University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 9th December 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 4th November 20	Approval	Mr D Wakefield	Enclosure	
5 mins	5.	Matters Arising via the Post Meeting Action Log	Assurance	Mr D Wakefield	Enclosure	
15 mins	6.	Chief Executive's Report –November 2020 • Covid-19	Information	Mrs T Bullock	Enclosure	**BAF 6**
10:15	**PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES**					
5 mins	7.	Quality Governance Committee Assurance Report (25-11-20)	Assurance	Ms S Belfield	Enclosure	**BAF 1**
10 mins	8.	IPC Board Assurance Framework	Assurance	Mrs M Rhodes	Enclosure	**BAF 1**
5 mins	9.	Update following NHS England and NHS Improvement Visit	Assurance	Mrs M Rhodes	Enclosure	**BAF 1**
10 mins	10.	Quality Account	Approval	Mrs M Rhodes	Enclosure	**BAF 1**
10:45	**ENSURE EFFICIENT USE OF RESOURCES**					
5 mins	11.	Performance & Finance Committee Assurance Report (24-11-20)	Assurance	Mr P Akid	Enclosure	**BAF 9**
10:50	**ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT AND RESEARCH**					
5 mins	12.	Transformation and People Committee Assurance Report (22-11-20)	Assurance	Prof G Crowe	Enclosure	**BAF 2 & 3**
10:55 – 11.10 : BREAK						
11:10	**ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS**					
45 mins	13.	Integrated Performance Report – Month 7	Assurance	Mrs M Rhodes Mr P Bytheway Mrs R Vaughan Mr M Oldham	Enclosure	
5 mins	14.	Winter Campaign Plan 2020/21 - Communications	Assurance	Mrs L Thomson	Enclosure	
12:00	**GOVERNANCE**					
5 mins	15.	Covid Terms of Reference	Approval	Miss C Rylands	Enclosure	
10 mins	16.	EPRR Annual Assurance Report	Assurance	Mr P Bytheway	Enclosure	
5 mins	17.	Calendar of Business 2020/21	Approval	Miss C Rylands	Enclosure	
12:20	**CLOSING MATTERS**					
5 mins	18.	Review of Meeting Effectiveness and Business Cycle Forward Look	Information	Mr D Wakefield	Enclosure	
	19.	Questions from the Public **Please submit questions in relation to the agenda, by 12.00 pm 7th December 2020 to claire.rylands@uhnm.nhs.uk**	Discussion	Mr D Wakefield	Verbal	
12:25	**DATE AND TIME OF NEXT MEETING**					
	20.	**Wednesday 6th January 2020, 9.30 am, via MS Teams**				

University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 4th November 2020, 9.30 am to 12.30 pm
Via Microsoft Teams

MINUTES OF MEETING

Attended	Apologies / Deputy Sent	Apologies

Voting Members:			A	M	J	J	J	A	O	N	D	J	F	M
Mr D Wakefield	DW	Chairman (Chair)												
Mr P Akid	PA	Non-Executive Director												
Ms S Belfield	SB	Non-Executive Director												
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:		
Mr P Foster	PF	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)

Members of Staff and Public via MS Teams: 7

No.	Agenda Item	Action
1.	**Patient Story**	
142/2020	Mr Foster recalled his story, whereby his partner, Neville, had fallen at home in Wales, 20 foot down a rock face in June 2020. He explained that Neville had fractured his skull and was subsequently transferred to Royal Stoke via air ambulance. Mr Foster explained that when he arrived at hospital, he was unable to see Neville and on the drive home he was contacted by the ward, who provided reassurance in terms of explaining how Neville was, and provided him with contact numbers for the ward. He explained that he had regular Zoom calls while Neville was on the Intensive Care Unit and the nurses kept Mr Foster completely up to date. He stated that despite the pressures on the staff, the attention provided was excellent and he felt part of Neville's care. He highlighted that when Neville moved to a ward, he was able to utilise Face Time and these calls were	

PROUD TO CARE

	facilitated by PALS and a volunteer, Sadif, which provided a great benefit to both Neville and Mr Foster. He added that during Neville's rehabilitation, support continued to be provided and Mr Foster was allowed to visit Neville once, and although he initially thought he was only able to stay for an hour, the ward staff let him stay for longer, which he appreciated. Mr Foster explained that Neville was transferred to Haywood Hospital once a bed became available and Mr Foster visited him twice, and on one occasion was able to take their dogs with him as therapy. He explained that as the second lockdown approached, he had been advised that the ward would only be able to facilitate Face Time once a week, whereas this had been provided twice a week previously. Mr Foster stated that he felt it would be beneficial if there was a facility for relatives to stay over at UHNM, given the Trauma Centre status and how far away some patients can live. Mr Wakefield thanked Mr Foster for his story and queried why it was not possible for Mr Foster to join Neville in the air ambulance. Mr Foster explained that the pilot apologised for him not being able to join as there was no room given the amount of clinicians in the helicopter. Mr Wakefield queried whether Mr Foster had any difficulties in using Face Time to which he responded that he found it easy to use. Mrs Bullock thanked Mr Foster for providing his story to the Board, and she agreed to highlight the issue of Face Time with the Chief Executive of Haywood Hospital to see if it could be utilised more frequently. She highlighted that the Trust Board had already considered the possibility of providing rest facilities for relatives, although this had been delayed due to Covid, but all options were being explored. She added that the Trust had also negotiated reduced rates with local hotels. Professor Hassell stated that he was involved with the Haywood Foundation charity which may be able to help and agreed for his email address to be passed onto Mr Foster. Mrs Rhodes paid thanks to Sadif for helping Mr Foster and Neville to communicate via Face Time and added that Sadif had since been substantively recruited to the PALS service. Mr Wakefield reiterated his thanks to Sadif for the help provided and welcomed the way in which Mr Foster was kept up to date with Neville's progress. Mr Foster, Mrs Grocott and Sadif left the meeting. **The Trust Board noted the patient story.**	**TB** **AG**
2.	**Chair's Welcome, Apologies & Confirmation of Quoracy**	
143/2020	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.	
3.	**Declarations of Interest**	

144/2020	The standing declarations were noted. Dr Griffin explained that with regards to the discussions on urgent care improvement, he was involved with MProve, who were providing support to UHNM, but he had been distanced from this. Mr Bytheway highlighted that in respect of the Project STAR business case which was to be discussed in the closed session, his husband was involved with one of the companies tendering for the contract, although he confirmed that he had not been involved in any of the tendering process.	
4.	**Minutes of the Previous Meeting held 5th October 2020**	
145/2020	The minutes of the meeting from 5th October 2020 were approved as an accurate record.	
5.	**Matters Arising from the Post Meeting Action Log**	
146/2020	PTB/445 – Mr Bostock confirmed that the IT project pipeline had been provided to members. PTB/446 – Mrs Vaughan explained that reminders had been issued to colleagues encouraging them to take their annual leave and records had been reviewed and shared with line managers, to ensure that leave was being taken and recorded. PTB/447 – Mrs Vaughan stated that she had fed the action back to the Equality and Diversity lead and requested that trend analysis be included and made clearer in future reports.	
6.	**Chief Executive's Report – October 2020**	
147/2020	Mrs Bullock highlighted a number of items from her report and particularly paid thanks to the staff for the way in which they have responded to the continued pressures associated with Covid. Mrs Bullock highlighted that some aspects of Delivering Exceptional Care had been paused due to Covid, and no training was to be undertaken until after Christmas, however work continued to take place in recruiting to the Quality Academy. Mr Wakefield referred to the flu vaccines and queried when the majority of staff would have been vaccinated. Mrs Bullock stated that she hoped that this would be before the end of the year and that vaccines were being received in batches and as soon as they are received, they were being administered. **The Trust Board received and noted the report.**	
PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES		
7.	**Quality Governance Committee Assurance Report (21-10-20)**	
148/2020	Professor Hassell highlighted the following: • The Committee noted the delay in progressing Get It Right First Time, due to	

	Covid, although the programmes had recommenced • The Committee welcomed the updates provided by the Infection Prevention team, particularly the positive increase in the number of flu vaccines provided • The Committee welcomed the breakdown of patient safety incidents, and the information provided in terms of low harm and no harm incidents which demonstrated that the increase in reporting was of low/no harm incidents which aided future learning. Mr Wakefield referred to the action regarding taking the staffing plan to the Transformation and People Committee and Mrs Rhodes explained that this was to be taken to the Committee in November. Mrs Rhodes explained that the Trust had asked staff to help administer the flu vaccinations this year and 233 peer vaccinators had been identified, covering all areas, and she paid thanks to those involved. Mr Wakefield queried the availability of the flu vaccine for those under 65 and Mrs Bullock explained that the main issue was the logistics as the vaccine was being delivered in phases with the vulnerable vaccinated first, then the over 65's and then those aged between 50 and 65. **The Trust Board received and noted the assurance report.**	
8.	**Winter Plan**	
149/2020	Mr Bytheway provided an update in relation to the second surge of Covid and highlighted the following: • The incident response was stood up 3 weeks ago, following a spike in cases, therefore a gold and silver command structure was in place. • Escalation space across the organisation had been opened, to reduce occupancy • Green zones had been maintained, to enable elective capacity to continue • If the same level of activity continued through critical care, the Trust may need to consider the implications of this in order to ensure that patients continued to be treated safely • Activity remained on track as part of the winter plan, but the main challenge was organising more purple capacity for emergency demand into Covid positive wards and giving greater focus on stranded and super stranded patients, and utilisation of community beds. • Work was ongoing with junior doctor teams to ensure each ward area was safely staffed by Junior Doctors and Consultants, and staff sickness continued to be a challenge • Some face to face outpatient appointments had been stood down in order to support critical care • The next Covid positive wards had been identified and actions were being taken to ensure that patients currently on those wards were appropriately discharged Professor Crowe thanked Mr Bytheway for the update and requested assurance in relation to system working, planning, the status of incident levels declared within the Trust and the way in which system decisions were enacted. Mr Bytheway stated that the local resilience forum declared a major incident earlier in the week, and the system structures had continued to be in place following the first wave, whereby daily silver and gold system calls were taking place to enable rapid decision making. He stated that the system had responded quickly to the	

Trust's need when the response was stood up 3 weeks ago.

Professor Hassell referred to the challenges associated with staffing and whether the 30 new nurses in the Emergency Department were in place. He queried whether the staffing of community beds was the responsibility of UHNM or Midlands Partnership NHS Foundation Trust (MPFT).

Mr Bytheway explained that the staffing of community beds was the responsibility of MPFT, although mutual aid had been discussed in terms of working together to address the challenges. He confirmed that the 30 nurses were in place. He stated that staffing was a significant risk and twice daily meetings were taking place to ensure safe staffing.

Mrs Bullock added that a national solution was required regarding agency staff and that this had been raised with regulators as there was a risk with regards to transmission and staff moving between hospitals. Therefore, if staff were going to work extra, it was preferable for this to be undertaken at their substantive organisation to help reduce transmission.

Mr Bytheway highlighted the following points with regards to the winter plan:

- The plan focussed on delivering the urgent care plan, creating occupancy and ensuring correct infection prevention measures were in place
- Focus on ward based processes to ensure patients were being discharged and transferred in a timely manner
- An 8 week programme was underway to embed changes in processes within urgent care
- Changes had been made in terms of working differently with Vocare, by changing system pathways to help with demand as well as working with the Ambulance Service and community partners to reduce conveyances and avoid admissions

Dr Griffin queried whether the plan was robust enough to address the challenges of Covid. Mr Bytheway explained that the plan had already started to be enacted, in terms of opening up escalation space and the main challenge was restricted beds, as the winter plan did not take these into account, resulting in a significant reduction in beds. He added that approximately 90% of non-elective demand and 90% of admissions had been factored into the winter plan and those assumptions were being realised.

Mr Wakefield referred to the assumption that County would remain Covid free and queried the current position. Mr Bytheway stated that County Hospital was no longer Covid free due to the size of escalation required, therefore a Covid ward had been opened at County Hospital, to reduce the number of patients transferred between sites which also helped to reduce the burden on the ambulance provider so they could focus on transporting patients for discharge. He stated that patients were only transferred if clinically required.

Mr Wakefield queried the robustness of the risk mitigation in relation to the ability to maintain the restoration and recovery programme, given that it was predicated on having a Covid free site. Mr Bytheway stated that restoration of services would continue for as long as possible, with ongoing work to protect green zones on both sites for as long as possible. He reiterated that the key point was critical care rather than bed availability, therefore the assumptions were correct, but the speed and complexity for the second wave required more day to day operational management.

Professor Crowe referred to the risks associated with workforce planning and

	sustaining the levels of staff required, and queried if the assumptions could be achieved. Mr Bytheway stated that the previous assumptions were correct at the time, and the workforce cells were reflecting on the numbers on a daily basis to ensure patient safety, with staff being redeployed to support ongoing care needs. Professor Crowe queried if the plan should be re-run, with different assumptions and Mr Bytheway stated that the difficulty would be that the different assumptions would only reflect a point in time due to the changing complexities associated with Covid. Mrs Bullock agreed, and stated that the plan would need to be rerun all of the time if it were to keep up to date with the changes. She stated that the incident structures in place dealt with the changes and added that Mrs Vaughan was leading on the workforce cell and was sighted on the key risks. She added that Mrs Rhodes was leading on nursing workforce and Dr Oxtoby on medical workforce, therefore she was unsure of the value of rerunning the plan, given that it would be out of date by time it had been completed. Mr Bytheway suggested that he could provide information in terms of elements of the plan which had not been delivered and the reasons for this and he agreed to consider providing narrative in terms of what had not been achieved. **The Trust Board considered and approved the UHNM winter plan 2020/21 which had been aligned to the Trusts operational and financial plans, but recognised that due to the constant changing environment, any impact of Covid and subsequent realignment would be articulated to Board members.**	**PB**
9.	**Infection Prevention Board Assurance Framework (BAF) Quarter 2**	
150/2020	Mrs Rhodes explained that risks 1 and 6 had changed since the previous quarter and added that by the end of quarter 3 it was hoped to reduce the risk levels. She stated that the main issues related to MRSA screening and fit testing of masks and added that the document was regularly reviewed by the Infection Prevention Committee as well as the Quality Governance Committee. Mr Wakefield welcomed the robustness of the document and referred to the introduction of Covid monitors in some Trusts, who challenged staff on compliance. He queried whether this had been considered. Mrs Rhodes stated that this had been considered and it had been agreed that the corporate nursing team would provide daily visits to wards, to talk to staff to see if they needed anything, to check on their wellbeing and to identify any gaps in personal protective equipment (PPE) / health and safety. Dr Griffin referred to the level of hospital Covid outbreaks and queried what steps were being taken to address these. Mrs Rhodes explained that an outbreak was identified when there were two or more positive patients/staff in the same area within a 7 day period. She stated that this was a low threshold and if it occurred, an outbreak was declared, both internally and to regulators. She stated that twice weekly outbreak meetings took place as well as unannounced visits, and track and trace would be instigated to establish any contacts. It was noted that there were several outbreaks across the Trust but as testing was quicker and more testing was being undertaken, the outbreaks were being confined. **The Trust Board received and noted the updated self-assessment in terms of compliance with Public Health England and other Covid-19 related infection prevention guidance.**	
ENSURE EFFICIENT USE OF RESOURCES		

10.	**Performance and Finance Committee Assurance Report (20-10-20)**	
151/2020	Dr Griffin highlighted the following: • The Committee noted the continued challenges associated with Covid as well as the continued focus on urgent care delivery and the associated improvement plan • The Committee reviewed the impact of the new financial regime for the remainder of the year and the associated system deficit • The impact and outcomes from Doing the Right Thing was to be provided at a future meeting **The Trust Board received and noted the assurance report.**	
ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT AND RESEARCH		
11.	**Transformation and People Committee Assurance Report (22-10-20)**	
152/2020	Professor Crowe highlighted the following: • The Committee noted the encouraging progress made in terms of statutory and mandatory training and appraisal rates • Positive assurance was provided in terms of mobilisation of staff and wellbeing • In terms of transformation and continuous improvement, whilst noting the pause of the Delivering Exceptional Care programme, the Committee was anxious of the need to sustain continuous improvement, and awaited further details on strategic priorities, service reviews and the associated roadmap **The Trust Board received and noted the assurance report.**	
ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS		
12.	**Integrated Performance Report – Month 6**	
153/2020	Mrs Rhodes highlighted the following in relation to the quality metrics: • Duty of candour compliance had improved in respect of follow up letters • In terms of inpatient sepsis screening a deep dive was being undertaken for one ward, with a significant improvement expected for October Mr Wakefield referred to the reported increase in patient safety incidents and queried the reasons for this. Mrs Rhodes stated that the increase related to low/no harm incidents which demonstrated a good reporting culture, and helped to ensure lessons were learned going forwards. Mr Bytheway highlighted the following in relation to urgent care performance: • Main challenges were workforce, flow around the organisation and challenges of restricted areas • During October, a test of change was undertaken for 3 weeks, looking at some of the challenges in the Emergency Department, such as navigating patients to other areas, use of Vocare, primary care referrals and patients being discharged in a timely manner. Some small changes had been implemented and improvements seen in time to assessment and time to decision made as well as patients moving out of the Department. It was noted that by the third week the Trust had started to escalate into Covid surge. • The Emergency Care Improvement Support Team (ECIST) were not able to	

come on site but some clinicians had been secured to work on site with clinical teams to drive forward the changes required, to ensure that pathways were completed

- Urgent care performance continued to be challenged with 50% of attendances being ambulance conveyances, whereby patients had increased acuity, resulting in challenges of keeping pace with the ambulances and flow
- Work was being planned on creating additional Covid spaces
- Transformation work had been difficult to take forward, due to the ongoing challenges and reduction in workforce, although the incident structure was helping
- ECIST had delivered a workforce plan and a test of change was to take place in terms of workforce for the Emergency Department, to establish the benefits which could be delivered if the workforce was correct. This aimed at improving quality metrics rather than overall performance
- A change in overall 4 hour performance was not expected in the coming months, but an improvement in quality metrics for decision making and admission reduction was expected

Mr Wakefield referred to the length of stay reviews and queried how these were progressing given that the number of super stranded patients had increased. Mr Bytheway explained that the main challenge was within Medicine and the Trust continued to work with partners to establish medical optimisation.

Dr Griffin queried the reasons for not expecting 4 hour performance to improve and Mr Bytheway stated that this was due to the impact of Covid, workforce and winter. He stated that performance usually decreased in December and January and given the issues with infection prevention and restrictive beds, the likelihood was that performance would not increase, which was why there was a focus on improving the quality metrics.

Professor Crowe referred to the delays with ambulance handovers and queried if this was to be addressed by the actions taken. Mr Bytheway stated that by opening additional capacity, it was anticipated that occupancy would be reduced and a reduction in super stranded patients would also help with ambulance handovers as patients would be moving more quickly throughout the organisation.

Mr Bytheway highlighted the following in relation to planned care, cancer and diagnostic performance:

- In September all trajectories had an improved position
- It was the aim to keep diagnostics open during the next few weeks and for planned care and cancer the aim was to protect this as much as possible

Mr Wakefield referred to patients across Stoke and Staffordshire and ensuring they were aware they could continue to go to their GP during the second wave, as well as coming into hospital. He queried what the Trust was doing in terms of communicating this to patients. Mr Bytheway stated that patients on the waiting list were being called to ensure they knew where they are in the process and messages continued to be reinforced on social media. Mrs Thomson described the work being undertaken by the Trust and with system partners to provide messages to the public, including animations and posters based on the lessons learned from the first wave.

Mrs Taylor referred to cancer performance and queried the reference to providing training for teams on having conversations with non-compliant patients. Mr

Bytheway explained that this related to patients who had not attended their 2 week pathway or diagnostics, and added that the corporate cancer team had been provided with additional training as they had started to be more patient facing, having regular contact with patients.

Mrs Vaughan highlighted the following in relation to workforce performance:

- September sickness had increased with a clear rise linked to Covid. There had been a slight improvement in the position towards the end of September but this had deteriorated in October
- The Trust was coping with demand for staff testing and the workforce bureau had been re-instigated with the focus on staff wellbeing, managing absence and supporting other teams with workforce redeployment
- Proactive actions were being taken in terms of staff wellbeing which included access for staff counselling sessions
- Covid risk assessments continued to be undertaken for staff and by the end of October, 91% had been completed for all staff and 93% for Black and Minority Ethnic colleagues. The Trust had asked managers to ensure that those staff at higher risk had a further conversation regarding their health and risk assessment
- There had been an increase in performance for appraisals and statutory and mandatory training for the end of September and this had increased again for October

Professor Owen requested clarification regarding staff wellbeing and queried what was being undertaken to ensure the staff voice was recognised. Mrs Vaughan stated that visits to wards and departments were being undertaken, to ask staff what they need and rest facilities were a constant theme, with actions being taken to address the issue. In addition, over 30 listen and learn events had been undertaken and actions were being identified in terms of the issues raised during the sessions. Mrs Vaughan added that the Trust continued to engage with the Staff Side and welcomed their feedback.

Professor Hassell welcomed the improvement in appraisal rates and queried the mechanisms for redeployment and how this worked in practice. Mrs Vaughan stated that the primary focus was ensuring staff were only redeployed where they were comfortable and felt competent to take forward the tasks given to them, managed via the workforce bureau for non-clinical roles and via the corporate nursing team for nursing/AHPs.

Professor Crowe welcomed the improvement in statutory and mandatory training and stated that he hoped to see this continue. He referred to staff who had not received a risk assessment and queried what actions were being taken to support the high risk groups, based on learning from the first wave. Mrs Vaughan stated that some of the non-compliance would be due to staff being on maternity or sick leave but some staff had also chosen not to undertake a risk assessment. She stated that discussion had taken place with staff in high risk groups about what support was required and in particular there had been engagement with staff from the Trust's Ethnically Diverse Staff Network.

Mr Wakefield queried whether there were any vulnerable staff who had not been risk assessed and requested confirmation that these staff were not working in Covid areas. Mrs Vaughan stated that managers had been asked to ensure that their staff had a risk assessment and added that the vast majority of completed assessments identified staff in category A which was low risk. Mrs Vaughan stated that assurance had been sought in terms of this and Mrs Rhodes added that as the number of Covid inpatients increased, there would be fewer and fewer

	green areas, and added that asymptomatic staff / patients continued to pose a risk. Mr Oldham highlighted the following in relation to financial performance: • The Trust achieved a break even position for Month 6 although it was the last month of the top up. £1.7 m Covid costs and £6.1 m top up had been received. • Activity continued to be significantly down and in terms of the elective incentive scheme the Trust had been asked to value the refund but not reflect this in the accounts • Covid costs were running as previously and pay costs had increased from month 5, primarily associated with the consultant pay award and provision for an anaesthetic rota changes • There had been a slight non pay overspend for drugs and pass through income • Capital continued to be challenged given the size of the programme, and was £2 m behind plan. Work was ongoing with estates, information technology and medical equipment teams to ensure the CRL was spent. The process for finalising the profile and securing cash had been slow, which reflected the level of national activity • The cash position remained strong at the month end • In terms of the month 7-12 forecast, the system had been challenged to close the gap on the deficit and the outstanding items related to technical items which were with NHSIE to determine. The impact on UHNM of closing the gap was £2 m non recurrent. **The Trust Board received and noted the report.**	
GOVERNANCE		
13.	**Audit Committee Assurance Report (22-10-20)**	
154/2020	Professor Crowe highlighted the following from his report: • Progress continued to be made in respect of the internal audit plan and it was on track to be delivered. • External audit continued to operate remotely • Positive assurance was provided for a number of internal audit reviews, with more limited assurance for private patients with a number of actions identified to tighten up controls • The Committee noted a good level of oversight provided by the Committees in relation to the BAF • Committee effectiveness had been reported to the Committee and it had been agreed for further updates to be provided to the Committee from the Chairs • There had been some changes to the Code of Audit Practice and the nature of reports for the next financial year would be different therefore the Committee would be keep abreast of these changes and the associated impact **The Trust Board received and noted the assurance report.**	
14.	**Board Assurance Framework – Quarter 2**	
155/2020	Miss Rylands highlighted the following: • There had been some movement in risk levels with increases in risk score for restoration and recovery and financial sustainability.	

	• There had been a reduction in the level of risk associated with system working as a result of the strong partnerships which had been established • The discussions held at each Committee had been summarised • Enhanced reporting of risks at Committee level had been provided, as a result of providing updates from the Executive Groups Mr Wakefield referred to the risk in relation to restoration and recovery and the overall score of 25. He referred to the individual risks which were scored no higher than 16 and queried if the risk scores were correct. Miss Rylands stated that the risk assessments at an operational level were under continuous review and this reflected an issue with timing, and she expected to see some movement in these going forwards. Mr Wakefield referred to the actions identified in relation to the restoration and recovery risk and queried whether these were powerful enough, in particular reviewing the waiting lists. Mr Bytheway explained that it was a national requirement to review the whole of the waiting list in terms of checking there was no deterioration in their condition as well as helping to determine the clinical prioritisation, therefore this was a key part of recovery in terms of ensuring patients were safe. **The Trust Board approved the Board Assurance Framework as at Quarter 2 and noted that the document had been considered by Committees of the Board with positive feedback received.**	
15.	**Speaking Up Report – Quarter 2**	
156/2020	Mrs Vaughan highlighted the following from her report: • Benchmarking information had been included • The speaking up charter had been launched which demonstrated a commitment to supporting staff in raising concerns • Positive assurance was provided from internal audit and all of the recommendations made had been accepted, with a number already implemented • 25 speaking up concerns had been received during the quarter and actions had been identified • The Trust awaited the provision of a national e-learning package and was in the process of recruiting additional Employee Support Advisors as well as an additional Associate Freedom to Speak Up Guardian Mr Wakefield welcomed the assurance provided by the audit report and welcomed the learning from cases and identification of themes. Professor Crowe welcomed the work undertaken and the desire to embed a strong Freedom to Speak Up culture. **The Trust Board noted the speaking up data and themes raised during Quarter 2 and the actions proposed to further encourage and promote a culture of speaking up at UHNM.**	
CLOSING MATTERS		
16.	**Review of Meeting Effectiveness and Business Cycle Forward Look**	
157/2020	Nothing further was raised.	

17.	**Questions from the Public**	
158/2020	Mr Syme referred to capacity at UHNM, and the previous discussion at the Board whereby it was stated that 99.2% theatre availability would be online. He queried the percentage that the Independent Sector contributed to theatre availability and queried the "indicative" volume percentage of completed episodes that the Independent Sector contributed to the total figure. Mr Bytheway explained that internal UHNM operating accounted for 89% and stated that he was unable to provide the competed episode number. He stated that utilisation was between 70% to 80% with the Independent Sector. Mr Syme referred to ambulance handovers and the Trust having previously achieved rapid ambulance turnaround for ambulances attending the emergency portal. He referred to the number of 60 minute breaches which had increased in September and October and queried what new actions were being taken to mitigate and improve swift ambulance handover. Mr Bytheway stated that as part of the urgent care plan, the challenges related to occupancy, flow through the Emergency Department and conveyances to UHNM. He stated that work had commenced with the system and with MPFT to reduce conveyances as well as opening up escalation capacity, with additional infrastructure to support the turnaround of beds to speed up the movement of patients from the Department onto wards. He stated that this remained a priority, to ensure patients could be brought into the department urgently. Mr Syme referred to the winter plan and bed planning. He queried whether the October growth of presenting Covid patients requiring inpatient admission had been taken into consideration in the winter plan and queried what contingencies regarding suspending electives had been considered and how the public would be informed of such suspensions. Mr Bytheway stated that the Trust would continue operating for as long as possible and while it remained safe to do so. Mr Wakefield referred to the previous discussion regarding identifying any changes to the plan and Mr Bytheway reiterated that each patient was being contacted to tell them where they were in terms of their treatment plan. He stated that by working with the Independent Sector, it was the aim to get up to 100% capacity as part of resilience plan. It was noted that a blanket ban on electives would not likely take place which would therefore complicate how and when communication with the wider public was made but the priority was to inform the patients affected Mr Syme queried what consideration had been given to "Long Covid". Dr Oxtoby referred to the ongoing work with MPFT for the community and added that for the Trust it had been recognised, and clinicians were in place to support patients with these types of diagnoses which was being led by respiratory clinicians with the involvement from cardiology, elderly care and therapists. Mr Wakefield thanked the whole workforce across the Trust and every member of staff for the work they continued to undertake during the second wave.	
DATE AND TIME OF NEXT MEETING		
18.	Wednesday 9th December 2020, 9.30 am, via MS Teams	

Trust Board (Open)

Post meeting action log as at **03 December 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	01/12/2020	The metrics highlighted in the report will be reported to respective Committees, based on the alignment of the strategic objectives i.e. quality to QGC, performance and finance to PAF, HR to TAP.	B
PTB/443	05/08/2020	Infection Prevention Assurance Framework Covid-19	To include information within the quality metrics.	Michelle Rhodes	09/12/2020	03/12/2020	Nosocomial infection numbers included within the IPR.	B
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	16/12/2020		RCA undertaken and to be provided to the next QGC.	GA
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	04/11/2020	IT pipeline provided to Board members.	B
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	04/11/2020	Update provided in November. Reminders have been issued to colleagues encouraging them to take their annual leave and records had been reviewed and shared with line managers, to ensure that leave was being taken and recorded.	B
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	04/11/2020	Update provided in November. Noted that the Equality and Diversity lead had been requested to include trend analysis in future reports.	B
PTB/448	04/11/2020	Patient Story	To discuss the issue raised in terms of reducing the number of Face Time calls for relatives during the second lockdown, with the Chief Executive of Haywood Hospital .	Tracy Bullock	21/12/2020		Contact has been made. Further update to be provided once response has been received.	GA
PTB/449	04/11/2020	Patient Story	To forward Professor Hassell's email address to Mr Foster regarding the Haywood Foundation Charity	Angela Grocott	13/11/2020	02/12/2020	Email address forwarded to Mrs Grocott.	B
PTB/450	04/11/2020	Winter Plan	To provide information in terms of the elements of the winter plan which had not been delivered, or had changed, and the reasons for this.	Paul Bytheway	09/12/2020	24/11/2020	Changes have been made to the IPR that demonstrate the changes to R&R as we go through winter - there is also a separate page for winter metrics.	B

University Hospitals of North Midlands NHS Trust

Chief Executive's Report to the Trust Board

FOR INFORMATION

Part 1: Trust Executive Committee

The Trust Executive Committee met on 2nd December 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:

- Licencing of the Pfizer Covid-19 Vaccine which would be received imminently to commence staff vaccination; development of an app. is also underway
- Continued roll out of testing kits with plans to switch to an alternative, saliva based kit when possible
- Launch of the Winter Campaign including NHS 111
- Christmas Advent Calendar available for all staff
- Challenges associated with PPE compliance which were being addressed
- Importance of ensuring structured judgement reviews are undertaken with a particular focus on those associated with Covid-19
- Semi-permanent solutions to ensure the provision of rest facilities for staff under development
- Provision of additional hydration for staff working at ward / departmental level, along with a change in opening hours for food / drink outlets to support staff wellbeing
- A number of Estates schemes underway and on track for completion in December
- Communication issued regarding those staff who should be shielding
- Risk assessment review, focussing on those at higher risk with the aim of 100% completion by 8th December
- Redeployment of administrative staff to provide support within clinical areas
- A reduction in numbers of patients with Covid-19 and within Critical Care starting to be seen
- The remarkable efforts of staff who have shown such dedication and commitment, whilst putting themselves at risk along with the importance of ensuring staff were supported to take annual leave, given the difficulties experienced during the year
- Our Pathology collaboration within the N8 Network between ourselves and the Cheshire Hospitals (Mid and East) continues to progress and we reached a key milestone on 1st December where 270 staff were TUPE'd across to UHNM to work within the partnership, in accordance with our agreement

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 October to 11th November, 1 contract award, which met this criteria was made, as follows:

- **RS/1496/CAP-A Children's Outpatient Ward – Lease (REAF 3978)** supplied by Portakabin at a total cost of £1,195,708.00, for the period 16/12/2020 (104 weeks), approved on 12/10/2020

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

Pharmacy Wholesale Agreement (REAF 3971)

Contract Value £15,148,326.39 incl. VAT
Duration 01/07/20 to 30/06/21
Supplier Phoenix, AAH Pharmaceuticals, Alliance healthcare and Mawdleys

REAF raised following recent competition via H.T.E framework. Same supplier award and discounts remain. Benchmarked against the East of England framework and H.T.E still remains the most competitive option.

Benchmarking will be done again in 12 months to ensure value for money.

The Majority of Medicinal products purchased for use throughout UHNM are supplied via the wholesale distribution route using the four largest providers included within the Wholesaler market. Medicinal products are ordered via Ascribe and delivered to Pharmacy Stores where they are stored and then distributed on-wards to the various Wards and Departments.

Savings – No savings.

