University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 4th November 2020 at 9.30 am to 12.30 pm via Microsoft Teams

AGENDA

Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
09:30	**PROCEDURAL ITEMS**					
20 mins	1.	Patient Story	Information	Mrs M Rhodes	Verbal	**BAF 1**
5 mins	2.	Chair's Welcome, Apologies and Confirmation of Quoracy	Information	Mr D Wakefield	Verbal	
	3.	Declarations of Interest	Information	Mr D Wakefield	Verbal	
	4.	Minutes of the Meeting held 5th October 2020	Approval	Mr D Wakefield	Enclosure	
5 mins	5.	Matters Arising via the Post Meeting Action Log	Assurance	Mr D Wakefield	Enclosure	
20 mins	6.	Chief Executive's Report –October 2020 • Covid-19	Information	Mrs T Bullock	Enclosure	**BAF 6**
10:20	**PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES**					
5 mins	7.	Quality Governance Committee Assurance Report (21-10-20)	Assurance	Ms S Belfield	Enclosure	**BAF 1**
15 mins	8.	Winter Plan	Assurance	Mr P Bytheway	Enclosure	**BAF 1** **BAF 6**
10 mins	9.	Infection Prevention Board Assurance Framework	Assurance	Mrs M Rhodes	Enclosure	**BAF 1**
10:50	**ENSURE EFFICIENT USE OF RESOURCES**					
5 mins	10.	Performance & Finance Committee Assurance Report (20-10-20)	Assurance	Mr P Akid	Enclosure	**BAF 9**
10:55	**ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT AND RESEARCH**					
5 mins	11.	Transformation and People Committee Assurance Report (22-10-20)	Assurance	Prof G Crowe	Enclosure	**BAF 2 & 3**
11.00 – 11.15 : BREAK						
11:15	**ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS**					
45 mins	12.	Integrated Performance Report – Month 6	Assurance	Mrs M Rhodes Mr P Bytheway Mrs R Vaughan Mr M Oldham	Enclosure	
12:00	**GOVERNANCE**					
5 mins	13.	Audit Committee Assurance Report (22-10-20)	Assurance	Prof G Crowe	Enclosure	
10 mins	14.	Board Assurance Framework – Quarter 2	Assurance	Miss C Rylands	Enclosure	**ALL**
10 mins	15.	Speaking Up Report – Quarter 2 2020-21	Assurance	Mrs R Vaughan	Enclosure	**BAF 2**
12:25	**CLOSING MATTERS**					
5 mins	16.	Review of Meeting Effectiveness and Business Cycle Forward Look	Information	Mr D Wakefield	Enclosure	
	17.	Questions from the Public **Please submit questions in relation to the agenda, by 12.00 pm 30th October claire.rylands@uhnm.nhs.uk**	Discussion	Mr D Wakefield	Verbal	
12:30	**DATE AND TIME OF NEXT MEETING**					
	18.	**Wednesday 9th December 2020, 9.30 am – 12.00 pm, via Microsoft Teams**				

University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Monday 5th October 2020, 9.30 am to 12.10 pm
Via Microsoft Teams

MINUTES OF MEETING

Attended	Apologies / Deputy Sent	Apologies

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

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

In Attendance:		
Mrs D Bailey	DB	ARTU Coordinator (item 1)
Mr P Buckley	PBu	Patient Representative (item 1)
Mrs T Buckley	TbU	Patient Representative (item 1)
Mrs A Grocott	AG	Head of Patient Experience (item 1)
Mrs N Hassall	NH	Deputy Associate Director of Corporate Governance (minutes)
Ms A Walsh	AW	Deputy Medical Director (rep Dr Oxtoby)

Members of Staff and Public via MS Teams: 11

No.	Agenda Item	Action
1.	**Patient Story**	
128/2020	Mr and Mrs Buckley recalled their son, Peter's story. Mr Buckley explained that Peter had been admitted to Royal Stoke for a procedure and had a subsequent cardiac arrest, and whilst in hospital the family felt his needs were not always being fully met, although they were complementary of his physiotherapy and speech and language therapy. The family felt that there was a lack of communication between the staff and themselves, and highlighted issues such as not addressing Peter's basic care needs and contradictory information being given to them.	

PROUD TO CARE

	Mr Wakefield apologised for Peter's treatment and queried how long he was on the ward. Mrs Bailey explained that Peter was admitted in November 2019 and was discharged at the end of July 2020. Mrs Bullock echoed Mr Wakefield's apologies and requested to hear more from the team. Mrs Bailey stated that the family felt the care was exceptional at the beginning and when concerns were raised she spoke to the team and it was felt these were addressed at times. She described Peter's extremely complex rehabilitation needs and noted that under normal circumstances Peter would have been discharged to a Care Home, however, through his intensive and exceptional rehabilitation and the support and training that ARTU provided to the family and out of area professional carers, he was enabled to be discharged home. Mr Wakefield referred to the issues of communication and if anything was done to address it and Mrs Buckley explained that she spoke to the Matron at times, but she felt that she received better answers from Mrs Bailey and the therapists. Mr Wakefield referred to the issues of washing Peter and Mrs Bailey explained at as part of planning for Peter's discharge, it would have been important to get the family prepared for washing Peter at home and that sometimes that led to delays in his full hygiene needs being met but reassured that until that point, care was provided. Mrs Rhodes referred to the staffing levels on the ward and stated that levels were reviewed twice a year; she agreed to take the comments into account as part of the next review. Mr Wakefield thanked Mr and Mrs Buckley for joining the meeting and for outlining the issues experienced. He apologised for the lack of communication and stated that actions would be taken to understand the reasons for mis-communication between the relatives and the staff. He agreed that the care provided could have been improved, although he recognised the positive comments made regarding Mrs Bailey, Rachel and Claire and the work they did to help get Peter discharged. Mr Wakefield queried how Peter was at present, and Mrs Buckley stated that he was doing well at home and had more movement and she also added that she was still being provided with support from the ARTU team. Mr Wakefield stated that additional feedback would be provided to the family of the actions taken. Mrs Grocott, Mr and Mrs Buckley and Mrs Bailey left the meeting. Mrs Rhodes agreed to provide an update of the actions taken in response to the story, to a future Quality Governance Committee (QGC) meeting. **The Trust Board noted the story.**	**MR**
2.	**Chair's Welcome, Apologies & Confirmation of Quoracy**	
129/2020	Mr Wakefield welcomed members of the Board and observers to the meeting. Apologies were received as noted above and it was confirmed that the meeting was quorate. Mrs Bullock highlighted that a number of staff had joined the meeting as part of 'Doing the Right Thing' which included representatives from the Emergency Care Intensive Support Team (ECIST), and that the work being done was to improve urgent care flow throughout the Trust, making sure patients get to the right	

	destination in the fastest way possible. She explained that the rapid improvement event was designed around the whole urgent care pathway and that all staff at all levels were engage in the process. It was noted that the 2 week journey would also help to support preparations for winter. Mr Wakefield highlighted that Dr Griffin, Mr Akid and Professor Crowe had been reappointed for different terms.	
3.	**Declarations of Interest**	
130/2020	The standing declarations were noted.	
4.	**Minutes of the Previous Meeting held 5th August 2020**	
131/2020	The minutes of the meeting from 5th August 2020 were approved as an accurate record.	
5.	**Matters Arising from the Post Meeting Action Log**	
132/2020	PTB/443 – Mrs Rhodes highlighted that infection prevention metrics would be included within the quality report in order to monitor progress going forwards, and she agreed to provide a revised target date.	
6.	**Chief Executive's Report – August & September 2020**	
133/2020	Mrs Bullock highlighted a number of areas from her report. Mr Wakefield referred to the number of staff absences associated with Covid and queried the impact of this on the restoration and recovery programme and whether this was being planned for. Mrs Bullock stated that the potential impact was not known as there were numerous factors that could impact on this such as the number of Covid positive patients and number of emergency patients, but noted these could trigger cessation of elective activity. She stated that the Trust would continue to monitor and factor this into the plans, as well as factoring in the potential surge in Covid positive patients. Professor Crowe referred to the Big Conversation and queried how the feedback from this would be reviewed and fed back to the Board and Committees. Mrs Vaughan added that listen and learn events were also taking place, as well as the Big Conversation, and the themes from these would be pulled together in a report and provided to the Transformation and People Committee (TAP). Mrs Thomson added that the Big Conversations enabled staff to get involved in their own way which was resulting in getting more feedback. Professor Hassell referred to the Delivering Exceptional Care programme and queried how the Trust was ensuring value for money. Mrs Bullock stated that the contract would be closely monitored and before the award of contract, a number of tests were undertaken to ensure value for money which included reducing the cost. She stated that once performance indicators were available for each area, these would be monitored and reported to TAP, in addition to whether the programme was adhering to timelines. Mr Wakefield referred to the key risks highlighted within the report, in relation to	

	capacity of the surgical robot, never events and theatre activity and queried where those risks were managed and recorded. Mrs Bullock stated that the investigation into the never events would be taken to the QGC and in terms of theatre activity the Trust had 99.2% of capacity online but there were issues with productivity due to Personal Protective Equipment (PPE) requirements and additional cleaning. She stated that in terms of the capacity of the surgical robot, whilst the Trust was lucky to have two robots, these were not enough to treat the backlog whilst maintaining Covid-19 requirements and therefore actions were being taken to identify how the system could identify a solution. Mr Wakefield referred to the statement regarding job planning and timing of this and Ms Walsh highlighted that the annual cycle commenced in September with the aim of finishing at the end of March but due to Covid, planning for 2020-21 had been delayed. **The Board received and noted the report and approved two REAFs; Pharmacy Dispensing Service for Ambulatory Patients (REAF 3878) – Extension and Renal Services provided at Leighton Hospital (REAF 3607) – Extension.**	
PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES		
7.	**Quality Governance Committee Assurance Report (24-09-20)**	
134/2020	Ms Belfield highlighted the following: • The Committee noted the position in terms of duty of candour, and formal letters being issued, whereby processes were being reviewed to ensure letters were provided after providing verbal feedback • The Committee noted the feedback received in terms of restrictive visiting and the number of associated complaints, with work ongoing in terms of communicating the restrictions with members of the public • The Committee welcomed the revised maternity dashboard, and requested additional splits between County Hospital and Royal Stoke to establish any differences in performance • Further deep dives were being undertaken in relation to c-difficile and Covid Mrs Taylor referred to compliance with duty of candour and given the issue had been ongoing for some time, queried when it was expected to see an improvement. Ms Belfield stated that she was expecting to see an improvement by the next meeting. Mr Wakefield referred to restrictive visiting in maternity and queried the current position given that Covid numbers were increasing and whether this would have an impact. Mrs Rhodes confirmed that visiting had not been completely banned and that it was down to the discretion of the ward as to whether visiting could be accommodated safely. She stated that some areas had allowed visiting, and one of the main issues was antenatal scanning as there was not enough space to enable partners to join whilst adhering to social distancing. It was noted that the Head of Midwifery was continuing to review this and as such was to provide a paper at a future Executive Team meeting. **The Trust Board received and noted the assurance report.**	
ENSURE EFFICIENT USE OF RESOURCES		

8.	**Performance and Finance Committee Assurance Report (22-09-20)**	
135/2020	Mr Akid highlighted the following: • The Committee noted the delay in receiving the Urgent Care Improvement Programme and requested interim updates before it was presented to October's Committee • The Committee received assurance in relation to the Data Security and Protection Toolkit and statutory and mandatory training • An update was provided on the financial projections as a result of the new financial allocations with an anticipated deficit • The Executive Infrastructure Group provided an update following their recent meeting Mr Wakefield referred to the implications of the potential deficit as a result of the new financial allocation which required further discussion at the Performance and Finance Committee (PAF) and Board. **The Trust Board received and noted the assurance report.**	
9.	**IM&T Strategy Progress Report**	
136/2020	Mr Bostock highlighted a number of areas from his report. Mrs Taylor referred to the Integrated Care Record and queried whether phase 1 had commenced. Mr Bostock confirmed that this had gone live to enable integrated information from across health and social care. Mr Wakefield referred to the LIMS project and the delays noted in the report and queried if this would affect the go live. Mr Bostock stated that the delay would not stop the go live of the system, which was to be phased and associated costs would be picked up by the N8 network. He confirmed that he anticipated the go live would go ahead as planned and Ms Ashley added that the roll out was in line with changes in the service articulated in the N8 business case, therefore it was expected that there would not be any financial consequence. Mr Wakefield referred to the Microsoft 365 project which was due to go live in October and queried if that remained the case. Mr Bostock stated that NHSx had brokered the contract to introduce the system which was to commence in January 2021. Mr Wakefield referred to the security updates and whether this put the Trust at risk if there was a delay in implementation and Mr Bostock stated that as the contract had been agreed, the Trust would continue to be supported by the existing version of Microsoft Office. Mr Wakefield asked Mr Bostock to update the report to reflect any slippage in projects and Mr Bostock confirmed that other projects were on track as stated. **The Trust Board received and noted the progress made in the last period.**	**MB**
ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT AND RESEARCH		
10.	**Transformation and People Committee Assurance Report (24-09-20)**	

137/2020	Professor Crowe highlighted the following: • Month 5 appraisal rates had improved • The Committee welcomed the update on the activities being undertaken to support staff health and wellbeing • There had been good completion rates in relation to Covid staff risk assessments • The progress in the Delivering Exceptional Care programme was noted which included appointments to new posts. Further insight was provided on the communication and engagement activity with staff to ensure that they had increased awareness of the programme • Limited assurance was provided in respect of the nursing establishment review. Following the full review, the mid-year review had been affected by Covid due to ward moves and the Committee were not able to obtain more assurance in terms of the required levels of staff being in place and effective use of skill mix, particularly in the Medical Division. • Talent and succession planning arrangements had been included on the business cycle going forwards, to be reviewed in more detail Mrs Taylor referred to the discussion regarding the nursing review and skill mix and requested assurance that this involved other roles to support nurses to which Mrs Rhodes confirmed. Mr Wakefield referred to the staffing establishment review and the links with the patient story and queried when the review would be completed. Mrs Rhodes explained that an interim review had been undertaken and a further update was to be provided to TAP in November. She added that the ward in the patient story had a small vacancy rate and the main issue was within Medicine. Mr Wakefield queried whether Board members were assured that staff were taking their annual leave. Mrs Vaughan stated that this was monitored via the Electronic Staff Record and staff were encouraged to take their leave during summer and phase it throughout the year. Mr Wakefield queried if staff would lose the entitlement if it was not taken and Mrs Vaughan stated that the usual process was to carry forward 5 days, although a national directive was that any outstanding leave could be phased over 2 years. Mrs Vaughan agreed to review the levels of annual leave outstanding from the current systems, and reiterate the messages to line managers to ensure their staff were taking appropriate leave. **The Trust Board received and noted the assurance report.**	**RV**
11.	**Workforce Race Equality Standard (WRES)**	
138/2020	Mrs Vaughan highlighted a number of areas from her report. Mr Smith commented on the metrics which seemed to show a distorted view when identifying improvements/deteriorations. Mrs Vaughan agreed to consider for future reports, if the data could be articulated differently in order to demonstrate any trends rather than comparing to the previous year. Professor Hassell welcomed further trend analysis and the emphasis on respect and dignity. He queried the cultural intelligence programme and what that entailed and Mrs Vaughan stated that further information was awaited as this was referred to in the national people plan. She stated that an approach was to be established across the system in order to raise awareness of different cultures,	**RV**

	enabling all staff to live in each other's shoes. She added that she felt it should also be incorporated into existing leadership development programmes in terms of equality, diversity and inclusion. Professor Crowe supported the focussed initiatives being taken forwards, in particular respect and dignity and civility. It was noted that progress against the various plans would be provided at TAP, including how the various elements were monitored and reviewed within the Divisions. Mrs Taylor referred to the need to hear the experiences from people from different backgrounds and reflect on these and Mrs Vaughan agreed that awareness needed to be raised and this had been discussed with the staff network with actions being taken forwards to create a wider network of cultural diversity and inclusion. Mr Wakefield welcomed the work being done to take forwards the cultural change and welcomed the actions identified, although he felt that the pace of some of the actions needed to increase where possible. **The Trust Board received and noted the report and the actions identified to close the gaps in career and workplace experience between our Black and Minority Ethnic (BAME) staff and the overall workforce at UHNM during 2020-21.**	
ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS		
12.	**Integrated Performance Report – Month 5**	
139/2020	Mrs Rhodes highlighted the following in relation to the quality metrics: • In relation to compliance in providing written confirmation of duty of candour, this had been raised at each Divisional Performance Review, despite achieving 100% for verbal confirmation, although there were small numbers involved. It was noted that Medicine had achieved 100% for written duty of candour for the past couple of months which was positive • Sepsis compliance for adult inpatients only achieved 50% which had been reviewed in detail and an issue identified in Children's, Women's and Diagnostics Division. Upon review it was determined that antibiotics were given within the hour for all patients but this had not been recorded correctly Mr Wakefield referred to sepsis compliance and whether levels of sepsis were rising, falling or static. Mrs Rhodes stated that if patients were not being adequately identified as having sepsis, she would expect there to be a deterioration in their condition as they would not have been administered with antibiotics. She stated that this was routinely monitored and no issues had been identified. Mr Smith referred to the grade 4 pressure ulcer on Ward 225 and queried the actions taken. Mrs Rhodes stated that Ward 225 dealt with a lot of patients with dementia, therefore investment in skill mix and equipment had been made in order to improve the care of these patients. She stated that over the last year, the team had been supported which included putting different staff in post and when the investigation into the ulcer was reviewed in detail via a compliance panel, a lot of work had been completed on training, increasing Tissue Viability presence and sharing the learning. She explained that while it would continue to be a ward which cared for patients susceptible to developing ulcers and remained a risk, she would not expect patients to obtain a grade 4 ulcer.	

Professor Hassell referred to the number of patient safety incidents per 1000 bed days with no harm and the information provided to QGC which was encouraging. He stated that this demonstrated that there was a low threshold for reporting, which enabled staff to learn from near misses which was positive.

Mr Wakefield referred to the number of medication incidents and whether this was higher or lower than usual. Mrs Rhodes stated that the number of incidents were not reducing, therefore additional actions were required and this was being used as a target for the Delivering Exceptional Care programme. She added that a deep dive was also being undertaken by Pharmacy.

Ms Walsh referred to the never event which occurred in Specialised Surgery whereby a patient underwent cataract surgery and had an incorrect lens fitted. She explained that the error had been identified while the patient was having the operation, therefore the lens was removed and the correct one inserted. It was noted that a Root Cause Analysis was being undertaken and the directorate had already taken a number of actions, including revising the WHO Surgical Safety Checklist and a specific question introduced.

Mr Wakefield queried if anything else could have been done to avoid the error and Ms Walsh stated that she hoped that the additional check to obtain written confirmation would prompt teams to focus. Mrs Bullock added that actions had also been taken by the Division to provide human factors training to staff.

Mr Bytheway highlighted the following in relation to urgent care performance:

- There had been a deterioration in performance through August and September related to workforce; due to changes in the Junior Doctor contract and the reduction in long term locums
- Consideration was being given as to how to engage with the Emergency Department team, and the rota was being reviewed which would be presented to the Executive Team, which would be compared with rotas for other Major Trauma Centres
- The urgent care improvement programme was to be articulated at PAF in October, and actions were being taken to identify the response required from each Division going forwards, which would have an effect on improving performance
- Actions were being taken to review the flow around wards as well as reviewing pathway changes

Mr Wakefield queried if the Executive were content that the Emergency Department were enthusiastic of the changes and the plan required to which Mr Bytheway confirmed.

Mr Akid requested assurance that there was buy in from staff into the improvement programme and Mr Bytheway confirmed that he felt the staff had the energy and belief in their ability to make improvements. He stated that the general sense from staff as the Trust moved towards Doing the Right Thing, was that they wanted to move forward with the improvement and the senior leadership team wanted to make the change and were actively involved.

Mr Akid queried when the weekly update of actions being taken would be provided to Non-Executives and Mrs Bullock explained that this was to be provided via her weekly update meetings.

Mr Akid referred to the misalignment between UHNM and Vocare KPI's and

queried whether this had been resolved. Mr Bytheway stated that discussions remained ongoing, and the Clinical Commissioning Group (CCG) had been asked to consider if different actions could be taken as part of the winter plan.

Mr Bytheway highlighted the following in relation to planned care performance:

- Cancer performance had continued to demonstrate good delivery, and the number of patients in the backlog had reduced to 110
- Theatre capacity had increased to 99.2% and the Trust was close to performing against the national phase 3 activity requirement. It was noted that capacity was being provided by using theatres and the independent sector to maximise throughput
- Theatres had undertaken a 'perfect week' at the beginning of the month in order to identify learning and improving the efficiency through theatres
- In terms of RTT, there were 900 patients waiting over 52 weeks, with ongoing validation and confirm and challenge taking place with specialties, in order to understand the plans in place for those patients

Mr Wakefield queried whether it was expected that the number of 52 week patients would grow to which Mr Bytheway confirmed, although additional actions continued to be identified.

Professor Hassell referred to cancer performance and welcomed the work in decreasing the backlog. He queried the reason for the number of treated patients within the month having remained static. Mr Bytheway stated that the number of treatments had remained the same, as those patients who did not have a cancer diagnosis had been removed as they had received their treatment separately.

Mr Bytheway added that there had continued to be an improving position for diagnostics.

Mrs Vaughan highlighted the following in relation to workforce performance:

- In relation to the national people plan, work was being undertaken on the Trust's delivery plan with future updates to be taken to TAP
- Sickness absence remained above target although there was an improvement in August compared to July. September had seen an increase in Covid related absences, largely driven by children returning to school
- There continued to be a focus on having wellbeing conversations with staff and undertaking Covid risk assessments
- There had been an improvement in appraisal compliance although further improvement was required as well as understanding Divisional performance against their trajectories particularly before winter
- There had been an improvement in statutory and mandatory training compliance to 92.22%

Mr Wakefield referred to staff testing and whether the Trust was able to meet the demand. Mrs Vaughan confirmed that current demand was being met although there were times at which this was challenged.

Mr Oldham highlighted the following in relation to financial performance:

- The Trust achieved a break-even position at Month 5, and the position was stable in terms of months 1 to 6, but more volatile in terms of understanding months 7 to 12
- There had been a small movement in the pay run rate when compared to July but this continued to be stable
- Non pay had increased, due to activity increasing particularly in relation to pass through drugs

	• The capital programme was slightly behind, in part due to the statutory maintenance programme and replacement equipment. The programme was becoming more complex due to the different schemes in place • No concerns were raised in terms of the cash position • A paper was to be taken to PAF in terms of months 7 – 12. It was highlighted that as a system, an indicative allocation had been identified which moved towards a fixed sum with the expectation that this would achieve break-even, although the system submission had identified a £49 m deficit, with the Trust's contribution standing at £19 m. This had been escalated to NHSIE, which detailed the drivers of the deficit and for the Trust, there were some errors in the way in which the allocation had been calculated i.e. not including the TSA support of £12.4 m and the assumption that other income would continue as previous, despite the Trust not receiving this from car parking, catering and other commercial income. In addition, the initial trajectories associated with the elective incentive scheme could result in a penalty of £3 m. **The Trust Board received and noted the report.**	
CLOSING MATTERS		
13.	**Review of Meeting Effectiveness and Business Cycle Forward Look**	
140/2020	Nothing further was raised.	
14.	**Questions from the Public**	
141/2020	It was noted that no questions had been received.	
DATE AND TIME OF NEXT MEETING		
15.	Wednesday 4th November 2020, 9.30 am, via MS Teams	

Trust Board (Open)

Post meeting action log as at **28 October 2020**

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/441	05/08/2020	Accountability and Performance Framework	To clarify the role of reporting the metrics via the IPR and which committees these were considered by, within the document.	Claire Rylands	30/11/2020		Action not yet due.	GB
PTB/443	05/08/2020	Infection Prevention Assurance Framework Covid-19	To include information within the quality metrics.	Michelle Rhodes	09/12/2020		To be included in November's IPR.	GB
PTB/444	05/10/2020	Patient Story	To provide an update of the actions taken in response to the story, to a future Quality Governance Committee (QGC) meeting.	Michelle Rhodes	25/11/2020		Action not yet due.	GB
PTB/445	05/10/2020	IM&T Strategy Progress Report	To update the report to reflect any slippage in projects	Mark Bostock	04/11/2020		To be provided in future reports.	GB
PTB/446	05/10/2020	Transformation and People Committee Assurance Report (24-09-20)	To establish the levels of annual leave outstanding, and reiterate the messages to line managers to ensure their staff were taking appropriate leave.	Ro Vaughan	04/11/2020		**Update to be provided.**	GB
PTB/447	05/10/2020	Workforce Race Equality Standard (WRES)	To consider if the data could be articulated differently in order to demonstrate any trends rather than comparing to the previous year.	Ro Vaughan	04/11/2020		**Update to be provided.**	GB

University Hospitals of North Midlands NHS Trust

Chief Executive's Report to the Trust Board

FOR INFORMATION

Part 1: Trust Executive Committee

The Trust Executive Committee met on 28th October 2020. The meeting was held virtually using Microsoft Teams; there was no agenda or papers as the purpose of the meeting was to provide an opportunity for:

- Providing the latest position with regard to the second surge of Covid-19
- Divisions to provide updates in terms of their latest position, next steps, staff wellbeing and any concerns/risks

Key points highlighted were as follows:

- Modelling for the coming weeks
- Plans regarding the standing down of elective activity to free up capacity, whilst ensuring risks are minimised
- Discussions with system partners regarding support for complex discharges
- Staffing levels which have seen an increase in Covid related sickness absence along with plans for redeployment of staff where required through re-establishment of the Workforce Bureau
- Key challenges and progress with plans within Clinical Divisions including alternative ways of working in order to maintain business as usual wherever possible
- The importance of ensuring strict adherence to Infection Prevention measures
- Progress being made with the establishment and implementation of rapid testing within Pathology
- Wellbeing initiatives being led both corporately and within Divisions

Any Board member seeking to obtain further information regarding the items considered by the Trust Executive Committee should contact Claire Rylands, Associate Director of Corporate Governance.

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

- **Supply of IV Fluids (REAF 3902)** supplied by various at a total cost of £529,401.00, for the period 30/09/20 - 31/05/21 providing savings of £44,863.00, approved on 24/09/2020
- **Pharmacy Dispensing for Ambulatory Services (REAF 3878)** supplied by Lloyds Pharmacy at a total cost of £13,500,000.00, for the period 01/10/20 – 31/03/21, approved on 06/10/2020
- **Supply of Ports and Trocars (REAF 3837)** supplied by Various at a total cost of £2,111,267.98, for the period 01/08/20 – 21/07/21, providing savings of £50,670.00, approved on 22/09/2020
- **Services of Junior Doctors (REAF 3830)** supplied by St Helens & Knowsley NHS at a total cost of £2,570,000.00, for the period 01/08/20 – 31/03/21, approved on 22/09/2020
- **Renal Services at Leighton Hospital (REAF 3607)** supplied by Fresenius Medical Ltd at a total cost of £4,720,614.00, for the period 11/03/20 – 31/03/23, approved on 22/09/2020

The following REAF had been approved by the Performance and Finance (PAF) Committee and Trust Board via chairs action, due to the timescales involved:

Children's Outpatient Ward - Lease (REAF 3978)

Contract Value £1,195,708.80 incl. VAT
Award of Contract
Duration 16/12/20 – for 104 weeks
Supplier Portakabin

This REAF is for the recurring revenue costs associated with the new Children's Outpatients modular ward. The building will be leased on a minimum hire period of 104 weeks and will link to the existing Children's Emergency Department in order to provide additional and urgent consulting rooms, in line with UHNM Covid-19 measures.

The Contract is being awarded compliantly via the Shared Business Services (SBS) framework contract reference number SBS/16/JS/PZS/9049.

Savings – No savings.

2. Consultant Appointments

The following table provides a summary of medical staff interviews which have taken place during October 2020:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Head & Neck MDT Lead	Vacancy	Yes	TBC
Consultant Diagnostic Neuroradiologist	Vacancy	Yes	29/12/2020

The following table provides a summary of medical staff who have joined the Trust during October 2020:

Post Title	Reason for advertising	Start Date
Consultant Histopathologist	Vacancy	01/10/2020
Microbiology Senior Medical Practitioner	New	01/10/2020
Locum Consultant Foot and Ankle Surgeon	Extension	01/10/2020
Locum Stroke Consultant	Extension	01/10/2020

Post Title	Reason for advertising	Start Date
Locum Consultant Breast Radiologist	Vacancy	05/10/2020
Locum Consultant Paediatrician with an interest in Gastroenterology	Vacancy	05/10/2020
Locum Consultant Orthopaedic Surgeon	Retire and Return	15/10/2020
Locum ENT Surgeon	New	19/10/2020
Radiologist	Retire and Return	19/10/2020
Consultant Clinical Oncologist with specialist interest in Breast and Skin malignancy	Vacancy	19/10/2020
Locum Consultant Paediatrician - PICU	Extension	20/10/2020

The following table provides a summary of medical vacancies which closed without applications / candidates during October 2020:

Post Title	Closing Date	Note
Respiratory Consultant - Interstitial Lung Disease	05/10/2020	No Applications
Locum Consultant - Winter Pressures	05/10/2020	No suitable applications
Clinical Lead for Neurology	18/10/2020	No Applications

3. Covid-19

We are beginning to feel the pressures of Covid-19 again as the numbers of inpatients and those in critical care have seen a marked increase over recent weeks. I am committed to holding onto business as usual for as long as we possibly can but that does not mean we will not act fast by stepping up our response to Covid-19 and creating additional capacity across both our hospitals when we need to maintain the safety of our staff and patients.

4. Do the Right Thing – It's Everybody's Business

Friday 16th October saw the end of our intensive transformation fortnight – 'Do the Right Thing, it's Everybody's Business' – but the drive to improve does not end here. The two weeks saw significant improvements across the three areas of focus in the Emergency Department, the site management and on our pilot wards to help improve patient flow. Patients arriving in the ED were quickly moved to the right place, for the right care at the right time to our portals or elsewhere and improved board rounds and discharge processes have meant that more patients have been identified as ready to leave hospital and therefore go home quicker and we have also seen better use of our Discharge Lounge. All of these improvements are better for our patients, their experience in hospital and their further recovery while also improving our flow and performance.

5. Delivering Exceptional Care

Our long term quality improvement movement Delivering Exceptional Care is gathering pace and together with Do the Right Thing means it is an exciting and positive time to be part of the UHNM family. Delivering Exceptional Care is being developed in direct response to staff feedback around improving our culture and giving responsibility and decision making back to staff within their own areas. Everyone will receive training on the Exceptional Care Improvement System which is how we will develop skills in every part of our organisation to improve what we do for our patients. This training will take place in waves and I am delighted that the first wave is starting this month, with the second wave scheduled for April 2021. The first wave of teams (Ward 102, Ward 104, Ward 109, AMU County, AMU Royal Stoke) are being briefed and I am looking forward to visiting these areas to discuss and see the improvements they are planning.

6. Wellbeing Festival

Our virtual Wellbeing Festival has taken place during the month with a number of opportunities being made available to our staff so that they can take some well-earned time out from their day to day responsibilities. A number of classes were available online from coaching support to relaxation classes and I took part in a 30 minute chair yoga session which was a first but I thoroughly enjoyed it!

7. Staff awards

The Trust's much valued staff awards have had to take place virtually this year and the online event on Friday 23rd October celebrated a record number of applications and what can only be described as outstanding winners and examples of everything which makes UHNM great. Fireworks included, the event, the runners up and the winners can be seen on the UHNM website.

8. Pirehill School

One of the highlights of the month was a very special Microsoft Teams call with Pirehill First School in Stone which was arranged by Michelle Rhodes, our Chief Nurse after pupils sent us hand written notes thanking staff for their efforts during the pandemic. We were joined by some senior nurses and other members of the Executive Team to personally thank them and to explain more about what we do. To say we enjoyed this opportunity was an understatement.

9. 999:Critical Condition

999:Critical Condition, the series currently being aired on Channel 5 and filmed at Royal Stoke Hospital, has proved exceptionally popular attracting high viewing figures, some reporting over 2 million per episode. Based on this success the production company are keen to film an additional series with us and our communications team is currently working with them on how we can broaden the next episodes to include more and different parts of the hospital.

10. UHNM Charity

Our charity activity has continued despite the challenges of social distancing and being unable to hold events. I would especially like to thank one of our patients Chris Gibb who completed a month-long fundraising walk from Eastbourne to Royal Stoke in aid of Children's Services in memory of his late son Thiago raising thousands of pounds for the UHNM Charity. I would also like to thank Tesla Owners Group UK, which is the officially recognised car club for Tesla UK, for donating a mini electric car for the use of children in our hospital. This has proved a great distraction for children and some are now even driving themselves to theatre!

11. Recruitment

Since August the Trust has been supporting recruitment via social media by advertising the staff nurse post on Facebook, Instagram and Messenger with a combined reach of 1.5 million people. In addition, the Trust hosted four live recruitment sessions which reached 28,209 people. We have also just started to utilise Google advertising, so our adverts will feature when using the Google search engine, watching videos on YouTube and on advertising space on websites owned by Google when certain keywords are used by the user e.g. NHS or staff nurse. This was set up on 6th October and has already reached 152,970 people. BBC Bitesize have also shown interest in promoting NHS careers with a particular interest in around career in Pathology. The impact of this activity in terms of numbers of applications, will be reviewed in the coming weeks to enable efforts to be refined and generate maximum awareness and applications to vacant posts.

Quality Governance Committee Chair's Highlight Report to Board

21st October 2020

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• An update in relation to Covid-19 was provided and the impact from the second surge. It was noted that some outbreaks had occurred which was causing operational difficulties and there had been an increase in staff sickness related to Covid, and the actions being taken to support any pressure points were outlined. • Following the suspension of Get It Right First Time (GIRFT) due to Covid, the programme had recommenced in August 2020 and actions were being taken to improve engagement going forwards	• To provide the staffing assurance plan to the Transformation and People Committee • Further analysis of nosocomial infections and outbreaks to be undertaken and reported going forwards • To liaise with each specialty to ensure that they are engaging in the GIRFT process • Revised Quality Impact Assessment Policy to be ratified within the month • To consider setting annual objectives for the Committee, based on its terms of reference and responses to the Committee Effectiveness Review • To include updates in respect of the Dementia Strategy on the business cycle going forwards
Positive Assurances to Provide	**Decisions Made**
• An update in relation to infection prevention was provided and up to date information was provided in relation to recent Covid outbreaks and the actions being taken to manage these. • Improvements had been made in sepsis screening within the Emergency Departments, following the completion of randomised audits and actions put in place to address any issues raised. • Over 4000 staff flu vaccinations had been provided and the Trust was awaiting the next delivery of vaccinations • The Committee welcomed the robustness of the infection prevention board assurance framework which had been updated to reflect current controls and assurance for quarter 2 • In terms of month 5 quality performance the Committee welcomed the inclusion of the splits between low and no harm incidents and received a further update in terms of the actions being taken in respect of pressure ulcers • The Committee noted the nursing recruitment plan which supported the actions being taken in terms of nurse staffing and welcomed the introduction of providing clearer staffing indicators • Harm reviews for 104 day and 52 week patients had been undertaken and to date 1 harm had been identified which was subject to a Root Cause Analysis. The Committee queried the actions being taken to review those patients waiting for an appointment and any potential harm. • 41 non-Covid research studies had recommenced and the National Institute for Health Research (NIHR) target was to recommence 80% by March 2021 which the Trust was on track with. The impact from Covid on commercial studies was highlighted and the Committee welcomed the positive results in relation to recruitment to Covid related studies. • The Committee formally noted that the section 31 notices in relation to mental health had been removed • The clinical audit programme had recommenced, following the delay due to Covid although the programme may be impacted further due to the second surge • An update in respect of litigation was provided and it was noted that the Maternity Incentive Scheme continued to be paused due to Covid	• The Committee approved the Board Assurance Framework as at Quarter 2
Comments on Effectiveness of the Meeting	
• The Committee agreed that the quality of papers provided had improved and provided members with additional assurance.	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Executive Directors Update including Covid-19	Information	11.	Get It Right First Time Update	Assurance
2.	Infection Prevention HAI Quarterly Report Q2	Assurance	12.	Clinical Audit Progress Report	Assurance
3.	A&E Sepsis Screening IVAB Compliance Report – Royal & County Hospitals	Assurance	13.	Litigation Report	Assurance
4.	IPC Board Assurance Framework Q2	Assurance	14.	Board Assurance Framework Q2	Approval
5.	Seasonal Influenza Staff Vaccination 2020/21	Assurance	15.	Quality Impact Assessment Report	Assurance
6.	M5 Quality & Safety Report	Assurance	16.	Committee Effectiveness Review	Assurance
7.	Monthly Staffing Report – Sept 2020	Assurance	17.	Executive Health & Safety Group Highlight Report	Assurance
8.	Harm Review Process for Long Wait Patients	Assurance	18	Quality & Safety Oversight Group Highlight Report	Assurance
9.	Research and Innovation Quality Update	Assurance	19.	Infection Prevention Annual Report	Information
10.	CQC Notice of proposal to refuse or remove an application to remove Section 31 conditions	Assurance	20.	Dementia Strategy Update	Information

3. 2020 / 21 Attendance Matrix

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

In addition Mr E Phillips, Mrs H Bucior, Mr R Bowler, Mrs D Meehan and Ms A Khela joined the meeting.

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	4th November 2020
Report Title:	Trust Capacity and Resource Proposal – Winter Plan 2020/21	**Agenda Item:**	8
Author:	Beryl Woodall, DCOO, Ray Casey, Head of Business Planning & Jonathan Tringham, Head of Operational Finance		
Executive Lead:	Paul Bytheway, Chief Operating Officer		

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

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

Summary of other meetings presented to and outcome of discussion:

Trust Winter Planning Group and Performance & Finance Committee

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

The UHNM Winter Plan covers the period October 2020 – March 2021 has been drafted and developed with the support of the Trust Winter Planning Group and has been aligned to the System Winter/Surge Plan. Key components of the plan include:

Essentially, this year's plan brings together:

- learning from the years 19/20 in terms long waits, IPC and the need to improve processes associated with side rooms
- plans to maintain the improvement in relation to occupancy, simple discharges and sustain the improvements associated with MFFD to support reduced overcrowding within ED
- the need to have improved 'timeliness' associated with flu / covid swabbing to allow for earlier in the day movement
- a pre /post-Christmas plan to support delivery and the recovery

Our plan will cover the following areas:

- **A Reflection of Winter 19/20 Experience, Covid19 Response and Restoration of Services:** a summary of urgent care performance and outcomes from last year is reported that has informed the 2020/21 plan and the enabler schemes for 20/21, together with the approach to restoration of services.

- The 'Lessons Learnt' outcomes included in this year's plan features: earlier focus on managing medically fit patients with our System Partners, to avoid the early winter escalation of length of stay, through the improved case management approach that has been developed through Covid.

- Increased portal capacity for Medicine, Specialised and CWD Divisions to reduce wait time in ED

though expedited pull to specialty services, reducing the length of time these patients wait within the emergency department and this is work is supported through the ECIST test of change and the enhanced urgent care plan.

- Creation of the 3rd floor emergency portal with 67 side rooms across the floor to support the IPC agenda and enhance the numbers of siderooms available within Acute Medicine

- Further Investment in pathology workforce and testing equipment required to support 24/7 front door turnaround within agreed turnaround times to allow for the timely management of our side room capability

- **Winter Schemes and Bed Model:** this year with 47 beds removed due to social distancing , the need to maintain the green zone for elective patients we have modelled both on trust and zoning to maintain the 92% occupancy, the bed summary on page 16 reflects the bed deficit to meet the 92% occupancy and where further support is required from system partners. This takes into account Covid19, Seasonal Influenza and Phase 3 Restoration and Recovery plans, aligned to the statutory mandates issued by Public Health England (PHE) and our NHSEI regulators.

- **Increased Focus on Urgent care** through coordinated approach to divisional schemes, this planning has been supported during the summer and early Autumn by ECIST and has enabled a 2 week test of change initiative to ' kick start' Phase 1 of our winter plan, our winter delivery has 4 parts

    - Phase 1 - 2 week test of change initiative
    - Phase 2 – 8 week embedding and enabling work as part of UCC governance
    - Phase 3 – Home for Christmas Campaign week before Christmas
    - Phase 4 – Rest week End of January

- **Phase 3 Recovery and Restoration** will be maintained through the Green zones at Royal Stoke and County Hospital with continued use of the Independent Sector

- **System Partners** to progress their winter capacity schemes that will see sub-acute and medically fit patients transferred to primary and community placements that meet with their on-going needs to ensure Green bed capacity can remain ring fenced when urgent care demand escalates.

- **Winter Financial Plan:** The Trust's planned revenue investment for winter totals £5.2m with £4.6m approved for immediate release with a further £0.6m to be released subject to demand; the latter being the additional funding that may be required should demand and discharge profiles dictate that additional capacity is required to be opened on the County site. Covid19 investment to the value of £1.7m capital (with a further £0.7m planned) will bolster the Trust response to Covid19 during the winter period.

- **Workforce/HR Programme Support:** the HR Team have an established portfolio of activities over winter that include rapid staff testing models, workforce roster support for Covid19/winter surge staff reallocation to areas of highest pressure, completion of the mandated central workforce situation reports, guidance and support to our staff around well-being services and having oversight of the workforce risk assessment programme, keeping this updated to ensure we are keeping our staff and patients protected.

- Corporate Nursing have commissioned 20 additional agency nursing posts to support portal and ward capacity over winter together with extended Bank support out of hours to facilitate coverage of workforce gaps at weekends.

- **Winter Communications Campaign:** **a** six week localised winter campaign is scheduled based on

highlighting public awareness of Covid19 and urgent care demand, reinforcing UHNM winter preparations and seeking to change public behaviour through the social marketing campaign – 'Where For Care?' which was deployed with successful impact last year.

- **Performance and Information:** the informatics teams have been working with Divisions and Corporate services on the refresh of existing real time data collection systems (Ward Information Systems, SAFER dashboard, Hospital at a Glance, Hospital at Night, Vital Pack).

- The information services teams have been developing the Urgent Care/Winter Performance report that will be used to monitor activity against our non-elective pathways linked to winter/Covid19 surge and escalation measures and urgent care programme KPIs. UHNM have been working with system partners on the commissioning of command and control software (SHREWD) which will support system wide escalation management as part of the collective surge response, once operational.

- **UHNM Winter Plan Risk Evaluation:** For Winter 2020/21 and any second Covid19 surge, the central directive is that there will be no blanked cessation of services and Trusts are expected to continue to manage their urgent and planned care programmes against the agreed trajectories which constitutes ***considerable*** challenges and risks. The following denote a high level risk evaluation based on factors that impact the Trust plans but for which the Trust cannot solely deliver solutions as they are subject to external impacts and enablers.

- **Workforce:** availability to open and maintain UHNM escalation areas in the event of a second Covid19 surge or other winter viruses should planned mitigations be insufficient to manage the demand as detailed in the plan.

- **System Resilience**:
- Primary care ability to maintain admission/attendance avoidance and Community/Social Care to support medically fit / sub-acute patients from the hospital footprint against agreed standards if faced with similar oversubscribed workforce/ patient demand and winter virus/Covid19 challenges.

- **Specialist Paediatric and Adult Mental Health bed Capacity:** (Nationally and local system) for vulnerable, specialist patients who need substantive 24/7 workforce support

- **Critical Care Network capacity:** capacity to decant Adult and Paediatric Critical Care patients in the network, should UHNM capacity become compromised due to Covid19 or Major Trauma impact.

- **EU Exit:** impact on specialist workforce availability, and availability of equipment/medicines sourced from outside of the United Kingdom once all contingency supply chains have been accessed.

Key Recommendations:
The Board is asked to consider and approve the UHNM winter plan 2020/21 which has been aligned to the Trusts operational and financial plans and includes drafted narrative from the System Winter Resilience plan shared to date.

1. Introduction

This document sets out the Winter Plan 2020/201 for the University Hospital North Midlands NHS Trust. The hospital has been working with Staffordshire and Surrounds system partners to establish a capacity review and whole system approach to prepare for the winter period with schemes targeted at generating additional capacity to cope effectively with surges in demand for Covid19 and Seasonal Influenza. This document sets out the UHNM contribution, its internal schemes, fit with the Operating Plan for Restoration and Recovery Phase 3 together with risks both internal and external to the plan and how these will be mitigated. Whilst this paper sets out UHNM contribution to this plan, it should be read alongside the West Staffordshire Winter Plan 2020/21 attached in **Appendix 1.** A summary of Winter Improvement Schemes are detailed below against the high level principles of:

1. **Reducing Overcrowding :** Securing reduced waits within ED through a reconfigured footprint across ED and increased space within all of the emergency portals , enhanced IPC testing to support early decision making and maximising side rooms.
2. **Improving Ward Based Processes:** Management of simple and complex discharges based on ECIST test of change recommendations linked to
   SAFER (EDDs, Criteria Led Discharge/ LOS Reviews, Earlier in the Day Discharge) and R2G principles (Ward/Board Rounds/Huddles, utilising WIS), proactive outlier management
3. **Enhanced System Pathways:** Working with System Partners to identify pathways that are about admission avoidance i.e CRIS and nursing homes, reducing ambulance conveyances alongside the work that has been undertaken on complex discharge pathways management during Covid working on the principle of same day assessment and transfers for continuing care management.

UHNM has a number of investment and planned improvements as part of its winter plan to help streamline processes and ultimately improve performance and patient experience. These include:

Royal Stoke:

- Expanded ED footprint to support the challenges associated with Flu / Covid but also Investment to support a Paediatric Modular Build in Emergency Department, to ensure capacity to see chidren
- Partnership Working to support the diversion of pathways to the Haywood WiC
- Investment in Specialised Decision Unit adjacent to the Emergency Department Footprint (10 beds) to improve immediate specialised interventions out of the Emergency Department
- Additional Critical Care Capacity 2 escalation beds on the RSUH plus a realignment of our existing General beds to support our Covid / Winter response (also a further 2 Level 1 beds have been funded so that we can improve the discharge time from Critical Care)
- The purchase of PODS to provide isolation capacity on the 'new' wards that do not have the appropriate isolation facilities that will support IPC guidance

- Reconfiguration of Medicine portal and acute ward capacity into a single zone on the top floor PFI build to support improved pull and flow of patients from the Emergency Department and ensure Covid19 suspected patient isolation from the main hospital flow.
- Emergency Access Unit for our Haematology and Oncology Patients to be able to pass through the Emergency Department and receive treatments which may support discharge rather than admission to an acute bed base.
- Investment in staffing with 30 new nurses min the Emergency Department from October.
- Investment in 20 Agency Nursing staff to supplement Ward/Portal capacity as a contingency to any workforce attrition during Covid19/winter non elective demand impact.
- System partners to support diversion of appropriate pathways to Haywood WiC.
- Investment in pathology workforce and equipment to deliver 24/7 Covid19/flu test reporting during winter.
- Investment in Pharmacy and Imaging resources to expedite medication administration and diagnostics interventions with rapid reporting to support no delays pathways through the Emergency Department.
- Investment in additional PTS /Paramedic ambulance provision to support the safe and timely transfers of our patients between sites or out of county repatriations.

County Hospital:

- Additional 25 + 7 bed escalation capacity.
- Equipment provision to maintain an elective orthopaedic service.
- Ambulance provision to support expedited transfers of diagnosed Covid19 patients to Royal Stoke.

Each of our clinical divisions, as part of the urgent care transformation and the ECIST work are supporting through pathway redesign, these include

- **Medicine:**
- Implement Same Day Emergency Cohort Pathways/Acute Medicine Pathways, avoiding ED
- Implement ED Internal Navigation / Front of House Process to reduce the foot fall in ED
- Implement Direct to Specialty Referrals to improve ambulatory flow
- **Surgery:**
- GP Direct Referrals to SAU with 'pull' methodology from ED
- Ensure timely Critical Care Step Down, improving flow through Critical Care
- Implement Direct to Speciality Referral Pathways
- CEPOD capacity/demand exercise to maintain flow through the surgical bed base
- **Specialised:**
- Implement/develop the Specialty Decision Unit and adopt the 'pull' methodology
- Implement Patient Pathways to support GP Direct Referrals
- **CWD:**
- CAU/CED Relocation
- Implement EAU Ambulatory Model
- Pathology-Maintaining Agreed turn around times (Blood/HAIs/Covid & Flu) through enhanced workforce
- Implement Plain Film/CT operating 24/7

Our system partners are also supporting through a number of system enablers that support our priorty of reducing overcrowding within our urgent care portals. These include:

Urgent Care System Enablers

- Think 111 ambulatory/minors pathway pre attendance bookings to be launched December, 2020 and this is being worked through to support redirection aaay from ED to enhanced primary care or to UHNM ambulatory care teams
- Continuation of the Clinical Response Intervention Service to support admission avoidance pathways, with particular focus on nursing homes to try and ensure care as close to home as possible
- Increasing the number of 'hours' associated with home forst by about 10% and to maintain the same day discharge we have seen during Covid

2. A Reflection of Winter 19/20 Experience, Covid19 Response and Restoration of Services

2.1 Winter Debrief:

Winter 2019 saw an early surge in Seasonal Influenza during December following a prior paediatric rise in attendances during November 2019. The urgent care performance by month synopsis is detailed as follows:

Winter non elective demand continued as modelled until the end of November 2019 where a significant rise in paediatric attendances was experienced. More paediatric attendances treated within 4 hours than the same period last year (114 more seen in time) and to cope with the increased demand rapid access slots were doubled within the Children's Assessment Unit. Growth of adult acute attendances in month was mainly seen in Type 3 activity with the UCC seeing 34 more patients a day than the previous year indicating streaming at the front door success but therefore a higher level of need left in the type 1 patients attending.

During December 2019, despite attendances to Type 1 ED remaining similar to Dec-2018, the age of patients attending Royal Stoke shifted, with 344 more patients over the age of 55 (106 over 80) seen and 276 more patients under 16 attending, sustaining the increased paediatric attends profile. Type 1 ambulance attendances to RSUH continued to rise in December, 2019 which saw an increase of 64 more arrivals than in November (1.1% rise). Ambulance corridor occupancy rose in December to 3638 from 3455 patients in November. A total of 58 escalation beds were used at RSUH in December 2019 in line with the Winter plan. Medical beds occupied at midnight rose to 508 which is in line with that seen in December 2017 (the year this winter plan demand was modelled upon). Despite opening escalation beds, Medical bed occupancy remained above 99% at RSUH due to the extended length of stay for the influenza case mix in the first spike.

