University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 6th July 2022 at 9.30 am to 11.45 am
to be held in the Trust Boardroom, Third Floor, Springfield, Royal Stoke Hospital

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 8th & 20th June 2022	Approval	Mr D Wakefield	Enclosure	
	5.	Matters Arising via the Post Meeting Action Log	Assurance	Mr D Wakefield	Enclosure	
15 mins	**6.**	Chief Executive's Report – June 2022	Information	Mrs T Bullock	Enclosure	
10:10		**HIGH QUALITY**				
5 mins	**7.**	Quality Governance Committee Assurance Report (30-06-22)	Assurance	Prof A Hassell	Enclosure	BAF 1
10 mins	**8.**	IPC Board Assurance Framework – June 2022	Assurance	Mr S Malton	Enclosure	BAF 1
10 mins	**9.**	Care Quality Commission Action Plan	Assurance	Mr S Malton	Enclosure	BAF 1
10:35		**PEOPLE**				
5 mins	**10.**	Transformation and People Committee Assurance Report (29-06-22)	Assurance	Prof G Crowe	Enclosure	BAF 1, 2, 3, 4 5
10:40		**RESOURCES**				
5 mins	**11.**	Performance & Finance Committee Assurance Report (28-06-22)	Assurance	Dr L Griffin	Enclosure	BAF 6, 7, 8 & 9
10:45 – 11:00: COMFORT BREAK						
11:00		**RESPONSIVE**				
40 mins	**12.**	Integrated Performance Report – Month 2	Assurance	Mr S Malton Mr P Bytheway Mrs R Vaughan Mr M Oldham	Enclosure	BAF 1, 2, 3, 6 & 9
11:40	**CLOSING MATTERS**					
5 mins	**13.**	Review of Meeting Effectiveness and Business Cycle Forward Look	Information	Mr D Wakefield	Enclosure	
	14.	Questions from the Public **Please submit questions in relation to the agenda, by 9.00 am 4th July to nicola.hassall@uhnm.nhs.uk**	Discussion	Mr D Wakefield	Verbal	
11:45	**DATE AND TIME OF NEXT MEETING**					
	15.	**Wednesday 3rd August 2022, 9.30 am, Trust Boardroom, Third Floor, Springfield, RSUH**				

University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 8th June 2022 at 9.30 am to 12.30 pm
Via Microsoft Teams

MINUTES OF MEETING

Attended	Apologies / Deputy Sent	Apologies

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

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

In Attendance:	
Mrs D Brayford	Quality & Risk Manager (item 13)
Mrs S Jameson	Head of Midwifery (item 13)
Mr C Parkes	Patient (item 1)
Mrs R Pilling	Head of Patient Experience (item 1)

Members of Staff and Public via MS Teams: 3

No.	Agenda Item	Action
1.	**Patient Story**	
085/2022	Mr Parkes described his roles while working at the Trust before explaining how his symptoms started 12 years ago and that he was subsequently diagnosed with spondylolisthesis. He explained that he had numerous treatments for his condition, which had significantly worsened in the past year resulting in an attendance to the Emergency Department whereby he was told he required spinal surgery. In December 2021, he underwent surgery which required him to be in a prone position for a prolonged period of time, resulting in pressure damage to his forehead and chin which he was aware of as a recognised complication. Following discharge, Mr Parkes described the excellent progress he had made.	

PROUD TO CARE

	Mrs Bullock thanked Mr Parkes for how he managed himself and his condition and the way in which he prioritised his patients. Dr Griffin queried if Mr Parke's experience had changed the way in which he treated patients. Mr Parkes referred to the confusion he suffered after the surgery and stated that this had a positive impact on how he was able to relate to patients on his ward who suffer from some form of cognitive impairment. Mr Wakefield queried whether the operation should have been considered sooner although Mr Parkes highlighted that the reason for not having the operation earlier had been explained to him and it depended on the severity of the condition. Professor Hassell queried if Mr Parkes had been told of the action to take if his condition deteriorated prior to surgery, and Mr Parkes confirmed that he had been told to go to his GP for a referral to the Consultant but although he was being managed by medication, he went to the Emergency Department due to the impact his condition was having on his mobility. Mr Wakefield suggested that the post-operative impact from surgery be reviewed to establish if this could have been managed differently, and he reiterated the thanks and recognition to Ward 100 and Ward 109 as well as the care Mr Parkes received from Mr Shahoda and the theatre, recovery and therapies teams. **The Trust Board noted the story.** Mr Parkes and Mrs Pilling let the meeting. Dr Lewis explained that following the patient story in December he had received positive feedback from Mrs Luyt who referred to a recent attendance to the Trust whereby the quality of care received was professional and compassionate and the experience had improved greatly since the previous attendance.	**ML**
2.	**Chair's Welcome, Apologies & Confirmation of Quoracy**	
086/2022	Mr Wakefield welcomed members of the Board and observers to the meeting. It was confirmed that the meeting was quorate. Mr Wakefield stated that it was intended to return to face to face meetings from July onwards pending Infection Prevention and Control guidance and venue requirements. He explained that Ms Belfield's term was due cease at the end of June and he thanked her for the work she had undertaken in her role as Non-Executive Director. In addition, he congratulated Baroness Gohir's appointment to the House of Lords as a non-party political peer and explained that Baroness Gohir was to commence as Non-Executive Director from July and would also take on the role as Non-Executive Maternity Lead, also chairing the specific maternity Quality Governance Committee (QGC). Mr Wakefield added that Professor Hassell was to chair the QGC going forwards and Dr Griffin was to step into the role of chairing the Performance and Finance (PAF) Committee. Mr Wakefield thanked Mr Akid for the time he had served as Chair of PAF.	
3.	**Declarations of Interest**	
087/2022	There were no declarations of interest made.	

4.	**Minutes of the Previous Meeting held 4th May 2022**	
088/2022	The minutes of the meeting from 4th May 2022 were approved as an accurate record.	
5.	**Matters Arising from the Post Meeting Action Log**	
089/2022	PTB/521 & PTB/522 – Mr Bytheway confirmed that both actions had been completed.	
6.	**Chief Executive's Report – May 2022**	
090/2022	Mrs Bullock highlighted a number of areas from her report, in particular the appointment of four Consultant Histopathologists. Professor Maddock referred to the move of the Urgent Care Centre to UHNM from Vocare and queried how this was progressing. Mrs Bullock stated that more patients were being seen by the service than previously which was positive and Mr Bytheway referred to the improvement in triage times. Baroness Gohir referred to the refugee nurses and queried if they had been given named mentors and suggested hearing from the refugee nurses in 12 months' time. Mrs Bullock referred to the way in which pastoral care was provided to international nurses and stated that wraparound support was also provided to the nurses, the effectiveness of which was demonstrated by the retention of international nurses. Mr Wakefield requested an additional update in relation to the resumption of elective procedures at County Hospital and Mrs Bullock stated that work was focussing on orthopaedics as well as staffing the seventh theatre and reducing the number 104 week wait patients. **The Trust Board received and noted the report.**	
STRATEGY		
7.	**Quality Strategy**	
091/2022	Mrs Riley presented the Quality Strategy and highlighted that some of the wording within the Annual Plan and Quality Account needed to align to the information in the Quality Strategy which would be undertaken subsequently. Professor Crowe referred to the investment in the Chief Nurse Fellowship and queried the anticipated impact. Mrs Riley described the 12 month development opportunity which aimed to support staff to drive improvement as well providing them with the opportunity to undertake master classes for professional development. Mr Wakefield welcomed the document and queried the timeframes for establishment reviews in particular the Allied Healthcare Professionals and Mrs Riley stated that while reviews had been undertaken previously for inpatient areas, expanding this to other areas would take longer and would take time to see any recognised impact.	

	Mr Wakefield queried the reference to increasing capacity of virtual wards and Dr Lewis referred to the national initiative to increase capacity and he described the benefits of taking this forward in terms of admission avoidance and improving discharge. Mrs Riley stated that a separate strategy would be developed for maternity which would dovetail with the overall Quality Strategy. Mr Wakefield suggested that further discussion be undertaken in relation to Improving Together and the resource of the team given the importance on delivering the programme. **The Trust Board approved the Quality Strategy 2022-25.**	**AMR**
8.	**People Plan Annual Report 2021/22**	
092/2022	Mrs Vaughan referred to the report which provided an overview of system and Trust initiatives as part of the HR Delivery Plan as well as considering the 2022/23 priorities. Mrs Vaughan added that the National People Plan was being reflected upon, particularly focussed on improving staff experience and engagement, and the Trust plan was being refreshed to align with the four main pillars. Mr Wakefield queried if the reasons why some key metrics had fallen more than national comparators was available and Mrs Vaughan stated that it was difficult to obtain useful information in terms of the responses. Baroness Gohir referred to the recent comments from Sajid Javid regarding a potential bullying culture in the NHS and the need to focus on behaviours during appraisals rather than performance, and she queried whether this was already in place at the Trust. Mrs Vaughan stated that Trust processes already considered this although any national changes that were not currently in place would be taken on board in due course. Ms Bowen queried whether particular improvements were expected following the easing of covid pressures and Mrs Vaughan stated that she expected the appetite to increase from staff to undertake additional development which was positive. **The Trust Board noted the progress made in relation to the People Strategy.**	
9.	**Annual Plan 2022/23**	
093/2022	Ms Ashley referred to the document, which had already been considered by the Transformation and People (TAP) Committee following which comments had been incorporated into the final version. She explained that the plan brought together the priorities for UHNM alongside national priorities. It was noted that going forwards an annual cycle of business was being considered to ensure the Annual Plan was brought for consideration prior to April. Miss Rylands added that the annual priorities of enabling strategies would also be reviewed at the same time to ensure future synchronisation and alignment. Ms Bowen referred to the reference to the Research and Innovation priority and whether this needed to be expanded upon. Ms Ashley stated that a number of strategies were in different stages of development and as such this was reflected	

	in the need to further expand upon some areas such as improving and innovating. Professor Crowe welcomed the approach to coordinate and consider priorities going forwards. Mr Wakefield reiterated the importance of considering the resource of the Improving Together team and queried why efficiency had not been included. Ms Ashley stated that previously resources did not require the same level of focus and whilst references to efficiency were required this would feature within the resources priority. Mr Bytheway added that rather than referring to efficiency, the Trust was looking to focus on transformation as well as engaging with staff to consider how the Trust could achieve what it needs to deliver. **The Trust Board noted and approved the Annual Plan.**	
PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES		
10.	**Quality Governance Committee Highlight Report**	
094/2022	<u>Maternity Quality Governance Committee Highlight Report (25-05-22)</u> Professor Hassell referred to the specific QGC meeting whereby it was agreed that separating out items in relation to maternity and neonatal metrics at a specific meeting was beneficial. He highlighted the risks in relation to perinatal mortality and serious incidents in addition to staffing challenges in terms of investigating incidents and a particular staffing concern raised on Ward 206. Further assurance was requested by the Committee in terms of improving outcomes following investigation of serious incidents. Mrs Riley referred to the staffing challenges and the robust escalation process in place to ensure resources were in the right place, and added that staffing was reported to the regional team on a daily basis. Professor Hassell referred to the confirmation of funding for the smoking cessation programme which was welcomed by the Committee. Dr Griffin referred to the reinstated Home Birth Service and queried whether there was assurance on the safety of this given the availability of community midwives. Mrs Riley stated that risk assessments were undertaken daily to establish whether the necessary staffing was place, which informed any decisions regarding running the service. <u>Quality Governance Committee Highlight Report (01-06-22)</u> Professor Hassell highlighted the areas for escalation focussing on serious incidents and the action to take forward any learning from incidents as well as evidencing that actions had been completed. **The Trust Board noted and received the Committee Highlight report.**	
11.	**Infection Prevention Board Assurance Framework (BAF) – May 2022**	
095/2022	Mrs Riley stated that the BAF had been updated to reflect the change in regional guidance, although additional guidance was expected and would be further reflected upon.	

	Professor Hassell queried the functionality of the air scrubber and UV air system technology and Mrs Riley highlighted that this related to ventilation systems which breaks down mould, bacteria etc, so that it cannot be reproduced although this was being trialled to establish any improvements and required further evaluation. Mr Wakefield requested a further update on such technology at a future Non-Executive Director meeting, in addition to establishing any limitations on impact. **The Trust Board noted and received the BAF.**	**AMR**
12.	**2021/22 Quality Account**	
096/2022	Mrs Riley referred to the draft document which was to be updated to include the remaining stakeholder comments. It was agreed to circulate the final Quality Account to Board members with the inclusion of the comments. Dr Griffin referred to adherence to national clinical audits and the reference of not being registered with the national cardiac arrest audit and asked that the reason for this be included within the report. Dr Lewis agreed to establish the reasons for this and update the report accordingly. Mr Wakefield referred to the reference of the re-launch of the Its OK to Ask Campaign and queried if this had already been taken forward. Mrs Riley agreed to update the narrative accordingly. Mr Wakefield queried the reference to the Structured Judgement Reviews (SJR) and Dr Lewis stated that after a significant event the SJR process would be undertaken to establish any learning and take forward any changes in practice required as a result. **The Trust Board noted and approved the draft version of the Quality Account and quality priorities for 2022/23 which were to be aligned with the priorities within the Quality Strategy.**	**AMR** **ML** **AMR**
13.	**Maternity Serious Incident Report Quarter 4**	
097/2022	Mrs Brayford highlighted that 7 serious incidents had been reported, 1 of which had subsequently been de-escalated. It was noted that the main themes related to the reduction of triage breach on the Maternity Assessment Unit, and the last audit demonstrated that breaches had been reduced by half and this would continue to be audited quarterly. Mr Wakefield queried whether the team were assured that mothers and babies were safe relative to the staffing challenges. Mrs Jameson referred to the overall national ambition of reducing stillbirths and the need to focus on outcomes, and via the maternity dashboard and direct outcomes she expected this to demonstrate a reduction in stillbirths and improved management of post-partum haemorrhage. Mrs Jameson also outlined the processes in place to maintain appropriate staffing to ensure mothers and babies were kept safe. Mr Wakefield referred to the Ockenden review and the additional maternity specific meetings which had been established and he queried whether these were of benefit to the team. Mrs Jameson referred to the increase in staffing within the Directorate which was enabling specific focus on key elements of maternity care, resulting in improvements in outcomes and Mrs Brayford	

	commented that the specific meetings were positive in ensuring the team's voice was being heard and any concerns were being acted upon. She explained that she had described the benefits of this approach with the regional team. Ms Bowen referred to the learning following incidents and queried how recruitment was progressing with phone triage. Mrs Brayford stated that the complete budgeted establishment had been secured and interviews were being held in the next two weeks which would complete recruitment to all outstanding roles. **The Trust Board received and noted the report.** Mrs Jameson and Mrs Brayford left the meeting.	
ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT AND RESEARCH		
14.	**Transformation and People Committee Highlight Report (31-05-22)**	
098/2022	Professor Crowe highlighted the positive progress made in a number of Organisational Development programmes, including the ENABLE programme. In addition, staff support and counselling had continued. He raised a number of areas of concern, including some staffing constraints within the Improving Together team, and the Committee was to consider the roll out plan of Improving Together at a future session, in addition to considering this at the development session included within the Board Development Programme. Dr Griffin referred to the wellbeing walks which were being planned and encouraged the involvement of Non-Executive Directors with these. **The Trust Board noted and received the Committee Highlight report.**	
ENSURE EFFICIENT USE OF RESOURCES		
15.	**Performance & Finance Committee Highlight Report (31-05-22)**	
099/2022	Dr Griffin highlighted the business cases which had been approved by the Committee and referred to the deep dive on urgent care which focussed on the actions being taken and associated trajectories. The Committee noted the areas of challenge such as ultrasound performance and pathology turnaround times and concern was raised regarding retrospective contract awards. In addition, the growing instability in fixed pricing and impact on the capital programme from the inflationary pressures within the construction industry was noted. Professor Crowe referred to the investment programme and queried if accrued investments were visible. Mr Oldham noted that an investment assurance report was planned to be taken to the next PAF and this would include available funds as well as committed and uncommitted funds. Dr Lewis referred to the Internal Professional Standards for referrals and admissions which were considered by the Committee and noted that this could identify deficiencies which would require further consideration. **The Trust Board noted and received the Committee Highlight report.**	

ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS		
16.	**Integrated Performance Report – Month 1**	
100/2022	Mrs Riley highlighted the following in relation to quality and safety: • In terms of sepsis performance, there had been a continued decline in Emergency Department performance and the reasons related to staffing challenges and broader pressures. It was noted that an A3 was to be undertaken in relation to this to establish the actions required for improvement and it was agreed to take a specific update to QGC on measuring the impact on patients of the deterioration in performance. Mr Wakefield referred to duty of candour and queried the reason performance was less for written duty of candour. Dr Lewis explained that for the 2 cases where written duty of candour was not undertaken within the required timeframe the reasons for the delay were being explored which would be used as learning going forwards. Professor Maddock referred to pressure ulcers and data for April whereby the graph referred to 0 ulcers in April. Mrs Riley apologised for the error and it was noted that the number of ulcers had increased in month. Mr Bytheway highlighted the following in relation to urgent care: • During the month there had been a reduction to EMS level 2 for the first time since the beginning of covid, demonstrated by a reduction in 12 hour waits, reduction in medically fit for discharge (MFFD) patients and reduction in ambulance holds • It was noted that since the jubilee weekend, the EMS level had increased to level 3 although overall this had improved Mr Bytheway highlighted the following in relation to cancer: • There had been an increase in the number of first attendances seen • A plan was in place to address the breast cancer challenges, which aimed to improve from July • More people were being treated who had breached the 62 day position which was impacting upon the 62 day performance, and a deep dive into cancer and planned care was to be taken to PAF which would provide assurance regarding delivering improvement Mr Wakefield queried if the Trust had continued to perform better than the national average in relation to the proportion of patients waiting over 62 days to treatment which Mr Bytheway confirmed that was the case, due to seeing and treating more patients. Ms Bowen referred to the breast pain clinic and queried if the pace of the clinic was increasing, Mr Bytheway stated that there had been a number of workforce delays but it was anticipated to roll this out more widely within the next 3 months. Mr Bytheway highlighted the following: • In relation to planned care, the number of 104 week waits had reduced to less than 40 patients • In terms of diagnostics the main area of challenge was ultrasound and MRI although a new mobile MRI scanner had been approved and a plan was in place to address the workforce capacity within ultrasound Mrs Vaughan highlighted the following in relation to workforce:	**AMR**

	• Sickness absence had increased significantly in April to 7.29% although absence levels had since improved, and covid related absences continued to be between 10% to 15% • There had been an increase in staff turnover, over the 11% target with a higher number of leavers in April Mr Wakefield queried if the Trust was content with the level of sickness absence relative to peers and Mrs Vaughan stated that the level was higher than anticipated and reflected national challenges. Ms Bowen referred to the 60 days average time to hire and queried whether this was comparable with peers and in term of turnover, she queried if the Trust was being too optimistic on turnover projections. Mrs Vaughan referred to benchmarking for recruitment and time to hire was comparable with peers although given the pressures within the organisation, the Trust aimed to improve this position. In terms of turnover, no national guidance had been provided, although other Trusts were dealing with similar concerns regarding workforce supply and staff retention. Professor Hassell queried if any information was being utilised from leaver interviews to identify any trends for reasons why staff were leaving. Mrs Vaughan stated that the information was obtained and this would inform the actions required in terms of improving staff retention. Mr Oldham highlighted the following in relation to finance: • There had been a deficit of £1.4 m which was £2 m below plan, primarily driven by the specialist commissioning contract which had not yet been agreed in addition to the risk associated with the non-delivery of the cost improvement programme (CIP) • Covid costs of £1.2 m were incurred in month and an overspend in this area was expected from June onwards since national covid monies had been withdrawn • The cash position was lower than planned although this was expected to improve from May Mr Wakefield queried if the position was recoverable given the risks highlighted and Mr Oldham stated that he expected that the specialised commissioning risk was recoverable, although the CIP risk required further consideration and this would be discussed further at PAF in terms of the individual risks and mitigation in place. **The Trust Board received and noted the performance report.**	**MO**
GOVERNANCE		
17.	**Annual Evaluation of Committee Effectiveness & Rules of Procedure**	
101/2022	Miss Rylands highlighted a change which was to be made to the Quoracy arrangements, clarifying expectations. She added that in terms of the board role and responsibilities, consultation was underway on a revised code of governance and therefore the Rules of Procedure would be updated to reflect any changes once the revised code of governance was published. Professor Crowe suggested that changes to the Code of Governance be provided to the Audit Committee as they become available.	**CR**

	Mr Wakefield referred to the Maternity Quality Governance Committee and asked for this to be separated within the Terms of Reference. **The Trust Board noted the outcome of the Committee self-assessment process and the annual reports which had been provided to each of the respective Committees and approved the revised Rules of Procedure for 2022/23.**	**CR**
18.	**Non-Executive Director Roles**	
102/2022	Miss Rylands referred to the NHSIE review which had consolidated the number of specific Non-Executive Director roles and referred to the assessment which had been undertaken to establish the actions required to ensure existing arrangements met the recommended practice. Mr Wakefield queried if there was any benefit for the lead for children and young people and safeguarding to be the same person and Mrs Bullock stated that safeguarding was broader than children as it also related to adults and she welcomed the scrutiny by the two different leads. Professor Crowe referred to the need to continually review the Terms of Reference for TAP to ensure these reflected the additional reporting requirements in terms of security and digital transformation. Miss Rylands stated that this would be reflected within the business cycles which were updated in real time for presentation at each Committee. Baroness Gohir queried how assurance was provided in relation to the safeguarding of children moving into the remit of adult safeguarding and ensuring these continued to be supported. Mrs Bullock described the internal governance arrangements in place which fed into the Local Safeguarding Children and Adult Boards and the work undertaken in the Trust regarding transitional care arrangements. **The Trust Board noted the assurance arrangements in place and approved the actions identified.**	
CLOSING MATTERS		
19.	**Review of Meeting Effectiveness and Business Cycle Forward Look**	
103/2022	Professor Crowe queried how updates on system working would be provided to future meetings and Miss Rylands agreed to consider this further with Mrs Bullock and Ms Ashley.	**CR**
20.	**Questions from the Public**	
104/2022	Mr Syme referred to the Chief Executives report and reference to bariatric surgery. He requested clarification as to the Surgical Division seeking support from the Procurement team regarding bariatric services for patients and what support had been sought and when this would be operational. Mr Bytheway noted that the support related to the long wait bariatric patients and procurement was in relation to engaging with a private provider and the issue had since been resolved.	

	Mr Syme referred to the finance report and queried whether the 'NHS Inflation' impacting on the Trust had been quantified and if so what the figure was expressed as a percentage and a financial risk. He also queried whether any support had been allocated to the Trust to address the specific inflation risk and if the support would fully cover the risk. Mr Oldham referred to the original planning assumption of 2.7% which equated to £5.2 m for the Trust, also the PFI linked to the Retail Price Index of 8.9% equating to £3 m. It was noted that the original planning assumption had increased to 5.3% equating to an additional £6 m. In addition there was £400 m available nationally for specific inflation. It was noted that 2% had been assumed for pay inflation and a further 1% nationally but this was subject to ongoing discussions. Mr Syme referred to the PAF highlight report and implementation of the new Internal Professional Standards. He queried whether the standards were fully implemented and whether these would be subject to continual review and queried whether these replaced previous standards. Dr Lewis stated that previous standards were in place and these had been updated to ensure they remained relevant and were in place to ensure patients were cared for by the most appropriate team as well as ensuring patients moved through the Emergency Department more quickly. It was noted that the standards had been consulted on with clinical teams prior to implementation and would be evaluated for impact.	
DATE AND TIME OF NEXT MEETING		
21.	Wednesday 6th July 2022, 9.30 am, Trust Boardroom, Third Floor, Springfield, Royal Stoke University Hospital	

University Hospitals of North Midlands NHS Trust

Extraordinary Trust Board (Open)

Meeting held on Monday 20th June 2022 at 9.00 am to 9.20 am
Via Microsoft Teams

MINUTES OF MEETING

Attended	Apologies / Deputy Sent	Apologies

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

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

In Attendance:		
Mrs N Hassall	NH	Deputy Associate Director of Corporate Governance (minutes)
Mrs S Preston	SP	Strategic Director of Finance

Members of Staff and Public via MS Teams: 0

No.	Agenda Item	Action
1.	**Chair's Welcome, Apologies and Confirmation of Quoracy**	
105/2022	Mr Wakefield welcomed members to the meeting and confirmed that the meeting was quorate.	
2.	**Declarations of Interest**	
106/2022	There were no declarations of interest raised.	
3.	**Audit Committee Assurance Report (17-06-22)**	

PROUD TO CARE

107/2022	Professor Crowe highlighted the following: • The External Audit had been completed, and the Committee recognised the increased requirements on External Audit. The responsiveness of the Trust in working with the Auditors on the audit was welcomed • A modified opinion had been provided, due to the stocktake issue arising from the pandemic. In addition, the difference in interpretation of the accrual for annual leave was highlighted. Mr Wakefield referred to the modified opinion and whether this would cause concern going forwards. Professor Crowe stated that after this year the stock issue should no longer be a problem. Mr Oldham added that the issue was due to auditors being unable to attend on site to undertake a physical stock take, due to the pandemic, which acted the opening balances and year on year comparisons. He stated that 2021/22 would be the last year it impacted upon the accounts and added that the same issue affected other Trusts. Mr Wakefield referred to the outcome of the internal audits and those with partial and reasonable assurance and queried the difference. Professor Crowe highlighted that partial assurance was below the line and reasonable assurance was above the line. **The Trust Board received and noted the assurance report.**	
4.	**2021/22 Annual Report and Annual Governance Statement & 2021/22 Annual Accounts**	
108/2022	Miss Rylands highlighted the Audit Report which had been prepared in line with the Department of Health and Social Care, Group Accounting Manual. She highlighted that following the discussion at Audit Committee, a number of changes had been made which included an additional declaration of interest, amendment to the membership of the Transformation and People Committee and an amendment to the first paragraph on the Chief Executive's foreword. Mr Wakefield referred to the position reported on page 68 of the report which differed to the surplus position reported earlier in the report. Mr Oldham agreed to reconcile the two figures and provide an explanation to Mr Wakefield outside of the meeting. Mr Wakefield thanked Miss Rylands for preparing the report and Dr Griffin added his thanks, recognising the effort taken to prepare the Annual Report. Mr Wakefield queried if the cumulative deficit would be cancelled out by PDC and Mr Oldham stated that PDC had used to repay borrowings to maintain liquidity when the Trust was in deficit. It did not in its own right impact on the Income and expenditure position. **The Trust Board approved the Annual Report and Annual Governance Statement.** **The Trust Board approved the annual accounts and sign-off of the relevant statements and certificates, to enable the submission of the final audited accounts on the 22nd June 2022.**	**MO**
DATE AND TIME OF NEXT MEETING		
5.	Wednesday 6th July 2022, 9.30 am, Trust Boardroom, Third Floor, Springfield, Royal Stoke University Hospital	

Trust Board (Open)

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

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

Ref	Meeting Date	Agenda Item	Action	Assigned to	Due Date	Done Date	Progress Report	RAG Status
PTB/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 Ann Marie Riley	05/10/2022		To be added into the next quarterly CQC update - due date moved.	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 Ann Marie Riley	05/10/2022		To be added into the next quarterly CQC update - due date moved.	GA
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	31/05/2022	08/06/2022	It was confirmed this action was complete at Junes' meeting.	B
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 Jen Freer	31/05/2022	08/06/2022	It was confirmed this action was complete at Junes' meeting.	B
PTB/524	06/04/2022	Chief Executives Report	To provide an update to QGC on the implications and risks associated with the new patient covid testing guidance	Ann-Marie Riley Scott Malton	30/06/2022	30/06/2022	Included within the IPC BAF.	B
PTB/527	04/05/2022	Quality Governance Committee Assurance Report (28-04-22)	To provide a timeline to address and complete the outstanding mortality reviews to the Quality Governance Committee (QGC) identifying key learning points.	Matthew Lewis	30/06/2022	28/06/2022	Paper taken to QGC 28th June 2022.	B
PTB/528	04/05/2022	Integrated Performance Report – Month 12	To provide additional analysis of pressure ulcers to QGC including age profile.	Ann Marie Riley	28/07/2022		To be taken to July's QGC meeting.	GB
PTB/530	04/05/2022	Integrated Performance Report – Month 12	To provide information on key recruitment metrics to the TAP.	Ro Vaughan	30/06/2022	30/06/2022	Recruitment metrics such as average time to hire, number of vacancies in the recruitment pipeline included within the TAP report.	B
PTB/531	04/05/2022	Questions from the Public	To confirm that risk assessments had been undertaken for the MLU for previous years and to confirm any learning.	Ann-Marie Riley	30/06/2022	30/06/2022	Risk Assessments have been completed and the ones undertaken in the past couple of years have been reviewed. Learning from the reviews subsequently informs the Quality Impact Assessment.	B
PTB/532	08/06/2022	Patient Story	To establish if the management of prone patients and assessing the risk of pressure damage was undertaken correctly	Matthew Lewis Ann-Marie Riley	31/07/2022	15/06/2022	As part of considering the patient story, the Tissue Viability team have been involved in the patient's care post operatively in relation to the pressure damage. Since this time, new products have been sourced (memory foam/facial blocks) to support with pressure relief; and an evaluation of a new barrier product is being launched for patients who are identified as high risk procedures i.e prone patients and patients with superficial damage from trauma. The patient has also been involved in the consideration of new products to establish his views.	B
PTB/533	08/06/2022	Quality Strategy	To identify a time for further discussion with the Non-Executive Directors of the resourcing of the Improving Together team.	Ann-Marie Riley	31/07/2022		Action not yet due.	GB
PTB/534	08/06/2022	IPC BAF May 22	To provide an update on ventilation system technology at a future Non-Executive Director meeting, and establishing any limitations.	Ann-Marie Riley	31/07/2022		Action not yet due.	GB
PTB/535	08/06/2022	Quality Account 2021/22	To amend the document to include stakeholder comments, inclusion of reference to the reasons for not registering with the national cardiac arrest audit and clarifying the narrative related to the Its OK to Ask Campaign and circulate the final version to Board Members.	Ann-Marie Riley Matthew Lewis Jamie Maxwell	30/06/2022	28/06/2022	Document updated to reflect the comments made and to be published by 30th June.	B
PTB/546	08/06/2022	Integrated Performance Report - Month 1	To take an update to a future QGC meeting regarding measuring the impact on patients who had not received appropriate sepsis screening within the Emergency Department	Ann-Marie Riley	31/07/2022		Action not yet due.	GB
PTB/547	08/06/2022	Integrated Performance Report - Month 1	To discuss the risk and mitigation associated with the Cost Improvement Programme at a future PAF meeting	Mark Oldham	31/07/2022		Action not yet due.	GB
PTB/548	08/06/2022	Annual Evaluation of Committee Effectiveness & Rules of Procedure	To provide a summary of changes to the Code of Governance at a future Audit Committee	Claire Rylands	TBC		Action not yet due.	GB
PTB/549	08/06/2022	Annual Evaluation of Committee Effectiveness & Rules of Procedure	To separate the reference to the specific maternity QGC meeting within the Terms of Reference	Nicola Hassall	30/06/2022	29/06/2022	Complete. Incorporated into revised Rules of Procedure	B

PTB/550	08/06/2022	Review of Meeting Effectiveness	To work with Mrs Bullock and Ms Ashley regarding a regular update to the Board on system working.	Claire Rylands	31/07/2022		Action not yet due.	GB
PTB/551	20/06/2022	Annual Report	To reconcile the differences in numbers reported within the financial summary section.	Mark Oldham	20/06/2022	20/06/2022	Complete. It was noted that the figures reported had been included within the wrong rows which was subsequently rectified.	B

Chief Executive's Report to the Trust Board

FOR INFORMATION

Part 1: Trust Executive Committee

The Trust Executive Committee met virtually on the 22nd June 2022.

Divisions took the opportunity to highlight any key matters requiring escalation, the following points were noted:

- CWD had discussed a number of risks on their risk register covering a range of issues, largely relating to resource, which impact on other Divisions in terms of diagnostics for patient pathways
- CWD have appointed 25 WTE student midwives and a further business case is in progress to respond to Birthrate Plus
- A Paediatric End of Life Care Nurse had been appointed
- Surgery had celebrated a senior sister who had stepped in to help a patient who became critically ill whilst on an aeroplane flight
- Surgery were in the process of gathering data on the impact on SAU and SACU following the new standards for referral and admission and would bring this back to the team
- Surgery also shared some very positive stories from their wards about acts of compassion for their patients including personalised chocolates during the Jubilee and food packages for those in hardship who were being discharged.
- Specialised highlighted challenges around backlogs within cardiology and the action being taken to address this
- Specialised had observed a dip in their Clinically Ready to Proceed performance following the new standards for referral and admission although were undertaking further analysis to better understand this position and will be working with colleagues in ED to review patient pathways
- Specialised were meeting with clinicians to complete their job planning, cost improvement meetings were also taking place and the Division were moving to the next phase of the elective hub at County
- A trial was underway within the Emergency Department (ED) associated with the closure of the Red Assessment unit (RAU); concerns were also raised around non-admitted patients within the ED

Executive Directors gave the following key updates:

- Work being undertaken on a business case for County Hospital to support elective recovery which will be progressed through to NHSIE for approval
- Business case for additional foundation year doctors following an approach by Health Education England to take on additional cohorts to address the current shortfall; given financial constraints this would take approximately 25% of the investment fund for 2023/24 and would be progressed through the Performance and Finance Committee and Board
- Quality Strategy now approved by the Trust Board – a follow up discussion will be focussed around year 1 objectives
- National 104 week wait position was achieved by end of June. Trust has c40 patients which are waiting over 104 but which are part of the national accepted exceptions for patient choice and highly complex procedures where nationally there are problems in delivery such as Complex Spinal Surgery. This is a significant achievement. The focus is now on 78 week waits which is also seeing a reduction
- Now finalised the 22/23 financial plan which is breakeven as an organisation and a system; this had recently improved due to additional allocations for inflation although there are significant risks associated in terms of pay awards, non-pay expenditure, Covid allocations and the elective recovery fund
- An alternative approach in order to manage risk associated with investments was currently being developed and would be taken to the Finance and Performance Committee
- Formal planning approval had been given for the new car park at Grindley Hill as part of Project STAR, with works having now commenced on site
- 999 Critical Condition continues to be a successful TV programme with a numerous request for good news stories being requested by the media
- The Charity are currently seeking new projects for the next two years whilst they continue with the programme of works on the Cancer Centre
- A follow up review of Divisional Board Effectiveness was currently underway
- Connects Leadership Development programme currently underway and continues to be successful, along with the system wide High Potential Programme
- NHS Integrated Care Boards will become a legal entity on 1st July which will mean that Clinical Commissioning Groups will cease to exist

Part 2: Chief Executive's Highlight Report

1. Contract Awards and Approvals

Department of Health Procurement Transparency Guidance states that contract awards over £25,000 should be published in order that they are accessible to the public. Since 12th May to 13th June, 3 contract awards, which met these criteria, were made, as follows:

- **Trent Wave 4b - New 26 Bed Ward** supplied by IHP Vinci, at a total cost of £4,470,598.31, approved on 13/05/22
- **Endoscopy Diagnostics Services – 18 Weeks Support** supplied by NHS SBS, for the period 01/04/22 - 30/09/22, at a total cost of £780,000.00, approved on 01/06/22
- **Supply of Imaging Contrast Media (2022/23 Extension)** supplied by various, for the period 01/05/22 - 31/04/23, at a total cost of £3,717,582.00, approved on 01/06/22

In addition, the following eREAFs were approved at the Performance and Finance Committee on 28th June 2022, and also require Trust Board approval due to their value:

Grindley Hill Multi-Storey Car Park - PSCP Appointment Extension (eREAF 9363)

Contract Value	£32,975,157.45 incl. VAT
Duration	Capital Purchase
Supplier	IHP Vinci Construction

Provision of Car Park Management at Royal Stoke University Hospital (eREAF 9355)

Contract Value	£1,559,494.40 incl. VAT
Duration	01/08/22 - 31/07/24
Supplier	APCOA Parking (UK) Limited

ELFS Shared Finance Systems (eREAF 9212)

Contract Value	£2,708,676.00 incl. VAT
Duration	01/11/22 - 31/10/22
Supplier	ELFS Shared Service Centre

Agency Nursing Master Vendor Contract (eREAF 8847)

Contract Value	£35,603,419.00 incl. VAT
Duration	01/10/22 - 30/09/23 (with the option of 3 x 12 month extensions)
Supplier	Day Webster

County Modular Theatre (eREAF 9440)

Contract Value	£2,078,341.76 incl. VAT
Duration	Capital purchase
Supplier	Portakabin

The Trust Board is asked to approved the above eREAFs.

2. Consultant Appointments – June 2022

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

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Acute Medicine Specialist Grade	New	Yes	01/06/2022
Consultant Colorectal Surgeon	Vacancy	Yes	TBC

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

Post Title	Reason for advertising	Start Date
Director of Respiratory Research	Extension	01/06/2022
Consultant in Acute Medicine	Vacancy	01/06/2022
Specialist Doctor in Clinical Oncology	Vacancy	01/06/2022
Consultant Spinal Surgeon	New	01/06/2022
Respiratory Consultant	Vacancy	20/06/2022
Consultant Gastro Intestinal Radiologist (Colorectal)	New	20/06/2022
Locum Consultant Neurosurgeon	Extension	28/06/2022
Locum Consultant Spinal Surgeon	Extension	01/06/2022

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

Post Title	Closing Date	Note
Locum Consultant Geriatrician	06/06/2022	No Applications
Consultant Clinical Oncologist – Head & Neck, Thyroid and UGI	05/06/2022	No Applications
Consultant Clinical Oncologist - Lung and Urology	05/06/2022	Applicant not suitable
Consultant Obstetrician with an Interest in Maternal / Fetal Medicine	23/06/2022	No applications

3. Internal Medical Management Appointments – June 2022

The following provides a summary of Medical Management interviews which have taken place during June 2022:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Deputy Medical Director Performance	Vacancy	Yes	TBC
Deputy Medical Director System	Vacancy	Yes	TBC

The following provides a summary of Medical Management who have joined the Trust during June 2022:

Post Title	Reason for advertising	Start Date
Surgical Division Clinical Governance Lead	Vacancy	01/06/2022

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

Post Title	Closing Date	Note
N/A	N/A	N/A

4. Covid 19 and Trust Pressures

During the last few weeks there has been an increase in the number of patients with Covid in the community. As per the usual pattern, we are now seeing a corresponding increase in patients being admitted to hospital. As at the 23 June 2022 we have 107, which is an increase from the previous 50 patients. Unfortunately, this means that our staff sickness levels are also increasing. This describes the picture with Covid-19 at a national level. Whilst we are seeing this upturn, as of yet this has not impacted on our delivery plan for planned and elective procedures and we continue to make good progress in relation to elective backlogs. .

5. Physical Health NHS Trust ICB Partner Member

The new NHS architecture becomes a legal construct on the 1 July 2022 and my previous briefings have covered the detail of what this means. Two things we will see are the abolition of Clinical Commissioning Groups and the creation of Integrated Care Partnership and the NHS Integrated Care Board (ICB). A process is underway to determine membership of the NHS ICB and I am pleased to confirm that following nomination and system agreement, I have been appointed to the NHS ICB to represent physical health with effect from 1 July 2022. The process remains underway to determine Mental Health representation and will conclude on the 28 June 2022.

6. Care Quality Commission (CQC) Formal Criminal Investigation

On 13 June 2022, we received notification of CQC's decision to open a formal criminal investigation following review of records relating to a specific incident which occurred in November 2021 at the Royal Stoke Hospital. We are working with the CQC to ensure they have the detail required for their investigation. As this is in relation to a single patient further detail will be given in Closed Board.

7. Developments at County Hospital

We have been holding a number of sessions with our staff to talk about exciting proposed developments at County Hospital and these have been exceptionally well attended. The discussions have been focussed around investing in and expanding services and it has been really positive to hear the views of our staff. The outline strategy for County Hospital will be the focus of discussion at our Board Seminar in July. Once a detailed strategy and plan is in place, this will come to Board for approval

8. Project STAR

I was delighted with the news that our plans for a new staff car park at Grindley Hill Court had been approved by Stoke-on-Trent City Council. This means we have been able to move forward with our plans to help improve NHS parking facilities for our staff as well as support the local authority in regenerating the Infirmary site for possible housing and community facilities.

