University Hospitals of North Midlands NHS Trust

# Trust Board (Open)

**Meeting held on Wednesday 6th April 2022 at 9.30 am to 12.20 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 Malton | 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 9th March 2022 | Approval | Mr D Wakefield | Enclosure | |
| | 5. | Matters Arising via the Post Meeting Action Log | Assurance | Mr D Wakefield | Enclosure | |
| 20 mins | 6. | Chief Executive's Report – March 2022 | Information | Ms H Ashley | Enclosure | |
| **10:15** | **STRATEGY** | | | | | |
| 10 mins | 7. | Clinical Strategy | Approval | Ms H Ashley | Enclosure | |
| **10:25** | **PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES** | | | | | |
| 5 mins | 8. | Quality Governance Committee Assurance Report (24-03-22) | Assurance | Ms S Belfield | Enclosure | **BAF 1** |
| 5 mins | 9. | IPC Board Assurance Framework –March 2022 | Assurance | Mr S Malton | Enclosure | **BAF 1** |
| 10 mins | 10. | UHNM Ockenden and Kirkup Update / Action Plan & Maternity Services Workforce Establishment | Assurance | Mr S Malton | Enclosure | **BAF 1** |
| **10:45** | **ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT AND RESEARCH** | | | | | |
| 5 mins | 11. | Transformation and People Committee Assurance Report (23-03-22) | Assurance | Prof G Crowe | Enclosure | **BAF 1, 2, 3, 4 5** |
| 15 mins | 12. | brap Review | Assurance | Mrs L Thomson | Presentation | |
| 10 mins | 13. | Staff Survey Results | Assurance | Mrs R Vaughan | Presentation | |
| **11:15 – 11:30: COMFORT BREAK** | | | | | | |
| **11:30** | **ENSURE EFFICIENT USE OF RESOURCES** | | | | | |
| 5 mins | 14. | Performance & Finance Committee Assurance Report (22-03-22) | Assurance | Dr L Griffin | Enclosure | **BAF 6, 7, 8 & 9** |
| **11:35** | **ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS** | | | | | |
| 40 mins | 15. | Integrated Performance Report – Month 11 | Assurance | Mr S Malton<br>Mrs B Woodall<br>Mrs R Vaughan<br>Mr M Oldham | Enclosure | **BAF 1, 2, 3, 6 & 9** |
| **12:15** | **CLOSING MATTERS** | | | | | |
| 5 mins | 16. | Review of Meeting Effectiveness and Business Cycle Forward Look | Information | Mr D Wakefield | Enclosure | |
| | 17. | Questions from the Public<br>**Please submit questions in relation to the agenda, by 9.00 am 4th April March to** nicola.hassall@uhnm.nhs.uk | Discussion | Mr D Wakefield | Verbal | |
| **12:20** | **DATE AND TIME OF NEXT MEETING** | | | | | |
| | 18. | **Wednesday 4th May 2022, 9.30 am via Microsoft Teams** | | | | |

University Hospitals of North Midlands NHS Trust

# Trust Board (Open)

**Meeting held on Wednesday 9th March 2022, 9.30 am to 12.20 pm**
**Via Microsoft Teams**

# MINUTES OF MEETING

**Attended** | **Apologies / Deputy Sent** | **Apologies**

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

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

| **In Attendance:** | |
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| Mrs J Barnett | Programme Manager (item 1) |
| Mrs R Barwick | Patient (item 1) |
| Dr N Coleman | Deputy Medical Director – Revalidation (representing Dr Lewis) |
| Mrs J Freer | Associate Director – Medicine (representing Mr Bytheway) |
| Mrs N Hassall | Deputy Associate Director of Corporate Governance (minutes) |
| Dr I Hussain | Consultant in Respiratory Medicine (item 1) |
| Mrs S Jamieson | Director of Midwifery (item 10) |
| Mr S Malton | Deputy Chief Nurse (representing Mrs Riley) |

**Members of Staff and Public via MS Teams:** 3

| No. | Agenda Item | Action |
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| **1.** | **Patient Story** | |
| *032/2022* | Dr Hussain provided an update in relation to the targeted lung health check programme which commenced in 2019 and he highlighted that the numbers of patients screened had steadily increased year on year, resulting in lung cancer being identified earlier. Dr Hussain explained that after an initial scan, patients were recalled 2 years later and new cancers continued to be identified. | |



PROUD TO CARE

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| | Dr Griffin queried the plans and any barriers in extending the screening into Staffordshire. Dr Hussain explained that Stoke was the focus due to having the worst cancer outcomes and the screening was being expanded from there.<br><br>Professor Hassell queried how patients were identified for screening and Dr Hussain explained that the population was provided by Primary Care Networks following which those who were between 55 and 75 years of age, and who had previously smoked were identified (noting some exclusions).<br><br>Mrs Barwick explained that she had been invited in 2019 for a lung health check following which an aneurysm was identified and treated. Subsequently, at her 2 year follow up, 5 nodes were identified on her lung which would not have been identified otherwise. She explained that she had always felt supported by the staff and praised the service provided.<br><br>Dr Griffin queried what Mrs Barwick would say to friends to ease any nervousness in attending the screening and she stated that they should not be worried, and even during covid, contact had been maintained and staff were always available to ease any worries or concerns.<br><br>Mr Wakefield thanked Mrs Barwick for attending the meeting and particularly noted the praise she provided.<br><br>**The Trust Board noted the patient story.**<br><br>Mrs Barwick, Dr Hussain and Mrs Barnett left the meeting.<br><br>Professor Crowe queried if there was an opportunity to write up the impact and leaning from the screening within national reports and literature and Ms Ashley stated that the findings had been shared and incorporated into the national programme. Mrs Thomson added that dedicated communications support was in place for the programme with the aim of increasing the number of people screened. | |
| **2.** | **Chair's Welcome, Apologies & Confirmation of Quoracy** | |
| *033/2022* | Mr Wakefield welcomed members of the Board and observers to the meeting. It was confirmed that the meeting was quorate.<br><br>Mr Wakefield highlighted that Mr Akid had been appointed for a further 2 year term. | |
| **3.** | **Declarations of Interest** | |
| *034/2022* | Dr Griffin highlighted his standing declaration where he was providing support to the Nottingham University Maternity Thematic Review. The standing declarations were noted. | |
| **4.** | **Minutes of the Previous Meeting held 9th February 2022** | |
| *035/2022* | The minutes of the meeting from 9th February 2022 were approved as an accurate record. | |

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| **5.** | **Matters Arising from the Post Meeting Action Log** | |
| *036/2022* | PTB/503 – Ms Ashley highlighted that the Trust was on track to procure the required equipment by 31st March, although it was noted that the wider system programme had been delayed into the new financial year. It was agreed to close and continue to provide updates as required going forwards. | |
| **6.** | **Chief Executive's Report – February 2022** | |
| *037/2022* | Ms Ashley highlighted a number of areas from the report.<br><br>Ms Gohir queried if the Trust was at risk in terms of the supply chain, as a result of situation in Russia and Ukraine and queried how staff were being supported. Mr Oldham explained that analysis had been undertaken by the Procurement team which concluded that there were no products or services (including energy supply) being used from Ukraine or Russia return, and therefore there were no supply chain risks.<br><br>Mrs Vaughan stated that there was a small number of staff whose nationality had been identified as being from Ukraine, and communications had been issued to staff highlighting the support available for any staff who may be impacted, in addition to highlighting the national offer of support from the Secretary of State.<br><br>Mr Wakefield referred to the JAG accreditation and queried why the length of the extension was only until October 2022, Ms Ashley agreed to confirm the reason for this.<br><br>Mr Akid queried the current utilisation of the helpline for Operation Anzu and Mrs Thomson stated that whilst the Trust was taking phone calls and providing support as required, patients were contacting the Police directly as requested.<br><br>Professor Hassell referred to the 2 internal appointments to senior leadership posts which had no applicants and queried whether this was cause for concern. Mrs Vaughan referred to the plans in place to develop medical leaders which included programmes for aspiring Clinical Directors in addition to plans for succession and talent management.<br><br>Dr Griffin referred to the system developments highlighted within the report and queried the progress on the ICP strategy. Ms Ashley stated that it had been recognised that the ICB / ICS required its own strategy although this remained work in progress.<br><br>Mr Wakefield referred to the appointments made and queried whether it was correct that no senior roles were being advertised for the Emergency Department (ED). Mrs Freer confirmed that there were no current substantive gaps in the ED Consultant workforce.<br><br>**The Trust Board approved the following eREAFs 8858, 8831, 8814, 8801, 8740, 8693, 8624, and 8547.** | **HA** |
| **PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES** | | |
| **7.** | **Quality Governance Committee Assurance Report (24-02-22 & 02-03-22)** | |
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| *038/2022* | Professor Hassell highlighted the following from the report:<br>• The Committee noted the regional guidance received, to reduce the risk of in-utero transfers which included specific requirements for the Trust as a level 3 unit. The impact of this guidance on the Trust was being worked through<br>• The Committee noted that neonatal mortality data was being investigated internally following which actions for improvement would be identified<br>• The Committee noted the change in reporting in that it was no longer required to report on caesarean section targets and Robson criteria was to be reported on going forwards<br>• In terms of the midwifery workforce the Trust's current ratio was 1:26 against the recommended 1:25 and further work was being undertaken to improve the staffing position, whilst accepting the levels had implications for potential safety and staff morale. It was noted that positive assurance was provided in that throughout the past year, the maternity team had ensured that all women in active labour received 1:1 care<br>• The Committee noted that home births had recommenced in February 2022<br>• Maternity staff training was challenged and the Committee requested a plan to address the gaps identified<br>• The Committee received an update in relation to medicines optimisation and considerable assurance was provided in terms of achieving national benchmarks despite staffing challenges<br><br>Mr Wakefield highlighted that an additional Board Seminar had been scheduled for 1st April, to cover specific items in relation to maternity and the Ockenden review.<br><br>**The Trust Board received and noted the assurance report.** | |
| **8.** | **IPC Board Assurance Framework (BAF) – February 2022** | |
| *039/2022* | Mr Malton highlighted the following:<br>• The risk scores for BAF 1 and BAF 2 had reduced, in relation to the CPE outbreak following implementation of mitigation<br>• It was noted that the CPE outbreak had been stepped down and the Trust remained under surveillance. NHSI had visited the Trust twice and a further visit was expected in March at which point it was hoped the Trust's status would reduce to green<br><br>Mr Wakefield queried the actions being taken in relation to risk 6.10 and monitoring staff who were asymptomatic. Mr Malton highlighted that further guidance was awaited in terms of the change in lateral flow testing and how this should be considered for NHS staff.<br><br>Professor Maddock referred to the sink replacement programme and queried the timescale for completion. She also referred to the issues previously identified in terms of bed cleaning and queried whether any additional actions had been identified. Mr Malton stated that good progress was being made on the sink replacements, a number of which had already been installed and the work was due to be completed by the end of March.<br><br>Mr Malton stated that the issue of bed cleaning had been raised at a national level, and links were being made into the national procurement process.<br><br>**The Trust Board received and noted the report.** | |

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| **9.** | **Care Quality Commission (CQC) Action Plan** | |
| *040/2022* | Mr Malton highlighted the following:<br>• The action plan had been updated to address the areas identified within the most recent inspection<br>• The previous action plan had been reviewed to identify any actions which needed to be rolled forward to ensure one action plan was in place<br>• 9 must dos and 19 should dos were identified with 36 sub actions, a number of which were in progress<br><br>Professor Hassell referred to the need to differentiate between the process related actions versus performance and queried whether the metrics in the Integrated Performance Report could be highlighted, to correlate to specific areas identified by the CQC. Mr Malton agreed to consider and establish a way of highlighting performance going forwards.<br><br>Ms Bowen referred to the target date for the introduction of digitalised care records and Mr Malton stated that further consideration was required in terms of what action was required and agreed that this should be rated as amber until a date had been identified.<br><br>Professor Crowe queried how often the Trust Board would receive progress on delivering the action plan and agreed with Professor Hassell's point in terms of the need to confirm implementation as well as delivery. In addition, he queried the progress being made in removing the Section 31 notice.<br><br>Mr Malton agreed to amend the document to identify measures of implementation and delivery and highlighted that dialogue had been held with the CQC on the Section 31 notice and a further meeting was scheduled for 18th March to discuss the process for requesting this to be removed and a further update would be provided in due course.<br><br>Mr Malton stated that in terms of monitoring performance, Divisions would be held to account on a monthly basis and Mr Wakefield suggested that quarterly updates on progress would be provided to the Board.<br><br>Ms Gohir referred to the mental health needs assessments and queried if equality was considered as part of the risk assessment. Mr Malton highlighted that the current assessment captured demographic information and he agreed to consider how this could be reported going forwards.<br><br>**The Trust Board received and noted the action plan and noted the proposed panel review process to monitor progress and enable escalation of problematic actions.** | **SM**<br><br>**SM**<br><br>**SM** |
| **10.** | **Maternity Serious Incident Report – Quarter 3** | |
| *041/2022* | Mrs Jamieson highlighted the following:<br>• 12 serious incidents remained ongoing, and 3 new incidents had been reported during quarter 3<br>• Each incident reported during the quarter was described which included a stillbirth and 2 maternal deaths, in addition to highlighting the immediate actions taken<br><br>Dr Griffin welcomed the inclusion of outcomes within the report and he queried | |

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| | the timescales associated with completion of reviews, given the 12 which were ongoing. Dr Griffin suggested that the ethnicity of mothers should be provided on an annual basis rather than quarterly and this was agreed.<br><br>Mrs Jamieson referred to the timescales of investigations and stated that she expected the perinatal mortality review tool to be completed within 3 months and added that timeliness could be impacted on by HSIB delays in addition to occasional delays in meeting with families.<br><br>Ms Bowen referred to her previous visit to the neonatal unit and stated that the parents she spoke to were very positive and congratulated the team on the positive feedback provided.<br><br>Ms Bowen referred to the delay in reporting for the incident which occurred in January 2021 (2021/3974) and suggested that the outcomes did not seem to correlate with the date of the incident. Mrs Jamieson stated that the delay was due to the completion of the perinatal mortality review tool and subsequent review and she agreed to provide further information in relation to the outcomes within the next report.<br><br>Mr Akid queried whether there any particular themes identified from previous incidents and Mrs Jamieson stated that incidents and themes were reviewed weekly, via a multidisciplinary approach.<br><br>Mr Wakefield summarised that future reports should include anticipated timescales to complete investigations in addition to identifying any particular learning points regarding emerging themes.<br><br>**The Trust Board received and noted the report.** | **SJ**<br><br>**SJ** |
| **ENSURE EFFICIENT USE OF RESOURCES** | | |
| **11.** | **Performance & Finance Committee Assurance Report (22-02-22)** | |
| *042/2022* | Mr Akid highlighted the following from the report:<br>• The Committee welcomed the updates in relation to business case reviews timeliness of which had improved since a new process had been put into place<br>• Ongoing sickness absences had continued to impact upon performance<br>• Discussions remained ongoing with regards to cohorting of patients in ED, as a result of the number of ambulance holds, following approaches from other Trusts<br>• The Executive Infrastructure Group highlighted delays in the capital programme and the areas of focus on moving programmes along<br>• The Executive Digital, Data Security and Protection Group highlighted issues with obtaining real time bed numbers which was impacting on effective bed management<br><br>**The Trust Board received and noted the assurance report.** | |
| **ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT & RESEARCH** | | |
| **12.** | **Transformation and People Committee Assurance Report (23-02-22)** | |
| *043/2022* | Dr Griffin highlighted the following from the report: | |

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| | • The Committee approved the revised clinical strategy which was to be considered by the Board in due course following further discussion by the Trust Executive<br>• A workforce plan was provided to the Committee which identified possible pressure points<br>• The impact of the pandemic on the level of clinician appraisals as part of revalidation was highlighted and the Committee noted the actions being taken to get return to business as usual<br>• The Committee welcomed the change in approach to transformation projects and ensuring these were aligned to the Trust's strategy<br><br>**The Trust Board received and noted the assurance report.** | |
| **ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS** | | |
| **13.** | **Integrated Performance Report – Month 10** | |
| *044/2022* | Mr Malton took the paper as read but highlighted the following:<br>• Continued good performance with harm free care and in particular highlighted the good performance in relation to sepsis<br>• An increase to the number of falls was noted and a direct correlation between increased falls and nurse absences had been identified. It was noted that the incidents were being reviewed to establish further information<br>• Scores from the friends and family test were not reliable due to low numbers and it was hoped that due to the change in visiting, that additional information would be able to be obtained going forwards<br>• A never event had been identified in relation to a retained swab and the report from the incident was due in April 2022<br><br>Mr Wakefield referred to the number of falls and queried whether the high numbers reported in AMU had continued. Mr Malton explained that figures had improved although the unit had consistently reported higher numbers due to the type of area and cohort of patients. He explained that support was being provided by the Quality Nurse and a business case for additional staff had been written, which would help to improve visibility of patients in addition to the nurse: patient ratio.<br><br>Ms Gohir queried if the Trust was on track to reduce waiting times for gynaecological procedures and queried how the Trust benchmarked against others. Ms Ashley stated that specific data was available in terms of waiting times to differentiate between non-urgent/non-cancer versus those on a cancer pathway. She added that historically treatments for the non-urgent/non-cancer gynaecology patients were usually the first to be cancelled, therefore the Trust was aiming to increase available capacity at County Hospital in order to reduce waiting times going forwards.<br><br>Ms Bowen commented on pressure ulcers welcomed the provision of new chairs and mattresses which she hoped would make a positive impact on performance.<br><br>Mr Wakefield referred to nosocomial infections and queried the current position. Mr Malton stated that whilst the numbers were reducing, in January there had been a specific outbreak which increased the figures. He added that there were currently two Covid outbreaks but the levels of nosocomial infections were not as high as previous waves. | |

Professor Hassell queried if data was available on the covid variant for those patients who had died and Mr Malton stated that this was being considered as part of the covid mortality reviews which would be reported at Quality Governance Committee (QGC) in due course. He added that once the number of cases increased past a certain level that public health typing stopped, due to the expectation that all cases would have been the omicron variant.

Ms Ashley highlighted the following in relation to cancer performance and planned care performance:

- A number of specialties had continued to be challenged due to January particularly due to the number of theatre cancellations
- A summit had been held to address the concerns raised regarding histology following which an improvement in turnaround times had been seen
- Elective capacity had started to come back online and the number of treatments was increasing week on week
- There continued to be a specific focus on reducing the number of patients waiting over 104 weeks and whilst the original requirement was for the Trust to reduce this to 0 by 31st March, the Trust had been clear from the outset that this could not be achieved and had instead aimed at reducing this to 452 patients. However, due to capacity and workforce restraints this position was expected to deteriorate to approximately 500 patients but efforts would continue to be made to reduce the number

Mr Wakefield queried the main reason for the deterioration in the 104 week position and Ms Ashley stated that this was due to reduced capacity and workforce constraints and the inability to stand services back up. Mr Wakefield requested further information to be provided to him for the reasons for the deterioration. **HA**

Mr Wakefield queried the revised trajectory associated with cancer 62 day performance and Ms Ashley agreed to provide this separately. **HA**

Ms Bowen referred to the timing of introducing the breast pain clinic and Ms Ashley stated that this was expected to be in place by the end of March.

Dr Griffin referred to the number of patients being seen each month which was below trajectory, whilst the number of new referrals was above the trajectory and he queried, given the shortfall in performance, whether the impact of the delays on the patient were assessed in terms of their overall outcomes. Ms Ashley highlighted that harm reviews were undertaken for patients waiting longer than planned and she agreed to request an update to be provided to QGC. **AMR**

Professor Crowe referred to the vulnerabilities in delivering the trajectories and queried how these could be adequately highlighted to Committees going forwards. Ms Ashley agreed of the need to highlight what was planned to be achieved in the next few months, in addition to identifying any vulnerability so that this could be considered. **PB**

Mrs Freer highlighted the following in relation to urgent care:

- 7% substantive sickness absence was noted across the whole of medicine during January which impacted upon performance
- In terms of attendance management, some inroads had been made into improving ambulance handovers which included aligning staff at key points during the day in addition to changing the initial assessment of ambulatory patients
- Delays in ambulance holds continued to be a significant challenge and

conversations with regards to cohorting and enacting the associated standard operating procedure was continuing to be discussed with clinicians
- The wait to be seen in the morning had improved but the focus was on improving senior decision making, which included recruitment to outstanding positions
- The number of medically fit for discharge (MFFD) patients were continuing to be high, but as part of refresh week the numbers had reduced and as a result bed occupancy had improved

Mr Wakefield referred to the investment previously made in the ED medical workforce which had resulted in no impact on improving performance and he queried the reasons for this. Mrs Freer highlighted that performance was impacted by occupancy, delays and inability to find space to see the patient which was resulting in patients waiting longer. She stated that non-admitted performance was expected to improve due to the increase in workforce.

Mr Akid queried when the Trust could expect to see an improvement in performance and Mrs Freer stated that once infection prevention restrictions were relaxed this would help in terms of moving patients and getting them into the right specialty. She added that a reduction in the number of MFFD patients was also required. Mrs Freer summarised that the amount of complex patients was above the worst case plan and overlaying that with the infection prevention restrictions and amount of lost capacity due to the number of MFFDs, this was causing difficulties in improving performance.

Professor Hassell requested an update on kiosk usage and Mrs Freer stated that for those patients able to use them it was having the desired impact, and she added that 4% of ambulatory patients were presently using the kiosks.

Ms Bowen referred to the sickness absence levels in January and queried current absence levels. Mrs Freer stated that this reduced to 'normal' levels of 2.7%.

Mr Wakefield requested a further update to be provided to the Performance and Finance Committee, in terms of the assumptions associated with improving performance, the trajectory for improvement and associated timescales. **PB**

Mrs Vaughan highlighted the following in relation to workforce performance:
- Sickness absence stood at 7.44% and covid related absence had recently reduced to 26% although this continued to fluctuate
- Discussions with Divisions had been held regarding projections for absence with the view that it was most likely to have a cumulative figure of 5.25%
- Specific focus was being placed within Medicine and Surgery to address particular hot spots of sickness absence
- PDR compliance had reduced and the forecast for the year end was to achieve between 70% to 80%, recognising the shortfall had been impacted by the pause on PDRs during the year due to operational pressures
- An increase in turnover had been identified and based on benchmarking undertaken last year the Trust was demonstrating higher levels of vacancies than other Trusts in the Midlands

Professor Hassell referred to current sickness absence figures and stated that once covid related absences were removed, performance was 5%. He queried how this compared with previous winters and Mrs Vaughan stated that this was consistent with previous years, although there had been a slight increase in stress/mental health related absences.

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| | Mr Oldham highlighted the following in relation to financial performance:<br>• Performance remained consistent with previous months and in line with forecast<br>• Covid allocations were being rebased<br>• The capital programme was slightly behind plan but it was expected to catch up with the main risks relating to the TIF schemes in addition to digital pathology<br>• Cash continued to be positive at £82.4 m which was better than planned<br><br>Professor Crowe queried the delays on TIF schemes and whether these could be recovered or would require further applications. Mr Oldham stated that some further applications would be required, although there was significant capital available in 2022/23 and therefore it was not considered to be a risk to delivery.<br><br>**The Trust Board received and noted the performance report.** | |
| **GOVERNANCE** | | |
| **14.** | **Gender Pay Gap Report** | |
| *045/2022* | Mrs Vaughan highlighted that there had been a slight deterioration in the median pay gap although there had been an improvement in the median bonus pay gap.<br><br>Professor Maddock queried how the Trust was encouraging women to come forward to apply for the Clinical Excellence Awards (CEA) and it was noted that the application process had not been in place for 2 years due to covid, therefore all eligible staff had received the award based on their current level of pay. ~~She~~ Mrs Vaughan highlighted that efforts had been made previously to encourage female applicants to apply, in addition to working with the BMA on improving this area.<br><br>Professor Hassell stated that it would be helpful to identify the percentage of eligible consultants for CEA awards to assist in determining the equity and it was agreed to identify this in terms of those eligible and how many received the awards.<br><br>**The Trust Board approved the report and noted the recommended actions to further improve the Gender Pay Gap at UHNM.** | **RV** |
| **CLOSING MATTERS** | | |
| **15.** | **Review of Meeting Effectiveness and Business Cycle Forward Look** | |
| *046/2022* | No further comments were raised. | |
| **16.** | **Questions from the Public** | |
| *047/2022* | Mr Syme referred to the Chief Executive's report and the clarification he had received in terms of the 'System Financial Performance' forecasting a deficit for 2022/23 and a £5.7 million surplus for 2021/22. He queried the system in place from 1st July. Mr Oldham explained that the contract had been structured across the system which would share the deficit across all organisations, in order to get the system to a break even position. | |

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| | Mr Syme referred to Elective Recovery, and the latest requirement of a baseline of 104% of pre Covid activity with extra funding above that baseline threshold and also a 110% Completed Pathways Standard. He queried that given there were marginal rates for activity both for over and under the baseline threshold, whether this constituted a 'risk' for UHNM and if so whether this been quantified. Mr Oldham stated that there were some risks although £36 m was available for the system to commission 104% of the value of 19/20 activity, to deliver 110% of activity. It was noted that the 75% marginal rate was a risk but not significant. He stated that the challenges were follow up appointments being capped at 85% of 19/20 activity which impacted on reducing the follow up backlogs and this was being worked through.<br><br>Mr Syme referred to MFFD numbers and that these had exceeded 220 but reduced to 120. He queried the most recent numbers and Ms Ashley stated that numbers had had reduced to 120 but continued to fluctuate. She stated that in terms of reset week, efforts were being made by all system partners to increase the number of complex discharges on a daily basis in order to improve this position further. | |
| **DATE AND TIME OF NEXT MEETING** | | |
| **17.** | Wednesday 6th April 2022, 9.30 am, via MS Teams | |

# Trust Board (Open)

**Post meeting action log as at** **30 March 2022**

| CURRENT PROGRESS RATING | | |
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| B | Complete / Business as Usual | Completed: Improvement / action delivered with sustainability assured. |
| GA / GB | On Track | Improvement on trajectory either:<br>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/502 | 07/12/2021 | Integrated Performance Report - Month 7 | To take an update to the QGC in terms of covid / nosocomial death reviews | Matthew Lewis | 24/03/2022 | 24/03/2022 | A report was taken to the meeting in March | B |
| PTB/503 | 07/12/2021 | Integrated Performance Report - Month 7 | To confirm the timescale associated with the planned care national pilot | Helen Ashley | 09/03/2022 | 30/03/2022 | National pilot has now commenced. | B |
| PTB/505 | 07/12/2021 | Integrated Performance Report - Month 7 | To obtain an update in relation to the timescales associated with completion of the Digital Pathology programme. | Helen Ashley | 09/03/2022 | 09/03/2022 | Update provided at March's meeting: The Trust was on track to procure the required equipment by 31st March, although it was noted that the wider system programme had been delayed into the new financial year. It was agreed to close and continue to provide updates as required going forwards. | B |
| PTB/509 | 09/02/2022 | Bi-Annual Nurse Staffing Review Update | To provide feedback to the Transformation and People Committee (TAP) on net numbers of nursing recruitment, how the position related to previous years, including turnover rates for nurses. | Ann Marie Riley | 23/03/2022 | | **Update to be provided** | GB |
| PTB/510 | 09/02/2022 | Integrated Performance Report - Month 9 | To provide the Quality Governance Committee with further information in relation to deep tissue pressure ulcers | Ann Marie Riley | 28/04/2022 | | Due on QSOG agenda on 11th April, followed by QGC on 28th April. | GB |
| PTB/511 | 09/02/2022 | Integrated Performance Report - Month 9 | To provide an update to TAP in relation to statutory and mandatory training, identifying any areas and pockets of concern and low percentages which needed to be addressed. | Ro Vaughan | 23/03/2022 | 23/03/2022 | Included in Month 11 report taken to TAP in March. | B |
| PTB/512 | 09/03/2022 | Chief Executive's Report – February 2022 | To confirm the reason for the short timescale in relation to the Trust's JAG accreditation. | Helen Ashley | 06/04/2022 | 30/03/2022 | JAG accreditation is for 5 years but we undergo annual validation – The Trust was last awarded full accreditation in 2019 | B |
| PTB/513 | 09/03/2022 | CQC Action Plan | To consider and establish a way of highlighting the performance metrics associated with the action plan going forwards within the IPR . | Scott Malton<br>Ann Marie Riley | 04/05/2022 | | Action not yet due. | GB |
| PTB/514 | 09/03/2022 | CQC Action Plan | To update the action plan and expand on the points raised in terms of measures of implementation and delivery and provide future updates on a quarterly basis. | Scott Malton<br>Ann Marie Riley | 08/06/2022 | | Action not yet due. | GB |
| PTB/515 | 09/03/2022 | CQC Action Plan | To consider how demographic information within mental health needs risk assessments could be reported on going forwards. | Scott Malton<br>Ann Marie Riley | 06/04/2022 | | **Update to be provided** | GB |
| PTB/516 | 09/03/2022 | Maternity Serious Incident Report – Quarter 3 | To amend future reports to analyse ethnicity over a 12 month period. | Sarah Jamieson | 08/06/2022 | | Action not yet due. | GB |
| PTB/517 | 09/03/2022 | Maternity Serious Incident Report – Quarter 3 | To amend future reports to include anticipated timescales to complete investigations in addition to identifying any particular learning points regarding emerging themes. | Sarah Jamieson | 08/06/2022 | | Action not yet due. | GB |
| PTB/518 | 09/03/2022 | Integrated Performance Report - Month 10 | To provide the Chairman with an update in relation to the reasons for the deterioration in the 104 week wait position | Helen Ashley | 10/03/2022 | 30/03/2022 | Complete. | B |
| PTB/519 | 09/03/2022 | Integrated Performance Report - Month 10 | To provide the revised trajectory associated with cancer 62 day performance | Helen Ashley | 06/04/2022 | 30/03/2022 | To be provided as part of the annual planning process | B |
| PTB/520 | 09/03/2022 | Integrated Performance Report - Month 10 | To provide an update to QGC in relation to the harm reviews undertaken for those patients waiting longer than planned, in terms of establishing any impact on their outcomes. | Ann Marie Riley | 28/04/2022 | | Action not yet due. | GB |
| PTB/521 | 09/03/2022 | Integrated Performance Report - Month 10 | To provide a summary of the key trajectories to be achieved in the next few months in addition to identifying any particular vulnerabilities / challenges and discuss at PAF. | Paul Bytheway | 26/04/2022 | | Action not yet due. | GB |
| PTB/522 | 09/03/2022 | Integrated Performance Report - Month 10 | To provide an update to PAF in terms of the assumptions associated with improving ED performance, the trajectory for improvement and associated timescales. | Paul Bytheway<br>Jen Freer | 26/04/2022 | | Action not yet due. | GB |
| PTB/523 | 09/03/2022 | Gender Pay Gap Report | To identify the percentage of eligible consultants for CEA awards to assist in determining the equity, including the numbers eligible and how many received the awards. | Ro Vaughan | 06/04/2022 | 29/03/2022 | Complete - circulated to NEDs 29.03.22 | B |

University Hospitals of North Midlands NHS Trust

# Chief Executive's Report to the Trust Board

FOR INFORMATION

## Part 1: Trust Executive Committee

The Trust Executive Committee met virtually on the 30th March 2022. The meeting was a shortened meeting to focus on current pressures and plans. The following points were highlighted:

- 226 Covid-19 patients with a significant proportion being incidental findings which is creating challenges with regard to capacity
- Staffing levels and total numbers are worse than those reported in January
- Focussing on discharge of patients, ensuring Estimated Dates of Discharge although there are very high levels of medically fit for discharge patients which is adding to capacity challenges
- Long ambulance waits are being seen due to the high levels of pressure being seen and this position is mirrored across the NHS
- Critical Care is not being as affected as has been previously
- Focussing on Board rounds at multidisciplinary team level to support discharges; Full Hospital Policy being implemented in order to manage the risk across the system
- Working with partners at Haywood Hospital so that where possible, patients can be sent to them
- The government have announced that national funding for free staff parking will cease on Friday 1st April – internal arrangements are to be communicated

# 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 11th February to 11th March, 17 contract awards, which met this criteria, were made, as follows:

- **O365 implementation project services** supplied by CDW at a total cost of £639,510.00, approved on 28/02/2022
- **UTF - hardware and devices** by SCC at a total cost of £651,256.00, approved on 28/02/22
- **National Blood Service** supplied by NHS Blood & Transport at a total cost of £3,800,000.00, for the period 01/04/22 - 31/03/23, approved on 28/02/2022
- **Interventional Radiology Consumables** supplied by SCCL at a total cost of £1,526,930.68, providing savings of £96,141.54, for the period 01/04/22 - 31/03/24, approved on 10/03/2022
- **Theatres Da Vinci Xi Eco System Surgical Robot** supplied by Intuitive Surgical at a total cost of £2,038,800.00, providing savings of £526,000, approved on 10/03/2022
- **Supply Chain Coordination Limited (SCCL)** supplied by SCCL at a total cost of £28,790,291.08, for the period 01/04/22 - 31/03/23, approved on 10/03/2022
- **CCN to incorporate anticoagulation (INR) testing** supplied by Roche Diagnostics at a total cost of £1,375,664.00, providing savings of £48,893.99, for the period 01/04/22 - 31/03/27, approved on 10/03/2022
- **Endoscopy Diagnostic Services** supplied by 18 weeks at a total cost of £1,099,000.00, for the period 01/04/21 - 31/03/22, approved on 10/03/2022
- **Pharmacy Outsourced Dispensing Service - Drug costs** supplied by Lloyds Pharmacy at a total cost of £42,000,000.00, for the period 01/04/22 - 31/03/25, approved on 11/02/2022
- **Pharmacy Outsourced Dispensing Service** supplied by Lloyds Pharmacy at a total cost of £2,785,893.00, for the period 01/04/22 - 31/03/25, approved on 11/02/2022
- **M2 Managed print solution** supplied by SCC at a total cost of £1,444,036.90, for the period 01/03/22 - 28/02/25, approved on 11/02/2022
- **Darktrace** supplied by SoftCat at a total cost of £1,646,328.00, providing savings of £26,341.25, for the period 26/03/22 - 25/03/27, approved on 10/03/2022
- **Cath Lab Interventional Cardiology Consumables** supplied by various at a total cost of £4,165,056.96, for the period 01/03/22 - 28/04/24, approved on 11/02/2022
- **Blood Sciences Siemens Managed Service Contract - Year 10 Premium** supplied by Siemens Healthineers at a total cost of £5,146,184.50, for the period 01/10/21 - 30/09/22, approved on 11/02/2022
- **Cytotoxic Dose Banded - Chemo, Immunotherapy and Monoclonal Medicines** supplied by various at a total cost of £4,048,104.50, for the period 01/12/21 - 31/03/22, approved on 10/03/2022
- **Home Delivery of Darbepoetin** supplied by Fresenius Medical at a total cost of £1,173,208.00, for the period 01/12/21 - 30/11/22, approved on 11/02/2022
- **Outsourcing of Radiology Reporting** supplied by Medica Reporting at a total cost of £800,000.00, providing savings of £16,000.00, for the period 01/09/21 - 31/03/22, approved on 28/02/2022

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

Services of Junior Doctors via the Health Education England Contract (eREAF 8974)

| | |
|---|---|
| Contract Value | £4,259,482.00 incl. VAT |
| Duration | 01/04/22 - 31/03/23 |
| Supplier | Health Education England |

Nursing Master Vendor Contract (eREAF 8939)

| | |
|---|---|
| Contract Value | £1,200,000.00 incl. VAT |
| Duration | 01/04/22 - 30/09/22 |

Supplier Medacs Healthcare

Savings - £24,000 Negated Inflation Saving

Outsourcing of Radiology Reporting (eREAF 8788)

Contract Value £2,000,000.00 incl. VAT
Duration 01/04/22 - 31/03/23
Supplier Medica Reporting Ltd

Maintenance of Siemens X-Ray Equipment (eREAF 9054)

Contract Value £3,036,704 incl. VAT
Duration 01/04/22 – 31/03/27
Supplier Siemens Healthcare via NHS Supply Chain (SCCL)

Savings - Negated Inflation saving of £16,151 per annum

**The Trust Board are asked to approve the above eREAFs.**

## 2. Consultant Appointments – March 2022

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

| Post Title | Reason for advertising | Appointed (Yes/No) | Start Date |
|---|---|---|---|
| Locum Consultant Cardiothoracic Anaesthetist x 2 | New | Yes | TBC |
| Locum Consultant Radiologist MSK | New | Yes | TBC – Applicant has another interview |
| Specialist Doctor in Elderly Care | Vacancy | Yes – Internal Transfer | 01/04/2022 |
| Locum Consultant Orthopaedic Surgeon | Vacancy | Yes | 04/04/2022 |
| Locum Consultant General Anaesthetist | Maternity | Yes | 02/05/2022 |
| Consultant Imaging - Neuro Radiologist | New | Yes | 01/06/2022 |
| Consultant Imaging - Breast Radiologist | Vacancy | Yes | TBC – Dependent on CESR |
| Consultant Gastro Intestinal Radiologist (Colorectal) | New | Yes | TBC – Dependent on CESR |
| Consultant Gastro Intestinal Radiologist (Colorectal) | New | Yes | 15/06/2022 |
| Consultant Cardiothoracic Radiologist | New | Yes | 01/09/2022 |
| Locum Consultant General Surgeon - Upper GI (HPB) Surgery | Vacancy | No | Candidate not appointable |
| Consultant Imaging - Breast Radiologist | Vacancy | No | Candidate not appointable |

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

| Post Title | Reason for advertising | Start Date |
|---|---|---|
| Consultant Neurologist (Epilepsy) | Vacancy | 01/03/2022 |
| Consultant Geriatrician | Extension | 22/03/2022 |
| Specialist Doctor in Clinical Haematology | Vacancy | 25/03/2022 |
| General Paediatric Consultant | Vacancy | 23/03/2022 |

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

| Post Title | Closing Date | Note |
|---|---|---|
| Respiratory Consultant 3 x Various specialties | 27/02/2022 | No Applicants |
| Locum Consultant in Emergency Medicine | 20/03/2022 | No Suitable Applicants |
| Consultant Microbiologist | 20/03/2022 | No applications |
| Locum Glaucoma Consultant Ophthalmology | 21/03/2022 | No applications |
| Consultant Clinical Oncologist – Head & Neck, Thyroid and UGI | 22/03/2022 | No applications |
| Consultant Clinical Oncologist - Lung and Urology | 22/03/2022 | No applications |

## 3. Internal Medical Management Appointments – March 2022

There were no Medical Management interviews held during March 2022 and no new medical management starters during March 2022.

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

| Post Title | Closing Date | Note |
|---|---|---|
| Surgical Division Clinical Governance Lead | 23/03/2022 | No Applicants |

## 4. Covid 19 and Trust Pressures

We have had another really busy month operationally as we have seen the numbers of patients we are caring for with Covid-19 rise quite significantly along with the number of our staff off sick due to Covid-19. That said we have continued to make progress treatment both our emergency and elective patients and we would like to say a huge thank you to the teams working exceptionally hard to see and treat our patients as quickly as possible. We know we have a long way to go and that Covid-19 rates in the community are rising but by focussing on our own infection prevention measures, including hands, face, space and fresh air, we can continue to build on the progress we have already made.

## 5. Voices for Action Against Racism

On Monday 28th March we supported the International Day for the Elimination of Racial Discrimination by sharing our commitment to this. The International Day focuses on the them 'Voices for Action against Racism' and highlights the importance of strengthening meaningful and safe public participation and representation in all areas of decision making to prevent and combat racial discrimination; reaffirming the importance of full respect for the rights to freedom of expression and peaceful assembly and of protecting civil space, recognising the contribution of individuals and organisations that stand up against racial discrimination and the challenges they face.

## 6. Virtual Reality Session

Together with our partners at North Staffordshire Combined NHS Trust we held what we think is a first in the NHS, a virtual reality session. Some of our staff from medical students to senior consultants took part to experience being 'inside the head' of a patient with delirium. All participants were able to experience both poor and compassionate care, finding out how empathy and attention to detail supported the clinical care for these patients. This was a productive and innovative event and regarded as a leading example of team work and using technology to help improve patient care.

## 7. Ukraine

No-one could have failed to be affected by the news of what is happening in Ukraine. Our thoughts are with everyone who is caught up in this conflict. Many of our staff may have family and friends in that region or may be ex-armed forces. We are supporting the national effort and the Charity Commission and Fundraising Regulator has urged the public to 'give safely' to registered charities. The Disasters Emergency Committee, a coalition of 15 leading UK charities has launched its appeal to provide emergency aid and rapid relief to civilians suffering during the conflict. We have reminded all of our staff of the support that is available to them during this time through our wellbeing offerings.

## 8. Reset and Restart

Reset and Restart launched during the month, to support efforts to ensure that our patients are given the right care, in the right place and returning to the place they call home when they are ready to. It was great to see the energy and high levels of engagement across all divisions to make improvements, despite the high volume of patients entering our emergency departments and needing a hospital bed. Even with the challenges of rising hospital numbers and norovirus, we reduced the total time people were waiting in the emergency department by nearly 500 hours and we significantly reduced the number of ambulances being held. Our medically fit for discharge had also reduced. Our HR colleagues also reported a further 34 staff recruited. A huge thank you to everyone involved.

## 9 Patient Portal

Following an intensive competitive procurement process, including live demonstrations scored by 68 of our staff and patients, we have selected 'Patients Know Best' as our new Patient Portal. This is amazing news and will allow us to offer patients access to letters, appointments, test results, surveys, questionnaires, self-care advice and more.

## 10. HealthCare Science Week / National Cancer Clinical Nurse Specialist Day

During the month celebrated HealthCare Science week which shines a light on the fantastic work of our Healthcare Scientists and we also celebrated the first ever National Cancer Clinical Nurse Specialist Day. We highlighted various roles and patient journeys through our social media channels and staff from Pathology promoted their roles to local students to inspire our future workforce. We are planning a Pathology Open Day in the coming months which will provide an opportunity for participants to come and talk to staff and tour our facilities.

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## 12. Royal College of Surgeons Coyler Gold Medal

I am delighted and thrilled to have been notified that Dr Karen Juggins, consultant orthodontist at Royal Stoke, has been presented with the Royal College of Surgeons Coyler Gold Medal. This prestigious award has been given in recognition of the hugely successful Keep Stoke Smiling initiative which Karen

spearheaded to improve the oral health of our young population and also for her contribution to orthodontics standards.

## 13. Freedom to Speak Guardian

Our newly appointed Freedom to Speak Up Guardian, Kerry Flint commences her role on Monday 4th April. This is such an important role in our organisation which has now been made full time so more resource is available to provide staff with a route to raise concerns so they can be investigated. Kerry has some great ideas about the role, emphasising its importance for quality and safety for our patients and how she wants to take the role forward. I know she is keen to get out and about and meet staff so please say hello when she drops in to your department and do let her know of any issues or concerns you may have.

## 14. ICS – Integration White Paper

The new 'integration' White Paper has been published which has been discussed by our shadow Integrated Care Board. This will change the configuration of Place within Staffordshire and Stoke-on-Trent. Further details will be shared on this as progress is made at system level.

# Executive Summary

| | | | |
|---|---|---|---|
| **Meeting:** | Public Trust Board | **Date:** | 6 April 2022 |
| **Report Title:** | Clinical Strategy | **Agenda Item:** | 7 |
| **Author:** | Helen Ashley | | |
| **Executive Lead:** | Helen Ashley, Director of Strategy & Transformation | | |

## Purpose of Report

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

## Alignment with our Strategic Priorities

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

## Risk Register Mapping

## Executive Summary

In 2014, the University Hospitals of North Midlands was formed, bringing together North Staffordshire University Hospital and Mid Staffordshire NHS Foundation Trust. The organisation, spanning two sites, now known as Royal Stoke University Hospital (RSUH) and County Hospital, amalgamated all clinical and non-clinical services to deliver our '2025 Vision'. The Vision set a clear direction for the organisation to become a world-class centre of clinical care and academic achievement. Incorporating our Clinical Strategy, the Vision outlined our strategic intentions for our clinical services and set the framework within which our staff would all work together with a common purpose to ensure patients receive the highest standard of care and to be the place in which the best people would want to work.

Whilst much of the Vision remains relevant, we have progressed considerably as an organisation and as a key system partner. The NHS landscape has evolved and we recognise that we must respond to the changing requirements in order to ensure the sustainability of our services. To achieve this we will need to transform our services through integrated system working with health and social care partners to change how and where services are provided, as well as who provides the service, to ensure that we can focus on delivering acute care for our secondary care and tertiary population.

Therefore, in 2019, we embarked upon a series of Service Line Reviews with each of our clinical divisions. This was an extensive programme of activity, led by our Programme Management Office (PMO). Undertaken through a series of facilitated workshops, the reviews provided opportunity for multidisciplinary teams to develop a collective understanding of their challenges, successes and to agree their strategic ambitions for their service. These reviews provided us with detailed insight into each our clinical services and we have been able to build upon their outputs in shaping this Clinical Strategy.

The Strategy is supported by the Trust senior clinical leadership and has received input and support from the Transformation and People Committee

## Key Recommendations:

The Trust Board are to support and approve the Trust's Clinical Strategy and through the Transformation and People Committee receive regular updates on its delivery and note the on-going work to strengthen the assurance framework going forward.

NHS
University Hospitals of North Midlands
NHS Trust

# Draft Clinical Strategy

## 2021 – 2026

Together Compassion Safe Improving

# Contents

# 1. Introduction

**We are pleased to present our Clinical Services Strategy for the University Hospitals of North Midlands NHS Trust (UHNM). Responding to Covid-19 has been an unprecedented challenge for us and has resulted in significant changes in how our services are provided and has demonstrated to us, the positive impacts that come from working together across our health care system.**

Through integrated system working we will be able to ensure patients receive the right care, in the right place, from the right organisation. This will enable our capacity and services to be focussed on the patients who require acute hospital care. This is an exciting time for us and a great opportunity to deliver through this Clinical Strategy, real benefits for not only our patients, but also for our staff, and we look forward to continuing to work with all of our stakeholders to achieve this.

# 2. Background

In 2014, the University Hospitals of North Midlands was formed, bringing together North Staffordshire University Hospital and Mid Staffordshire NHS Foundation Trust. The organisation, spanning two sites, now known as Royal Stoke University Hospital (RSUH) and County Hospital, amalgamated all clinical and non-clinical services to deliver our '2025 Vision'. The Vision set a clear direction for the organisation to become a world-class centre of clinical care and academic achievement. Incorporating our Clinical Strategy, the Vision outlined our strategic intentions for our clinical services and set the framework within which our staff would all work together with a common purpose to ensure patients receive the highest standard of care and to be the place in which the best people would want to work.

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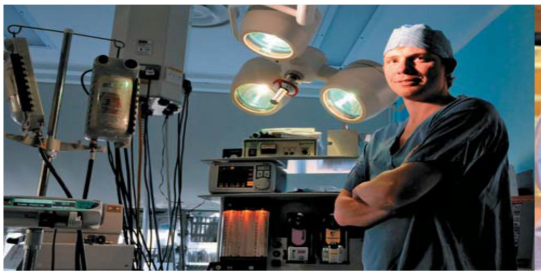


# 3. Context – where are we now?

**The NHS Long Term Plan (LTP) published in January 2019, set out a vision for services and identified key priorities to support this. In response to this the Staffordshire and Stoke-on-Trent Integrated Care System (ICS) developed a Five Year Service Delivery Plan (FYSDP), setting out a range of priorities and commitments.**

**The majority of the objectives set out in the FYSDP remain as valid now as when first written, but Covid-19 has highlighted the urgency with which we should take action, and the need to focus on working as a system to make rapid change to improve services.**

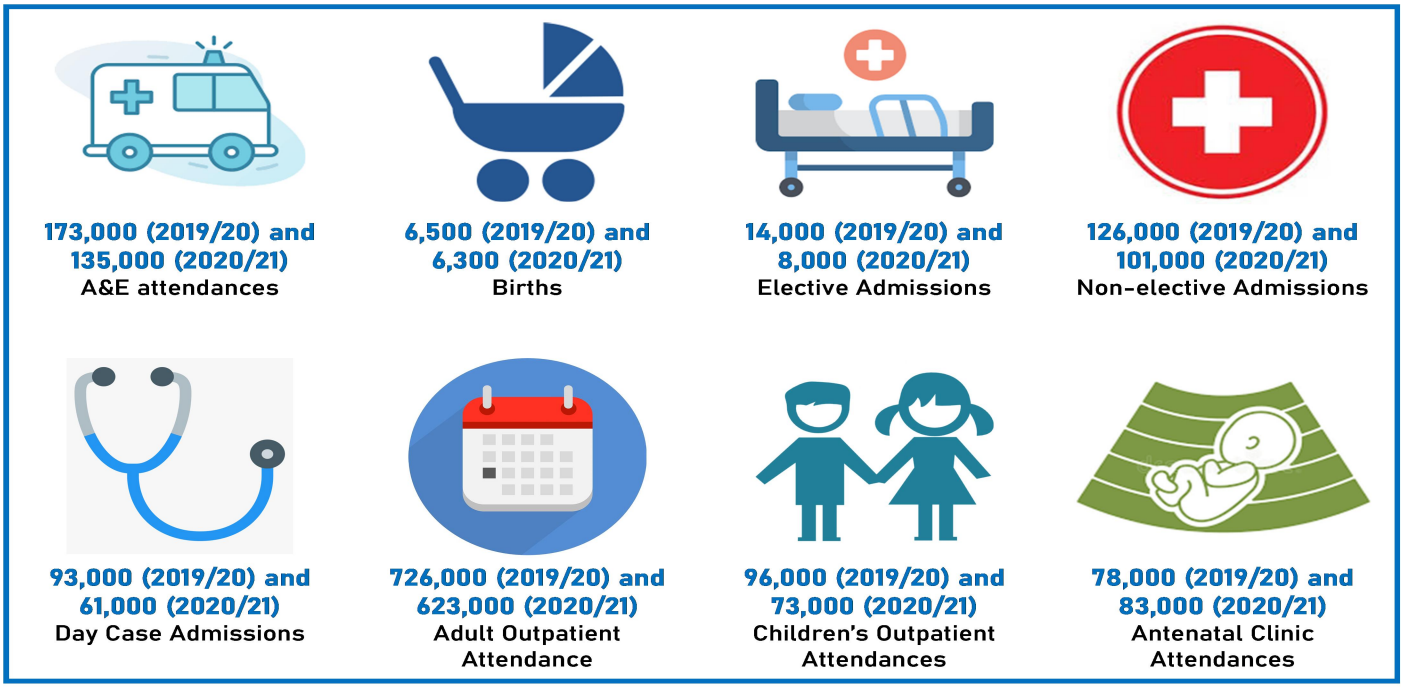
In addition to this, some aspects of what we would have included within our Clinical Strategy have already been delivered in response to Covid-19, such as transforming how we provide outpatient services and using more telephone and video consultations so that patients do not have to travel unnecessarily to our hospitals.

In terms of service delivery we have historically focussed on the services that are provided within the four walls of our hospitals, and though we recognise our role as part of the wider health and social care system, there have only been a limited number of examples where the Trust has sought to deliver care beyond its traditional boundaries.

In recent years we have begun to explore more and more opportunities to deliver services in collaboration with our partners across Staffordshire and services that support admission avoidance or early discharge from our hospitals have been the early focus.

In respect of our Tertiary services we have continued to implement previous plans to retain and develop more complex and specialist services. This has been achieved by a combination of attracting and retaining high quality staff, as well as continuing to invest in new technologies and equipment to deliver world class care to our patients.

## Overview of Activity 2019/20 and 2020/21



# Our Services

Services provided from the Royal Stoke and County Hospital form part of a wider network of healthcare services providing care to the residents of Staffordshire and beyond.

**These networks include:**

- Primary, Community and Mental Health services in Staffordshire and Stoke-on-Trent, ensuring that appropriate pathways are in place between these services and the acute hospital services in order to deliver care in the patient's own home or residential setting where possible.

- Secondary Care networks provide a range of general and acute services, ensuring the on-going resilience of services in our smaller, neighbouring trusts or to ensure a critical mass of services to support on-going provision of clinical expertise and timely access to services. They also include clinical support services such as Pathology and Imaging.

- Major trauma and specialised services networks that provides timely access to specialist, life threatening / critical services. Based on integrated pathways these services rely on other local hospitals / rehabilitation facilities to ensure the best outcomes for patients.

- Tertiary Networks, across the Midlands and North West including specialist services for rare or complex cancers, stroke, cardiovascular disease, renal, neurosurgery, spinal surgery, cardiac surgery and thoracic surgery, adult and paediatric critical care, surgery in children, neonates, radiotherapy and interventional radiology

# 4. Where do we want to get to?

## Our Vision

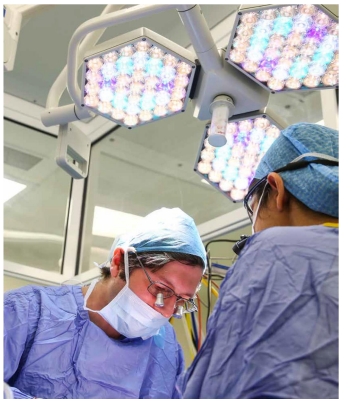
**Our goal is to be a world-class centre of clinical and academic achievement, where staff work together to ensure patients receive the highest standards of care and the best people want to come to learn, work and research. We have created a vision document that sets out our vision for the future and our plans to become a successful, competitive partner in the healthcare economy.**

## The Clinical Strategy within our Strategic Framework

Through our 'Improving Together' programme, we have already revisited key elements of our 2025 Vision, in particular around refining our overarching priorities and strategic objectives as part of our work to ensure strategic alignment and agreement of our 'True North'; these are illustrated below. Our Values of 'Together', 'Compassion', 'Safe' and 'Improving' remain the same and we have made considerable progress over recent years in embedding these into the culture of our organisation.

We have identified the key strategies which will enable the delivery of our overarching strategic objectives, and our Clinical Strategy is one of those enabling strategies. We recognise that our Clinical Strategy is key to shaping the delivery of our services and that it will be underpinned by a number of enabling strategies in particular our Estate Strategy, Workforce Strategy, Digital Transformation Strategy and our Research and Innovation Strategy.

## Our Clinical Strategy



**The Trust is highly ambitious in its drive to continue to deliver innovative and world class services for the patient catchment that we serve. By continuing to align our workforce capability, research, education and innovation we will inspire our staff, students and partners to allow our teams to continue to strive to deliver world class services.**

We will continue to develop and improve our acute and elective care services to our local population and will increasingly look to do this in partnership with neighbouring acute providers as well as local providers across primary, community and social care services. As the drive to clinical networking continues we will look to strengthen collaboration with other acute providers within the region, exploring opportunities to host networked arrangements for specialist services.

The future model of care will include a material shift from hospital care to a whole system approach, with care integrated across providers and locations. Many of the services will be provided in a community or home setting and pathways will be joined up, both in terms of information and care delivery.

This will mean that patients only come into the acute hospital when it is clinically appropriate to do so and time spent in hospital will be reduced due to timely discharge and ongoing support in the community, as well as increased efficiency within the hospital.

# Our Objectives

**Within our overarching strategy, we have refreshed our strategic objectives and these are aligned to our Priorities (as illustrated below). As a key enabling strategy, there is alignment to each of our six strategic objectives, however of these six, there are four specific objectives that our Clinical Strategy has been designed to enable; High Quality, Systems and Partners, Improving and Innovating and Responsive Care.**

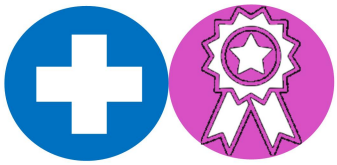
## Strategic Priorities


## Strategic Objectives


## Enablement through our Clinical Strategy

### We will provide High Quality and be Responsive

**In the care that we deliver to our patients by:**



- Consistently exceeding their expectations in the quality of care that is delivered
- Ensuring that the patient experience that they receive as well as the outcomes that are achieved
- The nature of services that we provided, that are innovative and research driven in the way they are delivered

### We will work in Partnership

**By supporting alternatives to pathways to hospital care, by maintaining a healthier population and reducing hospital attendance and admissions by:**

- Driving integrated care pathways across care settings and locations
- Building strong relationships between acute, community and primary care clinicians to work together to deliver care to our patients
- Our workforce working flexibly across healthcare settings
- Delivering and supporting opportunities to divert patients to a more appropriate alternative service and settings

### We will Improve and Innovate

**By creating an efficient hospital with a focus on outcomes and user experience by providing:**

- Developing standardised acute pathways, with reduced variation, which are consistently delivered across all locations
- Ensure sufficient capacity exists for non-elective and elective pathways, ensuring neither is compromised by high levels of demand for services
- Redefine how Royal Stoke and County Hospital operate, focussing on non-elective and complex surgery at Royal Stoke, with elective care (high volume, low complexity centralised at County)

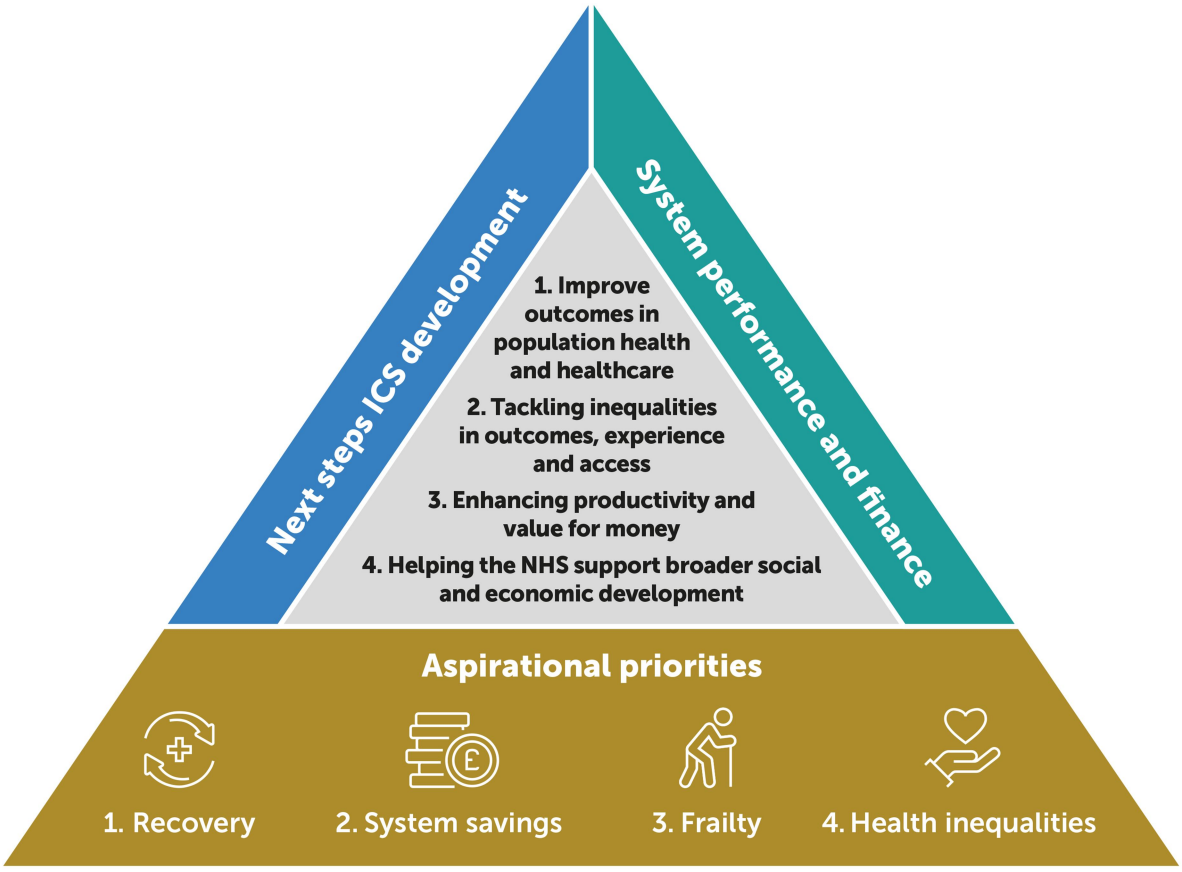
# Links to Staffordshire & Stoke–on-Trent ICS Priorities

**The ICS is clear in its commitment to improving health outcomes for its residents that:**

- **If you live in Staffordshire or Stoke-on-Trent, your children will have the best possible start in life and will start school ready to learn.**
- **Through local services, we will help you to live independently and stay well for longer.**
- **When you need help, you will receive joined-up, timely and accessible care, which will be the best that we can provide.**

Partners from across the Health and Care sectors as well as the voluntary sector and the communities that they represent will need to continue to come together to support the delivery of the ICS priorities through the adoption of seamless pathways, the principles of care closer to home and empowering patients to support their own health and wellbeing.