Supply of Domestic products (REAF 4056)

Contract Value £1,950,000.00 incl. VAT
Duration 01/12/20 to 31/11/22
Supplier Arrow County Supplies

REAF raised for the Contract renewal of domestic products which are held in the Supplies and Procurement warehouse and distributed to wards and departments across the Royal Stoke and County site. The contract covers a mixture of products from Hand towels, waste sacks, Tissues etc.
Items are being procured via the SBS framework

Savings – Yes, £58,000.00 incl.VAT

Data Centre Refresh Part 1 (REAF 5124)

Contract Value £1,744,529.51 incl. VAT
Capital Purchase
Supplier SCC

REAF raised to cover the current Datacentre (DC) infrastructure which runs many of the core clinical applications and stores all departmental and user data (Z: drives) which is now running in its second year of extended warranty. This DC infrastructure replacement ensures the Trust have a modern, scalable and resilient platform to deliver critical clinical applications. This REAF is supported by the Business Case [BC-0366] which has been approved by the UHNM Executive Board and has been procured via the H.T.E commit 2 framework.

Savings – No Savings

The following REAF has not been provided to Performance and Finance (PAF) Committee for approval due to a technical issue, therefore it is being brought straight to the Board approval in the interest of time:

Pharmacy Dispensing Service (REAF 3946) - Extension

Contract Value £2,948,066.00 incl. VAT (value of Extension £769,999.00 incl. VAT)
Extension of Contract
Duration 1/10/20-30/9/21
Supplier Lloyds Pharmacy

The current contract for the provision of a pharmacy dispensing service began on 1st April 2017 to 31st March 2020. The contract included an option to extend by 2 x 12 month periods. A short term (6 month) extension had previously been agreed to 30th September 2020 and a further extension has been agreed with Lloyds Pharmacy until 30th September 2021.

Savings – No Savings

The Trust Board are asked to approve the above REAFs.

2. Consultant Appointments

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

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Divisional Chair	Vacancy	Yes	01/12/2020
Consultant Anaesthetist General x 2	Vacancy	Yes	03/02/2021
Consultant Orthopaedic Surgeon, Specialising in Foot & Ankle	Vacancy	Yes	TBC

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

Post Title	Reason for advertising	Start Date
Acting up Consultant in Obstetrics & Gynaecology	Vacancy	02/11/2020
Locum Consultant Plastic Surgeon	Extension	01/11/2020
Locum Consultant Foot and Ankle Surgeon	Extension	01/11/2020
Consultant in Acute Medicine	Vacancy	02/11/2020
Radiologist	Retire & Return	02/11/2020
Head & Neck MDT Lead	Vacancy	02/11/2020
Locum Consultant Neurologist	Extension	11/11/2020
Locum Consultant Haematologist	Vacancy	16/11/2020
Locum Consultant Paediatrician - PICU	Extension	20/11/2020

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

Post Title	Closing Date	Note
Locum Consultant - Winter Pressures	04/11/2020	No Applications

3. Covid-19

We continue to face significant pressures across both of our hospitals while we juggle the numbers of patients arriving in our Emergency Departments, together with our urgent elective work and increasing staff absence due to Covid-19.

We continue to work closely with our partners to manage these pressures across the system, although it is becoming increasingly challenging and I am very grateful to all of our staff who are helping us through this with their hard work and endless commitment. To support our staff we have been running UHNM Live Q&A sessions. These are viewed on average by 3,000 staff with positive feedback received of presenting an honest and open organisation and viewed as an excellent way of communicating.

Summary of Key Decisions Made:
As Chief Executive, I have exercised my authority to make a number of decisions which have been necessary to assist with our management and response to the critical incident. These are summarised as follows:

- **12th November 2020:** Extension provided for replying to complainants agreed.
- **13th November 2020:** Performance and Development Reviews paused, for an initial period of 4 weeks
- **16th November 2020:** Policy change regarding P3 and P4 waiting list patients, not to be listed due to capacity, sickness and infection rates. Patients being managed through clinical priority meetings.
- **17th November 2020:** Policy reviews to be considered for extensions on a case by case basis.
- **17th November 2020:** Covid-19 Business Continuity Terms of Reference agreed by Board members and enacted. Agreed streamlined papers, focused agendas and use of virtual technology as alternative.
- **18th November 2020:** Minor Injuries Unit transferred from Royal Stoke to Haywood, with immediate effect.
- **23rd November 2020:** Tertiary Paediatric Intensive Care Unit referrals to move to Birmingham Women's and Children's Hospital with immediate effect.
- **26th November 2020:** Agreement with Critical Care Major Trauma Network to formally divert some major trauma via secondary transfer to be reviewed 30th November.

4. Level 4 Major Incident – Critical Care

Our Critical Care Unit has experienced particular challenges due to the volume of patients requiring high dependency treatment combined with high numbers of staff sickness. As a result, we took the decision on 26th November to escalate Critical Care to level 4, with the rest of our hospitals remaining at level 3.

As a result of the actions taken in response to the level 4 incident, the Critical Care Unit pressures eased considerably and as of 12:00 on 1 December the Critical Care internal incident level 4 was stood down. This means the agreement with partners and colleagues across the Midlands Critical Care and Major Trauma Networks and neighbouring hospitals to reduce the impact on critical care of major trauma and other tertiary services ceased although we will keep the position of our critical care unit under daily review.

We are particularly grateful to the University Hospitals of Birmingham NHS Foundation Trust and Coventry and Warwickshire NHS Trust for their agreement to support the secondary transfer of major trauma patients if required and to surrounding trusts who have supported the decongestion of our Critical Care Unit by accepting a number of our critical care patients.

In relation to the secondary transfer of major trauma patient that was agreed, I can confirm that no patients were transferred. The majority of the decongestion was as a result of the usual mutual aid transfers that occurred.

5. Staffordshire and Stoke-on-Trent – Tier 3

It has been confirmed that Staffordshire is to join Stoke-on-Trent in the Covid-19 Very High Alert Level (Tier 3) when the current national lockdown restrictions end on December 2.

Sticking to the Very High Tier rules will be the best chance of bringing down community infection rates and reducing hospital admissions. Covid seven-day case rates in Staffordshire are currently around 300 per 100,000 population, still above the West Midlands and England averages.

The Very High Alert Level will come into force when lockdown ends on December 2. This means:

- No mixing anywhere indoors with other households, unless part of your support bubble
- Up to six people can meet in public parks, but not in private gardens
- Hospitality such as pubs and restaurants to stay shut, apart for takeaway and drive-through services
- Gyms and non-essential shops to reopen
- Work from home if you can, avoid non-essential travel and no overnight stays outside the area
- Wedding receptions banned

Full details can be found at www.gov.uk.

6. Maternity Partners and Visiting

There is mounting political pressure on all maternity services to unlock services to allow for visiting by partners, which had been restricted as a result of Covid-19. A red / amber / green rating has been applied to all organisations with maternity services, with our own service currently rated as amber.

We are required to submit a weekly national return setting out our position and this is being co-ordinated and submitted by our Head of Midwifery.

7. Lateral Flow Staff Testing

Our Pre-AMS Team and Corporate Nursing Team continue to roll out lateral flow device (LFD) screening kits across the Trust to all patient facing staff (defined as those staff who have regular face to face contact with patients). These tests are undertaken by our staff, at home, prior to starting a shift and are key to identifying Covid-19 positive cases where they may not be experiencing any symptoms.

Whilst we are currently rolling out testing kits to patient facing staff only, this will be subject to review, based on any further allocations of the testing kits from the Department of Health and Social Care.

8. Spending Review

Below is a summary of the spending review in relation to health and social care. It confirms an additional £38bn to tackle the virus in 2020/21, as well as setting aside £55bn in 2020/21 for a COVID support package for public services.

Core Revenue Funding

- The core revenue budget will grow from £132.4bn in 2019/20 to £147.1bn in 2021/22 – a real terms increase of 3.5%
- This includes an NHS England budget of £136.1bn in 2021/22, with the government reaffirming its long-term commitment to increase the NHS funding to £148.5bn by 2023/24

Core Capital Funding

- The DHSC's core capital budget will grow from £7.0bn in 2019/20 to £9.4bn in 2021/22 – a real terms increase of 13.4%
- This includes £4.2bn in 2021/22 for NHS operational capital investment to allow hospitals to refurbish and maintain their infrastructure

- The government also made two multi-year capital funding commitments, both of which will come out of DHSC core capital funding:
  - £3.7bn until 2024/25 to make progress on building 40 new hospitals by 2030
  - £1.7bn until 2024/25 for over 70 hospital upgrades to improve health infrastructure across the country over the long-term

COVID-19 Funding

- The government announced £20.3bn to help the NHS cover COVID-19 related costs in 2021/22, on top of the more than £50bn made available in 2020/21
- The 2021/22 funding includes £15bn for Test and Trace, £2.1bn to maintain and distribute stocks of personal protective equipment, and £163m for medicines and therapeutics
- It also includes £3bn for an 'NHS recovery package' and, as first announced on 22 November 2020, this will cover:
- Around £1bn to begin tackling the elective backlog
  - Around £500m to address waiting times for mental health services
  - Around £1.5bn to help ease existing pressures in the NHS caused by COVID-19.

In addition to the recovery package set out above, the Chancellor also announced:

- £325m for the NHS to invest in new diagnostics equipment, such as MRI and CT scanners
- £260m for Health Education England to support the training and retention of the NHS workforce
- £559m to support the modernisation of technology across the health and care system
- £165m for the eradication of mental health dormitories
- £9.4m to improve maternity safety (the government will also publish a consultation next year aimed at improving patient safety and tackling the rising costs of clinical negligence)

Social Care

The Chancellor announced that local authorities will be able to access over £1bn of spending for social care through £300m of social care grant and the ability to levy a 3 per cent adult social care precept. This funding is additional to the £1 billion social care grant announced last year which is being maintained. The government expects to provide local authorities with over £3 billion to address COVID-19 pressures, including in adult social care. In the longer term, the government states that it is committed to sustainable improvement of the adult social care system and will bring forward proposals next year. An additional £2.1 billion will be provided to local authorities through the Better Care Fund which will be pooled with the NHS to help meet adult social care needs and reduce pressures on the NHS.

Further COVID-19-related funding commitments:
Since the beginning of the pandemic, the government has spent over £280bn to support the economy through the coronavirus pandemic. The Chancellor announced today an additional £38bn of support for public services for 2020-21 and £55bn for 2021-22. Within the £55bn, £21bn will be contingency funding. The government says that it 'remains committed to ensuring the NHS has the certainty it needs to plan and will agree further funding for operationally necessary direct COVID-19 costs with the NHS next year'.

The £38bn for 2020-21 includes:

- £52bn for frontline health services to tackle the pandemic including £22 billion for the Test and Trace programme, over £15 billion for the procurement of personal protective equipment (PPE) and £2.7 billion to support the development and procurement of vaccines
- Over £5.4 billion to help local authorities in England respond to the impact of COVID-19 in 2020-21, on top of £1.6 billion awarded in 2019-20, bringing the total to date to over £7 billion
- £12.8 billion for the transport network.
- Education funding of £1.4 billion
- £1.9 billion for DWP to deliver labour market support, including through the Kickstart Scheme
- Over £270 million in 2020-21 to support the recovery of the justice system,

Funding for 2021-22 includes:

- £733m in 2021-22 for the UK Vaccines Taskforce to purchase successful vaccines and £128 million for research and development (R&D) and vaccines manufacturing.
- £15bn to support enhanced testing capacity, including regular testing of NHS staff and social care workers.
- £163m to increase supplies of key medicines for treating COVID-19 patients.

Public Sector Pay
The Chancellor announced a pay freeze for public sector workers in 2021-22, excluding NHS workers.

The NHS Pay Review Body and Doctor and Dentist's Review Body will report as usual next spring, and the government will take their recommendations into account. The government will also provide a minimum increase of £250 to public sector workers earning less than £24,000.

At this stage, it is still unclear what the total additional funding needs associated with COVID-19 might be for next year.

9. Imaging Network

We have received correspondence regarding the establishment of one Imaging Network covering the West Midlands. This is currently subject to consideration and review by our Imaging Department who will liaise with our regulators at NHSIE around our preferred approach.

Further information on how this progresses will be shared with the Board when this becomes available.

10. Number CEO Awards

While our staff are facing such unprecedented challenges, it is more important than ever that we continue to recognise their achievements and commitment. Therefore, during November I was delighted to award the Critical Care Team, Medical Secretary Sue Robinson and Ward 221 with my CEO Award.

The Critical Care Team have launched a new pilot clinic which aims to help patients with 'long Covid'. The comprehensive and innovative virtual clinic will be provided by a multidisciplinary team and will act as a one-stop-shop for patients who have recovered from a critical illness secondary to Covid-19. It will involve rehabilitation coordinators, specialised therapists (speech and language therapy, occupational therapy, physiotherapy and psychology) and critical care consultants. UHNM is one of the first trusts in the northern area to offer this service, which will run for four months.

Sue Robinson has demonstrated exemplary safeguarding practice when she received a distressed call from a member of the public whilst in the office and her prompt and professional response ensured appropriate escalation, potentially saving a person from coming to harm.

Ward 221 have had a challenging eight months. From March of this year they became a Covid ward. All staff were supportive of each other and they adapted amazingly to a new way of working. They remained positive and provided high quality care to their patients. They reverted back to cardiology in June and again were very supportive and resilient. They have now become a Covid ward for the second time.

11. Virtual Christmas Tree Lights Switch-on

Light Switch-on ceremonies will take place virtually on **Monday 30 November 2020**. The service will be available at 11am and is available on the UHNM Charity Facebook account, UHNM Staff Facebook Group and also on the staff intranet.

The Christmas Tree at County Hospital has been funded solely by UHNM Charity, whilst the Christmas Tree at Royal Stoke has been jointly funded again by UHNM Charity and Sodexo. Staff, patients, their families and carers and members of the public are warmly invited to tune in to watch the switch-ons, which will include a service led by our chaplaincy, and choirs sent in from local schools.

12. Christmas Charity Appeal

Christmas at UHNM is always great fun and while we have to do so many things differently this year, we are determined that Christmas 2020 will be extra special for all our staff and patients. Our UHNM Charity team has planned a number of fantastic surprises – most of which will be virtual – and these kicked off

with the Christmas light switch on our social media channels and I will even be speaking to the big man in red myself to ensure he can still visit our Staffordshire Children's Hospital! There will be a virtual advent calendar offering fun facts and some special messages from UHNM supporters so please do follow closely. The charity and communications team are also appealing for staff and local companies and organisations to get involved, so if you want to share any messages for staff, patients or our local communities please get in touch at communications@uhnm.nhs.uk and find out how.

In previous years, generous individuals, businesses and community groups donate gifts to patients and staff at County Hospital and Royal Stoke University Hospital. However, this year festive drop-offs cannot take place as usual due to Covid-19 restrictions within the hospitals so the UHNM Charity has launched an online appeal where people can donate online or by text. UHNM Charity will use all of the funds donated to its appeal to purchase thousands of gifts which will be distributed to wards across its two hospitals. People can donate by going to the UHNM Charity website fundraising page or use their mobile to donate through text. **Text santauhnm5 to 70450 to donate £5, santauhnm10 to 70450 to donate £10 or santauhnm20 to 70450 to donate £20**. For more information you can head to UHNM Charity's website or call them on 01782 676444.

13. UHNM Magazine – Covid Special

UHNM News Covid Special edition is now out and contains an amazing compilation of stories highlighting the exceptional work our staff have done over this unprecedented period. Throughout the year, the Trust has seen a steady rise in the numbers of people engaging with the social media channels and the Trust's intranet now has over 10,000 unique visits per day (this measure does not count the same person twice).

The Trust has launched its winter communications campaign which is builds on the successes of the 2019/2020 the Where for Care? campaign which reached 860,000 people in Staffordshire and Stoke-on-Trent - a 18% increase in reach compared to the previous year. The 2020/21 Where for Care? campaign re-introduces our UHNM 'Winter' family as well as some additional characters who each have their own 'mini-emergency' and require care in the right place. The campaign strongly links to the national winter campaign Help Us Help You and in line with national and regional plans to launch Think 111 First - the campaign includes calls to action for Think 111/ 111 First.

14. NHS Midlands STaR Board

As Board are aware I am a member of one of the STaR Boards Sub-groups 'Clinical Services and Commissioning Strategies'. The last meeting took place in November and a brief highlight is provided below:

Three clinical areas have been identified as areas for focused action - cancer, mental health/learning disabilities and paediatrics/ maternity/neonatal. The Groups are clinically led, and patient views are being sought. Through further analysis and discussion the sub-groups are honing in on specific pathways or services where it is felt most benefits can be generated, including a particular focus on benefits in relation to reducing health inequalities:

- **Cancer**: Focus on pre-hospital late-stage presentation with the aim to develop a framework that systems can use to optimise pre-hospital pathways and address inequalities in accessing services. The second element is to build on Cancer Alliance led work on reducing unwarranted variation in MDT treatment of five complex tumour pathways, with the potential to use the outputs and then apply the learning to more common cancers. Myself and our Cancer Manager are attendees of these meetings.
- **Paediatrics / Maternity / Neonatal:** A long list of potential areas are being considered by the sub-group and these will be prioritised so that one chosen pathway or life-course is selected as the first area to focus on
- **Mental Health/Learning Disabilities:** Initial data on inequalities has been generated for consideration by the workstream.

Quality Governance Committee Chair's Highlight Report to Board

26th November 2020

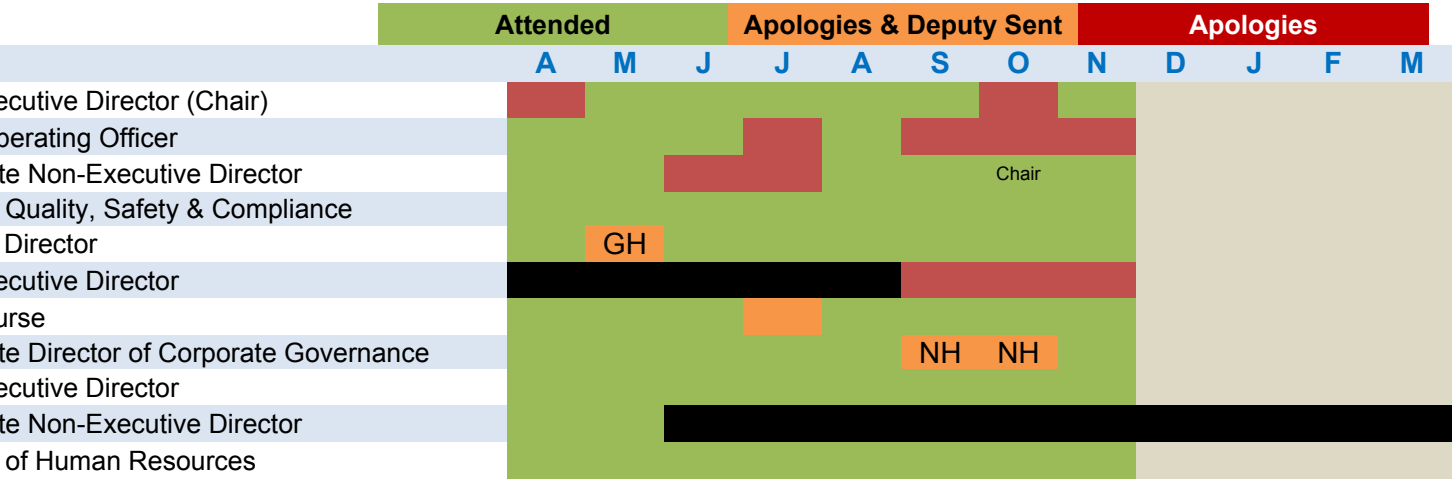
1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Still very challenged with absence levels with 63% absence being Covid related; being supported by staff testing, with lateral flow testing now underway although this is picking up around 1% positive tests which is in line with other organisations • Key challenges with nursing numbers and as a result have seen increased numbers of falls and pressure ulcers which is currently being investigated and will be reported back to the Committee; as a result staff are feeling very tired and anxious • Escalated to Level 4 in Critical Care due to the number of patients / dependency and also low staffing numbers; there are transfers being undertaken although this is having a negative impact on patient experience with issues being raised by their family members • Despite the significant challenges, it is not believed that the peak in critical care has been reached as yet • Maternity services are under pressure from the national team to allow for partner visiting; this is a highly political matter – a weekly return on progress is being submitted each week • Key issues within the CQC action plan related to the 15 minute treatment time and patient flow	• A review of incidents which have demonstrated an increase in harm as a result of staffing pressures is being undertaken and will be shared with the Committee • Confirm and Challenge Sessions being organised with Divisions, focussing on the delivery of CQC Action Plans • Patient First is a support tool for clinicians in Emergency Departments; this is being worked through within the Medical Division who have undertaken a gap analysis and the actions/risks will be added into the Assurance Framework which will come to the Committee in January • Outstanding Mortality Outlier reports as highlighted within the CQC Insights Report have been discussed with the CQC and have been responded to; these have now been closed by the CQC which should feed through into the January report
Positive Assurances to Provide	**Decisions Made**
• 69% staff have received their flu vaccine and this is 25% ahead of this time in the previous year; over 8000 staff have received their vaccine • Plans are in place for roll out of the Covid vaccine • Sepsis indicators have been updated so as to ensure alignment to those reported to the Infection Prevention Committee • Improvement has been seen in Duty of Candour indicators with further support being provided to Divisions in ensuring that letters are issues in accordance with the requirements • Improvements are being seen in the number of open Serious Incidents; an internal audit review has been undertaken which demonstrates positive initial findings – the final report will be presented to Audit Committee	• Approval of the Quality Account 2019/20 which incorporated comments from CCG's regarding content of the report; this will be taken to the Trust Board for final approval prior to publication
Comments on Effectiveness of the Meeting	
• Although a shorter meeting, members found the meeting to be helpful – consideration is to be given as to the format of December's meeting	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Clinical Negligence Scheme for Trusts	Assurance	8.	CQC Patient First	Assurance
2.	Saving Babies Lives Care Bundle Divergence	Approval	9.	CQC Insight Report	Assurance
3.	Q2 Perinatal Mortality Report	Assurance	10.	Quality Account 2019/20	Approval
4.	Fire Annual Report	Assurance	11.	Executive Health & Safety Group Highlight Report	Assurance
5.	M6 Quality and Safety Report	Assurance	12.	Quality and Safety Oversight Group Highlight Report	Assurance
6.	Q2 Serious Incident Summary	Assurance	13.	Review of Meeting Effectiveness	Information
7.	CQC Action Plan Update	Assurance	14.	Review of Business Cycle	Information

3. 2020 / 21 Attendance Matrix



In addition Mrs Dudley, Ms Meehan, Ms Moppett and Mrs Wallis joined the meeting.

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	9th December 2020
Report Title:	Infection Prevention Board Assurance Framework COVID-19 – November 2020	**Agenda Item:**	8.
Author:	Helen Bucior, Infection Prevention Lead Nurse Emyr Philips , Associate Chief Nurse Infection Prevention/Deputy DIPC Claire Rylands Associate Director of Corporate Governance		
Executive Lead:	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	✓	
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 is 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 systems, 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.

University Hospitals of North Midlands NHS Trust

Infection Prevention and Control Board Assurance Framework

November 2020

2020/21

Summary Board Assurance Framework as at Quarter 1 2020/21

Ref / Page	Requirement / Objective	Risk Score				
		Q1	Q2	Q3	Q4	Change
BAF 1 Page x	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 Page x	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	6	3			↓
BAF 3 Page x	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	9	9			→
BAF 4 Page x	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 Page x	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 Page x	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 Page x	Provide or secure adequate isolation facilities.	6	3			↓
BAF 8 Page x	Secure adequate access to laboratory support as appropriate.	6	6			→
BAF 9 Page x	Have and adhere to policies designed for the individuals and provide organisations that will help prevent and control infections.	6	3			↓
BAF 10 Page x	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	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 • Aerosol generating procedures in single rooms with doors closed • ED navigator records patient temperature and asked COVID screening questions. Patient then directed to either remain in purple or blue single room • ED pathways and SOP • When ambulance identify suspected	• From June 2020 IP team to review patients that are found COVID positive and nursed in bay to ascertain compliance with pathway and IP control measures are in place Review pathways and identify theme • Theme report to IPCC • Pre AMS check COVID -19 screening results, if patient arrives in green area with no COVID screen a Datix is raised.	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls	Gaps in Control or Assurance
		COVID patients are received in respiratory assessment Unit ED • All patients screened for COVID -19 when decision made to admit • Maternity pathway in place • Elective Pre Amms Plan to swab • Patients72 hours pre admission SOP in place • Radiology /interventional flow chart • Children's unplanned admission. ED Navigator asked COVID questions then child directed to either RED of Green Areas. • All children, symptomatic or asymptomatic are swabbed in child health. This is recorded within their medical records, placed onto the nursing and medical handover so that we are made of the results and whether we need to chase if not received within a timely manner. The patient flow reports to the Child Health tactical meeting every morning how many children have been swabbed result and any outstanding • All children swabbed are placed into a sideward upon receiving their result are either kept within a side ward or moved to a bay if the swab is negative. • Screening for patients on systematic anticancer treatment and radiotherapy • Out patient flow chart in place • Thermal imaging cameras in some areas of	• June 2020 Children department plan to audit of 10 patients to check the process	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls	Gaps in Control or Assurance
		the hospital • Iportal alert in place for COVID positive patients • Extremely vulnerable patient placement added into new COVID ward round guidelines (October 2020)		
1.2	Patients with possible or confirmed Covid-19 are not moved unless this is essential to their care or reduces the risk of transmission.	• 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	• Unannounced visits for clinical areas with clusters or HAI cases of COVID-19 • Review of HCAI COVID cases by IP Team • Datix /adverse incidence reports for inappropriate transfers	• NHSI key point 4 : Patients are not moved until at least two negative test results are obtained, unless clinically justified
1.3	Compliance with the national guidance around discharge or transfer of Covid-19 positive patients.	• Infection prevention step down guidance available on Trust intranet • All patients who are either positive or s are positives are advised to complete self –isolation if discharged or transferred within that time frame  actions-to-be-taken-i f-a-patient-is-identifie • All patients are screened 48 hours prior to transfer to care homes • New UHNM ward round guidance October 2020. This also included placement of the extremely vulnerable patient	• Datix/adverse incidence reports	• Patient COVID -19 discharge information letter for patient who are discharged but contact of a positive case

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls	Gaps in Control or Assurance
1.4	**All staff (clinical and non-clinical)** are trained in putting on and removing PPE, know what PPE they should wear for each setting and context and have access to the PPE that protects them for the appropriate setting and context as per national guidance. Linked NHSIE Key Action 3: Staff wear the right level of PPE when in clinical settings, including use of face masks in non-clinical settings.	• Key FFP3 mask fit trainers in place in clinical areas • PPE posters and information available on the Trust COVID -19 page. This provides the what, where and when guide for PPE • Infection Prevention Questions and Answers Manual include donning and doffing information. • Areas that require high level PPE are agreed at clinical and tactical • Aerosol generating procedures (AGP's) which require high level PPE agreed at clinical and tactical group • COVID -19 Clinical Group reviews any proposed changes in PPE from the clinical areas • Link to Public Health England donning and 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	• Daily stock level of PPE distributed via email and agenda item for discussion at COVID-19 tactical group • IP complete spot check of PPE use if cluster/OB trigger • Records of Donning and Doffing training for staff trained by IP • A number of Clinical areas have submitted PPE donning an doffing records to the IP team • Donning and Doffing training also held locally in clinical areas • Cascade training records held locally by Divisions • Sodexo and Domestic service training records	• 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?
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	• Clinical Group meeting action log held by emergency planning	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls	Gaps in Control or Assurance
		• 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 held daily. The Group made decided and agreed tactical actions into the incident. UHNM is now in Restoration phase with daily tactical meetings • Chief nurse updates • Changes/update to staff are included in weekly Facebook live sessions • COVID -19 intranet page • COVID -19 daily bulletin with updates • IP provide daily support calls to the clinical areas		
1.6	Changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted.	• Incidence Control Centre (ICC) Governance • Clinical Group , Divisional cells, Workforce Bureau , Recovery cells subgroup feed in to tactical group. • COVID Gold command , decisions /Assurance reported to Trust Board Via CEO Report/COO	• Meeting Action log held by emergency planning • Trust Executive Group Gold command – Overall decision making and escalation • Tactical, Operational Delivery Group - The delivery of the objectives	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls	Gaps in Control or Assurance
			and benefits, and programme communications COVID 19 response and R&R. Co - ordination of resources. Escalation forum for linked Groups and Cells ensuring that the interdependencies are effectively managed, including system. Makes recommendations to Gold Command for key decisions. • Clinical steering Group – Coordinate clinical decision – making to underpin continual service delivery and COVID 19 related care • Workforce Group – Lead the plan and priorities for our people recovery . Health and Wellbeing. Agree significant pipeline changes in working practices. Agree the impact if change made during COVID and priorities to support recovery • Divisional Groups – Agree infection Prevention measures  COVID19RRGOVERNANCE NOV20v1.pptx	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls	Gaps in Control or Assurance
1.7	Risks are reflected in risk registers and the Board Assurance Framework where appropriate. • Linked NHSIE Key Action 5: Daily data submissions have been signed off by the Chief Executive, the Medical Director or the Chief Nurse and the Board Assurance Framework is reviewed and evidence of reviews is available. • Linked NHSIE Key Action 9: Local Systems must assure themselves, with commissioners that a Trust's infection prevention and control interventions are optimal, the Board Assurance Framework is complete and agreed action plans are being delivered.	• Risk register and governance process • Datix incidents • Board assurance document standing agenda item Trust board and IPCC. • TOR • Outbreak IImarch submissions are copied to Chief Nurse/DIPC and exec Team • Outbreak areas are included in daily tactical meeting • Definite Nosocomial COVID 19 case numbers are in included in Quality Performance Report	• IP risks are agenda item at Infection Prevention and Control committee (IPCC) • Definite Nosocomial COVID 19 case numbers are in included in Quality Performance Report	
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	• 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	• 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, haematology/oncology wards and renal ward, this is under review.

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls	Gaps in Control or Assurance
		establish person to person transmission, Leeds Hospital are now undertaking this service • Proud to care booklets revised an reinstated August/September 2020	England. Clostridium difficile, MRSA blood stream infections (bacteraemia) and Gram Negative blood stream infections • Seasonal influenza reporting • Audit programme for proud to care booklets	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 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	
2	1.1	Revised pathways to include actions for extremely vulnerable patients who are admitted into the Trust	ACN's	31/10/2020	4th September Chief Nurse DIPC request at senior meeting that extremely vulnerable patients are included in revised pathways. October 2020 Extremely vulnerable patient recommendations included into the COVID ward round guidance document. November 2020 – Confirmation from ED County highly vulnerable patients are admitted into single cubicle. Consultant ED Royal confirms the same process. Children's – highly vulnerable have direct access to ward	
3	1.2	NHSI key point 4 : Patients are not moved until at least two negative test results are obtained, unless clinically justified	Microbiologist	13/12/2020	Testing and re testing, Interpretation of swabs and step down of IP precaution process in place at UHNM. Patients are occasionally moved after one negative but only on **clinical need/assessment** and in line with UHNM step down process. Previously swabs are repeated on patients who test negative on admission on day 5 17th November NHSI guidance recommended that the second	

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
					test is taken on day 3 after admission and day 5-7 after admission. Implementation of the new guidance is underway and a manual prompt is provided to the clinical areas.	
3	1.3	Patient COVID -19 discharge information letter for patient who are discharged but contact of a positive case	IP Team	31/11/2020	Action at COVID weekly meeting was to create an information leaflet for patients and household members on discharge, with information on isolating, symptoms and useful information for informing the local authorities and the test and trace system. 6th November leaflet sent out for comments	
4	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	
5.	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.	
6.	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	

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
7.	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	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	• SOP and cleaning method	• Spot check assurance audits	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls	Gaps in Control or Assurance
	in required techniques and use of PPE are assigned to Covid-19 isolation or cohort areas.	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	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		

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls	Gaps in Control or Assurance
2.6	Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses.	• Virusolve and Tristel disinfectant used • Virusolve wipes also used during height of pandemic	• Evidence from manufacture that these disinfectants are effective against COVID -19 • Evidence of Virusolve weekly strength checks , held locally at ward /department level • IP checks that disinfectant is available during spot checks	
2.7	Manufacturers guidance and recommended product 'contact time' must be followed for all cleaning / disinfectant solutions / products.	• Contact times detailed in SOP and cleaning methods statements • Included in mandatory training • Included in IP Q+A • Disinfectant used routinely		
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). Linked NHSIE Key Action 1: All high touch surfaces and items are decontaminated multiple times every day – once or twice a day is insufficient.	• Frequently touch points included in Barrier clean process • Offices and back offices also supplied with disinfectant wipes to keep work stations clean. • Non- invasive medical equipment is decontaminated after each use. IP Q+A manual	• IP checks • Barrier clean request log • Terminal clean request log	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls	Gaps in Control or Assurance
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 • Red alginate bags available for the clinical areas • Infected linen route	• IP audits held locally by divisions • Datix reports/adverse incidents	
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 • UHNM has established a Ventilation Safety Group as recommended by the Specialised Ventilation for Healthcare Society in order to provide assurance to the Trust Board on the safe operation and	• Estates have planned programme of maintenance • The Authorising Engineer Ventilation will provide external independent specialist advice and support as well as carrying	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls	Gaps in Control or Assurance
		reduction in risk of infection transmission through ventilation systems. TOR written • The Trust also appointed external authoring Engineers. This is in line with the NHS estates best practise and guidance from Health Technical Memorandum (HTM) namely 03/01 Specialised Ventilation for Healthcare Premises.	out an annual audit for system compliance.	