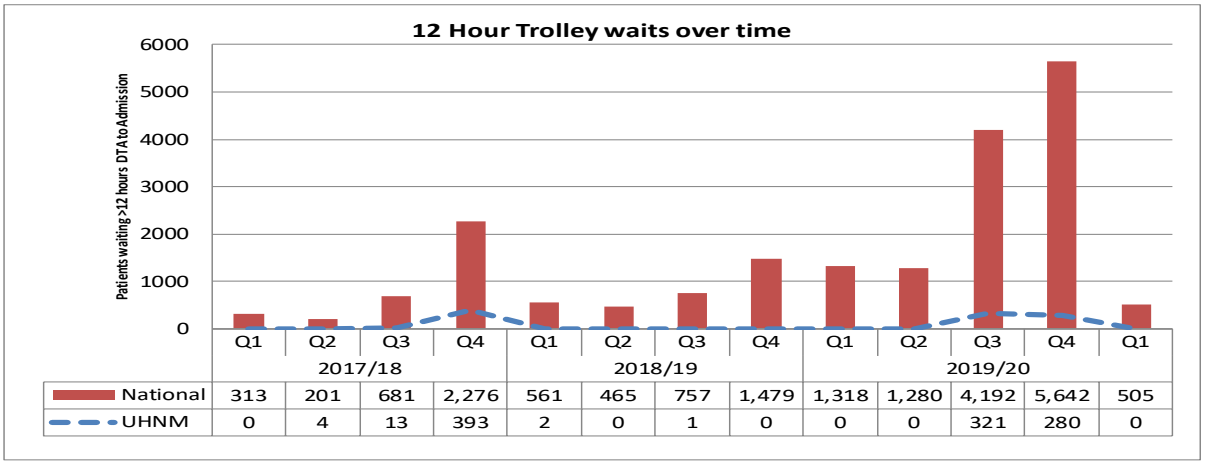
Community IPC issues, were a feature over the winter period resulting in closed CCG/Community beds which increased MFFD, stranded and super stranded length of stay with delayed complex discharges. Whilst urgent care demand returned to forecast levels, simple discharges started to increase after the first week January by c80 patients per week and which released capacity to decongest ED.

An analysis of the factors contributing to long wait pathways in ED together with the UHNM performance has been compared to the national experience in order to ensure we capture the key enablers for inclusion in this year's plan.

Reducing Long Waits in ED*:*

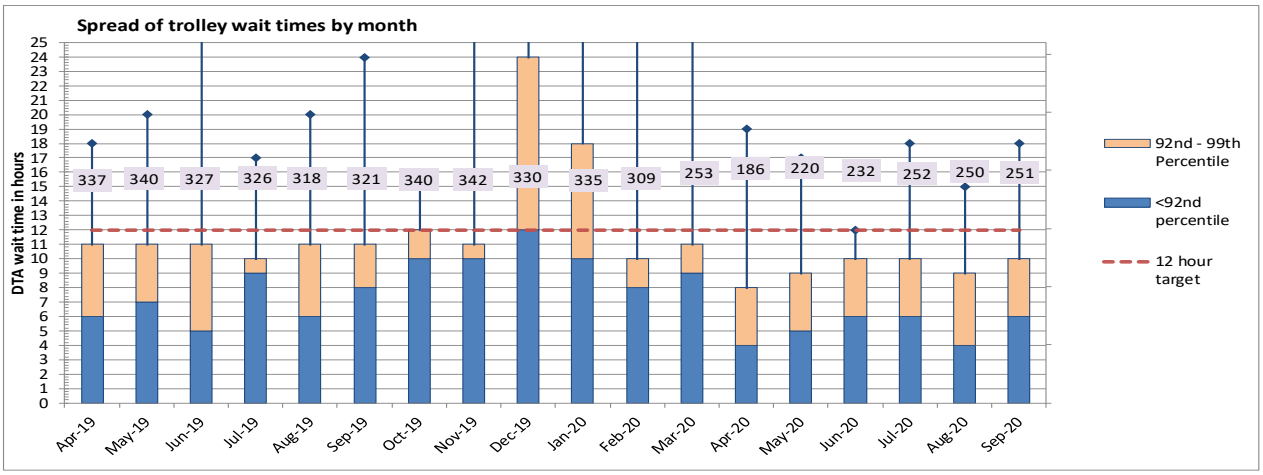
The below chart shows the number of 12 hour Trolley breaches recorded at UHNM and nationally. It is clear that winter 2019/20 was a difficult winter both locally at UHNM and Nationally. Nationally Q3 saw a significant

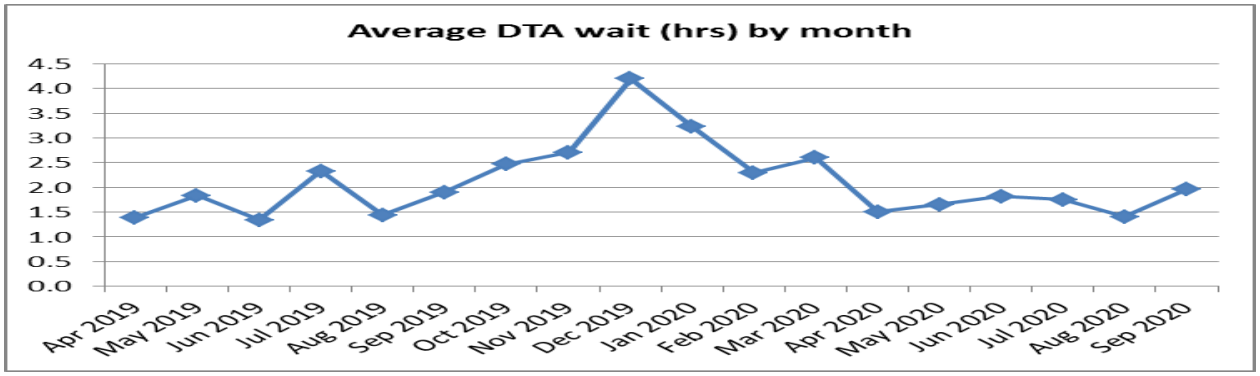
increase in 12 hour breaches, followed with a further increase in Q4 to 5,642. UHNM although contributing to the poor national performance were able to recover relatively early and locally saw the number of breaches reduce in Q4 reversing the trend of the national picture.



	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
	2017/18				2018/19				2019/20				
National	313	201	681	2,276	561	465	757	1,479	1,318	1,280	4,192	5,642	505
UHNM	0	4	13	393	2	0	1	0	0	0	321	280	0

The below two graphs demonstrate that last year the top 8% of trolley waits shifted into the 12+ hour time in December. This percentage roughly equated to the 321 recorded 12 hour trolley breaches in December. In both October and November 2019 the 92nd percentile was 10 hours with no waits breaching the 12 hour mark. With the average trolley wait time increasing by c1.5 hours from October/November to December, the 92nd percentile moved to 12 hours, meaning all patients in the top 8% breached the 12 hour standard.





The two evidence the improvements made in ensuring a left shift can be seen. The 92nd percentile for July/August/September has this year tracked at a lower level that seen in 2019 (by at least 2 hours); with

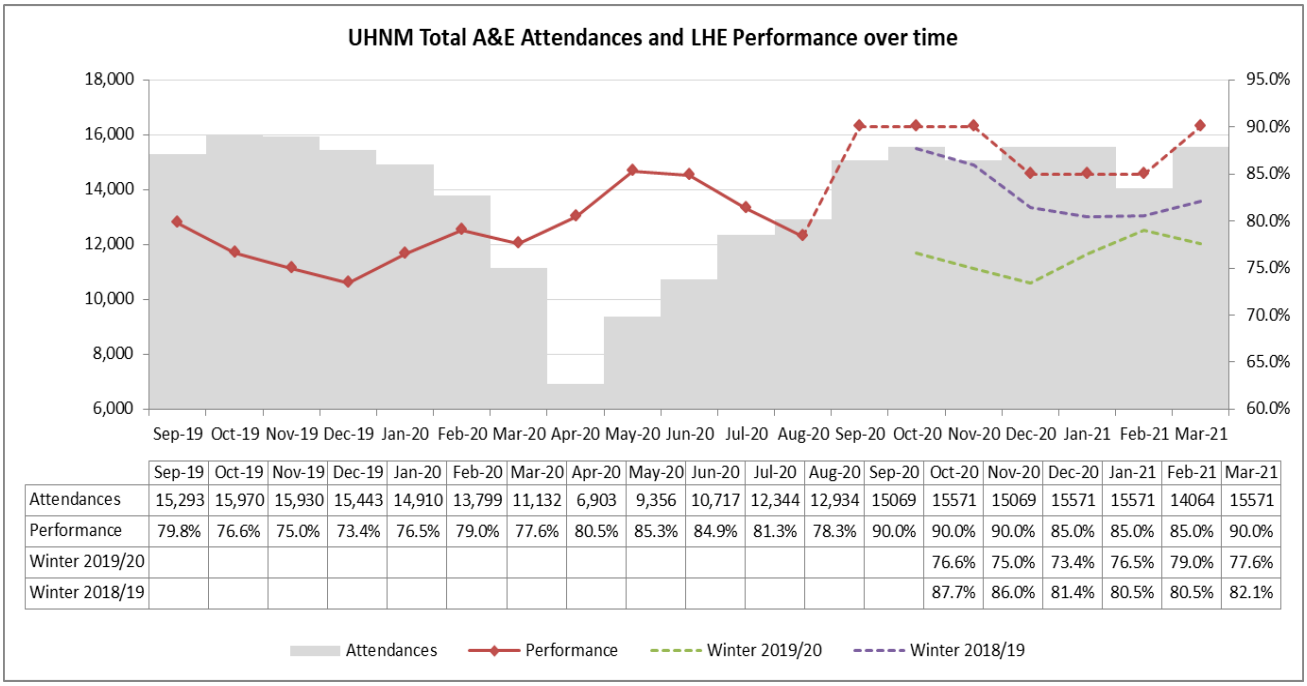
September 2020 showing the 92nd percentile as 6 hours vs 8 last year. Assurance can be taken from this that should a similar average increase in wait times take place this winter, far fewer 12 hour breaches would occur.

The following operational measures were implemented as part of the urgent care response, following lessons learnt from December 2019, to mitigate against the risk of further 12 hour breaches:

- **Outlier Management**: de-escalation plan enacted based on specialised and escalation bed capacity to reduce outlier volumes across non-medical bed base.
- **Increased Discharge Facilitator Resource** over 7 days in addition to the workforce plan.
- **Simple and timely and complex discharge targets revised** – increased discharge numbers for Mondays and Tuesdays with emphasis on "golden patients" to ensure pre 10:00 discharges to support early decongestion of ED;
- **Emergency Physician in Charge – decision on pathways > 15 hours:** ED and Emergency Physician in Charge decisions on patients waiting over 12 hours with no decision to admit to move to first referred specialty.
- During March 2020 the Trust responded to the rising national Covid19 pandemic impact with the decommissioning of non-essential services in accordance with the central mandates and the preparations for a scaled up emergency care response. This resulted the ED at Royal Stoke being expanded to deliver a segmented access route for suspected Covid19 patients together with re-zoning of the ED footprint and Imaging routes into Blue – Covid19 pathways and Purple non elective, non Covid19 pathways and Green ambulatory pathways. In this month, Type 1 attendances reduced in volume but heightened in acuity and conversion to in patient ratio whilst other ambulatory and minors modalities reduced due to patient aversion and alternative minors pathway at Haywood WiC urgent care centre.

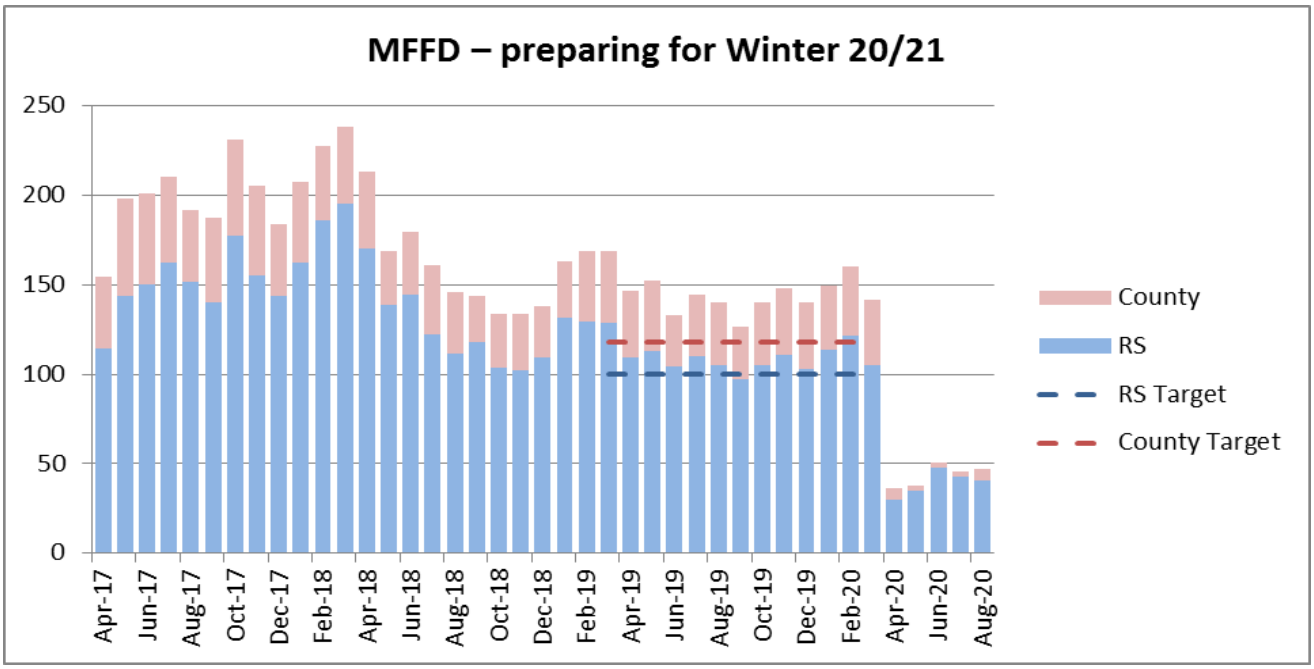
- The table below shows the UHNM summary attendance profile by month which includes a trend showing the impact of the Covid19 surge in April 2020 and the slow return to pre-covid attendance levels but with a notable skew towards a greater proportion of Type 1 acute patient case mix of patients who require extended processing time in ED, have a higher conversion rate into specialty beds.

UHNM ED Performance and Trajectory 2019-2021



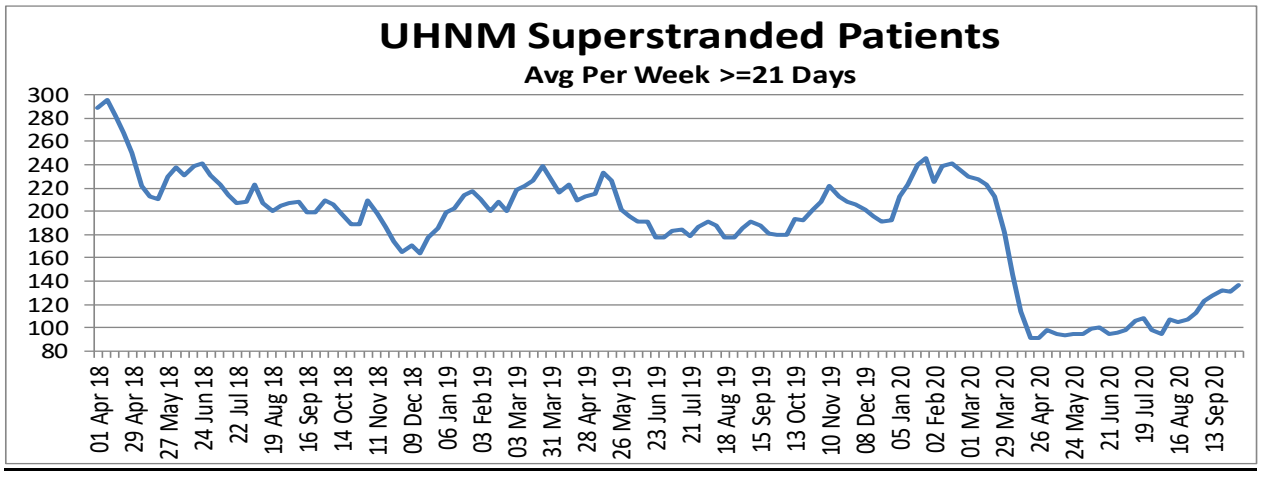
	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Attendances	15,293	15,970	15,930	15,443	14,910	13,799	11,132	6,903	9,356	10,717	12,344	12,934	15069	15571	15069	15571	15571	14064	15571
Performance	79.8%	76.6%	75.0%	73.4%	76.5%	79.0%	77.6%	80.5%	85.3%	84.9%	81.3%	78.3%	90.0%	90.0%	90.0%	85.0%	85.0%	85.0%	90.0%
Winter 2019/20														76.6%	75.0%	73.4%	76.5%	79.0%	77.6%
Winter 2018/19														87.7%	86.0%	81.4%	80.5%	80.5%	82.1%

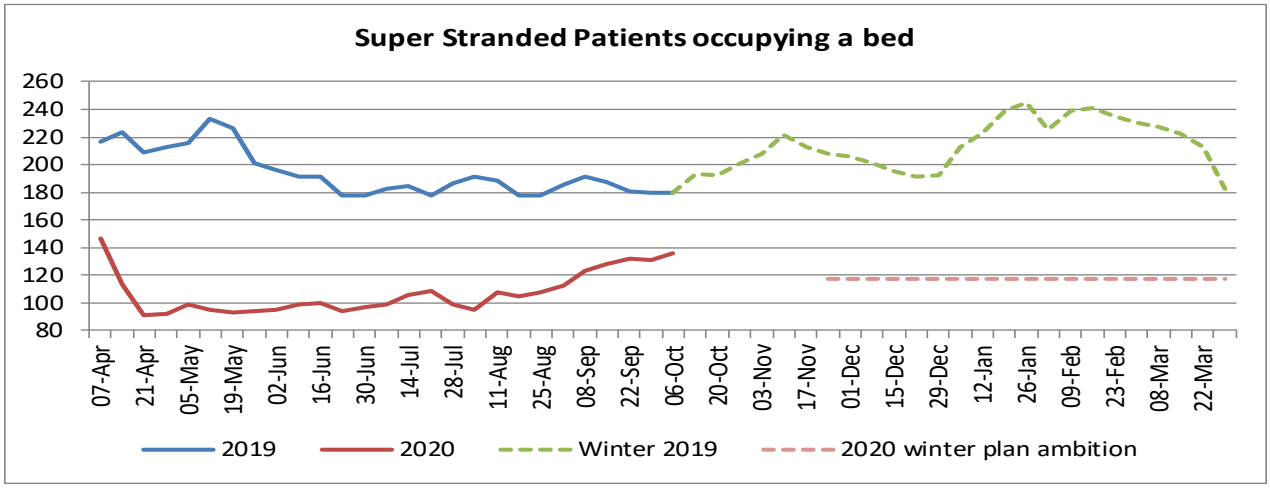
In terms of in-patient urgent care measures, over the last two years the number of MFFDs (Medically Fit For Discharge patients remaining on the Trust footprint once their acute episode of care is complete) have been reducing with numbers seemingly plateauing at around 110 for Royal Stoke and 30 at County. With the onset of Covid19 the levels of MFFD dropped dramatically giving opportunity to now to maintain the numbers for winter, delivering additional acute bed capacity flex for times of surge. The table below demonstrates the MFFD profile.



Winter bed modelling for 2020 has used an assumption that there will be a requirement for 100 beds for patients who are considered MFFD (compared to 150 in 2019/20). Current monitoring shows UHNM are on track to meet this.

The number of patients with a LoS 21 days or more (Super Stranded) dropped in line with the drop in MFFD numbers due to Covid19 impact in April 2020 (based on our system partners moving sub-acute patients off the acute site footprint as part of the Trust pandemic response). Since this time, the numbers have started to show an increasing trend (cira 140 in September 2020) but this is well below the average rolling profile seen last September and sustaining this is part of the joint UHNM and System Integrated Discharge Response with initiatives like Hospital at Home to secure a further 10% reduction in volume by December 2020 to avoid a repeat of the previous winter's escalation impacts. The two graphs below provide illustrative reference.





3. Winter Schemes and Bed Model

UHNM bed plan has been pulled together based on a number of activity assumptions that have been requested by guidance issued during September 2020 requiring the Trust to draft capacity plans for the period October 2020 to March 2021 to provide assurance of a sustainable operational response for both non elective demand over winter, which includes the advent of a second Covid19 surge at a rate of 5% or 20%, seasonal influenza and other viral winter illnesses together with maintenance of the planned care recovery programme. NHSI have worked with our system to quality assure the numbers and have been pleased with the model and the level of system work that has been shown through the planning stages.

Our enablers as discussed within Section 1 will further more contribute to the improvements needed to support winter, Covid and flu resilience as part of a 'normal' winter.

In the event of a more intense peak of Covid19, the system would look to enact plans that were put into place during the first phase of Covid19.

Given the geography of Staffordshire and Stoke -on-Trent and its proximity to the Nightingale Hospitals, the system would look to enact plans to use previously designated Community hospital beds as sub-acute beds to support the Covid19 pathway. The system has a clear escalation process to opening the additional beds that will be staffed by MPFT as part of its own workforce plans.

UHNM will continue to maintain the County Hospital site in Stafford as a non-Covid 19 site. This will support the maintenance of activity in the event of a further surge, though this relates to non-complex activity only. This however becomes compromised as we move to a 20% or 35% Covid19 bed base scenario.

A waterfall planning approach has been designed that will enact the opening of capacity as demand dictates with a clear daily visibility of when beds will be utilised. The approach will also work on assumptions of clear management to retain continual bed flow when required, perpetual cycle planning. Assumption planning has been based on 100% of the April 2020 peak with a 5% and 20% increase to allow all scenarios to be managed.

Plans for a further surge in Covid19 demand are not anticipated to impact upon primary care, mental health, or screening services.

There is no intention to stand down screening services and anticipate that these will be maintained unless directed otherwise. UHNM will continue to accept all types of referrals regardless of the demand from Covid19. As in the first wave, significant Cancer elective operating capacity will be maintained and all referrals will be

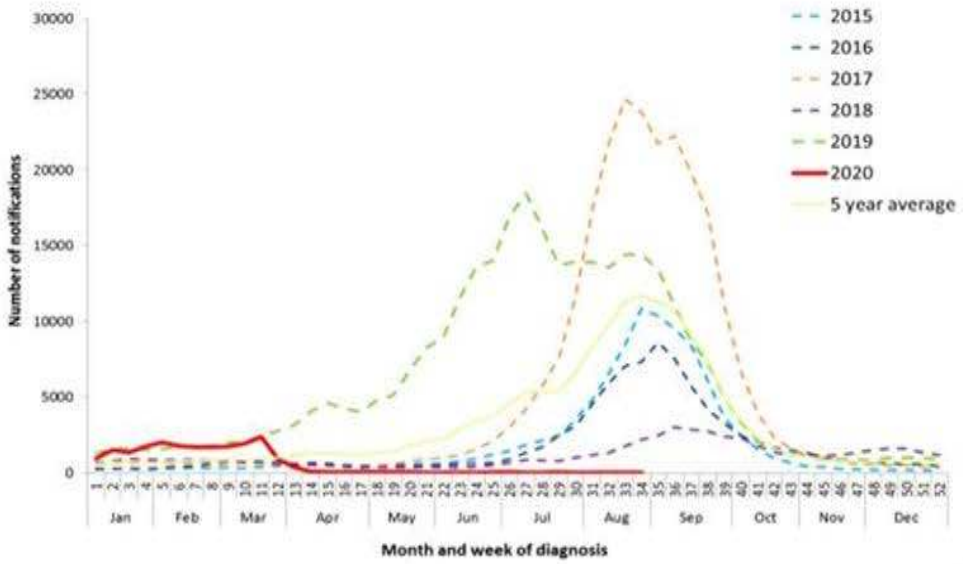
reviewed / triaged by a Clinician within 7 days of receipt in order to assess urgency, prioritisation, and opportunities for advice and guidance.

In respect of additional mitigations, UHNM has already incorporated IS capacity into its Phase 3 Restoration and Recovery Plans. Though initial responses from the IS did not suggest that further capacity beyond the allocated 75% of capacity could be made available to the NHS, the Trust would look to explore that again in the event of a further surge.

In relation to mutual aid, the Trust would look to work within existing networks, with UHNM looking to work closely with Shrewsbury and Telford NHS Trust both in respect of Critical care capacity to support complex elective surgery, as well as for specialities that are already strongly networked. The model of mutual aid is still in its early stages of discussion and will be finales in the coming weeks.

Seasonal influenza will align to the Southern Hemisphere experience of minimal impact this winter with bed modelling being based on similar volume to 2019/20 experience. The table below shows the current profile from Australian public health sources where notifications from all jurisdictions remains low and significantly below profile compared to winter 2019/20. This impact is considered to be linked to increased public awareness and compliance with social distancing methods and local lock down together with other social and health infrastructure actions which are not dissimilar to the UK pandemic response.

Figure 9. Notifications of laboratory confirmed influenza, Australia, 1 January 2013 to 23 August 2020, by month and week of diagnosis*



Source: NNDSS

3.1 UHNM Winter Bed plan 2020/21

The Trust winter bed model has been drafted on the following assumptions and the full document is shown in **Appendix 2:**

- Urgent Care demand modelled to UHNM Annual Planning assumptions (c 2% growth)
- Elective Demand modelled to 90% UHNM Annual Plan (in line with Phase 3 letter)
- Occupancy 92% (but with variations at zone level) supported by West Midlands System Plans.

- AMU to stay on wards 230 & 231 following maintenance programme and create an urgent care floor.
- Children's ED will be part of the capital bid approved for modular but will have 3 beds on 218 to maintain paediatric elective surgery.
- Priority Assessment Unit (PAU) business case is approved and implemented by December 2020 (10 spaces).
- Gastro stays on ward 100/101 (current SAU) post maintenance
- Critical Care expansion into ward 100/101 does not take place (QIA completed – 36 bed deficits is too significant to support in winter with prospect of Covid19 surge).
- Baseline model assumes RSUH/County activity split is the same as 2019/20, any changes to this will be overlaid on the plan
- 46 beds out for social distancing across two acute sites. (31 RSUH, 8 County, 7 paeds)
- Bed demand includes additional beds which would have been occupied by ED boarders in 2019/20.
- Blue Zone beds and Side Rooms modelled to support containment and initial surge capacity (subject to adherence to Covid19 swab turnaround KPIs)
- Wards with mix of Purple and Green to operate against strict IPC criteria which will be tracked daily for outbreak/nosocomial impact
- Critical care capital scheme (10 beds) – medicine would lose 36 beds due to SAU having to be re-provided for enabler works with a loss of 36 beds that is not viable during the winter period. QIA attached. **Appendix 2a.**

- **Medicine**: converted to non-elective purple capacity with all acute medicine portals and Short Stay Ward configured on the top floor PFI. Initial Covid19/Flu surge through 67 side rooms on PFI floor then Covid19 and Flu cohort separate wards identified.
- **Surgery:** carve out of elective (green) bed capacity from purple capacity with SAU extension.
- **Specialised:** blended ward cohorts for specialist bed bases in order to manage flow through beds.
- **CWD:** modular capital approved, use of 210 for paediatrics until move to modular in December 2020 with plans for expedited works to support day case unit and 218 bed capacity as winter and R&R enablers. Oncology and Haematology EAU scheme will support increased ambulatory flow through the bed capacity.
- **Escalation Ward Capacity:** circa 108 beds.

Trust Flu Campaign & IPC Team Plans: the influenza flu plan for this year and the IPC team will ensure delivery of the usual exceptional coverage through their actions and interventions to ensure the Trust staff are protected and can maintain front line service support at UHNM and the wider community. Plans are rolling out for flu vaccinations with social distancing measures in place. The Team are also providing advice/guidance and support on PPE mask fit and ward/service actions in the face of infection outbreaks; a service that is greatly valued and appreciated by all operational teams.

The UHNM Winter Bed Model Summary is shown below:

Bed Base	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Core Bed Base (excluding Maternity, Paediatric or Critical Care Beds)	**1,177**	**1,177**	**1,177**	**1,177**	**1,177**	**1,177**	**1,177**
RSUH	992	992	992	992	992	992	992
Blue	32	32	32	32	32	32	32
Purple	564	564	564	564	564	564	564
Green	67	67	67	67	67	67	67
Mixed	329	329	329	329	329	329	329
County	185	185	185	185	185	185	185
Blue	-	-	-	-	-	-	-
Green	45	45	45	45	45	45	45
Purple	140	140	140	140	140	140	140
Demand	**Oct-20**	**Nov-20**	**Dec-20**	**Jan-21**	**Feb-21**	**Mar-21**	**Apr-21**
Anticipated Bed Demand (Based on 92% bed occupancy)	**1,268**	**1,290**	**1,334**	**1,362**	**1,327**	**1,327**	**1,363**
Royal Stoke	1,098	1,119	1,150	1,168	1,137	1,137	1,167
Blue	51	51	51	51	51	51	51
Purple	650	675	703	739	699	699	701
Green	80	84	82	62	65	65	84
Mixed	318	309	314	316	323	323	331
County	169	171	184	194	189	189	196
Blue	-	-	-	-	-	-	-
Green	23	22	21	22	25	25	23
Purple	146	149	163	172	164	164	173
Core Bed Gap	-91	-113	-157	-185	-150	-150	-186
Mitigated by:							
Escalation Capacity	**Oct-20**	**Nov-20**	**Dec-20**	**Jan-21**	**Feb-21**	**Mar-21**	**Apr-21**
County Ward 1 (25 beds)	25	25	25	25	25	25	25
County AAU (6 beds)	6	6	6	6	6	6	6
RSUH Ward 75 (19 beds)	19	19	19	19	19	19	19
RSUH ward 120/121 (44 beds)	44	44	44	44	44	44	44
RSUH Ward 100/101 (9 beds)	9	9	9	9	9	9	9
RSUH Ward 104/105 SAU (5 beds)	5	5	5	5	5	5	5
Total Escalation Capacity	**108**	**108**	**108**	**108**	**108**	**108**	**108**
Core Bed Gap After Escalation Capacity applied	**17**	**-5**	**-49**	**-77**	**-42**	**-42**	**-78**
Internal Enablers Capacity	**Oct-20**	**Nov-20**	**Dec-20**	**Jan-21**	**Feb-21**	**Mar-21**	**Apr-21**
EAU Pilot (3 beds on Oncology & Haematology)	3	3	3	3	3	3	3
Use of IS sector for Ortho (7 beds)	7	7	7	7	7	7	7
PAU for Specialised (10 beds - December 2020). Business Case awating NHSI approval							
Total Internal Enablers Capacity	**10**	**10**	**10**	**10**	**10**	**10**	**10**
Core Bed Gap After Escalation & Internal Enablers Capacity applied	**27**	**5**	**-39**	**-67**	**-32**	**-32**	**-68**
External Enablers Capacity	**Oct-20**	**Nov-20**	**Dec-20**	**Jan-21**	**Feb-21**	**Mar-21**	**Apr-21**
TBC BY SYSTEM PARTNERS							
Total External Enablers Capacity	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Core Bed Gap After Escalation & Internal and External Enablers Capacity applied	**27**	**5**	**-39**	**-67**	**-32**	**-32**	**-68**
ASSUMPTIONS							
Key Assumptions - number of MFFDs based on similiar levels as last year (2019/20) included in above Demand							
RSUH MFFDs adjusted	75	79	74	82	87	87	75
County MFFDs adjusted	25	27	27	26	28	28	25
Total MFFDs	**100**	**106**	**101**	**108**	**114**	**114**	**100**
Key Assumptions - number of FLU based on similiar levels as last year (2019/20) included in above Demand							
RSUH FLU	3	9	54	38	19	9	5
County FLU	1	6	19	10	5	3	1
Total FLU	**4**	**15**	**73**	**49**	**24**	**12**	**6**

The core bed gap has been profiled with the assumption that escalation capacity can be commissioned from October 2020 in response to any Covid19 surge together with Length of Stay kept within KPI and Medically Fit Patients not exceeding the 100 level to give core bed capacity flex. Hospital Zoning means that wards are carved out for particular function which reduces the efficiency of throughput across the bed base (ie surgery cannot flex their elective and urgent care patients through all ward beds).

- Medicine- highest profiled purple bed deficit in January -34 mitigated by escalation capacity
- Surgery – highest purple bed deficit September -44 in a range of 17 – 39 (offset IS operating and County – especially for T&O to release purple beds, including step down beds at County)
- Specialised- no purple bed deficit due to blended ward capacity.
- CWD - highest bed deficit -4 October in a range of -1 to -3 (EAU to enable ambulatory pathways)

The bed deficit from December 2020 to April 2021 is required to be supported by system partner capacity

plans, with maintenance of the MFFD numbers within tolerance of those seen during the April 2020 Covid19 surge in order for the Trust to be able to cope within the profiled escalation bed base.

3.3 System Partner Winter Capacity Plan Alignment 2020/21

System partners are aligning their system capacity plans to cover off the bed deficit based profiled on the following plans:

The flow out of the acute hospitals is determined by a national policy and standard operating procedures. In order to support surge demand between October 2020 and March 2021 and mitigate the bed gap in UHNM, the following escalations will be delivered by system partners working in the community.

Pathway zero: simply and timely discharges: UHNM will be responsible for the management of all simple and timely patients to have clear set estimated day of discharge plans on admission. Working with a clinical pathway ethos patients will be provided with acute treatment and then transferred home without delay.
UHNM will work towards the national guidance to support patients back to their place of residence within the pathway and only those who require on-going care will be supported into the community service pathways 1, 2,3.

Pathway one: home-based rehabilitation: Complex Medically Fit for Discharge (MFFD) will be maintained at the low levels of 100 across both of UHNM's sites.

- This will be delivered using current commissioned capacity within Home First and, where required, the use of additional contracted capacity with private provider agencies.
- Seven day cover will be retained by Track and Triage, covering 8am - 8pm.
- Local authority partners are committed to ensuring that no patients are held any longer than two days, once listed for long-term care provision. There is a clear escalation process.
- A case management approach through effective system-wide MDTs and clinical escalation will identify early those individuals with co-morbid or complex social situations which could be a barrier to timely discharge. This addresses Patients at Risk of Increased Length of Stay in Hospital (PARIS).
- A wrap around service to Home First has been designed that includes additional therapy, social care and mental health input as well as a night sitting service provided by the voluntary sector.
- From November 2020, ten beds can be released by maximising physical and mental health in older people. Care home liaison and outreach teams will be enhanced by the employment of a GP and Advanced Nurse Practitioner. They will reduce the length of stay on wards 6 and 7 at Harplands Hospital and reduce the need for transfers to UHNM.

Pathway two: community bed: from November 2020, an additional four beds on ward 4 at Harplands Hospital will contribute to closing the UHNM bed gap by increasing the flow of EMI patients, with support from Outreach.

Avoiding admissions using CRIS: While there is no resilience builds into this plan on admission avoidance schemes to mitigate the bed gap there is an expectation schemes will contribute towards ensuring that patients get appropriate care in the best setting for them. The Community Rapid Intervention Service (CRIS) within North Staffordshire continues, with implementation within the South East and South West, supporting the management of patients within their own home without need to access acute care. Care home management and visiting to be retained as part of the North Staffordshire service.

Escalations close UHNM bed gap: taking into account UHNM's internal escalations and the contribution of

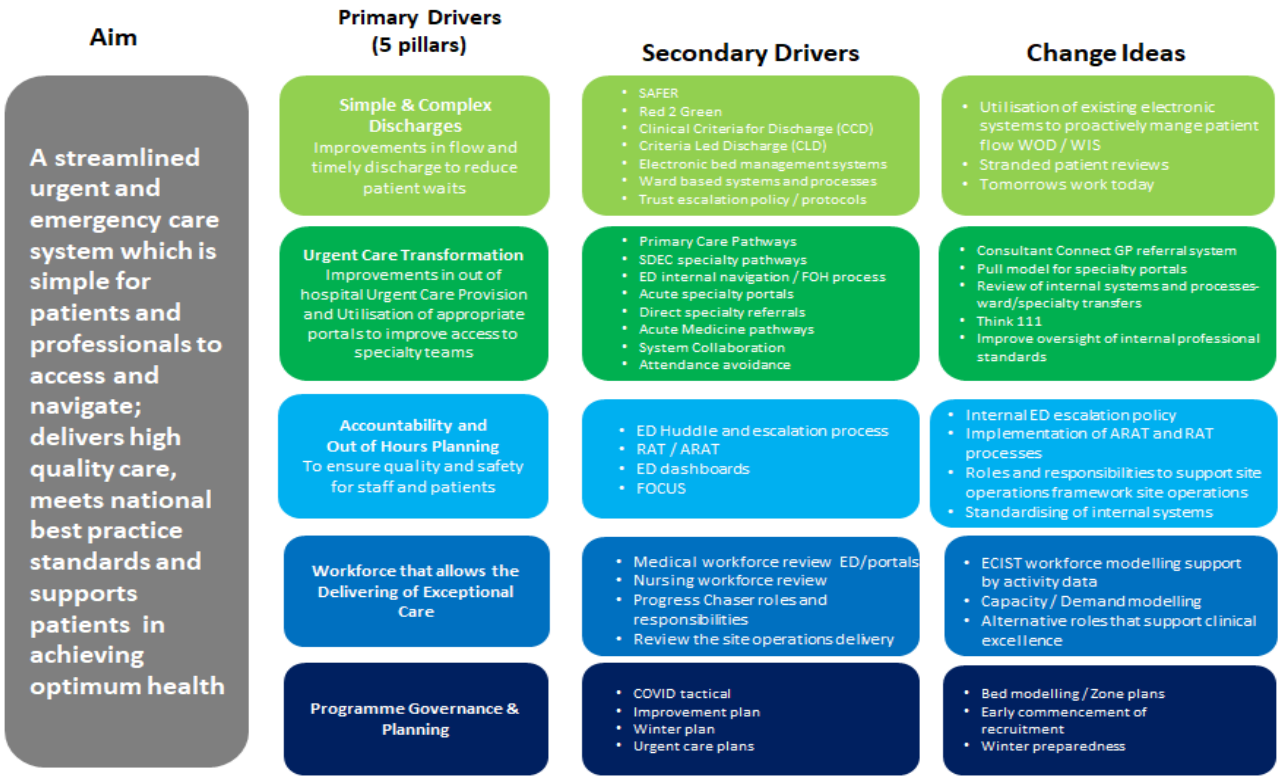
system partners, the UHNM bed gap is closed in October 2020 and November 2020. In December 2020 and January 2021, UHNM's bed gap is closed using additional capacity within community hospitals. In February and March 2021, there remains a bed gap without using community hospitals that will need to be accommodated. In April 2021 the residual bed gap requires community hospitals for sub-acute activity.

4. The Urgent Care Programme Plan

Divisional improvement schemes blended with the ECIST urgent recommendations make up the urgent care plan October – March 21, starting with a 2 week Test of Change initiative starting 5th October 2020. This is based on a whole hospital response to urgent care improvement from 'Ward to Board' linked to a revised Governance Model that will see a Chief Executive Chaired Urgent Care Board with weekly confirm and challenge meetings by the Executive TRI with Divisional Senior Leaders.

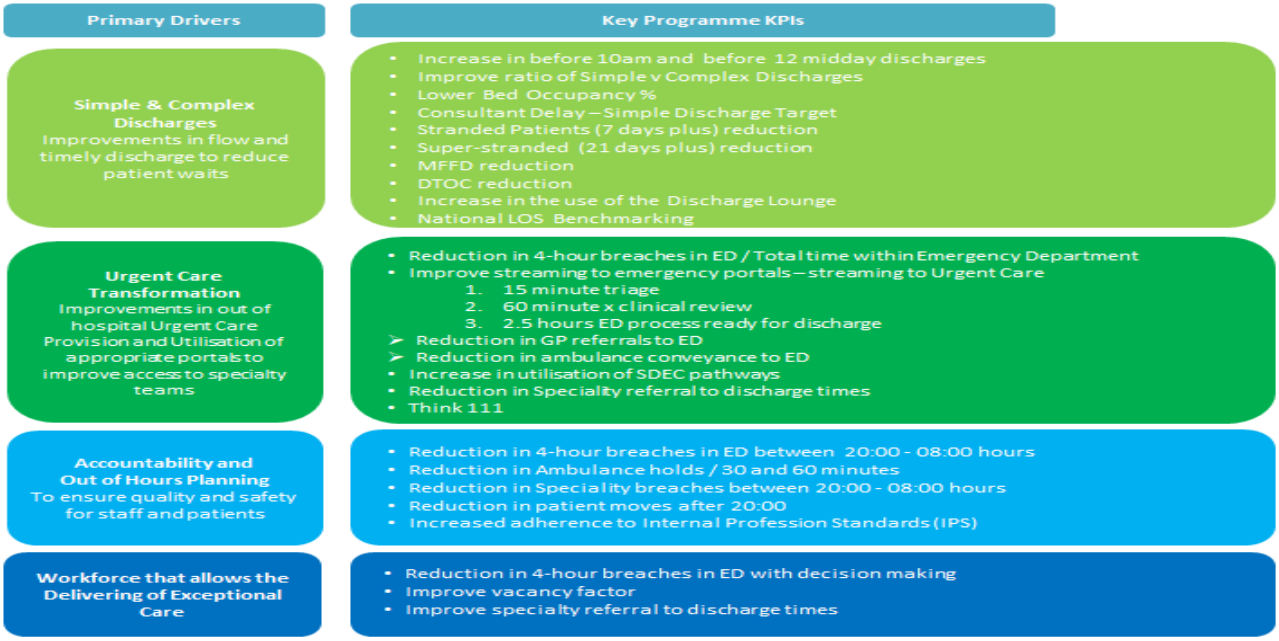
The programme overview is shown below. This is based on ECIST recommendations and Divisional urgent care improvement plans together with other cross cutting improvement enabler schemes.

Urgent Care Programme Overview:



The aligned Urgent Care Performance measures are detailed below which will be tracked daily by the refreshed and corporately managed Site Operational Teams in partnership Divisional Silver Duty Managers and specialty Triumvirates.

Urgent Care Programme KPI Measures:



5. Winter Financial Plan

The Trust's planned revenue investment for winter totals £5.2m with £4.6m approved for immediate release with a further £0.6m to be released subject to demand; the latter being the additional funding that may be required should demand and discharge profiles dictate that additional capacity is required to be opened on the County site.

"In addition to the direct investment in Winter capacity the Trust has also invested £1.7m capital (with a further £0.7m planned) in additional equipment to support the Trust's response to COVID19-19 which will support the Trust through the Winter period."

The additional nursing costs associated with the ward escalation capacity for the Stoke site has not been funded as part of the Winter plan. Operational teams have been instructed to fully recruit to ward establishments using bank and agency staff where necessary with block bookings being made to secure resources through the winter period; with no vacancies across the site it will be possible to open additional capacity within budgeted resources. An allowance has been made within the financial forecast for the year to accommodate the increased actual run rate that we will see over the last 6 months of the year. **Appendix 4** provides the detailed report.

The financial investment plan enablers are detailed in the following table which reflect all the winter enabler schemes described in this paper.

Proposed Winter Plan investment 2020/21

	Profiled Cost (£)							Approved	Approved subject to demand
	Oct	Nov	Dec	Jan	Feb	Mar	Total Cost	£	£
Medicine Division									
Weekend Consultant Cover	-	8,910	7,920	9,900	7,920	7,920	42,570	42,570	
Additional weekend discharge facilitators	108	324	288	360	288	288	1,656	1,656	
Escalation Capacity Ward 75									
medical	20,240	44,880	47,520	45,760	42,240	47,520	248,160	248,160	
non-pay	3,667	10,000	10,000	10,000	10,000	10,000	53,667	53,667	
Escalation Capacity Ward 230									
medical	-	-	67,760	64,240	59,840	67,760	259,600	259,600	
non-pay			30,000	30,000	30,000	30,000	120,000	120,000	
Escalation Capacity Ward 231									
medical	-	-	57,640	55,000	51,040	57,640	221,320	221,320	
non-pay			15,000	15,000	15,000	15,000	60,000	60,000	
Ward 80/81 convert to Acute	-	-	-	112,984	109,640	114,392	337,016	337,016	
Escalation Capacity Ward 1	-	-	155,520	153,760	150,240	155,520	615,040		615,040
Matron to cover winter escalation	-	4,879	4,879	4,879	4,879	4,879	24,395	24,395	
Extended working hours AEC = 1hr	-	4,284	4,427	4,427	3,998	4,427	21,562	21,562	
Uplift Infectious Diseases Consultant	7,167	7,167	7,167	7,167	7,167	7,167	43,000	43,000	
Additional ED Resources 5 SHO	-	29,505	29,505	29,505	29,505	29,505	147,525	147,525	
ED Acute Med Medics and Nurses	-	-	139,589	139,589	126,080	139,589	544,846	544,846	
Weekend Elderly Care ENP	-	4,879	4,879	4,879	4,879	4,879	24,395	24,395	
Sub Total Medicine	**31,181**	**114,827**	**582,093**	**687,449**	**652,716**	**696,485**	**2,764,751**	**2,149,711**	**615,040**
Surgery									
Critical Care (2 beds)		59,116	59,116	59,116	59,116	59,116	295,579	295,579	
Critical Care Discharge Facilitator	3,457	3,457	3,457	3,457	3,457	3,457	20,739	20,739	
Lyme Building Pharmacist	4,284	4,284	4,284	4,284	4,284	4,284	25,705	25,705	
SAU (6 trollies)	45,903	45,903	45,903	45,903	45,903	45,903	275,419	275,419	
Sub Total Surgery	**53,644**	**112,760**	**112,760**	**112,760**	**112,760**	**112,760**	**617,442**	**617,442**	**0**
Specialised									
Specialised Decisions Unit (SDU)	82,100	82,100	82,100	82,100	82,100	82,100	492,600	492,600	
Neurology Services	17,634	17,634	17,634	17,634	17,634	17,634	105,806	105,806	
Trauma:Extension of Early Support Discharge (ESD)	11,697	11,697	11,697	11,697	11,697	11,697	70,181	70,181	
Heart Centre:Extension of locum Thoracic consultant - 5 months	15,000	15,000	15,000	15,000	15,000	15,000	90,000	90,000	
Sub Total Specialised	**126,431**	**126,431**	**126,431**	**126,431**	**126,431**	**126,431**	**758,587**	**758,587**	**0**
Child Health									
Cons Ward Round and additional speciality docs to cover evening CAU		5,180	5,180	5,180	5,180		20,720	20,720	
Pharmacy									
ED Pharmacy Support team	5,346	6,857	6,857	6,857	6,857	6,857	39,631	39,631	
Winter Pressure Ward Pharmacy (4 wards)			23,963	23,963	23,963	23,963	95,852	95,852	
Additional Band 2 ATO to support hub dispensing of TTOs as current staffing levels means that hubs are not fully staffed		1,978	1,978	1,978	1,978	1,978	9,890	9,890	
Technical Services - to make up Tazocin injection for A&E on both sites and portals. Saves 20 mins nursing time for reconstition per dose. Sepsis - quick needle / treatment time as pre-prepared		2,713	2,713	2,713	2,713	2,713	13,565	13,565	
Band 3 Medicine Mgt asst	2,215	2,215	2,215	2,215	2,215	2,215	13,290	13,290	
Bend 5 Medicine Management Technician	3,131	3,131	3,131	3,131	3,131	3,131	18,786	18,786	
Band 8a to support 2 additional level 3 critical care beds in surgery		1,324	1,324	1,324	1,324	1,324	6,620		
Pathology									
Virology band 6 (Sat/Sun additional lab cover)		818	818	818	818	818	4,090	4,090	
Flu Testing (est spend - will depend on severity)		40,000	40,000	40,000	40,000	40,000	200,000	200,000	
Flu testing (4* band 6 BMS)	16,366	16,366	16,366	16,366	16,366	16,366	98,196	98,196	
Flu testing (Premium rota compliance payment)	6,667	6,667	6,667	6,667	6,667	6,667	40,002	40,002	
Flu testing (ROCHE MSC increase - Analyser)							-		
Covid planning x6 band 3 mlas serology	12,875	12,875	12,875	12,875	12,875	12,875	77,250		
Covid planning x4 band 4 Aps covid pcr automated	9,809	9,809	9,809	9,809	9,809	9,809	58,854		
Covid planning x4 band 6 covid manual pcr	16,366	16,366	16,366	16,366	16,366	16,366	98,196		
COVID Assays	158,400	158,400	158,400	158,400	158,400	158,400	950,400		
Imaging									
Early bird 7 days per week (Band 6)		2,192	2,192	2,192	2,192	2,192	10,960	10,960	
Early bird 7 days per week (Band 3)		1,257	1,257	1,257	1,257	1,257	6,285	6,285	
Ad hoc reporting of ED images-premium shifts for existing staff		6,000	6,000	6,000	6,000	6,000	30,000	30,000	
Inpatient mobile imaging - plain film (Band 5)		8,921	8,921	8,921	8,921	8,921	44,605	44,605	
Inpatient mobile imaging - plain film (Band 2)		6,806	6,806	6,806	6,806	6,806	34,030	34,030	
Transfer nurse band 5		3,395	3,395	3,395	3,395	3,395	16,975	16,975	
Ext Hours CT (Band 3)		2,297	2,297	2,297	2,297	2,297	11,485	11,485	
Nighthawk reporting		8,333	8,333	8,333	8,333	8,333	41,665	41,665	
US Sonographer		2,204	2,204	2,204	2,204	2,204	11,020	11,020	
US IDA weekend cover		1,002	1,002	1,002	1,002	1,002	5,010	5,010	
Onc and Haem									
EAU pilot (5.4 x Band 4	16,131	16,131	16,131	16,131	16,131	16,131	96,786	96,786	
Sub Total CWD	**247,306**	**343,237**	**367,200**	**367,200**	**367,200**	**362,020**	**2,054,163**	**862,843**	**0**
Access Coordinator		**11,762**	11,762	11,762	11,762	11,762	**58,810**	**58,810**	
Transport		**19,453**	20,102	20,102	15,563	20,102	**95,322**	**95,322**	
Communication		700	700	700	700	700	**3,500**	**3,500**	
Grand Total	**458,562**	**729,170**	**1,221,048**	**1,326,404**	**1,287,132**	**1,330,260**	**6,352,576**	**4,546,216**	**615,040**

6. Winter HR and Workforce Planning Schemes

- One of the confounding variables to winter planning relates to workforce availability of various grades of clinical, medical and professional and technical grades of staff. In 2019/20 workforce challenges were experienced in December and January at the height of the influenza surge. Medicine had challenges recruiting doctors for escalation wards and critical care had core establishment gaps on top of winter recruitment challenges to recruit to.

- This year, at UHNM, earlier approval and recruitment has been actioned from July 2020 with confirmed fill of medical staff for Locum Consultant, Registrar and SHO grades of staff. Surgery have progressed early recruitment for staff for portals, wards and critical care. CWD have confirmed expedited recruitment of pathology and ward staff for EAU to support phased commissioning of the wards and pathology swabbing services with 24/7 testing for swabs from December 2020. Specialised recruitment to support PAU and medical posts confirmed to be advanced.

- The Trust has also commissioned an External Recruitment Company to source 20 Agency nursing to cover portals over winter to focus on active pull and movement of patients from ED (referred to under finance section).

- However, the Trust currently holds vacancies across a range of specialties due to difficulties in recruitment/sickness or maternity leave (ED, Portals, Critical Care, Specialty Cohort wards) so scaling up for winter with the prospect of a second Covid19 surge may see a revisiting of the staff rate of attrition for winter viruses generally, as seen last winter/ April 20, which will give the Trust a sizable challenge. The Band 5 RN Grades are particularly challenged across all Divisions.

- To try and mitigate against this, the UHNM HR department have been proactive in supporting enablers which will secure proactive identification and management of workforce issues and this, together with well-being systems, will ensure we can keep our staff safe, well and supported through winter. 'Examples of schemes in progress include:

    - **Workforce Bureau:** the Workforce Bureau team has been stepped up with weekend working recommencing to support staff testing.