There are opportunities to prevent ill-health by working together to look at all the factors that affect health – including education and housing. We want to keep our population at the centre of our care provision, to ensure that it is available closer to where they live, and that it is delivered in a joined-up way. All our partners are committed to making changes that will improve health and care services for local people.



# The Approach to developing our Clinical Strategy

Our service review process brought together multidisciplinary teams within each speciality, including medical staff, nursing staff, allied health professionals along with management teams. Through a facilitated workshop based approach, the reviews provided an opportunity for multidisciplinary teams to develop a collective understanding of their challenges, successes and to agree their strategic ambitions for their services. The reviews provided us with detailed insight into each of our clinical services and their outputs have been used in shaping this Clinical Strategy.

Given the size of our organisation and the number of clinical services we provide, though each of our clinical services have separately articulated their future plan, we have consolidated these around 9 clinical pathway based groupings drawing out common themes and opportunities for the future. The clinical pathway groupings are illustrated below.

Aligned to the 3 core objectives for our future model of care, we have developed our future plans for each of our clinical pathway groups which are focussed around:

**Providing High Quality care and being Responsive in the care we deliver to our patients.**

**Working in Partnership by supporting alternative pathways to hospital care, maintaining a healthier population and reducing hospital attendances and admissions.**

**Improving and Innovating by creating an efficient hospital with a focus on outcomes and user experience.**

# Clinical Pathway Groupings

In developing the organisations Clinical Strategy, the services have been segmented into a number of clinical groupings. These groupings are intended to capture at a high level the services that the Trust provides, and allow plans to be developed across these themes.

# 5. How we will get there

## Key Components of our Model

### 5.1 Proactively working with partners on alternative pathways to acute hospital attendances and admissions care

In recent years the Trust has begun to explore opportunities to work more closely with system partners in delivery of patient pathways that support patients to continue to be cared for in the community without the requirement for a hospital attendance or admission.

Building on the principles of establishing a "Hospital without walls" the Trust will continue to prioritise:

- Working with primary and community teams to use the skills and expertise that we hold within the organisations to support care in the community
- Further development of admission avoidance schemes to prevent unnecessary conveyances and admissions to the Trust. Supporting a range of conditions that can be safely supported in the community
- 'Taking A&E to the patient' through the provision of rapid intervention services, remote monitoring and virtual wards

### 5.2 Addressing Health Inequalities

There is a broad acknowledgement that the Covid pandemic has broadened health inequalities across the population that we serve. Covid-19 has shone a light on inequalities and highlighted the urgent need for both commissioners and providers of healthcare provision to strengthen action to prevent and manage ill health in deprived and ethnic minority communities.

Specifically, for UHNM there is a necessity for action required to ensure that any new service developments, as an absolute minimum, do not widen health inequalities, and wherever possible, recognise that in setting up and delivering the service, opportunities to reduce inequalities are seized. The Trust must ensure that whilst recovering from the pandemic, and in addressing the significant waiting list backlog, acknowledgement is given and actions are taken to ensure those from deprived or ethnic minority groups are not further disadvantaged.

The Trust will put in place mechanisms to both ensure that records and reports are able to be segmented by factors that may drive health inequalities such as age, ethnicity or relative deprivation, and seek to use that in planning the delivery of its services.

Additionally the Trust must continue to play its part in the promotion of the wider public health agenda. This will be achieved by continuing to use day-to-day interactions that the Trust and our workforce have with patients, to support them in making positive changes to their physical and mental health and wellbeing, as well as working with system partners to signpost patients be access services such as smoking cessation, healthy lifestyle choices and living well.

### 5.3 Working with partners to facilitate timely discharge and ongoing support

- Early discharge planning that includes early identification of patients requiring complex support upon discharge
- Close working between community and social care in order to ensure smooth discharges and the avoidance of readmissions due to failure of community support packages
- Timely access to community hospital / step down beds in order to ensure that any delayed discharges are minimised.
- The establishment of virtual wards to ensure that patients can be safely discharged, once the acute phase of their care is complete, whilst remaining under the care of secondary care services, as well as exploiting the benefits of telecare and telehealth to care for patients in their own home

## 5.4 Making the best use of our facilities and delivering the best outcomes for our patients

### Royal Stoke University Hospital

It is envisaged that the Royal Stoke site will continue to focus on the delivery of tertiary services and complex acute surgery, alongside the provision of secondary care medical and diagnostic services.

In respect of the secondary care offer, and in supporting our local population, the Clinical Strategy seeks to ensure it facilitates the delivery of care against the principles of 'Right Care, Right Place, Right Time'. Medically, the site will continue to support the full range of patients who have acute medical needs, through either its emergency and short stay portals or its specialist medical wards. Beyond their acute medical phase the Trust will look to ensure that patients are safely discharged into appropriate step down care, either back to their own home or residential care or to community based hospital beds, whilst at the same time maximising the use of virtual wards.

Similar principles will apply to the provision of acute general surgery, paediatric services as well as maternity and obstetrics.

In respect of diagnostic services, the site will continue to provide the full range of services for unplanned care including imaging, endoscopy and pathology. By 2022/23, and in line with national policy, the Trust will look to build its elective diagnostic capacity away from the acute site, as part of a community diagnostic hub.

In respect tertiary services, that by their very nature support a wider regional population base, the Trust will continue to aspire to deliver national and internationally recognised services, through a series of centres of excellence. It is essential that the Trust continues to safeguard and develop the full range of these services on the Royal Stoke site, in support of the specialist Major Trauma Centre and Cancer Centre. In addition, other main specialist services for the region will continue to be located at Royal Stoke such as major specialties of Cardiovascular, Neurosciences, Metabolic/GI, Women's & Children's services, Musculo-Skeletal Services/Trauma, Oncology and Haematology.

### County Hospital

We will continue to develop the elective offer at County Hospital by building on the existing range of outpatient and diagnostic services. In line with the current direction of travel the Trust will establish an Elective Hub for high volume low complexity surgery. The Trust will seek to maximise the use of its elective facilities, to cater for a broader range of surgical interventions in order to safeguard the Royal Stoke site for more complex and urgent surgery.

Medically, we will consolidate the existing model for step down medical beds from the Royal Stoke site whilst at the same time continuing to receive admissions for less acute general medical conditions. In line with the wider model of care being developed across the health and social care system the Trust will explore the possibility of step up medical care.

Opportunities will be explored that seek to improve the current services delivered under the heading of "Women's Health" ensuring that opportunities for co-location are explored and that facilities have sufficient scope to accommodate the growing needs of the population.

We will continue to provide a range of day treatments for oncology and renal patients and will look to further develop this by looking to develop a dedicated day treatment centre on the County Hospital site.

## 5.5 Approach to efficiency and effectiveness

### GIRFT

The Trust has traditionally used the Getting it Right First Time (GIRFT) reviews in order to benchmark itself against best practices as well as to identify opportunities for improvement. In respect of our surgical specialities we will look to adopt GIRFT principles as part of our Elective Recovery.

The Trust will look to adopt GIRFT's High Volume Low Complexity programme in focusing initially on driving improvement in six high-volume specialties – ophthalmology, general surgery, trauma and orthopaedics (including spinal surgery), gynaecology, ENT and urology – but will support with other surgical and medical specialties going forwards.

In the first instance these tools will be used to drive up productivity through County Hospital as we continue to develop surgical services through the site.

### Approach to Medicines Optimisation

Reducing unwarranted variation and increasing value through medicines optimisation is a crucial element to the Trust approach to efficiency and effectiveness.

Medication is a crucial element of almost every type of care, and is the most common form of healthcare intervention in secondary care. However, ineffective use of medicines is a recognised problem that has an impact on the economy, society, healthcare system and patients.

Medicines optimisation is a patient-focused approach to getting the best from investment in, and use of, medicines. By focusing on patients and their experiences, the goal is to help patients to: improve their outcomes; take their medicines correctly; avoid taking unnecessary medicines; reduce wastage of medicines; and improve medicines safety.

In the coming years the Trust will continue to focus on:

- Digital Medicines Optimisation, and the procurement and implementation of Trust-wide Electronic Prescribing and Medicines Administration software
- The on-going adoption and administration of newly licenced medicines, including an inevitable focus on the treatment of Covid 19
- Improvements in access to medicines to help address health inequalities

# 6. Key Enablers

**The key enablers to our clinical strategy include:**

- On-going development of our estate, both within our hospitals and within the community in order to ensure that capacity is fit for purpose in delivering our model of care
- Extended access to diagnostics in the hospital and the community
- Education and training to support workforce redesign through collaboration with our education partners
- Adoption of new technology and innovation, including digital and artificial intelligence, that spans both hospital and community settings
- Best practice quality improvement approaches
- Service transformation, both internally and across our system

## 6.1 Technological Developments

These technological opportunities have been considered by our clinical services as part of the service review process and have been reflected in the development of this strategy as a key enabler of the new models of care required.

As we have seen during the response to the Covid pandemic, technologies are likely to have a material impact on the delivery of care, improving population health outcomes and reducing costs in the future. These include:

- Artificial intelligence including image and predictive analytics
- Tech enabled patient driven care and self-management including telemedicine, telehealth and sensors and devices e.g. COPD Predict, use of patient portals
- Personalisation of treatment including reading and writing genome
- Interventional and rehabilitation robotics

## 6.2 Developments to our Estate

The Trust has in place a Clinical Estates Strategy that articulates how the Trust Estate will support the delivery of the Trusts Clinical Strategy.

The Estate Strategy has been written in accordance with exemplar guidance and sits alongside several other UHNM strategic planning documents. It sets out:

- the existing Trust estate and an analysis of its condition and performance and summarises the estate strategies that will drive estate change.
- potential options and proposed changes to the estate over future years.

## 6.3 Developing our People

The Trust has in place a People Plan that in addition to other areas of focus will support the delivery of the Clinical Strategy. This includes:

- ensuring we have staff with the right skills and experience to deliver the clinical services and respond to change, including supporting new roles and ways of working.
- Supporting with the education and development of individuals and teams
- Ensuring staff have opportunities to continuously improve and develop
- Developing the organisation to support transformational change to deliver services in new and innovative ways

## 6.4 Developing our Research and Innovation

With the aspiration to undertake world-class health services research and innovation, in collaboration with regional partners, there should be significant improvements generated to the delivery of our clinical services which in turn will deliver enhanced care of our patients. Areas of focus will include:

- Cancer Clinical Research Facility
- Hyper Acute Stroke facility
- Staffordshire Children's Hospital
- Pharmacy

## 6.5 Developing our Approach to Quality Improvement

As a Trust we are committed to embedding a consistent approach to quality improvement throughout the entire organisation:

- We will encourage and support front line staff to take part in quality improvement by providing them with a series of tools and techniques to enable change.
- We will make quality and continuous improvement a priority for all of our leadership teams in order that they can consistently model leadership behaviours in support of this approach

# 7. Clinical Services Strategy by Clinical Grouping

## Urgent and Emergency Services

**Emergency Medicine has departments on both the Royal Stoke on County sites. The Emergency Department sees more than 150,000 patients each year and treats both adults and children. The team treat a whole range of conditions which include urgent care cases, emergency medical, major trauma and minor injuries with a separate Children's Emergency Department and Children's Assessment Unit.**

**The Emergency Department at County Hospital is open from 8am to 10pm, 7 days a week and it sees around 30000 – 35000 patients per year. The Department treats a range of conditions although there are specific exclusion criteria that the Department is unable to treat due to the lack of level 2/3 support and there are pathways in place for patients outside of the criteria to be diverted and treated at Royal Stoke.**

### Challenges

- Demand for services continues to grow on both hospital sites, with limited alternatives for patients to access if they do not require the services of an Acute Trust Emergency Department.
- Ability to stream patients at the front door and the management of GP referrals which result in congestion within the department, and patients not always accessing the most appropriate pathway for their care.
- Aligning the workforce model to the demand for services will require further investment in workforce. The Trust needs to recruit additional medical workforce to ensure all patients are treated in a timely way.

### The Future

We will work in **partnership** with health and social care organisations to develop alternative pathways to avoid attendance at our Emergency Departments. We will build on our existing relationships with Primary Care to develop appropriate advice and guidance to clinicians to support patients to receive their care in the most appropriate setting.

We will **improve** the management of GP referred cases by providing access to specialist advice and our emergency portals through the provision of Same Day Emergency Care through the full range of diagnostic services as well as discharge support into the community.

We will provide **high quality** and **responsive** care to our critically ill patients, including patients referred to our major trauma service patients with the best possible care with access to a full range of specialist expertise and services that span the Trust.

We will work with our **partners**, our patients and our population in establishing a vision for County Hospital Emergency Department including the possibility of an Urgent Treatment Centre (UTC) at County Hospital.

We will continue to **improve** our services in support of both attendance and admission avoidance where it is clinically appropriate. Using the skills and expertise of our workforce we will continue to develop pre-hospital services supporting patients to continue to be cared for in their own homes.

# Acute Medical Services

**Our Acute medical service is focussed on the immediate and early specialist management of adult patients with a wide range of medical conditions who present as emergencies. We have a nationally recognised acute medicine model made up of Acute Medical Rapid Assessment Unit (AMRAU), Royal Stoke Acute Medical Unit (AMU), Ambulatory Emergency Care (AEC), Royal Stoke Short Stay Unit (SSU), County Acute Medical Unit (AMU) and Medical Receiving Unit (MRU).**

## Challenges

! The ability to be able to recruit and retain a skilled workforce to support the full range of emergency portals and ambulatory pathways, through robust workforce planning.

! The Trust needs to be able to retain flexibility in respect of its capacity to meet peaks in demand for services, in order to be able to deliver a responsive model that serves the changing needs of our patients.

! Capacity and flow throughout the inpatient bed base directly impacts upon the ability to deliver a responsive clinical model.

## The Future

We will work with local **partners** to improve pathways for critically ill patients to provide proactive and preventative care to avoid unnecessary admissions to hospital.

We will **improve** the time spent in secondary care ensuring that it is minimal and that patients are able to return home quickly, whilst in some instances continuing to undertake diagnostics in an ambulatory setting.

We will provide **high quality** and **responsive** care in all aspects of acute medical service provision through:

- redesigning our acute floor to receive patients directly from the community
- accepting direct admissions to our Frail Elderly Assessment Unit (FEAU) from GPs, the Ambulance Service and the Community Rapid Intervention Service (CRIS)
- Focussing on ambulatory pathways and hot clinics to facilitate discharges and help prevent admissions
- Expanding our falls service to offer 7 day cover
- Utilising RESPECT documentation to plan and document ceiling of care decisions and to prevent admission if this differs from the patient's wishes

We will also work in **partnership** with community services to:

- Identify early frailty related syndromes and work to support and prevent further deterioration through outpatient services, Consultant Connect and staying well clinics
- Up-skill care home and residential home staff
- Provide input into community care home MDT's

# Cancer Services

**At UHNM we offer a comprehensive range of surgical, haematology and oncology services. We provide surgical treatment for most types of cancer and collaborate with specialist centres for rare cancers. We have a number of specialist cancer multidisciplinary teams delivering a tertiary service and work closely with referring hospitals. In addition, we have a dedicated cancer centre that provides specialist cancer treatments such as targeted radiotherapy, chemotherapy, stem cell transplantation and immunotherapy. We work in partnership with neighbouring Trusts to provide seamless care pathways including diagnostics and treatments. We diagnose over 4000 cancers each year and treatment is planned through our weekly Multi-disciplinary Team meetings.**

## Challenges

! Capacity constraints have been a long-term challenge. This problem has been accentuated by the Covid pandemic, which has both reduced capacity to diagnose and treat cancer patients, and is also expected to increase numbers of patients suspected as having cancer. The capacity constraints are at every stage of the patient pathway from initial assessments, diagnostics and treatment.

! Ability to invest in services and workforce to ensure access to the best cancer service, against a backdrop of growing demand as well as ongoing funding constraints

## The Future

We will work with system **partners** to ensure patients get the care they need in the most appropriate setting. Examples of this include implementing alternative diagnostic pathways that are specialist led in the community and provision of supportive cancer care closer to home.

We will **improve** wait times for patients attending first appointments or tests, to within seven days, with improved turnaround times in diagnostics investigations, to be able to achieve the new 28 day faster diagnosis standard. This will improve cancer care experience.

We will provide **high quality** and **responsive** care by fully embedding best practice pathways and implementing new Rapid Diagnostic Services to improve access for patients enabling earlier diagnosis and providing personalised care and support.

We will work with our **partners** to minimise delays to diagnostic or treatment pathways by enabling seamless links with system partners and regional providers.

We will deliver **high quality** and **responsive** care by continuing to develop our cancer services through workforce recruitment and retention as well as on-going investment in state of the art surgical and radiotherapy equipment and developing patient centric facilities.

We will **improve** and **innovate** by developing cutting edge research and clinical trials with dedicated health care professionals in a cancer clinical research facility supported by the Research and Innovation Department.

# Planned Care

**Though waiting times for elective care have always been a challenge for a number of specialities, the Covid Pandemic and the need to prioritise non-elective and Covid demand has resulted in a significant lengthening of those waiting times.**

**We have worked in partnership with the independent sector to prioritise what capacity has been available to those most in need. Fragmentation and inconsistency in pathways mean that many patients continue to experience lengthy waits for their care.**

## Challenges

- Significant waiting times have built up during the Covid pandemic, with the Trust required to prioritise those patients who are most urgent alongside those that have waited a significant time.
- Demand consistently outstripping the capacity available to deliver care for patients meaning that significant changes are required to the way in which planned care is delivered in terms of productivity and efficiency.
- Ensuring that variation practice is minimised and that best practice pathways are adopted and followed consistency.

## The Future

We will work in **partnership** to transform outpatients locally, to further improve access, waiting times and patient experience, building on the progress we have made as a result of Covid in terms of digital technology.

We will **improve** our Outpatients pathway to avoid unnecessary hospital appointments by increased use of advice and guidance, continued use of digital technology, promotion of self-care and remote testing, patient initiated follow up (PIFU), direct access to rapid community diagnostics and increased delivery of care by advanced nurses and other healthcare practitioners.

We will deliver **high quality** and **responsive** care through optimisation of surgical productivity and theatre utilisation with more procedures provided in outpatient / day care settings.

We will also work with system **partners** on appropriate and timely discharge pathways, enhanced recovery programmes and increased access to step down capacity and rehabilitation services.

We will **improve** our use of digital innovations and robotics to enhance care and more effective utilisation of County Hospital to increase elective activity in the form of an elective centre of excellence for high volume low complexity procedures

We will continue to collaborate with, support and improve our existing **partnership** networks with neighbouring Trusts, such as Vascular Surgery and Urology.

We will work in **partnership** with commissioners to provide 'one-stop shops' wherever practical, with the services designed both to diagnose cancer but also to exclude cancer.

We will **improve** access though development of clinical criteria for 'straight to test' and ensure that this is applied consistently.

# Women's Health

**We provide a full range of maternity services at our Royal Stoke site, including high risk, vulnerable patients and a Level 3 tertiary Neonatal Centre, as part of a regional network of providers to support babies from neighbouring areas, e.g. Shropshire, Cheshire.**

**Antenatal and postnatal services are provided at County Hospital although a temporary closure of our Freestanding Midwifery Birth Unit (FMBU) remains in place. A home birthing service is offered for all ladies in the UHNM catchment area.**

**The Trust provides a range of female surgical services, which in the future, could be developed to draw on the specialist skills available to deliver these services in different environments**

## Challenges

! Ongoing workforce shortages and responding to the recommendations of the Ockenden Report, and the ability to undertake robust workforce planning to respond to the changing needs of our patients

! The need for a greater focus on Women's Health across the system, with a strong emphasis on collaborative partnership working and the need to recognise and act on the inequalities over the life course of women from adolescence through to old age.

## The Future

We will collaborate with and support the Local Maternity and Neonatal System's (LMNS) in delivery of the Maternity Transformation Plan and the provision of safe maternity care. This **partnership** approach will include continuity of carer with provision of a named midwife and team supporting each woman through her maternity journey.

We will **improve** the role that women have in their care and treatment by placing women's voices at the centre of their health and care, and improve the quality and accessibility of information and education on women's health.

We will ensure **high quality** and **responsive** care through our collaborative approach, including implementation of all recommendations of the Ockenden Review.

We will promote **high quality** and **responsive** care and the maximisation of women's health in the workplace, both as an employer as well as an advocate for others.

We will collaborate with **partners** across health and social care in order to ensure that all organisations understand and are responsive to women's health and care needs across the life course.

# Children and Young People

**Staffordshire Children's Hospital at Royal Stoke is a 'hospital within a hospital' and provides a dedicated Children's Emergency Department, an Intensive Care Unit, inpatient wards, a dedicated Surgical Day Case Unit as well as an outpatients area, to meet the demand of a growing population with increasingly complex needs.**

**The Children's Hospital was officially launched in June 2020 and is supported by a separate 'Children's Hospital Strategy.'**

Staffordshire Children's Hospital at Royal Stoke

## Challenges

! Ability to be able to recruit and retain appropriately skilled medical workforce to deliver full range of paediatric specialities for the local population.

! Estate challenges, with service developments hampered by lack of suitable estate to grow services. Some services occupy temporary facilities which will need to be resolved in the medium term.

! On-going need to working with partners to ensure appropriate pathways into Mental Health Services for those children that require such support.

## The Future

We will continue to work in **partnership** with our local partners to reduce avoidable admissions; working with GP and community colleagues to keep children and young people well, providing same day access to specialist advice via the Children's Assessment Unit.

We will **improve** the quality and experience of care in hospital by establishing new roles to mitigate workforce gaps.

We will continuously seek to improve and deliver **high quality** and **responsive** care in the provision of paediatric and neonatal care, both for our local and regional populations.

We will **improve** clinical pathways for patients with long term conditions and complex care requirements, and support the transition of our patients from paediatric to adult services, through the provision of a transitional care unit.

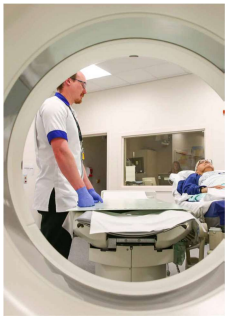
We will continue to work in **partnership** with other specialist centres in respect of paediatric surgery in order to increase the range of paediatric surgery, and provide care closer to home.

We will **improve** the range of digital solutions available to patients and their families in order to support them to manage their care in their own homes.

# Diagnostics

**Diagnostic services are delivered at both the Royal Stoke and County Hospital sites, along with community based services at GP Surgeries and Community facilities. Historically diagnostic services have performed well against a backdrop of increasing demand and have consistently achieved waiting times in line with national standards.**

**North Midlands and Cheshire Pathology Services (NMCPS) was formed on 1st December 2020, with the intention to develop into the full N8 Network with Shrewsbury and Telford Hospitals in future, whilst imaging services are continuing to develop as part of the newly established West Midlands Imaging Network.**



## Challenges

- Requirement to establish regional diagnostic networks: Imaging, Pathology, Endoscopy and Physiological Sciences to ensure the Trusts ability to continue to deliver the full range of sustainable diagnostic services
- Supporting recovery of waiting times as a result of the backlog built up during the Covid pandemic and ability to address workforce shortages, equipment capacity and increasing demand

## The Future

In **partnership** with ICS colleagues we will prioritise investment to transform services to deliver seven-day access at the hospital site and provide a range of services in community based diagnostic centres, in order to support the provision of seamless care across the ICS, as well as screening and easy access to early diagnosis

We will **improve** and build upon existing clinical networks with system partners, focussing on:

- Reducing the demand for hospital diagnostics
- Introducing point of care diagnostics for those with long term conditions
- Diagnosing cancer early, providing rapid access diagnostics for cancer services
- Supporting the delivery of seven day services to improve flow in the hospital with faster access to diagnostics for inpatients and outpatients
- Increasing capacity within diagnostics for cancer diagnosis and treatment (imaging, endoscopy and histology)

We will **collaborate** with colleagues in primary care to ensure timely access to a range of diagnostic tests that allows patients to continue to be managed and cared for in the community.

We will provide **high quality** and **responsive** care through the best use of innovative technologies such as rapid access diagnostics, including point of care diagnostics which will be linked to electronic care records and other information systems, such as digital pathology.

# Critical Care Services

**Critical Care is integral to the delivery of services across the Trust and supports patient pathways for both local and regional services including complex surgery and major trauma.**

**Currently all services are provided from the Royal Stoke site, the full range of critical care support services include adult critical care, high dependency level 2, Surgical Special Care Unit, Cardiothoracic Critical Care Unit, Coronary Care Unit, non-invasive ventilation level 2 and specialist level 1 beds for neurosurgery and Acute Rehabilitation Treatment Unit. General Medical and Surgery inpatients are additionally supported by critical care outreach services.**

## Challenges

- ! Opportunities to further grow and develop the current critical care service are constrained by the existing estate footprint at Royal Stoke.
- ! Requirement to review Level 1 and Level 2 beds across the Trust in order to be able to support the extended Critical Care pathway
- ! Capacity to sustainably manage recovery for urgent and complex elective cases against fluctuations in emergency demand

## The Future

We will collaborate with our **partners** within the Midlands Acute Critical Care Network to develop mutual aid working arrangements wherever possible. Our collaboration with Shrewsbury and Telford NHS Trust will facilitate meaningful partnership work through sharing best practice, developing a sustainable workforce plan, embedding a joint digital solution and demand modelling across a multi system footprint.

We will **improve** our facilities including increased critical care capacity to meet future demand and support strategic developments of tertiary services, including:

- Expanding our Critical Care consultant workforce
- Expanding the Pharmacy workforce to provide weekend cover
- Building resilience and stability within our existing bed base to manage any future Covid surge and patient flow across the Trust
- Reviewing the additional bed capacity required to support future demographic growth and other service developments across the Trust
- Increasing the number of enhanced beds across the Trust, improving flow and aiding sustainability

We will enhance the **quality** of our survivorship through investment in our rehabilitation service, through the ongoing development of critical care rehab ensuring patients receive the highest quality of care 7 days a week from a co-ordinated interdisciplinary team.

# Tertiary Services

**We provide a range of tertiary services to a regional population, that enhance our ability to attract and retain high quality staff and there is a growing focus on clinical networks as the forum where discussion of future developments and delivery of these services take place. The patient catchment is drawn from Staffordshire, Shropshire, Wales, Cheshire, South Manchester and the Black Country. A number of our services are nationally recognised centres of excellence.**

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

## Challenges

- Capacity and infrastructure is sub-optimal for a number of our tertiary specialties resulting in sub-optimal service delivery
- Demand for the Trusts services frequently results in competing pressure for general inpatient as well as critical care facilities as a result of demand and the requirement to deliver high quality secondary care in a hospital with a large and very busy Emergency Department.
- Collaboration with referring centres in the interest of improving access and quality of care, whilst making the most effective and efficient use of resources, from end to end of patients' journeys.
- The ability of the Trust to attract and retain staff in order to deliver the full range of tertiary services that the Trust is commissioned to provide

## The Future

We will work strenuously to excel in our provision of both acute and planned tertiary care services. We will aspire to consistently deliver **high quality** and **responsive** standards of clinical care that we would expect of ourselves and families.

We will work in **partnership** closely with colleagues in both referring hospitals and other networked tertiary providers to offer high quality and timely specialist care to the wider group of patients relying on us and our partners for it.

We will continue to **improve** our services by measuring and benchmarking our performance, and adapting our practice according to what we find, by prioritising continuous service development with the aim of being a leading centre and preferred employer nationally for each of our tertiary services.

We will excel in the provision of **high quality** services as an influential partner in clinical networks, including the regional leadership of the spinal network and the host for the Integrated Stroke network

We will continue to **improve** the outcomes for those patients that receive care from our major trauma centre, and continue to perform better than the national average across all outcomes.

We will continue to ensure timely and **responsive** access to both cardiology and cardiothoracic surgery, both of which are currently nationally recognised as centres of excellence. We will continue to develop these services in order to retain this recognition through workforce recruitment and retention as well as on-going investment in equipment

We will work in **partnership** with the other neurosurgical, specialist tertiary centres in the West Midlands, in order to continue to develop our service and to continue to offer to our wider catchment population

# 8. Resources Required

Some of the ambitions within our strategy are already in progress; through our business planning process we will work closely with our clinical services and system partners to identify the further resources needed to deliver our objectives. These will be identified through a combination of the annual focussed negotiation process as well as on a more frequent basis when opportunities present.

As part of the annual planning process the Trust will seek to identify priorities for the forthcoming year against its strategic priorities. Service developments will be considered at this point and be part of the prioritisation process to identify any resources required to support delivery.

# 9. How we will measure our success

The Trust will establish a roadmap for the delivery of the clinical strategy that will be presented to the Board for its approval, and its delivery reported through the Transformation and People Committee. On an annual basis a more detailed version will be produced with key deliverables established against key schemes

**Strategy Delivery Plan (TBC)**

| No. | Strategic Objective | Action Required | Intended Benefit | Measure of Success | Delivery Date | Lead | Progress Report | BRAG |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
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# 10. How we will monitor our progress

We will monitor progress against our strategy, primarily through our Executive Strategy and Transformation Group, escalating any areas of concern to the Trusts Transformation and People Committee. We will develop KPI's and a means of reporting on progress on a quarterly basis, as well as highlighting risks requiring mitigation in accordance with our Risk Management Process.

A more detailed 6 monthly review will be presented to TAP as part of the annual cycle of business

# 11. How we will communicate this strategy

Though engagement and involvement with our clinical teams has played a key part in the development of the strategy, when approved by the Board, we will communicate our Clinical Strategy with all of our staff, our partners and our key stakeholders with the support of our Communications Department.

The communication plan will reflect the following factors:

- Use of multiple communications platforms.
- Use of existing briefings and communications, at both Executive, Divisional and Directorate level
- Creation of a quick read guide or plan on a page

# Committee Chair's Highlight Report to Board

**Quality Governance Committee**
**24th March 2022**

NHS
University Hospitals of North Midlands
NHS Trust

## 1. Highlight Report

| ! | Matters of Concern of Key Risks to Escalate | Major Actions Commissioned / Work Underway |
|---|---|---|
| | • Analysis associated with **Neonatal Emergency Readmissions** demonstrated 112 readmissions in 3 months against the benchmark of 55.5. The differential between what Trusts class as a readmission was highlighted and it was recognised that improvements to the pathways could be made for 4 clinical groups, which would have related to 94 of the episodes.<br>• An internal review of **Cardiothoracic Surgery** from a clinical and non-clinical perspective had been undertaken which identified a range of actions; of which 29 actions were complete, 5 actions not yet started, 16 actions on track 6 actions requiring additional intervention and 4 actions off track requiring additional recovery plans.<br>• A review of definite **nosocomial Covid 19 deaths** recorded up to 15th January 2022 has been undertaken which has identified a number of areas for improvement alongside areas of good practice.<br>• Nine wards have been identified as requiring additional support or monitoring from a **staffing and quality** perspective during Q1 and Q2 with a further 3 wards identified during Q3.<br>• 79% achievement of **Duty of Candour** compliance for the 10 working day letter during Month 11 – this has been reviewed<br>• There was an increase in **complaints** referred to the PHSO during Quarter 3, with 4 new cases compared to 1 case per quarter in previous three quarters. It is worth noting that 3 out of the of 4 cases had previously been upheld by the Trust.<br>• Two risks relating to **Research and Innovation** were highlighted in relation to adherence to MHRA regulatory requirements and Covid-19 affecting core research functions – both are being managed in accordance with the Risk Management Policy<br>• Of the 70 trust wide indicators in the **CQC Insights Report** in January 2022, (1%) are categorised as much better, 1 (1%) as better, 8 (11%) as worse and 1 (1%) as much worse, 47 indicators have been compared to data from 12 months previous, of which 4 (9%) have shown an improvement and 6 (13%) have shown a decline<br>• Continued concerns with regard to **staffing levels** and the impact on undertaking risk assessments, were highlighted through the Executive Health & Safety Group; corporate support is in place<br>• 1 Never Event into **wrong site surgery** had been reported; this will be reported separately to the Board | • A detailed action plan is in place to address any gaps identified through the self-assessment against **Ockenden and Kirkup recommendations**, a programme of audit is in place to inform the self-assessment process<br>• An observation of mortality and morbidity meetings within **Cardiothoracic Surgery** will be undertaken to provide the Committee with additional assurance<br>• Work to be undertaken between the Medical Director and the Patient Experience Team around **communication letters to patients**, to ensure that they are fully involved in matters regarding their care and treatment<br>• Further work to be undertaken on the Research and Innovation report to ensure it provides a broader overview of research activity and how it aligns to the strategic priorities<br>• A review of **membership of the Quality & Safety Oversight Group** will be undertaken as part of the Committee Effectiveness Review process |
| ✓ | **Positive Assurances to Provide** | **Decisions Made** |
| | • An assessment against the immediate and essential actions set out within the **Ockenden Report** has demonstrated 99% compliance as at March 2022; this will be subject to ongoing audit.<br>• 11 **quality indicators** were achieved during Month 11<br>• **Patient Experience Report** demonstrates that children and young people feel that their experience is at its best around being involved in decisions about their care, providing activities and play whilst in hospital.<br>• At 98%, the Trusts satisfaction rate as part of the **Family and Friends Test** continues to exceed the national average<br>• Mapping of **CQC Insights indicators** has been undertaken against the Corporate Governance Structure to identify where oversight of each indicator will take place<br>• The Executive **Clinical Effectiveness Group** had been established, chaired by the Medical Director. Terms of Reference have been prepared and once finalised they will be submitted for approval of the Committee as part of the Committee Effectiveness process | • There were no items requiring decision |

**Comments on the Effectiveness of the Meeting**

- A very complex report was presented in relation to neonatal readmissions although it was recognised that this had perhaps gone into a lot of detail - reiteration of coaching points to be undertaken

## 2. Summary Agenda

| No. | Agenda Item | BAF Mapping | | Purpose | No. | Agenda Item | BAF Mapping | | Purpose |
|---|---|---|---|---|---|---|---|---|---|
| | | BAF No. | Risk | | | | BAF No. | Risk | |
| 1. | Ockenden and Kirkup Update and Action Plan | BAF 1 | 16432, 13419 | Assurance | 8. | Q3 Patient Experience Report 2021/22 | BAF 1 | | Assurance |
| 2. | Sharps Regulatory Compliance | - | 22876 | Assurance | 9. | Research & Innovation Update | - | 9607, 16504 | Assurance |
| 3. | Neonatal Emergency Readmission Analysis | - | | Assurance | 10. | CQC Insights Report (January 2022) | BAF 1 | | Assurance |
| 4. | Cardiothoracic Surgery Review Update | - | | Assurance | 11. | Executive Health & Safety Group Assurance Report | - | | Assurance |
| 5. | COVID-19 Nosocomial Mortality Review Report | BAF 1 | | Assurance | 12. | Clinical Effectiveness Group Assurance Report | - | | Assurance |
| 6. | Nursing and Midwifery Staffing and Quality Report: Quarter 3 2021/22 | BAF 1/3 | | Assurance | 13. | Quality & Safety Oversight Group Assurance Report | BAF 1 | | Assurance |
| 7. | M11 Quality & Safety Report | BAF 1 | | Assurance | 14. | Quality Impact Assessment Update | - | | Assurance |

## 3. 2021 / 22 Attendance Matrix

| | | | Attended | Deputy Sent | Apologies Received |
|---|---|---|---|---|---|

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

# Executive Summary

| | | | |
|---|---|---|---|
| **Meeting:** | Trust Board | **Date:** | 6th April 2022 |
| **Report Title:** | Infection Prevention BAF | **Agenda Item:** | 9 |
| **Author:** | Helen Bucior, Infection Prevention Lead Nurse<br>Emyr Philips , Associate Chief Nurse Infection Prevention/Deputy DIPC | | |
| **Executive Lead:** | Mrs Ann-Marie Riley, Chief Nurse/DIPC | | |

## Purpose of Report

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

## Alignment with our Strategic Priorities

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

## Risk Register Mapping

*Identified throughout the document.*

## 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/risks

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

<u>Progress</u>

- External company continues to assist with mask fit testing
- Ward are currently receiving reminder calls to prompt COVID screening
- Cleaning Collaborative work stream (multi-disciplinary representation) established and using Improving Together tools and methodologies to work through the actions needed to respond to the cleaning issues in West Building highlighted during the CPE Outbreak
- West Building estates non complaint hand wash sinks replacement work is in progress

## Key Recommendations:

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

NHS
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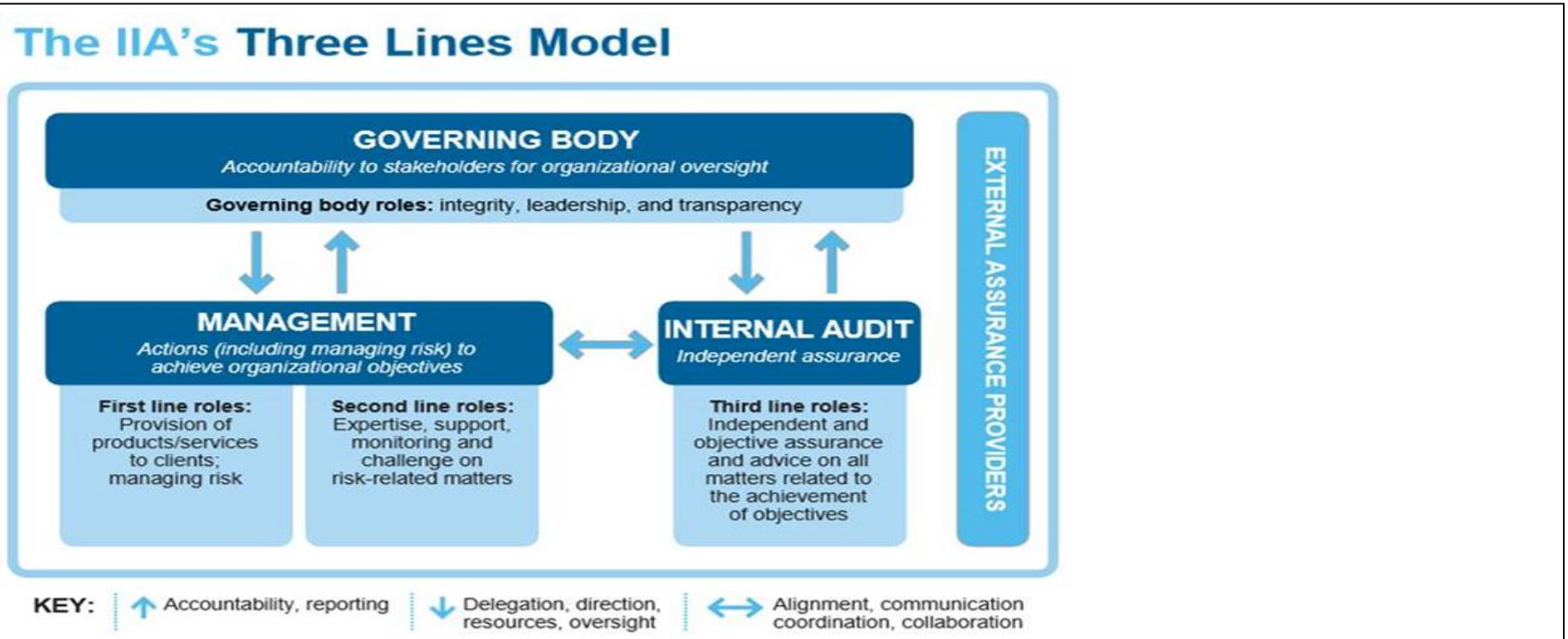
NHS Trust

# Infection Prevention and Control Board Assurance Framework

## February 2022

## Summary Board Assurance Framework

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




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

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

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

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

| Control and Assurance Framework | | | | |
|---|---|---|---|---|
| Key Lines of Enquiry (KLOE) | | Controls in Place | Assurance on Controls (Source, Timeframe and Outcome) | Gaps in Control or Assurance |
| **Systems and processes are in place to ensure:** | | | | |
| 1.1 | Systems and processes are in place ensure:<br><br>Update V 1.8<br>A respiratory season/winter plan is in place: that includes<br>• point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs, prevalence, and care services to enable appropriate segregations of cases depending on the pathogen<br>• Plan for and manage increasing case numbers where they occur.<br>• a multidisciplinary team approach is adopted with hospital leadership, estates | • All emergency patients are screened on decision to admit and set intervals of stay as per protocol.<br>• Elective screening protocol in place<br>• UHNM have access to rapid PCR testing circumstances that require a rapid result to facilitate placement<br>• Elective screening protocol in place<br>• EPRR forum<br>• UHNM Major Incident response and recovery plan<br><br>• Super serge identified and reviewed QIA completed for each area<br>• Multidisciplinary team approach | • From June 2020 IP team to review patients that are found COVID positive and nursed in bay to ascertain compliance with pathway and IP control measures are in place Review pathways and identify theme<br>• Theme report to IPCC<br>• 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** |
| | & facilities, IP Teams and clinical staff to assess and plan for creation of adequate isolation rooms/units as part of the Trusts winter plan | • Exec sign off | • Datix<br>• OB meetings | |
| | • Risk assessments are carried out in all areas by a competent person with the skills, knowledge and experience to be able to recognise the hazards associated with respiratory infectious agents<br>• Local risk assessments are based on the measure as prioritised in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff<br>• The documented risk assessment includes:<br>• A review of the effectiveness of the ventilation in the area<br>• Operational capacity<br>• Prevalence of infections/variants concern in the local area<br>• Triaging and SARS-CoV-2 testing is undertaken for all patients either at the pointe of admission or soon as possible/practical following admission across all pathways; | • Nominated ventilation lead to liaise with IP<br>• Risk assessment follow Hierarchy of controls<br>• QIA process<br>• Daily Tactical meetings<br>• Work with LRF to obtain community rates<br>• IP attends the weekly Staffordshire and Stoke on Trent , Test, Trace and Outbreak Management Group<br>• On arrival in ED patients are immediately identified either asymptomatic for COVID -19 and apply infection prevention precautions.<br>• ED navigator in place<br>• Colour coded areas in ED to set out COVID | | |

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

| Control and Assurance Framework | | | | |
|---|---|---|---|---|
| | Key Lines of Enquiry (KLOE) | Controls in Place | Assurance on Controls (Source, Timeframe and Outcome) | Gaps in Control or Assurance |
| | | to chase if not received within a timely manner. The patient flow reports to the Child Health tactical meeting every morning how many children have been swabbed result and any outstanding<br>• 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.<br>• Screening for patients on systematic anticancer treatment and radiotherapy<br>• Out patient flow chart in place<br>• Thermal imaging cameras in some areas of the hospital<br>• Iportal alert in place for COVID positive patients<br>• Extremely vulnerable patient placement added into new COVID ward round guidelines (October 2020)<br>  covid-19-care-plan-jan-22.pdf  4th-february-2021-covid-ward-round-guic<br>• Doors fitted to resus areas in both ED's | | |
| | Update V 1.8<br>• When an unacceptable risk of transmission remains following the risk assessment, consideration to the | • Discussed at Clinical group. Paper prepared by Deputy Medical Director | | |

| Control and Assurance Framework | | | | |
|---|---|---|---|---|
| | Key Lines of Enquiry (KLOE) | Controls in Place | Assurance on Controls (Source, Timeframe and Outcome) | Gaps in Control or Assurance |
| | extended use of respiratory RPE for patient care in specific situations should be given | which received exec approval w/c 26 July 2021<br>• August 2021 Introduction of FFP3 masks for all contact/ within 2 metres of COVID positive patients. The use of FFP3 masks for aerosol generating procedures remains in place<br>• UKHSA issued updated guidance 17th January 2022 re FFP3 or equivalent for staff when with confirmed or suspected patients / organisms spread through the airborne route | | |
| 1.2 | Patients with possible or confirmed Covid-19 are not moved unless this is essential to their care or reduces the risk of transmission.<br><br>There are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically imperative<br><br>Update V 1.8. Ensure that patients are not transferred unnecessarily between care areas unless; there is a change in their infectious status, clinical need, or availability of services.<br><br>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<br>• All patients that test negative are rescreened on days 4, 6, 14 and weekly<br>• Critical care plan with step down decision tree<br>• COVID-19 Divisional pathways<br>• Step down guidance available on COVID 19 intranet page<br>• Barrier and Terminal clean process in place<br>• IP PHE guidance<br>• Isolation guidance IP Q+A manual<br>• COVID Q+A available on Trust intranet<br>• COVID 19 outbreak meetings<br>• Patient COVID -19 discharge information letter for patient who are discharged but contact of a positive case | • Unannounced visits for clinical areas with clusters or HAI cases of COVID-19<br>• Review of HCAI COVID cases by IP Team/RCA<br>• Datix /adverse incidence reports for inappropriate transfers | • NHSI key point 4 : Patients are not moved until at least two negative test results are obtained, unless clinically justified |

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

| Control and Assurance Framework | | | |
|---|---|---|---|
| **Key Lines of Enquiry (KLOE)** | **Controls in Place** | **Assurance on Controls** (Source, Timeframe and Outcome) | **Gaps in Control or Assurance** |
| Linked Key Infection Prevention points – COVID 19 vaccination sites<br><br>Monitoring of IP practices, ensuring resources are in place to enable compliance with IP practice of staff adherence to hand hygiene?<br><br>• Staff adherence to hand hygiene<br>• Patients, visitors and staff are able to maintain 2 metre social and physical distancing in all patient care areas, unless staff are providing clinical/personal care and wearing appropriate PPE<br>• Staff social distancing across the workplace<br>• Staff adherence to wearing of fluid resistant surgical face masks<br>a) clinical<br>b) non clinical setting<br><br>Monitoring of staff compliance with wearing appropriate PPE, within the clinical setting<br><br>The role of PPE guardians/safety champions to embed and encourage best practice has been considered<br><br>There are visual reminders displayed communicating the importance of wearing face | • Aerosol generating procedures (AGP's) which require high level PPE agreed at clinical and tactical group<br>• COVID -19 Clinical Group reviews any proposed changes in PPE from the clinical areas<br>• Link to Public Health England donning and doffing posters and videos available on Trust intranet<br>• Chief Nurse PPE video<br>• Extended opening hours supplies Department<br>• Risk assessment for work process or task analysis completed by Health and Safety<br>• Estates in house teams and contractors<br>• are issued with SOP for working in clinical and non- clinical areas<br>• PHE announced from 11th June 2020 all staff to wear mask in both clinical and non-clinical health care setting<br>• Matrons walk rounds<br>• Specialised division summarised BAF and circulated to matrons<br>• ACN's to discuss peer review of areas<br>• Poster displayed in entrances and along corridors reinforcing the use of masks social distancing and one way systems<br>• Catch it , bin in, kill it posters in ED waiting rooms<br>• Lessons learnt poster | have submitted PPE donning an doffing records to the IP team<br>• Donning and Doffing training also held locally in clinical areas<br>• Cascade training records held locally by Divisions<br>• Sodexo and Domestic service training records<br>• IP unannounced assurance visits<br>• Review of UHNM vaccination areas against key infection prevention points COVID -19<br>• Hand hygiene audits<br>• FFP3 testing records can be added as a skill to Health roster. | |

| Control and Assurance Framework | | | |
|---|---|---|---|
| **Key Lines of Enquiry (KLOE)** | **Controls in Place** | **Assurance on Controls** (Source, Timeframe and Outcome) | **Gaps in Control or Assurance** |
| masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace<br><br>Update V 1.8<br><br>Resources are in place to implement and measures adherence to good IP practice. This must include all care areas and all staff (permanent , agency and external contractors)<br><br>The application of IP practices within this guidance is monitored e.g.<br>• Hand hygiene<br>• PPE donning and doffing training<br>• Cleaning and decontamination<br><br>Health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone.<br><br>The Trust in not reliant on a particular mask type and ensure that a range of predominantly UK mask FFP3 masks are available to users as required<br><br>Organisational/employers risk assessment in the context of managing seasonal respiratory |  Lessons learnt - Non Clinical June 2021.pdf  Lessons learnt - Clinical June 2021.pdf<br>  unannounced-ip-visit -template-2020-11.pdf  non-clinical-assurance-visit-checklist-2020<br><br>• QIA process for occasions when risk assess that the 2 metres can be reduced<br>  SOP beds social distance Jan 2022.do<br>•<br><br>• PPE available<br>• Mask fit testers throughout the Trust<br>• PPE videos and posters available<br>• IP Q+A manual<br>• QIA/risk assessments<br>• Trust Ventilation authorising engineer (AE) is the lead author of SVHP guidance around COVID. AE attends the Trust Ventilation safety group and has a fixed agenda item for any updates and changes to guidance and legislation. | | |

| Control and Assurance Framework | | | | |
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| | **Key Lines of Enquiry (KLOE)** | **Controls in Place** | **Assurance on Controls** (Source, Timeframe and Outcome) | **Gaps in Control or Assurance** |
| | infectious agents are<br><br>• based on the measures as prioritised in the hierarchy of controls including evaluation of the ventilation in the area, operational capacity, and prevalence of the infection/new variant of concern in the local areas<br>• Applied in order and include elimination , substitution , engineering , administration and PPE/RP<br>• Communicated to staff<br><br>Safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems. | • The Trust has a list of available models of FFP3 masks to use. A number of staff are trained on 2 types of masks but this work is on-going as the priority it to ensure all staff who require FFP3 are tested on a suitable model first then tested on an alternative model | • Local FFP3 records held by the division<br>• Health roster FFP3 records | |
| 1.5 | National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way. | • Notifications from NHS to Chief nurse/CEO<br>• IP team COVID lead checks Public Health England webpage daily ( Monday-Friday) for updates<br>• Changes raised at -19 clinical groups which was held originally twice weekly, reduced to weekly and now increased back to twice weekly due to surge of COVID.<br>• Purpose of the Clinical Group - The Group receive clinical guidance and society guidance which is reviewed and if agreed | • Clinical Group meeting action log held by emergency planning | |

| Control and Assurance Framework | | | | |
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| Key Lines of Enquiry (KLOE) | | Controls in Place | Assurance on Controls (Source, Timeframe and Outcome) | Gaps in Control or Assurance |
| | | used to advise clinical teams after approval at Exec COVID -19 meeting which is held twice monthly.<br>• The clinical group initially weekly , now stepped down to Bi weekly<br>• Tactical group – The tactical Group held daily. April 2021 now stepped down. The Group decide and agreed tactical actions Makes recommendations to Gold command<br>• Chief nurse updates<br>• Changes/update to staff are included in weekly Facebook live sessions<br>• COVID -19 intranet page<br>• COVID -19 daily bulletin with updates<br>• 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<br>• Clinical Group, Divisional cells, Workforce Bureau, Recovery cells subgroup feed in to tactical group.<br>• COVID Gold command , decisions /Assurance reported to Trust Board Via CEO Report/COO | • Meeting Action log held by emergency planning<br>• Trust Executive Group Gold command – Overall decision making and escalation<br>• Tactical, Operational Delivery Group - The delivery of the objectives and benefits, and programme communications COVID 19 response and R&R. Co - ordination of resources. Escalation forum for linked | |

| Control and Assurance Framework | | | | |
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| | Key Lines of Enquiry (KLOE) | Controls in Place | Assurance on Controls (Source, Timeframe and Outcome) | Gaps in Control or Assurance |
| | | | Groups and Cells ensuring that the interdependencies are effectively managed, including system. Makes recommendations to Gold Command for key decisions.<br>• Clinical steering Group – Coordinate clinical decision – making to underpin continual service delivery and COVID 19 related care<br>• 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<br>• Divisional Groups – Agree infection Prevention measures  COVID19RRGOVERNANCE NOV20v1.pptx | |
| 1.7 | Risks are reflected in risk registers and the Board Assurance Framework where appropriate.<br><br>• Linked NHSIE Key Action 5: Daily data | • Risk register and governance process<br>• Datix incidents<br>• Board assurance document standing agenda item Trust board and IPCC.<br>• TOR | • IP risks are agenda item at Infection Prevention and Control committee (IPCC)<br>• Definite Nosocomial COVID 19 case numbers are in | |

| Control and Assurance Framework | | | | |
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| | **Key Lines of Enquiry (KLOE)** | **Controls in Place** | **Assurance on Controls** (Source, Timeframe and Outcome) | **Gaps in Control or Assurance** |
| | 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.<br><br>• Trust Board has oversight of on going outbreaks and actions plans<br><br>• The Trust Chief Executive, the Medical Director or the Chief Nurse has oversight of daily sitrep.in relation to COVID-19, other seasonal respiratory infections, and hospital onset cases<br><br>• 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.<br><br>• There are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas | • Outbreak IImarch submissions are copied to Chief Nurse/DIPC and exec Team<br>• Outbreak areas are included in daily tactical meeting<br>• Outbreak areas included in Gold update slides<br>• Outbreak meetings attended by CCG and PHE<br>• Definite Nosocomial COVID 19 case numbers are in included in Quality Performance Report<br>• Nosocomial death review process<br>• Visiting /walk round of areas by executive/senor leadership team<br><br>  <br>SOP bed removal due to social distancir | included in Quality Performance Report<br>• Nosocomial death review process – paper to Quality and Governance Committee 20th January 2021<br>• COVID themes report to IPCC<br>• RCA process for all probable and definite COVID 19 | |

| Control and Assurance Framework | | | | |
|---|---|---|---|---|
| | **Key Lines of Enquiry (KLOE)** | **Controls in Place** | **Assurance on Controls** (Source, Timeframe and Outcome) | **Gaps in Control or Assurance** |
| 1.8 | Robust IPC risk assessment processes and practices are in place for non Covid-19 infections and pathogens. | • IP questions and answers manual<br>• Section in IP questions and answer manual 2.1 priority of isolation for different infections and organisms<br>• Sepsis pathway in place<br>• Infection Risk assessment in proud to care booklets and admission documentation<br>• C.diff care pathway<br>• IP included in mandatory training<br>• Pre Amms IP Screening<br>• 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<br>• Proud to care booklets revised an reinstated August/September 2020<br>• Revised pathways to include actions for extremely vulnerable patients who are admitted into the Trust<br>• Advantages and disadvantages to reinstating MRSA screening as per UHNM policy undertaken and recommenced May 2021 | • MRSA screening compliance<br>• Monthly Sepsis Compliance audits. Screening compliance for sepsis and time to antibiotics for Red flag patients<br>• IP audits<br>• Infection Prevention Health care associated infection report, including submitted to monthly to Quality and Safety.<br>• Submission of Infection figures to Public Health England. Clostridium difficile, MRSA blood stream infections ( bacteraemia) and Gram Negative blood stream infections<br>• Seasonal influenza reporting<br>• Audit programme for proud to care booklets<br>• CPE colonisation outbreak team closed the outbreak on 14th December 2021 following NHSEi whereby only minor points picked up at the inspection and the Trust was moved back to AMBER | |

| Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite) | | | | | | |
|---|---|---|---|---|---|---|
| **No.** | **KLOE** | **Action Required** | **Lead** | **Due Date** | **Quarter 3 Progress Report** | **BRAG** |
| 3 | 1.2 | NHSI key point 4 : Patients are not moved until at least two negative test results are obtained, unless clinically justified | Microbiologist/ ACN's | 31/05/2020<br>31/08/2021<br>29/10/2021<br>31/12/2021<br>28/02/2022<br>03/04/2022 | Testing and re testing, Interpretation of swabs and step down of IP precaution process in place at UHNM. Suspected or positive patients are moved on clinical need/assessment and in line with UHNM step down process. For patients who test negative on admission re screening is undertaken.<br>17th November NHSI guidance recommended that the second test is taken on day 3 after admission and day 5 after admission. Implementation of the new guidance is in place and a manual prompt is provided to the clinical areas. (Days 4 and 6 admission day counted as day 1). Waiting for 2 negatives swabs before moving for patients that are not COVID suspected does not always occur.<br>September 2021 A COVID themes review paper is presented at IPCC bi monthly and is an agenda item. Investigation of themes and discussions at COVID outbreak meetings provide an opportunity to review not always achieving this standard and whether this has an impact on potential transmission or outbreak. A number of specialised ward strive to isolate admissions into a single room until COVID results are known.<br>November & December 2021 actions continues to remain under surveillance | Action under surveillance |