9. Military Support

During Covid-19 we have recognised the particular skills and expertise our colleagues from the military can bring to our organisation and earlier in the month I had the opportunity to meet with a Commander and Squadron Leader to discuss further potential opportunities for army personnel in our Emergency Departments, Critical Care as well as other areas. Feedback from those who have been on placement at UHNM was universally positive and this working relationship is one we want to continue and expand to mutually share skills and experience.

On 20 June we said a special thank you to the men and women who make up the Armed Forces Community as part of Armed Forces Day which takes place on the last Saturday each June. Alongside a number of events, we raised a flag on our grounds to mark the occasion.

10. Health Library at Post Graduate Medical Centre County

I was pleased to be asked to cut the ribbon to officially re-open the health library at the Post Graduate Medical Centre at County Hospital. The library has undergone a major refurbishment and modernisation with the top floor being completely transformed into an area which is relaxed, warm and welcoming for any member of staff to study or meet. Our health libraries provide a valuable resource for all staff working at the Trust and to students on placement.

11. 999 Critical Condition

I am delighted to report that the Channel 5 series 999 Critical Condition, which is filmed at Royal University Stoke Hospital, is proving as popular as ever with one million people watching an episode when it is scheduled and many more watching on catch-up. Showcasing our amazing staff, viewers are able to see a wide range of services we provide and the difficult decisions jointly made by the clinical teams, families and patients.

12. UHNM Charity

In June our UHNM Charity was successful in its bid for £500,000 to work with community and voluntary groups across Staffordshire to help to tackle loneliness and social isolation as a result of the Covid-19 pandemic. NHS Charities Together (NHSCT) has given the award to UHNM Charity as part of its Community Partnerships Grants programme. Fourteen community groups and projects from the Staffordshire and Stoke Integrated Care System (ICS) will receive grant funding to help address the issue of loneliness and social isolation. UHNM Charity worked with other organisations including Stoke-on-Trent City Council, Staffordshire County Council and Support Staffordshire to identify the projects which will get a share of the half a million pound grant over the next two years. The grant will fund a range of initiatives including improvements to existing services for people at risk of loneliness and isolation, the creation of new projects and groups to improve social connection and the use of new technology.

Also in June, Barlaston Golf Club hosted a Corporate Golf Day with local businesses and Club members raising funds for UHNM Charity. The event raised over £5,800 and I would like to thank everyone involved and for their generosity, and especially the Club for announcing that they will be holding another UHNM Charity day on the 16 June 2022.

13. Deputy Medical Directors

Dr Matthew Lewis, was recently pleased to announce the appointment of two new Deputy Medical Directors in June; Dr Mark Poulson will take responsibility for Performance and Dr Zia Din will support and engage with system working. They will work alongside Dr Grant Heatlie, who continues to look after Quality, and Dr Nick Coleman, who remains as Responsible Officer, with oversight of medical workforce (People). There was considerable interest in the posts, and these individuals were appointed after a thorough selection process.

Quality Governance Committee Chair's Highlight Report to Board

30th June 2022

University Hospitals of North Midlands NHS Trust

1. Highlight Report

!	Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
	• The cyber security risk in relation to the Pharmacy EMIS system was highlighted as having increased in June due to ongoing actions with the solution, and this was to be considered further with the Executive. In addition a new risk in relation to a deterioration in chemotherapy turnaround time by external suppliers was highlighted. The spend on medicines had increased during 2021/22 to £102 m, and the actions being taken to manage the budget for medicines across the system were highlighted.	• Ongoing work being undertaken to stratify the data for falls and pressure damage, to determine cases which were avoidable • To confirm any correlation between the increase in falls and reduced nurse staffing via completion of a deep dive • To obtain specialist input and review of the paediatric sepsis screening cases • To provide an update at September's meeting on the work being undertaken to review and improve the accuracy of reporting in relation to sepsis screening • To defer the CQC safety, equity and engagement in maternity services to the Maternity Quality Governance Committee • Review of complaints process being undertaken, including the consideration of accessibility, in addition to validation of complaints outcomes • To provide an update at a future meeting in terms of the progress made to assess harm for long waiters
✓	**Positive Assurances to Provide**	**Decisions Made**
	• The positive assurance received following an external radiopharmacy audit was welcomed • 100% of deaths across both sites were being reviewed by the Medical Examiners office and the Committee welcomed the extension of reviews to include coroners cases which was considered best practice, in addition to extending cover on Saturdays which in turn improved the service provided • The updated CQC Action Plan demonstrated the 35 individual actions to address the 9 must do actions, and the 31 individual actions to address the 19 should do actions, the majority of which had been completed or were on track. Assurance was provided on the ongoing work to address and progress the 3 'problematic' actions • The audit into care at the end of life was provided which demonstrated positive results when compared to the national average and in particular, more positive results were provided from the bereavement survey • Quarter 4 Patient Experience report continued to demonstrate consistent top themes in relation to suitability of treatment and diagnosis and these were being considered further with the Medical Director	• The Committee supported the proposal to undertake a full review of all Covid deaths within the next 4 months • The Committee approved the 2022/23 Clinical Audit Programme • The Committee approved the Terms of Reference for the Quality Safety Oversight Group, which were to be amended to include the change to membership to reflect Divisional representation rather than specific roles, and the Clinical Effectiveness Group

Comments on the Effectiveness of the Meeting

- The Committee felt the meeting went well and the items were discussed opening and sufficiently.

2. Summary Agenda

No.	Agenda Item	BAF Mapping		Purpose	No.	Agenda Item	BAF Mapping		Purpose
		BAF No.	Risk				BAF No.	Risk	
1.	Medical Examiner Update			Assurance	9.	Q4 Patient Experience Report			Assurance
2.	Mortality Update: • Option Appraisal for Completion of Covid Mortality Reviews	BAF 1	18987	Approval	10.	CQC Safety, Equity and Engagement in Maternity Services	BAF 1		Assurance
3.	Q4 Nursing and Midwifery Staffing and Quality Report	BAF 1/3		Assurance	11.	Clinical Effectiveness Group Assurance Report	BAF 1		Assurance
4.	M2 Quality & Safety Report	BAF 1		Assurance	12.	Quality & Safety Oversight Group Assurance Report	BAF 1		Assurance
5.	2022/23 Clinical Audit Programme	BAF 1	8877, 8500, 22876	Approval	13.	Executive Groups Effectiveness Reviews / Terms of Reference			Approval
6.	CQC Action Plan	BAF 1		Assurance	14.	Quality Impact Assessment Report	BAF 1		Information
7.	Medicines Optimisation Q4 21/22 & Q1 22/23	BAF 1	24556, 17977	Assurance	15.	Final Quality Account	BAF 1		Information
8.	National Audit of Care at the End of Life			Assurance					

3. 2022 / 23 Attendance Matrix

			Attended	Deputy Sent	Apologies Received

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

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	6th July 2022
Report Title:	Infection Prevention Board Assurance Framework	**Agenda Item:**	8.
Author:	Helen Bucior, Infection Prevention Lead Nurse		
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	X	**People**		**Systems & Partners**	
Responsive		**Improving & Innovating**		**Resources**	X

Executive Summary:

Situation

To update the Committee on the self-assessment compliance with UKHSA and NHSEi regional COVID guidance

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

- IP next steps letter - Universal wearing of masks in clinical areas continues
- 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
- Risk assessment undertaken to support deviating from national guidance. This approach has been supported by a recent document (Midlands Regional IPC principles) released by NHSE/I
- Visiting for patients has been increased to 2 visitors for each patient 2-4 pm , 6-8 pm. The 2 visits for the majority of cases do not need to be the same visitors

<u>Progress</u>

- External company continues to assist with mask fit testing
- Cleaning Collaborative work stream (multi-disciplinary representation) established and using Improving Together tools and methodologies continues to review cleaning standards
- Estates and IP are exploring the use of air scrubber technology
- May 2022 UV air system on trial ward 225 and business case in progress
- Monkey pox UK outbreak UHNM response in progress

Key Recommendations:

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

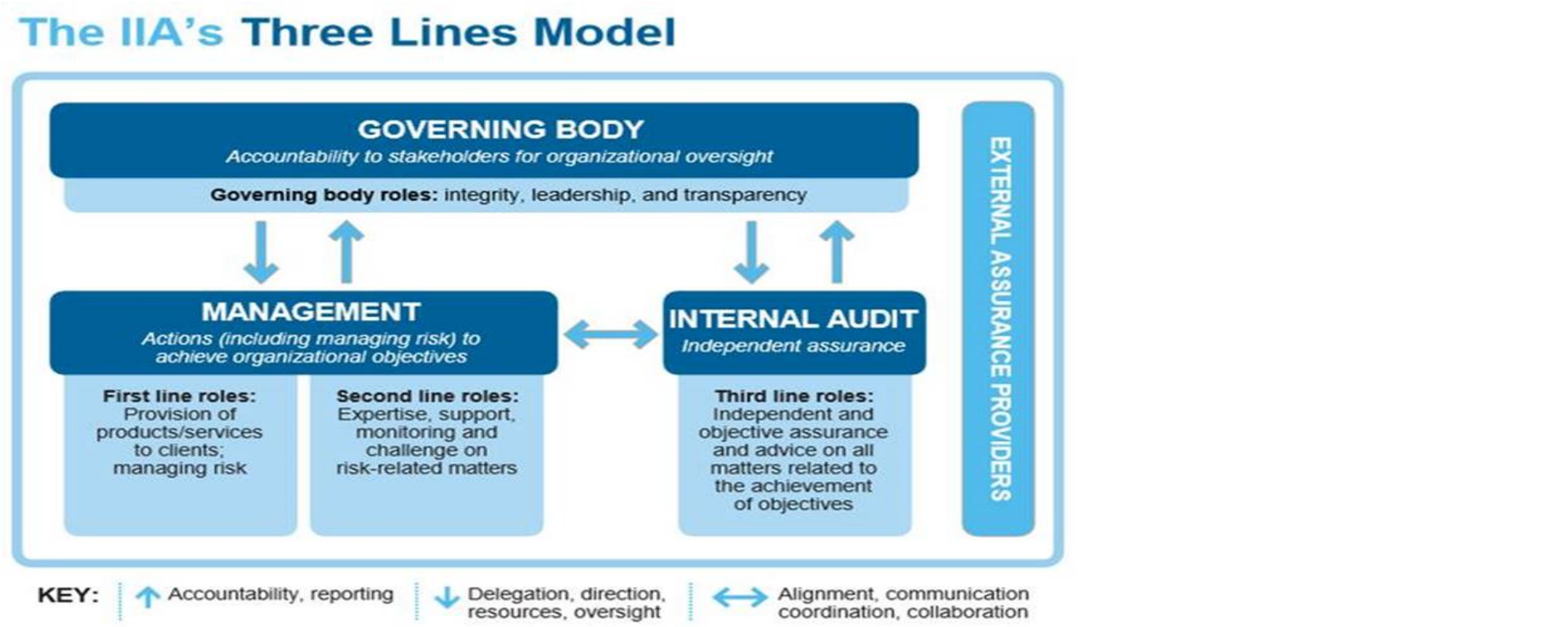
NHS
University Hospitals of North Midlands
NHS Trust

Infection Prevention and Control Board Assurance Framework

June 2022

Summary Board Assurance Framework

Ref / Page	Requirement / Objective	Risk Score					
		Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Change
BAF 1 Page 4	Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users.	High 9	Mod 6				↑
BAF 2 Page 19	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	Mod 6	Mod 6				→
BAF 3 Page 29	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	Mod 6	Mod 6				→
BAF 4 Page 32	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care, in a timely fashion.	Low 3	Low 3				→
BAF 5 Page35	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	Low 3	Low 3				→
BAF 6 Page41	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.	Low 3	Low 3				→
BAF 7 Page 47	Provide or secure adequate isolation facilities.	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	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3					There are a number of controls in place. UHNM Risk assessment are in place where deviation from regional COVID guidelines and testing recommendations	Likelihood:	1	End of Quarter 3
Consequence:	3						Consequence:	3	
Risk Level:	9						Risk Level:	3	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
1.1	**Next Steps on Infection Prevention , date 1st June** **For health and care staff:** • Health and care staff should continue to wear facemasks as part of personal protective equipment required for transmission-based precautions when working in COVID-19/respiratory care pathways, and when clinically caring for suspected/confirmed COVID-19 patients. This is likely to include settings where un triaged patients may present such as emergency departments or primary care, depending on local risk assessment. In all other clinical care areas, universal masking should be applied when there is known or suspected cluster transmission of SARS-CoV-2, eg during an outbreak, and/or if new SARS-CoV-2 VOC	• 14th June 2022 discussed at Clinical Group. Masks to continue in all clinical areas for staff, visitors and patients due to increase in admission portal positivity rate and within 2 weeks of jubilee celebrations decision to maintain routine wearing of face masks in all clinical areas. To revisit again at Clinical group every 2 weeks	• Datix • OB meetings • Monitoring COVID patient numbers at UHNM for any increase in cases • Monitoring the number of COVID outbreaks for any increase	

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
emerge.			
• Universal masking should also be considered in settings where patients are at high risk of infection due to immunosuppression e.g. oncology/haematology. This should be guided by local risk assessment.	• To continue with universal wearing of masks		
• Health and care staff are in general not required to wear facemasks in non-clinical areas e.g. offices, social settings, unless this is their personal preference or there are specific issues raised by a risk assessment. This should also be considered in community settings.	• Discussed at clinical Group 30/05/22 risk assessment completed. From 1st June the wearing of masks in non- clinical area no longer mandatory. Staff can continue to wear masks through personal choice or specific risk following a risk assessment. In additions From 9th June non wearing of masks in public corridors		
For inpatients: • Inpatients with suspected or confirmed COVID-19 should be provided with a facemask on admission. This should be worn in multi-bedded bays and communal areas, e.g. waiting areas for diagnostics, if this can be tolerated and is deemed safe for the patient. They are not usually required in single rooms, unless, e.g., a visitor enters.	• Inpatient mask wearing where tolerated by patient continues		
• All other inpatients are not necessarily required to wear a facemask unless this is a personal preference. However, in settings where patients are at high risk of infection due to immunosuppression e.g. oncology/haematology, patients may be encouraged to wear a facemask following a local risk assessment.	• Inpatient mask wearing where tolerated by patient continues		
• Patients with suspected or confirmed COVID-	• Inpatient mask wearing where tolerated by		

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
19 transferring to another care area should wear a facemask (if tolerated) to minimise the dispersal of respiratory secretions and reduce environmental contamination.	patient continues		
• The requirement for patients to wear a facemask must never compromise their clinical care, such as when oxygen therapy is required or where it causes distress, e.g. paediatric/mental health settings.	• mask wearing where tolerated by patient continues		
For outpatients, UEC and primary care: • Patients with respiratory symptoms who are required to attend for emergency treatment should wear a facemask/covering, if tolerated, or offered one on arrival. • All other patients are not required to wear a facemask unless this is a personal preference.	• mask wearing where tolerated by patient continues		
For visitors: • In inpatient settings where patients are at high risk of infection due to immunosuppression, e.g. oncology/haematology, visitors may be asked to wear a facemask following a local risk assessment. • Visitors and individuals accompanying patients to outpatient appointments or the emergency department are not routinely required to wear a facemask unless this is a personal preference, although they may be encouraged to do so following a local risk assessment.	• Wearing of masks for visitors in clinical areas continues		
Emergency department	• On arrival in ED patients are immediately		

Control and Assurance Framework			
Key Lines of Enquiry (KLOE)	**Controls in Place**	**Assurance on Controls** (Source, Timeframe and Outcome)	**Gaps in Control or Assurance**
• Maintain at least 1 metre with areas for post testing and triaged respiratory infection • For confirmed negative patients return to pre COVID -19 pandemic distancing	identified either asymptomatic for COVID -19 symptoms and infection prevention precautions applied. • ED navigator in place • Colour coded areas in ED to set out COVID and Non COVID areas in place • Aerosol generating procedures in single rooms with doors closed • Major's resuscitation area for all patients requiring this level of medical care. This area consists of single rooms with sliding doors and neutral pressure ventilation. Signage in place to set out level of PPE required for each room depending on infectious status of patient. • Patients are asked to wear face covering/mask		
Inpatient Settings • Revert to pre COVID 19 pandemic bed spacing in all inpatient areas - ensure move to comply with all appropriate HTMs/HBNs if not currently the case	 20220401 Midlands Regional IPC principl • UHNM risk assessment in place • Social distancing no returned to pre- pandemic spacing, a number of wards had beds removed to comply with 2 metre social distance rule • Emergency admission COVID PCR screening in place • Pre OP - Elective admission screening in place , lateral flow 72 hours pre admission and day of admission • Pre Op - PCR testing in place for patients that require critical care post operatively • Encourage patients to wear masks • Staff to continue mask wearing		
Non clinical areas	• Social distancing returned to pre-pandemic		

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	• Revert to pre COVID 19 pandemic desk/chair spacing OR • Consideration to ventilation of these areas should be taken into account when making decisions. • Compliance and risk assessments should be documented	spacing in non- clinical areas • Advised window opening for a minimum of 10 minutes per hour • Cleaning of work station remains		
1.2	**Patient safety and governance** • There should be systems in place to identify those harmed through acquiring COVID 19 in health care settings, or where harm had occurred through COVID -19 related interventions and report through existing organisational patient safety and organisational learning mechanisms • Outbreak reporting • Local deviation As in previous versions of the national IP guidance, organisations may choose to adopt practices that differ from these regional principles or nations guidance.	• Reporting of hospital onset COVID 19 infection in place • COVID 19 definite and probable mortality reviews • SI framework National definition of outbreak in place • Outbreak report • Outbreak meetings • UHNM outbreak closure time is 7 days after the last positive case - then ward monitored for the next 28 days • Staff to undertake daily lateral flow testing for 7 days from the date of outbreak declared • UHNM risk assessments in place • Screening options paper presented and option agreed with execs • 22nd April 2022 -To continue PCR testing on day 1 and day 4 –emergency admissions. Day 6 , 14 and weekly no longer in place. To continue PCR testing if patient develops COVID symptoms or in outbreak situation Risk Assessment COVID IPC reducing	• COVID outbreak • DATIX • Monitoring COVID patient numbers at UHNM for any increase in cases • Monitoring the number of COVID outbreaks for any increase	

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 to continue with twice weekly lateral flow testing – UHNM positivity rates monitored • Flow chart in place with actions to take if test is positive – return to work guidance • Flow chart in place for staff who test negative by are symptomatic request a PCR test • Consultant Microbiologist monitors admission screening positivity rates		
1.3	• Testing of asymptomatic staff in non-outbreak settings Options 1 1 Clinical staff to continue to test using LFT twice weekly 2 As community prevalence decrease consider stepping down routine asymptomatic testing in some or all clinical areas	• Clinical staff to continue twice weekly LTF testing • Flow chart in place with actions to take if test is positive – return to work guidance • Flow chart in place for staff who test negative by are symptomatic request a PCR test • Consultant Microbiologist monitors admission screening positivity rates	• Datix • OB meetings • Monitoring COVID patient numbers at UHNM for any increase in cases • Monitoring the number of COVID outbreaks for any increase	
	National Infection Prevention Manual released • Changes in list of Aerosol Generating Procedures (AGP)	• Clinical Group to review and advise on revised APG list • Evidence supporting the AGP list to be reviewed.	• Audit • OB monitoring • Datix	
1.4	• Monkey pox outbreak in UK • Recommendations for the use of pre and post vaccination during a monkey pox incident	• Clinical group in place to review latest guidance and recommendations • Pathways in place for unanticipated monkey pox presentations at ED • GUM referrals for swabbing direct to ward 117 • IP measure in place • Monkey pox Trust intranet page in place • UHNM identified as vaccination hub • Vaccination pathways construction are in	• OB monitoring • Audit • Datix	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		progress		

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 4 Progress Report	BRAG
1						

2. 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	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2					Whilst cleaning procedures are in place to ensure the appropriate management of premises further work is in progress re cleaning standards and role and responsibilities	Likelihood:	1	End of Quarter 1 2022
Consequence:	3						Consequence:	3	
Risk Level:	6						Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
2.1	**Intervention and Principles - Environmental Cleaning** In all clinical areas with asymptomatic patients , staff or visitor the 2021 National Standards of Cleanliness should apply • Respiratory - Enhanced environmental decontamination should be undertaken in clinical areas where respiratory transmission based precautions are practice • Outbreak –Enhanced environmental cleaning, touch point cleaning minimum 2 hourly • Designated nursing/medical teams with appropriate training are assigned to care for and treat patients in Covid-19 isolation or cohort areas.	• National standards of cleanliness in place – options analysis paper submitted against the 2021 standards • SOP and cleaning method statements for cleaning teams • High level disinfectant , Virusolve and Tristel in place and used for all decontamination cleans • Increased cleaning process (barrier clean) included in Infection Prevention Questions and Answers manual • Process in place for clinical areas with clusters and HAI cases of COVID -19 requiring increased cleaning and /or terminal cleans • Cleaning schedules in place • Barrier cleans (increased cleaning frequency) process in place which includes sanitary ware and other frequent touch points • Process and designated staff for ED to ensure cleans are completed timely	• CEF audits • C4C audits • Audits and assurance visits by IP • Ward audits • Spot check assurance audits completed by cleaning supervisors/managers • Cleanliness complaints or concerns are addressed by completing cleanliness audit walkabouts with clinical teams, and CPM / domestic supervisors • Patient survey feedback is reviewed by joint CPM / Sodexo/EFP group and action plan completed if needed. • Reports produced after each visit, and re-audits completed if disciplines fail to achieve agreed %. • C4C report presented at IPCC • GREAT training record cards are held centrally by Sodexo for all	• Decontamination of beds returned for repair process non conformities • Srengthen our assurance process on standards of cleanliness

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
			individual domestics • Key trainers record • Notes from Sodexo Performance Monthly meeting , Sodexo Operational meeting , Divisional IP Meeting and facilities/estates meeting	
2. 2	**Ventilation** • As part of heirachy of controls assessment : ventilation systems, particularly in, patient care areas (natural or mechanical) meets national recommendations for the minimum of air changes refer to specific guidance, In patients care health building note 04-01 Adult in-patient facilities • The assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations authorised engineer • A systematic review of the ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways • Where possible air is diluted by natural ventilation by opening windows and doors were appropriate • Review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission. • Where a clinical space has a very low air changes and it is not possible to increase dilution effectively , alternative technologies	• UHNM has established a Ventilation Safety Group as recommended by the Specialised Ventilation for Healthcare Society in order to provide assurance to the Trust Board on the safe operation and reduction in risk of infection transmission through ventilation systems. TOR written • The Trust also appointed external 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. • 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 • Lessons learnt poster which encourage regular opening of windows to allow fresh air  ventilation-air-changes-per-hour-2021-06 • • IP and estates have worked with areas know to be undertaking aerosol generating	• Estates have planned programme of maintenance • The Authorising Engineer Ventilation will provide external independent specialist advice and support as well as carrying out an annual audit for system compliance.	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
	are considered with estates/ventilation group • Ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air	procedures and completed the fallow times • IP have nominated point of contact re ventilation advise • Most wards have mechanical ventilation in core areas and natural ventilation in bays (window opening) • January 2022 Estates and IP are exploring the use of air scrubber technology • May 2022 UV air system on trial ward 225 • Business case proposal for UV air system in selected areas in progress		

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 1 Progress Report	BRAG
2	2.1	Review of cleaning standards	Divisions Facilities/ACN	12/11/2021 31/12/2021 End of quarter 1 2022	November 2021 Cleaning Collaborative work stream (multi-disciplinary representation) established and using Improving Together tools and methodologies to work through the actions needed to respond to the cleaning issues that were highlighted during the CPE Outbreak. March 2022 Collaborative work continues	In progress
	2.2	To explore alternative technologies to enhance ventilation in bays that have natural ventilation	Infection Prevention Team/Estates	End of Quarter 2 2022	May 2022 UV Light air technology on trial ward 225	

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	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	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						Consequence:	3	
Risk Level:	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. Update V 1.8 Previous antimicrobial history is considered The use of antimicrobials is managed an monitored: Update V 1.8 • To reduce inappropriate prescribing • To ensure patients with infections are treated promptly with correct antibiotic	• Regular, planned Antimicrobial stewardship (AMS) ward rounds • Trust antimicrobial guidelines available 24/7 via intranet and mobile device App • Antimicrobial action plan in place • Clostridium *difficile* Period of increased incidence and outbreaks are reviewed by member of AMS team and actions generated cascaded to ward teams • Regional and National networking to ensure AMS activities are optimal • Formal regional meetings and informal national network activities • AMS CQUIN further mandates key AMS principles to be adhered to • All national CQUINS currently suspended by NHSE / PHE • Monthly review of antimicrobial consumption undertaken by AMS team. Available online at UHNM	• Same day escalation to microbiologist, if concerns. Outcome recorded on I portal • Metric available around the number of times App accessed by UHNM staff • Compliance with guidelines and other AMS metrics reported to Infection prevention and control Committee (IPCC) • Meeting minutes reviewed and actions followed up • Real time discussions / requests for support / advice enabled via regional and national social media accounts. National (incl. PHE) thought leaders members • Trust and commissioners require timely reporting on compliance with AMS CQUIN targets. • Wards showing deviation from targets are followed up by targeted AMS team ward reviews generating action plans	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
			for ward teams. On hold during COVID19 due to redeployment of duties • The pharmacy team undertook a trust-wide point prevalence audit using a new electronic data capture tool. Results will be reviewed during January and shared with ACN's and Microbiologist.	
3.2	• Mandatory reporting requirements are adhered to and boards continue to maintain oversight. • Linked NHSIE Key Action 5: Daily data submissions have been signed off by the Chief Executive, the Medical Director and the Chief Nurse and the Board Assurance Framework is reviewed and evidence of reviews is available. • Linked to NHSIE Key Action 10: Local systems must review system performance and data, offer peer support and take steps to intervene as required. Update V 1.8 Risk assessments and mitigations are in place to avoid unintended consequences from other pathogens	• Quarterly point prevalence audits maintained by AMS team at UHNM despite many regional Trusts not undertaking any more. These have restarted in December 2020 as held during COVID-19. Results online. • Results from all AMS audits and targeted ward reviews are reported at the Antimicrobial Stewardship Group and minutes seen by IPCC • CQUIN submissions completed in timely manner and generate action plans for AMS and ward teams to follow up concerns each quarter. Currently suspended.	• Whilst only a snap-shot audit the Trust value the output from these audits. Work is underway Q1 and Q2 20/21 to review potential change in data collection to optimise impact. • IPCC scrutinise results. Divisions held to account for areas of poor performance. Audit outputs will be used as basis of feedback on performance to individual clinical areas going forward. • Trust CQUIN contracts manager holds regular track and update meetings to challenge progress vs AMS CQUINS, Currently suspended.	

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

Risk Scoring									
Quarter	Q4	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	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						Consequence:	3	
Risk Level:	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	• Continues use of Fluid resistant Surgical Masks in all patient facing and non –clinical setting (unless clinically exempt)	• Posters and signage in place • Mask available at hospital entrance	• Monitored by clinical areas • PALS complaints/feedback from service users • Outbreak meetings	
4.2	**Patient visiting**	• 30th May visiting updated .The majority of inpatients are permitted to have two visitors, between 2pm and 4pm and again between 6pm and 8pm. In the majority of cases these do not have to be the same two visitors.	• Monitoring of number of Outbreak	

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	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	1					Whilst arrangements are in place ensure the screening of all patients. To continue to reinforce COVID screening protocol and work towards lateral flow testing for those patients that remain an inpatient	Likelihood:	1	
Consequence:	3						Consequence:	3	
Risk Level:	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	**Testing** • All NHS patients in a hospital setting requiring a test by a clinical to support clinical decisions during their care and treatment pathway should be offered a PCR test as part of their usual diagnostic pathway • Testing for asymptomatic in patients on day 3 and days 5-7 of their stay should now be undertaken by lateral flow device LFD	• CR testing in place for all emergency inpatient admissions and symptomatic patients • PCR continues on day 1 and day 4 of inpatient stay, Risk assessment completed, no day 6 screens, 14 or weekly. • In addition PCR testing for patient who have or develop COVID 19 symptoms • No system in place for inpatient lateral flow testing (POCT) and recording of results on electronic system to allow for surveillance of cases and alert when possible or definite outbreak • PCR remains for outbreak screening, both patients and staff UHNM isolation period remains at 10 days - no POCT in place to release patients earlier • Planned elective admissions are now tested using lateral flow 72 hours prior to admission and on the day of admission • PCR testing for patients discharged to nursing/care home	• COVID 19 -Themes report to IPCC • COVID screening spot check audits • Datix • Outbreak investigation	

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 1 Progress Report	BRAG

5	5.1	Introduction of lateral flow testing for day 4 and 6 of inpatient stay	Deputy Chief Nurse	End of July	April 2022 Lateral flow testing introduced for elective cases. Meeting held to discuss the use of lateral flow (POCT) for patients who remain an in- patient. Challenge to ensure results are recorded electronically and feed into electronic system to enable reporting and to ensure the Infection Prevention Team are aware of positive cases and outbreak to enable outbreak actions to be instigated. In addition time and staff required to ensure compliance with POCT rules- explore swabbing team.	On- going

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

Risk Scoring									
Quarter	Q4	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	1					Information and communication/controls are in place to ensure staff are aware of their responsibilities spot audits continue.	Likelihood:	1	End of Quarter 2
Consequence:	3						Consequence:	3	

Risk Level:	3						Risk Level:	3	2021

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	**Intervention and Principles PPE** • Non Respiratory - for symptomatic patients staff should follow standard infection control precautions • Respiratory - for caring for patients with respiratory symptoms direct contact staff should take respiratory transmission based precautions Consider the use of FFP3 for prolonged contact with positive symptomatic patients , especially in areas where ventilation is not complaint with ventilations standards	• Infection Prevention Questions and Answers manual, chapter Q1 standard precautions • PPE posters are available in the COVID -19 section of trust intranet page • UHNM recommend staff use of for highly suspected or confirmed COVID 19 patients • FFP3 mask /hood • Eye protection • Gloves • Apron(gown for AGP)	• Divisional FFP3 training records • Mandatory training records • Assurance visits/spot checks • Ward audits	

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 1 Progress Report	BRAG
6						

7. Provide or secure adequate isolation facilities

Risk Scoring									
Quarter	Q4	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	1					Isolation facilities are available and hospital zoning currently in place, however there is a need to explore increasing single room availability (pods).	Likelihood:	1	
Consequence:	3						Consequence:	3	
Risk Level:	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	**Intervention and principles – Contact Isolation** (assuming the patients area asymptomatic and have agreeing with the Trust testing protocol and have recent negative test) • 10-day isolation from time of last positive contact • 7-day isolation from time of last positive contact • 5- day isolation from time of last positive contact • Retain contacts on same clinical area with separate toilet and bathroom facilities to other patients • Patients with possible or Covid-19 are isolated in appropriate facilities or designated areas where appropriate. Restricted access between pathways if possible,	• UHNM risk assessment with Exec sign off Considered related to risk within the organisation and system • UHNM have reduced patient COVID contact classification period from 10 days to 7 days if patient remains asymptomatic and tests negative PCR COVID screen on day 6 after exposure then contact isolation can discontinue • COVID contacts are cohorted with similar isolation periods to reduce risk • Where possible cohort nursing staff to provide care for the contact and the negative or positive patients separately • PPE changed when moving between cohorts • Clinical equipment where possible designed to cohort and decontaminated after use UHNM risk assessment • Mixing contact (negative) patients with non-contact (negative) patients when the Trust is	• If patient found to be positive in the bay and exposing other patient. IP liaise with clinical are, apply bay restrictions. • Contact tag to electronic records applied by IP Team • Spot check audits • Assurance obtained for monitoring of inpatient compliance with wearing face masks via Matrons daily walk round • June 2020 IP team to review patients that are found COVID positive and nursed in bay to ascertain compliance with pathway and IP control measures are in place Review pathways and identify themes which are presented at IPCC . • Themes report to IPCC	Work in progress to assess the need for more single room availability to facilitate patient flow and surgical pathway

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
		on escalation level 4 with significant numbers of ambulances holding unable to offload, a significant number of specialties being held within the emergency portals and 90 or more medically fit for discharge patients are being held at the Trust. • Non-contact patients selection criteria for admission to a contact ward - this is contained in the risk assessment	• Inappropriate patient moves reported via Datix. Daily process Discuss at outbreak meetings as necessary	

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 1 Progress Report	BRAG
7	7.1	To assess the need for further single room isolation facilities (PODS) to facilitate COVID patients remaining on their original ward, facilitate flow and surgical pathway	DIPC	End of July 2022	May 2022 Request made to analyst to map/predict isolation need.	

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

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	6th July 2022
Report Title:	CQC Action Plan	**Agenda Item:**	9.
Author:	Scott Malton, Deputy Chief Nurse/Debra Meehan, Lead Nurse Quality & Safety		
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	X	**People**	X	**Systems & Partners**	
Responsive	X	**Improving & Innovating**		**Resources**	

Risk Register Mapping

BAF 1	Delivering Positive Patient Outcomes	Extreme 20

Executive Summary

The University Hospitals of North Midlands CQC report was published on 22 December 2021. The inspection took place 24 and 25 August 2021 and involved:

- Royal Stoke -urgent and emergency care; medicine
- County – medicine; surgery

The CQC also spoke with 179 members of staff, 25 patients and they reviewed 61 patient records. A Well Led inspection took place 5 and 6 October 2021. Following the initial inspection, the Trust was served a warning notice under Section 29a of the Health and Social Care Act 2008. The warning notice served to notify the Trust that the CQC had formed the view that the quality of health care provided in relation to medical staffing in urgent and emergency care at the Royal Stoke University Hospital and the risk management of patients with mental health need in medicine at County Hospital required significant improvement. The remedial actions were required to be completed by the end November 2021 and evidence to support the actions completed have been submitted to the CQC. As of 14th June 2022, we are still awaiting notification if we have met the requirements.

The CQC rated the following services:

- Medicine (County) - Requires Improvement
- Surgery (County) – Good
- Urgent and Emergency Care (RSUH) - Requires Improvement
- Medicine (RSUH) - Good

The CQC rated the Trust overall as 'Requires Improvement' overall but we did see improvement in two domains:

- Caring improved to a rating of 'Outstanding'
- Well Led improved to a rating of 'Good'

The report noted the over-arching actions the Trust must take (9) and should take (19) to improve.

The attached action plan, addresses both the 9 over-arching actions that the CQC stipulated that the Trust must take and the 19 over-arching actions that the CQC suggested the Trust should take and includes sections to document progress and assurance.

Action leads will be required to refine the actions, monitor progress against the actions and to enable escalation of problematic actions on a monthly basis. The updated Action Plan will be presented to QGC and Trust Board on a Quarterly basis.
As of 14th June 2022, the action status is as follows:

Must Do Actions

Total Number of Actions = 35 Individual Actions
Total Number Complete = 16 (45.7%)
Total Number on Track = 17 (48.6%)
Total Number Problematic = 2 (5.7%)

2 Actions (5.7%) are considered to be "problematic", which are attributable to compliance with 15 minute assessment times in Royal Stoke Emergency Department and compliance with consent training. Mitigating actions are summarised in the action plan.

Should Do Actions

Total Number of Actions = 31 Individual Actions
Total Number Complete = 6 (19.3%)
Total Number on Track = 24 (77.5%)
Total Number Problematic = 1 (3.2%)

1 Action (3.2%) is considered to be "problematic", which is attributable to the recommendation that the Trust SHOULD consider making the speech and language therapy service provision equitable across County Hospital.

Of the 24 (77.5%) actions deemed to be on track, a number of actions are still under development/not yet commenced so a more accurate view of progress will be clearer by Q2.

Feedback from the CQC Working Group is for each action to be assigned an Executive lead, which is in process of being actioned and will be included in Q2 update.

Key Recommendations

The Trust Board is asked to note the contents of the CQC action plan. The Board is asked to consider and approve the proposed monthly review process to monitor progress against the actions and to enable escalation of problematic actions.