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	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.

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls	Gaps in Control or Assurance
			generating action plans for ward teams	
3.2	Mandatory reporting requirements are adhered to and boards continue to maintain oversight. Linked NHSIE Key Action 5: Daily data submissions have been signed off by the Chief Executive, the Medical Director of the Chief Nurse and the Board Assurance Framework is reviewed and evidence of reviews is available. Linked to NHSIE Key Action 10: Local systems must review system performance and data, offer peer support and take steps to intervene as required.	• Quarterly point prevalence audits maintained by AMS team at UHNM despite many regional Trusts not undertaking any more. • 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. Escalation process to be agreed. Meeting between Antimicrobial Pharmacist and Deputy DIPC undertaken. Escalation process to be discussed at November Antimicrobial Stewardship Group.	

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	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 bedside care. We will continue to monitor prevalence and changes in	• Monitored by clinical areas • PALS complaints/feedback from service users	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls	Gaps in Control or Assurance
		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. Linked NHSIE Key Action 4: Patients are not moved until at least two negative test results are obtained, unless clinically justified.	• Transfer policy C24 in place , expires November 2020 • IP COVID step down process in place	• Datix process	

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

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	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 • ED navigator provide masks	• Hospital entrances Mask dispensers and hand gel available	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls	Gaps in Control or Assurance
		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. Linked NHSIE Key Action 6: Where bays with high numbers of beds are in use, these must be risk assessed, and where 2m can't be achieved, physical segregation of patients must be considered and wards are effectively ventilated.	• 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 • Chief Nurse/DIPC visited clinical areas to review social distancing within bays. A number of beds have been removed throughout the Trust.	• 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	• If patient found to be positive in the bay and exposing other patient. IP liaise with clinical are, apply bay restrictions.	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls	Gaps in Control or Assurance
		• 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	• Patient who tested negative on admission and remain an inpatient are retested for COVID at day 5	
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	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	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls	Gaps in Control or Assurance
		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	• Monthly hand hygiene audits completed by the clinical areas • Infection Prevention hand	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls	Gaps in Control or Assurance
	Linked NHSIE Key Action 1: Staff consistently practices good hand hygiene.	• Poster for hand hygiene technique displayed at hand wash sinks and stickers on hand soap and alcohol dispensers • Alcohol gel availability at the point of care	hygiene audit programme. Overview of results fed into 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	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 • Blue COVID wards identified at both sites created during second wave • 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	
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	• Infection Prevention Questions and Answers	• RCA process for Clostridium *difficile*	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls	Gaps in Control or Assurance
	appropriate patient placement.	Manual includes alert organisms/resistant organism • Support to Clinical areas via Infection Prevention triage desk • Site team processes	• Outbreak investigations • MRSA bacteramia investigations • Datix reports	

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 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	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. This has been updated in November 2020 • Laboratory services for UHNM are located in the purpose built Pathology Laboratory on-site at RSUH. The Laboratory is United Kingdom Accreditation Service (UKAS) accredited.	• 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. Linked NHSIE Key Action 7: Staff Testing: a) Twice weekly lateral flow antigen testing for NHS patient facing staff is implemented. Whilst lateral flow	• All patients that require an overnight stay are screened for COVID-19 • Screening process in place for elective surgery and some procedures e.g. upper endoscopy	• Empactis reporting • Team Prevent systems • Datix/adverse incidence reporting • Cluster /outbreak investigation procedures	

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

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls	Gaps in Control or Assurance
	within 3 days before admission and patients must be asked to self-isolate from the day of the test until the day of admission.			
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	Champions COVID-19 swabbing technique in clinical areas	Deputy Director if infection Prevention	31/12/2020	Training package and recording system to be devised. Work to commence. 1st September swabbing video recorded, minor changes to be completed week commencing 14th September then video will be circulated to key people for preview and comments. Child positioning included in video Screening video now complete and uploaded on to Trust intranet November 2020. A number of areas have identified swabbing Champions, request sent to ACN's. Implementation of champions in progress.	
2	8.2	NHSIE Key Action - Those who test negative upon admission must have a second test 3 days after admission and a third test 5-7 days post admission	Microbiologist/IP Team	07/12/2020	Following NHSI new guidance Those who test negative for COVID on admission are to be retested on day 4 and day 6, with **admission day counted as day** one. Implementation of this is underway	
3	8.2	Those who test negative upon admission must have a second test 3 days after admission and a third test 5 days post admission	Deputy Chief Nurse	07/12/2020	Report received by Deputy Chief Nurse on a daily basis with list of patients that are due for re screen. Clinical areas then contacted and prompt to re screen.	
4.	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	

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

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

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

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 2 Progress Report	BRAG
1.	9.1	CEF Audits to recommence	Deputy Director of Quality and Safety	30/09/2020	Review of tool kit with Chief Nurse planned, aiming to trial during August and reinstate audits fully during September 2020. CEF audits reinstated.	
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	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	• SOP for reusable face masks and	• Training records for reusable	• Availability of locally held

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls	Gaps in Control or Assurance
	undergo training that is compliant with PHE national guidance and a record of this training is maintained.	respiratory hoods in place	masks	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 care pathways and urgent and emergency care pathways, as per national guidance.	• Restore and Restorations plans	• Incidence process/Datix	
10.4	All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas. Linked NHSIE Key Action 2: Staff maintain social distancing in the workplace, when travelling to work (including avoiding car sharing) and to remind staff to follow public health guidance outside of the workplace.	• Social distancing tool kit available on COVID 19 intranet page • Site circulation maps • Keep your distance posters • COVID-19 secure declaration • Social distancing risk assessment guidance for managers presentation 5th June2020 • Meeting room rules • Face masks for all staff commenced 15th June • Visitor face covering • COVID secure risk assessment process in place • November 2020 – Care sharing instructions added to COVID Bulletin	• Social distance monitor walk round introduced Friday 5th June • Social distance department risk assessments • COVID-19 secure declarations	
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	• Team Prevent available to offer	• Team prevent monitoring	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls	Gaps in Control or Assurance
	staff who are self-isolating are supported and able to access testing.	guidance and treatment to staff presenting with onset of symptoms.	process • Work force bureau	
10.7	Staff who test positive have adequate information and support to aid their recovery and return to work.	• Team Prevent available to offer guidance and treatment to staff presenting with onset of symptoms. • Empactis line will first ask – is the absence related to coronavirus. To which the employee must say yes or no • Once the absence is reported to the employees manger via email, the manager will categorise the absence type specified in the flow chart. • Team prevent complete COVID 19 staff screening • Areas where transmission has occurred are discussed at clinical group and relevant staff screening under an ILOG number is agreed. • Flow charts or staff returning to work available on COVID 19 section of intranet	• Via emapactis • Staff queries' through workforce bureau or team prevent	

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

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	9th December 2020
Report Title:	NHS England and NHS Improvement IPC Visit	**Agenda Item:**	9.
Author:	Michelle Rhodes, Chief Nurse/DIPC		
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		✓
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 following the NHSEI visit held on 10th November 2020 which took place due to a number of outbreaks within the Trust, and focussed on Covid-19 outbreak management.

Background

The visit was undertaken as part of the NHSEI assessment of the escalation matrix and considered the actions and meetings taking place in relation to management of Covid-19, visits to clinical areas and discussions and observations of staff.

Assessment

Correspondence has since been received following the visit which will be discussed by the Quality Governance Committee in December 2020. The Trust had previously been assessed as Green on the NHSEI internal escalation matrix and following the visit, this was increased to Amber. An action plan will therefore be developed to address the issues raised.

Key Recommendations:

The Trust Board is asked to note receipt of the letter, which will be considered through the usual governance process, with discussion to be held at the next Quality Governance Committee.

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	9th December 2020
Report Title:	UHNM Quality Account 2019/2020	**Agenda Item:**	10.
Author:	Head of Quality, Safety & Compliance Department		
Executive Lead:	Chief Nurse		

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

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

Summary of other meetings presented to and outcome of discussion:

Quality & Safety Oversight Group (12/10/ 2020) – draft received and approved pending Executive Director agreement and circulation to External Stakeholders and publication in December 2020.

Executive Team (20/10/2020) – approved and noted link to new Delivering Exceptional Care

Audit Committee (22/10/2020) – approved by Audit Committee

Quality Governance Committee (26/11/2020) – approved by the Quality Governance Committee and acknowledged thorough and readable document.

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

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

The Quality Account has been shared with external stakeholders for completion and return of the final Stakeholder comments by 23rd November 2020, from Clinical Commissioning Groups, Overview & Scrutiny Committees of both Stoke-on-Trent City Council and Staffordshire County Council and Healthwatch. The final account including the stakeholder comments will be published on NHS Choices and website by 15th December 2020

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

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

The identified priorities for 2020/21, and agreed at Trust Executive level, are:

To continue to improve safe care and treatment to patients

How will we do this:

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

To improve staff engagement and well being

How will we do this:

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

To improve patient experience

How will we do this:

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

Part B of the account reviews the Trust's Quality Performance for 2018/19 against the priorities that were identified last year. These include both local and national results and how the indicators compare against the initial targets that had been set at the start of 2019/20.

Part C has been updated with the received comments from our external stakeholder. Unfortunately due to the COVID-19 pandemic Healthwatch and the Adults & Neighbourhoods Overview & Scrutiny Committee of Stoke on Trent City Council have been unable to return comments

Key Recommendations:

The Trust Board is asked to:

- To approve the final version of the Quality Account 2019/209 along with the new quality priorities for 2020/21 as identified at the Stakeholder Event in September 2020 and links to existing Trust aims and objectives.
- To recommend the Quality Account for final publication on NHS Choices and UHNM Trust website by 15th December 2020

NHS
University Hospitals of North Midlands
NHS Trust

We love our values

Together

Compassion

Safe

Improving

Quality Account

2019 / 2020

CONTENTS

Part A: Statement on Quality

OVERVIEW

1. Introduction to UHNM

Welcome to our new Quality Account about the University Hospitals of North Midlands NHS Trust (UHNM). The past 12 months 2019/2020 have been another challenging yet exciting year for us, nevertheless we have continued to deliver on our commitment to transform health services in Staffordshire, ensuring stability and future resilience. The past year will without question be remembered primarily for the devastating impact of Covid-19. Across the country the personal and family tragedies inflicted upon thousands of people across the UK were truly heartbreaking. Our sympathies and condolences go out to every single person affected by this terrible disease.

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

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

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

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

Many emergency patients are brought to us from a wide area by both helicopter and land ambulance because of our Major Trauma Centre status.

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

The County Hospital (Stafford)

Royal Stoke University Hospital

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

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

2. Statement on Quality

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

The year ended with us completely transforming the way we do things as a result of the Covid-19 pandemic and we have been overwhelmed with the professionalism, flexibility and positive attitudes from our staff. They have developed and implemented new ways of working and have been innovative and creative in finding solutions to sometimes seemingly impossible problems. Whilst we are fortunate to have escaped some of the levels of pressure seen in other parts of the country; with the support of our partners within the system and beyond, we are confident that our planning will provide us with the capacity needed to continue to provide safe and quality care should it become necessary to utilise. Covid-19 will continue to bring further challenges for us throughout 2020/21 and beyond but we have no doubt that together, we will come through and we look forward to seeing how the 'new NHS' evolves.

Our workforce is our greatest asset as without them, we would not be able to provide the care we do for our patients. We expect that staff will be professional, respectful and kind to each other and instil pride in their teams, working together for our patients. We will actively listen to our staff and encourage them to speak openly about their concerns or when things go wrong. We will learn from our mistakes and further develop knowledge and skills to improve.

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

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

- 29% reduction in rate of Patient Safety Incidents with harm per 100 admissions from 2018/19 to 2019/20
- 34% and 49% reduction respectively in Category 2 and Category 3 Hospital Acquired Pressure Ulcers with 'lapses in care' in 2019/20 compared to 2018/19
- Continued improvement in both the sepsis screening results for 2019/20 (over 90%)
- Exceeding the 95% National Target for Harm Free Care (New Harms) throughout 2019/20
- 23% Reduction in rate patient falls reported per 1000 bed days with harm during 2019/20 compared to 2018/19
- UHNM continues to compare well against peers during 2019/20 and remains within expected ranges for both HSMR and SHMI mortality indicators

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

- Emergency Department 4 hour target performance
- Continued improvement in Sepsis pathway and provision of Antibiotics within 1 hour
- Cancer 62 day standard

- 18 week Referral to Treatment standard
- Staff health, wellbeing and morale

Overall, we are proud of the progress we have made over the last year and we value the work of our staff in their contribution in achieving this. We know our staff strive for excellence for our patients and we are confident that through strong team working we will achieve our full potential together.

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

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

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

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

David Wakefield
Chairman

Tracy Bullock
Chief Executive Officer

2.2 Strategic Objectives

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

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

Our Strategic Objectives

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

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

Our Values

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

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

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

Priorities for Improvement

3.1 Our Quality Priorities and Objectives for 2020/21

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

We want everyone who works at UHNM to share this vision and place quality at the heart of everything we do by embracing and demonstrating the following values:

Delivering Exceptional Care

During 2020/21, we are beginning our new exciting quality improvement journey with the introduction of our Delivering Exceptional Care programme. Delivering Exceptional Care will help us become and world-class centre of clinical and academic achievement where staff work together to deliver high standards of care.

We are establishing a new Quality Improvement Academy to build greater capacity and support for all of our staff to use established quality improvement methodologies and lead in local and organizational quality improvement projects.

As part of the Quality Improvement Academy, UHNM are working closely with our local Universities to support the programme and link with the national NHS Patient Safety Strategy and the development of Patient Safety Specialists and involving our patients with the introduction of our Patient Safety Partners to help improve the quality of our services and care. The coming year and the identified priorities will form part of our improvement journey as UHNM moves forward in Delivering Exceptional Care.

Prioritising our quality improvement areas

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

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

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

Stakeholder Workshops

In September 2020, we held a stakeholder workshop and invited our members of staff and our partners from local councils, Clinical Commissioning Groups and Healthwatch. The aim of the workshops was to agree our priority quality objectives for 2020/21 with a focus on continuing to improve the priorities set in 2019/20.

Our Overall Goal for 2020/21 is:

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

Aims

To continue to improve safe care and treatment to patients

How will we do this:

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

Measure this through:

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

To improve staff engagement and well being

How will we do this:

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

Measure this through:

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

To improve patient experience

How will we do this:

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

Measure this through:

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

3.2 How we have performed against Quality KPIs during 2019/20

Quality Indicator	Previous Period		Current Period	
The value of the Summary Hospital level Mortality Indicator (SHMI)	**October 2017 – September 2018** 1.06 (Band 2)		**March 2019 – February 2020** 0.98 (Band 2)	
The percentage of deaths with palliative care coded at either diagnosis and/or specialty level	43.8%		47%	
Patient Reported Outcome Measures scores* *(National Average)* Groin hernia surgery Varicose Vein Surgery Hip Replacement Primary Surgery Knee Replacement Primary Surgery **EQ-5D scores finalised data release*	**Participation Rate 2017/18** 6.5% *(49.6%)* 0.0% *(55.8%)* 67.3% *(67.0%)* 72.4% *(65.7%)*	**Adjusted Health Gain 2017/18** *- (0.089)* *- (0.096)* 0.443 *(0.468)* 0.309 *(0.338)*	**Participation Rate 2018/19** - - 57.7% *(66.4%)* 66.3% *(73.7%)*	**Adjusted Health Gain 2018/19** - - 0.447 *(0.465)* 0.327 *(0.338)*
Percentage of patients aged 0 to 15; and 16 and over Readmitted to a hospital which forms part of the Trust within 28 days of being discharged from hospital	**No new data publication available from NHS Digital portal**		**No new data publication available from NHS Digital portal**	
The Trust's responsiveness to the personal needs of its patients	**2018/19 Survey** **64.3** *(England average 67.2)*		**2019/20 Survey** **66.0** *(England average 67.1)*	
Percentage of staff employed by the Trust who would recommend the trust as a provider of care to their friends and family (Agree / Strongly Agree)	**2018** **71.5%** *(England Average Acute Trusts 71.3%)*		**2019** **74%** *(England Average Acute Trusts 71%)*	
Percentage of patients who were admitted to hospital and who were risk assessed for Venous Thromboembolism (Acute Trusts) *(National Average)*	**2018/19** Q1 93.4% (95.63%) Q2 94.27% (95.49%) Q3 95.34% (95.65%) Q4 94.67% (95.74%)		**2019/20** Q1 93.79% (95.56%) Q2 93.99% (95.47%) Q3 93.29% (95.33%) Q4 TBC % (TBC%)	
The rate per 100,000 bed days of Clostridium Difficile infection reported within the Trust amongst patients aged two or over [1] (Trust apportioned)	**2017/18** 39.0 *(England Average 23.9)*		**2018/19** 29.1 *(England Average 22.1)*	
The number and rate of patient safety incidents reported within the trust - Acute trusts (non specialist)	*6322 (Oct 2017 – March 2018)* *26.0 per 1000 bed days*		*6332 (Oct 2018 – March 2019)* *27.3 per 1000 bed days*	
The number and percentage of such patient safety incidents that resulted in severe harm or death—acute (non specialist)	18 *(Oct 2017 – March 2018)* 0.4%		1 *(Oct 2018 – March 2019)* 0.01%	

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

Commissioning for Quality and Innovation (CQUIN) Indicators for 2019/20

CQUIN is a payment framework which allows Commissioners to agree payments to Providers based on agreed qualitative improvements. Below is a summary of the CQUIN schemes for 2019/20, the targets for each scheme together with an assessment of the Trust's performance. Whilst there was no financial claw back against the Local CCG CQUINs, all CQUINS were monitored for improvements to service delivery and quality benefits to patients. 0.75% of Specialised Commissioning income was dependent on achievement of the CQUINs and whilst not all elements were achieved in full, no CQUIN funding was withheld. To note, that due to COVID19 pressures some of the data was not available for Quarter 4 and submission requirements were relaxed therefore the below is based on Quarter 1-4 performance where data was available and submitted.

The national CQUIN guidance set out that Trusts would be paid proportionally based on their performance however, as UHNM was paid on an Intelligent Fixed Payment agreement, there was no financial claw back for underachievement of any schemes that did not achieve the maximum threshold. Where achievement is described as partially achieved, this reflects that the minimum threshold was achieved but not the maximum threshold however CQUIN funding was not affected.

Performance against objectives

Ref no.	Indicator	Target for the Year	Internal assessment of performance
Main Contract CQUIN 2019/20			
1	ANITMICROBIAL (AMR) RESISTANCE	**a)** Lower UTI in older people: Achieving 90% of antibiotic prescriptions for lower UTI in older people meeting guidance for diagnosis and treatment of lower UTI.	*Part achieved - 77%*
		b) Antibiotic Prophylaxis in Colorectal Surgery: Achieve 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose and prescribed in accordance to local antibiotic guidance	*Achieved 92%*
2	STAFF FLU VACCINACTIONS	Achieving an uptake of flu vaccinations by frontline clinical staff of 80% by the end of February 2020	*Achieved - 86.5%*
3	ALCOHOL & TOBACCO	a) Tobacco screening: Achieving 80% of adult inpatient admissions are screened for both alcohol and tobacco use	*Achieved - 90%*
		b) Tobacco brief advice: Achieving 90% of patients identified as smoking tobacco are given brief advice	*Part achieved - 86%*
		c) Tobacco referral and medication offer: Achieving 90% of patients identified as drinking above low risk levels are given brief advice or offered a specialist referral	*Achieved - 91%*
4	FALLS	Achieving 80% of older inpatients receiving key falls prevention actions: ▪ Lying and standing blood pressure to be recorded ▪ no hypnotics or anxiolytics to be given during stay or rationale documented ▪ mobility assessment and walking aid to be provided (if required)	*Part achieved - 35%*
5	SAME DAY EMERGENCY CARE (SDEC)	a) Pulmonary Embolus: Achieving 75% of patients with confirmed pulmonary embolus are managed in a same day setting where clinically appropriate	*Achieved - 98%*
		b) Atrial Fibrillation: Achieving 75% of patients with confirmed atrial fibrillation are managed in a same day setting where clinically appropriate	*Achieved - 95%*
		c) Community Acquired Pneumonia: Achieving 75% of patients with confirmed Community Acquired Pneumonia are managed in a same day setting where clinically appropriate	*Achieved - 79%*

Specialised Contract CQUIN 2019/20			
1	CYSTIC FIBROSIS SELF-CARE	Recruit 50-70% of patients with chronic pseudomonas to the self-management programme. This supports a change in clinician and patient behaviour that will transform Cystic Fibrosis care from a clinician led reactive hospital based rescue service to a patient led community based prevention. Self-management approach supported by electronic tracking.	*Achieved*
2	ENABLING THROMBECTOMY	Training of 2 new interventionists to support the expansion of mechanical thrombectomy from to allow more people to be independent after their stroke each year	*Part achieved - 1 trainee recruited*
3	MEDICINES OPTIMISATION	4 Triggers: a) Improving efficiency in the IV chemo pathway b) Accurate completion of prior approval proformas c) Faster adoption of prioritised best value medicines and treatments d) Implementation of Antifungal Stewardship	*Achieved*
4	ARMED FORCES	Embedding the Armed Forces Covenant to support improved health outcomes for the Armed Forces Community	*Achieved*
5	AAA SCREENING	Identify and reduce local inequalities in abdominal aortic aneurysm screening	*Achieved*
6	BREAST SCREENING	Identify and reduce local inequalities in breast cancer screening	*Achieved*

For further information, please contact Debra Meehan, Acting Director of Nursing (Quality & Safety), on 01782 675679

4. Patient Story

4.1 "I had no doubt our son was in safe hands following a car accident"

Our 19 year old son had just finished his first year at Birmingham University where he was studying Biochemistry. A neighbour knocked on my door to tell me he had been involved in a road traffic accident a couple of miles from home. After a long, dry summer it had rained for the first time in ages causing the roads to be extremely slippy. Even though a witness's dash cam showed that he was driving at a safe speed he lost control of his car on a corner causing him to skid round a bend, a car coming the opposite way hit him and then he went through a hedge into a field.

When I arrived at the scene there were already fire engines and ambulances there. They could see how critically unwell our son was and pulled him out of his car as quickly as possible. I travelled with him in the ambulance to Royal Stoke A&E where he was diagnosed with collapsed lungs, 5 or 6 fractured ribs and a severe head injury to the back of his skull. The staff in A&E were excellent. I had no doubt that our son was in safe hands and they even found time to make sure I was Ok and make me a cup of tea. I remember joking with the anaesthetist that this was an ideal opportunity to remove a recently acquired tattoo! A brain scan identified a fracture and air around the brain so my son had a pressure monitor fitted and was put into an induced coma and taken to POD 6 in Critical Care. The staff in Critical Care were very understanding of the extremely difficult time this was for us and I was able to stay at my son's bedside throughout the night.

A few days later the team tried to bring my son out of his coma but this was unsuccessful so he had to be quickly put back under and sent for a repeat scan. The scan showed that he had experienced a watershed stroke and that this had damaged areas all over his brain. We were kept well informed of our son's condition throughout his time in critical care and understood that he was extremely unwell. We were warned that his recovery was unpredictable and that it was likely that his brain injuries may cause permanent damage. The next month was the most worrying time for us all. Our son had to be fully paralysed to stop him shivering and he had to undergo lumber punctures to help to relieve the pressure on his brain. He developed both lung and a spinal fluid infections and we were so close to losing him at times. Despite all the odds he did slowly regain consciousness and although he couldn't talk I was so relieved when I realised he could communicate with his tongue to show me he could understand what I was saying.

We can't begin to thank the critical care team enough for the care and treatment both our son and his friends and family received over this awful time. We were involved in his care every step of the way and incredibly well informed. I trusted the team enough to go home overnight and I would phone every morning for an update from the night shift. My ex-husband or I then stayed with my son every day from 10 in the morning until 10 at night, The care I witnessed during this period was second to none. The whole team cared for our son, without any hierarchy as every member of the team, regardless of their role, helped with every aspect of his care.

We were also helped through this difficult time as our

son's friends were allowed to visit him without restrictions. They brought him a Manchester City football shirt that they had all signed and his aunt was allowed to bring her dog to his bedside. Everyone including physio's, nurses and doctors made such a fuss of our son and we really felt that they genuinely cared about him. Nothing was too much trouble; the physio even put him in a wheelchair and took him outside for some extra stimulation which was really appreciated.

On the 3rd October 2019 our son was strong enough to be moved to a ward to continue with his rehabilitation. Although we had been warned that he would no longer be receiving the 1:1 care that he had on Critical Care it still came as a shock when we realised how stretched the team were on the ward. It was also immediately apparent that it was considered a healthcare support workers role to carry out personal care and we were used to the whole team getting involved on the unit. This really took some getting used to and it took a while for us to gain confidence that his care would be of a good standard. As our son was still unable to communicate we knew it was our responsibility to speak for him to ensure his needs were met. At first it felt like we were having to ask for even the most basic things like could he be sat out in a chair or could he have his hair washed, however over time we did build up a good relationship with the staff and we could see that they were fond of him. One nurse in particular was lovely. She always included our son in her conversation speaking to him as she would any other person and we valued that a lot.
We did complete an "about me" tool so that the staff knew our son's likes and dislikes making conversation easier. The staff were also very flexible with my prolonged visiting hours as they understand that I felt I needed to be there to support him as he couldn't move or communicate himself. It was lovely when we could sit in the dayroom for a change of scenery. Initially our son was in a 4-bedded bay with 3 other patients who were unconscious. Eventually they were all moved into single rooms, only one of which had a window looking over the helipad. Unfortunately our son wasn't given the room with the view which was disappointing as he was the only one who would have benefited from this at the time with being the only one conscious and able to look out.

The Physio team on the ward were excellent, they made the activities fun and interesting and you could tell our son loved his sessions with the team. They recognised that he was a young lad so could chat about teenage nights out and university with him.

On the 25th October 2019 our son was well enough to be cared for on a less acute ward with a mini tracheostomy. One of the male nurses was a Liverpool fan and he had an immediate rapport with our son despite supporting Manchester City. The tracheostomy was eventually removed on a Monday morning. It was a real turning point when we received a phone call from the tracheotomy nurse telling us our son had said he was hungry and wanted a Chinese meal as his first words!

At around this time there was a planned procedure to insert a shunt into our son's brain, however his temperature was raised on the day of theatre and he was sick on the way there so the procedure was postponed and everything started to improve from that day onwards so the shunt wasn't needed after all.

The physiotherapy was great on this ward too and available 7 days a week, this was good as there would typically be one extra session at the weekend. Our son still had a nasogastric tube for feeding and it was really difficult persevering with the pureed food to regain his swallowing reflex as the food was so unpalatable. It was the thought of eventually being able to eat a pizza that kept him going! He did find the cultural menu appetising and felt that this could have been advertised a bit better as the majority of patients don't know about this is an option.

Our son was desperate to be taken outside for a change of scenery but staff were extremely cautious about this. We knew he would be ok but he had to undergo a psychological test first. This left us all feeling quite deflated as the staff wouldn't trust our judgement that he would be ok. He "failed" the test on the first attempt but this made him all the more determined to pass it so he knew he had to take it seriously. Visiting was also a lot stricter on this ward from 2-7pm. This made it quite difficult for his dad to visit as he works in Manchester so had very little time with our son by the time he got back to Stoke in the evening.

After 3 months as an inpatient, our son said goodbye to the Royal Stoke hospital and was transferred to the Haywood on the 30th November. It felt like everything was going in slow motion initially. He was desperate to get back onto his own two feet and he became quite impatient while the physiotherapy concentrated on strengthening his core. However, after Christmas things progressed rapidly and all aspects of our son's independence gradually recovered with the intensive rehabilitation including crossing the road and paying for items when shopping.

Our son returned home on the 29th March 2019, 7 months after his accident. He plans to return to university as soon as possible and we will be eternally grateful for the skills and expertise of Mr Harrison and his teams at Royal Stoke University Hospital and the Haywood. His rehabilitation continues in a local Stoke Boxing gym that we had been told about by Headway and he is getting physiotherapy at Macclesfield hospital now too. The local support after leaving hospital took 6-8 weeks to get started. He is also proactively raising charitable funds for the Royal Stoke Hospital raising over £3000 to date.

We have made some close relationships with other families who were in hospital at the time including one lady whose son died and are able to offer each other for on-going support. Keeping a patient diary was an enormous help during our son's time on Critical Care and we now have this in our possession to refer too. We did have to ask for this and were told that they are only issued once a patient leaves and is ready to receive it. This is a good idea but we were a little worried for a while as the nurses on the wards didn't seem to know anything about it. It would be really good to be given a name and contact number of a person to contact so we always know who to ask when the relative and/or patient is ready. The presentation of the diary and the opportunity to meet the teams again was wonderful. We can never find the right words to thank them enough for all they have done

5. Statement of Assurances

5.1 Review of Services

Care Quality Commission

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

- Urgent and Emergency Care
- Medical Care
- Surgical
- Critical Care
- End of Life Care

During June and August 2019, the CQC inspected the core services of Medical care, Urgent and Emergency care, Outpatients, Children and Young People and Maternity at the Royal Stoke University Hospital and Maternity, Outpatients and Urgent and Emergency Care at the County Hospital.

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

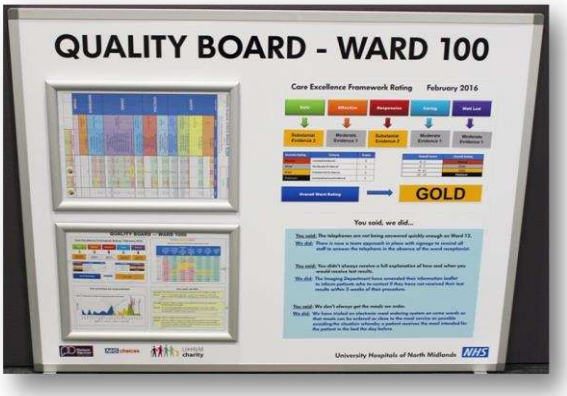
- The CQC had concerns regarding the care and treatment of patients in the Emergency Department at Royal Stoke Hospital
- They also raised concerns in relation to the care and treatment of patients with mental health needs and patients who lacked mental capacity to make decisions
- Governance systems although embedded were over complicated and unreliable. The CQC acknowledged that the newly appointed CEO was undertaking extensive work to improve these systems
- In rating the Trust, the CQC took into account the current ratings of services not inspected this time
- Immediate actions have been taken to address the issues identified with regard to the care of patients with mental health needs
- Improvements to the triage system and process were implemented immediately and the Board subsequently agreed significant investment for nurse staffing
- The ED Improvement plan seen by the Board in Sept 2019 remains in place and is being refreshed following the challenges in December 2019

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

The table below shows the rating by the 5 key domains and compares results to the 2015 inspections:

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

Care Excellence Framework



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

- Safety
- Effectiveness
- Responsive
- Caring
- Well led

Each clinical area has at least one Excellence visit per year reviewing all domains and receives ad hoc visits throughout the year to seek assurance with regards to individual domains. The CEF is delivered in a supportive style fostering a culture of learning, sharing and improving, and reward and recognition for achievement. Each domain consists of clinical observations, documentation reviews, patient interviews and feedback from staff forums.

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

PLACE Inspection

The 2019 PLACE inspections were undertaken at the Royal Stoke University Hospital on 22nd October 2019 and 7th November 2019 at County Hospital. Inspections are patient led by their nature and cannot take place without 50% patient representation. A number of patient assessors and managers were representatives across both PLACE inspections and ensured consistency in approach and opportunity to compare environmental standards across both sites. The PLACE scores were published nationally on 30th January 2020 and UHNM achieved scores well above the national average against all domains assessed, overall as a Trust and for each site respectively, as summarised below.

Site Name	CLEANING Score %	FOOD Score %	PRIVACY, DIGNITY & WELLBEING Score %	CONDITION & MAINTENANCE Score %	DEMENTIA Score %	DISABILITY Score %
THE ROYAL STOKE UNIVERSITY HOSPITAL	99.94	94.75	90.17	99.51	90.34	92.45
THE COUNTY HOSPITAL	100	96.75	99.56	99.88	96.47	96.10
UHNM TRUST SCORE	99.95	95.03	91.49	99.56	91.21	92.97
NATIONAL AVERAGE	**98.6**	**92.2**	**86.1**	**96.4**	**80.7**	**82.5**

Of particular note is the 100% cleaning score achieved at the County Hospital site for the second consecutive year.