    - **Performance/KPI:** All Covid19 related call backs by the HR team within 24 hours, the ideal within 16 hours (takes into account Saturday and Sunday afternoon downtime in call backs)
    - Staff (and household members) to be tested within 24 hours of the call back, the ideal within 16 hours.
    - Results delivered by SMS and email within 48 hours, the ideal being 24 hours

    - There is a virtual wellbeing festival planned for early October for staff at both sites led by Team Prevent which will look at a range of wellbeing topics

    - The Trust has secured £50k funding form NHS Charities Together to purchase and maintain a mobile staff wellbeing unit and an oversight group is being set up with reps form a variety of areas to manage this. This will be available across both sites and agreements are in place re. transportation between sites when up and running

    - A premium rate factor has been included within the financial plan.

7. Winter Communication Plan:

The 2020/21 campaign will follow the same principles as which all partners have contributed key metrics which will measure the enabling schemes along with health services and options available to them such as Pharmacies, Walk-in Centres and GPs. The focus will shift from a clinically-led staff –fronted campaign and introduce our "UHNM family" who will each have their own "mini-emergency" and require care in the right place. The campaign "Where for Care?" will strongly link to the national winter campaign Help Us Help You?

A graphic of the UHNM Family is shown below.

Key Messages - admission avoidance and improved hospital flow through rapid diagnostics, proactive discharge to the right placement at the right time.

We know that most patients want to be treated at home wherever possible, rather than be admitted to hospital. This is better for patients and it is better for the NHS as a whole.

A number of initiatives are in the UHNM winter plan and new services developed for winter are designed to keep people well at home or discharged from hospital in a timely manner to ensure they can return home.

The Communication Team at UHNM have provided a dynamic and responsive communications portfolio throughout the Covid19 pandemic that has been applauded by UHNM staff for the quality and timeliness of publications, guidance and informative and creative use of social media and Trust IM&T systems. The Winter Communication Plan encapsulates all these features to support the Trust in keeping staff informed and patients informed and safe.

Details of the Winter Communication Slide Set are shown in **Appendix 5.**

8. Restoration and Recovery – Phase 3 Plan:

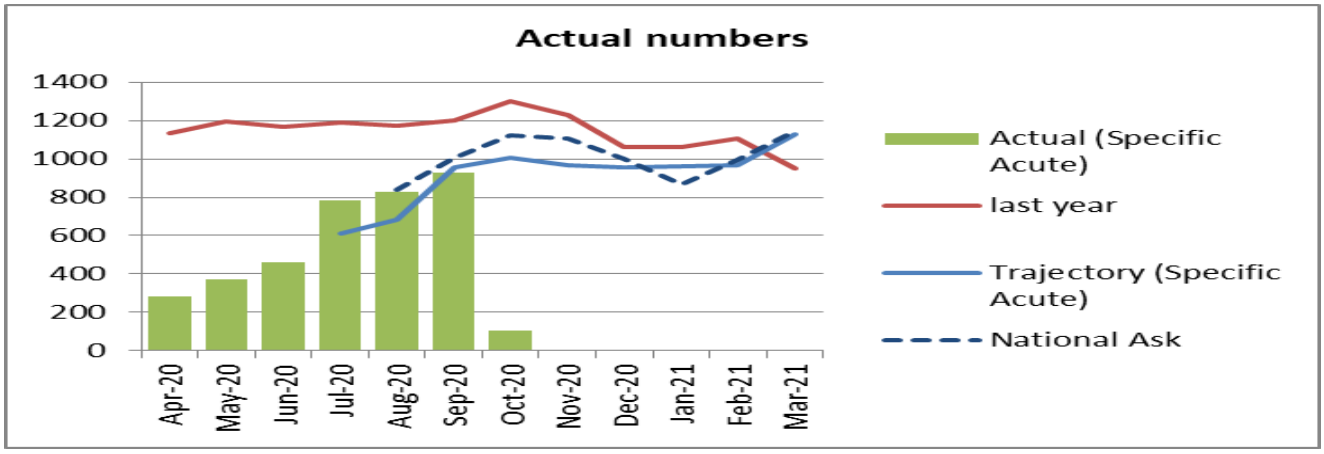
The Trust continues to implement "Phase 3" of the NHS response to Covid19 to get services back to pre Covid19 levels of activity based on the mandated objectives set by our regulators as follows:

- Electives and Day cases getting back to 80% of last year's activity
- MRI, CT and Endoscopy procedures at 90% of last year's activity
- First outpatient attendances and follow-ups (face to face or virtually) getting back to 100% of last year's activity

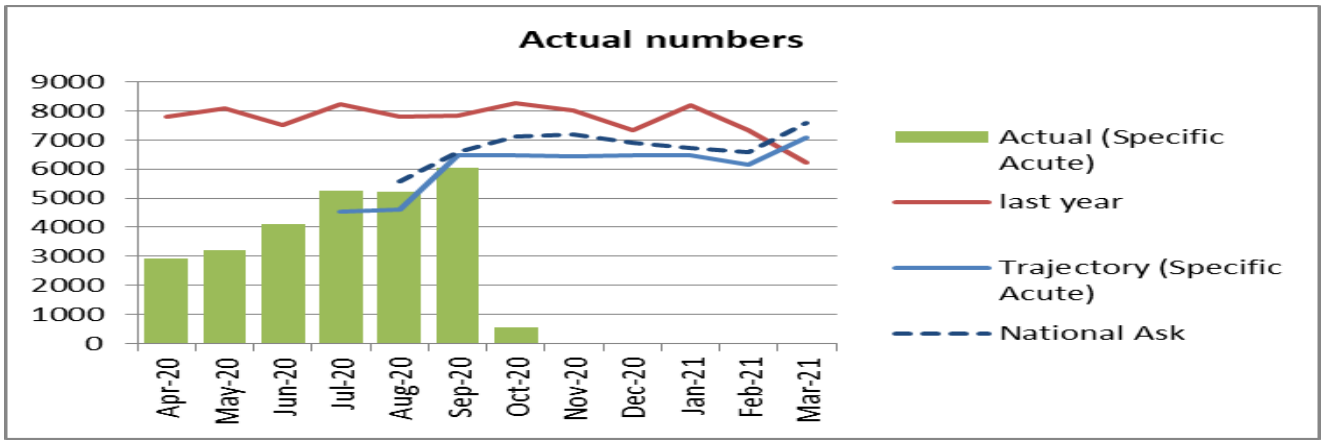
During September 2020, check and challenge sessions were convened with the Divisions on the levels of activity that could be delivered safely and within our current capacity, and these trajectories were submitted to NHSI (21st September 2020). Performance against these metrics will be reported at the R&R Cell Meetings, Monthly Divisional Performance Reviews and the Executive R&R meeting as part of the revised Governance model.

Restoration and Recovery Phase 3 Trajectories are shown below as follows :

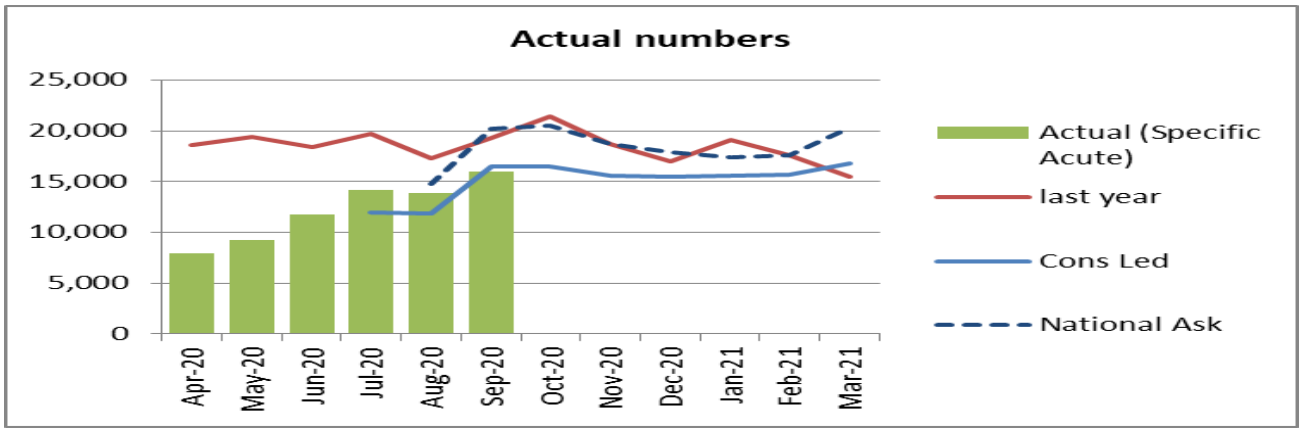
Elective pathways: delivered through acute theatres at Royal Stoke and County together with Independent Sector capacity and some selective In Sourcing options for high volume, long waiter or cancer/urgent prioritised patients.



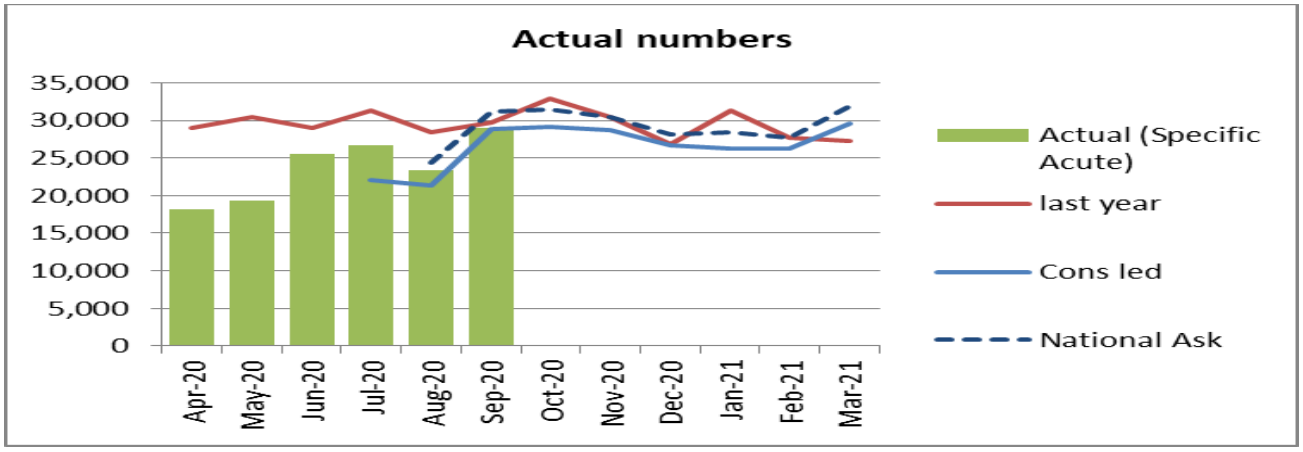
Day Case Pathways: with Clinical Treatment Centre Focus and County and Independent Sector support.



New Out Patient Pathways: delivered through telephone assessment clinics, virtual telephone consultations and face to face consultations where associated interventions are needed as the first line approach to triage.



Out Patient Follow up pathways: continue to be prioritised and maintained following detailed clinical validation reviews during the Covid19 elective 'pause'.



Key assumptions

- If NEL patients admitted required Critical Care beds this could impact on the available theatre beds as part of extended recovery it also assumes that both sites would be treating Covid19 patients and that would stop T&O electives at County.

- Assume some level of non-patient compliance will impact on Day Case, OP, Cancer and Diagnostics. Workforce need to remain on shift to support plans (no rate of attrition for Covid19 or other winter viruses) and assumes no requirement for medical staff to be pulled to support Covid19 response to ED/Wards or Critical Care.

- Respiratory services will be differentially impacted as these first line responders for Covid19.

- Workforce response same as 5% scenario but at its peak UHNM saw 1200 staff off of which 700-800 were suspected Covid19 related, as we cannot predict the areas that are effected the Workforce Cell will work with Divisions and Corporate Service to understand the gaps and make recommendations for Executive review for either service reduction or reallocation of staff to maintain essential services balanced against patient safety and experience priorities.

9. Performance & Information: Measuring our success

The system has formed an overarching Balance Score Card which all partners have contributed key metrics which will measure the enabling schemes along with their impact on activity and performance over winter.

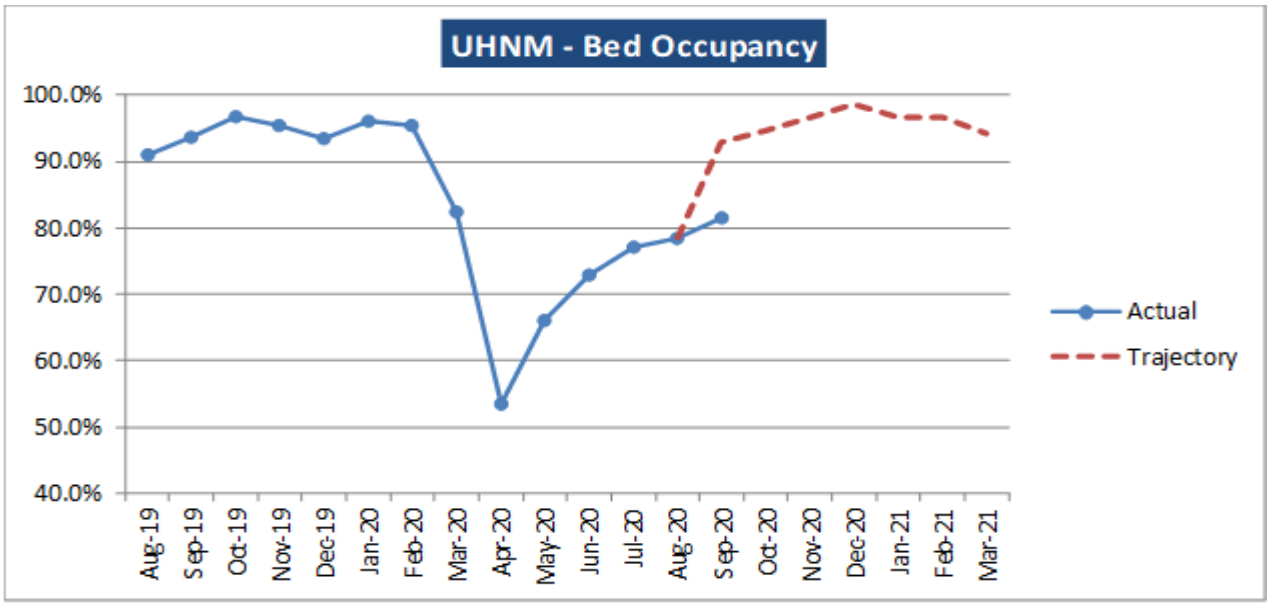
Many of the schemes across UHNM and system partners are inter-related and it is difficult to isolate the impact of any one intervention without maintain oversight over other interdependent schemes.

For this reason the system is looking at a software solution to support escalation and information resilience which gives a platform and portfolio of module that has the ability to take complex data from all system providers across health and social care, creating clear visibility of pressure and potential impact on demand and capacity.

9.1 UHNM Urgent Care Reporting Framework

- Trust teams are able to access a set of daily reports that track urgent care performance against key urgent care measures – termed the Sentinel Report. This includes daily tracking of ED attends, our ambulatory performance and conversion rates to in patient together with our urgent care KPIs for ward and discharge enablers. A more formal dashboard linked to some of the IM&T enablers in train (Power BI live ED dashboard will deliver more real time reporting and operational responsiveness once released, this will be used as a headline report within the IPR.

- UHNM occupancy management remains a key performance and quality measure to sustain throughout the winter period and the table below shows the occupancy trajectories to support the winter bed plan. The graph below shows the expected trajectory for occupancy based on the new hospital zoning configuration.



10. Winter Risk Evaluation Summary

There are risks with the ability of the Trust to achieve its objective of a well-managed winter which will enable it to achieve the 92% occupancy goal that the hospital, with support from system partners, has committed to.

- **Unplanned Emergency demand may exceed acute inpatient and emergency portal capacity.**

  UHNM Winter Planning based on ensuring 92% occupancy and activity modelled on the 2019/20 winter numbers in support of this. System partner plans drafted to support closure of the modelled UHNM bed deficit but impact unknown if routine urgent care demand (non-infectious) together with other winter viruses and Covid19 surge at the same time, this will add time critical pressures to pathways and will need to managed on a day by day and week by week process though Covi19 tactical meetings

- **Medical and Nurse staffing and Prof and Tech grades may fall beneath planned levels due to sickness / inability to recruit (alongside existing workforce recruitment).**

- UHNM have recruitment strategies in place to support the winter schemes with agency and locum backfill provision if substantive recruitment is not secured for some of the scarcer medical and prof and tech posts as drafted in the winter plan this may cause continuity management issues for some services.

- **Influenza demand may exceed planned cohort capacity and increase pressure on bed base.**

- Launch of IPC mitigation schemes across community services and acute IPC teams continuing with the vaccination campaign and vigilance around IPC measures across all wards. The Covid19 tactical forum will be tracking activities day by day in accordance with escalation levels.

- **MFFD numbers may exceed planned levels, impacting on patient flow (LoS, Bed Occupancy Rates).**

- Seasonal work plans to reduce length of stay, particularly with our over 7, 14 and 21 day patients has been articulated in the plan. Focus on admission avoidance and use of portals to mitigate against inappropriate admissions outlined in the plan and the ECIST test of change work is very much towards ward enablers like early Board Rounds supporting discharge, use of Discharge Lounge and same day movement of patients who have completed their acute episode of care will assist in mitigation of this risk. MFFDs must be maintained at 100 on both acute sites in totality and the current MFFD whilst lower than on previous years at September 2020, this needs capacity in the community to align to the daily review and identification of patients to place in off-site onward care locations.

- **No deal EU Exit will impact on service provision at UHNM and across the LHE.**

- UHNM planning well advanced with command and control structure in place led by UHNM COO/DCOO and Trust stakeholder teams but central government advice and guidance on current situation/actions are awaited.

- **Inability to maintain Non Urgent Elective activity in the event of increased capacity pressures.**

- UHNM plan has provided additional level 3 (x2) and L1 (x1) beds in support of the extension of Critical Care to meet increased elective and unplanned surgical demand. This, together with clinical prioritisation meeting

at 8am every day for clinical teams to review the balance of NEL and EL take and work through plans to manage theatre lists 24/7 will be the daily mitigation plan. The Covid19 response may overwhelm available capacity and the Trust will review appropriate actions around essential services and electives at the point of challenge.

- **Inability to maintain diagnostic and support services in the event of increased capacity pressures.**

- UHNM Winter Plan ensures provision of additional support to Pharmacy and Diagnostic support based on the success of similar schemes deployed last year. Use of the Independent Sector to support continuation of diagnostics is a new feature for this year together with the commissioning of temporary mobile capacity. Daily Tactical Covid19 meetings will keep this under review.

11. Conclusion

UHNM has worked in partnership with system organisations to deliver robust winter plans for 2020/21, that support our 3 main priorities, these being

- **Reducing Overcrowding :** through ensuring that we have the available capacity (and workforce) to support the increased demands of winter and supporting this through this additional resilience within the Pathology teams to support improved turnaround times for both Flu and Covid testing

- **Improving Ward Based Processes:** that allows for easier access to our ward based beds through a renewed transformation agenda split across 4 phases of delivery, supported by ECIST and an on-site clinical transformation project that will embed new ways of working that support improved patient journey

- **Enhanced System Pathways:** that will reduce both ED attendances and ambulance conveyances through improved access to primary care / community led urgent care pathways, utilising CRIS to support the most vulnerable and ensuing that the good work we have achieved during covid in relation to MFFD is further improved during winter

Our plan reflects a number of key assumptions based on Phase 2 / 3 recovery trajectories an takes into account the learning from Covid which will enable us to maintain our recovery (unless we see a significant escalation in Covid cases to 30% bed stock)

The financial investment seen for both Covid19 and the Winter allocation has been focussed on enabler schemes that will support our urgent care response and this together with a revised Urgent Care Plan and supported ECIST work programmes, will ensure UHNM can be responsive to our winter challenges and to deliver consistent quality care for our patients whilst maintaining and supporting the wellbeing of our valued and highly skilled workforce.

The Board is asked to endorse this UHNM Winter Plan for delivery during the period 1st October 2020 to 31st March, 2021.

12. Appendices

1. LHE Winter Plan

Enclosed – Appendices A to H

2. UHNM Winter Bed Plan & QIA for Critical Care Capital deferral


Bed Zones v4.xlsx


QIA Bed reduction 071020.XLSX

3. UHNM Urgent Care Plan


7. Appendix Urgent Care Programme Dra

4. UHNM Winter Financial Plan


FINAL Updated Winter Plan 2020 v2..

5. UHNM Winter Communication Slide Set


05 Winter 2020 -Campaign and comn

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	4th November 2020
Report Title:	Infection Prevention Board Assurance Framework COVID-19 – Quarter 2 2020/2021	**Agenda Item:**	9
Author:	Helen Bucior, Infection Prevention Lead Nurse Emyr Philips , Associate Chief Nurse Infection Prevention/Deputy DIPC Claire Rylands Associate Director of Corporate Governance		
Executive Lead:	Michelle Rhodes, Chief Nurse/DIPC		

Purpose of Report:

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

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

Executive Summary:

Situation

To update the Trust Board on the self- assessment compliance framework with Public Health England and other COVID-19 related infection prevention guidance.

This will enable the Trust to identify any areas of risk and show corrective actions taken in response.

The framework is structured around the 10 existing 10 criteria set out in the code of practice on the prevention and control of infection which links directly to the Health and Social Care Act 2008

Background

Understanding of COVID-19 has developed and is still evolving. Public Health England and related guidance on required Infection Prevention measures has been published, updated and refined to reflect the learning.

This continuous self- assessment process will ensure organisations can respond in an evidence based way to maintain the safety and patients, services users and staff.

Each Criteria had been risk scored and target risk level identified with date for completed.

Although work in progress the self-assessment sets out what actions, processes and monitoring the Trust already has in place for COVID-19.

Assessment

- There are a number of symptoms, processes and controls in place, however evidence of assurance

monitoring has demonstrated some gaps which will be addressed through the action plan

- Whilst there are controls and assurances in place to ensure appropriate antimicrobial use some of the findings of the antimicrobial audits demonstrate areas of non-compliance therefore further control are to be identified and implemented in order to reduce the level of risk

- There is a substantial amount of information available to provide to patients this is continually updated as nation guidance changes, however at present limit arrangement in place to monitor the provision of this information.

Key Recommendations:

To update the Board on Trust position against self- assessment compliance framework with Public Health England and other COVID-19 related infection prevention guidance.

NHS
University Hospitals of North Midlands
NHS Trust

Infection Prevention and Control Board Assurance Framework

Quarter 2 2020/21

Summary Board Assurance Framework as at Quarter 1 2020/21

Ref	Requirement / Objective	Risk Score				
		Q1	Q2	Q3	Q4	Change
BAF 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.	9	9			→
BAF 2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	6	3			↓
BAF 3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	9	9			→
BAF 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.	6	6			→
BAF 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.	9	3			↓
BAF 6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	9	9			→
BAF 7	Provide or secure adequate isolation facilities.	6	3			↓
BAF 8	Secure adequate access to laboratory support as appropriate.	6	6			→
BAF 9	Have and adhere to policies designed for the individuals and provide organisations that will help prevent and control infections.	6	3			↓
BAF 10	Have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	6	6			→

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

Risk Scoring								
Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3			There are a number of controls in place, however evidence of evidence of assurance monitoring has demonstrated some gaps which will be addressed through the action plan	Likelihood:	1	End of Quarter 3
Consequence:	3	3				Consequence:	3	
Risk Level:	9	9				Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
1.1	Infection risk is assessed at the front door and this is documented in patient notes.	• On arrival in ED patients are immediately identified either asymptomatic for COVID -19 and apply infection prevention precautions. • ED navigator in place • Colour coded areas in ED to set out COVID and Non COVID areas. This has been revised in September mirror inpatient areas. Purple ED with blue single rooms and respiratory assessment unit • ED navigator records patient temperature and asked COVID screening questions. Patient then directed to either remain in purple or blue single room • ED pathways and SOP • When ambulance identify suspected COVID patients are received in respiratory	• From June 2020 IP team to review patients that are found COVID positive and nursed in bay to ascertain compliance with pathway and IP control measures are in place Review pathways and identify theme • Theme report to IPCC • Pre AMS check COVID -19 screening results, if patient arrives in green area with no COVID screen a Datix is	• COVID -19 Pathways to include actions for clinically extremely vulnerable patient placement

		assessment Unit ED • All patients screened for COVID -19 when decision made to admit • Maternity pathway in place • Elective Pre Amms Plan to swab patients72 hours pre admission SOP in place • Radiology /interventional flow chart • Children's unplanned admission. ED Navigator asked COVID questions then child directed to either RED of Green Areas. • All children, symptomatic or asymptomatic are swabbed in child health. This is recorded within their medical records, placed onto the nursing and medical handover so that we are made of the results and whether we need to chase if not received within a timely manner. The patient flow reports to the Child Health tactical meeting every morning how many children have been swabbed result and any outstanding • All children swabbed are placed into a sideward upon receiving their result are either kept within a side ward or moved to a bay if the swab is negative. • Screening for patients on systematic anticancer treatment and radiotherapy • Out patient flow chart in place • Thermal imaging cameras in some areas of the hospital • Iportal alert in place for COVID positive patients • Extremely vulnerable patient placement	raised. • June 2020 Children department plan to audit of 10 patients to check the process	

		added into new COVID ward round guidelines (October 2020)		
1.2	Patients with possible or confirmed Covid-19 are not moved unless this is essential to their care or reduces the risk of transmission.	• All patients admitted to the Trust are screened for COVID -19 • All patients are rescreened on days 5-7 • Critical care plan with step down decision tree • COVID-19 Divisional pathways • Step down guidance available on COVID 19 intranet page (August 2020)	• Unannounced visits for clinical areas with clusters or HAI cases of COVID-19 • Review of HCAI COVID cases by IP Team • Datix /adverse incidence reports for inappropriate transfers	
1.3	Compliance with the national guidance around discharge or transfer of Covid-19 positive patients.	• Infection prevention step down guidance available on Trust intranet • All patients who are either positive or contacts are positives are advised to complete self –isolation if discharged or transferred within that time frame • All patients are screened 48 hours prior to transfer to care homes • New UHNM ward round guidance October 2020	• Datix/adverse incidence reports	• Patient COVID -19 discharge information letter for patient who are discharged but contact of a positive case
1.4	**All staff (clinical and non-clinical)** are trained in putting on and removing PPE, know what PPE they should wear for each setting and context and have access to the PPE that protects them for the appropriate setting and context as per national guidance.	• Key FFP3 mask fit trainers in place in clinical areas • PPE posters and information available on the Trust COVID -19 page. This provides the what, where and when guide for PPE • Infection Prevention Questions and Answers Manual include donning and doffing information. • Areas that require high level PPE are agreed at clinical and tactical • Aerosol generating procedures (AGP's) which require high level PPE agreed at clinical and tactical group	• Daily stock level of PPE distributed via email and agenda item for discussion at COVID-19 tactical group • IP complete spot check of PPE use if cluster/OB trigger • Records of Donning and Doffing training for staff trained by IP • A number of Clinical areas have submitted PPE donning an doffing records to the IP team	• Training completed in areas - records are held locally by clinical areas, these include Divisional donning and doffing training records and Divisional FFP3 mask fit training records • FFP3 Training records require central holding/recording?

		• COVID -19 Clinical Group reviews any proposed changes in PPE from the clinical areas • Link to Public Health England donning and doffing posters and videos available on Trust intranet • Chief Nurse PPE video • Extended opening hours supplies Department • Risk assessment for work process or task analysis completed by Health and Safety • PHE announced from 1th June 2020 all staff to wear mask in both clinical and non-clinical health care setting	• Donning and Doffing training also held locally in clinical areas • Cascade training records held locally by Divisions • Sodexo and Domestic service training records	
1.5	National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way.	• Notifications from NHS to Chief nurse/CEO • IP team COVID lead checks Public Health England webpage daily (Monday-Friday) for updates • Changes raised at -19 clinical groups which was held originally twice weekly, reduced to weekly and now increased back to twice week due to second surge of COVID weekly. • Purpose of the Clinical Group - The Group receive clinical guidance and society guidance which is reviewed and if agreed used to advise clinical teams after approval at Exec COVID -19 meeting which is held twice monthly. • Tactical group – The tactical Group originally was held daily. The Group made decided and agreed tactical actions into the incident. UHNM is now in Restoration phase with daily tactical meetings	• Clinical Group meeting action log held by emergency planning	

		• Chief nurse updates • Changes/update to staff are included in weekly Facebook live sessions • COVID -19 intranet page • COVID -19 daily bulletin with updates • IP provide daily support calls to the clinical areas		
1.6	Changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted.	• Clinical Group feeds subgroup to tactical group. • COVID Gold/strategic/Exec meetings	• Meeting Action log held by emergency planning	
1.7	Risks are reflected in risk registers and the Board Assurance Framework where appropriate.	• Risk register and governance process • Datix incidents	• IP risks are agenda item at Infection Prevention and Control committee (IPCC)	
1.8	Robust IPC risk assessment processes and practices are in place for non Covid-19 infections and pathogens.	• IP questions and answers manual • Section in IP questions and answer manual 2.1 priority of isolation for different infections and organisms • Sepsis pathway in place • Infection Risk assessment in proud to care booklets and admission documentation • C.diff care pathway • IP included in mandatory training • Pre Amms IP Screening • Birmingham paused ribotyping service for C.DIFF due to COVID-19. During periods of increased incidence ribotyping is useful to establish person to person transmission, Leeds Hospital are now undertaking this service • Proud to care booklets revised an reinstated August/September 2020	• MRSA screening compliance • Monthly Sepsis Compliance audits. Screening compliance for sepsis and time to antibiotics for Red flag patients • IP audits • Infection Prevention Health care associated infection report, including submitted to monthly to Quality and Safety. • Submission of Infection figures to Public Health England. Clostridium difficile, MRSA blood stream infections (bacteraemia) and Gram Negative blood stream infections	• Current Emergency admission document in place which does not include MRSA decolonisation – place for documentation • Date to re instate admission documentation, paper due for IPCC September 2020 • Universal MRSA Screening of all emergency admission in emergency portals paused due to COVID -19. Only MRSA weekly screening continued on critical care/HDU both adult and paediatric,

			• Seasonal influenza reporting • Audit programme for proud to care booklets	haematology/oncology wards and renal ward, this is under review.

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	**KLOE**	**Action Required**	**Lead**	**Due Date**	**Quarter 2 Progress Report**	**BRAG**
1.	1.1	Up- to- date COVID -19 Divisional pathways	ACN's	30/09/2020	Associate Chief Nurse contacted and request made for COVID -19 pathways 28th July 2020. ED pathways in place and also County to Royal transfer of COVID positive patients. Divisional restoration plans in progress	
	1.1	Revised pathways to include actions for extremely vulnerable patients who are admitted into the Trust	ACN's	31/10/2020	4th September Chief Nurse DIPC request at senior meeting that extremely vulnerable patients are included in revised pathways. October 2020 Extremely vulnerable patient recommendations included into the COVID ward round guidance document.	
	1.3	Patient COVID -19 discharge information letter for patient who are discharged but contact of a positive case	IP Team	31/10/2020	Leaflets to be devised Action at COVID weekly meeting 14th September was to create an information leaflet for patients and household members on discharge, with information on isolating, symptoms and useful information for informing the local authorities and the test and trace system.	
	1.4	Improving staff FFP3 mask fit staff training data recording and retention of records.	Health and Safety	31/12/2020	Proposed Fit Testing compliance improvement Task and Finish Group. Inaugural meeting planned for 29th July 2020. Health and Safety ESR will be up and running for the purpose of recording fit test records as soon as the Trust gives the go ahead to procure Portacount fit test systems, this is a project lead by Health and Safety	

3.	1.4	Divisions to retain current mask fit training records and compliance score for their areas whilst central recording and retention of records process is agreed	ACN'S	30/09/2020	Associate Chief Nurse contacted and request made for assurance with staff mask fit compliance. Compliance also added to Divisional papers for infection Prevention and Control Committee (IPCC). Current process that clinical areas hold their own training records and can also enter basic details on OLM. A number of clinical areas have also forwarded training records to the IP Team. IP Team. IP have a list of mask fit testers .	
4.	1.8	Re instate admission proud to care documentation, currently emergency admission document in place	Deputy Director of Quality and Safety	30/09/2020	Original proud to care booklet reinstated now in	
5.	1.8	To complete an analysis (Advantages and disadvantages) to reinstating MRSA screening as per UHNM policy	Deputy Director Infection Prevention	31/12/2020	MRSA screening had reduced temporarily due to the COVID pandemic but UHNM are still following PHE 2014 guidance. This was an agreed temporary change in UHNM practice. Previously the Trust were screening over and above the 2014 guidance. Due to the COVID pandemic less elective work is taking place therefore less elective screening. High risk areas all still screen on admission. Risk based screening is for lower risk areas. Prior to the 2014 guidance the DIPC at the time (supported by the CCGs) did not want to reduce the screening policy the Trust already had in place. The CCG requested screening policy have to be approved by the CCGs. Discussed at IPCC. DIPC requested a pro's and con's exercise re screening changes due to the COVID pandemic. The Trust has not dropped below national guidance. October MRSA screening is around 50% of pre COVID screening, laboratory does not have the capacity to process COVID work and level of MRSA screens pre COVID. Paper to November IPCC. This continues to be under review during COVID Pandemic.	

6.	1.8	To explore an alternative laboratory for Clostridium difficile ribotying	Kerry Rawlin Laboratory	31/08/2020	Leeds Hospital has agreed to help with ribotyping Clostridium difficile specimens. Await first batch of results to gain assurance that process is working 04/09/2020 we are experiencing problems in receiving ribotyping results back from Leeds. Usually they would arrive electronically. UHNM have contacted Leeds and are awaiting a resolution with their IT team and the PHE reference electronic reporting system. Ribotype now being received from Leeds and added to ICNET patient case	

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

Risk Scoring								
Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2	1			Whilst cleaning procedures are in place to ensure the appropriate management of premises further evidence to confirm compliance e.g. c4c audits to be reinstated	Likelihood:	1	End of quarter 2
Consequence:	3	3				Consequence:	3	
Risk Level:	6	3				Risk Level:	3	

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

2.2	Designated cleaning teams with appropriate training in required techniques and use of PPE are assigned to Covid-19 isolation or cohort areas.	• SOP and cleaning method statements for domestic teams/Sodexo • PPE education for Domestic /Sodexo staff • Initial meetings held with facilities/estates to discuss and plan COVID-19 requirements IP agenda item • Representatives from the division are attending the daily tactical meetings, and an E,F & PFI daily meeting is taking place which includes our partners	• Spot check assurance audits completed by Sodexo and retained during COVID period • Cleanliness complaints or concerns • PPE and FFP3 mask fit training records with are held by Sodexo /retained services • Key trainers record • Notes from facilities/estates meeting	
2.3	Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance.	• SOP for terminal and barrier cleans in place • High level disinfectant , Virusolve and Tristel in place	• C4C audits reinstated July 2020 • Spot checks • Terminal clean request log • Patient survey feedback	
2.4	Increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance.	• Increased cleaning process (barrier clean) included in Infection Prevention Questions and Answers manual • Process in place for clinical areas with clusters and HAI cases of COVID -19 requiring increased cleaning and /or terminal cleans	• Barrier clean request log held by Sodexo • IP spot checks for clinical areas with clusters of COVID -19 or HAI cases of COVID - 19 • Disinfectant check completed during IP spot checks	
2.5	Attention to the cleaning of toilets / bathrooms, as Covid-19 has frequently been found to contaminate surface in these areas.	• Cleaning schedules in place • Barrier cleans (increased cleaning) process in place which includes touch points		
2.6	Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution	• Virusolve and Tristel disinfectant used	• Evidence from manufacture that these disinfectants are	

	at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses.	• Virusolve wipes also used during height of pandemic	effective against COVID -19 • Evidence of Virusolve weekly strength checks , held locally at ward /department level • IP checks that disinfectant is available during spot checks	
2.7	Manufacturers guidance and recommended product 'contact time' must be followed for all cleaning / disinfectant solutions / products.	• Contact times detailed in SOP and cleaning methods statements • Included in mandatory training • Included in IP Q+A • Disinfectant used routinely		
2.8	As per national guidance: • 'Frequently touched' surfaces, e.g. door / toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions and bodily fluid. • Electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily. • Rooms / areas where PPE is removed must be decontaminated, timed to coincide with periods immediate after PPE removal by groups of staff (at least twice a day).	• Frequently touch points Included in Barrier clean process • Offices and back offices also supplied with disinfectant wipes to keep work stations clean.	• IP checks • Barrier clean request log • Terminal clean request log	
2.9	Linen from possible and confirmed Covid-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken.	• Included in IP questions and answers manual • Linen posters depicting correct linen bag displayed in clinical areas and linen waste holds	• IP audits held locally by divisions • Datix reports/adverse incidents	

		• Red alginate bags available for the clinical areas • Infected linen route		
2.10	Single use items are used where possible and according to single use policy.	• IP question and answers manual • Medical device policy • SOP for Visor decontamination in time of shortage	• IP audits held locally by divisions	
2.11	Reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance.	• IP question and answers manual covers decontamination • Air powered hoods – SOP in place which includes decontamination process for the device • Re usable FFP3 Masks – Sundstrom. SOP in place which includes decontamination process • Medical device policy • Availability of high level disinfectant in clinical areas • Sterile services process • Datix process	• IP audits held locally by divisions • Datix reports/adverse incident reports	
2.12	Review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission.	• HTM hospital ventilation	• Estates have planned programme of maintenance	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 2 Progress Report	BRAG
1.	2.3	To re instate C4C cleanliness audits and patients survey	Head of CPM Estates, Facilities & PFI Division	30/09/2020	Soft FM cleaning services and Sodexo recovery plan in place which includes the process for reinstating the monitoring process and patient surveys which have commenced 6th July 2020. 04/09/2020 The C4C audits programme are now covering all areas but are not fully multi-disciplinary audit team e.g. only CPM on them due to social distancing. (yet to invite Sodexo, Nurse). We are likely to expand this out during October	

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

Risk Scoring								
Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3			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:	1	End of quarter 3
Consequence:	3	3				Consequence:	3	
Risk Level:	9	9				Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
3.1	Arrangements around antimicrobial stewardship are maintained.	• Regular, planned Antimicrobial stewardship (AMS) ward rounds • Trust antimicrobial guidelines available 24/7 via intranet and mobile device App • Clostridium *difficile* Period of increased incidence and outbreaks are reviewed by member of AMS team and actions generated cascaded to ward teams • Regional and National networking to ensure AMS activities are optimal • AMS CQUIN further mandates key AMS principles to be adhered to • Monthly review of antimicrobial consumption undertaken by AMS team.	• Same day escalation to microbiologist if concerns • Compliance with guidelines and other AMS metrics reported to Infection prevention and control Committee (IPCC) • Meeting minutes reviewed and actions followed up • Real time discussions / requests for support / advice enabled via regional and national social media accounts. National (incl. PHE) thought leaders members • Trust and commissioners require timely reporting on compliance with AMS CQUIN targets. • Wards showing deviation from targets are followed up by targeted AMS team ward reviews	• Further controls required due to elements of non - compliance with audits • Gap in control identified as there is no current escalation of areas not complying with antimicrobial guidelines.

			generating action plans for ward teams	
3.2	Mandatory reporting requirements are adhered to and boards continue to maintain oversight.	• Quarterly point prevalence audits maintained by AMS team at UHNM despite many regional Trusts not undertaking any more. • Results from all AMS audits and targeted ward reviews are reported at the Antimicrobial Stewardship Group and minutes seen by IPCC • CQUIN submissions completed in timely manner and generate action plans for AMS and ward teams to follow up concerns each quarter.	• Whilst only a snap-shot audit the Trust value the output from these audits. Work is underway Q1 and Q2 20/21 to review potential change in data collection to optimise impact. • IPCC scrutinise results. Divisions held to account for areas of poor performance. • Trust CQUIN contracts manager holds regular track and update meetings to challenge progress vs AMS CQUINS	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 2 Progress Report	BRAG
1.	3.1	Further controls are required to improve compliance	ACN'S	31/12/2020	Antimicrobial audits results discussed at IPCC 27th July 2020. Separate meeting with chief nurse/IP and ACN's to be arranged during August to discussed results and any corrective actions. Feedback meeting completed 4th September 2020. – Senior meeting. To review escalation of areas that are not compliant with antimicrobial guidelines.	
2.	3.1	To review current escalation of areas that are not compliant with antimicrobial guidelines	DIPC	31/10/2020	Raised at September Antimicrobial Pharmacist Group and IPCC	

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

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

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

		bedside care. We will continue to monitor prevalence and changes in visiting restrictions will be reinstated with immediate effect should it be necessary • The only exceptional circumstances where on visitor , an immediate family member or care will be permitted to visited are listed below- • The patient is in last days of life- palliative care guidance available on Trust intranet • The birthing partner accompany a women in established labour • The parent or appropriate adult visiting their child • Other ways of keeping in touch with loved ones e.g. phone calls , video calls are available • COVID-19 information available on UHNM internet page		
4.2	Areas in which suspected or confirmed Covid-19 patients are being treated are clearly marked with appropriate signage and have restricted access.	• ED colour coded areas are identified by signs • Navigator manned ED entrance • Hospital zoning in place	• Daily Site report for county details COVID and NON COVID capacity	
4.3	Information and guidance on Covid-19 is available on all trust websites with easy read versions.	• COVID 19 section on intranet with information including posters and videos	• COVID-19 page updated on a regular basis	
4.4	Infection status is communicated to the receiving organisation or department when a possible or confirmed Covid-19 patient needs to be moved.	• Transfer policy C24 in place , expires November 2020	• Datix process	• Transfer policy not specific to COVID-19

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

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

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

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
5.1	Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed Covid-19 symptoms and to segregate them from non Covid-19 cases to minimise the risk of cross-infection as per national guidance.	• ED navigator records patient temperature and asked screening questions. Patient then directed to colour coded area • All patients who are admitted are now screened for COVID 19	• June 2020 IP team to review patients that are found COVID positive and nursed in bay to ascertain compliance with pathway and IP control measures are in place Review pathways and identify theme . Themes report to IPCC • ED pathways including transfer of COVID positive patient from County to Royal Hospital	
5.2	Mask usage is emphasized for suspected individuals.	• Use of mask for patients included in IP COVID -19 • question and answers manual • All staff and visitors to wear masks from Monday15th June	• Manned hospital entrances to prompt mask wearing	

		• ED navigator provide masks to individual in ED • Mask stations at hospital entrances • Covid-19 bulletin dated 12th June 2020 • 28th August updated guidance from PHE recommends in patients to also wear surgical masks if tolerated and does not compromise care		
5.3	Ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff.	• Colour coded areas in ED to separate patients, barriers in place. • Colour coded routes identified in ED • Social distancing risk assessment in place • Perspex screens agreed through R+R process for reception area • Social distance barriers in place at main reception areas	• Division/area social distancing risk assessments	
5.4	For patients with new-onset symptoms, it is important to achieve isolation and instigation of contact tracing as soon as possible.	• Process for isolation symptom patient in place • Process for cohorting of contacts • Contacting patients who have been discharged from hospital then later found to be a close contact of a COVID-19 positive case , patient to be informed by the clinical area	• If patient found to be positive in the bay and exposing other patient. IP liaise with clinical are , apply bay restrictions. • Patient who tested negative on admission and remain an inpatient are retested for COVID at day 5-7	

5.5	Patients with suspected Covid-19 are tested promptly.	• All patients who require overnight stay are screened on admission	• Adverse incident monitor /Datix	
5.6	Patients who test negative but display or go on to develop symptoms of Covid-19 are segregated and promptly re-tested and contacts traced.	• Screening protocol discussed at Clinical group which includes re testing • Inpatient contacts are cohorted	• Datix process • IP reviews	.
5.7	Patients who attend for routine appointments and who display symptoms of Covid-19 are managed appropriately.	• Restoration and Recovery plans • Thermal temperature checks in imaging, plan to extent to other hospital entrances • Patient temperature checks in outpatient department • Mask or face coverings for patients attending appointments from Monday 15th June	• Datix process	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 2 Progress Report	BRAG
1.	5.1	Up- to- date COVID -19 Divisional pathways	ACN's	30/09/2020	Associate Chief Nurse contacted and request made for COVID -19 pathways 28th July 2020. ED pathways in place and also County to Royal transfer of COVID positive patients. Divisional recovery plans and identification of COVID wards due to second wave continues	
2.	5.4	Process for contacting patients who have been discharged home and have then been found to in close contact with a COVID -19 positive patient during their stay	Deputy of Director Infection	31/08/2020	IP guide liaise with clinical areas to identify closed contacts, close contact are isolated for remainder of hospital stay for 14 day or if discharged home continue isolation at home. Clinical team inform patient who have already been discharged COVID intranet page. October COVID -19 ward round guidance	
3.	5.7	Process to monitor patients who attend routine appointments who display symptoms of COVID-19 are managed appropriately	ACN'S	31/07/2020	Thermal camera located in a number outpatient areas – with SOP if patient triggers. Script in place for scheduling outpatient/ investigations	

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

Risk Scoring								
Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3			Whilst information and communication/controls are in place to ensure staff are aware of their responsibilities spot audits undertaken have demonstrated some gaps in compliance	Likelihood:	1	End of Q3
Consequence:	3	3				Consequence:	3	
Risk Level:	9	9				Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
6.1	All staff (clinical and non-clinical) have appropriate training, in line with the latest PHE and other guidance, to ensure their personal safety and working environment is safe.	• PPE discussed at tactical group • Training videos available • FFP3 mask fit key trainers • Donning and Doffing posters, videos and PHE available on Covid-19 section of Trust intranet	• Tactical group action log • Divisional training records • Mandatory training records	
6.2	All staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation, and on how to safely don and doff it.	• PPE and standard precautions part of the infection prevention Questions and Answers manual. • FFP3 train the trainer programme in place • Trust mask fit strategy • SOP and training for reusable FFP3 masks • SOP and training for use of air powered hoods • PPE posters are available in the	• Training records • IP spot checks	

		COVID -19 section of trust intranet page		
6.3	A record of staff training is maintained.	Mask fit strategy in place	• FFP3 training records entered onto OLM and held on L drive for those trained by the infection prevention team • Training records held locally by the Clinical areas	• FFP3 Mask Training records held locally by divisions for training completed by key trainers in the clinical areas • OLM captures that staff member attended IP training session but not the outcome e.g. passed or failed mask fit training
6.4	Appropriate arrangements are in place so that any reuse of PPE is in line with the CAS Alert is properly monitored and managed.	• SOP in place for reuse of visors • SOP in place for use of air powered filters systems plus key trainers • SOP in place for the care of reusable FFP3 masks (Sundstrum))	• SOP 's available on Trust intranet • Training logs held divisionally for air powered systems • IP training log for air powered systems key trainers and distribution of reusable FFP3 masks (Sundstrum)	
6.5	Any incidents relating to the re-use of PPE are monitored and appropriate action taken.	• PPE standard agenda at COVID Tactical meeting • Datix process • Midlands Region Incident Coordination Centre PPE Supply Cell	• Tactical group action log • Datix process • Incidents reported by procurement to centre PPE supply Cell	
6.6	Adherence to the PHE national guidance on the use of PPE is regularly audited.	• PPE Audits • PPE volume use discussed at tactical COVID-19 Group	• Spot audits completed by IP team	
6.7	Staff regularly undertake hand hygiene and observe standard infection control precautions.	• Hand hygiene requirements set out in the infection prevention Questions and Answers manual • Poster for hand hygiene technique displayed at hand	• Monthly hand hygiene audits completed by the clinical areas • Infection Prevention hand hygiene audit programme. Overview of results fed into	

		wash sinks and stickers on hand soap and alcohol dispensers • Alcohol gel availability at the point of care	infection Prevention committee • Independent hand hygiene audits completed by IP Senior Health Care	
6.8	The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance Guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas	• Paper Towels are available for hand drying in the Clinical areas	• IP audits to check availability	
6.9	Staff understand the requirements for uniform laundering where this is not provided on site.	• Instruction for staff laundering available on the Trust COVID - 19 section of intranet • Dissolvable bags to transport uniforms home available for staff • Communications /daily bulletin to remind staff not to travel to and from work in uniforms	• Clinical areas to monitor • Reports of member of public reporting sighting of staff in uniform	
6.10	All staff understand the symptoms of Covid-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household displays any of the symptoms.	• For any new absences employee should open and close their usual absence via Empactis system • Symptom Advice available on Trust intranet	• Cluster /outbreak investigations	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	**KLOE**	**Action Required**	**Lead**	**Due Date**	**Quarter 2 Progress Report**	**BRAG**
1.	6.3	Improving staff FFP3 mask fit staff training data recording and retention of records	Health and Safety	31/12/2020	Proposed Fit Testing compliance improvement Task and Finish Group. Inaugural meeting planned for 29th July 2020. ESR will be up and running for the purpose of recording fit test records as soon as the Trust gives the go ahead to procure Portacount fit test system as this is part of the project lead by Health and Safety	

7. Provide or secure adequate isolation facilities.

Risk Scoring								
Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2	1			Isolation facilities are available and hospital zoning in place. Further work is currently being undertaken to align ED to Trust Zoning model	Likelihood:	1	Quarter 2
Consequence:	3	3				Consequence:	3	
Risk Level:	6	3				Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
7.1	Patients with possible or Covid-19 are isolated in appropriate facilities or designated areas where appropriate.	• Hospital zoning in place • Recovery and Restoration plans for the Trust • COVID prevalence considered when zones identified • Purple wards with blue single rooms • Green wards for planned screened elective patients	• June 2020 IP team to review patients that are found COVID positive and nursed in bay to ascertain compliance with pathway and IP control measures are in place Review pathways and identify theme	Patients in ED if suspected or confirmed or contact COVID are isolated, however the area is being reviewed to follow Trust zoning model.
7.2	Areas used to cohort patients with possible or confirmed Covid-19 are compliant with the environmental requirements set out in the current PPE national guidance.	• Areas agreed at COVID-19 tactical Group • Restoration and Recovery plans	• Action log and papers submitted to COVID-19 tactical and Clinical Group	
7.3	Patients with resistant / alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement.	• Infection Prevention Questions and Answers Manual includes alert organisms/resistant organism	• RCA process for Clostridium *difficile* • Outbreak investigations • MRSA bacteramia investigations • Datix reports	

		• Support to Clinical areas via Infection Prevention triage desk • Site team processes		

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	**KLOE**	**Action Required**	**Lead**	**Due Date**	**Quarter 2 Progress Report**	**BRAG**
1.	7.1	ED to align with inpatient zoning model	ED leads	18/09/2020	Both sites have remodel ED areas. Corridor ED Royal review planned	

8. Secure adequate access to laboratory support as appropriate.

Risk Scoring								
Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2	2			Laboratory services for UHNM are located in the purpose built Pathology Laboratory on-site at RSUH. The Laboratory is United Kingdom Accreditation Service (UKAS) accredited. Work is currently in progress to improve COVID-19 swab screening for clinical staff to improve the risk of false COVID-19 negative results	Likelihood:	1	End of Q3
Consequence:	3	3				Consequence:	3	
Risk Level:	6	6				Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
8.1	Testing is undertaken by competent and trained individuals.	• How to take a COVID screen information available on Trust intranet • Laboratory services for UHNM are located in the purpose built Pathology Laboratory on-site at RSUH. The Laboratory is United Kingdom Accreditation Service (UKAS) accredited.	• Review of practice when patient tests positive after initial negative results	• Key trainers for COVID screening technique to reduce risk of false COVID-19 negative results for clinical staff
8.2	Patient and staff Covid-19 testing is undertaken promptly and in line with PHE and other national guidance.	• All patients that require an overnight stay are screened for COVID-19 • Process in place for staff screening via empactis system and Team Prevent • All patient discharged to care setting as screened 48 hours prior to transfer/discharge	• Empactis reporting • Team Prevent systems • Datix/adverse incidence reporting • Cluster /outbreak investigation procedures	

8.3	Screening for other potential infections takes place.	• Screening policy in place, included in the Infection Prevention Questions and Answers Manual	• MRSA screening compliance • Prompt to Protect audits completed by IP • Spot check for CPE screening	• Blanket screening for MRS A paused due to COVID -19

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 2 Progress Report	BRAG
1.	8.1	Key trainers for COVID-19 swabbing technique in clinical areas	Deputy Director if infection Prevention	31/12/2020	Training package and recording system to be devised. Work to commence. 1st September swabbing video recorded, minor changes to be completed week commencing 14th September then video will be circulated to key people for preview and comments. Child positioning included in video	
2.	8.3	To complete an analysis (Advantages and disadvantages) to reinstating pre COVID 19 UHNM screening policy	Deputy Director if infection Prevention	31/12/2020	MRSA screening had reduced temporarily due to the COVID pandemic but UHNM are still following PHE 2014 guidance. This was an agreed temporary change in UHNM practice. Previously the Trust were screening over and above the 2014 guidance. Due to the COVID pandemic less elective work is taking place therefore less elective screening. High risk areas all still screen on admission. Risk based screening is for lower risk areas. Prior to the 2014 guidance the DIPC at the time (supported by the CCGs) did not want to reduce the screening policy the Trust already had in place. The CCG requested screening policy have to be approved by the CCGs. Discussed at IPCC. DIPC requested a pro's and con's exercise re screening changes due to the COVID pandemic. The Trust has not dropped below national guidance. October MRSA screening is around 50% of pre COVID screening; laboratory does not have the capacity to process COVID work and level of MRSA screens pre COVID. Paper to November IPCC. This continues to be under review during COVID Pandemic.	