CQC Action Plan - Must Do's

2022 / 2023 Updated 09/06/2022

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

Action Number	Domain	Site	Division	Core Service	Observation / Issue	Improvement Required	Operational Lead	Target Date for Completion	Revised Target Date	Current Progress Rating	Assurance Mechanism	Assurance Based Progress Report	Responsible Committee / Group
A1	SAFE	Royal Stoke	Medicine	Urgent and Emergency	The Trust MUST ensure that there are enough suitably qualified, competent, skilled and experienced medical staff on each shift to deliver safe and effective care and treatment. **Regulation 18 (1)**	The Directorate will develop a Standard Operating procedure to mitigate gaps in the ED Medical Staffing Rota.	Richard Hall Clinical Director Nik Kennelly Directorate Manager	Complete			Staffing figures Number of incidents relating to staffing levels	•SOP in use •New Rota System commencing in June 2022 which will demonstrate skill mix and gaps •Agreed rates of pay for rota cover	Quality Safety Oversight Group Quality Governance Committee
						The Directorate will continually monitor gaps in the rota and associated mitigation by the ED Senior Leadership Team.	Richard Hall Clinical Director Nik Kennelly Directorate Manager	Jul-22			Staffing figures Number of incidents relating to staffing levels	•SOP in use •New Rota System commencing in June 2022 which will demonstrate skill mix and gaps •ANP's to be included on new rota as per Royal College Guidance	Quality Safety Oversight Group Quality Governance Committee
						The Directorate will introduce Emergency Department Operational and Safety Huddles (8 times each day)	Richard Hall Clinical Director Nik Kennelly Directorate Manager	Complete			Minutes / actions from Safety Huddles	•Actions from huddles documented by progress chaser (in hours)	Quality Safety Oversight Group Quality Governance Committee
						The agreed actions to mitigate the risk to patient safety from Medical Staff Shortages in ED will be included as points of consideration for the ED Safety Huddles	Richard Hall Clinical Director Nik Kennelly Directorate Manager	Complete			Staffing figures Number of incidents relating to staffing levels	•Medical staffing gaps also discussed three times daily at the Junior Doctor Handovers in a structured WHO chgecklist style approach	Quality Safety Oversight Group Quality Governance Committee
						To recruit to the approved establishment in the ED business case	Richard Hall Clinical Director Nik Kennelly Directorate Manager	Sep-22			Recruitment against plan monitored through CQC action plan oversight group	•Junior and Middle Grade Medical Staff recruitment ongoing •A focus upon Consultant and Paedicatric ED Consultants ongoing •Development of EHCP role	Quality Safety Oversight Group Quality Governance Committee
A2	SAFE	Royal Stoke	Medicine	Urgent and Emergency	The Trust MUST ensure they provide patients with a first assessment within 15 minutes of arrival to the ED in line with the conditions placed upon their registration. **Regulation 12 (1) (2) (a)**	Compliance with the 15 minute assessment times will be monitored following implementation of the new model that was developed following successful Emergency Department Test of Change.	Rebecca Viggars Deputy Associate Director	Oct-22			Clinical Audit of time to triage times	•Current Development of Enhanced Primary care service to afford UHNM aitonomy of triage and recruitment •Successful recruitment to triage nurse posts- predicting 3% vacancy factor by October 2022	Quality Safety Oversight Group Quality Governance Committee
						Compliance with the 15 minute assessment time will be reported to the CQC on a monthly basis in line with the Section 31 conditions placed upon our registration.	Rebecca Viggars Deputy Associate Director	Complete			Monthly Section 31 Reports	•Monthly Section 31 Reports available •Initial impact of the Enhanced Primary Care Service has shown an increase in RSUH ED Triage compliance in all arrivals from 60% on 01/05/2022 to 66.2% on 01/06/2022	Quality Safety Oversight Group Quality Governance Committee
						The new national standards and guidance on triage assessment times will be reviewed to ensure full compliance with the new regulations.	Rebecca Viggars Deputy Associate Director	Oct-22			SOP incorporating new standards Clinical Audit of time to triage times	•Project Group convened to implement new regulations	Quality Safety Oversight Group Quality Governance Committee
						The Trust will implement the new Triage Model that was developed following successful Emergency Department Test of Change	Joanne Allen Matron	Complete			Clinical audit of Documentation CEF	•New triage model in place •Successful recruitment to triage nurse posts- predicting 3% vacancy factor by October 2022	Quality Safety Oversight Group Quality Governance Committee

Action Number	Domain	Site	Division	Core Service	Observation / Issue	Improvement Required	Operational Lead	Target Date for Completion	Revised Target Date	Current Progress Rating	Assurance Mechanism	Assurance Based Progress Report	Responsible Committee / Group
A3	SAFE	Royal Stoke	Medicine	Urgent and Emergency	The Trust MUST ensure that patients are risk assessed appropriately, in a timely way and provide mitigation for risks when identified. **Regulation 12 (1) (2) (b)**	The Directorate will conduct harm reviews for patients experiencing long ambulance and trolley waits in order to identify any potential harm and areas for improvement in the standard of care delivered	Joanne Allen Matron/ Debra Meehan lead Nurse - Quality & Safety	Oct-22			Review of incidents relating to harm in the ED Department	•Harm Review Process in place supported by the Corporate Nursing Team •Summary Reports presented to patient Safety Group •Plan to redesign process in relation to new National Standards	Quality Safety Oversight Group Quality Governance Committee
						To review the MH proforma and actions to include the risk assessment of MH patients behind the cubicle doors	Joanne Allen Matron	Oct-22			Review of incidents relating to harm in the ED Department	•SOP under development for assessment of MH patients behind cubicle doors •Feasibility Study being undertaken to replace cubicle doors with full glass / high visibility doors	Quality Safety Oversight Group Quality Governance Committee
						Directorate Governance Meetings will ensure that all incidents are discussed in a timely manner and mitigating actions are put in place	Joanne Allen Matron	Complete			Meeting agenda Meeting minutes Review of risk register	•Meeting notes available •Risk Register Reviews undertaken	Quality Safety Oversight Group Quality Governance Committee
						The Directorate will continue the daily Matron CEF reviews supported by the corporate nursing team assurance process	Joanne Allen Matron	Complete			Clinical Audit of Documentation	•Daily CEF reports available •Toolkit being updated	Quality Safety Oversight Group Quality Governance Committee
A4	SAFE	Royal Stoke	Medicine	Urgent and Emergency	The Trust MUST ensure patients are kept safe from infection and avoidable harm and staff receive appropriate guidance and support to enable them to do this. **Regulation 12 (1) (2) (h)**	Infection Prevention poster which describes correct PPE for red and green areas to be displayed through ED	Joanne Allen Matron	Complete			Review of incidents relating to harm in the ED Department	•PPE Posters in place	Quality Safety Oversight Group Quality Governance Committee
						The Directorate will ensure that all staff receive updates in PPE training/mask fit training, according to latest National Guidance	Joanne Allen Matron	Sep-22			Training figures	•Infection Prevention training compliance 93.53% as of 04/05/2022	Quality Safety Oversight Group Quality Governance Committee
						To ensure all appropriate clinical assessments are undertaken as appropriate (eg.VTE, Falls, MH etc.)	Richard Hall Clinical Director Joanne Allen Matron	Sep-22			Escalation paper to Divisional Governance Group	•Documentation review as part of the Daily CEF reviews •Tendable audit under development	Quality Safety Oversight Group Quality Governance Committee
						Weekly CEF reviews to include equipment cleaning checks	Joanne Allen Matron	Complete			Environment Audit Results	•Audit results available	Quality Safety Oversight Group Quality Governance Committee
A5		Royal Stoke	Medicine	Urgent and Emergency	the Trust **MUST** ensure all risks are appropriately identified, assessed and mitigation put in place where possible. **Regulation 17 (1)**	The risk register will be updated to include all current risk relating to the ED Department	Richard Hall Clinical Director Joanne Allen Matron	Complete			Escalation paper to Divisional Governance Group	•Risk Register Review Process in place	Quality Safety Oversight Group Quality Governance Committee
						The Directorate will develop a harm review process against the new Emergency Care Standards	Chris Pickering ED Consultant	Oct-22			Review of incidents relating to harm in the ED Department	•Plan to redesign harm review process in relation to new National Standards	Quality Safety Oversight Group Quality Governance Committee
						The Trust will further develop the ED Mental Health Assessment Tool to accompany the patient on admission and facilitate ongoing mental health assessment in assessment and ward areas.	Kirsty Smith Matron Mental Health	Complete			Clinical Audit of the Mental Health Assessment Tool Review of incidents relating to the provision of mental health assessments	•Audit Process inplace on both sites	Quality Safety Oversight Group Quality Governance Committee

Action Number	Domain	Site	Division	Core Service	Observation / Issue	Improvement Required	Operational Lead	Target Date for Completion	Revised Target Date	Current Progress Rating	Assurance Mechanism	Assurance Based Progress Report	Responsible Committee / Group
A6	SAFE	County	Medicine	Medicine Care	The Trust must ensure associated with acute mental health needs are assessed, recorded and mitigated. **Regulation 12 (1) (2) (a) (b)**	The Trust will report and monitor the number of mental health referrals via the Mental Health Operational Group, which has representation from all clinical divisions, the mental health liaison team and psychiatric liaison team. The Group will oversee operational priorities such as referrals, access to Mental Health Act assessment, training and incidents. Areas of escalation and assurance will be reported into the Trust Mental Health and Learning Disability Group.	Kirsty Smith Matron	Complete			Mental Health Operational Group agenda and minutes Escalation report to the Trust Mental Health and Learning Disability Group	•Reporting process in place via Mental Health Operational Group	Quality Safety Oversight Group Quality Governance Committee
						The Trust will further develop the current audit tool of the ED Mental Health Assessment Tool (Report published June 2020) to reflect it's use through to AMU and all Ward areas. The Revised audit will be prioritised on the Trust Clinical Audit Programme 2022 / 2023	Kirsty Smith Matron	Nov-22			Clinical Audit of the Mental Health Assessment Tool Review of incidents relating to the provision of mental health assessments	•Audit Process in place •Planned rollout to other emergency portals and ward areas	Quality Safety Oversight Group Quality Governance Committee
						Development of a Trust-Wide Harm Free Care Alert	Kirsty Smith Matron	Nov-21			Review of incidents relating to the provision of mental health assessments		
A7	SAFE	County	Medicine	Medicine Care	The Trust MUST ensure nutritional risk assessments and care plans are completed in line with their policy. **Regulation 12 (1) (2) (b)**	The Trust will relaunch a training programme emphasising key learning around assessing, managing and monitoring patients nutrition	Ann Griffiths Chief Dietician	Sep-22			Training compliance CEF visits	•Nutrition and Hydration awareness training delivered within new NA programme. •Update training delived at County by dietetics team. •Ward based training targetted to Purple AMU and FEAU at Royal Stoke. •Ward staff have requested a video training to be	Quality Safety Oversight Group Quality Governance Committee
						A Focus Group will be convened to review the current Nutrition bundle (evidence of care planning). Representatives from Ward teams and Dietetics will explore the barriers to its use, how we can revitalise and consider its digitalisation journey.	Ann Griffiths Chief Dietician	Sep-22			CEF Visits Clinical Audit of Nutritional Management	•Audit of comletion complaince undertaken. •Focus group identified. • Initial feedback, wards are happy with the document.	Quality Safety Oversight Group Quality Governance Committee
						The Trust will develop a process of sharing Vital Pac reports detailing MUST compliance with Ward teams	Ann Griffiths Chief Dietician	Sep-22			CEF Visits Clinical Audit of Nutritional Management	•Dashboard developed by BI team, initial validation completeted, •Changes made to include actual MUST scores, and risk category in addition to MUST completeion within 24hrs and rescreening compliance.For final validation after Vitals upgrade June 2022 • Approval to be sought from deteriorating/aing	Quality Safety Oversight Group Quality Governance Committee
						In order to promote on-going monitoring around the assessment and management of nutrition, a spot check audit will be developed using the Tendable Audit Programme	Ann Griffiths Chief Dietician	Jul-22			Tendable Audit Spot Check results	•Questions agreed for Monthly Tendable audit,	Quality Safety Oversight Group Quality Governance Committee
A8	SAFE	County	Medicine	Medicine Care	The Trust MUST ensure patients receive timely swallow assessments. **Regulation 12 (1) (2) (a) (b)**	A position paper will be presented at the Acute Patient Flow group which will highlights the shortfalls in the service provision to inpatient medical wards, across both sites	Lois Dale Head of Speech and Language Therapy	Complete			Acute Patient Flow Group Minutes	•The position paper was presented to the Acute Patient Flow group in April 2022	Quality Safety Oversight Group Quality Governance Committee
						The Trust will develop an education programme to support ward teams regarding 'what makes a good referral' and how to escalate referrals	Lois Dale Head of Speech and Language Therapy	Sep-22			Review of incidents relating to insufficient referrals Review of the number of rejected referrals	•Guidance hasd been developed to advise wards how to escalate referrals •To be circulated via Comms	Quality Safety Oversight Group Quality Governance Committee

Action Number	Domain	Site	Division	Core Service	Observation / Issue	Improvement Required	Operational Lead	Target Date for Completion	Revised Target Date	Current Progress Rating	Assurance Mechanism	Assurance Based Progress Report	Responsible Committee / Group
						MNP/ANP nurse swallow screening training will be implemented at RSUH to support service provision. Consider rollout at County Hospital	Lois Dale Head of Speech and Language Therapy	Sep-22			Review of incidents relating to SALT provision at Ward level	• MNP training at RSUH took place in Jan 2022 and was completed successfully. •ANP training for the respiratory team, to be rescheduled	Quality Safety Oversight Group Quality Governance Committee
A9	SAFE	County	Medicine	Medicine Care	The Trust MUST ensure Mental Capacity Act Assessments are consistently completed in a timely and responsive manner. **Regulation 11 (1) (2) (3)**	The Clinical Audit Programme will be reviewed to ensure that all audits relating to the delivery of care include questions around whether mental capacity should have/was assessed	Victoria Lewis Quality Assurance Manager	Complete			Clinical Audit results	•Clinical Audit programme reviewed	Vulnerable Adult Group Quality Safety Oversight Group Quality Governance Committee
						The following audits will be prioritised on the Trust Clinical Audit programme to monitor compliance with Trust Policy: Audit of the Mental Capacity Act Audit of Deprivation of Liberty	Victoria Lewis Quality Assurance Manager	Complete			Clinical Audit results	•Clinical Audit programme reviewed	Vulnerable Adult Group Quality Safety Oversight Group Quality Governance Committee
						The Trust will introduce a template to remind / guide staff through the MCA assessment process	Kirsty Smith Lead Nurse: Mental Health & Learning Disability	Sep-22			Clinical Audit results	•A MCA template and guide is available on the Safeguarding Intranet page- plan to relocate this information into its own resource area on the intranet for ease of location. •Monitor outcome through audit results	Vulnerable Adult Group Quality Safety Oversight Group Quality Governance Committee
						The Trust will undertake a baseline review of current training compliance in relation consent training. A trajectory of improvement will be developed and monitored	Victoria Lewis Quality Assurance Manager Executive Lead: Dr Matthew Lewis Medical Director	Apr-22	Oct-22		Clinical Audit of the Consent Process	•A consent compliance clinical audit has been included in the audit programme •Identify training needs and develop trajectory for improvement according to audit results	Vulnerable Adult Group Quality Safety Oversight Group Quality Governance Committee
						A review of the current training packages will be undertaken to ensure that any training around the provision of care to vulnerable patients, includes MCA information	Kirsty Smith Lead Nurse: Mental Health & Learning Disability	Sep-22			Clinical Audit of the Mental Capacity Act	•Ensure that training packages contain reference/signposting to the MCA template and Guide •Monitor outcome through audit results	Vulnerable Adult Group Quality Safety Oversight Group Quality Governance Committee

CQC Action Plan - Should Do's

2022 / 2023 updated 09/06/2022

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

Action Number	Domain	Site	Division	Core Service	Observation / Issue	Improvement Required	Operational Lead	Target Date for Completion	Revised Target Date	Current Progress Rating	Assurance Mechanism	Assurance Based Progress Report	Responsible Committee / Group
B1	Safe	Trust wide	Corporate	Trust wide	The Trust SHOULD ensure it reviews and investigates significant incidents in a timely manner and in line with Trust Policy	The Trust has developed a twice weekly Serious Incident review meeting to review new incidents and ensure that 72 hour reports and plans for investigation are confirmed	Jamie Maxwell Head of Quality, Safety and Compliance	Complete			Quality and Safety Report	•Action log available from twice-weekly meetings	SI Review Group Risk management Panel Quality Safety Oversight Group Quality Governance Committee
						The Trust will work collaboratively with the local CCG to monitor timescales for submission on STEIS and to redefine the TOR of the SI Sub-Group	Jamie Maxwell Head of Quality, Safety and Compliance	Complete			SI Sub Group Presentation	•SI Sub-group presentations and SI Reports available	SI Review Group Risk management Panel Quality Safety Oversight Group Quality Governance Committee
B2	Responsive	Trust wide	Corporate	Trust wide	The Trust SHOULD ensure all complaints are reviewed, investigated and responses are managed in a timely manner and in line with Trust policy	The Trust are reviewing the current formal complaints process to improve the quality and timeliness of reports and to streamline the sign off process	Debra Meehan Lead Nurse: Quality and	Oct-22			Complaints Report	•Complaint triage process in place •Electronic sign off process under development	Patient Experience Group Quality Safety Oversight Group Quality Governance Committee
B3	Well Led	Royal Stoke	Medicine	Urgent and Emergency	The Trust SHOULD ensure that measures are in place to keep patients records secure.	The Data Protection and Security Team will conduct a review of patient records storage in the ED, Royal Stoke to identify any risks and mitigating actions	Jean Lehnert Data Protection and Security Manager	Sep-22			Review of incidents around record management and storage	•Digitalisation of ED records under development •A paper detailing any incidents due to be presented to the Record Services Operations Group meeting in July 2022 – which will highlight any mitigating actions.	Urgent and Emergency Medicine Directorate Governance Meeting
B4	Well Led	Royal Stoke	Medicine	Urgent and Emergency	The Trust SHOULD ensure there is a recovery process in place to ensure all staff complete mandatory training and essential role training	The Directorate Team will develop a trajectory to improve compliance with mandatory training and essential role training. Progress will be monitored via the Directorate Governance Meeting	Richard Hall Consultant Joanne Allen Matron	Oct-22			Training figures	•Protected time allocated for training •Current compliance with annual Stat/Mand training is 81.32% •Current compliance with 3 yearly Stat/Mand training is 94.15%	Urgent and Emergency Medicine Directorate Governance Meeting
						The Departmental rotas will be adapted to highlight identifying on rotas when time is allocated for individuals to complete training	Richard Hall Consultant Joanne Allen Matron	Oct-22			Training figures	•Protected time allocated for training	Urgent and Emergency Medicine Directorate Governance Meeting
B5	Safe	Royal Stoke	Medicine	Urgent and Emergency	The Trust SHOULD ensure all staff follow best practice when completing care records to ensure they are an accurate record of care and treatment provided	The Trust will introduce digitalised care records to ensure the provision of individualised, accurate care plans.	Richard Hall Consultant Joanne Allen Matron	Sep-22			CEF Clinical Audit of documentation	•Digitalisation of ED records under development	Urgent and Emergency Medicine Directorate Governance Meeting
						The Department will continue daily Matron CEF reviews supported by the Corporate Nursing Team	Joanne Allen Matron	Complete			CEF Clinical Audit of documentation	•CEF reports available	Urgent and Emergency Medicine Directorate Governance Meeting
B6	Responsive	Royal Stoke	Medicine	Urgent and Emergency	The Trust SHOULD consider how they can improve information management for certain patient groups	A review of current documentation will be undertaken to ensure the provision of standardised templates for electronic referrals and Medical/Nursing handovers	Richard Hall Consultant Joanne Allen Matron	Sep-22			Clinical Audit of documentation	•Digitalisation of ED records under development	Urgent and Emergency Medicine Directorate Governance Meeting
B7	Safe	Royal Stoke	Medicine	Urgent and Emergency	The Trust SHOULD consider how the current layout of the Department is impacting on the safe running of the Department	The Directorate will conduct a feasibility Study to explore options to mitigate risk of patients being nursed in majors cubicles with doors, from both an infection prevention and avoidable harm perspective	Richard Hall Consultant Joanne Allen Matron	Complete			Review of incidents relating to harm in the ED Department	•Feasibility Study Complete •Business case under development	Quality Safety Oversight Group Quality Governance Committee

Action Number	Domain	Site	Division	Core Service	Observation / Issue	Improvement Required	Operational Lead	Target Date for Completion	Revised Target Date	Current Progress Rating	Assurance Mechanism	Assurance Based Progress Report	Responsible Committee / Group
B8	Well Led	Royal Stoke	Medicine	Medical Care	The Trust SHOULD ensure that it continues to work toward meeting trust targets for all mandatory training	The Divisional Management Team will develop a trajectory to improve compliance with mandatory training and essential role training. Progress will be monitored via the Directorate Governance Meeting	Gwen Hatton Associate Chief Nurse	Sep-22			Training figures	•Trajectory under developme	Directorate and Divisional Governance Meetings
						The Divisional rotas will be adapted to highlight identifying on rotas when time is allocated for individuals to complete training	Gwen Hatton Associate Chief Nurse	Sep-22			Training figures	•Under Development	Directorate and Divisional Governance Meetings
B9	Effective	Royal Stoke	Medicine	Medical Care	The Trust SHOULD ensure that all wards display up to date audit results such as results from hand hygiene audits	Up to date audit results to form part of Tendable Ward audit system	Gwen Hatton Associate Chief Nurse Vicky Lewis Quality Assurance Manager	Jul-22			CEF Visits, perfect ward	•Under Development	Directorate and Divisional Governance Meetings
B10	Safe	Royal Stoke	Medicine	Medical Care	The Trust SHOULD ensure medical wards are provided with adequate storage space	Ward teams will be encouraged to take part in "Dump the Junk" initiatives	Estates Team / Medical Division Matrons	Sep-22			CEF Visits	•Under Development	Directorate and Divisional Governance Meetings
						Ward Teams will be encouraged to adopt Lean Methodologies with regard to equipment/storage as part of their Improving together/Shared Governance projects	Estates Team / Medical Division Matrons	Sep-22			CEF Visits	•Under Development	Directorate and Divisional Governance Meetings
B11	Safe	Royal Stoke	Medicine	Medical Care	The Trust SHOULD ensure patient records are kept in a structured and consistent format so that staff can easily access them	The Trust will conduct an options appraisal of available standardised formats for health records	Documentation Group/Health records Department	Sep-22			Record Keeping Clinical Audit	•Under Development	Quality Safety Oversight Group Quality Governance Committee
B12	Responsive	Royal Stoke	Medicine	Medical Care	The Trust SHOULD ensure complaints are managed in a timely way	The Trust are reviewing the current formal complaints process to improve the quality and timeliness of reports and to streamline the sign off process	Debra Meehan Lead Nurse: Quality and Safety Gwen Hatton Associate Chief Nurse	Oct-22			Complaints Report	•Formal complaint triage process has been developed and implemented •Electronic formal complaint sign-off process under development	Quality Safety Oversight Group Quality Governance Committee
B13	Responsive	Royal Stoke	Medicine	Medical Care	The Trust SHOULD ensure that waiting times from referral to treatment and arrangement to admit, treat and discharge to be in line with national standards	Monitor waiting times and assign mitigating actions through Directorate, Divisional and Corporate meeting structures	Divisional Leadership Team	Sep-22			Divisional Performance Report	•Monitoring processes in place •Harm review process under review	Quality Safety Oversight Group Quality Governance Committee
B14	Well Led	County	Medicine	Medical Care	The Trust SHOULD ensure that it continues to work toward meeting trust targets for all mandatory training	The Divisional Management Team will develop a trajectory to improve compliance with mandatory training and essential role training. Progress will be monitored via the Directorate Governance Meeting	Gwen Hatton Associate Chief Nurse Dr Tony Cadwgan Divisional Chair	Sep-22			Training figures	•Trajectory under developme	Directorate and Divisional Governance Meetings
						The Divisional rotas will be adapted to highlight identifying on rotas when time is allocated for individuals to complete training	Gwen Hatton Associate Chief Nurse Dr Tony Cadwgan Divisional Chair	Sep-22			Training figures	•Under Development	Directorate and Divisional Governance Meetings
B15	Safe	County	Medicine	Medical Care	The Trust SHOULD ensure all serious incidents are investigated effectively and in a timely manner to reduce the risk of future harm	The Division will ensure that immediate mitigating actions are identified and shared, following all Serious Incidents	Gwen Hatton Associate Chief Nurse Dr Tony Cadwgan Divisional Chair	Jul-22			Quality and Safety Report	•Monitored through governance meetings and performance review packs	Directorate and Divisional Governance Meetings
						The Division will monitor timeliness of investigations and share learning through Divisional Governance Structures	Gwen Hatton Associate Chief Nurse Dr Tony Cadwgan Divisional Chair	Jul-22			Quality and Safety Report	•Monitored through governance meetings and performance review packs	Directorate and Divisional Governance Meetings

Action Number	Domain	Site	Division	Core Service	Observation / Issue	Improvement Required	Operational Lead	Target Date for Completion	Revised Target Date	Current Progress Rating	Assurance Mechanism	Assurance Based Progress Report	Responsible Committee / Group
B16	Safe	County	Medicine	Medical Care	The Trust SHOULD consider taking action to ensure key information about patients care in consistently recorded. For example, ensuring clear wound care plans are in place for all patients with a wound	A review of the proposed Clinical Audit programme will be undertaken to ensure that appropriate documentation audits are in place to review the standards of patient documentation and identify areas for improvement	Victoria Lewis Quality Assurance Manager	Complete			Clinical Audit Progress Report	•Clinical Audit programme reviewed	Clinical Effectiveness Group
						The Trust has developed a Wound Care Document. The document is currently being ratified and a roll-out plan is being finalised	Katie Leek Lead Nurse: Tissue Viability	Sep-22			Review of Tissue Viability incidents	•Proof document currently being developed by printers	Quality Safety Oversight Group Quality Governance Committee
B17	Safe	County	Medicine	Medicine Care	The Trust SHOULD consider making the speech and language therapy service provision equitable across County Hospital	A position paper will be presented at the Acute Patient Flow group which will highlight the shortfalls in the service provision to inpatient medical wards, across both sites	Lois Dale Head of Speech and Language Therapy	Complete			Meeting Minutes	•The position paper was presented to the Acute Patient Flow group in April 2022	Quality Safety Oversight Group Quality Governance Committee
						The Trust will develop an education programme to support ward teams regarding 'what makes a good referral' and how to escalate referrals	Lois Dale Head of Speech and Language Therapy	Sep-22			Review of incidents relating to insufficient referrals Review of the number of rejected referrals	•Guidance hasd been developed to advise wards how to escalate referrals •To be circulated via Comms	Quality Safety Oversight Group Quality Governance Committee
						MNP/ANP nurse swallow screening training will be implemented at RSUH to support service provision. Consider rollout at County Hospital	Lois Dale Head of Speech and Language Therapy	Sep-22			Review of incidents relating to SALT provision at Ward level	• MNP training at RSUH took place in Jan 2022 and was completed successfully. •ANP training for the respiratory team, to be rescheduled •Rollout yet to be considered at County	Quality Safety Oversight Group Quality Governance Committee
B18	Safe	County	Medicine	Medicine Care	The Trust SHOULD continue to work towards the provision of a full multidisciplinary seven-day service at the County Hospital site	The Division will initiate a number of promotional activities to ensure that Ward staff are aware of the services available at County Hospital across seven days	Claire Mackirdy Site Director of Operations	Sep-22			Divisional Performance Report	•Plan of activities under development	Operational Groups
						The Trust will include consideration of seven-day service provision in all service reviews at County Hospital	Claire Mackirdy Site Director of Operations	Sep-22			Divisional Performance Report	•Under Development	Operational Groups
B19	Well Led	County	Surgery	Surgical Care	The Trust SHOULD ensure that medical staff are up to date with all mandatory training	The Divisional Management Team will develop a trajectory to improve compliance with mandatory training and essential role training. Progress will be monitored via the Directorate Governance Meeting	Dr Stephen Merron Clinical Director	Sep-22			Training Figures	•Trajectory under development •Current overall Surgical Division Stat & mandatory Training figures 94.22%	Directorate and Divisional Governance Meetings
						The Divisional rotas will be adapted to highlight identifying on rotas when time is allocated for individuals to complete training	Dr Stephen Merron Clinical Director	Sep-22			Training Figures	•All permanent staff have 1 SPA included in job plans for CEPD. This will include the completion of Statutory & Mandatory Training. Each Directorate also allocates time during Audit and Training afternoons to address some of the Stat & Mand maintenance. •Rotational trainees all undergo Stat & Mand Training as part of the induction process, and are required to maintain certain elements as a requirement for ARCP.	Directorate and Divisional Governance Meetings

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

29th June 2022

1. Highlight Report

!	Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
	• A number of risks associated with the Cultural Improvement Programme were identified, in relation to attendance at development programmes due to operational pressures, a number of ongoing employee relations issues, scale and complexity of the organisation, if leadership development fails to change behaviours and the impact of low staff engagement on patient experience and outcomes – these will be captured as part of the Board Assurance Framework • Covid related staff absence has increased up to 31% of total absence (as at the time of the meeting) with a creeping increase now being seen	• Engagement and development of an improvement plan in response to the Culture Review, which will continue to evolve through ongoing discussions although would be presented for approval at the Culture Review Committee • Additional resource has been agreed within the Organisational Development Team in terms of delivery of the Cultural Improvement Programme • Clinical Leaders fundamentals development programme underway and any person wanting to take on a clinical lead role is required to participate • Development of a Cultural Heat Map underway, drawing together a variety of indicators associated with the culture of the organisation as a means of monitoring progress against • Business case for additional capacity within the Quality Improvement Academy currently underway • Transformation and People Committee to take further 'deep dives' into the Strategic Initiatives identified as part of the Improving Together Programme • Culture Review Committee reviewing the Culture Improvement Plan for sign off and to make a decision about discharging their responsibilities to TAP
✓	**Positive Assurances to Provide**	**Decisions Made**
	• Fundamentals of management and leadership for clinical leaders has received excellent feedback • Surgical and Specialised Division have demonstrated strong performance in terms of adoption of tools associated with the Improving Together programme • Root Cause Analysis into the Network Incident which occurred recently had identified that lessons learned from a previous incident had been beneficial in terms of a partnership approach	• Approval of Terms of Reference for the Executive Health & Safety Group, Executive Workforce Assurance Group, Executive Research & Innovation Group, Executive Strategy & Transformation Group and the Executive Digital and Data Security and Protection Group

Comments on the Effectiveness of the Meeting

- Where future deep dives take place, the agenda will be restricted to the subject matter and then highlight reports only
- Material being delivered by presentation should be circulated in advance at future meetings.

2. Summary Agenda

No.	Agenda Item	BAF Mapping		Purpose	No.	Agenda Item	BAF Mapping		Purpose
		BAF No.	Risk				BAF No.	Risk	
1.	Creating a Great Place to Work: Improving our Organisational Culture	BAF 2/3		Discussion	7.	M2 Workforce Performance Report	BAF 2/3		Assurance
2.	Improving Together Highlight Report			Assurance	8.	Q4 Nursing and Midwifery Staffing and Quality Report	BAF 1/3		Assurance
3.	Executive Strategy & Transformation Assurance Report	BAF 4/5		Assurance	9.	Executive Workforce Assurance Group Assurance Report	BAF 2/3		Assurance
4.	NASSTAR Network Incident Debrief	BAF 7/8		Assurance	10.	Health & Safety Annual Report 21/22		18673, 22876, 21284, 22837, 18675, 21915, 21740	Assurance
5.	Executive Digital and Data Security & Protection Group Assurance Report	BAF 7		Assurance	11.	Fire Annual Report 21/22	BAF 8		Assurance
6.	Executive Groups Effectiveness Reviews / Terms of Reference			Approval	12.	Executive Health & Safety Group Assurance Report			Assurance

3. 2022 / 23 Attendance Matrix

			Attended			Apologies & Deputy Sent								
Members:			A	M	J	J	A	S	O	N	D	J	F	M
Prof G Crowe	GC	Non-Executive Director (Chair)												
Ms H Ashley	HA	Director of Strategy and Transformation												
Ms S Belfield	SB	Non-Executive Director												
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												
Miss C Rylands	CR	Associate Director of Corporate Governance												
Mrs R Vaughan	RV	Chief People Officer												

Performance and Finance Committee Chair's Highlight Report to Board

28th June 2022

University Hospitals of North Midlands NHS Trust

1. Highlight Report

!	Matters of Concern of Key Risks to Escalate	Major Actions Commissioned / Work Underway
	• An update on Emergency Department medical workforce was provided which demonstrated good progress in recruiting to the posts previously invested in, which included recruitment to 18 of the 24 SHO doctors. The Committee challenged and considered the reasons for the additional recruitment not having yet resulted in a demonstrable improvement in overall performance, which related to flow and ambulance waits. It was also noted that a tiered rota was being put in place which would be aligned to the demand profile of the Department • Financial performance for May reported a £1.7 m deficit, against £0.6 m planned surplus resulting in a £3.2 m cumulative deficit. It was noted that the main issues affecting performance were delivery of the Cost Improvement Programme, which had previously been identified as a risk and issues in relation to specialised commissioning • The risk on future year investments was highlighted given the approval of the Foundation Year business case which would impact on future investment monies, although assurance was provided separately on the approach to taking additional investments	• To bring a further update to September's meeting on the triangulation of metrics in the IPR that looks at benchmarking information • Top 3 actions to be taken to improve performance to be noted on the IPR going forwards, to understand improvement • Neonatal team to provide further detail to members, in relation to the neonatal business case and impact on CNST and BAPM standards • To provide a more detailed update on any significant risks highlighted via the Infrastructure Highlight Report at the next meeting • To provide a breakdown of the non-pay overspend and levels associated with CIP and inflation etc • To undertake scenario analysis in relation to the cash flow forecast and impact on the balance sheet
✓	**Positive Assurances to Provide**	**Decisions Made**
	• A deep dive into planned care improvement was provided which included an update on the trajectories associated with RTT, cancer, outpatient recovery and diagnostics. The Committee queried whether the anticipated improvements in performance were realistic, for which assurance was provided in terms of the ongoing recruitment which was taking place • The final 2022/23 system plan was noted and the significant risks associated with delivery were recognised, which would be monitored via a system-wide finance risk register • The Committee welcomed the investment assurance report which demonstrated investments to date were affordable on a recurrent basis • Positive assurance was provided in relation to progress made with the various procurement work streams, which included a forecast of £5.331 m bottom line savings with 108 individual projects identified for delivery	• The Committee approved business case 0452 in relation to an expansion in Foundation Year medical posts • The Committee approved business case 0477 in relation to NICU nurse staffing at Royal Stoke • The Committee approved the approach to making additional investments for 2022/23 and proposed release of funding • The Committee approved the revised capital plan 2022/23 • The Committee approved eREAFs 9363, 9355, 9348, 9277, 9212, 8847, 9440 • The Committee approved the Terms of Reference for the Executive Infrastructure and Executive Business Intelligence Groups

Comments on the Effectiveness of the Meeting

- The meeting overran, due to the inclusion and consideration of the deep dive and it was agreed to consider the timing of future deep dives to enable adequate discussion of remaining agenda items

2. Summary Agenda

No.	Agenda Item	BAF Mapping		Purpose	No.	Agenda Item	BAF Mapping		Purpose
		BAF No.	Risk				BAF No.	Risk	
1.	Month 2 Performance Report – 2022/23 • Planned Care Improvement Deep Dive	BAF 6		Assurance	8.	Investment Assurance	BAF 9		Approval
2.	Emergency Department Medical Workforce Update	BAF 3/6	8442	Assurance	9.	Revised Capital Plan 2022/23	BAF 9		Approval
3.	Operational Delivery Group Assurance Report	BAF 1/6		Assurance	10.	Quarterly Procurement Update Report	BAF 9		Assurance
4.	Executive Infrastructure Group Assurance Report	BAF 8		Assurance	11.	Authorisation of New Contract Awards, Contract Extensions and Non-Purchase Order (PO) expenditure	-		Approval
5.	BC-0477 NICU Nurse Staffing Establishment RSUH			Approval	12.	Executive Business Intelligence Group Assurance Report			Assurance
6.	Expansion in Foundation Posts Business Case		1884, 8822, 24272, 9345, 23787, 10868	Approval	13.	Executive Groups Effectiveness Reviews / Terms of Reference			Approval
7.	Month 2 Finance Report 2022/23 • System Plan 2022/23	BAF 9		Assurance	14.	Non-Elective Improvement Board Minutes	BAF 6		Information

3. 2022 / 23 Attendance Matrix

Attended | **Apologies & Deputy Sent** | **Apologies**

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

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	6th July 2022
Report Title:	Integrated Performance Report, Month 2 2022/23	**Agenda Item:**	12.
Author:	Quality & Safety: Jamie Maxwell, Head of Quality & safety; Operational Performance: Warren Shaw, Associate Director of Performance & Information; Matt Hadfield, Deputy Associate Director of Performance & Information. Workforce: Claire Soper, Assistant Director of Human Resources; Finance: Jonathan Tringham, Director of Operational Finance		
Executive Lead:	Anne-Marie Riley: Chief Nurse Paul Bytheway: Chief Operating Officer Ro Vaughan: Chief People Officer 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

Key messages

The Trust achieved the following standards in May 2022:

- Friend & Family (Inpatients) 98.9% and exceeds 95% target.
- Friend & Family (Maternity) increased to 100% and above 95% target.
- Harm Free exceeded 95% target rate with 96.5%
- 100% verbal Duty of Candour compliance
- 0 Never Events reported
- Trust rolling 12 month HSMR continues to be below expected range.

- VTE Risk Assessment completed during admission continues to exceed 95% target with 99.1% (point prevalence audit via Safety Thermometer).
- Zero avoidable MRSA Bacteraemia cases reported.
- There have been no Category 4 Pressure Ulcers attributable to lapses in care during May 2022.
- Inpatient Sepsis IVAB within 1 hour achieved 95% and exceeded 90% target rate
- Maternity Sepsis Screening compliance 90% against 90% target

The Trust did not achieve the set standards for:

- Friend & Family Test for A&E 72.4% and below 85% target.
- Falls rate was 5.9 per 1000 bed days
- There were 23 Pressure ulcers including Deep Tissue Injury identified with lapses in care during May 2022.
- 80% (8 out of 10 cases) Duty of Candour 10 working day letter performance following formal verbal notification. 6 patients have received written notification but 2 cases are waiting update on Datix and 2 cases the relative/patient have confirmed that no follow up letter is required.
- C Diff YTD figures below trajectory with 9 against a target of 8.
- Inpatients Sepsis Screening 86.3% below 90% target rate
- Children's Sepsis Screening compliance 84% and below the 90% target.
- Sepsis Screening compliance in Emergency Portals below the target 90% with 75%.
- Emergency Portals Sepsis IVAB in 1 hour 72% and is below the 90% target for audited patients
- Maternity IVAB compliance is 80% against 90% target

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

- The rate of complaints per 10,000 spells is 31.39 and is below the target of 35 and within normal variation. Majority of complaints in May 2022 relate to clinical treatment.
- Total number of Patient Safety Incidents decreased in month (1703) and the rate per 1000 bed days has also decreased at 43.39 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 but within normal variation.
- Increase in total reported incidents relating to staffing shortages and lack of appropriate staff on wards/departments during March 2022. 81 in total although 33 were coded as patient related, the remaining 48 were reported as staff related incidents.
- Rate of falls reported that have resulted in harm to patients currently at 1.5 per 1000 bed days in May 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 4.9 and patient related 4.2 which are similar to previous month and mean rates. The monthly variation is within the normal expected variation and consistent with Trust mean rates.
- Pressure Ulcers per 1000 bed days developed under UHNM care has seen a decrease during May 2022
- 19 Definite Hospital Onset / Nosocomial COVID-19 cases reported in May 2022.
- 1 COVID-19 death falling in to the 'Definite' category (according to the National definition of Nosocomial deaths of first positive result 15 days or more after admission to hospital).
- 13 Serious Incidents reported during May 2022.

Operational Performance

Emergency Care

- May saw an increase in Type 1 attendances to 14800. Attendance numbers have not been seen at this level since August 2021.
- 4 hour performance remained static to 62.5% which is a positive given the increase in attendances.
- The 12 hour delays in the department reduced to 400 in May which is much lower than experienced in previous months, this was on the back of operating at EMS level 2 for most days in the month and an increase seen in pre noon and simple discharges.
- WTBS remained relatively static month on month although this is maintenance of a poor position and is expected to improve as the ED Workforce embeds.
- Ambulance handovers remain a challenge however delays over 60 minutes have been reduced to their lowest levels since October and have almost halved since last month.

- The Non-Elective Improvement Programme PMO Lead post was advertised in May with interviews planned for June for approval for interim support in place. This post will provide project management, governance, and transformational support across all three workstreams and will support a more consistent and cohesive approach to the delivery of the programme as a whole.
- Refreshes of all workstreams continue to develop and be positively received with an overarching drive to ensure a consistent, data driven and targeted approach to operational improvements and transformational change management.
- May saw improvements across a number of critical metrics underpinned by a reduction in occupancy. The focus for next month will be on maintaining this momentum and finalising workstream refreshes.

Cancer

- Most recent submitted Cancer Waiting Times position is April 22. The May 22 position is a performance prediction which will be impacted as histology results confirm a cancer or non-cancer diagnosis for patients treated.
- Both Skin and Breast have a recovery plan for 14 day first appointment. Breast has improved their target days from 45 to 30 and is commissioning extra activity to remove the remaining backlog. Skin have improved from 36 to 28 days but have stabilised so plan for short term extra capacity and longer term reduction in demand including Telederm.
- The 104+ backlog has increased this month to 157. 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. 25% of the 104+ backlog is within Colorectal and 25% is with Skin. Colorectal delays are being supported by COO and the Clinical director to produce a robust plan.
- In May 22, the proportion of patients waiting over the key standard, 62 days to treatment, was 12% which is 2% better than the regional average. This is a maintained position since last month.
- The 14 day position for May 22 is predicted to achieve in the region of 41%. However the trust saw around 200 more patients than the previous month despite the bank holiday. Breast delays are improving but the top priority is an improvement plan for Colorectal.
- The 28 Day Faster Diagnosis position is currently at 59% with the majority of breaches currently recorded in Colorectal, Breast and Skin.
- There are currently 657 patients in the 2WW backlog. Of the 2WW patients who have breached, 171 patients are in Colorectal and 221 are in Skin.

Planned Care

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

- Day Case has shown a marked improvement, up to 92% in May from 86% in April. Elective Activity delivered 96% BAU in May up from 86% in April. This is still some way from the national ask of 110%.
- Theatre plan for Q1 2022/23 gives 104% of 19/20 capacity. County theatre re-opened 11th April – all 7 theatres now online. The aim is to increase to 104% activity compared to 19/20 levels.
- A combined site focus on Theatres, by booking ahead, ensuring all lists are fully used and only for the most urgent and longest waiting patients is being enabled by a revitalised “6-5-4” weekly meeting which will continue to increase theatre throughput. County Theatres moved from 97% to 111% of 2019/20 capacity from April to May, and Royal Stoke moved from 86% to 98% giving a total move from 88% to 100% and reflecting the strategy of maximising County for elective work.
- Modular theatre has now received final approval from the board, enabling the Trust to increase activity to the 110% national ask and beyond by end of 2022/23.

RTT

- The overall Referral To Treatment (RTT) Waiting has started to stabilise throughout May. For April the indicative number of Incomplete pathways has risen to 76,023, but decreased to in 75,858 in May. This is the first decrease since Summer 2020.
- The number of patients > 18 weeks has decreased to 34,928 –the first decrease since Autumn 2021.
- At the end of May the numbers of > 104 weeks was 159 (unvalidated) - a decrease of almost 50% from 314 in April. The Planned Care group is monitoring progress against treatment plans for these patients. The Trust will achieve the national standard of all eliminating 104 week waits end of June, with the allowed exception of those patients who have chosen not to be treated in June or are too complex to have their treatment arranged during June. There remains a residual risk of last minute cancellations which are being rapidly rebooked.

Diagnostics

- Histology turnaround times remain a high risk; there is an action plan in place both for increased staff in post to remove block delays and improved reporting through put which is improving the position. Cancer related histology is being treated urgently and all cancer related escalations are being prioritised and the escalation process is in place allowing the cancer team to directly access patient data.
- Within DM01, the greatest proportion of > 6 week waits is 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. The Non-obstetric ultrasound waiting list decreased from 9,631 to 9,930. A viable insourcing company for non-obstetric ultrasound scanning is being progressed to business case and if supported will deliver Non-Obs Ultrasound at 4 weeks by January 2023.
- Plain film is also an area with a high volume of waiters, predominantly due to staffing shortages.
- Walk in centres for P/F MSK starts in July. Walk in centres for all other P/F will start in August, which will give capacity for immediate imaging from referral and will allow decisive recovery for P/F waits.
- The Diagnostic Cell is progressing solutions for ensuring that annual / planned patients are reflected correctly against their RTT pathway.
- Endoscopy remains a high risk area, with a recovery plan in place, and medium term plans to outsource triaging to reduce endoscopies.