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

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

| Control and Assurance Framework | | | | |
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| | Key Lines of Enquiry (KLOE) | Controls in Place | Assurance on Controls (Source, Timeframe and Outcome) | Gaps in Control or Assurance |
| **Systems and processes are in place to ensure:** | | | | |
| 2.1 | Designated nursing/medical teams with appropriate training are assigned to care for and treat patients in Covid-19 isolation or cohort areas. | • Higher risk areas with own teams<br>• Zoning of hospital in place with cleaning teams<br>• UHNM clinical guidance available on the intranet<br>• Trust COVID -19 clinical group established to discuss and agree clinical pathways<br>• Nice Guidance and National Clinical Guidance COVID-19 available on the Trust intranet<br>• Links to PHE guidance on assessing COVID-19 cases available on Trust intranet page<br>• Education videos clinical and non - clinical videos on Trust intranet<br>• Process and designated staff for ED to ensure cleans are completed | • Clinical Group action log<br>• 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 |
| | | timely | | |
| 2.2 | Designated cleaning teams with appropriate training in required techniques and use of PPE are assigned to Covid-19 isolation or cohort areas.<br><br>Assurance processes are in place for monitoring and sign off terminal cleans as part of outbreak management | • SOP and cleaning method statements for cleaning teams<br>• PPE education for cleaning teams<br>• Initial meetings held with facilities/estates to discuss and plan COVID-19 requirements IP agenda item<br>• Representatives from the division are attending the daily tactical meetings, and an E,F & PFI daily meeting is taking place which includes our partners<br>• 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.<br>• Spot check assurance audits completed by cleaning supervisors/managers during COVID<br>• Cleanliness complaints or concerns are addressed by completing cleanliness audit walkabouts with clinical teams, and CPM / domestic supervisors<br>• PPE and FFP3 mask fit training records with are held by cleaning services<br>• GREAT training record cards are held centrally by Sodexo for all individual domestics<br>• Key trainers record<br>• Notes from Sodexo Performance Monthly meeting , Sodexo Operational meeting , Divisional IP Meeting and facilities/estates meeting | • Learning from CPE outbreak. We have recognised areas we can strengthen our assurance process on standards of cleanliness |
| 2.3 | Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line | • SOP for terminal and barrier cleans in place and was reviewed in | • C4C audits reinstated July 2020 these results are fed | |

| Control and Assurance Framework | | | | |
|---|---|---|---|---|
| | **Key Lines of Enquiry (KLOE)** | **Controls in Place** | **Assurance on Controls** (Source, Timeframe and Outcome) | **Gaps in Control or Assurance** |
| | with PHE and other national guidance.<br><br>Update V 1.8<br><br>A terminal clean /deep clean of inpatient rooms is carried out:<br><br>• Following resolutions of symptoms and removal of precautions<br>• When vacated following discharge or transfer ( this includes removal and disposal /or laundering of all curtains and bed screens)<br>• Following an AGP if room vacated ( clearance of infectious particles after an AGP is dependent on the ventilation and air changes within the room) | February 21.<br>• High level disinfectant , Virusolve and Tristel in place and used for all decontamination cleans<br>• 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.<br>• Terminal cleans are requested via IP Team<br>• Terminal clean process included in IP Q+A manual | into IPCC<br>• Completion of random 10% rooms each week by cleaning supervisors/managers to ensure that all rooms are cleaned to the agreed cleaning standards – Any rooms that are found to be below standard are rectified immediately.<br>• Terminal clean electronic request log<br>• Patient survey feedback is reviewed by joint CPM / Sodexo/EFP group and action plan completed if needed.<br>• IP assurance visits and audits | |
| 2.4 | Increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance.<br><br>A minimal of twice daily cleaning of<br>• Patients isolation rooms<br>• Cohort areas<br>• Donning and doffing areas<br>• Frequently touched surfaces e.g. door/toilet handles, patient call bells over bed tables and | • Increased cleaning process ( barrier clean) included in Infection Prevention Questions and Answers manual<br>• Process in place for clinical areas with clusters and HAI cases of COVID -19 requiring increased cleaning and /or terminal cleans<br>• Feedback from NHSI provided to cleaning teams and action plan | • Barrier clean request electronic log held by Sodexo and circulated following any updates / removal of barrier cleans to Sodexo and Trust staff including IP Team.<br>• IP spot checks for clinical areas with clusters of COVID -19 or HAI cases of COVID -19 | |

| Control and Assurance Framework | | | | |
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| | **Key Lines of Enquiry (KLOE)** | **Controls in Place** | **Assurance on Controls** (Source, Timeframe and Outcome) | **Gaps in Control or Assurance** |
| | bed rails.<br>Where there may be higher environmental contamination rates including<br>• Toilets/commodes particularly if patient has diarrhoea<br><br>Update V 1.8<br><br>Increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas |  <br>Action Plan Following NHS England NHS Im<br>devised<br>  <br>NHSI action plan June 21.docx<br><br>• Increased cleaning process ( barrier clean) included in Infection Prevention Questions and Answers manual | • Disinfectant check completed during IP spot checks<br>• Additional ad-hoc cleaning requests can be requested by clinical teams 24/7 should the environment become contaminated between scheduled cleans.<br>• November 2021 Implementation of IPS audit<br>• C4C audit programme in place | |
| 2.5 | Attention to the cleaning of toilets / bathrooms, as Covid-19 has frequently been found to contaminate surface in these areas. | • Cleaning schedules in place<br>• Barrier cleans ( increased cleaning frequency) process in place which includes sanitary ware and other frequent touch points<br>• Barrier cleans also requested for other infections /period of increased incidence /outbreaks e.g C.diff , Norovirus | • Cleaning schedules are displayed on each ward<br>• Additional ad-hoc cleaning requests can be requested by clinical teams 24/7 should the environment become contaminated between scheduled cleans. | |
| 2.6 | Update V 1.8<br><br>Where patients with respiratory infection are cared for:<br>Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution | • Virusolve and Tristel high level disinfectant used as routine for cleaning/disinfecting environment and non invasive equipment<br>• Virusolve wipes also used during height of pandemic | • Evidence from manufacture that these disinfectants are effective against COVID -19<br>• Evidence of Virusolve weekly strength checks , held locally at ward | |

| Control and Assurance Framework | | | | |
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| | Key Lines of Enquiry (KLOE) | Controls in Place | Assurance on Controls (Source, Timeframe and Outcome) | Gaps in Control or Assurance |
| | 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. | | /department level<br>• IP checks that disinfectant is available during spot checks | |
| 2.7 | Manufacturer's guidance and recommended product 'contact time' must be followed for all cleaning / disinfectant solutions / products. | • Contact times detailed in SOP and cleaning methods statements<br>• Included in mandatory training<br>• Included in IP Q+A<br>• 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.<br>• Where outbreaks are identified, regular staff who clean in this area have competency checks to ensure that they are following GREAT card training<br>• Spot checks completed by CPM includes observation of cleaning techniques by the domestic staff. | |
| 2.8 | As per national guidance:<br>• '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.<br>• Electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should | • Cleaning of frequently touch points included in Barrier clean process<br>• Offices and back offices also supplied with disinfectant wipes to keep work stations clean.<br>• Non- invasive medical equipment must be decontaminated after each use. IP Q+A manual | • IP checks<br>• Barrier clean request log<br>• Terminal clean request log<br>• Additional ad-hoc cleaning requests can be requested by clinical teams 24/7 should the environment become contaminated | |

| Control and Assurance Framework | | | | |
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| | Key Lines of Enquiry (KLOE) | Controls in Place | Assurance on Controls (Source, Timeframe and Outcome) | Gaps in Control or Assurance |
| | be cleaned at least twice daily.<br>• 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).<br><br>Linked NHSIE Key Action 1: All high touch surfaces and items are decontaminated multiple times every day – once or twice a day is insufficient. | | between scheduled / barrier cleans.<br>• 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<br>• Linen posters depicting correct linen bag displayed in clinical areas and linen waste holds<br>• Red alginate bags available for infected linen in the clinical areas<br>• Infected linen route | • IP quarterly audits , undertaken by own areas, audits held locally by divisions and requested to also send to harmfreecare email<br>• Datix reports/adverse incidents<br>• IPS audits undertaken by the IP Team | |
| 2.10 | Single use items are used where possible and according to single use policy. | • IP question and answers manual<br>• Medical device policy<br>• SOP for Visor decontamination in time of shortage | • IP audits held locally by divisions and requested to also send to harmfreecare email | |

| Control and Assurance Framework | | | | |
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| | **Key Lines of Enquiry (KLOE)** | **Controls in Place** | **Assurance on Controls** (Source, Timeframe and Outcome) | **Gaps in Control or Assurance** |
| 2.11 | Reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance.<br><br>Update V 1.8<br><br>Resuable non –invasive care equipment is decontaminated:<br>○ Between each use<br>○ After blood and/or body fluid contamination<br>○ At regular predefined interval as part of an equipment cleaning protocol<br>○ Before inspection, service or repair equipment<br><br>Update V 1.8<br><br>Compliance with regular cleaning regimes is monitored including that of reusable equipment | • IP question and answers manual covers decontamination<br>• Air powered hoods – SOP in place which includes decontamination process for the device<br>• Re usable FFP3 Masks – Sundstrom/ GVS Elipse. SOP's in place which includes the decontamination process<br>• Medical device policy<br>• Availability of high level disinfectant in clinical areas<br>• Sterile services process<br>• Datix process<br>• Bed Storage Group looking at non conformities for beds that require repair<br>• Clinical cleaning schedules<br>• Domestic cleaning schedules<br>• Cleaning of electronic beds part of collaborative cleaning | • IP audits held locally by divisions<br>• Datix reports/adverse incident reports<br>• IP assurance visits | • Decontamination of beds returned for repair process non conformities<br><br>• Electronic beds – difficult dismantle the bed base mechanism to allow for effective cleaning –this issue has been raised regionally by NHSI |
| 2.12 | Update V 1.8<br><br>As part of heirachy of controls assessment : ventilation systems, particularly in, patient care areas ( natural or mechanical) meets national recommendations for the minimum of air changes refer to specific guidance<br><br>In patients care health building note 04-01 Adult in patient facilities | • UHNM has established a Ventilation Safety Group as recommended by the Specialised Ventilation for Healthcare Society in order to provide assurance to the Trust Board on the safe operation and reduction in risk of infection transmission through ventilation systems. TOR written<br>• The Trust also appointed external | • Estates have planned programme of maintenance<br>• 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 | | | |
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| **Key Lines of Enquiry (KLOE)** | **Controls in Place** | **Assurance on Controls** (Source, Timeframe and Outcome) | **Gaps in Control or Assurance** |
| The assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations authorised engineer<br><br>A systematic review of the ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways<br><br>Where possible air is diluted by natural ventilation by opening windows and doors were appropriate<br><br>Review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission.<br><br>Where a clinical space has a very low air changes and it is not possible to increase dilution effectively , alternative technologies are considered with estates/ventilation group<br><br>When considering screens/partitions in reception /waiting areas , consult with estates/facilitates teams , to ensure that air flow is not affected, and cleaning schedules are in place<br><br>Ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air<br>Where possible ventilation is maximised by opening | 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.<br>• Trust Estates Ventilation Aps attended week long Specialized ventilation in health care at Leeds University – Much of this content contact relates to airborne respiratory infections<br>• Lessons learnt poster which encourage regular opening of windows to allow fresh air<br>  <br>ventilation-air-chang es-per-hour-2021-06<br>•<br>• IP and estates have worked with areas know to be undertaking aerosol generating procedures and completed the fallow times<br>• IP have nominated point of contact re ventilation advise<br>• January 2022 Estates and IP are exploring the use of air scrubber machine to try on ward in West Building<br>• Review of areas that request Perspex screens to check need and requirement for | | |

| Control and Assurance Framework | | | | |
|---|---|---|---|---|
| | **Key Lines of Enquiry (KLOE)** | **Controls in Place** | **Assurance on Controls** (Source, Timeframe and Outcome) | **Gaps in Control or Assurance** |
| | windows where possible to assist the dilution of air. | cleaning/ventilation not affected | | |
| 2.13 | Update V 1.8<br>The Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level.<br><br>Update V 1.8<br>The organisation had systems and processes in place to identify and communicate changes in the functionality of area/rooms<br><br>Update V 1.8<br>Ensure cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment<br><br>Monitor adherence environmental decontamination with actions in place to mitigate any identified risk<br><br>Monitor adherence to the decontamination of shared equipment | • Cleaning standards meetings in place, review of National standards<br>• Cleaning collaborative improvement project now underway<br>• 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<br>• 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 %.<br>• C4C report presented at IPCC | Cleanliness assurance processes around |

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

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

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

| Control and Assurance Framework | | | | |
|---|---|---|---|---|
| Key Lines of Enquiry (KLOE) | | Controls in Place | Assurance on Controls (Source, Timeframe and Outcome) | Gaps in Control or Assurance |
| **Systems and processes are in place to ensure:** | | | | |
| 3.1 | Arrangements around antimicrobial stewardship are maintained.<br>Update V 1.8<br>Previous antimicrobial history is considered<br><br>The use of antimicrobials is managed an monitored:<br>Update V 1.8<br>• To reduce inappropriate prescribing<br>• To ensure patients with infections are treated promptly with correct antibiotic | • Regular, planned Antimicrobial stewardship (AMS) ward rounds<br>• Trust antimicrobial guidelines available 24/7 via intranet and mobile device App<br>• Antimicrobial action plan in place<br>• Clostridium *difficile* Period of increased incidence and outbreaks are reviewed by member of AMS team and actions generated cascaded to ward teams<br>• Regional and National networking to ensure AMS activities are optimal<br>• Formal regional meetings and informal national network activities<br>• AMS CQUIN further mandates key AMS principles to be adhered to<br>• All national CQUINS currently | • Same day escalation to microbiologist, if concerns. Outcome recorded on I portal<br>• Metric available around the number of times App accessed by UHNM staff<br>• Compliance with guidelines and other AMS metrics reported to Infection prevention and control Committee (IPCC)<br>• Meeting minutes reviewed and actions followed up<br>• Real time discussions / requests for support / advice enabled via regional and national social media accounts. National (incl. PHE) thought leaders members<br>• Trust and commissioners require | |

| Control and Assurance Framework | | | | |
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| Key Lines of Enquiry (KLOE) | | Controls in Place | Assurance on Controls (Source, Timeframe and Outcome) | Gaps in Control or Assurance |
| | | suspended by NHSE / PHE<br>• Monthly review of antimicrobial consumption undertaken by AMS team. Available online at UHNM | timely reporting on compliance with AMS CQUIN targets.<br>• 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<br>• The pharmacy team undertook a trust-wide point prevalence audit using a new electronic data capture tool. Results will be reviewed during January and shared with ACN's and Microbiologist. | |
| 3.2 | Mandatory reporting requirements are adhered to and boards continue to maintain oversight.<br><br>Linked NHSIE Key Action 5: Daily data submissions have been signed off by the Chief Executive, the Medical Director and the Chief Nurse and the Board Assurance Framework is reviewed and evidence of reviews is available.<br><br>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.<br><br>• Results from all AMS audits and targeted ward reviews are reported at the Antimicrobial Stewardship Group and minutes seen by IPCC<br><br>• CQUIN submissions completed in timely manner and generate action plans for AMS and ward teams to follow up concerns each quarter. | • Whilst only a snap-shot audit the Trust value the output from these audits. Work is underway Q1 and Q2 20/21 to review potential change in data collection to optimise impact.<br>• 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.<br>• Trust CQUIN contracts manager holds regular track and update meetings to challenge progress vs AMS CQUINS, Currently | |

| Control and Assurance Framework | | | | |
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| | Key Lines of Enquiry (KLOE) | Controls in Place | Assurance on Controls (Source, Timeframe and Outcome) | Gaps in Control or Assurance |
| | Update V 1.8<br><br>Risk assessments and mitigations are in place to avoid unintended consequences from other pathogens | Currently suspended. | suspended. | |

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

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

| Control and Assurance Framework | | | | |
|---|---|---|---|---|
| | Key Lines of Enquiry (KLOE) | Controls in Place | Assurance on Controls (Source, Timeframe and Outcome) | Gaps in Control or Assurance |
| **Systems and processes are in place to ensure:** | | | | |
| 4.1 | Implementation of national guidance on visiting patients in a care setting.<br><br>Update V 1.8<br>Visits from patients relatives and/or carers ( formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients , staff and visitors<br><br>There is clearly displayed , written information available to prompt patients, visitor and staff to comply with hand washing, wearing of facemask /face coverings and physical distancing<br><br>Restrictive visiting may be considered appropriate during outbreaks within inpatient areas. This is an organisational decision following a risk assessment | • To help protect patients and staff from Covid-19, the NHS suspended all visiting to hospitals. This national suspension has now been lifted and visiting is to be introduced in some areas of our hospitals, subject to certain conditions. From Monday 17 August 2020 visiting will be phased in across some areas and will be allowed in the West Building at Royal Stoke and in Wards 7, 12, 15 at County Hospital. All visiting will have to be pre-booked and relatives will be provided with the correct information and contact details to book in advance. Visitors will be instructed to wear face masks and | • Monitored by clinical areas<br>• PALS complaints/feedback from service users<br>• Outbreak meetings | |

| Control and Assurance Framework | | | |
|---|---|---|---|
| **Key Lines of Enquiry (KLOE)** | **Controls in Place** | **Assurance on Controls** (Source, Timeframe and Outcome) | **Gaps in Control or Assurance** |
| Update V 1.8<br><br>If visitors are attending a care areas with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be a FRSM.<br><br>Update V 1.8<br><br>Visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reason (e.g. parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible.<br><br>Update V 1.8<br><br>Visitors are not present during AGPs on infectious patient unless they are considered essential following a risk assessment e.g. care/parent/guardian. | 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<br>• The only exceptional circumstances where on visitor , an immediate family member or carer will be permitted to visited are listed below-<br>• The patient is in last days of life- palliative care guidance available on Trust intranet<br>• The birthing partners are able to attend all scans and antenatal appointments induction of labour and post natal appointments<br>• The parent or appropriate adult visiting their child<br>• Other ways of keeping in touch with loved ones e.g. phone calls , video calls are available<br>• EOL visiting guidance in place<br>• Guidance to accommodate visitor if appropriate and necessary to assist a patients communication and/or to meet their health, emotional , religious or spiritual need<br>• A familiar care/parent or guardian/support/personal assistant<br>• Children both parents /guardian | | |

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

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

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

| Control and Assurance Framework | | | | |
|---|---|---|---|---|
| | Key Lines of Enquiry (KLOE) | Controls in Place | Assurance on Controls (Source, Timeframe and Outcome) | Gaps in Control or Assurance |
| **Systems and processes are in place to ensure:** | | | | |
| 5.1 | Update V 1.8<br>Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival<br><br>Update V 1.8<br>Infection status of the patient is communicated to the receiving organization, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred<br><br>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 | • ED navigator records patient temperature and asked screening questions. Patient then directed to relevant coloured area<br>• All patients who are admitted are screened for COVID 19<br>• Work completed to install doors to resus areas in both ED's<br>• December 2021 – review of green resus doors and use of area<br>• Posters in place for visitors re respiratory instructions<br><br>• Clinical letter/ pre op screening in place to identify /enable early recognition of respiratory symptoms | • June 2020 IP team review patients that are found COVID positive and nursed in bay to ascertain compliance with pathway and IP control measures are in place Review pathways and identify theme . COVID 19 -Themes report to IPCC<br>• ED pathways including transfer of COVID positive patient from County to Royal Hospital<br>• COVID screening spot check audits | |

| Control and Assurance Framework | | | |
|---|---|---|---|
| **Key Lines of Enquiry (KLOE)** | **Controls in Place** | **Assurance on Controls** (Source, Timeframe and Outcome) | **Gaps in Control or Assurance** |
| minimise the risk of cross-infection as per national guidance.<br><br>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.<br><br>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<br><br>Staff are aware of agreed template for triage questions to ask<br><br>Update V 1.8<br>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<br><br>Screening for COVID -19 is undertaken prior to attendance wherever possible to enable early recognition and to clinically assess patients prior to any patients attending a healthcare environment<br><br>Patients with respiratory symptoms are assessed in segregated areas, ideally a single room, and away from other patients pending their test result. | • Hospital zoning/pathways<br>• COVID 19 care pathway<br><br>• Screening protocol in place | | |

| Control and Assurance Framework | | | | |
|---|---|---|---|---|
| | Key Lines of Enquiry (KLOE) | Controls in Place | Assurance on Controls (Source, Timeframe and Outcome) | Gaps in Control or Assurance |
| | There is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved | | | |
| 5.2 | Mask usage is emphasized for suspected individuals.<br>Face coverings are used by all outpatients and visitors<br>Update V 1.8<br><br>Facemask are worn by staff and patients in all health care facilitates<br><br>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<br>Update V 1.8<br><br>Patients with suspected or confirmed respiratory infection are provided with a surgical face mask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated.<br><br>Monitoring of Inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so) and is not detrimental to their physical or mental | • Use of mask for patients included in IP COVID -19<br>• question and answers manual<br>• All staff and visitors to wear masks from Monday15th June2020<br>• ED navigator provide masks to individual in ED<br>• Mask stations at hospital entrances<br>• Covid-19 bulletin dated 12th June 2020<br>• 28th August updated guidance from PHE recommends in patients to also wear surgical masks if tolerated and does not compromise care<br>• IP Assurance visits<br>• Senior walk rounds of clinical areas<br>• Matrons daily visits<br>• Patient who are clinically extremely vulnerable should remain in a single room for the duration of their hospital stay<br>• Patient are encourage to wear mask – leaflet in place<br>8th-march-2021-covid-ward-round-guidan<br>covid-19-care-plan-jan-22.pdf | • Hospital entrances Mask dispensers and hand gel available<br><br>• Datix /incidents<br>• COVID-19 themes report to IPCC | |

| Control and Assurance Framework | | | | |
|---|---|---|---|---|
| | Key Lines of Enquiry (KLOE) | Controls in Place | Assurance on Controls (Source, Timeframe and Outcome) | Gaps in Control or Assurance |
| | needs<br><br>Individuals who are clinically extremely vulnerable form COVID 19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room<br>Update V 1.8<br>Patients at risk of severe outcomes of respiratory infection receive protective IP measures depending in their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation and risk for their families and carers accompanying them for treatments /procedures must be considered | • Trust internet and social media provide information re the need for wearing of face masks whilst in /visiting hospital<br><br>• Included in COVID 19 care pathway<br>• IP Q+A isolation manual | | |
| 5.3 | Ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff.<br><br>Linked NHSIE Key Action 6: Where bays with high numbers of beds are in use, these must be risk assessed, and where 2m can't be achieved, physical segregation of patients must be considered and wards are effectively ventilated.<br><br>Update V 1.8<br>Patient visitors , and staff can maintain 1 metre or greater social and physical distancing in all patient care areas: ideally segregation should be spate spaces , but there is potential | • Colour coded areas in ED to separate patients, barriers in place.<br>• Screens in place at main ED receptions<br>• Colour coded routes identified in ED<br>• Social distancing risk assessment in place<br>• Perspex screens agreed through R+R process for other reception area<br>• Social distance barriers in place at main reception areas<br>• Chief Nurse/DIPC visited clinical areas to review social distancing within bays. A number of beds have been removed throughout the Trust.<br>• January 2022 – 2 metre rule maintained. Risk assessments completed and signed off by | • Division/area social distancing risk assessments | |

| Control and Assurance Framework | | | | |
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| | Key Lines of Enquiry (KLOE) | Controls in Place | Assurance on Controls (Source, Timeframe and Outcome) | Gaps in Control or Assurance |
| | to use screens e.g. to protect reception staff | DIPC for ward areas need to use closed beds due to social distancing<br>• January 2022 - Risk assessments to be revisited for Out- patient /imaging area that need to reduce distance to 1 metre – this work is in progress | | |
| 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<br>• Process for cohorting of contacts<br>• 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<br>• 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.<br>• Patient who tested negative on admission and remain an inpatient are retested for COVID days 4 and 6, day 14 then weekly<br>• Spot check audits<br>• Assurance obtained for monitoring of inpatient compliance with wearing face masks via Matrons daily walk round | |
| 5.5 | Patients with suspected Covid-19 are tested promptly.<br>There is evidence of compliance with routine testing protocols in line with key actions | • All patients who require overnight stay are screened on admission and patients who develop symptoms – UHNM screening guidance in place<br>• December 2021 – surveillance of Omicron cases in place to monitor number of inpatients with the variant | • Adverse incident monitor /Datix | |
| 5.6 | Patients who test negative but display or go on to develop symptoms of Covid-19 are | • Screening protocol in place which includes rescreening /re testing. Pathways in place for | • Datix process<br>• IP reviews | |

| Control and Assurance Framework | | | | |
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| | Key Lines of Enquiry (KLOE) | Controls in Place | Assurance on Controls (Source, Timeframe and Outcome) | Gaps in Control or Assurance |
| | segregated and promptly re-tested and contacts traced.<br><br>Isolation , testing an instigation of contact tracing is achieved for all patients with new onset symptoms , until proven negative | positive COVID 19 patients<br>• Iportal alert and April 2021 contact alert in place iportal/medway<br>• The IP team have been applying a Covid-19 contact alert within the ICNET system since November 2020 and this continues.<br>• Inpatient contacts are cohorted<br>• COVID 19 positive patients are cared for on blue wards or single rooms or COVID 19 cohort areas on critical care unit | | |
| 5.7 | Patients who attend for routine appointments and who display symptoms of Covid-19 are managed appropriately.<br>Update V 1.8<br>Where treatment is not urgent consider delaying this unit resolution of symptoms providing this does not impact negatively on patient outcomes | • Restoration and Recovery plans<br>• Thermal temperature located in a number outpatient areas – with SOP if patient triggers. Script in place for scheduling outpatient/ investigations<br>• Mask or face coverings for patients attending appointments from Monday 15th June 2020<br>• Process at PREAMMS if patient positive for COVID | • Datix process | |

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

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

| Control and Assurance Framework | | | | |
|---|---|---|---|---|
| | Key Lines of Enquiry (KLOE) | Controls in Place | Assurance on Controls (Source, Timeframe and Outcome) | Gaps in Control or Assurance |
| **Systems and processes are in place to ensure:** | | | | |
| 6.1 | Update V 1.8<br>Appropriate infection prevention education is provided for staff, patients and visitors<br><br>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.<br><br>Patient pathways and staff flow are separated to minimise contact between pathways. E.g. this could include provisions of spate entrances/exits or use of one way system , clear signage and restricted access to communal areas, | • PPE discussed at tactical group<br>• Training videos available<br>• FFP3 mask fit key trainers<br>• Donning and Doffing posters, videos and PHE available on Covid-19 section of Trust intranet<br>• Posters in corridors - keep to the left<br>• One way signs in place along corridors | • Tactical group action log<br>• Divisional training records<br>• 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.<br>Update V 1.8<br>Training in IP measures is provided to all staff, | • PPE and standard precautions part of the infection prevention Questions and Answers manual.<br>• FFP3 train the trainer | • Training records<br>• IP spot checks of PPE on wards and Departments undertaken | |

| Control and Assurance Framework | | | | |
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| | Key Lines of Enquiry (KLOE) | Controls in Place | Assurance on Controls (Source, Timeframe and Outcome) | Gaps in Control or Assurance |
| | including : the correct use of PPE including an intial face fit test/and fit check each time when wearing a filters face piece (FFP3) respirator and the correct technique of putting on and removing ( donning/diffing ) PPE safely.<br><br>Gloves are worn when exposure to blood and/or other body fluids , non intact skin or mucous membranes is anticipated or in line with SICP's and TBP's | programme in place<br>• Trust mask fit strategy<br>• SOP and training for reusable FFP3 masks<br>• SOP and training for use of air powered hoods<br>• Critical care - Elipse FFP3 reusable introduced<br>• 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<br>• Records held on L drive for those trained by the infection prevention team<br>• April 2021,Option now available to enter FFP3 training onto Health Rostering this captures the model of mask and date trained<br>• Test certificate must continue to be filed in personal folder and this is reiterated to mask fit tester. November 2021 wider spot checks commenced IP<br>• Health and Safety leading on portacount mask fit business case which has the potential to | |

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

| Control and Assurance Framework | | | |
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| Key Lines of Enquiry (KLOE) | Controls in Place | Assurance on Controls (Source, Timeframe and Outcome) | Gaps in Control or Assurance |
| available for all<br><br>• Hand hygiene facilities including instructional posters<br><br>• Good respiratory hygiene measures<br><br>• Staff maintain physical distancing of 1 metre or greater wherever possible in the workplace unless wearing PPE as part of direct care<br><br>• 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<br><br>• Frequent decontamination of equipment and environment in both clinical and non-clinical areas<br><br>• clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas<br><br>• Staff regularly undertake hand hygiene and observe standard infection prevention precautions<br><br>• Guidance on hand hygiene, including drying should be clearly displayed in all public toilet | • Hand washing technique depicted on soap dispensers<br>• Social distance posters displayed throughout the Trust<br><br>• IP assurance visits<br>• Matrons visits to clinical areas<br><br>Recommendation that physical distancing should be at least 1 metre, increasing whenever feasible to2 metres across all health and care settings.<br><br>• Car sharing question forms part of OB investigation process<br>• Communications reminding staff re car sharing<br>• IP Q+A decontamination section<br>• COVID Q+A<br><br>• Wearing of mask posters displayed throughout the Trust<br>• Advise and videos' on the Trust internet page<br>• Hand hygiene posters /stickers | • Spot checks in the clinical area<br>• IP assurance visits<br><br>• Cleanliness audits<br>• IP environmental audits<br>• Quarterly audits conducted and held by the clinical areas<br>• Hand hygiene audits | |

| Control and Assurance Framework | | | | |
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| | Key Lines of Enquiry (KLOE) | Controls in Place | Assurance on Controls (Source, Timeframe and Outcome) | Gaps in Control or Assurance |
| | areas as well as staff areas | on dispenser display in public toilets | | |
| 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<br>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<br>• Dissolvable bags to transport uniforms home available for staff<br>• Communications /daily bulletin to remind staff not to travel to and from work in uniforms | • Clinical areas to monitor<br>• Reports of member of public reporting sighting of staff in uniform | |
| 6.10 | All staff understand the symptoms of Covid-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household displays any of the symptoms ( even if experiencing mild symptoms)<br><br>Update V 1.8<br>To monitor compliance and reporting for asymptomatic staff testing | • For any new absences employee should open and close their usual absence via Empactis system<br>• Symptom Advice available on Trust intranet<br>• Communications updated to reflect changing national guidance<br>• Staff report Lateral flow testing via the national route only | • Cluster /outbreak investigations | |
| 6.11 | All staff understand the symptoms of COVID-19 | • Communication /documents | • Cluster /outbreak investigations | |

| Control and Assurance Framework | | | | |
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| Key Lines of Enquiry (KLOE) | | Controls in Place | Assurance on Controls (Source, Timeframe and Outcome) | Gaps in Control or Assurance |
| | 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 | • Reminders on COVID bulletins Trust intranet<br>• Staff Lateral flow testing<br>• Communications updated to reflect changing national guidance | | |
| 6.12 | A rapid and continued response through on- going surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patient/individuals) | • ICNET surveillance system<br>• Reports<br>• Trust wide daily COVID Dashboard/report<br>• COVID -19 Tactical daily<br>• briefing | • COVID Dashboard<br>• COVID -19 Tactical daily briefing<br>• 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<br>• Reports<br>• RCA's are required for all Probable and Definite HAI Covid-19 cases | • Theme report IPCC<br>• 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<br>• Daily COVID reports of cases | • Outbreak investigation<br>• Outbreak minutes | |

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

# 7. Provide or secure adequate isolation facilities

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

| Control and Assurance Framework | | | | |
|---|---|---|---|---|
| Key Lines of Enquiry (KLOE) | | Controls in Place | Assurance on Controls (Source, Timeframe and Outcome) | Gaps in Control or Assurance |
| **Systems and processes are in place to ensure:** | | | | |
| 7.1 | Patients with possible or Covid-19 are isolated in appropriate facilities or designated areas where appropriate.<br><br>Restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff<br><br>Areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas<br><br>Update V 1.8<br>That clear advice is provided , and monitoring is carried out of inpatients compliance with wearing face masks ( particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their ( physical or mental ) care needs | • Hospital zoning in place<br>• Recovery and Restoration plans for the Trust –<br>• December 2020 –another increased wave of COVID 19<br>• COVID prevalence considered when zones identified<br>• Purple wards<br>• Blue COVID wards identified at both sites created during second wave<br>• Green wards for planned screened elective patients<br>• Recovery and Restoration plans<br>• Ward round guidance available on COVID 19 intranet page<br>• Patient are offered and encouraged to wear masks – stickers have been developed to record if patients are unable to | • June 2020 IP team to review patients that are found COVID positive and nursed in bay to ascertain compliance with pathway and IP control measures are in place Review pathways and identify themes which are presented at IPCC .<br>• Themes report to IPCC<br>• Inappropriate patient moves reported via Datix. Daily process Discuss at outbreak meetings as necessary | |

| Control and Assurance Framework | | | | |
|---|---|---|---|---|
| | Key Lines of Enquiry (KLOE) | Controls in Place | Assurance on Controls (Source, Timeframe and Outcome) | Gaps in Control or Assurance |
| | | wear masks | | |
| 7.2 | Patients with suspected or confirmed COVID -19 are isolated in appropriate facilities or designated areas where appropriate;<br><br>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.<br><br>Update V 1.8<br>On -going regular assessment of physical distancing an bed spacing, considering potential increases in staff to patient ratios and equipment needs ( dependent on clinical requirements)<br><br>Separation ins space and /or time is maintained between patients with and without suspected respiratory infection by appointment or clinic scheduling to reduce waiting times in receptions areas and avoid mixing of infectious and non-infectious patient<br><br>Patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where treatment cannot be deferred, their care is provided from services able to operate in a way which minimises the risk of spread of virus to other patients/individuals<br><br>Standard infection prevention precautions (SPIC's) are used at the point of care for patient who have been | • Areas agreed at COVID-19 tactical Group<br>• Restoration and Recovery plans<br><br>• QIA process<br><br>• Hospital zoning in place<br>• Pre Amms process<br>• IP Q+A isolation section | • Action log and papers submitted to COVID-19 tactical and Clinical Group | |

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

# 8 Secure adequate access to laboratory support as appropriate.

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

| Control and Assurance Framework | | | | |
|---|---|---|---|---|
| | Key Lines of Enquiry (KLOE) | Controls in Place | Assurance on Controls (Source, Timeframe and Outcome) | Gaps in Control or Assurance |
| **Systems and processes are in place to ensure:** | | | | |
| 8.1 | Testing is undertaken by competent and trained individuals.<br><br>• 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<br>• Swabbing training package in place and swabbing Champions identified<br>• 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.<br>• 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.<br><br>Linked NHSIE Key Action 7: Staff Testing: | • All patients that require an overnight stay are screened for COVID-19 on admission or pre admission if planned/elective surgery | • Empactis reporting<br>• Team Prevent systems<br>• Datix/adverse incidence reporting<br>• Cluster /outbreak investigation | |

| Control and Assurance Framework | | | |
|---|---|---|---|
| Key Lines of Enquiry (KLOE) | Controls in Place | Assurance on Controls (Source, Timeframe and Outcome) | Gaps in Control or Assurance |
| a) Twice weekly lateral flow antigen testing for NHS patient facing staff is implemented. Whilst lateral flow technology is the main mechanism for staff testing, this can continue to be used alongside PCR and LAMP testing.<br>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.<br><br>That all emergency patients are tested for COVID -19 and other respiratory infections appropriate on admission<br><br>Linked to NHSIE Key Action 8: Patient Testing:<br>a) All patients must be tested at emergency admission, whether or not they have symptoms.<br>b) Those with symptoms of Covid-19 must be retested at the point symptoms arise after admission.<br>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<br>d) All patients must be tested 48 hours prior | • Screening process in place for elective surgery and some procedures e.g. upper endoscopy<br>• Process in place for staff screening via empactis system and Team Prevent<br>• Patients who test negative are retested 4, day 6 and day 14 and weekly<br>• Patient who develop COVID symptoms are tested<br>• Staff screening instigated in outbreak areas<br>• 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<br>• 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<br>• All patient discharged to care setting as screened 48 hours prior to transfer/discharge<br>• Designated care setting in | procedures<br>• Report received by Deputy Chief Nurse on a daily basis with list of patients that are due for re screen. Clinical areas then contacted and prompt to re screen. Day 14 and weekly screening in place. | |

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

| Control and Assurance Framework | | | | |
|---|---|---|---|---|
| | Key Lines of Enquiry (KLOE) | Controls in Place | Assurance on Controls (Source, Timeframe and Outcome) | Gaps in Control or Assurance |
| | within their 14 day isolation period should be discharged to a designated care setting, where they should complete their remaining isolation.<br>Update V 1.8<br><br>There is an assessment of the need for a negative PCR and 3 days self-isolation before certain elective procedures on selected low risk patient who are fully vaccinated, asymptomatic, and not a contact of cases suspected/confirmed cases of COVID-19 within the last 10days. Instead these patients can take a lateral flow test ( LFT) on the day of the procedure as per national guidance | • UHNM continue with PCR testing pre operatively but are exploring using lateral flow tests for day case surgery | | |
| 8.3 | Screening for other potential infections takes place. | • Screening policy in place, included in the Infection Prevention Questions and Answers Manual<br>• MRSA Screening recommenced in May 2021 | • MRSA screening compliance<br>• Prompt to Protect audits completed by IP<br>• Spot check for CPE screening | |

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

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

| Control and Assurance Framework | | | | |
|---|---|---|---|---|
| | Key Lines of Enquiry (KLOE) | Controls in Place | Assurance on Controls (Source, Timeframe and Outcome) | Gaps in Control or Assurance |
| **Systems and processes are in place to ensure:** | | | | |
| 9.1 | Update V 1.8<br><br>The application of IP practices and monitored and that resources are in place to implement and measures adherence to good IP practice. This must include all care areas and all staff (permanent , agency and external contractors )<br><br>Staff are supported in adhering to all IPC policies, including those for other alert organisms.<br><br>Update V 1.8<br><br>Safe spaces for staff break areas/changing facilities are provided | • IP included in mandatory update<br>• Infection Prevention Questions and Answers manual with ICON on every desk top for ease of use<br>• Infection Prevention triage desk which provides advice and support to clinical areas<br>•<br><br>• Rest pods are in place<br>• Additional rest areas in place<br>• List of changing areas available on the Trust intranet | • IP audit programme<br>• Audits undertaken by clinical areas<br>• CEF audits recommenced Sept 2020<br>• Proud to care booklet audits recommenced Sept 2020<br>• Compliance with correct mask wearing and Doctors complaint with Bare Below the Elbow monitored via senior walk rounds of clinical areas | |
| 9.2 | Any changes to the PHE national guidance on PPE are quickly identified and effectively | • Notifications from NHS to Chief nurse/CEO | • 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 |
| | communicated to staff. | • IP team COVID lead checks Public Health England webpage daily ( Monday-Friday) for updates<br>• Changes raised at COVID clinical group which is held twice weekly<br>• Daily tactical group<br>• Incident control room established where changes are reported through<br>• Chief nurse updates<br>• Changes/update to staff are included in weekly Facebook live sessions<br>• COVID -19 intranet page<br>• 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<br>• 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).<br>This includes:<br>• Ensuring the waste is stored safely.<br>• Ensuring the waste is only transferred to an authorised carrier and disposer of the waste.<br>• Transferring a written description of the waste<br>• Using the permitted site code on all documentation.<br>• Ensuring that the waste is | |

| Control and Assurance Framework | | | | |
|---|---|---|---|---|
| Key Lines of Enquiry (KLOE) | | Controls in Place | Assurance on Controls (Source, Timeframe and Outcome) | Gaps in Control or Assurance |
| | | | disposed of correctly by the disposer.<br>• 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<br>• Stores extended opening hours<br>• PPE at clinical level stores in store rooms<br>• Donning and doffing stations at entrance to wards | • PPE availability agenda item on Tactical Group meeting | |

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

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

| Control and Assurance Framework | | | | |
|---|---|---|---|---|
| | Key Lines of Enquiry (KLOE) | Controls in Place | Assurance on Controls (Source, Timeframe and Outcome) | Gaps in Control or Assurance |
| **Systems and processes are in place to ensure:** | | | | |
| 10.1 | Update V 1.8<br><br>Staff seek advice when required from their Occupational l Health department/GP or employer as per their local policy<br><br>Update V 1.8<br>Bank, agency and locum staff follow the same deployment advice as permanent staff<br><br>Update V 1.8<br>Staff who are fully vaccinated against COVID-10 and are a close contact of a case of COVID-19 are able to return to work without the need to self isolate \9 see staff isolation : approach following updated government guidance)<br><br>Update V 1.8 | • All managers carry our risk assessment<br>• Process available on the COVID 19 Trust intranet page<br>• BAME risk assessment<br>• Young persons risk assessment<br>• Pregnant workers risk assessment<br>• Risk assessment to identify vulnerable workers<br><br>• Isolation tool available for staff on Trust intranet<br><br>• UHNM follow National guidance | • Risk assessment and temporary risk mitigation will be reported to the workforce bureau. To protect confidentiality individual risk assessments will not be requested as these should be kept in the employees personal file<br>• 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 |
| Staff understand and are adequately trained in safe systems of working including donning and doffing of PPE<br><br>Staff in 'at risk' groups are identified and managed appropriately, including ensuring their physical and psychological wellbeing is supported.<br><br>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<br><br>Update V 1.8<br>A risk assessment is carried for health and social care staff including pregnant and specific ethnic minority groups who may be a high risk of complications from respiratory infection such as influenza and severe illness from COVID -19<br><br>○ A discussion is had with employees who are in the at-risk groups: including those who are pregnant and specific ethnic minority groups;<br>○ That advice is available to all health and social care staff, including specific advice to those at risk from complications<br>○ Bank, Agency and locum staff who fall onto these categories should follow the same deployment advice as permanent staff<br>○ A risk assessment is required for health and social care staff at high risk of | • PPE donning and doffing videos available on the intranet<br>• PPE posters<br>• IP Q+A manual<br><br>• Staff risk assessment process already in place at UHNM<br>• Staff risk assessment information available on the Trust intranet page | • 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 |
| | complications, including pregnant staff | | | |
| 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<br><br>Staff who carryout fit testing training are trained and competent to do so<br><br>All staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used<br><br>A record of the fit test and result is given to and kept by the trainee and centrally within the organisation<br><br>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<br><br>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<br><br>Following consideration of reasonable adjustments e.g. respiratory hoods, personal re- | • Mask fit strategy in place<br>• Mask fit education pack<br>• SOP for reusable face masks and respiratory hoods in place<br>• PHE guidance followed for the use of RPE<br>• PPE poster available on the intranet<br>• Training records held locally<br>• Fit testers throughout the Trust<br><br>• Complete and issue Qualitative Face Fit Test Certificate<br><br>• Divisions hold records<br>• Option now available on Health roster to capture mask fit testing<br>• SOP for reusable face masks and respiratory hoods in place | • Training records for reusable masks<br>• Training records held locally<br>• FFP3 testing records now available on Health Rostering to record mask type and date and divisional mask fit compliance % monitored | |

| Control and Assurance Framework | | | | |
|---|---|---|---|---|
| | Key Lines of Enquiry (KLOE) | Controls in Place | Assurance on Controls (Source, Timeframe and Outcome) | Gaps in Control or Assurance |
| | usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal<br><br>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<br><br>Update V 1.8<br><br>A fit testing programme is in place for those who may need to wear respiratory protection<br><br>Staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection prevention precautions, including PPE and outlined in national guidance | • For staff groups that use Heather roster FFP3 mask fit testing details can be added as a skill to this system.<br><br>• Fit testing in place<br><br>• PPE requirement applicable to all staff , no exemptions for those who have recovered or received vaccination | | |
| 10.3 | Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the crossover of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance. | • Restore and Restorations plans | • Incidence process/Datix | |
| 10.4 | All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas. | • Social distancing tool kit available on COVID 19 intranet page<br>• Site circulation maps<br>• Keep your distance posters | • Social distance monitor walk round introduced Friday 5th June<br>• Social distance department 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 |
| | Health and care settings are COVID 19 secure workplaces as far as practical, that is that any work place risks are mitigated maximally for everyone<br><br>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. | • COVID-19 secure declaration<br>• Social distancing risk assessment guidance for managers presentation 5th June2020<br>• Meeting room rules<br>• Face masks for all staff commenced 15th June<br>• Visitor face covering<br>• COVID secure risk assessment process in place<br>• November 2020 – Car sharing instructions added to COVID Bulletin | • COVID-19 secure declarations | |
| 10.5 | Consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas. | • Social distancing tool kit<br>• Staff encouraged to keep to 2 metre rule during breaks<br>• Purpose build rooms for staff breaks in progress | • Social distance monitor walk rounds<br>• 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<br>• Work force bureau | |
| 10.7 | Staff who test positive have adequate information and support to aid their recovery and return to work.<br><br>Update V 1.8<br><br>Where there has been a breach in infection prevention procedures staff are reviewed by Occupational Health , who will<br><br>• Lead on the implementation of system | • Team Prevent available to offer guidance and treatment to staff presenting with onset of symptoms.<br>• Empactis line will first ask – is the absence related to coronavirus. To which the employee must say yes or no<br>• Once the absence is reported to the employees manger via email, the manager will categorise the absence type specified in the flow | • Via emapactis<br>• Staff queries' through workforce bureau or team prevent | |

| Control and Assurance Framework | | | | |
|---|---|---|---|---|
| | Key Lines of Enquiry (KLOE) | Controls in Place | Assurance on Controls (Source, Timeframe and Outcome) | Gaps in Control or Assurance |
| | to monitor for illness and absence<br>• Facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the health care workforce<br>• Lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19 | chart.<br>• Team prevent complete COVID 19 staff screening<br>• Areas where transmission has occurred are discussed at clinical group and relevant staff screening under an ILOG number is agreed.<br>• Flow charts of staff returning to work available on COVID 19 section of intranet | | |

| CURRENT PROGRESS RATING | | |
|---|---|---|
| B | Complete / Business as Usual | Completed: Improvement / action delivered with sustainability assured. |
| GA / GB | On Track | Improvement on trajectory either:<br>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:** | Public Trust Board | **Date:** | 6th April 2022 |
| **Report Title:** | UHNM Ockenden and Kirkup update and action plan | **Agenda Item:** | 10 |
| **Author:** | Donna Brayford, Quality and Risk Manager | | |
| **Executive Lead:** | Ann-Marie Riley, Chief Nurse | | |

## Purpose of Report

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

## Alignment with our Strategic Priorities

| | | | | | |
|---|---|---|---|---|---|
| **High Quality** | | **People** | | **Systems & Partners** | |
| **Responsive** | | **Improving & Innovating** | x | **Resources** | |

## Risk Register Mapping

| | | |
|---|---|---|
| 16432 | Covid 19 and Compliance with CNST Maternity Safety Actions | Extreme (15) |
| 13419 | Midwifery Safe Staffing | Extreme (16) |

## Executive Summary

### Situation

This report provides an action plan update (table 1) of UHNM Maternity Services progress with the key recommendations of the Regional and KPMG feedback against the Immediate and Essential Actions of the Ockenden report published in December 2020 and a self- assessment against the Kirkup report recommendations (2015).

### Background

In June 2017 the then Secretary of State for Health and Social Care commissioned a review into maternity services at the Shrewsbury and Telford Hospital NHS Trust following concerns raised by bereaved families where babies or mothers had died or suffered serious harm whilst receiving care at that Trust. In December 2020 the Ockenden review reported its initial findings following 250 clinical reviews, which contained seven Immediate and Essential Actions ('IEAs') for all providers to take to assess the quality and safety of maternity services at local NHS providers, which encourages providers to increase partnership working through Local Maternity and Neonatal Systems ('LMNSs'), ensuring patient feedback is acted upon, and that risk assessments are undertaken at each contact throughout the maternity pathway. In addition, all providers have also been asked to re-visit gaps/actions as a result of the recommendations outlined in the Kirkup Report (2015).

### Assessment

**UHNM current compliance against the Immediate and Essential Actions of the Ockenden report are:**

100 % compliance
75 – 99 % compliance
0 – 75 % compliance

| Immediate and Essential Actions: | Original Regional Team Assessment October 2021: | Current Compliance March 2022: |
|---|---|---|
| IEA 1, Enhanced Safety | 81 % | 95 % |
| IEA 2, Listening to women | 88 % | 100 % |
| IEA 3, Staff training and working together | 91 % | 100 % |
| IEA 4, Managing complex pregnancy | 79 % | 100 % |
| IEA 5, Risk Assessment throughout Pregnancy | 47 % | 100 % |
| IEA 6, Monitoring fetal well-being | 83 % | 100 % |
| IEA 7, Informed Consent | 79 % | 100 % |
| Leadership and NICE Guidelines | 90 % | 100 % |
| Overall Compliance | 79.5 % | 99 % |

**UHNM Compliance against Kirkup Report (2015):**

| Recommendation: | UHNM Current Compliance: |
|---|---|
| R2 | 70 % |
| R3 | 100 % |
| R8 | 50 % |
| R11,12 | 100 % |
| R26 | 100 % |
| R31 | 100 % |
| R39 | 100 % |
| Overall Compliance | 86 % |

The ongoing assurance of compliance and sustainability of improvement will be supported by Regional Chief Midwives and their teams. These processes may include quality assurance visits but this process will be agreed and managed regionally – further information to follow on from this. Members of the national team may periodically choose to join regional visits/engage with the assurance processes.

## Key Recommendations

To receive this update report as assurance of progress towards achieving compliance with Ockenden and Kirkup Report.

**Table 1 UHNM Ockenden and Kirkup action plan**

| Recommendation | | Action | Action status | RAG status | Date for completion | Responsible | Completed date & evidence |
|---|---|---|---|---|---|---|---|
| 1 | **KPMG recommendation: Minimum required supporting documentation.** The Trust should maintain a clear log of outstanding documentation to ensure that all required documentation as set out by NHSI/E is collated, in order to be prepared for future submissions. | **1.1** Develop and maintain a data base of minimum required evidence against all the Immediate and Essential Actions.<br>**1.2** Develop an organogram to demonstrate how maternity services report the clinical maternity dashboard both internally and externally through the LMNS. | **1.1** Database developed.<br>**1.2** Standard Operating Procedures (SOP) developed; organogram included as an appendix currently being approved via governance process. | | **1.1** Completed and on-going.<br>**1.2** 31/08/21. | **1.1** Head of Midwifery (HoM) and **Quality** & Risk Manager.<br>**1.2 Quality** & Risk Manager. | **1.1** 31/07/21 Evidence database.<br>**1.2** 08/10/21 SOP with organogram. |
| 2. | **KPMG recommendation: Identifying gaps within self-assessment.** The Trust should update its self-assessment to ensure any missing documentation is identified as a "further action needed," with a corresponding action lead and due date.<br><br>As documentation is collated, these actions should be marked as complete in a timely manner in order to ensure the self-assessment is as up-to-date as possible at any given time. | **2.1** Identify evidence gaps within the self-assessment database.<br>**2.2** Develop a Maternity specific Serious Incident Report Summary to be received by the Trust Board.<br>The report should include key learning points, recommendations and actions taken to address with timescales for completion. | **2.1** Completed and on-going as additional reports received.<br>**2.2** Completed. | | **2.1** Completed and on-going.<br>**2.2** Completed and on-going. | **2.1** HoM and Quality & Risk Manager.<br>**2.2** Quality & Risk Manager. | **2.1** July 2021 – on-going.<br>**2.2** July 2021 Completed and regular agenda items at respective forums. |

| Recommendation | | Action | Action status | RAG status | Date for completion | Responsible | Completed date & evidence |
|---|---|---|---|---|---|---|---|
| 3. | **KPMG recommendation: Team resilience.**<br>The Trust should consider adding an additional layer of support to the Director of Midwifery and Quality & Risk Manager (Maternity), to ensure that there is always adequate personnel in place to act as a main point of contact for any queries in relation to the Ockenden submission. | **3.1** Recruit an Ockenden project lead. | **3.1** HoM emailed Director of PMO and Transformation to establish the feasibility of project support from within UHNM.<br>Ockenden Lead role part of workforce plan. | | **3.1** 31/05/22. | **3.1** Director of Midwifery (DoM). | **3.1** |
| 4. | **KPMG recommendation: Update of Standard Operating Procedures (SOPs).**<br>The Trust should update its SOPs to ensure it is in line with the minimum requirements set out by NHSI/E (maternal medicine pathways).<br>Going forwards, SOPs should be reviewed on an annual basis and any amendments should be verified by the relevant Executive Group. | **4.1** UHNM to develop a Maternal Medicine SOP that includes referral to the maternal medicine centre pathway.<br>UHNM are part of the West Midlands Maternal Medicine Network working towards being a hub and bespoke model of care.<br>**4.2** SOPs in Obstetrics & Gynaecology (O&G) are developed and updated in accordance with UHNM governance process. | **4.1** SOP to be developed once model of care developed.<br>**4.2** No further action required. | | **4.1** 30/7/22.<br>**4.2** No action required. | **4.1** Consultant Obstetric Lead maternal medicine Clinical Director. | **4.1**<br>**4.2** No action required. |
| 5. | **KPMG recommendation: Performance review of Lead Midwives and Lead Obstetricians for fetal monitoring.**<br>The Trust should update job plans for key senior maternity staff to ensure that it reflects the key requirements as per IEA6. Additionally, the Trust should implement a formal | **5.1** Job descriptions for both roles to reflect the key requirements of Ockenden (these reflect the recommendations of the Saving Babies Lives Car Bundle) and include a formal feedback mechanism as part of the appraisal process. | **5.1** Review job descriptions to ensure that they reflect the key requirements. All UHNM appraisals included a discussion relating to the employees current role. | | **5.1** 31/07/21 | **5.1** HoM Clinical Director. | **5.1** 31/07/21<br>Job descriptions<br>Outcomes of appraisals. |

| Recommendation | | Action | Action status | RAG status | Date for completion | Responsible | Completed date & evidence |
|---|---|---|---|---|---|---|---|
| | feedback mechanism as part of the appraisal process is identified for these roles, as this would provide further assurance that these responsibilities are being carried out effectively. | | | | | | |
| 6 | **Regional Feedback:**<br>**IEA 1 Q3.**<br>Maternity Serious Incidents are presented to the Trust Board & LMNS every 3 months. | **6.1** Develop a SOP to demonstrate how Maternity Serious Incidents are presented to the Trust Board & Local Maternity and Neonatal System every 3 months. | **6.1** SOP developed and process in place. | | **6.1** 31/01/2022 | **6.1** Quality &Risk Manager. | **6.1** 31/1/22<br>New SOP developed. |
| 7 | **Regional Feedback:**<br>**IEA 1 Q7.**<br>Plan to implement the Perinatal Clinical Quality Surveillance Model. | **7.1** Implement the Perinatal Clinical Quality Surveillance Model.<br>**7.2** Develop a LMNS SOP that describe how this is embedded in the ICS governance structure and signed off by the ICS. | **7.1** Gap Analysis against the Perinatal Quality Surveillance Model completed.<br>**7.2** SOP completed in draft.<br>ICS Structure not yet embedded. | | **7.1** 31/01/2022<br>**7.2** 31/05/2022 | **7.1** Quality & Risk Team.<br>**7.2** LMNS Quality and Safety Lead Midwife. | **7.1** Completed UHNM compliant with all provider actions.<br>**7.2** |
| 8 | **Regional Feedback:**<br>**IEA 2 Q14.**<br>Trust safety champions meeting bimonthly with Board level champions. | **8.1** Revise Maternity Safety Champion Meeting Agenda and Terms of Reference.<br>**8.2** Develop a SOP that includes role descriptors for all key members who attend by-monthly safety meetings.<br>**8.3** LMNS to receive Safety Champion feedback. | **8.1** Maternity Champion Meeting Structure/ Agenda / Terms of Reference revised.<br>**8.2** SOP that includes role descriptors for all key members who attend by-monthly safety meetings completed.<br>**8.3** Currently, LMNS receive Safety Champion feedback from the maternity dashboard. | | **8.1** Completed.<br>**8.2** 31/01/2022.<br>**8.3** Completed. | **8.1/8.2/8.3**<br>Quality & Risk Manager. | **8.1** Completed.<br>**8.2** Completed.<br>**8.3** Completed. |
| 9 | **Regional Feedback:**<br>**IEA 3 Q19.**<br>External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only. | **9.1** Provide evidence from the Director of Finance.<br>**9.2** Provide evidence that additional external funding has been spent on funding including staff can | **9.1** Evidence obtained from Director of Finance.<br>**9.2** Evidence Obtained from Quality & Risk Training Team. | | **9.1** 31/01/2022.<br>**9.2** 31/01/2022. | **9.1** Directorate Manager.<br>**9.2** Directorate Manager. | **9.1** Completed.<br>**9.2** Completed. |

| Recommendation | | Action | Action status | RAG status | Date for completion | Responsible | Completed date & evidence |
|---|---|---|---|---|---|---|---|
| | | attend training in work time. | | | | | |
| 10 | **Regional Feedback:**<br>**IEA 4 Q28.**<br>All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. | **10.1** Develop a SOP that states women with complex pregnancies must have a named consultant lead. | **10.1** SOP developed by Outpatient Matron and Ante-Natal Clinic Manager | | **10.1** 31/01/2022. | **10.1** Outpatient Manager. | **10.1** Completed. |
| 11 | **Regional Feedback:**<br>**IEA 4 Q29.**<br>Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres. | **11.1** Develop agreed pathways.<br>**11.2** Develop criteria for referral to Maternal Medicine Centre. | **11.1** Pathway to be agreed.<br>**11.2** Criteria for referral to be developed. | | **11.1** 31/03/21.<br>**11.2** 31/03/21. | **11.1/11.2** Clinical Director and Lead Consultant Obstetrician for Maternal Medicine Centre. | **11.1**<br>**11.2** |
| 12 | **Regional feedback**<br>**IEA 5 Q30**<br>All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional.<br>**IEA 5 Q31.**<br>A risk assessment at every contact should include ongoing review and discussion of intended place of birth. | **12.1** Develop a SOP to describe and explain the process for a formal risk assessment at every antenatal contact.<br>**12.2** Develop electronic K2 wizard template. | **12.1** Inpatient and Outpatient SOP developed.<br>**12.2** K2 Wizard developed. | | **12.1** 31/01/2022.<br>**12.2** 30/11/2022. | **12.1/12.2** Inpatient and Outpatient Matron. | **12.1** Completed.<br>**12.2** Completed. |
| 13 | **Regional Feedback:**<br>**IEA 5 Q33.**<br>A risk assessment at every contact should include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place | **13.1** Personalised care and Support Plan should be in place.<br>**13.2** 5% audit should be in place to demonstrate compliance with PCSP. | **13.1** To be implemented as part of K2 update, 30/11/21.<br>**13.2** Completed quarterly. | | **13.1** 30/11/2021.<br>**13.2** Completed quarterly. | **13.1** Digital Midwife.<br>**13.2** Clinical auditor. | **13.1** Completed.<br>**13.2** Completed. |

| Recommendation | | Action | Action status | RAG status | Date for completion | Responsible | Completed date & evidence |
|---|---|---|---|---|---|---|---|
| | to assess PCSP compliance. | | | | | | |
| 14 | **Regional Feedback:**<br>**IEA 6 Q34.**<br>Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring. | **14.1** Review job descriptions to include:<br>- Incident investigations and reviews.<br>- Improving the practice & raising the profile of fetal wellbeing monitoring.<br>- Keeping abreast of developments in the field. | **14.1** Job description updated. | | **14.1** 31/07/2021. | **14.1** DoM and Quality& Risk Manager. | **14.1** Completed 31/7/21. |
| 15 | **Regional Feedback:**<br>**IEA 7 Q41.**<br>Women must be enabled to participate equally in all decision-making processes. | **15.1** Share CQC report and action plan. | **15.1** Evidence available of action plans. | | **15.1** Completed yearly. | **15.1** DOM and Quality & Risk Manager. | **15.1** Completed yearly. |
| 16 | **Regional Feedback:**<br>**IEA 7 Q42.**<br>Women's choices following a shared and informed decision-making process must be respected. | **16.1** Develop a SOP to demonstrate how women's choices are respected and how this is evidenced following a shared and informed decision-making process, and where that is recorded. | **16.1** All SOPs relating to completion of the maternity information system (electronic patient record) are located on the staff intranet and include how and where to record discussion, decision making and information given regarding women's preferences and choices. | | **16.1** 31/12/2021 | **16.1** Professional Midwifery Advocate (PMA). | **16.1** Completed. |
| 17 | **Regional Feedback:**<br>**IEA 7 Q44.**<br>Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. | **17.1** To co-produce an action plan to address gaps identified | **17.1** Action plan developed with the Maternity Voice Partnership (MVP). | | **17.1** 31/01/2022. | **17.1** Professional Midwifery Advocate (PMA). | **17.1** Completed 2021. |
| 18 | **Regional Feedback:**<br>**Work Force Q48**<br>Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for | **18.1** To develop a manifesto where action not met. | **18.1** Action Plan not required<br>All manifesto met. | N/A | **18.1** 31/01/2022 | **18.1** HoM | **18.1** Action Plan not required. |

| Recommendation | | Action | Action status | RAG status | Date for completion | Responsible | Completed date & evidence |
|---|---|---|---|---|---|---|---|
| | better maternity care. | | | | | | |
| 19 | **Self-Assessment: Kirkup Recommendations R2.** Review the current induction programme for locum doctors.<br><br>Review the current provision of education and training for locum doctors with the aim of introducing streamlined bespoke training for this group. | **19.1** Review the current induction programme for locum doctors.<br>**19.2** Review the current provision of education and training for locum doctors with the aim of introducing streamlined bespoke training for this group. | **19.1** To be completed.<br>**19.2** To be completed. | | **19.1/19.2** 31/5/22 | **19.1/19.2** Directorate Manager and Clinical Director. | **19.1**<br>**19.2** |
| 20 | **Self-Assessment: Kirkup Recommendations R2.** Review the educational opportunities available for staff working in postnatal areas to increase their understanding of the compromised neonate, including consideration of bespoke educational sessions and HEI courses e.g. Care of the compromised baby module at University of Salford. | **20.1** Clinical Education Team to obtain information and costings on Care of the Compromised baby module at University of Salford and identify staff for training. | **20.1** To be completed. | | **20.1** 31/5/22. | **20.1** Clinical Educator. | **20.1** |
| 21 | **Self-Assessment: Kirk up Recommendations R8.** Develop and implement a recruitment and retention strategy specifically for the obstetric directorate. | **21.1** Develop and implement a recruitment and retention strategy specifically for the obstetric directorate. | **21.1** To be completed. | | **21.1** 31/5/22 | **21.1** Clinical Retention Lead Midwife and DoM. | **21.1** |

