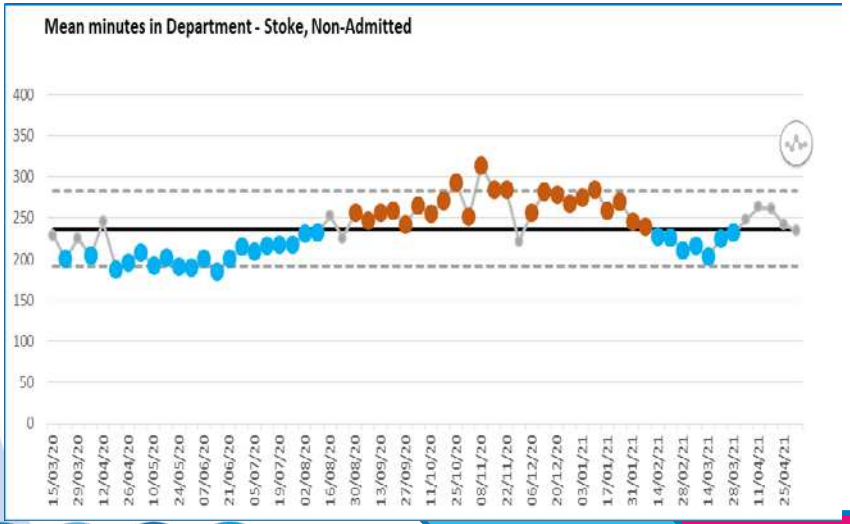
4. Average (mean) time in Department – non admitted patients

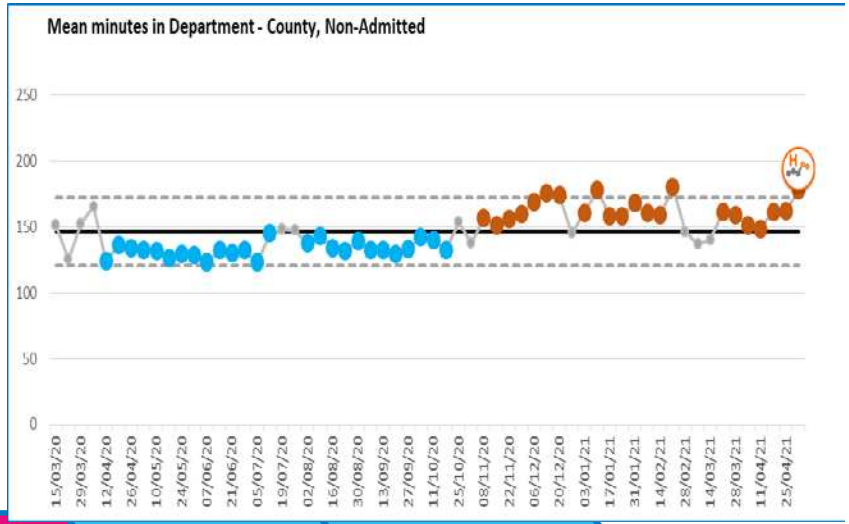


The mean time in the department through April had risen and was reported as 235 minutes at the end of the month. Although this is still normal variation.

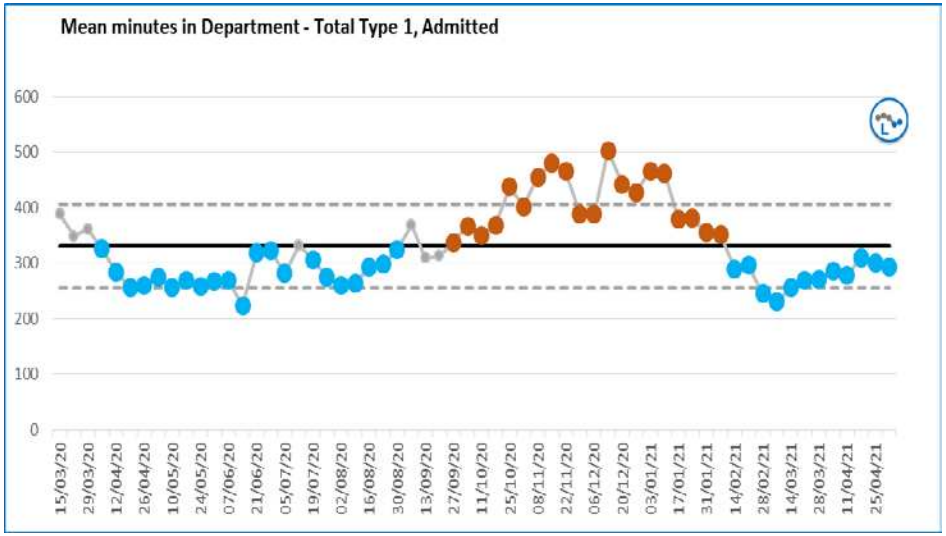
For Royal Stoke the mean time for April rose at the beginning and reduced to the mean at the end of the month.