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

Risk Scoring								
Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	2	1			There is a range of information, procedures , pathways available along with mechanism to monitor however, some of these mechanisms were paused and need to be re -instated	Likelihood:	1	Q2
Consequence:	3	3				Consequence:	3	
Risk Level:	6	3				Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
9.1	Staff are supported in adhering to all IPC policies, including those for other alert organisms.	• IP included in mandatory update • Infection Prevention Questions and Answers manual with ICON on every desk top for ease of use • Infection Prevention triage desk which provides advice and support to clinical areas	• IP audit programme • Audits undertaken by clinical areas • CEF audits • Proud to care booklet audits	• CEF audits paused during COVID -19 period , aim to reinstate during September 2020
9.2	Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff.	• Notifications from NHS to Chief nurse/CEO • IP team COVID lead checks Public Health England webpage daily (Monday-Friday) for updates • Changes raised at COVID clinical group which is held twice weekly • Daily tactical group • Incident control room established where changes are reported through • Chief nurse updates	• Clinical Group meeting action log held by emergency planning	

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

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 2 Progress Report	BRAG
1.	9.1	CEF Audits to recommence	Deputy Director of Quality and Safety	30/09/2020	Review of tool kit with Chief Nurse planned, aiming to trial during August and reinstate audits fully during September 2020. CEF audits reinstated.	
2.	9.1	Proud to care booklet audits paused. Plan for recommencing	Deputy Director of Quality and Safety	30/9/2020	Original proud to care booklets reinstated	

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

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

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
10.1	Staff in 'at risk' groups are identified and managed appropriately, including ensuring their physical and psychological wellbeing is supported.	• All managers carry our risk assessment • Process available on the COVID 19 Trust intranet page • BAME risk assessment • Young persons risk assessment • Pregnant workers risk assessment • Risk assessment to identify vulnerable workers	• Risk assessment and temporary risk mitigation will be reported to the workforce bureau. To protect confidentiality individual risk assessments will not be requested as these should be kept in the employees personal file • Managers required to complete , review and update risk assessments for vulnerable persons	
10.2	Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained.	• SOP for reusable face masks and respiratory hoods in place	• Training records for reusable masks	• Availability of locally held training records. • Lack of central holding of FFP3 records
10.3	Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the crossover of care pathways between planned and elective	• Restore and Restorations plans	• Incidence process/Datix	

	care pathways and urgent and emergency care pathways, as per national guidance.			
10.4	All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas.	• Social distancing tool kit available on COVID 19 intranet page • Site circulation maps • Keep your distance posters • COVID-19 secure declaration • Social distancing risk assessment guidance for managers presentation 5th June2020 • Meeting room rules • Face masks for all staff commenced 15th June • Visitor face covering • COVID secure risk assessment process in place	• Social distance monitor walk round introduced Friday 5th June • Social distance department risk assessments • COVID-19 secure declarations	
10.5	Consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas.	• Social distancing tool kit • Staff encouraged to keep to 2 metre rule during breaks	• Social distance monitor walk rounds • Social distance posters identify how many people allowed at one time in each room	
10.6	Staff absence and wellbeing are monitored and staff who are self-isolating are supported and able to access testing.	• Team Prevent available to offer guidance and treatment to staff presenting with onset of symptoms.	• Team prevent monitoring process • Work force bureau	
10.7	Staff who test positive have adequate information and support to aid their recovery and return to work.	• Team Prevent available to offer guidance and treatment to staff presenting with onset of symptoms. • Empactis line will first ask – is the absence related to coronavirus. To which the employee must say yes or no • Once the absence is reported to the employees manger via email, the manager will categorise the absence type specified in the flow	• Via emapactis • Staff queries' through workforce bureau or team prevent	

		chart. • Team prevent complete COVID 19 staff screening • Areas where transmission has occurred are discussed at clinical group and relevant staff screening under an ILOG number is agreed. • Flow charts or staff returning to work available on COVID 19 section of intranet		

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	**KLOE**	**Action Required**	**Lead**	**Due Date**	**Quarter 2 Progress Report**	**BRAG**
1.	10.2	Improving Staff FFP3 mask fit recording and retention of records	Health and Safety	31/12/2020	Proposed fit testing compliance improvement task and finish group Inaugural meeting planned for 29th July 2020. ESR will be up and running for the purpose of recording fit test records as soon as the Trust gives the go ahead to procure Portacount mas k fit systems as this is part of the project lead by Health and Safety	

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

Performance and Finance Committee Chair's Highlight Report to Board

19th October 2020

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• An update in relation to Covid was provided and the Committee noted the increase in the number of Covid positive patients in the Trust, which was reflecting activity elsewhere within the region. The challenges associated with staffing and nosocomial infections were also discussed. • Ongoing discussions were taking place with regulators regarding the anticipated system deficit and options available, which continued to be a risk • Ongoing work with the Emergency Care Intensive Support Team had identified an issue in relation to medical workforce which needed to match demand, and this was being worked through. • Whilst the Committee welcomed the receipt of the Urgent Care Improvement Plan, which aimed to improve flow and timely discharge of patients, focussing on 5 key drivers, it was agreed that further detail was required in terms of deliverables and associated timescales	• The outputs from Doing the Right Thing, to be reported to Board members • To share the full urgent care plan with members and articulate how the planned activities aimed to improve performance, in order for the Committee to track performance going forwards and whether this was on plan, or not • To provide the system plan to Committee members once available • To provide an update in relation to the medical device equipment strategy via a future Executive Infrastructure Group report • To reflect on risks 1 and 2 on the Board Assurance Framework further, at the Quality Governance Committee and Transformation and People Committee and whether the risk scores were reflective of the current position • To clarify the capital expenditure and interdependences of schemes. • To provide an overview of investment decisions for 2020/21, the list of commitments, funding sources and any residual risks.
Positive Assurances to Provide	**Decisions Made**
• The Committee considered the proposal to take forward a 9 week programme to improve emergency care performance and requested further consideration by the Executive in terms of the activities and expected yield • In terms of month 6 the financial position was at break even and included top up and Covid payments. Activity continued to be less than planned and the risks associated with the elective incentive scheme were discussed. • Work had continued in terms of working through the backlog of 62 day wait cancer patients and reducing the number of 52 week breaches. • The winter plan was presented whereby it was highlighted that the system plan was awaited, and aimed to close the gap. • Risk assessments in relation to the EU Exit had been reviewed and updated with no increases in risk identified, and pharmacy and supplies continued to pose the highest risk. • In relation to the month 7 to 12 income and expenditure forecast, work had been undertaken to close the gap from £49 m to £28 m deficit which was positive, and additional work was being undertaken in respect of the outstanding issues • An update on available capital allocations for 2020/21 was provided, which demonstrated a number of scenarios with associated upsides and risks. • The Committee requested assurance that the accumulation of the business cases presented were affordable both in this financial year and recurrently where appropriate	• The Committee approved the Board Assurance Framework for Quarter 2 • The Committee approved the North Midlands and Cheshire Pathology Service Commercial Agreement which would be considered further by the Trust Board • The Committee approved the mobile MRI rental business case • The Committee approved the Covid testing business case which was to be considered further by the Trust Board • The Committee approved the respiratory patient follow up business case • The Committee approved the draft case for development of a car parking solution and agreed that further discussion was required by the Trust Board • The Committee approved REAFs in relation to the Children's Outpatient Ward - Lease (REAF 3978) and Supply of IV Fluids (REAF 3902) Extension • The Committee approved the actions identified in respect of the responses to the Committee Effectiveness review in order to make improvements going forwards

Comments on Effectiveness of the Meeting
• The Committee overran due to the number of items for consideration

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Executive Directors Update including Covid-19	Assurance	8.	Update on Available 2020/21 Capital Resource	Assurance
2.	Month 6 Performance Report	Assurance	9.	Board Assurance Framework Q2	Approval
3.	Urgent Care Improvement Plan	Assurance	10.	North Midlands and Cheshire Pathology Service Commercial Agreement	Approval
4.	Trust Capacity and Resource Proposal – Winter Plan 2020/21	Assurance	11.	Business Case Approvals	Approval
5.	Briefing on EU Exit Operational Readiness	Assurance	12.	Authorisation of New Contract Awards and Contract Extensions	Approval
6.	Month 6 Finance Report	Assurance	13.	Committee Effectiveness Review	Approval
7.	M7-12 Income and Expenditure Forecast	Assurance	14.	Executive Infrastructure Group Highlight Report	Assurance

3. 2020 / 21 Attendance Matrix

Attended	Apologies & Deputy Sent	Apologies

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

Transformation and People Committee Chair's Highlight Report to Board

22nd October 2020

1. Highlight Report

Matters of Concern / Key Risks / Escalations	Major Actions Commissioned / Work Underway
• An update in relation to Covid-19 was provided, highlighting the current number of positive patients which was increasing and impacting upon staffing. • In terms of workforce performance for month 6 there had been a significant increase in staffing absence related to Covid which was causing some pressure points. Although a system workforce plan had been identified, the Committee recognised it would be difficult to achieve the full recruitment plans given the current pressures.	• Ongoing work was being undertaken on the triggers for absenteeism, which was being monitored on a weekly basis, and the alternative arrangements to be put in place. • Future transformation reports to identify the anticipated impact from the projects, and whether these were transformational or enabled broader organisational transformation • To provide the roadmap in relation to the delivering exceptional care programme, in terms of the service reviews, the True North objectives, associated milestones and key deliverables. • To provide assurance of what local actions were continuing to be taken despite national delays, in respect of revalidation, job planning, and national reports • In terms of suspensions, it was agreed to provide additional narrative in future reports when these have been open for a certain length of time and the reasons for any delays • To reflect on BAF 5 in terms of the target risk score date given that it was felt that it would not be achievable by December 2020. To update BAF 6 to assign it to PAF.
Positive Assurances to Provide	**Decisions Made**
• The Committee noted that staff support services continued to be in place following the first wave and in preparation for the second surge • In terms of the Quarter 2 transformation programme the Committee welcomed the updates but challenged whether the projects listed were transformational or focussed on operational improvement. • The Committee noted that some services reviews had recommenced in October 2020 and the Committee challenged whether these would be completed in time to inform other work. It was noted that specialties were expected to collate and provide feedback to the Executive in respect of the reviews which would inform the wider strategic direction. • The Committee welcomed the improvement in statutory and mandatory training and appraisal rates. • It was noted that 92% of Covid risk assessments had been completed for staff, and work continued to be undertaken to identify the outcomes from the risk assessments as well as taking actions to strengthen the process going forwards. • The Committee explored the adequacy of the health and wellbeing support in place for staff and it was noted that the main issue was enabling staff had access to, and were aware of, the support on offer. The issues in relation to adequate rest facilities which had reduced due to social distancing were also highlighted. • A quarterly update in relation to speaking up was provided and the Committee welcomed the level of assurance provided and the actions being taken in response to speaking up. There had been a reduction in the number of concerns raised during the quarter, although 5 of these were raised anonymously. The Committee welcomed the deep dive into bullying and harassment and future consideration of the definitions and welcomed the updating of the benchmarking data. • An update in relation to disciplinary activity within quarter 2 was provided which outlined 40 ongoing cases and no referrals to professional bodies. The Committee challenged the timeliness of completing investigations and stressed the importance of ensuring continuing communication with members of staff during investigations as well as sharing any lessons more widely throughout the Trust	• The Committee considered the risks on the Board Assurance Framework and agreed with the risk scores, controls and assurances which had been articulated. • The Committee supported the actions identified in respect of the responses to the Committee Effectiveness Review

Comments on Effectiveness of the Meeting
• Committee members felt that there had been a good level of discussion with sufficient time provided for each agenda item.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Executive Directors Update including COVID-19	Information	6.	Q2 Speaking Up Report	Assurance
2.	Q2 Transformation Programme Update	Assurance	7.	Q2 Formal Disciplinary Activity	Assurance
3.	Delivering Exceptional Care Highlight Report	Assurance	8.	Board Assurance Framework Q2	Approval
4.	Update on Postgraduate Medical and Dental Education / GMC Survey / NETS Survey	Information	9.	Committee Effectiveness Review	Assurance
5.	M6 Workforce Report	Assurance	10.	Executive Workforce Assurance Group Highlight Report	Assurance

3. 2020 / 21 Attendance Matrix

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

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

In addition, Mrs F Taylor joined the meeting.

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	4th November 2020
Report Title:	Integrated Performance Report, month 6 2020/21	**Agenda Item:**	12.
Author:	Performance Team		
Executive Lead:	Helen Ashley: Director of Strategy and Transformation /Deputy Chief Executive		

Purpose of Report:

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

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

Executive Summary:

Background

The NHS Improvement (NHSI) single oversight framework was implemented from October 2016 and revised August 2019. The framework is comprised of 35 metrics across the following domains:
1. Quality of Care - safety, caring and Effectiveness
2. Operational Performance
3. Organisational Health
4. Finance and use of resources

The Trust has continued with its commitment to holding onto business as usual for as long as possible with plans to create additional capacity across both sites when needed. There have been considerable investments to tackle some of the challenges including those expected over the Winter period. All this alongside the continued work on Restoration and Recovery and responding to an increasing number of Covid-19 patients with increasing admissions. While some of the performance against key safety indicators is variable, the Trust has been working flat out to care for patients as we bring services back and reduce waiting lists.

Operational performance: The waiting lists for outpatient appointments (first new) that had reduced following the national mandate to cease routine referrals have begun to increase with the opening of E-Referrals. Activity is increasing but not in line with demand, hence the continued rise in the waiting list. The diagnostic waiting list however, is falling as activity increases.

Also, the number of Referral to Treatment pathways, which decreased as routine referrals were held, are now continuing to increase and in September there was a further 3% rise in the number of RTT pathways with performance showing signs of recovery at 60.46% (a rise of 8%) as more patients are seen and treated. The number of patients over 18 weeks has reduced by a further 15% to 17,607 with 1297 patients over 52 weeks. These are both in line with the predicted trajectory.

Patients who are on the inpatient waiting list have been stratified into clinical urgency classifications so that patients can be treated in clinical priority. Diagnostics has a significant improved performance of 75.28% (59.2% in August), with more patients being offered appointments.

For patients waiting to be seen, diagnosed and treated for Cancer the picture is variable. For September, the Trust is currently performing against five of the Cancer Standards: Breast symptomatic (98%), 31 Day first treatment (96.3%), 31 Day subsequent radiotherapy (96.2%), 62 Day screening (100.0%). The 28 day FDS standard is currently at 78.5%.

The remaining four standards are currently below: 2WW (82.7%), 31 Day subsequent chemotherapy (96.9%), 31 day (subsequent surgery (92.86%), 62 Day standard (69.35%). The Trust saw a significant rise in the number of 2ww referrals (up 20% on the previous month) with numbers now at the same levels as that pre-covid

For urgent care, the performance seen in August (78.3%) has fallen with UHNM performance for September being 75.8%. Attendances across the system continue to rise. Attendances increased at Royal Stoke by an average of 10 per day, weekly averages rose from 2148 to 2272. Ambulance attendances rose at RS by an average of 14/ week. There were zero 12 hour Trolley waits in September and 55 patients that had a reported ambulance handover delay > 60 minutes.

The two week intensive focus on urgent care will start on 5th October and be led by clinicians, with the support of the Emergency Care Improvement and Support Team (ECIST) from NHS England and will look how we change the way we do things across all divisions to support how our patients flow through the hospital to their appropriate destination in a more timely manner and avoid unnecessary waits. This is key to ensuring we are providing safer care and a better experience for patients.

Financially,

The Trust has delivered a breakeven for the month; this is after the receipt of £1.7m of funding for additional expenditure relating to COVID-19 and a £6.1m "top-up" from NHSI in line with the temporary financial framework established by NHSI. Activity delivered in Month 6 is significantly lower than plan although NHS income levels from patient activities have been maintained due to the temporary funding arrangements. The Trust incurred £1.7m of additional costs relating to COVID-19 which was £0.1m higher than in Month 5 mainly due to claims from the Anaesthetists for additional shifts worked in the first half of the year.

The Elective Incentive Scheme (EIS) comes into effect from September with the Trust estimating the impact being a £0.5m reduction to income. This is not reflected in the Month 6 position in line with guidance from NHSI/E.

Quality & Safety: During August 2020, the following quality highlights are to be noted:

During September 2020, the following quality highlights are to be noted:

- The rate of complaints per 10,000 spells has increased to 36 and above the target of 35 but is within normal variation.
- Total number of Patient Safety Incidents increased in September as well as the rate per 1000 bed days
- Patient Safety Incidents with moderate harm or above and rate of incidents with moderate harm or above per 1000 bed days has remained low and below the long term average. The rate of incidents reported with no harm or near misses has increased whilst the low harm remained relatively stable. The increases in overall numbers and rate is therefore attributable to increased reporting of no harm incidents and near misses which are used as indicators of potentially good reporting culture within an organisation
- Falls rate with harm has reduced during September with 1.3 falls per 1000 bed days which echoes the overall PSI profile, with falls being the largest PSI category
- The numbers of pressure ulcers that have developed under our care continue to show a decreasing trend and is currently below the organisation mean.

- There have been continued reductions in the number of Pressure Ulcers (category 2 – 3) with lapses in care as UHNM moves into Restoration & Recovery Plans and UHNM is on target to achieve a further 10% year on year reduction target for 2020/2021.
- HAI E.Coli Bacteraemia cases have been added into the report. September 2020 noted 12 cases above the mean of 9
- Sepsis Indicators have been updated to reflect indicators used in the IPCC reports and contract reporting requirements. Rationale is ensure reporting consistency

Workforce:

The strategic focus of our People Plan remains on supporting recruitment, workforce deployment, staff wellbeing, absence management and staff testing. Recruitment campaigns are in place to recruit to the Winter Plan and we continue to work jointly towards system-wide campaigns.

Covid-related absences have continued to increase, as has the demand for staff testing. Resources have been applied to ensure staff testing is carried out in line with demand. As a result of the escalating position regarding covid-19, the Workforce and Nursing Bureaus have been stepped back up, including links to Gold and Silver Command. The Bureau will ensure Staff Wellbeing and Support; Internal Workforce Supply (recruitment, retire and return, bank etc); links to the STP Workforce Supply; Volunteers and Training; Internal Deployment of staff; Staff Testing; Staff FAQs and national horizon scanning, and Supporting vulnerable worker risk assessments and links to Occupational Health

The key performance issues remain compliance with statutory and mandatory training and PDR requirements, and the sickness rate being above target.

Key Recommendations:

The Trust Board is asked to note performance for month 6.

NHS
University Hospitals of North Midlands
NHS Trust

Integrated Performance Report

Month 6 2020/21

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Contents

A note on **SPC**

University Hospitals of North Midlands NHS Trust

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

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

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

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

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

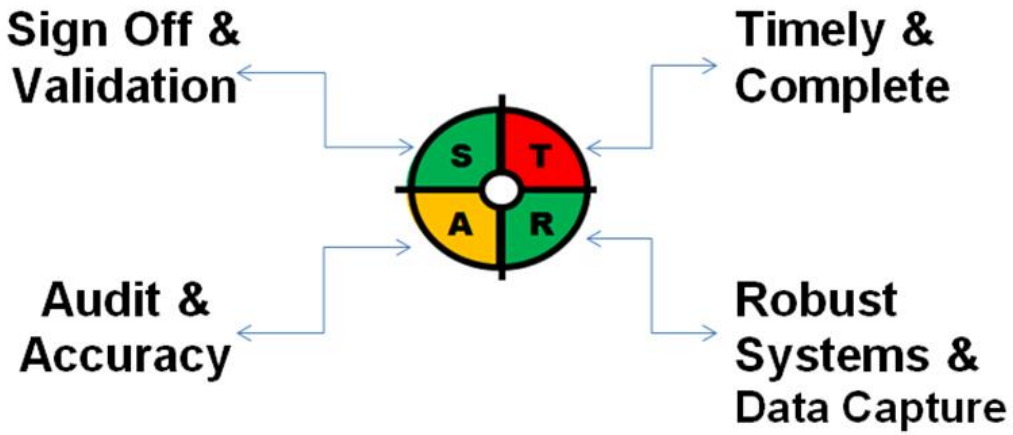
Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

A note on **Data Quality**

University Hospitals of North Midlands NHS Trust

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



Explaining each domain

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

RAG rating key

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

Quality

Caring and Safety

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

Quality Spotlight Report

University Hospitals of North Midlands NHS Trust

Key messages

The Trust achieved following standards in September 2020:

- Harm Free Care increased to 97.5 and continues to be above the national 95% target
- Trust rolling 12 month HSMR and SHMI continue to be below expected
- Patient Falls rate per 1000 bed days continues to be better than target with further improvement in September 2020 at 5.4 falls per 1000 bed days which is similar to pre COVID rates and long term mean
- 100% of patients/family informed verbally of incidents that are reported as meeting duty of candour threshold
- VTE Risk Assessment improved to 99.3% (via Safety Express audit)
- Zero avoidable MRSA Bacteraemia cases reported
- Currently there have been zero Category 3 or 4 pressure ulcers identified with lapses in care during September 2020 but these are under continued review
- Sepsis Screening Compliance in Adult A&E achieved 93% and Paediatric A&E Screening compliance 93.1%
- Zero Never Events reported in September 2020

The Trust did not achieve the set standards for:

- Written Duty of Candour has improved during September but was below the 100% target at 93.9% (14 out of 15 cases). The 1 case that was outside the 10 working days has had letter sent to the patient but this was outside the 10 day target of the initial notification date.
- The Trust was above the national average rate of 15% for Emergency C Sections, with a rate of 15.4%, however the rate has been reducing following the peak in June 2020.
- C Diff target above trajectory target of 8 during September 2020 with 11 cases reported
- Sepsis Screening compliance (adult Inpatients), 77.4% against a target of 90% Sepsis IVAB in 1 hour reported 89% for Adult A&E

During September 2020, the following quality highlights are to be noted:

- The rate of complaints per 10,000 spells has increased to 36 and above the target of 35 but is within normal variation.
- Total number of Patient Safety Incidents increased in September as well as the rate per 1000 bed days
- Patient Safety Incidents with moderate harm or above and rate of incidents with moderate harm or above per 1000 bed days has remained low and below the long term average. The rate of incidents reported with no harm or near misses has increased whilst the low harm remained relatively stable. The increases in overall numbers and rate is therefore attributable to increased reporting of no harm incidents and near misses which are used as indicators of potentially good reporting culture within an organisation
- Falls rate with harm has reduced during September with 1.3 falls per 1000 bed days which echoes the overall PSI profile, with falls being the largest PSI category
- The numbers of pressure ulcers that have developed under our care continue to show a decreasing trend and is currently below the organisation mean.
- There have been continued reductions in the number of Pressure Ulcers (category 2 – 3) with lapses in care as UHNM moves into Restoration & Recovery Plans and UHNM is on target to achieve a further 10% year on year reduction target for 2020/2021.
- HAI E.Coli Bacteraemia cases has been added into the report. September 2020 noted 12 cases above the mean of 9
- Sepsis Indicators have been updated to reflect indicators used in the IPCC reports and contract reporting requirements. Rationale is ensure reporting consistency

Quality Dashboard

Metric	Target	Latest	Variation	Assurance
Patient Safety Incidents	N/A	1638		
Patient Safety Incidents per 1000 bed days	N/A	49.26		
Patient Safety Incidents per 1000 bed days with no harm	N/A	33.89		
Patient Safety Incidents per 1000 bed days with low harm	N/A	12.36		
Patient Safety Incidents per 1000 bed days reported as Near Miss	N/A	2.47		
Patient Safety Incidents with moderate harm +	N/A	18		
Patient Safety Incidents with moderate harm + per 1000 bed days	N/A	0.54		
Harm Free Care (New Harms)	95%	98%		
Patient Falls per 1000 bed days	5.6	5.4		
Patient Falls with harm per 1000 bed days	1.5	1.3		
Total Pressure Ulcers developed under UHNM Care	TBC	44		
Category 2 Pressure Ulcers with lapses in Care	8	0		
Category 3 Pressure Ulcers with lapse in care	4	0		
Category 4 Pressure Ulcers with lapses in care	0	0		
Unstageable Pressure Ulcers with lapses in care	0	0		

Quality Dashboard

NHS University Hospitals of North Midlands NHS Trust

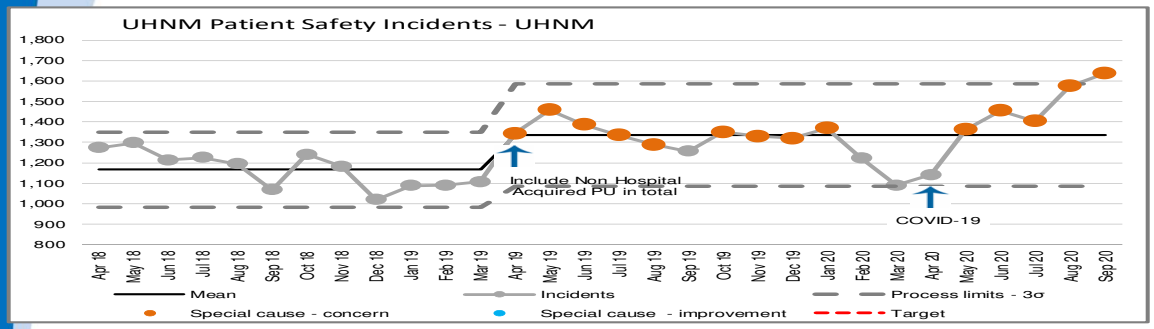
Metric	Target	Latest	Variation	Assurance
Medication Incidents per 1000 bed days	N/A	6	H	?
Medication Incidents % with moderate harm or above	TBC	1%		P
Serious Incidents reported per month	N/A	6	L	?
Never Events reported per month	0	0		?
Duty of Candour - Verbal	100%	100%		P
Duty of Candour - Written	100%	93%		?
Inpatient Sepsis Screening Compliance (Contracted)	90%	77.4%		?
Inpatient IVAB within 1hr (Contracted)	90%	N/A	H	?
Children Sepsis Screening Compliance (All)	90%	94.3%		P
Children IVAB within 1hr (All)	90%	N/A	H	F
Emergency Portals Sepsis Screening Compliance (Contracted)	90%	84.6%		?
Emergency Portals IVAB within 1 hr (Contracted)	90%	89.5%		?
Maternity Sepsis Screening (All)	90%	N/A	H	F
Maternity IVAB within 1 hr (All)	90%	N/A	H	P

Metric	Target	Latest	Variation	Assurance
Friends & Family Test - A&E	N/A	N/A	H	?
Friends & Family Test - Inpatient	N/A	98.7%		P
Friends & Family Test - Maternity	N/A	N/A	H	?
Written Complaints per 10,000 spells	35	36.24		?
Rolling 12 Month HSMR (3 month time lag)	100	94.63	L	P
Rolling 12 Month SHMI (4 month time lag)	100	99.67	L	P
VTE Risk Assessment Compliance	95%	99.3%	H	?
Emergency C Section rate % of total births	15%	15.5%	H	?
Reported C Diff Cases per month	8	11	H	?
Avoidable MRSA Bacteraemia Cases per month	0	0		P
HAI E. Coli Bacteraemia Cases per month	N/A	12		

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Reported Patient Safety Incidents

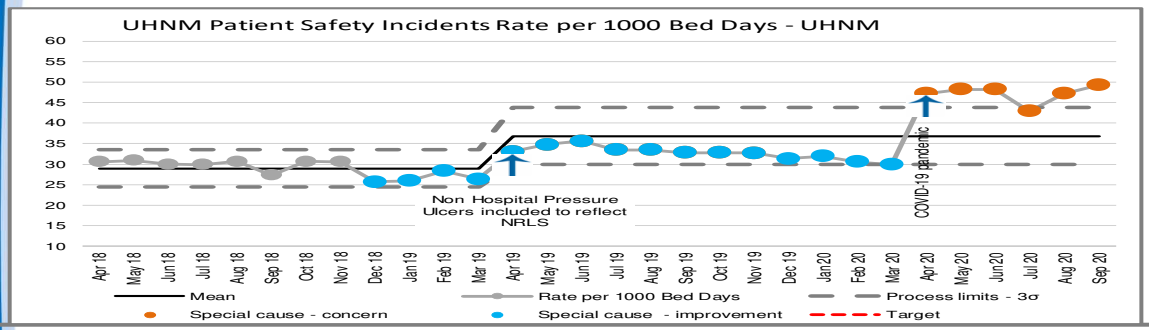


Variation	Assurance
H	

Target	Jul 20	Aug 20	Sep 20
N/A	1403	1575	1638

Background

Total Reported patient safety incidents



Variation	Assurance
H	

Target	Jul 20	Aug 20	Sep 20
N/A	42.95	47.24	49.26

What is the data telling us:

The above data relates to **all** reported Patient Safety Incidents (PSIs) across the Trust. August 2020 has seen an increase in total number of reported PSIs but is still within normal variation limits. The increase in incidents is reflected by the increasing level of activity as Recovery & restoration plans continue to increase activity. The reporting of incidents and near misses should continue to be encouraged and promoted.

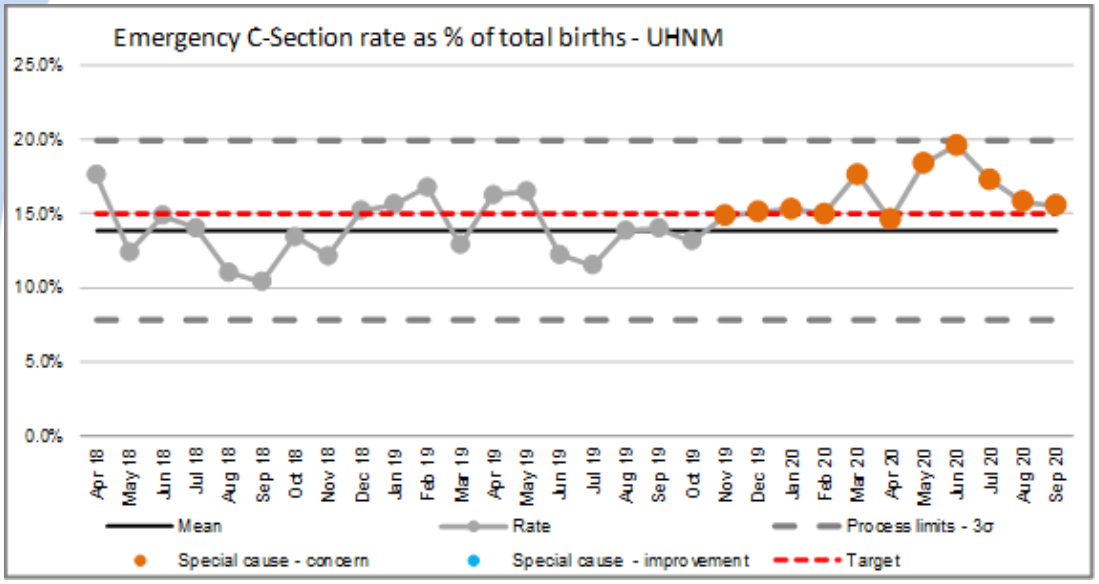
The largest categories for reported patient safety incidents excluding Non Hospital acquired Pressure Ulcers are:

- Patient related Slip/Trip/Fall (181),
- Clinical assessment (Including diagnosis, images and lab tests) (71)
- Patient flow incl. access, discharge & transfer (122)
- Treatment/Procedure (79)
- Medication incidents (171)

T
here have been increases in Medication and Patient Flow incidents compared to august 2020 totals.
Patient Safety Incidents are reviewed and analysis undertaken on locations and themes.
The Directorates reporting most PSIs are Emergency Medicine, General Medicine, Anaesthetics Theatres & Critical Care. Obstetrics & Gynaecology and Trauma. Specific incidents are reviewed at specialist forums for themes / trends as well at Divisional level.

The rate of reported patient safety incidents per 1000 bed days has increased compared to August 2020. The increase in total incidents is due to more incidents with no harm or low harm (see following slides and indicators) being reported compared to incidents with harm. The Patient Safety Group are reviewing the themes and trends of the no and low harm incidents to ensure that learning is identified and required actions taken.

Emergency C Section rate as % of total Births



Variation	Assurance
H	?

Target	Jul 20	Aug 20	Sep 20
15%	17.3%	15.8%	15.5%

Background

Emergency C-Section rate as % of total births

What is the data telling us:

What is the data telling us:

Emergency C Section Rate as percentage of total births at UHNM is over the target rate of 15%. The latest available figures reports 15.54% Emergency C Section rate. During COVID-19 Pandemic there has been a lower threshold for Emergency C Sections which may have contributed to the higher rates during recent months. The rolling 12 month Emergency C Section rate is 16.4% but the last 2 months have been approaching the national mean of 15%

Emergency C sections are divided in to 2 categories;

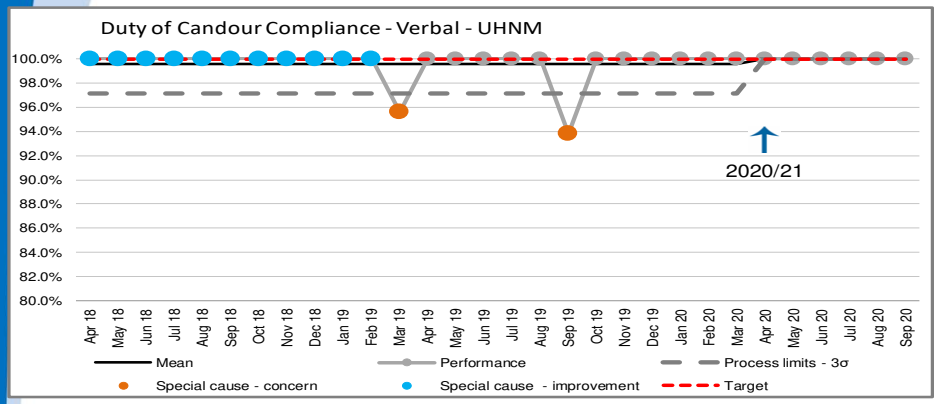
Category 1 - immediate threat to life of woman or fetus (delivery within 30 minutes of decision)

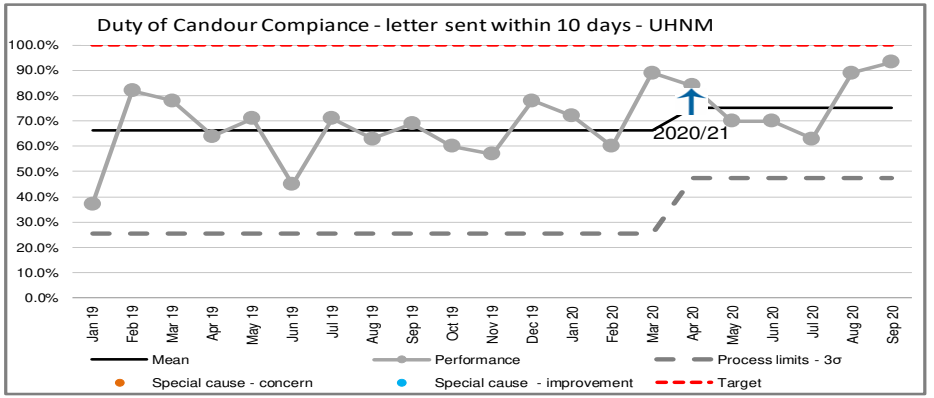
Category 2 – threat of maternal or fetal compromise (delivery within 90 minutes of decision)

Consultant is currently undertaking an audit of emergency C Sections which will be reported at Directorate and Divisional Governance Forums once completed.

The Emergency C Section rate fluctuates on a month by month basis; this demonstrates the fluctuation and variation which occurs in both C section rates and number of births.

Duty of Candour Compliance





Variation	Assurance
	P

Target	Jul 20	Aug 20	Sep 20
100%	100.0%	100.0%	100.0%

Background

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

Variation	Assurance
	?

Target	Jul 20	Aug 20	Sep 20
100%	63.0%	89.0%	93.3%

Background

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

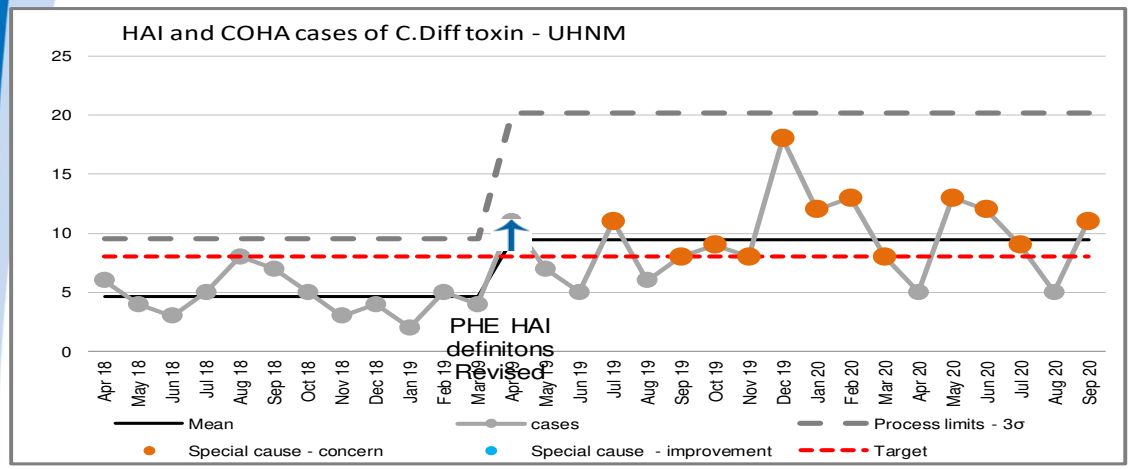
What is the data telling us:

Verbal Duty of Candour has been recorded in 100% of all incidents (15 cases) that have formally triggered meeting the threshold during September 2020.
Written Duty of Candour Compliance for receiving the letter within 10 working days of verbal notification has improved in September 2020. During September 2020 the performance was 93.3% (14 cases) within 10 working days . The 1 case that was outside the 10 working days has had letter sent to the patient but this was outside the required time period.

Actions taken:

The letter from the Medical Director has been written to all Divisions outlining clinicians responsibilities in relation to completing duty of candour with written notification as well as verbal discussions. The escalation and follow up on incidents which formally trigger duty of candour is being escalated within the Divisions to support the improvement in meeting the 10 working day target. Escalations on outstanding letters are provided to relevant directorates and divisions via the Divisional Governance & Quality Managers.
Support with the drafting of the 10 day notification letters for clinicians continues to be provided by the Divisional Governance & Quality team with compliance being included in Divisional reports for discussion and action.

Reported C Diff Cases per month



Variation	Assurance
H	?

Target	Jul 20	Aug 20	Sep 20
8	9	5	11

Background

Number of HAI + COHA cases reported by month

What do these results tell us?

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

There have been 7 Hospital Associated Infection (HAI) cases and 4 Community Onset Hospital Associated (COHA) cases identified in September.

For September 2020, UHNM is above trajectory (11 versus a target of 8) based on 2019/20 target and for the year to date 2020/21 UHNM is above trajectory with 55 cases versus a year to date target of 48.

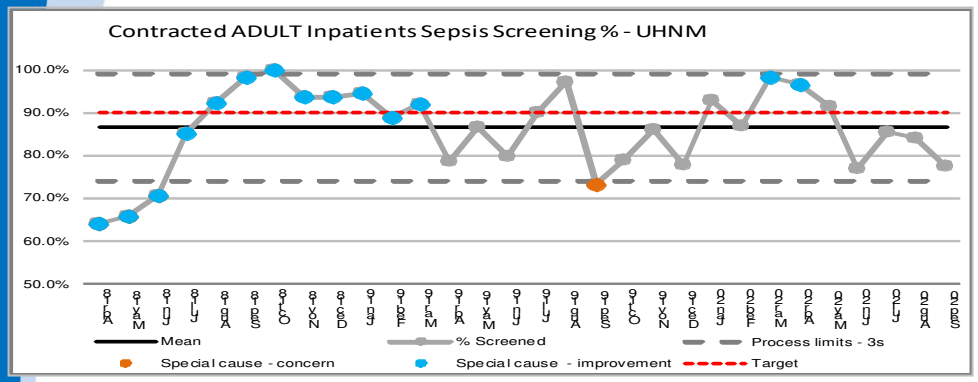
Actions:

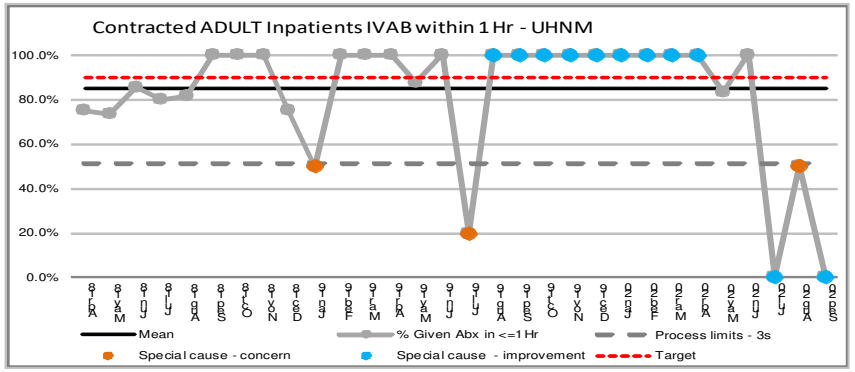
Continue surveillance for HAI C diff with continued immediate implementation of control measures to prevent transmission

In all cases control measures are instigated immediately, and RCA's are reviewed by the CCG. Each in-patient is reviewed by the C difficile nurse at least 3 times a week, and forms part of a weekly multi-disciplinary review. Routine typing is on hold due to COVID-19. There has been one clinical area that has had more than one case of HAI C difficile toxin to report within a 28 day period in September 2020 but following further investigation it was proven they were not linked based on ribo-typing results.

A 'deep dive' into all cases in April 2020 and May 2020 has been undertaken and reported at July's IPCC – this analysis will continue. With the increase in cases during September the scope of the investigation will be widened to include September given the increase in hospitalised cases of COVID recently encountered and the associated use of antibiotics to treat such patients.

Sepsis Screening Compliance (Inpatients Contract)





Variation	Assurance

Target	Jul 20	Aug 20	Sep 20
90%	85.3%	84.0%	77.4%

Background

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

Variation	Assurance

Target	Jul 20	Aug 20	Sep 20
90%	N/A	50.0%	N/A

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:

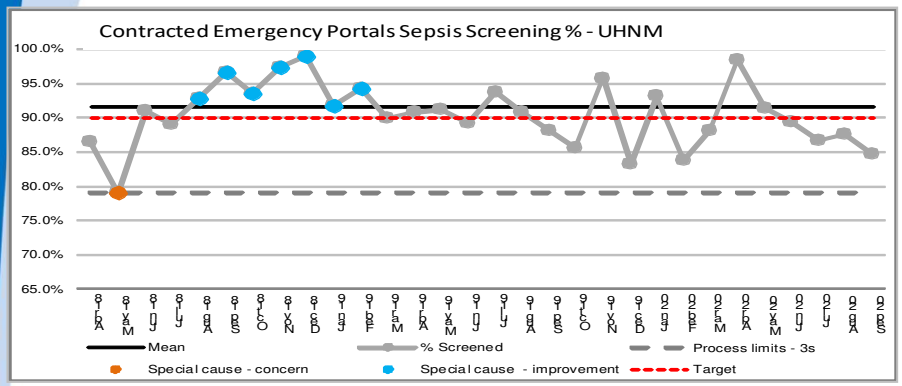
September results show Adult inpatient areas achieved 77.4% for sepsis screening for the 62 patients audited. All of the red flag sepsis patients identified (n=26) had alternative diagnosis and were already on IVAB treatment during the audit therefore the result for IVAB for the month is N/A. The sample size was reduced during September 2020. However, Quarterly we are required to report 150 samples for selected inpatient areas excluding Maternity and Child Health.

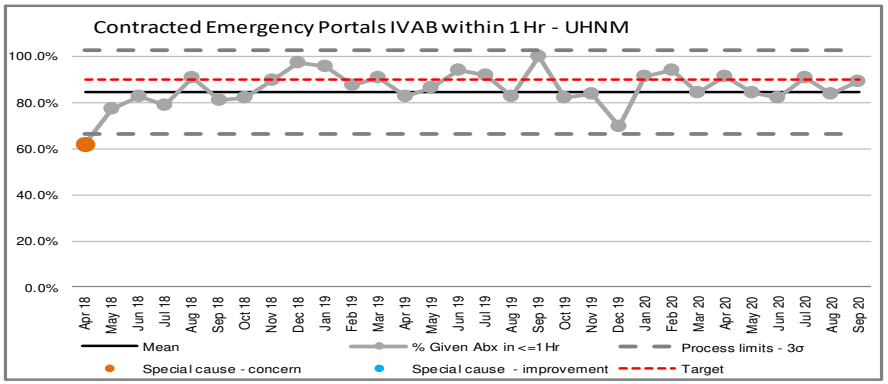
Actions:

Sepsis Team have updated educational tools in conjunction with the new Vitalpac system updates and these will be the focus to deliver to clinical areas that are identified as the priority to deliver support via adhoc or ward based training (15 minute practical sessions) to all levels of clinical staff. New training dates for face to face session s (1 hour) specific to nursing assistants, nursing staff and new sepsis champions is underway and will be released in the next few days. The sepsis team continue to monitor Inpatient wards and work closely with the Vitalpac team with issue around sepsis vitals assessment compliance . Few of the issues identified were due to clinical staff working with incorrect access and some staff are still completing paper screening instead of electronic. Any issue identified by the sepsis team have been dealt with immediately and learning is feedback to the clinical senior team and the staff involved. Sepsis & Vitals action plan has been created for all of the divisions to ensure improvement in compliance. A deep dive of June's compliance data is currently underway and the provision of ward based refresher training as required.

A Sepsis Specialist Nurse has been appointed which will greatly strengthen the team.

Sepsis Screening Compliance (Emergency Portals Contract)





Variation	Assurance

Target	Jul 20	Aug 20	Sep 20
90%	87%	88%	85%

Background

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

Variation	Assurance

Target	Jul 20	Aug 20	Sep 20
90%	91%	84%	89%

Background

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

What is the data telling us:

Adult screening in September achieved 85% for the 52 patients audited whilst IVAB within 1 hour improved to 89.5% for the 19 red flag sepsis patients identified during the audit.

This indicator currently relates to all Emergency Portals that had been audited (including AMU Royal & County, SAU, FEAU)

Actions:

- The sepsis bleep is no longer in use in the department, instead they have few designated doctors now in each areas that can be contacted via portable phone when they are required to review patients with red flag sepsis or with low-moderate risks triggers which serves more effective.
- The A&E education team and A&E sepsis doctor will continue to provided sepsis virtual education for both A&E sites if required again, as well as the 'Sepsis Talk' on Sepsis management delivered by the sepsis clinical lead & sepsis team via Microsoft Team to capture wider numbers of both clinical and medical staff.
- The delayed IVAB and missed screening in September will be escalated, reviewed and discussed with A&E clinicians/ nursing staff for lessons learnt, including missed screening in AMU Royal & County, SAU and FEAU.

Operational Performance

2025 Vision "Achieve NHS Constitutional patient access standards"

Contents

A note on **SPC**

In some areas of the following report, statistical process control (SPC) methods are used to draw two main observations of performance data;

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

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

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

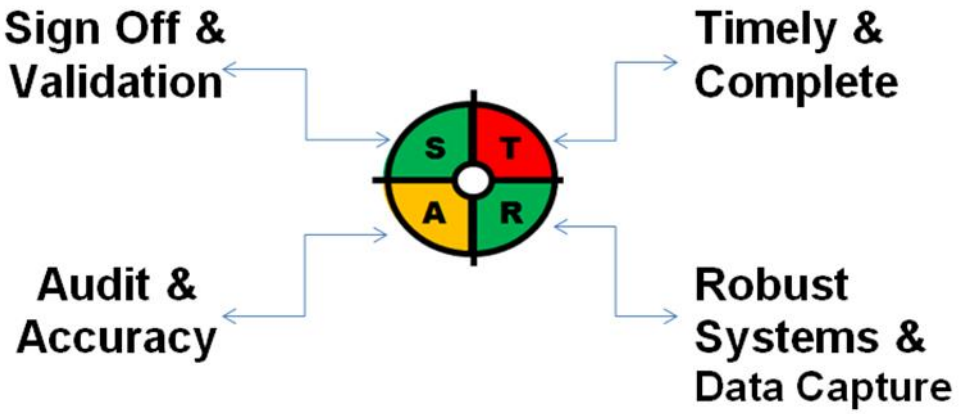
Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling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

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

A note on **Data Quality**

University Hospitals of North Midlands NHS Trust

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



Explaining each domain

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

RAG rating key

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

Restoration and Recovery

Spotlight Report from Chief Operating Officer

NHS University Hospitals of North Midlands NHS Trust

Emergency Care

Trajectories for attendances to A&E, non elective admissions and bed occupancy have been developed to give a view of what the rest of 20/21 is expected to look like.