In summing up the inspections our Patient Assessors provided very positive comments in relation to what they had observed on the day. These comments are confirmed below and are testament to the hard work and commitment of all staff, clinical and non-clinical and our private sector partners, in providing a high quality care environment.

UHNM – Royal Stoke PLACE Inspection Feedback 22nd October 2019. Our patient assessors said:-
"100% positive response from the patients they spoke to about the care and compassion they are receiving. We've never seen such dedicated staff in every single area they went to and although the areas are very busy every single ward area greeted us with a friendly welcome and a smile. The staff are clearly working together very well in teams from the cleaners to the head of the department. We definitely saw a more positive attitude from staff this year and we were very impressed with West Building and the older estate considering its age and layout. There was a definite improvement on site overall across each of PLACE domains from last year. The food on the wards that we tasted was excellent." Rob Beddis and Margaret Foulkes – Patient Assessors

UHNM County Hospital Inspection Feedback 7th November 2019. Our patient assessors said:- *"The site was immaculately clean including the corridors and common areas and the environment was calm and supported patients privacy and dignity very well. The patient care we saw was second to none with very dedicated medical, nursing and support staff who were very open and welcoming who should be proud of their work. The grounds and gardens were also exceptionally well kept by the grounds team and the food we tasted on the wards was superb. It was evident that all the teams worked together to care for their patients and the continuity of staff on each area was noticeable and paid off. We felt very confident about the environment we saw".* John Duggan, Volunteer and Patient Assessor and David Hardy, Patient Assessor

External Validator – Rosemary Brown, Head of PFI and Commercial Services, Birmingham Mental Health NHS Trust said "the wards and departments were spotless and I couldn't fault anything throughout the inspections"

5.2 Participation in Clinical Audit

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

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

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

During 2019/20 - 50 National Clinical Audits and 6 - National Confidential Enquiries covered the NHS Services that the Trust provides.

The National Clinical Audits and NCEPOD enquiries that the Trust participated in, and for which data collection was completed during 2019/20 alongside the number of cases submitted, are referred to in the tables below:

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

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

NCEPOD Study	UHNM Registered	Completed
Bowel Obstruction	Yes	Action Planning / Implementation
Pulmonary Embolism	Yes	Action Planning / Implementation
Long Term Ventilation	Yes	Awaiting Report
Out of Hospital Cardiac Arrest	Yes	Data Collection
Dysphagia in People with Parkinson's	Yes	With Lead to complete Organisational Questionnaire

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

Compliance Spot Check Audits
The provision of feedback sessions and the development of ward specific action plans provide a mechanism for wards to identify areas requiring improvement with a view to implementing timely, effective changes at Ward level.
Initiatives such as themed weeks, poster development, ward audits, peer reviews and dissemination of good practice demonstrate that wards are taking positive action to ensure compliance.
During 2019/20 these spot checks have shown general improvements in different elements of clinical care.

5.3 National Clinical Audits

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

National Clinical Audit National Audit	UHNM Registered	% of cases Submitted
Assessing Cognitive Impairment in Older People / Care in Emergency Departments	Yes	100%
BAUS – Cystectomy Audit	Yes	100%
BAUS – Female Stress Incontinence Audit	Yes	100%
BAUS – Nephrectomy Audit	Yes	100%
BAUS – Percutaneous Nephrolithotomy Audit	Yes	100%
BAUS – Radical Prostatectomy Audit	Yes	100%
Care of Children in Emergency Departments	Yes	100%
Case Mix Programme (CMP)	Yes	100%
Child Health Clinical Outcome Review Programme	Yes	100%
Elective surgery (National PROMs Programme	Yes	100%
Endocrine and Thyroid National Audit	Yes	100%
Falls and Fragility Fractures Audit Programme (FFFAP)	Yes	100%
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	Yes	100%
Major Trauma: The Trauma Audit & Research Network (TARN)	Yes	100%
Mandatory Surveillance of Bloodstream and Infections and Clostridium Difficile Infection	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	100%
Medical and Surgical Clinical Outcome Review Programme	Yes	100%
Mental Health – Care in Emergency Departments	Yes	100%
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP)	Yes	100%
National Audit of Breast Cancer in Older People (NABCOP)	Yes	100%
National Audit of Cardiac Rehabilitation (NACR)	Yes	100%
National Audit of Care at End of Life (NACEL)	Yes	100%
National Audit of Dementia (Care in general hospitals)	Yes	100%
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes	100%
National Bariatric Surgery Registry (NBSR)	Yes	100%
National Cardiac Arrest Audit (NCAA)	No	0%
National Cardiac Audit Programme	Yes	100%
National Diabetes Audit - Adults	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	100%

National Gastric-Intestinal Cancer Programme	Yes	100%
National Joint Registry (NJR)	Yes	100%
National Lung Cancer Audit (NLCA)	Yes	100%
National Maternity and Perinatal Audit (NMPA)	Yes	100%
National Neonatal Audit Programme - Neonatal and Special Care (NNAP)	Yes	100%
National Ophthalmology Audit	Yes	100%
National Paediatric Diabetes Audit (NPDA)	Yes	100%
National Prostate Cancer Audit	Yes	100%
National Smoking Cessation Audit	Yes	100%
National Vascular Registry	Yes	100%
Neonatal Intensive and Special Care (NNAP)	Yes	100%
Neurosurgical National Audit Programme	Yes	100%
Paediatric Intensive Care Audit Network (PICANet)	Yes	100%
Perioperative Quality Improvement Programme (PQIP)	Yes	100%
Reducing the impact of serious infections (Antimicrobial resistance and Sepsis)	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
Serious Hazards of Transfusion: UK National Haemovigilance Scheme	Yes	100%
Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	100%
Surgical Site Infection Surveillance Service	Yes	100%
UK Cystic Fibrosis Registry	Yes	100%
UK Parkinson's Audit	Yes	100%

Corporate and Local Clinical Audits

A total of 132 clinical audit projects were completed by Clinical Audit Staff and a further 330 clinician led audit projects were registered during 2019/20. These audits help us to ensure that we are using the most up to date practices and identify areas where we can make further improvements. Examples of improvements made in response to the audit results are:

Audit of Delirium: NICE Clinical Guidance 103

Action	Co-ordinator	Action Completed By
To ensure that all relevant staff are aware of the results of the audit, the report was shared with: a) The Lead Consultants of the three portals of entry asking them to cascade the results to their colleagues. b) The Elderly Care Audit Meeting.	Audit Lead Audit Lead	Complete Complete
In order to ensure that all patients have their delirium risk assessed:		
Consultants at County Hospital have been reminded of the importance of completing a timely 4AT Assessment on admission. If the assessment is not completed in the emergency portal, then is must been completed on admission to the ward.	Audit Lead	Complete
Consultants in FEAU and AMU at Royal Stoke and County will ensure that the 4AT has been completed by the clerking doctor. In FEAU, box 6 on the consultant review orange form must be completed.	All Consultants / Junior Doctors	Complete
All Junior Doctors have been reminded to complete the score in full on the scoring columns entering the date and their grade; circling ad hoc items on the left side of the page is not sufficient	All Consultants / Junior Doctors / ANPs	Complete
Staff have been re-educated about the difference between the 4AT and 6CIT. A screensaver will be developed to ensure on-going awareness.	Audit Lead	Complete
To determine if improvements in practice have taken place a re-audit will be undertaken as part of the 2020/21 Clinical Audit programme.	Clinical Audit Department	May 2020

5.4 Participation in Clinical Research

UHNM participates in clinical trials across the healthcare sector from novel interventions and drugs to device innovations which aim to improve quality of life and outcomes for our patients. Research Practitioners and Midwives work alongside clinical teams and support services to identify and consent potential research participants, discussing trials with patients and providing care throughout the studies.

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

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

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

Strategic Aims

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

Research and Innovation highlights from 2019/2020

- At the end of 2019/2020 we had more than 350 open studies across a wide range of specialities. In the last year we recruited over a thousand patients to these studies.
- We continued to support the management and evaluation of the £1.2M Innovate UK Heart Failure Test Bed. This project uses commercially available digital technologies combined with a more efficient and responsive heart failure pathway to improve early detection of deteriorating health in Heart Failure patients.
- R&I also continued their support of the FLiP-GD2 study (Professor Hanna), which aims to determine whether women with gestational diabetes mellitus (diabetes first detected during pregnancy) who also have fat in the liver, have a higher risk of developing full diabetes.
- The Academic Development Team submitted 10 grants to external funders (value in excess of £4M). Two have already been funded (discussed below) with the others still under review.
- In January 2020, A&E Department were awarded £15k to undertake a project aiming to improve patient flow within A&E and enable services to more easily flex to patient demand.
- In February 2020, Research & Innovation Department's bid for £96k from the Clinical Research Network Improvement and Innovation Strategic fund was successful. The aim of the project is to develop an accreditation programme that recognises organisations according to their degree of engagement with patients and public during the research process.

5.5 Data Quality

Good Data Quality supports the planning and provision of excellent patient care and supporting services. The strategic aims of the Trust rely on the management of information to a sufficient standard to support the planning, decision making and the provision of excellent services to patients and other customers. The Trust continues to take the following actions to support and maintain improvement of data quality:

- A programme of inpatient Data Quality audits is being undertaken with valuable feedback for improvements encouraged within ward teams.
- A number of Data Quality Key Performance Indicators are monitored through the Trust's Data Quality Steering Group and regular updates are provided for assurance to the Executive Committee of the Trust
- A corporate level Data Quality Strategy has been formulated to be supported by robust monitoring via the Trust's Data Quality Steering Group, providing an assurance framework to assist with feedback to the Executive Committee
- A Data Quality Assurance Indicator has been developed for implementation within Board Integrated Performance reporting.

2019/20 has been a productive year for the data quality team and we aim to build on this throughout 2020/21, supporting the strategic aims of the Trust.

5.6 NHS Number & General Medical Practice Code Validity

University Hospitals of North Midlands NHS Trust submitted records to the Secondary Uses System (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data. This is a single source of comprehensive data which enables a range of reporting an analysis in the UK. The Trust reported the majority indicators as "green" (equal to or above the national average) in 2019/20 and has maintained these results.

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

- 99.3% for admitted patient care; national performance is 99.4%
- 99.7% for outpatient care; national performance is 99.7%
- 97.0% for accident & emergency care; national performance is 97.8%

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

- 100% for admitted patient care; national performance is 99.7%
- 100% for outpatient care; national performance is 99.6%
- 99.8% for accident & emergency care; national performance is 97.9%

Trust performance for GMP code is higher than the national average.

5.7 Clinical Coding Accuracy Rate

The annual internal Data Security & Protection Toolkit (DSPT) clinical coding audit took place during 2019/20, achieving an overall 'mandatory' rating in all areas of the audit and 'advisory' in 3 of the 4 areas audited. This is an improvement on last year's audit which identified 2 out of 4 areas as 'advisory' All recommendations from the 2018/19 audit have been actioned. The Trust's Clinical Coding auditors carried out this year's audit.

The Trust was not subject to an external Payment by Results (PbR) audit in 2019/20.

The internal Staff Audit Programme continues for all coding staff and has been updated for 2020/21.

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

U-codes (no associated income due to missing information) have remained consistently low throughout 2019/20, reporting 2% or less at all monthly submissions.

5.8 Information Governance Toolkit Attainment Levels

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

However due to the current COVID-19 pandemic, Trusts were given an extension to 30th September 2020. This extension includes the timeframe for completion of the mandatory Data Security & Protection training which was also been extended to 30th September 2020. The toolkit was revised to embrace the National Data Guardian's 10 data security standards. (The National Data Guardian. 2016 National Data Guardian for Health and Care Review of Data Security, Consent and Opt-Outs Crown Copyright) although the emphasis is more on Cyber Security measures rather than the traditional data protection requirements of previous toolkits. The toolkit submission for 2019/2020 requires all 40 assertions to be completed.

The Trust has submitted its self-assessment, using the extension to ensure all 40 assertions have been addressed. An action plan is in place, incorporating feedback from the internal auditors, with the key focus on the percentage of staff successfully completing the level 1 data security awareness training. The Trust's Executive Data Security & Protection Group is monitoring the situation providing assurance to the Trust Board, via the Finance & Performance Committee and Quality Governance Committee. However, if the Trust does not achieve the training target, the Trust's rating will be classified as 'Standards not fully met (plan agreed)' and we will need agreement from NHS Digital on this point.

5.9 Seven Day Services

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

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

Achieving the 4 high priority clinical standards for 7 day working sits as a Critical Success Factor (CSF) under Strategic Objective 1: Provide safe, effective, caring and responsive services. UHNM 7 day services Clinical Steering Group in agreed to adopt a targeted improvement approach in order to maintain assurance around achievement of the 4 high priority and associated standards with 3 specialties of focus:

- ENT
- Paediatrics
- Elderly Care

Part B: Review of Quality Performance

6. Quality Priorities 2019/20

In 2019/20, in partnership with our stakeholders we identified 4 specific priorities to focus on:

One: To further reduce patient harm

Two: To improve staff feeling of belonging and ownership through increased involvement in the development and delivery of the UHNM Clinical Strategy

Three: To increase the involvement of people at all levels, from the patient and carers at the bedside about their care, to the wider community in the planning and evaluation of the services we provide.

Four: To promote further the use of technology to improve the efficiency and effectiveness of patient care.

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

Priority 1:
To further reduce patient harm

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

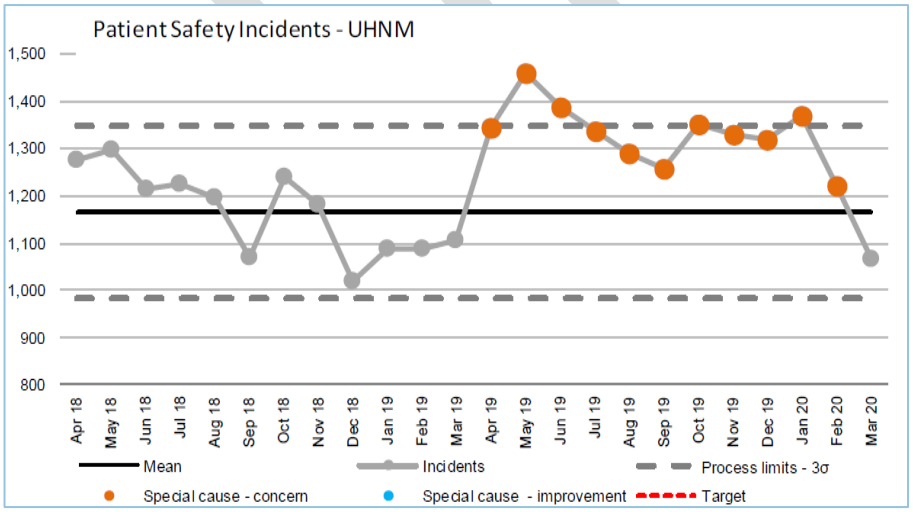
We said we would achieve this by

- ✓ **Improving timely recognition and treatment of Sepsis.**
- ✓ **Recognising and responding to deteriorating patients**
- ✓ **Reducing by 10% patient falls resulting in moderate harm or above.**
- ✓ **Eliminating hospital acquired Category 4 pressure ulcers and reducing the incidence of Category 2 and 3 pressure ulcers with lapses in care by 5%:**
- ✓ **Undertaking RCAs to learn from reported incidents**
- ✓ **To report on key indicators in monthly reports to provide analysis and assurance on actions taken**

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

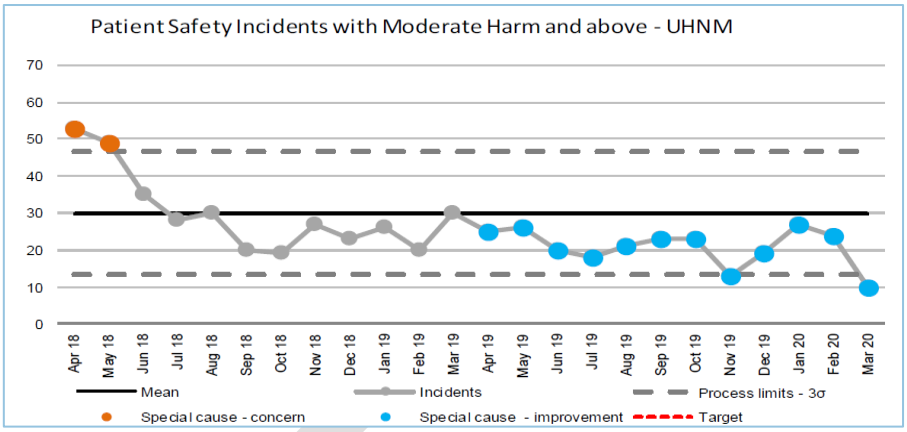
Patient Safety Incidents

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

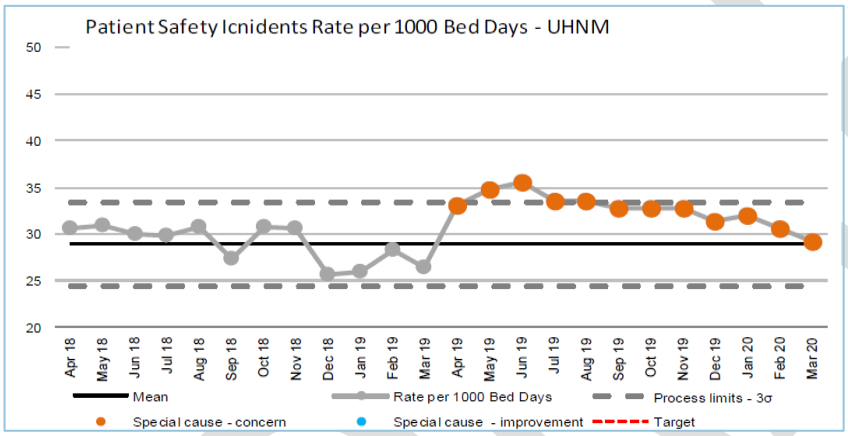


12% increase in total reported Patient Safety Incidents from 2018/19 to 2019/20
Increase result of inclusion of Non hospital acquired pressure damage to reflect NRLS reporting requirements to include all pressure damage identified by the provider

30% reduction in total reported Patient Safety Incidents with harm 2018/19 to 2019/20

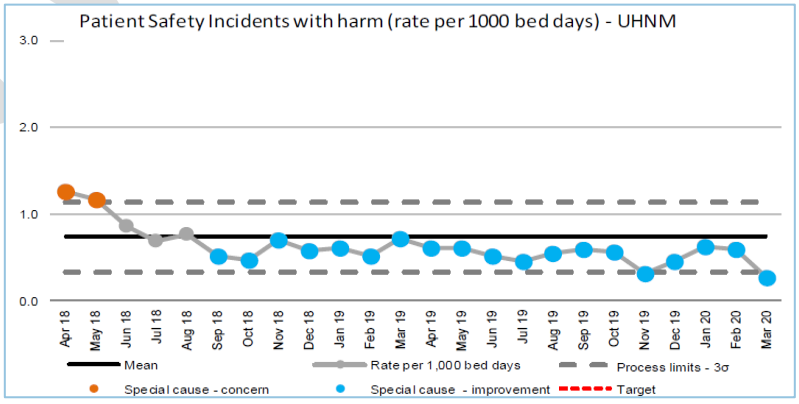


Total reported patient safety incidents have increased as result of including all pressure damage identified on admission to UHNM in line with including these incidents in the Trust submission to the National Reporting & Learning System (NRLS) from April 2019. However, there have been reducing numbers of patient safety incidents reported as resulting on moderate harm or above during 2019/20 compared to 2018/19.



13% increase in rate of reported Patient Safety Incidents per 1000 bed days from 2018/19 to 2019/20

29% reduction in rate of reported Patient Safety Incidents with harm per 1000 bed days from 2018/19 to 2019/20



Never Events

UHNM has introduced strong systems to allow for the reporting of adverse incidents to ensure lessons are learnt whenever possible. During 2019/20, we have reported 6 Never Events which compares to 6 reported in 2018/19. The following provides a summary of these Never Events, per Quarter, together identified learning to prevent recurrence.

6 reported Never Events during 2019/20

Quarter 1 (April - June)

Retained foreign object post procedure – retained guidewire (2019/7835)

Learning identified:

A full check of a guidewire after a procedure should ensure that the full length of the guidewire has been removed and that the outer sleeve and inner core elements have not separated. Possible consideration regarding measurement of the guide wire on removal (if logistically and financially possibly).

Actions Taken:

- An internal safety alert regarding the possibility that the outer sleeve and the inner stiffener of a guidewire can become separated was developed and shared Trust wide
- Current stock were checked to see if any issues with the batch used had been identified. No other incidents/issues identified
- Notified guidewire manufacturers of incident regarding outer sleeve and inner sleeve stiffener becoming seperated

Wrong site surgery – incorrect lesion removed (2019/11200)

Learning identified:

The operating surgeon had difficulty accessing iPortal. This meant that he was unable to view the patient's clinical notes and the dermatology doctor's photograph detailing the correct lesion that was to be operated upon. Surgeon did not follow the correct procedure for surgical site marking as laid out in policy C04 - Ensuring the Safety of Patients Undergoing Surgical Interventions. Policy states that a surgical site must be marked and checked against reliable documentation i.e. iPortal clinic notes. No significant harm to the patient.

Actions taken:

- All plastic surgery consultants ensure that they have sufficient access to ICT systems.
- All plastic surgery consultants to ensure aware of Policy C04.

Wrong site surgery – incorrect procedure undertaken (2019/14295)

Learning identified:

Error in the consent process and incorrect patient identified during checking process before procedure commenced.
Patient had correct procedure.
There was Incomplete theatre list and the Theatre List was not available at consent stage
Theatre lists not available to Anaesthetist.
Theatre list not available at check in to theatre.

Actions Taken:

- Processes for checking patients prior to procedure changed and details entered onto electronic system which is available within Theatres
- Newly defined and agreed booking process for urgent cases identified.
- Pause and Check stage of WHO process reasserted with all staff
- The team brief Must include the anaesthetist.
- The WHO checklist must be completed.

Quarter 2 (July – September)

No Never Events reported

Quarter 3 (October – December)

Wrong site surgery – wrong side nerve root injection (2019/26942)

Learning identified:

There was a lack of clarity on initial referral to imaging and this led to confusion as the initial referral should have been rejected. Consent was discussed and taken from the patient – but for the incorrect side. No significant harm to the patient. Correct nerve block subsequently administered

Actions taken:

- All referrals reviewed and protocolled / justified.
- Any confusion or lack of clarity the referrals are now rejected and new referral requested to confirm clinical details.

Wrong site surgery – incorrect ophthalmology procedure (2019/23043)

Learning identified:

Patient underwent cataract procedure but incorrect biometry used and current checks are not adequate and required change to process in theatres

Do not use pre-printed patient labels on any printed results sheets (including biometry sheets) which have patient details (name, unit number, date of birth) already printed on them.

Printed Biometry sheets to be signed, printed name and dated by staff member printing off the sheets and filing in the notes.

To ensure that the correct cataract surgery consent form is used (including Cataract WHO Checklist) for all appropriate patients.

No significant harm to the patient and vision improved.

Actions taken:

Have communicated to Ophthalmic Pre Assessment Clinics not to use pre printed patient labels on printed results sheets

Second check process introduced in Ophthalmic Pre Assessment Clinics

New Cataract Consent From introduced and old versions removed from use

Quarter 4 (January – March)

Wrong implant/prosthesis – incorrect hip prosthesis (2020/3961)

Learning identified:

Failure in the 3 person check to identify the femoral head implant was the wrong size.

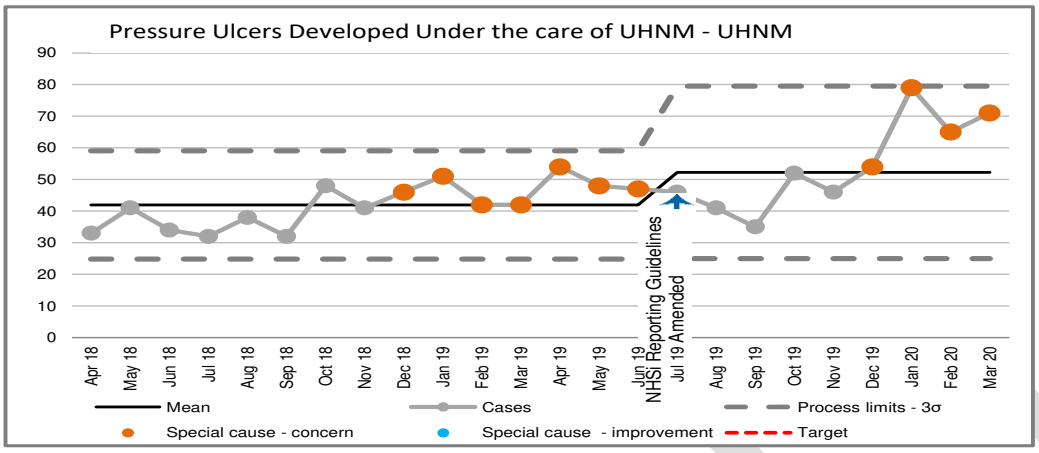
Actions taken:

SOP developed by theatres including:

- Continuation of the 3 person check and confirmation of the implant prior to opening
- Implant details to be written on the whiteboard by the Theatre runner after passing to the scrub nurse
- All staff are empowered to query any implant issues or potential mismatch.

Pressure Ulcers developed under UHNM Care

We have seen an increase in Pressure Ulcers developed whilst under the care of UHNM. During 2019/20 there were 638 reported pressure ulcers developed at UHNM compared to 480 in 2018/19. This equates to 33% rise in identified pressure ulcers.

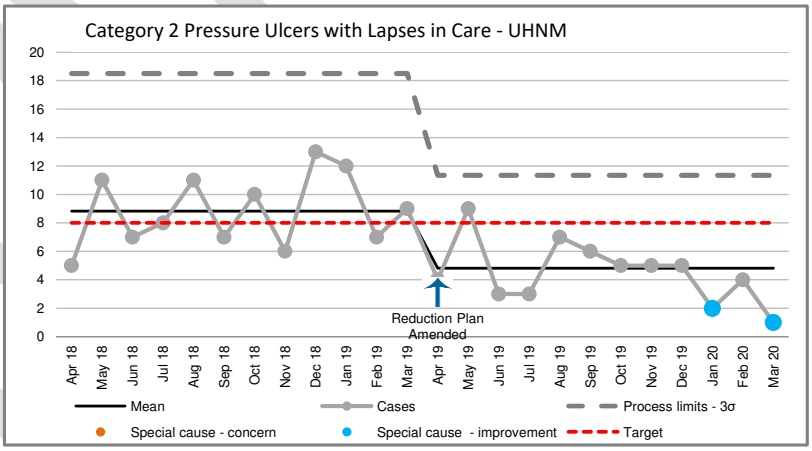


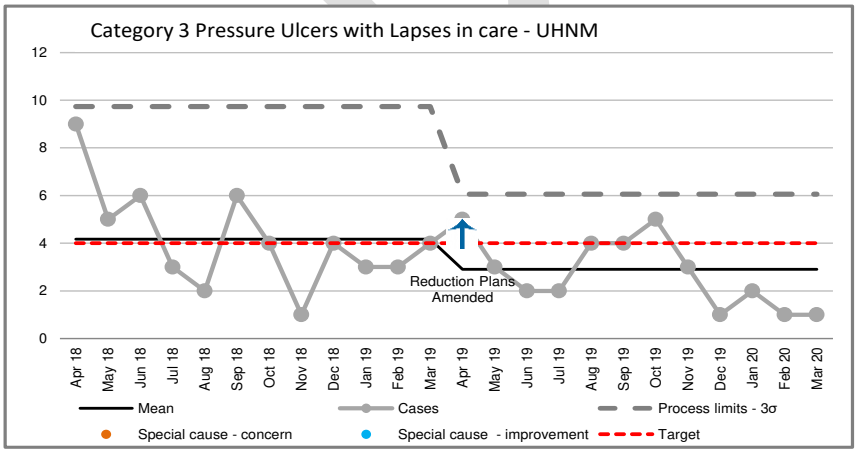
33% increase in reported Pressure Ulcers Developed whilst under care of UHNM

1 Category 4 Hospital Acquired Pressure Ulcer with lapse in care identified during 2019/20

However, there have been reductions in Categories of Pressure Ulcers which have had lapses in care identified during 2019/20, due to the high standard of care provided.

34% reduction in Category 2 Pressure Ulcers with 'lapses in care' in 2019/20 compared to 2018/19





49% reduction in Category 3 Pressure Ulcers with 'lapses in care' in 2019/20 compared to 2018/19

Improvement in Sepsis Recognition and Treatment

During 2019/20, there has been a marginal decrease in the sepsis screening results whilst there has been an improvement in the performance for anitibiotics being administered with 1 hour in Emergency Portals and Inpatient areas from the sepsis audits undertaken.

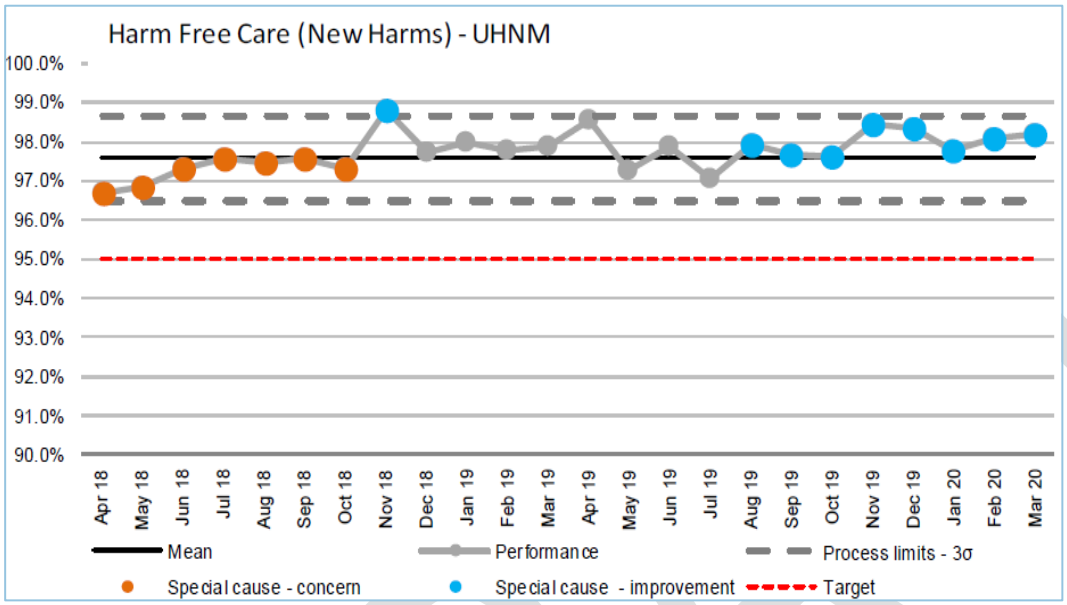
SEPSIS Audit Quarterly Summary – 2019/20

			Sepsis Screening Results			Abx Given within 1 Hr		
Clinical Area	**Qtr**	**Fiscal Month**	**Pt Count**	**Screened Count**	**% Screened**	**RED Flag Pts**	**Abx IN 1 Hr**	**% Abx in 1Hr**
Emergency Portals	Qtr 1		236	213	90.3%	118	103	87.3%
	Qtr 2		242	221	91.3%	96	87	90.6%
	Qtr 3		303	266	87.8%	119	93	78.2%
	Qtr 4		241	215	89.2%	77	69	89.6%
Emergency Portals Total			**1022**	**915**	**89.5%**	**410**	**352**	**85.9%**
Inpatients	Qtr 1		182	148	81.3%	13	12	92.3%
	Qtr 2		151	127	84.1%	13	9	69.2%
	Qtr 3		222	178	80.2%	21	21	100.0%
	Qtr 4		359	335	93.3%	16	16	100.0%
Inpatients Total			**914**	**788**	**86.2%**	**63**	**58**	**92.1%**
Grand Total			**1936**	**1703**	**88.0%**	**473**	**410**	**86.7%**

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

Harm Free Care (New Harms)

The national target for Harm Free Care (New Harms) is 95% and UHNM have continually exceeded this target and during 2019/20 and the final overall average rate is 97.9% (refer to chart below). The results are gathered during the monthly Safety Thermometer assessments where all UHNM Inpatients are reviewed on 1 day of the month to assess whether they have experienced harm from a fall, pressure ulcer, pulmonary embolism/deep vein thrombosis or catheter associated urinary tract infection during their current inpatient admission. These results are reported nationally on monthly basis.