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





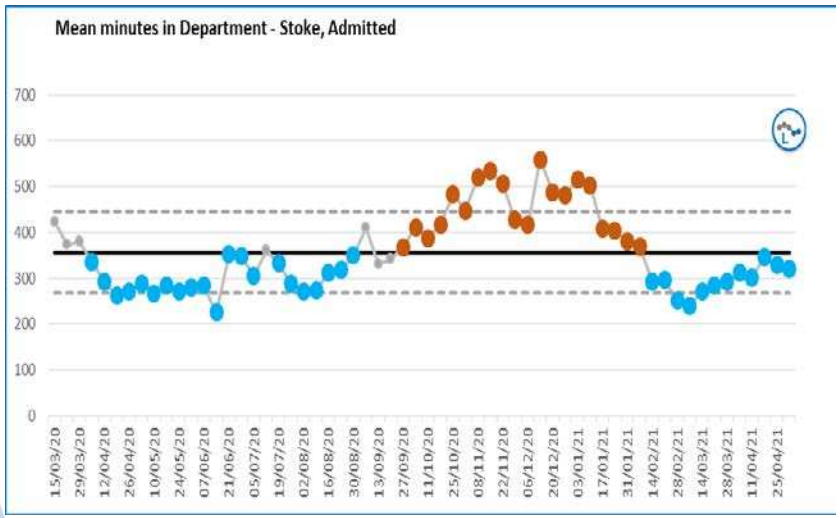
5. Average (mean) time in Department – admitted patients

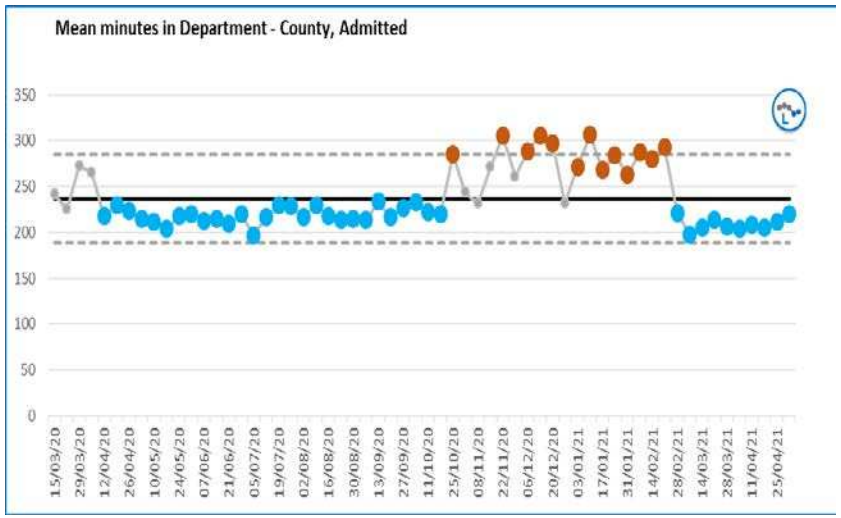


The reduced mean time in the department for admitted patients has been maintained through April at around 290mins.

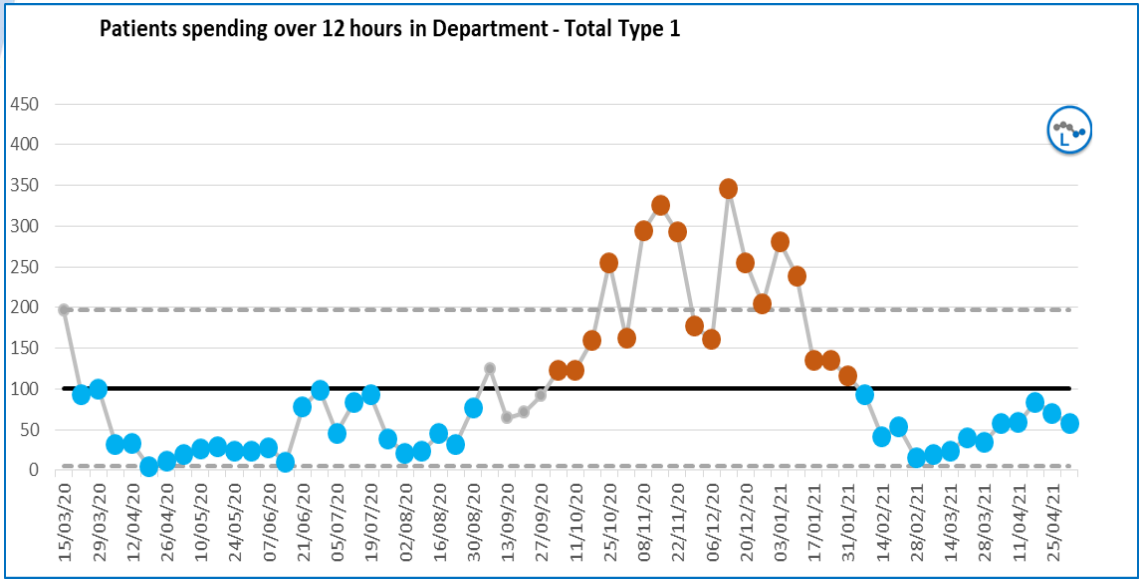
This was seen at both sites.