Workforce

Key messages

- The strategic focus of our People Plan remains on supporting recruitment, staff wellbeing and absence management.
- The sustainable workforce risk remains high because there is still an impact of covid surges on sickness levels and workforce availability, although there are plans in place to mitigate risks and additional recruitment is taking place. Operational pressures, high sickness rates and vacancy levels contribute to the staffing challenges. Additionally, the UK Visas and Immigration (UKVI) are processing the high number of emergency visas related to the war in Ukraine as a priority. This has resulted in a significant delay in processing work, study and family visa applications, which may cause delays in the recruitment process for sponsored candidates and employees

Sickness

- The in-month sickness rate was 5.50% in May (7.29% in April 22). The 12 month cumulative rate increased to 6.10% (6.02% at 30/04/22). Covid-related absence continues to fluctuate. As of 14 May 2022, covid-related open absences numbered 131 which was 20% of all absences [*includes absences resulting from adhering to isolation requirements]
- The focus remains on managing areas of high sickness, with specific deep dives in to stress/anxiety, MSK and covid-related absences, with assurance meetings having taken place in the Divisions and continued daily monitoring of sickness absence rates, including COVID related absence

Appraisals

- At 31 May 2022, the PDR Rate continued to decline to 73.26%, down from 73.78% at 30 April 2022
- There will be a renewed focus with the Divisions on ensuring completion of PDRs with weekly update reports detailing compliance and outstanding PDR's being circulated; focused discussions to improve performance; Management time being reinstated, and improved guidance on 'How to' add PDRs to ESR.

Statutory and Mandatory Training

- The Statutory and Mandatory training rate at 31 May 2022 was 94.30% (94.25% at 30 April 2022). This compliance rate is for the 6 'Core for All' subjects only
- We continue to raise the issue of compliance with Divisions and communicate to staff the need to complete statutory and mandatory training.

Vacancies

- The overall vacancy rate was 11.79% at 31 May 2022 (11.10% at 30 April 2022), equivalent to 1324.02 FTE.
- Staff in post decreased in May 2022 by 2.34 fte, and budgeted establishment increased by 84.47 fte which increased the vacancy rate by 86.81 overall. In month, Bank and Agency fte was 906.91, which covered 68.5% of this vacancy position and there was 1319.4 FTE in the recruitment pipeline.
- Overall the target *average time to hire* (from vacancy creation to checks complete) is 60 days and although this average is achieved, there are aspects of recruitment, such as pre-employment, which currently exceed the local performance target (17days of the overall 60 day target).

Finance

Key messages

- Key elements of the financial performance are:
- In month the Trust delivered an actual deficit of £1.7m against an in month planned surplus of £0.6m. This adverse variance to plan is primarily driven by non-delivery of CIP in month which was identified as a key risk in our financial plan submission.
- The Trust incurred £1.2m of costs relating to COVID-19 in month which is comparable with the prior month figure with £0.5m being chargeable on top of this allocation for COVID-19 testing costs.
- To date the trust has validated £1.04m CIP savings in year; these schemes have a full year impact of £4.4m, which presents a considerable variance to the Trust's recurrent target of £13.6m.
- Capital planned expenditure for 2022/23 as reported to Performance and Finance Committee in April 2022 is £69.8m. In Month 2 total expenditure has been incurred of £1.7m which is £0.2m behind plan. The majority of the expenditure year to date is the pre-committed repayment of the PFI and IFRS16 lease liabilities.
- The cash balance at Month 2 is £70.2m, which is £10.4m lower than plan. The main year to date variances from plan are driven by Health Education Training income being lower than plan and general payables being in excess of 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 2 2022/23

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Contents

A note on **SPC**

University Hospitals of North Midlands NHS Trust

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

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

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

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

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

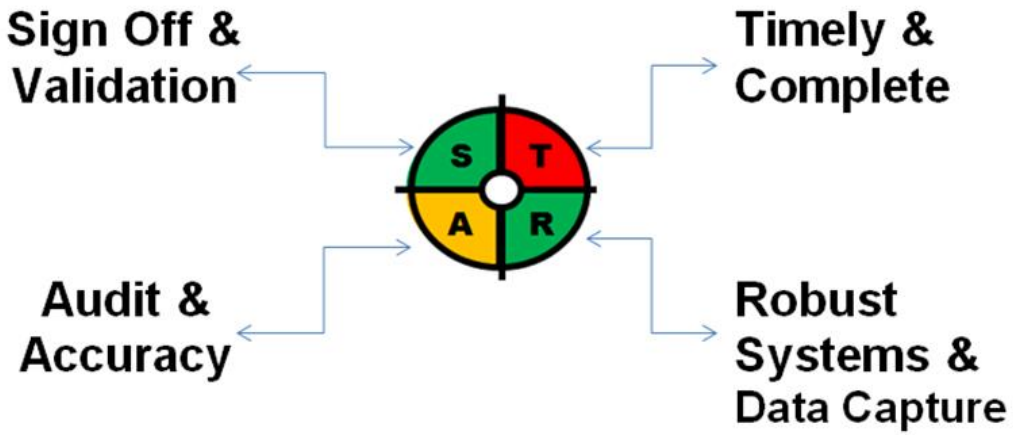
Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

A note on **Data Quality**

NHS
University Hospitals of North Midlands
NHS Trust

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



Explaining each domain

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

RAG rating key

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

Quality

Caring and Safety

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

Quality Spotlight Report

NHS University Hospitals of North Midlands NHS Trust

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Quality Dashboard

NHS University Hospitals of North Midlands NHS Trust

Metric	Target	Latest	Variation	Assurance
Patient Safety Incidents	N/A	1703	H	
Patient Safety Incidents per 1000 bed days	50.70	43.39		
Patient Safety Incidents per 1000 bed days with no harm	N/A	28.18		
Patient Safety Incidents per 1000 bed days with low harm	N/A	12.84		
Patient Safety Incidents per 1000 bed days reported as Near Miss	N/A	1.53		
Patient Safety Incidents with moderate harm +	N/A	31	H	
Patient Safety Incidents with moderate harm + per 1000 bed days	N/A	0.79		
Harm Free Care (New Harms)	95%	96.5%		?
Patient Falls per 1000 bed days	5.6	5.9		
Patient Falls with harm per 1000 bed days	1.5	1.5		?
Medication Incidents per 1000 bed days	6	4.9		?
Medication Incidents % with moderate harm or above	0.50%	0.52%		?
Patient Medication Incidents per 1000 bed days	6	4.2		F
Patient Medication Incidents % with moderate harm or above	0.50%	0.60%		?

Metric	Target	Latest	Variation	Assurance
Serious Incidents reported per month	0	13		?
Serious Incidents Rate per 1000 bed days	0	0.31		?
Never Events reported per month	0	0		?
Duty of Candour - Verbal/Formal Notification	100%	100%		?
Duty of Candour - Written	100%	72.0%		?
All Pressure ulcers developed under UHNM Care	TBC	90	L	
All Pressure ulcers developed under UHNM Care per 1000 bed days	N/A	2.42	H	
All Pressure ulcers developed under UHNM Care lapses in care	12	24		?
All Pressure ulcers developed under UHNM Care lapses in care per 1000 bed days	0.5	0.64		?
Category 2 Pressure Ulcers with lapses in Care	8	10		?
Category 3 Pressure Ulcers with lapse in care	4	0		?
Deep Tissue Injury with lapses in care	0	8		
Unstageable Pressure Ulcers with lapses in care	0	6		?

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%	72.4%	L	F
Friends & Family Test - Inpatient	95%	98.9%		P
Friends & Family Test - Maternity	95%	100.0%		
Written Complaints per 10,000 spells	35	31.39		?
Rolling 12 Month HSMR (3 month time lag)	100	98.44	H	P
Rolling 12 Month SHMI (4 month time lag)	100	102.51	H	?
Nosocomial COVID-19 Deaths (Positive Sample 15+ days after admission)	N/A	1	L	
VTE Risk Assessment Compliance	95%	99.3%		
Reported C Diff Cases per month	8	9		?
Avoidable MRSA Bacteraemia Cases per month	0	0		?
HAI E. Coli Bacteraemia Cases per month	8	13		?
Nosocomial "Definite" HAI COVID Cases - UHNM	0	19		

Metric	Target	Latest	Variation	Assurance
Inpatient Sepsis Screening Compliance (Contracted)	90%	86.3%		?
Inpatient IVAB within 1hr (Contracted)	90%	95.0%	H	P
Children Sepsis Screening Compliance (All)	90%	84.0%	L	?
Children IVAB within 1hr (All)	90%	N/A	H	F
Emergency Portals Sepsis Screening Compliance (Contracted)	90%	75.4%	L	?
Emergency Portals IVAB within 1 hr (Contracted)	90%	72.2%	L	?
Maternity Sepsis Screening (All)	90%	90.0%	H	F
Maternity IVAB within 1 hr (All)	90%	80.0%	L	F

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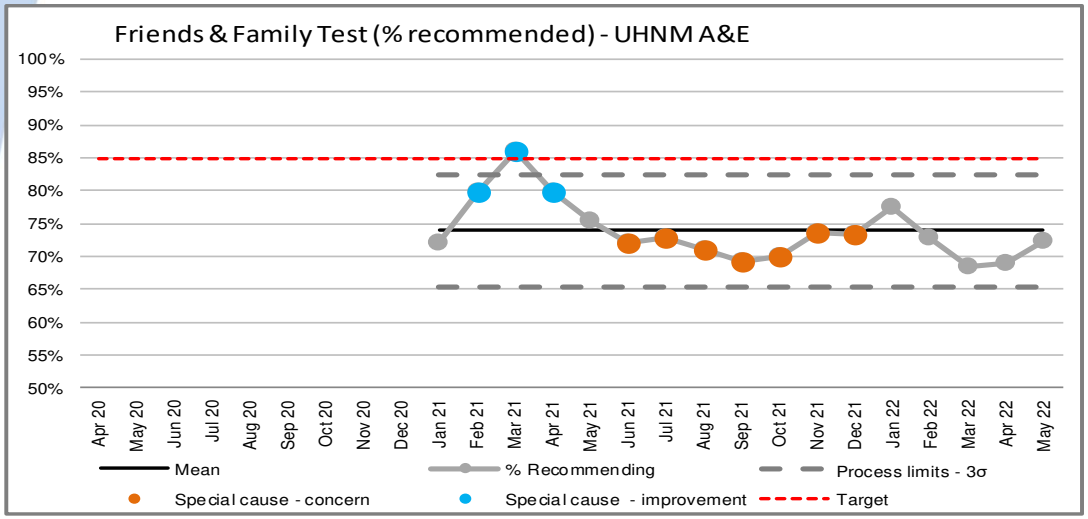
Friends & Family Test (FFT) – A&E



Variation	Assurance
	

Target	Mar 22	Apr 22	May 22
85%	68.5%	69.1%	72.4%

Background

The % of patients who would recommend the service to friends and family if they needed similar care or treatment

What do the results tell us?

- Although the satisfaction rate for ED remains below our internal target at 72% for May, the Trust received 1767 responses in May which is within the top 15 Trusts across the county for number of responses received. The Trust overall satisfaction rate is lower than the national average of 75% (NHS England).
- Feedback from patient experience of using 111First and the kiosks is being monitored. 24% of respondents used 111First prior to attending ED, slightly higher which remains static. Satisfaction score of patients using 111First was 67% which continues to show an upwards trend.

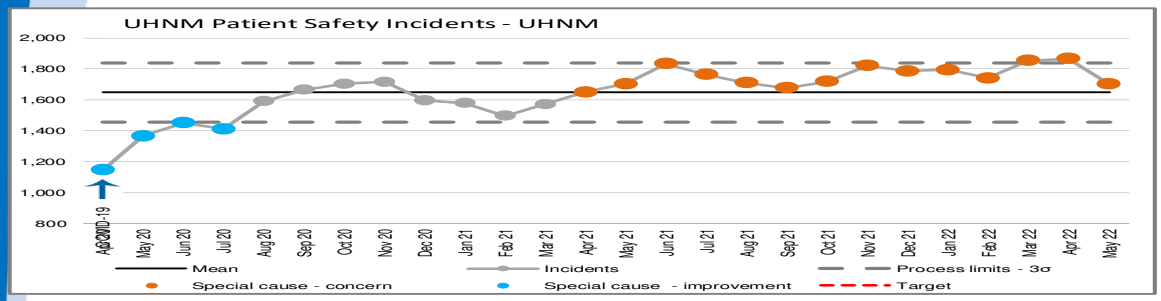
Actions :

Themes from patient feedback are predominantly around wait times, staff attitude and access to paint relief. Patient Experience team will liaise with Matron Allen with regards to re-establishing the departmental patient experience meeting to discuss themes and plans for improvement. Invitation to the monthly Patient Experience Group meetings have also been extended to the ED management team so progress against any improvements can be monitored.

We are looking at Pain and involvement in treatment and care within the High Quality Improving Together strategic priorities and we now have a suite of patient priorities based on patient feedback:

- Timely medications
- Pain management
- Involvement in care and decision making
- Supporting the voice of women/partner (maternity specific)
- Improving the experience of our oncology patients

Reported Patient Safety Incidents

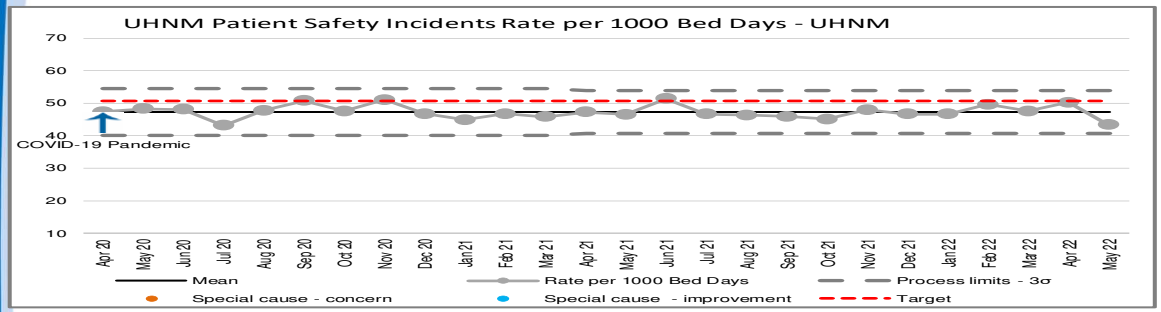


Variation	Assurance
	

Target	Mar 22	Apr 22	May 22
N/A	1855	1867	1703

Background

Total Reported patient safety incidents



Variation	Assurance
	

NRLS Mean	Mar 22	Apr 22	May 22
50.70	47.61	50.20	43.39

What is the data telling us:

The above data relates to **all** reported Patient Safety Incidents (PSIs) across the Trust. The May 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 Falls, Medication, Patient Flow and Clinical assessment related incidents. There has been no significant changes in these categories during May compared to previous months.

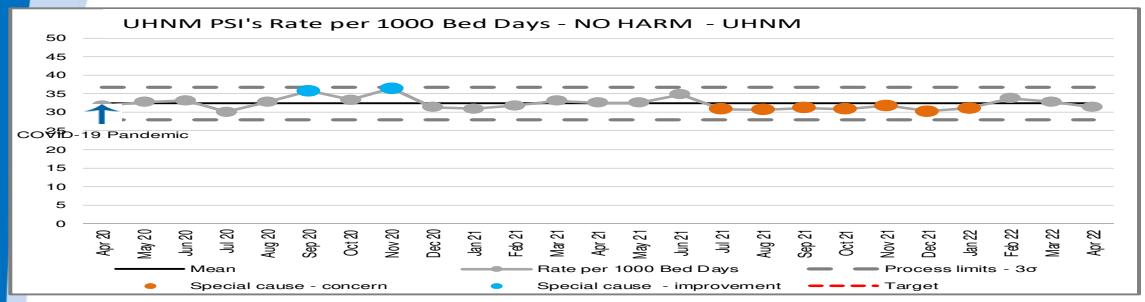
There has been significant decrease in the number of total staffing related incidents submitted during May 2022 with 38 in total compared to previous months (81 in April, 85 in March, 55 in February, 60 in January, 74 in December, 60 in November and 61 in October).

33 (77 in April, 63 in March ,48 in February, 49 in January 2022 and 69 in December 2021) – insufficient professional healthcare staff
3 (9 in April, 13 in March, 2 in February, 13 in January 2022 and 7 in December 2021) – insufficient non professional healthcare staff
3 (7 in April, 9 in March, 6 in February, 9 in January 2022 and 6 in December 2021) – insufficient support staff

The rate of reported PSIs per 1000 bed days has decreased below long term mean rate but remains in normal variation

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

University Hospitals of North Midlands NHS Trust

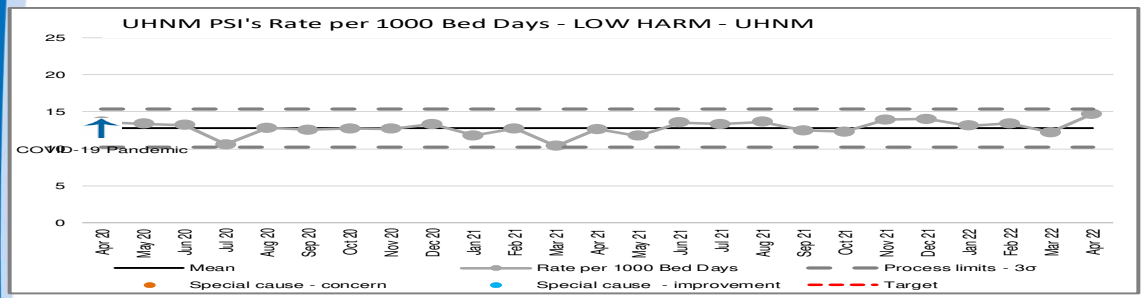


Variation	Assurance

Target	Feb 22	Mar 22	Apr 22
N/A	33.81	32.89	31.35

Background

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

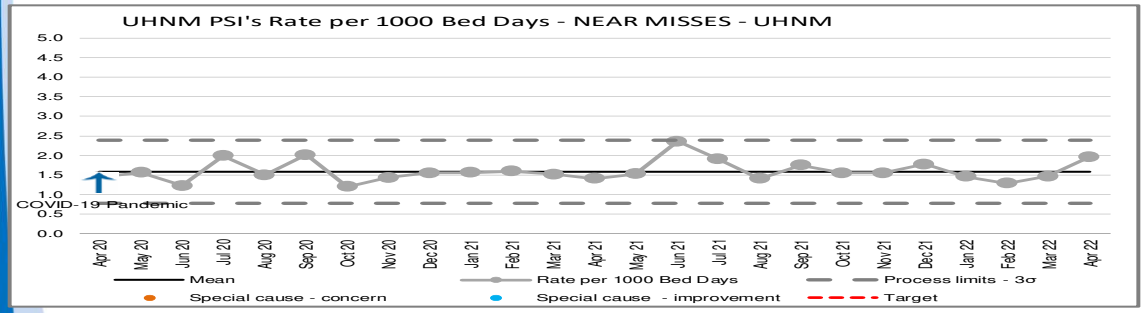


Variation	Assurance

Target	Feb 22	Mar 22	Apr 22
N/A	13.43	12.22	14.70

Background

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



Variation	Assurance

Target	Feb 22	Mar 22	Apr 22
N/A	1.28	1.46	1.96

Background

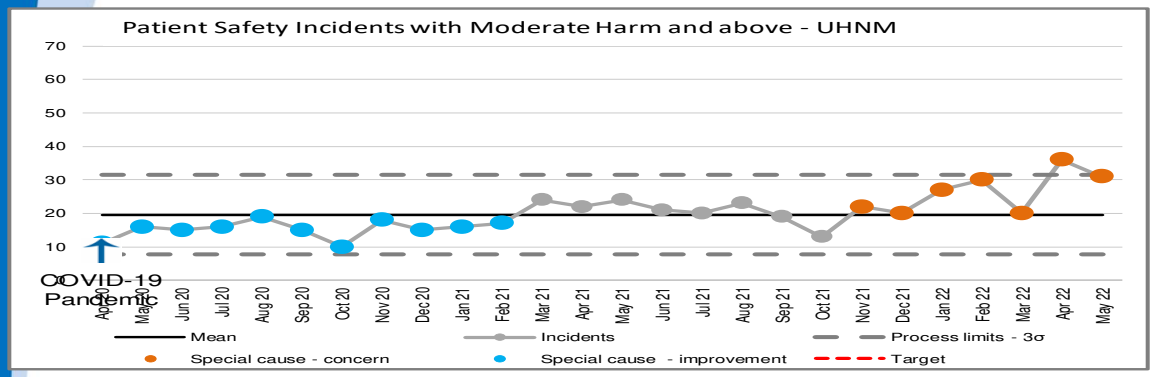
The rate of Patient safety Incidents per 1000 bed days that are reported as NEAR MISS

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 and within normal variation.

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

Reported Patient Safety Incidents with Moderate Harm or above

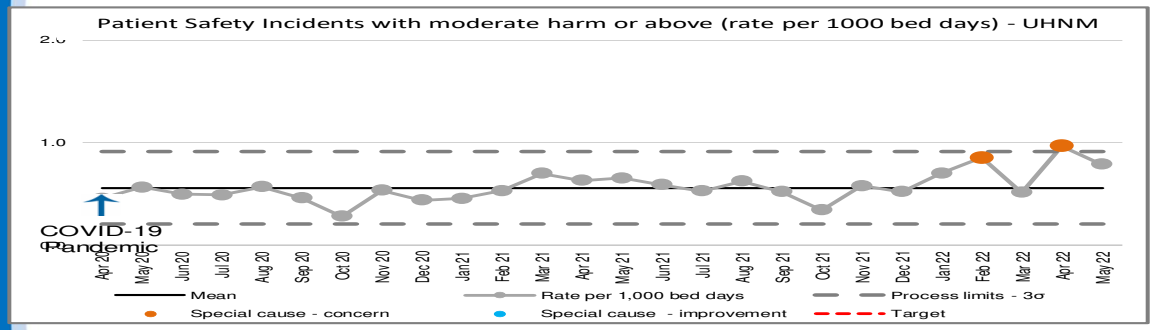


Variation	Assurance

Target	Mar 22	Apr 22	May 22
N/A	20	36	31

Background

Patient safety incidents with reported moderate harm and above



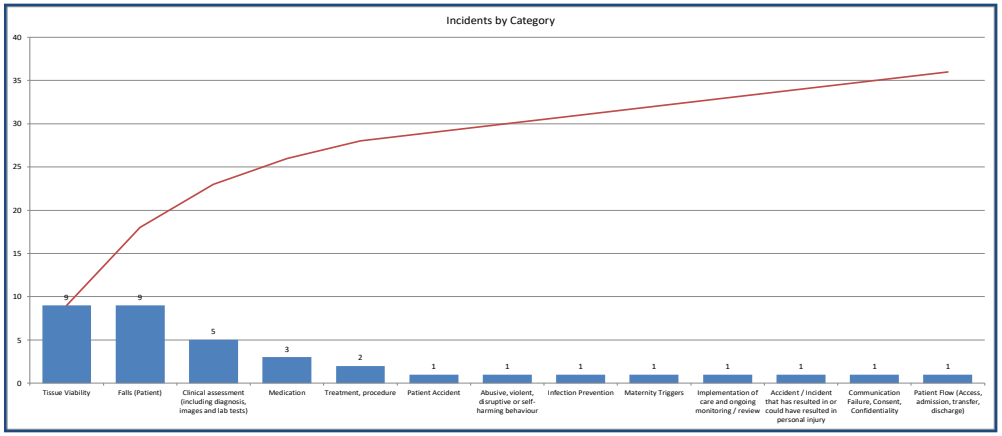
Variation	Assurance

Target	Mar 22	Apr 22	May 22
N/A	0.51	0.97	0.79

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 at the upper process control and the past 7 months is above the mean rate hence the higher variation indicator. 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 9 Falls, 9 Tissue Viability related, 5 clinical assessment, 3 medication and 2 Treatment related being top 5 categories.



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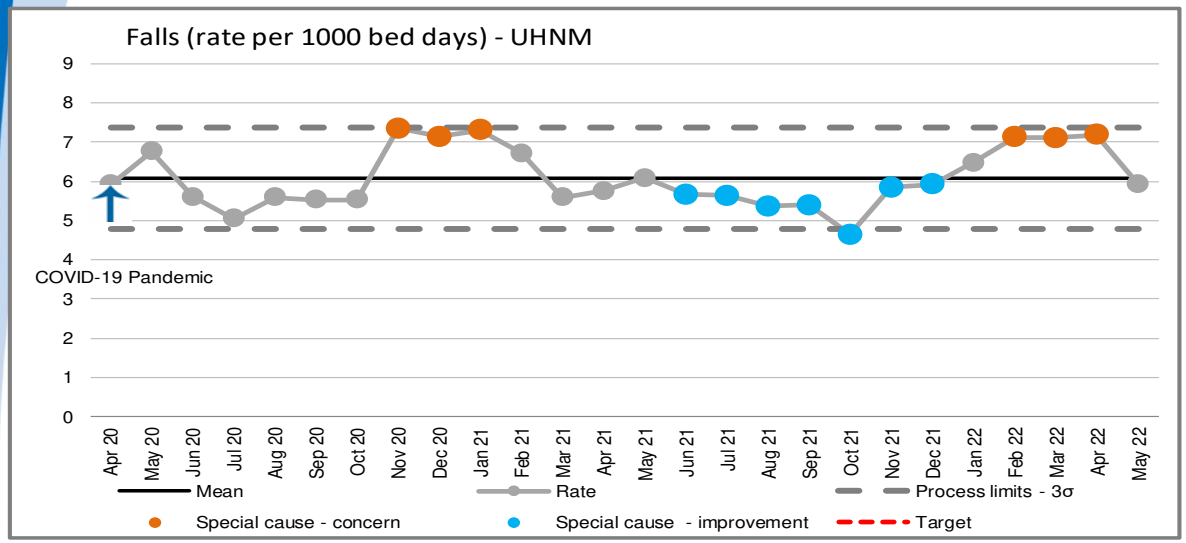
Patient Falls Rate per 1000 bed days



Variation	Assurance

Target	Mar 22	Apr 22	May 22
N/A	7.1	7.2	5.9

Background

The number of falls per 1000 occupied bed days

What is the data telling us:

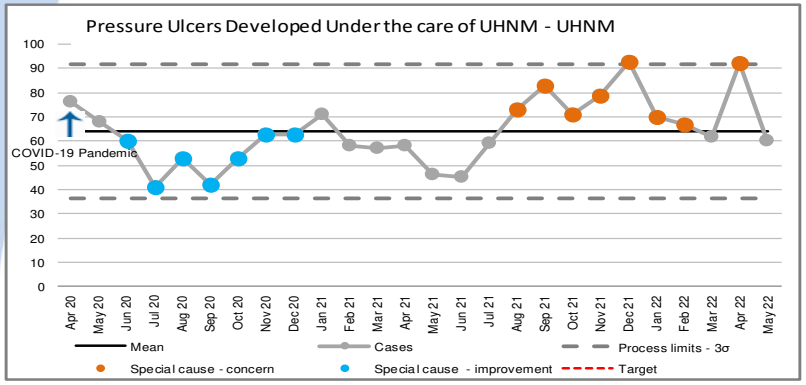
The Trust's rate of reported patient falls per 1000 bed days was within the normal range in May.

The areas reporting the highest numbers of falls in May 2022 were:
Royal Stoke AMU- 27 falls Royal Stoke ED – 13 falls Royal Ward 110 – 12 falls

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

- A Further 2 refresher dates for existing falls champions and a new falls champion date have taken place.
- The monthly falls audits have been shared with the divisions to provide awareness of the individual areas.
- Audits have been carried out to determine compliance with documentation, call bells, bed rails, falls alert symbols and footwear.
- Due to the Datix's that have been submitted where patients have fallen whilst using a bed table as a mobility aid, inquiries have begun costing bed tables with breaks attached.
- A trial audit has commenced in ECC for 2 weeks identifying if patients have had the opportunity to sit out, this is to support deconditioning and hopefully the reduction in falls.
- ED have seen reductions in recent months as the replacement programme for ED doors providing greater visibility continued.

Total Pressure Ulcers developed under care of UHNM

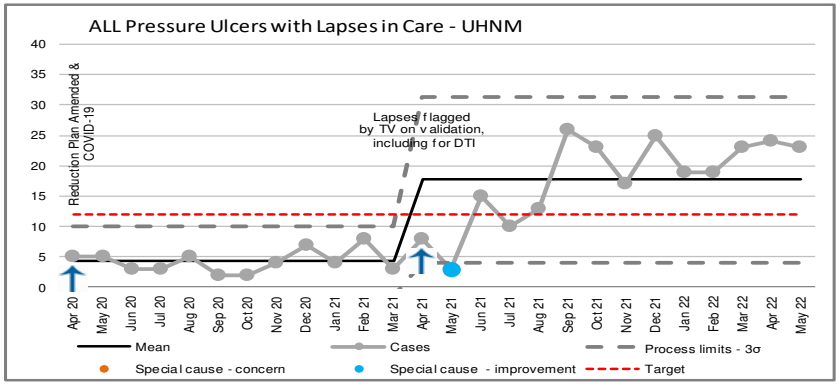


Variation	Assurance

Target	Mar 22	Apr 22	May 22
N/A	62	92	60

Background

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



Variation	Assurance

Target	Mar 22	Apr 22	May 22
12	23	24	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 was within normal range in May. The tables below show breakdowns of the pressure ulcers reported last month.

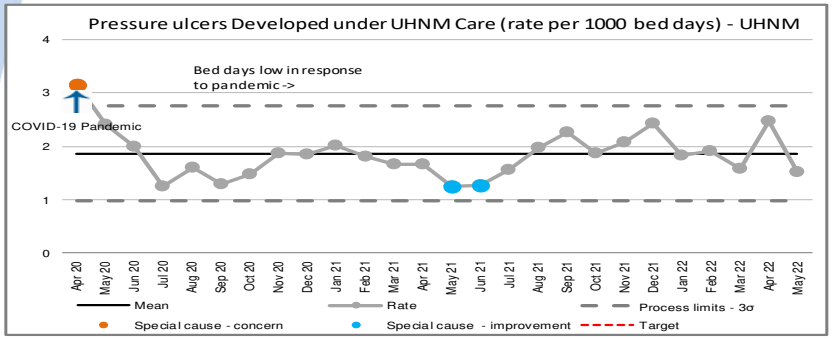
Category	Total (May 2022)
DTI	25
Category 2	19
Category 3	6
Category 4	0
Unstageable	10
Total	**60**

Top Body Locations	Total (May 2022)
Heel	16
Buttock	14
Sacrum	6
Nose	5
Gluteal Cleft	5

The monthly number of DTI's reported as developed under UHNM care has been above average since August 2021. Numbers within other categories were within normal range in May.

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

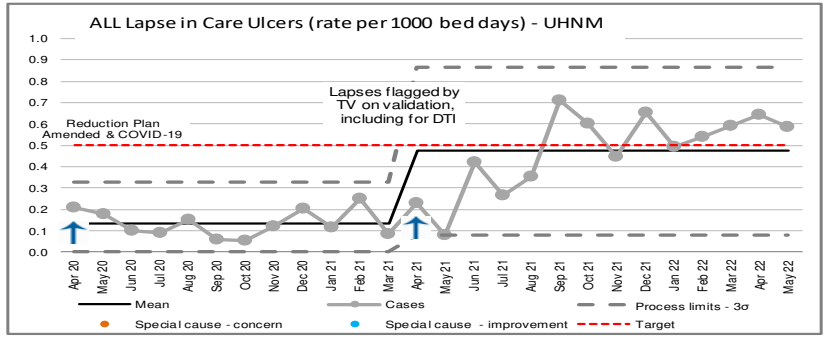


Variation	Assurance

Target	Mar 22	Apr 22	May 22
N/A	1.59	2.47	1.53

Background

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



Variation	Assurance

Target	Mar 22	Apr 22	May 22
0.5	0.59	0.65	0.59

Background

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

What the data is telling us

The rate of pressures ulcers reported as developed under UHNM care appears stable, showing only expected variation. The rate of ulcers with lapses in care has been significantly higher than in previous years, but there does not currently appear to be a further statistically significant increasing trend.

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

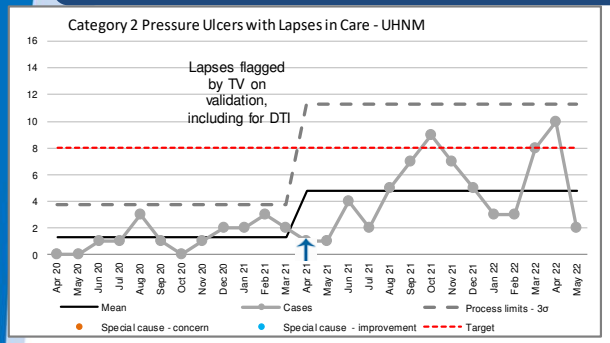
High reporting areas will be presenting all incidents at bespoke RCA panels, to allow identification of trends, and establish their improvement and educational focus. The Tissue Viability team and Corporate Nursing Quality & Safety Teams will support with this.

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

Actions

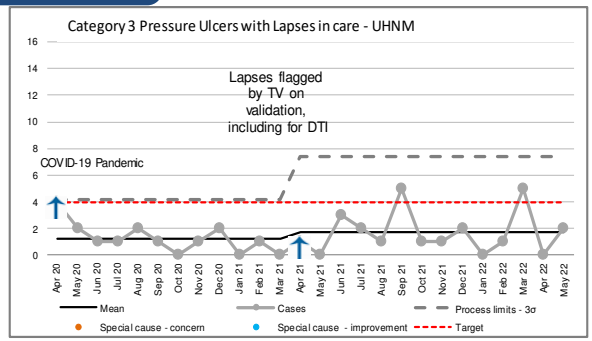
- Pressure Ulcer Prevention (PUP) education is now delivered on multiple platforms including the Nursing Assistant, adaptation nurse and Preceptorship induction programme , new starters in ED and child health. Mandatory ED training and ward PUP champions has been re-launched to cascade information. Education and support can also be requested as required. Summer conference for further learning happening in July
- 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.
- RCA process is under constant review for improvement and to support ward in learning
- Review of surfaces in ED to enhance Pressure ulcer prevention, 15 Stryker trollies with high quality pressure relieving mattresses have been purchased. ED repose companions have arrived and staff will receive training by June.
- 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



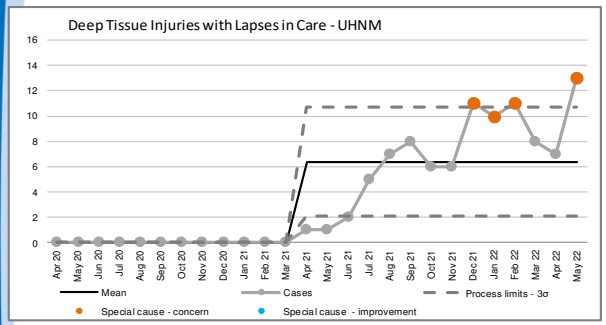
Variation	Assurance

Target	Mar 22	Apr 22	May 22
8	8	10	2
Background			



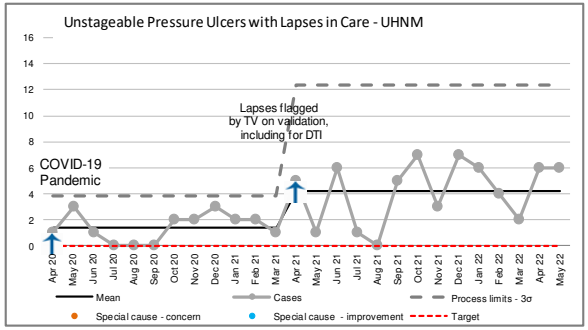
Variation	Assurance

Target	Mar 22	Apr 22	May 22
4	5	0	2
Background			
Category 3 pressure ulcers which developed under the care of UHNM with lapses in care associated			



Variation	Assurance

Target	Mar 22	Apr 22	May 22
N/A	8	7	13
Background			
Deep Tissue Injuries which developed under the care of UHNM with lapses of care associated			



Variation	Assurance

Target	Mar 22	Apr 22	May 22
0	2	6	6
Background			
unstageable ulcers which developed under the care of UHNM with Lapses in care associated			

What is the data telling us:

The number of pressure ulcers reported as developing under UHNM care with identified lapses in care is showing only normal variation in each of the categories .

As shown in the table below, the most common lapses identified was management of repositioning.

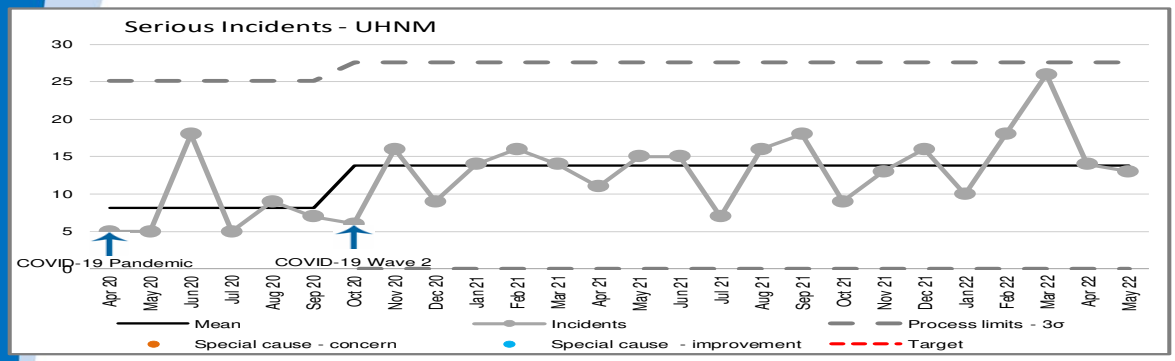
Root Cause(s) of damage - Lapses - May 2022	Total
Management of repositioning	14
Management of heel offloading	8
Management of device	3
Management of non-concordance	1

Locations with more than 1 lapse in May 2022 were:
Ward 225 (3), Ward 228 (2), Critical Care Pod 1 (2 cases for same patient - buttock 10/5, heel 17/5)

Actions:

- High reporting wards will be sent notification, with Hot Debriefs taking place on the wards, with audits and action plans to be implemented along this.
- 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.
- To plan a focus for lapses of repositioning
- Pressure Ulcer Prevention (PUP) Champions training dates have commenced, along with other training from the TV team
- Tendable audit questions completed which will support with RCA learning and 5 key questions which link into common RCA themes will be added to CEF

Serious Incidents per month

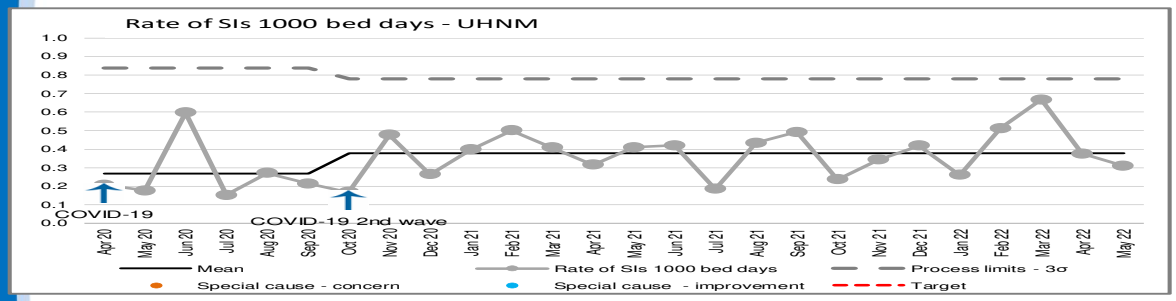


Variation	Assurance

Threshold	Mar 22	Apr 22	May 22
0	26	14	13

Background

The number of reported Serious Incidents per month



Variation	Assurance

Target	Mar 22	Apr 22	May 22
0	0.67	0.38	0.31

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. May 2022* saw 13 incidents reported:

9 Falls related incidents

1 Surgical/invasive procedure related

1 Diagnostic related

1 Blood product/transfusion related

1 Sub optimal care of deteriorating patient related

The rate of SIs per 1000 bed days has varied consistently within confidence limits indicating normal variation and there has not been any significant trends. The current rate of SIs per 1000 bed days for May 2022 is 0.31 and is below the long term mean of 0.4 since COVID-19 started in December 2020.