The daily average attendances -system wide - saw another rise by an average of 30 per day . Type 1 A&E attendances are up to 87% of last years demand . with Royal Stoke seeing an average of 15 more a day. The daily average rise in ambulance attendances rose again by a further 2 per day reaching on average 160 ambulances per day (in Feb 20 this was 170). Paediatric attendances have shown an increasing rise with an average daily number of 66 (up from 42 in August). Some days ambulance attendances were 50% of the total attendances for the day .

The performance for UHNM (system wide) in September is 75.8% (August 78.3%). The key area is the Type 1 at Royal Stoke where performance fell from 58.7% in August to 53.6% in September. In the main this is due to i) WTBS ii) the ambulance profile; surges in ambulance attendances on successive days and for several hours (resulting in ambulance attendances making up > 50% of total attendances iii) ward discharge profiles.

There were zero 12 hour Trolley waits in September and 55 patients that had a reported ambulance handover delay > 60 minutes.

Cancer

Trajectories for 2WW activity, cancer treatments and 62 day pathway backlogs have been developed and monitor through the Cancer Cell. The demand in September, for 2ww, is 87% of pre-Covid levels. The actual numbers of 2ww patients seen in month is back to pre-Covid levels.

The 62 day backlog has deviated from trajectory, but remains low at 133. The aim is to bring this down to a sustainable level of 58 pathways by the Autumn 20.

Referrals were 87% against pre Covid levels. There are currently 21 patients reported at 104+ days. This is a reduction of 29 since the previous month.

For September we predict achieving 5 of the 8 National targets. Key issues for the 3 standards below were i) 2ww - the high number of colorectal referrals (a revised referral to triage process has been implemented) and patient choice. Ii) 62 day – delays on the diagnostic element of the pathway iii) 31 day anti cancer – small number of treatments with just 1 breach.

Planned Care

For September, outpatient activity was **88%** of last year's business as usual while Elective inpatient activity was **74%** and Day Cases was **74%** of last year's business as usual. This is set against the ask of 80% for both.

Trajectories have been developed taking plans to the end of the year.

- Restore all cancer services
- Recover 100% of outpatient (first and follow-up) activity from September
- Recover 100% of MRI/CT and endoscopy procedures by October
- Recover the maximum elective and day case activity possible between now and winter aiming for: 80% last year's activity in September & 90% last year's activity in October

RTT

Waiting list rose to 44,520 in September (up 1165 from August). Activity constraints mean demand will outweigh the capacity of the Trust causing the waiting list to increase. A Trust trajectory for this has been developed and monitored through the planned care cell. The Trust has 1297 over 52 week breaches as a consequence of standing down elective work. Recovery plans include prioritised actions for recovery of the long waiting patients. RTT performance in September is 60.46% (August 50.12%). We are currently 79% of the Independent Sector capacity available.

Diagnostics

September saw a further increase in diagnostic activity rising to 24,114 .The trust trajectory for activity to the end of the year consistently meets the national ask and will see numbers return to similar levels as previous year.

The diagnostic performance for September is currently 75.3%, a further rise on the previous month by 15.1%. The waiting list size is also showing a reduction: down to 15,385. Recovery plans are now being transacted and monitored via the Diagnostic Cell to end of March 2021, with investment requests approved for DMO1 modalities to support this recovery timescale.

Urgent Care - Summary

NHS University Hospitals of North Midlands NHS Trust

Summary

- September saw a further rise in attendances across the system with total type 1 attendances (RS & County) increasing to an average of 441/ day (a rise on average of 10/ day from the previous month).
- The total TYPE 1 for the month was 13,230. This is 87% of the demand seen last September and a continuation of the return to business as usual albeit at a slower rate than predicted in the trajectory.
- For Royal Stoke type 1, the 7-day rolling average saw a steady rise from the end of April to July and from then on a slower rise through August and September. It is expected to continue to climb.
- Ambulance attendances rose again by an average of 14/ week at RS and over 60 minute handover delays reduced from 66 to 55, given that now space is now being used flexibly
- Children's attendances saw a significant rise . On average the daily attendances were up to 66/day compared to 49/day in August. For the same period last year the daily average was 89.
- The system wide performance seen in September (75.8%) has fallen from August (78.3%). Type 1 (RS) saw a performance of 53.6% (August 58.7%)and at County performance was 92.8%. In the main this is due to i) WTBS ii) the ambulance profile; surges in ambulance attendances on successive days and for several hours (resulting in ambulance attendances making up > 50% of total attendances iii) ward discharge profiles.
- At Royal Stoke the performance fell from 58.7% to 53.6% and at County performance was 92.8%.
- As the number of attendances to A&E continues to increase, the conversion rate has continued to decrease and is now 37% for September. (August 37.5%). At this point last year the conversion rate was 39.8%.
- Performance for admitted patients at 39.2% (August 46.4%).
- Performance for the non-admitted at RS also fell from an average of 66% to 62% .
- O Day NEL admissions are remaining fairly steady following the initial rise in May, and are 68% of the previous years levels.
- NEL 1+ day admissions are now up to 92% of last year levels. Further increase back to 100% is expected for winter.
- The average LoS for patients staying 1+ days has shown a slight increase in September when compared to August, however the 7-day rolling average is consistent with levels seen last year.
- Bed occupancy is increasing month on month and expected to continue to increase into Winter. September is 81.6%. (Stoke 94.7% & County 74%)
- The number of medical patients in beds at midnight, on average, has remained fairly static. We are seeing 90% of the medical patients in beds for the same time last year.
- The specialty referrals (for all specialties) were up slightly; daily average of 124 (August 117). This is almost the same as last year (daily ave. of 126). However, the daily average referral to discharge time has risen from 175 to 217 mins. This remains a real focus of work for the Trusts Urgent Care plan and has significant impact on non-admitted performance.

Urgent Care - Actions

University Hospitals of North Midlands NHS Trust

Do the Right Thing… It's everybody's business
Starting from 5th October, it's everybody's business intensive transformation fortnight to rapidly test and implement improvements designed to help improve patient safety, patient flow and improve performance.

The fortnight is the culmination of some of the work we have been doing in partnership with NHS Improvement's emergency care intensive support team (ECIST) to help understand and support patient flow across our hospital sites, particularly Royal Stoke.

- ED Huddles and internal ED escalation trigger tool
- ED Escalation policy and Site / Operational Patient Flow
- Roles and Responsibilities framework
- Internal Professional Standards
- GP referrals direct to specialty portals
- Reduction in ED diagnostics
- Discharge Lounge Utilisation
- SAFER pt flow bundle
- R2G
- Application of right to reside criteria
- Discharge to assess
- Patient flow through the Division and 30 minute turnaround times when beds are declared as empty
- Transfer protocols to support timely movement between portals and wards

Level 3 Acute Floor implemented with final phase completing mid October with FEAU moving to the 3rd floor, to support purple pathways for acute medicine and frail elderly and giving access to 36 side rooms within acute portals.

Acute Medicine Huddles – An additional Multidisciplinary board round implemented to identify any delays in discharging or transferring patients to their onward specialty to support 7 day discharges

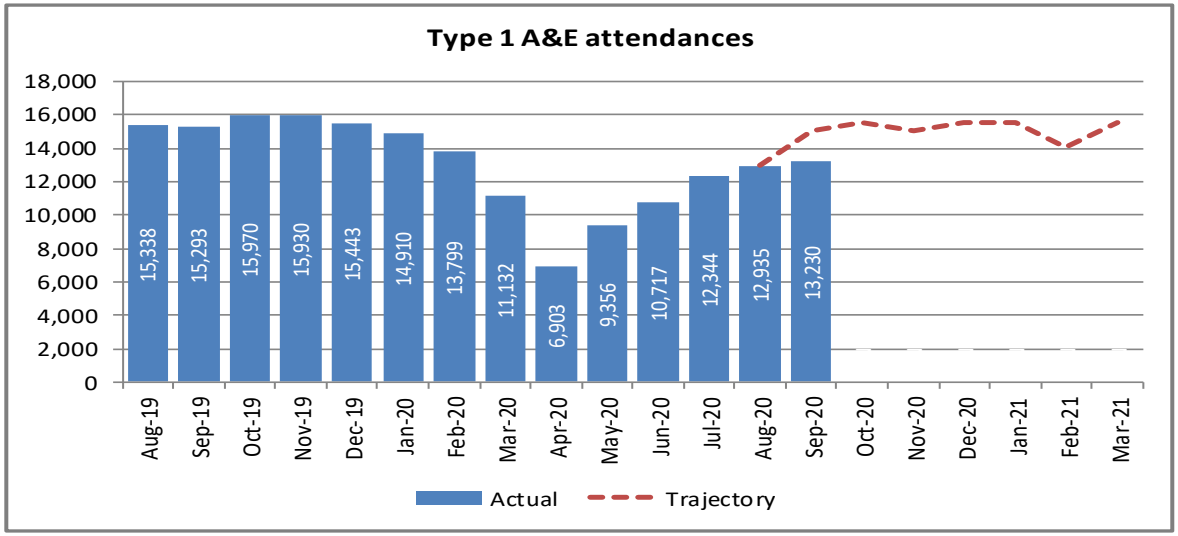
SDU implemented with Specialised Division with a continued focus on broadening the clinical pathways and diagnostic elements. To further improve flow within ED

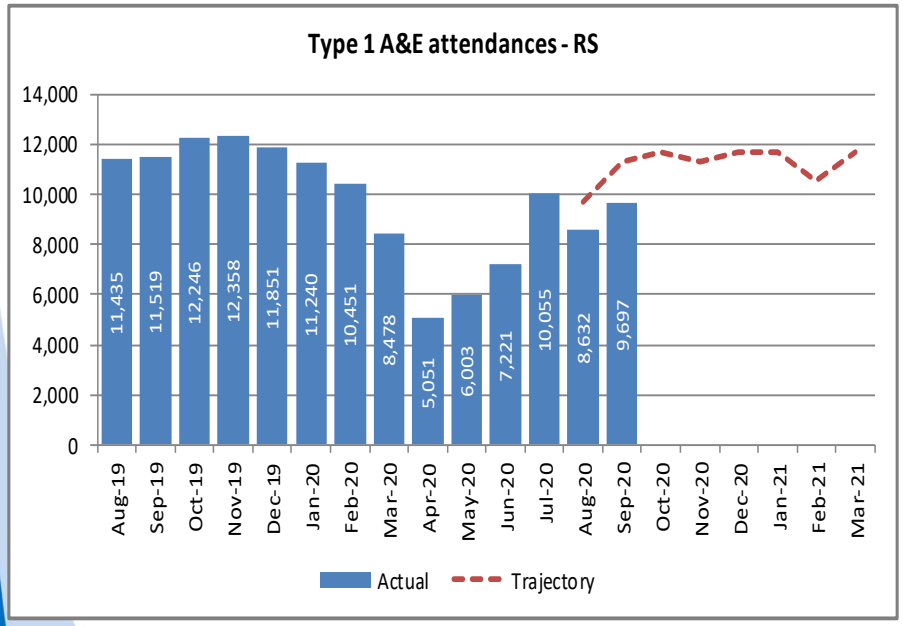
Ward 120 / 121 refurbishment completed mid October supporting the Winter and Covid Escalation Plan

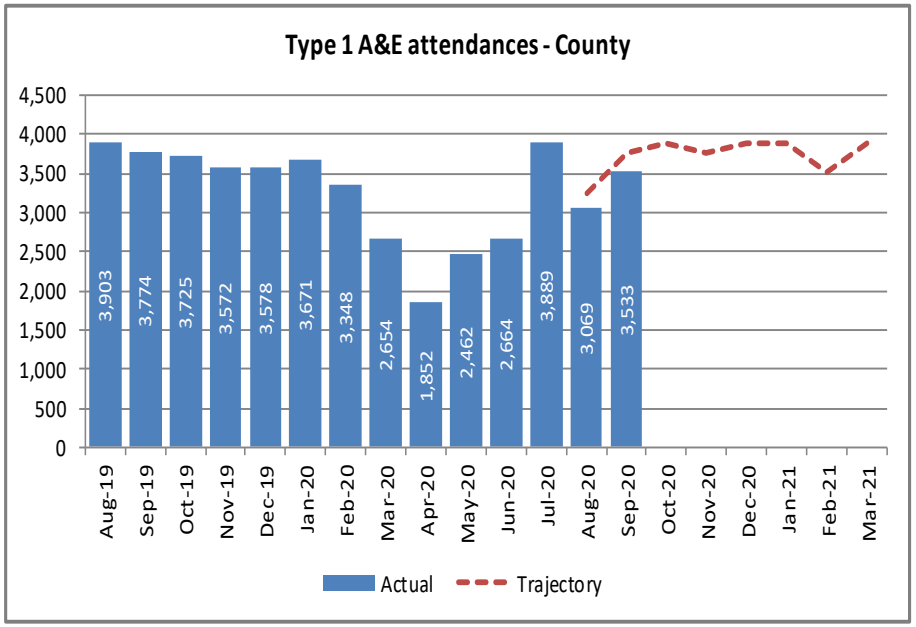
Gap analysis is being undertaken to support the CQC guidance and social distancing in ED and will be reported to the Urgent Care Board.

Implementation of the revised governance structure to support the delivery of Urgent Care has been implemented during October, chaired by the CEO and weekly oversight for COO, CNO and MD.

Urgent Care *(attendances)*

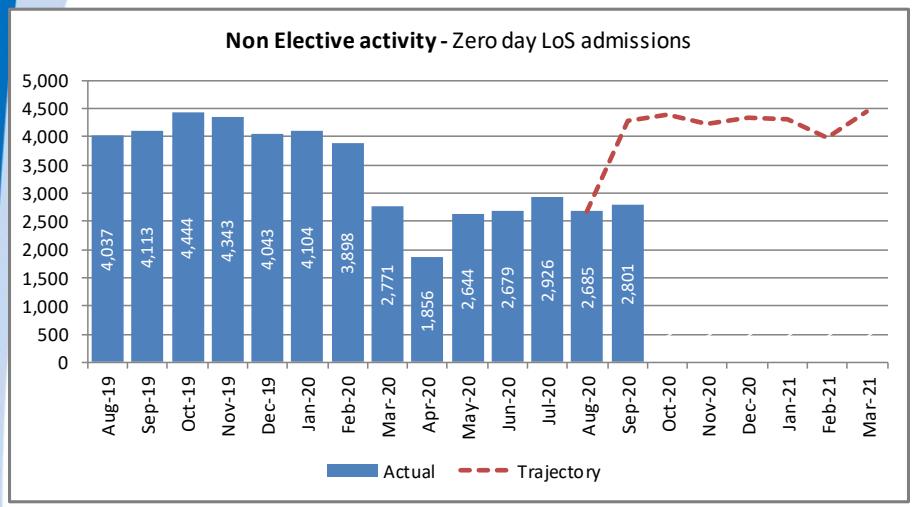


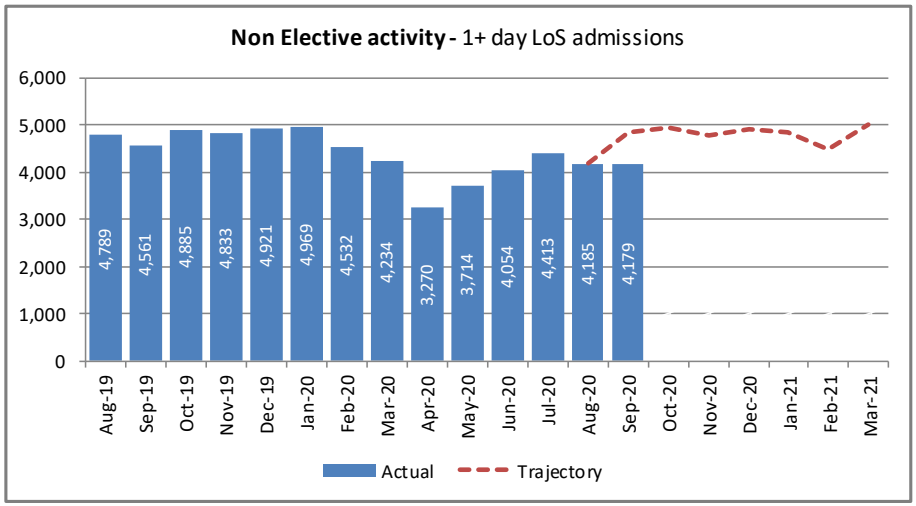




Urgent Care *(admissions)*

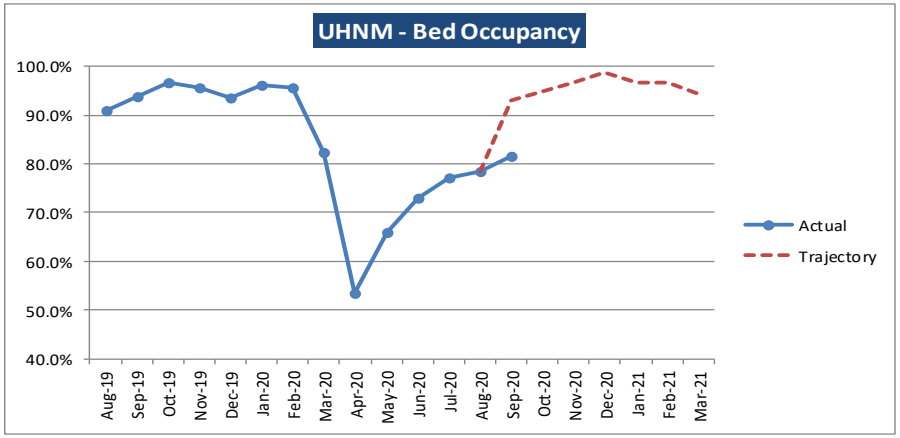
University Hospitals of North Midlands NHS Trust





	Jul 20	Aug 20	Sep 20
Previous year	4,094	4,037	4,113
2020 Actual	2,926	2,685	2,801
% of BAU	71%	67%	68%

	Jul 20	Aug 20	Sep 20
Previous year	4,851	4,789	4,561
2020 Actual	4,413	4,185	4,179
% of BAU	91%	87%	92%



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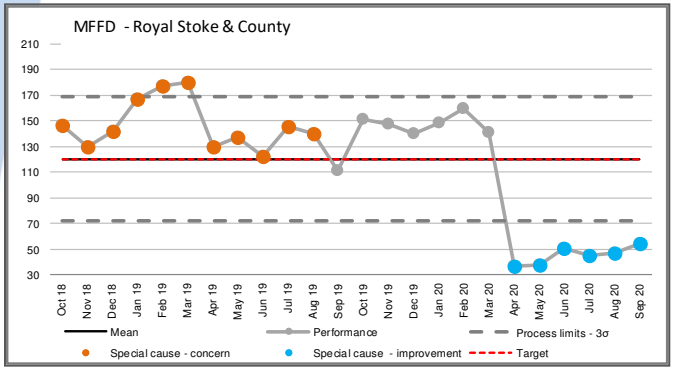
Urgent Care *(discharges)*

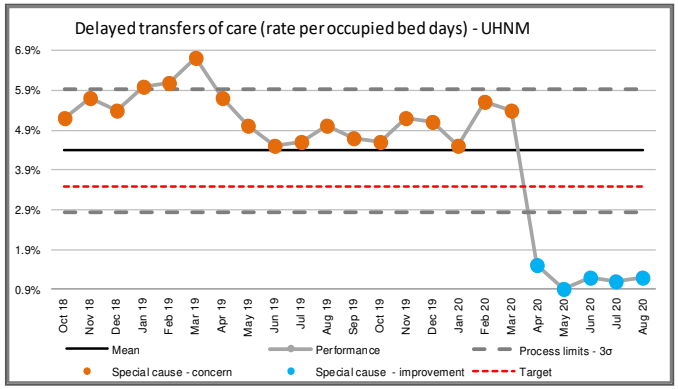


Variation	Assurance
L	?

Target	Jul 20	Aug 20	Sep 20
120	45	47	55

Background

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

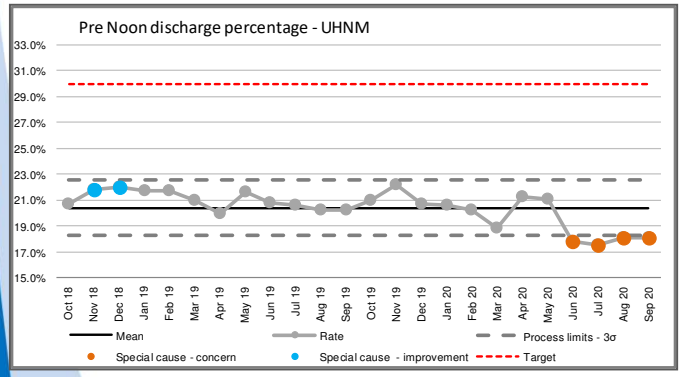


Variation	Assurance
L	?

Target	Jun 20	Jul 20	Aug 20
3.5%	1.2%	1.1%	1.2%

Background

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



Variation	Assurance
L	F

Target	Jul 20	Aug 20	Sep 20
30%	17.5%	18.1%	18.1%

Background

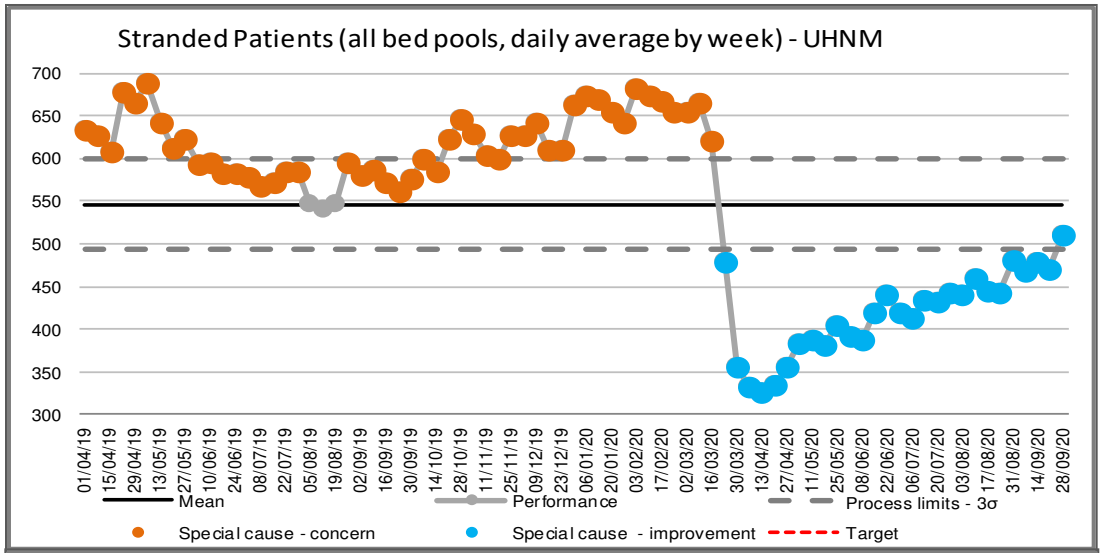
The percentage of discharges complete before 12 noon.

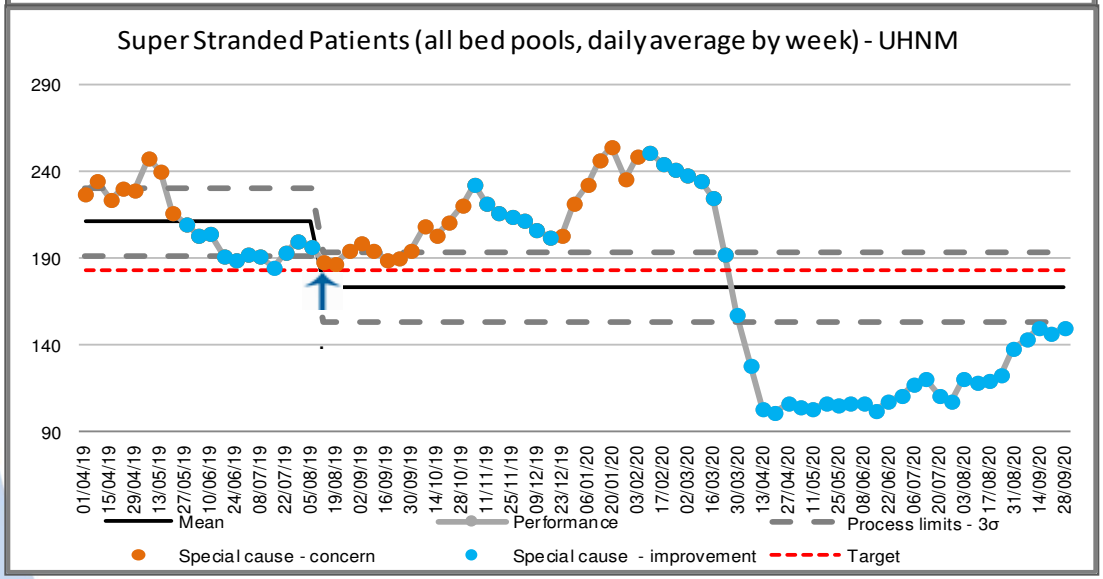
Medically fit for discharge (MFFD):
September has again seen a slight rise in total MFFD patients. However numbers are still c50% of the levels seen last year.
Since the beginning of Coronavirus there has been a pull system in place to ensure timey discharge of patients to ensure that flow is supported.
There has been an increase in admissions and trust activity post first wave which has increased the level of MFFD in to the 50's.
This remains significantly lower that previous year profiles but work streams are in place to reduce this again to below 40 in advance of a second wave of Covid-19.

Delayed Transfers of Care (DToC) – I month in arrears
The rate has seen a significant improvement. August remains below the 3.5% national ambition. Although the Covid-19 pandemic has resulted in less beds occupied at the Trust in September, this measure shows that proportionately fewer occupied beds are patients waiting for transfer of care.

Discharges before midday
Discharges before midday has shown little variation from June/July but remains below the lower control limit. Improvement forms part of the urgent care improvement actions.

Urgent Care *(discharges)*





Summary

- There is evidence that the rolling weekly average for the complex caseload is increasing
- Stranded patients across all bed pools continues to rise although levels still significantly below that seen pre-Covid-19
- Super Stranded patient numbers also saw a rise.

Actions

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

Cancer

NHS
University Hospitals of North Midlands
NHS Trust

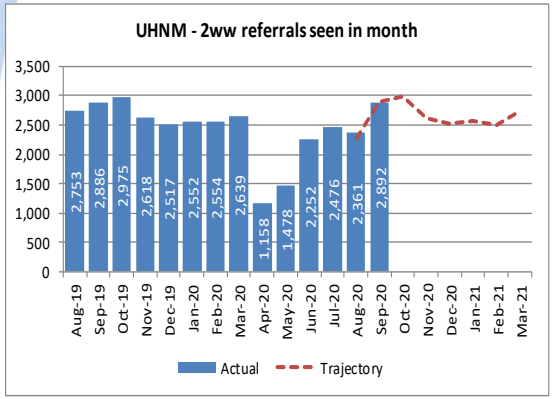
Summary:

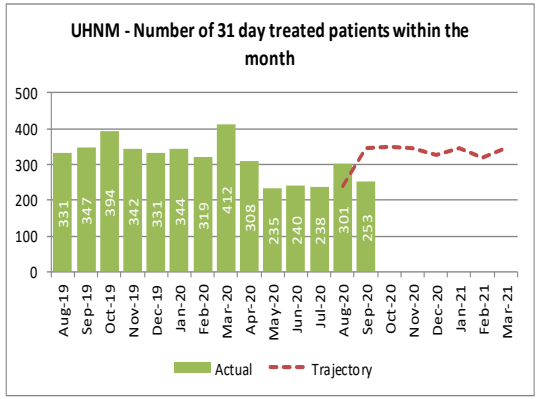
- For September the Trust is predicting to achieve 5 of the 8 standards plus the 28 day standard. The three not achieved are 2ww; 31 Day Anti Cancer Drugs and 62 Day. For September we predict achieving 5 of the 8 National targets. Key issues for the 3 standards below were i) 2ww - the high number of colorectal referrals (a revised referral to triage process has been implemented) and patient choice. Ii) 62 day – delays on the diagnostic element of the pathway iii) 31 day anti cancer – small number of treatments with just 1 breach.
- 2WW activity has increased after the initial drop in April, and is expected to be in line with previous years activity going forward.
- The 62 day backlog continues to reduce, with a further reduction in September to 133. The decrease is steadily continuing during the period of the backlog coordinator trial. The aim is to bring this down to a sustainable level by the Autumn 20.
- The backlog volume is currently higher than trajectory, as screening and others service have come back online and R&R is increasing in pace.
- The number of cancers treated is still low in comparison to previous year treats, as a result of the decreased referrals through the pandemic.
- As a result of screening services going offline, decreased referral rates, covid delays to diagnostics and reduced theatre capacity through the summer months, the trust missed performance standards; 31 day, 31 day sub surgery, 62 day and 62 day screening in August.
- However, the number of cancers treated is expected to increase in line with increasing referral rates over the next few months. The September position is predicted to describe an increased number of cancers treated against these standards.
- There are currently a total of 21 cancer pathways over 104 days which continues in the on-going reduction plan. This is significantly below that predicted.
- Performance against 28 day Faster Diagnosis Standard continues to be above target at 76%.

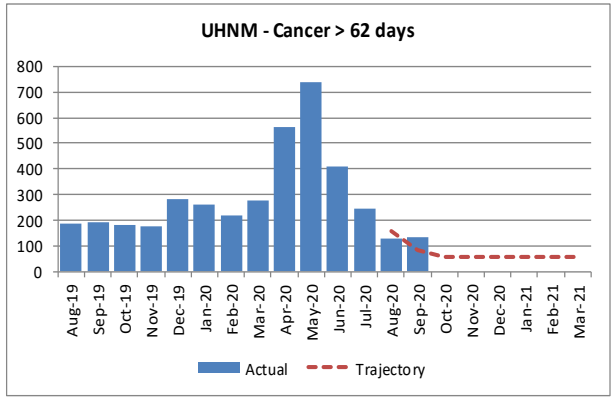
Actions

- Cancer waiting times and COSD training programme is being delivered to the corporate cancer team before roll out to the Trust.
- Pioneering hub models will link in to share their blueprint and learning.
- Enhanced scrutiny of long waiters by backlog co-ordinator.
- Weekly backlog PTL meeting and escalations to divisions.
- Referral Assessment Service being regularly reviewed, with reduced length of time from receipt of referral to booking 1st attendance.
- Capacity and demand modelling with divisions provided assurance that 2ww capacity is available for OCT and NOV.
- Creation of individualised action plans for all patients who have exceeded 104+ days.
- Patients who are non-compliant with the pathway are referred to the clinical team for a safety review.
- 'Having conversations with patients' training has been delivered to cancer services staff by the Macmillan Info Centre, to support development of the team and to help manage the backlog and non compliant patients.

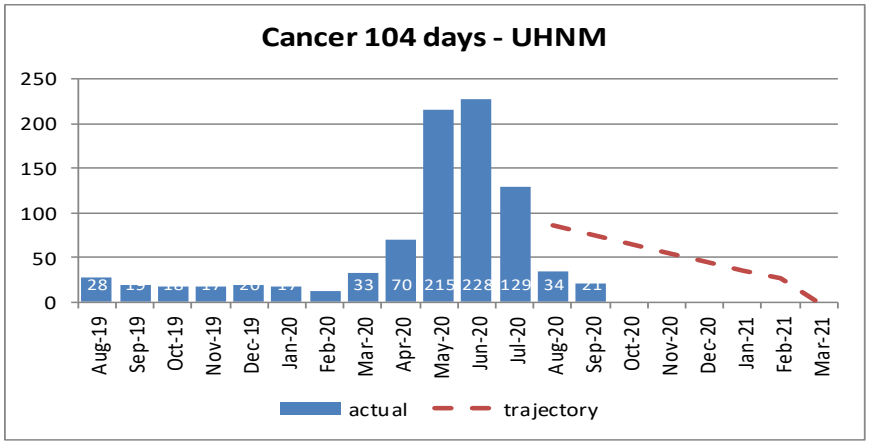
Cancer







	Standard	National August	UHNM August	UHNM Predicted September
Two week wait	93%	87.76%	93.14%	82.59%
2ww Breast Symptomatic	93%	82.28%	95.45%	98.00%
31 Day First Treatment	96%	94.53%	93.36%	96.80%
31 Day Subsequent Surgery	94%	87.31%	89.36%	94.60%
31 Day Anti-Cancer	98%	99.16%	100.00%	95.00%
31 Day Subsequent Radiotherapy	94%	96.08%	98.31%	96.05%
62 Day (2ww) First Treatment	85%	77.94%	71.43%	69.31%
63 Day Screening First Treatment	90%	55.87%	0.00%	100.00%



Planned care - *Inpatients*

University Hospitals of North Midlands NHS Trust

Elective inpatients Summary

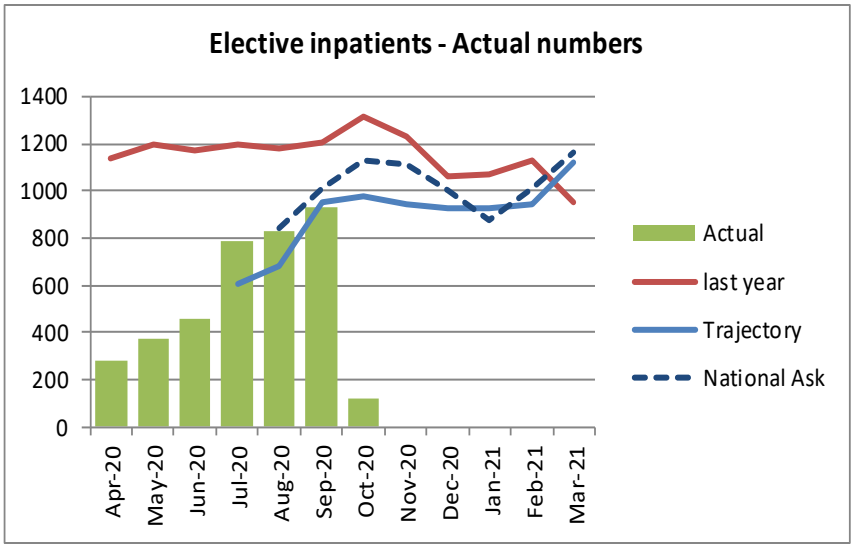
- Elective/Daycase activity has seen a steady rise since April 20 in line with restoration plans.
- For September, total Elective inpatient activity has increased month on month. Activity, for September, has risen to **74%** of business as usual (the National ask is to be at 80% by September). This is against Phase 3 plans of 75% and was 24 short of trajectory.

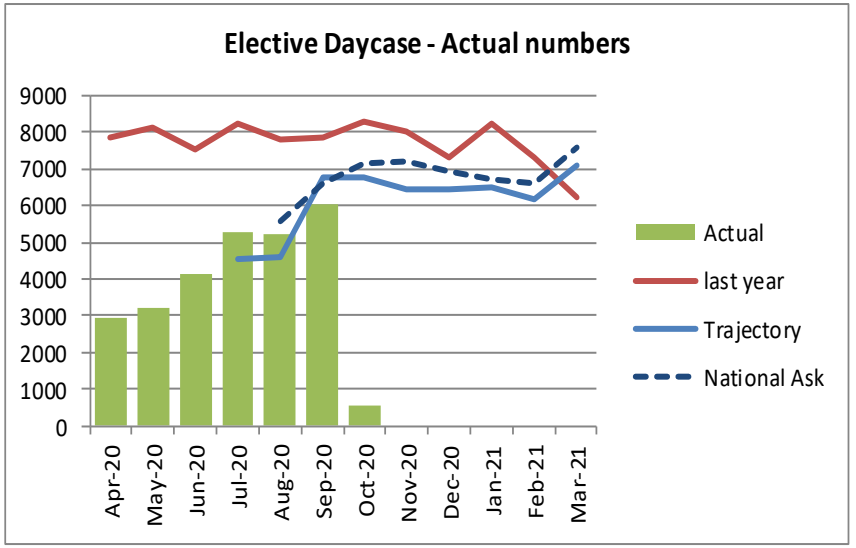
- Daycases have also risen since April and in September the activity was **74%** of last years BAU. However the activity is below that of the set trajectory by c700 cases. This is against Phase 3 plans of 82% and was 740 short of trajectory
- Theatre capacity is now operating at 91.35% of pre-covid, with utilisation at 81%. The revised theatre timetable, commencing in October, representing an 8% rise resulting a proposed capacity of 99.35% including the Independent sector.

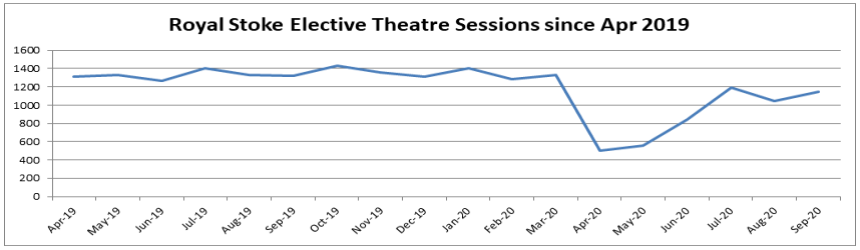
Actions

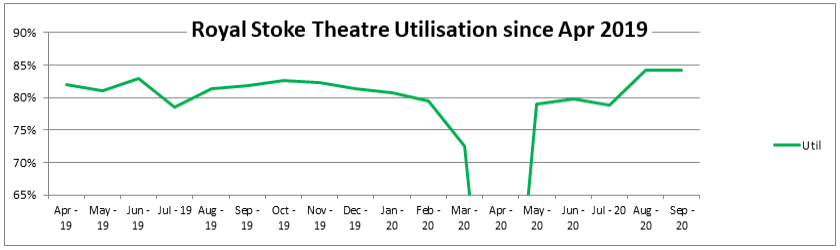
- Divisional confirm & challenge meetings took place through September to ensure plans are robust and ambitious and Phase 3 trajectories to be re-submitted in early October.
- Plans are being drawn up to increase Orthopaedic / trauma activity at County.
- Plans in progress to insource theatre sessions will begin with Endoscopy through 18week source group and SHS. Insourcing group will provide a team of health cares, nurses, scrub nurses, surgeons, anaesthetists in collaboration with a booking team and receptionist. They will run theatre sessions at UHNM over the weekends to reduce theatre backlog. We also have a team of external validators that will commence validation work on our long waiting patients from 13/10/20.
- Long waiters governance assurance paper now complete. New weekly assurance meetings to take place to monitor long waits and specialty plans for the over 52 week patients. This is also supported by a clinical harm review process.
- **New Waiting list categories P5 and P6** have been introduced this week. P5 for covid related delays and P6 for non covid related delays. We have c. 4000 patients to contact via telephone to advise of their new priority category, we have been doing work streams around the resources needed to commence.

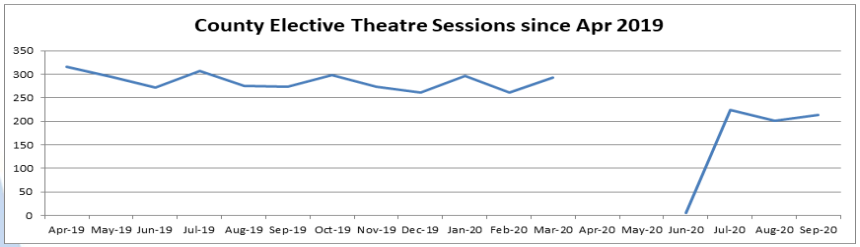
Planned care – *Inpatient activity*

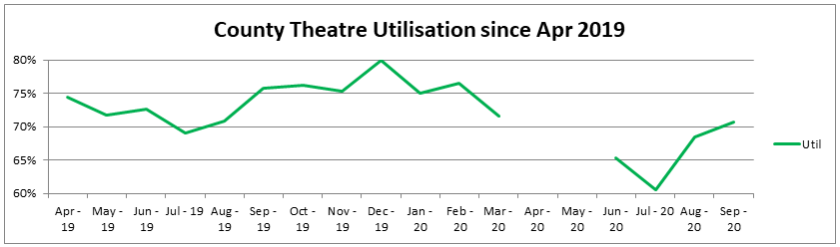












Planned care - *Outpatients*

NHS
University Hospitals of North Midlands
NHS Trust

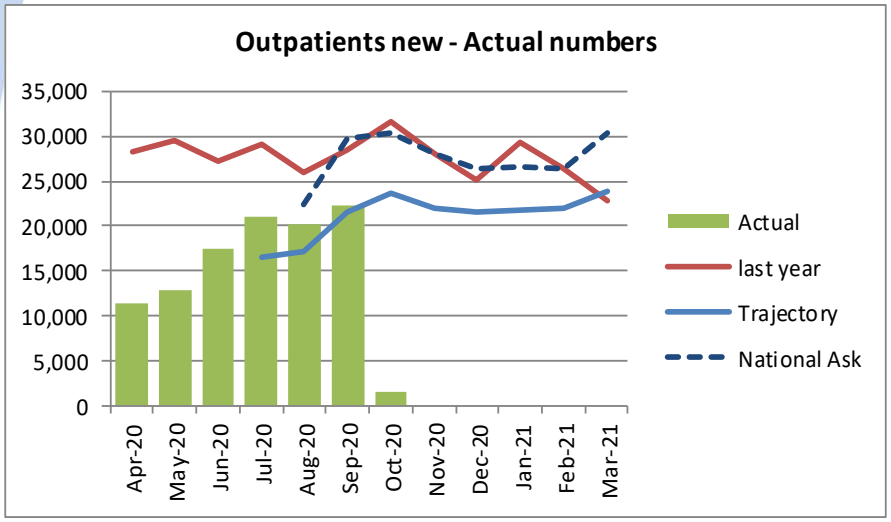
Summary

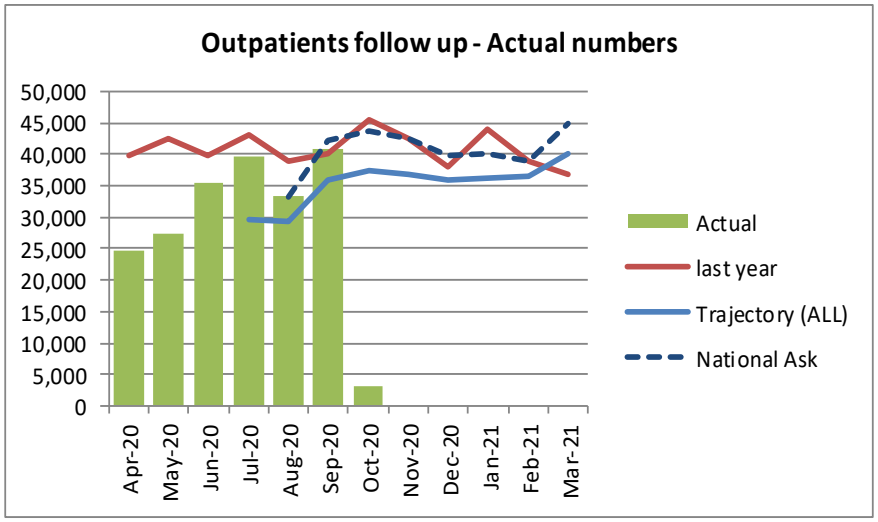
- Outpatients have seen activity levels rise since April in line with Restoration plans.
- For September, total outpatient activity was **88%** of last year's business as usual (the Phase 3 ask is to be at 90% by September. Improvements are seen for both first new and follow ups.
- The overall Referral To Treatment (RTT) Waiting list at UHNM saw a decline due to Covid-19 but is now rising. An increase has been seen over the last four months. The Trust trajectory has been developed based on the assumption that referrals will return to 100% of last year demand (Phase 3 ask)
- Demand for RTT is not at the peak seen pre-covid, therefore the shape of the waiting list is changing with more patients waiting over 18 weeks. In particular in the over 40 weeks and 52 weeks.
- The numbers of 52 week waits in September were 1315. These are expected to grow further through the year with the Trust trajectory reaching 2756 in March 2021.
- September's performance (71.6%) for ASIs has seen a month on month *decrease* in ASI of 6.4% of ASIs being triaged within 3 working days, however it is still 18% higher than July.
- First Outpatient appointments are currently delivering 65% Face to Face and 35% Non-face to Face (Telephone & Video), Follow Up appointments are 55% Face to Face and 45% Non-face to Face (Telephone & Video)

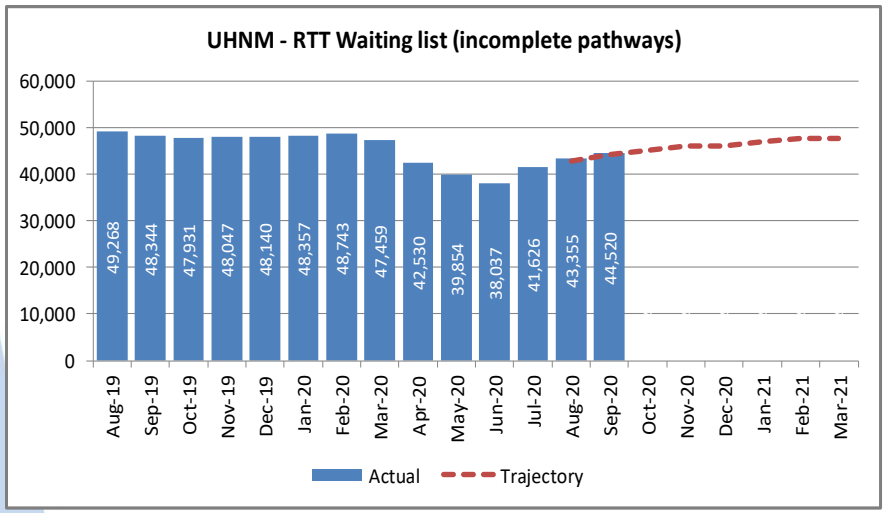
Actions

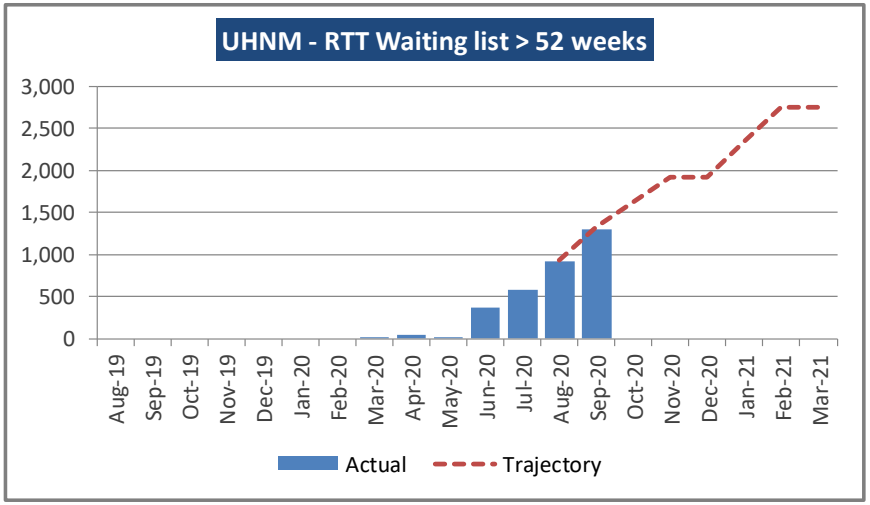
- Divisional confirm & challenge meetings have taken place and trajectories amended as appropriate to ensure plans are robust and ambitious.
- Work is required on template reconfiguration based on Divisional assumptions - this needs to be aligned to the in patient and diagnostics plans for the purpose of substantive job planning.
- An Interim Head of Elective Access has been appointed to co-ordinate the RTT recovery strategy and align our UHNM Access Policy to ensure consistency of application of PTL processes and management of pathways across all modalities.
- National PTL and clinical validation programmes: The new Clear PTL 'Go Live' date is set for 12th October 2020
- The Independent Sector contract is being renewed but with a 75% split for NHS (acute and CAB) that will enable 52 ww patients to be profiled.
- In Patient PTL now coded and R&R clinical group have drafted a set of clinical principles that will enable the alignment of theatres and beds to urgent categorised patients in order to optimise treatment/clearance.
- Revised 52 ww trajectory to be drafted once all cell plans confirmed to reduce the end of March 2021 delivery.
- 40+ week waiters are being planned with a combination of IS in/outsourcing and hospital capacity targeting categories 1, 1a, 2 and log waiters.

Planned care - *Outpatient activity & RTT*

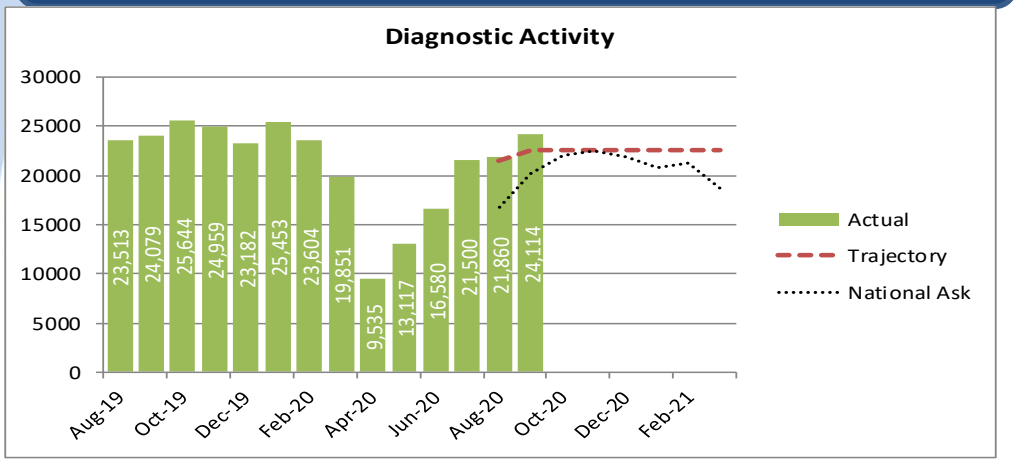








Diagnostic Activity



	Jul 20	Aug 20	Sep 20
Trajectory	#N/A	21,500	22,608
Actual	21,500	21,860	24,114
Varience	#N/A	360	1,506
Background			

Number of diagnostic tests completed in month for 6 key testing modalities; MRI, CT, ultrasound, colonoscopy, flexi sigmoidoscopy and gastroscopy.

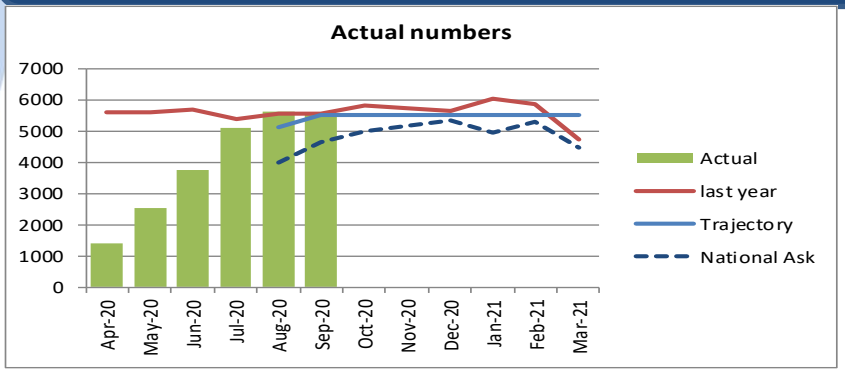
Summary

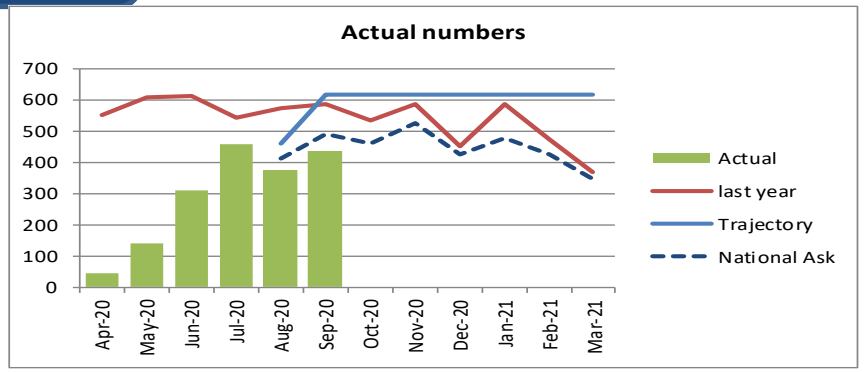
- September saw a further increase in diagnostic activity rising to 24,114.
- The trust trajectory for activity to the end of the year consistently meets the national ask and will see numbers return to similar levels as previous year.
- The diagnostic waiting list had significantly grown as patients were added and reached 20,287. With the increased activity being seen, the waiting list is continuing to reduce and is currently at 15,385, a reduction of 1596 from the previous month.
- The total number of patients > 6 weeks also reduced again to 3803.