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



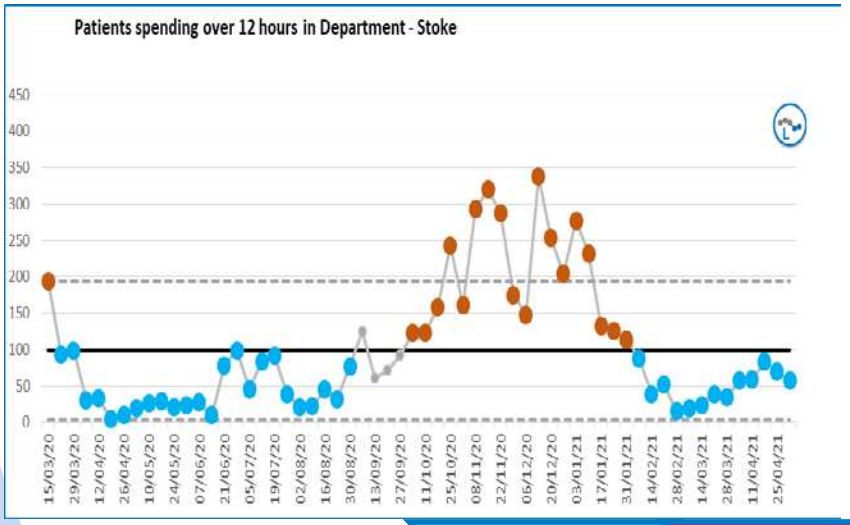


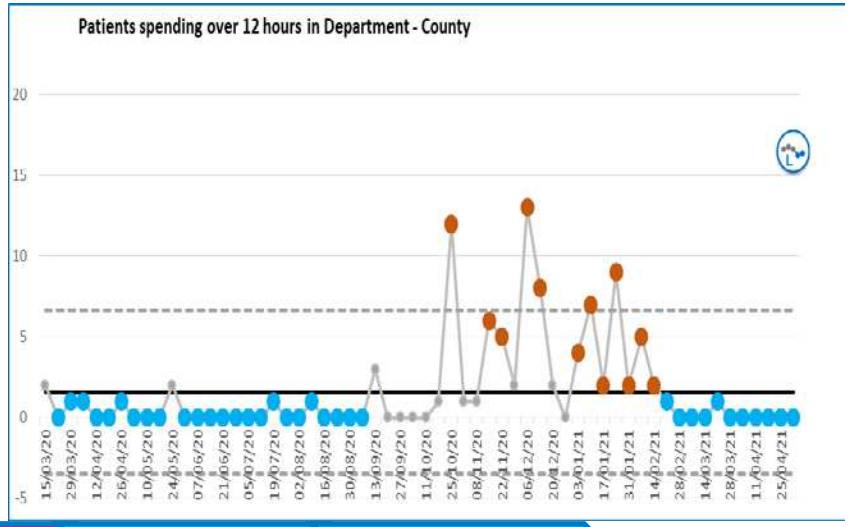
6. Patients spending more than 12 hours in the department



The reduced number of patients spending over 12 hours Tin the department has been maintained in April when compared to Nov/Dec 20.

This standard is more applicable to 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 11th May 2021, covid-related open absences numbered 45, which was 8.32% of all absences (16.8% at 7th April 2021). The Trust has commissioned covid rehabilitation courses from our Occupational Health provider to support staff suffering from long-covid

The staff health and wellbeing offer has developed incrementally during the pandemic with a combination of UHNM created as well as nationally available support and interventions. The wellbeing offer is updated weekly and includes

- The Staff Psychological and Wellbeing Hub opened on 14th May.
- Listening support sessions continuing until June
- Suicide Awareness for Professionals will be launched in June
- A further CISM practitioners course was delivered in May

Staff across the Trust accessed 255 Staff Support and Counselling sessions throughout April in comparison to 119 in the same period last year.

The key performance issues are that the sickness rate remains above target and that compliance with PDR requirements is below target.. The expectation that overdue PDRs are scheduled from Q2 has been communicated and the compliance rate has improved over the last 3 months.

Sickness

The in-month sickness rate was 4.23% (4.42% reported at 31/03/21). The 12 month cumulative rate reduced to 5.21% (5.37% at 31/03/21)

Appraisals

The Non-Medical PDR compliance rate was 77.42% at 30 April 2021 (75.56% at 31st March 2021).

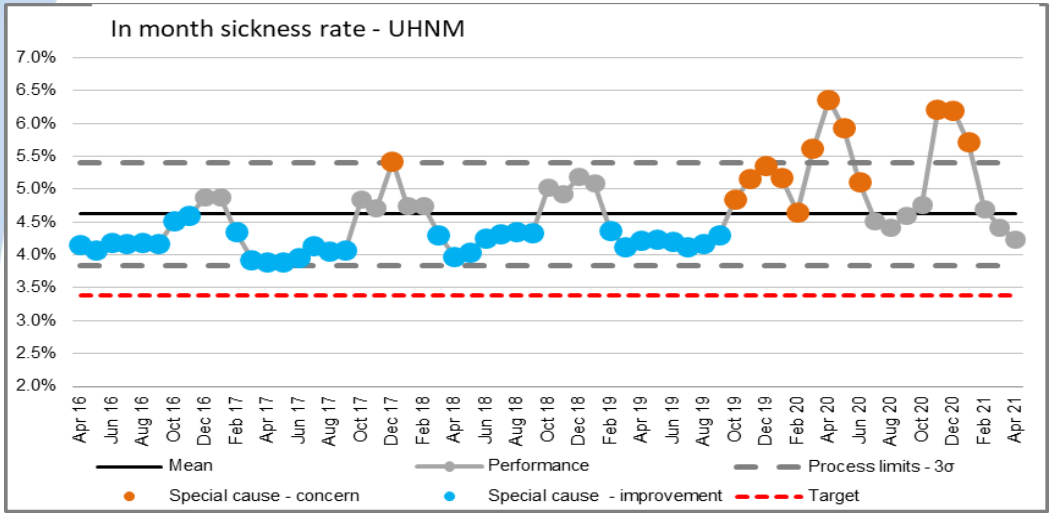
Statutory and Mandatory Training

The Statutory and Mandatory training rate at 30 April 2021 was 94.19% (93.85% at 31 March 2021). At 30 April 2021, 90.32% of staff had completed all 6 Core for All modules (90.19% at 31/03/21)

Workforce Dashboard

Metric	Target	Latest	Variation	Assurance
Staff Sickness	3.4%	4.23%		
Staff Turnover	11%	9.28%		
Statutory and Mandatory Training rate	95%	94.19%		
Appraisal rate	95%	77.42%		
Agency Cost	N/A	3.30%		

Sickness Absence



Variation	Assurance

Target	Feb 21	Mar 21	Apr 21
3.4%	4.7%	4.4%	4.2%

Background

Percentage of days lost to staff sickness

What is the data telling us?