**Kirkup report recommendations**
**Regional Update 31st December 2021**

**Those that are greyed out are superseded by Ockenden and do not need completing on this tab.**

| | | | | Staffordshire |
|---|---|---|---|---|
| **Kirkup Action no.** | **Relating to Kirkup Recommendation (see Kirkup Recommendations tab for further information)** | **Action** | **Suggested documents that may support Trust assurance.** | **UNIVERSITY HOSPITALS OF NORTH MIDLANDS** |
| **5** | **R2** | Review the current preceptorship programme | Midwives/ Nurses are allocated a buddy in each clinical area and that this is supported by the clinical team. | |
| | | | The buddy midwife is allocated time to support the preceptee | |
| | | | Midwives are supported throughout the programme, progress is monitored and there is a clear plan developed for any midwife that is struggling to | |
| | | | Midwives are confident and competent to go through the gateway within the agreed timeframe | |
| **6** | **R2** | Obtain feedback from midwives and nurses who have recently completed a preceptorship programme to identify any improvements that can be made to the programme | Utilise PMA feedback | |
| **7** | **R2, R3** | Review the skills of Band 6 midwives to identify and address any training needs to ensure a competent and motivated workforce | Develop a robust support package for new band 6 midwives | |
| | | | Completion of the Mentoring module | |
| | | | Suturing competency | |
| | | | IV therapy competency | |
| | | | Care of women choosing epidural anaesthesia. | |
| **8** | | Review the current induction and orientation process for midwives and nurses joining the organisation at Band 6 to ensure they are competent and confident to provide care | Practice educator reports and feedback | |
| **9** | **R2** | Review the current induction programme for locum doctors | Locum policies | |
| **10** | | Review the current provision of education and training for locum doctors with the aim of introducing streamlined bespoke training for this group. | | |
| **11** | **R2** | Review the provision of maternal AIMS courses and ensure that all places are allocated appropriately and staff attend the session. | Practice educator meeting notes, discussion with DoMS/HoMs | |
| **12** | **R2** | Review the educational opportunities available for staff working in postnatal areas to increase their understanding of the compromised neonate, including consideration of bespoke educational sessions and HEI courses e.g. Care of the compromised baby module at University of Salford | Practice educator reports and feedback | |
| **13** | **R2** | Improve staff knowledge, response time and escalation processes in relation to a woman's deteriorating condition | Incident review and feedback, related lessons learnt, training opportunities | |
| **14** | **R2** | Implement a process for cascading learning points generated from incidents or risk management in each clinical area e.g. email to staff, noticeboard, themed week / message of the week, core huddles, NICU news | | |
| **15** | **R3** | Review the current process for staff rotation to ensure that a competent workforce is maintained in all clinical areas. | | |

| Kirkup Action no. | Relating to Kirkup Recommendation (see Kirkup Recommendations tab for further information) | Action | Suggested documents that may support Trust assurance. | UNIVERSITY HOSPITALS OF NORTH MIDLANDS |
|---|---|---|---|---|
| **17** | **R3** | Review the support provided when staff are allocated to a new clinical area and what supernumerary actually means in order to manage staff expectations | | |
| **20** | **R8** | Develop and implement a recruitment and retention strategy specifically for the obstetric directorate | | |
| **22** | | Ensure that all staff who leave are offered an exit interview with a senior member of staff and use the information gained from these interviews to inform changes aimed at improving retention | | |
| **23** | | Provide Staff Forum meetings where staff are encouraged to attend and discuss concerns | | |
| **24** | **Only applicable to multi-site trusts.** | Improve working relationships between the different sites located geographically apart but under the same organization. | | |
| **26** | **R11, R12** | Ensure that staff receive education during their induction regarding the incident reporting process including the process for reporting incidents, the incidents that should be reported and the rationale for learning from incidents. | | |
| **28** | | Ensure that staff undertaking incident investigations have received appropriate education and training to undertake this effectively | All consultants to have completed RCA training | |
| | | | Identified midwives to have completed RCA training | |
| | | | Staff who have completed RCA training undertake an investigation within 1 | |
| | | | Develop a local record of staff who have completed RCA training and the | |
| **36** | **R26** | Ensure that all staff are aware of how to raise concerns | Whistle blowing staff policy | |
| **37** | **R31** | Provide evidence of how we deal with complaints | | |
| **38** | **R31** | Educate staff regarding the process for local resolution and support staff to undertake this process in their clinical area | Identifying situations where local resolution is required | |
| **41** | **R39** | Ensure that Confidential Enquiry reports are reviewed following publication and that an action plan is developed and monitored to ensure that high standards of care are maintained | MBRRACE action plan | |

**Ockenden Inital report reccomendations**
**Results of Regional Update January 22**

| | | | | Staffordshire | Staffordshire |
|---|---|---|---|---|---|
| **IEA** | **Question** | **Action** | **Evidence Required** | **UNIVERSITY HOSPITALS OF NORTH MIDLANDS** | **UNIVERSITY HOSPITALS OF NORTH MIDLANDS - UPDATED MARCH 2022** |
| **IEA1** | **Q1** | Maternity Dashboard to LMS every 3 months | Dashboard to be shared as evidence. | 100% | 100% |
| | | | Minutes and agendas to identify regular review and use of common data dashboards and the response / actions taken. | 100% | 100% |
| | | | SOP required which demonstrates how the trust reports this both internally and externally through the LMS. | 100% | 100% |
| | | | Submission of minutes and organogram, that shows how this takes place. | 100% | 100% |
| | | **Maternity Dashboard to LMS every 3 months Total** | | 100% | 100% |
| | **Q2** | External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death | Audit to demonstrate this takes place. | 100% | 100% |
| | | | Policy or SOP which is in place for involving external clinical specialists in reviews. | 100% | 100% |
| | | **External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death Total** | | 100% | 100% |
| | **Q3** | Maternity SI's to Trust Board & LMS every 3 months | Individual SI's, overall summary of case, key learning, recommendations made, and actions taken to address with clear timescales for completion | **100%** | **100%** |
| | | | Submission of private trust board minutes as a minimum every three months with highlighted areas where SI's discussed | **100%** | **100%** |
| | | | Submit SOP | **0%** | **100%** |
| | | **Maternity SI's to Trust Board & LMS every 3 months Total** | | **67%** | **100%** |
| | **Q4** | Using the National Perinatal Mortality Review Tool to review perinatal deaths | Audit of 100% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review. | **100%** | **100%** |
| | | | Local PMRT report. PMRT trust board report. Submission of a SOP that describes how parents and women are involved in the PMRT process as per the PMRT guidance. | 100% | 100% |
| | | **Using the National Perinatal Mortality Review Tool to review perinatal deaths Total** | | 100% | 100% |
| | **Q5** | Submitting data to the Maternity Services Dataset to the required standard | Evidence of a plan for implementing the full MSDS requirements with clear timescales aligned to NHSR requirements within MIS. | 100% | 100% |
| | | **Submitting data to the Maternity Services Dataset to the required standard Total** | | 100% | 100% |
| | **Q6** | Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme | Audit showing compliance of 100% reporting to both HSIB and NHSR Early Notification Scheme. | 100% | 100% |
| | | **Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme Total** | | **100%** | 100% |
| | **Q7** | Plan to implement the Perinatal Clinical Quality Surveillance Model | Full evidence of full implementation of the perinatal surveillance framework by June 2021. | **0%** | **100%** |
| | | | LMS SOP and minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS. | **0%** | **0%** |
| | | | Submit SOP and minutes and organogram of organisations involved that will support the above from the trust, signed of via the trust governance structure. | 100% | 100% |
| | | **Plan to implement the Perinatal Clinical Quality Surveillance Model Total** | | 33% | 66% |
| **IEA1 Total** | | | | 81% | 95% |
| | | | Evidence of how all voices are represented: | 100% | 100% |
| | | | Evidence of link in to MVP; any other mechanisms | 100% | 100% |

| IEA | Question | Action | Evidence Required | UNIVERSITY HOSPITALS OF NORTH MIDLANDS | UNIVERSITY HOSPITALS OF NORTH MIDLANDS - UPDATED MARCH 2022 |
|---|---|---|---|---|---|
| IEA2 | Q11 | Non-executive director who has oversight of maternity services | Evidence of NED sitting at trust board meetings, minutes of trust board where NED has contributed | 100% | 100% |
| | | | Evidence of ward to board and board to ward activities e.g. NED walk arounds and subsequent actions | 100% | 100% |
| | | | Name of NED and date of appointment | 100% | 100% |
| | | | NED JD | 100% | 100% |
| | | **Non-executive director who has oversight of maternity services Total** | | 100% | 100% |
| | Q13 | Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services | Clear co-produced plan, with MVP's that demonstrate that co production and co-design of service improvements, changes and developments will be in place and will be embedded by December 2021. | **100%** | **100%** |
| | | | Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps) | **100%** | **100%** |
| | | | Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP. | **100%** | **100%** |
| | | **Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services Total** | | **100%** | **100%** |
| | Q14 | Trust safety champions meeting bimonthly with Board level champions | Action log and actions taken. | **100%** | **100%** |
| | | | Log of attendees and core membership. | **100%** | **100%** |
| | | | Minutes of the meeting and minutes of the LMS meeting where this is discussed. | **0%** | **100%** |
| | | | SOP that includes role descriptors for all key members who attend by-monthly safety meetings. | **0%** | **100%** |
| | | **Trust safety champions meeting bimonthly with Board level champions Total** | | **50%** | **100%** |
| | Q15 | Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. | Clear co produced plan, with MVP's that demonstrate that co-production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021. | **100%** | **100%** |
| | | **Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. Total** | | 100% | 100% |
| | Q16 | Non-executive director support the Board maternity safety champion | Evidence of participation and collaboration between ED, NED and Maternity Safety Champion, e.g. evidence of raising issues at trust board, minutes of trust board and evidence of actions taken | 100% | 100% |
| | | | Name of ED and date of appointment | 100% | 100% |
| | | | Role descriptors | 100% | 100% |
| | | **Non-executive director support the Board maternity safety champion Total** | | 100% | 100% |
| **IEA2 Total** | | | | 88% | 100% |
| | Q17 | Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year. | A clear trajectory in place to meet and maintain compliance as articulated in the TNA. | 100% | 100% |
| | | | LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. | 100% | 100% |
| | | | Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session. | 100% | 100% |

| IEA | Question | Action | Evidence Required | UNIVERSITY HOSPITALS OF NORTH MIDLANDS | UNIVERSITY HOSPITALS OF NORTH MIDLANDS - UPDATED MARCH 2022 |
|---|---|---|---|---|---|
| IEA3 | Q17 | | Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements. | 100% | 100% |
| | | | Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. | 100% | 100% |
| | | **Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year. Total** | | **100%** | **100%** |
| | Q18 | Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward. | Evidence of scheduled MDT ward rounds taking place since December, twice a day, day & night. 7 days a week (e.g. audit of compliance with SOP) | **100%** | **100%** |
| | | | SOP created for consultant led ward rounds. | **100%** | **100%** |
| | | **Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward. Total** | | **100%** | **100%** |
| | Q19 | External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only | Confirmation from Directors of Finance | **0%** | **100%** |
| | | | Evidence from Budget statements. | **100%** | **100%** |
| | | | Evidence of funding received and spent. | **100%** | **100%** |
| | | | Evidence that additional external funding has been spent on funding including staff can attend training in work time. | **0%** | **100%** |
| | | | MTP spend reports to LMS | **100%** | **100%** |
| | | **External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only Total** | | **60%** | **100%** |
| | Q21 | 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session | A clear trajectory in place to meet and maintain compliance as articulated in the TNA. | **100%** | **100%** |
| | | | Attendance records - summarised | **100%** | **100%** |
| | | | LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. | **100%** | **100%** |
| | | **90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session Total** | | 100% | 100% |
| | Q22 | Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. | Evidence of scheduled MDT ward rounds taking place since December 2020 twice a day, day & night; 7 days a week (E.G audit of compliance with SOP) | 100% | 100% |
| | | **Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. Total** | | **100%** | **100%** |
| | Q23 | The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place | A clear trajectory in place to meet and maintain compliance as articulated in the TNA. | **100%** | **100%** |
| | | | LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation described as checking the accuracy of the data. | **100%** | **100%** |
| | | **The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place Total** | | **100%** | **100%** |
| **IEA3 Total** | | | | **89%** | **100%** |
| | Q24 | Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre | Audit that demonstrates referral against criteria has been implemented that there is a named consultant lead, and early specialist involvement and that a Management plan that has been agreed between the women and clinicians | **100%** | **100%** |
| | | | SOP that clearly demonstrates the current maternal medicine pathways that includes: agreed criteria for referral to the maternal medicine centre pathway. | **100%** | **100%** |

| IEA | Question | Action | Evidence Required | UNIVERSITY HOSPITALS OF NORTH MIDLANDS | UNIVERSITY HOSPITALS OF NORTH MIDLANDS - UPDATED MARCH 2022 |
|---|---|---|---|---|---|
| IEA4 | | **Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre Total** | | **100%** | **100%** |
| | **Q25** | Women with complex pregnancies must have a named consultant lead | Audit of 1% of notes, where all women have complex pregnancies to demonstrate the woman has a named consultant lead. | **100%** | **100%** |
| | | | SOP that states that both women with complex pregnancies who require referral to maternal medicine networks and women with complex pregnancies but who do not require referral to maternal medicine network must have a named consultant lead. | **100%** | **100%** |
| | | **Women with complex pregnancies must have a named consultant lead Total** | | **100%** | **100%** |
| | **Q26** | Complex pregnancies have early specialist involvement and management plans agreed | Audit of 1% of notes, where women have complex pregnancies to ensure women have early specialist involvement and management plans are developed by the clinical team in consultation with the woman. | **100%** | **100%** |
| | | | SOP that identifies where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the teams. | 100% | 100% |
| | | **Complex pregnancies have early specialist involvement and management plans agreed Total** | | 100% | 100% |
| | **Q27** | Compliance with all five elements of the Saving Babies' Lives care bundle Version 2 | Audits for each element. | 100% | 100% |
| | | | Guidelines with evidence for each pathway | 100% | 100% |
| | | | SOP's | 100% | 100% |
| | | **Compliance with all five elements of the Saving Babies' Lives care bundle Version 2 Total** | | 100% | 100% |
| | **Q28** | All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. | SOP that states women with complex pregnancies must have a named consultant lead. | 0% | 100% |
| | | | Submission of an audit plan to regularly audit compliance | 100% | 100% |
| | | **All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. Total** | | 50% | 100% |
| | **Q29** | Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres | Agreed pathways | 0% | 100% |
| | | | Criteria for referrals to MMC | 0% | 100% |
| | | | The maternity services involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs. | 100% | 100% |
| | | **Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres Total** | | 33% | 100% |
| **IEA4 Total** | | | | 79% | 100% |
| | | All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional | How this is achieved within the organisation. | 0% | 100% |
| | | | Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above. | 100% | 100% |
| | | | Review and discussed and documented intended place of birth at every visit. | 0% | 100% |

| IEA | Question | Action | Evidence Required | UNIVERSITY HOSPITALS OF NORTH MIDLANDS | UNIVERSITY HOSPITALS OF NORTH MIDLANDS - UPDATED MARCH 2022 |
|---|---|---|---|---|---|
| IEA5 | Q30 | appropriately trained professional | SOP that includes definition of antenatal risk assessment as per NICE guidance. | 100% | 100% |
| | | | What is being risk assessed. | 0% | 100% |
| | | **All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional Total** | | 40% | 100% |
| | Q31 | Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture. | Evidence of referral to birth options clinics | 100% | 100% |
| | | | Out with guidance pathway. | 100% | 100% |
| | | | Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above. | 100% | 100% |
| | | | SOP that includes review of intended place of birth. | 0% | 100% |
| | | **Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture. Total** | | 75% | 100% |
| | Q33 | A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance. | Example submission of a Personalised Care and Support Plan (It is important that we recognise that PCSP will be variable in how they are presented from each trust) | 100% | 100% |
| | | | How this is achieved in the organisation | 0% | 100% |
| | | | Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above. | 0% | 100% |
| | | | Review and discussed and documented intended place of birth at every visit. | 0% | 100% |
| | | | SOP to describe risk assessment being undertaken at every contact. | 100% | 100% |
| | | | What is being risk assessed. | 0% | 100% |
| | | **A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance. Total** | | 33% | 100% |
| **IEA5 Total** | | | | 47% | 100% |
| | Q34 | Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring | Copies of rotas / off duties to demonstrate they are given dedicated time. | 100% | 100% |
| | | | Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs. | 100% | 100% |
| | | | Incident investigations and reviews | 0% | 100% |
| | | | Name of dedicated Lead Midwife and Lead Obstetrician | 100% | 100% |
| | | **Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring Total** | | 75% | 100% |
| | | | Consolidating existing knowledge of monitoring fetal wellbeing | 100% | 100% |

| IEA | Question | Action | Evidence Required | UNIVERSITY HOSPITALS OF NORTH MIDLANDS | UNIVERSITY HOSPITALS OF NORTH MIDLANDS - UPDATED MARCH 2022 |
|---|---|---|---|---|---|
| IEA6 | Q35 | The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health | Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g clinical supervision | 100% | 100% |
| | | | Improving the practice & raising the profile of fetal wellbeing monitoring | 0% | 100% |
| | | | Interface with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. | 100% | 100% |
| | | | Job Description which has in the criteria as a minimum for both roles and confirmation that roles are in post | 100% | 100% |
| | | | Keeping abreast of developments in the field | 0% | 100% |
| | | | Lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. | 100% | 100% |
| | | | Plan and run regular departmental fetal heart rate (FHR) monitoring meetings and training. | 100% | 100% |
| | | **The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health Total** | | 75% | 100% |
| | Q36 | Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? | Audits for each element | 100% | 100% |
| | | | Guidelines with evidence for each pathway | 100% | 100% |
| | | | SOP's | 100% | 100% |
| | | **Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? Total** | | 100% | 100% |
| | Q37 | Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019? | A clear trajectory in place to meet and maintain compliance as articulated in the TNA. | 100% | 100% |
| | | | Attendance records - summarised | 100% | 100% |
| | | | Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements. | 100% | 100% |
| | | **Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019? Total** | | 100% | 100% |
| **IEA6 Total** | | | | 83% | 100% |
| | Q39 | Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery | Information on maternal choice including choice for caesarean delivery. | 100% | 100% |
| | | | Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites. | 100% | 100% |
| | | **Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery Total** | | 100% | 100% |
| | Q41 | Women must be enabled to participate equally in all decision-making processes | An audit of 1% of notes demonstrating compliance. | 100% | 100% |
| | | | CQC survey and associated action plans | 0% | 100% |
| | | | SOP which shows how women are enabled to participate equally in all decision making processes and to make informed choices about their care. And where that is recorded. | 100% | 100% |
| | | **Women must be enabled to participate equally in all decision-making processes Total** | | 67% | 100% |

| IEA | Question | Action | Evidence Required | UNIVERSITY HOSPITALS OF NORTH MIDLANDS | UNIVERSITY HOSPITALS OF NORTH MIDLANDS - UPDATED MARCH 2022 |
|---|---|---|---|---|---|
| IEA7 | Q42 | Women's choices following a shared and informed decision-making process must be respected | An audit of 5% of notes demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction. | 100% | 100% |
| | | | SOP to demonstrate how women's choices are respected and how this is evidenced following a shared and informed decision-making process, and where that is recorded. | 0% | 100% |
| | | **Women's choices following a shared and informed decision-making process must be respected Total** | | 50% | 100% |
| | Q43 | Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services? | Clear co produced plan, with MVP's that demonstrate that co production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021. | 100% | 100% |
| | | | Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps) | 100% | 100% |
| | | | Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP. | 100% | 100% |
| | | **Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services? Total** | | 100% | 100% |
| | Q44 | Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. | Co-produced action plan to address gaps identified | 0% | 100% |
| | | | Gap analysis of website against Chelsea & Westminster conducted by the MVP | 100% | 100% |
| | | | Information on maternal choice including choice for caesarean delivery. | 100% | 100% |
| | | | Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites. | 100% | 100% |
| | | **Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. Total** | | 75% | 100% |
| **IEA7 Total** | | | | 79% | 100% |
| WF | Q45 | Demonstrate an effective system of clinical workforce planning to the required standard | Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan | 100% | 100% |
| | | | Evidence of reviews 6 monthly for all staff groups and evidence considered at board level. | 100% | 100% |
| | | | Most recent BR+ report and board minutes agreeing to fund. | 100% | 100% |
| | | **Demonstrate an effective system of clinical workforce planning to the required standard Total** | | 100% | 100% |
| | Q46 | Demonstrate an effective system of midwifery workforce planning to the required standard? | Most recent BR+ report and board minutes agreeing to fund. | 100% | 100% |
| | | **Demonstrate an effective system of midwifery workforce planning to the required standard? Total** | | 100% | 100% |
| | Q47 | Director/Head of Midwifery is responsible and accountable to an executive director | HoM/DoM Job Description with explicit signposting to responsibility and accountability to an executive director | 100% | 100% |
| | | **Director/Head of Midwifery is responsible and accountable to an executive director Total** | | 100% | 100% |

| IEA | Question | Action | Evidence Required | UNIVERSITY HOSPITALS OF NORTH MIDLANDS | UNIVERSITY HOSPITALS OF NORTH MIDLANDS - UPDATED MARCH 2022 |
|---|---|---|---|---|---|
| | Q48 | Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care: | Action plan where manifesto is not met | 0% | 100% |
| | | | Gap analysis completed against the RCM strengthening midwifery leadership: a manifesto for better maternity care | 100% | 100% |
| | | **Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care: Total** | | 50% | 100% |
| | Q49 | Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. | Audit to demonstrate all guidelines are in date. | 100% | 100% |
| | | | Evidence of risk assessment where guidance is not implemented. | 100% | 100% |
| | | | SOP in place for all guidelines with a demonstrable process for ongoing review. | 100% | 100% |
| | | **Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Total** | | 100% | 100% |
| **WF Total** | | | | 90% | 100% |

# Executive Summary

| | | | |
|---|---|---|---|
| **Meeting:** | Trust Board | **Date:** | 6th April 2022 |
| **Report Title:** | Maternity services workforce establishment | **Agenda Item:** | 10 |
| **Author:** | Lynn Dudley, Interim Head of Midwifery<br>Carla Bickley, Head of Business Development<br>Kathryn Kelter, Directorate Manager and Kelsey Chahal (costs) | | |
| **Executive Lead:** | Anne-Marie Riley, Chief Nurse. | | |

## Purpose of Report

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

## Alignment with our Strategic Priorities

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


## Risk Register Mapping

| | | |
|---|---|---|
| 13419 | Midwifery safe staffing | 16 (Extreme) |
| 11518 | Midwifery Continuity of Care | 15 (Extreme) |
| 15993 | Maternity triage | 15 (Extreme) |

## Executive Summary:

### Background

Following the publication of the reports of the University Hospitals of Morecambe Bay (2015), the Shrewsbury and Telford Hospital NHS Trust (2020) and the East Kent Hospitals University NHS Foundation Trust enquiry; maternity services are under intense scrutiny to provide significant assurance relating to how they are improving the safety of the care provided to mothers, babies and families.

UHNM Maternity Services provides care to approximately 6 500 women, babies and families. This report aims to provide the Obstetrics Directorate, CWD Division, the wider UHNM organisation and Trust Board what the maternity services workforce establishment needs to have in place to be able to deliver on time the evidence for assurance of compliance against multiple national reports.

An additional paper regarding the clinical midwifery workforce will be completed and presented following our clinical workforce establishment review by Birth Rate Plus. The establishment review is expected to commence before the end of 2021.

This report will:

- Outline the national maternity services publications that UHNM are required to respond to
- Provide a summary of our current position in terms of the workforce already in place to deliver the key recommendations of the national publications
- Identify what workforce establishment gaps we currently have
- Risk assess the impact of not having the required workforce establishment
- Recommend required establishment to ensure compliance and assurance

## Position

Following an in depth review of our current position and compliance assurance against the key national patient safety recommendations the following uplift in establishment is required.

| Role | Band | WTE | Funding requirement |
|---|---|---|---|
| **Bereavement Midwife** | 7 | 0.2 | £11,533 |
| **PMRT Lead Midwife** | 7 | 1.0 | £52,881 |
| **Lead Midwife Maternal and Newborn Screening lead required – new post** | 7 | 1.0 | £52,881 |
| **Digital Midwife – additional hours** | 7 | 0.2 | £10,576 |
| **Digital Midwife Support – new post** | 6 | 0.6 | £25,591 |
| **Project lead for CNST & Ockenden – new post** | 7 | 1.0 | £52,881 |
| **Smoke free pregnancy lead Midwife – new post** | 6 | 1.0 | £42,652 |
| **Maternity Support Worker Smoking Cessation** | 3 | 1.0 | £26,702 |
| **1 wte band 4 administration support for training – new post** | 4 | 0.6 | £18,419 |
| **1 wte Lead Midwife Clinical Guideline new post** | 7 | 1.0 | £52,881 |
| **Clinical audit lead – additional hours** | 5 | 0.2 | £6,885 |
| **Maternity Triage Midwife 24/7** | 6/7 | 5.4 | £269,476-£334,102 |
| **Midwife to receive telephone calls 24/7** | 6/7 | 5.4 | £269,476-£334,102 |
| **Continuity of Care lead/Low Risk (Consultant Midwife 8B / or 8A** | 8A/B | 1.0 | £60,335-£72,174 |
| **Pre-term birth midwife** | 7 | 0.6 | £31,729 |
| **TOTAL** | | **19.6** | **£984,898-£1,125,989** |
| **Maternity Pharmacist support Directorate Budget to be confirmed** | 8A | 0.5 | |

## Risks

The risks associated with not having the required workforce in place are:

**1.** Failure to provide the required assurance against the CNST Maternity Incentive Strategy 10 Safety Actions
**2.** Failure to provide the required assurance against Ockenden IAS
**3.** Failure to receive incentivised funding
**4.** Work related stress/burn out
**5.** Under resourced workforce with the potential for this to adversely affect retention and recruitment
**6**. Adverse publicity.

## Conclusion

This report outlines the required workforce establishment for maternity services to deliver the key patient safety recommendations and provide evidence and assurance both internally and externally in relation to compliance against multiple local, regional and national reports and recommendations.

There is currently a shortfall in budget and establishment of 19.6 WTE specialist, clinical and non-registrant roles therefore it is imperative that the organisation supports the funding and recruitment to these posts.

## Key Recommendations:

The Trust Board is asked to support the development of a business case for the additional funding required to ensure that maternity services are able to provide assurance of compliance against the national maternity drivers for patient safety.

# 1. Background

Following the publication of the reports of the University Hospitals of Morecambe Bay (2015), the Shrewsbury and Telford Hospital NHS Trust (2020) and the East Kent Hospitals University NHS Foundation Trust enquiry; maternity services are under intense scrutiny to provide significant assurance relating to how they are improving the safety of the care provided to mothers, babies and families.

UHNM Maternity Services provides care to approximately 6 500 women, babies and families. This report aims to provide the Obstetrics Directorate, CWD Division, the wider UHNM organisation and Trust Board

what the maternity services workforce establishment needs to have in place to be able to deliver on time the evidence for assurance of compliance against multiple national reports.

This report will:

- Outline the national maternity services publications that UHNM are required to respond to
- Provide a summary of our current position in terms of the workforce already in place to deliver the key recommendations of the national publications
- Identify what workforce establishment gaps we currently have
- Risk assess the impact of not having the required workforce establishment
- Recommend required establishment to ensure compliance and assurance

# 2. Key Publications and Requirements

### National Maternity Publications

UHNM Maternity Services are currently required to provide assurance against the recommendations of the following national publications:

- NHS Resolution Maternity Incentive Scheme year 4: 10 safety actions launched 9th August 2021 [2.1]
- Ockenden Report (2020) Immediate and Essential Actions [2.2]
    - KPMG, UHNM internal auditors recommendations following a local audit of assurance against the Ockendon report (July 2021)
- NHS England Better Births, (2016) [2.3]
- Public Health England and the UK National Screening Committee (UK NSC): Antenatal & Newborn Screening Programmes [2.4]
- UNICEF UK Baby Friendly Initiative (BFI) [2.5]
- RCM Strengthening midwifery leadership: a manifesto for better maternity care [2.6]
- NHS England/Improvement (June 2020) Four specific actions, to minimise the additional risk of COVID-19 for Black, Asian and minority ethnic women and their babies. [2.7]
- MBRRACE-UK (2021) Saving Lives, Improving Mothers' Care Rapid report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK June 2020-March 2021. [2.8]
- HSIB (2021) National Learning Report Intrapartum stillbirth: learning from maternity safety investigations that occurred during the COVID-19 pandemic, 1 April to 30 June 2020 [2.9]

## 2.1 Maternity Incentive Scheme (MIS) year 4: 10 Maternity Safety Actions

**MIS Safety action 1:** UHNM need to provide assurance that we are using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

**A Notification:**
i. UHNM must evidence that all perinatal deaths eligible to be notified to MBRRACE-UK from 1 September 2021 onwards are notified to MBRRACE-UK within two working days and the surveillance information where required is completed within one month of the death.

**A Perinatal Mortality Review Tool (PMRT):**
ii. UHNM must provide evidence that we are using the PMRT of 95% of all deaths of babies, suitable for review using the PMRT, from 8 August 2021 will have been started within two months of each death. This includes deaths after home births where care was provided by UHNM.

**B PMRT report**
UHNM must provide evidence that at least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died at UHNM, including home births, from 8 August 2021 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death

**C. Parental involvement:**
UHNM must provide evidence that for at least 95% of all deaths of babies who died at UHNM from 8 August 2021, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought

**D. Quarterly reports:**
UHNM must provide evidence that quarterly reports have been submitted to the Trust Board from 8 August 2021 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions

**MIS Safety action 2:** UHNM need to provide assurance that we are submitting data to the Maternity Services Data Set (MSDS) to the required standard?

**MIS Safety action 3:** UHNM need to provide assurance that we have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?

**MIS Safety action 4:** UHNM need to provide assurance that we have an effective system of clinical workforce planning to the required standard?

**MIS Safety action 5:** UHNM need to provide assurance that we have an effective system of midwifery workforce planning to the required standard?

**MIS Safety action 6:** UHNM need to provide assurance that we are compliant with all five elements of the Saving Babies' Lives care bundle version two. See Core Competency Framework below in safety action 8.

**MIS Safety action 7:** UHNM need to provide assurance that we have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?

**MIS Safety action 8:** UHNM need to provide assurance that we have a local training plan in place to ensure that all six core modules of the Core Competency Framework are included UHNM training programme over the next 3 years, starting from the launch of MIS year 4?
In addition, UHNM need to provide assurance that at least 90% of each relevant maternity unit staff groups has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4.

The Core Competency Framework has been developed in collaboration with national maternity and neonatal partner organisations including the Royal Colleges, Neonatal Critical Care CRG, HSIB, NMC and NHS Resolution, the Maternity Transformation Programme has led on the development of a Core Competency Framework to address known variation in training and competency assessment and ensure that training to address significant areas of harm are included as minimum core requirements for every maternity and neonatal service.

The Core Competency Framework modules are listed below.

**Saving Babies Lives Care Bundle: education and training in accordance with the 5 key elements**
This is MIS safety action number 6 (audits are also required against each element)

- Smoke free pregnancy.
    - NHS Long Term Plan: Prevention Programme; Maternity Tobacco Strategy
- Monitoring growth restriction
- Fetal movements
- Fetal monitoring ( see fetal surveillance in labour below)
- Pre-term birth

**Fetal surveillance in labour**
This is MIS safety action number 6

- Risk assessment throughout labour
- Fetal monitoring: Intermittent auscultation (IA)
- Fetal monitoring: Electronic Fetal Monitoring EFM)
- Use of local case histories

**Maternity emergencies and multi-professional training**
This is MIS safety action number 6

- Impacted Fetal head
- Pre-eclampsia/eclampsia severe hypertension
- Uterine Rupture
- Maternal resuscitation
- Vaginal breech birth
- Shoulder dystocia
    - Cord prolapse
    - The use of maternal critical care observation charts
    - Structured review proformas
    - Deterioration and escalation thresholds
- These training sessions should also cover an understanding of Covid-19 specific therapies in pregnancy and the importance of twice-daily multidisciplinary structured reviews to ensure comprehensive, multidisciplinary and coordinated care across different care settings.

**Personalised care**

Provision of education and training relating to:

- On-going antenatal and intrapartum risk assessment with a holistic view from a woman's personal perspective, offering her informed choice
- Maternal mental health
- Vulnerable women and families
    - social factors requiring referral
    - families with babies on NICU
- Bereavement care

**Care during labour and the immediate postnatal period**

Provision of education and training relating to:

- Management of labour
- VBAC and uterine rupture
- GBS in labour
- Management of epidural anaesthesia
- Operative vaginal birth: ROBuST (Operative vaginal Birth Simulation Training)
- Perineal Trauma: prevention of and obstetric anal sphincter injury (OASI) pathway
- Maternal Critical Care
- Recovery Care after general anaesthetic

**Neonatal life support**

Provision of education and training relating to:

- Identification of a baby requiring resuscitation after birth including:
    - Knowledge and understanding of the NLS algorithm
    - How to call for help within the organisation
- Situation, Background, Assessment Recommendation (SBAR) or equivalent communication tool handover on arrival of help
- Recognition of the deteriorating newborn infant with actions to be taken.

**Covid-19 specific training**

Provision of education and training relating to:

- Multi-professional training for all staff caring for pregnant & postpartum women with suspected or confirmed Covid-19.
- Women requiring maternal critical care.
- Triage of pregnant and postpartum women with mental health concerns.
- An overview of care principles, and individual susceptibility e.g. ethnicity, hypertension and diabetes**.**

**Training targeted at local learning**

UHNM training syllabus needs to be based on current evidence, national guidelines/recommendations, any relevant local audit findings, risk issues and case review feedback, and include the use of local charts, emergency boxes, algorithms and proformas. Delivery of the training requirements must also include consideration of human factors, local transfer processes and policies (hospital and community settings), use of locally agreed safety language and communication with women, families and staff, particularly where debrief is required as part of emergency scenario training.

There is a requirement that the local training faculty at UHNM should be multi-professional so that they are representative of the current maternity and neonatal teams. In addition to the midwifery educators, the Obstetric, Anaesthetics, Neonatology Directorates need to ensure that there is

protected time for obstetricians, neonatologists/paediatricians and anaesthetists to be able to support this local training.

In meeting the requirements of the Core Competency Framework, UHNM clinical teams will also need to take into account the need for training to be undertaken safely during COVID. The training content might need to be delivered remotely or digitally and should include fetal monitoring as well as standard emergencies to share and address learning from local maternity and neonatal outcomes.

**MIS Safety action 9:** UHNM need to provide assurance that we have robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

**MIS Safety action 10:** UHNM need to provide assurance that we have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22?

## 2.2 Ockenden Immediate and Essential Actions (IEA)

UHNM along with all NHS providers of maternity care are required to upload their evidence against the seven Immediate and Essential Actions (IEAs) listed below to a central portal. This will be an iterative process.

**IEA 1:** Enhanced Safety
**IEA 2:** Listening to Women and Families
**IEA 3:** Staff Training and Working Together
**IEA 4:** Managing Complex Pregnancy
**IEA 5:** Risk Assessment Throughout Pregnancy
**IEA 6:** Monitoring Fetal Wellbeing
**IEA 7:** Informed Consent

Evidence related to Workforce planning, Midwifery Leadership, NICE Guidance related to maternity is also required.

In addition to the evidence upload to the Ockenden portal UHNM also commissioned an internal audit by KPMG to establish local assurance against the Ockenden IEAs. UHNM maternity services were awarded significant assurance with minor improvement opportunities outlined below.

**KPMG recommendation 1: Minimum required supporting documentation**
The Trust should maintain a clear log of outstanding documentation to ensure that all required documentation as set out by NHSI/E is collated, in order to be prepared for future submissions.

**KPMG recommendation 2: Identifying gaps within self-assessment**
The Trust should update its self-assessment to ensure any missing documentation is identified as a "further action needed", with a corresponding action lead and due date.
As documentation is collated, these actions should be marked as complete in a timely manner in order to ensure the self-assessment is as up-to-date as possible at any given time.

**KPMG recommendation 3: Team resilience**
The Trust should consider adding an additional layer of support to the Head of Midwifery and Quality and Risk Manager Maternity, to ensure that there is always adequate personnel in place to act as a main point of contact for any queries in relation to the Ockenden submission.

**KPMG recommendation 4: Update of Standard Operating Procedures (SOPs)**
(i) The Trust should update its SOPs to ensure it is in line with the minimum requirements set out by NHSI/E (maternal medicine pathways)
(ii) Going forwards, SOPs should be reviewed on an annual basis and any amendments should be verified by the relevant Executive Group.

**KPMG recommendation 5: Performance review of Lead Midwives and Lead Obstetricians**
The Trust should update job plans for key senior maternity staff to ensure that it reflects the key requirements as per IEA6. Additionally, the Trust should implement a formal feedback mechanism

as part of the appraisal process is identified for these roles, as this would provide further assurance that these responsibilities are being carried out effectively.

## 2.3 Better Births

UHNM Maternity services in partnership with our Local Maternal and Neonatal System (LMNS) continue to implement the recommendations and actions of Better Births (2016).

1. **Personalised care** centred on the woman her baby and her family based around their needs and their decisions where they have genuine choice informed by unbiased information.
2. **Continuity of carer**, to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decisions
3. **Safer care**, with professionals working together across boundaries to ensure rapid referral, and access to the right care in the right place; leadership for a safety culture within and across organisations; and investigation, honesty and learning when things go wrong
4. **Better postnatal and perinatal mental health care,** to address the historic underfunding and provision in these two vital areas, which can have a significant impact on the life chances and wellbeing of the woman, baby and family.
5. **Multi-professional working,** breaking down barriers between midwives, obstetricians and other professionals to deliver safe and personalised care for women and their babies.
6. **Working across boundaries** to provide and commission maternity services to support personalisation, safety and choice, with access to specialist care whenever needed.
7. **A payment system** that fairly and adequately compensates providers for delivering high quality care to all women efficiently, while supporting commissioners to commission for personalisation, safety and choice.

## 2.4 Public Health England and the UK National Screening Committee (UK NSC): Antenatal & Newborn Screening Programmes

UHNM Maternity Services are required to produce an annual report for antenatal and postnatal screening programmes (listed below) that are conducted at the Trust. The annual report demonstrates compliance against the screening programmes standards. UHNM Maternity Services also have a PHE Quality Assurance inspection visit every three years. Data collection and production of the annual report is led by the Antenatal Clinic Manager and ANNB Screening Co-ordinator; this is currently 1 wte role.

**Antenatal and postnatal screening programmes**

- Sickle Cell and Thalassemia Screening Programme (SCT)
- Infectious Diseases in Pregnancy Screening Programme (IDPS)
- Fetal Anomaly Screening Programme (FASP)
- Newborn Blood Spot Screening Programme (NBS)
- Newborn Hearing Screening Programme (NHSP)
- Newborn and Infant Physical Examination Screening Programme (NIPE)
- Diabetic eye screening

## 2.5 UNICEF UK Baby Friendly Initiative (BFI)

UHNM Maternity Services are BFI accredited. To achieve this award several stages of compliance assurance have to be achieved

**Stage 1: Building a firm foundation**

- Have written policies and guidelines to support the standards

- Plan an education programme that will allow staff to implement the standards according to their role
- Have processes for implementing, auditing and evaluating the standards
- Ensure that there is no promotion of breastmilk substitutes, bottles, teats or dummies in any part of the facility or by any of the staff

**Stage 2: An educated workforce**

- Educate staff to implement the standards according to their role and the service provided

**Stage 3: Parents' experiences of Maternity services**

- Support pregnant women to recognise the importance of breastfeeding and early relationships for the health and wellbeing of their baby.
- Support all mothers and babies to initiate a close relationship and feeding soon after birth
- Enable mothers to get breastfeeding off to a good start
- Support mothers to make informed decisions regarding the introduction of food or fluids other than breastmilk
- Support parents to have a close and loving relationship with their baby

**Achieving UNICEF UK BFI sustainability**

UHNM Maternity Services must ensure that we provide the leadership, culture and monitoring needed to maintain and progress the standards over time.
As UHNM Maternity Services are fully accredited as Baby Friendly we can now consider going for Gold. The Award is designed as the next step for accredited services whose audit results consistently show
that the Baby Friendly standards are largely being met.

## 2.6 RCM Strengthening midwifery leadership: a manifesto for better maternity care

UHNM Maternity services must ensure that we implement the following key recommendations from the RCM seven steps to strengthen midwifery leadership

1. A Director of Midwifery in every trust and health board
2. Consultant midwives
3. Specialist midwives in every trust and health board
4. Strengthen and support sustainable midwifery leadership in education and research
5. A commitment to fund on-going midwifery leadership development
6. Professional input into the appointment of midwife leaders

## 2.7 NHS England/Improvement (2020): Perinatal support for Black, Asian and minority ethnic Women during the COVID-19 Pandemic.

The letter required maternity services to implement 4 actions.

1. Local Maternity Systems are asked to increase support for at-risk pregnant women
2. Reach out and reassure pregnant Black, Asian and minority ethnic women with tailored communications
3. Minimise the risk of Vitamin D insufficiency
4. Make sure maternity services are gathering the correct data

## 2.8 MBRRACE-UK (2021) Saving Lives, Improving Mothers' Care Rapid report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK June 2020-March 2021.

This recent publication detailed 17 recommendations for maternity services

## 2.9 HSIB 2021: National Learning Report Intrapartum stillbirth: learning from maternity safety investigations that occurred during the COVID-19 pandemic, 1 April to 30 June 2020

This recent publication detailed 8 recommendations for maternity services including
Safety recommendation R/2021/149:
HSIB recommends that NHS England and NHS Improvement leads the development of minimum operating standards for pre assessment maternity telephone triage services to support safe and consistent telephone triage to ensure reliable identification of risks.
Safety recommendation R/2021/147:
HSIB recommends that NHSX develops specifications for electronic patient record (EPR) systems that require adherence to national interconnectivity standards for the exchange of core maternity healthcare information. The specifications should include functionality to enable both women and pregnant people and professionals to add to the record, and also support alerting functionality.

### 2.10 Maternity Pharmacist support

Maternity services also require a 0.5 WTE Band 8A pharmacist to ensure compliance with national drivers (Ockenden, Saving Babies Lives Care Bundle and the Tobacco Programme). This is essential to support:

- The development and review of essential obstetric guidelines involving medication regimes; all need review by an appropriately trained pharmacist with experience in obstetrics. Historically the review was provided by a pharmacist who worked part-time for NICU and maternity and worked additional hours to provide the required level of input to review the guidelines. There is a risk of inappropriate treatments being recommended without an appropriate review. Example given of recent hypertension guideline where extensive input from pharmacist to develop consensus on treatment in light of medicines being unavailable/discontinued
- The significant number of new and existing PGDs requiring development and approval will need the support and review of an appropriate pharmacist.
- Low molecular weight heparin prescribing for pregnant patients with VTE – currently initiated by maternity consultants and continued by GPs but GPs now declining to prescribe as risk should remain with the UHNM. This will cause significant risk for patients if no suitable, safe process for obtaining prescriptions and will increase the existing pressures on maternity consultants.
- The maternity wards to ensure the teams have input into safe and effective prescribing and administration for obstetric patients, particularly for those with chronic conditions (e.g. diabetes/epilepsy) to prevent harm from omitted or incorrect doses.
- Leadership on safe medicines use in obstetric patients both within the maternity unit and the wider trust – of particular note is the recent incident with ondansetron use in first trimester.

## 3. Current Position

Table 1 provides UHNM current position of the workforce establishment that are delivering the required assurance against key recommendations of the National Publications. The table outlines where the funding for the posts originates and where the gaps are.

**Table 1 UHNM current maternity workforce establishment to deliver assurance of the key recommendations of National Publications**

| PUBLICATION | WORKFORCE REQUIRED | IN PLACE YES/PARTIAL/NO | FUNDING | COMMENTS |
|---|---|---|---|---|
| **CNST MIS** | **CNST MIS WORKFORCE REQUIRED** | **CNST MIS WORKFORCE IN PLACE YES/PARTIAL/NO** | **CNST MIS WORKFORCE FUNDING** | **CNST MIS WORKFORCE COMMENTS** |
| **MIS Action 1: Perinatal Mortality Review Tool (PMRT)** | **1.1** Bereavement midwives 2 wte to support the parents<br>**1.2** PMRT lead midwife<br>**1.3** Lead Neonatologist<br>**1.4** Lead Obstetrician for SB & NND | **1.1** Yes<br>**1.2** No<br>**1.2** Partial<br>**1.3** Yes | **1.1** Maternity & 0.2 Neonatology<br>**1.2** Not in current maternity budget<br>**1.3** Neonatology<br>**1.4** Obstetrics | **1.1** Neonatology agreed funding for 0.2 wte to ensure the sustainability of support for parents & NND reviews.<br>Note from recent MBRRACE conference: PMRT involvement is not a role for the bereavement midwives. However at UHNM we now have 2 wte bereavement midwives and pre-population of the PMRT by the bereavement is a process that works well at UHNM. The PMRT investigation review is then completed at a MDT perinatal case review.<br>**1.2** Not in place.<br>Recent national recommendation that the PMRT is not a role that the Bereavement Midwives should lead on<br>'The role of the bereavement team member(s) is to advocate on behalf of the parents presenting their questions, concerns and comments, and not to take responsibility for the PMRT review process' (Kurinczuk 2021, Learning from Standardised Reviews, When Babies Die, National Perinatal Mortality Review Tool Third Annual Report.<br>**1.3** Need support in job planning to facilitate 2 NND reviews per month 2 additional sessions (Neonatal and Obs Consultant)<br>**1.4** In place |
| | **2.1** Directorate data analyst | **2.1** Yes | **2.1** CWD | **2.1** In place |

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| **MIS Action 2: MSDS** | **2.2** Digital midwife 1.0 wte<br>**2.3** Digital Midwife support 0.6 wte<br>**2.4** HoM & CD | **2.2** Partial 0.8<br>**2.3** No<br>**2.4** Yes | **2.2** Maternity<br>**2.3** Maternity & O & G | **2.2** Bid submitted to support digital midwife role. Band 7 1.0 WTE<br>Band 6 support role also required 1 WTE<br>**2.3** In place |
| **MIS Action 3: ATAIN** | **3.1** Neonatology Consultant Lead<br>**3.2** NNU Matron<br>**3.3** DoM /Inpatient Matron/CD | **3.1** Yes<br>**3.2** Yes<br>**3.3** Yes | **3.1** Neonatology<br>**3.2** Neonatology<br>**3.3** Maternity | **3.1** In place<br>**3.2** In place<br>**3.3** In place |
| **MIS Action 4: CLINICAL WORKFORCE**<br><br>**4.1 Obstetric medical workforce** | **4.1** CD O & G | **4.1** Yes | **4.1** | **4.1** In place<br>The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service (MBRRACE, 2021). |
| **4.2 Anaesthetic medical workforce** | **4.2** Anaesthetics lead | **4.2** Yes | **4.2** CWD | **4.2** In place<br>A duty anaesthetist is immediately available for the obstetric unit 24 hours a day |
| **4.3 Neonatal medical workforce** | **4.3.1** Lead Neonatologist<br>**4.3.2** The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing | **4.3.1** Yes<br>**4.3.2** Yes | **4.3.1** Neonatology<br>**4.3.2** Neonatology | **4.3.1** Neonatology<br>**4.3.2** Neonatology |
| | **4.4.1** NNU Matron<br>**4.4.2** Nursing workforce | **4.4.1** Yes<br>**4.4.2** No | **4.4.1** Neonatology | **4.4.1** In place<br>**4.4.2** Separate business case |

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| **4.4 Neonatal nursing workforce** | establishment in accordance with the service specification for neonatal nursing standards | | **4.4.2** Neonatology | |
| **MIS Action 5:**<br><br>**MIDWIFERY WORKFORCE** | **5.1** DoM<br>**5.2** Chief Nurse<br>**5.3** Workforce establish aligns to Birth rate plus review | **5.1** Yes<br>**5.2** Yes<br>**5.3** Yes | **5.1** Maternity<br>**5.2** Corporate<br>**5.3** Maternity/LMNS | **5.1** In place<br>**5.2** In place<br>**5.3** Due Birth rate plus evaluation Autumn 2021 |
| **MIS Action 6: SBLCB (5 elements)**<br><br>**Element 1: Smoke free pregnancy** | **6.1** SBLCB Lead Midwife 1 wte<br>**6.2** Smoke free pregnancy specialist midwife lead 0.6 wte. This is a number 1 priority for implementing the maternity tobacco plan strategy<br>**6.3** Maternity Support Worker (MSW) smoking cessation | **6.1** Yes<br>**6.2** No<br>**6.3** No | **6.1** O & G<br>**6.2 –**<br>**6.3 –** | **6.1** Seconded post funded by LMNS. Currently advertised<br>**6.2** Smoke free pregnancy lead midwife & MSW currently not in budget. Recurrent funding available as part of the NHS Long term Plan / Tobacco plan. LMNS currently establishing process for this. |
| **Element 2: Monitoring growth restriction** | **6.2.1** SBLCB Lead Midwife 1 wte<br>**6.2.2** Obstetric Consultant Lead | **6.2.1** Yes<br>**6.2.3** Yes | **6.2.1** LMNS<br>**6.2.3** Obstetrics | **6.2.1** In place<br>**6.2.3** In place |
| **Element 3: Fetal movements** | **6.3** SBLCB Lead Midwife wte | **6.3** Yes | **6.3** | **6.3** In place |
| **Element 4: Fetal monitoring** | **6.4.1** Fetal Monitoring Midwife Lead 0.6<br>**6.4.2** Fetal Monitoring Consultant | **6.4.1** Yes<br>**6.4.2** Yes | **6.4.1**<br>**6.4.2** | **6.4.1** In place, substantive post out to advert<br>**6.4.2** In place |

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| | Lead | | | |
| **Element 5: Pre-term birth** | **6.5.1** SBLCB Lead Midwife 1.0 wte<br>**6.5.2** Obstetric Consultant Lead | **6.5.1** Yes<br>**6.5.2** Yes | **6.5.1**<br>**6.5.2** | **6.5.1** In place<br>**6.5.2** In place |
| **MIS Action 7: MVP** | **7.1** DoM<br>**7.2** MVP Lead<br>**7.3** PMAs | **7.1** Yes<br>**7.2** Yes<br>**7.3** Yes | **7.1** Maternity<br>**7.2** LMNS<br>**7.3** Maternity | **7.1** In place<br>**7.2** In place<br>**7.3** In place |
| **MIS Action 8: MDT TRAINING & CORE COMPETENCY FRAMEWORK**<br><br>**8.1 SBLCB in accordance with the 5 key elements** | **8.1**. SBLCB Lead Midwife 1.0 wte | **8.1** Yes | **8.1** LMNS | **8.1**<br><br>3.26 wte band 6 posts secured via OKENDEN bid to support Core competency framework training currently out to recruitment |
| **8.2 Fetal surveillance in labour (core competency framework)** | **8.2.1** Fetal Monitoring Midwife Lead 0.6<br>**8.2.2** Fetal Monitoring Consultant Lead | **8.2.1** Yes<br>**8.2.2** Yes | **8.2.1** Maternity<br>**8.2.2** Obstetrics | **8.2.1** In place, substantive post out to advert<br>**8.2.1** In place |
| **8.3 Maternity Emergencies and** | **8.3.1** Lead Midwives for Education and Development 2 wte posts<br>**8.3.2** PROMPT trainers<br>**8.3.3**.Lead Obstetric Consultant | **8.3.1** Yes<br>**8.3.2** Yes<br>**8.3.3** Yes<br>**8.3.4** Yes | **8.3.1** Maternity<br>**8.3.2** Maternity<br>**8.3.3** Obstetrics<br>**8.3.4** Anaesthetics | **8.3.1** In place<br>**8.3.2** In place<br>**8.3.3** In place<br>**8.3.4** In place |

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| **multi-professional training** | **8.3.4** Lead Anaesthetic Consultant<br>**8.3.5** Administration support 1.0 wte<br>**8.3.6** Neonatal life Support | **8.3.5** Yes<br>**8.3.6** Yes | **8.3.5** Maternity<br>**8.3.6** Maternity /LMNS | **8.3.5** In place<br>**8.3.6** In place |
| **8.4 Personalised care (core competency framework)** | **8.4.1** Perinatal Mental Health Lead<br>**8.4.2** Bereavement specialist midwives 1.8 wte<br>**8.4.3** CSW specialist interest<br>**8.4.4** Lead Midwife Specialist Interest in alcohol and substance<br>**8.4.5** Safe guarding lead midwife 1 wte | **8.4.1** In progress<br>**8.4.2** No 1.8 wte in post require uplift 0.2 (2 wte)<br>**8.4.3** Yes<br>**8.4.4** Yes<br>**8.4.5** Yes | **8.4.1** Maternity<br>**8.4.2** Maternity<br>**8.4.3** Maternity<br>**8.4.4** Maternity<br>**8.4.5** Maternity | **8.4.1** Currently out to advert<br>**8.4.2** 0.2 band 7 required<br>**8.4.3** In place<br>**8.4.4** In place<br>**8.4.5** In place |
| **8.5 Care during labour and the immediate postnatal period (core competency framework)** | **8.5.1** Lead Midwife Specialist interest VBAC<br>**8.5.2** Lead Midwife Specialist Interest in Perineal Trauma<br>**8.5.3** Clinical educator midwife with specialist interest in<br>▪ Maternal Critical Care<br>▪ Recovery Care after general anaesthetic<br>▪ Management of epidural anaesthesia<br>▪ GBS in labour<br>**8.5.4** Obstetric Consultant Lead for Operative vaginal birth: ROBuST (Operative vaginal Birth Simulation Training)<br>**8.5.5** Administration support | **8.5.1** Yes<br>**8.5.2** Yes<br>**8.5.3** In progress<br>**8.5.4** Yes<br>**8.5.5** No | **8.5.1** Maternity<br>**8.5.2** Maternity<br>**8.5.3** Ockenden<br>**8.5.4** O & G<br>**8.5.5 -** | **8.5.1** In place<br>**8.5.2** In place<br>**8.5.3** 3.26 post out to advert from<br>**8.5.4** Obs consultant lead for instrumental birth in place.<br>**8.5.5** 0.6 wte band 3/4 required |
| **8.6 Neonatal life support (core competency framework)** | **8.6.1** NLS trainers<br>**8.6.2** Administration support | **8.6.1** Partial<br>**8.6.2** Yes | **8.6.1** Maternity<br>**8.6.2** Maternity | **8.6.1** Train the trainer days being funded by the LMNS<br>**8.6.2** In place |

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| **8.7 Covid-19 specific training (core competency framework)** | **8.7.1** Clinical educator midwife with specialist interest in Covid-19 specific training.<br>▪ Women requiring maternal critical care.<br>▪ Triage of pregnant and postpartum women with mental health concerns.<br>▪ An overview of care principles, and individual susceptibility e.g. ethnicity, hypertension and diabetes.<br>**8.7.2** Administration support | **8.7.1** No<br>**8.7.2** No | **8.7.1** Ockenden funding<br>**8.7.2 -** | **8.7.1**<br>**8.7.2** 0.6 wte band 3/4 required |
| **8.9 Training targeted at local learning** | **8.9.1** Quality and Risk Manager 1 wte<br>**8.9.2** Lead Midwives for Education and Development 2 wte | **8.9.1** Yes<br>**8.9.2** Yes | **8.9.1** Maternity<br>**8.9.2** Maternity | **8.9.1** In place<br>**8.9.2** In place |
| **8.10 Administration support for all maternity specific mandatory MDT training** | **8.10** 1.0 wte in place<br><br>Training records, agendas and data sets are crucial evidence that must be retained to ensure compliance trajectories are met and assurance can be provided; feedback from training is received and responded to. | **8.10** Partial<br><br>This is only in place for 8.3 Maternity Emergencies and multi-professional training | **8.10** Maternity | 8.10 A 0.6 Additional band 3 / 4 needed |
| **MIS Action 9 MATERNITY SAFETY CHAMPIONS** | **9.1** Maternity & neonatal champions in place including one NED | **9.1** Yes | **9.1** Corporate | **9.1** In place |

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| **MIS Action 10 NHSR & HSIB reporting** | **10.1** Quality & Risk Manager<br>**10.2** HSIB leads<br>**10.3** UHNM legal team | **10.1** Yes<br>**10.2** Yes<br>**10.3** Yes | **10.1** Maternity<br>**10.2** HSIB<br>**10.3** Corporate | **10.1** In place<br>**10.2** In place<br>**10.3** In place |
| **Project lead for CNST** | No current post in place | No | | **0.6 wte required** |
| **OCKENDEN** | **OCKENDEN WORKFORCE REQUIRED** | **OCKENDEN WORKFORCE IN PLACE YES/PARTIAL/NO** | **OCKENDEN WORKFORCE FUNDING** | **OCKENDEN WORKFORCE COMMENTS** |
| **IEA 1: Enhanced Safety** | Linked to CNST MIS | Yes | Maternity | |
| **IEA 2: Listening to Women and Families** | Linked to CNST MIS | Yes | Maternity | |
| **IEA 3: Staff Training and Working Together** | Linked to CNST MIS | Yes | Maternity | 3.26 wte band 6 clinical educator midwives out to advert funding secured from Ockenden bids |
| **IEA 4: Managing Complex Pregnancy** | Linked to CNST MIS | Yes | Maternity | |
| **IEA 5: Risk Assessment Throughout Pregnancy** | Linked to CNST MIS | Yes | Maternity | |
| **IEA 6: Monitoring Fetal Wellbeing** | Linked to CNST MIS | Yes | Maternity | 0.6 band 7 fetal monitoring midwife lead out to advert<br>Consultant lead in post |
| **IEA 7: Informed Consent** | Linked to CNST MIS | Yes | Maternity | |
| **Midwifery Leadership** | **1.** DoM<br>**2.** Consultant Midwife Public Health | Yes<br>Yes | Maternity<br>Maternity | In place<br>In place |
| **Evidence related to Workforce planning** | Linked to CNST MIS | | | |
| **NICE Guidance related to maternity is also required** | No current clinical guideline lead in place | No | - | 1 wte band 7 |
| **Project lead for Ockenden** | No current post in place | No | - | 0.6 wte band 7 |
| **Audit lead for Ockenden/CNST/Clinical** | Band 5 Directorate clinical audit lead in post 0.6 | Partial | Maternity | Need funding to support an additional 0.6 wte band 5 post to be able to provide evidence of |

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| **Guidelines** | Additional 0.6 clinical audit lead required | | | compliance against SBLCB/CNST MIS/Clinical guidelines |
| **BETTER BIRTHS** | **BETTER BIRTHS WORKFORCE REQUIRED** | **BETTER BIRTHS WORKFORCE IN PLACE YES/PARTIAL/NO** | **BETTER BIRTHS WORKFORCE FUNDING** | **BETTER BIRTHS WORKFORCE COMMENTS** |
| **1. Personalised care** | Linked to MIS | | | |
| **2. Continuity of carer** | Consultant Midwife for Continuity of Care/Low risk (band 8B) or Lead Midwife for Continuity of Care/Low risk band 8A | No current post in place | - | 6 wte band 6 midwives will be supported by LMNS |
| **3. Safer care** | Linked to Ockenden IEAs<br>Linked to MIS | | | |
| **4. Better postnatal and perinatal mental health care** | 1. Perinatal Mental Health Nurse<br>2. Midwife specialist interest in Perinatal Mental Health | **1.** In post<br>**2.** No | Maternity | |
| **5. Multi-professional working** | Linked to MIS | | | |
| **6. Working across boundaries to provide and commission maternity services to support personalisation, safety and choice, with access to specialist care whenever needed.** | | | | |
| **7. A payment system that fairly and adequately compensates providers for delivering high quality care to all women efficiently, while supporting commissioners to commission for personalisation, safety and** | | | | |

| | | | | |
|---|---|---|---|---|
| **choice.** | | | | |
| **UK NSC: AN & NEWBORN SCREENING PROGRAMMES** | **SCREENING WORKFORCE REQUIRED** | **SCREENING WORKFORCE IN PLACE YES/PARTIAL/NO** | **SCREENNG WORKFORCE FUNDING** | **SCREENING WORKFORCE COMMENTS** |
| **Antenatal (AN) and postnatal (PN) screening programmes**<br>**1.** Sickle Cell and Thalassemia Screening Programme (SCT)<br>**2.** Infectious Diseases in Pregnancy Screening Programme (IDPS)<br>**3.** Fetal Anomaly Screening Programme (FASP)<br>**4.** Newborn Blood Spot Screening Programme (NBS)<br>**5.** Newborn Hearing Screening Programme (NHSP)<br>**6.** Newborn and Infant Physical Examination Screening Programme (NIPE)<br>**7.** Diabetic eye screening | **1.0 WTE Band 7** | **Partial** | **Maternity** | 1 wte Band 7 Screening lead required (PHE recommendation)<br>Antenatal Clinic (ANC) Manager is currently leading this in addition to her ANC role. |
| **UNICEF UK BFI** | **BFI WORKFORCE REQUIRED** | **BFI WORKFORCE IN PLACE YES/PARTIAL/NO** | **BFI WORKFORCE FUNDING** | **BFI WORKFORCE COMMENTS** |
| Re-accreditation of UNICEF UK BFI<br>Sustainability and progress towards gold award | Infant Feeding Lead Band 7 1 wte in post | Partially 0.8 wte | Maternity | Need 0.2 wte additional hours |

| | | | | |
|---|---|---|---|---|
| **DIGITILISATION & MATERNITY** | **WORKFORCE REQUIRED** | **WORKFORCE IN PLACE YES/PARTIAL/NO** | **WORKFORCE FUNDING** | **WORKFORCE COMMENTS** |
| Digital maturity<br>Electronic patient records<br>My pregnancy notes<br>Accurate data gathering<br>Training | **1.** 1.0 wte Digital Midwife<br>**2.** 1.0 wte Digital Midwife support<br>**3**. 0.6 Band 3/4 | **1**. 0.8 in place<br>**2.** No<br>**3**. No | **1**. Maternity<br>**2.** –<br>**3.** – | **1.** Need 1.0 wte Digital Midwife band 7<br>**2.** Need 1.0 Digital Midwife support band 6<br>**3.** Need 0.6 CSW band 3/4 |
| **RCM MIDWIFERY LEADERSHIP** | **WORKFORCE REQUIRED** | **WORKFORCE IN PLACE YES/PARTIAL/NO** | **WORKFORCE FUNDING** | **WORKFORCE COMMENTS** |
| Strong midwifery leadership to deliver high quality, safe maternity services | A Director of Midwifery (DoM)<br>Consultant midwives<br>Specialist midwives | Yes DoM in post<br>Yes Consultant Midwife: Public Health in post<br>Yes specialist interest midwives in place | Maternity | DoM recruited to, Deputy DoM currently vacant out to advert<br>Need Consultant Midwife for Continuity of Care to provide expertise to drive the low risk agenda forward. |
| **MBRRACE-UK (2021) LEARNING FROM SARS-COV-2-RELATED AND ASSOCIATED MATERNAL DEATHS IN THE UK** | **WORKFORCE REQUIRED** | **WORKFORCE IN PLACE YES/PARTIAL/NO** | **WORKFORCE FUNDING** | **WORKFORCE COMMENTS** |
| Meeting the requirements of equality, inequality and diversity legislation and guidance | Consultant Midwife, Public Health | Yes | Maternity | |

| | | | | |
|---|---|---|---|---|
| **HSIB NATIONAL THEMED REPORTS** | **WORKFORCE REQUIRED** | **WORKFORCE IN PLACE YES/PARTIAL/NO** | **WORKFORCE FUNDING** | **WORKFORCE COMMENTS** |
| Need for maternity triage and telephone calls by senior midwives 24/7<br><br>MAU triage currently on the obstetric risk register | **1.1** 5.4 wte band 6/7 to receive telephone calls 24/7<br>**1.2** 5.4 band 6/7 to triage 24/7<br>**1.3** Designated Consultant presence on MAU | **1.1** No<br>**1.2** No<br>**1.3** Partial | **1.1** –<br>**1.2** –<br>**1.3** Obstetrics | UHNM MAU does provide triage in accordance with BSOTS a recognised triage system however there is not the required workforce to deliver this 24/7. Serious Incident reporting has identified this as a risk with a recommendation for 24/7 telephone calls and triage to be the role of band 6/7. There is no designated post for either at present. In times of high acuity a telephone call will be received by a MSW who seeks advice from a midwife. |
| **MULTIPLE NATIONAL MATERNITY DRIVERS** | **WORKFORCE REQUIRED** | **WORKFORCE IN PLACE YES/PARTIAL/NO** | **WORKFORCE FUNDING** | **WORKFORCE COMMENTS** |
| Need for pharmaceutical input into the development and review of clinical guidelines, standard operating procedures and PGDS | 0.5 wte band 8A | **No** | To be confirmed | A significant number of maternity documents, systems and processes require input from pharmacy. |

Table two identifies the current gaps in workforce establishment

**Table two gaps in the workforce establish against national recommendations**

| ROLE | BAND | WTE | FUNDING |
|---|---|---|---|
| **Bereavement midwife** | 7 | 0.2<br>Increase 0.8 to 1.0 | Neonatology |
| **PMRT lead midwife** | 7 | 1.0 | New post not in the maternity budget |
| **Screening lead** | 7 | 1.0. | New post not in the maternity budget |
| **Digital Midwife** | 7 | 0.2<br>Increase 0.8 to 1.0 | Additional hours not in the maternity budget |
| **Digital Midwife Support** | 6 | 0.6 | New post not in the maternity budget |
| **Project lead for CNST & Ockenden** | 6/7 | 0.6 – 1.0 | New post not in the maternity budget |
| **Smoke free pregnancy lead Midwife** | 6 | 0.6 | New post not in the maternity budget |
| **Maternity Support Worker Smoking Cessation** | 3 | 1.0 | New post not in the maternity budget |
| **1 wte band 4 required administration support for training** | 3/4 | 0.6 | New post not in the maternity budget |
| **1 wte Lead Midwife Clinical Guideline** | 7 | 1.0 | New post not in the maternity budget |
| **Clinical audit lead** | 5 | 0.6 | Additional hours 0.2 not in the maternity budget (0.4 in the budget) |
| **Maternity Triage Midwife 24/7** | 6/7 | 5.4 | New post not in the maternity budget |
| **Midwife to receive telephone calls 24/7** | 6/7 | 5.4 | New post not in the maternity budget |
| **Continuity of Care lead/Low risk** | 8A/8B | 1.0 | New post not in the maternity budget |
| **Maternity Pharmacist** | 8A | 0.5 | New post not in the pharmacy budget |

## 4. Risks

The risks associated with not having the required workforce in place are:

1. Failure to provide the required assurance against the CNST Maternity Incentive Strategy 10 Safety Actions
2. Failure to provide the required assurance against Ockenden IAS
3. Failure to receive incentivised funding
4. Work related stress/burn out
5. Under resourced workforce with the potential for this to adversely affect retention and recruitment
6. Adverse publicity

## 5. Finance

| Role | Band | WTE | Funding requirement |
|---|---|---|---|
| **Bereavement Midwife** | 7 | 0.2 | £11,533 |
| **PMRT Lead Midwife** | 7 | 1.0 | £52,881 |
| **Lead Midwife Maternal and Newborn Screening lead required – new post** | 7 | 1.0 | £52,881 |
| **Digital Midwife – additional hours** | 7 | 0.2 | £10,576 |
| **Digital Midwife Support – new post** | 6 | 0.6 | £25,591 |
| **Project lead for CNST & Ockenden – new post** | 7 | 1.0 | £52,881 |
| **Smoke free pregnancy lead Midwife – new post** | 6 | 1.0 | £42,652 |
| **Maternity Support Worker Smoking Cessation** | 3 | 1.0 | £26,702 |
| **1 wte band 4 administration support for training – new post** | 4 | 0.6 | £18,419 |
| **1 wte Lead Midwife Clinical Guideline new post** | 7 | 1.0 | £52,881 |
| **Clinical audit lead – additional hours (0.4 in budget)** | 5 | 0.2 | £6,885 |
| **Maternity Triage Midwife 24/7** | 6/7 | 5.4 | £269,476-£334,102 |
| **Midwife to receive telephone calls 24/7** | 6/7 | 5.4 | £269,476-£334,102 |
| **Continuity of Care lead/Low Risk (Consultant Midwife 8B / or 8A** | 8A/B | 1.0 | £60,335-£72,174 |
| **Pre-term birth midwife** | 7 | 0.6 | £31,729 |
| **TOTAL** | | 19.6 | £984,898-£1,125,989 |
| **Maternity Pharmacist support** | 8A | 0.5 | |

## 6. Conclusion

This report outlines the required workforce establishment for maternity services to deliver key recommendations and provide evidence and assurance both internally and externally in relation to compliance against multiple local, regional and national reports and recommendations.
There is currently a shortfall in budget and establishment of 19.6 wte with a cost of £984,898-£1,125,989 plus an additional 0.5 wte band 8A Maternity Pharmacist support therefore it is imperative that the organisation supports the funding and recruitment to these posts to enable:

- The delivery of safe and sustainable maternity services
- Mitigate the risks identified in section 4
- UHNM to attract and retain a talented workforce

## 7. Recommendations

The Committee is asked to support the development of a business case for the additional funding required to ensure that maternity services are able to provide assurance of compliance against the national maternity drivers for patient safety.