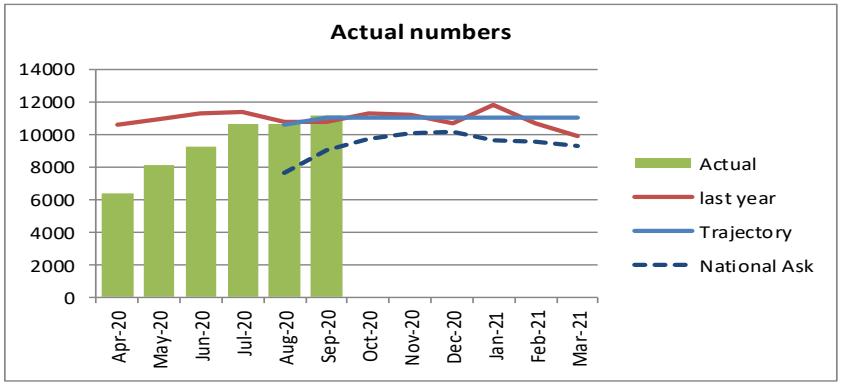
Actions

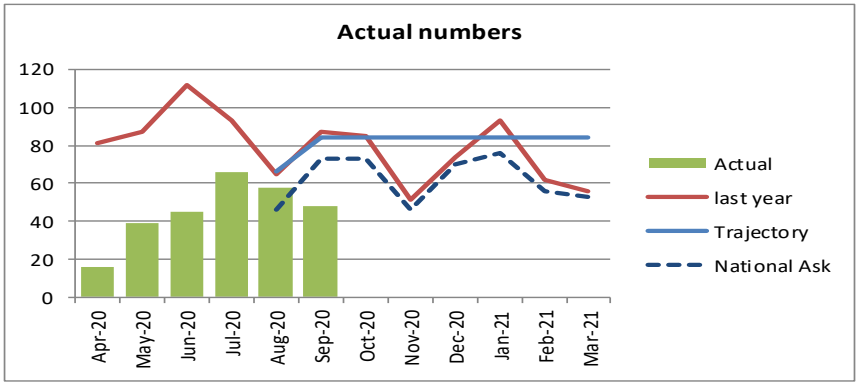
- Imaging – sourcing capacity from IS and mobile units to supplement.
- New ways of working are being reviewed with the transformation team

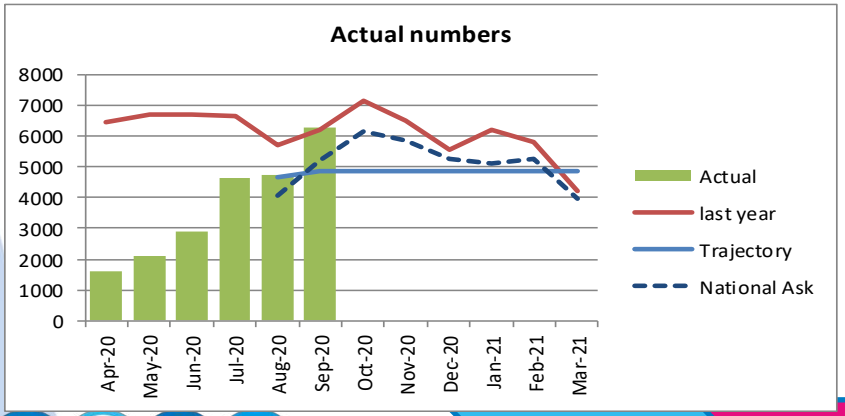
Diagnostics

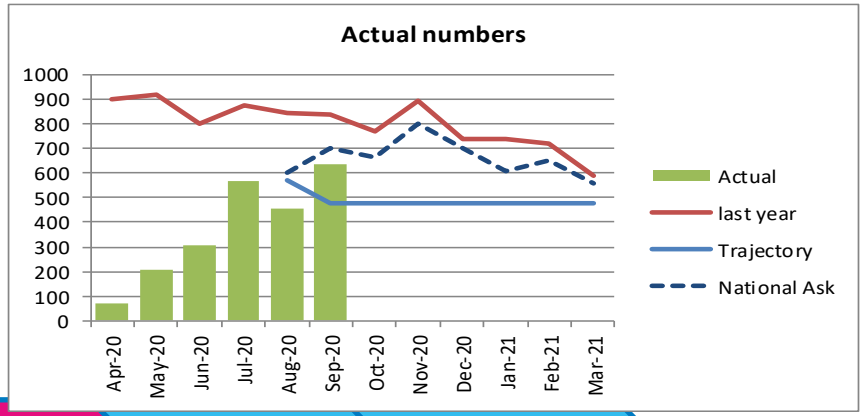












APPENDIX 1

Operational Performance

Constitutional standards

	Metric	Target	Latest	Variation	Assurance	DQAI
A&E	A&E 4 hour wait Performance	95%	78.30%		F	
	12 Hour Trolley waits	0	0	L	?	
Cancer Care	Cancer Rapid Access (2 week wait)	93%	93.20%		?	
	Cancer 62 GP ref	85%	71.70%		?	
	Cancer 62 day Screening	90%	0.00%	L	?	
	31 day First Treatment	96%	93.30%		?	
Elective waits	RTT incomplete performance	92%	52.38%	L	F	
	RTT 52+ week waits	0	911	H	?	
	Diagnostics	99%	59.20%	L	F	

	Metric	Target	Latest	Variation	Assurance	DQAI
Use of Resources	DNA rate	7%	7.2%		?	
	Cancelled Ops	150	57	L	?	
	Theatre Utilisation	85%	80.9%		F	
Inpatient / Discharge	Same Day Emergency Care	30%	30.5%	H	?	
	Super Stranded	183	142	L	?	
	DToC	3.5%	1.10%	L	?	
	Discharges before Midday	30%	18.1%	L	F	
	Emergency Readmission rate	8%	12.7%		F	
	Ambulance Handover delays in excess of 60 minutes	10	42		?	

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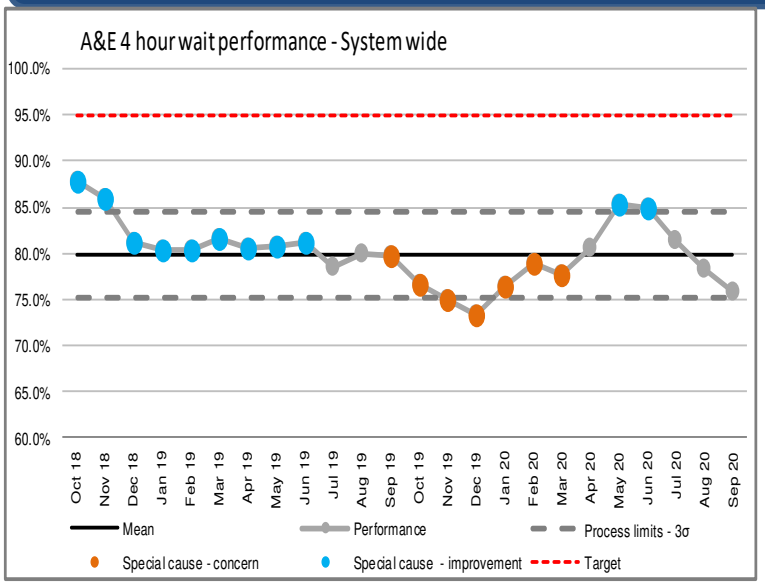
Quality | Operational | Workforce | Finance

URGENT CARE – 4 hour access performance



Variation	Assurance
	F

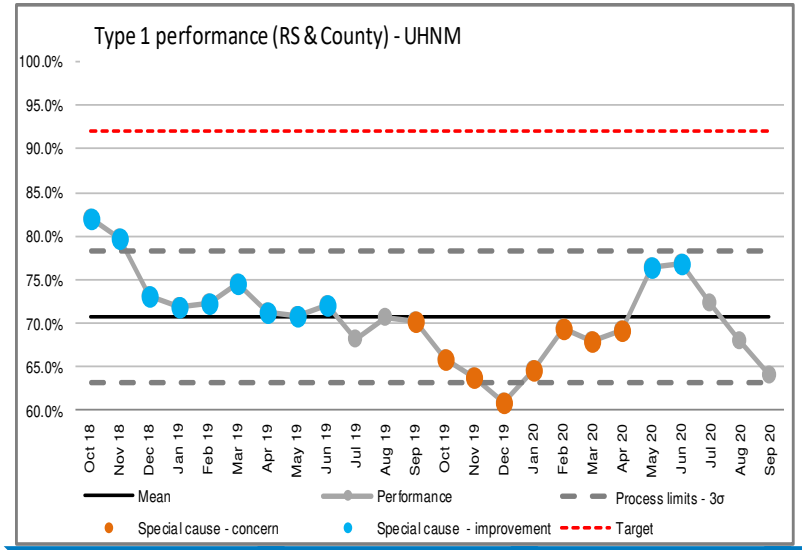
Target	Jul 20	Aug 20	Sep 20
95%	81.3%	78.3%	75.8%

Background

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

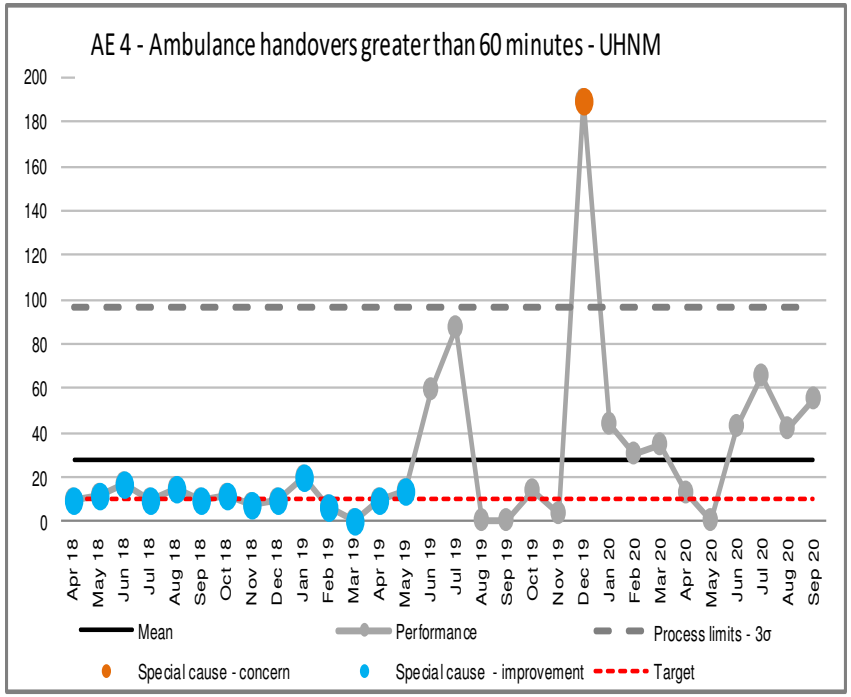
What is the data telling us?

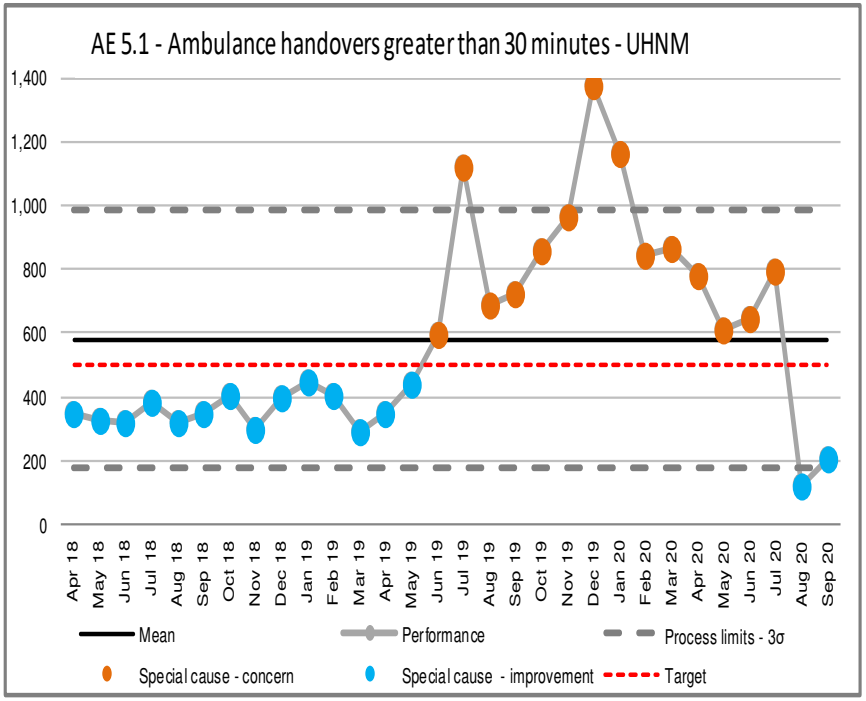
The improvemnets seen in May and June have not been sustained. However performance is still within the control limits and remains around the mean.



Quality | Operational | Workforce | Finance

URGENT CARE – 4 hour access – ambulance handovers

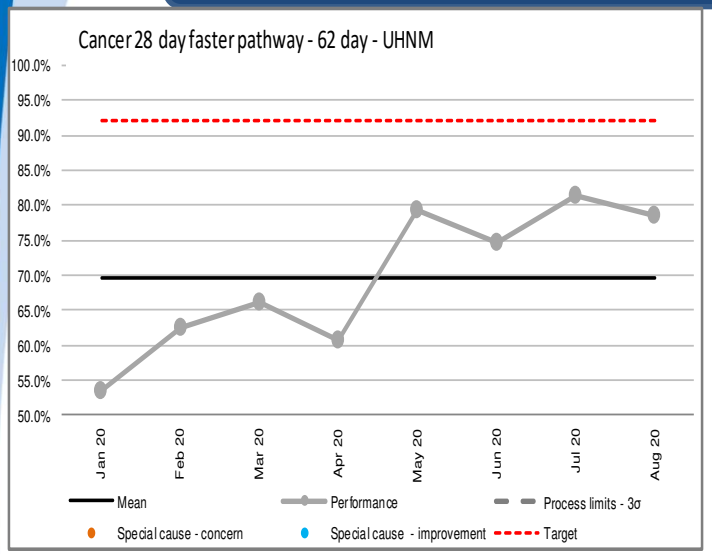


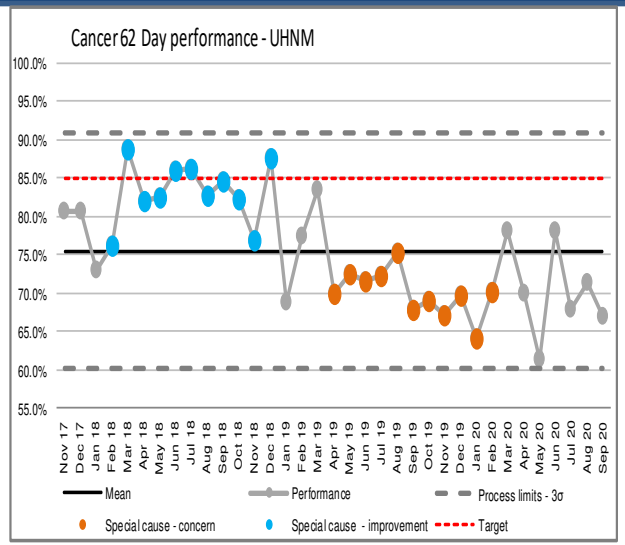


From August – internal validation of > 30 minutes

Quality | Operational | Workforce | Finance

Cancer – 62 Day





Variation	Assurance

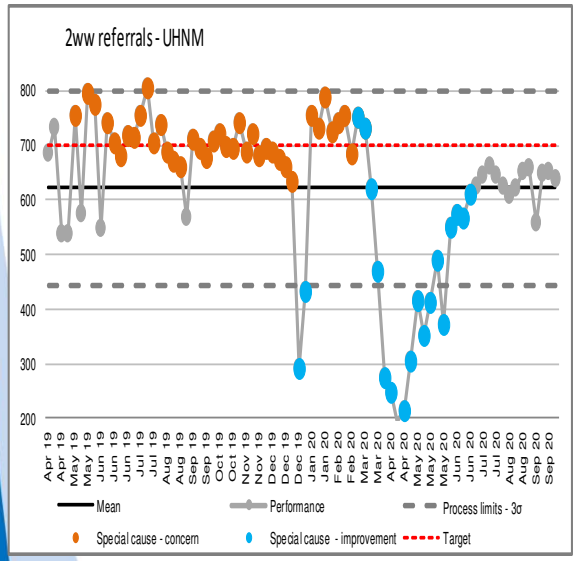
Target	Jul 20	Aug 20	Sep 20
85%	68.0%	71.4%	67.0%

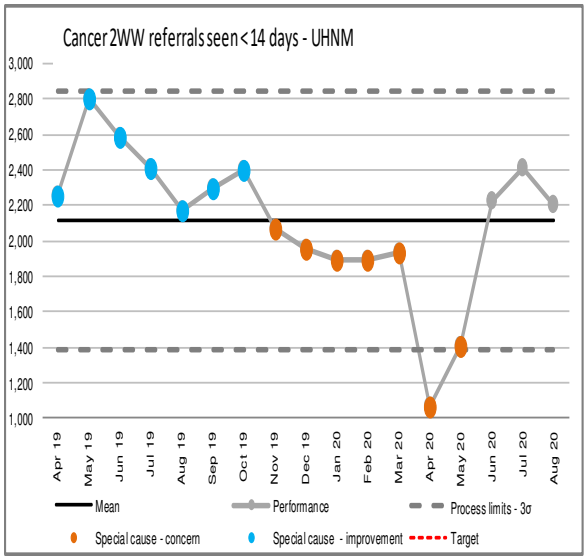
Background

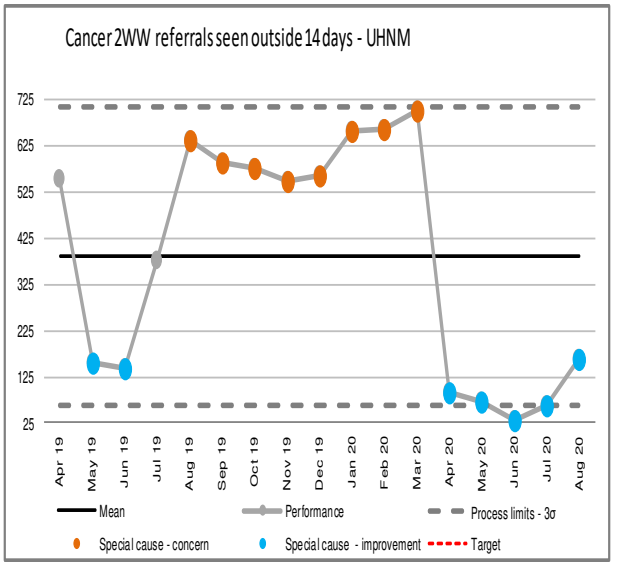
% patients beginning their treatment for cancer within 62 days following an urgent GP referral for suspected cancer

What is the data telling us?

Performance shows special cause concern from April 2019. The variation indicates consistently falling short of the standard.

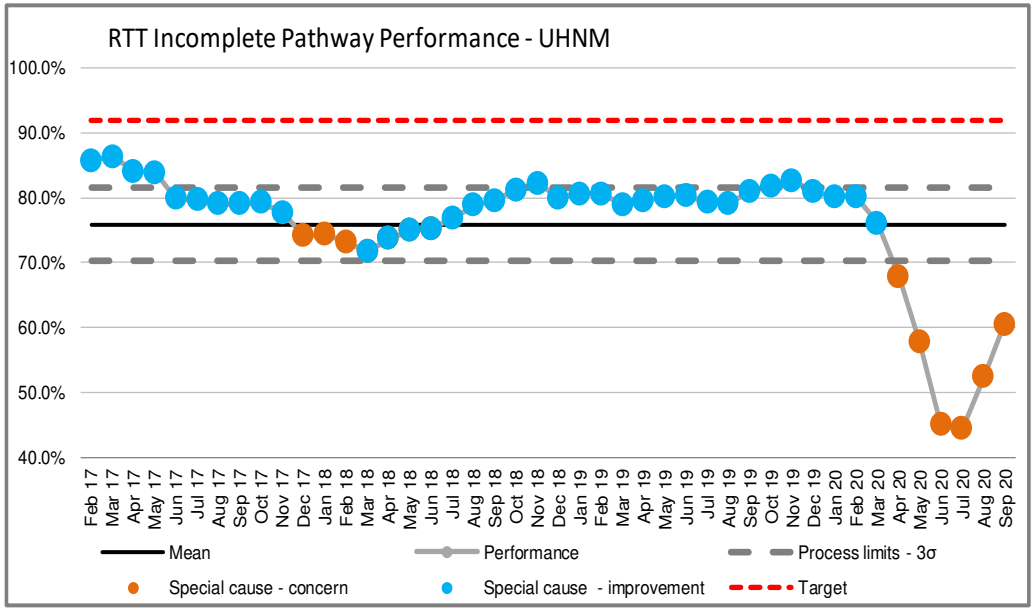






Quality | Operational | Workforce | Finance

Referral To Treatment



Variation	Assurance
L	F

Target	Jul 20	Aug 20	Sep 20
92%	44.4%	52.4%	60.5%

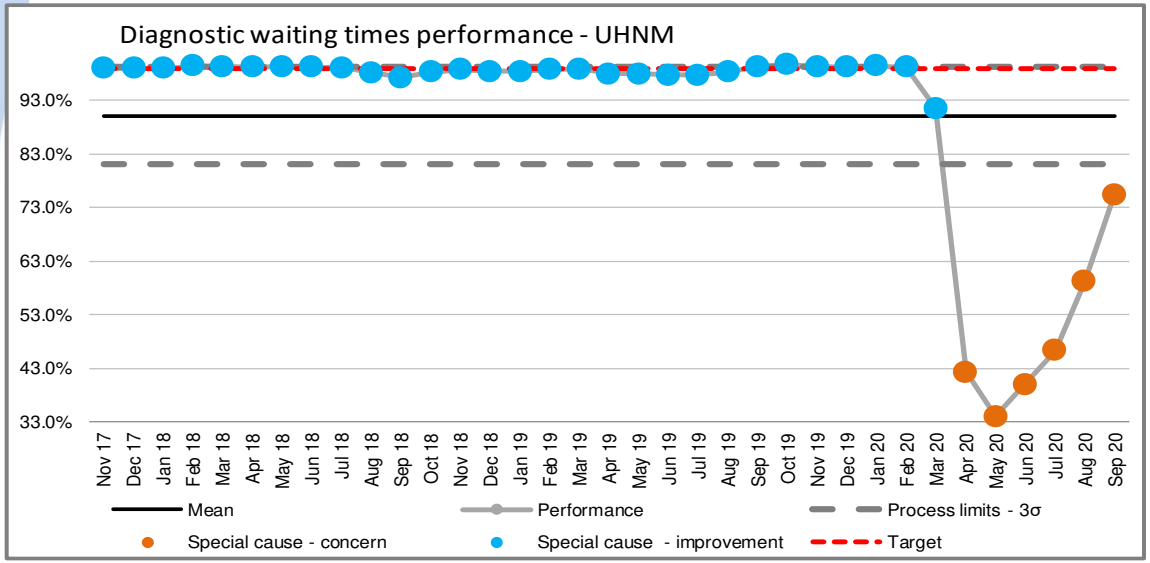
Background

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

What is the data telling us?

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

Diagnostic Standards



Variation	Assurance
	

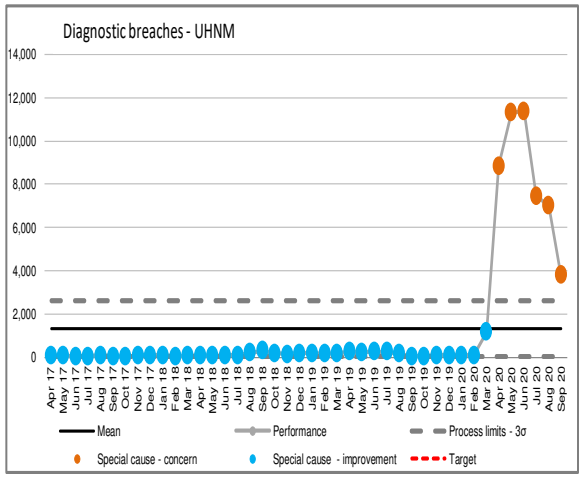
Target	Jul 20	Aug 20	Sep 20
99%	46.3%	59.2%	75.3%

Background

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

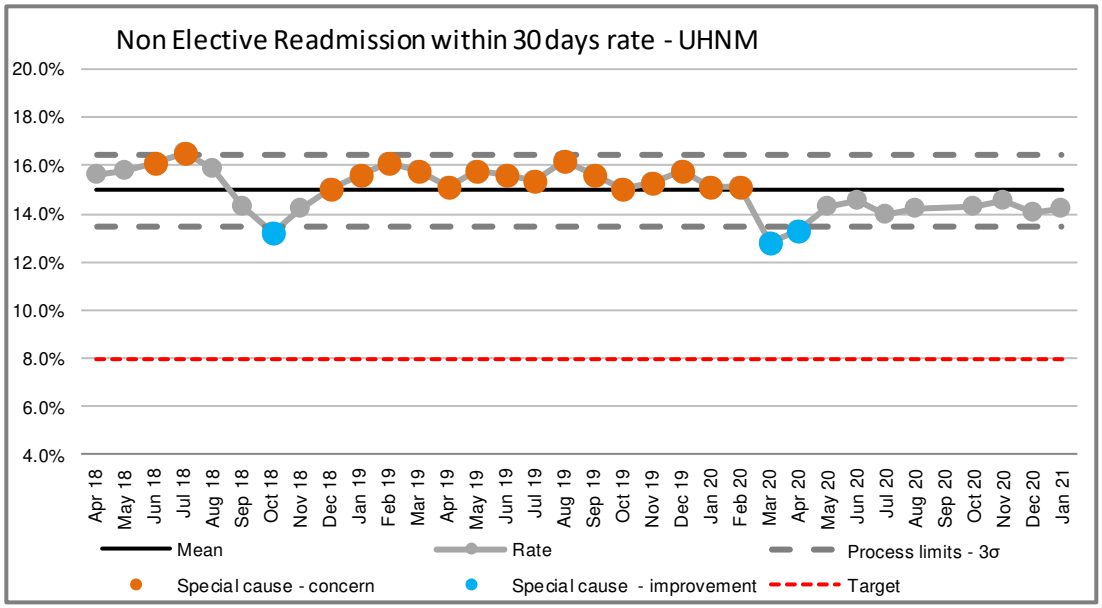
What is the data telling us?

The diagnostic performance has shown normal variation up until March 2020. Special cause variation occurred from March (COVID-19).



Quality | Operational | Workforce | Finance

Non-elective Re-admissions



Variation	Assurance

Target	Nov 20	Dec 20	Jan 21
8.0%	14.5%	14.0%	14.2%

Background

the percentage of patients who return as an emergency admission within 30 days of an inpatient/daycase spell.

What is the data telling us?

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, workforce deployment, staff wellbeing, absence management and staff testing. Recruitment campaigns are in place to recruit to the Winter Plan and we continue to work jointly towards system-wide campaigns.

Covid-related absences have continued to increase, as has the demand for staff testing. Resources have been applied to ensure staff testing is carried out in line with demand. As a result of the escalating position regarding covid-19, the Workforce and Nursing Bureaus have been stepped back up, including links to Gold and Silver Command. The Bureau will ensure Staff Wellbeing and Support; Internal Workforce Supply (recruitment, retire and return, bank etc); links to the STP Workforce Supply; Volunteers and Training; Internal Deployment of staff; Staff Testing; Staff FAQs and national horizon scanning, and Supporting vulnerable worker risk assessments and links to Occupational Health

The key performance issues remain compliance with statutory and mandatory training and PDR requirements, and the sickness rate being above target.

Sickness

The sickness rate remains above target. The in-month sickness rate was 4.60% (4.41% at 31/08/20). During September, 9.7% of sickness absence was due to Chest and Respiratory problems (7.7% in August).

The 12 month cumulative rate increased slightly from 5.12% to 5.17% and for the 12months ending 30th September 2020, 14% of sickness absence was due to Chest and Respiratory problems.

Note: A proportion of sickness is transferred to ESR as 'Unknown causes / Not specified' which may include covid-related absence which was not validated by the line manager at the time of transfer.

As at 18th October, 91% of all permanent and fixed term staff have completed a covid-related risk assessment with their manager and 93% of BAME staff have a completed covid risk assessment.

Appraisals

The Non-Medical PDR compliance rate was 77.48% at 30 September 2020 (76.35% at 31st August 2020) with improvement across 5 of the 6 Divisions

Statutory and Mandatory Training

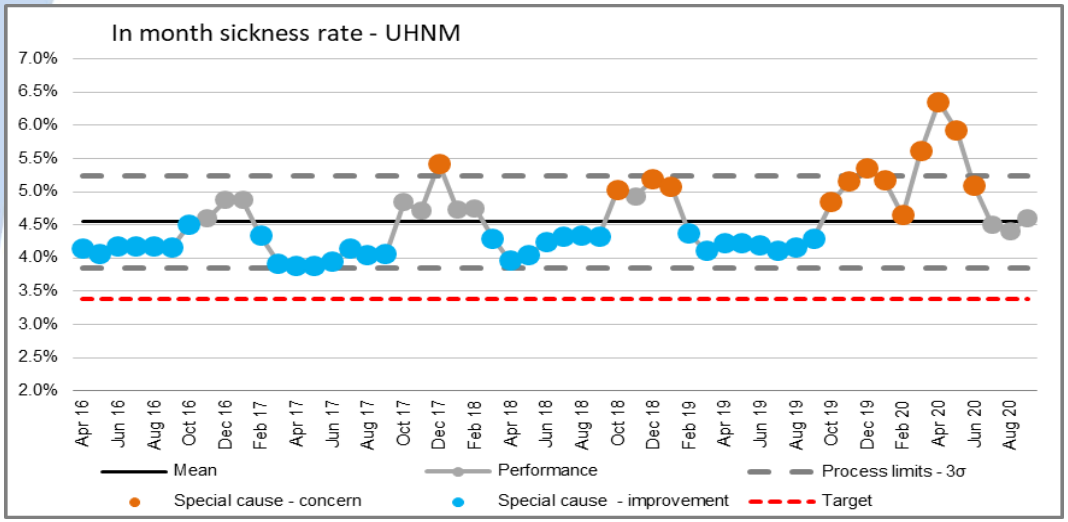
The Statutory and Mandatory training rate at 30 September 2020 was 93.51% ((92.22% at 31st August 2020). At 31 August 2020, 86.32% of staff had completed all 6 Core for All modules (at 2 decimal places - no change on previous month)

Turnover – There was a special cause variation from August 2020 as a result of a one off event when the Student Nurses, who had supported the Trust throughout the first wave of covid-19, returning to University. However, the 12m rolling turnover rate remains below the target 11%

Workforce Dashboard

Metric	Target	Latest	Variation	Assurance
Staff Sickness	3.4%	4.60%		
Staff Turnover	11%	9.61%		
Statutory and Mandatory Training rate	95%	93.51%		
Appraisal rate	95%	77.48%		
Agency Cost	N/A	3.03%		

Sickness Absence



Variation	Assurance
	F

Target	Jul 20	Aug 20	Sep 20
3.4%	4.5%	4.4%	4.6%

Background

Percentage of days lost to staff sickness

Sickness rate is consistently above the target of 3.4%. The special cause variation seen from March through to July was a result of covid-19.

Covid-related absences have been increasing again since 8th September

Summary

The in-month sickness rate was 4.60% (4.41% at 31/08/20). The 12 month cumulative rate increased from 5.12% to 5.17%

Covid related absences and staff testing remains an area of focus, with additional resources being applied to manage staff testing.

Wellbeing Support has continued throughout September and October, with the provision of wellbeing and psychological support offerings, as well as signposting to the national wellbeing offer on the NHS People and other websites.

A virtual wellbeing festival commenced in October for staff at both sites and the Project Wingman initiative, which provides a safe space for staff respite and conversation, commenced.

The Annual NHS Staff Survey has been issued to those staff eligible to take part

The Trust has secured £50k funding from NHS Charities Together to purchase and maintain a mobile staff wellbeing unit and an oversight group is being set up with representatives from a variety of areas to manage this. This will be available across both sites

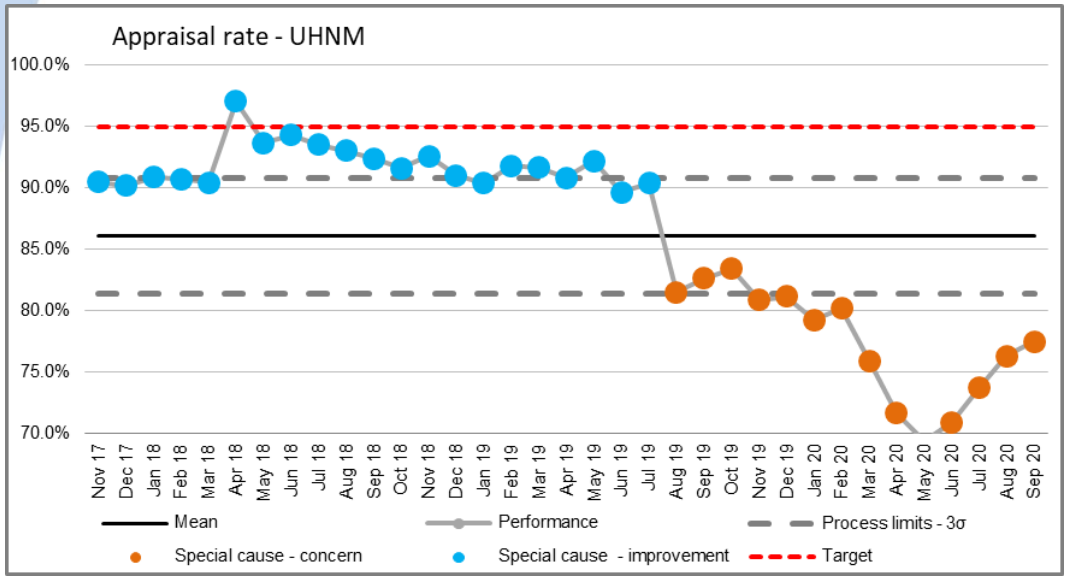
Actions

Phase 3 of the covid-19 risk assessment process is continuing, with resources being applied to chase the outstanding risk assessments. Support to input completed risk assessments to the Empactis System is available

We are in discussion with our OH provider about embedding the risk assessments into the pre-hire health assessment process for new starters and we are engaging with managers to ensure that they update our Empactis system with the RA data to ensure a full data capture

In recognition of the concerns raised by staff, a review of rest facilities has commenced across the Trust

Appraisal (PDR)



Variation	Assurance
	

Target	Jul 20	Aug 20	Sep 20
95.0%	73.8%	76.4%	77.5%

Background

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

The appraisal rate is consistently below the target of 95%. More recently the rate shows special cause variation. There has been a drop below the lower control limit since August 2019.

Summary

The Non-Medical PDR compliance rate was 77.48% at 30 September 20 (76.35% at 31st August 20).

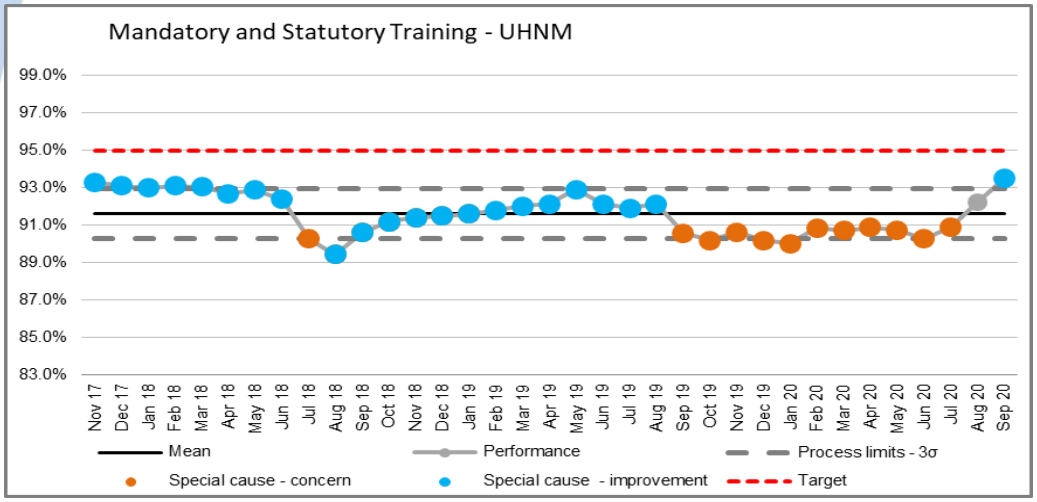
There was an improvement in performance across 5 of the 6 Divisions

Actions

Divisions have produced improvement trajectories which are managed via the performance review meetings.

We will be writing to divisional leads to draw their attention to the areas where there are gaps and to ask them to prioritise these areas over the course of the next two months. It is recognised that this time of year becomes more challenging to timetable PDR discussions due to operational pressures across the Trust.

Statutory and Mandatory Training



Variation	Assurance
H	F

Target	Jul 20	Aug 20	Sep 20
95.0%	90.9%	92.2%	93.5%

Background

Training compliance

What is the data telling us?

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

Summary

The Statutory and Mandatory training rate at 30th Sept 20 was 93.51% (92.22% at 31st August 2020) and 86.32% of staff had completed all 6 Core for All modules (at 2 decimal places - no change on previous month)

Competence Name	Assignment Count	Required	Achieved	Compliance %
205|MAND|Security Awareness - 3 Years|	10293	10293	9668	93.93%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	10293	10293	9692	94.16%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	10293	10293	9409	91.41%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	10293	10293	9618	93.44%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	10293	10293	9687	94.11%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	10293	10293	9676	94.01%

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

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Fire Safety - 1 Year|	10293	10293	8445	82.05%
NHS|CSTF|Information Governance and Data Security - 1 Year|	10293	10293	9126	88.66%

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

Actions

Alternatives to e-learning are being investigated as possible solutions for delivering Statutory & Mandatory training to medical staff

We will be writing to divisional leads to draw their attention to the areas where there are gaps and to ask them to prioritise these over the course of the next two months

Finance

2025 Vision "Ensure efficient use of resources"

Finance Spotlight Report

NHS University Hospitals of North Midlands NHS Trust

Key messages

- This report presents the financial performance of the Trust for September (Month 6); key elements of the financial performance for the year to date are:
- The Trust has delivered a breakeven for the month; this is after the receipt of £1.7m of funding for additional expenditure relating to COVID-19 and a £6.1m "top-up" from NHSI in line with the temporary financial framework established by NHSI.
- Activity delivered in Month 6 is significantly lower than plan although NHS income levels from patient activities have been maintained due to the temporary funding arrangements.
- The Elective Incentive Scheme (EIS) comes into effect from September with the Trust estimating the impact being a £0.5m reduction to income. This is not reflected in the Month 6 position in line with guidance from NHSI/E.
- The Trust incurred £1.7m of additional costs relating to COVID-19 which was £0.1m higher than in Month 5 mainly due to claims from the Anaesthetists for additional shifts worked in the first half of the year.
- Pay expenditure includes £0.9m of back pay relating to the Consultant's pay award that was paid in September.
- Non pay expenditure is £1.0m overspent mainly driven by tariff excluded drugs which overspent by £1.2m.
- Capital expenditure for the year to date stands at £17.2m which is £2.0m behind plan with small variances across a number of schemes. The forecast CRL expenditure remains on track.
- The month end cash balance is £80.8m which is £13.6m higher than plan.

Finance Dashboard

	Metric	Target	Latest	Variation	Assurance
I&E	Trust Income	variable	69.4		
	Expenditure - Pay	variable	44.0		
	Expenditure - Non Pay	variable	23.7		
Activity	Daycase/Elective Activity	variable	6,971		
	Non Elective Activity	variable	8,639		
	Outpatients 1st	variable	22,030		
	Outpatients Follow Up	variable	40,578		

Income & Expenditure

Income & Expenditure Summary Month 6 2020/21	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Income From Patient Activities	731.0	61.9	68.2	6.3	371.1	387.1	15.9
Other Operating Income	85.1	6.9	4.0	(2.9)	43.0	24.6	(18.4)
Total Income	816.1	68.8	72.2	3.4	414.1	411.7	(2.4)
Pay Expenditure	(512.3)	(42.7)	(44.0)	(1.2)	(257.6)	(254.3)	3.2
Non Pay Expenditure	(268.2)	(22.7)	(23.7)	(1.0)	(137.6)	(130.5)	7.2
Total Operational Costs	(780.5)	(65.5)	(67.7)	(2.2)	(395.2)	(384.8)	10.4
EBITDA	35.6	3.3	4.5	1.2	18.9	26.9	8.0
Depreciation & Amortisation	(29.2)	(2.4)	(2.4)	(0.0)	(14.6)	(14.6)	(0.0)
Interest Receivable	0.3	0.0	0.0	(0.0)	0.1	0.1	(0.0)
PDC	(7.6)	(0.6)	(0.6)	0.0	(3.8)	(3.9)	(0.1)
Finance Cost	(17.2)	(1.4)	(1.4)	0.0	(8.6)	(8.6)	0.0
Other Gains or Losses	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Surplus / (Deficit)	(18.0)	(1.2)	(0.0)	1.1	(7.9)	(0.0)	7.9
MRET central funding	4.2	0.4	0.0	(0.4)	2.1	0.0	(2.1)
Financial Recovery Fund	13.8	3.4	0.0	(3.4)	6.9	0.0	(6.9)
Total	0.0	2.6	(0.0)	(2.7)	1.1	(0.0)	(1.1)

- The Trust delivered a breakeven position for the month against a planned surplus of £2.6m. This position was after accounting for a "true up" payment from NHSI/E of £7.8m relating to additional COVID-19 costs of £1.7m and a payment of £6.1m to bring the Trust to a breakeven position for the month; these transactions are in line with NHSI/E temporary funding arrangements for NHS Trusts.

Capital Spend

Capital Expenditure as at Month 6 2020/21 £m	Revised Annual	In Month			Year to Date		
	Plan	Revised Budget	Actual	Variance	Revised Budget	Actual	Variance
ICT Infrastructure	(2.8)	(0.1)	(0.0)	0.0	(0.3)	(0.2)	0.1
Estates Infrastructure	(2.3)	(0.4)	(0.4)	(0.0)	(1.1)	(1.4)	(0.4)
Medical Equipment	(2.2)	(0.2)	-	0.2	(0.8)	(0.4)	0.4
PFI lifecycle and equipment	(1.9)	(0.2)	(0.2)	-	(1.0)	(1.0)	-
PFI enabling	(0.1)	-	-	-	-	-	-
Health & Safety Compliance	(0.2)	(0.1)	-	0.1	(0.1)	-	0.1
Other Central schemes	(1.4)	(0.1)	-	0.1	(0.4)	(0.2)	0.2
Project Star	(0.9)	-	-	-	(0.9)	(0.6)	0.3
Investment schemes	(0.5)	(0.2)	-	0.2	(0.2)	-	0.2
COVID-19 Trust funded (awaiting PDC funding)	(0.7)	(0.0)	-	0.0	(0.7)	(0.5)	0.2
Linac	(2.2)	-	-	-	-	-	-
IR2 Bi Plane	(1.4)	-	-	-	-	-	-
LIMS	(0.9)	(0.3)	(0.0)	0.2	(0.5)	(0.1)	0.4
EPMA	(0.8)	(0.0)	(0.0)	0.0	(0.2)	(0.1)	0.1
Trust funded capital programme	(18.3)	(1.6)	(0.7)	0.9	(6.1)	(4.7)	1.5
Royal Infirmary Site demolition	(5.5)	(0.6)	(0.4)	0.2	(1.2)	(1.0)	0.3
COVID-19 PDC (approved)	(1.7)	(0.3)	(0.0)	0.2	(1.7)	(1.3)	0.4
PDC award for HSLI	(1.2)	-	-	-	(1.1)	(1.1)	0.0
Wave 4b funding - modular wards	(9.1)	-	-	-	(9.1)	(9.1)	-
Critical Risk Infrastructure	(3.2)	-	(0.1)	(0.1)	-	(0.1)	(0.1)
Emergency Department funding	(4.3)	-	(0.0)	(0.0)	-	(0.0)	(0.0)
Other PDC funding	(0.5)	-	(0.1)	(0.1)	-	(0.1)	(0.1)
PDC funded capital schemes	(25.4)	(0.8)	(0.5)	0.3	(13.1)	(12.6)	0.5
Overall capital expenditure	(43.8)	(2.4)	(1.2)	1.2	(19.2)	(17.2)	2.0

Trust funded schemes

Estates sub-group expenditure is £0.4m higher than plan due to expenditure on a number of schemes such as ward 121/122 refurbishment, replacement of emergency lighting and work on Pod 6 roof being slightly ahead of plan.

Medical equipment sub-group expenditure is behind plan year to date by £0.4m due to the planned expenditure in Month 6 on the Stealth Station and replacement of radiotherapy schemes being delayed. The schemes are still forecast to be in line with plan at the year end.

PDC funded schemes

The main reason for the under spend on PDC funded capital is due to COVID-19 related expenditure and is linked to the funding not being confirmed by NHSI and delays from suppliers. A £0.3m under spend on the RI demolition scheme is due to initial delays due to COVID-19 restrictions.

Cash flow

Cash Summary at Month 6 2020/21		In Month			Year to date		
	Budget £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Opening balance	26.7	70.7	80.5	9.8	26.7	26.7	-
Block mandate payments (to 31st October 2020)	473.2	59.2	64.1	4.9	414.1	425.7	11.6
Contract income 2019/20	(9.2)	-	-	-	(9.2)	(7.4)	1.8
Other Income (including other NHS)	34.3	6.5	6.2	(0.3)	40.1	38.4	(1.7)
Health Education England Training Income	20.0	2.0	-	(2.0)	12.9	8.8	(4.1)
PSF/FRF - 2019/20 Q4	9.7	-	-	-	9.7	9.7	-
Department of Health and NHS England Deficit support	-	-	-	-	-	-	-
Capital funding (PDC capital)	11.8	-	-	-	9.1	9.1	-
Total Receipts	539.8	67.7	70.3	2.6	476.7	484.3	7.6
Payroll (excluding agency)	(282.8)	(41.7)	(41.6)	0.1	(242.8)	(242.3)	0.5
Accounts payable	(202.0)	(29.0)	(27.9)	1.1	(176.9)	(173.4)	3.5
PDC Dividend	-	-	-	-	-	-	-
Capital payments	(17.8)	(0.5)	(0.5)	-	(16.6)	(14.6)	2.0
Total Payments	(502.5)	(71.2)	(70.0)	1.2	(436.2)	(430.3)	6.0
Closing Balance	64.0	67.2	80.8	13.6	67.2	80.8	13.6

The cash flow budget above covers the period 1 April 2020 to 31st October 2020 and is based on the block mandate income that the Trust is currently receiving. This will be updated from Month 7-12 to reflect the plan submitted for the second half of the financial year.

Prior year contract income is lower than plan as NHS England took credit notes in April and July relating to the 2019/20 Specialised Commissioners year end agreement, however a number of older credit notes still remain outstanding.

Health Education England training income received is lower than plan and reflects a change in payment profile from HEE from quarterly in advance, the Trust is expecting to receive cash relating to months 5-6 in October 2020.

Capital payments are lower than plan and reflect the current capital position where there are underspends due to lower than plan spend on COVID-19 capital, medical devices and Project Star. The cash flow assumes that the current capital funding not finally allocated for Royal Infirmary site demolition, Critical Risk Infrastructure, HSLI, COVID-19 Capital and ED funding will be received as planned.

Balance sheet

Balance sheet as at Month 6	31/03/2020	30/09/2020			
	Actual £m	Revised Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment	483.0	487.3	485.4	(2.0)	Note 1
Intangible Assets	24.5	22.0	21.9	(0.2)	Note 1
Other Non Current Assets	-	-	-	-	
Trade and other Receivables	0.4	0.4	0.4	(0.0)	
Total Non Current Assets	507.9	509.8	507.6	(2.1)	
Inventories	13.3	13.3	13.1	(0.2)	
Trade and other Receivables	49.6	48.1	50.5	2.4	Note 2
Cash and Cash Equivalents	26.7	67.2	80.8	13.6	Note 3
Total Current Assets	89.6	128.6	144.4	15.8	
Trade and other payables	(74.8)	(117.3)	(130.1)	(12.9)	Note 4
Borrowings	(208.0)	(10.6)	(10.7)	(0.0)	
Provisions	(6.7)	(6.7)	(6.7)	0.0	
Total Current Liabilities	(289.5)	(134.6)	(147.5)	(12.9)	
Borrowings	(276.6)	(270.6)	(270.7)	(0.0)	
Provisions	(1.2)	(1.2)	(1.2)	-	
Total Non Current Liabilities	(277.7)	(271.8)	(271.8)	(0.0)	
Total Assets Employed	30.3	231.9	232.7	0.8	
Financed By:				-	
Public Dividend Capital	409.7	614.9	614.9	0.0	
Retained Earnings	(476.2)	(479.8)	(479.1)	0.7	
Revaluation Reserve	96.9	96.9	96.9	(0.0)	
Total Taxpayers Equity	30.3	231.9	232.7	0.8	

Note 1 - Property, plant and equipment and intangibles are £2.2m lower than plan. This reflects the lower than planned ytd capital spend on COVID-19 capital, medical equipment and Project Star.

Note 2 - Trade and other receivables is £2.4m higher than plan. This is mainly due to the Trust not yet receiving payment from Health Education England for Augusts and September training income; this is expected to be received in October. This is partly offset by prior year credit notes of £1.7m remaining outstanding mainly with Specialised Commissioners and CCGs

Note 3 - Cash is £13.6m higher than plan and reflects lower than planned levels of general and capital payments. The cash received from block payments is £11.6m higher than plan to reflect top up cash received although this is partly offset by the timing of training income received from Health Education England.

Note 4 - Payables are £12.9m higher than plan and reflect higher levels of goods received not invoiced and NHS and Non NHS accruals being higher than plan.