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

Serious Incidents Summary

University Hospitals of North Midlands NHS Trust

Summary of new Maternity Serious Incidents

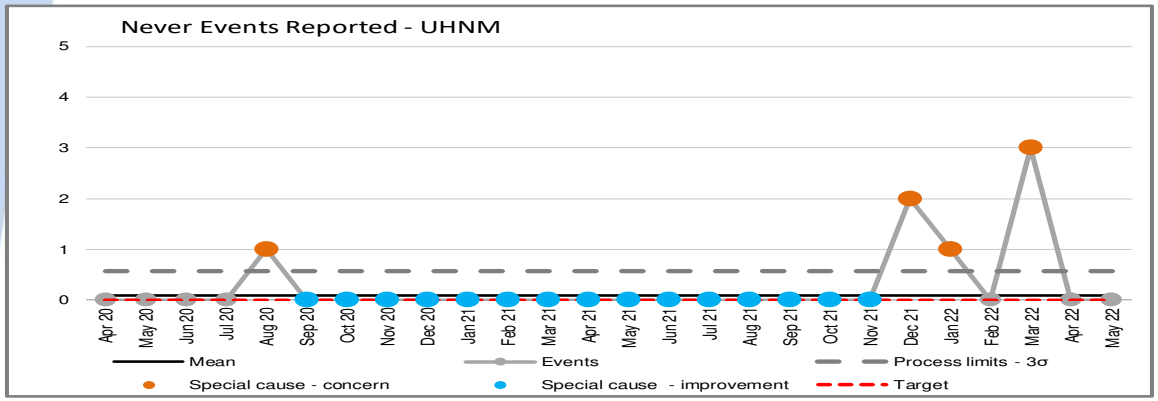
Following the formal recommendations in the Ockenden Report, below is an outline of the Maternity related serious incidents reported during May 2022. The new recommendation requires the Trust Board to receive summary on the new Maternity related Serious Incidents along with previously reported summary 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 May 2022

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

Never Events



Variation	Assurance

Target	Mar 22	Apr 22	May 22
0	3	0	0

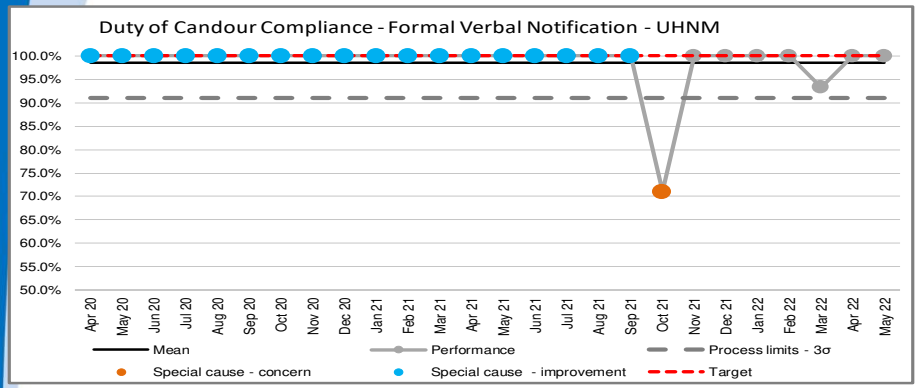
Background

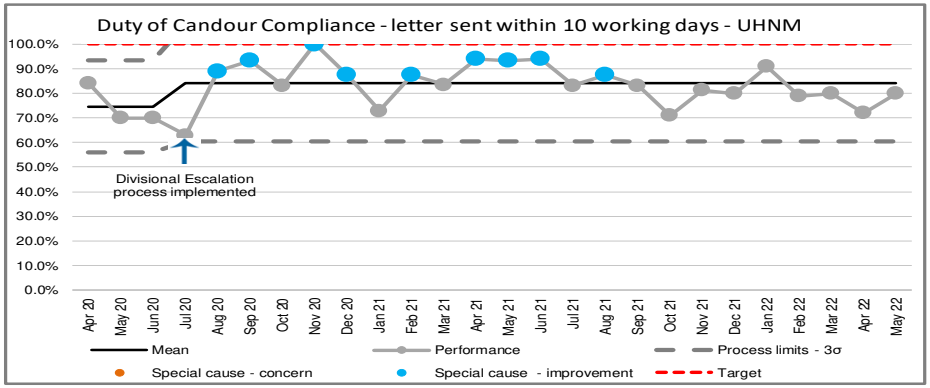
Defined as Serious Incidents that are wholly preventable, as strong systemic protective barriers should be in place

There has been 0 reported in May 2022 and 6 in total for 2021/22. The target is to have 0 Never Events.

Log No.	STEIS Category	Never Event Category	Description	Target Completion date

Duty of Candour Compliance





Variation	Assurance

Target	Mar 22	Apr 22	May 22
100%	93.3%	100.0%	100.0%

Background

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

Variation	Assurance

Target	Mar 22	Apr 22	May 22
100%	80.0%	72.0%	80.0%

Background

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

What is the data telling us:

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

Confirmed Follow up Written Duty of Candour compliance (i.e. receiving the letter within 10 working days of verbal notification) during May 2022 is 80%.

There were 2 cases where relatives/patient did not want any follow up letter and there are 2 cases awaiting update on Datix following incident report at end of May 2022.

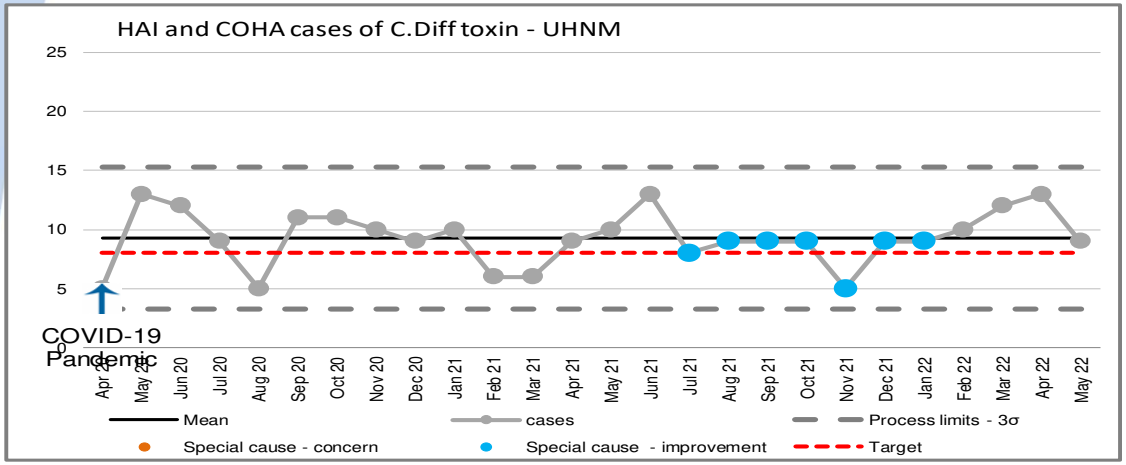
Actions taken:

The Divisions have escalated performance within their governance and performance forums and follow up with clinicians is being taken to ensure tat letters are provided within the timeframe. 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	Mar 22	Apr 22	May 22
8	12	13	9

Background

Number of HAI + COHA cases reported by month

What do these results tell us?

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

There have been 9 reported C diff cases in May with 7 being Hospital Associated Infection (HAI) cases and 2 COHA cases.

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

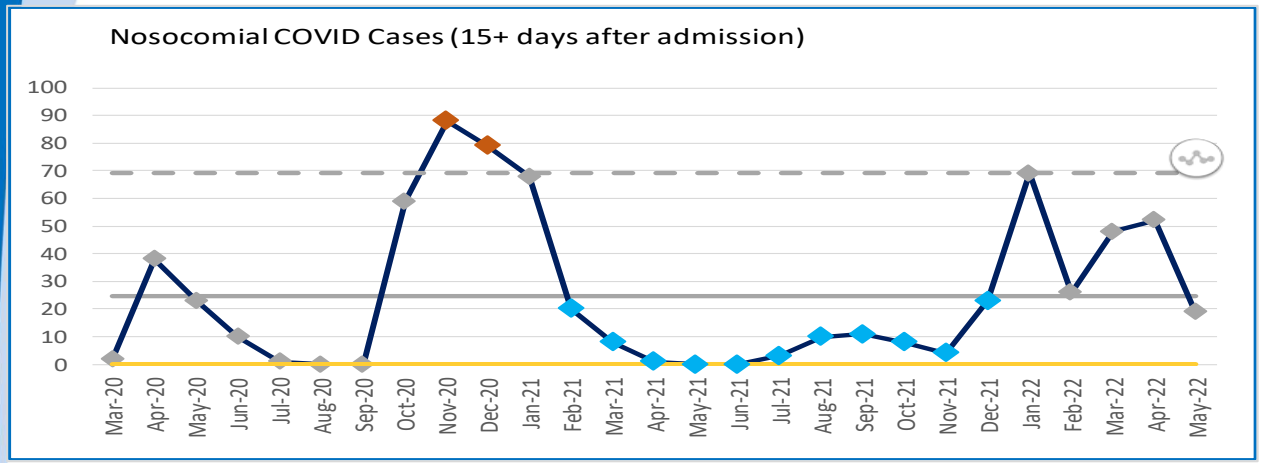
COHA: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks

There has been one clinical area that has had more than one Clostridium *difficile* case in a 28 day period. Ribotyping results have been reported however in one of the specimens CDiff was not grown by the testing centre so it is not possible to determine whether patient to patient transmission has occurred.

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?

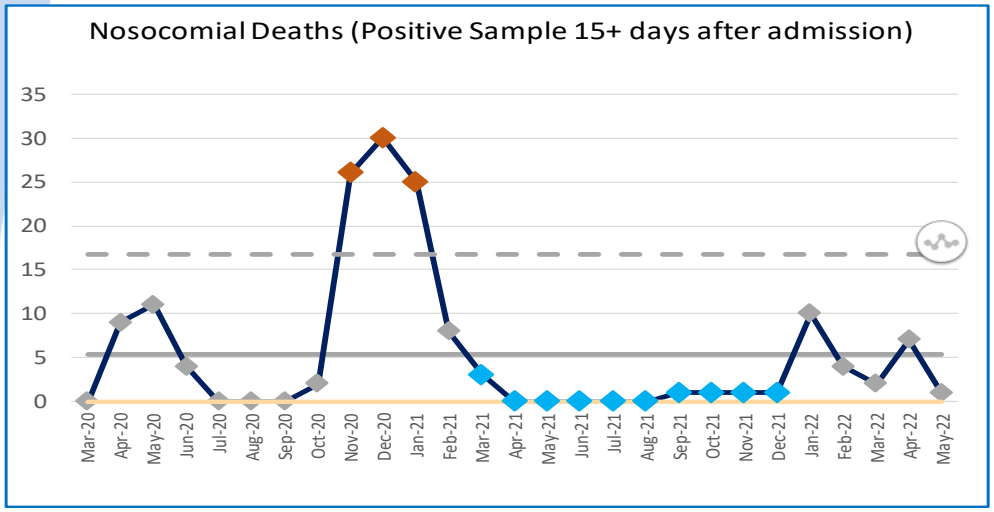
- Increase in cases throughout April 2022 with 51 definite Healthcare Acquired COVID -19 cases.
- May has seen decrease in Probable and definite Hospital Onset COVID
- Monthly total is within normal variation

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

	UHNM		
	Total Admissions	COVID cases	
		Prob	Def
Oct 20	17006	63	59
Nov 20	14956	109	88
Dec 20	14701	107	79
Jan 21	14255	128	68
Feb 21	14101	31	20
Mar 21	17105	12	8
Apr 21	16554	3	1
May-21	17273	0	0
Jun-21	18527	0	0
Jul-21	18168	4	3
Aug-21	17160	14	10
Sep-21	17327	11	10
Oct-21	17055	8	8
Nov-21	17700	4	4
Dec-21	16688	13	23
Jan-22	16109	67	69
Feb-22	16278	39	26
Mar-22	18518	71	48
Apr-22	16538	72	52
May-22		14	19

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



What do these results tell us?

Decrease in monthly total but within normal variation limits

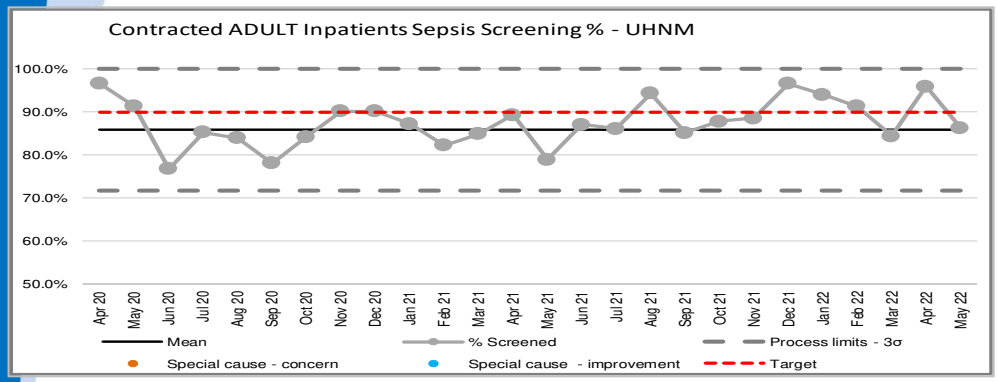
The criteria for the Definite Hospital acquired/Nosocomial COVID-19 is that the patient had **first positive** COVID-19 swab result 15 days or more following admission to UHNM.

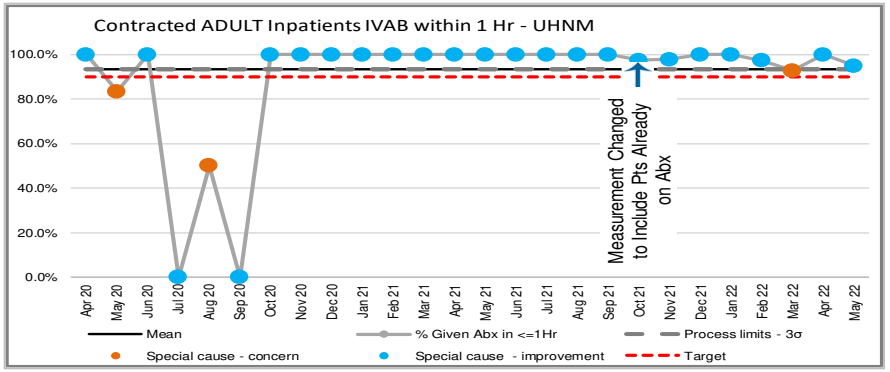
- 1 recorded definite hospital onset COVID-19 deaths in May2022
- Total 144 hospital acquired COVID-19 deaths with 1st positive results 15 days or more following admission recorded since 1st March 2020 up to 31st May 2022
- 20 Definite Hospital acquired COVID-19 deaths during 2021/2022
- The mean number of deaths per month since March 2020 is 6.

Actions :

All definite Nosocomial COVID-19 deaths up to March 2022 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)





Variation	Assurance

Target	Mar 22	Apr 22	May 22
90%	84.4%	96.0%	86.3%

Background

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

Variation	Assurance

Target	Mar 22	Apr 22	May 22
90%	92.9%	100.0%	95.0%

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 failed to achieve the screening target in May 2022. There were 95 cases audited with 13 missed screening.

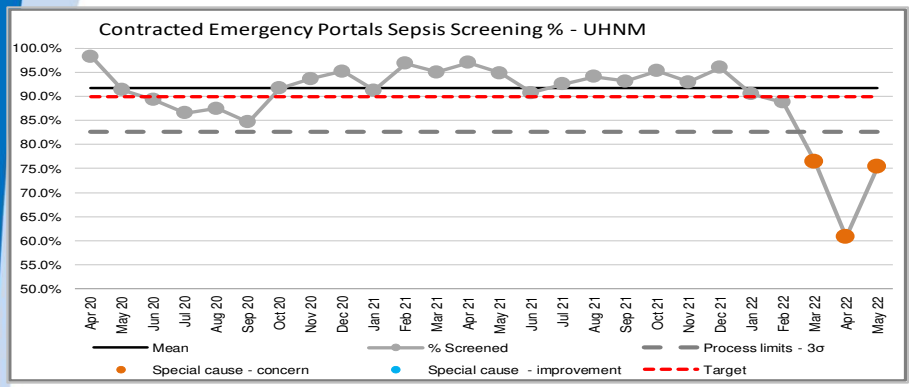
IVAB within 60 minutes was above target rate with consistently high results. Out of 95 cases audited, 76 cases were identified as red flags sepsis with 36 cases have alternative diagnosis and 40 cases were true red flags. Out of 40 true red flags cases, 37 were already on IVAB treatment, 1 given within 1 hour and 2 delayed treatment (1 given within two hours and 1 above two hours).

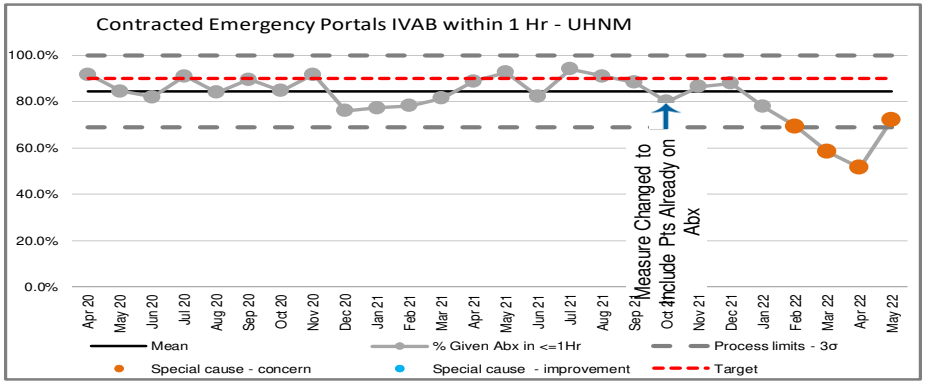
Actions:

- The Sepsis team have continued to focus on providing ward based sepsis session/kiosks on targeted clinical areas
- The Sepsis team regularly identify areas of poor compliance and prioritise those areas for more focused sepsis re-enforcement: on-going
- The Sepsis team continued to work closely with the VitalPac team in order to address issues in timely manner and work in sepsis vitals upgrade is 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, students and new nursing staff induction programmes: on-going

Sepsis Screening Compliance (Emergency Portals Contract)

NHS University Hospitals of North Midlands NHS Trust





Variation	Assurance
L	?

Target	Mar 22	Apr 22	May 22
90%	76%	61%	75%

Background

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

Variation	Assurance
L	?

Target	Mar 22	Apr 22	May 22
90%	58%	51%	72%

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:

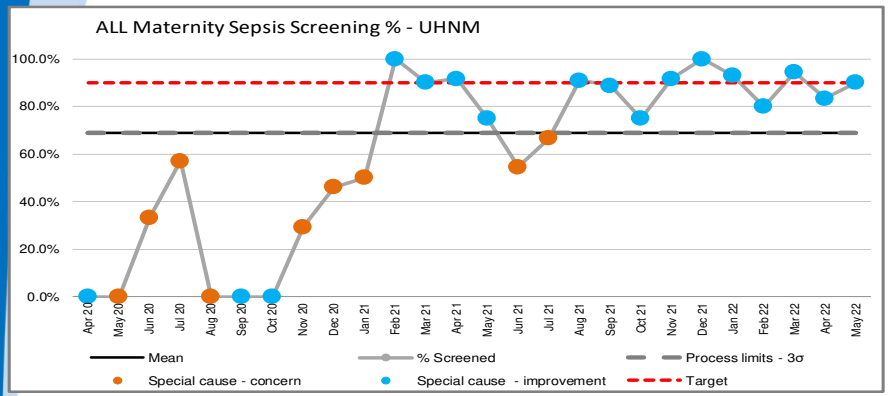
Adult Emergency Portals screening below target for May 2022 but has improved compared to April 2022. There were 61 cases audited with 15 missed screening in total from 3 of the emergency portals.

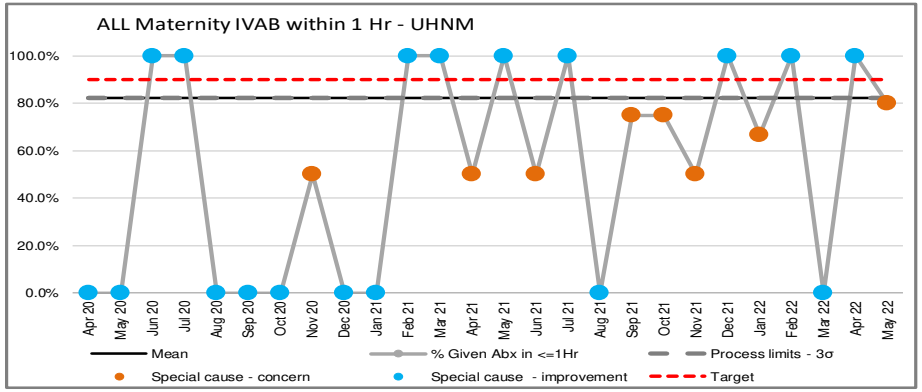
The performance for IVAB within 1hr below target rate in May 2022 at 72%. Out of 61 cases, there were 52 red flags sepsis in which 11 cases already on IVAB, 25 cases were newly identified sepsis and 16 cases have alternative diagnosis. There were 9 delayed IVAB with 4 cases delayed within 2 hours and 5 cases above 2 hours.

Actions:

- The Sepsis team continued to closely monitor compliance by visiting and auditing A&E regularly. Provide sepsis session when staffing and acuity allows: on-going
- The Sepsis team is working collaboratively with the A&E Quality nurses, sepsis champions, senior team and A&E sepsis clinical lead to provide support with late IVAB incidents. The screening documentation and late IVAB have been addressed through escalation however, on-going plan to resolve issue with holding ambulances remain the challenge .
- Face to face A&E sepsis induction for new nursing staff, nursing assistant and medical staff will recommence once capacity pressure/flow improve in the department
- Regular meeting with A&E senior team reinstated to review current robust actions in place

Sepsis Screening Compliance ALL Maternity





Variation	Assurance
H	F

Target	Mar 22	Apr 22	May 22
90%	94.4%	83.3%	90.0%

Background

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

Variation	Assurance
L	F

Target	Mar 22	Apr 22	May 22
90%	N/A	100%	80%

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 above the mean rate with meeting the target performance with 90% in May 2022. There were 20 cases audited from both Emergency portal and Inpatients areas with 2 missed screening.

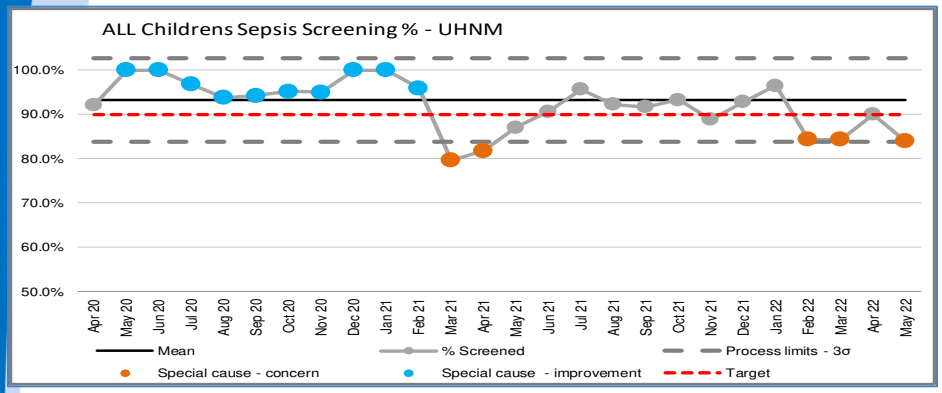
80% of the red flag sepsis patients identified in the May 2022 audits achieved IV antibiotics within an hour.

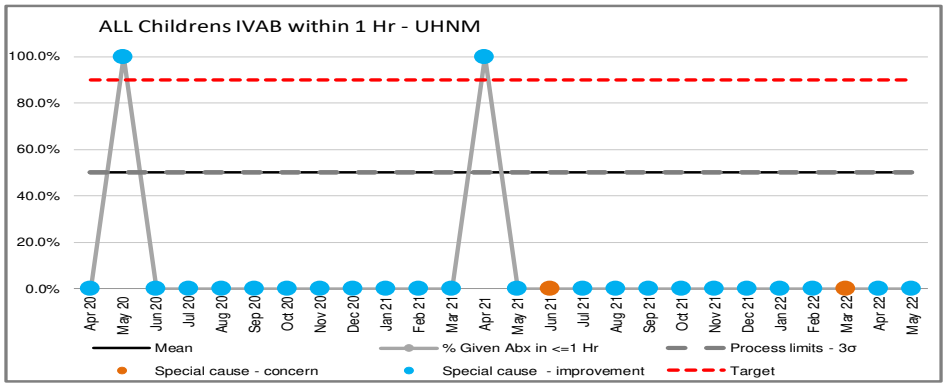
Actions:

- 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 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
- PGD for sepsis led by Maternity educator/team is underway and this will be supported by the sepsis team, micro consultant, pharmacist and sepsis clinical lead
- Future plan for Maternity 5 hour sepsis CPD champion training remain in the pipeline however, has been temporarily put on-hold due to current operational pressures

Sepsis Screening Compliance ALL Children

NHS University Hospitals of North Midlands NHS Trust





Variation	Assurance
L	?

Target	Mar 22	Apr 22	May 22
90%	84.4%	90.0%	84.0%

Background

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

Variation	Assurance
H	F

Target	Mar 22	Apr 22	May 22
90%	0.0%	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 variation at lower process limit with 3 out of the last 4 points at lower process limit for Sepsis Screening. Previously achieved the target rate but not consistently achieving the 90% rate and recent months indicate that there is need for improvement.

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).

There were a total of 50 cases audited for both emergency and inpatients areas with 8 missed screening. IVAB within 60 minutes was not applicable as no red flags sepsis identified from the 50 cases.

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; on-going
- 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 but plan to reinstate in the next few months

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

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

- May saw an increase in Type 1 attendances to 14800. Attendance numbers have not been seen at this level since August 2021.
- 4 hour performance remained static to 62.5% which is a positive given the increase in attendances.
- The 12 hour delays in the department reduced to 400 in May which is much lower than experienced in previous months, this was on the back of operating at EMS level 2 for most days in the month and an increase seen in pre noon and simple discharges.
- WTBS remained relatively static month on month although this is a maintenance of a poor position and is expected to improve as the ED Workforce embeds.
- Ambulance handovers remain a challenge however delays over 60 minutes have been reduced to their lowest levels since October and have almost halved since last month.
- The Non-Elective Improvement Programme PMO Lead post was advertised in May with interviews planned for June for approval for interim support in place. This post will provide project management, governance, and transformational support across all three workstreams and will support a more consistent and cohesive approach to the delivery of the programme as a whole.
- Refreshes of all workstreams continue to develop and be positively received with an overarching drive to ensure a consistent, data driven, and targeted approach to operational improvements and transformational change management.
- May saw improvements across a number of critical metrics underpinned by a reduction in occupancy. The focus for next month will be on maintaining this momentum and finalising workstream refreshes.

Cancer

- Most recent submitted Cancer Waiting Times position is April 22. The May 22 position is a performance prediction which will be impacted as histology results confirm a cancer or non cancer diagnosis for patients treated.
- Both Skin and Breast have a recovery plan for 14 day first appointment. Breast have improved their target days from 45 to 30 and are commissioning extra activity to remove the remaining backlog. Skin have improved from 36 to 28 days but have stabilised so plan for short term extra capacity and longer term reduction in demand including Telederm.
- The 104+ backlog has increased this month to 157. 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. 25% of the 104+ backlog is within Colorectal and 25% is with Skin. Colorectal delays are being supported by COO and the Clinical director to produce a robust plan.
- In May 22, the proportion of patients waiting over the key standard, 62 days to treatment, was 12% which is 2% better than the regional average. This is a maintained position since last month.
- The 14 day position for May 22 is predicted to achieve in the region of 41%. However the trust saw around 200 more patients than the previous month despite the bank holiday. Breast delays are improving but the top priority is an improvement plan for Colorectal.
- The 28 Day Faster Diagnosis position is currently at 59% with the majority of breaches currently recorded in Colorectal, Breast and Skin.
- There are currently 657 patients in the 2WW backlog. Of the 2WW patients who have breached, 171 patients are in Colorectal and 221 are in Skin.

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 has shown a marked improvement, up to 92% in May from 86% in April. Elective Activity delivered 96% BAU in May up from 86% in April. This is still some way from the national ask of 110%.
- Theatre plan for Q1 2022/23 gives 104% of 19/20 capacity. County theatre re-opened 11th April – all 7 theatres now online. The aim is to increase to 104% activity compared to 19/20 levels.
- A combined site focus on Theatres, by booking ahead, ensuring all lists are fully used and only for the most urgent and longest waiting patients is being enabled by a revitalised "6-5-4" weekly meeting which will continue to increase theatre throughput. County Theatres moved from 97% to 111% of 2019/20 capacity from April to May, and Royal Stoke moved from 86% to 98% giving a total move from 88% to 100% and reflecting the strategy of maximising County for elective work.
- Modular theatre has now received final approval from the board, enabling the Trust to increase activity to the 110% national ask and beyond by end of 2022/23.

RTT

- The overall Referral To Treatment (RTT) Waiting has started to stabilise throughout May. For April the indicative number of Incomplete pathways has risen to 76,023, but decreased to in 75,858 in May. This is the first decrease since Summer 2020.
- The number of patients > 18 weeks has decreased to 34,928 –the first decrease since Autumn 2021.
- At the end of May the numbers of > 104 weeks was 159 (un-validated) - a decrease of almost 50% from 314 in April. The Planned Care group is monitoring progress against treatment plans for these patients. The Trust will achieve the national standard of all eliminating 104 week waits end of June, with the allowed exception of those patients who have chosen not to be treated in June or are too complex to have their treatment arranged during June. There remains a residual risk of last minute cancellations which are being rapidly rebooked.

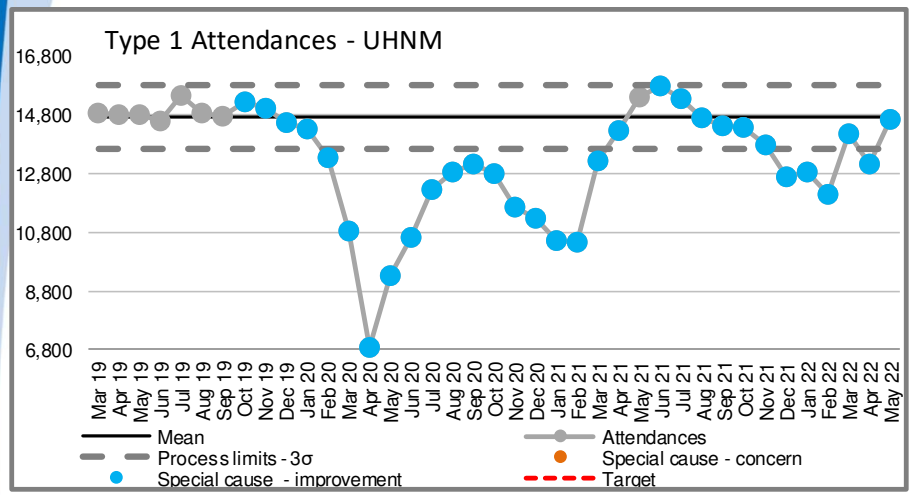
Diagnostics

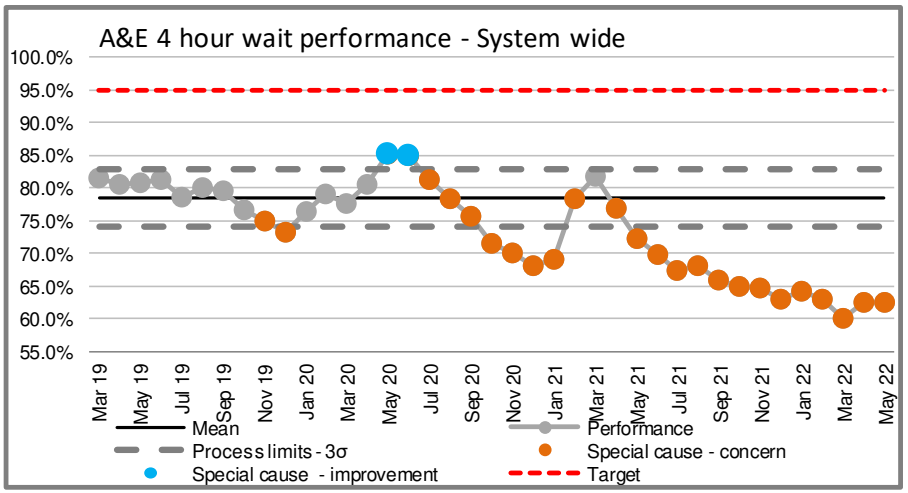
- Histology turnaround times remain a high risk; there is an action plan in place both for increased staff in post to remove block delays and improved reporting through put which is improving the position. Cancer related histology is being treated urgently and all cancer related escalations are being prioritised and the escalation process is in place allowing the cancer team to directly access patient data.
- 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. The Non-obstetric ultrasound waiting list decreased from 9,631 to 9,930. A viable insourcing company for non-obstetric ultrasound scanning is being progressed to business case, and if supported will deliver Non-Obs Ultrasound at 4 weeks by January 2023.
- Plain film is also an area with a high volume of waiters, predominantly due to staffing shortages.
- Walk in centres for P/F MSK starts in July. Walk in centres for all other P/F will start in August, which will give capacity for immediate imaging from referral and will allow decisive recovery for P/F waits.
- The Diagnostic Cell is progressing solutions for ensuring that annual / planned patients are reflected correctly against their RTT pathway.
- Endoscopy remains a high risk areas, with a recovery plan in place, and medium term plans to outsource triaging to reduce endoscopies.

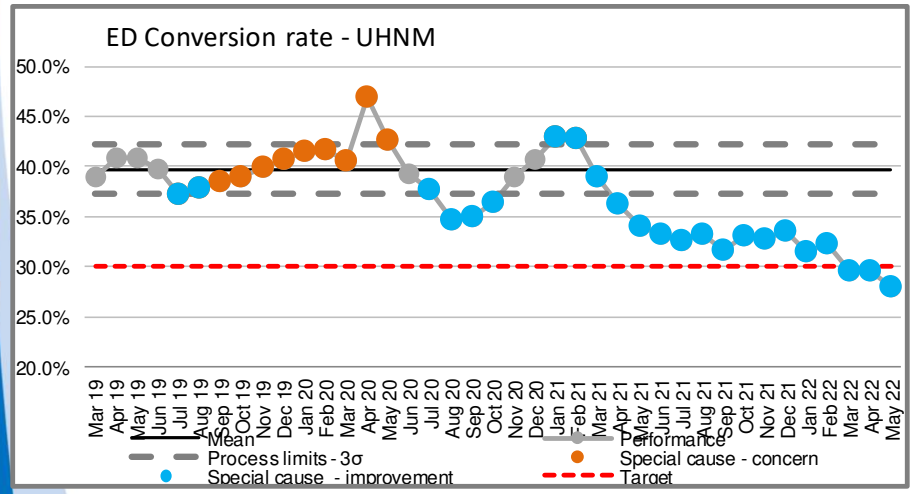
Section 1: Urgent Care

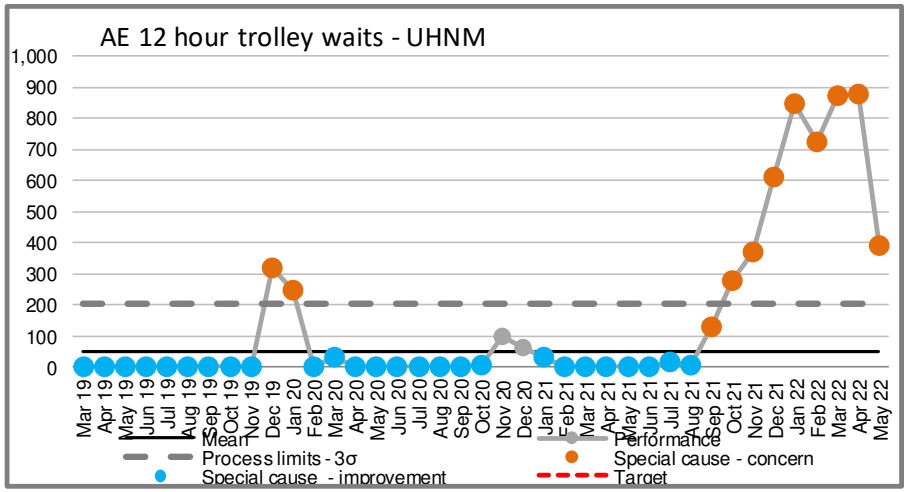
Headline Metrics

Urgent Care – monthly *(context)*



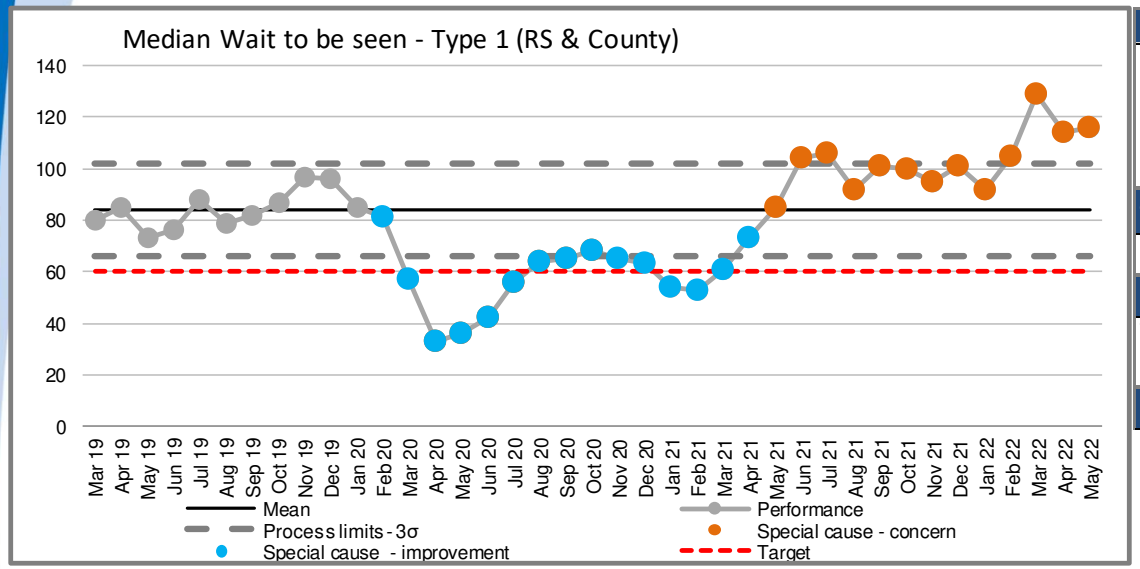






WTBS & 12 Hour in department

NHS University Hospitals of North Midlands NHS Trust



Variation	Assurance
H	F

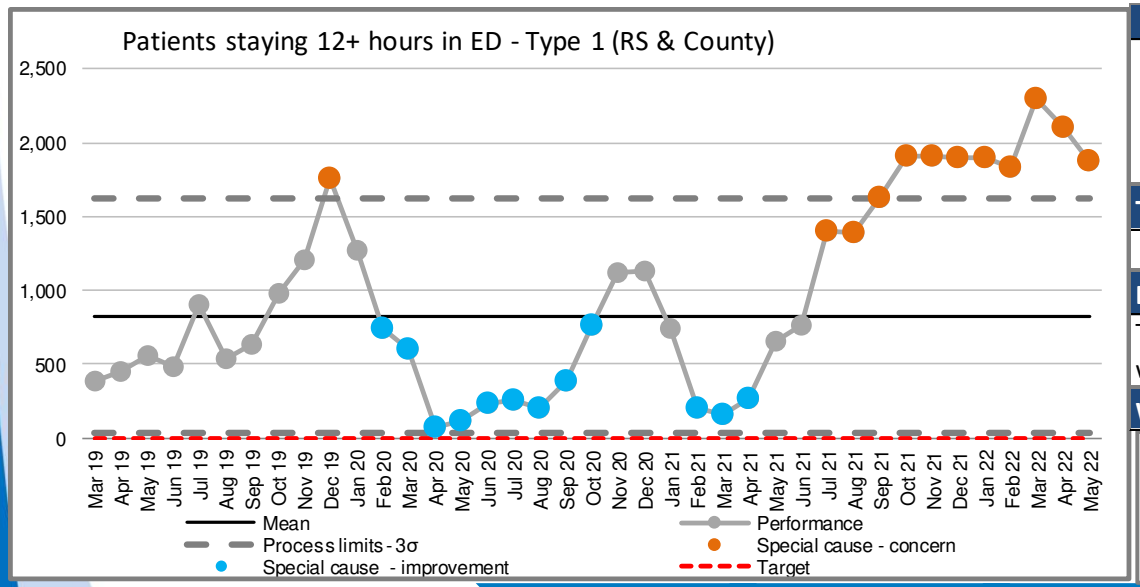
Target	Mar 22	Apr 22	May 22
60	129	114	116

Background

The average (median) time in minutes for a patient to be first seen

What is the data telling us?