# Transformation and People Committee Chair's Highlight Report to Trust Board

**23rd March 2022**

## 1. Highlight Report

| Matters of Concern or Key Risks to Escalate | Major Actions Commissioned / Work Underway |
|---|---|
| • An in depth review of **resources within maternity** has been undertaken against a wide range of national expectations; this has demonstrated a number of gaps in terms of roles required and the risk associated with those gaps<br>• During Quarter 3 for **nursing and midwifery staffing**, there is evidence that sickness and absence has been negatively impacted by the legal requirement for contact isolation, that temporary staffing fill has increased and that red flag and Safe Care compliance shows large variation between Divisions which will be addressed through the establishment review process<br>• The Trust has scored lower than the national average in all 7 themes within the **national staff survey**, with staff engagement and staff morale theme scores also seeing a reduction<br>• The **workforce report** Staff in post decreased in February 2022 and budgeted establishment increased resulting in an overall increase in the vacancy position and rate<br>• Covid related **sickness absence** has increased considerably up to 44%<br>• There are 3 main areas of concern with regard to **essential to role training** and work is being undertaken around a review of resource needed to address this – further exception reporting will be provided to the Committee to monitor progress<br>• Two existing members of staff within the **Improving Together** QIA have been promoted into new roles which leaves a significant gap to be addressed; a full options appraisal into resourcing is being developed | • The Committee supported the development of a rounded business case to be taken through to the Performance and Finance Committee to address the gaps in resources identified within **maternity services**<br>• Priority areas for action in 2022/23 in response to the **national staff survey** will be focussed around enabling leadership and middle management development, implementing the Civility and Respect agenda and delivering our Equality, Diversity and Inclusion actions; these were supported by the Committee who expressed a strong appetite in seeing new resources / approaches to deliver this and requested a Project Plan with dedicated time for a 'deep dive' early during Quarter 1 – this will be aligned to the work in response to the Brap Report which will, when appropriate, be overseen as a whole by this Committee<br>• The trajectory for cumulative training on **the Improving Together** will be refreshed and represented so that the over performance on induction training does not mask underperformance more broadly, as a result of constraints by training and coaching capacity within the QIA team<br>• Meeting to be organised to look at the **Business Cycle** as part of the Effectiveness Review |
| **Positive Assurances to Provide** | **Decisions Made** |
| • Compliance with roster Key Performance Indicators for **nursing and midwifery staffing** has largely been consistent during Quarter 3<br>• Non-medical **Performance Development Review** compliance has improved during month 11 from 75.91% to 79.08%<br>• **Improving Together** tools and routines adopted by divisions is demonstrating positive uptake | • There were no items requiring decision |
| **Comments on the Effectiveness of the Meeting** | |
| • Useful meeting with energy and engagement despite continuing to work through Teams | |

## 2. Summary Agenda

| No. | Agenda Item | BAF Mapping | | Purpose | No. | Agenda Item | BAF Mapping | | Purpose |
|---|---|---|---|---|---|---|---|---|---|
| | | BAF No. | Risk | | | | BAF No. | Risk | |
| 1. | Maternity Services Workforce Establishment to Deliver Assurance of Maternity Safety | 1 | 13419, 11518, 15993 | Assurance | 4. | M11 Workforce Report | 2, 3 | | Assurance |
| 2. | Nursing and Midwifery Staffing and Quality Report Q3 21/22 | 1, 3 | | Assurance | 5. | Improving Together Highlight Report | | | Assurance |
| 3. | 2021 NHS Annual Staff Survey | 2, 3 | | Assurance | 10. | Executive Strategy & Transformation Group Assurance Report | 4, 5 | | Assurance |

## 3. 2022 / 23 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) | | | | | | | | | | | Chair | |
| Ms H Ashley | HA | Director of Strategy and Transformation | | | | | | | | | | | | HA |
| Ms S Belfield | SB | Non-Executive Director | | | | | | | | | | | | |
| Mrs T Bowen | TBo | Non-Executive Director | | | | | | | | | | | | |
| Mrs T Bullock | TB | Chief Executive | | | | | | | | | | | | |
| Mr P Bytheway | PB | Chief Operating Officer | | | | | | | | | | | | |
| Dr L Griffin | LG | Non-Executive Director | | | | | | | | | | | | |
| Mrs S Gohir | SG | Associate Non-Executive Director | | | | | | | | | | | | |
| Dr K Maddock | KM | Non-Executive Director | | | | | | | | | | | | |
| Mrs AM Riley | AR | Chief Nurse | MR | | SP | | | | | | | | | |
| Miss C Rylands | CR | Associate Director of Corporate Governance | | | NH | | | | | NH | | NH | NH | |
| Mrs R Vaughan | RV | Chief People Officer | | | | | | JH | | | | | | |

# Committee Chair's Highlight Report to Board

**Performance and Finance Committee**
**22nd & 28th March 2022**

NHS
University Hospitals of North Midlands
NHS Trust

## 1. Highlight Report

| ! Matters of Concern of Key Risks to Escalate | Major Actions Commissioned / Work Underway |
|---|---|
| • The update from the **Digital and Data Security and Protection Group** highlighted the risk in not achieving the DSP toolkit requirements, in addition to the increased cyber security risk associated with situation in eastern Europe. The group noted that the Freedom of Information response rate was expected to improve going forwards and the work to decommission Winscribe was considered.<br>• The update from the **Operational Delivery Group** considered the 10 high impact changes for planned care which were focussing on making processes more efficient. The Committee noted the learning which had been identified from the Get It Right First Time workshop held 21st March on high volume, low complexity specialties, and the ongoing discussions regarding histopathology and laboratory escalated payments were highlighted, aimed at recovering the position for histopathology and microbiology<br>• **Month 11 Operational Performance** demonstrated continued high occupancy across the organisation, with improvements required on increasing weekend discharges, although positively length of stay for long stay patients was reducing. It was noted that until occupancy reduced, there would continue to be high number of DTAs and a number of actions were being undertaken to address this. The Committee considered the continuing challenges associated with inability to reduce the number of medically fit for discharge patients and in terms of cancer performance 2 week and 62 day performance was decreasing although the patient tracking list demonstrated that more patients were being treated. Cancer referrals remained high with the main areas of concern relating to colorectal and urology although the histopathology backlog was continuing to reduce. The main challenge affecting diagnostics related to ultrasound scanning due to vacancies<br>• **Procurement** highlighted challenges with the increasing number of vacancies due to staff leaving for the private sector<br>• The Committee considered the **System Plan** which had been submitted with a £48.2 m deficit, with a broadly flat cash position and assumed costs rising by 3.5%. The difficulties in achieving the required efficiency savings was highlighted in addition to the known risks to the position which related to the need to agree specialised commissioning contracts, having no contingencies, the risk of further price inflation and the ability to deliver substantive workforce changes | • Data analysis was being undertaken in terms of comparing operational performance with 19/20 with progress from each of the workstreams being regularly monitored<br>• Procurement to identify whether there were any opportunities for international recruitment to help address the vacancy levels<br>• To circulate the narrative plan to Committee members in order for any comments to be considered at the Extraordinary Meeting on 28th March<br>• To provide further information in relation to the Speech Recognition & Digital in terms of equality, diversity and inclusion |
| **✓ Positive Assurances to Provide** | **Decisions Made** |
| • The Committee welcomed the improvement in theatre efficiency and performance, particularly at County Hospital<br>• Comments were provided on the **Digital Strategy** regarding the need to consider how the strategy fits with the system digital strategy, and welcomed the inclusion of 'what good looks like'. The Committee queried whether the RAG ratings reflected current performance and welcomed the progress on the DSP and procurement framework. The Committee were concerned of some of the delays to projects as a result of workforce issues and clarification was required of when the systems were due to be implemented.<br>• The update from **Procurement** highlighted £5.14 m of savings which was above target demonstrating strong performance in terms of reducing influencable spend. The 2022/23 workplan had been finalised with an anticipated £4.9 m savings and the progress made in terms of the integrated performance model was highlighted.<br>• **Month 11 Financial Performance** demonstrated £5.2m year to date surplus and the Trust was expecting to achieve the forecast position. The year to date slippage on winter plan monies was highlighted in addition to slight slippage on the capital programme which was £1.1 m behind plan although it was anticipated that this would be caught up | • The Committee approved the following **eREAFs** 8974, 8939, 8911, 8788, 8706, 8674, 9054, 9131 and 9162<br>• The Committee approved the following **business cases**; Enhanced Primary Care (EhPC) in ED, BC-0460 Unified Tech Fund, BC-0449 Speech Recognition & Digital Dictation, BC-0462 Patient Portal, BC-0465 Elective Recovery of T&O Services, BC-0466 Neurology External Support , BC-0468 Theatre Timetable Recovery & Investment, BC-0469 Burcot Hall – Bariatrics and BC-0472 Elective Recovery Endoscopy |

| Comments on the Effectiveness of the Meeting |
|---|
| • The Committee welcomed the reduction in the size of the agenda by considering business cases via an extraordinary meeting, enabling a robust discussion on operational performance |

## 2. Summary Agenda

| No. | Agenda Item | BAF Mapping | | Purpose | No. | Agenda Item | BAF Mapping | | Purpose |
|---|---|---|---|---|---|---|---|---|---|
| | | BAF No. | Risk | | | | BAF No. | Risk | |
| **MEETING HELD ON 22ND MARCH 2022** | | | | | | | | | |
| 1. | Executive Digital and Data Security & Protection Group Assurance Report | 7 | 22938, 22949, 12536, 17542 | Assurance | 5. | Quarterly Procurement Update Report | - | | Assurance |
| 2. | Operational Delivery Group Assurance Report | 6 | 11294 | Assurance | 6. | Authorisation of New Contract Awards and Contract Extensions | - | | Approval |
| 3. | Month 11 Performance Report – 2021/22 | 6 | 10342, 21101, 18664, 15788, 9910, 20739 | Assurance | 7. | Month 11 Finance Report 2021/22 | 9 | | Assurance |
| 4. | Digital Strategy Progress Report | 7 | | Assurance | 8. | System Plan Submission | 9 | | Assurance |
| **MEETING HELD ON 28TH MARCH 2022** | | | | | | | | | |
| 1. | Enhanced Primary Care (EhPC) in ED | 6 | 16636, 16643, 8542, 19463 | Approval | 6. | BC-0466 Neurology External Support | 6 | 17932, 23518 | Approval |
| 2. | BC-0460 Unified Tech Fund | 7 | | Approval | 7. | BC-0468 Theatre Timetable Recovery & Investment | 6 | 22649 | Approval |
| 3. | BC-0449 Speech Recognition & Digital Dictation | 7 | | Approval | 8. | BC-0469 Burcot Hall – Bariatrics | 6 | 10333 | Approval |
| 4. | BC-0462 Patient Portal | 7 | | Approval | 9. | BC-0472 Elective Recovery Endoscopy | 6 | 20739, 15788 | Approval |
| 5. | BC-0465 Elective Recovery of T&O Services | 6 | 22532, 15064 | Approval | 10. | Authorisation of New Contract Awards and Contract Extensions | - | | Approval |

## 3. 2021 / 22 Attendance Matrix

| Attended | Apologies & Deputy Sent | Apologies |
|---|---|---|

| Members: | | A | M | J | J | A | S | O | N | D | J | F | M | M |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mr P Akid (Chair) | Non-Executive Director | | | | | | | | | | | | | |
| Ms H Ashley | Director of Strategy | | | | | | | | | | | | | |
| Ms T Bowen | Non-Executive Director | | | | | | | | | | | | | |
| Mrs T Bullock | Chief Executive | | | | | | | | | | | | | |
| Mr P Bytheway | Chief Operating Officer | | | | | | | | | | | | | |
| Dr L Griffin | Non-Executive Director | | | | | | | | | | Chair | | Chair | |
| Mr M Oldham | Chief Finance Officer | | | | | | | | | | | | | |
| Mrs S Preston | Strategic Director of Finance | | | | | | | | | | | | | |
| Miss C Rylands | Associate Director of Corporate Governance | NH | NH | NH | NH | NH | NH | NH | NH | NH | NH | NH | NH | NH |
| Mr J Tringham | Director of Operational Finance | | | | | | | | | | | | | |

# Executive Summary

| | | | |
|---|---|---|---|
| **Meeting:** | Trust Board | **Date:** | 6th April 2022 |
| **Report Title:** | Integrated Performance Report, month 11 2021/22 | **Agenda Item:** | 15. |
| **Author:** | Quality & Safety: Jamie Maxwell, Head of Quality & safety;<br>Operational Performance: Warren Shaw, Associate Director of Performance & Information; Matt Hadfield, Deputy Associate Director of Performance & Information.<br>Workforce: Claire Soper, Assistant Director of Human Resources;<br>Finance: Jonathan Tringham, Director of Operational Finance | | |
| **Executive Lead:** | Anne-Marie Riley: Chief Nurse<br>Paul Bytheway: Chief Operating Officer<br>Ro Vaughan: Chief People Officer<br>Mark Oldham: Chief Finance Officer | | |

## Purpose of Report

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

## Alignment with our Strategic Priorities

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


## Risk Register Mapping

| | | |
|---|---|---|
| | | |

## Executive Summary

### Situation

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

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

### Assessment

**Quality & Safety**

**The Trust achieved the following standards in February 2022:**

- Friend & Family (Inpatients) improved to 99.3% and exceeds 95% target.
- Friend & Family (Maternity) improved to 100% and exceeds 95% target.
- Harm Free exceeded 95% target rate with 96.7%
- Trust rolling 12 month HSMR continues to be below expected range.
- VTE Risk Assessment completed during admission continues to exceed 95% target with 99.4% (point prevalence audit via Safety Thermometer).
- Zero avoidable MRSA Bacteraemia cases reported.
- C Diff YTD figures below trajectory with 0 against a target of 8.
- There have been no Category 4 Pressure Ulcers attributable to lapses in care during February 2022.

- Sepsis Screening compliance in Emergency Portals exceeded the target 90% with 90.5%.
- Inpatients Sepsis Screening 91.3% above 90% target rate and Inpatient Sepsis IVAB within 1 hour achieved 97.2% and exceeded 90% target rate
- Maternity Sepsis in 1 hour compliance 100% against 90% target

**The Trust did not achieve the set standards for:**
- Friend & Family Test for A&E has decreased to 72.9% and below 85% target.
- Falls rate was 7.2 per 1000 bed days
- There were 23 Pressure ulcers including Deep Tissue Injury identified with lapses in care during February 2022.
- 90.9% Duty of Candour 10 working day letter performance following formal verbal notification. All patients have received written notification but 1 case was over 10 day target.
- 0 Never Event reported
- Children's Sepsis Screening compliance 84.4% and below the 90% target.
- Emergency Portals Sepsis Screening in 1 hour improved to 89% but is below the 90% target for audited patients
- Emergency Portals Sepsis IVAB in 1 hour 69% and is below the 90% target for audited patients
- Maternity Sepsis Screening compliance 80.0% against 90% target

**During February 2022, the following quality highlights are to be noted:**
- The rate of complaints per 10,000 spells is 35.63 and is slightly above the target of 35 but within normal variation. Majority of complaints in February 2022 relate to clinical treatment.
- Total number of Patient Safety Incidents decreased in month (1712) and the rate per 1000 bed days has also increased at 46.14 and both measures are within normal variation.
- Total incidents with moderate harm or above and the rate of these incidents above normal variation levels and incidents are under review to identify issues/themes.
- Decrease in total reported incidents relating to staffing shortages and lack of appropriate staff on wards/departments during January 2022. 60 in total although 31 were coded as patient related, the remaining 29 were reported as staff related incidents.
- Rate of falls reported that have resulted in harm to patients currently at 1.8 per 1000 bed days in February 2022. The rate of patient falls with harm continues to be within the control limits and normal variation but is above the mean rate which indicates there may be improvement in reducing harm from falls.
- Medication related incidents rate per 1000 bed days is 5.5 and patient related 4.4 which are increases compared to previous months. The monthly variation is within the normal expected variation and consistent with Trust mean rates. However whilst it is below the previously published NRLS national mean rate of 6.0 the rate is nearer to the national mean rate.
- Pressure Ulcers developed under UHNM care has seen a decrease during February 2022 along with a similar decrease in number with lapses in care compared to previous months.
- 26 Definite Hospital Onset / Nosocomial COVID-19 cases reported in February 2022.
- 4 COVID-19 death falling in to the 'Definite' category (according to the National definition of Nosocomial deaths of first positive result 15 days or more after admission to hospital).
- 18 Serious Incidents reported February 2022. All the serious incidents were reported on STEIS within the 2 working date target following confirmation of SI criteria.

## Operational Performance

**Emergency Care**
- Attendances remain under forecast in February 2022 still reduced from previous months. High numbers of DTA's were held in ED overnight due to bed based acuity, high numbers of MFFD with all escalation capacity being open and utilised and infection issues compounding flow
- Ambulance handover delays over 60 minutes were high at 880 being held over one hour, however this was an improvement against January 2022. The percentage of handovers within 15 minutes was 64.4% for the month. Instances of surge evidenced for WMAS attends which provides challenges for triage, especially when stand by patients have to be managed on clinical need.
- Time to initial assessment mean position was slightly reduced at 53.8%.
- Time to Treatment in ED increased in February and was at 105 minutes.

**Cancer**
- The overall 2WW position for February 22 is predicted to achieve in the region of 55%. Specialties with

the most 14 day breaches are Breast, Skin and Upper GI.

- The 28 Day Faster Diagnosis position is currently at 64% with the majority of breaches in Colorectal and Skin. System challenge for Q4 to secure primary care traction on the FIT pathway given the direct link to improved performance potential. Decision to bring UHNM in line with best practice pathway (sequential FIT model) was flagged at the regional T&F group 11.03.22
- The 62 day backlog has reduced for the 9th consecutive week. There are currently 491 patients in the 2WW backlog. A reduction of 23 since last week. Of the 2WW patients who have breached, 148 patients are in Colorectal and 125 are in Skin.
- The 104+ backlog is slowly reducing, currently at 164. Divisions have been asked to focus on this cohort and discharge patients where appropriate – e.g. where there are patients waiting over 104 days with an outstanding clinical review.
- Of the patients waiting over 104 days, 58 are on a Colorectal pathway – 35%.

**Planned Care**

- Day Case and Elective Activity delivered 87% and 73% respectively for February 22 against the national ask of 95%, an improvement on January's position for Day Case (86%), but a decrease on Electives (75%).
- In month Planned Care Cell focuses on elective recovery based on 10 high impact changes in accordance with the elective plan.
- Theatre plan for Q1 2022/23 gives 104% of 19/20 capacity. Targeted booking on-going to meet P2 demand and 104+ waits.
- County theatre due to open 4th April.
- T&O have 111% of pre-covid capacity in line with having the largest proportion of 104s.
- Theatre utilisation and booking processes to be focus of Q1

**RTT**

- The overall Referral to Treatment (RTT) Waiting list continues to rise. For February the indicative number of Incomplete pathways has risen to 73, 360 (January 71,321).
- The number of patients > 18 weeks has risen to a level of 32,831 (December 32,147).
- The numbers of 52 week waits in February has stayed the same with an unvalidated total of 4,461 (January 4,463) this figure is below the trajectory.
- At the end of February the numbers of > 104 weeks is looking to be around 561, an increase of 40 on January (starting to decrease as of March 1st). The Planned Care group is monitoring progress against treatment plans for these patients.

**Diagnostics**

- Total waiting list has increased in February from 21083 to 22529. The Non-obstetric ultrasound waiting list increased slightly from 9,368 to 9,394. Due to the challenges in Non-Obstetric Ultrasound this has adversely affected performance. The current DM01 diagnostic performance is at 72%.
- Within DM01, the greatest proportion of > 6 week waits are within Non-obstetric ultrasound and endoscopy. The ultrasound position is related to an increase in demand alongside workforce shortfalls, a number of actions are in place. Non obstetric ultrasound performance remains a Driver Metric for CWD and has specific focus for improvement, albeit this is related to workforce retention, recruitment and innovative ways to train and recruit. Further outsourcing of non-obstetric ultrasound scanning is continuing to be explored.
- DM01 performance excluding non obs ultrasound would be c84%.
- Histology turnaround times remain a high risk; there is an action plan in place and the position is improving. Cancer related histology is being treated urgently and all cancer related escalations are being prioritised

## Workforce

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

**Sickness**

- The in-month sickness rate was 6.14% (7.44% reported at 31/01/22). The 12 month cumulative rate increased to 5.54% (5.41% at 31/01/22).
- Covid-related absence has been reducing throughout February since hitting a peak on 5th January

2022. However, since 1st March 2022, there has been a further upturn in covid-related absence.

- The focus remains on areas with high sickness levels, with actions including:
- Assurance meetings taking place in the Divisions, focussing on the top 10 long term and top 10 frequent absences.
- Continued daily monitoring of sickness absences, specifically all COVID related absence and stress related absence.
- Joint focused absence huddles for Medicine and Surgery taking place with the HR Director and Divisional Representatives
- Divisions have set trajectories for achieving a reduction in Sickness Absence (subject to Covid Pandemic spikes, Winter Pressures and staffing deficiencies) with a year-end target of around 5.5%, which will be monitored via the Improving Together Programme.

**Appraisals**

- February saw an upturn in the Non-Medical PDR compliance rate from 75.91% on 31st Jan to 79.08% on 28th February 2022
- There was an improvement across all Divisions except Surgery, which had a very slight deterioration. Overall performance remains below target
- Statutory and Mandatory Training
- The Statutory and Mandatory training rate at 28th February 2022 was 95.34% (95.41% at 31st Jan 2022). This compliance rate is for the 6 'Core for All' subjects only
- Vacancies
- The overall Trust vacancy rate was 11.55% as a result of an uplift in budgeted establishment to account for Winter planning and business cases (54.83 fte), and a decrease in staff in post (37.4 fte). Bank and Agency covered 65% of the vacancy position and there is sufficient activity in the recruitment pipeline to cover the vacancies, should all of that activity be converted to staff in post.

## Finance

**Key messages**

- The Trust set a plan at the start of the year for a H1 surplus of £8.3m and a full year deficit of £8.8m. The guidance for H2 was issued in September 2021 and at both a National and System level an agreement was reached that the Trust was to carry forward the surplus of £14.5m delivered in H1 and therefore the planned position for H2 was a £14.5m deficit to achieve a breakeven plan for the financial year ending 31 March 2022. Since then, the Trust has worked through the submitted activity plans and calculated an expected income of £5.1m against the Elective Recovery Fund. Therefore in November 2021, the Trust formally submitted a revised annual plan of a £5.1m surplus for the financial year ending 31 March 2022.
- The Trust has delivered an actual deficit of £9.9m in month against an in month planned deficit of £0.6m and a year to date surplus of £5.2m resulting in a favourable variance of £1.8m against the year to date plan. The negative position against plan in month is primarily due to a £10m reduction in block income to support non-recurrent investment across the system.
- A full year forecast has been undertaken at Month 9 and reviewed at Month 11 which presents a £5.2m surplus, although there is a risk of delivering a surplus in excess of this figure due to the TIF ITU funding which the Trust will be receiving in Month 12.
- The Trust incurred £0.9m of costs relating to COVID-19 in month which is a decrease of £0.5m compared with Month 10's figure. This remains within the Trust's YTD fixed allocation with £0.4m being chargeable on top of this allocation for COVID-19 testing costs.
- Capital expenditure for the year to date stands at £23.9m which is £1.1m behind the plan mainly due to an underspend relating to digital pathology and estates infrastructure.
- The cash balance at Month 11 is £78.7m which is £0.3m higher than plan, the main reason being lower than forecast capital payments which reflects the overall slippage against the capital plan.

## Key Recommendations

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

NHS
University Hospitals of North Midlands
NHS Trust

# Integrated Performance Report

Month 11 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?

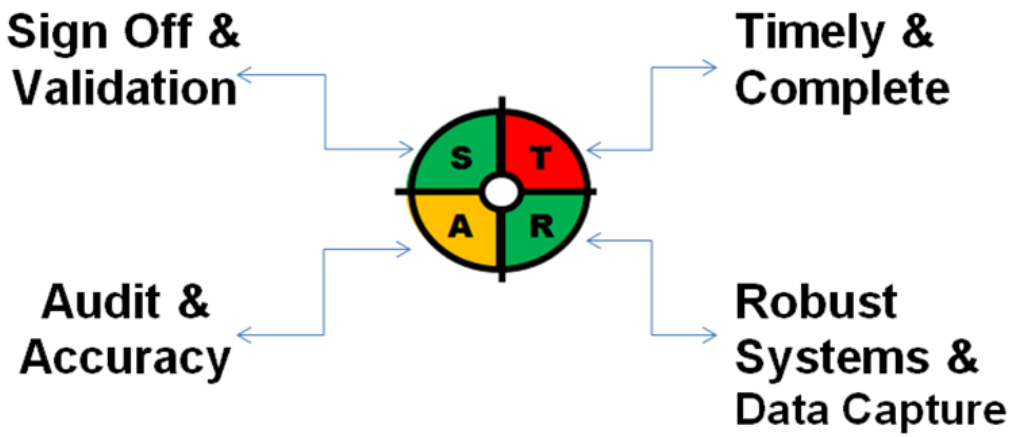
The below key and icons are used to describe what the data is telling us;

| 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**

University Hospitals of North Midlands NHS Trust

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




## Explaining each domain

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

## RAG rating key

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

# Quality

*Caring and Safety*

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

# Quality Spotlight Report

NHS University Hospitals of North Midlands NHS Trust

**Key messages**

The Trust achieved the following standards in February 2022:

- Friend & Family (Inpatients) improved to 99.3% and exceeds 95% target.
- Friend & Family (Maternity) improved to 100% and exceeds 95% target.
- Harm Free exceeded 95% target rate with 96.7%
- Trust rolling 12 month HSMR continue to be below expected range.
- VTE Risk Assessment completed during admission continues to exceed 95% target with 99.4% (point prevalence audit via Safety Thermometer).
- Zero avoidable MRSA Bacteraemia cases reported.
- C Diff YTD figures below trajectory with 0 against a target of 8.
- There have been no Category 4 Pressure Ulcers attributable to lapses in care during February 2022.
- Sepsis Screening compliance in Emergency Portals exceeded the target 90% with 90.5%.
- Inpatients Sepsis Screening 91.3% above 90% target rate and Inpatient Sepsis IVAB within 1 hour achieved 97.2% and exceeded 90% target rate
- Maternity Sepsis in 1 hour compliance 100% against 90% target

The Trust did not achieve the set standards for:

- Friend & Family Test for A&E has decreased to 72.9% and below 85% target.
- Falls rate was 7.2 per 1000 bed days
- There were 23 Pressure ulcers including Deep Tissue Injury identified with lapses in care during February 2022.
- 90.9% Duty of Candour 10 working day letter performance following formal verbal notification. All patients have received written notification but 1 case was over 10 day target.
- 0 Never Event reported
- Children's Sepsis Screening compliance 84.4% and below the 90% target.
- Emergency Portals Sepsis Screening in 1 hour improved to 89% but is below the 90% target for audited patients
- Emergency Portals Sepsis IVAB in 1 hour 69% and is below the 90% target for audited patients
- Maternity Sepsis Screening compliance 80.0% against 90% target

During February 2022, the following quality highlights are to be noted:

- The rate of complaints per 10,000 spells is 35.63 and is slightly above the target of 35 but within normal variation. Majority of complaints in February 2022 relate to clinical treatment.
- Total number of Patient Safety Incidents decreased in month (1712) and the rate per 1000 bed days has also increased at 46.14 and both measures are within normal variation.
- Total incidents with moderate harm or above and the rate of these incidents above normal variation levels and incidents are under review to identify issues/themes.
- Decrease in total reported incidents relating to staffing shortages and lack of appropriate staff on wards/departments during January 2022. 60 in total although 31 were coded as patient related, the remaining 29 were reported as staff related incidents.
- Rate of falls reported that have resulted in harm to patients currently at 1.8 per 1000 bed days in February 2022. The rate of patient falls with harm continues to be within the control limits and normal variation but is above the mean rate which indicates there may be improvement in reducing harm from falls.
- Medication related incidents rate per 1000 bed days is 5.5 and patient related 4.4 which are increases compared to previous months. The monthly variation is within the normal expected variation and consistent with Trust mean rates. However whilst it is below the previously published NRLS national mean rate of 6.0 the rate is nearer to the national mean rate.
- Pressure Ulcers developed under UHNM care has seen a decrease during February 2022 along with a similar decrease in number with lapses in care compared to previous months.
- 26 Definite Hospital Onset / Nosocomial COVID-19 cases reported in February 2022.
- 4 COVID-19 death falling in to the 'Definite' category (according to the National definition of Nosocomial deaths of first positive result 15 days or more after admission to hospital).
- 18 Serious Incidents reported February 2022. All the serious incidents were reported on STEIS within the 2 working date target following confirmation of SI criteria.

# Quality Dashboard

University Hospitals of North Midlands NHS Trust

| Metric | Target | Latest | Variation | Assurance |
|---|---|---|---|---|
| Patient Safety Incidents | N/A | 0 | | |
| Patient Safety Incidents per 1000 bed days | N/A | - | | |
| Patient Safety Incidents per 1000 bed days with no harm | N/A | 0.00 | | |
| Patient Safety Incidents per 1000 bed days with low harm | N/A | 0.00 | | |
| Patient Safety Incidents per 1000 bed days reported as Near Miss | N/A | 0.00 | | |
| Patient Safety Incidents with moderate harm + | N/A | 0 | | |
| Patient Safety Incidents with moderate harm + per 1000 bed days | N/A | - | | |
| Harm Free Care (New Harms) | 95% | 96.7% | | |
| | | | | |
| Patient Falls per 1000 bed days | 5.6 | 0.0 | | |
| Patient Falls with harm per 1000 bed days | 1.5 | 1.8 | | |
| | | | | |
| Medication Incidents per 1000 bed days | 6 | 5.5 | | |
| Medication Incidents % with moderate harm or above | 0.50% | 1.56% | | |
| Patient Medication Incidents per 1000 bed days | 6 | 3.8 | | |
| Patient Medication Incidents % with moderate harm or above | 0.50% | 1.95% | | |

| Metric | Target | Latest | Variation | Assurance |
|---|---|---|---|---|
| Serious Incidents reported per month | 0 | 18 | | |
| Serious Incidents Rate per 1000 bed days | 0 | 0.51 | | |
| | | | | |
| Never Events reported per month | 0 | 0 | | |
| | | | | |
| Duty of Candour - Verbal/Formal Notification | 100% | 100% | | |
| Duty of Candour - Written | 100% | 79.0% | | |
| | | | | |
| All Pressure ulcers developed under UHNM Care | TBC | 68 | | |
| All Pressure ulcers developed under UHNM Care per 1000 bed days | N/A | 1.93 | | |
| All Pressure ulcers developed under UHNM Care lapses in care | 12 | 21 | | |
| All Pressure ulcers developed under UHNM Care lapses in care per 1000 bed days | 0.5 | 0.65 | | |
| Category 2 Pressure Ulcers with lapses in Care | 8 | 4 | | |
| Category 3 Pressure Ulcers with lapse in care | 4 | 0 | | |
| Deep Tissue Injury with lapses in care | 0 | 13 | | |
| Unstageable Pressure Ulcers with lapses in care | 0 | 4 | | |

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

# Quality Dashboard

NHS University Hospitals of North Midlands NHS Trust

| Metric | Target | Latest | Variation | Assurance |
|---|---|---|---|---|
| Friends & Family Test - A&E | 85% | 72.9% | | |
| Friends & Family Test - Inpatient | 95% | 99.3% | | |
| Friends & Family Test - Maternity | 95% | 100.0% | | |
| Written Complaints per 10,000 spells | 21.11 | 35.63 | | |
| | | | | |
| Rolling 12 Month HSMR (3 month time lag) | 100 | 97.33 | | |
| Rolling 12 Month SHMI (4 month time lag) | 100 | 101.79 | | |
| Nosocomial COVID-19 Deaths (Positive Sample 15+ days after admission) | N/A | 4 | | |
| VTE Risk Assessment Compliance | 95% | 0.0% | | |
| | | | | |
| | | | | |
| | | | | |
| Reported C Diff Cases per month | 8 | 10 | | |
| Avoidable MRSA Bacteraemia Cases per month | 0 | 0 | | |
| HAI E. Coli Bacteraemia Cases per month | 8 | 7 | | |
| Nosocomial "Definite" HAI COVID Cases - UHNM | 0 | 26 | | |

| Metric | Target | Latest | Variation | Assurance |
|---|---|---|---|---|
| Inpatient Sepsis Screening Compliance (Contracted) | 90% | 91.3% | | |
| Inpatient IVAB within 1hr (Contracted) | 90% | 97.2% | | |
| Children Sepsis Screening Compliance (All) | 90% | 84.4% | | |
| Children IVAB within 1hr (All) | 90% | N/A | | |
| Emergency Portals Sepsis Screening Compliance (Contracted) | 90% | 88.8% | | |
| Emergency Portals IVAB within 1 hr (Contracted) | 90% | 69.4% | | |
| Maternity Sepsis Screening (All) | 90% | 80.0% | | |
| Maternity IVAB within 1 hr (All) | 90% | 100.0% | | |
| | | | | |
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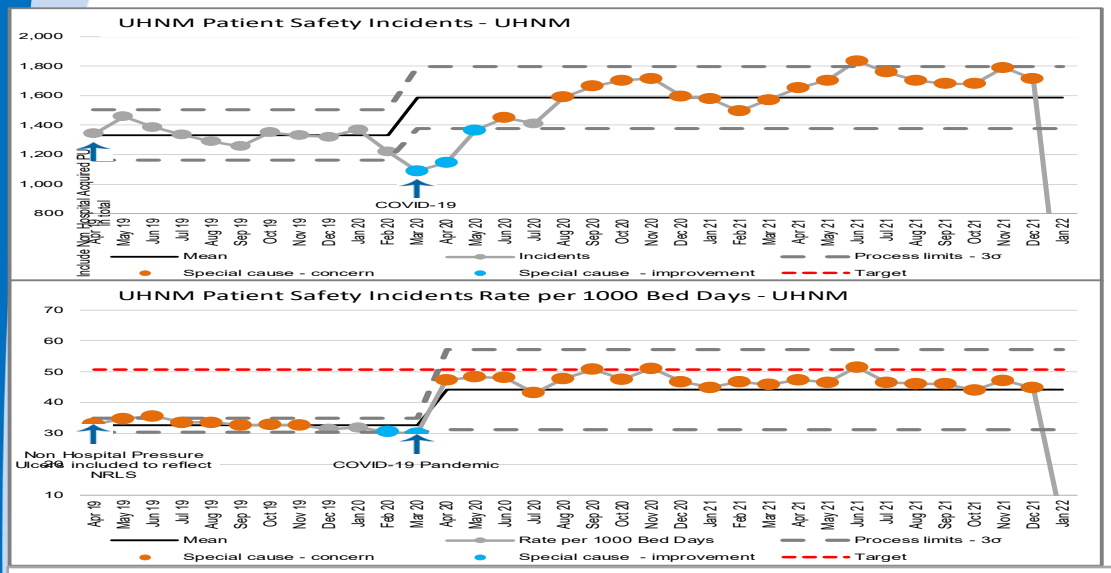
# Reported Patient Safety Incidents




| Variation | Assurance |
|---|---|
|  | |

| Target | Nov 21 | Dec 21 | Jan 22 |
|---|---|---|---|
| N/A | 1791 | 1715 | 0 |

**Background**

Total Reported patient safety incidents

| Variation | Assurance |
|---|---|
|  |  |

| NRLS Mean | Nov 21 | Dec 21 | Jan 22 |
|---|---|---|---|
| 50.70 | 47.15 | 44.77 | - |

**What is the data telling us:**

The above data relates to **all** reported Patient Safety Incidents (PSIs) across the Trust. The February 2022 total remains above the mean total since COVID-19 started. However, the reporting of incidents and near misses should continue to be encouraged and promoted and increasing rates and numbers of total incidents is not necessarily to be viewed as concern. It is important to review the different levels of harm within the overall totals.

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

- Patient related Slip/Trip/Fall - 250 (249)
- Clinical assessment (Including diagnosis, images and lab tests) – 85 (84)
- Patient flow incl. access, discharge & transfer - 107 (81)
- Documentation – 46 (51)
- Pressure Ulcers (Hospital acquired) – 78 (79)
- Treatment/Procedure - 58 (63)
- Medication incidents - 150 (149)
- Infection Prevention – 39 (62)
- Staffing – 28 (31)

There has been decrease in the number of staffing related incidents submitted during February with 55 (60 in January, 74 in December, 60 in November and 61 in October) incidents reported. 28 of these were under patient related and the remaining 27 were reported as staff related. All of these incidents were relating to lack of suitable trained staff. Individual incidents may relate to lack of different staff groups and during February 2022 the following were reported:

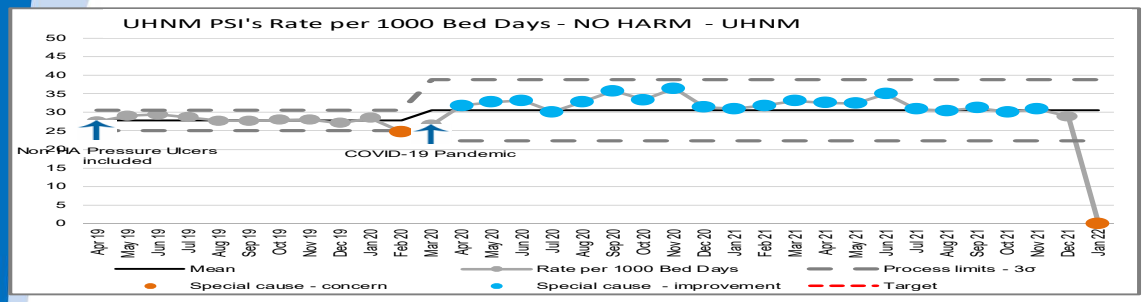
48 (49 in January 2022 and 69 in December 2021) – insufficient professional healthcare staff

2 (13 in January 2022 and 7 in December 2021) – insufficient non professional healthcare staff (6 of these were reported at County Hospital Ward 1)

6 (9 in January 2022 and 6 in December 2021) – insufficient support staff

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

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

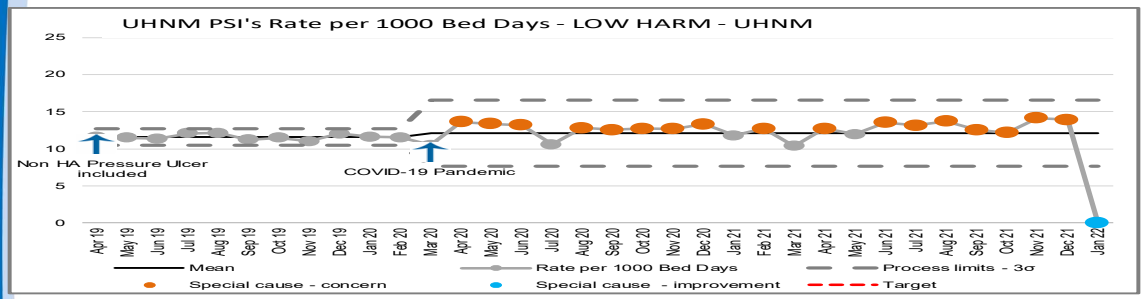



| Variation | Assurance |
|---|---|
| | |

| Target | Nov 21 | Dec 21 | Jan 22 |
|---|---|---|---|
| N/A | 30.91 | 28.90 | 0.00 |

**Background**

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

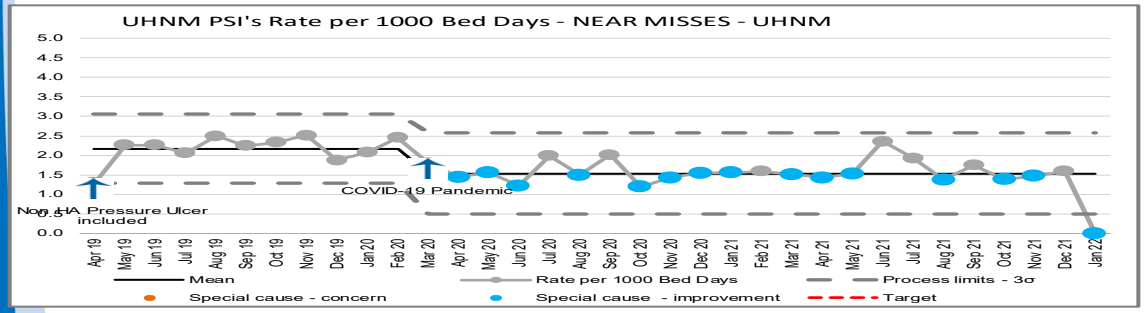



| Variation | Assurance |
|---|---|
| | |

| Target | Nov 21 | Dec 21 | Jan 22 |
|---|---|---|---|
| N/A | 14.14 | 13.94 | 0.00 |

**Background**

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




| Variation | Assurance |
|---|---|
| | |

| Target | Nov 21 | Dec 21 | Jan 22 |
|---|---|---|---|
| N/A | 1.47 | 1.59 | 0.00 |

**Background**

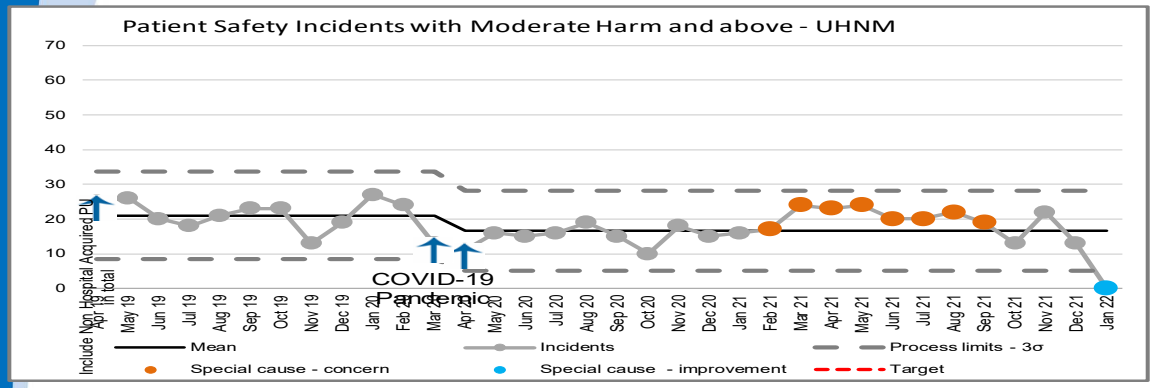
The rate of Patient safety Incidents per 1000 bed days that are reported as NEAR MISS

**What is the data telling us:**

The Rate of Patient Safety Incidents per 1000 bed days with no harm or low harm are showing consistent trends. Although Low harm has seen increase in recent months the rate is still within normal variations and around the long term mean for no harm, low harm and near miss incidents.

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

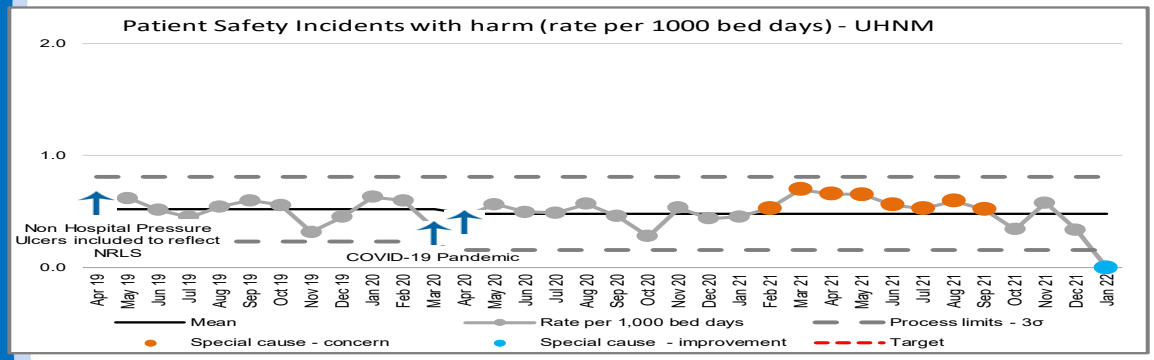



| Variation | Assurance |
|---|---|
| | |

| Target | Nov 21 | Dec 21 | Jan 22 |
|---|---|---|---|
| N/A | 22 | 13 | 0 |

**Background**

Patient safety incidents with reported moderate harm and above



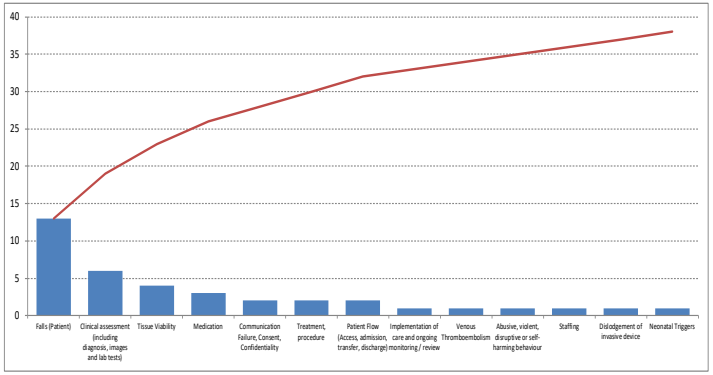

| Variation | Assurance |
|---|---|
| | |

| Target | Nov 21 | Dec 21 | Jan 22 |
|---|---|---|---|
| N/A | 0.58 | 0.34 | - |

**What is the data telling us:**

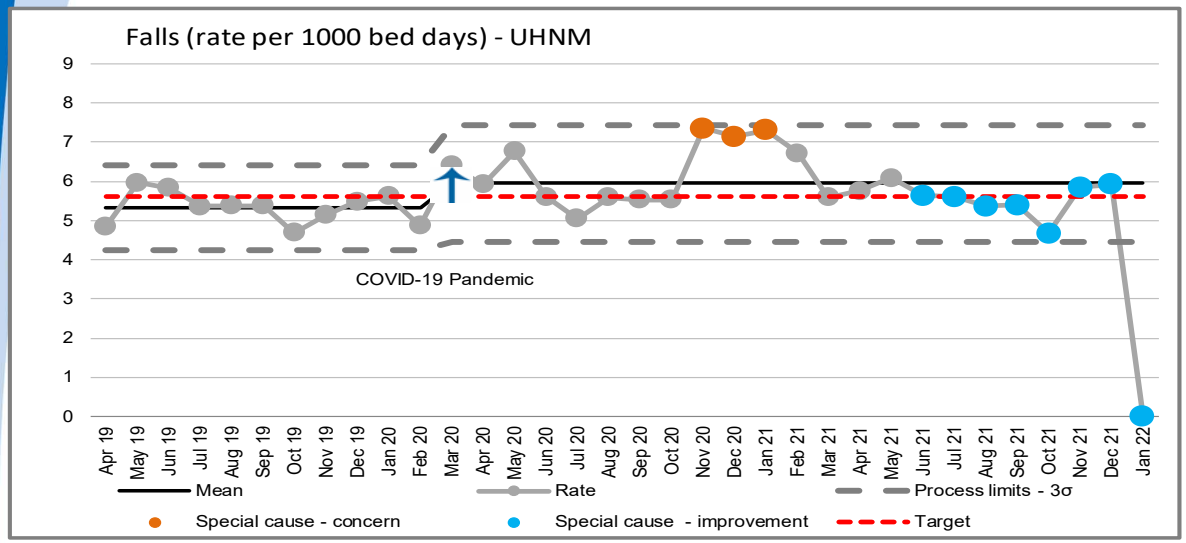
The variation noted in charts above for moderate harm or above total and rate per 1000 bed days is within outside variation and with monthly special cause noted. The monthly total may be amended following investigation of the incidents and level of harm reviewed and confirmed.

The top category of incidents resulting in moderate harm reflect the largest reporting categories with 13 Falls, 6 clinical assessment, 4 pressure ulcer, 3 medication and 2 communication and Implementation of care related being top 6 categories.
National Comparison taken from latest CQC Insight Report is that 26.1% of reported patient safety incidents to NRLS resulted in harm. UHNM latest results are 22.8% .



# Patient Falls Rate per 1000 bed days

University Hospitals of North Midlands NHS Trust




| Variation | Assurance |
|---|---|
|  |  |

| Target | Nov 21 | Dec 21 | Jan 22 |
|---|---|---|---|
| 5.6 | 5.8 | 5.9 | 0.0 |

**Background**

The number of falls per 1000 occupied bed days

**What is the data telling us:**

The Trust's rate of reported patient falls per 1000 bed days remains within the control limits and normal variation.

The Trust adopted the average rate of 5.6 patient falls per 1000 bed days from the Royal College of Physicians National Falls Audit report (2015) as a target rate.

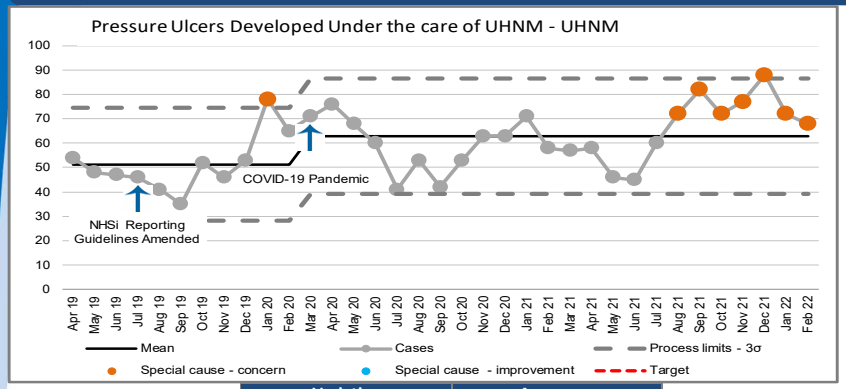
The areas reporting the highest numbers of falls in February 2022 were:

Royal Stoke ED- 31 falls Royal Stoke Ward 112 – 17 falls Royal Stoke AMU – 15 falls Royal Stoke Ward 124 – 11 falls Royal Stoke Ward 230 – 11 falls

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

- A meeting has taken place in ECC with Q&S, Matron, Falls link and education team. Discussion included updating the training presentation, duty of candour, outstanding RCA's, datix's and preventative measures. Q&S will meet with Matron weekly and review falls within the department.
- A risk assessment regarding the doors in majors is being completed, a further meeting is planned for this Friday.
- Ward 112 has been supporting to care for medical patients. Q&S has linked in with the deputy matron and the ward. An audit was carried out regarding the prescription of bed rails against actual position. Documentation was checked for risk assessments and plans of care. Any omissions in preventing a patient fall was put into place. The ward had 3 patients that were multiple fallers, these patients have now been discharged which has reduced the amount of falls for the ward.
- There has been an increase of falls on ward 124 recently. Discussion between Q&S, quality nurse and junior sister regarding the preventative measures that are required to improve the falls agenda.

# Total Pressure Ulcers developed under care of UHNM

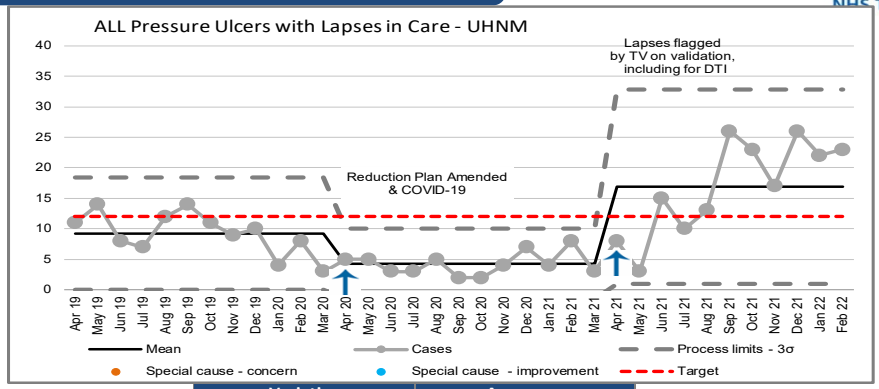



| Variation | Assurance |
|---|---|
|  | |

| Target | Dec 21 | Jan 22 | Feb 22 |
|---|---|---|---|
| N/A | 88 | 72 | 68 |

**Background**

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




| Variation | Assurance |
|---|---|
|  |  |

| Target | Dec 21 | Jan 22 | Feb 22 |
|---|---|---|---|
| 12 | 26 | 22 | 23 |

**Background**

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

The number of pressure ulcers reported as developed under UHNM care has been above average for 7 consecutive months, which may indicate a significant change. The tables below show breakdowns of the pressure ulcers reported in February 2022.

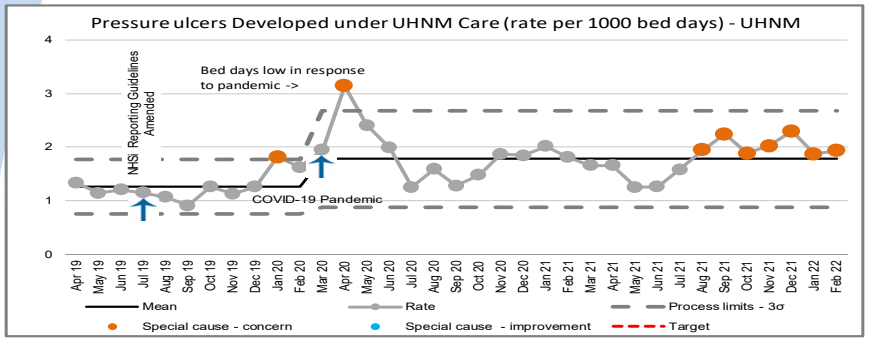
| Category | Total (Feb 2022) |
|---|---|
| DTI | 35 |
| Category 2 | 21 |
| Category 3 | 6 |
| Category 4 | 0 |
| Unstageable | 6 |
| **Total** | **68** |

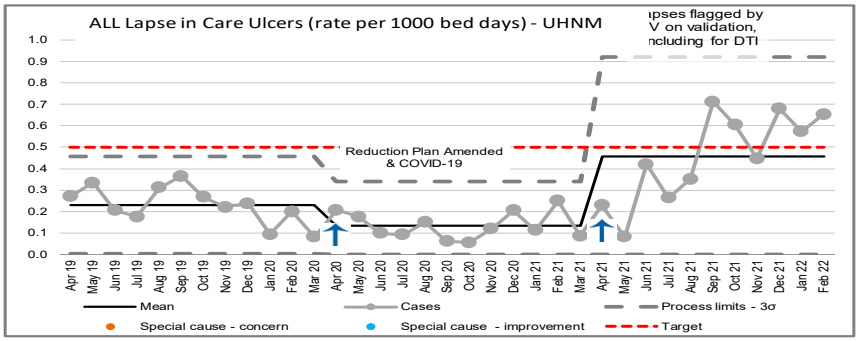
| Top Body Locations | Total (Feb 2022) |
|---|---|
| Heel | 14 |
| Buttock | 9 |
| Sacrum | 4 |
| Toe | 3 |

The number of DTI's reported in February was significantly above average for the third consecutive month. Numbers within other categories are stable.