The cash and payables plan figures do not account for the top-up funding received from NHS England for months 1-6 to achieve break-even.

Expenditure - Pay and Non Pay

NHS University Hospitals of North Midlands NHS Trust

WTE In month			Pay Summary (£m)	Annual	In month			YTD		
Plan	Actual	Variance		Plan	Plan	Actual	Variance	Plan	Actual	Variance
1,389	1,458	69	Medical	(150.9)	(14.0)	(14.5)	(0.5)	(75.7)	(77.6)	(1.8)
3,263	3,010	(252)	Registered Nursing	(157.4)	(13.0)	(12.3)	0.6	(78.5)	(74.8)	3.7
1,232	1,181	(51)	Scientific Therapeutic & Technical	(57.6)	(4.8)	(4.9)	(0.1)	(28.8)	(28.6)	0.2
2,340	2,422	82	Support to Clinical	(68.8)	(5.6)	(5.9)	(0.3)	(35.4)	(35.3)	0.1
2,423	2,300	(123)	Nhs Infrastructure Support	(77.6)	(5.4)	(6.4)	(1.0)	(39.1)	(38.1)	1.1
10,647	10,371	(276)	Total Pay	(512.3)	(42.7)	(44.0)	(1.2)	(257.6)	(254.3)	3.2

Pay - The pay run rate in Month 6 is £1.7m higher than the level seen in Month 5; this is mainly due to the payment of the Medical Consultants' pay award which increased the run rate in September by £1.1m with a provision for additional shifts worked by Anaesthetists in the first 6 months of the year being the other significant variance.

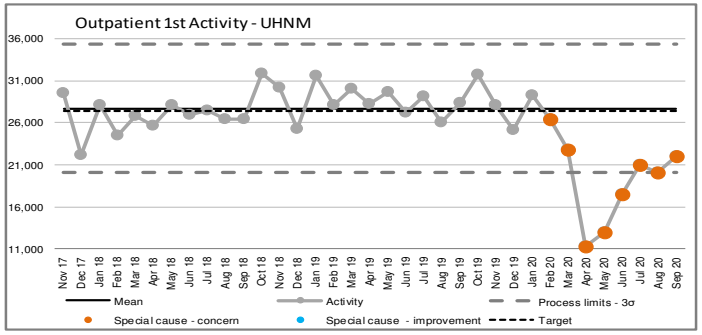
Non PaySummary (£m)	Annual	In Month			YTD		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance
Tariff Excluded Drugs Expenditure	(59.2)	(5.1)	(6.3)	(1.2)	(29.5)	(33.7)	(4.2)
Other Drugs	(21.5)	(1.8)	(1.7)	0.1	(10.8)	(9.8)	1.0
Supplies & Services - Clinical	(70.5)	(6.2)	(5.8)	0.4	(36.0)	(27.7)	8.3
Supplies & Services - General	(8.1)	(0.6)	(0.5)	0.1	(4.3)	(3.6)	0.6
Purchase of Healthcare from other Bodie	(12.1)	(1.0)	(1.0)	0.0	(6.3)	(5.9)	0.4
Consultancy Costs	(2.3)	(0.2)	(0.1)	0.0	(1.2)	(0.3)	0.9
Clinical Negligence	(22.3)	(1.9)	(1.9)	0.0	(11.5)	(11.5)	0.0
Premises	(31.8)	(2.7)	(2.4)	0.3	(17.0)	(15.0)	2.1
PFI Operating Costs	(33.4)	(2.8)	(2.9)	(0.1)	(16.7)	(17.4)	(0.7)
Other	(6.9)	(0.4)	(1.1)	(0.7)	(4.4)	(5.7)	(1.3)
Total Non Pay	(268.2)	(22.7)	(23.7)	(1.0)	(137.6)	(130.5)	7.2

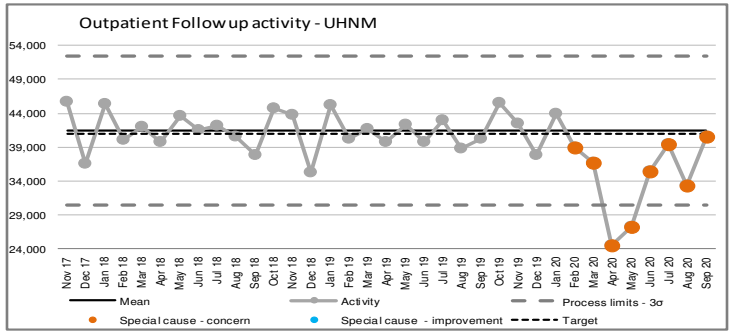
Non-pay - Expenditure is overspent by £1.0m in Month 6 with the most significant variance relating to Tariff excluded drugs expenditure which is £1.1m overspent for the month and £4.2m overspent for the year to date; this is offset by a year to date underspend of £8.3m against Clinical Supplies with expenditure returning to plan level as activity recovers.

Activity

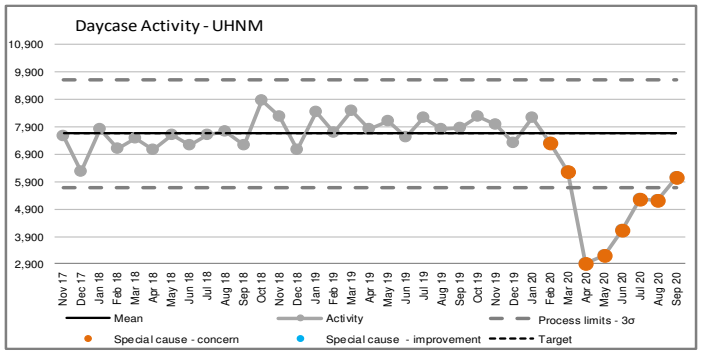
NHS University Hospitals of North Midlands NHS Trust

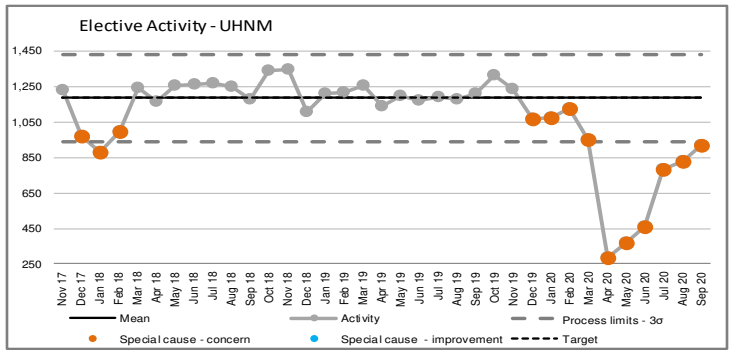
Planned care Outpatient



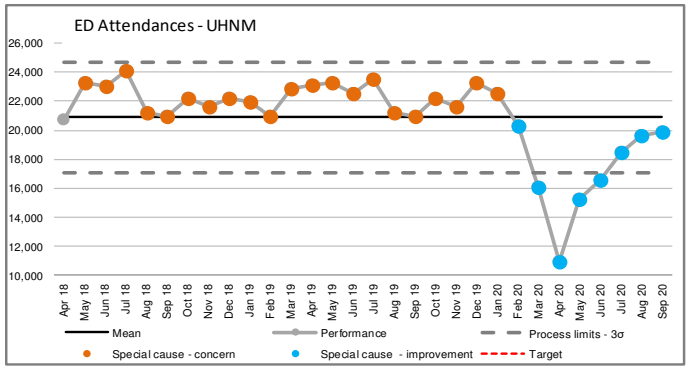


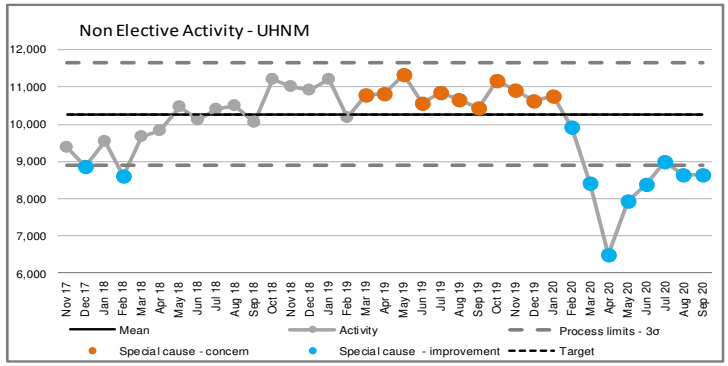
Planned care Inpatient





Urgent Care





Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Audit Committee Chair's Highlight Report to Board

22nd October 2020

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• A number of changes to the external audit deliverables were highlighted to the Committee which were a result of Covid 19 • Changes had been made to the Code of Audit Practice which impacted upon the value for money conclusion. Some of the changes aimed at improving public reporting and accountability, resulting in the external annual report being made a publicly available document.	• To escalate any issues in relation to the outstanding internal audit recommendation to the Chair, should it not be completed in line with the revised timescale. • To confirm whether existing practice in relation to investigation processes, was in line with current guidelines, given that the revised framework was not expected until April 2022. • To include a verbal update from the Chairs of PAF, QGC and TAP at a future meeting, to provide them with an opportunity to highlight any challenges associated with process, procedures and compliance for their Committee. • To review the implications associated with the changes to the Code of Audit Practice and consider any education required of Audit Committee members • To undertake a deep dive into the write offs associated with interventional radiology ensuring a process was in place to limit exposure to risk going forwards • To consider whether the Quality Account needed to be provided to Staffordshire County Council for comments
Positive Assurances to Provide	**Decisions Made**
• The Committee received 4 completed internal audit reviews, 3 of which received a rating of significant assurance with minor improvement opportunities; charitable funds governance, sickness absence and freedom to speak up. The remaining review on private patients received a rating of partial assurance with improvement required and actions had been identified to address the deficiencies in controls. • The Committee welcomed the continuing progress with the internal audit recommendation tracker and the improvements made in reporting. • In relation to the Corporate Governance Report it was noted that cross references were to be made in relation to private practice, linking to the recent internal audit review. The Committee welcomed the continued progress made. • In terms of the Board Assurance Framework (BAF), the Committee commented on the increasing maturity of approach within the organisation in terms of more debate in Committees on the risks outlined, and more challenge of the assurances and actions being taken. • The committee effectiveness reviews demonstrated that sound governance arrangements were in place and the Committee considered whether further specific updates were required from Committee chairs. It was agreed that the BAF was a good source of assurance and demonstrated the linkages between other committees and it was suggested to periodically include reports from committee chairs in terms of governance and any challenges.	• The Committee approved the deferral of Consultant Job Planning and Care Quality Commission (CQC) response internal audit reviews, and approved the addition of discharge letters and Infection Prevention and Control Board Assurance Framework. • The Committee approved that the charitable funds accounts would not be consolidated but this would be kept under review in terms of materiality • The Committee approved the Management of Patient Property Policy • The Committee received the draft Quality Account which had been delayed in publication due to changes in national requirements as a result of Covid, and noted that it would be considered by the Quality Governance Committee and Trust Board in due course

• An update was provided from the Local Counter Fraud Specialist in respect of the 2 open cases and the actions being taken to investigate these further • Deep dives had been undertaken in relation to a number of SFI breaches resulting in a number of lessons learned and the Committee welcomed the approach being taken to strengthen the process going forwards	

Comments on the Effectiveness of the Meeting

- Members agreed that the meeting was effective and that items were discussed sufficiently

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Internal Audit Progress Report	Assurance	7.	External Audit Progress Report	Assurance
2.	Quality Account	Assurance	8.	Local Counter Fraud Progress Report	Assurance
3.	Internal Audit Recommendation Tracker	Assurance	9.	Non-consolidation of UHNM Charitable Fund Accounts	Approval
4.	Corporate Governance Report	Assurance	10.	Losses and Special Payments Q2	Assurance
5.	Board Assurance Framework Q2	Approval	11.	SFI Breaches and Single Tender Waivers Q2	Assurance
6.	Committee Effectiveness Reviews: • Transformation & People Committee • Quality Governance Committee • Performance & Finance Committee	Assurance	12.	F16 Management of Patient Property Policy	Approval

3. 2019 / 20 Attendance Matrix

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

Members:			Apr	June	Jul	Oct	Jan
Prof G Crowe	GC	Non-Executive Director (Chair)					
Mr P Akid	PA	Non-Executive Director					
Ms S Belfield	SB	Non-Executive Director					
Attendees:			**Apr**	**June**	**Jul**	**Oct**	**Jan**
Mr A Bostock	AB	Internal Audit					
Ms A Khela	AK	Internal Audit	RC				
Ms N Combes	EM/NC	External Audit					
Mrs N Hassall	NH	Deputy Associate Director of Corporate Governance					
Mr M Oldham	MO	Chief Finance Officer					
Mr R Percival	RP	External Audit					
Mrs S Preston	SP	Strategic Director of Finance					
Miss C Rylands	CR	Associate Director of Corporate Governance					
Mr S Stanyer	SS	LCFS					

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	4th November 2020
Report Title:	Board Assurance Framework (Q2 20/21)	**Agenda Item:**	14.
Author:	Claire Rylands, Associate Director of Corporate Governance		
Executive Lead:	Chief Operating Officer, Chief Nurse, Medical Director, Director of Estates, Facilities & PFI, Director of IM&T, Director of Human Resources		

Purpose of Report:

Assurance		Approval	✓	Information	

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

Executive Summary:

Situation

The Board Assurance Framework (BAF) provides a structure and process that enables a focus for the Board on the key risks which might compromise the achievement of the organisation's Strategic Objectives.

Background

The Strategic Risks contained within the 2020/21 BAF were identified by the Executive Team in January 2020 and agreed by the Board at a development session in February 2020. This saw a reduction in the number of Strategic Risks when compared to the BAF for 2019/20 in order to ensure that the focus was strategic as opposed to operational.

Assessment

Of the 9 risks set out within the Board Assurance Framework, the following changes should be noted for Quarter 2 when compared to the previous quarter:

2 risks have seen an increase in the level of risk:

- BAF 6 Restoration and Recovery (Ext 16 to Ext 25)
- BAF 9 Financial Sustainability (High 9 to High 12)

1 risk has seen a reduction in the level of risk:

- BAF 4 System Working – Vertical (High 12 to High 9)

6 risks have remained at the same level of risk:

- BAF 1 Harm Free Care (High 9)
- BAF 2 Leadership, Culture and Values (High 12)
- BAF 3 Sustainable Workforce (High 12)
- BAF 5 System Working – Horizontal (High 12)
- BAF 7 IM&T Infrastructure (Ext 16)
- BAF 8 Estates Infrastructure (Ext 16)

Strategic Risk Heat Map
The most **significant strategic risk** identified within the BAF is in relation to 'Restoration and Recovery'; not only does this risk have the highest score, it threatens the achievement of all 5 Strategic Objectives.

The Heat Map also demonstrates that 8 / 9 risks identified within the BAF could threaten the achievement of Strategic Objective 1: Provide safe, caring, effective and responsive services.

Each of the strategic risks have been considered by respective Committees, and specifically:

- Performance and Finance Committee (PAF) challenged whether the risk scores associated with BAF 1 and BAF 2 were reflective of the current position and performance.
- BAF 1 was considered further by the Quality Governance Committee, and it was agreed that the risk score was reflective of the current situation, and that this was supported by the assurances documented within the standalone Infection Prevention and Control BAF
- BAF 2 was considered by the Transformation and People Committee and it was agreed not to increase the risk score, but to keep a watching brief in terms of the widespread effect of clinical leadership.
- BAF 3 was considered by the Transformation and People Committee and it was agreed that this would need to continue to be subject to regular review, in light of Covid and the second surge
- BAF 5 was considered by the Transformation and People Committee and the target date for achieving the target risk level was challenged given that the risk score had remained the same and related to the impact of Covid. This has therefore been extended, to reflect the possible impact from the second surge

Committees also received assurance from their respective Executive Groups, in terms of the continued oversight of risks scoring 12 or above and received an extract of the risk register for those risks linked to the strategic risks on the BAF.

Key Recommendations:

The Trust Board is asked to **approve** the Board Assurance Framework as at Quarter 2 and to note that the document has been considered by Committees of the Board with positive feedback received.

NHS
University Hospitals of North Midlands
NHS Trust

Board Assurance Framework (BAF)

Quarter 2 2020/21

1. Introduction

Situation

The Board Assurance Framework (BAF) provides a structure and process that enables a focus for the Board on the key risks which might compromise the achievement of the organisation's Strategic Objectives. The BAF maps out the key controls which are in place to support delivery of those objectives and to mitigate risk and provide a framework of assurance which the Board can draw upon when considering the effectiveness of those controls. These controls and assurances have been set out in line with the '3 lines of defence' model (appendix 1), aiding the identification of areas of weakness.

Background

The Strategic Risks contained within the 2020/21 BAF were identified by the Executive Team in January 2020 and agreed by the Board at a development session in February 2020. This saw a reduction in the number of Strategic Risks when compared to the BAF for 2019/20 in order to ensure that the focus was strategic as opposed to operational. However, shortly after that point, the organisation became faced with unprecedented challenges brought to us by the global pandemic, Covid-19. Whilst further work on the BAF was paused, in line with the interim governance arrangements approved by the Board, the Executive Team took the opportunity to reflect upon the appropriateness of the initial Strategic Risks agreed and concluded that whilst they remain relevant and appropriate, the impact of Covid-19 will alter some of the controls, assurances and actions to be taken and this has therefore been reflected throughout the BAF. In addition, a specific risk has been included which focuses on Restoration and Recovery.

Assessment

It should be noted that significant work has been undertaken to improve the format and function of BAF over recent years and this has resulted in two consecutive annual reviews undertaken by our Internal Auditors concluding with a rating of 'Significant Assurance with Minor Improvement Opportunities'. These findings have contributed to the positive and improved overall Head of Internal Audit Opinion for 2019/20 of 'Significant Assurance with Minor Improvement Opportunities'. A programme of risk management improvement remains an ongoing focus for the organisation and this will continue throughout the course of 2020/21.

In contrast to the findings from our Internal Audits which found that 'risks are clearly signposted to strategic and business objectives so that the BAF links through to the aims of the Trust'; feedback from the Care Quality Commission following their 2019 inspection highlighted that the BAF 'was not aligned to the strategic objectives and lacked clarity'. This has been taken into consideration within the development of the revised BAF for 2020/21 and has resulted in a change to the way in which risks are mapped to our Strategic Objectives. In the 2019/20 BAF, risks were broken down under the headings of each of our five Strategic Objectives whereas within this 2020/21 BAF, risks are mapped to multiple Strategic Objectives, relevant to their impact. This has been done through the inclusion of a simple mapping key within each section of the BAF as shown below:

The 'Strategic Risk Heat Map' at section 4 of this document is drawn from the content of the BAF and aims to illustrate at a high level the degree of risk exposure associated with the Strategic Objectives.

2. Committee / Board Consideration of Risk

The Quarter 2 BAF for 2020/21 has been considered by Committees as follows:

- Performance and Finance Committee on 20th October 2020
- Quality Governance Committee on 21st October 2020
- Transformation and People Committee on 22nd October 2020
- Audit Committee on 22nd October 2020

Committees were asked to consider the following questions, based on the evidence provided on the BAF for each objective:

- Are the levels of risk assigned to each risk appropriate, in particular when compared to other risks within the BAF?
- To what extent are the key controls (i.e. existing controls) effective?
- What are the gaps in the controls, how significant are they in relation to the current risk score?
- What internal assurances and independent external assurances are in place? Are they sufficient / adequate and are there any gaps? Are additional assurances required?
- Are there any areas where assurance is duplicated, repeated or excessive when compared to the activity undertaken?
- What actions are there in place to further mitigate the risk to the agreed tolerated level? Are they current and active? Are they adequate? Does more need to be done?
- Has the impact of Covid-19 been sufficiently drawn into the strategic risks identified?

3. Index and Summary Board Assurance Framework as at Quarter 2 2020/21

Ref / Page	Summary Risk Title	Strategic Objectives Under Threat	3 Lines of Defence					Change in Risk Score				
			1st Line of Defence		2nd Line of Defence		3rd Line of Defence	Q1	Q2	Q3	Q4	Change
			Controls	Assurances	Controls	Assurances						
BAF 1 Page 6	Harm Free Care		✓	✓	✓	✓	✓	High 9	High 9			→
BAF 2 Page 9	Leadership / Culture and Delivery of Trust Values and Aspirations		✓	✓	✓	✓	✓	High 12	High 12			→
BAF 3 Page 12	Sustainable Workforce		✓	✓	✓	✓	✓	High 12	High 12			→
BAF 4 Page 15	System Working – Vertical		✓	✓	✓	✓	✓	High 12	High 9			↓
BAF 5 Page 17	System Working – Horizontal		✓	✓	✓	✓	✗	High 12	High 12			→
BAF 6 Page 19	Restoration and Recovery		✓	✓	✓	✓	✓	Ext 20	Ext 25			↑
BAF 7 Page 21	Infrastructure to Deliver Compliant Services – IM&T		✓	✓	✓	✓	✓	Ext 16	Ext 16			→
BAF 8 Page 23	Infrastructure to Deliver Compliant Services - Estate		✓	✓	✓	✓	✓	Ext 16	Ext 16			→
BAF 9 Page 26	Financial Sustainability		✓	✓	✓	✓	✓	High 9	High 12			↑

SO1: Safe, caring, effective, responsive

SO2: Achieve constitutional patient access targets

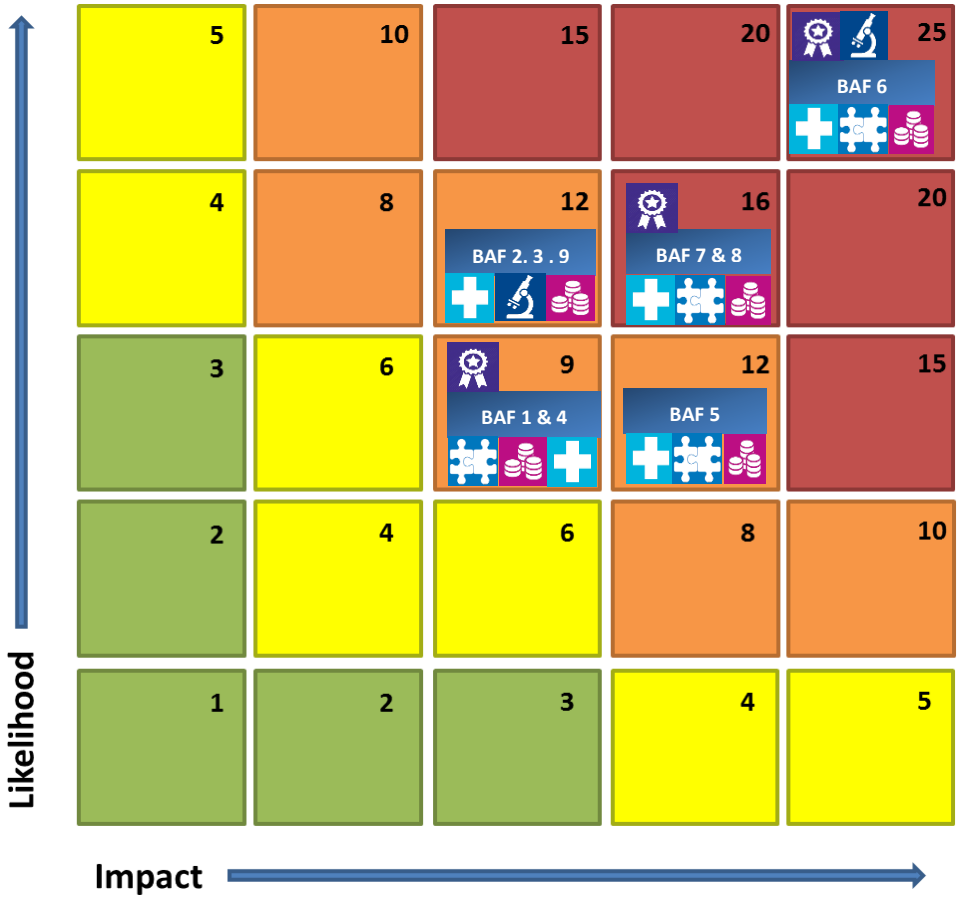
SO3: Excellent employment, education, teaching, research

SO4: Lead strategic change in Staffordshire and beyond

SO5: Ensure efficient use of resources

BAF Action Plans – Key to Progress Ratings		
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.

4. Strategic Risk Heat Map



Review of Impact on our Strategic Objectives

The maps shown above aim to illustrate where the risks set out within the BAF impact upon the achievement of our Strategic Objectives. As shown within the summary on page 4, the most significant strategic risk is associated with Restoration and Recovery (BAF 6). Not only does this risk have the highest score, it impacts upon all five of our Strategic Objectives.

The maps also show that 8 / 9 risks on the BAF have the potential to threaten the achievement of Strategic Objective 1 – Safe, caring, effective and responsive services.

5. Board Assurance Framework 2020/21

Risk Summary					
BAF Reference and Summary Title:	**BAF 1: Harm Free Care**			**SO's Impacted Upon**	
				✓	✓
Risk Description:	**If the Trust does not deliver harm free care, then the trajectory reduction in Pressure Ulcers, Patient Falls, Venous Thromboembolism (VTE) and infection rates (including Covid-19) may not be achieved, resulting in increased patient harm, increased mortality and poor patient experience.**				
Lead Director:	Chief Nurse and Medical Director	**Supported By:**			
Lead Committee:	Quality Governance Committee	**Executive Group:**	Quality and Safety Oversight Group		
Links to Risk Register:	**Title**	**Current Risk Score**			
	ID 8877 Risk of Avoidable Hospital Acquired Infections	**High 12**			

Risk Scoring								
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	3	3			**Whilst the Quality indicators are in general showing improvement there continues to be the need to embed the improvements and assurance that the improvements are consistent and practice embedded throughout the Trust.**	**Likelihood:**	2	**31 March 2021**
Consequence:	3	3				**Consequence:**	2	
Risk Level:	**High 9**	**High 9**				**Risk Level:**	**Mod 4**	

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	**2nd Line of Defence**	**3rd Line of Defence**
Controls:	• Senior leadership team in place for each ward and department, with overarching accountability for delivering quality and minimising hospital acquired harm • Falls Champion role in each Ward/Department. • Tissue Viability Link Nurses in each Ward/Department • Corporate Quality & Safety Team co-ordinate Improvement Programmes for Pressure Ulcers, Falls and VTE • Infection Prevention Team co-ordinate Improvement Programmes for infections, including • Specific governance arrangements in place for Maternity Services, including compliance with CNST	• Validation of pressure ulcers undertaken by Corporate Tissue Viability Team • Validation of infections undertaken by Infection Prevention/Microbiology Teams • Datix and Root Cause Analysis (RCA) training available to ensure accurate reporting and investigation of patient harm • Root Cause Analysis (RCA) Scrutiny Panels in place for Pressure Ulcers, Patient Falls, Venous Thromboembolism (VTE) and Infections • Agreed reduction trajectories in place for each patient harm • Collaborative working in place with CCG representatives regarding harm reduction • Care Excellence Framework in place • Covid-19 deaths have been included in the Trust's SJR process	• Annual External Audit of Quality Account • CQC Inspection Programme • Process in place with Commissioners to undertake Clinical Quality Review Meetings (CQRM) • NHSEI scrutiny of Covid-19 cases/Nosocomial infections/Trust implementation of Social distancing, Patient/Staff screening and PPE Guidance • Trust have nominated 6 new Patient Safety Specialists to work with NHSI as part of national NHS Patient Safety Strategy. Induction / Training to commence in October 2020 • Full compliance for years 1 & 2 against CNST 10 Standards

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
	requirements. • Sepsis and Nosocomial Covid-19 infections. • Training Programmes in place for all key harms. • Patient experience team in place • Crude Mortality rates - monitoring and notification from Medical Examiner • Monthly Directorate Mortality and Morbidity meetings (M&M) are held to review deaths and discuss cases. • Clinical, Tactical and Gold Governance Processes well established to respond to changes in Regional and National Guidance in relation to Covid-19, with particular focus on social distancing, patient/staff screening, zoning of Ward/Department areas, visiting guidance and PPE Guidance	to allow for review of care provided to patients and identify any potential areas for improvement/learning • Nosocomial Covid-19 Infections will be subject to RCA and reported to the Infection Prevention Committee • A strengthened clinical governance framework including revised Terms of Reference for the Quality and Safety Oversight Group (QSOG) and Quality Governance Committee (QGC) have been introduced, with effect from April 2020 •	
Assurance:	• Quality dashboard available on Intranet • Quality dashboard and Patient Experience dashboard in place • Monthly Patient Safety Reports from Ward to Board • Training Records available at Ward and Corporate level • Care Excellence Framework Visit Reports shared with Ward and Divisional Teams • Mortality report to Mortality Review Group includes analysis of rates and outcomes from mortality reviews. • Monthly highlight reports from Trust Risk Management Panel to Patient Safety Group and QSOG • Presentation of annual M&M activity by Directorate Mortality leads at Mortality Review Group • Infection Prevention Board Assurance Framework – Covid-19	• Scrutiny of level of Patient Harm and Patient Experience within Executive-Led Divisional Performance Reviews on a monthly basis • Outcome of the Nursing Establishment review presented to the Trust Board in March 2020, action plan and associated business case to be developed. • Outcome letters as a result of RCA Panels sent to Senior Sisters/Charge Nurses, Matrons and Associate Chief Nurses • Audit programme to monitor compliance with relevant Trust policies • Quality Account developed and published according to NHSEI Guidance • Patient stories reported to the Trust Board on a monthly basis • Friends and family test results are reported and monitored on a regular basis • Internal Audit planned to review Trust's Incident Reporting and investigation processes. • Maternity Services Board Assurance Framework in place.	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 2 Progress Report**	**BRAG**
1.	Quality & Safety Improvement Strategy to be finalised	Chief Nurse and Medical Director	31/12/2020	New Quality Improvement Academy is being established and key posts currently being advertised (September 2020). Strategy to be developed as move forward with academy and appointment of posts – target date revised.	A

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 2 Progress Report**	**BRAG**
2.	Quality Account to be developed and published according to NHSEI Guidance	Chief Nurse and Medical Director	01/12/2020	Action not yet due. Stakeholder event held 4th September 2020 and priorities identified. Draft Account produced awaiting circulation to stakeholders for comments	GA
3.	Impact of Covid-19 Pandemic upon Trust Mortality Rates to be analysed and reported to Trust Mortality meeting	Medical Director	30/10/2020	COVID mortality rates have reduced and at similar levels as overall crude rate in August 2020 at 4.5%. Monthly reporting provided at Mortality Review Group. Agreed 29/09/2020 to receive review paper at Mortality review Group (October 2020) to include crude mortality up to end of Q2 (September 2020)	GB

Risk Summary					
BAF Reference and Summary Title:	**BAF 2: Leadership / Culture and Delivery of Trust Values and Aspirations**			**SO's Impacted Upon**	
Risk Description:	**If we fail to develop a leadership and culture that delivers Trust values and aspirations, then staff may become disengaged, which will impact on the delivery of services to our patients.**				
Lead Director:	Director of Human Resources	**Supported By:**	Chief Nurse, Medical Director and Chief Operating Officer		
Lead Committee:	Transformation and People Committee	**Executive Group:**	Executive Workforce Assurance Group		
Links to Risk Register:	***Title***	***Current Risk Score***	**Title**	**Current Risk Score**	
	ID 15525 Cultural issues within the department	**High 12**	ID 9151 Mismatch between Trust Culture and Values	**High 9**	
	ID 9149 If staff don't feel supported, listened to and valued	**Mod 6**			

Risk Scoring							
Quarter	**M1 of Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**	**Target Date**
Likelihood:	**3**	**3**			• Covid-19 pandemic meant that a significant portion of July to September 2020 development & talent activities to support active and recovery phases were postponed. • The impact of socially distanced training and suitably sized training space continues to impact People and OD capacity to deliver both leadership development training • There has been a significant uplift in Divisions requesting OD support. Plans have been created for each Division with limited capacity for direct OD consultant support • The 2020 Annual Staff Survey has recently been issued to those staff eligible to take part	**Likelihood:** **3**	**31 March 2021**
Consequence:	**4**	**4**				**Consequence:** **3**	
Risk Level:	**High 12**	**High 12**				**Risk Level:** **Mod 6**	

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	**2nd Line of Defence**	**3rd Line of Defence**
Controls:	• Annual NHS Staff Survey and periodic pulse checks • Actions to improve staff experience are detailed in the Corporate and Divisional Staff Engagement Plans • Programme launched to support the development of the STP High Potential Scheme participants	• People Strategy and supporting HR Delivery Plan, with performance reported to the TEC on a quarterly basis and annually to the Trust Board The HR Delivery Plan has been updated to take account of the actions required to address Restoration and Recovery, post covid-19 • Partnership working with the STP to introduce a range of Recruitment and Retention initiatives • The Trust has set targets for staff engagement rates, sickness and turnover and actual rates are monitored on a monthly basis against these targets.	• Periodic pulse checks – the Staff Friends and Family Test has been suspended during the covid-19 pandemic
Assurance:	• Annual NHS Staff Survey – At 6.9, the 2019 staff engagement score remained just below the acute	• Monthly reports to Transformation and People Committee cover hard to recruit posts and long term agency	

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
	trust average of 7.0. The Trust has not yet been notified of the details of the 2020 NHS Staff Survey, although indications are that an abbreviated survey will be carried out. • HRBP's report actual performance to Divisional Boards and Divisions are held to account via Performance Reviews • The diagnostic phase of the NHSi Culture and Leadership Programme commenced in 2019/20 and will provide an additional indicator of staff engagement. However, this was suspended due to covid-19 and now needs to be reinstated as part of the recovery and restoration programme • Feedback from staff via listening events, facebook live comments and senior leadership team walkabouts	• The Executive Workforce Assurance Group is in place • Agency costs are reported in the monthly Finance Report to Performance and Finance Committee The Trust monitors how effectively we address any gaps in the treatment and experience of our Black, Asian and Minority Ethnic (BAME) workforce through the Workforce Race Equality Standard (WRES), and our Disabled workforce through the Workforce Disability Equality Standard (WDES). We have three active Staff Networks, the Black, Asian and Minority Ethnic (BAME) Staff Network, the LGBT+ Staff Network and the Disability Staff Network. Our Staff Networks each have an Executive Sponsor. Our Gender Pay Gap report shows the difference in the average earnings between all men and women employed at UHNM and the actions we are taking to further reduce the gender pay gap. We also participate in the Stonewall Workplace Equality Index as measure of our commitment to LGBTQ+ equality. Analysis of data and historic trends, reported in monthly performance reports to TAP and Trust Board show: • In August, the in-month sickness rate was 4.41% (4,51% at 31/07/20). The 12 month cumulative rate reduced from 5.15% to 5.12% • For the 12 months ending 31/08/20, the turnover rate was 9.65% and the stability rate was 91.64% • The vacancy level at 31/08/20 was 7.84% Leadership Development in Q2 included: • Silver – 77 Completed to date & 83 currently enrolled. • Gold – 30 Completed & 17 currently on Cohort 3 • Platinum – 15 Completed & 22 delegates still currently on Cohort 2 • Coaching – ongoing Career & Developmental Coaching • Reverse mentoring - online training for 26 Reverse Mentors.	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 2 Progress Report**	**BRAG**
1.	Undertake a Trust-wide cultural analysis	Director of Human Resources	30/06/2021	The programme has been suspended during the Covid-19 pandemic	GA
2.	Implement a UHNM plan relating to the launch of the "Leadership Compact" document within the NHS People Plan	Director of Human Resources	31/12/2020	Development of the Leadership Compact will commence on completion of the Culture analysis, which has been suspended during the Covid-19 pandemic	GA
3.	Leadership and Management Development offer: Internal and External offer focus on managers across the Trust to ensure a competency level is embedded	Director of Human Resources	31/03/2021	All managers completed internal offer. Next steps are to potential platforms for these and other leadership programmes to be delivered in a "blended" manner or completely virtually so that all new managers into the Trust can complete GTM/GTL within 3 months of commencing.	GA
5.	Enhancing staff experience Trust-wide through a comprehensive staff engagement plan	Director of Human Resources	Ongoing	• Listen & Learn Events – 16 events have been held across the Trust. A thematic analysis is being collated • Wellbeing Communications continue with Divisional briefings &Trust communications signposting to National, regional and local psychological support opportunities increased. • Wellbeing calendar is published on the intranet including system training, staff development & support available. • Project Wingman has been launched at Royal Stoke reaching 150 Attendees. • Staff Awards have been held at Royal Stoke introducing our finalists. Winners will be announced on Friday 23rd October. • The 2020 Annual NHs Staff Survey has recently been issued to those staff eligible to take part	GA

Risk Summary					
BAF Reference and Summary Title:	**BAF 3: Sustainable Workforce**			**SO's Impacted Upon**	✓ ✓ ✓
Risk Description:	**If our workforce becomes unsustainable, then premium pay costs will be incurred, staff sickness may increase and staff may become disengaged, all of which will impact on the delivery of services to our patients.**				
Lead Director:	Director of Human Resources	**Supported By:**	Chief Nurse, Medical Director and Chief Operating Officer		
Lead Committee:	Transformation and People Committee	**Executive Group:**	Executive Workforce Assurance Group		
Links to Risk Register:	**Title**	**Current Risk Score**	**Title**	**Current Risk Score**	
	ID 9739 Nurse Staffing in ED	**Ext 16**	ID 16633 Medical Division Workforce Plans	**Ext 15**	
	ID 10259 Clinical Vacancies in General Surgery & Urology	**High 12**	ID 8580 Medical Staffing in ED	**High 12**	
	ID 9458 NICU Consultant Rota	**High 12**	ID 12423 Nurse Vacancies in Medical Division	**High 12**	

Risk Scoring								
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	**3**	**3**			The Phase 3 Workforce plan which incorporates staffing required for the Winter Plan highlights a significant staffing need to March 2020 as do System Partner plans. The Trust is working with System Partners on recruitment and retention plans so that a system-wide approach can be taken to resourcing the Phase 3 plans	**Likelihood:**	**3**	**31 March 2021**
Consequence:	**4**	**4**				**Consequence:**	**3**	
Risk Level:	**High 12**	**High 12**				**Risk Level:**	**High 9**	

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	**2nd Line of Defence**	**3rd Line of Defence**
Controls:	• Workforce planning process ensures alignment with activity and financial plans • Actions to improve staff experience are detailed in Divisional Staff Engagement Plans • Ongoing recruitment processes underway • Rotas and rota coordinators management of roster processes • Directorate and divisional management teams to monitor staffing levels • Chief Nurse staffing reviews	• People Strategy and supporting HR Delivery Plan, with performance reported to the Transformation and People Committee (TAP) and annually to the Trust Board • A consistent and cost effective approach to deploying medical workforce across the Trust and support improvements in medical productivity is in place (Medic On Duty, Medic Online, Activity Manager) • Partnership working with the STP to introduce a range of Recruitment and Retention initiatives • We work closely with our education partners and continue to implement our Apprenticeship Strategy and Widening Participation initiatives in recognition of the need for clear educational pathways from schools and colleges into the NHS for clinical support, healthcare scientists, administration and	• Annual NHS Staff Survey – At 6.9, the 2019 staff engagement score remained just below the acute trust average of 7.0. The Trust has not yet been notified of the details of the 2020 NHS Staff Survey, although indications are that an abbreviated survey will be carried out. • Periodic pulse checks – the Staff Friends and Family Test has been suspended during the covid-19 pandemic. • NHSIE Business Continuity Staffing reporting

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
		nursing assistant roles. • We have well-established Banks for Medical Staffing, Nursing, Nursing support and Admin and Clerical staff • Trust Nursing Recruitment Plan	
Assurance:	• HRBPs report actual performance to Divisional Boards and Divisions are held to account via Performance Reviews • Chief Nurse regular reports on Staffing Levels and use of the safe staffing tools	• Monthly reports to Transformation and People Committee cover hard to recruit posts and long term agency • Agency costs are reported in the monthly Finance Report to Performance and Finance Committee • We have implemented a ***Just & Learning Culture*** approach promoting a culture of fairness openness and learning where staff feel confident to speak up supporting staff when things go wrong so errors can be prevented from being repeated • The wellbeing governance structure is led by an Executive Director who oversees delivery of a consistent approach to managing the key processes associated with health, absence and engagement. Analysis of data and historic trends, reported in monthly performance reports to TAP and Trust Board show: • In August, the in-month sickness rate was 4.41% (4,51% at 31/07/20). The 12 month cumulative rate reduced from 5.15% to 5.12% • For the 12 months ending 31/08/20, the turnover rate was 9.65% and the stability rate was 91.64% • The vacancy level at 31/08/20 was 7.84%	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 2 Progress Report**	**BRAG**
1.	Proactive medical recruitment plans aligned to business planning process/ supply and demand. Consideration to redesigning of roles and recruitment initiatives	Director of Human Resources	31/03/2022	Development of Trainee Fellowship programme launch date agreed with advertising to commence April 2020 for start dates August 2020. Medical Division have procured BMJ Careers to support the attraction of national and international candidates to the Trust commencement to be confirmed likely April 2020.	GA
2.	Partnership working with the STP for Recruitment and Retention initiatives	Director of Human Resources	31/03/2021	Recruitment and attraction documentation has been updated We are working with System Partners on a joint approach with plans including: • Development of standard process for Retire and Return, Itchy feet and staff transfer • Corporate Campaigns, a wider Public Campaign and campaigns targeted towards B5 Nurses. There will also be consideration of International Recruitment.	GA

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 2 Progress Report**	**BRAG**
				• As a system, there is development of branding and marketing to build a reservist bank across Staffordshire, plus 3 pilots	
4.	Improve organisation and management interest in and action on health and wellbeing	Director of Human Resources	**Complete.**	Trust wellbeing plan has been approved and Divisional wellbeing leads appointed. Going forward: • Wellbeing Communications continue with Divisional briefings &Trust communications signposting to National, regional and local psychological support opportunities increased. • Wellbeing calendar is published on the intranet including system training, staff development & support available. • Project Wingman has been launched at Royal Stoke reaching 150 Attendees. • Staff Awards have been held at Royal Stoke introducing our finalists. Winners will be announced on Friday 23rd October. • The 2020 Annual NHs Staff Survey has recently been issued to those staff eligible to take part • We continue to work with Combined Healthcare and system partners on offerings supporting psychological support and mental health.	**B**
5.	Nursing recruitment plans to be put this in place to address shortfalls following Chief Nurse establishment review	Director of Human Resources	31/03/2021	An open day was planned for May, but postponed due to covid-19. Plans are being developed on how to manage this going forward. Working with System Partners, plans include recruitment campaigns targeted towards B5 Nurses. There will also be consideration of International Recruitment.	**GA**

Risk Summary					
BAF Reference and Summary Title:	**BAF 4: System Working - Vertical**			**SO's Impacted Upon**	✓ ✓ ✓
Risk Description:	**If the Staffordshire and Stoke on Trent system do not collaborate and vertically integrate appropriate services then we will not be able to deliver high quality, safe, sustainable and VFM services for our population resulting in fragmented, poor quality, inefficient and ineffective services**				
Lead Director:	Chief Executive	**Supported By:**	Director of Strategy and Transformation		
Lead Committee:	Transformation and People Committee	**Executive Group:**	Strategy & Transformation Group		
Links to Risk Register:	**Title**	**Current Risk Score**			
	n/a	n/a			

Risk Scoring								
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	**3**	**3**			Risk is reduced due to proven excellent system working as a result of Covid -19 and significantly improved relationships. Risk remains above target due to imminent and significant changes to the STP leadership and continued focus of Covid-19, R&R and planning for winter.	**Likelihood:**	**2**	**31 March 2021**
Consequence:	**4**	**3**				**Consequence:**	**3**	
Risk Level:	**High 12**	**High 9**				**Risk Level:**	**Mod 6**	

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	**2nd Line of Defence**	**3rd Line of Defence**
Controls:	• STP Partnership Board in place, Shadow ICS Board in development • System Wide Executive Forum • STP Independent Chair and STP Director in place • Recruitment for Independent Chair underway, decision awaiting approval by Simon Stevels • Three ICP's in place	• Transformation and Delivery Unit • STP Workstreams • Current system LTP in place • Organisational operational plan in place	• NHS E / I approval of system becoming an ICS
Assurance:	• UHNM Chair, Chief Executive and Director of Strategy are members of relevant system groups / meetings • Regular meetings now take place between UHNM CEO and Northern PCN Clinical Leadss • System working regular UHNM Board agenda	• Regular reports from the TDU to the Executive Forum, with escalations to the Shadow ICS Board as appropriate.	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)

No.	Action Required	Executive Lead	Due Date	Quarter 2 Progress Report	BRAG
1.	Appoint ICS Independent Chair	NSC Director of Human Resources	31/09/2020	Recruitment concluded, decision awaiting authorisation by Simon Stevens.	GA
2.	Appoint ICS Executive Lead	NSC Director of Human Resources	31/12/2020	To be completed once a Chair has been appointed.	GA
3.	System becomes full ICS	STP Director / Chief Executive	01/04/2021	Went into Shadow ICS form from 1st April. Following this, one meeting took place before Covid-19 impacted. Therefore progress was paused. As of May Shadow ICS Partnership Board meetings recommenced to review single agenda items such as Covid-19 and Restoration and Recovery.	GA
4.	Develop a revised Integrated Strategy for Health and Social Care	STP Director / Chief Executive	01/04/2021	Meetings have taken place with a range of system partners to begin the R&R work through to March 2021. Directors of Strategy are developing a framework for ICP to undertake robust recovery and restoration.	GA
5.	Development of the three ICPs.	STP Director / Chief Executive	31/03/2021	Ongoing	GA
6.	Review Long Term Plan workstreams in the light of Covid / Recovery and Restoration.	STP Director / Chief Executive	31/12/2020	Not yet started.	GA

Risk Summary					
BAF Reference and Summary Title:	**BAF 5: System Working - Horizontal**			**SO's Impacted Upon**	
				✓	✓ ✓
Risk Description:	**If UHNM does not collaborate horizontally with other acute providers (both within & outwith the STP) then some specialist services will potentially not be sustainable and opportunity to achieve economies of scale within clinical support functions will be lost resulting in unsustainable, fragmented, poor quality, inefficient and ineffective services that are not VFM.**				
Lead Director:	Chief Executive	**Supported By:**	Director of Strategy and Transformation		
Lead Committee:	Transformation and People Committee	**Executive Group:**	Strategy & Transformation Group		
Links to Risk Register:	**Title**	**Current Risk Score**	**Title**	**Current Risk Score**	
	n/a	n/a			

Risk Scoring								
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	**3**	**3**			The risk level remains at 12 due to the lack of progress as a result of: • Capacity from all partners due to meeting demands in relation to Covid-19, Restoration and Recovery and planning for Covid-19 resurgence and winter • Inability to engage due to regulatory / inspectorate pressures on some partners • Target date moved to March 2021 given impact of Covid	**Likelihood:**	**2**	**31 Mar 2021**
Consequence:	**4**	**4**				**Consequence:**	**3**	
Risk Level:	**High 12**	**High 12**				**Risk Level:**	**Mod 6**	

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	**2nd Line of Defence**	**3rd Line of Defence**
Controls:	• Designated Lead for UHNM - Director of Strategy • Exec : Exec meetings - need to be formalised with SaTH and re-launched with MCHFT • DoS represents Trust on Spec Com discussions in respect of network development for Midlands	• Newly formed Transformation & People Committee • Strategy and Transformation Group to be established to oversee Strategic Partnerships • Informal Exec to Exec discussions to be re-established post COVID	• None available at present.
Assurance:	• Re-launch / development of governance and programmes of work will be reported through TAP with escalations to Trust Board • Trust clinical strategy development will be inclusive of strategic developments with other partners	• System working updates to the Board each month through the Chief Executive demonstrate that progress is in early stages of development.	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 2 Progress Report**	**BRAG**
1.	Exec: Exec discussion with MCHFT to establish joint status of the Stronger Together Programme.	Director of Strategy	17/11/2020	Discussions need to take place first to test the appetite before proceeding with this.	GB
2.	Develop formal governance for a collaborative programme with SaTH	Director of Strategy	Post Covid	Work has commenced through an initial meeting although was paused due to Covid. Being reinstated through Restoration and Recovery Programme.	GB
3.	Utilise the Recovery & Restoration programme to develop improved relationships with Specialist Commissioners.	Chief Executive / Director of Strategy	30/06/2020	Chief Executive is now part of the NHS Midlands Clinical Strategy Group which is largely related to specialist services and has agreed to be part of a Task and Finish Group in respect of specialist cancer services. Therefore ensuring UHNM is contributing to and influencing developments.	B
4.	Refresh / development and agreement of UHNM Trust wide Strategy.	Director of Strategy	31/12/2020	Clinical service revie4ws have commenced; new timeframe being developed by Helen Ashley. Progress may be impacted by Covid resurgence.	GA
5.	Strategies for each Trust to be reviewed to ensure that strategic developments between UHNM / MCHFT and UHNM / SATH are taken into account.	Director of Strategy	31/03/2021	To be undertaken when a UHNM strategy is agreed.	GA
6.	Ensure that Restoration and Recovery is taken into account in development of UHNM Strategy.	Director of Strategy	31/03/2021	To be done as part of the reinstated strategy development work.	GA
7.	Review and interpretation of national operational planning guidance for 21/22.	Director of Strategy	31/03/2021	National guidance awaited.	GA
8.	Review of current network arrangements for Specialised Services to be completed by Specialised Commissioners.	Chief Executive / Director of Strategy	31/12/2020	Network arrangements will follow the Microsoft Teams Meeting described above.	GA

Risk Summary					
BAF Reference and Summary Title:	**BAF 6: Restoration and Recovery**			**SO's Impacted Upon**	✓ ✓ ✓ ✓ ✓
Risk Description:	**If we are unable to develop and deliver restoration and recovery plans that are aligned to the changing national expectations and guidance, then we will be unable to restore all services in a timely manner resulting patient harm, longer waits, increased waiting lists impacting upon RTT, poor patient experience.**				
Lead Director:	Director of Strategy and Transformation	**Supported By:**	Chief Operating Officer		
Lead Committee:	Performance and Finance Committee	**Executive Group:**	Executive Restoration and Recovery Group		
Links to Risk Register:	**Title**	**Current Risk Score**	**Title**	**Current Risk Score**	
	ID 17542 R&R IM&T	**Ext 16**	ID 18014 R&R Planned Care	**High 12**	
	ID 17570 R&R Outpatients	**High 12**	ID 18746 Phase 3 Workforce Availability	**High 12**	
	ID 18052 R&R Diagnostics	**High 9**	ID 17536 R&R Urgent Care	**High 8**	
	ID 17693 R&R Transformation	**High 8**	ID 17693 R&R Transformation	**High 8**	
	ID 17549 R&R Workforce	**Mod 6**	ID 17551 R&R Performance & Information	**Mod 6**	
	ID TBC Elective Incentive Scheme	**TBC**			

Risk Scoring								
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	4	5			**Covid numbers are starting to increase as a second resurgence is anticipated, we are also heading into winter.**	**Likelihood:**	3	**31 March 2021**
Consequence:	5	5				**Consequence:**	4	
Risk Level:	**Ext 20**	**Ext 25**				**Risk Level:**	**High 12**	

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	**2nd Line of Defence**	**3rd Line of Defence**
Controls:	• Restoration and Recovery Operational Group established • Operational Lead for Restoration and Recovery agreed – Chief Operating Officer • Divisional Restoration and Recovery Plans in place • Systems and processes identified to aid monitoring of progress against individual workstreams	• Restoration and Recovery Executive Oversight Group established • Executive Lead for Restoration and Recovery agreed – Director of Strategy • Workstreams / Cells with nominated leads identified for Restoration and Recovery Programme • NHSEI Guidance on priorities for Restoration and Recovery – 'Trilogy' of correspondence issued • Confirm and Challenge process in place with each Clinical Division undertaken to review plans / risks / actions to be taken	• Positive verbal feedback received from NHSEI in response to the submission of our Restoration and Recovery Plan on 5th October.