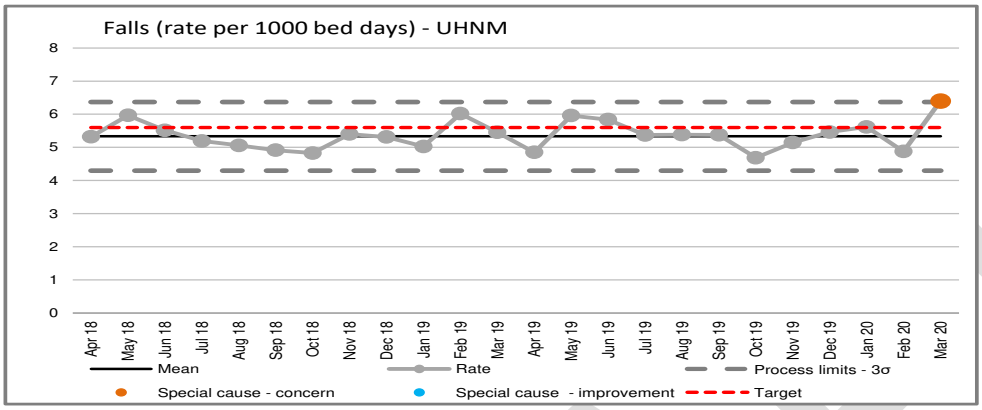
Exceeding the 95% National Target for Harm Free Care (New Harms) throughout 2019/20

Average Rate 97.9%

Patient Falls

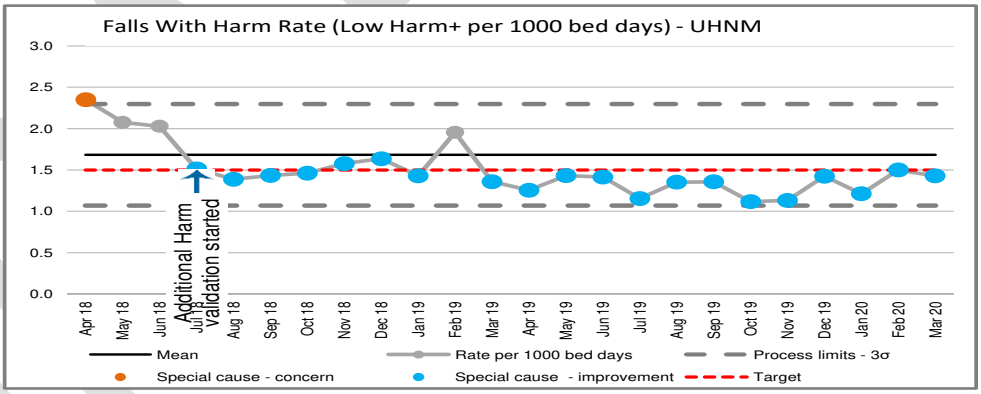
During 2019/20 there were 2603 reported patient falls compared to 2587 in 2018/19 which is 0.6% increase. In order to be able to account for changes in activity the Trust uses the patient falls rate per 1000 bed days. During 2019/20 the overall rate was 5.4 compared to 5.3 in 2018/19.

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



1.8% increase in rate of reported patient falls in 2019/20 compared to 2018/19.

23% reduction in rate of harm to patients as result of falls per 1000 bed days in 2019/20 with 1.3 compared to 1.7 in 2018/19

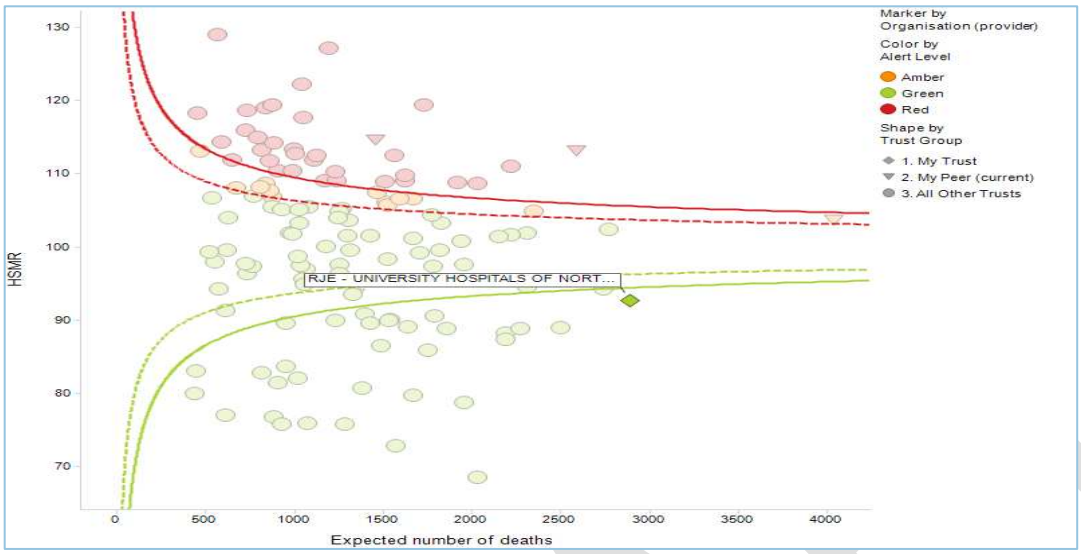


Whilst there have been overall increases in the total number and rate of all reported patient falls there have been reductions in both the total numbers and rate of patient falls that have resulted in harm. This is important as the aim was to reduce harm from falls by 10% whilst encouraging incidents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

Total falls with harm have reduced by 21.9%, with 631 in 2019/20 compared to 808 in 2018/19. This has also seen the rate of falls with harm reducing by 23%.

Mortality

Our mortality rate with current HSMR for 2019/20 reported at 92.68. This means that UHNM's number of in hospital deaths is less than expected range based on the type of patients that have been treated. This compares to 100.34 for 2018/19.



UHNM continues to compare well against peers during 2019/20 and is better than expected based on standardized casemix

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

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

Like HSMR the prediction takes into account factors such as age and sex of patients and their diagnosis. The current SHMI value for the Trust is 0.99. This is a rolling 12 month measure and covers the period January 2019 – December 2019

Why are the two measure different?

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

Learning from Deaths Mortality Reviews

During 2019/20, we continued to use our online Mortality Review Proforma to allow in hospital deaths to be electronically reported following review of the patient death and included the outcomes of these reviews within Mortality Summary Report presented at the Trust's Quality Governance Committee and reported to the Trust Board.

2837 patient deaths (83% of all in hospital deaths during 2019/20 have been reviewed during 2019/20

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

During April 2019 – March 2020, the Trust have completed 2837 online proformas, accounting for 83% of all the hospital deaths recorded during 2019/20. Each one of these deaths is assessed to classify the level of care the patient received. It should be noted that the mortality reviews are currently ongoing and these figures relate to deaths in 2019/20 that have also had completed reviews submitted by 31st March 2020. There are deaths that are still being reviewed as part of the Trust's local Mortality & Morbidity Review meetings but whilst the deaths may have occurred in 2019/20 the review will be completed in 2020/21.

	2019/20 Total		Q1		Q2		Q3		Q4	
Total Number of Deaths in reporting period	3404		824		758		906		916	
Total Number of Deaths in reporting period subject to review (% of total deaths)	2837	83%	709	86%	672	89%	776	86%	680	74%
Total Number of reviewed deaths with suboptimal care identified – NCEPOD grade E (% of reviews)	2	0.07%	1	0.14%	0	0%	0	0%	1	0.15

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

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

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

- The importance of the timely involvement of the Palliative Care Team and care given that met the patient's Advance Directive
- Importance of clear documentation and legibility
- The impact of multiple ward moves on patients and their relatives
- Inappropriate times of transfers between wards / sites can have negative impacts on patients care

- Awareness of potential effects of prescribed medications i.e. coamaxiclav could contributed to patient experiencing diarrhoea
- Delay in requesting CT scan for potential bowel perforation but delay not contribute to death
- Importance of timely observations and checking of medication as prescribed
- Regular review of medications to ensure appropriate as patients' conditions change.
- Patient sent to Step Down but was not MFFD
- Ensuring there is a more timely referral to ITU
- Improvements in communication and sharing of information between teams
- Importance of clear documentation of agreed Do Not Attempt Cardio Pulmonary Resuscitation decisions to allow delivery of agreed care
- Good discussions and involvement with families and patients in discussing DNACPR decisions

Hospital Acquired Infections

The Trust continues to strive to reduce the number of avoidable hospital associated infections. Two of the key infection associated indicators that are used are Methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium Difficile (C Diff). During 2019/20, we have seen increases in like for like numbers compared to 2018/19 for C Diff. It is important to note that from 1st April 2019 the national definitions used for C Diff were changed, consequently we expected there to be higher numbers and although the target was increased to accommodate this change UHNM, like many other Trusts, saw much higher numbers of infections than expected.

Indicator	2019/20 Target	2018/19	2019/20	Change
To reduce C Difficile infections	93	56	116	é
To reduce MRSA infections	0	1	0	ê

Priority 2:
To improve staff feeling of belonging and ownership through increased involvement in the development and delivery of the UHNM Clinical Strategy

We said we would do this by:

- ✓ **Improving staff experience through a range of activities focusing on staff wellbeing, reward and recognition**
- ✓ **Undertake further work at Board and Divisional level to share our vision and strategy, and progress on delivery throughout the year**
- ✓ **Increase visibility of senior leaders across both sites via walkabouts, holding local meetings and CEO staff forums at which UHNM clinical and non-clinical developments will be shared**
- ✓ **Respond to the Staff Survey results via the Divisional and corporate action plans**
- ✓ **Continue with our staff appreciation visits and recognition activities such as employee and team of the month awards.**

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

Freedom to Speak Up

The Trust has continued to promote Freedom to Speak Up Guardians and supporting staff in raising concerns or issues. There are regular reports are provided to the Quality Assurance Committee and Trust Board on matters raised and resolved

Actions taken in 2019/20:

- Our Speaking Up Policy (previously Raising Concerns at Work (Whistleblowing) Policy has reviewed and updated during 2019 and includes our commitment to a Just and Learning Culture is available on the intranet.
- The Trust's intranet has a Speaking Up page on the Staff Room section, with guidance for workers and managers.
- The Raising Concerns and Workforce Equality Manager is the Trust Freedom To Speak Up (FTSU) Guardian, supported by three Associate Guardian roles and a network of Employee Support Advisors.
- The FTSU Guardians have ready access to senior leaders and others to enable rapid escalation of issues, maintaining confidentiality as appropriate.
- The Trust has named Executive and Non-Executive Leads for speaking up who meet regularly with the FTSU Guardian.
- The FTSU Guardian reports quarterly to the Transformation and People Committee, and through this to Trust Board.
- UHNM has outlined its vision and strategy for speaking up in its Speaking Up Plan created from FTSU Self Review Tool
- The updated Guidance for boards was presented to the Trust Board by the Executive Lead for Speaking Up in September 2019 which summarised the expectations of Executive Directors in relation to freedom to speak up, and the roles and responsibilities of individual Trust Board members.
- The Trust Board had a board development session on Speaking Up delivered by NHS England & Improvement in January 2020
- Updated our Disciplinary Policy to include the Just and Learning framework

2019 NHS Staff Survey – The National Context and Trust Outcomes

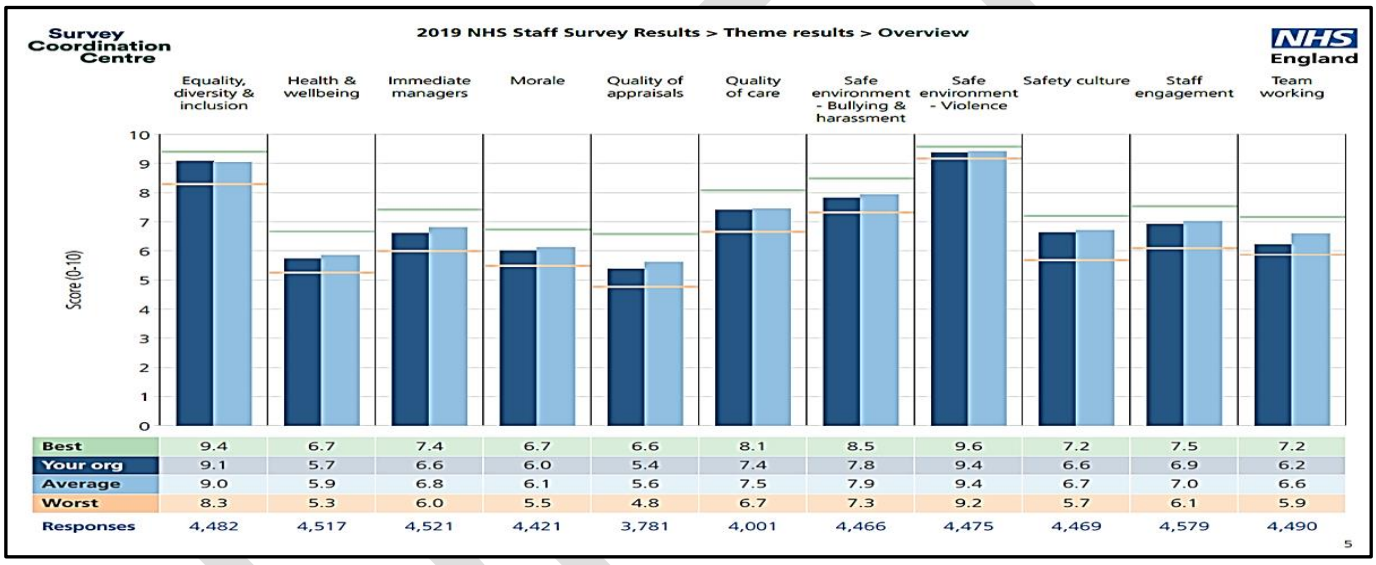
The 2019 NHS Annual Staff Survey was carried out between September and December 2019 and the Trust response rate was 45%. The national response rate was 47% and there were 85 organisations in the acute benchmarking group.

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

There were a number of statistically significant improvements in the 2019 scores when compared to the previous year's data.

- Equality and Diversity
- Morale
- Safety Culture
- Immediate Managers
- Quality of Appraisals
- Staff Engagement

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



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.4	6.7	7.4	6.7	6.6	8.1	8.5	9.6	7.2	7.5	7.2
Your org	9.1	5.7	6.6	6.0	5.4	7.4	7.8	9.4	6.6	6.9	6.2
Average	9.0	5.9	6.8	6.1	5.6	7.5	7.9	9.4	6.7	7.0	6.6
Worst	8.3	5.3	6.0	5.5	4.8	6.7	7.3	9.2	5.7	6.1	5.9
Responses	4,482	4,517	4,521	4,421	3,781	4,001	4,466	4,475	4,469	4,579	4,490

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

1. **Equality and Diversity –** The theme score was 9.0 out of 10 against an acute trust average of 9.0. The main issue for staff in 2018 was their perception of fairness as regards career progression and/or promotion. This perception improved from 80.9% in 2018 to 84.3% in 2019.

   Staff experience of discrimination at work from colleagues/managers also improved from 8.6% to 7.4%, better than the national average of 7.5%

2. **Health and wellbeing** – all aspects of this theme improved except the percentage of staff experiencing MSK problems, which increased from 26.1% to 27.0%. Positively, however, staff perceptions on opportunities for flexible working improved from 47.5% to 48% and the organisation taking positive action on health and wellbeing improved from 21.9% to 24.4%. Also, fewer staff said they had felt unwell due to work related stress (reduced from 41.8% to 40.2%).

3. **Immediate Managers – In 2018, staff** perception was that immediate managers did not appear to take a positive interest in staff health and well-being. This perception improved from 63.3% to 65.25%. Staff also reported improved support and feedback from managers, and that they felt managers value their work.
4. **Morale -** Staff say they have unrealistic time pressures, less choice in deciding how to do their work, and that relationships are increasingly strained. However, staff noted small improvements in receiving the respect they deserve from colleagues and encouragement from their immediate manager. This has reduced the percentage of staff who said they are thinking of leaving the Trust.
5. **Quality of Appraisals -** all aspects of staff perceptions around appraisals improved, with more staff saying it helped them improve how they do their job; agree clear objectives for their work and left them feeling their work is valued by the Trust
6. As regards **Team Working** however, fewer staff felt their team had shared objectives and the percentage saying they meet to discuss team objectives reduced from 52.9% to 50.9%, which is well below the national average of 60.3%
7. **Safety Culture –** Positively, staff reported improvements in every aspect of this theme:
    - those involved in an error, near miss or incident are treated fairly improved from 55.9% to 57.4%
    - organisational action to ensure errors or incidents don't happen again improved from 67.6% to 70%
    - feedback to staff in response to reported incidents improved from 57.7% to 58.9%
    - feeling secure about raising unsafe clinical practice improved from 65.6% to 67.8%
    - confidence that the organisation would address staff concerns increased from 52.7% to 56.2%, and
    - Trust acting on concerns raised improved from 68.8% to 71.4%
8. **Safe Environment –** Sadly, there was an increase in staff saying they experienced harassment, bullying and abuse from patients/service users (from 26.4% to 28.2%), and an increase in experience of violence (15.9% up to 16.5%) from patients/services users

    Staff experience of harassment, bullying and abuse from managers reduced from 15.6% to 14.1%, but increased from colleagues (22.0% up to 22.9%). Experience of violence from colleagues reduced from 1.9% to 1.4%, which is now below the national average
9. **Staff engagement –** At 6.9, the staff engagement score remains just below the acute trust average of 7.0.

    Although fewer staff said they look forward to coming to work, there was an improvement in the percentage who said they are enthusiastic about their job and that time passes quickly for them while at work. Despite this, there were improvements in staff saying care of patients is the Trusts top priority; they would recommend the Trust as a place to work, and if a friend or relative needed treatment, they would be happy with the standard of care provided, which scored 73.9% compared to a national average of 70.5%.
10. **Quality of Care** – there has been very little change in staff perceptions around quality of care, which scores 7.4 against a national average of 7.5. The main issue for staff is that they say they feel less able to deliver the care they aspire to.

Next Steps

To improve and evidence the positive action taken on health and wellbeing, we will:

- Continue to embed the Empactis Absence Management system to support improvements to sickness absence case management and continue to promote staff wellbeing, including financial wellbeing, in line with the Trust's wellbeing plan. We will undertake specific work with the health and safety team and staff physiotherapy service to consider how we can provide further support to those staff members with musculoskeletal problems.

Towards improving equality and diversity, staff morale and a culture of safety, we will maintain the focus on:

- Building on the work that commenced during 2019 to promote careers, i.e. Apprenticeships; Project Search; career campaigns with a focus on diversity; engagement with Department for Work and Pensions, and ensuring that recruitment campaigns are targeted at a broad pool of talent from protected staff groups.
- Continuing to promote inclusion at all levels of our workforce and promoting workforce diversity by raising awareness of under-represented groups through our leadership offerings. We will continue to work with our staff networks to identify any barriers to accessing development opportunities.
- Embedding a just and learning culture, approach into disciplinary and capability processes and promoting civility and respect across all areas of the Trust.
- Working with the security team to redesign conflict resolution training to increase the number of sessions and tailor to particular service needs and raise awareness of the Trust's zero tolerance to violence and aggression
- Introducing disability awareness training for managers and further promote disability leave as a reasonable adjustment
- Reviewing freedom to speak up messaging at Induction to ensure all staff feel able to raise concerns. We will also introduce a 'Speaking Up' Staff Charter and embed 'Cut It Out' as ongoing messaging that violence, bullying and harassment are unacceptable behaviours.

We will support Divisions to produce tailored action plans to address the survey findings specific to each area and ensure that Divisional People Plans incorporate actions to address the above and to improve team working, promote team discussions and awareness of objectives

Priority 3:
To increase the involvement of people at all levels, from the patient and carers at the bedside about their care, to the wider community in the planning and evaluation of the services we provide.

We said we would do this by:

- ✓ **Supporting patients to be involved in decisions about their own care.**
- ✓ **Provide a variety of forums/opportunities for patients to provide feedback**
- ✓ **Developing a culture that welcomes public engagement to actively influence the strategic direction of the Trust.**
- ✓ **Providing transparent patient feedback data for both staff and the public.**
- ✓ **Continue to develop close links with the community and expert groups to enable the voice of the hard to reach populations to be heard and identify need.**
- ✓ **Introducing a structured Patient Leadership training programme to provide Patient Leaders with the confidence and skills to become effective agents of change to improve the quality of services and promote health and wellbeing within communities.**
- ✓ **Supporting ideas and generate solutions to current health care problems from the patients' perspective.**
- ✓ **Providing learning and support for staff, patients, carers and the public.**
- ✓ **Moving from 'nice to have' to a 'must do' (always events)**
- ✓ **Implementing the refreshed Patient Involvement Strategy**

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

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

The introduction of Volunteer Patient leaders is an integral part of this commitment. During Quarter 2 we formally recruited our first cohort of four Patient Leaders.
We have developed a training programme in collaboration with the West Midlands Leadership Academy and the UHNM Organisational Development team to support us to equip our Patient Leaders with the skills they need to:

- Work with the Trust to find meaningful opportunities, identified through lived experience, to influence the on-going work of the Trust
- Use creative and innovative thinking in developing solutions
- Actively influence the strategic direction of the Trust.
- Work with us to co-create a culture which is 'patient-centred '
- Support the development of high quality patient and public engagement.

Our Patient Leaders bring a wealth of expertise to the Trust including:

- A willingness to develop their understanding and be committed to improving the NHS and its services.
- The ability to think widely about health and wellbeing.

- The ability and willingness to reflect; and represent the different views and diversity of patients/users, including those living with different conditions and who may be from different backgrounds.
- An understanding of the different challenges faced by the local community accessing the hospital.
- Experience of recently accessing NHS services and/or have experience of caring for or managing health/long term condition(s).

From left to right: Mr John James, Mr David Thorley, Mrs Lorraine Dale and Mrs Nicki Haywood.

University Hospitals of North Midlands places the quality of patient and carer experience at the heart of everything we do. We are always striving to exceed expectations, with the belief that patient experiences can always be improved on. We recognise that to achieve our Trust values we need to deliver an organisational culture centred on patient involvement, engagement and experience and that putting the people who use our services at the centre of decision making will improve the quality of services we deliver.

Members of the Board including Non-Executive actively participate in Quality Walkabouts and are involved in working with staff to enable improvements where the need is identified.

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

- Hospital User Group
- Clinical Quality Review Group
- Healthwatch
- Overview and Scrutiny Committee
- Quality review visits of the patient pathway which are Director led with Clinical Commissioning Group and GP involvement
- Complaint Peer Review Workshops
- Patient Information Leaflet Ratification Workshops
- PLACE inspections
- dDeaflinks
- Local pregnancy loss support groups

- Learning Disability Service User Group
- Stoke on Trent Public Health
- Community Health Learning Foundation

Annual Inpatient Survey

The Survey was conducted by Picker Institute, on behalf of the Care Quality Commission, on a sample of patients, aged 16 or over who had at least an overnight stay in University Hospital of North Midlands during July 2019. A total of 1250 patients, who were discharged from UHNM during July 2019, were sent a postal questionnaire asking them to feedback on their experience. The questionnaire consisted of 72 questions in total. 42% of patients responded. This is an improvement on the 2018 response rate of 36% but slightly below the average "Picker" response rate of 44%.

The Trust continues to implement a comprehensive improvement programme to support our overall ambition of being within the top 20% of Trusts nationally.

	Top 5 scores (compared to average)
68%	Q14. Hospital: not bothered by noise at night from other patients
25%	Q71+. Overall: received information explaining how to complain
76%	Q6. Planned admission: was admitted as soon as necessary
18%	Q70+. Overall: asked to give views on quality of care
84%	Q13. Hospital: staff completely explained reasons for changing wards at night

	Bottom 5 scores (compared to average)
56%	Q56. Discharge: patients given written/printed information about what they should or should not do after leaving hospital
51%	Q19+. Hospital: food was very good or good
53%	Q29. Nurses: always or nearly always enough on duty
80%	Q59+. Discharge: given clear written/printed information about medicines
58%	Q9. Admission: did not have to wait long time to get to bed on ward

	Most improved from last survey
78%	Q62+. Discharge: family, friends or carers given enough information to help care
25%	Q71+. Overall: received information explaining how to complain
71%	Q33. Care: staff did not contradict each other
88%	Q46. Procedure: told how to expect to feel after operation or procedure
93%	Q47. Procedure: explained how it had gone in an understandable way

	Least improved from last survey
58%	Q9. Admission: did not have to wait long time to get to bed on ward
11%	Q52. Discharge: delayed by no longer than 1 hour
53%	Q29. Nurses: always or nearly always enough on duty
83%	Q48+. Discharge: felt involved in decisions about discharge from hospital
76%	Q6. Planned admission: was admitted as soon as necessary

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

Improvement initiatives include:

- "It's OK to ask" campaign: to encourage patients to ask the questions about their care and treatment that matter to them. This campaign has been extended in the community to prepare patients for their GP

Consultation and hospital visit and support Shared Decision Making. The Health Literacy training is now being rolled out to other areas in the Trust.

- "Top 20 wards" introduced to encourage staff to gain patient feedback about their experience of the Trust
- Redesign of patient information leaflets to promote patient awareness and development of an electronic Patient Information library to support staff to have easy access to patient information leaflets
- Measurement of effectiveness of initiatives with patient surveys to inform the Clinical Excellence Framework audit programme
- Triangulation of quality and safety data through an internally designed Quality Management System data base to identify themes.
- Production of a Food and Hydration strategy which pays close attention to the end quality of food and drink served so that everyone received meals they enjoy.
- There continues to be a firm focus on patient experience at Trust induction.
- Purple Bow initiative established to provide additional support for relatives of end of life patients.
- Proactive recruitment of volunteers to assist with the improvement of service delivery and the patient experience.

Complaints

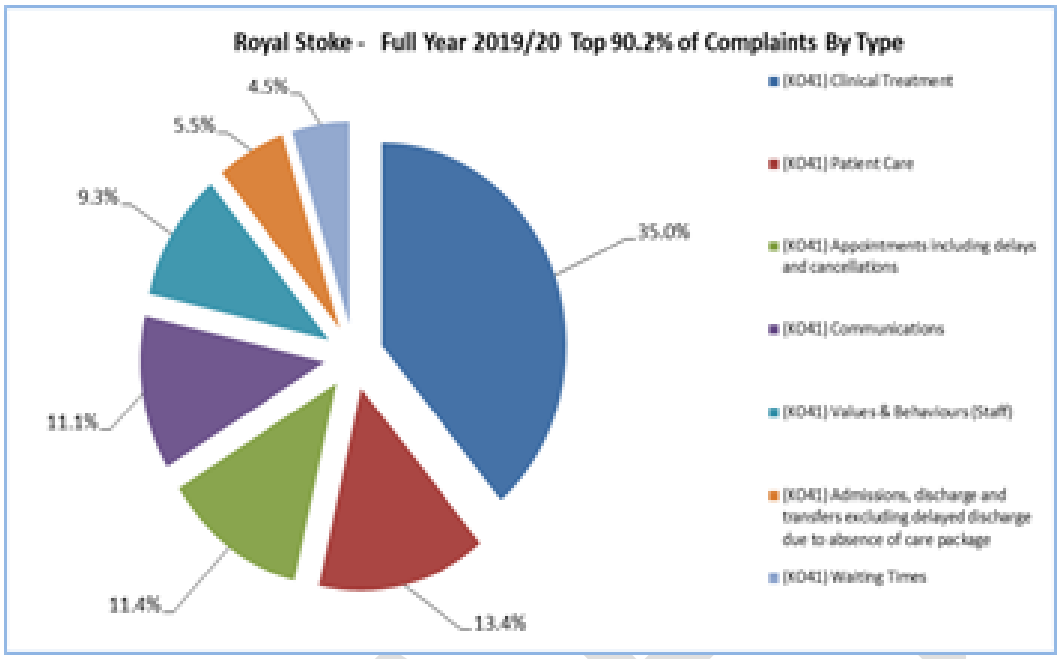
The total number of complaints opened at Royal Stoke University Hospital during 2019/20 is 635 which is an increase of 12.6% over the same period in 2018/19 when 564 complaints were opened.
The total number of complaints opened at County Hospital was 95 in 2019/20, which is a 15.2% reduction from 2018/19 with 112 complaints received.

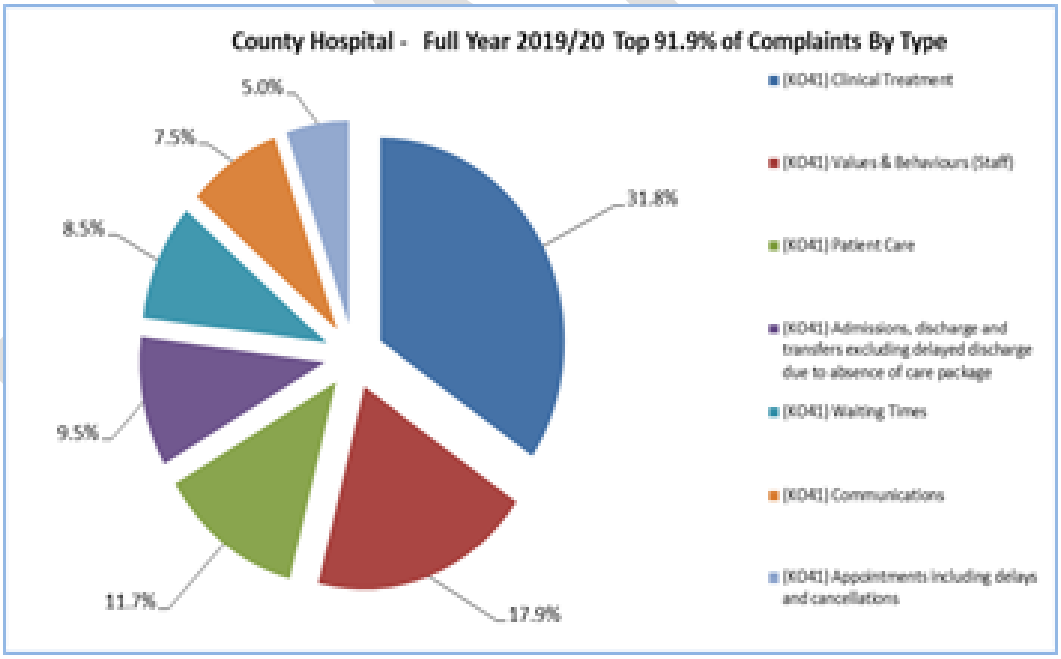
During 2019/20, the Complaints Team have achieved the following:

- Complaints are categorised to assist in analysing their trends and themes.
- Complaints processes have been aligned across UHNM sites so working practices are consistent
- On-going review of the current process to facilitate an improvement in the timeliness of responses from receipt of complaint to final response
- Improved consistency and quality of responses
- Average of 56.6 days during 2019/20 for complaints to be closed compared to 45.4 days in 2018/19 and 47.7 days in 2017/18. However, during COVID-19 Pandemic holding letters were sent to every complainant explaining there would be delay in responding to concerns raised whilst the Trust were managing the pandemic.
- Development of a Trust-wide Peer Review Programme which provides consistency of approach to reviewing complaints across both hospital sites and forms an integral part of the Trust's governance for evidencing the learning from complaints through a robust peer review programme.


Royal Stoke - Complaints Opened by Month 2019/20
No of Complaints
0
10
20
30
40
50
60
70
80
90
62
60
43
45
70
53
85
38
36
57
46
40
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20


County Hospital - Complaints Opened by Month 2019/20
No of Complaints
0
2
4
6
8
10
12
14
11
12
12
3
6
6
12
9
6
8
7
3
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20


Royal Stoke - Full Year 2019/20 Top 90.2% of Complaints By Type
4.5%
5.5%
9.3%
35.0%
11.1%
11.4%
13.4%
[KD41] Clinical Treatment
[KD41] Patient Care
[KD41] Appointments including delays and cancellations
[KD41] Communications
[KD41] Values & Behaviours (Staff)
[KD41] Admissions, discharge and transfers excluding delayed discharge due to absence of care package
[KD41] Waiting Times


County Hospital - Full Year 2019/20 Top 91.9% of Complaints By Type
5.0%
7.5%
8.5%
31.8%
9.5%
11.7%
17.9%
[KD41] Clinical Treatment
[KD41] Values & Behaviours (Staff)
[KD41] Patient Care
[KD41] Admissions, discharge and transfers excluding delayed discharge due to absence of care package
[KD41] Waiting Times
[KD41] Communications
[KD41] Appointments including delays and cancellations

Learning from Complaints

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

You said: You were told by your Consultant that you would receive Physiotherapy but this did not happen.
We did: The therapy discharge documentation has been reviewed, to ensure that there is a fully robust process in place

You said: That you were unhappy with your relatives care and the lack of documentation on wound care.
We did: The ward is in the process of producing a separate documentation sheet solely for the purpose of wounds and dressing changes. This concern has also been discussed with staff in ward meetings alongside patient's notes to give examples of the lack of documentation.

You said: That you were unhappy that you were not weighed at your appointment, only given a blood card
We did A process has been put in place to ensure that in the future all patients that attend the Gastroenterology clinics are weighed prior to their consultation

You said: You were concerned that the Children's Emergency Department reception is unmanned, and children are opening the main doors which is allowing anyone to enter the department.
We did: An additional intercom system is to be installed near the main nursing workspace so that clinical staff can ensure that only the appropriate patients and relatives are allowed to enter the Children's ED area.