The number of pressure ulcers reported as developing under the care of UHNM, where lapses in care have been identified, has been significantly higher than in previous years, but there does not currently appear to be a further increasing trend.

# Pressure Ulcers developed under care of UHNM per 1000 bed days




| Variation | Assurance |
|---|---|
|  | |

| Target | Dec 21 | Jan 22 | Feb 22 |
|---|---|---|---|
| N/A | 2.30 | 1.87 | 1.93 |

**Background**

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

| Variation | Assurance |
|---|---|
|  |  |

| Target | Dec 21 | Jan 22 | Feb 22 |
|---|---|---|---|
| 0.5 | 0.68 | 0.57 | 0.65 |

**Background**

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

**What the data is telling us**

Rate of pressures ulcer developed under UHNM care and with lapses in care are similar to previous months and within normal variation

Acuity for ward areas is taken into account in line with lapses in care.

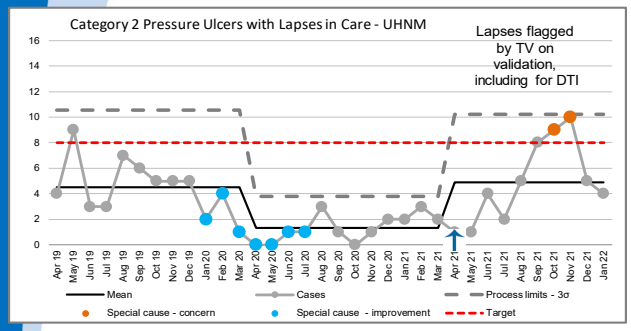
High reporting areas will be presenting all incidents at bespoke RCA panels, to allow identification of trends, and establish their improvement and educational focus. The Tissue Viability team and Corporate Nursing Quality & Safety Teams will support with this.

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

**Actions**

- Documentation is under constant review to reduce identified lapses, aSSKINg bundle has recently been amended to address panel themes
- Pressure Ulcer Prevention (PUP) education is now delivered on multiple platforms including the Nursing Assistant, adaptation nurse and Preceptorship induction programme , new starters in ED and child health, Mandatory ED training and ward champions . Education and support can also be requested as required.
- Communication is provided by SSR for Q&S to multiple reporting wards to highlight learning needs and support formulation of the action panel ahead of RCA panel.
- Following RCA panel assurance is sought from clinical areas by SSR for Q&S, spot audits are completed during the visit.
- Seating audits are being completed across the trust and a proposal for new chairs has been submitted for the Royal Stoke site. Care of the elderly received their new chairs with funds supported by PHE. The County site have also been audited identifying poor pressure relief within the cushion. Action to be taken.
- Review of surfaces in ED to enhance Pressure ulcer prevention, 15 Stryker trollies with high quality pressure relieving mattresses have been purchased. ED will be ordering repose companions for all surfaces. An Ambulance assessment tool has been devised to implement early intervention of PUP however support is still being sought from WMAS.

# Pressure Ulcers with lapses in care

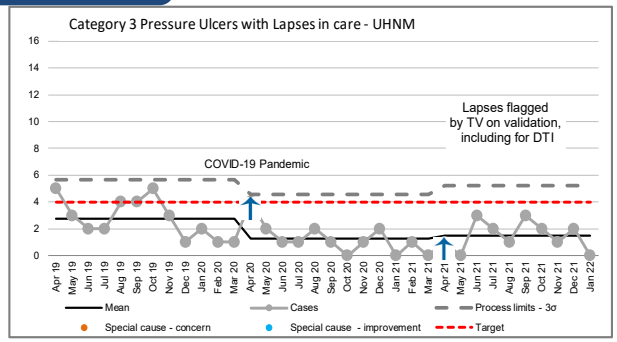



| Variation | Assurance |
|---|---|
|  |  |

| Target | Nov 21 | Dec 21 | Jan 22 |
|---|---|---|---|
| 8 | 10 | 5 | 4 |

**Background**

Category 2 pressure ulcers which developed whilst under the care of UHNM which had lapses of care associated

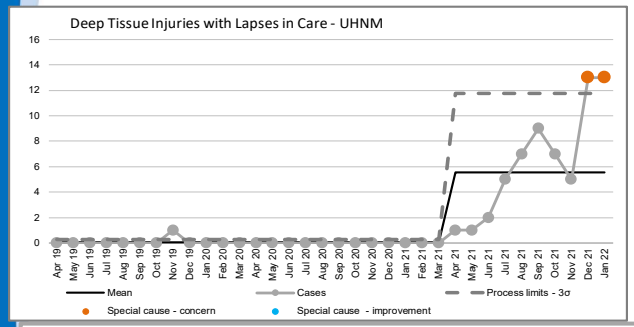



| Variation | Assurance |
|---|---|
|  |  |

| Target | Nov 21 | Dec 21 | Jan 22 |
|---|---|---|---|
| 4 | 1 | 2 | 0 |

**Background**

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

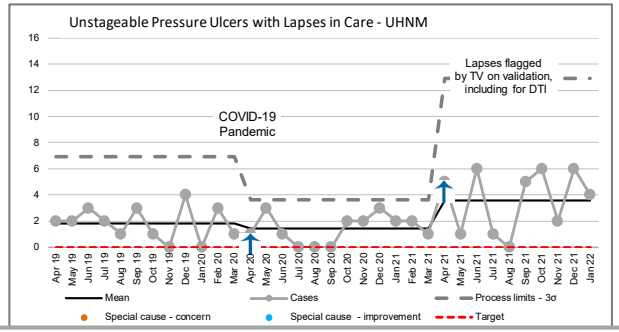



| Variation | Assurance |
|---|---|
|  | |

| Target | Nov 21 | Dec 21 | Jan 22 |
|---|---|---|---|
| N/A | 5 | 13 | 13 |

**Background**

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




| Variation | Assurance |
|---|---|
|  |  |

| Target | Nov 21 | Dec 21 | Jan 22 |
|---|---|---|---|
| 0 | 2 | 6 | 4 |

**Background**

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

**What is the data telling us:**

Deep Tissue Injuries are noted with potential special cause variation and Deep Dive into these DTIs is currently ongoing with the Tissue Viability team and will report the outcome of the review at March 2022 Quality Governance Committee. This analysis is being undertaken to assess the potential causes for increased pressure ulcers with lapses in care and whether this is result of the current operational pressures across the Trust and potentiallinks with long waits in Emergency Department and/or on ambulances.

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

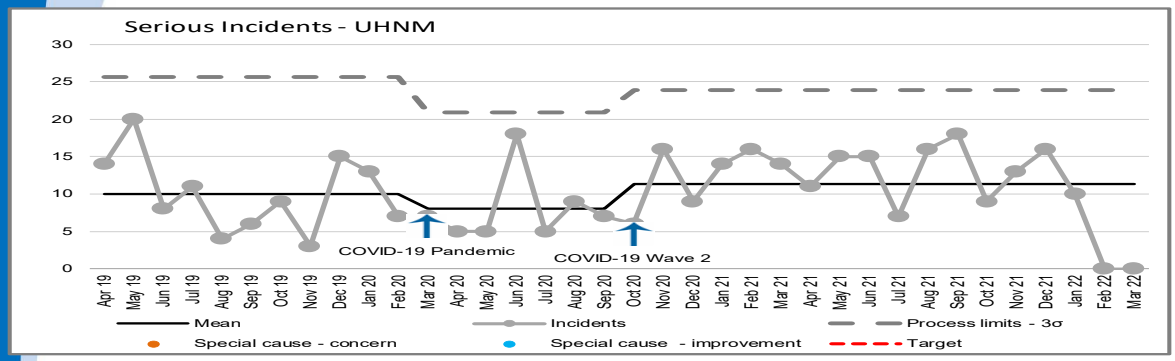
Locations with more than 1 lapse in January 2022 were:
**Ward 221 (3), Ward 126 (2), Emergency Care Centre (2), (County) Ward 15 (2), (County) Ward 14 (2)**

| Root Cause(s) of damage - Lapses - Jan 2022 | Total |
|---|---|
| Management of repositioning | 11 |
| Management of heel offloading | 8 |
| Management of device | 1 |
| Management of non-concordance | 2 |

**Actions:**

- High reporting wards will be sent notification, with Hot Debriefs taking place on the wards
- Education continues on high reporting areas from TV Team and Corporate team
- Pressure Ulcer Prevention (PUP) Champions training is in process planning for next year and focuses on learning from incidents.
- Engage house keepers to support wards with ensuring adequate equipment is available for heel offloading.
- Learning form RCA's educational guide has been shared with staff.

# Serious Incidents per month

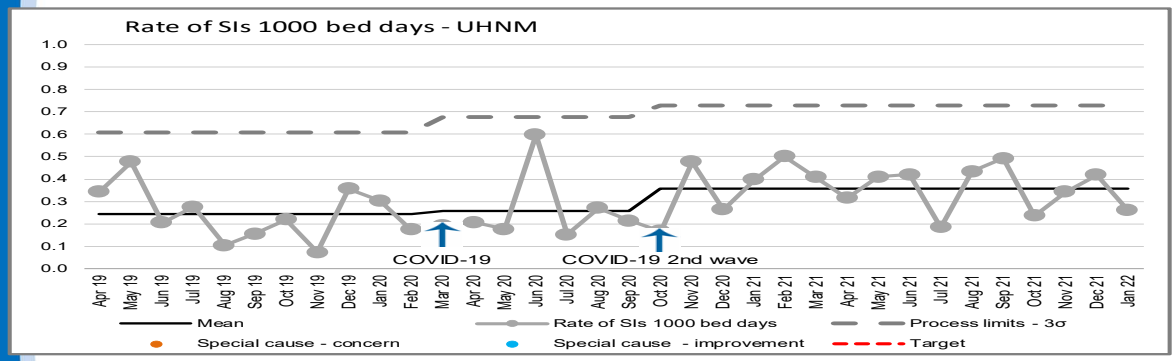



| Variation | Assurance |
|---|---|
| | |

| Threshold | Jan 22 | Feb 22 | Mar 22 |
|---|---|---|---|
| 0 | 10 | 0 | 0 |

**Background**

The number of reported Serious Incidents per month




| Variation | Assurance |
|---|---|
| | |

| Target | Nov 21 | Dec 21 | Jan 22 |
|---|---|---|---|
| 0 | 0.34 | 0.42 | 0.26 |

**Background**

The rate of Serious Incidents Reported per 1000 bed days

**What is the data telling us:**

Monthly variation is within normal limits. Target has been set at 0 for serious incidents but this is under review to develop trajectory for reducing serious incidents across UHNM.

January 2022* saw 10 incidents reported with all 10 at RSUH:

- 7 Falls related incidents
- 1 Surgical/invasive procedure related incidents
- 1 Diagnostic related incidents
- 1 Pending Category – awaiting confirmation of cause of death

**Reported on STEIS as SI in January 2022, the date of the identified incident may not be January 2022.*

# Serious Incidents Summary

University Hospitals of North Midlands NHS Trust

**Summary of new Maternity Serious Incidents**

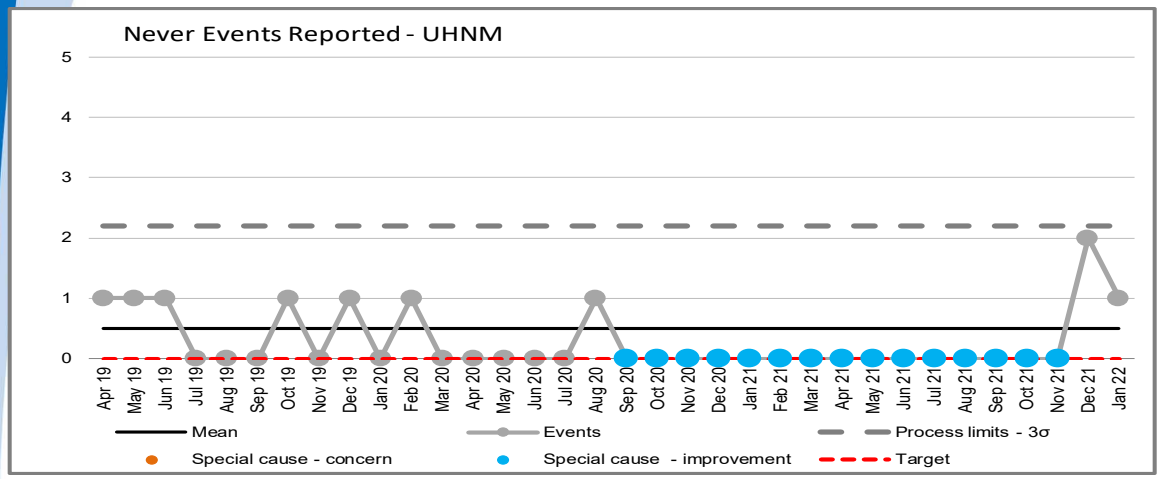
Following the formal recommendations in the Ockenden Report, below is an outline of the Maternity related serious incidents reported during December 2021. The new recommendation requires the Trust Board to receive summary on the new Maternity related Serious Incidents along with previously reported summary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

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

There were 0 Maternity related Serious Incidents reported on STEIS during January 2022

| Log No | Patient Ethnic Group: | Type of Incident | Target Completion date | Description of what happened: |
|---|---|---|---|---|

# Never Events




| Variation | Assurance |
|---|---|
| | |

| Target | Nov 21 | Dec 21 | Jan 22 |
|---|---|---|---|
| 0 | 0 | 2 | 1 |

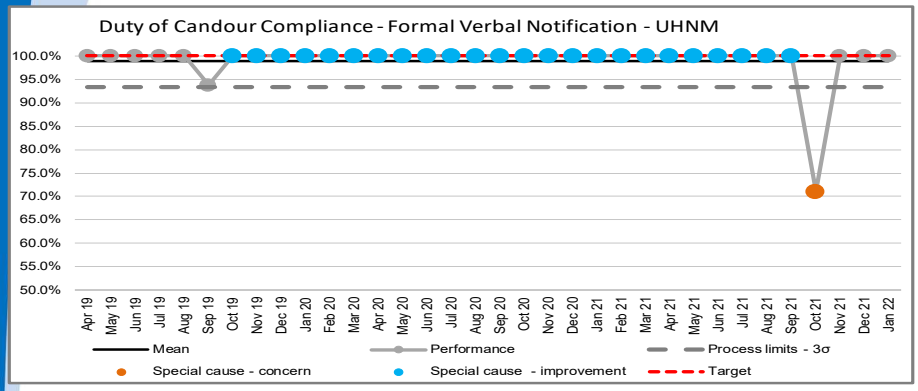
**Background**

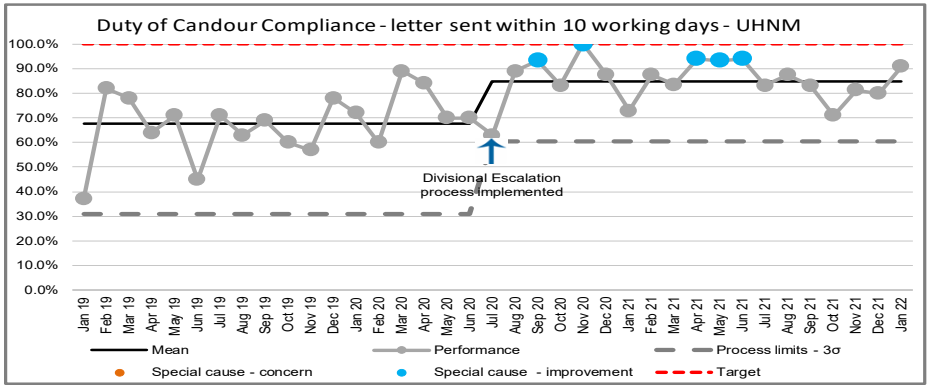
Defined as Serious Incidents that are wholly preventable, as strong systemic protective barriers should be in place

There has been 1 reported in January 2022 and 3 in total for year to date 2021/22. The target is to have 0 Never Events.

| Log No. | STEIS Category | Description | Target Completion date |
|---|---|---|---|
| 2022/1446 | Surgical invasive procedure incident | On 11/1/2022 it was identified that there had been an issue detected with a patient that had been operated on the 2/1/2022. The surgery which was carried out on the 2/1/2022 had required further intervention due to poor reduction and there was a foreign body detected on x-rays. This looks like a radio opaque fibre from a swab. | 19/04/2022 |

# Duty of Candour Compliance




| Variation | Assurance |
|---|---|
| | |

| Target | Nov 21 | Dec 21 | Jan 22 |
|---|---|---|---|
| 100% | 100.0% | 100.0% | 100.0% |

**Background**

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

| Variation | Assurance |
|---|---|
| | |

| Target | Nov 21 | Dec 21 | Jan 22 |
|---|---|---|---|
| 100% | 81.3% | 80.0% | 90.9% |

**Background**

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

**What is the data telling us:**

During January there were 11 incidents reported and identified that have formally triggered the Duty of Candour. All 11 of these cases (100%) have recorded that the patient/relatives been formally notified of the incident in Datix.

Confirmed Follow up Written Duty of Candour compliance (i.e. receiving the letter within 10 working days of verbal notification) during January 2022 is 90.%.

Whilst there was 1 case that had not received the letter within 10 days, the letters has subsequently been circulated .

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

**Actions taken:**

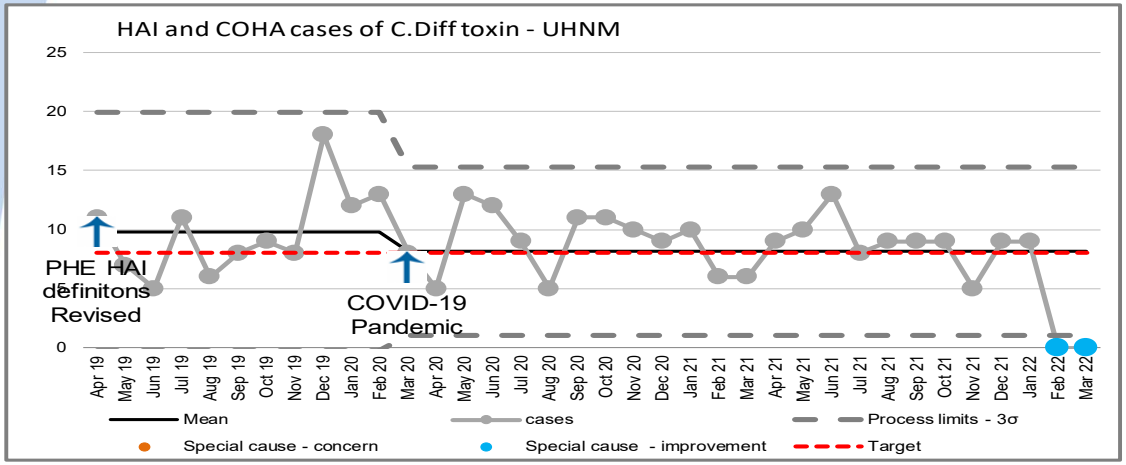
The previous decline in performance had been escalated with Divisions via Quality & Safety Oversight Group and support is being provided to facilitate the completion of the written notifications during the increased pressures and staffing shortages. January 2022 has seen improvement in the compliance with the 10 day target.

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

Compliance is included in Divisional reports for discussion and action.

# Reported C Diff Cases per month

University Hospitals of North Midlands NHS Trust




| Variation | Assurance |
|---|---|
|  |  |

| Target | Jan 22 | Feb 22 | Mar 22 |
|---|---|---|---|
| 8 | 9 | 0 | 0 |

**Background**

Number of HAI + COHA cases reported by month

**What do these results tell us?**

Number of C Diff cases cases are within SPC limits and normal variation .

There have been 9 reported C diff cases in January with 6 being Hospital Associated Infection (HAI) cases and 3 COHA cases.

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

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

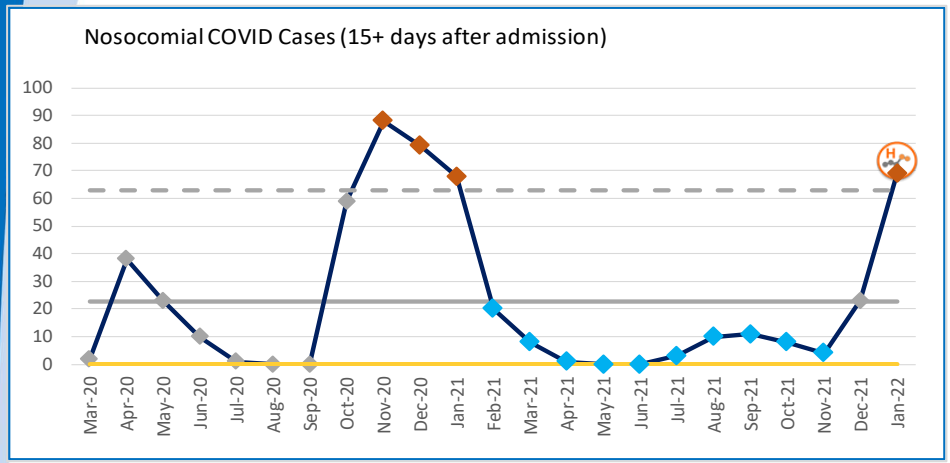
There has been one clinical area that has had more than one Clostridium *difficile* case in a 28 day period.

- Ward 102 (2*HAI) and Ward 110 (2 * HAI). Ribotypes are still outstanding so it is not possible to say whether person to person transmission has occurred.
- IP measures in place

**Actions:**

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

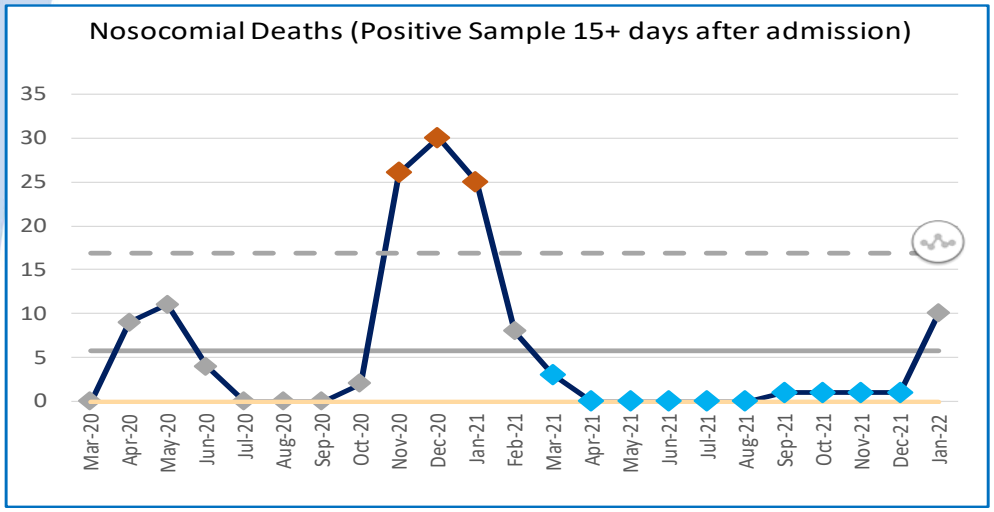
- Significant increase in cases throughout January 2022 with 67 definite Healthcare Acquired COVID -19 cases. This was contributed by Ward 79 Outbreak during January 2022
- January has seen increase in Probable and definite Hospital Onset COVID but is below January 2021 figures for probable cases and 1 more definite case with 69 compared to 68

| | Community COVID-19 rate per 100,000 population (as at month end) | | | | UHNM | | |
|---|---|---|---|---|---|---|---|
| | England | W Mids | Staffs | Stoke | Total Admissions | COVID cases | |
| | | | | | | Prob | Def |
| Oct 20 | 232.1 | 273.7 | 352.2 | 373.3 | 17006 | 63 | 59 |
| Nov 20 | 152.2 | 188.0 | 206.0 | 350.3 | 14956 | 109 | 88 |
| Dec 20 | 526.0 | 404.1 | 370.2 | 318.7 | 14701 | 107 | 79 |
| Jan 21 | 283.0 | 328.0 | 296.0 | 239.5 | 14255 | 128 | 68 |
| Feb 21 | 86.60 | 113.2 | 104.6 | 125.2 | 14101 | 31 | 20 |
| Mar 21 | 56.0 | 61.6 | 56.2 | 76.8 | 17105 | 12 | 8 |
| Apr 21 | 24.1 | 23.6 | 17.7 | 35.1 | 16554 | 3 | 1 |
| May-21 | 49.0 | 36 | 27.9 | 18.3 | 17273 | 0 | 0 |
| Jun-21 | 100.4 | 76.9 | 62.4 | 93.6 | 18527 | 0 | 0 |
| Jul-21 | 290.1 | 273.5 | 242.9 | 223.3 | 18168 | 4 | 3 |
| Aug-21 | 310.8 | 321.7 | 360.5 | 375.6 | 17160 | 14 | 10 |
| Sep-21 | 355.3 | 414.0 | 512.2 | 423.3 | 17327 | 11 | 10 |
| Oct-21 | 484.9 | 468.8 | 569.7 | 532.7 | 17055 | 8 | 8 |
| Nov-21 | 476.1 | 400.2 | 455.2 | 492.2 | 17700 | 4 | 4 |
| Dec-21 | 1591.6 | 1461.3 | 1574.0 | 1298.4 | 16688 | 13 | 23 |
| Jan-22 | 904.4 | 856.7 | 824.5 | 1044.7 | 16109 | 67 | 69 |

**Actions :**

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

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




**What do these results tell us?**

Increase in monthly total but within normal variation limits

The criteria for the Definite Hospital acquired/Nosocomial COVID-19 is that the patient had **first positive** COVID-19 swab result 15 days or more following admission to UHNM.

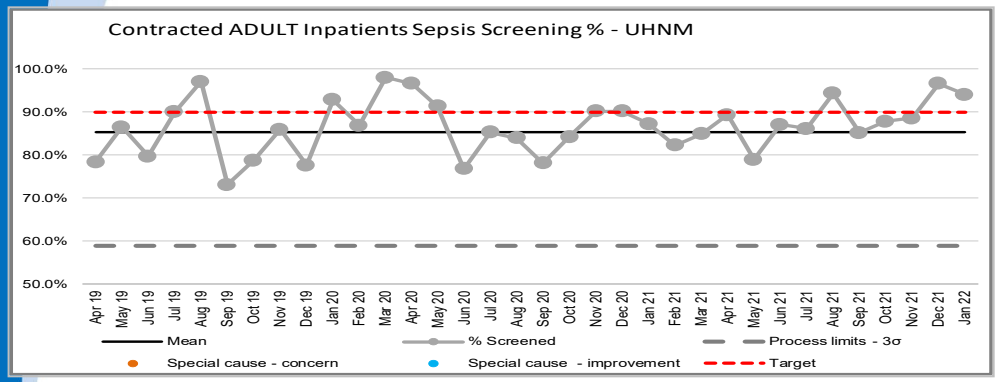
- 10 recorded definite hospital onset COVID-19 deaths in January 2022
- Total 136 hospital acquired COVID-19 deaths with 1st positive results 15 days or more following admission recorded since 1st March 2020 up to 31st January 2022
- The mean number of deaths per month since March 2020 is 6.

**Actions :**

All definite Nosocomial COVID-19 deaths have been reviewed and report has been submitted to the Mortality Review Group identifying the outcome of the case reviews assessing the aspects of COVID-19 management of the patients. Reviews for any further deaths will be undertaken and outcomes compared to the reviews already completed.

# Sepsis Screening Compliance (Inpatients Contract)

University Hospitals of North Midlands NHS Trust

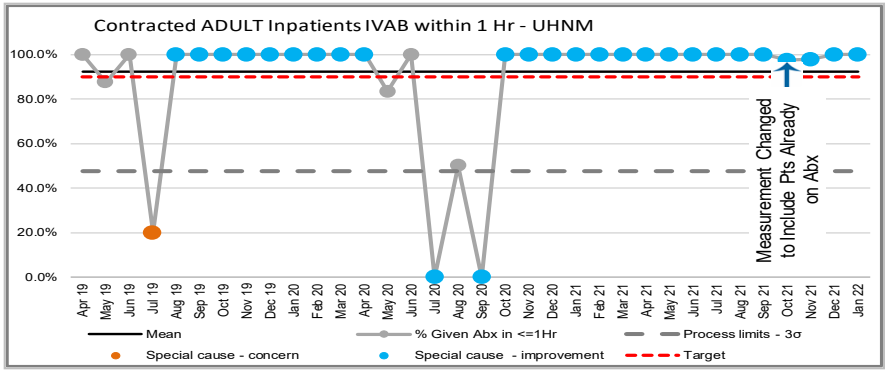



| Variation | Assurance |
|---|---|
| | |

| Target | Nov 21 | Dec 21 | Jan 22 |
|---|---|---|---|
| 90% | 88.6% | 96.6% | 94.0% |

**Background**

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




| Variation | Assurance |
|---|---|
| | |

| Target | Nov 21 | Dec 21 | Jan 22 |
|---|---|---|---|
| 90% | 97.8% | 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:**

Inpatient areas are exceeding the screening target but variation is within normal ranges.

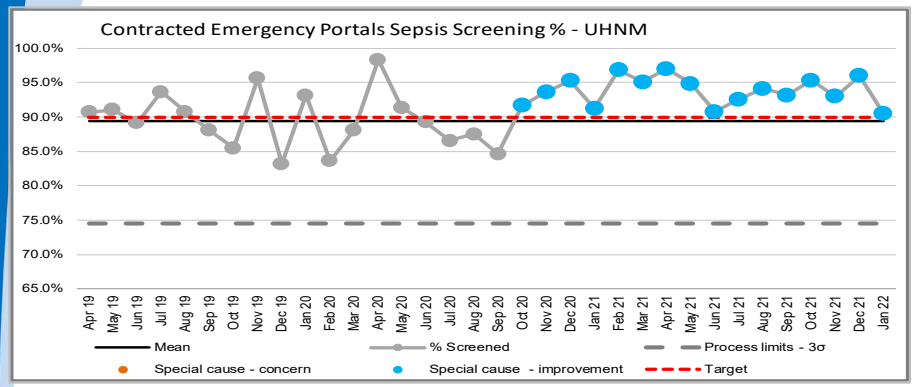
IVAB within 60 minutes is also above target rate with consistently high results.

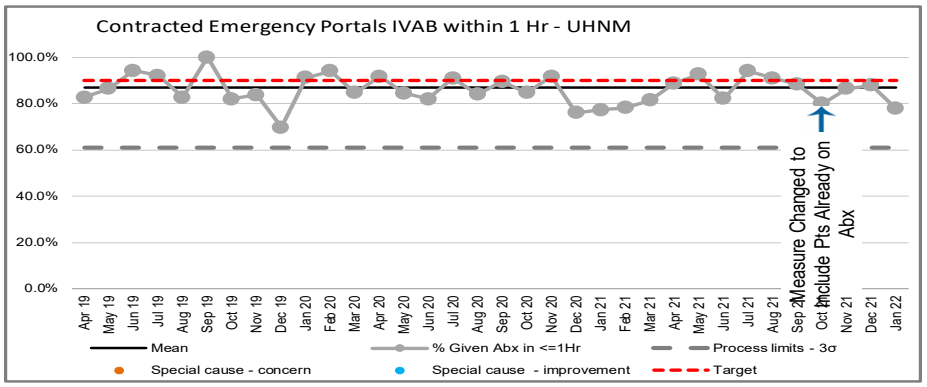
**Actions:**

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

# Sepsis Screening Compliance (Emergency Portals Contract)

NHS University Hospitals of North Midlands NHS Trust




| Variation | Assurance |
|---|---|
| H | ? |

| Target | Nov 21 | Dec 21 | Jan 22 |
|---|---|---|---|
| 90% | 93% | 96% | 90% |

**Background**

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

| Variation | Assurance |
|---|---|
| | ? |

| Target | Nov 21 | Dec 21 | Jan 22 |
|---|---|---|---|
| 90% | 86% | 88% | 78% |

**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 exceeding target and performance is embedded with consistent achievement above the target rate..

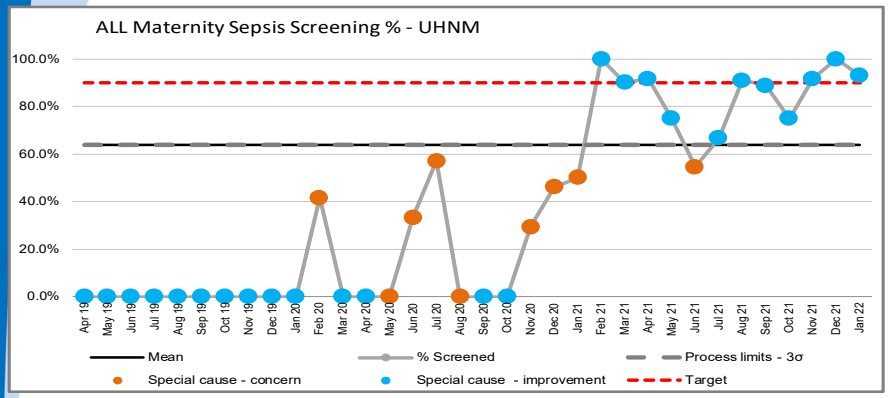
The performance for IVAB within 1hr below target rate but within normal variation.

**Actions:**

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

# Sepsis Screening Compliance ALL Maternity

University Hospitals of North Midlands NHS Trust

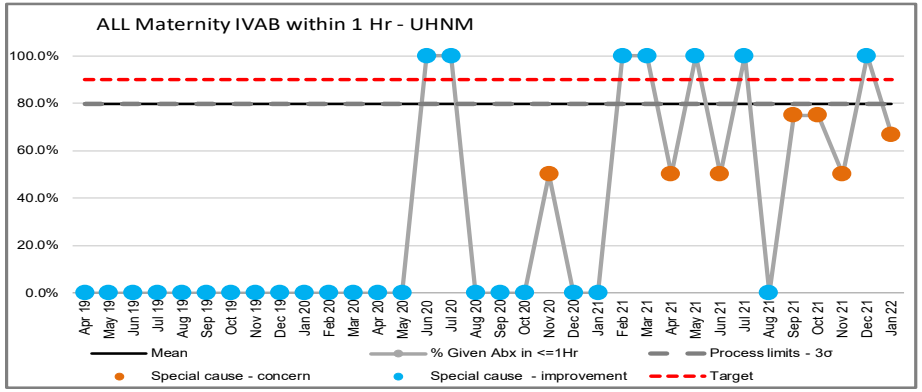



| Variation | Assurance |
|---|---|
| H | F |

| Target | Nov 21 | Dec 21 | Jan 22 |
|---|---|---|---|
| 90% | 91.7% | 100.0% | 92.9% |

**Background**

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




| Variation | Assurance |
|---|---|
| L | F |

| Target | Nov 21 | Dec 21 | Jan 22 |
|---|---|---|---|
| 90% | 50% | 100% | 67% |

**Background**

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

**What is the data telling us:**

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

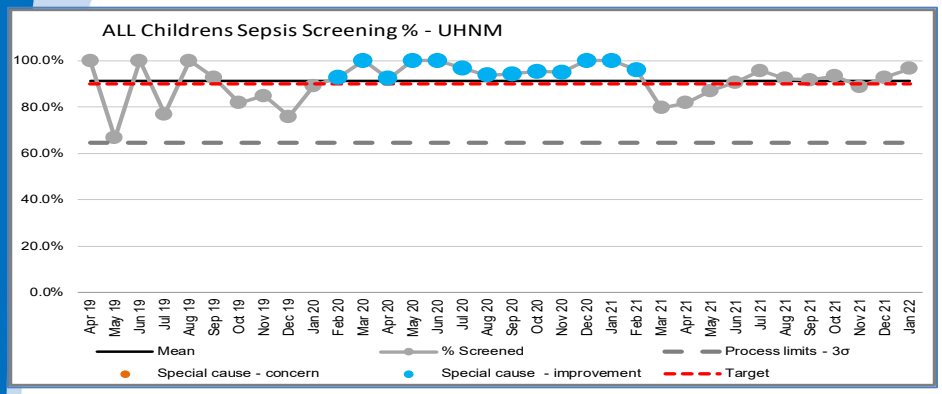
Overall, considering the small size samples for December, the Maternity sepsis screening and IVAB within hour compliance were excellent.

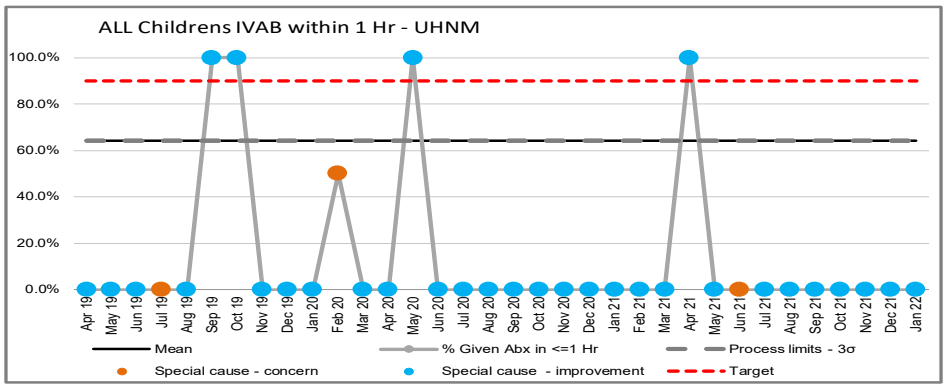
**Actions:**

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

# Sepsis Screening Compliance ALL Children

University Hospitals of North Midlands NHS Trust




| Variation | Assurance |
|---|---|
| | |

| Target | Nov 21 | Dec 21 | Jan 22 |
|---|---|---|---|
| 90% | 88.9% | 92.9% | 96.6% |

**Background**

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

| Variation | Assurance |
|---|---|
| | |

| Target | Nov 21 | Dec 21 | Jan 22 |
|---|---|---|---|
| 90% | N/A | N/A | N/A |

**Background**

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

**What is the data telling us:**

Children's Services show normal variation for Sepsis Screening and have achieved the target rate but as yet not consistently achieving the 90% rate.
Most inpatients Paediatrics are already on oral antibiotics or IV antibiotics prior to trigger of PEWS >5 (this is both of moderate and high risks) and hence N/A results returned for IVAB in 60 minutes compliance

**Actions:**

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

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# Operational Performance

**2025 Vision** "Achieve NHS Constitutional patient access standards"

# Spotlight Report from Chief Operating Officer

NHS University Hospitals of North Midlands NHS Trust

**Emergency Care**

- Attendances remain under forecast in February 2022 still reduced from previous months. High numbers of DTA's were held in ED overnight due to bed based acuity, high numbers of MFFD with all escalation capacity being open and utilised and infection issues compounding flow.
- Ambulance handover delays over 60 minutes were high at 880 being held over one hour, however this was an improvement against January 2022. The percentage of handovers within 15 minutes was 64.4% for the month. Instances of surge evidenced for WMAS attends which provides challenges for triage, especially when stand by patients have to be managed on clinical need.
- Time to initial assessment mean position was slightly reduced at 53.8.%.
- Time to Treatment in ED increased in February and was at 105 minutes.

**Cancer**

- The Trust continues to conduct a high number of 1st appointments, with around 2750 patients being seen in February.
- The overall 2WW position for February 22 is predicted to achieve in the region of 55%. Specialties with the most 14 day breaches are Breast, Skin and Upper GI.
- The 28 Day Faster Diagnosis position is currently at 64% with the majority of breaches in Colorectal and Skin. System challenge for Q4 to secure primary care traction on the FIT pathway given the direct link to improved performance potential. Decision to bring UHNM in line with best practice pathway (sequential FIT model) was flagged at the regional T&F group 11.03.22
- Some specialties are predicted to achieve 28 day FDS in February – e.g. UGI as a result of Rapid Diagnostic Centre investments.
- The overall 62 day position for February 22 is currently at 45%. This is an incomplete and un-validated position that is expected to change as histology confirms a cancer or non cancer diagnosis for patients treated.
- The 62 day backlog has reduced for the 9th consecutive week. There are currently 491 patients in the 2WW backlog. A reduction of 23 since last week. Of the 2WW patients who have breached, 148 patients are in Colorectal and 125 are in Skin.
- The 104+ backlog is slowly reducing, currently at 164. Divisions have been asked to focus on this cohort and discharge patients where appropriate – e.g. where there are patients waiting over 104 days with an outstanding clinical review.
    - Of the patients waiting over 104 days, 58 are on a Colorectal pathway – 35%.

# Spotlight Report from Chief Operating Officer

NHS University Hospitals of North Midlands NHS Trust

**Planned Care**

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

- Day Case and Elective Activity delivered 87% and 73% respectively for February 22 against the national ask of 95%, an improvement on January's position for Day Case (86%), but a decrease on Electives (75%).
- In month Planned Care Cell focus on elective recovery based on 10 high impact changes in accordance with the elective plan.
- Theatre plan for Q1 2022/23 gives 104% of 19/20 capacity. Targeted booking on-going to meet P2 demand and 104+ waits.
- County theatre due to open 4th April.
- T&O have 111% of pre-covid capacity in line with having the largest proportion of 104s.
- Theatre utilisation and booking processes to be focus of Q1.

**RTT**

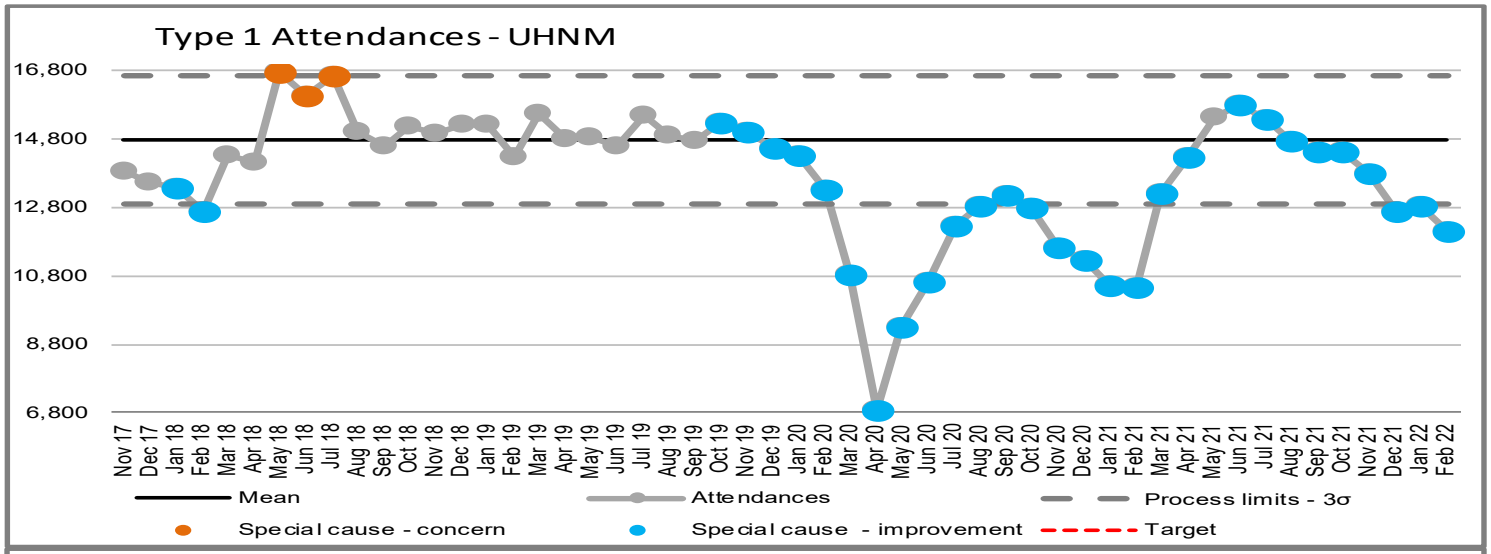
- The overall Referral To Treatment (RTT) Waiting list continues to rise. For February the indicative number of Incomplete pathways has risen to 73, 360 (January 71,321).
- The number of patients > 18 weeks has risen to a level of 32,831 (December 32,147).
- The numbers of 52 week waits in February has stayed the same with a unvalidated total of 4,461 (January 4,463) this figure is below the trajectory.
- At the end of February the numbers of > 104 weeks is looking to be around 561, an increase of 40 on January (starting to decrease as of March 1st). The Planned Care group is monitoring progress against treatment plans for these patients.
- Performance has slightly improved throughout February at provisional 55.7% (January 55.1%).
- Work plans around long wait patient validation and treatment tracking are in progress to support the Data Quality Strategy & Audit requirements.

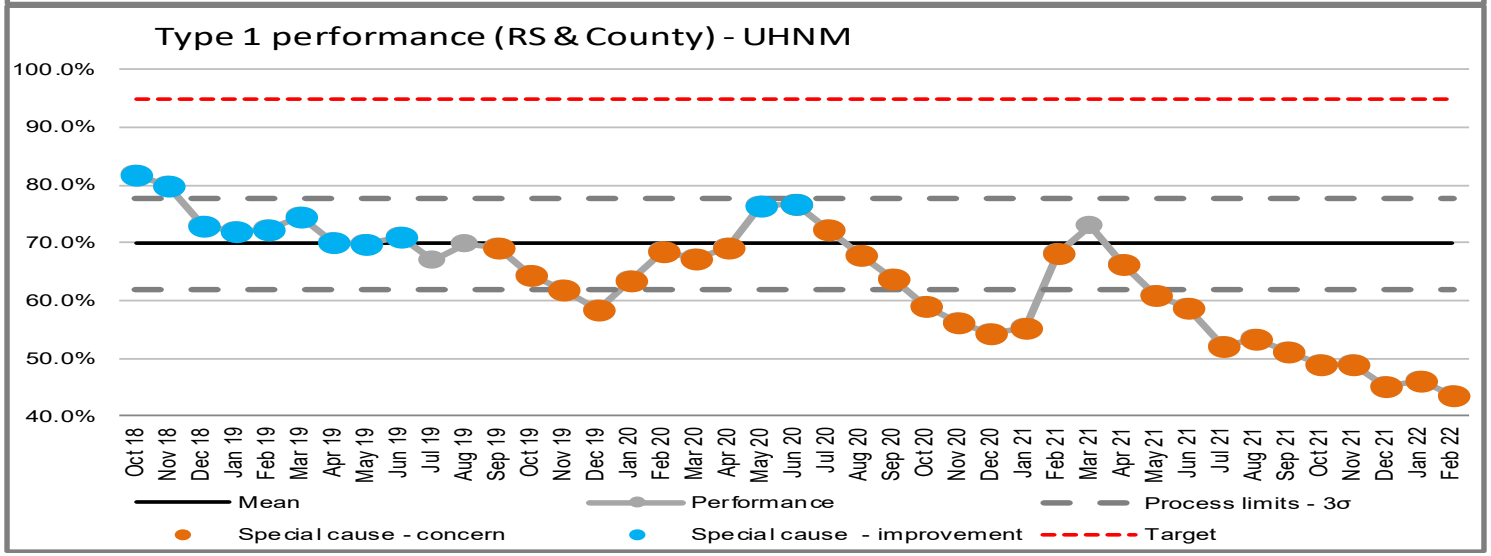
**Diagnostics**

- For DM01 (15 nationally identified Dx tests) the validated position for total waiting list has increased in February from 21083 to 22529. The Non-obstetric ultrasound waiting list increased slightly from 9,368 to 9,394. Due to the challenges in Non-Obstetric Ultrasound this has adversely affected performance. The current DM01 diagnostic performance is at 72%.
- Within DM01, the greatest proportion of > 6 week waits are within Non-obstetric ultrasound and endoscopy. The ultrasound position is related to an increase in demand alongside workforce shortfalls, a number of actions are in place. Non obstetric ultrasound performance remains a Driver Metric for CWD and has specific focus for improvement, albeit this is related to workforce retention, recruitment and innovative ways to train and recruit. Further outsourcing of non-obstetric ultrasound scanning is continuing to be explored.
- DM01 performance excluding non obs ultrasound would be c84%.
- Histology turnaround times remain a high risk; there is an action plan in place and the position is improving. Cancer related histology is being treated urgently and all cancer related escalations are being prioritised.

# Section 1: NON ELECTIVE IMPROVEMENT

# Urgent Care – Attendances and 4 hour performance



# Urgent Care – In Month Performance Summary

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*Attendances;* Total type 1 attendances declined further than January 2022 and now in line with attendances seen pre Xmas 2021. The drop is in line with previous drops in attendances numbers due to surges in Covid prevalence.

*Triage;* Initial assessment within 15 minutes decreased in February to 53.8% from 56%. Performance is influenced most where there are surges of over 30 attendances within the hour, particularly in the evening. This can be where staff shortages, particularly decision makers has been a challenge. The department are aiming to stop the decline in triage time with re-deployment of staff in the department at the time and are looking at tiered rotas in line with RCEM guidance. A business case addressing workforce challenges was approved in early October and staff are being recruited to as per the planning timescale in that case, a separate paper was presented at PAF this month to share the current position against the funding, a further update will be due back to PAF in April 2022.

*Ambulance;* The percentage of ambulance handovers within 15mins at RSUH site increased in February to 64.4% compared to 61% in January. Handover delays over 60 minutes also slightly decreased from January with 880 rather than over 900. However longer delays occurred during peak ambulance arrival times in early evening, when multiple Crews arrive on site in succession. An action plan to improve ambulance holds is now in progress as well as a Go, Look, Learn of evaluation and leaning to be implemented.

*Long waits;* The number of patients in the department for > 12 hours also was reduced to 372, slightly lower than seen in January. However there is still work to be done to reduce this number further, and is one of the aims of the Reset week planned in March.

*Admissions;* The number of patients attending and admitted with Covid-19 peaked late January with bed demand remaining high until mid February. 1+ LoS spell are at around 92% of 1920 BAU. Discharges pre-noon remained much the same as previous months.

*4 hour Performance;* In February the 4 hour performance (total type 1) slightly declined to 44.35 % in February. When split out by site, RSUH performance was 35% compared to 37% in January and County was 67.5% slightly higher than January at 66%.

# Improvement Overview and Focus

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

## Acute Front Door

**STREAMING & DEFLECTION REDESIGN:**

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

**COMPLEX TRIAGE:**

- Go Look Learn - 15 min triage standard review
- Go Look Learn - Ambulance handover processes

### *MEASURED BY*

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

## Acute Front Door

**WORKFORCE REVIEW & RECRUITMENT:**

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

### *MEASURED BY*

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

## Ward based Principles

**REDUCING CONGESTION:**

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

### *MEASURED BY*

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

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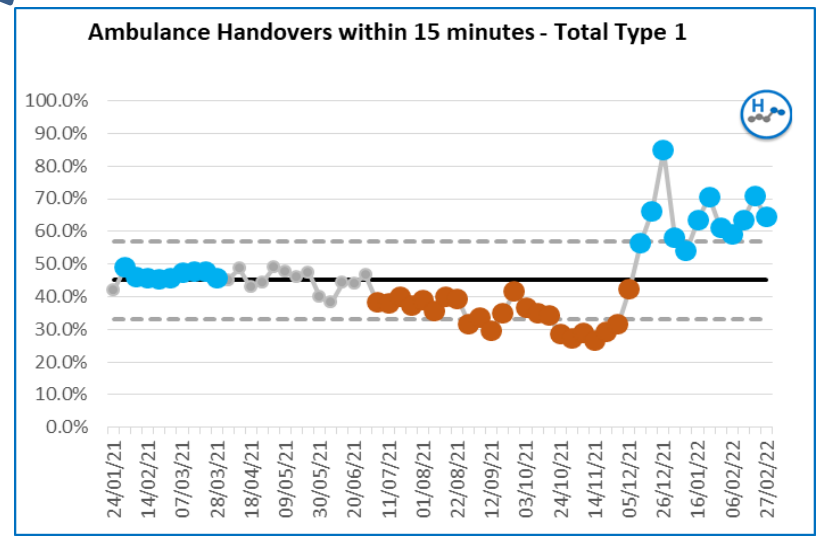
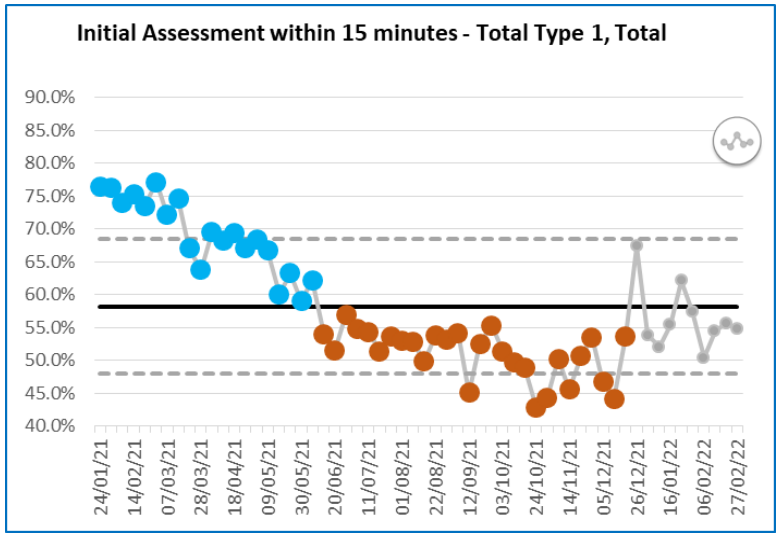
TIME FOCUSED METRICS / UEC Standard

# Front Door - Attendance Management

**RECENT AND IMMINENT ACTIONS**

- Test of change from Navigator at the front door fully embedded which continues to support redirection to alternative places of care including portals (if attending with GP letter) and primary care services from December. Increases seen in patients being deflected to UCC and reductions in those needing to go for triage assessment. Phase 2 of Non specific GP letters went ahead as planned from 07.02.22 with minimal issues occurring and good buy in and support to ED seen from all Specialty teams.
- Internal UHNM – UCC model group commenced reporting to COO with a view of delivering 'UCC like' model from April 1st, initial intention paper to ask for support approved at PAF in January with 2nd update paper sent to PAF for February. Full business case now being drafted.
- Working closely with WMAS to effect earlier handover against 'rapid handover' policy should it be implemented by WMAS. Go Look Learn for Ambulance handovers planned for early February and will support actions to improve.
- 'RED' GP reinstated and capacity increased - daily monitoring of referrals demonstrates that Vocare are currently seeing on average 23 Children (increase from 17) and 31 adults per day (decrease from 38).
- Use of GP referral hub and consultant connect to prevent GP walk in directed to ED
- Regular social media campaigns to highlight alternative services on offer in the community and use of 111First
- 111 Kiosks - early review of the data available indicates that only 4% of patients are being redirected to alternative pathways

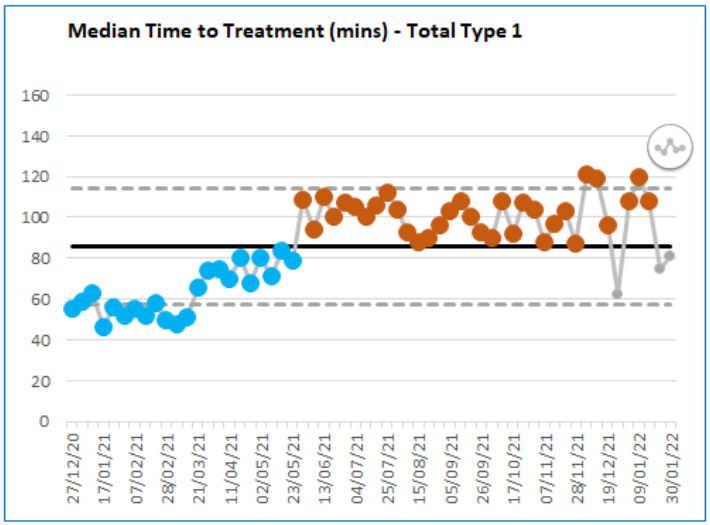


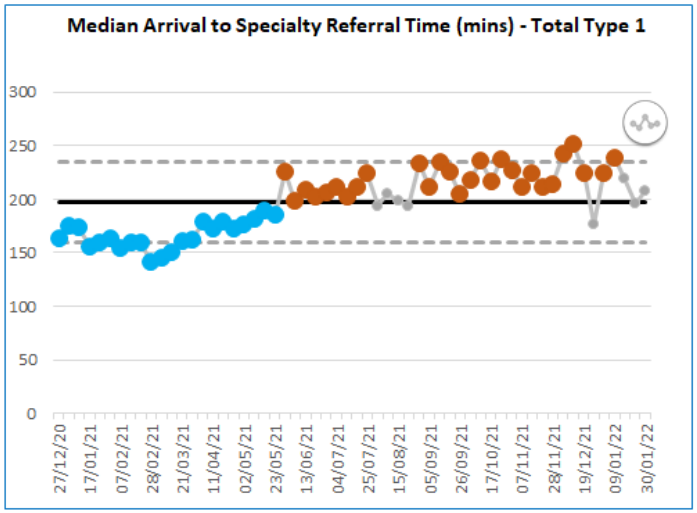



# Front Door - Prompt Decisions

**RECENT AND IMMINENT ACTIONS**

- ED Medical Workforce business case, initial review paper went to PAF February 2022, further update due in April.
- Engage senior clinicians. Re-set department structures and revise rotas, commenced Nov 21 – further work being planned
- Medical rota alignment to the new Tier's recommended by RCEM is underway
- A&E internal improvements including roles and responsibilities, huddles and rounding to improve grip, supported by visible improvement and escalation dashboards