Sickness rate is consistently above the target of 3.4%. 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 4.23% (4.42% reported at 31/03/21). The 12 month cumulative rate reduced to 5,21% (5.37% at 31/03/21)

As of 11th May 2021, covid-related open absences numbered 45, which was 8.32% of all absences (16.8% at 7th April 2021)

As of 1st April 2021, staff members who were shielding but not able to work from home have been supported to return to the workplace.

Lateral-Flow asymptomatic testing and PCR Testing to strengthen our efforts to prevent and control the spread of infection is continuing, and PCR testing continues

The Trust has commissioned 5 x 6-week covid rehabilitation courses from our Occupational Health provider for staff suffering from long-covid

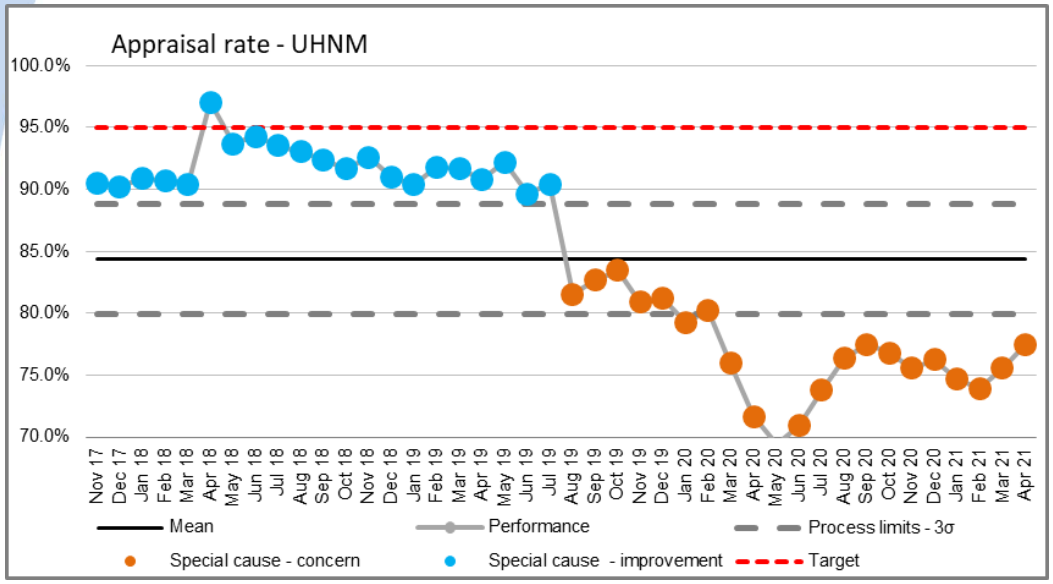
Staff Wellbeing and wellbeing support have continued as a priority. The Wellbeing Plan has been refreshed and updated and the focus going forward remains on the continued provision of staff support to ensure the psychological wellbeing of staff.

The Staff Psychological and Wellbeing Hub opened on 14th May

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	Feb 21	Mar 21	Apr 21
95.0%	73.9%	75.6%	77.4%

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

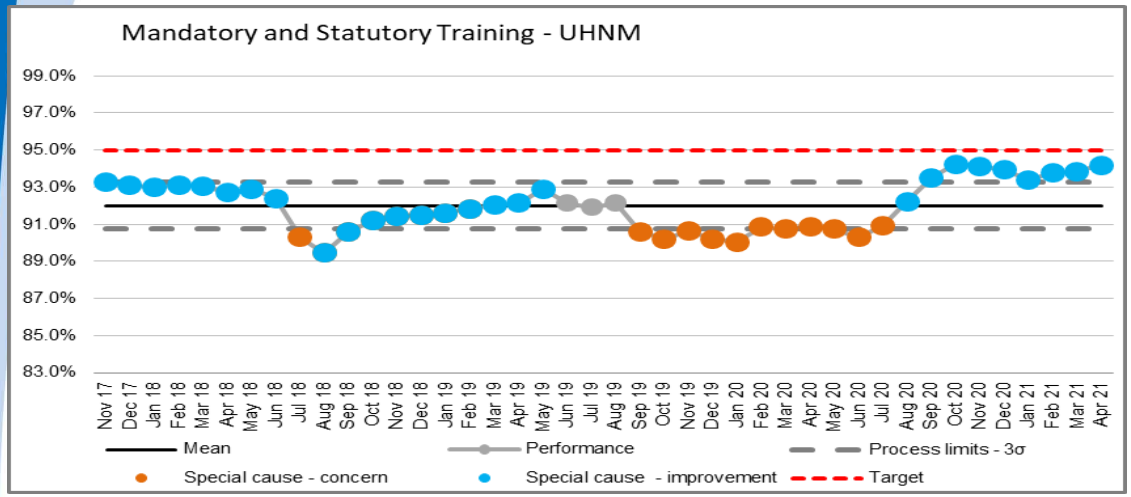
The Non-Medical PDR compliance rate was 77.42% at 30 April 2021 (75.56% at 31st March 2021).

Actions

The Executive decision to suspend PDR's unless there was capacity to continue to undertake them has been lifted with the expectation that overdue PDRs are scheduled from Q2.

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

Statutory and Mandatory Training



Variation	Assurance
H	F

Target	Feb 21	Mar 21	Apr 21
95.0%	93.8%	93.9%	94.2%

Background

Training compliance

What is the data telling us?