Wait to be seen has increased over the last 12 months with the last 4 months being above the upper control limit



Variation	Assurance
H	F

Target	Mar 22	Apr 22	May 22
0	2292	2106	1877

Background

The number of patients admitted,transferred or discharged with in 12 hours of arrival at A&E

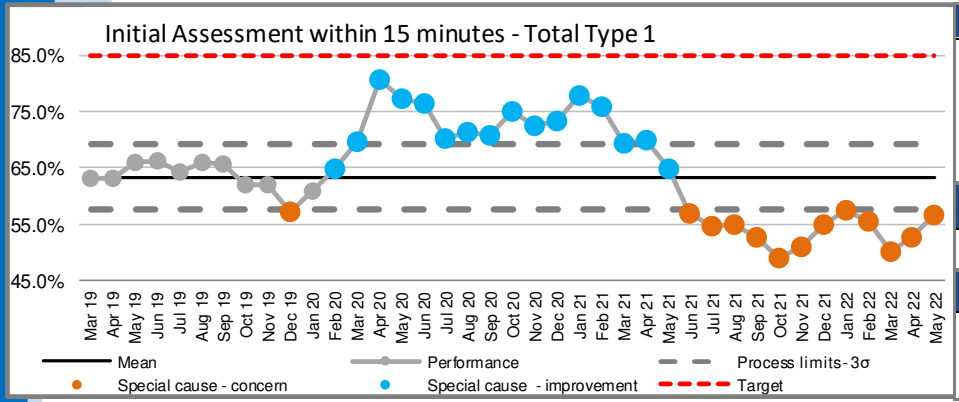
What is the data telling us?

The number of patients waiting over 12 hours has increased significantly over the last 12 months. With 8 points sitting above the upper control limit

Section 1: Urgent Care

Workstream 1; Acute Front Door

Time To Triage, Ambulance Handover, & Non admitted average time



Variation	Assurance
L	F

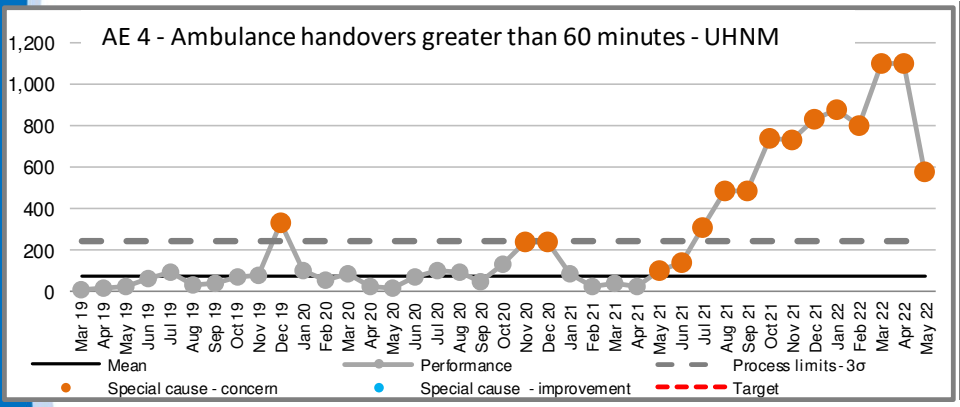
Target	Mar 22	Apr 22	May 22
85%	50.2%	52.5%	56.5%

Background

The Percentage of patients attending Type 1 A&E, triaged within 15 minutes of arrival

What is the Data telling us?

Performance remains below the 1920 lower control limit at 56.5% in May. This is back at the level seen at the beginning of last summer.



Variation	Assurance
H	?

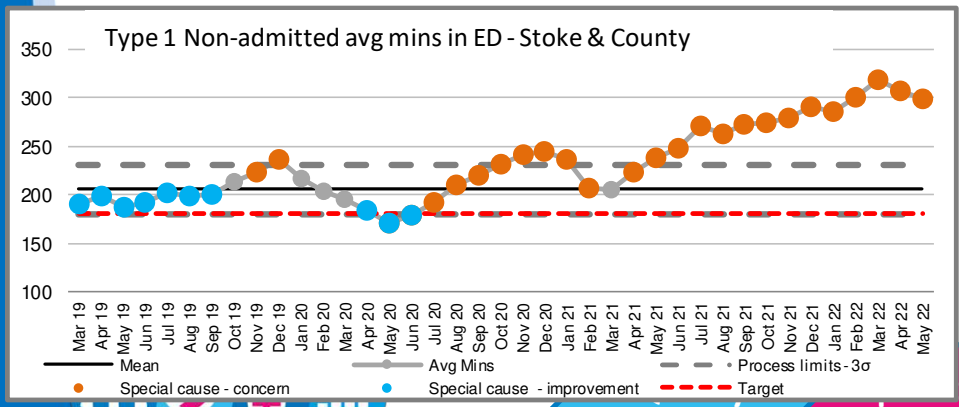
Target	Mar 22	Apr 22	May 22
0	1100	1097	577

Background

The number of ambulance handovers greater than 60 mins

What is the Data telling us?

Handover delays over 1 hour have risen dramatically over the last 12 months with the last 11 data points sitting outside of the control limits of 201920



Variation	Assurance
H	?

Target	Mar 22	Apr 22	May 22
180	318	307	299

Background

The mean time spent in A&E department for patients not admitted to an inpatient bed

What is the Data telling us?

Mean time in department has been increasing since March 2021. The last 12 month data points have been outside of the control limits set using 2019/20

Time To Triage, Ambulance Handover, & Treatment

University Hospitals of North Midlands NHS Trust

Summary

- Time to initial assessment has improved further last month since the recently appointed Triage Nurses have commenced in post and is at 56.5% total for Type 1 attendances. This improvement in triage represents the maintenance of safety in the ED despite ambulance handover delays.
- Ambulance handovers remain a challenge however delays over 60 minutes have been reduced to their lowest levels since October and have almost halved since last month.
- Despite ongoing ambulance handover delays the triage of patients arriving via ambulance within the 15 minute standard is at 70% in month and is the highest performance seen in recent months.
- The average time in department for non-admitted patients has now stabilised and has seen modest reductions for its second month in a row.

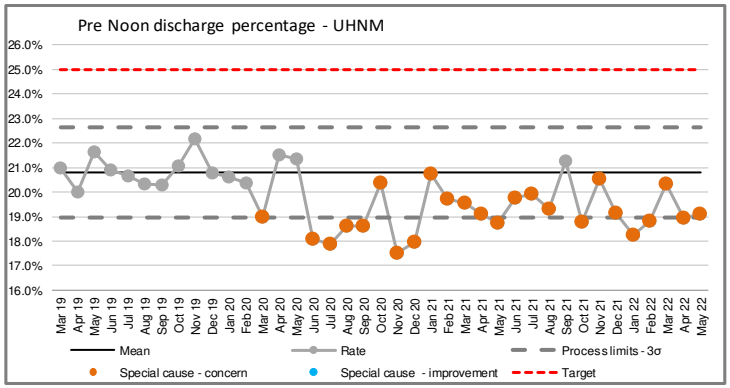
Actions

- ED weekly meeting in place from June to track through remaining vacancies from both the ED Medical Workforce and EhPC Business Cases. This meeting will also review roles to ensure appropriate skill mix recruited.
- Bi-weekly meetings continue with DAD – UEC and Head of Patient Flow for WMAS to continue to improve working relationships.
- ED Tiered Medical Rota has been developed and is to go live in June 2022. This will provide a clear and accessible picture of medical and Senior Decision Maker coverage in the ED. There is further development required to enable the rota to show proportional fill rate of medical staffing on shift.
- Review of ED layout post social distancing to ensure best distribution of workforce and space for efficiency has been completed with a paper to be submitted to Execs for formal approval.
- There is a Focus Week planned for Medicine with aims of a refreshed new Transfer of Care form to reduce delays, improve patient experience, and increase pre noon discharges.

Section 1: Urgent Care

Workstream 2; Acute Patient Flow

Pre-Noon, Simple & Timely, & Occupancy



Variation	Assurance
L	F

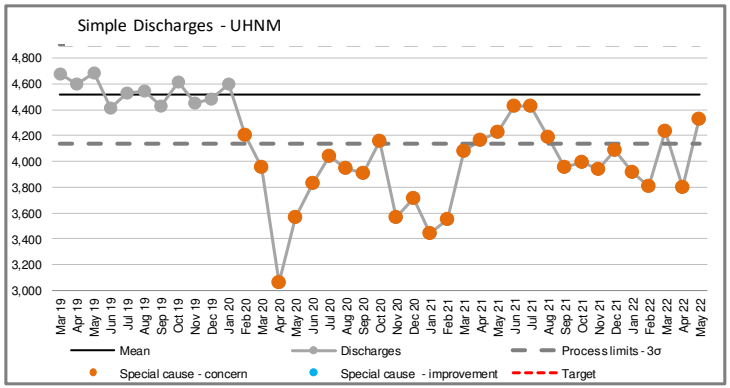
Target	Mar 22	Apr 22	May 22
25%	20.3%	19.0%	19.1%

Background

The percentage of discharges complete before 12 noon.

What is the data telling us?

Pre noon discharges have been below the 1920 mean for the last 8 months triggering the cause for concern SPC rule.



Variation	Assurance
L	

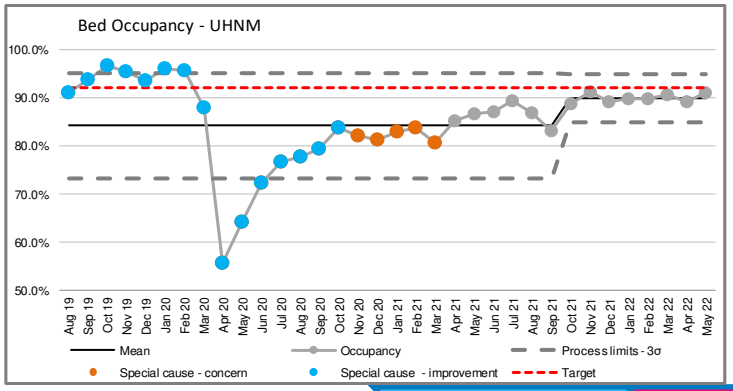
Target	Mar 22	Apr 22	May 22
N/A	4234	3798	4327

Background

Patients discharged without complex needs

What is the data telling us?

Simple & timely discharges are below pre pandemic levels and have moved in line with bed demand



Variation	Assurance
	?

Target	Mar 22	Apr 22	May 22
92%	90.7%	89.2%	91.2%

Background

The percentage of general and acute beds occupied overnight at UHNM

What is the data telling us?

COVID had a significant impact on bed occupancy however the last 7 months have been fairly consistent averaging 89%.

Pre-Noon, Simple & Timely, & Occupancy

NHS
University Hospitals of North Midlands
NHS Trust

Summary

- Pre noon discharges and overall bed occupancy continue to remain at a relatively static level. Having said that, occupancy has varied in month and continues to be a barometer of flow through the hospital and subsequently the level of risk held in the ED.
- The number of Simple & Timely discharges has seen a gradually improving trend since September with a notable improvement seen from April to May.
- The renewed focus on areas to support continues with the greatest opportunities for improvement being identified via data analysis of NHS Trust in our peer group. This will allow for more focussed improvement work which will then be rolled out in a tiered fashion. The results of this analysis will be available for sharing in next month's report.

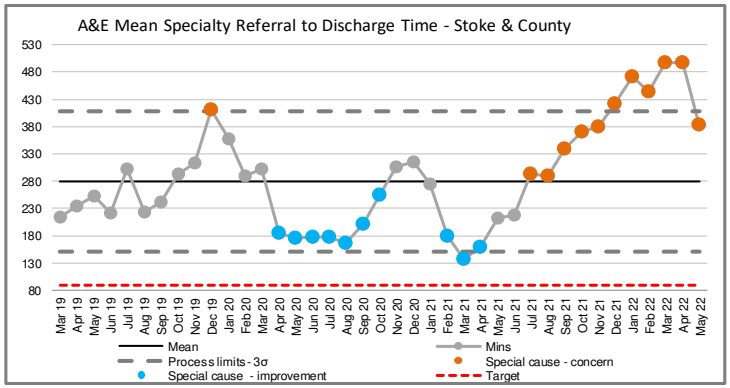
Actions

- Complete peer analysis to identify areas of greatest opportunity to ensure focussed improvement efforts.
- Refresh Workstream 2 Improvement Plan projects to ensure operational and transformational improvements and not BAU performance management.
- Plan to share Step Change Project learning across medical Division planned by the end of August.

Section 1: Urgent Care

Workstream 3; Delivering UEC Standards

CRPT+1, SDEC Utilisation, & Mean Time In ED



Variation	Assurance
H	F

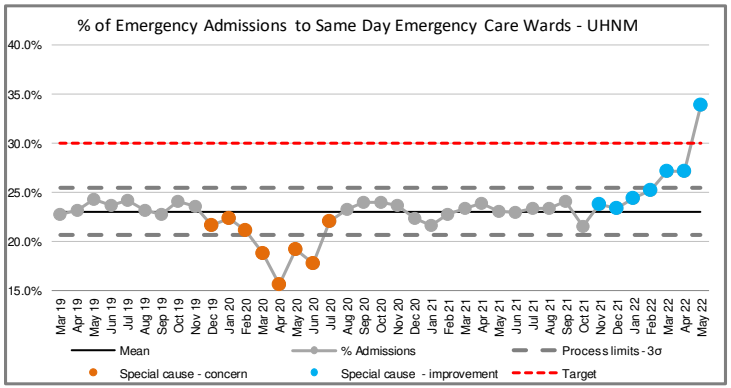
Target	Mar 22	Apr 22	May 22
90	497	498	383

Background

The average time from the ED referral to a specialty to discharge from the ED

What is the data telling us?

The average time from referral to discharge has increased since March 2021. May 2022 has seen a dramatic improvement of over 100 minutes vs April/March.



Variation	Assurance
H	F

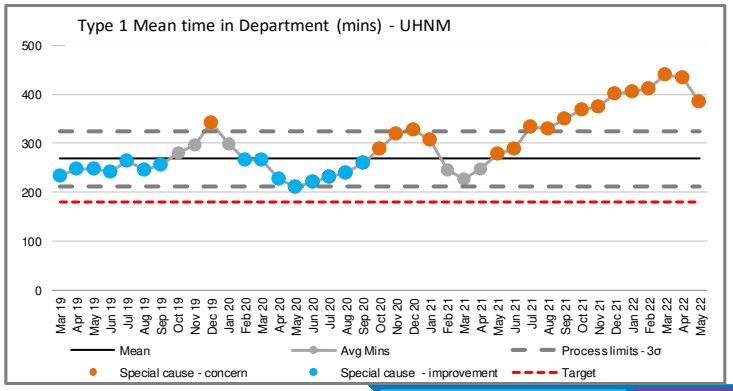
Target	Mar 22	Apr 22	May 22
30%	27.1%	27.1%	33.9%

Background

% of emergency admissions that are admitted to the Trust's SDEC wards, and discharged within 24 hours

What is the data telling us?

The Trust has been consistently in line with pre pandemic proportions of patients going through SDEC with the last 4 months seeing a significant increase up to 34% in May.



Variation	Assurance
H	F

Target	Mar 22	Apr 22	May 22
180	441	435	385

Background

The mean time (in minutes) spent in the A&E department

What is the data telling us?

Total time in department has been increasing since March 2021 with the last 8 data points sitting above the control limits. May 2022 is the first clear improvement for 14 months.

CRTP+1, SDEC Utilisation, & Mean Time In ED

NHS
University Hospitals of North Midlands
NHS Trust

Summary

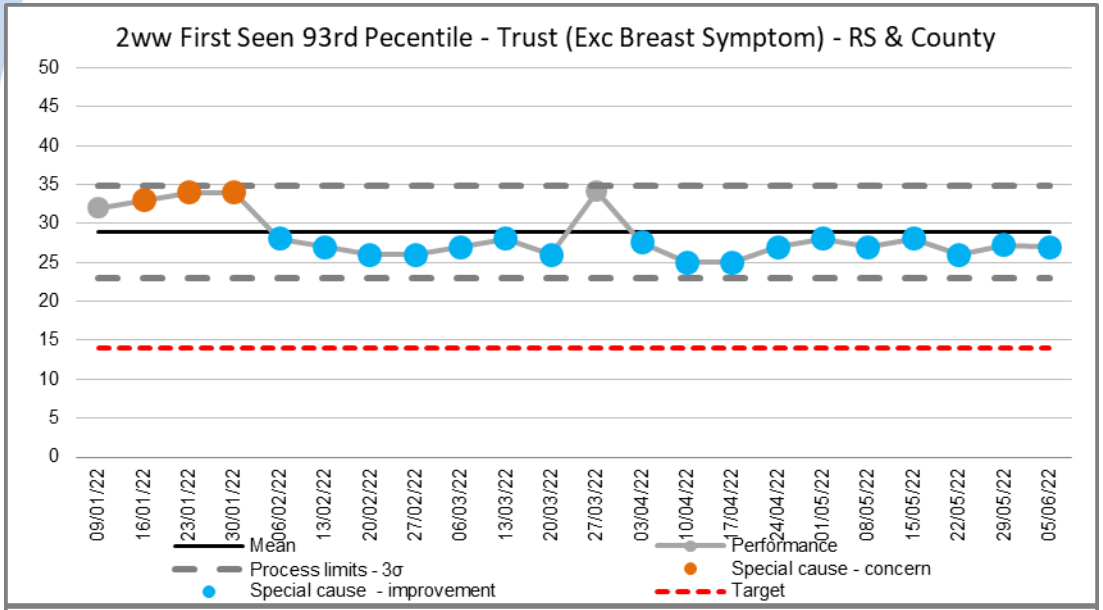
- It has been pleasing to see SDEC numbers rise further to a record 34%. These increase will in part have been impacted with the changes made at Navigation in ED and empowering staff to direct GP referrals to SDEC areas directly.
- While improvements are demonstrable from last month the proxy measure for CRPT+1 and mean time in the ED remain at relatively high levels. It is expected that improvements seen at the front door, including the introduction of the Nurse Navigator role and EHPC service will continue to precipitate improvements as they continue to embed and develop from next month and beyond.

Actions

- Workstream 3 structure is being redesigned in line with the development of the corporate projects and A3 development.
- Workstream leads are being appointed and Task & Finish Groups re-focused with the aim of driving the improvements to reduce 12 hour waits in ED and increase of patients moving from ED when CRTP has been applied.
- User testing of the AE to Ward dashboard with acute clinical/ward colleagues planned in June with the aim of the dashboard go live date by end of June.
- SAU digitalisation meeting took place in May 2022 (will support SAU having e-referrals from ED and live view of surgical patients awaiting care in ED). Further meeting in June planned with clinical leads to develop electronic referrals.

Section 2: ELECTIVE CARE

Cancer – Headline metrics



Variation	Assurance
L	F

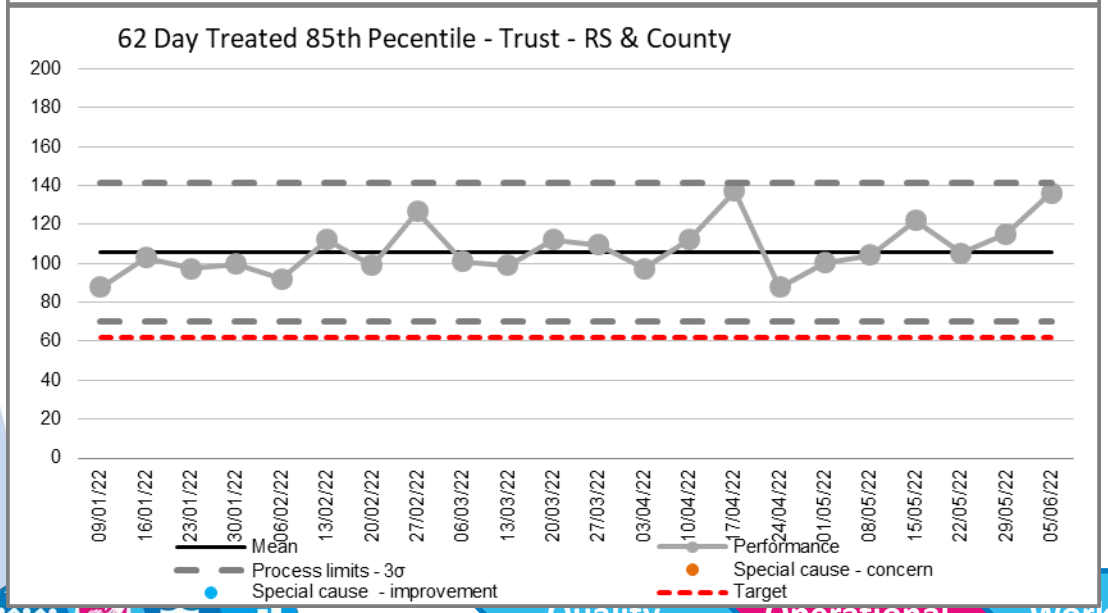
Target	May 22	May 22	Jun 22
14	26	27	27

Background

The standard is for 93% of patients to be seen within 14 days. This SPC demonstrates within which day 93% of patients were seen on across all tumour sites.

What is the data telling us?

Trust wide – all suspected cancer 2WW referrals. Excluding Breast symptomatic referrals where cancer is not suspected.
93 % of patients first seen for week ending 05/06 had a 14 day clock stop within day 27 of the pathway.



Variation	Assurance
	F

Target	May 22	May 22	Jun 22
62	105	115	136

Background

The standard is for 85% of patients to be seen within 62 days. This SPC demonstrates at which day 85% of patients were treated on.

What is the data telling us?

Trust wide – across all GP referred suspected cancer tumour sites :
85 % of patients treated on a 62 day pathway for week ending 05/06 were treated within day 136 – far higher than the target of 62 days.

Cancer

Summary

- Diagnostic delays on going in pathology. Endoscopy have recovered the position with most patients dated within 7 days.
- Most challenged pathways are Breast, Colorectal and Skin – breakdown within percentile graphs on following slides.

Actions

Diagnostics:

- Pathology: Elective Recovery Funds have been used to commission a benchmarking service that provides a comparative analyses of Pathology activity. The analysis looks at volume, case-mix and complexity of specimens and highlights opportunities to introduce standardisation, consolidation, or conformance with best practice. Although focused on routine testing activities, the efficiencies gained within the lab is expected to contribute to the overall recovery of TATs, that have been impacting cancer pathways.
- Endoscopy: on-going recovery means that activity is running at pre-pandemic levels. The dept have reduced number of days taken to investigation scheduled – meaning now most patients are dated within 7 days. A new external provider is being commissioned to continue reduction of the backlog, commencing in July.

Skin:

- The transformational delivery unit (TDU) of the ICS are supporting a system wide meeting looking at delivery of GP initiated Teledermatology. Learning from and implementing best practice from other areas, this system has been proven to reduce suspected cancer referrals by up to 20% - releasing capacity of specialists within the hospital to see most complex cases and improve waits for patients on a cancer pathway.

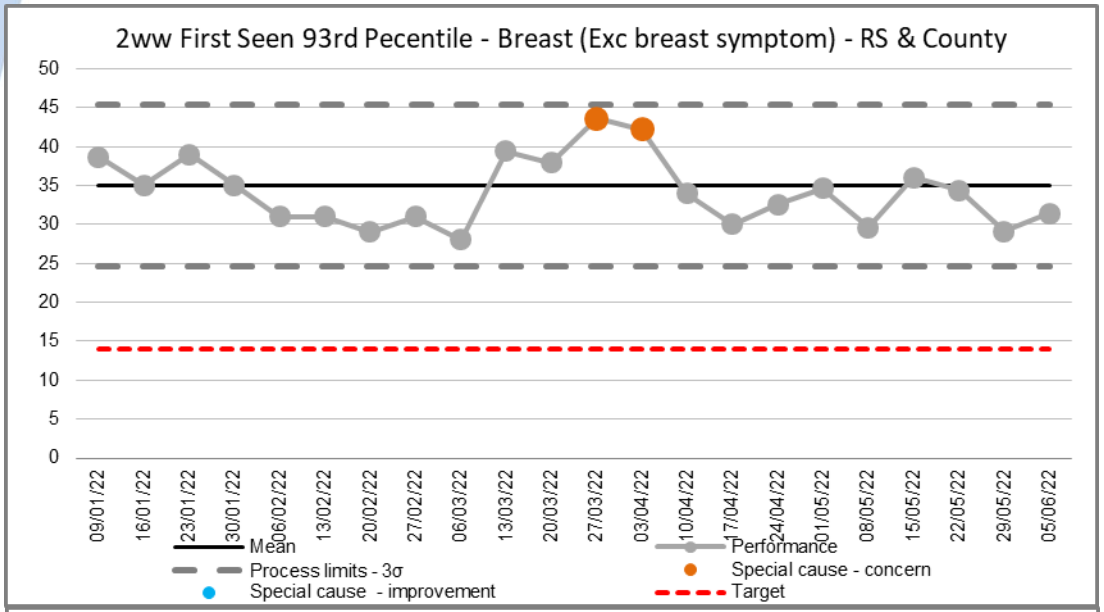
Breast:

- 18 week mobilisation meetings underway to commission extra activity to recover the backlog of patients waiting.
- The team are running extra clinics and clinically prioritising patients into relevant slots to ensure higher risk patients are seen sooner.
- Breast pain clinics in the community continue to run and increase throughput as the pilot progresses.
- Business case submitted describes the recovery and scheduled clinic capacity / slots volume to meet demand by September 22.

Colorectal:

- Demand management significantly challenged but the team are double booking clinical activity to ensure patients are triaged and can progress on the pathway.
- Private providers have been explored and the new directorate manager is conducting a whole service review to understand extra support needed – expected by the end of June.
- Cancer work is being prioritised however there is a risk that this leads to routine patients entering the suspected cancer route, as waits on routine pathways are extended.

Cancer



Variation	Assurance
	F

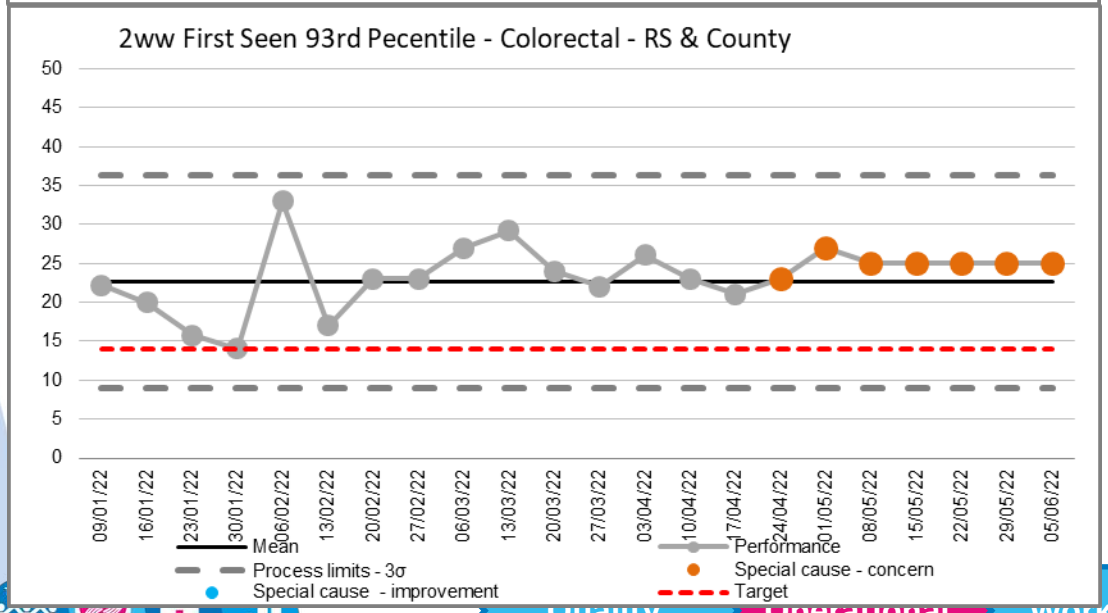
Target	May 22	May 22	Jun 22
14	34	29	31

Background

The standard is for 93% of patients to be seen within 14 days. This SPC demonstrates at which day 93% of patients were seen – who were referred on a suspected cancer Breast 2WW pathway.

What is the data telling us?

93 % of patients first seen for week ending 05/06 had a 14 day clock stop within day 31 on the suspected Breast cancer pathway.
This is an improving position.



Variation	Assurance
H	?

Target	May 22	May 22	Jun 22
14	25	25	25

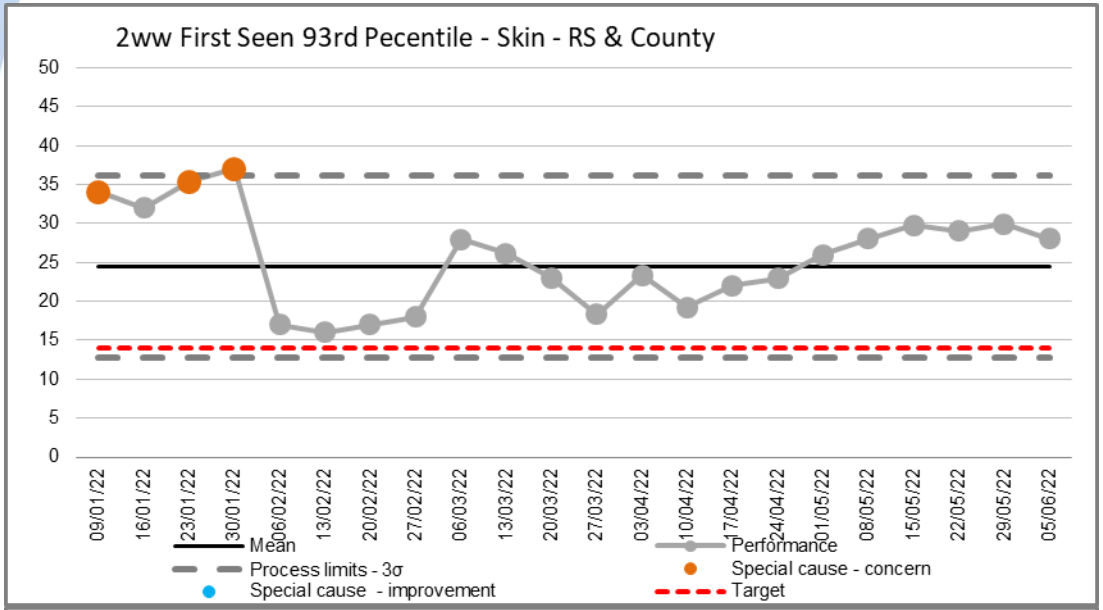
Background

The standard is for 93% of patients to be seen within 14 days. This SPC demonstrates at which day93% of patients received a 14 day clock stop – who were referred on a suspected cancer LGI 2WW pathway.

What is the data telling us?

93 % of patients first seen for week ending 05/06 had a 14 day clock stop within day 25 on the suspected LGI cancer pathway.

Cancer



Variation	Assurance

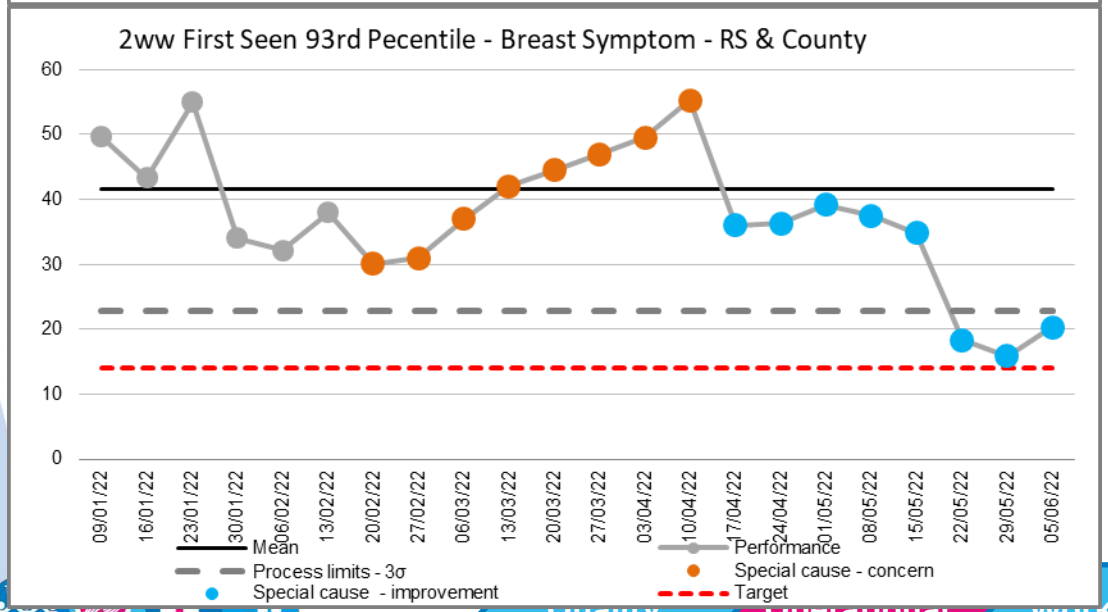
Target	May 22	May 22	Jun 22
14	29	30	28

Background

The standard is for 93% of patients to be seen within 14 days. This SPC demonstrates at which day 93% of patients were seen – who were referred on a suspected cancer Skin 2WW pathway.

What is the data telling us?

93 % of patients first seen for week ending 05/06 had a 14 day clock stop within day 28 on the suspected Breast cancer pathway.
This position has deteriorated significantly over the past 6 weeks as demand has increased and capacity has been impacted by bank holidays.



Variation	Assurance

Target	May 22	May 22	Jun 22
14	18	16	20

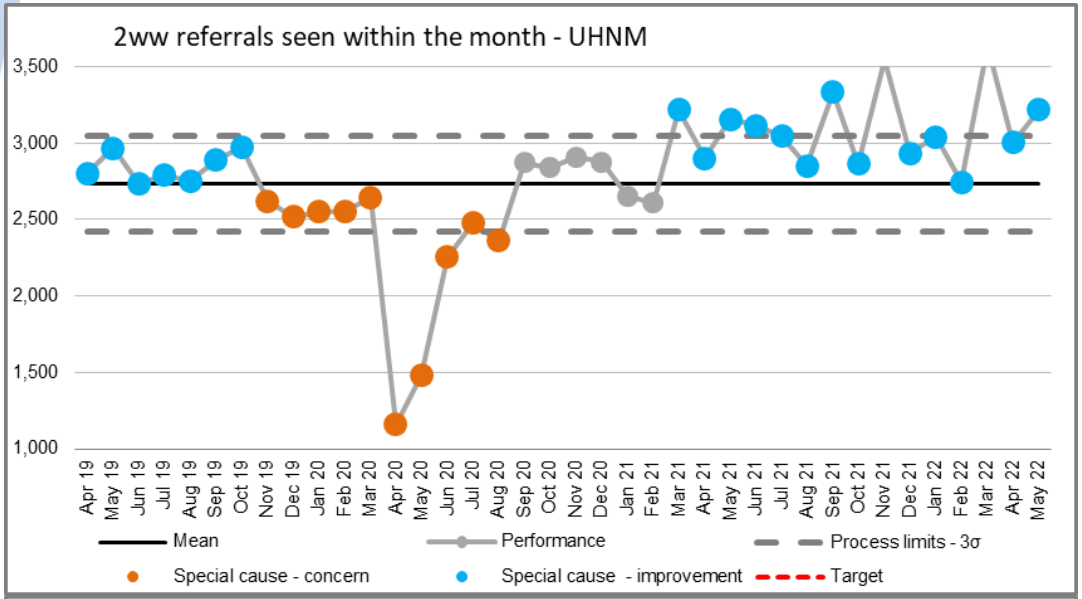
Background

The standard is for 93% of patients to be seen within 14 days. This SPC demonstrates at which day93% of patients received a 14 day clock stop – who were referred on Breast Symptomatic pathway

What is the data telling us?

93 % of patients first seen for week ending 05/06 had a 14 day clock stop within day 20 on the Breast Symptomatic pathway. These are patients where cancer is not suspected. The position has recovered within the past 2 months from a wait of 50+ days seen in March / April.

Cancer



Variation	Assurance
	

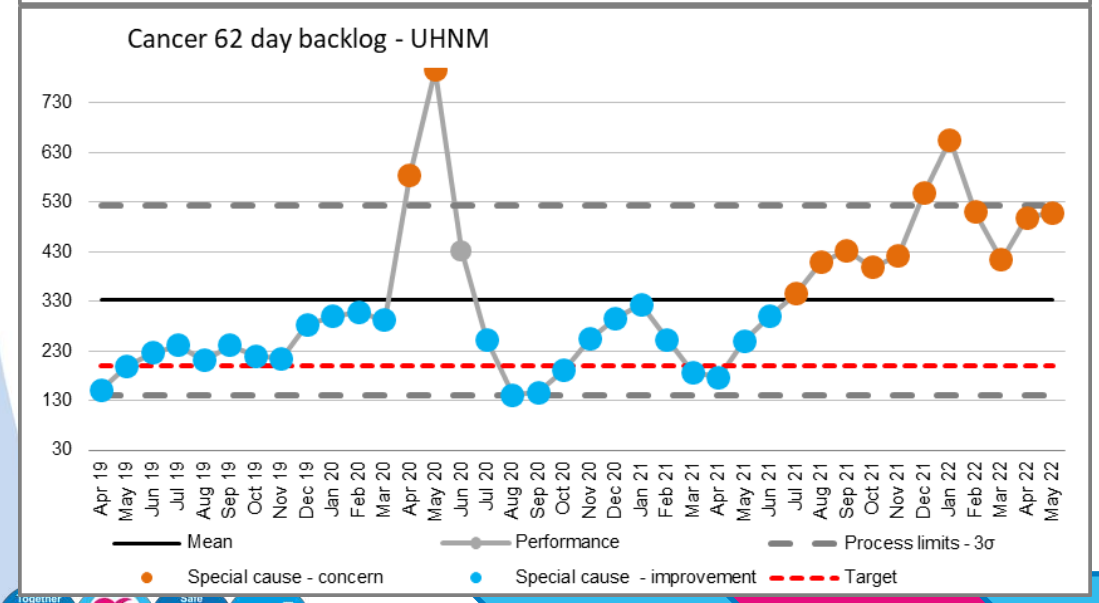
Target	Mar 22	Apr 22	May 22
N/A	3636	3003	3218

Background

Demonstrates the total volume of 2WW referrals seen in month

What is the data telling us?

The trust continues to see a high volume of 2WW patients per month – 3218 in May which is 215 more than the previous month.



Variation	Assurance
	

Target	Mar 22	Apr 22	May 22
200	414	498	509

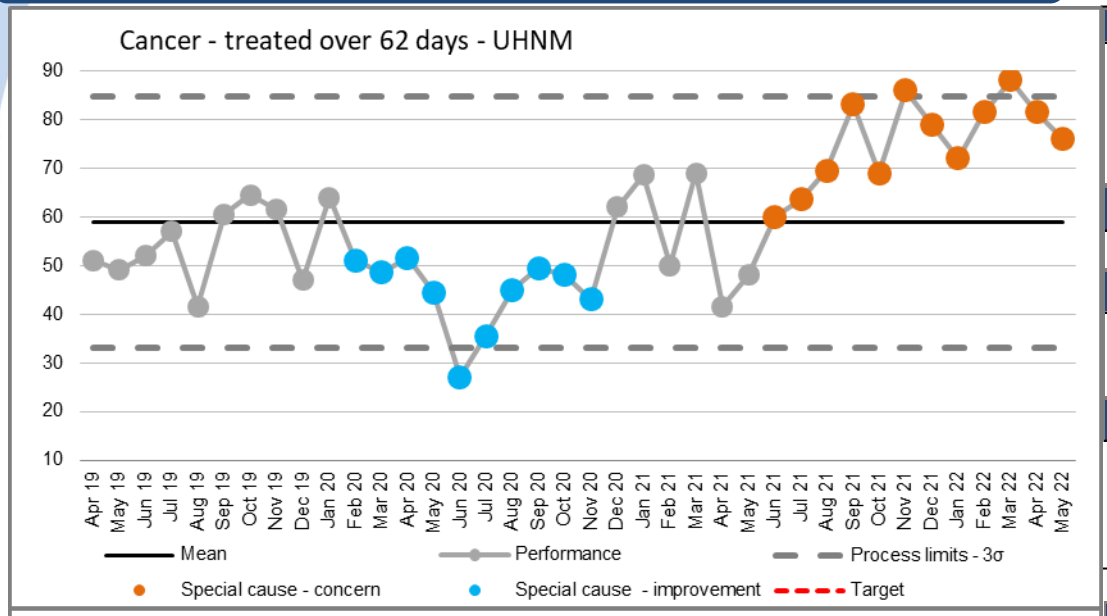
Background

This is the total number of patients waiting beyond 62 days without a future treatment date scheduled. The total may figure is taken from a snapshot of the final week in May.