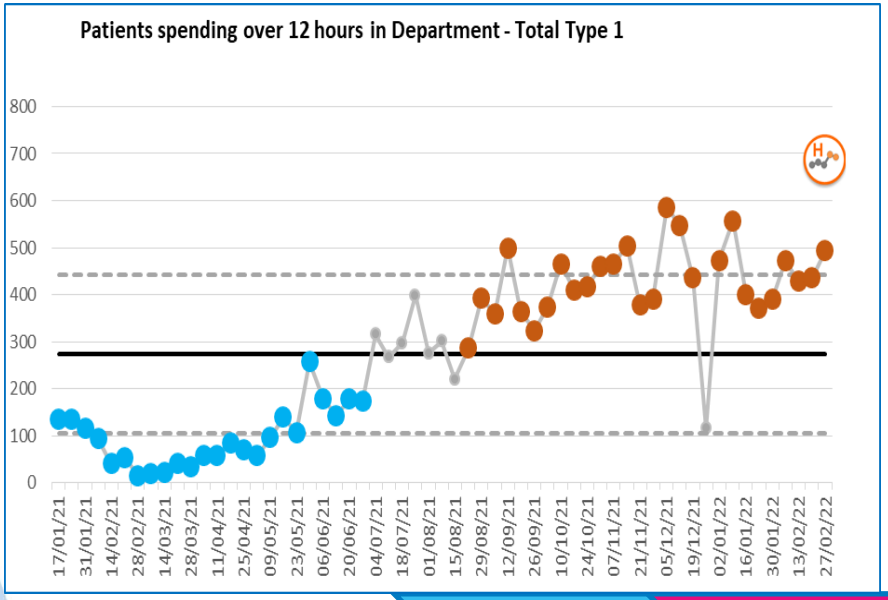


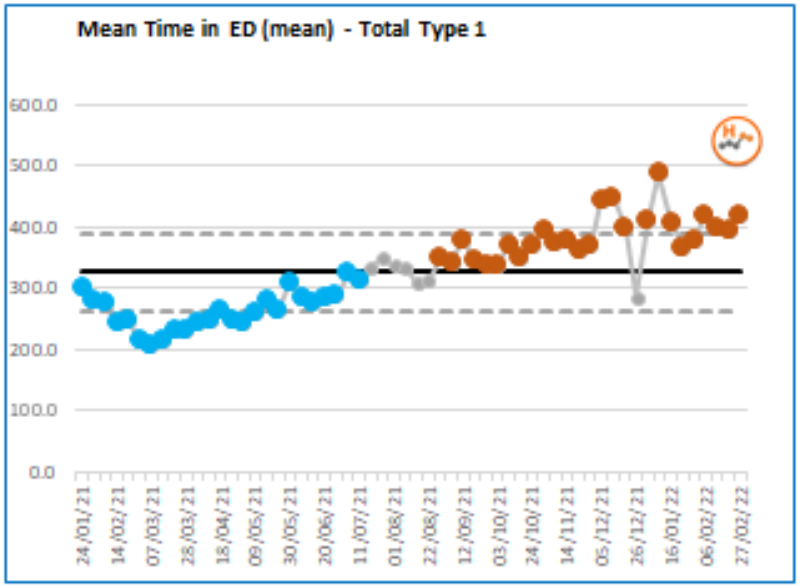



# Ward based Principles - Early Egress for Admissions

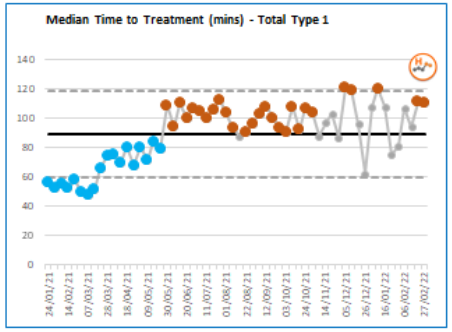
**RECENT AND IMMINENT ACTIONS**

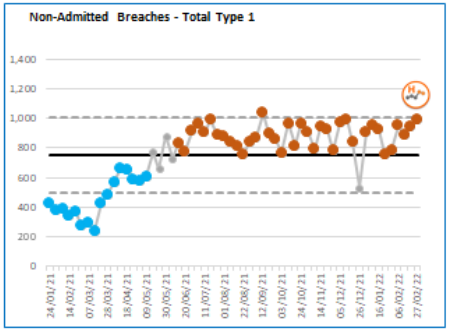
- Medicine division piloting new approach to EDD management to define true capacity/demand at start of the day and to drive behaviours at ward level
- Daily touch points with IPC and Red to Green Meetings in place in January to aid flow
- Application of MFFD and possible transition to Medically Optimised for Transfer (MOFT) to be reviewed and wards instructed on use
- Continued LOS work on stranded patients – great success seen in 21+ day waits.
- Reset week being ran in March – information on aims provided to tactical

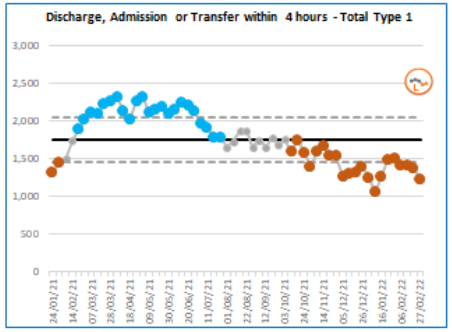


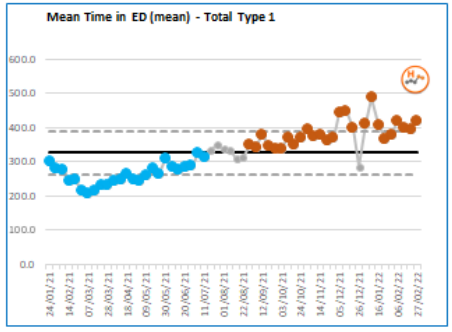



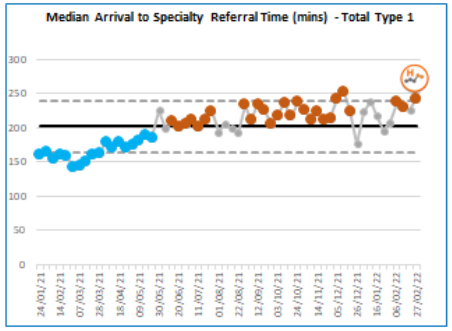
# Front door

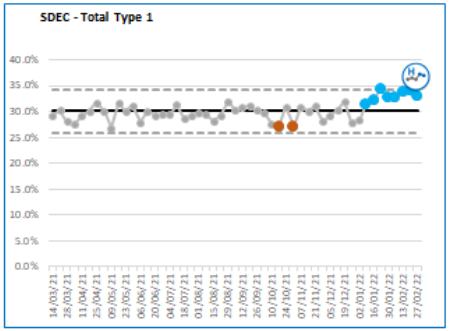


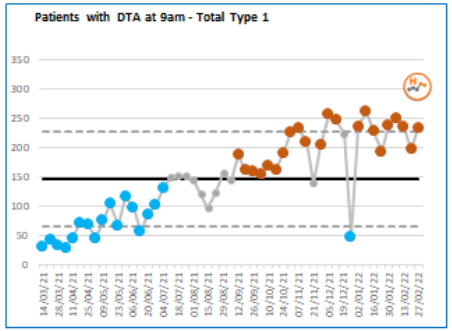



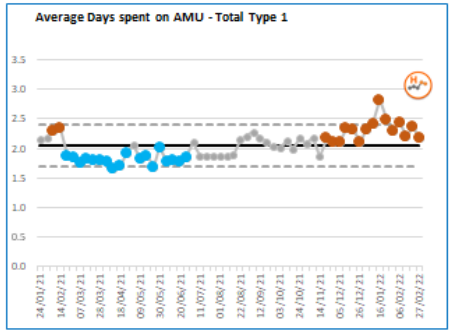



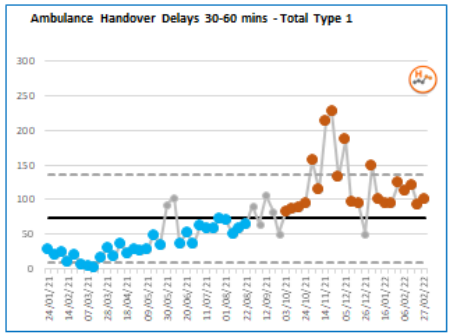



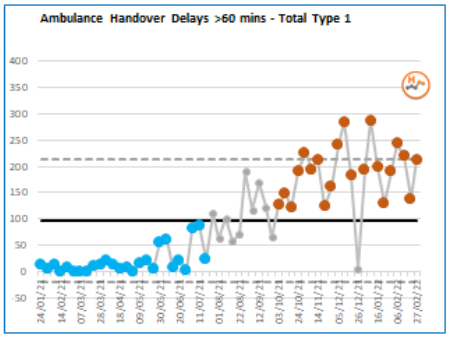



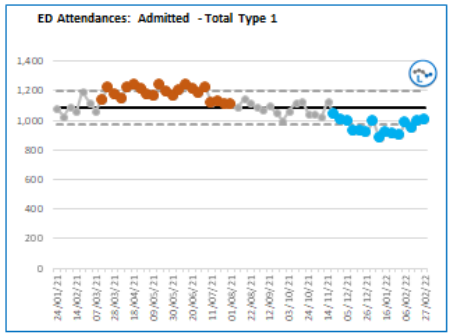



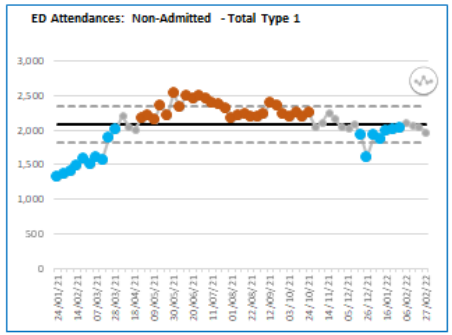

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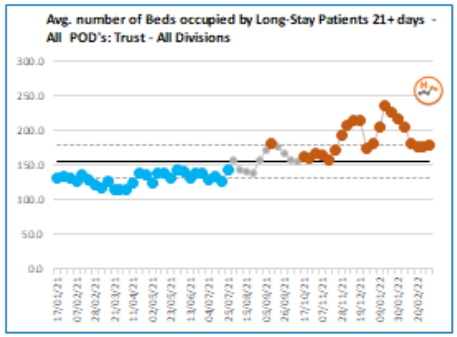
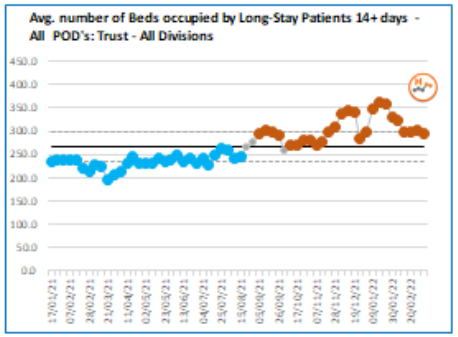
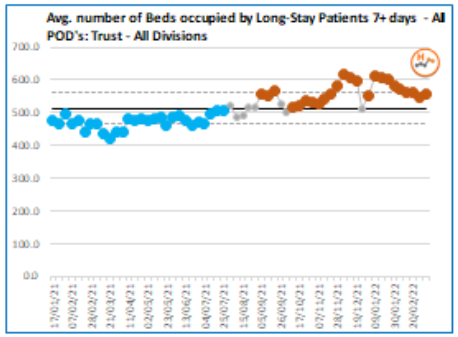
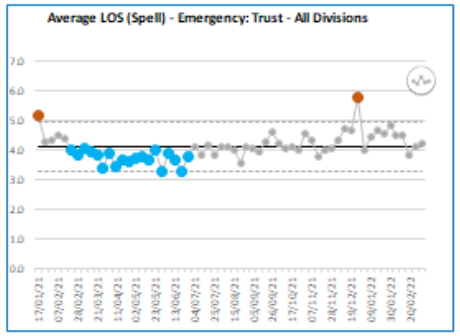
# Flow

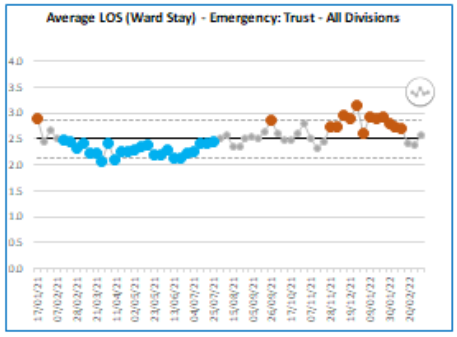


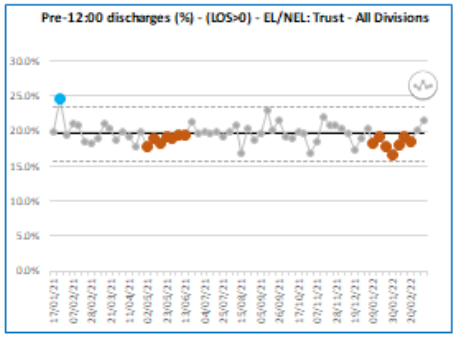

Avg. number of Beds occupied by Long-Stay Patients 21+ days - All POD's: Trust - All Divisions

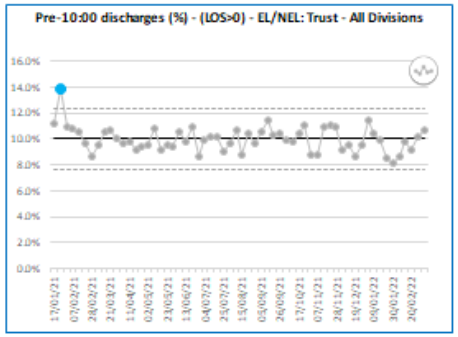

Avg. number of Beds occupied by Long-Stay Patients 14+ days - All POD's: Trust - All Divisions

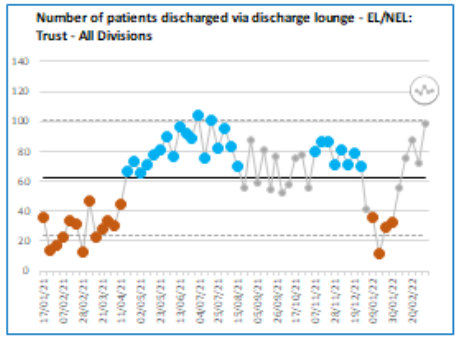

Avg. number of Beds occupied by Long-Stay Patients 7+ days - All POD's: Trust - All Divisions

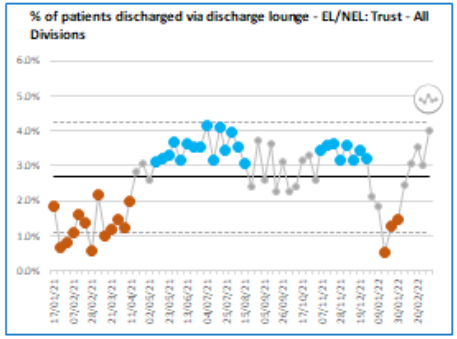

Average LOS (Spell) - Emergency: Trust - All Divisions

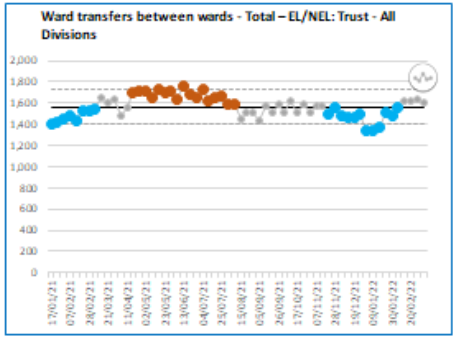

Average LOS (Ward Stay) - Emergency: Trust - All Divisions

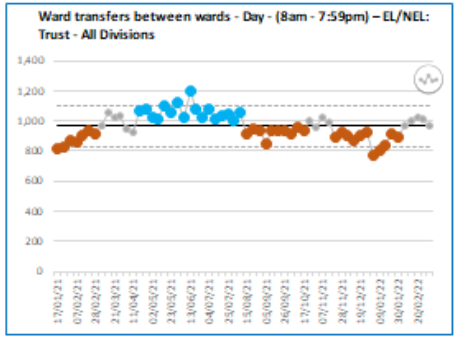

Pre-12:00 discharges (%) - (LOS>0) - EL/NEL: Trust - All Divisions

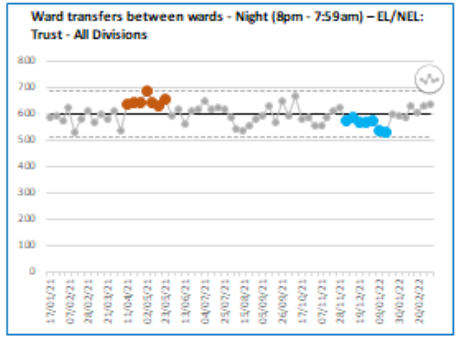

Pre-10:00 discharges (%) - (LOS>0) - EL/NEL: Trust - All Divisions


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


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


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


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


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

# Section 2: ELECTIVE CARE

# Cancer

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NHS Trust

**Challenges:**

- Histology pressures on-going – weekly PTL meeting instated dedicated 2WW pathways outstanding Histo. Escalation timeframe has shifted to only include specimens over 19 days old. Pathology Quality Summit feedback presented to MDT Leads through the Cancer Strategy Group.
- 40 day delay for TRUS Bx on UROL 2WW pathway impacting performance. RALPS also booking into May / July due to capacity constraints.

**Actions:**

- The Lower GI 2WW pathway currently receives 30% of referrals with a FIT result. This has so far demonstrated a reduction in number of Colonoscopies and CTCs, as FIT result guides first investigation and level of pathway urgency. Radiology have demonstrated an increase in yield of low intermediate and high risk polyps and an increased cancer detection rate as a result. To continue to optimise this pathway and align to best practice, UHNM updated on the decision to move to a sequential FIT model at the regional task and finish group.
- The Cancer Services training outreach continues to be a success – with staff from across the trust actively approaching cancer services for support and specific Cancer Waiting Times training requirements.
- Gynae One Stop Model implemented. This provides enhanced workforce for provision of increased clinic slots . New Gynae ANP's have maintained 14 day performance however the 28 day position has been impacted by Pathology turn around times.
- RDC investment in diagnostic services. E.g. Endoscopy – Nurses , admin and improved pathways have driven down wait times. **2300 more endoscopy procedures were delivered as a result of RDC funds** and radiology escalations have expedited pathways and improved turn around times.
- Cytosponge and Capsule Endoscopy pilots on-going. These innovations funded externally release capacity in house for more urgent patients, and diagnose cancers earlier. Pathways that use Endoscopy for first test have seen an improvement in **28 day FDS – UGI predicted to achieve the standard for the first time in Feb22.** (provisional)
- The Vague Symptoms RDC pathway has provided direct access for patients who would've had repeat attendances on many different pathways.
- Denise Coates Foundation – this fund has enabled big ticket items e.g. new Da Vinci robot to be purchased plus new MDT video conferencing kit to improve efficiency of the growing number of MDT discussions taking place.
- Pathology Demand Analytics has been commissioned to improve lab efficiency on non cancer pathways, to aid recovery of the backlog.
- DCF Schemes are progressing – A strategy group has been set up to guide and implement the vision for holistic therapies services within the newly refurbished cancer centre. Complimentary / Holistic Therapies, Information & Support are being scoped . Lead Nurse and Info Centre manager seeking best practice from other areas that deliver complimentary therapies.
- The 'National Cancer CNS Day' will take place on 15th March that will celebrate the role of a cancer CNS, raise awareness of the position to encourage interest, and show gratitude to those already in position.

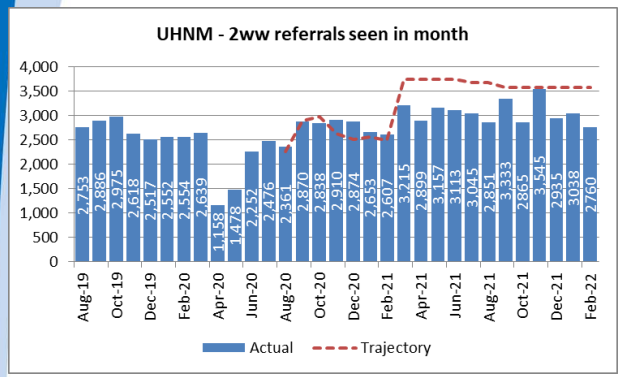
# Cancer

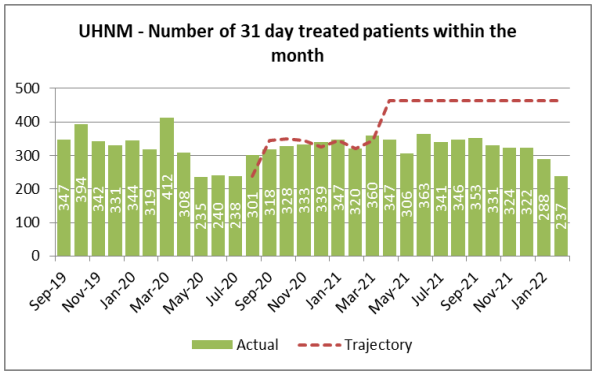
NHS University Hospitals of North Midlands NHS Trust

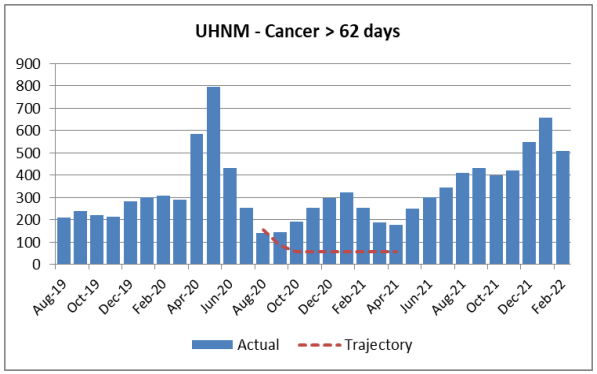
- Trajectories have been agreed and are being tracked against the actual positions. Most recent published data is for January.
- January and February are predicted to have a high proportion of breaches as the trust has been impacted in the Omicron wave. It is predicted that as this backlog of patients waiting is cleared that performance against the 62 day standard will improve from March 22.
- Risks to cancer recovery are diagnostic and treatment capacity within the trust. Particularly in Pathology, where turn around times are being impacted by workforce challenges. Treatment capacity impacted by non elective demand and workforce shortages.
- Key assumptions in the H2 plan were that cancer pathway transformation activities were accelerated at pace, i.e. implementation of best practice pathways in LGI to include FIT results in all LGI 2WW referrals as soon as possible. Other schemes presented at a system cancer summit align to cancer priorities and aim to prevent cancer, or support the shift in stage at which cancer is diagnosed, release consultant capacity that will support a reduction in the backlog of patients waiting and support the workforce through enhancements to facilitate 28 Day FDS.

| Trust | | | Apr 2021 | May 2021 | Jun 2021 | Jul 2021 | Aug 2021 | Sep 2021 | Oct 2021 | Nov 2021 | Dec 2021 | Jan 2022 | Feb 2022 | Mar 2022 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 14 Day Standard 93% *(suspected cancer, excluding breast symptom)* | TRAJECTORY | First Seen | 3745 | 3745 | 3745 | 3666 | 3666 | 3566 | 3566 | 3566 | 3566 | 3566 | 3566 | 3566 |
| | | Breaches | 809 | 769 | 699 | 961 | 901 | 641 | 481 | 366 | 306 | 246 | 186 | 166 |
| | | Performance | 78.3% | 79.4% | 81.3% | 73.7% | 75.4% | 82.0% | 86.5% | 89.7% | 91.4% | 93.1% | 94.7% | 95.3% |
| | ACTUALS | First Seen | 2899 | 3157 | 3113 | 3045 | 2851 | 3333 | 2865 | 3545 | 2967 | 3038 | 2760 | 2653 |
| | | Breaches | 640 | 593 | 318 | 665 | 961 | 1042 | 1019 | 1927 | 1264 | 1373 | 1246 | 1531 |
| | | Performance | 77.9% | 81.2% | 89.7% | 78.1% | 66.2% | 68.7% | 64.4% | 45.6% | 57.3% | 54.8% | 54.8% | 42.2% |
| | | Variation | -0.4% | 1.8% | 8.4% | 4.4% | -9.2% | -13.3% | -22.1% | -44.1% | -34.1% | -38.3% | -39.9% | -53.1% |
| | | Regional (Midlands) | 81.7% | 85.0% | 81.1% | 83.4% | 84.0% | 81.4% | 79.9% | 73.5% | 74.8% | | | |
| | | National | 85.4% | 87.5% | 84.9% | 85.6% | 84.7% | 84.1% | 81.3% | 77.4% | 78.6% | 74.9% | | |
| 31 Day First Treatment Standard 96% | TRAJECTORY | Treatment | 463 | 463 | 463 | 463 | 463 | 463 | 463 | 463 | 463 | 463 | 463 | 463 |
| | | Breaches | 49 | 46 | 43 | 38 | 34 | 29 | 25 | 23 | 22 | 20 | 19 | 18 |
| | | Performance | 89.4% | 90.0% | 90.7% | 91.7% | 92.6% | 93.7% | 94.6% | 95.0% | 95.2% | 95.6% | 95.8% | 96.1% |
| | ACTUALS | Treatment | 347 | 306 | 363 | 341 | 346 | 353 | 331 | 324 | 322 | 288 | 237 | 74 |
| | | Breaches | 23 | 19 | 22 | 22 | 29 | 46 | 42 | 46 | 22 | 34 | 21 | 13 |
| | | Performance | 93.3% | 93.7% | 93.9% | 93.5% | 91.6% | 86.9% | 87.3% | 85.8% | 93.1% | 88.1% | 91.1% | 82.4% |
| | | Variation | 3.9% | 3.7% | 3.2% | 1.8% | -1.0% | -6.9% | -7.4% | -9.3% | -2.1% | -7.6% | -4.7% | -13.7% |
| | | Regional (Midlands) | 91.9% | 92.5% | 91.9% | 91.9% | 90.2% | 88.7% | 90.2% | 89.7% | 90.3% | | | |
| | | National | 94.2% | 95.1% | 94.6% | 94.7% | 93.7% | 92.6% | 93.5% | 93.0% | 93.4% | 89.6% | | |
| 62 Day (2ww) Standard 85% | TRAJECTORY | Treatment | 246.0 | 246.0 | 246.0 | 246.0 | 246.0 | 246.0 | 246.0 | 246.0 | 246.0 | 246.0 | 246.0 | 246.0 |
| | | Breaches | 75.5 | 71.5 | 67.5 | 62.5 | 59.5 | 57.5 | 50.0 | 44.0 | 38.0 | 32.0 | 32.0 | 32.0 |
| | | Performance | 69.3% | 70.9% | 72.5% | 74.5% | 75.8% | 76.6% | 79.6% | 82.1% | 84.5% | 86.9% | 86.9% | 86.9% |
| | ACTUALS | Treatment | 181.0 | 166.5 | 198.0 | 186.5 | 187.5 | 199.0 | 168.0 | 178.0 | 172.5 | 152.5 | 128.5 | 47.5 |
| | | Breaches | 42.0 | 48.5 | 59.0 | 64.0 | 69.5 | 84.0 | 70.0 | 87.0 | 81.0 | 73.0 | 66.5 | 31.5 |
| | | Performance | 76.7% | 70.8% | 70.2% | 65.6% | 62.9% | 57.7% | 58.3% | 51.1% | 53.0% | 52.1% | 48.2% | 33.6% |
| | | Variation | 7.4% | -0.1% | -2.3% | -8.9% | -12.9% | -18.9% | -21.3% | -31.0% | -31.5% | -34.8% | -38.7% | -53.3% |
| | | Regional (Midlands) | 69.9% | 66.4% | 66.4% | 63.3% | 61.6% | 58.3% | 57.3% | 56.9% | 57.1% | | | |
| | | National | 75.4% | 73.0% | 73.3% | 72.1% | 70.7% | 68.0% | 67.8% | 67.5% | 67.0% | 61.8% | | |

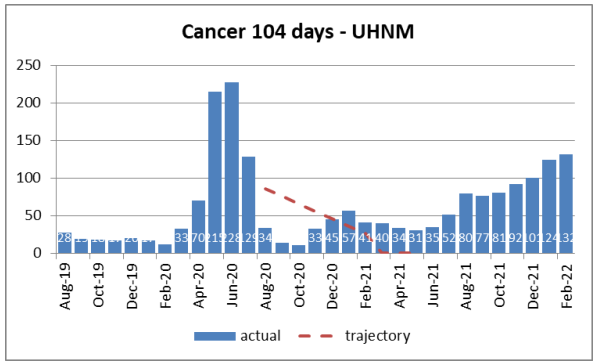
# Cancer




| February Provisional | Target | Trust Actual | Clock Stops | Breaches | Breaches Over | Needed Treatments |
|---|---|---|---|---|---|---|
| TWW Standard | 93% | 54.9% | 2760 | 1246 | 1053 | 15041 |
| TWW Breast Symptomatic | 93% | 6.5% | 77 | 72 | 67 | 952 |
| 31 Day First | 96% | 91.1% | 237 | 21 | 12 | 289 |
| 31 Day Subsequent Anti Cancer Drug | 98% | 93.5% | 31 | 2 | 2 | 69 |
| 31 Day Subsequent Surgery | 94% | 81.5% | 27 | 5 | 4 | 57 |
| 31 Day Subsequent Radiotherapy | 94% | 93.0% | 100 | 7 | 1 | 17 |
| 62 Day Standard | 85% | 48.2% | 128.5 | 66.5 | 48 | 315.5 |
| Rare Cancers - 31 Day RTT pathway | 85% | - | 0 | 0 | 1 | 1 |
| 62 Day Screening | 90% | 29.2% | 24 | 17 | 15 | 147 |
| 28 Day FDS Standard | 75% | 64.6% | 2198 | 777 | 228 | 911 |
| 62 Day Consultant Upgrade | 93% | 69.8% | 63 | 19 | 15 | 209 |
| Closed Pathways > 104 Day | | | 16.5 | | | |




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

# Planned care - *Inpatients*

University Hospitals of North Midlands NHS Trust

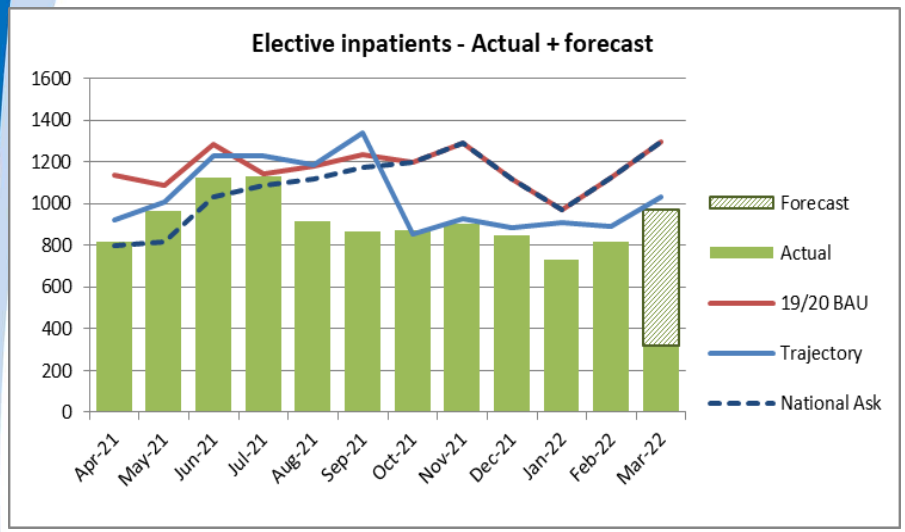
**Elective inpatients Summary**

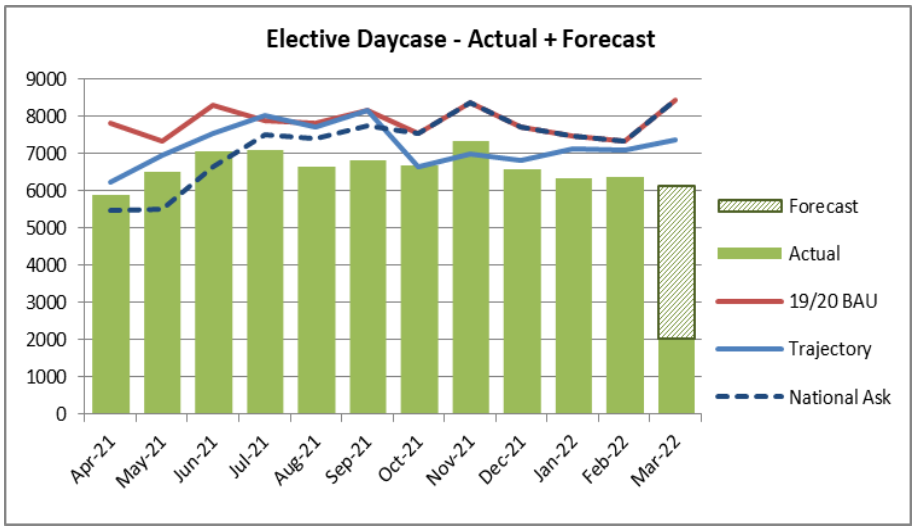
- For February the total inpatient actuals against BAU was 84.9%, and improvement on January (83.3) Insourcing arrangements at week ends continue and have been bolstered to provide more weekend capacity in T&O started Feb.
- CCG offer of Spire for additional capacity and patients going via CCG Choose and Book Service.
- Contracting arrangements for 2022/23 confirmed – extension of existing IPT contracts for Ramsay & Nuffield. Business case in progress for subcontracts for Endoscopy due to nature of pathways.
- Ramsay continue to treat patients to contract but again their admin processes are impacting on our numbers reported. This has improved with renewed focus on chasing for missing discharge summaries/patient updates.
- Referral Hub has been scoped and further developed to encompass triage functions as well as investigation requesting and review and discharge if necessary or handover to internal team.
- Work with Deloitte to understand capacity across the region completed. Cataract patients have largely declined to transfer due to transportation issues (UHNM funding taxis being investigated). Hand/foot and Hernia transfers underway. Bariatric subcontracted patients have been sent, and first progress report received.

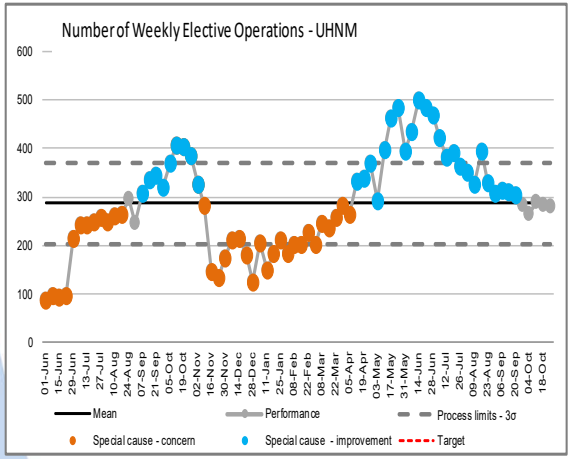
**Actions**

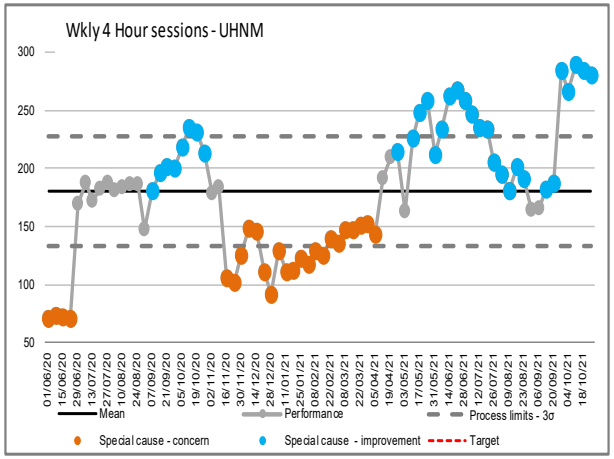
- External validation support to commence 21st March.
- Progressing with transferring additional patients to the IS on the back of Deloitte or own internal reviews of capacity.
- Demand scoping for 22/23 IS complete & shared with CCGs.
- Elective Storyboard and Slide set finalised that covers off internal and external performance measures for assurance of a consistent approach to tracking activity linked to performance. Shared with Regional Director of Performance at NHSEI and well received.
- Corporate validation plan currently being rewritten alongside external validation support to ensure a clean PTL and highlight areas for targeted training.
- 'Validation summit' planned to bring Corporate Team, DQ & Information teams together with divisional representation to scope out root causes and define strategy for improvement.
- Training continues on RTT for new staff and where post validation has found incorrect actioning of pathway for staff to be retrained. Extra training capacity sought to provide clinician & refresher training, as well as "at elbow" bespoke training & support for groups of staff. Band 5 to be recruited to support.

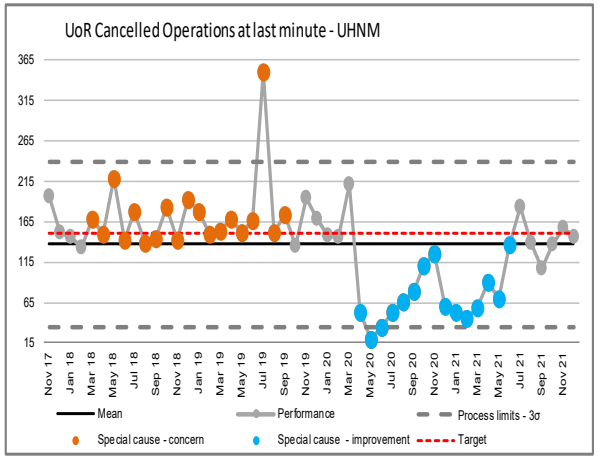
# Planned care – *Inpatient Activity*




Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

# Planned care - *Outpatients*

NHS University Hospitals of North Midlands NHS Trust

**Summary**

- For February (as at 07/03), the total outpatient actuals against BAU for outpatients was 98%. This is higher in follow ups than new (90% New, 104% follow up).
- For outpatient appointments (appointment type) the Trust delivered **71.4%** F2F and **28.6%** non F2F(Telephone & Video). For new appointment types F2F was **75%** & non F2F **25%** & follow ups F2F **69.4%** & non F2f **30.6%**
- OP Cell A3 work has helped to define current overall waiting list position by category; vs pre covid increase of 15,000 (6.5%) to 250,000, and increase in those >52 weeks (vs Review Date) by 7,800 (200%) to c.12,000 (half of increase attributable to use of Review Date). As at 27/02/2022, total WL has increased further to 268,000. Recent increases in the waiting list attributed to 2 categories; New (18 weeks) & New (Non-18 weeks).
- Reduction from 11,631 (end of June) to 10,010 (25th July) in >52 week patients (14%). Further reduction to 9,184 as at 5th September (21% vs end of June). Up to 10,441 as at 27th February; has been at a similar level for last 13 weeks.

**RTT**

- The overall Referral To Treatment (RTT) Waiting list continues to rise. For February the indicative number of Incomplete pathways has risen to 73,360 (January 71,382).
- The number of patients > 18 weeks has risen to a level of 32,668 (January 31,325).
- The numbers of 52 week waits in January has increased with a provisional 4,461 (January 4,456) this figure is below the trajectory.
- At the end of February the numbers of > 104 weeks reported were 561. The Planned Care group is monitoring progress against treatment plans for these patients.
- Performance has slightly increased at 55.7% (January 55.5%).
- Work plans around long wait patient validation and treatment tracking are in progress

# Planned care - *Outpatients*

NHS University Hospitals of North Midlands NHS Trust

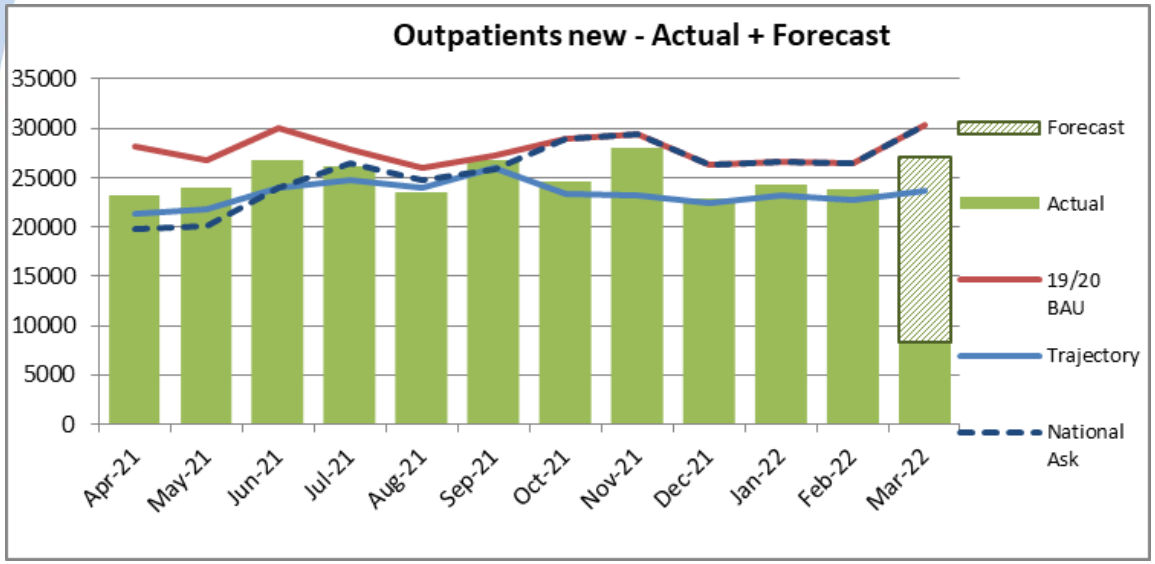
**Actions**

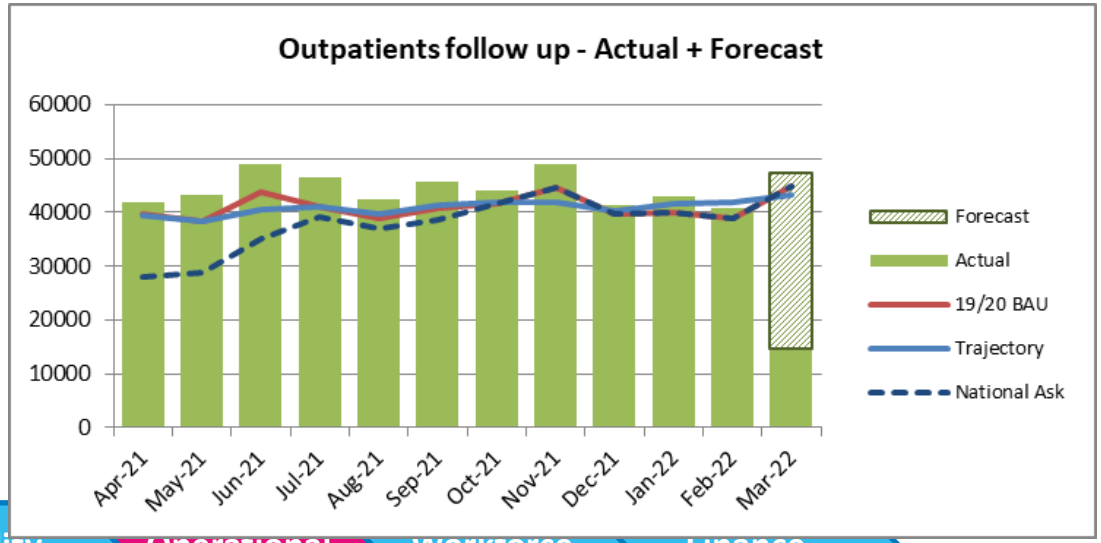
- Actions progressing on Divisional Waiting List Management with a focus on validation, data quality and >52 weeks patients. Divisions have fed back details of their plans relating to OP New Waits AVG >16 weeks & >52 week patients. Outpatient Reviews with COO scheduled for March for New Waits (104+/78/52/18 wks), plus follow up backlog, PIFU, EAG & Non Face to Face. OP Waiting List reporting now amended to include 78 & 104+ wk band to support focus in line with 22/23 Elective Care Guidance. SMS via Netcall approach targeting follow up backlog patients trialled successfully in dermatology and plastics, with similar approach planned for additional specialties. Of the 919 patients who acknowledged the message, 17% wished to be discharged back to their GP.
- Outpatient Service Delivery & Performance workstream delivering vs. plans for Partial Booking Rollout, Netcall Rollout, CAF Issues Action Plan, and OP Clinic Process vs. Maturity model. Review Date training prioritised; DQ Alert circulated & Quick Reference Guides created, plus floor walking support. Wider training plan being developed with Ongoing input into Trust training considerations (systems & processes), and links to DQ group.
- Enhanced Advice & Guidance sub workstream (linking with system). Task & Finish Groups for Urology, Neurology, Respiratory and Gastro to take actions forward to increase A&G, develop pathways FAQs. Work underway to directly contact 21 GP practices not using A&G and a further 32 practices with a high volume of referrals and less than 12% A&G usage. CCG developing training cohorts for PLT to include A&G and liaising directly with practice managers to increase awareness & uncover barriers.
- PIFU sub-workstream rolling out vs plan. Regular meetings with 7 live specialties (neurology & plastics went live in January), including NHSE meeting re heart failure in cardiology; meetings with ENT & T&O to discuss specific pathways & work through checklist, and presenting at Urology Consultants' Audit Meeting. Watch & wait report / benchmarking used to identify next target areas for PIFU including gynaecology & therapies. Actions around Discharge to PIFU approach to support wider rollout commencing March 2022, as per focus advice from meeting with NHSE contact. Letter drafted to be sent to clinicians across UHNM in March to raise awareness and further identify existing and potential PIFU pathways.
- Submissions to Elective Recovery Fund in place for A&G & PIFU. Consultant Connect data is included and confirmed, but recent query around Community RAS data inclusion, and discussions ongoing with NHSE supported by Information Services. Method of recording of PIFU removals/conversions still to be determined; testing option of PIFU flag for recording activity.
- Virtual Care 25%; SUS submission 'fix' implemented from Nov 2021 (with BI); longer term, alignment of clinic booking and media type outcomes. Launch of a new teledermatology service; skin cancer wait times decreased from 28 days to an average of 10 days in February
- Elective Recovery 2022/23; narrative plans submitted in February for EAG (16% target), PIFU (5% target) & Virtual Care (25% target).
- Support provided to identify potential OP benefits from a patient portal, following demos from suppliers to a wide UHNM audience & patients.
- 1m+ plans approved (March 2022) based on risk assessments, supports FTF activity increase where necessary.

**Risks:**

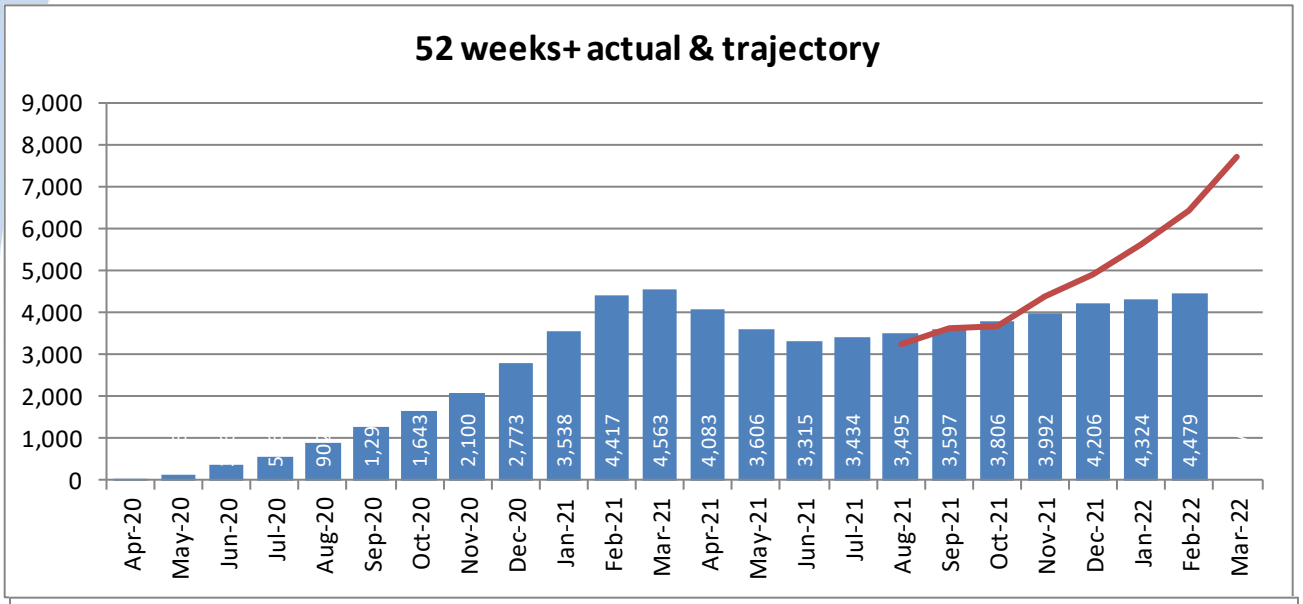
- Deteriorated waiting list position vs pre-covid; volume of patients requiring DQ and clinical validation very challenging, on Divisional Risk Registers.
- PIFU H2 end target of 2% of all outpatient activity moved or discharged to PIFU. Whilst achieving rollout to initial specialties in low volumes, shortfall projected currently against this target (nationally an issue). Actions identified to extend rollout and close the gap as outlined above, moving towards 5% March 2023 target including all 'major' outpatient specialties. Meeting held in Feb with NHSE; advised to focus on capturing Discharge to PIFU.

# Planned care – *Outpatient activity & RTT*



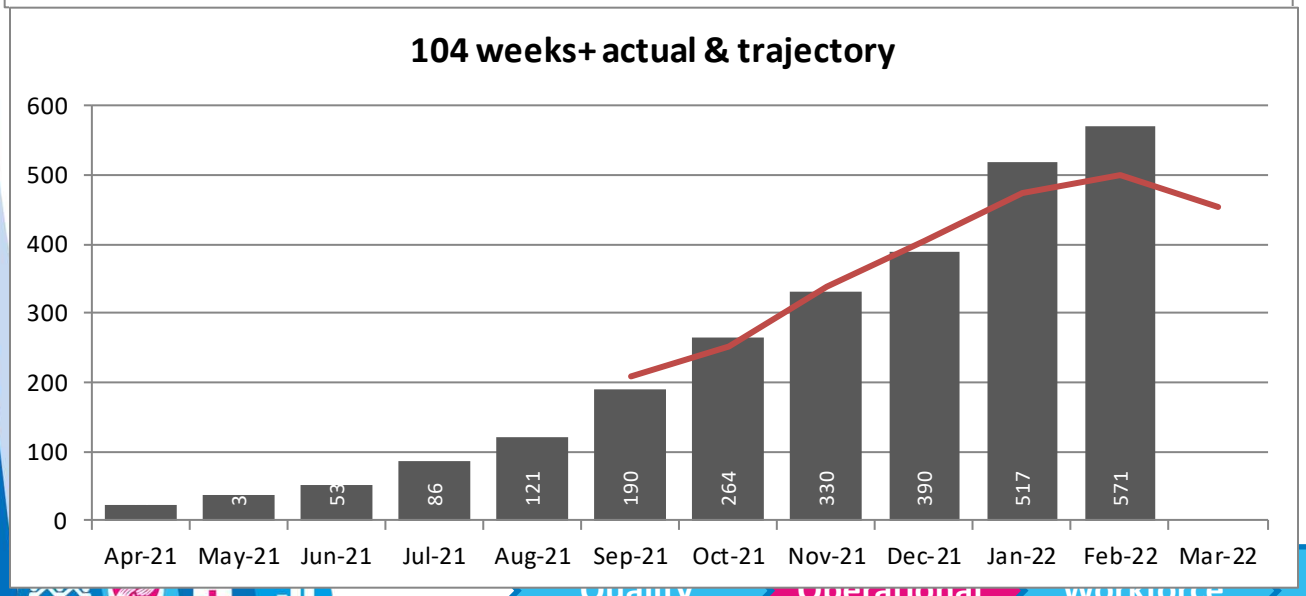



# Planned care – *RTT Trajectories*



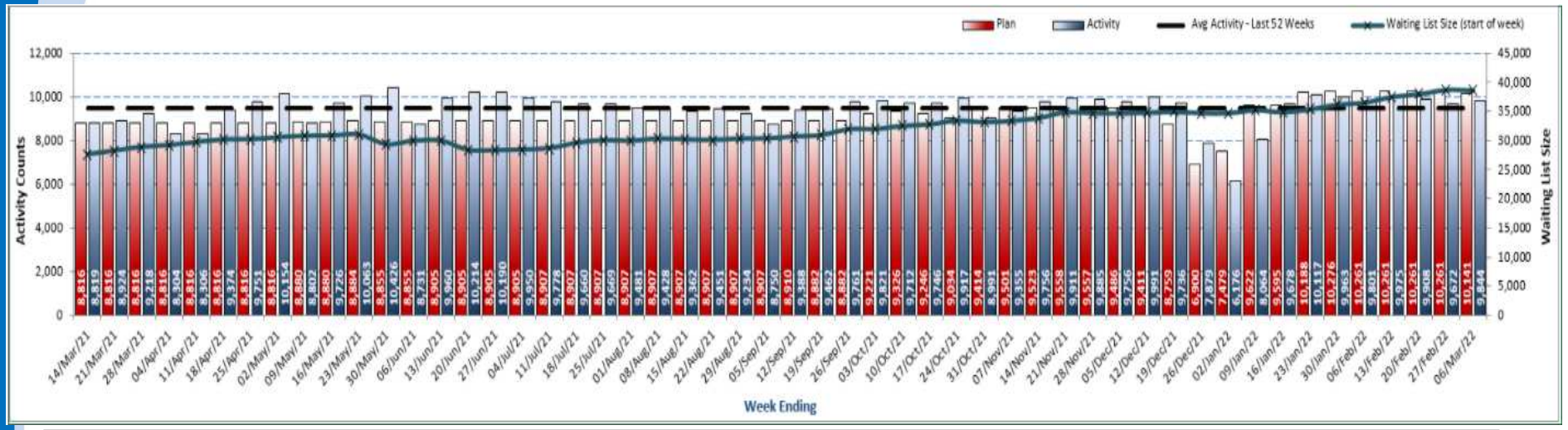

52 Week Waits are expected to increase over the next 3 months.

The Trust is currently ahead of trajectory and expecting to finish well ahead of trajectory.




104 Week Waits are also expected to increase before decreasing throughout March.

# Diagnostic Activity




**Summary**

- For DM01 (15 nationally identified Dx tests) the validated position for total waiting list has increased in February from 21083 to 22529. The Non-obstetric ultrasound waiting list increased slightly from 9,368 to 9,394. Due to the challenges in Non-Obstetric Ultrasound this has adversely affected performance. The current DM01 diagnostic performance is at 72%.
- Within DM01, the greatest proportion of > 6 week waits are within Non-obstetric ultrasound and endoscopy. The ultrasound position is related to an increase in demand alongside workforce shortfalls, a number of actions are in place. Non obstetric ultrasound performance remains a Driver Metric for CWD and has specific focus for improvement, albeit this is related to workforce retention, recruitment and innovative ways to train and recruit.
- DM01 performance excluding non obs ultrasound would be c84%.
- The Diagnostic Cell is looking to adopt the Improving Together principles for diagnostic recovery, which will link to either the Responsive or High Quality key priority domains.
- Capacity and Demand work has been completed within Imaging relating directly to Consultant Radiologist and SpR capacity and a business case is being developed.
- Histology and Endoscopy remain high risk areas both have plans for improvement.
- A Histology Quality Summit was held on 15th February and a full action plan and trajectory is in place, with fortnightly communications to all 3 member Trusts, clinicians, and cancer services. There are clear routes for cancer escalations.
- Plain film is also an area with a high volume of waiters, predominantly due to staffing shortages and covid social distancing guidance.