You said: The medication to treat your pneumonia was delayed in ED, as there was a confusion as to which prescription chart was being used due to there being two.
We did: Our ED Governance Lead and the Lead Pharmacist for Medication Safety are currently investigating ways in the Emergency Department that we can simplify the process of drug prescription as we currently use both the ED prescription chart within the casualty card and separate hospital drug cards.

You said: That following an iron transfusion you have had yellow marks over your arm and did not know why this was
We Did: Your experience and the need for ensuring that patients are fully aware of the potential consequences of an iron transfusion will be shared with the Gastroenterology Consultant Team. A Trust wide communication/memo will be sent to all clinicians with a safety alert reminding them of the potential consequences of an iron transfusion.

You said: You were unhappy with lack of attention to your relative's dietary needs
We did: As a result of your complaint Ward 15 now has an allergen box containing gluten free products. Your concerns regarding the gluten free diet will be fed back to staff to ensure lessons are learnt and to ensure that staff are responding effectively to the dietary needs and allergen risks of patients. The meal service will be monitored to ensure that this does not occur again.

You said: You were unhappy that your daughter was discharged from the Emergency Department without clear diagnosis of her problem
We did: The clinician confirms that the issue you have raised with be shared in the ED monthly newsletter, so that all ED consultants can reflect and ensure if presented with a similar case, they would be mindful to consider x-ray at an earlier opportunity if appropriate

You said: You were unhappy with the delay you experienced waiting for bariatric surgery
We Did: The Bariatric Team are now looking into the possibility of restarting the treatment initiative theatre sessions in order to improve waiting times for patients.

Priority 4:
To promote further the use of technology to improve the efficiency and effectiveness of patient care.

During 2019/20 UHNM have promoted and improved patient care with the innovative use of technology. These include:

World Class Surgical Robot

The surgical system consists of a four-arm robot connected to a remote console which the surgeon operates while seated. Foot pedals are used for control, and 3-D displays provide a unique depiction of the surgical field.

February 2020 saw the exciting installation of the latest and most advanced generation of surgical robot, providing our patients with the very latest in surgical care.

The 'Da Vinci Xi' is the second surgical robot to be used at our Royal Stoke site, making us the only Trust in the West Midlands to have two robots and the latest robotic technology. Together they will radically improve the treatment of our urology, general surgery and gynaecology patients.

The robot is the most advanced in its range and the surgical system provides a surgeon with a cutting edge set of instruments to use in performing robotic assisted minimally invasive surgery.

Improved Vascular Patient Care

Our Vascular patients are now being treated and discharged more quickly, thanks to the innovative work of the specialist nursing team.

The team created a 'complex dressing clinic' to help facilitate a more timely discharge and patient flow within our surgical division. The initiative helped to save more than £40, 000 and has contributed to successful patient discharges.

The clinic has also proven to be beneficial to the patient pathway and reducing inpatient hospital stays.

The team were invited to present the initiative at the Society for Vascular Nursing's Annual Conference in Manchester.

New Linac Accelerator Machine

Our new Linac Accelerator machine was installed in June 2019, providing Stereotactic Ablative Radiotherapy, a more intensive form of treatment which only causes minimal damage to surrounding organs.

The linac machine, which cost £1.7million has enabled clinicians to treat smaller tumours in areas of the body that were previously difficult to access and therefore improve change of survival and quality of life

Part C: Statements from our key stakeholders

Healthwatch Stoke-on-Trent and Healthwatch Staffordshire will not be commenting this year due to being unable to distribute the draft to our volunteers nor discuss the document in the normal way due to the COVID-19 pandemic. It is our intention to fully participate and comment on the UHNM Quality Account next year.

In the meantime, we would simply pass on our sincere thanks to the staff at the UHNM who have worked so hard to minimise the impact of the Covid-19 pandemic and we look forward to renewing our contact with the hospitals early in 2021.

Stoke-on-Trent Clinical Commissioning Group

North Staffordshire Clinical Commissioning Group

Stafford and Surrounds Clinical Commissioning Group

Staffordshire & Stoke-on-Trent Clinical Commissioning Groups (CCGs) are pleased to comment on this Quality Account 2019/2020.

The quality assurance framework that Commissioners use reviews information on quality, safety, patient experience, outcomes and performance, in line with national and local contractual requirements. The CCGs' Quality representatives meet with the Trust on a monthly basis to seek assurance on the quality of services provided. The CCGs work closely with the Trust and undertake continuous dialogue as issues arise, attend relevant Trust internal meetings and conduct quality visits to clinical areas to experience the clinical environment, listening to the views of patients and front line staff.

The CCGs would like to recognise the Trust's commitment to improving quality as demonstrated by the following achievements:

- 29% reduction in rate of Patient Safety Incidents with harm per 100 admissions from 2018/19 to 2019/2020
- 34% reduction in Category 2 and 49% reduction in Category 3 Hospital Acquired Pressure Ulcers with 'lapses in care' in 2019/20 compared to 2018/19
- 23% reduction in the rate of patient falls reported per 1000 bed days with harm during 2019/20 compared to 2018/19
- HSMR and SHMI mortality indicators are both within expected ranges
- The PLACE scores published nationally on 30th January 2020 achieved scores well above the national average.
- The CQC rated Critical Care as an Outstanding Service following the inspection June 2019

However, 2019/20 has not been without its challenges and we look forward to working closely with the Trust to see further improvements in these areas over the coming year:

- The CQC inspection rated the Trust as 'requires improvement' (summer 2019). Concerns were raised regarding the care and treatment of patients in the Emergency Department (Royal Stoke) and patients with mental health needs and those who lacked capacity to make decisions.
- The Emergency Department 4 hour performance target has for many years not been achieved. The CCG would welcome patients being seen and treated in a timely manner.
- Improvement in the Cancer 62 day standard to improve patient outcomes and experience
- Continued focused work towards achieving the 18 week Referral to Treatment standard for patients
- Strive towards ensuring and embedding learning from Never events to prevent reoccurrence
- Continued focused work on Infection, prevention control to reduce the number of avoidable hospital associated infections
- Continued improvement in Sepsis pathway and provision of Antibiotics within 1 hour

Priorities for 2020/21

Commissioners attended (virtually) and contributed to the development of the Trust's Quality priorities for 2020/21 and have recognised the following areas as requiring further focused work to ensure that required standards are consistently achieved:

- To continue to improve safe care and treatment to patients and to improve patient experience
- The introduction of the 'Delivering Exceptional Care programme' supported by the establishment of a new Quality Improvement Academy to build greater capacity and support staff to use established quality improvement methodologies to deliver high standards of care.
- To improve staff engagement and well being

Commissioners recognise the impact Covid-19 has had on patients, families and staff. We would like to thank all of the staff for their continued hard work, resilience and adaptability at an extremely challenging time.

We look forward to working together with the Trust to ensure continued improvement over the coming year. The CCGs wish to state that to the best of their knowledge, the data and information contained within the quality account is accurate.

Heather Johnstone
Director of Nursing and Quality
Staffordshire and Stoke on Trent CCGs

Marcus Warnes
Accountable Officer
Staffordshire and Stoke on Trent CCGs

City of
Stoke-on-Trent

Unfortunately, due to the pandemic the Adults and Neighbourhoods Overview and Scrutiny Committee has not been meeting until recently. Mindful of the pressure on our NHS colleagues and our own Health Directorate, the business we are undertaking at present is very limited. Consequently we are not in a position to comment on this year's accounts. Hopefully, we will all be in a better position in 2021 and able to comments on next year's accounts.

Performance and Finance Committee Chair's Highlight Report to Board

24th November 2020

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Urgent care performance had been challenged and was variable due to fluctuations in the mix of patients • Ambulance handover performance continued to be challenged at times of significant peak attendances • The Trust saw the largest number of Covid admissions in the region, over the previous weekend and critical care capacity remained challenged with associated risks in terms of staffing • There were 35 restricted beds in place due to previous outbreaks and trigger points continued to be monitored in terms of deciding when the Trust would be required to move onto level 4 incident • The Committee queried whether planning for staffing over the Christmas period had been determined and it was confirmed that this had been discussed and planned • The Trust continued to wait for additional information to be provided, in relation to the elective incentive scheme	• To provide a comparison of performance with similar localities experiencing similar Covid levels • To provide definitions for the prioritisation of patients e.g. cancer, urgent etc to Non-Executive Directors • To provide an outline of underlying run rate to the Committee in January 2021
Positive Assurances to Provide	**Decisions Made**

• The Trust had performed well in terms of planned care performance for October with continued progress made with referral to treatment (RTT) targets
• Continued positive performance made in terms of diagnostics and cancer trajectories
• As part of winter planning, 31 additional beds had been accessed although there was some difficulty in accessing the remaining beds due to staffing
• Financial position for month 7 delivered a deficit of £0.8 m which was better than planned, the Trust had incurred £1.2 m Covid related costs which were lower than month 6 and capital expenditure was £4.9 m behind plan
	• The Committee approved the business case in relation to Endoscopy Insourced Service
	• The Committee approved the contracts for the following:
	  ○ Supply of Instruments for DaVinci Robot System (REAF 4059) – Extension
	  ○ Pharmacy Wholesale Agreement (REAF 3971)
	  ○ Supply of Domestic products (REAF 4056)
	  ○ Data Centre Refresh Part 1 (REAF 5124)

Comments on Effectiveness of the Meeting	
• Due to operational pressures and in line with the Covid Terms of Reference, it was agreed with the Chair beforehand to shorten the meeting by focusing on key items for assurance and approval.	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Month 7 Performance Report	Assurance	7.	Investment Assurance Report	Information
2.	Executive Directors Update including Covid-19	Assurance	8.	EPRR Annual Assurance	Information
3.	Month 7 Finance Report	Assurance	9.	Quarterly Procurement Update Report	Information
4.	BC-0382 Endoscopy Insourced Service	Approval	10.	Annual Audit into Overseas Visitor Policy	Information
5.	Authorisation of New Contract Awards and Contract Extensions	Approval	11.	Executive Data Security & Protection Group Highlight Report	Information
6.	PFI Governance and Contract Performance Management Report	Information			

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	NH				
Mr J Tringham	**JT**	Director of Operational Finance												

Transformation and People Committee Chair's Highlight Report to Board

27th November 2020

1. Highlight Report

Matters of Concern / Key Risks / Escalations	Major Actions Commissioned / Work Underway
• Concerns regarding increasing numbers of patients with Covid-19, including those within the Critical Care Unit • Staffing levels within Critical Care are particularly challenged with 54 high dependency patients at present; Level 4 Major Incident has been declared for Critical Care meaning that divert arrangements are in place where appropriate • Agreement has been reached for Major Trauma patients to be diverted to Coventry and Warwick and Birmingham • In order to increase Critical Care capacity to 60; a nationally agreed process through the Critical Care Network will be enacted to support staffing • Executive Directors have taken the decision to pause appraisals where not possible to deliver although have encouraged Wellbeing Discussions • 61% staff absence is Covid related in latest figures • NHSEI have downgraded UHNM from green to amber in their latest assessment of Infection Prevention measures as a result of concerns identified during a recent visit	• Risk assessments, particularly for those vulnerable groups of staff are being reviewed and updated • Implementation of Lateral Flow Testing is currently underway; this can and is expected to further impact upon sickness figures – around 1% tests are positive in latest data and this is in line with peers • A team of triage call handlers are in place to organise testing for staff • Deep Dive underway to review staff absences associated with the Track and Trace application which is hoped to enable some staff to return to work
Positive Assurances to Provide	**Decisions Made**
• Staff Wellbeing Package in place, including for those staff who have been affected by family / friends and colleagues with Covid-19 • Some success with appointment of 5 staff to support the Delivering Exceptional Care Programme • Nursing Recruitment Plan in place which sets out a number of work streams to improve recruitment with opportunity to submit an expression of interest to secure nationally available funding to support a nursing apprentice programme; Committee very pleased with the report and work underway • Recruitment activity, including consultant recruitment which is now virtual, has remained ongoing despite Covid pressures • Statutory and Mandatory Training has not been paused despite pressures and 94.25% had been achieved	• All items considered at the meeting were for information / assurance only • Papers regarding Succession Planning / Talent Management and the Listen and Learn process will be deferred to a future meeting
Comments on Effectiveness of the Meeting	
• A shorter meeting due to current pressures associated with Covid-19; the next meeting will be less formal and held in 'workshop' format focussing on key issues	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Delivering Exceptional Care Highlight Report	Assurance	6.	Annual Equality and Inclusion Report 2019 - 20	Assurance
2.	Update on Local Actions for Revalidation, Job Planning and National Reports	Assurance	7.	Succession Planning and Talent Management	Assurance
3.	Guardian of Safe Working Q2	Assurance	8.	Listen and Learn (Covid-19)	Approval
4.	Nursing Recruitment Plan	Assurance	9.	Review of Meeting Effectiveness	Assurance
5.	M7 Workforce Report	Assurance	10.	Summary of Items for Escalation to Trust Board	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:**	9th December 2020
Report Title:	Integrated Performance Report M7 2020/21	**Agenda Item:**	13.
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:

Situation

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

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

Assessment

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 and continue the work on Restoration and Recovery. October saw the beginning of the 2 week intensive programme supported by ECIST ***Do the right thing campaign*** which looks at ways the Trust can do things differently both in the emergency department and across the organisation. Early signs were encouraging and improvements were seen in the number of patients being treated in the right place at the right time.

Inevitably, with the second wave of the pandemic, October brought an increase in attendances of patients with suspected Covid-19. The challenges were felt across the trust but specifically in critical care. This reflected a similar position to that seen across the region.

During October Quality & Safety achieved a number of standards.

- Harm Free Care 96.2% 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 October 2020 at 5.3 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 9943% (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 October 2020 but these are under continued review
- Sepsis Screening Compliance in Emergency achieved 91.7%
- Children's sepsis Screening Compliance 95.2%
- Inpatients IVAB within 1 hour achieved 100% for audited patients
- Zero Never Events reported in October 2020

The Trust did not achieve the set standards for:

- Written Duty of Candour has improved during October but was below the 100% target at 93.3% (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.
- C Diff target above trajectory target of 8 during October 2020 with 11 cases reported
- Inpatient Sepsis Screening compliance (adult Inpatients), 84.3% against a target of 90%
- Emergency Portals Sepsis IVAB in 1 hour reported 84.6%
- During October 2020, the following quality highlights are to be noted:
- The rate of complaints per 10,000 spells has decreased to 23 and below (positive) the target of 35 but is within normal variation.
- Total number of Patient Safety Incidents increased in October 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 October with 1.2 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 phase and UHNM is on target to achieve a further 10% year on year reduction target for 2020/2021.
- HAI E.Coli Bacteraemia cases for October 2020 noted 10 cases above the mean of 9
- Nosocomial Hospital Acquired Infection indicator has been included in the QPR.

Operationally the Trust continued to face challenges. Whilst, in total, Emergency attendances fell slightly, the Type 1 attendances at Royal Stoke continued to rise with ambulances remaining high and accounting for 50% of the overall RS attendances. This indicates a higher acuity of patients who are more likely to be cared for in majors and more likely to be admitted. Although the number of admissions overall remained the same, more covid positive patients were admitted. By the end of October, the number of Covid +ve patients in the hospital reached 181 (with expectations that this would continue to rise through November). This mirrored the changing picture across North Staffordshire which saw itself alongside Stoke on Trent in Teir2

Key challenges included managing Covid-19 positive and suspected cases in line with infection prevention and outbreak measures as per the agreed pathways. The performance for UHNM (system wide) in October was 71.6% (September 75.8%) and this was influenced by the performance for Royal Stoke alone at 53.6% (September to 50.2%).

There were eight 12 hour Trolley waits in October, six of which were directly related to the operational challenges related to Covid-19. October saw an increase to 97 patients who had a reported ambulance handover delay > 60 minutes.

The Trust continued with its plan to see and treat elective patients. The demand for 2ww returned to pre-covid levels with September and October seeing the highest numbers in 12 months. In response to the demand, patients seen in the month has also risen with the percentage seen within 14 days at 94.2%. In addition to 2ww, the trust is predicted to achieve 4 other cancer targets in October; 31 day sub anti-cancer,

31 day sub radiotherapy, 62 day screening & 28 day FDS. The 104+ day backlog remains stable at 21 and the 62 day backlog continues to be monitored and is currently at 197.

The National ask for October was for Outpatients to be at 100% of last year's business as usual and for Inpatients 90%. The trajectories were set 89.4% and 81.8%. Successfully, for October, total outpatient activity was 89.3% of last year's BAU and total Elective inpatient activity has risen to 83.1%. The inpatient performance was supported by the increase in the number of 4hour elective theatre sessions and elective operations.

The overall effect on the Referral To Treatment position was mixed. Whilst performance improved to 66.16% the number of new pathways continues to rise as new pathways are started (demand from GPs and internal clock starts) which is outweighed by activity restraints. For October the number of pathways reported was 47,168. This is above the forecast 45,200. The number of new RTT clock starts rose steadily from May and October saw 11000+ new RTT pathways/ periods added. This is circa 72% of pre-covid numbers. A Trust trajectory for this has been developed and monitored through the planned care cell. The Trust has 1626 over 52 week breaches as a consequence of standing down elective work. This is as forecasted. Recovery plans include prioritised actions for recovery of the long waiting patients. To assist, the Trust is currently using 79% of the Independent Sector capacity available.

Diagnostic tests continue with improvements. As expected, October saw a further increase in diagnostic activity rising to 25,921. The trust trajectory for activity to the end of the year consistently meets the national ask and will be on trajectory to deliver to the year end, accepting that any covid surge will impact on this position.

The diagnostic performance for October is currently 88.3%, a further rise on the previous month by 15.1%. The waiting list size is also showing a reduction: down to 13,671. 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.

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.

The focus of the Workforce Bureau has been on risk assessments, staff wellbeing, staff testing and staff deployment. The daily sickness sitrep has been developed so that data is used to highlight wards and areas with high numbers of staff calling in as absent, which will then trigger the mitigating actions, set out in business continuity plans. Work to identify which staff could potentially be redeployed internally has been completed and Divisions are identifying where volunteer placements could offer support. A system-led workforce demand and supply process is in place to manage redeployment of staff where required.

The key performance issues remain compliance with statutory and mandatory training and PDR requirements, and the sickness rate being above target. The in-month sickness rate was 4.76% (4.60% at 30/09/20). The 12 month cumulative rate changed slightly to 5.16% from 5.17%. Sickness and covid-related absences continue to be monitored daily. Staff showing symptoms, or with household members showing symptoms, are tested and results returned within 24-48 hours. Since the 21st October, there have been an increasing number of absences and covid-related absences. Absence episodes have increased in line with the second covid wave and, as of 11th November, covid-related open absences numbered 728, which was 61% of all absences (28% at 13th October 2020). Wellbeing Support has continued throughout October and November and UHNM Charity has funded the development of semi-permanent rest facilities which should be available for use before Christmas. Weekly forums are taking place to enable Junior Doctors to raise issues regarding rest, support and wellbeing.

As at 11th November, 93.13% of all permanent and fixed term staff and 92.98% of BAME staff have a completed covid risk assessment. Of the completed risk assessments, the vast majority (95%) are in the lowest risk category.

A more detailed discussion on the absence position has taken place at the Transformation and People Committee

For appraisals, the Non-Medical PDR compliance rate was 76.81% (77.48% at 30th September 2020). Due to the surge in covid, an Executive decision has been taken to suspend PDR's unless there is capacity to continue to undertake them. An impact assessment is currently being completed to assess the potential effect on performance rates and service delivery. For Statutory and Mandatory training the rate at 31st October 2020 was 94.25% (93.51% at 30th September 2020) and 90.20% of staff had completed all 6 Core for All modules (86.32% at 30/09/20)

Financially, a positive message was received that the Trust was out of financial measures. Key messages are:

- The Trust has delivered a deficit of £0.8m for the month against a planned deficit of £0.8m.
- Activity delivered in Month 7 is significantly lower than plan although NHS income levels from patient activities have been maintained due to the temporary funding arrangements. Encouragingly activity from Non Staffordshire CCGs (which continues to be paid for on a Payment by Results basis) was higher in Month 7
- The Trust estimates the impact of the Elective Incentive Scheme (EIS) to be a £0.5m reduction to income in Month 7; as for Month 6 this is not reflected in the financial position in line with guidance from NHSI/E.
- The Trust incurred £1.2m of additional costs relating to COVID-19 which was £0.4m lower than in Month 6 mainly due to the inclusion of claims in the Month 6 accounts from the Anaesthetists for additional shifts worked in the first half of the year.
- Other Operating income has increase in month mainly as a result of reflecting the latest schedule from Health Education England (HEE) in the position.
- The actual deficit of £0.8m compares favourably against the Trust's forecast for Month 7 (against which it is now externally monitored against) which forecast a £1.7m deficit.
- Capital expenditure for the year to date stands at £19.1m which is £4.9m behind plan with the main driver being slippage on the PDC funded ED scheme.
- The month end cash balance is £90.6m which is £4.2m higher than plan.

Key Recommendations:

To note performance

NHS
University Hospitals of North Midlands
NHS Trust

Integrated Performance Report

Month 7 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

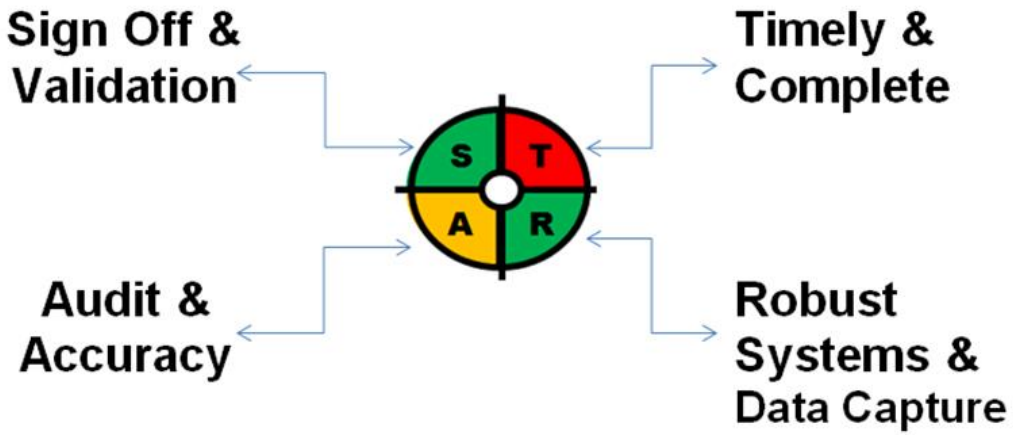
Together Compassion Safe Improving

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

NHS University Hospitals of North Midlands NHS Trust

Key messages

The Trust achieved following standards in October 2020:

- Harm Free Care 96.2% 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 October 2020 at 5.3 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 99.43% (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 October 2020 but these are under continued review
- Sepsis Screening Compliance in Emergency achieved 91.7%
- Children's sepsis Screening Compliance 95.2%
- Inpatients IVAB within 1 hour achieved 100% for audited patients
- Zero Never Events reported in October 2020

The Trust did not achieve the set standards for:

- Written Duty of Candour has improved during October but was below the 100% target at 83.3% (5 out of 6 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.
- C Diff target above trajectory target of 8 during October 2020 with 11 cases reported
- Inpatient Sepsis Screening compliance (adult Inpatients), 84.3% against a target of 90%
- Emergency Portals Sepsis IVAB in 1 hour reported 84.6%

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

- The rate of complaints per 10,000 spells has decreased to 23 and below (positive) the target of 35 but is within normal variation.
- Total number of Patient Safety Incidents increased in October 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 October with 1.2 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 phase and UHNM is on target to achieve a further 10% year on year reduction target for 2020/2021.
- HAI E.Coli Bacteraemia cases for October 2020 noted 10 cases above the mean of 9
- Nosocomial Hospital Acquired Infection indicator has been included in the QPR.

Quality Dashboard

Metric	Target	Latest	Variation	Assurance
Patient Safety Incidents	N/A	1669		
Patient Safety Incidents per 1000 bed days	N/A	44.67		
Patient Safety Incidents per 1000 bed days with no harm	N/A	30.67		
Patient Safety Incidents per 1000 bed days with low harm	N/A	12.04		
Patient Safety Incidents per 1000 bed days reported as Near Miss	N/A	1.58		
Patient Safety Incidents with moderate harm +	N/A	13		
Patient Safety Incidents with moderate harm + per 1000 bed days	N/A	0.35		
Harm Free Care (New Harms)	95%	96%		
Patient Falls per 1000 bed days	5.6	5.3		
Patient Falls with harm per 1000 bed days	1.5	1.2		
Total Pressure Ulcers developed under UHNM Care	TBC	45		
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	5	H	?
Medication Incidents % with moderate harm or above	TBC	0%		P
Serious Incidents reported per month	N/A	6		
Never Events reported per month	0	0		?
Duty of Candour - Verbal/Formal Notification	100%	100%		P
Duty of Candour - Written	100%	83%		?
Inpatient Sepsis Screening Compliance (Contracted)	90%	84.3%		?
Inpatient IVAB within 1hr (Contracted)	90%	100.0%		?
Children Sepsis Screening Compliance (All)	90%	95.2%	H	P
Children IVAB within 1hr (All)	90%	N/A	H	F
Emergency Portals Sepsis Screening Compliance (Contracted)	90%	91.7%		?
Emergency Portals IVAB within 1 hr (Contracted)	90%	84.6%		?
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	98.8%		P
Friends & Family Test - Maternity	N/A	N/A	H	?
Written Complaints per 10,000 spells	35	22.99		?
Rolling 12 Month HSMR (3 month time lag)	100	94.70	L	P
Rolling 12 Month SHMI (4 month time lag)	100	99.67	L	P
VTE Risk Assessment Compliance	95%	99.4%	H	?
Emergency C Section rate % of total births	15%	20.5%	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	10		
Nosocomial "Definite" HAI COVID Cases - UHNM	0	59		

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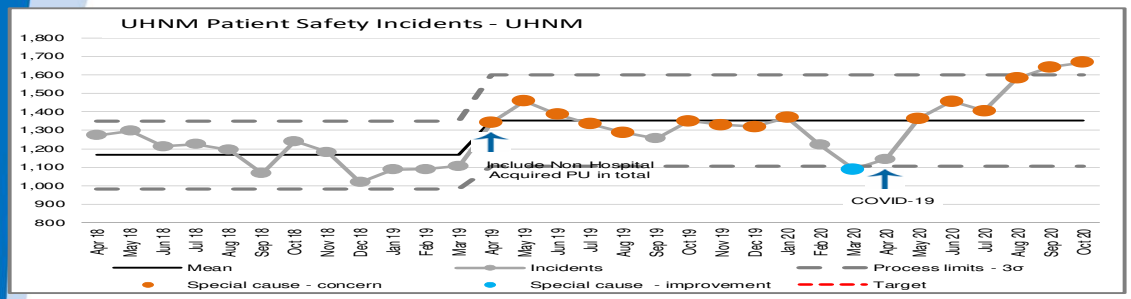
Reported Patient Safety Incidents

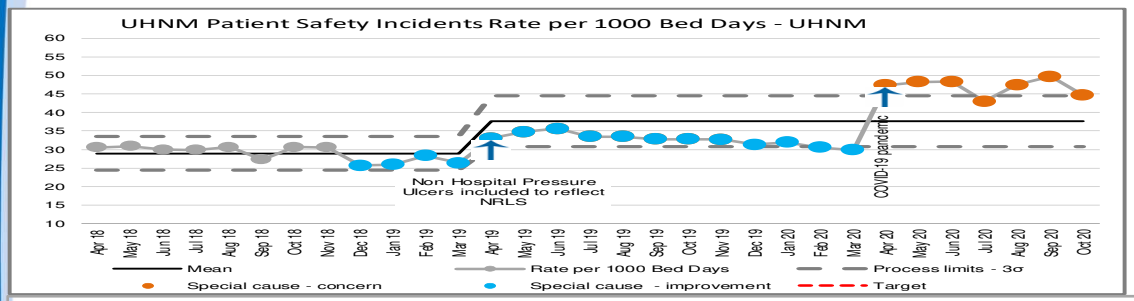


Variation	Assurance
	

Target	Aug 20	Sep 20	Oct 20
N/A	1583	1643	1669

Background

Total Reported patient safety incidents



Variation	Assurance
	

Target	Aug 20	Sep 20	Oct 20
N/A	47.51	49.69	44.67

What is the data telling us:

The above data relates to **all** reported Patient Safety Incidents (PSIs) across the Trust. October 2020 has seen an increase in total number of reported PSIs and is above 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 - 198 (181),
- Clinical assessment (Including diagnosis, images and lab tests) – 73 (71)
- Patient flow incl. access, discharge & transfer - 92 (122)
- Treatment/Procedure - 69 (79)
- Medication incidents - 187 (171)

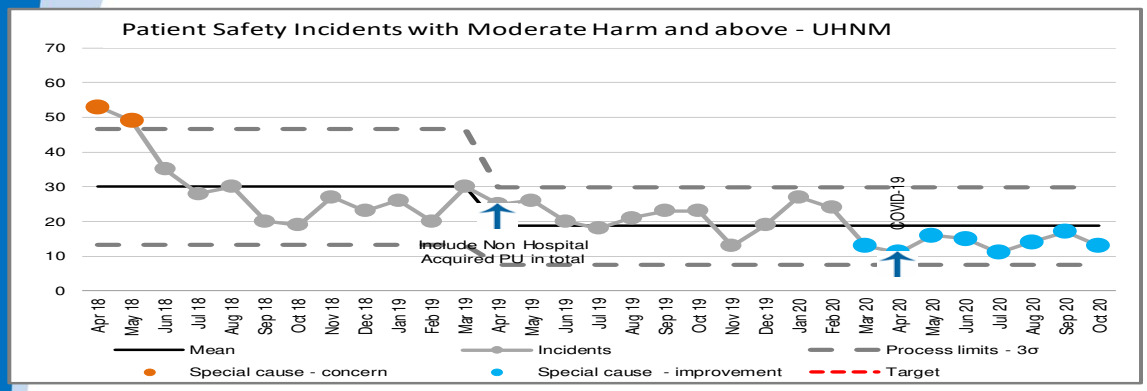
There have been increases in Falls, Medication and Clinical assessment incidents compared to September 2020 totals (in brackets). However, there have been reduced incidents in relation to Treatment/Procedure and Patient Flow.

Patient Safety Incidents are reviewed and analysis undertaken on locations and themes.

The Directorates reporting most PSIs are Emergency Medicine, General Medicine, Specialised Medicine, Anaesthetics Theatres & Critical Care, Obstetrics & Gynaecology and General Surgery & Urology. 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 September 2020. The increase in total incidents is due to more incidents with no harm or low harm 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.

Reported Patient Safety Incidents with Moderate Harm or above

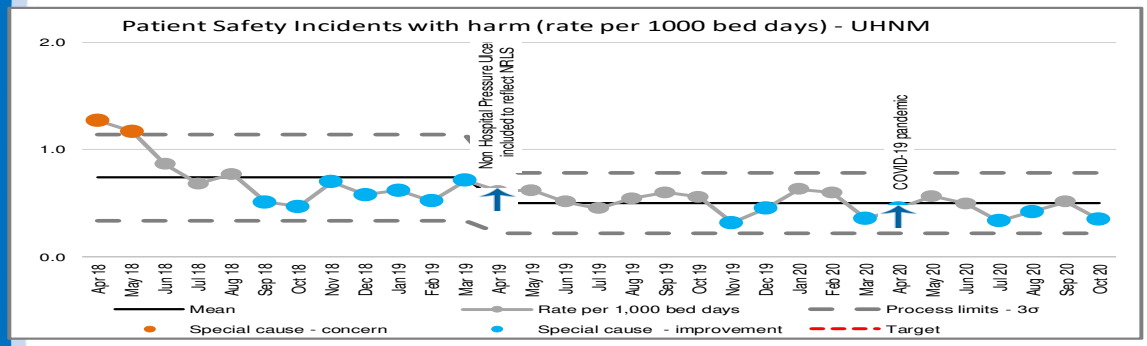


Variation	Assurance
	

Target	Aug 20	Sep 20	Oct 20
N/A	14	17	13

Background

Patient safety incidents with reported moderate harm and above



Variation	Assurance
	

Target	Aug 20	Sep 20	Oct 20
N/A	0.42	0.51	0.35

What is the data telling us:

The chart show that during October 2020 there has been a slight in month decrease in PSIs with moderate harm or above. The number of PSIs with moderate harm or above continues to be below the long term mean for the last 8 consecutive months. The second chart, shows the rate of PSIs with moderate harm or above per 1000 bed days and there are continued positive trends with 5 consecutive months below the mean. The data illustrates the positive outcomes from the incidents being reported as there are lower rates of harm despite rate of reporting increasing. This is an indicator of a potentially positive reporting culture and staff are willing and able to report incidents and near misses.