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

Summary

The Statutory and Mandatory training rate at 30 April 2021 was 94.19% (93.85% at 31 March 2021). At 30 April 2021, 90.32% of staff had completed all 6 Core for All modules (90.19% at 31/03/21)

Competence Name	Assignment Count	Required	Achieved	Compliance %
205|MAND|Security Awareness - 3 Years|	10904	10904	10287	94.37%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	10904	10904	10285	94.32%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	10904	10904	10198	93.53%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	10904	10904	10241	93.92%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	10904	10904	10260	94.09%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	10904	10904	10353	94.95%

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

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 1 Year|	10904	10904	9339	85.65%
NHS|CSTF|Information Governance and Data Security - 1 Year|	10904	10904	9780	89.69%

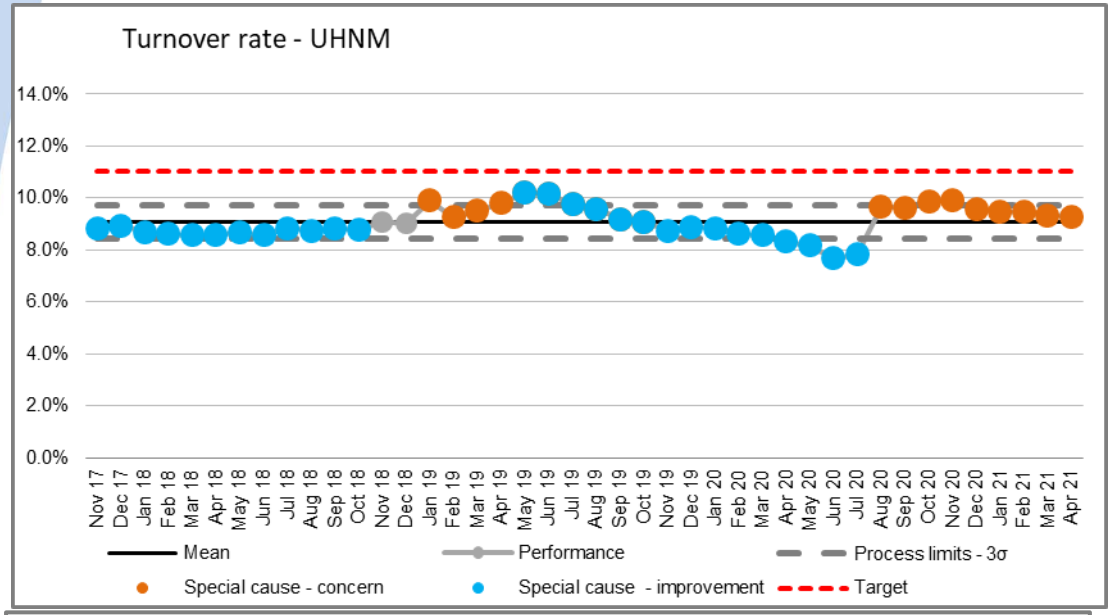
Note: The figures reported elsewhere to Board in respect of Information Governance and Data Security Training, have been adjusted for a 6 month extension due to COVID19. The figures reported in this report are unadjusted.

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	Feb 21	Mar 21	Apr 21
11.0%	9.5%	9.3%	9.3%

Background

Turnover rate

What is the data telling us?

There is special cause variation since August 2020 which was the result of a one-off event.

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

Summary

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

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 overall Trust vacancy rate, calculated as Budgeted Establishment less staff in post, was 7.49% and remains consistent with previous months

Vacancies at 30 April 2021	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous month %	
Medical and Dental	1,407.03	1,268.46	138.57	9.85%	13.05%	Changes are mainly a result of reductions in the budgeted establishment
Registered Nursing	3253.14	2922.29	330.86	10.17%	13.11%	
All other Staff Groups	6229.58	5882.92	346.66	5.56%	3.71%	
Total	10,889.75	10,073.67	816.08	7.49%	7.85%	

Actions

At 30th April 21, there were no Consultant Vacancies which had been advertised more than twice

The covid situation in India has impacted the international recruitment of nurses, meaning the planned arrival of nurses is suspended due to the cancellation of flights and because some nurses wish to delay to support their own healthcare system.

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 continuation of funding arrangements from the second half of 2020/21 into the first half of 2021/22 ("H1") have enabled the Trust to set a breakeven budget for the first half of the year (which is in agreement with System wide plans). The arrangements for the second half of the year ("H2") are not known; based on a high level assessment of income the trust is forecasting a £17.1m deficit for H2.
- The Trust has delivered a surplus of £2.7m 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 levels, underspends on pay (primarily qualified nursing) and slippage against reserves held by the Trust.
- The Trust incurred £1.1m of costs relating to COVID-19 in month which is a reduction in comparison with Month 12's figure of £1.8m primarily in pay due to reduced demands on additional shifts or backfill for sickness absence. This remains within the Trust's fixed allocation with £0.6m being chargeable on top of this allocation for COVID-19 testing costs.
- Capital expenditure for the year to date stands at £1.1m which is in line with the plan.
- The cash balance at Month 1 of £55.4m shows a reduction of £0.4m from the year end and is in line with expectations for Month 1. A cash plan will be prepared in line with the re-submission of the revenue plan to NHS England and NHS Improvement on 26 May and be reported against from Month 2 onwards.

Finance Dashboard

	Metric	Target	Latest	Variation	Assurance
I&E	TOTAL Income	variable	129.7		
	Expenditure - Pay	variable	80.0	H	?
	Expenditure - Non Pay	variable	46.0	H	P
Activity	Daycase/Elective Activity	variable	7,077	L	?
	Non Elective Activity	variable	9,543	L	?
	Outpatients 1st	variable	24,632	L	?
	Outpatients Follow Up	variable	45,868		?