What is the data telling us?

Although significant improvements were made in March to reduce the backlog, the May position has deteriorated – the number of patients within the 62 day backlog has increased slightly since last month and is off trajectory of 440 in May.

Cancer



Variation	Assurance
H	

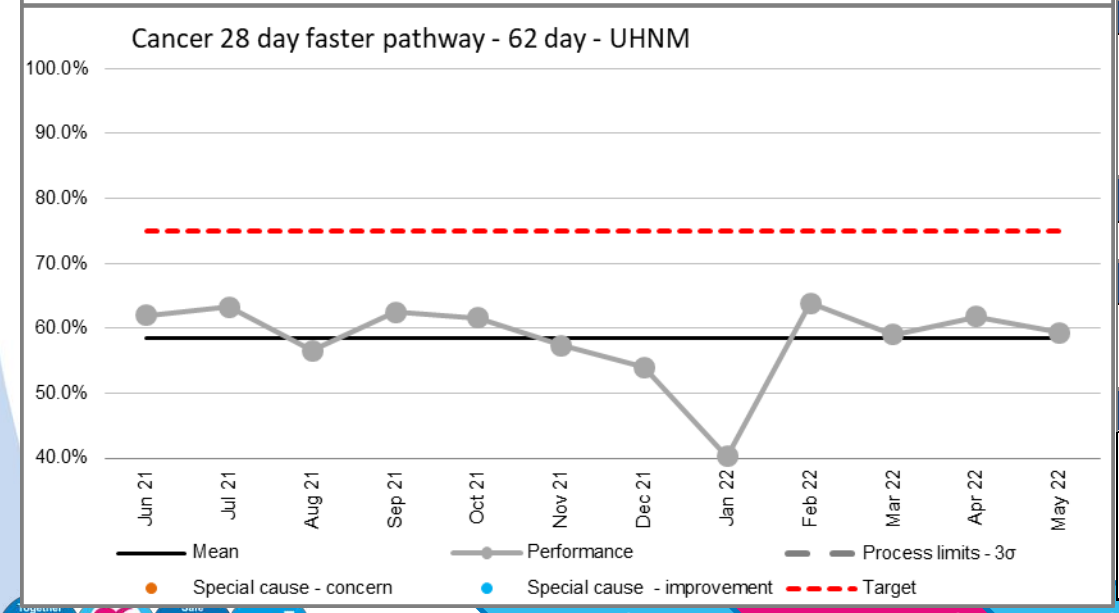
Target	Mar 22	Apr 22	May 22
N/A	88.0	81.5	76.0

Background

The number of patients treated over 62 days

What is the data telling us?

Demonstrates total volume of patients who have been treated beyond day 62 is a cause for concern and has been rising over the past 12 months.



Variation	Assurance

Target	Mar 22	Apr 22	May 22
75%	59.0%	61.8%	59.3%

Background

The precentage of patients who have reached a diagnosis by day 28.

What is the data telling us?

For the past 4 months performance has been above 60% - however this is still below the national standard of 75%

Cancer Trajectories

Provider Level					April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022	December 2022	January 2023	February 2023	March 2023
RJE	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	E.B.32	Count	The number of cancer 62-day pathways (patients with and without a decision to treat, but yet to be treated or removed from the PTL) waiting 63 days or more after an urgent suspected cancer referral excluding non-site specific symptoms	462	440	420	400	380	360	340	320	300	280	250	191
				UHNM Average Actual	533	509										

National planning guidance 22/ 23 set out the ambition to return the number of patients waiting over 62 days to the levels seen pre-pandemic. The trajectory for UHNM is set out above. For the month of May 2022, the average backlog position was 509 - this includes patients with a decision to treat and a future treatment date scheduled, however this is still 69 patients larger than the aim.

There are currently 657 patients in the 2WW backlog.
Of the 2WW patients who have breached, 157 patients are in Colorectal and 221 are in Skin.
The number of patients waiting over 104 days is 157. Of these, 39 are on a Colorectal pathway – 25%, 40 are on a Skin pathway – 26%.
There are 50 patients waiting over 104 days with a diagnosis of cancer. Of those, 9 are in Urology, 9 are in Breast and 6 in Skin.

Contributing factors include delays to pathology reports, urology robotic surgery due to capacity, complex pathways, increasing element of patient choice and outstanding clinical reviews. Divisions have been asked to focus on the backlog and discharge patients where appropriate – e.g. patients waiting over 104 days with an outstanding clinical review.

Planned care - *Inpatients*

University Hospitals of North Midlands NHS Trust

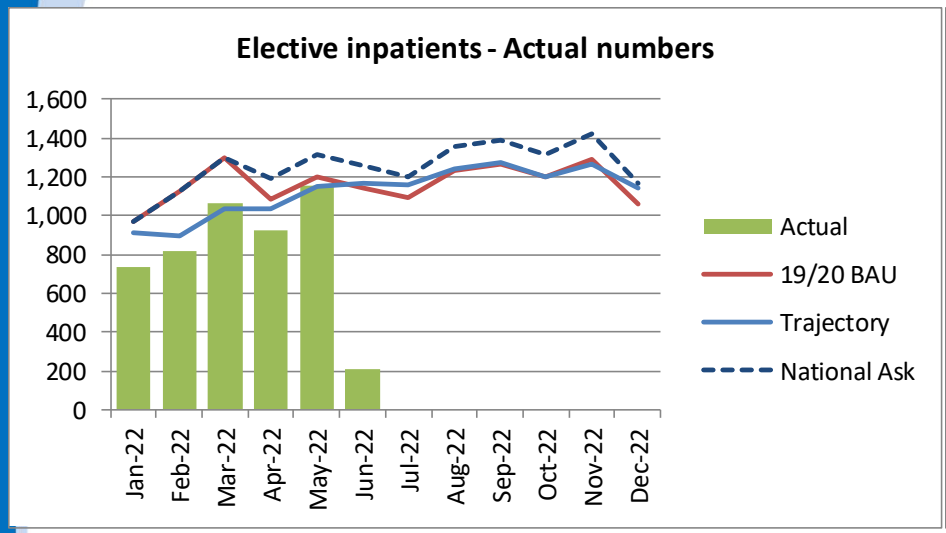
Elective inpatients Summary

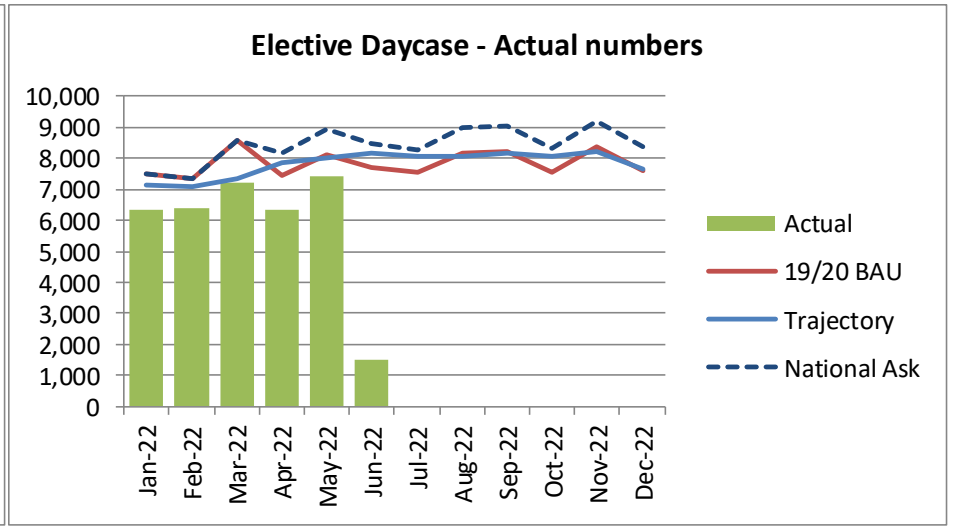
- Day Case and Elective Activity delivered 92% and 86% respectively for May 22 against the national ask of 110%, an improvement on March's position for Day Case (86%) and Electives (84.5%).
- At the end of May the numbers of > 104 weeks was 159 (unvalidated) - a decrease of almost 50% from 314 in April. The Planned Care group is monitoring progress against treatment plans for these patients. The Trust will not achieve the national ask of all eliminating 104 week waits end of June, but is forecast to be compliant with the ask to ensure any patients remaining are either complex or have chosen not to be treated in June.
- Insourcing arrangements at week ends continue and have been bolstered to provide more weekend capacity in T&O started Feb.
- Contracting arrangements for 2022/23 confirmed – extension of existing IPT contracts for Ramsay & Nuffield.
- Improvement in return of discharge summaries for subcontracted patients. All patients referred under ICF contracts expected to be completed end of June 2022.
- County and Royal Stoke Theatres have re-implented a "6-5-4" weekly operational meeting to ensure a higher proportion of available lists are fully used and to move capacity to the specialties most needing it. This also tracks and ensures bookings so that patients and staff are given more notice so cancellations and non-attendances can be driven down
- July 104 week patients are on track to be completed by mid-July as the focus moves to no 78 week waiting patients by March 2023

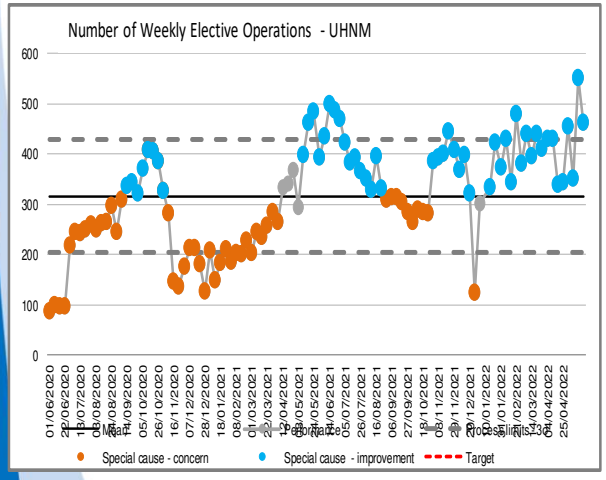
Actions

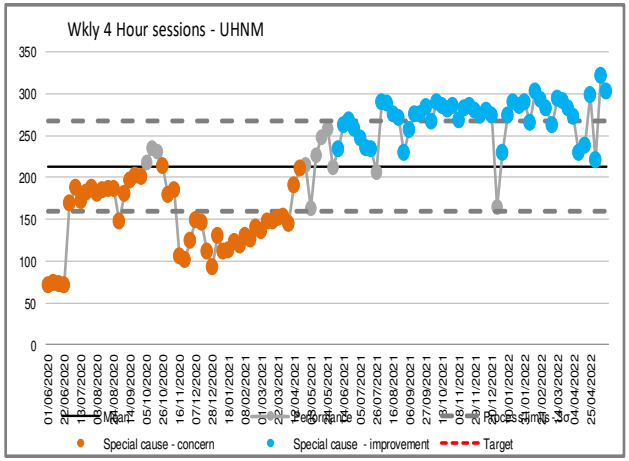
- External validation support commenced 21st March, focusing on long waiters, themes and trends.
- Demand scoping for 22/23 IS complete & shared with CCGs. Final numbers for capacity agreed.
- New electronic process for managing patients transfers to IS live and working.
- Trust wide revamp of validation & training underway, focusing on tracking long waiters, exposing and addressing bottlenecks in pathways. Phase 1 to deep dive training needs analysis. RTT Trainer now in post to commence work on Phase 1.
- Active reporting focus on ensuring the right patients (urgent and longest waiters) are the patients booked into all available capacity so that the limited resource available continues to be used for the right patients by clinical need
- Patient by patient monitoring by each specialty and by the corporate team on the small number of patients at risk of the end-June deadline for 104 weeks combined with forecasting for July and onwards
- Long wait focus moved to patients due to breach 104 weeks in Q2, with plans to eliminate 78 weeks by end of March 2023. Key enables are ring fencing of beds for Orthopaedics as RSUH, modular theatre at County and improvement in theatre utilisation and booking.

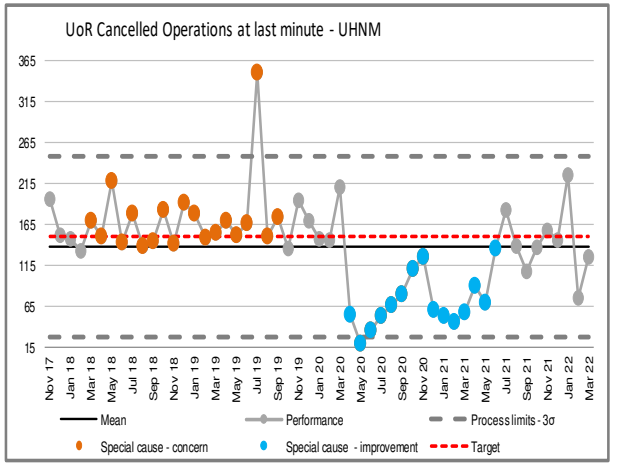
Planned care – *Inpatient Activity*











Planned care - *Outpatients*

NHS University Hospitals of North Midlands NHS Trust

Summary

- For April the total outpatient actuals against BAU for outpatients 98% New, 105% follow up.
- **Overall Waiting List;** 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 29/05/2022, total WL has increased further to 276K but now levelling off. Recent increases in the waiting list mainly attributed to Follow Up (Backlog).
- **>52 week patients;** 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 12,161 as 29/05/2022; small increase of 300 vs previous month.

RTT

- The overall Referral To Treatment (RTT) Waiting list has now started to stabilise. For May the indicative number of Incomplete pathways has decreased to 75,858 (April 76,023). A validation effort is increasing with extra recruitment to provide a more concrete picture of the clinical and administration resource required in the medium term to start reducing the list
- The number of patients > 18 weeks has decreased to a level of 34,928 (April 35,345)
- The numbers of 52 week waits in May has increased slightly with a total of 4,534 compared to 4,483 in April.
- At the end of May the numbers of > 104 weeks was 159 (unvalidated) - a decrease from 314 in April. The Planned Care group is monitoring progress against treatment plans for these patients.
- Performance has slightly decreased throughout May at provisional 55.29% (April 53.72%).
- Work plans around long wait patient validation and treatment tracking are in progress to support the Data Quality Strategy & Audit requirements.

Planned care - *Outpatients*

NHS University Hospitals of North Midlands NHS Trust

Actions

- OP Cell Programme Structure & TOR updated for 22/23 to reflect Elective Recovery Planning Guidance.
- **Workstream 3 Outpatient Waiting List Management & Reporting**
  - Outpatient Reviews - templates completed for March for New Waits (104+/78/52/18 wks), plus follow up backlog, PIFU, EAG & Non Face to Face. Long waiters in New Non-18 week category identified as issue. Clarifying & aligning recording & reporting requirements, seeking advice around specific cohorts from Elective Access Lead & Information Services. Clear actions confirmed relating to Cardiology anniversary patients.
  - Waiting List Validation plan being pulled together, to be shared for Divisional signoff.
  - 1m+ plans approved (March '22) from risk assessments, supports FTF activity increase where required; CAFs to be submitted to ensure managed.
  - SMS via Netcall targeting follow up backlog patients trialled successfully in derm & plastics. Netcall Partial Booking module purchased to facilitate similar approach for other specialties; urology & gastro first. Specialty/Outpatient process described, Rollout Plan being drafted, Netcall training to be scheduled as soon as available.
- **Workstream 1 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. Wider training plan being developed with ongoing input into Trust training considerations (systems & processes), and links to DQ group. Utilisation overview prepared.
- **Workstream 2 Outpatient Transformation**
  - **Enhanced Advice & Guidance** sub workstream (linking with system).

    ICS Referral Optimisation Steering Group set up, A3 being drafted to define the programme of work. Task & Finish Groups remain for Urology, Neurology, Respiratory and Gastro. Validating post referral A&G data with view to include this in June submission & to update the projected plan.
  - **PIFU sub-workstream** rolling out vs plan; divisional % PIFU Targets for 22/23 agreed with Divisions.

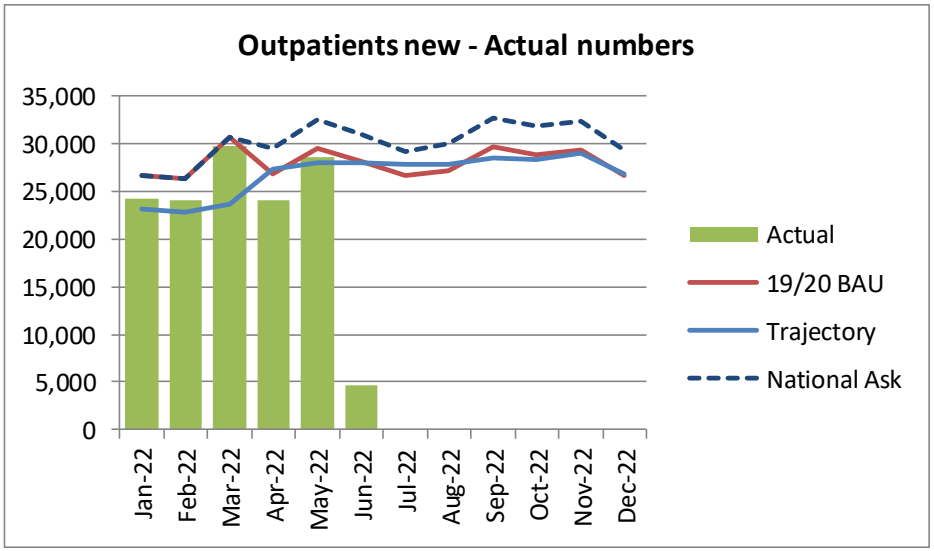
    Infrastructure; Review TOR for PIFU Implementation Group, progress Discharge to PIFU & Move to PIFU framework; iportal, Careflow, SOP, reporting, Review EHIA. Revision of terminology, communications plan drafted ahead of wider release.

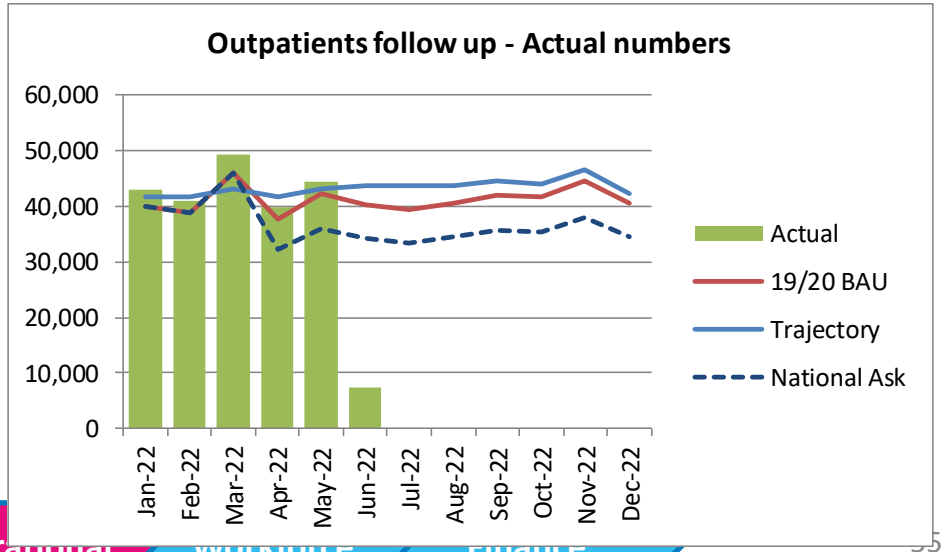
    Specialty Rollout Ahead of plan on rollout volume. From May now including midwifery, ophthalmology & endocrinology. Extending rollout in existing specialties, for example Sleep, IBD, T&O. On track for rollout for ENT, Sleep, Gynaecology & Child Health in June / July. Review Outcomes report with divisions & specialties to identify PIFU opportunities. Clinician Survey –results, fed back to Divisions.
  - **Virtual Care 25%;** SUS submission 'fix' implemented from Nov 2021 (with BI); longer term, alignment of clinic booking and media type outcomes.
  - **Patient Portal**; support provided to identify potential OP benefits, following demos from suppliers to a wide UHNM audience & patients.

Risks

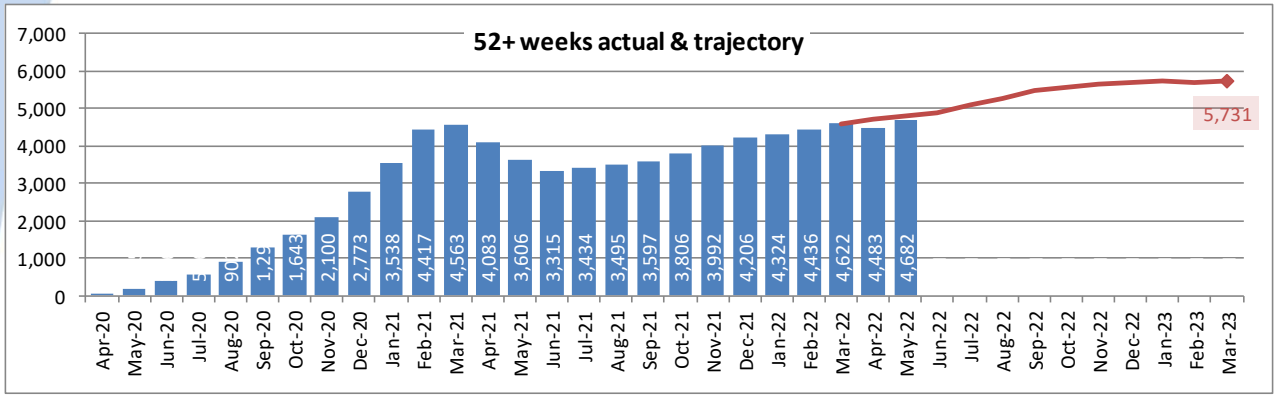
- Deteriorated waiting list position vs pre-covid; volume of patients requiring DQ and clinical validation very challenging, on Divisional Risk Registers.
- Clinical Validation requirement; risk of achieving vs resources available.

Planned care – *Outpatient activity & RTT*

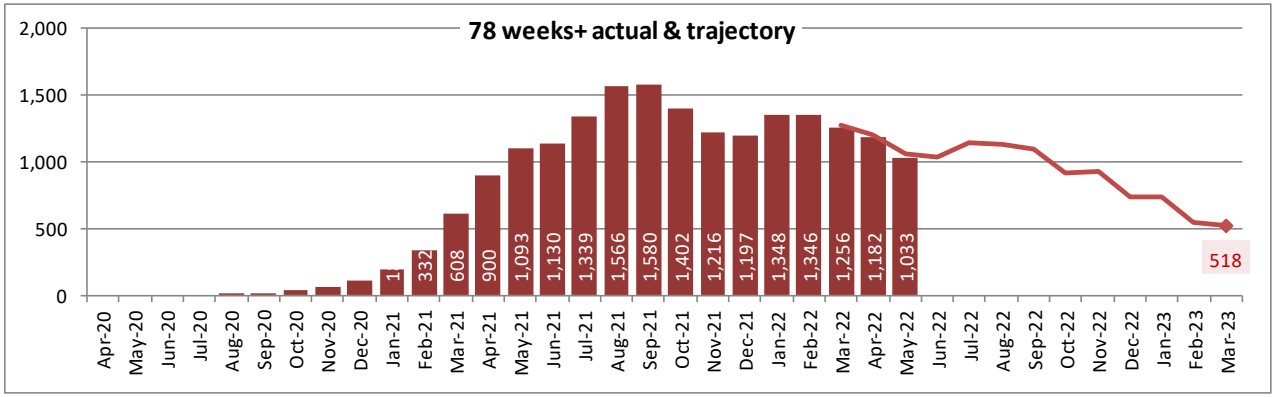




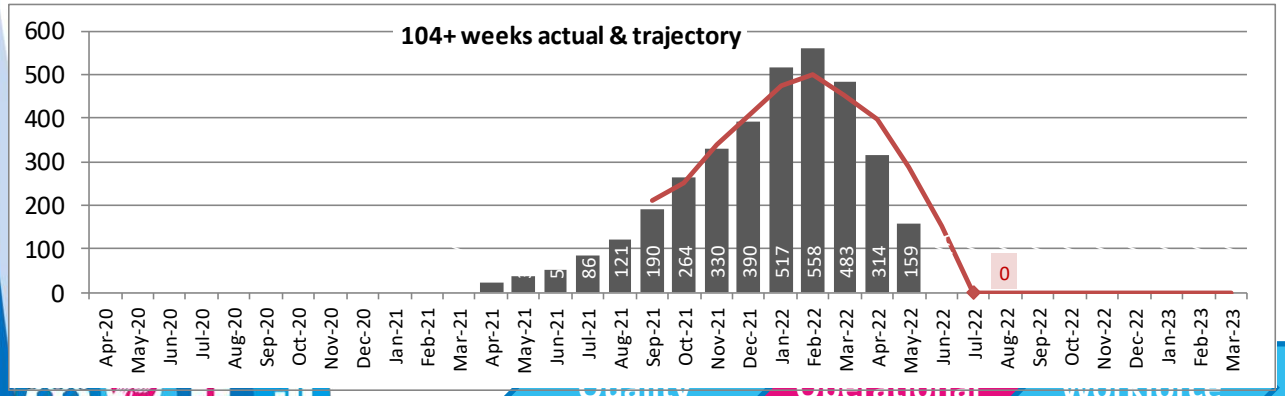
Planned care – *RTT Trajectories*



52 Week Waits have been gradually growing since June 21.



78 Week Waits have been reducing for the last 4 months.

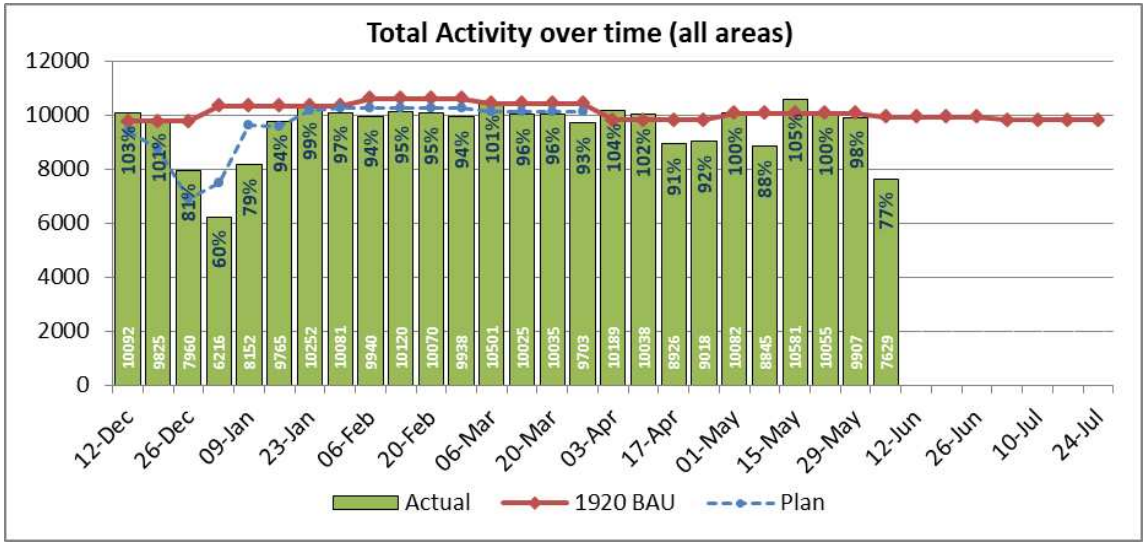


104 Week Waits have been continually decreasing since Early March. Reduction now exceeding the trajectory set. Most challenged specialties are T&O and Colorectal.

Diagnostic Activity

NHS University Hospitals of North Midlands NHS Trust

Area	DM01 Test	Feb-22 Total WL	Feb-22 6+	Feb-22 %	Feb-22 Activity	Mar-22 Total WL	Mar-22 6+	Mar-22 %	Mar-22 Activity	Apr-22 Total WL	Apr-22 6+	Apr-22 %	Apr-22 Activity
Imaging	Magnetic Resonance Imaging	4,582	674	85.3%	3,003	5,194	1,401	73.0%	3,277	3,631	1,429	60.6%	3,231
	Computed Tomography	3,597	12	99.7%	7,265	3,834	50	98.7%	7,987	3,418	31	99.1%	7,655
	Non-obstetric ultrasound	9,394	4,115	56.2%	4,506	9,550	4,306	54.9%	5,426	4,861	4,770	1.9%	4,354
	Barium Enema	0	0		0	0	0		0	0	0		0
	DEXA Scan												
Physiological Measurement	Audiology - Audiology Assessments	357	8	97.8%	379	277	6	97.8%	454	299	2	99.3%	359
	Cardiology - echocardiography	1,880	243	87.1%	1,092	1,893	306	83.8%	1,395	1,529	424	72.3%	1,331
	Cardiology - electrophysiology	0	0		5	1	1	0.0%	10	0	1		5
	Neurophysiology - peripheral neurophysiology	336	1	99.7%	214	276	0	100.0%	355	297	0	100.0%	215
	Respiratory physiology - sleep studies	308	3	99.0%	227	346	9	97.4%	218	372	12	96.8%	185
	Urodynamics - pressures & flows	0	0		0	1	0	100.0%	0	1	0	100.0%	0
Endoscopy	Colonoscopy	520	259	50.2%	434	598	258	56.9%	412	420	286	31.9%	315
	Flexi sigmoidoscopy	363	213	41.3%	65	441	214	51.5%	83	232	241	-3.9%	82
	Cystoscopy	126	13	89.7%	237	107	7	93.5%	233	126	6	95.2%	167
	Gastroscopy	1,066	588	44.8%	822	1,177	660	43.9%	898	528	586	-11.0%	812
	Totals	22,529	6,129	73%	18,249	23,695	7,218	70%	20,748	15,714	7,788	50%	18,711



Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Planned care - *Diagnostics*

University Hospitals of North Midlands NHS Trust

Diagnostics Summary

- 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, The Non-obstetric ultrasound waiting list decreased from 9,631 to 9,930. Due to the challenges in Non-Obstetric Ultrasound this has adversely affected DM01 performance.
- Plain film is also an area with a high volume of waiters, predominantly due to staffing shortages.
- Histology turnaround times remain a high risk.

Actions

- Non obstetric ultrasound performance remains a Driver Metric for CWD and has specific focus for improvement on workforce retention, recruitment and innovative ways to train and recruit.
- A viable insourcing company for non-obstetric ultrasound scanning is being progressed to business case, and if supported will deliver Non-Obs Ultrasound at 4 weeks by January 2023.
- Walk in centres for Plain Film MSK starts in July. Walk in centres for all other Plain Film will start in August, which will give capacity for immediate imaging from referral and will allow decisive recovery for P/F waits.
- The Diagnostic Cell is progressing solutions for ensuring that anniversary / planned patients are reflected correctly against their RTT pathway.
- For Histology 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. Increased staff are now in place for the blocks delay and the cancer team now have direct patient level access to reduce the time spent escalating delays and awaiting a response.
- Capacity and Demand work has been completed within Imaging relating directly to Consultant Radiologist and SpR capacity.
- Endoscopy remains a high risk areas, with a recovery plan in place using internal and external resources and a business case has been prepared to reduce unnecessary endoscopies by using a CQC accredited triage and clinical prioritisation service.

Inpatient and Outpatient Decile & Ethnicity

"In line with NHS Planning Guidance the Trust must ensure board papers are published that include an analysis of waiting times disaggregated by ethnicity and deprivation" The Trust has only recently had the capability to analyse this information and will therefore spend the coming months seeking to understand what the data and take action to positively impact upon unwarranted variation

Inpatient IMD Decile	1	2	3	4	5	6	7	8	9	10	Unknown
Weeks Waited- >104	9.99%	8.97%	8.50%	7.72%	7.62%	11.96%	12.63%	10.59%	13.53%	7.95%	0.55%
Weeks Waited- 78-104	13.91%	10.70%	9.96%	8.72%	7.65%	10.29%	11.60%	7.57%	13.33%	5.35%	0.91%
Weeks Waited- 52-77	14.83%	12.44%	10.12%	8.63%	6.81%	11.84%	9.77%	7.74%	11.87%	4.46%	1.50%
Weeks Waited- Under 52	13.07%	11.57%	9.75%	8.78%	7.67%	10.83%	10.79%	9.26%	11.60%	5.63%	1.05%

Outpatient IMD Decile	1	2	3	4	5	6	7	8	9	10	Unknown
Weeks Waited- >104	11.15%	10.65%	8.95%	9.05%	7.92%	11.33%	11.23%	10.01%	12.81%	6.04%	0.87%
Weeks Waited- 78-104	12.63%	9.62%	9.63%	9.45%	7.22%	11.52%	11.83%	9.72%	11.16%	5.99%	1.24%
Weeks Waited- 52-77	13.33%	11.20%	9.92%	8.81%	7.53%	10.88%	10.68%	9.17%	11.74%	5.89%	0.85%
Weeks Waited- Under 52	13.56%	11.52%	10.10%	9.01%	7.51%	10.53%	10.49%	8.92%	11.30%	6.01%	1.05%

Inpatient Ethnicity	African	Any Other Asian Background	Any Other Black Background	Any other ethnic group	Any Other Mixed Background	Any other White background	Bangladeshi	Caribbean	Chinese	Indian	Pakistani	White & Asian	White & Black African	White & Black Caribbean	White British	White Irish	Not Specified	Not Stated	Unknown
Weeks Waited- >104	0.20%	0.32%	0.07%	0.22%	0.40%	0.52%	0.05%	0.05%	0.20%	0.42%	0.40%	0.20%	0.05%	0.02%	93.77%	0.37%	0.72%	1.82%	0.22%
Weeks Waited- 78-104	0.58%	0.74%	0.16%	0.82%	0.25%	1.15%	0.16%	0.25%	0.16%	0.49%	1.07%	0.66%	0.08%	0.16%	88.31%	0.08%	1.48%	1.23%	2.14%
Weeks Waited- 52-77	0.25%	0.86%	0.21%	0.71%	0.57%	1.82%	0.11%	0.25%	0.11%	0.32%	1.18%	0.18%	0.04%	0.18%	86.60%	0.07%	2.07%	1.82%	2.67%
Weeks Waited- Under 52	0.39%	0.55%	0.14%	0.62%	0.54%	1.08%	0.08%	0.16%	0.13%	0.49%	1.39%	0.20%	0.15%	0.19%	85.37%	0.28%	2.68%	2.71%	2.84%

Outpatient Ethnicity	African	Any Other Asian Background	Any Other Black Background	Any other ethnic group	Any Other Mixed Background	Any other White background	Bangladeshi	Caribbean	Chinese	Indian	Pakistani	White & Asian	White & Black African	White & Black Caribbean	White British	White Irish	Not Specified	Not Stated	Unknown
Weeks Waited- >104	0.28%	0.50%	0.17%	0.50%	0.43%	0.76%	0.13%	0.20%	0.12%	0.52%	1.16%	0.31%	0.13%	0.12%	87.88%	0.30%	3.07%	2.30%	1.15%
Weeks Waited- 78-104	0.34%	0.51%	0.15%	0.54%	0.43%	1.26%	0.20%	0.15%	0.12%	0.27%	1.50%	0.27%	0.12%	0.14%	87.22%	0.36%	2.47%	1.92%	2.03%
Weeks Waited- 52-77	0.32%	0.67%	0.18%	0.61%	0.52%	1.06%	0.09%	0.20%	0.15%	0.45%	1.95%	0.37%	0.17%	0.17%	85.80%	0.21%	2.52%	2.27%	2.29%
Weeks Waited- Under 52	0.42%	0.63%	0.19%	0.64%	0.57%	1.20%	0.14%	0.17%	0.16%	0.58%	1.80%	0.32%	0.15%	0.24%	83.19%	0.29%	3.23%	2.75%	3.33%

APPENDIX 1

Operational Performance

Constitutional standards

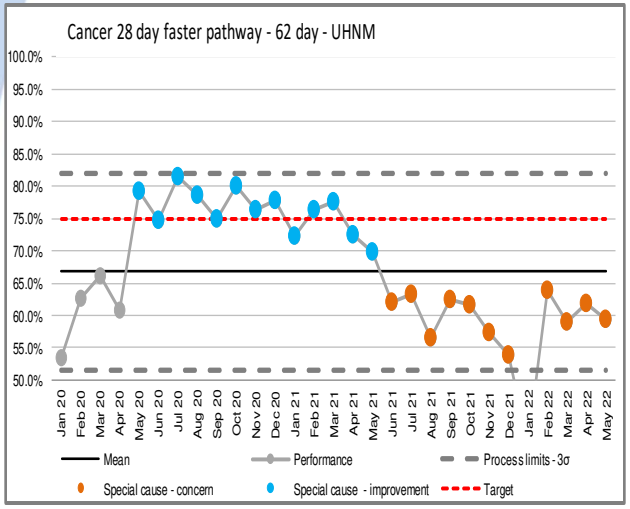
	Metric	Target	Latest	Variation	Assurance	DQAI
A&E	A&E 4 hour wait Performance	95%	62.50%	L	F	
	12 Hour Trolley waits	0	390	H	?	
Cancer Care	Cancer Rapid Access (2 week wait)	93%	41.77%	L	?	
	Cancer 62 GP ref	85%	36.93%	L	F	
	Cancer 62 day Screening	90%	57.14%	L	?	
	31 day First Treatment	96%	84.29%	L	?	
Elective waits	RTT incomplete performance	92%	53.97%	L	F	
	RTT 52+ week waits	0	4682	H	F	
	Diagnostics	99%	66.86%	L	F	

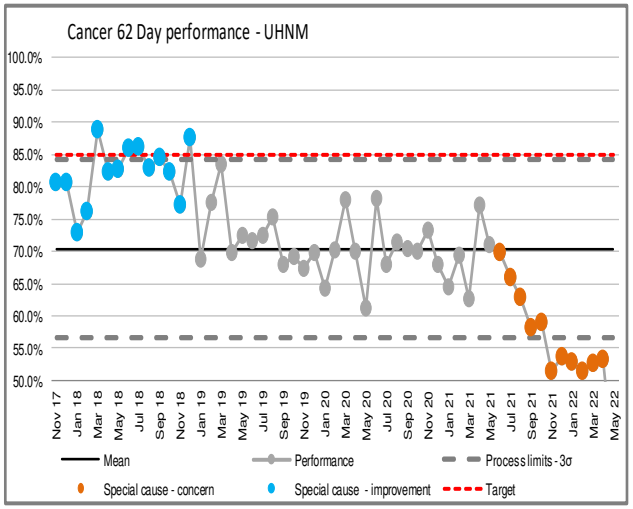
	Metric	Target	Latest	Variation	Assurance	DQAI
Use of Resources	DNA rate	7%	7.3%		?	
	Cancelled Ops	150	126		?	
	Theatre Utilisation	85%	76.0%			
Inpatient / Discharge	Same Day Emergency Care	30%	30.1%	H	F	
	Super Stranded	183	182	H	?	
	DToC	3.5%	4.40%		?	
	Discharges before Midday	25%	19.1%	L	F	
	Emergency Readmission rate	8%	11.8%	L	F	
	Ambulance Handover delays in excess of 60 minutes	0	577	H	?	