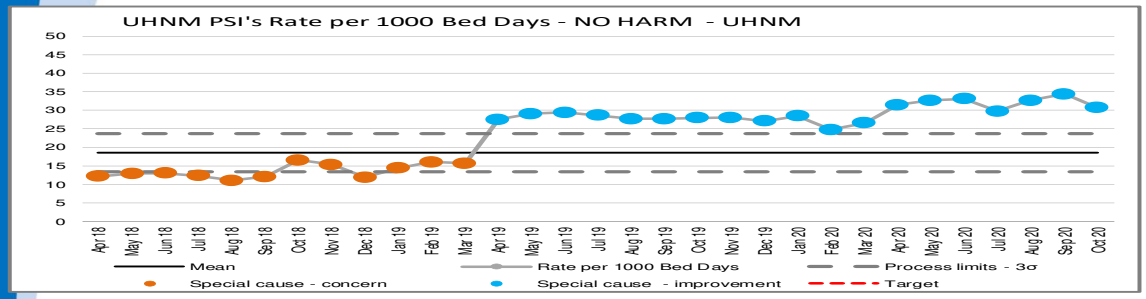
The top category of incidents resulting in moderate harm reflect the largest reporting categories with Slips/Trips/Falls being the largest category.

Other categories included Equipment failure, transport delay due to lack of porter availability, diagnostic delay following attendance at ED (SI reported) and treatment delay following identification of blocked PICC line which was replaced

The equipment failure related to Anaesthetic epidural catheter sheath identified as incomplete on removal. Reported to MHRA and not found retained following X Ray, CT scans and examination by spinal surgeons. A complaint has also been received from the patient.

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

University Hospitals of North Midlands NHS Trust

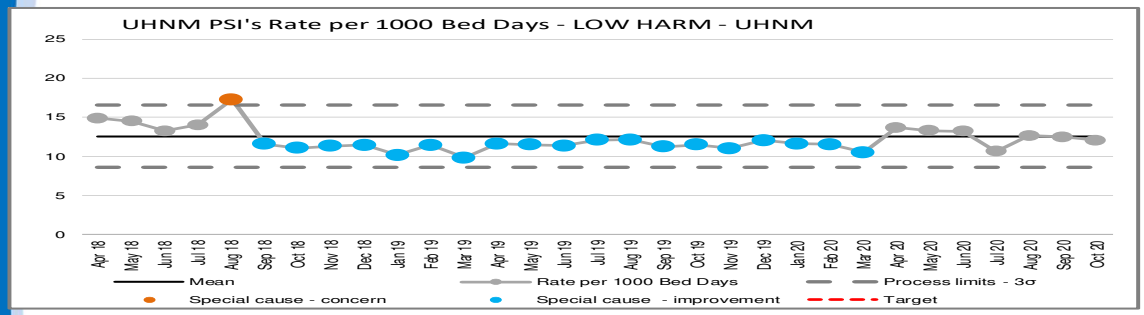


Variation	Assurance
H	

Target	Aug 20	Sep 20	Oct 20
N/A	32.66	34.36	30.67

Background

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

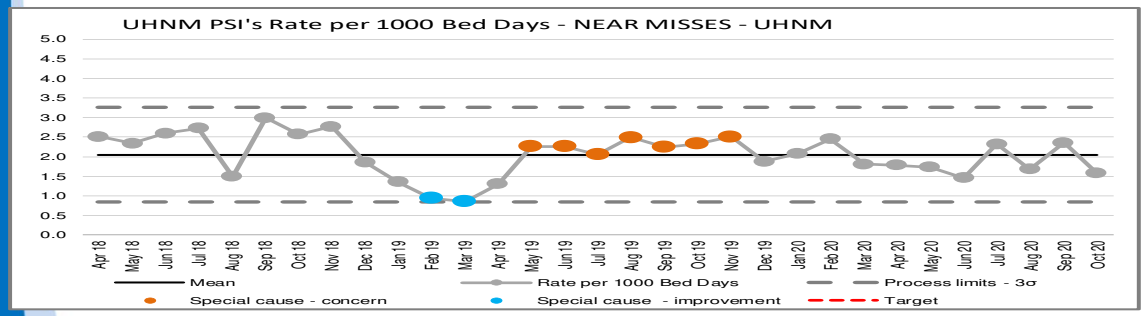


Variation	Assurance

Target	Aug 20	Sep 20	Oct 20
N/A	12.67	12.46	12.04

Background

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



Variation	Assurance

Target	Aug 20	Sep 20	Oct 20
N/A	1.68	2.36	1.58

Background

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

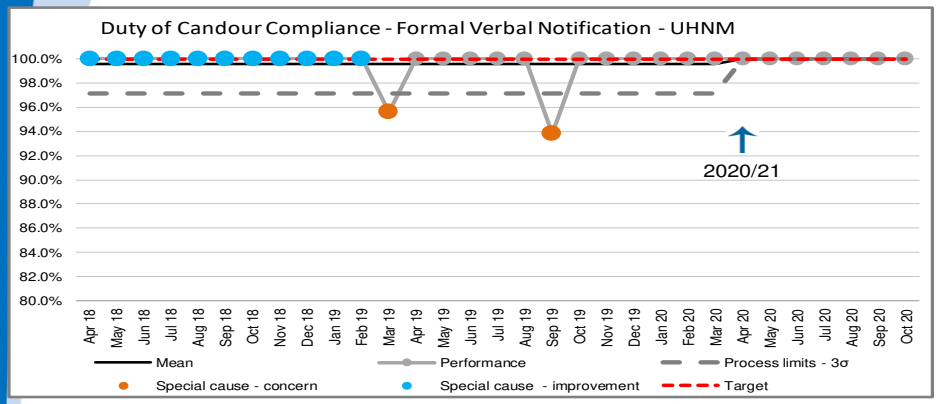
What is the data telling us:

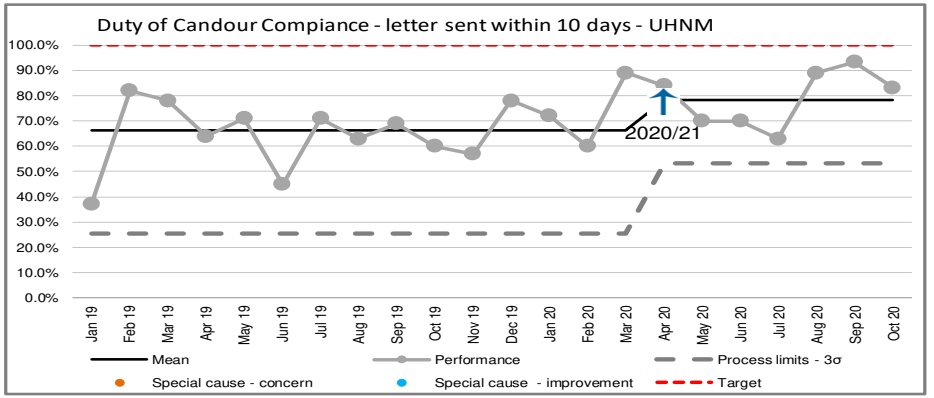
The Rate of Patient Safety Incidents per 1000 bed days with no harm or low harm are showing consistent trends. The rate of incidents reported resulting in no harm is continuing trend to increase and should be encouraged as reporting these incidents allows for actions and learning to be identified via potential trends of incidents.

Low harm rate has similar profile and is higher than pre pandemic although returned to long term organisational mean. Near misses rates had increased during earlier months of pandemic and have seen return to similar rates pre COVID.

Duty of Candour Compliance

University Hospitals of North Midlands NHS Trust





Variation	Assurance
	P

Target	Aug 20	Sep 20	Oct 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	Aug 20	Sep 20	Oct 20
100%	89.0%	93.3%	83.3%

Background

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

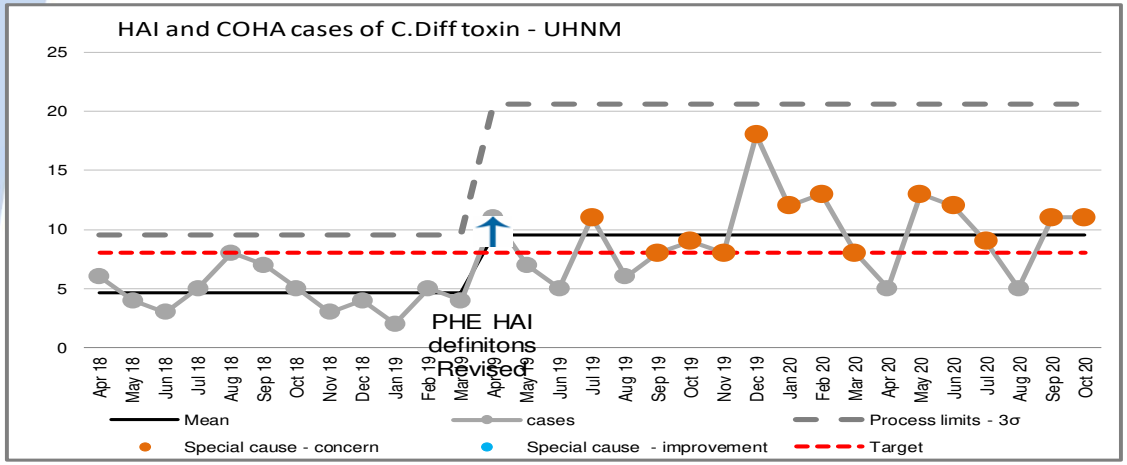
What is the data telling us:

Formal Verbal Notification Duty of Candour has been recorded in 100% of all incidents that have formally triggered meeting the threshold during October 2020. Follow up Written Duty of Candour Compliance for receiving the letter within 10 working days of verbal notification during October 2020 was 83.33% with 5 cases within 10 working days target . The 1 case that was outside the 10 working days has had letter sent but this was outside the required time period.

Actions taken:

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

Reported C Diff Cases per month



Variation	Assurance
	

Target	Aug 20	Sep 20	Oct 20
8	5	11	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 10 Hospital Associated Infection (HAI) cases and 1 Community Onset Hospital Associated (COHA) cases identified in October. 11 cases were also reported in September. Ribotype results received to date are not demonstrating a link in cases however, this work is on going as we are awaiting a number of ribotype results. For October 2020, UHNM is above trajectory (11 versus a target of 7) based on 2019/20 target and for the year to date 2020/21 UHNM is above trajectory with 66 cases versus a year to date target of 55.

Actions:

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

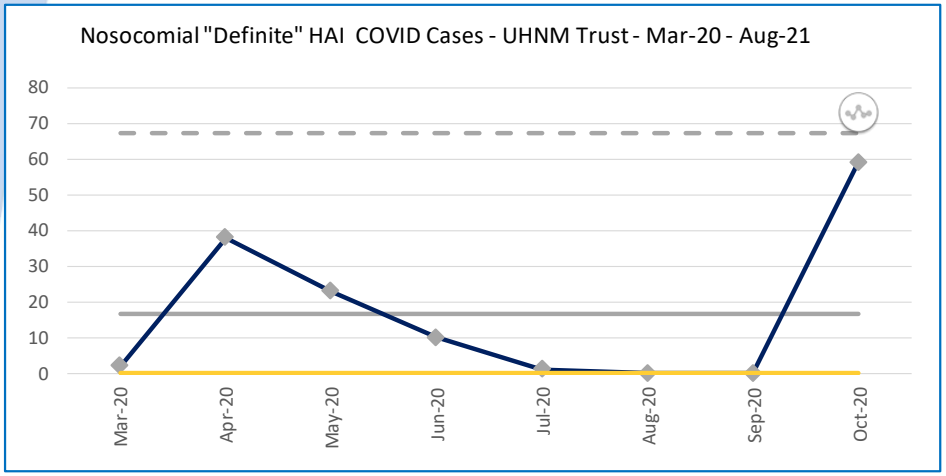
In all cases control measures are instigated immediately, and RCA's are reviewed by the CCG, this is paused due to COVID 19.

Each in-patient is reviewed by the C difficile nurse at least 3 times a week, and forms part of a weekly multi-disciplinary review.

Routine ribotyping of samples is now being undertaken at Leeds hospital. This will help determine if cases can be linked

A Clostridium *difficile* task and finish Group has been planned to review the CDI deep dive report with was presented at IPCC.

HAI Nosocomial COVID Cases per Month



	Metric Name	Latest Value	Lower process limit	Upper Process limit	Mean
1	Nosocomial "Definite" HAI COVID Cases - UHNM Trust	59	-33.9	67.2	16.6

What do these results tell us?

- The data shows an Increase in definite Healthcare Acquired COVID -19 cases. This increase started during the second wave of the COVID -19 pandemic.
- The number of community onset COVID 19 cases reported increased from week 37, this increase continued during October
- The average number of beds occupied with COVID 19 patients during October increased .
- A number of ward outbreaks were reported during October
- For patients the following time linked definitions apply:

Definite healthcare acquired infection (HAI)	SARS-CoV-2 detected ≥ 15 days into admission

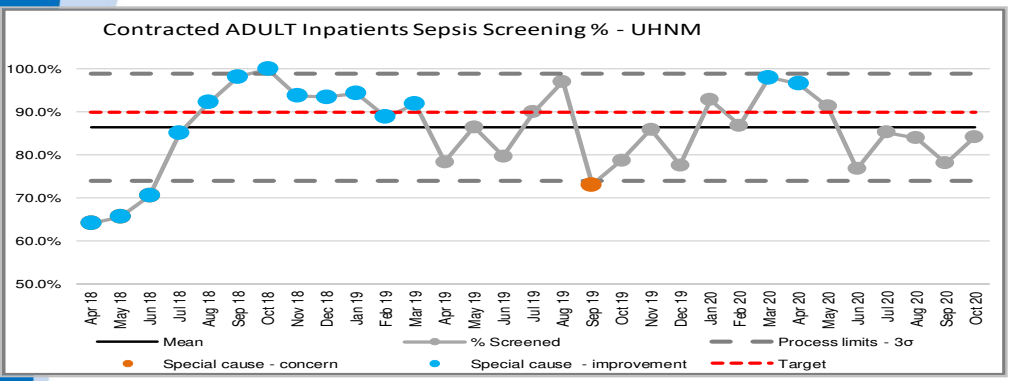
Actions :

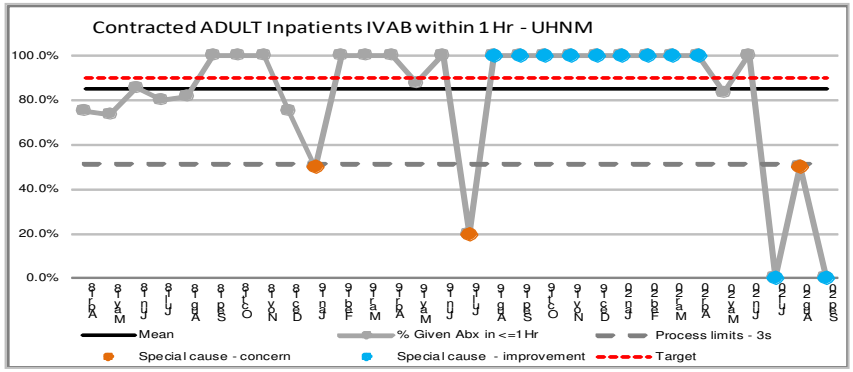
All Emergency patients screened for COVID 19 on admission to UHNM, screening programme in place for planned surgery/procedures.

- All inpatients who have received a negative COVID screen a repeat COVID screen on day 5 of stay
- COVID 19 themes report to IPCC
- UHNM Guidance on Testing and re-testing for Covid-19' plus step down of suspected/positive cases
- Isolate suspected patients on identification of symptoms
- Process for patients identified as contact of positive case via ICNet system
- Process in place for outbreak management and reporting
- Swabbing champions to be rolled out and improve compliance with day 5 screen

Sepsis Screening Compliance (Inpatients Contract)

University Hospitals of North Midlands NHS Trust





Variation	Assurance

Target	Aug 20	Sep 20	Oct 20
90%	84.0%	78.1%	84.3%

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

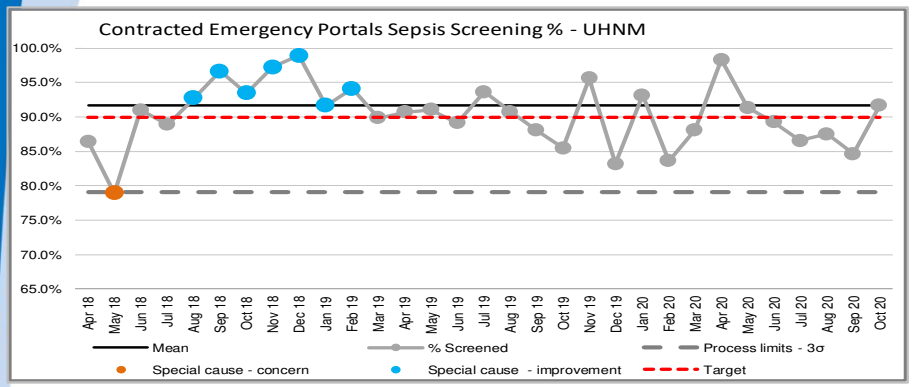
What is the data telling us:

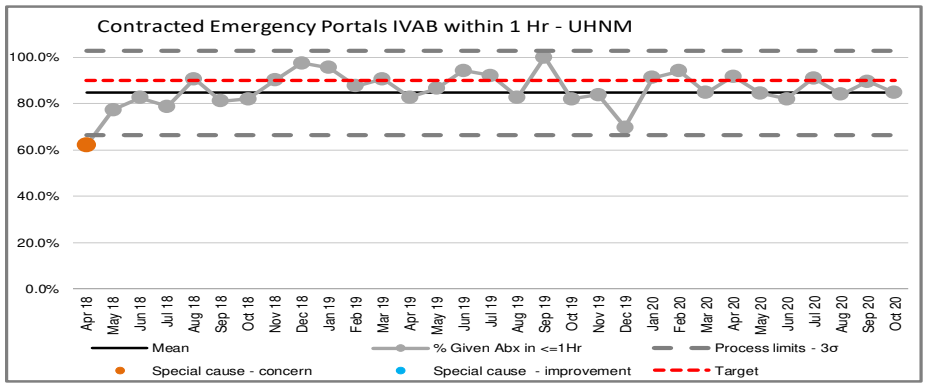
Shows October's results with an improvement on September for screening now at 84.4% which is an improvement of 7% from the previous month, but still short of the 90% target. Those that were not screened were investigated and actions put in place as indicated below. Inpatient areas also achieved 100% for IVAB within an hour, however this data continues to be from a very small sample size of just one patient for October. This is due to patients in inpatient areas either already being on IVAB or having alternative diagnosis.

Actions:

- Discussions opened within the sepsis and data analysis team to see how we can capture data that better reflects numbers of patients receiving sepsis treatment. We anticipate an update to the data collection tool to reflect this.
- In the absence of formal practical training due to COVID-19 restrictions, the sepsis team have begun a programme of sepsis re-enforcement, which consists of visiting ward areas to update clinical staff and promote awareness around sepsis whilst answering any queries they may have.
- The sepsis team now input data weekly rather than monthly in order to identify Inpatient areas with poor compliance and prioritise those areas for sepsis re-enforcement.
- The sepsis team continue to work closely with the VitalPacs team in order to address issues with staff access levels and trouble shooting. We have played an active role with the vitals steering group in order to help improve this system.

Sepsis Screening Compliance (Emergency Portals Contract)





Variation	Assurance

Target	Aug 20	Sep 20	Oct 20
90%	88%	85%	92%

Background

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

Variation	Assurance

Target	Aug 20	Sep 20	Oct 20
90%	84%	89%	85%

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 October achieved 92% for the 60 patients audited whilst IVAB within 1 hour reduced to 84.6% for the 26 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:

- Sepsis team will work collaboratively with A&E department regarding management of patients with sepsis triggers whilst held in the ambulance due to capacity pressures this winter; on-going

Operational Performance

2025 Vision "Achieve NHS Constitutional patient access standards"

Contents

A note on **SPC**

NHS University Hospitals of North Midlands NHS Trust

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;

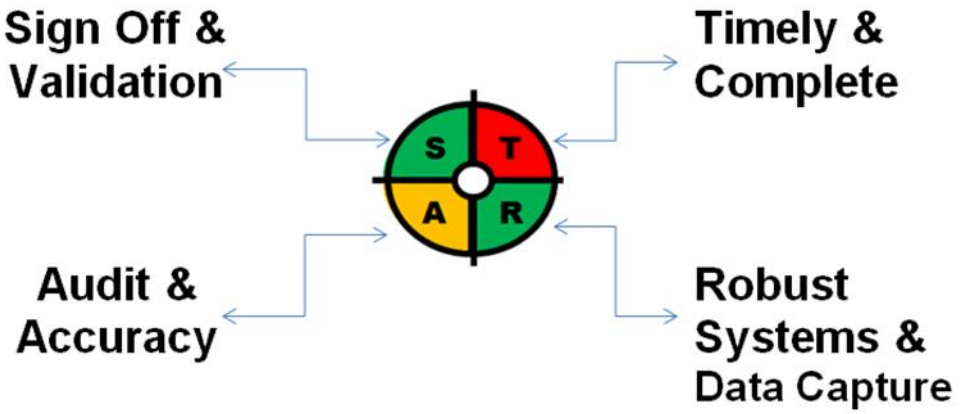
Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling 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 were developed to give a view of what the rest of 20/21 was expected to look like in the absence of a second wave of Covid-19.

October saw a fall in attendances both system wide and for total type 1. Royal Stoke Type 1, however continued to rise , averaging at 316/ day. Type 1 A&E attendances are up to 82% of last years demand. The daily average in ambulance attendances remained the same as the previous month at 160 per day (in Feb 20 this was 170). However, for most days this accounted for 50% of attendances.

The performance for UHNM (system wide) in October is 71.6% (September 75.8%). The key area is the Type 1 at Royal Stoke where performance fell from 53.6% in September to 50.2%. The key reason for the drop in performance is directly related to the rise in the number of patients attending with Covid-19 (a rise seen nationally). Although the number of admissions overall remained the same, more covid positive patients were admitted. By the end of October, the number of Covid +ve patients in the hospital reached 181 (with expectations that this would continue to rise through November). This mirrored the changing picture across North Staffordshire which saw itself alongside Stoke on Trent in Teir2.

There were eight 12 hour Trolley waits in October, six of which were directly related to the operational challenges related to Covid-19. October saw an increase to 97 patients who had a reported ambulance handover delay > 60 minutes.

Cancer

The demand for 2ww has returned to pre-covid levels with September and October seeing the highest numbers in 12 months. In response to the demand, patients seen in the month has also risen with the percentage seen within 14 days at 94.2%. In addition to 2ww, the trust is predicted to achieve 4 other cancer targets in October; 31 day sub anti-cancer, 31 day sub radiotherapy, 62 day screening & 28 day FDS.

Cancer Outcomes Services Dataset (COSD) completeness has improved for the 5th consecutive month, as a result of the new COSD role.

The 104+ day backlog remains stable at 21 and the 62 day backlog continues to be monitored and is currently at 197.

Planned Care

The National ask for October was for Outpatients to be at 100% of last years business as usual and for Inpatients 90%. The trajectories were set 89.4% and 81.8%. For October, total outpatient activity was 89.3% of last year's BAU and total Elective inpatient activity has risen to 83.1%. This is set against the increasing pressures the Trust experienced in October with more Covid-19 patients seen and admitted and bed closures due to Infection prevention. The number of 4hour elective theatre sessions and elective operations have risen throughout October.

RTT

The waiting list for RTT pathways continues to rise as new pathways are started (demand from GPs and internal clock starts) and are outweighed by activity restraints. For October the number of pathways reported was 47,168. This is above the forecast 45,200. The number of new RTT clock starts rose steadily from May and October saw 11000+ new RTT pathways/ periods added. This is circa 72% of pre-covid numbers. A Trust trajectory for this has been developed and monitored through the planned care cell. The Trust has 1626 over 52 week breaches as a consequence of standing down elective work. This is as forecasted. Recovery plans include prioritised actions for recovery of the long waiting patients. RTT performance in October is 66.16%. We are currently using 79% of the Independent Sector capacity available.

Diagnostics

As expected, October saw a further increase in diagnostic activity rising to 25,921 . The trust trajectory for activity to the end of the year consistently meets the national ask and would be on trajectory to deliver to the year end, accepting that any covid surge will impact on this position.

The diagnostic performance for October is currently 88.3%, a further rise on the previous month by 15.1%. The waiting list size is also showing a reduction: down to 13,671. 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

University Hospitals of North Midlands NHS Trust

Summary

- October saw a fall in attendances both system wide and for total type 1. Royal Stoke Type 1, however continued with rising attendances, averaging 316/ day. Type 1 A&E attendances are up to 82% of last years demand, returning to business as usual. The total TYPE 1 for the month was 13,045 with RS totalling 9697.
- Ambulance attendances had the same daily average of 160 and for most days this accounted for 50% or more of attendances, indicating the acuity levels of patients is high. Over 60 minute handover delays increased from 55 to 97.
- Significantly, whilst the number of attendances at Royal Stoke remained much the same as September, the number of patients attending with suspected Covid-19 rose sharply in October, this is in line with the national and regional picture. Although the number of admissions overall remained the same, more patients were admitted due to the virus. The number of Covid +ve patients in the hospital during October reached 181 (with expectations that this would continue to rise through November). This meant more patients were clinically managed through the high risk pathway. This caused huge operational challenges due to the demand for side rooms following Covid testing, deep cleaning and awaiting results (particularly overnight processing). This was compounded by the closure of some wards/ beds for infection prevention. Three wards closed for the latter weeks of October with other wards having restrictions due to exposure.
- The Trust reported eight 12 hour trolley waits, of which 6 were directly related to Covid-19 as above, 1 patient awaiting a NIV bed and 1 breached due to deep cleaning availability of SR.
- As a consequence, the system wide performance seen in September (75.8%) fell to 71.6% in October. Type 1 (RS) saw a performance of 50.2% (September 53.6%)and at County performance fell to 88.5%.
- Performance for admitted patients fell from 39.2% to 32.9%, reflecting the challenges faced with admitting patients with Covid-19 into inpatient beds.
- The average arrival to referral median time is above the 2 hour standard at 160 mins and the referral to discharge time rose in October by almost 60 mins on average One key area for delay were referrals to AMU. This remains a real focus of work for the Trusts Urgent Care plan and has significant impact on admitted performance.
- The number of medical patients in beds at midnight rose in October by, on average, 23/day. We are seeing 92% of the medical patients in beds for the same time last year. Also the number of MFFD/ Stranded and super stranded patients have all risen in October. Circa 25% of these are on COVID-19 wards. Discharge of COVID +ve patients can be delayed due to an inability to isolate in the follow on setting.
- O Day NEL admissions are remaining fairly steady following the initial rise in May, and are 63% of the previous years levels.
- NEL 1+ day admissions are also remaining fairly steady. now up to 88% of last year levels. Further increase back to 100% is expected for winter.
- SDEC is up to 30%+ of all NEL admissions.
- For the last two weeks of October, the 7 day average LoS for patients staying 1+ days was above that seen last year, however there is no significant variation in LOS for 1+ days NEL admissions for September & October.
- Bed occupancy is increasing month on month and expected to continue to increase into Winter. For Royal Stoke October is 86.6% and County 91.6%.

Urgent Care - Actions

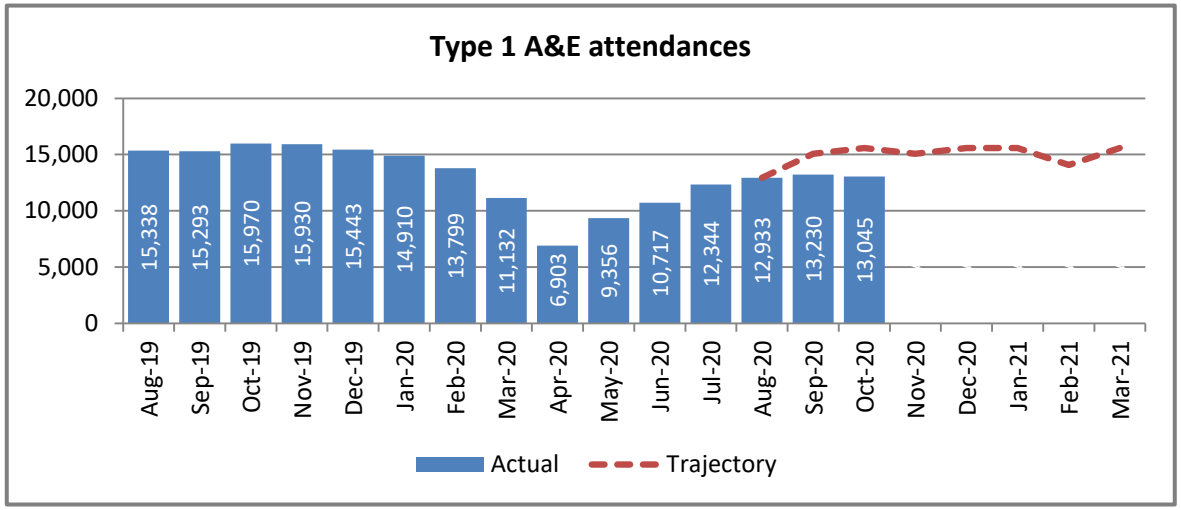
October saw the 2 week intensive programme supported by ECIST. The next steps are to continue to build and embed the systems and processes developed through the programme.
The areas of focus were ED, Ward and Site / Operational Flow. The initial findings from the test for change weeks demonstrated some small improvements to the quality elements of the ED pathways and earlier transfers to wards with improvements in discharge lounge utilisation and focus on the Red 2 Green pathways / SAFER bundles of care.