# Diagnostic Activity

University Hospitals of North Midlands NHS Trust

**Issue: Histology**

Histology have high pressures on current capacity; consultant reporting capacity, laboratory capacity, admin support. Expected increase in recovery requirement and cancer related demand

**Mitigation:**

- Significant Increase in Sendaway work to outsourced providers
- Request from SaTH for laboratory and reporting support
- SOS to other pathology networks for outsourced capacity – declined to date
- Quality Summit with network trusts taken place and action plan in place
- 2 histopathologists recruited in Jan / 4 histopathologists planned to be recruited in April and May for start between April and Oct
- Incentivised payments agreed for laboratory staff (to clear block backlog) and to consultants to increase available reporting sessions
- Sickness absence management in line with sickness abs policy
- Fortnightly updates to member Trusts, clinicians
- Cancer Services meetings in place weekly with member Trusts to ensure all cancer escalations are completed

**Impact:**

- Increase in Clinical risk
- Turnaround times not to required standard for some specialties for Cancer and non-cancer / Delays in results available for MDT and / or patient treatment
- Increase in outsourcing and locum costs
- Increase in reported errors

**Timescale:**

Extreme measures to be taken to reduce backlog as soon as possible

Trajectory in place (currently ahead of plan). May Target in place

**Non obstetric ultrasound** - capacity is insufficient to reduce the waiting list backlog any further

**Impact:**

Increase in waiting times and backlog for non urgent scans / Inability to meet DM01 standards

Increased stress for current staff, Poor patient experience

**Mitigation:**

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

Continuing to try to source locum sonographers

Reviewing workforce plans and AFC banding in line with other Trusts / Extension of bank rates for sonographers

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

**Impact:**

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

**Mitigation:**

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

# APPENDIX 1

# Operational Performance

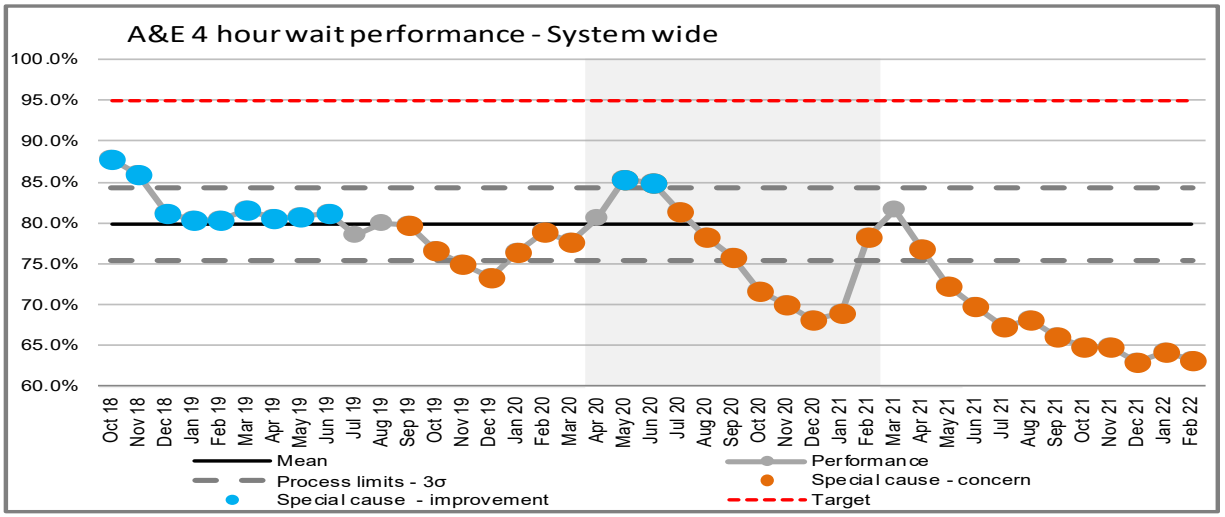
# Constitutional standards

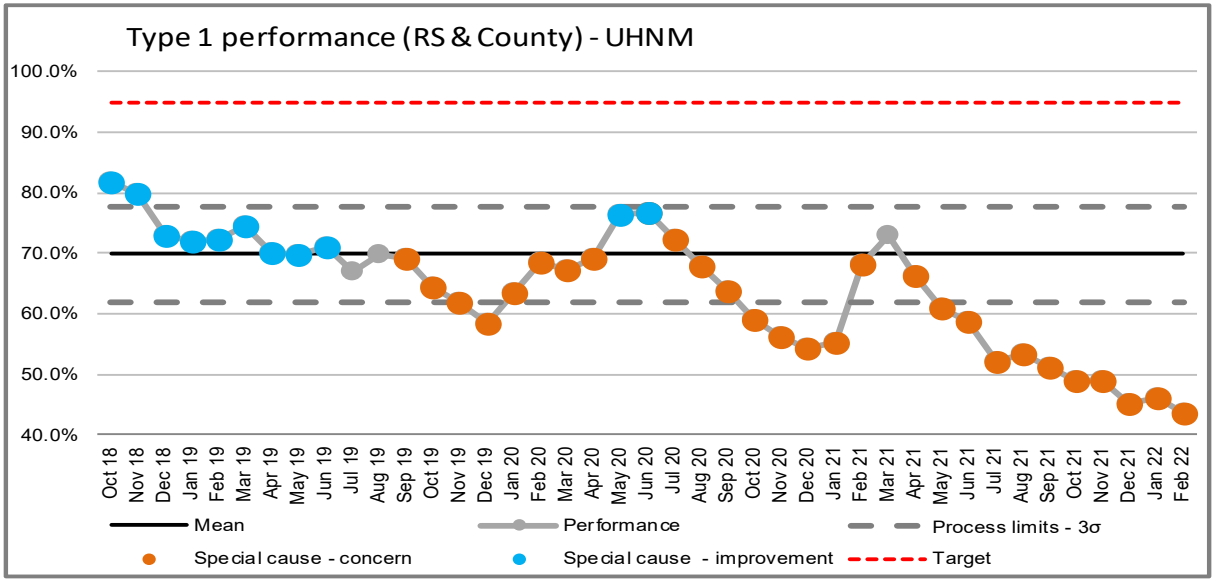
| | Metric | Target | Latest | Variation | Assurance | DQAI |
|---|---|---|---|---|---|---|
| A&E | A&E 4 hour wait Performance | 95% | 63.10% | L | F | |
| | 12 Hour Trolley waits | 0 | 372 | H | ? | |
| Cancer Care | Cancer Rapid Access (2 week wait) | 93% | 47.18% | L | ? | |
| | Cancer 62 GP ref | 85% | 48.25% | L | ? | |
| | Cancer 62 day Screening | 90% | 61.90% | | ? | |
| | 31 day First Treatment | 96% | 85.26% | L | ? | |
| Elective waits | RTT incomplete performance | 92% | 55.49% | L | F | |
| | RTT 52+ week waits | 0 | 4479 | H | F | |
| | Diagnostics | 99% | 67.40% | L | F | |

| | Metric | Target | Latest | Variation | Assurance | DQAI |
|---|---|---|---|---|---|---|
| Use of Resources | DNA rate | 7% | 7.3% | | ? | |
| | Cancelled Ops | 150 | 146 | | ? | |
| | Theatre Utilisation | 85% | 76.0% | | | |
| Inpatient / Discharge | Same Day Emergency Care | 30% | 30.1% | H | ? | |
| | Super Stranded | 183 | 205 | H | P | |
| | DToC | 3.5% | 3.40% | | ? | |
| | Discharges before Midday | 30% | 20.2% | | F | |
| | Emergency Readmission rate | 8% | 11.8% | L | F | |
| | Ambulance Handover delays in excess of 60 minutes | 10 | 800 | H | F | |

Quality | Operational | Workforce | Finance

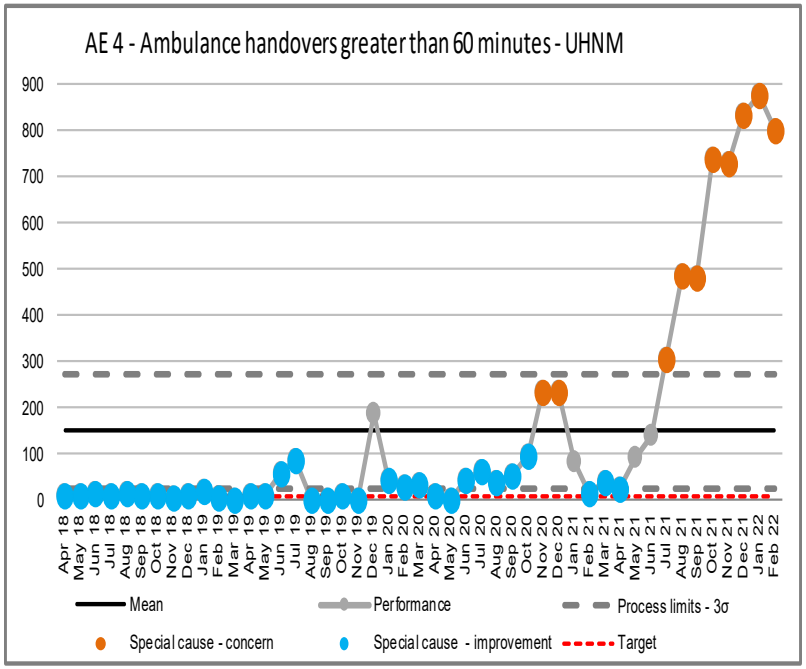
# URGENT CARE – 4 hour access performance

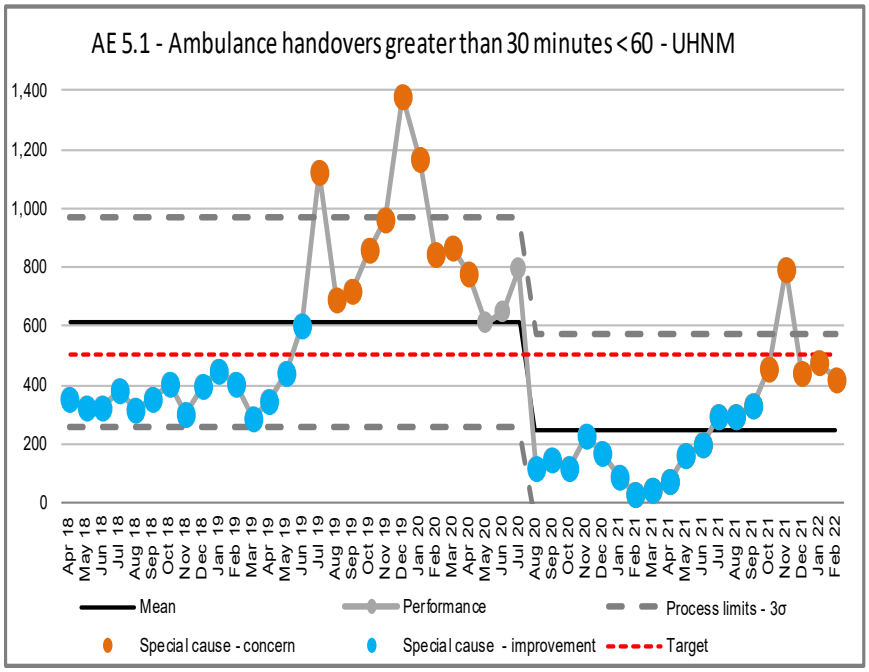



Quality | Operational | Workforce | Finance

# URGENT CARE – 4 hour access – ambulance handovers

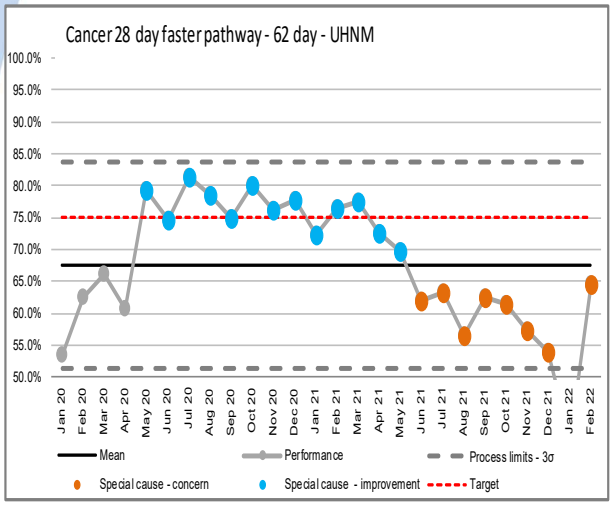


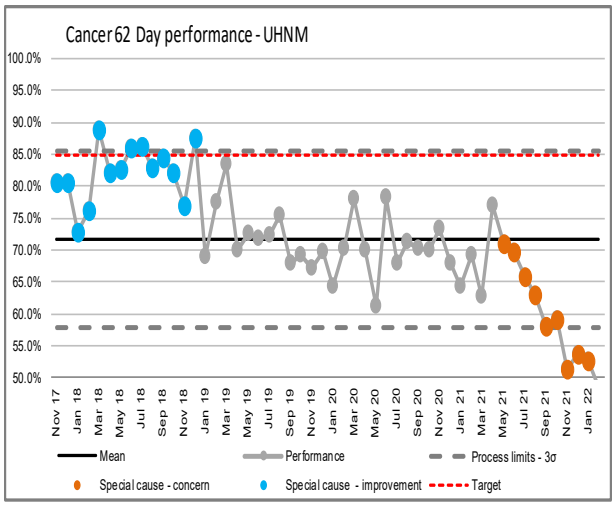




*From August – internal validation of > 30 minutes*

Quality | Operational | Workforce | Finance

# Cancer – 62 Day




| Variation | Assurance |
|---|---|
|  |  |

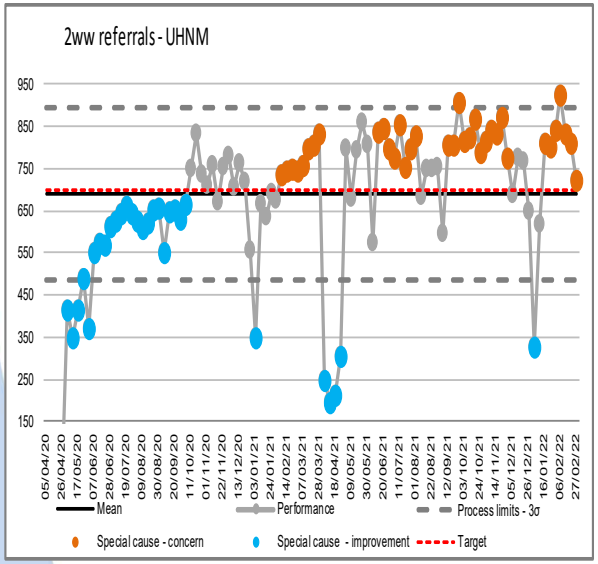
| Target | Dec 21 | Jan 22 | Feb 22 |
|---|---|---|---|
| 85% | 53.7% | 52.8% | 48.3% |

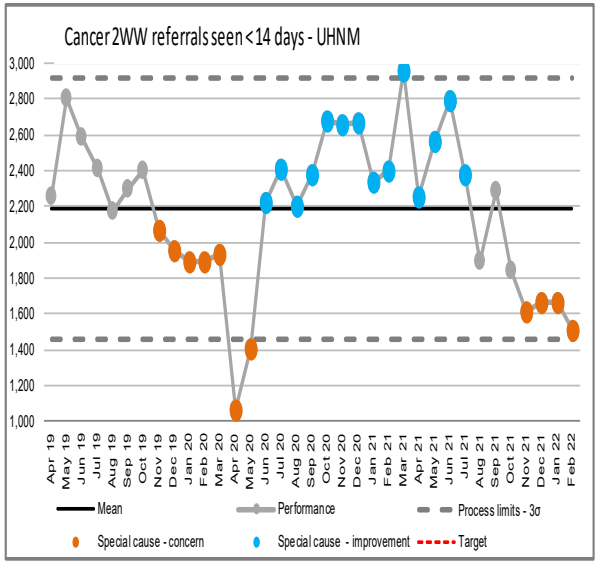
**Background**

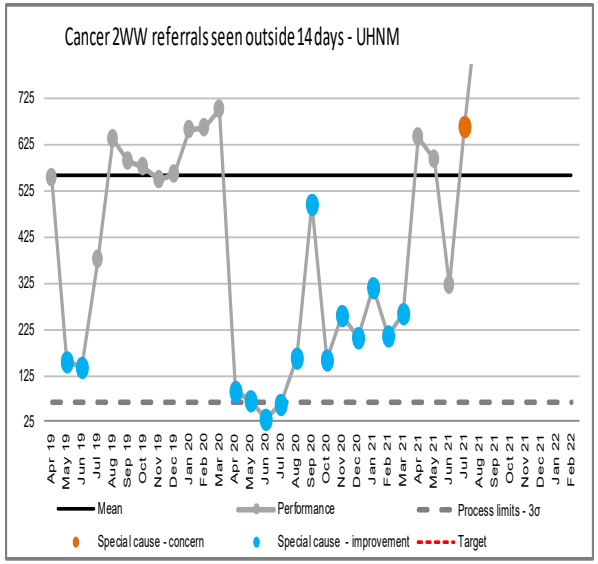
% patients beginning their treatment for cancer within 62 days following an urgent GP referral for suspected cancer

**What is the data telling us?**

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



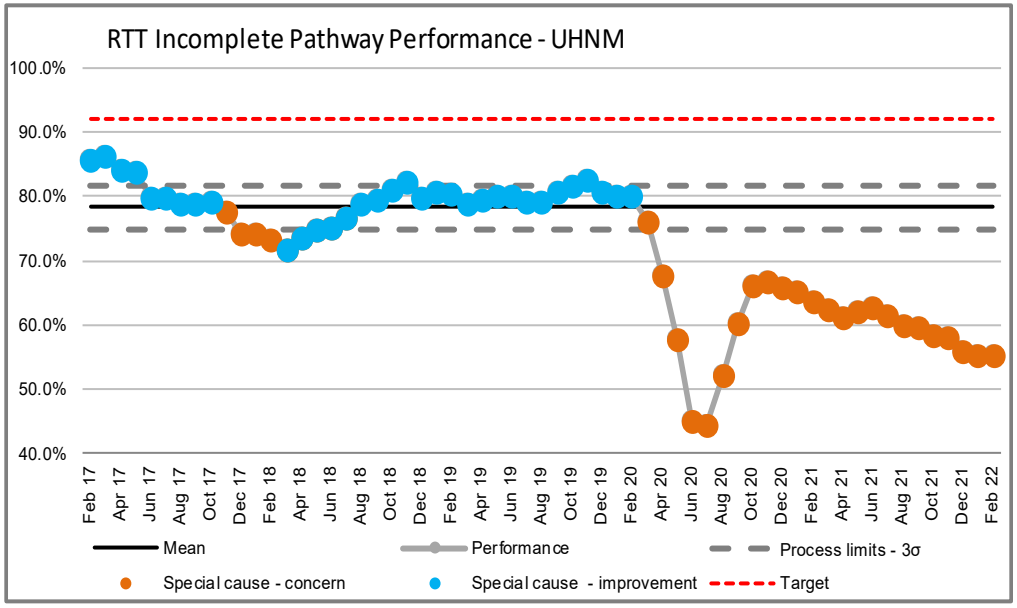




Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

# Referral To Treatment




| Variation | Assurance |
|---|---|
|  |  |

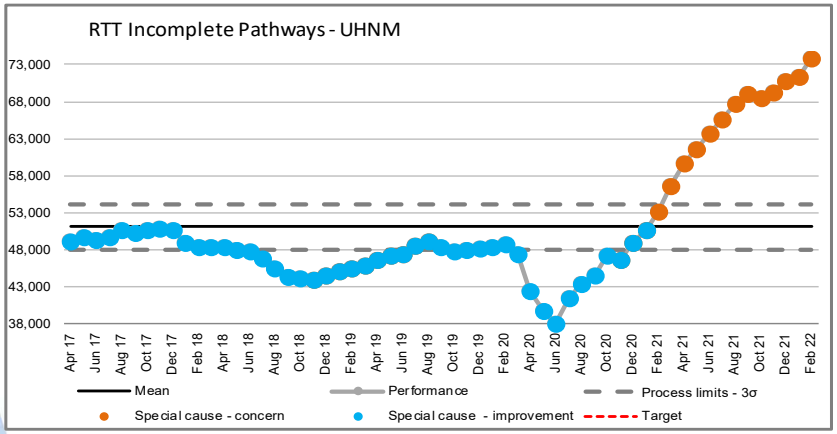
| Target | Dec 21 | Jan 22 | Feb 22 |
|---|---|---|---|
| 92% | 56.0% | 55.5% | 55.5% |

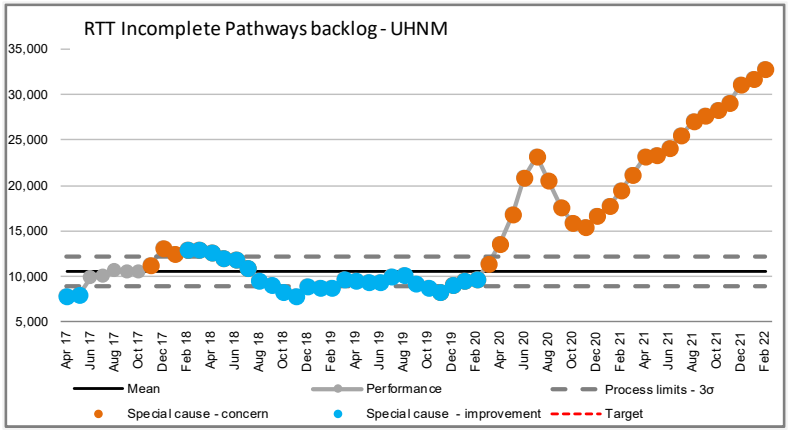
**Background**

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

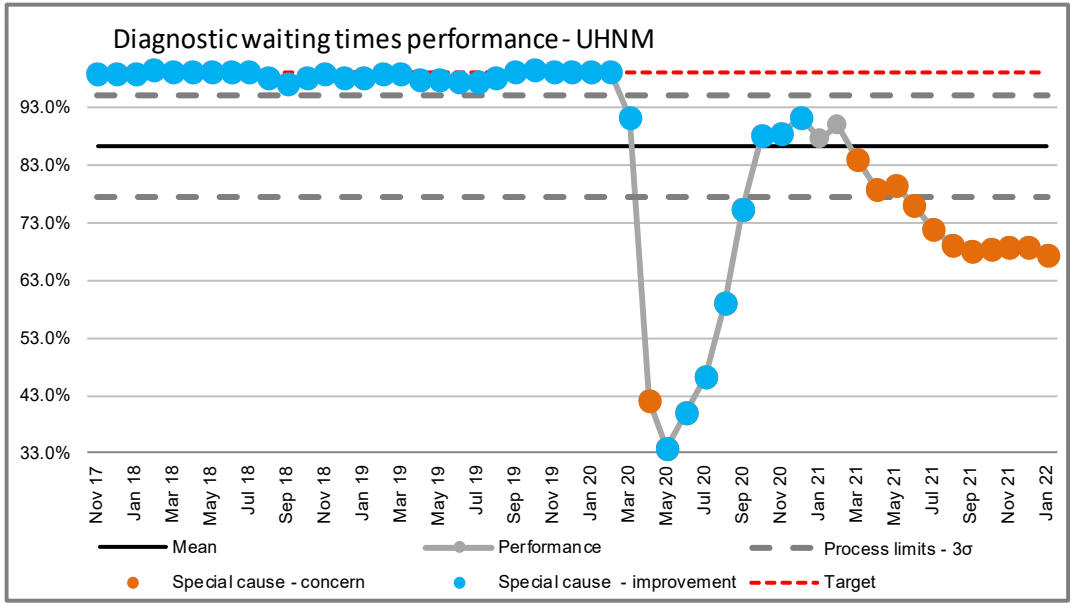
**What is the data telling us?**

Steady decline in performance since the pandemic began.



# Diagnostic Standards




| Variation | Assurance |
|---|---|
| | |

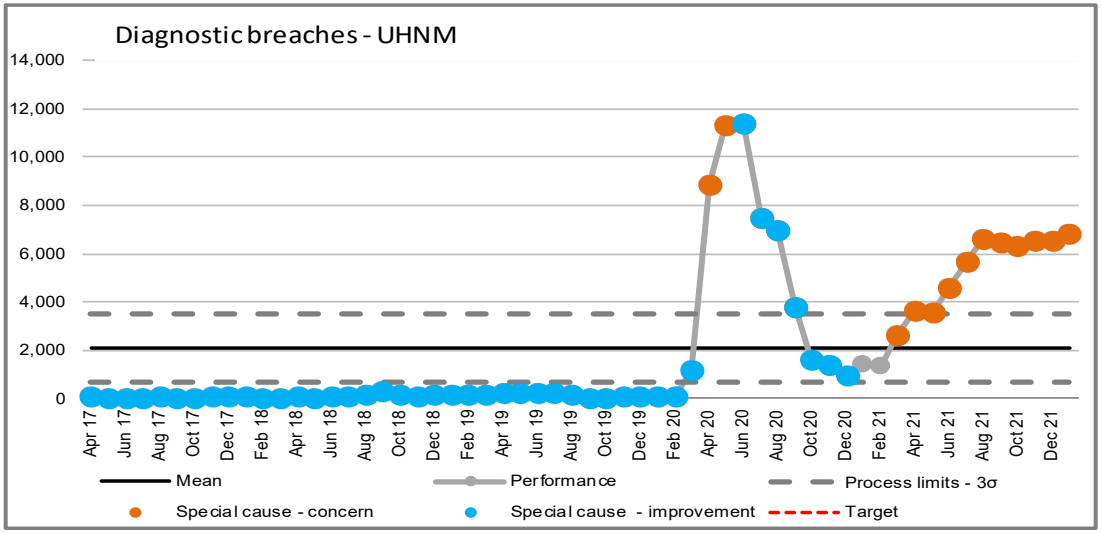
| Target | Nov 21 | Dec 21 | Jan 22 |
|---|---|---|---|
| 99% | 68.7% | 68.7% | 67.4% |

**Background**

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

**What is the data telling us?**

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



# 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 and absence management.

**Sickness**

The in-month sickness rate was 6.14% (7.44% reported at 31/01/22). The 12 month cumulative rate increased to 5.54% (5.41% at 31/01/22).

Covid-related absence has been reducing throughout February since hitting a peak on 5th January 2022. However, since 1st March 2022, there has been a further upturn in covid-related absence.

The focus remains on areas with high sickness levels, with actions including:

- Assurance meetings taking place in the Divisions, focussing on the top 10 long term and top 10 frequent absences .
- Continued daily monitoring of sickness absences, specifically all COVID related absence and stress related absence.
- Joint focused absence huddles for Medicine and Surgery taking place with the HR Director and Divisional Representatives

Divisions have set trajectories for achieving a reduction in Sickness Absence (subject to Covid Pandemic spikes, Winter Pressures and staffing deficiencies) with a year end target of around 5.5%, which will be monitored via the Improving Together Programme

**Appraisals**

February saw an upturn in the Non-Medical PDR compliance rate from 75.91% on 31st Jan to 79.08% on 28th February 2022

There was an improvement across all Divisions except Surgery, which had a very slight deterioration. Overall performance remains below target

**Statutory and Mandatory Training**

The Statutory and Mandatory training rate at 28th February 2022 was 95.34% (95.41% at 31st Jan 2022). This compliance rate is for the 6 'Core for All' subjects only

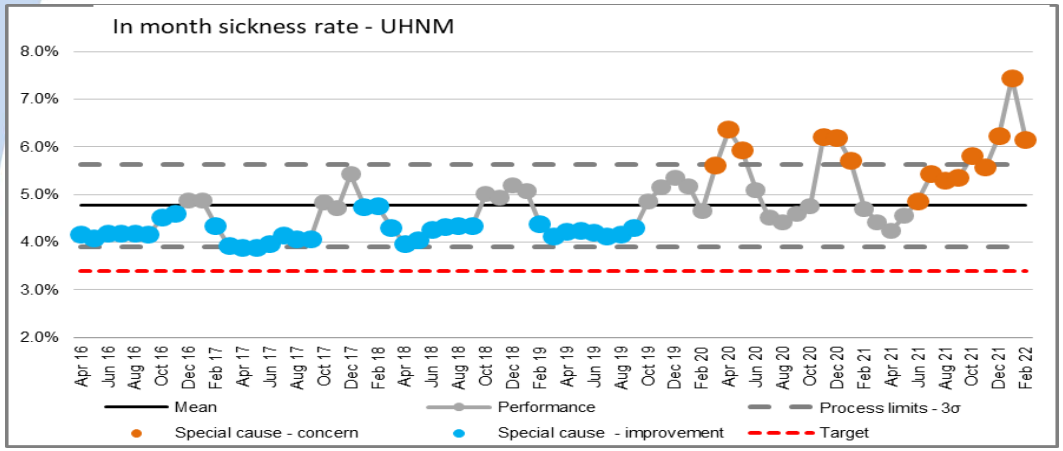
**Vacancies**

The overall Trust vacancy rate was 11.55% as a result of an uplift in budgeted establishment to account for Winter planning and business cases (54.83 fte), and a decrease in staff in post (37.4 fte). Bank and Agency covered 65% of the vacancy position and there is sufficient activity in the recruitment pipeline to cover the vacancies, should all of that activity be converted to staff in post.

# Workforce Dashboard

| Metric | Target | Latest | Variation | Assurance |
|---|---|---|---|---|
| Staff Sickness | 3.4% | 6.14% |  |  |
| Staff Turnover | 11% | 10.40% |  |  |
| Statutory and Mandatory Training rate | 95% | 95.34% |  |  |
| Appraisal rate | 95% | 79.08% |  |  |
| Agency Cost | N/A | 3.07% |  |  |

# Sickness Absence




| Variation | Assurance |
|---|---|
| H | F |

| Target | Dec 21 | Jan 22 | Feb 22 |
|---|---|---|---|
| 3.4% | 6.2% | 7.4% | 6.1% |

**Background**

Percentage of days lost to staff sickness

**What is the data telling us?**

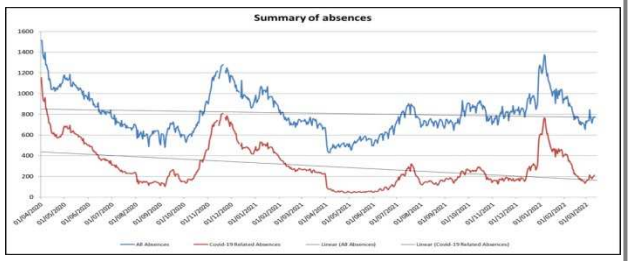
Sickness rate is consistently above the target of 3.4%. The special cause variation from April 2020 is a result of covid-19.

**Summary**

The in-month sickness rate was 6.14% (7.44% reported at 31/01/22). The 12 month cumulative rate increased to 5.54% (5.41% at 31/01/22).

Covid-related absence has been reducing since hitting a peak on 5th January 2022 although we have seen a small daily increase from 1st March 2022

As of 11th March 2022, covid-related open absences* numbered 212 which was 27.25% of all absences [**includes absences resulting from adhering to isolation requirements*]




To manage staff availability, the Workforce Bureau is operating as virtual bureau, in conjunction with Nursing and Medical Bureaus, to manage staff deployment as and when necessary. Daily Sitreps on staff absence continued to be produced, informing the tactical Covid Dashboard and decisions on the redeployment of staff. Deep dives into reasons for stress related absence are undertaken to help target actions for support, and the covid self-isolation tool continues to be updated as government guidance changes and communications with staff continue

**Actions**

Assurance meetings are taking place in the Divisions, focussing on the top 10 long term and top 10 frequent absences by specialty.

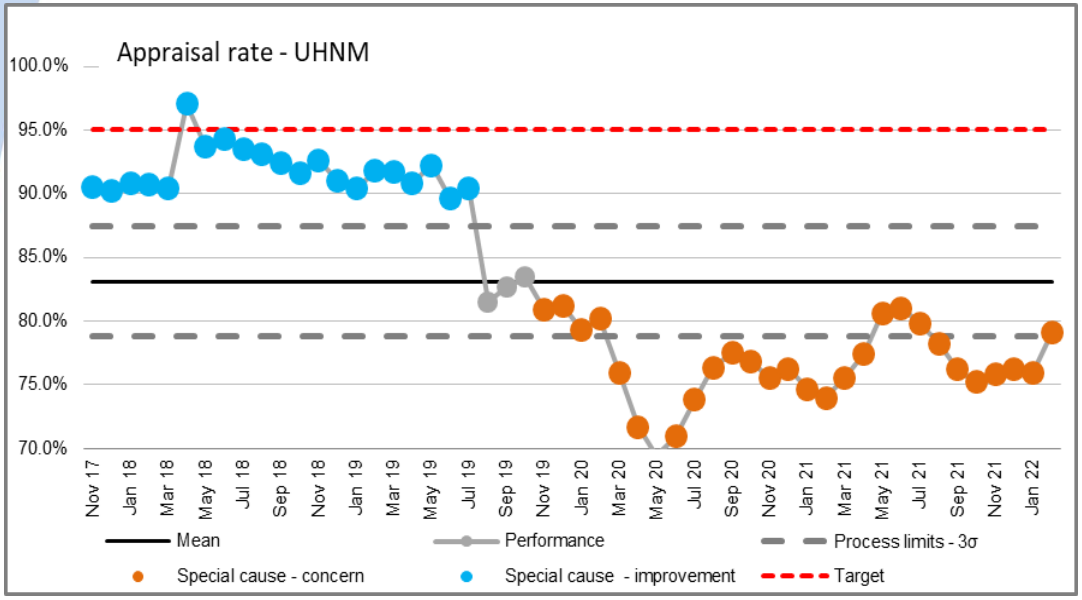
There is continued daily monitoring of sickness absence rates, including COVID related absence

Joint focused absence huddles for Medicine and Surgery take place with HR

There is improved access to Empactis, targeted training and monitoring of compliance with Empactis requirements

Divisions have set trajectories for achieving a reduction in Sickness Absence (subject to Covid Pandemic spikes, Winter Pressures and staffing deficiencies) with a year end target of around 5.5%, which will be monitored via the Improving Together Programme

# Appraisal (PDR)




| Variation | Assurance |
|---|---|
| L | F |

| Target | Dec 21 | Jan 22 | Feb 22 |
|---|---|---|---|
| 95.0% | 76.2% | 75.9% | 79.1% |

**Background**

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

**What is the data telling us?**

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

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

**Summary**

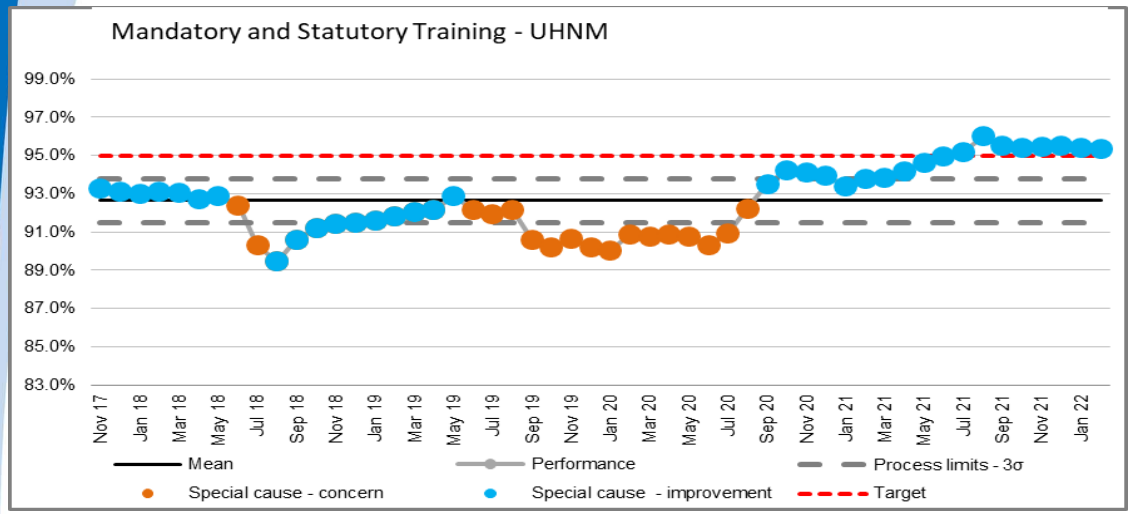
Completion of PDRs was suspended during January 2022, while the Trust was at Critical Incident level. February saw an upturn in the Non-Medical PDR compliance rate to 79.08% (75.91% at 31st January 2022).

Although overall performance remains below target, there was an improvement across all Divisions in February, except that Surgery Division had a slight deterioration.

**Actions**

Requirements for undertaking quality PDRs with staff will be a feature of the comprehensive 'Enable Middle Management' programme which will be delivered to 616 managers during 2022/2023.

# Statutory and Mandatory Training




| Variation | Assurance |
|---|---|
| H | F |

| Target | Dec 21 | Jan 22 | Feb 22 |
|---|---|---|---|
| 95.0% | 95.5% | 95.4% | 95.3% |

**Background**

Training compliance

**What is the data telling us?**

At 95.3%, the Statutory and Mandatory Training rate is better than the Trust target for the core training modules

**Summary**

The Statutory and Mandatory training rate at 28th February 2022 was 95.34% (95.41% at 31st Jan 2022). This compliance rate is for the 6 'Core for All' subjects only

| Competence Name | Assignment Count | Required | Achieved | Compliance % |
|---|---|---|---|---|
| 205\|MAND\|Security Awareness - 3 Years\| | 10574 | 10574 | 10047 | 95.02% |
| NHS\|CSTF\|Equality, Diversity and Human Rights - 3 Years\| | 10574 | 10574 | 10073 | 95.26% |
| NHS\|CSTF\|Health, Safety and Welfare - 3 Years\| | 10574 | 10574 | 10073 | 95.26% |
| NHS\|CSTF\|Infection Prevention and Control - Level 1 - 3 Years\| | 10574 | 10574 | 10064 | 95.18% |
| NHS\|CSTF\|Safeguarding Adults - Level 1 - 3 Years\| | 10574 | 10574 | 10085 | 95.38% |
| NHS\|CSTF\|Safeguarding Children (Version 2) - Level 1 - 3 Years\| | 10574 | 10574 | 10144 | 95.93% |

Compliance rates for the Annual competence requirements were as follows:

| Competence Name | Assignment Count | Required | Achieved | Compliance % |
|---|---|---|---|---|
| NHS\|CSTF\|Fire Safety - 1 Year\| | 10574 | 10574 | 9202 | 87.02% |
| NHS\|CSTF\|Information Governance and Data Security - 1 Year\| | 10574 | 10574 | 9453 | 89.40% |

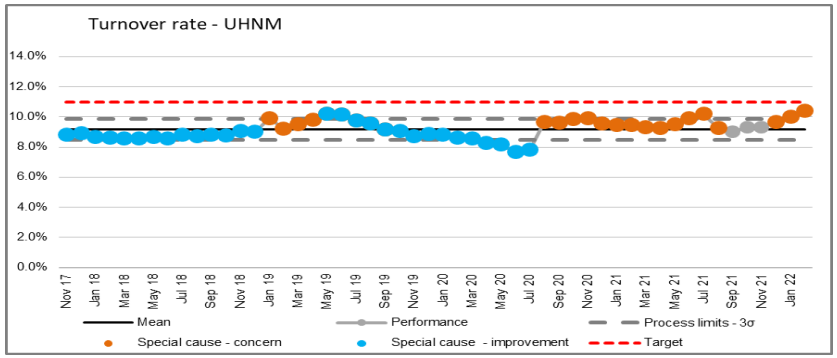
**Actions**

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

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

# Workforce Turnover

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




| Variation | Assurance |
|---|---|
| H | P |

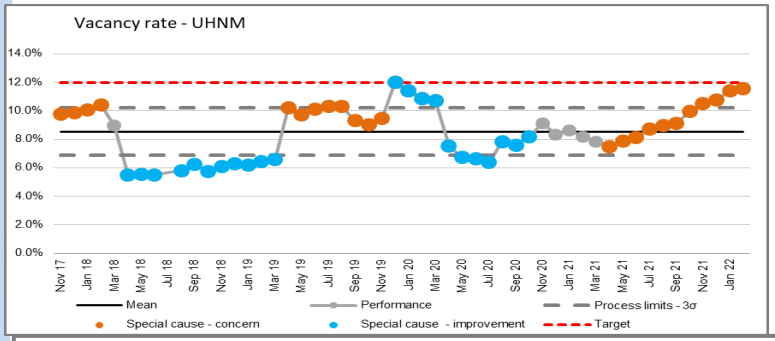
| Target | Dec 21 | Jan 22 | Feb 22 |
|---|---|---|---|
| 11.0% | 9.7% | 10.0% | 10.4% |

**Background**

Turnover rate

**What is the data telling us?**

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




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

**Actions**

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

**Summary**

The 12m Turnover rate was 10.40% (10.01% at 31/1/22).
Staff in post decreased in February 2022 by 37.43 fte*, and budgeted establishment increased by 54.83 fte. This resulted in an overall increase in the vacancy position by 92.26 fte
In month, Bank and Agency fte was 848.13, which covered 65.2% of this vacancy position and there was 1368.70FTE in the recruitment pipeline.
Other mitigations against the vacancy position include offering Additional PA's; extended / increased hours; On call payments and overtime.

| Vacancies at 28 Feb 22 | Budgeted Establishment | Staff In Post fte | Vacancies | Vacancy % | Previous month % |
|---|---|---|---|---|---|
| Medical and Dental | 1,467.21 | 1,270.69 | 196.52 | 13.39% | 13.95% |
| Registered Nursing | 3367.08 | 2935.52 | 431.56 | 12.82% | 13.20% |
| All other Staff Groups | 6430.71 | 5757.97 | 672.74 | 10.46% | 9.92% |
| Total | 11,265.00 | 9,964.18 | 1,300.82 | 11.55% | 11.43% |

# Finance

**2025 Vision** "Ensure efficient use of resources"

# Finance Spotlight Report

University Hospitals of North Midlands NHS Trust

**Key messages**

- The Trust set a plan at the start of the year for a H1 surplus of £8.3m and a full year deficit of £8.8m. The guidance for H2 was issued in September 2021 and at both a National and System level an agreement was reached that the Trust was to carry forward the surplus of £14.5m delivered in H1 and therefore the planned position for H2 was a £14.5m deficit to achieve a breakeven plan for the financial year ending 31 March 2022. Since then, the Trust has worked through the submitted activity plans and calculated an expected income of £5.1m against the Elective Recovery Fund. Therefore in November 2021, the Trust formally submitted a revised annual plan of a £5.1m surplus for the financial year ending 31 March 2022.
- The Trust has delivered an actual deficit of £9.9m in month against an in month planned deficit of £0.6m and a year to date surplus of £5.2m resulting in a favourable variance of £1.8m against the year to date plan. The negative position against plan in month is primarily due to a £10m reduction in block income to support non-recurrent investment across the system.
- A full year forecast has been undertaken at Month 9 and reviewed at Month 11 which presents a £5.2m surplus, although there is a risk of delivering a surplus in excess of this figure due to the TIF ITU funding which the Trust will be receiving in Month 12.
- The Trust incurred £0.9m of costs relating to COVID-19 in month which is a decrease of £0.5m compared with Month 10's figure. This remains within the Trust's YTD fixed allocation with £0.4m being chargeable on top of this allocation for COVID-19 testing costs.
- Capital expenditure for the year to date stands at £23.9m which is £1.1m behind the plan mainly due to an underspend relating to digital pathology and estates infrastructure.
- The cash balance at Month 11 is £78.7m which is £0.3m higher than plan, the main reason being lower than forecast capital payments which reflects the overall slippage against the capital plan.

# Finance Dashboard

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

# Income & Expenditure

| Income & Expenditure Summary Month 11 2021/22 | Annual Budget £m | In Month | | | Year to Date | | |
|---|---|---|---|---|---|---|---|
| | | Budget £m | Actual £m | Variance £m | Budget £m | Actual £m | Variance £m |
| Income From Patient Activities | 868.6 | 72.3 | 60.5 | (11.8) | 797.4 | 783.1 | (14.3) |
| Other Operating Income | 89.8 | 7.8 | 7.9 | 0.1 | 82.0 | 82.5 | 0.5 |
| Total Income | 958.4 | 80.0 | 68.3 | (11.7) | 879.4 | 865.6 | (13.8) |
| Pay Expenditure | (561.9) | (48.5) | (46.1) | 2.4 | (513.3) | (501.2) | 12.1 |
| Non Pay Expenditure | (337.9) | (27.7) | (27.8) | (0.0) | (310.0) | (309.9) | 0.1 |
| Total Operational Costs | (899.7) | (76.2) | (73.8) | 2.4 | (823.4) | (811.2) | 12.2 |
| EBITDA | 58.7 | 3.8 | (5.5) | (9.3) | 56.1 | 54.5 | (1.6) |
| Depreciation & Amortisation | (29.9) | (2.5) | (2.5) | (0.1) | (27.4) | (27.6) | (0.2) |
| Interest Receivable | 0.1 | 0.0 | 0.0 | (0.0) | 0.1 | 0.0 | (0.1) |
| PDC | (7.6) | (0.6) | (0.6) | 0.0 | (7.0) | (7.0) | 0.0 |
| Finance Cost | (16.1) | (1.3) | (1.3) | 0.0 | (14.8) | (14.7) | 0.1 |
| Other Gains or Losses | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Surplus / (Deficit) | 5.1 | (0.6) | (9.9) | (9.4) | 7.0 | 5.2 | (1.8) |
| Financial Recovery Fund | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Total | 5.1 | (0.6) | (9.9) | (9.4) | 7.0 | 5.2 | (1.8) |

The Trust delivered a £9.9m deficit for Month 11 against a planned deficit of £0.6m and a year to date surplus position of £5.2m against a planned surplus position of £7m; the main variances in month are:

- Income from patient activities has underperformed in month primarily due to a £10m reduction in block income to support non-recurrent investment across the system as was included within the Trust forecast position. Additionally, there are further underperformances in month as the trust has received no ERF income in month against a plan of £1.6m and the Trust has underperformed against the Independent Sector contract by £0.4m.
- Pay is underspent in month by £2.4m which is primarily driven by underspends across registered nursing and NHS infrastructure and non-recurrent funding underutilised in month for the System Elective Workforce Funding.
- In Month 11 £0.7m has been spent against the planned Winter figure of £1.1m and year date £2.7m has been spent against the planned Winter figure of £4.1m. This is primarily due to the on-going staffing shortages both from a recruitment and sickness perspective. This slippage is expected to continue until 31 March 2022 and has been factored into the forecast position presented below.

# Capital Spend

| Capital Expenditure as at Month 11 2021/22 £m | Revised 2021/22 Plan | 2021/22 year end forecast | In Month | | | Year to Date | | |
|---|---|---|---|---|---|---|---|---|
| | Plan | Actual | Budget | Actual | Variance | Budget | Actual | Variance |
| PFI & finance lease liability repayment | (9.2) | (9.2) | (0.8) | (0.8) | - | (8.4) | (8.4) | - |
| Pre-committed items | (9.2) | (9.2) | (0.8) | (0.8) | - | (8.4) | (8.4) | - |
| PFI lifecycle and equipment replacement | (5.3) | (5.3) | (0.2) | (0.2) | - | (1.8) | (1.8) | - |
| PFI enabling cost | (0.8) | - | - | - | - | - | - | - |
| PFI related costs | (6.1) | (5.3) | (0.2) | (0.2) | - | (1.8) | (1.8) | |
| RI demolition | (0.9) | (1.2) | - | (0.2) | (0.2) | (0.9) | (1.2) | (0.3) |
| Project STAR multi-storey car park | (1.2) | (1.4) | (0.1) | (0.1) | - | (0.9) | (0.9) | - |
| Thornburrow decant office accommodation | (1.9) | (2.0) | - | - | - | (1.9) | (2.0) | (0.1) |
| Wave 4b Funding - Lower Trent Wards | (2.2) | (2.2) | (0.4) | (0.4) | (0.0) | (2.2) | (1.8) | 0.4 |
| CT7 scanner enabling cost | (1.2) | (0.5) | - | - | - | - | - | - |
| STP diagnostic Funding and Cancer funding CT7 | (1.0) | (1.0) | - | - | - | - | - | - |
| PDC funding - elective recovery (CTS/theatre/CC) T | (1.8) | - | - | - | - | - | - | - |
| PDC funding Cyber Security/Home working TIF | (0.3) | (0.1) | - | - | - | - | - | - |
| PDC funding - Unified Tech funding | (1.6) | (1.4) | - | - | - | - | - | - |
| PDC funding - Digital Maternity Tech funding | (0.3) | (0.1) | - | - | - | - | - | - |
| PDC funding - Imaging Academy | (0.5) | (0.5) | - | - | - | - | - | - |
| PDC funding - Radiology digital | (0.5) | (0.5) | - | - | - | - | - | - |
| PDC funding - Pathology digital diagnostics | (0.2) | (0.2) | - | - | - | - | - | - |
| PDC funding - LIMS | (0.4) | (0.4) | - | - | - | - | - | - |
| PDC funding - Patient Portal | (2.0) | (0.9) | - | - | - | - | - | - |
| PDC funding - Cyber security | (0.3) | (0.3) | | | - | - | - | - |
| Schemes funded by PDC and Trust funding | (16.2) | (12.7) | (0.5) | (0.7) | (0.2) | (5.9) | (5.9) | (0.0) |
| LIMS (Laboratory Information Management System | (0.6) | (0.5) | - | (0.1) | (0.1) | (0.6) | (0.5) | 0.1 |
| EPMA (Electronic Prescribing) | (0.5) | (0.4) | (0.0) | (0.0) | 0.0 | (0.4) | (0.3) | 0.0 |
| Completion of RSUH ED doors | (0.2) | (0.2) | - | - | - | (0.2) | (0.2) | 0.0 |
| Pathology integration | (0.3) | (0.3) | - | - | - | - | (0.1) | (0.1) |
| Medical devices fleet replacement | (0.7) | (0.7) | - | - | - | - | (0.0) | (0.0) |
| Schemes with costs in more than 1 financial year | (2.3) | (2.2) | (0.0) | (0.1) | (0.0) | (1.2) | (1.1) | 0.1 |
| 2021/22 schemes | (15.4) | (16.2) | (0.5) | (1.9) | (1.3) | (7.7) | (6.7) | 1.0 |
| Donated/Charitable funds expenditure | (0.8) | (0.8) | (0.1) | (0.1) | - | (0.8) | (0.8) | - |
| Charity funded expenditure | (0.8) | (0.8) | (0.1) | (0.1) | - | (0.8) | (0.8) | - |
| Overall capital expenditure | (49.2) | (45.6) | (2.0) | (3.6) | (1.6) | (25.0) | (23.9) | 1.1 |

The main variances are explained below.

- Expenditure on the RI demolition is £0.3m higher than plan and reflects additional costs to remove asbestos and associated delays earlier in the financial year.
- Lower Trent is £0.4m behind the revised plan at Month 11 due to delays but is expected to be in line with plan at the year end.
- Within 2021/22 schemes there are 2 main underspends

1. The Digital Pathology scheme is £0.7m behind plan; this scheme is a finance lease asset as part of the managed equipment scheme. This is expected to be completed by the year-end.
2. The scheme to increase to the footprint of the pharmacy dispensary area is £0.5m behind plan due to delays in the legal agreement with Project Co for the changes to the building. The forecast is for slippage of £0.3m at the year end, this has been mitigated in 2021/22 by bringing forward £0.2m of Project Star costs from 2022/23.

The year end forecast expenditure of £45.6m is £3.6m lower than the plan. The variance from plan is due to the Trust not utilising £2.5m of funding in 2021/22 in relation to the TIF schemes for critical care, County CTS and theatres. There is no agreement to be able to carry forward the TIF funding to 2022/23, however the Trust is bidding for future TIF funding for the County hospital site.

The remaining £1.1m variance relates to the PDC funded patient portal, £2m of funding was allocated to the Trust in mid-February prior to costs being known. The latest forecast expenditure is £0.8m in 2021/22 and future year's capital costs will be included in the 2022/23 capital plan.

# Balance sheet

| Balance sheet as at Month 11 | 31/03/2021 | 28/02/2022 | | | |
|---|---|---|---|---|---|
| | Actual £m | Plan £m | Actual £m | Variance £m | |
| Property, Plant & Equipment | 531.2 | 526.2 | 524.2 | (2.0) | Note 1 |
| Intangible Assets | 22.8 | 17.1 | 17.4 | 0.3 | |
| Other Non Current Assets | - | - | - | - | |
| Trade and other Receivables | 0.5 | 0.5 | 0.5 | - | |
| Total Non Current Assets | 554.5 | 543.8 | 542.0 | (1.7) | |
| Inventories | 15.0 | 16.5 | 16.4 | (0.1) | |
| Trade and other Receivables | 47.4 | 46.1 | 48.2 | 2.0 | Note 2 |
| Cash and Cash Equivalents | 55.8 | 78.4 | 78.7 | 0.3 | |
| Total Current Assets | 118.2 | 141.0 | 143.3 | 2.3 | |
| Trade and other payables | (98.5) | (105.8) | (114.8) | (9.1) | Note 3 |
| Borrowings | (8.3) | (8.3) | (8.1) | 0.2 | |
| Provisions | (3.6) | (3.6) | (3.5) | 0.1 | |
| Total Current Liabilities | (110.4) | (117.7) | (126.5) | (8.8) | |
| Borrowings | (268.5) | (260.4) | (260.5) | (0.1) | |
| Provisions | (2.2) | (2.2) | (2.1) | 0.1 | |
| Total Non Current Liabilities | (270.7) | (262.6) | (262.6) | 0.0 | |
| Total Assets Employed | 291.5 | 304.5 | 296.3 | (8.2) | |
| Financed By: | | | | - | |
| Public Dividend Capital | 637.9 | 643.9 | 637.9 | (6.0) | Note 4 |
| Retained Earnings | (465.3) | (458.3) | (460.3) | (2.0) | Note 5 |
| Revaluation Reserve | 118.9 | 118.9 | 118.7 | (0.2) | |
| Total Taxpayers Equity | 291.5 | 304.5 | 296.3 | (8.2) | |

Variances to the plan at Month 10 are explained below:

1. The main areas of underspend are the Digital pathology scheme (£0.7m), the expansion of the pharmacy dispensary area (£0.5m) and the Lower Trent scheme (£0.4m). This is partly offset by the upward revaluations to Wilfred Place and the crèche at County to reflect the sale of the land.
2. Trade and other receivables are £2.0m higher than plan. The main reasons for the variance are sales ledger invoices outstanding in relation to Health Education England for Q4 training income totalling £5.3m and £2m owed from Mid Cheshire Hospitals NHS Foundation Trust in relation to the pathology network. The invoices are expected to be paid by the year end. The increases are partly offset by a credit note provision for the Specialised Services block payments in relation to high cost devices where activity has not matched the income received.
3. Trade and other payables are £9.1m higher than plan. The main reasons for the variance to plan are aged creditors and GRNI accruals (£4m), NHS accruals of (£2m) in relation to Mid Cheshire and NHS Litigation Authority and Deferred income is £3m higher than plan due to funding in relation to West Midlands Cancer alliance and invoiced Health Education Training income.
4. Public Dividend Capital is £6m lower than plan. Overall the Trust is utilising £10.4m of Capital PDC in 2021/22 and had requested a drawdown of cash of £6m (relating to RI demolition and purchase of linear accelerator) on 28 February from DHSC. The cash was not received until 3 March, the remaining PDC balance for approved schemes has been drawn down on the 7 March and 14 March.
5. Retained earnings show a variance of £2.0m from plan which reflects the revenue variance of £1.8m at Month 11 and the impact of donated income and expenditure of £0.2m

# Expenditure - Pay and Non Pay

NHS University Hospitals of North Midlands NHS Trust

| Pay Summary Month 11 2021/22 | Annual Budget £m | In Month | | | Year to Date | | |
|---|---|---|---|---|---|---|---|
| | | Budget £m | Actual £m | Variance £m | Budget £m | Actual £m | Variance £m |
| Medical | (170.1) | (14.5) | (14.1) | 0.4 | (155.6) | (154.4) | 1.3 |
| Registered Nursing | (163.4) | (14.4) | (13.4) | 1.0 | (148.9) | (143.5) | 5.4 |
| Scientific Therapeutic & Technical | (68.2) | (5.9) | (5.5) | 0.4 | (62.4) | (60.4) | 2.0 |
| Support to Clinical | (75.6) | (6.4) | (6.1) | 0.2 | (69.3) | (68.6) | 0.7 |
| NHS Infrastructure Support | (84.5) | (7.4) | (7.0) | 0.5 | (77.1) | (74.3) | 2.8 |
| Total Pay | (561.9) | (48.5) | (46.1) | 2.4 | (513.3) | (501.2) | 12.1 |

**Pay –Key variances**

- Within the above budget for Month 11 is £1.5m of reserves which have not been spent (split across numerous expenditure headings) with the main elements being £0.4m for the non-recurrent investment reserve primarily relating to System Elective recovery, £0.4m in respect of Specialised Commissioners and £0.3m against the System Workforce Funding.
- The underspend on registered nursing remains in line with the prior year trend as a result of the number of vacancies across the trust. Within the Month 11 budget there is £0.5m of underutilised budget in reserves (part of the £1.5m noted above) and within the Month 11 actual were total premium costs (bank and agency) of £1.4m covering existing workforce vacancies and absences.

| Non Pay Summary Month 11 2021/22 | Annual Budget £m | In Month | | | Year to Date | | |
|---|---|---|---|---|---|---|---|
| | | Budget £m | Actual £m | Variance £m | Budget £m | Actual £m | Variance £m |
| Tariff Excluded Drugs Expenditure | (79.8) | (6.2) | (6.7) | (0.5) | (73.2) | (76.2) | (3.1) |
| Other Drugs | (24.4) | (2.0) | (1.9) | 0.1 | (22.3) | (22.2) | 0.1 |
| Supplies & Services - Clinical | (88.8) | (7.5) | (7.8) | (0.3) | (81.1) | (82.1) | (1.1) |
| Supplies & Services - General | (7.0) | (0.6) | (1.0) | (0.4) | (6.4) | (7.2) | (0.8) |
| Purchase of Healthcare from other Bodies | (24.8) | (2.0) | (1.6) | 0.5 | (22.8) | (20.3) | 2.5 |
| Consultancy Costs | (1.9) | (0.1) | (0.1) | 0.0 | (1.8) | (1.8) | 0.1 |
| Clinical Negligence | (25.4) | (2.2) | (2.2) | 0.0 | (24.1) | (24.1) | 0.0 |
| Premises | (32.3) | (2.5) | (2.4) | 0.1 | (29.6) | (30.5) | (0.9) |
| PFI Operating Costs | (35.5) | (2.9) | (3.0) | (0.0) | (32.4) | (32.5) | (0.0) |
| Other | (18.0) | (1.5) | (1.2) | 0.3 | (16.2) | (12.9) | 3.3 |
| Total Non Pay | (337.9) | (27.7) | (27.8) | (0.0) | (310.0) | (309.9) | 0.1 |

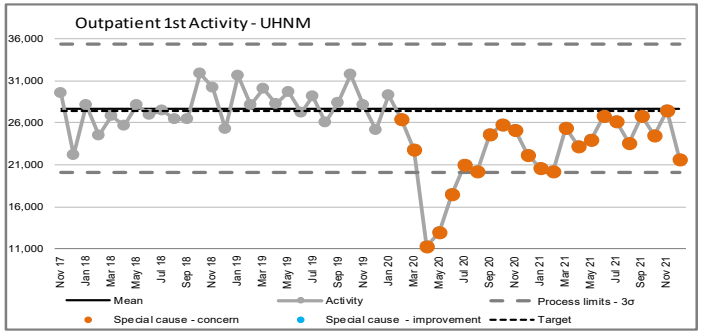
**Non Pay key variances:**

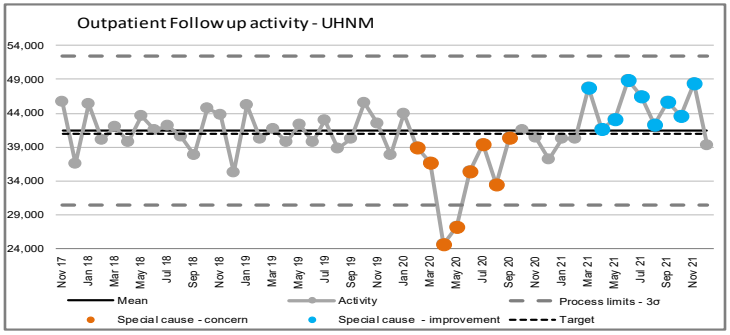
- Tariff Excluded Drugs Expenditure which is overspent in month by £0.5m across numerous specialities. Additional income has been received against some of this additional spend.
- Supplies & Services – Clinical is overspent in month by £0.3m which is in part driven by an increase in Pathology laboratory equipment purchases linked to the additional non-recurrent revenue spend which was approved by the Executive Team earlier in the calendar year.
- Supplies & Services – General is overspent in month by £0.4m this is primarily driven by recruitment fees for overseas nurses
- Purchase of Healthcare from other Bodies is reporting a variance of £0.5m primarily as a result of an underspend against the IS contract (£0.4m).

# Activity

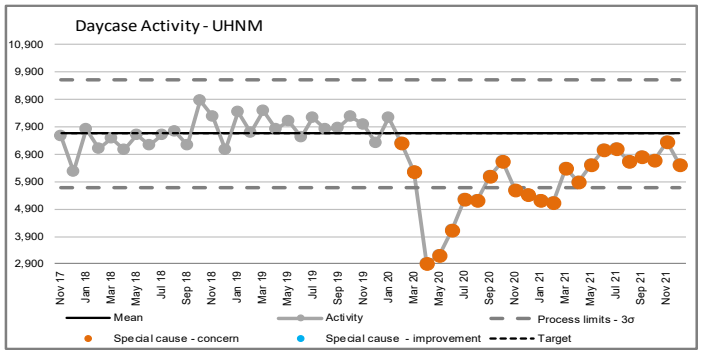
NHS University Hospitals of North Midlands NHS Trust

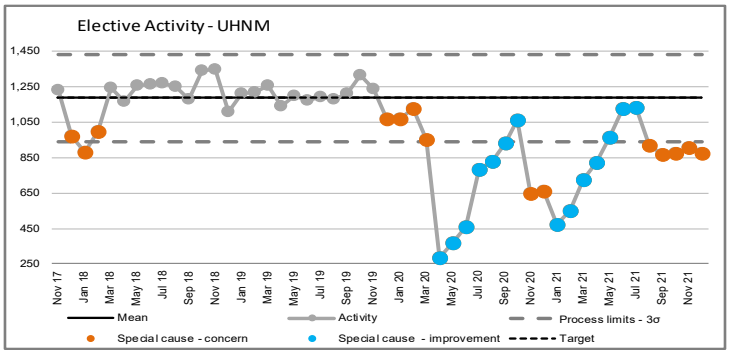
**Planned care** Outpatient



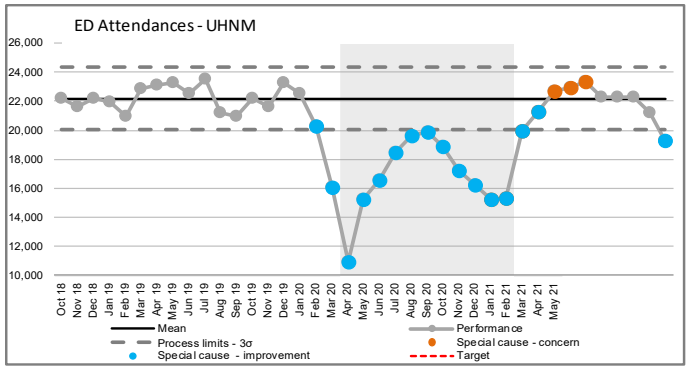



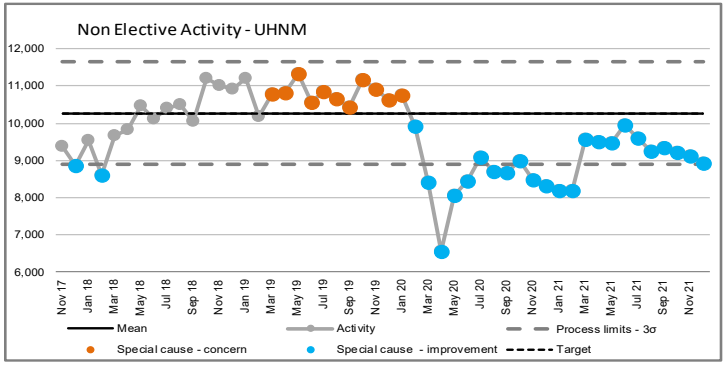

**Planned care** Inpatient




**Urgent Care**




Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

## Trust Board

**2022/23 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 6 | 4 | 8 | 6 | 3 | 7 | 5 | 9 | 7 | 11 | 8 | 8 | |
| **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 | | | | | | | | | | | | | |
| Quality Strategy Update | Chief Nurse | | | | | | | | | | | | | |
| Clinical Strategy | Director of Strategy | | | | | | | | | | | | | |
| Emergency Preparedness Annual Assurance Statement and Annual Report | Chief Operating Officer | | | | | | | | | | | | | |
| Care Quality Commission Action Plan | Chief Nurse | | | | | | | | | | | | | |
| Bi Annual Nurse Staffing Assurance Report | Chief Nurse | | | | | | | | | | | | | |
| Quality Account | Chief Nurse | | | | | | | | | | | | | |
| 7 Day Services Board Assurance Report | Medical Director | | | | | | | | | | | | | 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 | | | | | | | | | | | | | TBC |
| Infection Prevention Board Assurance Framework | Chief Nurse | | | | | | | | | | | | | |
| **ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS STANDARDS** | | | | | | | | | | | | | | |
| Integrated Performance Report | Various | M11 | M12 | M1 | M2 | M3 | M4 | M5 | M6 | M7 | M8 | M9 | M10 | |
| **ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT & RESEARCH** | | | | | | | | | | | | | | |
| Transformation and People Committee Assurance Report | Associate Director of Corporate Governance | | | | | | | | | | | | | |
| Gender Pay Gap Report | Chief People Officer | | | | | | | | | | | | | |
| People Strategy Update | Chief People Officer | | | | | | | | | | | | | |
| Revalidation | Medical Director | | | | | | | | | | | | | |
| Workforce Disability Equality Report | Chief People Officer | | | | | | | | | | | | | |
| Workforce Race Equality Standards Report | Chief People Officer | | | | | | | | | | | | | |
| Research Strategy | Medical Director | | | | | | | | | | | | | |
| Staff Survey Report | Chief People Officer | | | | | | | | | | | | | |
| **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 | | | | | | | | | | | | | |
| Digital Strategy Update | Director of Digital Transformation | | | | | | | | | | | | | TBC |
| Going Concern | Chief Finance Officer | | | | | | | | | | | | | |
| Estates Strategy Update | Director of Estates, Facilities & PFI | | | | | | | | | | | | | TBC |
| Annual Plan | Chief Finance Officer | | | | | | | | | | | | | |
| Capital Programme 2022/23 | 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 | Associate Director of Corporate Governance | | Q4 | | | Q1 | | | Q2 | | | Q3 | | |

| Title of Paper | Executive Lead | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Notes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 6 | 4 | 8 | 6 | 3 | 7 | 5 | 9 | 7 | 11 | 8 | 8 | |
| Accountability Framework | Associate Director of Corporate Governance | | | | | | | | | | | | | TBC |
| 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 | | | | | | | | | | | | | |