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
		• Estates Strategy reviewed to take into account requirements for recovery of safe services, maintaining Social Distancing	
Assurance:	• Highlight Report from Operational Group covering concerns / key actions / positive assurance and decisions presented to each meeting of the Restoration and Recovery Executive Oversight Group, demonstrating the establishment of Restoration and Recovery Programme	• Workstreams and associated governance arrangements approved by Transformation and People Committee in May 2020 • Highlight Report from Executive Oversight Group presented to Trust Board covering concerns / key actions / positive assurances and decisions following the initial meetings held • Ongoing updates provided to the Board outlining the Restoration and Recovery Programme and actions taken • Trust IPR now includes R&R trajectories and performance against them.	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	Action Required	Executive Lead	Due Date	Quarter 2 Progress Report	BRAG
1.	To undertake a review of the waiting list.	Chief Operating Officer	31/10/20	Further work now being undertaken as part of a national directive in respect of clinical validation.	GA
2.	To strengthen governance in respect of the monitoring and use of Independent Sector, to avoid underutilisation and risk of a national decision to terminate contract.	Chief Operating Officer	31/10/20	Underway.	GA

Risk Summary					
BAF Reference and Summary Title:	**BAF 7: Infrastructure to Deliver Compliant Services – IM&T**			**SO's Impacted Upon**	✓ ✓ ✓
Risk Description:	**If the organisations infrastructure and clinical systems do not receive or are not adequately protected from either a targeted or indirect attack then this could compromise the operation and delivery of care within the hospital resulting in a loss of IT systems for potentially a prolonged period, and potential cancellation of some services, as well as reputational damage, increased backlog of patients and operations and potential fines of up to 4% Trust budget by NHS England.**				
Lead Director:	Director of IM&T	**Supported By:**	Medical Director and Chief Finance Officer		
Lead Committee:	Performance and Finance Committee	**Executive Group:**	Infrastructure Group & Data Security and Protection Group		
Links to Risk Register:	**Title**	**Current Risk Score**	**Title**	**Current Risk Score**	
	n/a	n/a			

Risk Scoring								
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	**4**	4			**Risk remains at the same level given the risks associated with Cyber Security.**	**Likelihood:**	**2**	**30 June 2021**
Consequence:	**4**	4				**Consequence:**	**4**	
Risk Level:	**Ext 16**	**Ext 16**				**Risk Level:**	**High 8**	

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	**2nd Line of Defence**	**3rd Line of Defence**
Controls:	• Investment already made in enhanced Cyber Tools and defence (Intercept-X) to protect against 'wannacry' type attacks. • Server and PC patching in place and enhanced network firewalls and other network perimeter controls. • Cyber Action plan in place • Dedicated Cyber defence lead role appointed to • Deployment of Microsoft Advanced threat detection to improve cyber defences • Infrastructure – the increasing move to cloud based services and infrastructure as a service revenue based models reduce the reliance on available	• Implementation of National Cyber Security Centre recommendations on passwords • Raised staff awareness and understanding of cyber security through education and communication • NHS Digital accredited awareness training provided to Board members • NHS Digital Cyber essentials best practice being progressed • IM&T Programme Board in place • Infrastructure – warranty extensions can provide cover for infrastructure if funding is not available for replacement	• Auditing from NHS Digital and other agencies undertaken during 2018 to demonstrate good practice and areas for improvement (which have been addressed). • External Penetration Testing has been undertaken and a remediation plan developed

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
	capital. • Moved to a service contract for PCs and Laptops		
Assurance:	• During Q1 there have been no significant threats to cyber security		

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	Action Required	Executive Lead	Due Date	Quarter 2 Progress Report	BRAG
1.	Deployment of Windows 10 with improved in built security and based on National Cyber Security Centre and Microsoft best practice	Director of IM&T	31/12/2020	This remains ongoing up to the end of December.	GA
2.	Implementation of DarkTrace - uses Artificial Intelligence / Machine Learning to detect and respond to subtle, stealth attacks inside the network — in real time. Does not require previous experience of a threat or pattern of activity in order to understand that it is potentially threatening.	Director of IM&T	31/01/2021	HSLI Funding secured; Software implemented across both Royal Stoke and County Hospital sites. The Software changed from alerting of potential threats to blocking potential threats, and the next phase is to enable the autonomous mode of monitoring due to be enabled in January.	GA
3.	Continue work towards Cyber Essentials (plus) and ISO27001 compliance	Director of IM&T	30/06/2021	NHS Digital sponsored engagement with PA Consulting in progress to provide a readiness assessment for Cyber Essentials Plus.	GA

Risk Summary				
BAF Reference and Summary Title:	**BAF 8: Infrastructure to Deliver Compliant Services – Estate**			**SO's Impacted Upon**  ✓ ✓
Risk Description:	**If we fail to invest sufficiently in our retained estate infrastructure/services and fail to undertake statutory maintenance/lifecycle within our PFI; then we will fail to deliver a healthcare environment that enables the delivery of high quality clinical services, provided within a safe, secure and compliant environment, consistent with the objectives of our Estate Strategy and our statutory obligations.**			
Lead Director:	Director of Estates Facilities & PFI & Director of IM&T	**Supported By:**	Medical Director & Chief Finance Director	
Lead Committee:	Performance and Finance Committee	**Executive Group:**	Infrastructure Group	
Links to Risk Register:	**Title**	**Current Risk Score**	**Title**	**Current Risk Score**
	ID 8777: Retention of Royal Infirmary	**Ext 20**	ID 11152: Annual Statutory and Lifecycle Maintenance	**High 12**
	ID12720: Absence of side rooms in modular wards	**High 12**		

Risk Scoring								
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	4	4			• Infirmary Site (Project STAR) - Phase 1 Complete (fencing; design works; HV supply). Phase 2 Underway (asbestos removal & demolition). Phased handover to principle contractor IHP of Phases 1, 2, 3. Risks reduce further as more buildings handed over. • Estate Condition – Key risks are funding constraints & physical access. 2020 PFI Statutory Maintenance/Testing/Lifecycle Programme stood down (other than areas completed pre-March, activities don't require decant & Theatres). Decision made following review and balancing of risks of compliance against statutory regulations/PFI contractual requirements, against the delivery of R&R/Winter & 2nd Surge Plans. Focus now on producing and agreeing the PFI 2021 Programme which will require decant to allow for 5 year fixed wire testing. • COVID-19 impact – Capital schemes progressing to mitigate impact of Covid i.e. Paeds/Specialist Decision Unit; Pathology; Endoscopy; Trent and potentially Critical Care. Zoning Plans & Social Distancing Signage implemented. Risk Assessments completed and informed changes to the estate. • Estate configuration/utilisation/optimisation/adjacencies – Trent scheme stalled due to decant challenges of Market Testing Business Case and financial discrepancy affecting investment led solution of £3.5M and previously approved Business Case. Clinical Service Strategy work restarting to inform further changes. • Fire/Security – Fire Safety KPI's developed to improve fire safety culture.	**Likelihood:**	**2**	**31 March 2022**
Consequence:	4	4				**Consequence:**	**4**	
Risk Level:	**Ext 16**	**Ext 16**				**Risk Level:**	**High 8**	

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	Infirmary Site (Project STAR): • Emergency capital bids produced; fire Risk assessments completed, manned 24/7 security. Condition of the estate: • PPM; competent estates staff/APs; estates KPI's monitored through CEF/ Environmental Audits. • Maintenance Operational Board; Operational policies; Service Specifications PFI. COVID-19 Impact: • Capital schemes; social distancing methodology; zoning proposals agreed through ET & R&R. Estate configuration/optimisation/adjacencies • Clinical Service Strategy Review to conclude and inform changes to Estate Strategy/DCP. Fire / Security • Fire Safety/ Security Policies; Protocols; Guidelines; patrolling; CCTV; FRA's in place.	Infirmary Site (Project STAR): • Emergency capital bids approved. • Full Business Case for car park to conclude October 2020. Condition of the Estate • Estates Capital bids submitted to Trust Capital Investment Group (CIG) from 7 facet findings, investment prioritised. COVID-19 Impact • Appropriate control of all schemes – ET & R&R. Estate configuration/optimisation/adjacencies • Prioritised clinical service developments, as identified by Clinical Divisions, used to inform Estate Strategy. Fire/Security • 'On the spot' fire improvement notices by Fire Officers. • Fire Safety KPIs & ad-hoc audits/inspections. • LSMS close working with local Police and visibility on site	• NHSEI Review of Progress on Project STAR • Regulatory inspection/validation programmes including: CQC, PLACE, PAM and ERIC • External audits including those undertaken by the Fire and Police Service and external audit i.e. KPMG • Authorising Engineers Audits, appointed to provide external audit and assurance (governance) of building services and associated maintenance regimes. • Participation in National Programme hosted jointly by Cabinet Office & HM Treasury, showcasing the most successful Private/Public Sector Strategic Partnerships.
Assurance:	Project STAR: • Project Team, PRINCE principles applied. Condition of the estate • Estate-code 7 facet property appraisals conducted; Maintenance Operational Board; estates maintenance/validation audits; PFI performance against Service Spec; Divisional Board review. COVID-19 Impact • Updates ET & R&R Clinical Service Reviews • Clinical Service Reviews re-instated. Fire / Security • FRAs; ad-hoc inspections; on spot improvement notices; progress monitored Fire Safety Group and Executive Health & Safety Group.	Project STAR • Regular updates to Executive Team/Trust Board and external stakeholders including Regulators, STP, SOTCC & SHA. Condition of the estate • Estate Strategy, informed by Estate-code 7 facet property appraisal, Trust Strategy & clinical developments. • Regular reporting to CIG, H&S QGC, Infrastructure Committee, TEC, Infection Prevention Comm, TJNCC and LNC. • Strategic partnership - reviewed at Quarterly Liaison Committee, PAF and Infrastructure Committee. COVID-19 Impact: • Regular updates on progress on Risk Assessments from R&R to COVID Exec and Trust Board. Clinical Service Reviews: • Agreed to re-instate Clinical Service Reviews Fire / Security: • FRAs monitored through Trust Fire Committee; Divisional Management Board and Divisional H&S Meetings.	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 1 Progress Report**	**BRAG**
1.	RI Site - Asbestos removal/demolition	Director of E,F & PFI	2022	Asbestos removal Phase 1 & 2 handed over to the principle contractor.	GA
2.	RI/COPD - Create a car parking solution	Director of E, F&PFI	2023	Project STAR Full Business Case will be presented to Trust Board in October 2020.	GA
3.	RI/COPD - Release surplus land for land sale	Director of E,F& PFI	2023	Will require Project STAR Business Case approval.	GA
4.	Lower Ground Floor Trent Business Case	Director of E,F&PFI	Nov 2020	Requires alternative decant solution (linked to Market Testing issue)	GA
5.	Critical Care Potential Expansion	Director of E,F & PFI	Nov 2020	£7.1 National funds identified and options currently being explored as to how it can be delivered on site.	GA
6.	Market Testing Business Case (Financial Discrepancy)	Director of E,F&PFI	Dec 2020	Trust Board briefed; Commercial and Legal Advice commissioned; requires a review of the Financial Model. Proposals to fund the gap being assessed. Impacts on Trent Business Case (alternative options being explored).	GA
7.	Deferral of Elements of PFI Statutory Maintenance/Inspection/Lifecycle Programme 2020	Director of E,F&PFI	2020/21	Deferral of elements due to direct conflict with R&R/Winter/Surge 2. Agreed focus now needs to be on completion of Theatres (January 2021) and delivery of Programme for 2021/22 – must proceed and will require decant as incorporated fixed wire testing as well as elements not completed during 2020.	GA
8.	COVID Capital Schemes, space requirements/reconfiguration plans	Director of E, F&PFI	2020	Capital schemes progressing and continuing to respond to national guidance and looking at how we can improve social distancing particular in respect of Rest Facilities.	GA
9.	Strategic Supplier Relationship Management Programme (SSRM)	Director of E,F & PFI	2020	Continuation of programme (sponsored Cabinet Office and HM Treasury) and delivery of value release initiatives included within Joint Business Plan.	GA
10.	Introduce Fire KPI's to be monitored monthly through formal Divisional Performance Review Meetings	Director of EF & PFI	2020	Programme being developed for introducing Fire safety KPI's to support Clinical Divisions in achieving strong compliance against fire training, fire risk assessment and fire evacuation planning. The KPI's were presented to the Fire Safety Group in June 2020 and will now be introduced, on a phased basis, between now and the end of year, to maximise the opportunity of success.	GA
11	Estates Ops Workforce Review & additional temporary additional project staff (temporary)	Director of E, F&PFI	2020	Temporary project staff appointed to support capital developments. Estates Ops Workforce Review underway.	GA

Risk Summary					
BAF Reference and Summary Title:	**BAF 9: Financial Sustainability**			**SO's Impacted Upon**	✓
Risk Description:	**If we fail to operate within the resources available along with any flexibility agreed with the regulator then the services the Trust provides become financially unsustainable leading to increasing Cost Improvement Programmes / potential recovery action and a lack of ability to invest in the development of services in the future**				
Lead Director:	Chief Finance Officer	**Supported By:**			
Lead Committee:	Performance and Finance Committee	**Executive Group:**	Infrastructure Group		
Links to Risk Register:	**Title**	**Current Risk Score**	**Title**	**Current Risk Score**	
	ID15065 Trauma delivery of CIP	**High 12**			

Risk Scoring								
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	**3**	**3**			**The revised block values issued by NHSI gives a forecast deficit for the last 6 months of circa £20M. at UHNM and a system deficit of £49.9M. There remains significant errors in the financial modelling undertaken by NHSIE which have been highlighted in the return submitted. Risk level increased by consequence of a £20M deficit.** **In addition the introduction of the elective incentive scheme would drive a further deterioration in the position by circ £3.1M based on initial trajectories.**	**Likelihood:**	**2**	**31 March 2021**
Consequence:	**3**	**4**				**Consequence:**	**3**	
Risk Level:	**High 9**	**High 12**				**Risk Level:**	**Mod 6**	

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	**2nd Line of Defence**	**3rd Line of Defence**
Controls:	• Performance Management meetings in place with Divisions • Financial codes and procedures • Restoration and recovery group scrutiny	• Finance report in place to performance and Finance Committee with associated scrutiny • Standing Financial Instructions	• Consideration of Internal audit programme to reflect changing risks on COVID • STP Capital Programme in place in Line with Capital Resource Limit (CRL) • External audit programme in place
Assurance:	• All COVID revenue costs reimbursed claimed to date	• Performance at Month 5 on track	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 2 Progress Report**	**BRAG**
2.	Ensure the emerging financial regime post end of July is fully understood and risks identified	Chief Finance Officer	**31/07/2020**	**Guidance received and assimilated. Further guidance still expected for recurrent position.** **Capital allocation re COVID bids still remains outstanding**	**B**

3.	Develop processes to manage the Capital resource limit across the STP footprint	Chief Finance Officer	**31/07/2020**	**Complete – Allocations agreed across the STP and sub group being established to track and deal collectively with variation.**	**B**
4.	Develop financial reporting pack to support board oversight and scrutiny of financial performance	Chief Finance Officer	**30/06/2020**	**Complete – Finance Pack now shows run rate performance.** **Need to rebase budget to ensure adequate system of financial control is in place once system allocations finalised**	**B**
5.	To understand the impact of the wider restoration and recovery programme on UHNM performance	Chief Finance Officer	**31/07/2020**	**System submissions now made and impact evaluated against recovery trajectories.**	**B**
6.	To conclude discussions with NHSIE in respect of errors in financial allocations.	Chief Finance Officer	**31/10/2020**	**Complete.**	

Appendix 1 – Three Lines of Defence Model

The Three Lines of Defence model provides a simple and effective way to enhance communications on risk management and control by clarifying essential roles and duties.

To ensure the effectiveness of the risk management framework, the board and senior management need to be able to rely on adequate line functions – including monitoring and assurance functions – within the organisation.

As illustrated here, the Three Lines of Defence model provides a means of explaining the relationship between these functions and as a guide to how responsibilities should be divided:

- the first line of defence – functions that own and manage risk
- the second line of defence – functions that oversee or specialise in risk management, compliance
- the third line of defence – functions that provide independent assurance

From Quarter 2 2019/20, the Three Lines of Defence Model was incorporated into the BAF against each Strategic Risk. Whilst this is expected to evolve further, it provides an alternative 'lens' for Board and Committee members to consider – particularly around identifying areas of potential weakness.

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	4th November 2020
Report Title:	Speaking Up Report – Quarter 2 2020-21	**Agenda Item:**	15
Author:	Raising Concerns & Workforce Equality Manager		
Executive Lead:	Director of HR		

Purpose of Report:

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

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

Executive Summary:

Situation - when things go wrong we need to make sure that lessons are learnt and improvements are made. If we think something might go wrong, it's important we feel able to speak up so that potential harm is avoided. Even when things are going well, but could be made even better we should feel able to say something and should expect that what we say is listened to and used as an opportunity for improvement. Speaking Up is about all of these things.

Background - this quarterly Speaking Up Report provides an update to Trust Board on progress in relation to developing our speaking up culture, relevant national speaking up guidance published, and a summary of concerns raised at UHNM for the Quarter 2 period of July - September 2020.

Assessment – during the quarter 25 concerns were recorded on the speaking up tracker, which includes concerns raised with the Freedom to Speak Up Guardians and those raised to the Chief Executive's Office, within a division, or via CQC/other routes that have then been notified to the FTSU Guardian for inclusion on the speaking up tracker. 5 of the concerns were raised anonymously.

Progress against our FTSU Index action plan is included as an Appendix.

Key Recommendations:

Trust Board is asked to note:

- The speaking up data and themes raised during Quarter 2 2020-21.
- The actions proposed to further encourage and promote a culture of speaking up at UHNM.

Speaking Up
Quarter 2 Report 2020-21

1. Introduction

This Quarter 25 speaking up contacts have been made via the UHNM speaking up routes, which include concerns raised with the Freedom to Speak Up Guardians/Champions and those raised to the Chief Executive's Office, within a division, or via CQC/other routes that have then been notified to the FTSU Guardian for inclusion on the speaking up tracker. Five of these concerns were raised anonymously.

2. National Guardians Office (NGO) Update

NGO Case Reviews

There have been no new NGO Case Reviews released during the quarter. The NGO expects all NHS Trusts to consider their case review reports to identify whether they can adopt the recommendations within to help improve their speaking up culture. A recommendation from the most recent Case Review (Whittington Health NHS Trust) related to the trusts grievance policy including delays in handling grievances which exceeded the stated timeframes, conflict of interests in grievance proceedings and a failure to disclose the details of a grievance to a group of staff who were told they were not entitled to know what the grievances made against them were about. As an action our Employee Relations team have considered these recommendations against the UHNM Grievance Policy (HR03). As a result of this, the UHNM Grievance Policy will be updated to ensure that points about conflict of interests and how we inform individuals if a grievance is raised against them is included specifically within the policy.

Annual Data Report

On 1st October 2020 the National Guardian's Office published the latest data report, revealing that last year FTSU Guardians received 16,199 speaking up cases. The number of cases raised with FTSU Guardians last year represents a 32% increase on the previous year (12,244 cases) and more than double the number of cases handled two years ago (7,087) when the NGO started collecting data.

Dr Henrietta Hughes OBE, National Guardian for the NHS, said: "The opportunity is for leaders to use the information in our report in order to learn and improve. I want this report to resonate with Chairs and CEOs, Senior Partners, Accountable Officers, and everyone in a leadership role to foster a speaking up culture and improve their organisation. Why do some workers speak up anonymously? Why are workers fearing or actually suffering detriment? What are we doing to address bullying and harassment? These are questions that leaders need to ask so workers are not fearful about speaking up. This will bring about real improvements and help to make speaking up business as usual."

Appendix 2 is an updated benchmarking table demonstrating UHNM quarterly FTSU Guardian data for the year 2019-20 compared with our Model Hospital group.

3. Supporting our BAME staff to speak up

The UHNM Ethnic Diversity Staff Network (previously BAME Staff Network) provides a safe space for our BAME colleagues to raise issues and national evidence tells us that BAME workers are less likely to raise concerns, and are more likely to fear repercussions if they do. During October's Black History Month we are engaging in a number of activities to raise the speaking up agenda. The Trust site security lead attended the staff network meeting on 1st October to hear stories of staff experience of harassment and

abuse from patients and service users and to identify actions. On 21st October there will be a system wide event taking place with the BAME staff networks of the local trusts, and each Trusts FTSU Guardian will be attending to discuss the routes and support available for raising concerns.

4. Supporting a Speaking Up Culture – Update on Speaking Up Index Action Plan

UHNM Speaking Up Charter

In August we launched the UHNM Speaking Up Charter which has been designed to demonstrate our commitment to supporting staff to raise concerns. The Charter will be promoted across the Trust as part of our speaking up communications plan along with redesigned posters signposting staff to support from the FTSU team and Employee Support Advisors.

Tracy Bullock, in her Monday Message stated "The Board and I are committed to promoting an open, transparent and supportive culture to ensure that everyone feels safe and confident to speak up about issues that concern them and for you to know that we will act upon your concerns. Listening to our staff and patients and acting on feedback is fundamental in a learning organisation and with the onset of Covid-19 speaking up has never been more important. Therefore, I was pleased this week to join our staff-side chair Rob Irving to sign our Speaking Up Charter. The Charter highlights our organisation's commitment to support anyone who wants to make their voice heard, whether it be related to patient care, quality or safety; staff experience or a suggestion for improvement"

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

The Divisional management teams have all been sent Speaking Up Charters to sign, share with their wards and departments and to show their commitment to a healthy speaking up culture.

Rob Irving, Chair of Staff Side stated "I am delighted to be able to sign the Speaking Up Charter on behalf of Staff Side. It continues the great work that The Trust is doing with regards to staff wellbeing, the just and learning culture framework and generally changing the feel of the organisation into a more inclusive progressive and fair place to work. The Charter will hopefully give staff the confidence not only to speak up when they feel something isn't right, but to know that their employer fully supports them in doing so, and will endeavour to work with the employee to reach a fair and just outcome."

Freedom to Speak Up Training Update

New e-learning resources to support NHS staff to raise concerns on issues such as patient safety are being launched by Health Education England during October. They include 'Speak Up', the first instalment of a three-part 'Speak Up, Listen Up, Follow Up' e-learning programme for staff, volunteers and those in training, which explains how to speak up, and what to expect when colleagues do.

The subsequent modules aimed at middle managers and senior leaders will follow by March 2021. Work is now underway to incorporate the Speak Up training into the UHNM Statutory and Mandatory programme to ensure that all staff receive this essential training.

Speaking Up Month

October is national Speaking Up Month, the focus of the month will be on further promotion of the Speaking Up Charter which is our core messaging about how staff are supported to raise issues and we will also release a Speaking Up Month newsletter focusing on the routes for raising issues and the support available.

5. Internal Audit of Freedom to Speak Up

The Trusts internal auditors, KPMG have undertaken an audit of the UHNM freedom to speak up arrangements during the quarter. The Audit has provided an assessment of 'significant assurance with minor improvement opportunities', reflecting that the system (and relevant action plan and progress) is generally well designed. Five recommendations have been made and the management response to these with proposed actions and timescales will be considered at the Trust Audit Committee meeting on 15th October 2020.

6. Quarterly Speaking Up Cases – Quarter 2 – July - September 2020

The following information reflects speaking up contacts that have been recorded on the Speaking Up tracker. Contacts are recorded in accordance with guidance from the National Guardians Office. Contacts are themed in line with categories issued to NHS Trusts by the NGO. The following information is presented so that patterns emerge over time, whilst being mindful about the need for confidentiality. The data is intended to draw attention to particular issues, patterns of activity or themes:

Month	No. of contacts in the Quarter	Of which were raised anonymously	Of Which are Closed	Reports of detriment/ victimisation as a result of speaking up
July	10	1	9	0
August	10	3	9	0
September	5	1	2	0
Total	**25**	**5**	**20**	**0**

Five cases were reported anonymously. A signal of a health speaking up culture is that staff feel able to raise issues and concerns openly, as opposed to anonymously.

Theme	Number
Attitudes and behaviours	6
Equipment and maintenance	4
Staffing levels	2
Policies, procedures and processes	8
Quality and safety	3
Patient experience	0
Performance capability	0
Service Changes	2
Other	0
Total	**25**

Summary of speaking up contacts recorded on the Speaking Up Tracker during Quarter 2 July – September 2020

No.	Theme	Summary	Status
1.	Quality & Safety	CQC received anonymous concerns in relation to a Royal Stoke medical ward. The concerns covered:	The Trust responded to the CQC the following day after an immediate unannounced safety visit was conducted. The latest governance

		• There are not enough suitably qualified staff and impact on patient care experience • Bullying culture • Moving staff who are not FFP3 trained or at risk of Covid against staff wishes Further correspondence from the NMC via the CQC was received in September relating to the same area.	report for the ward was also submitted to the CQC for their information. No immediate concerns were identified. The Trust offered to meet with the CQC via teams to discuss the concerns but they were assured by the response. Due to previous concerns raised in 2019, the findings from the previous investigation were compared to identify improvements and any recurring themes, so that these can continue to be monitor closely. A comprehensive Care Excellence Visit to the Ward was undertaken in September 2020 and the report is currently being compiled. No immediate concerns were identified. Matron for the area continues to work with the team on an action plan of improvements identified from the concerns raised and will be working towards the recommendations from the CEF visit, once this is finalised.
2.	Attitudes & Behaviours	Staff member contacted FTSUG for advice following incident with line manager.	Discussed options, staff member to take personal action.
3.	Policies, Procedures & Processes	Staff member struggling with wearing PPE, particularly the mask when they have asthma.	Staff member supported to raise issue and revisit risk assessment with line manager and seek further referral to occupational health.
4.	Policies, Procedures & Processes	FTSUG contacted by staff member concerned about length of time a disciplinary investigation is taking.	Investigation concluded with no action. Feedback provided to staff member by line manager.
5.	Equipment & Maintenance	One of three concerns from a medical area sent to CEO Office about the impact on staff of wearing non vented face masks. Staff reporting difficulty in breathing, headaches drowsiness and skin irritation which is causing distress.	Division reviewed and staff are no longer wearing FFP3 masks for the full shift, only when undertaking AGPs and swabbing. Staff offered Occupational Health referral, if required. Senior sisters have set up regular meetings with their teams to ensure issues are dealt with in a timely manner to prevent staff feeling anxious and upset.
6.	Equipment & Maintenance	As above.	As above.
7.	Equipment & Maintenance	As above.	As above.

8.	Staffing Levels	Concern related to staff always being allocated to work (in the same area as above) when there are other staff available.	Allocation book in place to monitor staff deployment to minimise the reoccurrence day after day of staff being rostered to work in the high risk areas.
9.	Policies, Procedures & Processes	Anonymous concern received about the recruitment process for a medical support secretary - reporter believes the process to have been unfair.	Recruitment Manager undertook an independent review of the process. Process in accordance with Policy.
10.	Attitudes & Behaviours	FTSUG contacted by staff member about how their concerns of bullying from a colleague have been handled.	FTSUG met with staff member. Formal investigation is being undertaken.
11.	Attitudes & Behaviours	FTSUG contacted about behaviour of staff member.	Guidance provided and issue has now been raised formally.
12.	Policies, Procedures & Processes	FTSUG contacted for support to a member of staff with a disability experiencing negative behaviours from manager.	Support and guidance provided. Individual being supported to raise issues formally.
13.	Quality & Safety	Concerns raised in an anonymous letter sent to CEO office about a medical ward at Royal Stoke. Issues raised include: • Patient care and experience • Safety of medicine dispensing • Communication and attitudes and behaviours • Staff not feeling able to raise issues openly	CEF Review undertaken with no immediate concerns found. Report is currently being finalised. Comprehensive plan in place to address issues raised – see 'Learning from Cases' section.
14.	Quality & Safety	UHNM staff member raised issues about being part of a multi organisation service, with employees from other organisations being given different covid-19 guidance.	Escalated to next level manager for guidance.
15.	Staffing Levels	Concerns raised about workload and staffing levels.	Guidance provided on options to raise concerns. Personal action to be taken in first instance.
16.	Policies, Procedures & Processes	Advice sought on PPE use in non-clinical area.	Employee signposted to line manager for further guidance and occupational health recommendations.
17.	Equipment & Maintenance	Contacted FTSUG as not received feedback on issues raised and clarity about who should provide the feedback.	Staff member supported to obtain feedback.
18.	Policies, Procedures & Processes	Clarity sought from FTSUG about covid-19 staff shielding arrangements.	Trust guidance provided, signposted to support from Occupational Health and Human Resources.
19.	Policies, Procedures & Processes	Issues raised to FTSUG about dignity at work process.	Guidance and advice provided and options for way forward agreed.

20.	Policies, Procedures & Processes	Staff member unsure on guidance about covid-19.	Trust guidance provided, signposted to support from Occupational Health and Human Resources.
21.	Service Changes	Reporters concerned about service changes and behaviours within team.	Signposted to trade union support and supported to engage with line manager to discuss work plan best work practices.
22.	Service Changes	Advice sought from FTSUG on medical service change	Supported to discuss with line manager and signposted to access staff support services.
23.	Attitudes & Behaviours	Staff member experiencing relationship difficulties with colleague.	Worked through options in dignity at work policy.
24.	Attitudes & Behaviours	Staff member experiencing harassment related behaviours.	Supported to contact deanery and clinical supervisor to report behaviours. Provided with supportive strategies to deal with micro aggressors and behaviours which cause difficulty.
25.	Attitudes & Behaviours	Dignity at work issues related to covid-19 and PPE.	Supported to raise with line manager to resolve issue.

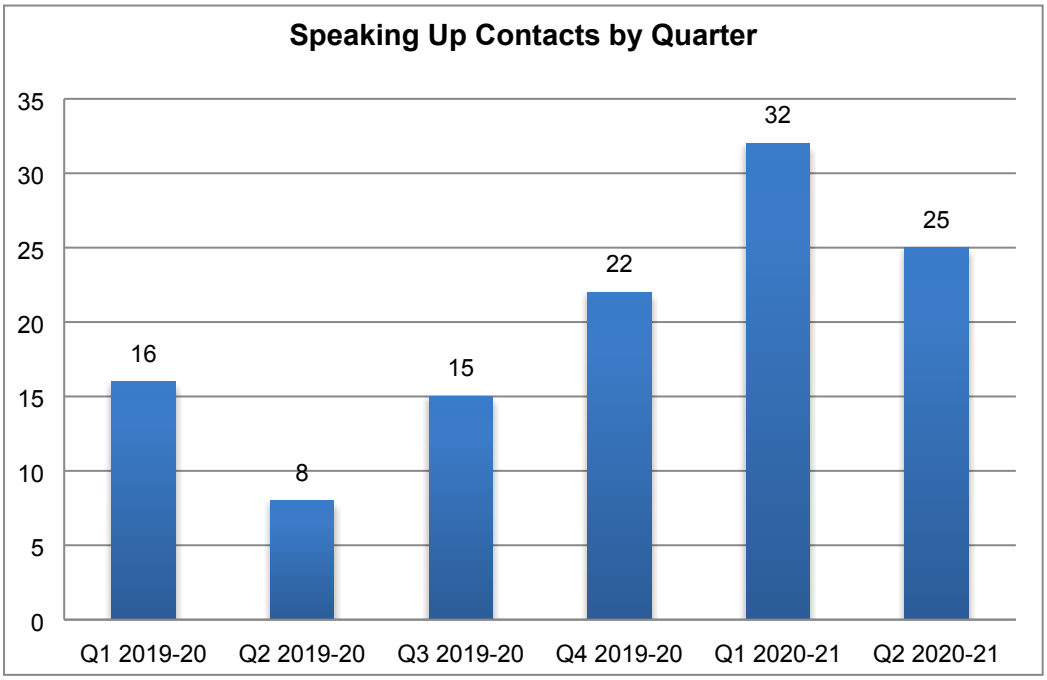
Open Speaking Up Cases from Previous Quarters

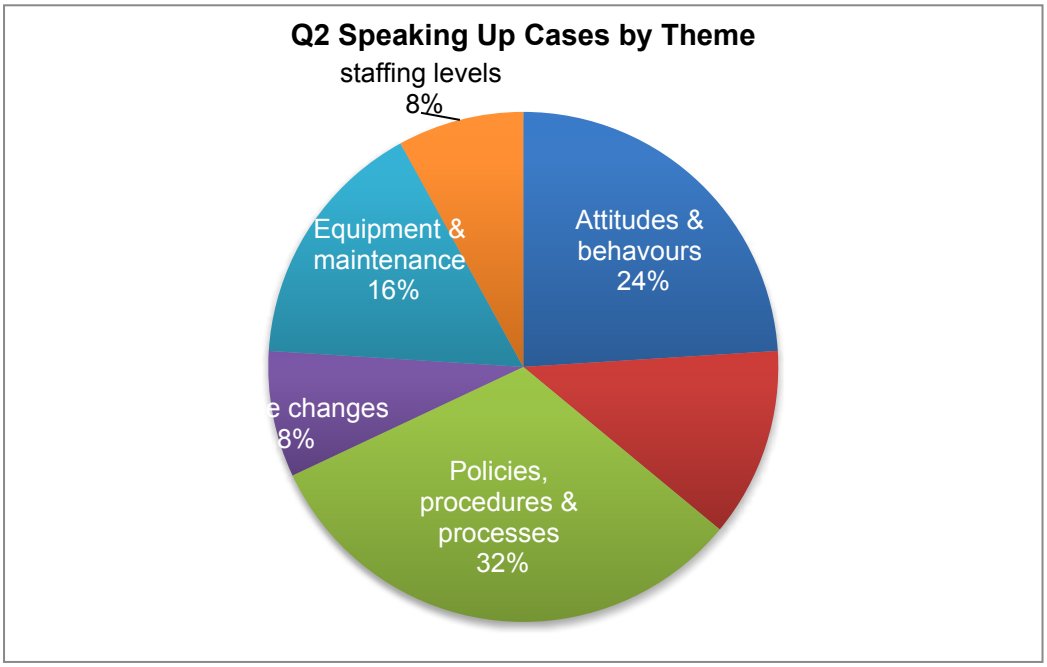
Theme	Summary	Month Case Raised	Status
Attitudes & Behaviours	Concerns raised about how a grievance is being managed.	June 2020	External Investigation into grievances agreed as way forward. Objection from the reporter to the proposed Investigating Officer and alternative being sought.
Attitudes & Behaviours	Concerns raised to CEO by member of staff regarding experiences	March 2020	Formal investigation commissioned. Response provided to reporter who has requested further meeting – currently being arranged.

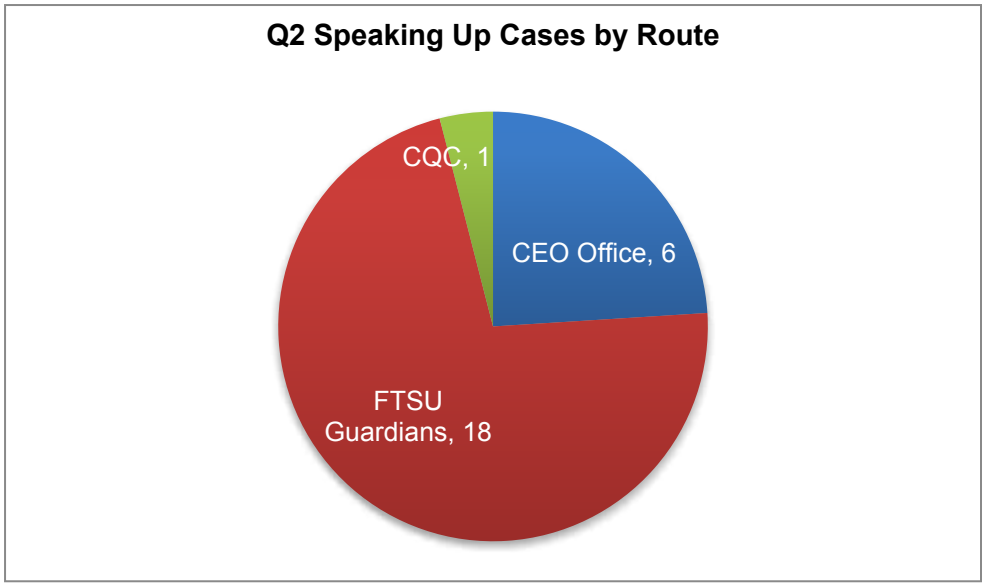
Issues raised with our Employee Support Advisors

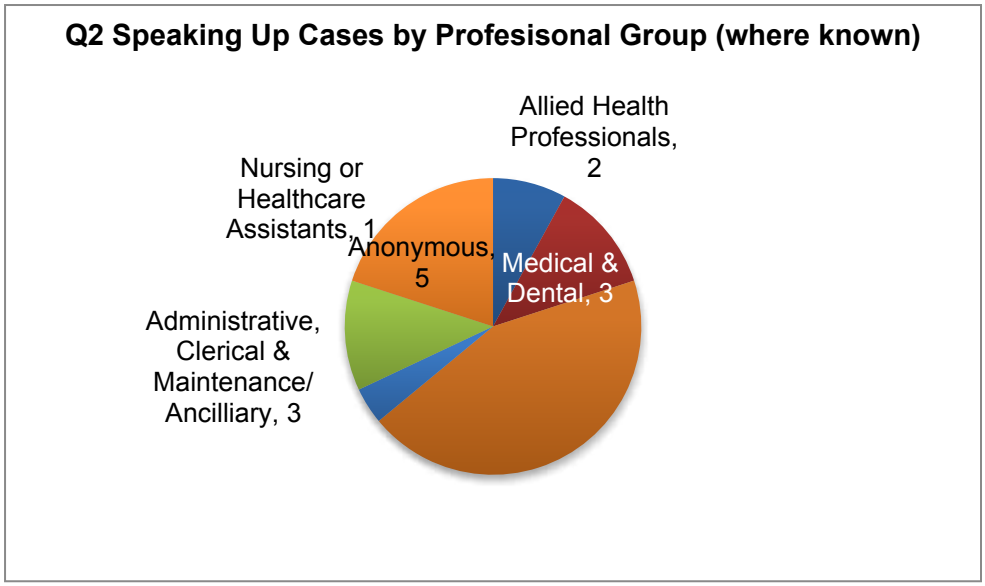
The NGO requests on a quarterly basis the number of concerns raised through freedom to speak up channels (i.e. Freedom to Speak Up Guardians and champions). Our Employee Support Advisors act as speaking up champions and therefore their activity is included in NGO data submissions. There have been no new contacts to our Employee Support Advisors during Quarter 2.

Quarter 2 Data Summary:









7. Learning from cases

Concerns were raised anonymously in September about worker experiences on AMU with the reporter raising issues about:

- Shortages of staff
- Patient care and experience
- Safety of medicine dispensing
- Communication and attitudes and behaviours
- Staff not feeling able to raise issues openly

The Medical Division has promptly investigated the issues raised and actions include:

Staffing levels - an agreed minimum staff to patient ratio on AMU is in place that facilitates decision making as to how many beds can remain open. The process was agreed and signed off by the Chief Nurse. All vacant shifts are escalated to bank and agency in a timely fashion. AMU will be fully recruited by December 2020.

Basic patient care - having reviewed DATIXs and complaints over the last 6 months this is not a common theme. Continue to monitor for trends and address any issues as they arise.

Medication – a plan is in place to provide further education and training.

Handovers - the Emergency Department and AMU Matrons are working together to produce a non-verbal handover process to expedite handovers and to ensure vital information is both captured and recorded for future reference. This process will be audited to ensure both accuracy and compliance, as well as getting feedback from both ED and AMU.

Staff engagement and culture – a range of staff engagement initiatives are being introduced (some on which had been on hold due to Covid) including:

- Staff newsletters (including you said/we did), Wellbeing Boards, Thank You Tuesdays
- Introduction of hour long staff clinics (across Acute Medicine for staff to raise issues with leaders)
- Listen and Learn events
- Pulse check survey (which will also continue throughout the winter)

A CEF review took place on AMU in the week commencing 14th September 2020. The report is currently being finalised but no immediate concerns were found.

8. Recommendations

Trust Board is asked to note the activity and actions relating to speaking up undertaken in the Quarter 2 of 2020-21, and the focus going forward over the next quarter, which will be:

- Incorporating the E-Learning for Health 'Speaking Up' training into UHNM Statutory & Mandatory training
- Advertise for a replacement Associate FTSU Guardian following the stepping down of one of the post holders
- Recruiting to our Employee Support Advisors

Appendix 1: FTSU Index Gap Analysis and Action Plan (updated July 2020, with 2019 Staff Survey Results)

FTSU Index Indicator	UHNM %	Acute Trust Average %	Gap %	Action / Recommendation	Timescale	Progress Rating
% of staff "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss or incident fairly	2018: 55.9% 2019: 57.4%	58.3% 59.6%	2.4% 2.2%	• Ongoing communications promoting Speaking Up Policy, which is based on NGO best practice and enables concerns to be raised anonymously or confidentially and that the policy clearly states that the harassment or victimisation of workers that raise issues will not be tolerated, nor any attempt to bully a worker into not raising a concern. Update: Speaking Up Charter launched in August 2020	Ongoing	B
				• Ongoing promotion of the Just and Learning Culture framework. The Just and Learning Culture Framework Decision Tree is used to support the consistent, constructive and fair evaluation of the actions of workers involved in an incident.	Ongoing	B
				• Introduce Speaking Up training as part of the statutory and mandatory provision for all workers in accordance with NGO national guidelines on Freedom to Speak Up training in the health sector in England (August 2019). To include the Just and Learning framework. Update: October 2020 E-learning for Health 'Speak Up' e-learning package released. Next steps to incorporate this training into statutory and mandatory training.	May 2020 Revised timescale: Feb 2021	R
				• Ratify and communicate the updated Disciplinary Policy (including Just and Learning approach) across the organisation.	December 2019	B
				• Update all Speaking Up Policy supporting materials to ensure these include the Just and Learning approach and maintain focus on learning not blaming.	December 2019	B
				• Continue to promote our Speaking Up Plan as part of a regular communications strategy.	Ongoing	B

				• Include information on detriment in FTSU quarterly reports.	January 2020	B
				• Widely promote Policy HR22 – Supporting Staff involved in an Incident, Complaint or Claim (the revised policy was approved at November 2019 TJNCC meeting).	January 2020	B
% of staff "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents	2018: 82.4% 2019: 84.5%	87.9% 88.2%	5.5% 3.7%	• Speaking Up training to be introduced for all workers as part of statutory and mandatory training with an emphasis on importance of speaking up and the routes available to do so. Update: October 2020 E-learning for Health 'Speak Up' e-learning package released. Next steps to incorporate this training into statutory and mandatory training.	May 2020 Revised timescale: Feb 2021	R
				• Continue to invest in compassionate leadership development, and update the Speaking Up training for line and middle management in line with the July 2019 NGO training guidance - Creating the right environment to encourage workers to speak up - Supporting speaking up and listening well - Conflicts - Induction and exit - Feedback Update: NGO to provide organisations with material for middle manager training as part the 3 part Speak Up, Listen Up, Follow Up e-learning package. **In the meantime, HEE updated e-learning is currently a required module for Gateway to Management delegates.**	May 2020 Updated timescale: March 2021	R

				• Further Board development session planned on FTSU to include NGO training for senior leaders to cover: - Regulation of speaking up - The benefits of speaking up - The role of senior leaders - Demonstrating leadership - Supporting FTSU Guardians - Measures - Protection - Communication - Learning - Continuous improvement	14.01.2020	B
				• On-going messaging encouraging a culture of speaking up from Board members, FTSU Guardian, HR and governance teams via electronic communications and face to face listening events such as ward and department visits, Care Excellence Visits CEO Time to Talk sessions and conferences and leadership events, such as Leaders Network. Speaking Up Charter launched during August 2020	Ongoing	B
% of staff "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice they would know how to report it	2018: 93.4% 2019: 92.7%	94.3% 94.2%	0.9% 1.5%	• Review FTSU messaging at Induction. – Reviewed.	December 2019	B
				• Update and promote Speaking Up Page and Staff Experience section of new intranet.	December 2019	B
				• Launch revised 'all workers' FTSU training and revise training delivered through Gateway to Management and Connects to reflect NGO requirements for line and middle managers. To include the routes available and how to raise issues. Update: NGO to provide organisations with material for middle manager training as part the 3 part Speak Up, Listen Up, Follow Up e-learning package. **In the meantime, HEE updated e-learning provided to Gateway to Management delegates.**	May 2020 Updated timescale: March 2021	R

				• Review communications strategy to ensure a programme of regular messaging that reinforces the message that speaking up is welcomed and how to raise issues. This needs to take into account ways in which more inaccessible workers can be reached.	December 2019	B
% of staff "agreeing" or "strongly agreeing" that they would feel secure raising concerns about unsafe clinical practice	2018: 65.6% 2019: 67.8%	69.3% 70.4%	3.7% 2.6%	• Trust wide communications and divisional championing of the Just and Learning Culture Framework.	In place and ongoing	B
				• Promote zero tolerance approach to victimisation of workers who raise concerns.	December 2019	B
				• Introduce newsletters and updates with a creative and engaging communication strategy to tell positive stories about speaking up – Newsletter for Speaking Up Month to be released during October	Quarterly	B
				• Have a sustained and on-going focus on the reduction of bullying, harassment and incivility, which in November 2019 will include the launch of the 'Cut it Out' campaign.	November 2019 and ongoing	B

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.

Appendix 2: Benchmarking Data

Freedom to Speak Up - National Guardian Reporting Data 2019-2020 - Model Hospital Group

	UHNM	Derby Teaching Hospitals	Gateshead Health	Nottingham University Hospitals	Royal Wolverhampton	Sheffield Teaching Hospitals	University Hospitals Southampton	University Hospitals Birmingham	University Hospitals Coventry and Warwickshire	Average quarterly
Total Concerns Reported										
Q1	27	20	7	12	14	3	8	7	12	12.2
Q2	11	59	6	8	28	9	14	16	11	18
Q3	30	61	5	18	22	9	18	14	12	21
Q4	27	76	4	10	28	4	13	15	14	21.2
Number raised anonymously										
Q1	3	3	1	2	0	0	0	0	6	1.7
Q2	2	5	3	1	0	2	0	0	9	2.4
Q3	1	17	0	3	2	0	1	0	0	2.7
Q4	1	40	0	1	4	0	1	0	2	5.4
Element of patient safety										
Q1	5	2	5	3	2	0	1	3	1	4.7
Q2	2	20	2	3	4	6	2	5	2	5.1
Q3	8	16	2	6	3	2	3	5	0	5
Q4	3	17	1	1	3	1	0	0	0	2.9
Element of bullying and harassment										
Q1	17	12	5	2	11	2	7	6	4	7.3
Q2	3	27	1	5	25	3	11	8	4	9.7
Q3	20	19	3	5	17	5	5	12	3	9.9
Q4	17	34	3	8	18	1	9	11	0	11.2
Reporting detriment										
Q1	0	0	0	1	1	0	0	1	0	1
Q2	0	0	1	0	11	2	1	4	0	2.1
Q3	0	3	0	3	8	0	0	3	0	1.9
Q4	0	2	0	1	2	0	1	2	0	0.9
FTSU Index Score (2020)	75.5%	77.7%	82.8%	79.8%	78.0%	79.2%	81.2%	74.7%	80.5%	**Average Index Score: 78.2%**

Trust Board

2020/21 BUSINESS CYCLE

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

Title of Paper	Executive Lead	Apr 8	May 6	Jun 10	Jul 8	Aug 5	Sep 16	Oct 7	Nov 4	Dec 9	Jan 6	Feb 3	Mar 10	Notes
PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES														
Chief Executives Report	Chief Executive													
Patient Story	Chief Nurse													Public Trust Board meetings did not take place in April - June due to social distancing
Quality Governance Committee Assurance Report	Associate Director of Corporate Governance													
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer													Delayed due to Covid. To be considered in December.
Care Quality Commission Action Plan	Chief Nurse													
Bi Annual Nurse Staffing Assurance Report	Chief Nurse													Deferred - taken to TAP and agreed changes required prior to presentation to the Board.
Quality Account	Chief Nurse													Timing moved due to changes in national requirements regarding submission
7 Day Services Board Assurance Report	Medical Director													Timing TBC due to national changes
NHS Resolution Maternity Incentive Scheme	Chief Nurse													Timing TBC due to national changes
Winter Plan	Chief Operating Officer													
PLACE Inspection Findings and Action Plan	Director of Estates, Facilities & PFI													
Infection Prevention Board Assurance Framework	Chief Nurse													
ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS STANDARDS														
Integrated Performance Report	Various													
ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT & RESEARCH														
Transformation and People Committee Assurance Report	Associate Director of Corporate Governance													
Gender Pay Gap Report	Director of Human Resources													
People Strategy Progress Report	Director of Human Resources													Deferred to August's meeting due to Covid
Revalidation	Medical Director													Delayed due to Covid and change in national reporting timescales.
Workforce Disability Equality Report	Director of Human Resources													
Workforce Race Equality Standards Report	Director of Human Resources													
Staff Survey Report	Director of Human Resources													
LEAD STRATEGIC CHANGE WITHIN STAFFORDSHIRE AND BEYOND														
System Working Update	Chief Executive / Director of Strategy													
ENSURE EFFICIENT USE OF RESOURCES														
Performance and Finance Committee Assurance Report	Associate Director of Corporate Governance													
Revenue Business Cases / Capital Investment / Non-Pay Expenditure £1,000,001 and above	Director of Strategy													
IM&T Strategy Progress Report	Director of IM&T													
Going Concern	Chief Finance Officer													

Title of Paper	Executive Lead	Apr 8	May 6	Jun 10	Jul 8	Aug 5	Sep 16	Oct 7	Nov 4	Dec 9	Jan 6	Feb 3	Mar 10	Notes
Estates Strategy Progress Report	Director of Estates, Facilities & PFI													Deferred due to Covid-19
Annual Plan 2020/21	Director of Strategy													Deferred due to Covid-19
Financial Plan 2021/22	Chief Finance Officer													
Capital Programme 2021/22	Chief Finance Officer													
GOVERNANCE														
Nomination and Remuneration Committee Assurance Report	Associate Director of Corporate Governance													
Audit Committee Assurance Report	Associate Director of Corporate Governance													
Board Assurance Framework	Associate Director of Corporate Governance		Q4		Q1				Q2			Q3		Covid Assurance Framework included in CEO Report May 20
Raising Concerns Report	Director of Human Resources		Q4			Q1			Q2			Q3		
Annual Evaluation of the Board and its Committees	Associate Director of Corporate Governance													Deferred due to Covid-19
Annual Review of the Rules of Procedure	Associate Director of Corporate Governance													
G6 Self-Certification	Chief Executive													Deferred to June's meeting
FT4 Self-Certification	Chief Executive													
Board Development Programme	Associate Director of Corporate Governance													Deferred due to Covid-19