Income & Expenditure

Income & Expenditure Summary Month 01 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	807.4	70.9	69.4	(1.5)	70.9	69.4	(1.5)
Other Operating Income	91.5	6.9	7.1	0.2	6.9	7.1	0.2
Total Income	898.8	77.8	76.5	(1.3)	77.8	76.5	(1.3)
Pay Expenditure	(537.4)	(45.1)	(44.0)	1.1	(45.1)	(44.0)	1.1
Non Pay Expenditure	(328.9)	(28.2)	(25.2)	2.9	(28.2)	(25.2)	2.9
Total Operational Costs	(866.3)	(73.3)	(69.2)	4.1	(73.3)	(69.2)	4.1
EBITDA	32.6	4.6	7.3	2.7	4.6	7.3	2.7
Depreciation & Amortisation	(30.2)	(2.5)	(2.5)	(0.0)	(2.5)	(2.5)	(0.0)
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	(0.6)	(0.6)	0.0
Finance Cost	(17.2)	(1.4)	(1.4)	0.0	(1.4)	(1.4)	0.0
Surplus / (Deficit)	(22.1)	0.0	2.7	2.7	0.0	2.7	2.7
Financial Recovery Fund	5.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	(17.1)	0.0	2.7	2.7	0.0	2.7	2.7

The Trust delivered a £2.7m surplus for the month 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 £1.0m lower than plan income in respect of the Independent Sector (IS) activity and £0.7m under performance on pass through device income; both of which are offset by corresponding underspends in non-pay.

Other operating income has over performed in month due to additional income in respect of cancer transformation and income for overseas nursing to offset the work permit costs in month noted within non pay establishment costs.

Pay is underspent in month by £1.1m which is driven by underspends across most staffing categories aside from medics. This is further driven by contingency and COVID funding not used in month.

Non-pay is underspent in month largely due to the supplies and services - clinical spend being 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. Furthermore, as noted above within pay the contingency and COVID-19 funds have not being fully utilised in month.

Capital Spend

Capital Expenditure as at Month 1 2021/22 £m	Annual	In Month			Year to Date		
	Plan	Budget	Actual	Variance	Budget	Actual	Variance
PFI & finance lease liability repayment	(9.2)	(0.8)	(0.8)	-	(0.8)	(0.8)	-
Pre-committed items	(9.2)	(0.8)	(0.8)	-	(0.8)	(0.8)	-
PFI lifecycle and equipment replacement	(5.3)	(0.2)	(0.2)	-	(0.2)	(0.2)	-
PFI enabling cost	(0.8)	-	-	-	-	-	-
Commitments b/f from 2020/21	(0.3)	(0.0)	-	0.0	(0.0)	-	0.0
ICT Infrastructure	(0.6)	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0
LIMS (Laboratory Information Management System	(0.6)	(0.1)	(0.0)	0.0	(0.1)	(0.0)	0.0
EPMA (Electronic Prescribing)	(0.5)	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0
Estates Infrastructure	(2.9)	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0
Critical Risk Infrastructure	(0.3)	-	-	-	-	-	-
Health & Safety Compliance	(0.2)	-	-	-	-	-	-
Completion of RSUH ED doors	(0.2)	-	-	-	-	-	-
Beds, mattresses and hoists	(0.1)	-	-	-	-	-	-
West building doctors accommodation	(0.1)	-	-	-	-	-	-
Sodexo accommodation	(0.1)	-	-	-	-	-	-
Lloyds dispensary footprint	(0.6)	-	-	-	-	-	-
Medical Equipment Replacement	(2.0)	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0
Medical devices fleet replacement	(0.7)	-	-	-	-	-	-
4th Linear Accelerator Replacement	(2.3)	-	-	-	-	-	-
Pathology integration	(0.1)	-	-	-	-	-	-
Digital Pathology (MES)	(0.7)	-	-	-	-	-	-
Investment schemes	(0.5)	-	-	-	-	-	-
Central contingency and risk	(0.5)	-	-	-	-	-	-
Depreciation funded balance to be allocated	(2.3)	-	-	-	-	-	-
Trust cash funded balance to be allocated	(2.3)	-	-	-	-	-	-
Trust funded capital programme	(17.6)	(0.2)	(0.1)	0.1	(0.2)	(0.1)	0.1
Emergency PDC - RI demolition	(2.4)	(0.1)	(0.1)	-	(0.1)	(0.1)	-
Emergency PDC - MRU decant	(1.1)	(0.0)	(0.0)	-	(0.0)	(0.0)	-
Wave 4b funding - lower Trent Wards	(6.5)	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0
Diagnostic Funding	(0.4)	-	-	-	-	-	-
PDC funded capital schemes	(10.4)	(0.1)	(0.1)	0.0	(0.1)	(0.1)	0.0
Donated/Charitable funds expenditure	-	-	(0.1)	(0.1)	-	(0.1)	(0.1)
Charity funded expenditure	-	-	(0.1)	(0.1)	-	(0.1)	(0.1)
Overall capital expenditure	(37.1)	(1.0)	(1.1)	(0.0)	(1.0)	(1.1)	(0.0)

The plan shown in the table on the left 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.

It was agreed that a plan needed to be in place by the end of June in order that funding can be allocated and spent in year.