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Cancer – 62 Day





Variation	Assurance

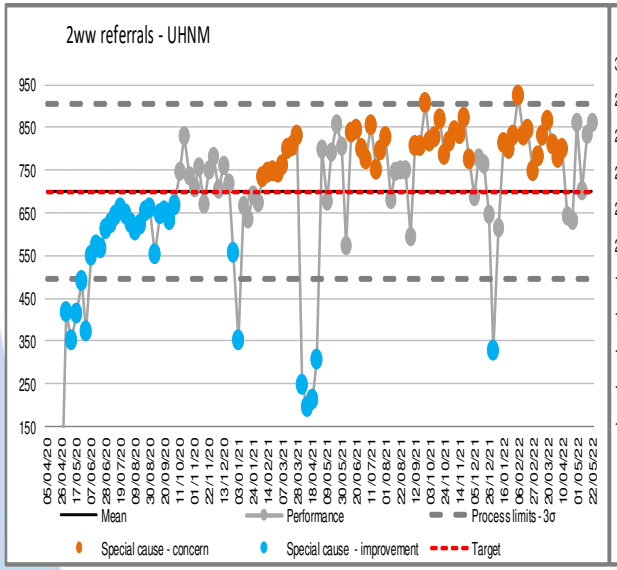
Target	Mar 22	Apr 22	May 22
85%	52.7%	53.2%	36.9%

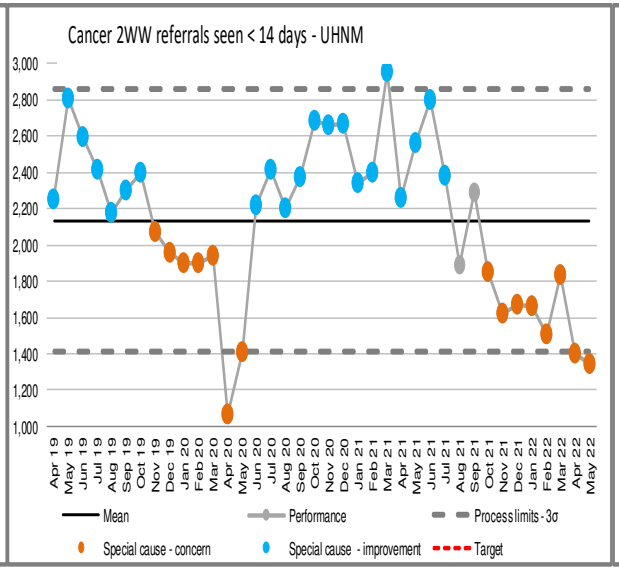
Background

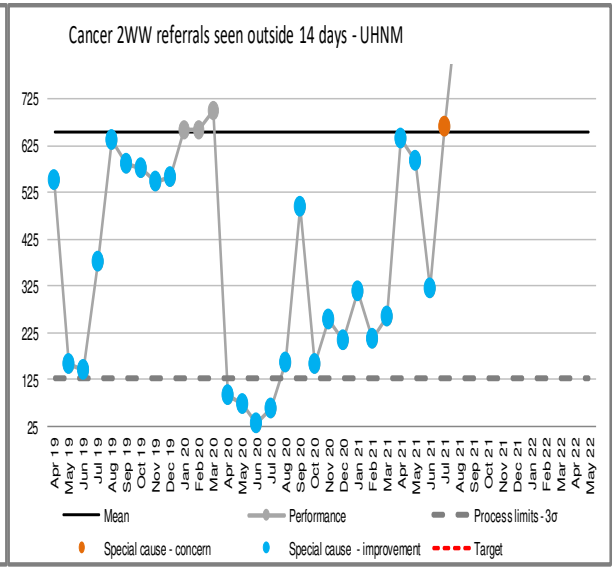
% patients beginning their treatment for cancer within 62 days following an urgent GP referral for suspected cancer

What is the data telling us?

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



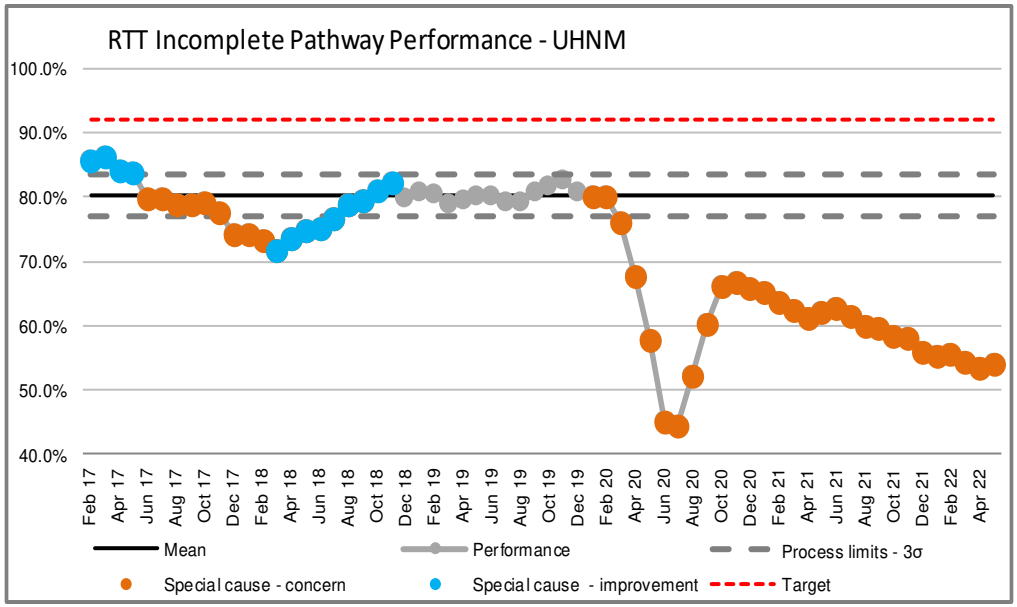


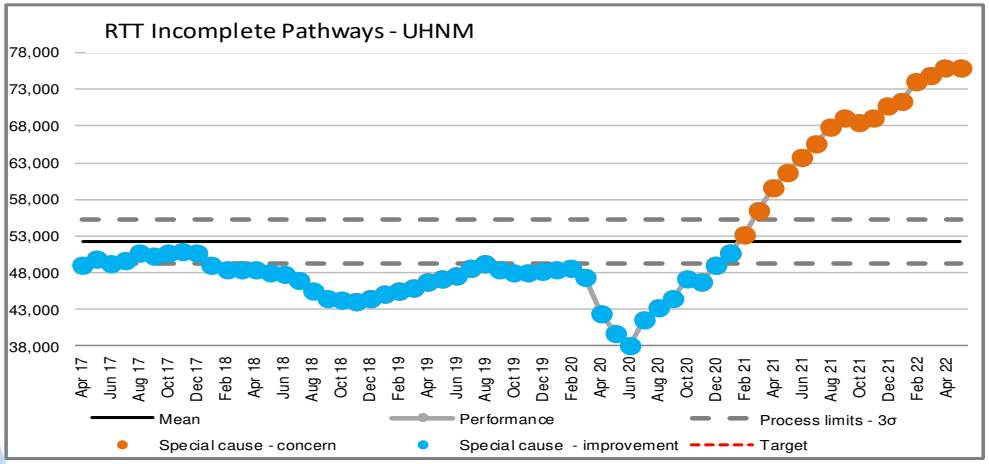


Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Referral To Treatment





Variation	Assurance

Target	Mar 22	Apr 22	May 22
92%	54.3%	53.5%	54.0%

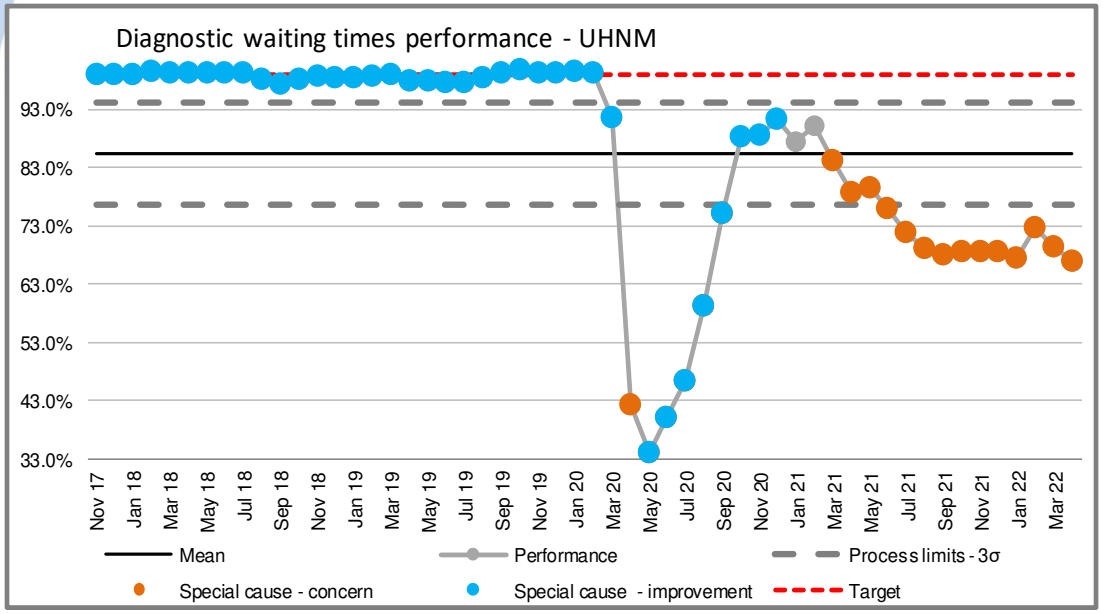
Background

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
L	F

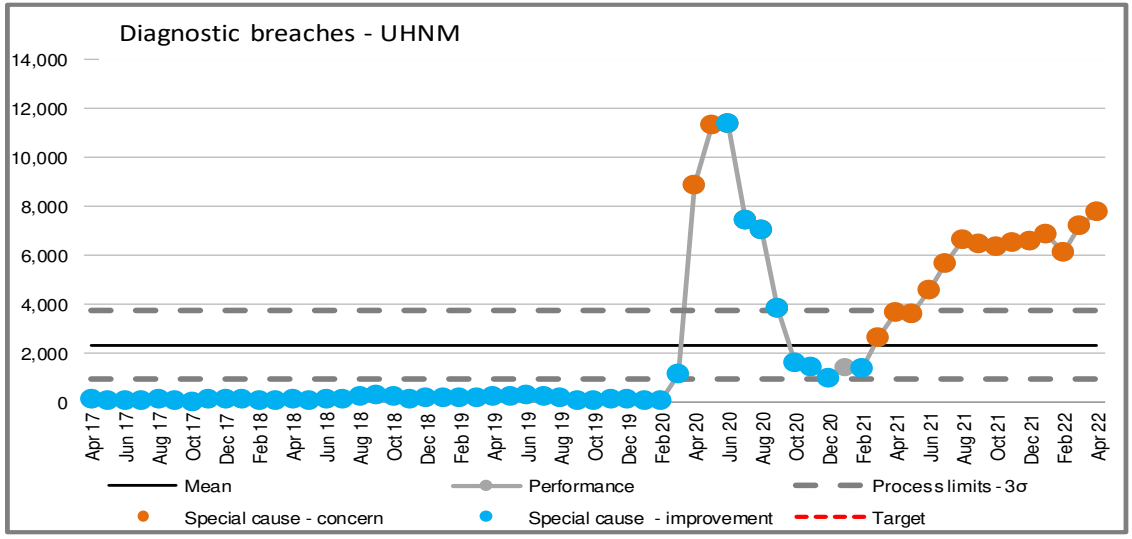
Target	Feb 22	Mar 22	Apr 22
99%	72.8%	69.5%	66.9%

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



Workforce

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

Workforce Spotlight Report

University Hospitals of North Midlands NHS Trust

Key messages

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

The sustainable workforce risk remains high because there is still an impact of covid surges on sickness levels and workforce availability, although there are plans in place to mitigate risks and additional recruitment is taking place. Operational pressures, high sickness rates and vacancy levels contribute to the staffing challenges. Additionally, the UK Visas and Immigration (UKVI) are processing the high number of emergency visas related to the war in Ukraine as a priority. This has resulted in a significant delay in processing work, study and family visa applications, which may cause delays in the recruitment process for sponsored candidates and employees

Sickness - The in-month sickness rate was 5.50% in May (7.29% in April 22). The 12 month cumulative rate increased to 6.10% (6.02% at 30/04/22). Covid-related absence continues to fluctuate. As of 14 May 2022, covid-related open absences numbered 131 which was 20% of all absences [*includes absences resulting from adhering to isolation requirements]

The focus remains on managing areas of high sickness, with specific deep dives in to stress/anxiety, MSK and covid-related absences, with assurance meetings having taken place in the Divisions and continued daily monitoring of sickness absence rates, including COVID related absence

Appraisals - At 31 May 2022, the PDR Rate continued to decline to 73.26%, down from 73.78% at 30 April 2022

There will be a renewed focus with the Divisions on ensuring completion of PDRs with weekly update reports detailing compliance and outstanding PDR's being circulated; focused discussions to improve performance; Management time being reinstated, and improved guidance on 'How to' add PDRs to ESR.

Statutory and Mandatory Training - The Statutory and Mandatory training rate at 31 May 2022 was 94.30% (94.25% at 30 April 2022). This compliance rate is for the 6 'Core for All' subjects only

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

Vacancies - The overall vacancy rate was 11.79% at 31 May 2022 (11.10% at 30 April 2022), equivalent to 1324.02 FTE.

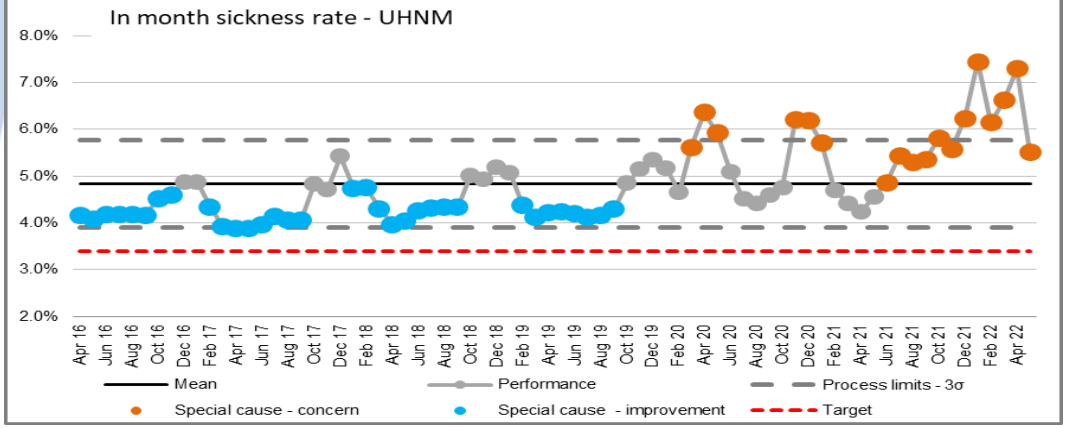
Staff in post decreased in May 2022 by 2.34 fte, and budgeted establishment increased by 84.47 fte which increased the vacancy rate by 86.81 overall. In month, Bank and Agency fte was 906.91, which covered 68.5% of this vacancy position and there was 1319.4 FTE in the recruitment pipeline.

Overall the target ***average time to hire*** (from vacancy creation to checks complete) is 60 days and although this average is achieved, there are aspects of recruitment, such as pre-employment, which currently exceed the local performance target (17days of the overall 60 day target).

Workforce Dashboard

Metric	Target	Latest	Variation	Assurance
Staff Sickness	3.4%	5.50%		
Staff Turnover	11%	11.38%		
Statutory and Mandatory Training rate	95%	94.30%		
Appraisal rate	95%	73.26%		
Agency Cost	N/A	3.87%		

Sickness Absence



Variation	Assurance
H	F

Target	Mar 22	Apr 22	May 22
3.4%	6.6%	7.3%	5.5%

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 5.50% in May (7.29% in April 22). The 12 month cumulative rate increased to 6.10% (6.02% at 30/04/22).

Covid-related absence continues to fluctuate. As of 14 May 2022, covid-related open absences* numbered 131 which was 20% of all absences [**includes absences resulting from adhering to isolation requirements*]

Performance against the Divisional trajectories for achieving a reduction in Sickness Absence (subject to Covid Pandemic spikes, Winter Pressures and staffing deficiencies) to a year-end target of around 5.5%, was as follows:

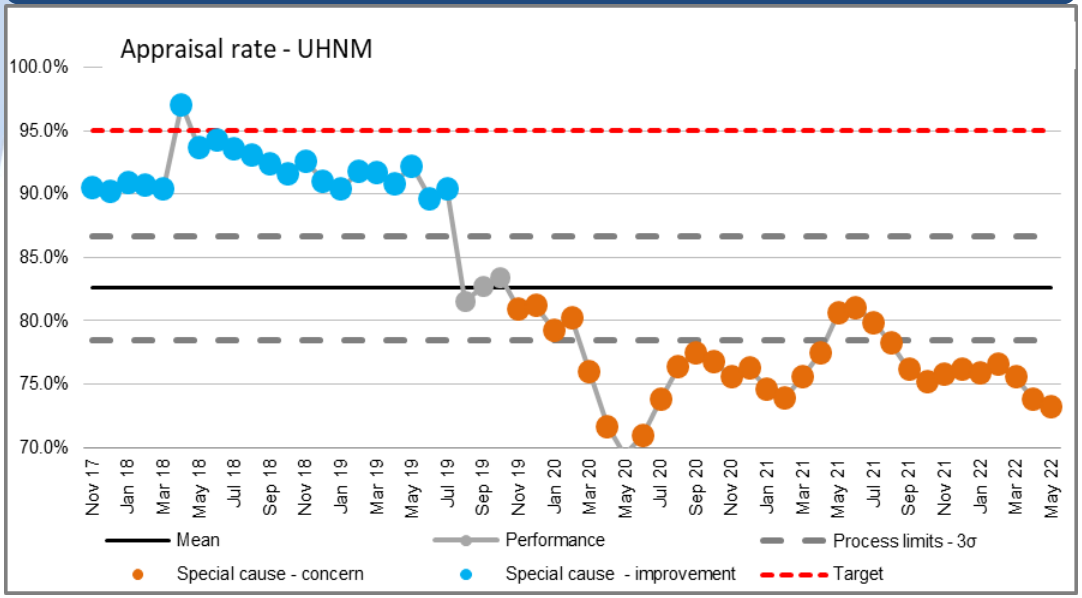
(12m cumulative Absence FTE %)

Org L2	Divisional Trajectory - by March 2023	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Change on previous month
205 Central Functions	3.39%	3.80%	3.83%	3.89%	4.13%	4.13%	↔
205 Children's, Women's & Diagnostics	5.25%	5.20%	5.29%	5.53%	5.88%	5.94%	↑
205 Estates, Facilities and PFI Division	5.25%	5.13%	5.26%	5.56%	5.81%	5.75%	↓
205 Medicine Division	5.25%	6.01%	6.14%	6.33%	6.56%	6.64%	↑
205 Specialised Division	5.25%	4.64%	4.78%	4.96%	5.32%	5.47%	↑
205 Surgical Division	4.50%	6.46%	6.57%	6.75%	7.02%	7.18%	↑

Actions

The focus remains on managing areas of high sickness, with specific deep dives in to stress/anxiety, MSK and covid-related absences, with assurance meetings having taken place in the Divisions and continued daily monitoring of sickness absence rates, including COVID related absence

Appraisal (PDR)



Variation	Assurance
L	F

Target	Mar 22	Apr 22	May 22
95.0%	75.6%	73.8%	73.3%

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

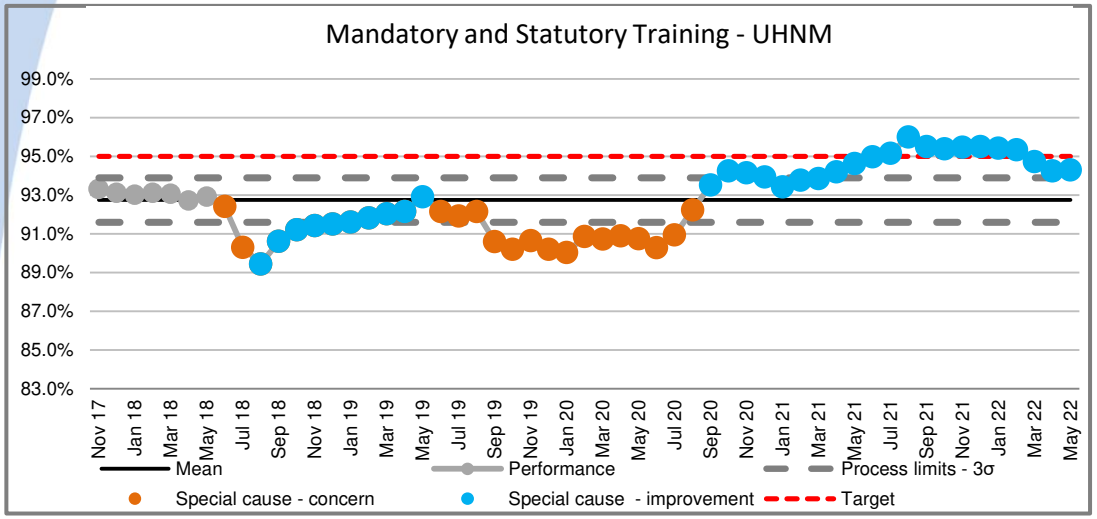
At 31 May 2022, the PDR Rate continued to decline to 73.26%, down from 73.78% at 30 April 2022

Actions

There will be a renewed focus with the Divisions on ensuring completion of PDRs with:

- Weekly update reports detailing compliance and outstanding PDR's being circulated
- Focused discussions to improve performance.
- Management time being reinstated
- Improving and sharing guidance on 'How to' add PDRs to ESR.

Statutory and Mandatory Training



Variation	Assurance
H	F

Target	Mar 22	Apr 22	May 22
95.0%	94.7%	94.3%	94.3%

Background

Training compliance

What is the data telling us?

At 94.3%, the Statutory and Mandatory Training rate just below the Trust target for the core training modules

Summary

The Statutory and Mandatory training rate at 31 May 2022 was 94.30% (94.25% at 30 April 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|	10572	10572	9973	94.33%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	10572	10572	10014	94.72%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	10572	10572	10020	94.78%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	10572	10572	9982	94.42%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	10572	10572	9987	94.47%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	10572	10572	9842	93.09%

Compliance rates for the Annual competence requirements were as follows:

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 1 Year|	10572	10572	9091	85.99%
NHS|CSTF|Information Governance and Data Security - 1 Year|	10572	10572	9368	88.61%

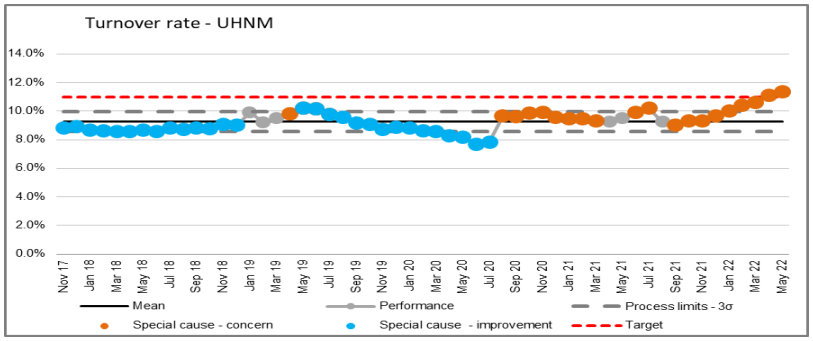
Actions

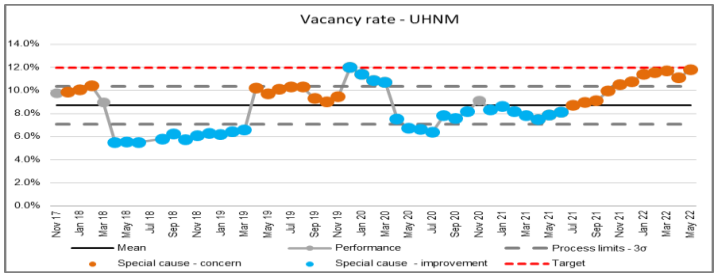
We continue to raise the issue of compliance with Divisions and communicate to staff the need to complete statutory and mandatory training.

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

Workforce Turnover

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





The overall Trust vacancy rate calculated as Budgeted Establishment less staff in post, increased to 11.78% (from 11.1%)
The vacancy rate is influenced by changes to budgeted establishment for Winter Workforce Plan and approved business cases, as well as changes to staff in post.

Variation	Assurance
H	P

Target	Mar 22	Apr 22	May 22
11.0%	10.6%	11.1%	11.4%

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%

Actions

The Recruitment service is currently working through a full review to identify process improvements using the Improving Together methodology and the development of a Step Change project. Activities have been process mapped and standard operating procedures revised.

Summary

The 12m Turnover rate was 11.38% (11.12% at 30/04/22). Staff in post decreased in May 2022 by 2.34 fte, and budgeted establishment Increased by 84.47 fte which increased the vacancy rate by 86.81 fte.

Vacancies at 31-05-22	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous month %
Medical and Dental	1,475.99	1,293.92	182.07	12.34%	13.16%
Registered Nursing	3,338.57	2,909.36	429.21	12.86%	12.20%
All other Staff Groups	6,412.05	5,699.31	712.74	11.12%	10.05%
Total	11,226.61	9,902.59	1,324.02	11.79%	11.10%

In month, Bank and Agency fte was 906.91, which covered 68.5% of this vacancy position.
There was 1319.4 FTE in the recruitment pipeline.
Other mitigations against the vacancy position include offering Additional PA's; extended / increased hours; On call payments and overtime.
Overall the target ***average time to hire*** (vacancy creation to checks complete) is 60 days and although this average is achieved, there are aspects or recruitment, such as pre-employment, which currently exceed the local performance target (17days off the overall 60 day target).
The UK Visas and Immigration (UKVI) are processing the high number of emergency visas related to the humanitarian crisis as a result of the war in Ukraine as a priority. This has resulted in a significant delay in processing work, study and family visa applications, which may cause delays in the recruitment process for sponsored candidates and employees

Finance

2025 Vision "Ensure efficient use of resources"

Finance Spotlight Report

NHS University Hospitals of North Midlands NHS Trust

This report presents the financial performance of the Trust for May (Month 2). Key elements of the financial performance are:

- In month the Trust delivered an actual deficit of £1.7m against an in month planned surplus of £0.6m. This adverse variance to plan is primarily driven by non-delivery of CIP in month which was identified as a key risk in our financial plan submission.
- The Trust incurred £1.2m of costs relating to COVID-19 in month which is comparable with the prior month figure with £0.5m being chargeable on top of this allocation for COVID-19 testing costs.
- To date the trust has validated £1.04m CIP savings in year; these schemes have a full year impact of £4.4m, which presents a considerable variance to the Trust's recurrent target of £13.6m.
- Capital planned expenditure for 2022/23 as reported to Performance and Finance Committee in April 2022 is £69.8m. In Month 2 total expenditure has been incurred of £1.7m which is £0.2m behind plan. The majority of the expenditure year to date is the pre-committed repayment of the PFI and IFRS16 lease liabilities.
- The cash balance at Month 2 is £70.2m, which is £10.4m lower than plan. The main year to date variances from plan are driven by Health Education Training income being lower than plan and general payables being in excess of plan.

Finance Dashboard

	Metric	Target	Latest	Variation	Assurance
I&E	TOTAL Income	variable	80.1		
	Expenditure - Pay	variable	67.7	H	?
	Expenditure - Non Pay	variable	33.0	H	P
Activity	Daycase/Elective Activity	variable	7,184	L	?
	Non Elective Activity	variable	8,921	L	?
	Outpatients 1st	variable	22,954		?
	Outpatients Follow Up	variable	37,569		?

Income & Expenditure

Income & Expenditure Summary Month 02 2022/23	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Income From Patient Activities	884.3	73.9	75.5	1.6	147.0	148.4	1.4
Other Operating Income	85.1	7.5	6.7	(0.8)	14.2	13.4	(0.8)
Total Income	969.4	81.4	82.2	0.8	161.2	161.8	0.6
Pay Expenditure	(582.9)	(48.2)	(48.0)	0.1	(95.9)	(95.0)	0.9
Non Pay Expenditure	(331.8)	(27.6)	(31.0)	(3.4)	(54.3)	(60.2)	(5.9)
Total Operational Costs	(914.7)	(75.8)	(79.1)	(3.2)	(150.1)	(155.1)	(5.0)
EBITDA	54.7	5.6	3.1	(2.4)	11.1	6.7	(4.4)
Depreciation & Amortisation	(33.6)	(2.8)	(2.9)	(0.1)	(5.6)	(5.7)	(0.1)
Interest Receivable	0.3	0.0	0.1	0.0	0.0	0.1	0.1
PDC	(8.9)	(0.7)	(0.7)	(0.0)	(1.5)	(1.5)	(0.0)
Finance Cost	(17.1)	(1.4)	(1.4)	0.0	(2.9)	(2.8)	0.0
Other Gains or Losses	0.0	0.0	0.1	0.1	0.0	0.1	0.1
Surplus / (Deficit)	(4.6)	0.6	(1.7)	(2.4)	1.2	(3.2)	(4.4)
Financial Recovery Fund	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	(4.6)	0.6	(1.7)	(2.4)	1.2	(3.2)	(4.4)

- Income from patient activities has over performed in month primarily due to accrued income relating to increased inflationary funding on all contracts for which there is no income target at present (this will be reflected in the June planning submission). There is also additional income in month in respect of drugs and devices (see non pay narrative below) for which corresponding spend is also reflected in the non-pay position.
- Other operating income has underperformed in month and this is primarily driven by a year to date budgetary adjustment in respect of Cancer Transformation income in month. A variance also remains due to the continued under performance on car parking income.
- Pay is underspent in month by £0.1m which is primarily driven by underspends across registered nursing and NHS Infrastructure. The pay award (2%) continues to be accrued for the remainder of the staff groups where the award has yet to be announced.
- Non-pay is overspent in month by £3.4m; primarily driven by non-delivery of recurrent CIP of approximately £0.8m. In month both drugs and devices have overspent against the plan by £1.5m of which we have received some additional income to offset this spend.

Capital Spend

Capital Expenditure as at Month 2 2022/23 £m	2022/23 Plan April PAF	In Month			Year to Date		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance
PFI lease liability repayment	(10.5)	(0.9)	(0.9)	-	(1.8)	(1.8)	-
Repayment of IFRS16 leases	(3.7)	(0.3)	(0.3)	-	(0.6)	(0.6)	-
Pre-committed items	(14.3)	(1.2)	(1.2)	-	(2.4)	(2.4)	-
PFI lifecycle and equipment replacement	(3.5)	(0.2)	(0.2)	-	(0.4)	(0.4)	-
PFI enabling cost	(0.3)	-	-	-	-	-	-
PFI related costs	(3.8)	(0.2)	(0.2)	-	(0.4)	(0.4)	
Wave 4b Funding - Lower Trent Wards	(4.9)	-	(0.0)	(0.0)	-	(0.1)	(0.1)
Project STAR multi-storey car park	(14.8)	(0.0)	-	0.0	(0.0)	-	0.0
PDC TIF2 County elective hub	(3.9)	-	-	-	-	-	-
Emergency Department (restatement costs)	(0.2)	-	-	-	-	-	-
Schemes funded by PDC and Trust funding	(23.7)	(0.0)	(0.0)	0.0	(0.0)	(0.1)	(0.0)
LIMS (Laboratory Information Management System)	(0.3)	-	(0.0)	(0.0)	-	(0.0)	(0.0)
EPMA (Electronic Prescribing)	(0.6)	-	(0.0)	(0.0)	-	(0.1)	(0.1)
Medical devices fleet replacement	(0.8)	-	-	-	-	-	-
CT7 enabling works (BC 415)	(1.1)	-	-	-	-	-	-
Patient Portal roll out costs (BC 462)	(0.5)	-	-	-	-	-	-
Pharmacy Dispensary	(0.3)	(0.1)	(0.1)	0.1	(0.3)	(0.3)	0.1
Anaesthetic medical records (Nasstar) (BC 444)	(0.1)	-	-	-	-	-	-
Home reporting implementation costs (BC 453)	(0.1)	-	-	-	-	-	-
Schemes with costs in more than 1 financial year	(3.9)	(0.1)	(0.1)	0.0	(0.3)	(0.4)	(0.0)
2022/23 schemes	(17.2)	(0.3)	(0.1)	0.2	(0.5)	(0.4)	0.2
IFRS 16 New Vehicles lease	(0.1)	-	-	-	-	-	-
IFRS 16 County Theatres TIF1 (IFRS16)	(1.8)	-	-	-	-	-	-
Lease liability re-measurement	(0.1)	-	-	-	-	-	-
IFRS16 funded schemes	(2.1)	-	-	-	-	-	-
Donated/Charitable funds expenditure	(4.7)	(0.0)	(0.0)	-	(0.0)	(0.0)	-
Charity funded expenditure	(4.7)	(0.0)	(0.0)	-	(0.0)	(0.0)	-
Overall capital expenditure	(69.8)	(1.9)	(1.7)	0.2	(3.7)	(3.6)	0.1

The table to the left sets out the capital plan for 2022/23 as reported to Performance and Finance Committee in April 2022. Total capital financing in 2022/23 is £69.8m of which £14.3m is allocated to the repayment of PFI and IFRS16 lease liabilities. The 2022/23 and future years capital programme has been revised to include a number of changes. A report detailing the changes is included separately on the agenda.

In Month 2 total expenditure of £1.7m is £0.2m behind the plan of £1.9m and year to date expenditure of £3.6m is £0.1m behind plan. A majority of the expenditure to date is the pre-committed repayment of the PFI and IFRS16 lease liabilities.

Balance sheet

Balance sheet as at Month 2	31/03/2022	31/05/2022			
	Actual £m	Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment	576.4	569.8	569.3	(0.6)	
Right of Use Assets	-	19.1	18.9	(0.2)	
Intangible Assets	20.7	19.9	19.8	(0.0)	
Trade and other Receivables	1.4	1.4	1.4	0.0	
Total Non Current Assets	598.6	610.2	609.5	(0.8)	
Inventories	16.3	16.3	15.8	(0.6)	
Trade and other Receivables	41.6	40.8	44.2	3.5	Note 1
Cash and Cash Equivalents	87.6	80.6	70.2	(10.4)	Note 2
Total Current Assets	145.5	137.7	130.2	(7.5)	
Trade and other payables	(116.6)	(106.2)	(102.1)	4.1	Note 3
Borrowings	(10.7)	(13.1)	(13.5)	(0.4)	
Provisions	(2.5)	(2.5)	(2.6)	(0.1)	
Total Current Liabilities	(129.8)	(121.8)	(118.2)	3.6	
Borrowings	(257.8)	(266.7)	(266.5)	0.2	
Provisions	(3.9)	(3.9)	(3.8)	0.1	
Total Non Current Liabilities	(261.6)	(270.6)	(270.3)	0.3	
Total Assets Employed	352.6	355.6	351.1	(4.5)	
Financed By:				-	
Public Dividend Capital	648.2	648.2	648.2	-	
Retained Earnings	(437.0)	(434.0)	(438.5)	(4.5)	Note 4
Revaluation Reserve	141.4	141.4	141.4	-	
Total Taxpayers Equity	352.6	355.6	351.1	(4.5)	

Variances to the plan at the year-end are explained below:

Note 1 - The receivables total includes an invoice of £6.9m in respect of Q1 training income with Health Education England, where the cash was expected to have been received by Month 2. This is partly offset by the reduced level of pre-payments and accrued income amounts outstanding with UHNM Charity compared to plan.

Note 2 – The lower than plan balance is primarily due to £6.9m of cash that was not received as expected from Health Education England relating to Q1 training income (the cash has been received in June 2022). The remaining variance is due to higher than forecast general payments.

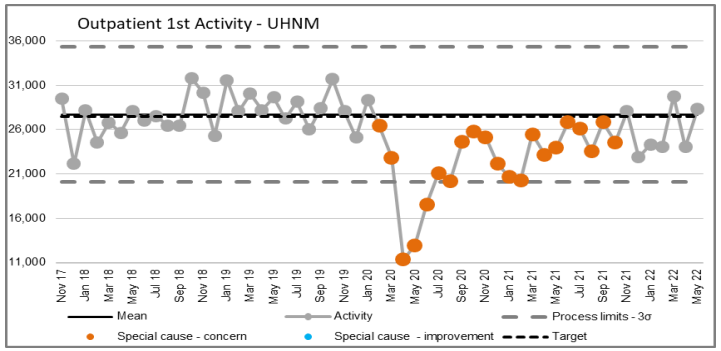
Note 3 - The plan value includes an expected £2.3m increase in deferred income in respect of the Q1 Health Education England training income referred to above. The remaining variance is due to the higher level of general payments made year to date.

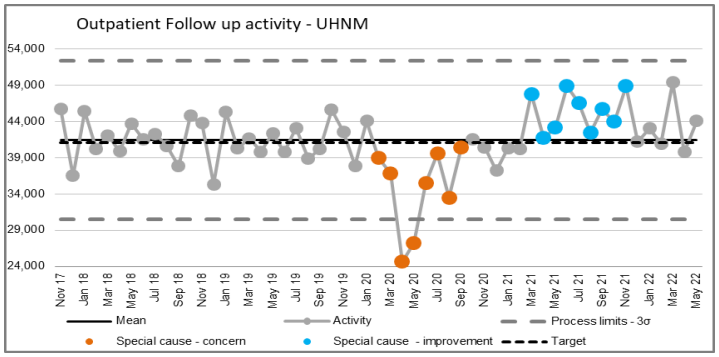
Note 4 - Retained earnings show a £4.5m variance from plan and reflects the revenue position at Month 2.

Activity

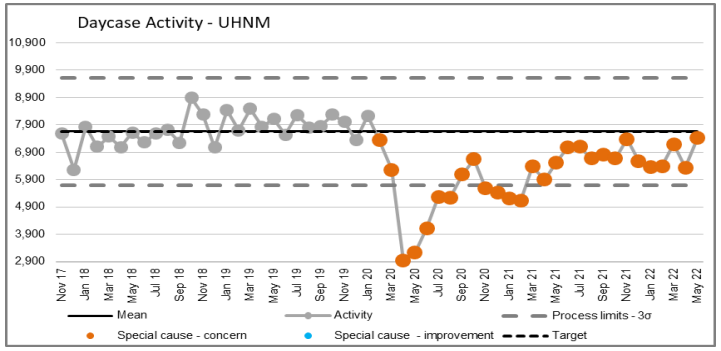
NHS University Hospitals of North Midlands NHS Trust

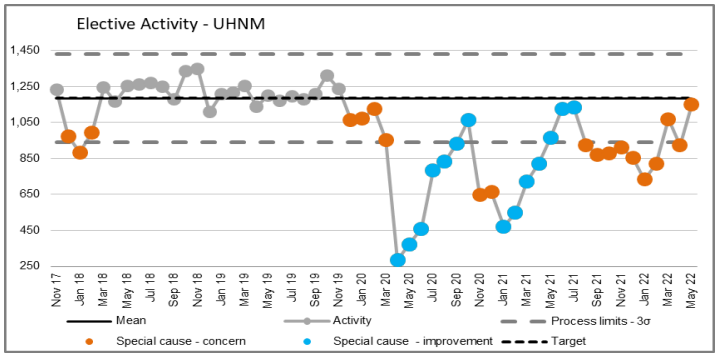
Planned care Outpatient



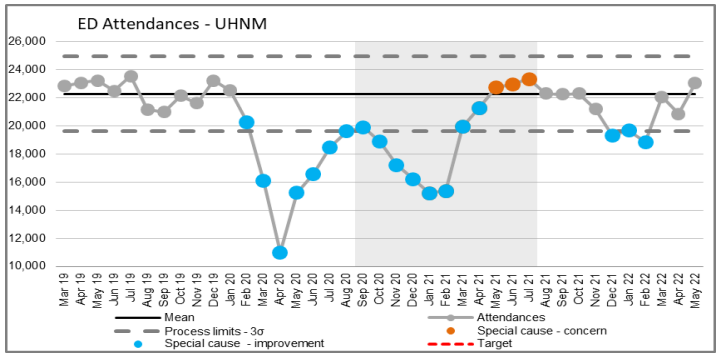


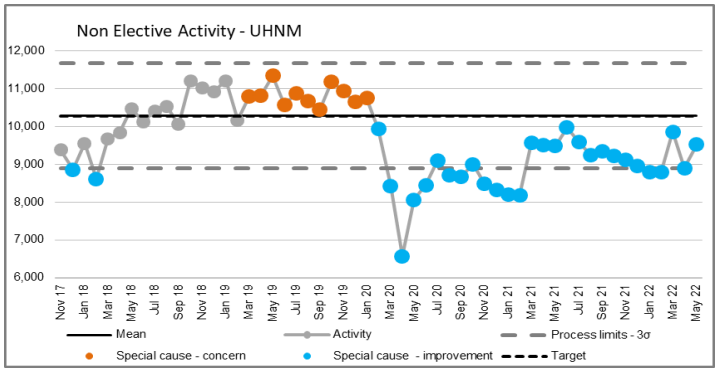
Planned care Inpatient





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	
HIGH QUALITY														
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													
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													
RESPONSIVE														
Integrated Performance Report	Various	M11	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer													
PEOPLE														
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													
Staff Survey Report	Chief People Officer													
Raising Concerns Report	Associate Director of Corporate Governance		Q4			Q1			Q2			Q3		
IMPROVING AND INNOVATING														
Research Strategy	Medical Director													Taken to TAP in April. Final version to be presented to Board in August
SYSTEM AND PARTNERS														
System Working Update	Chief Executive / Director of Strategy													
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		N/A											
Digital Strategy Update	Director of Digital Transformation													
Going Concern	Chief Finance Officer													Taken to Audit Committee
Estates Strategy Update	Director of Estates, Facilities & PFI													To be taken to the Board Seminar in July
Annual Plan	Chief Finance Officer													

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	
Capital Programme 2022/23	Chief Finance Officer													Taken to PAF
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		
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													