Balance sheet

Balance Sheet as at Month 1 £m	31/03/2021 Actual	30/04/2021 Actual	Variance	
Property, Plant & Equipment	531.2	529.6	(1.6)	Note 1
Intangible Assets	22.8	22.2	(0.6)	Note 1
Other Non Current Assets	-	-	-	
Trade and other Receivables	0.5	0.5	-	
Total Non Current Assets	554.5	552.3	(2.2)	
Inventories	15.0	15.9	0.9	Note 2
Trade and other Receivables	47.4	46.9	(0.5)	
Cash and Cash Equivalents	55.8	55.4	(0.4)	
Total Current Assets	118.2	118.2	(0.0)	
Trade and other payables	(98.5)	(94.3)	4.2	Note 3
Borrowings	(8.3)	(8.3)	(0.0)	
Provisions	(3.6)	(3.6)	(0.0)	
Total Current Liabilities	(110.4)	(106.3)	4.2	
Borrowings	(268.5)	(267.8)	0.7	Note 4
Provisions	(2.2)	(2.2)	0.0	
Total Non Current Liabilities	(270.7)	(270.0)	0.7	
Total Assets Employed	291.5	294.3	2.7	
Financed By:				
Public Dividend Capital	637.9	637.9	0.0	
Retained Earnings	(465.3)	(462.5)	2.8	Note 5
Revaluation Reserve	118.9	118.9	-	
Total Taxpayers Equity	291.5	294.3	2.8	

The table above compares the balance sheet at 30 April 2021 with the 2020/21 year end position. A balance sheet plan will be prepared in line with the re-submission of the revenue plan to NHS England and NHS Improvement on 26 May and be reported against from Month 2 onwards.

The significant movements in the balance sheet at Month 1 are explained below:

1. Property Plant and Equipment and Intangible assets have reduced by £1.6m and £0.6m compared to 31 March 2021. This is due to depreciation and amortisation of £2.6m charged for Month 1 being higher than capital expenditure of £0.4m incurred in Month 1.
2. Inventories have increased by £0.9m mainly due to a £1.1m increase in high cost devices within the pacemakers inventory count. This is partly offset by a reduction of £0.3m in virology.
3. Trade and other payables increased by £5m compared to 31 March 2021. This is mainly due to an increase in deferred income from Health Education England relating to cash received in April 2021.Capital creditors have reduced by £2m compared to the year-end which is offset by an increase in accruals.
4. Non-current borrowing has reduced by £0.7m compared to the year end, the reduction is in line with PFI and finance lease accounting models for the repayment of the liability for each scheme.
5. The movement of £2.8m on retained earnings reflects the Month 1 revenue position of a £2.7m surplus and the impact of donated asset income and depreciation £0.1m.

Expenditure - Pay and Non Pay

Pay Summary (£m)	Annual Plan	In Month			YTD		
		Plan	Actual	Variance	Plan	Actual	Variance
Medical	(160.0)	(13.5)	(13.7)	(0.2)	(13.5)	(13.7)	(0.2)
Registered Nursing	(159.7)	(13.3)	(12.5)	0.8	(13.3)	(12.5)	0.8
Scientific Therapeutic & Technical	(65.8)	(5.5)	(5.4)	0.1	(5.5)	(5.4)	0.1
Support to Clinical	(71.3)	(6.1)	(6.0)	0.1	(6.1)	(6.0)	0.1
Nhs Infrastructure Support	(80.6)	(6.7)	(6.4)	0.3	(6.7)	(6.4)	0.3
Total Pay	(537.4)	(45.1)	(44.0)	1.1	(45.1)	(44.0)	1.1

Pay –Key variances:

Overspend on medical staffing largely due to additional agency)spend on trainee grades against vacancies (primarily in medicine)
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 has decreased compared to prior periods in part due to the reduction in COVID-19 costs (see section 2.3 below).
Within the above budget for Month 1 is £0.7m of reserves which have not been spent (split across numerous expenditure headings) with the main element being £0.5m on the COVID-19 reserve driven by the reduction in costs compared to the prior quarter.

Non Pay Summary (£m)	Annual Plan	In Month			YTD		
		Plan	Actual	Variance	Plan	Actual	Variance
Tariff Excluded Drugs Expenditure	(78.2)	(6.2)	(6.3)	(0.1)	(6.2)	(6.3)	(0.1)
Other Drugs	(22.5)	(1.9)	(1.8)	0.1	(1.9)	(1.8)	0.1
Supplies & Services - Clinical	(82.8)	(7.3)	(5.8)	1.5	(7.3)	(5.8)	1.5
Supplies & Services - General	(7.5)	(0.6)	(0.5)	0.2	(0.6)	(0.5)	0.2
Purchase of Healthcare from other Bodies	(24.7)	(2.8)	(1.6)	1.1	(2.8)	(1.6)	1.1
Consultancy Costs	(2.3)	(0.2)	(0.2)	(0.0)	(0.2)	(0.2)	(0.0)
Clinical Negligence	(25.6)	(2.2)	(2.1)	0.0	(2.2)	(2.1)	0.0
Premises	(33.7)	(2.9)	(3.0)	(0.1)	(2.9)	(3.0)	(0.1)
PFI Operating Costs	(33.4)	(2.8)	(2.8)	0.0	(2.8)	(2.8)	0.0
Other	(18.2)	(1.3)	(1.1)	0.2	(1.3)	(1.1)	0.2
Total Non Pay	(328.9)	(28.2)	(25.2)	2.9	(28.2)	(25.2)	2.9

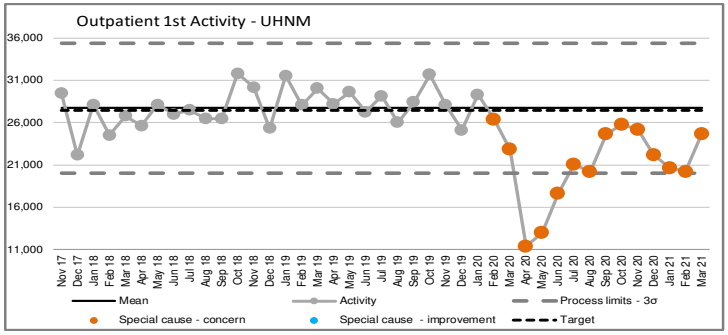
Non Pay key variances

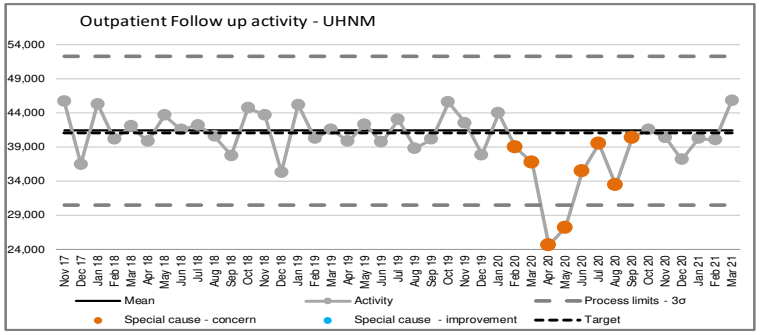
Underspend on supplies and services clinical which is made up of £0.7m underspend on pass through devices and £0.8m general underspend driven by activity levels still being below plan.
Purchase of healthcare from other bodies is underspent in month largely as a result of the IS contract as we had planned a £1.4m cost in Month 1 against an actual cost of £400k. This £400k is based on a draft figure provided by the Nuffield and still needs to be validated.
Within the above budget for Month 1 is £0.5m within reserves which was not spent (split across numerous expenditure headings) with the main element being £0.3m on the non-pay inflation reserve for drugs and general inflation.

Activity

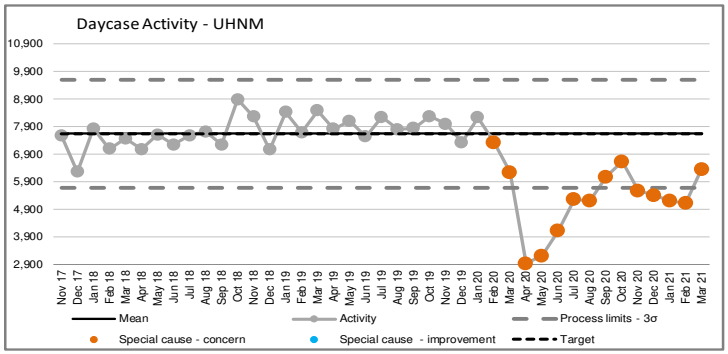
University Hospitals of North Midlands NHS Trust

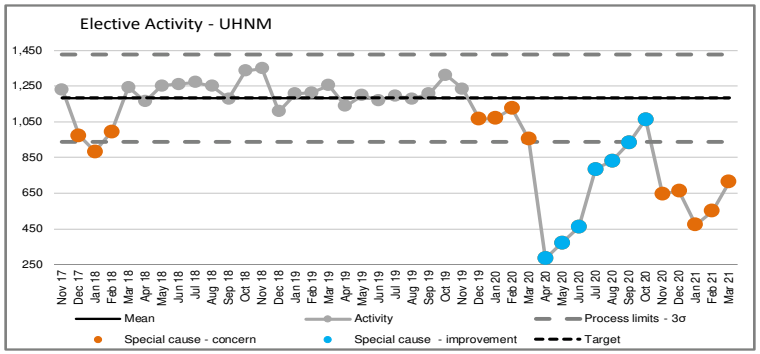
Planned care Outpatient



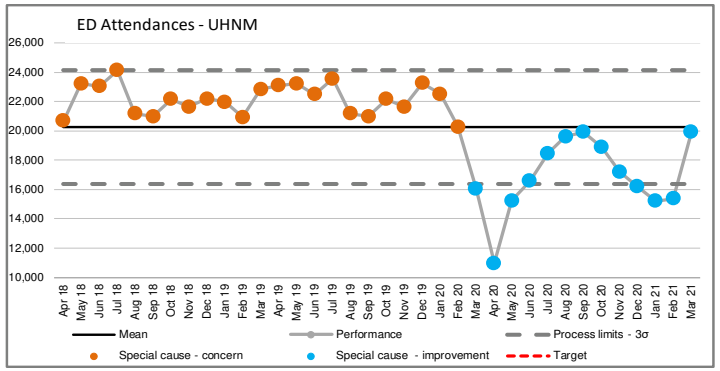


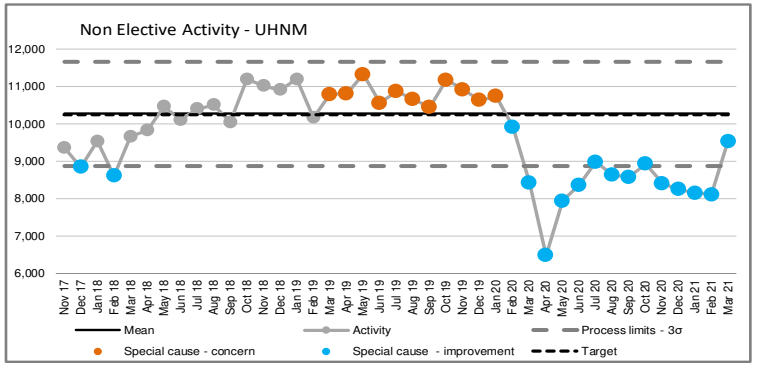
Planned care Inpatient





Urgent Care





Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Trust Board

2021/22 BUSINESS CYCLE

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

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Notes
		7	5	9	7	4	8	6	3	8	5	9	9	
PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES														
Chief Executives Report	Chief Executive													
Patient Story	Chief Nurse													
Quality Governance Committee Assurance Report	Associate Director of Corporate Governance													
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer													
Care Quality Commission Action Plan	Chief Nurse													Highlighted as part of QGC Assurance Summary
Bi Annual Nurse Staffing Assurance Report	Chief Nurse													
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													
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													
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		

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	
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			→	→									Seminar topics to be discussed with Executive Team prior to being presented to the Trust Board.