The key areas of focus over the next month are:
ED
- Continue to monitor the number of diverts by the Nurse Navigator and real time feedback to GPs
- Continue to embed the safety huddle and monitor performance through breach analysis
- Continue to report ED Escalation levels through the site structure and work with the Operation Team to ensure the site escalation levels reflect the ED status
- Commence the Medical Workforce Test of Change on 9th November for 1 week and monitor performance daily against the agreed KPIs
- Agree the SIFT resource and rota
- Monitor daily the numbers of patients seen within the red GP pathway and develop the pathway further to include children
- Roll out of Consultant Connect to commence on 23.11.2020
- Complete procurement process for the Vocera communication system and develop the implementation plan
- MProve has also commenced with the Trust during October and the work is dovetailing into the Test of Change during November to further embed the learning from October across multiple areas.
- Prepare for Think 111 Go live on 1st December

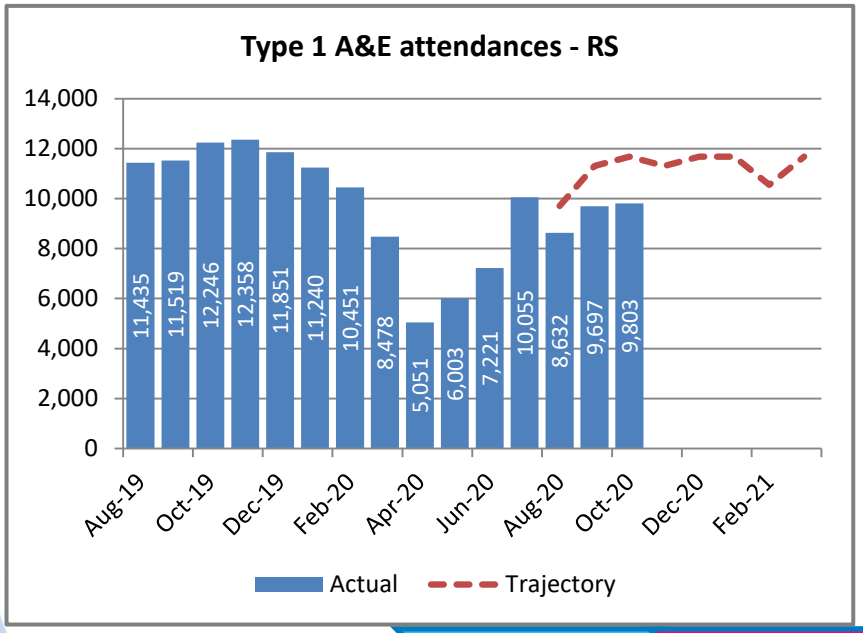
Ward Based Systems
- Further roll out of the SAFER principles to more medical wards
- Continue to monitor the use of the discharge lounge daily and ensure and challenge when the process is not followed
- Development of the daily metrics to continually monitor the SAFER principles
- Audit of board rounds for the next round of nominated wards
- Agree targets with wards for earlier in the day discharges and monitor daily
- Apply the SAFER principles to board round principles and monitor through observation and audit
- Revisit the “West Hub” principles

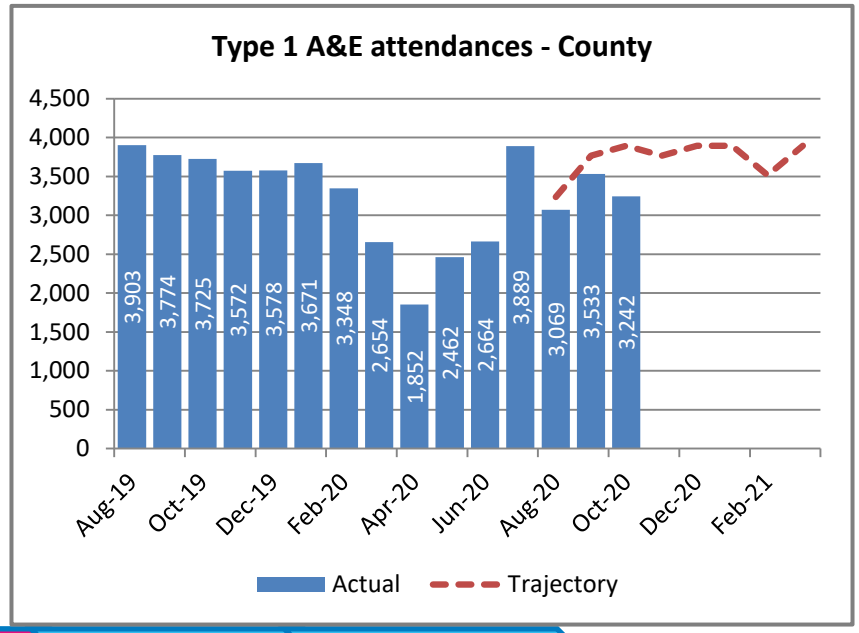
Acute Medicine
- Roll out the early pull Test of Change to more medical wards
- Monitor the effectiveness of the transfer team through issues log and observation and time to transfer data
- Complete the development of the metrics report with Information Services
- Continue and embed the weekly improvement meetings and agree the improvement plan

Urgent Care *(attendances)*

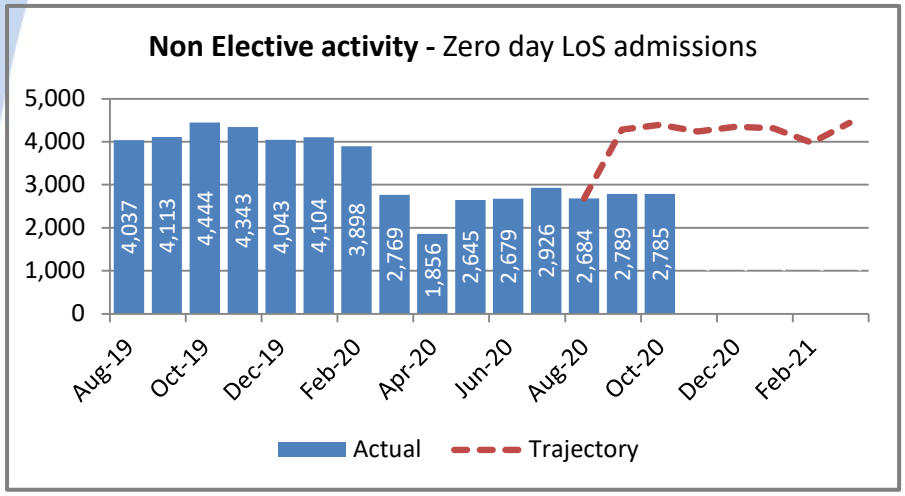


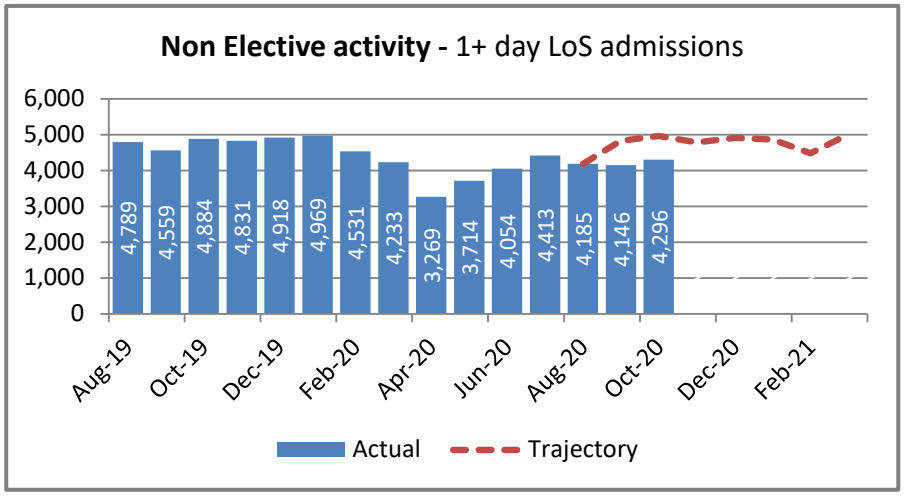
	% against Oct 19
Type 1	82%
RS	80%
County	87%





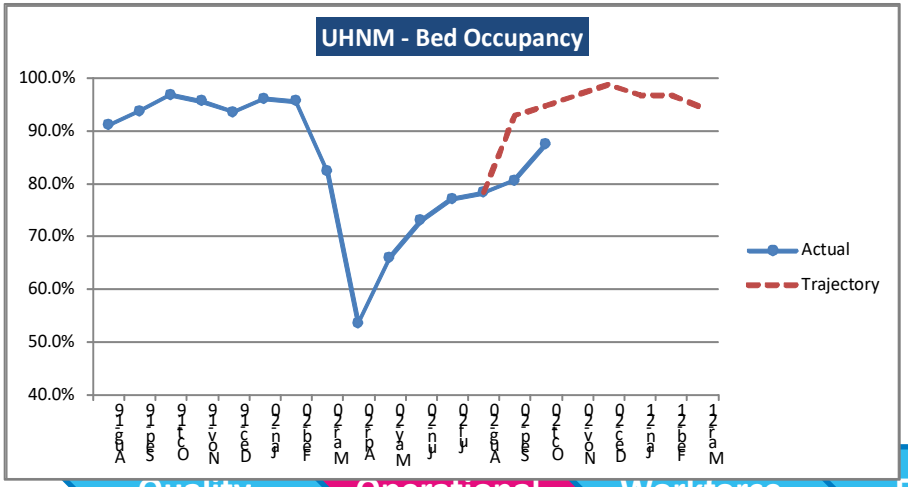
Urgent Care - *(admissions)*





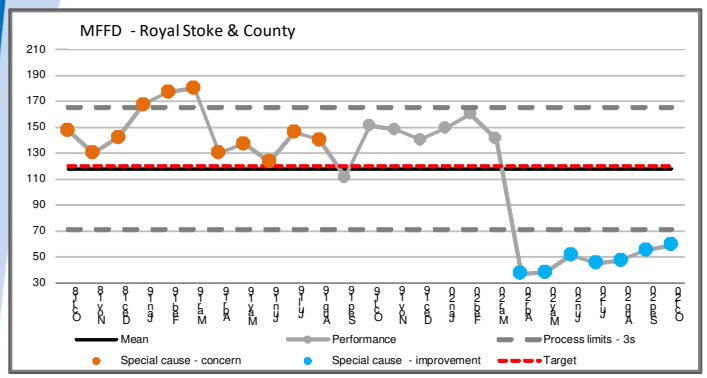
	Aug 20	Sep 20	Oct 20
Previous year	4,037	4,113	4,444
2020 Actual	2,684	2,789	2,785
% of BAU	66%	68%	63%

	Aug 20	Sep 20	Oct 20
Previous year	4,789	4,559	4,884
2020 Actual	4,185	4,146	4,296
% of BAU	87%	91%	88%



Quality | Operational | Workforce | Finance

URGENT CARE – *(Discharges)*



Variation	Assurance
L	?

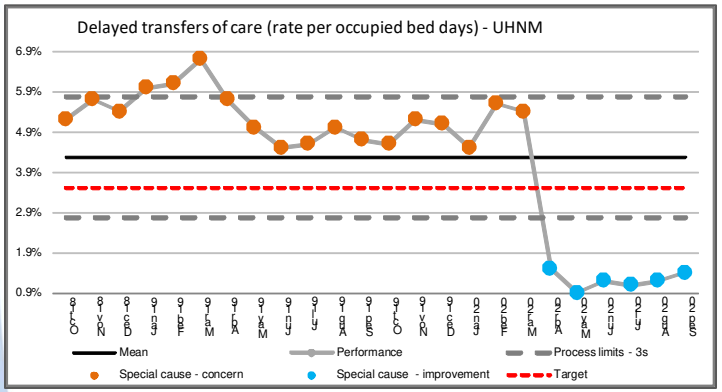
Target	Aug 20	Sep 20	Oct 20
120	47	55	59

Background

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

What is the data telling us?

There has be a series of data points indicating a sustained redduction in the number of MFFDs.



Variation	Assurance
L	?

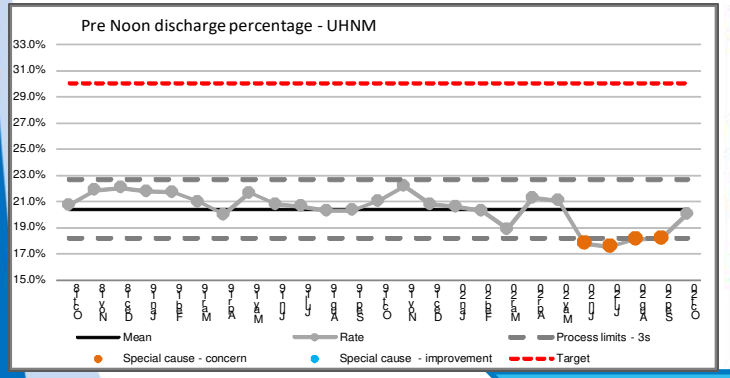
Target	Jul 20	Aug 20	Sep 20
3.5%	1.1%	1.2%	1.4%

Background

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

What is the data telling us?

The delayed transfers of care have been influenced by the actions taken in regards to Covid-19. There was a significant reduction from March when patients were discharged. To date the % remains below the national standard of 3.5%.



Variation	Assurance
~	F

Target	Aug 20	Sep 20	Oct 20
30%	18.1%	18.2%	20.0%

Background

The percentage of discharges complete before 12 noon.

What is the data telling us?

The Trust saw a reduction in the number of pre-noon discharges with an upturn seen in September.

Medically fit for discharge (MFFD):

October 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.

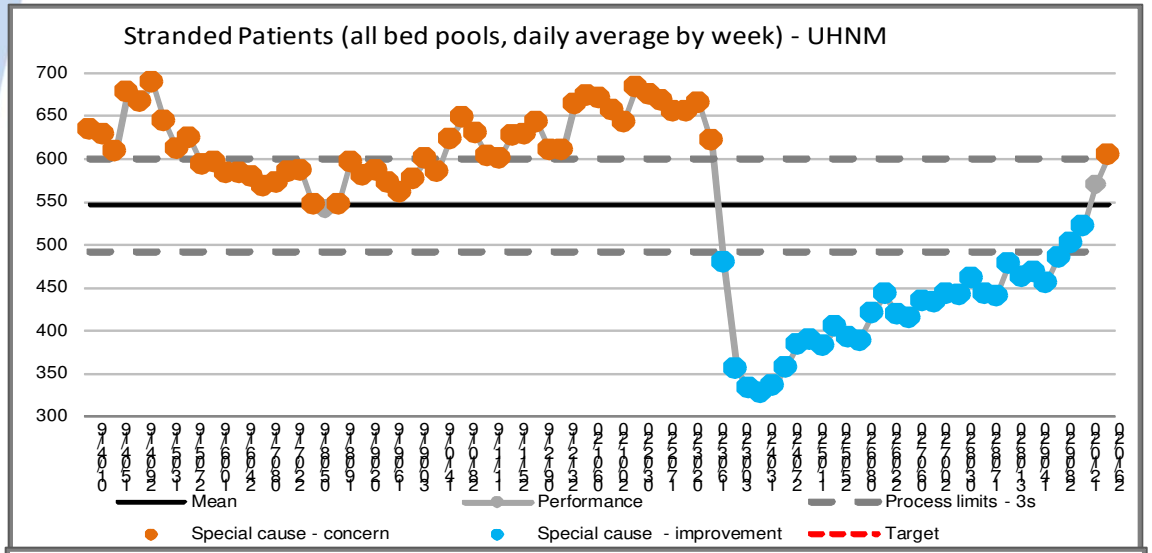
Delayed Transfers of Care (DToC) – I month in arrears

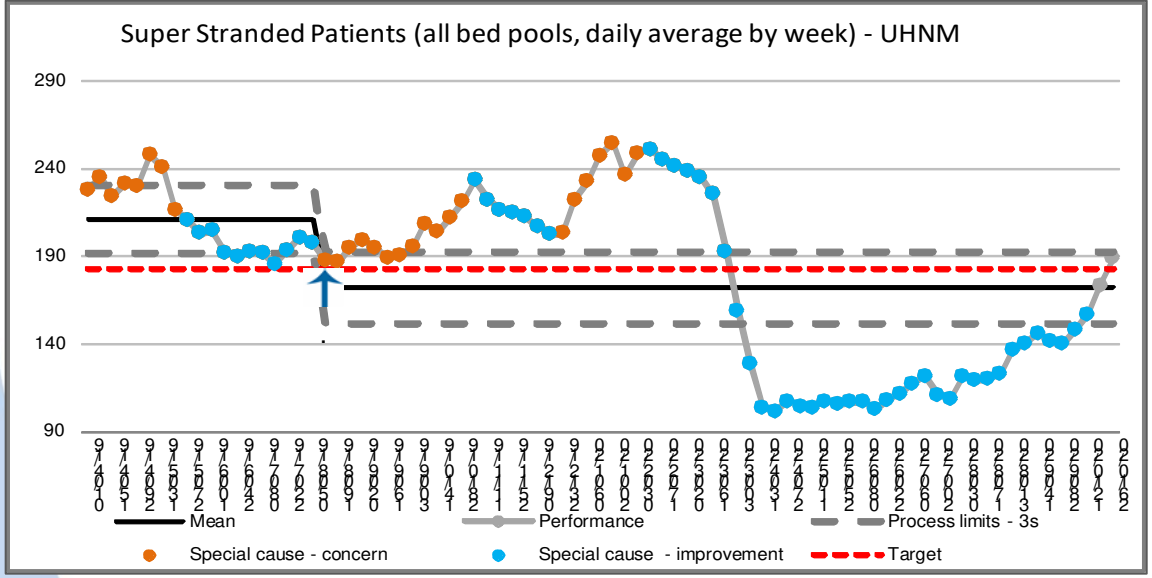
The rate has seen a significant improvement. August remains below the 3.5% national ambition. Although the Covid-19 pandemic has resulted in less beds occupied at the Trust in September, this measure shows that proportionately fewer occupied beds are patients waiting for transfer of care.

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 with early evidence that levels are returning to those seen pre-covid .
- Super Stranded patient numbers also saw a rise. Circa 25% of these are on COVID-19 wards. Discharge of COVID +ve patients can be delayed due to an inability to isolate in the follow on setting.

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

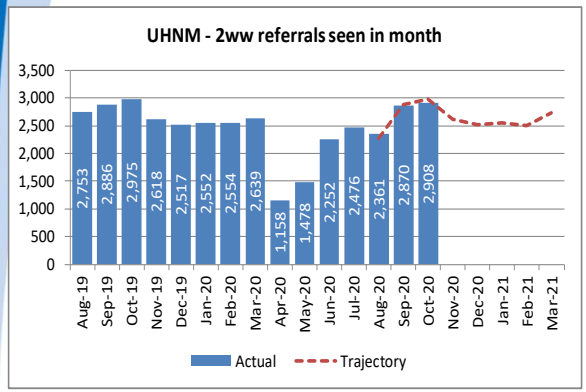
Summary:

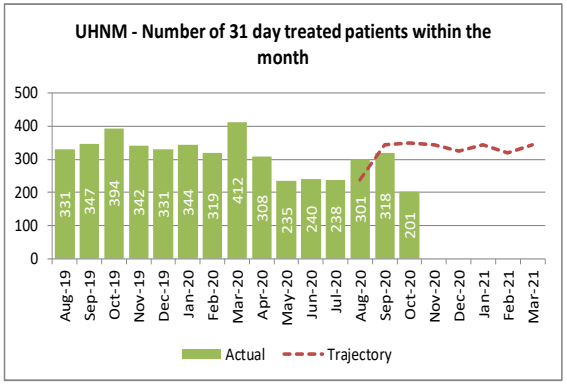
- The demand for 2ww has returned to pre-covid levels with September and October seeing the highest numbers in 12 months. In response to the demand, patients seen in the month has also risen with the percentage seen within 14 days at 94.2%. In addition to 2ww, the trust is predicted to achieve 4 other cancer targets in October; 31 day sub anti-cancer, 31 day sub radiotherapy, 62 day screening & 28 day FDS.
- October cancer treatments are awaiting further validation, however the position is predicted to demonstrate a slight increase in treatments since last month.
- Performance against the 28 Day faster diagnosis standard continues to be above standard at 81%
- The length of time 2WW patients are waiting to be appointed is at it's lowest in the past 3 months. Performance has been brought back in line with the KPI of 48 hours from receipt of referral to appointment booked. Challenged areas are Colorectal, Breast and Urology with high volumes of complex patients.
- Increasing referrals for MDT discussions has been escalated through the cancer transformation cell, as some meetings have exceeded capacity, causing delays.
- The Breast pathway has had a surge in 2WW demand, with 50 more referrals received in the last week of Oct compared with last week in Sept, however the site is still within the 2WW target.
- The Colorectal pathway remains the most challenged and highest volume PTL within the Trust, although this has reduced in recent weeks.
- COSD data completeness has improved for the 5th consecutive month, as a result of the new COSD role.

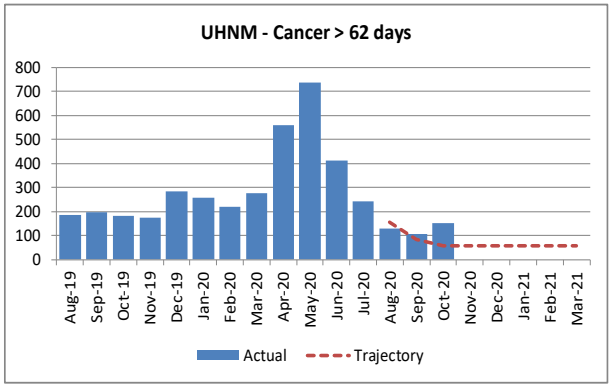
Actions

- MDT Seminar rooms have been evaluated, and videoconferencing solutions are being explored with company M8 solutions, to provide better facilities to host more efficient virtual MDTs.
- The UGI Multi-disciplinary team are planning to split HPB from OG, creating 2 separate UGI MDT meetings to gain efficiencies, both supported by corporate cancer team.
- A sustainable corporate cancer staffing model has been approved that will be progressed through HR to substantiate the transformation work within the team.
- Following the successful 2ww capacity and demand modelling exercise, the cancer team are building a surgical capacity and demand model to share with directorates and gain assurances of theatre slots needed to achieve 62 days in NOV & DEC.
- The cancer team is experiencing high absence, as mitigation to PTL tracking and in order to facilitate all MDTs, temporary overtime is being offered within the corporate cancer team.
- Capacity is challenged within UROL for follow up OPAs, currently taking over 2 weeks from MDT. An extra clinic has been instated in UROL for follow up OPAs. The impact of Covid surge will impact on 62 day performance if additional capacity cannot be secured/ring fenced to maintain treatments required to pathway.
- The Breast team are currently working to confirm extra weekend clinics to match the surge in demand.
- A business case for West Midland Cancer Alliance funding has been developed to deliver rapid diagnostic principles for Vague Symptoms and Lower GI pathways – this funding will equip the trust to be able to deliver earlier and faster diagnosis for cancer patients and support our most challenged and high volume pathway.

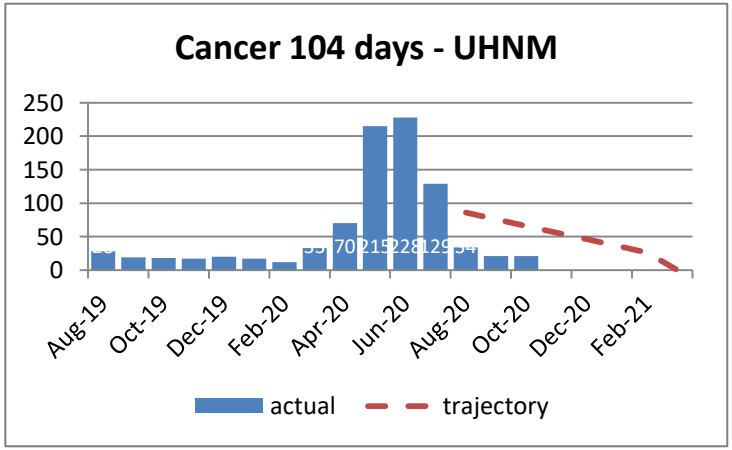
Cancer







Sep-20	National	UHNM	Standard
Two Week Wait	86.20%	82.79%	93%
2ww Breast Symptom	77.15%	97.96%	93%
31 Day First Treatment	94.53%	96.23%	96%
31 Day Subsequent Surgery	87.15%	94.03%	94%
31 Day Subsequent Anti-Cancer	99.20%	98.11%	98%
31 Day Subsequent Radiotherapy	96.15%	99.07%	94%
62 Day (2ww) First Treatment	74.67%	70.36%	85%
62 Day Screening First Treatment	84.63%	100.0%	90%



Planned care - *Inpatients*

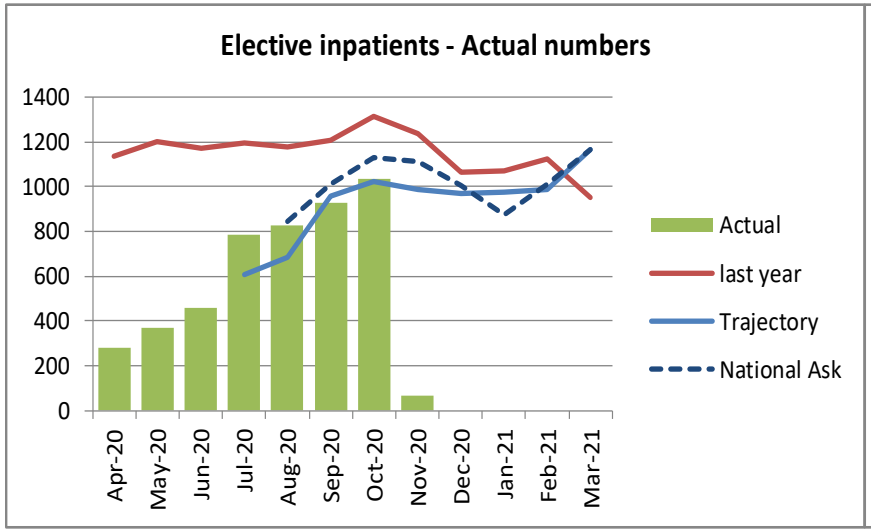
Elective inpatients Summary

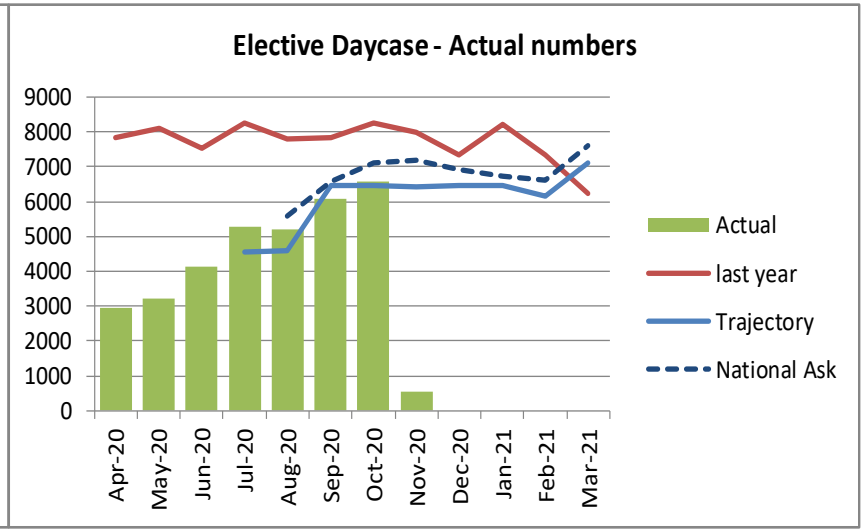
- Elective/Daycase activity has seen a steady rise since April 20 in line with restoration plans.
- For October, Elective inpatient activity (overnight) has risen to **82.5%** of business as usual (the National ask is to be at 90% by October). This is above the trajectory for Phase 3, which was set at 81.7% of the national ask and inpatients exceeded the trajectory by 10 patients. This is set against the increasing pressures the Trust experienced in October with more Covid-19 patients seen and admitted and bed closures due to Infection prevention.
- Daycases have also risen since April and in October the activity was **83.2%** of last years BAU. This is against Phase 3 plans of 81.8% and was 113 cases above trajectory. Priority is always given to cancers and urgent waiters.
- The number of 4 hour elective theatre sessions and the number of elective operations rose in October, at both Royal Stoke and County. However utilisation fell to 80% due to a significant increase in short-notice and on the day cancellations. These are being driven by a number of factors but can all relate back to the surge in COVID cases i.e. patients testing positive, no SSCU/critical care beds, patients changing their minds about surgery. Backfilling short notice cancellations is very difficult due to the COVID secure pathways (patients requiring swabs and isolation).

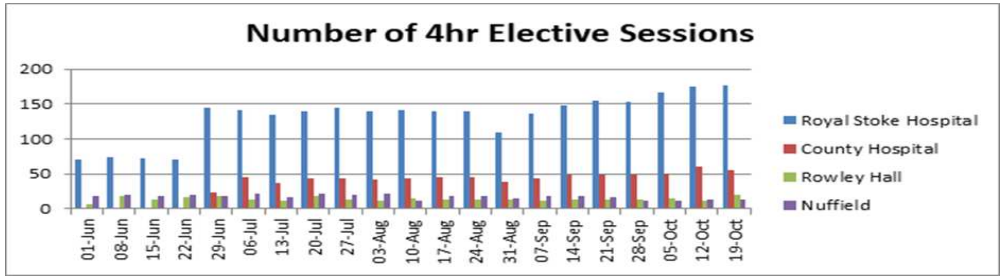
Actions

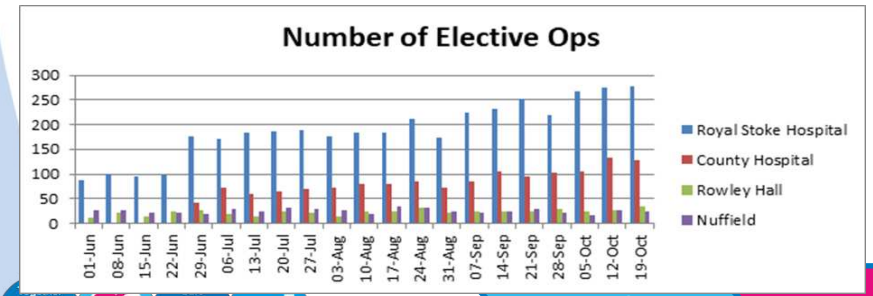
- **New Waiting list categories P5 and P6** were introduced in October. P5 for covid related delays and P6 for non covid related delays. We have c. 12000 patients to contact via telephone/letter to gain patients circumstances and change their priority category accordingly. Project due to start 9th November 2020.
- County to be reviewed for protected trauma and orthopaedic electives (risk inherent with any covid surge impact).
- 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. Contract is currently with finance panel. First pre-assessment due to take place 28/11/20 and first theatre session to commence 07/12/20. We also have a team of external validators that have commence validation work on our long waiting patients from 26/10/20.
- 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.

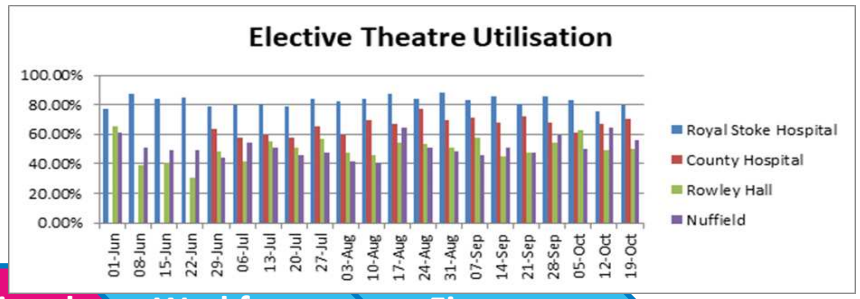
Planned care – *Inpatient Activity*











Planned care - *Outpatients*

University Hospitals of North Midlands NHS Trust

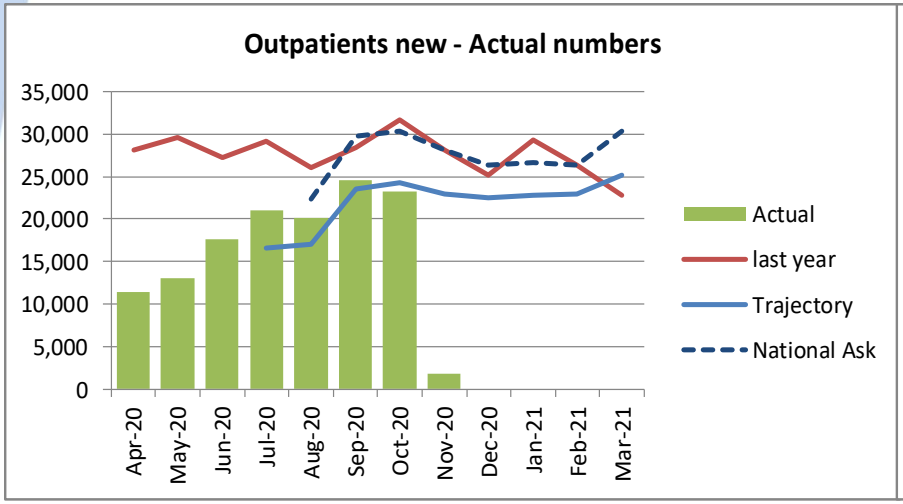
Summary

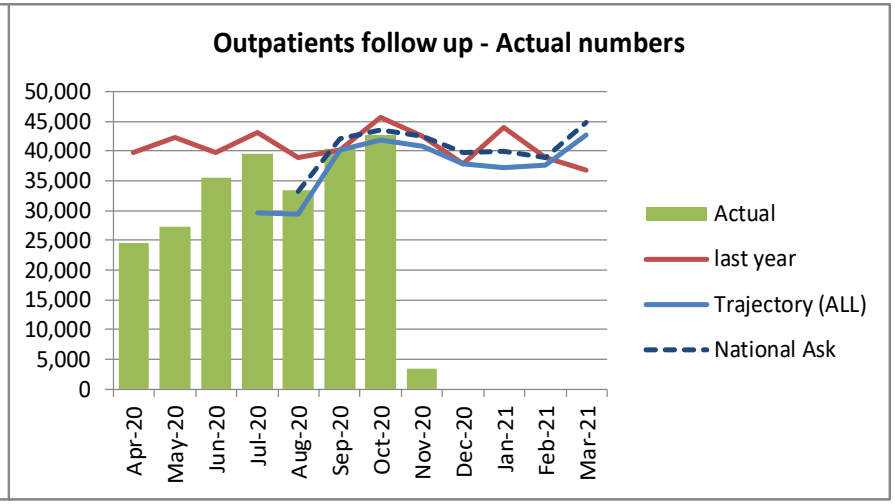
- Outpatients have seen activity levels rise since April in line with Restoration plans. Overall outpatient activity in October was in line with the trajectory at 89.5% vs. a trajectory of 89.4%.
- This was accounted for by the over performance in Follow ups – where 98.4% was achieved against a trajectory of 96%. This equates to 1000+ more patents attended than forecasted. The 1st new outpatient activity was below trajectory at 78.6% (trajectory 80%).
- The overall Referral To Treatment (RTT) Waiting list continues to rise. The Trust trajectory has been developed based on the assumption that referrals will return to 100% of last year demand (Phase 3 ask). The numbers of RTT pathways has exceeded the trajectory for October suggesting more demand from General Practitioners, however it is too early to say if this is a trend likely to continue. We are however, almost at a level seen last year.
- The waiting list shape has changed due to the reduction in activity. So whilst the size may be as it was last year the numbers over 18 weeks, over 40 weeks and over 52 weeks are higher resulting in a lower performance.
- The numbers of 52 week waits in October is 1,626 (September were 1315). These are expected to grow further through the year with the Trust trajectory reaching 2756 in March 2021.
- October's performance for ASIs has seen a month on month increase to 80.4%. ASIs being triaged within 3 working days.
- First Outpatient appointments are currently delivering 60.2% Face to Face and 39.8% Non-face to Face (Telephone & Video), Follow Up appointments are 55.7% Face to Face and 44.3% Non-face to Face (Telephone & Video)

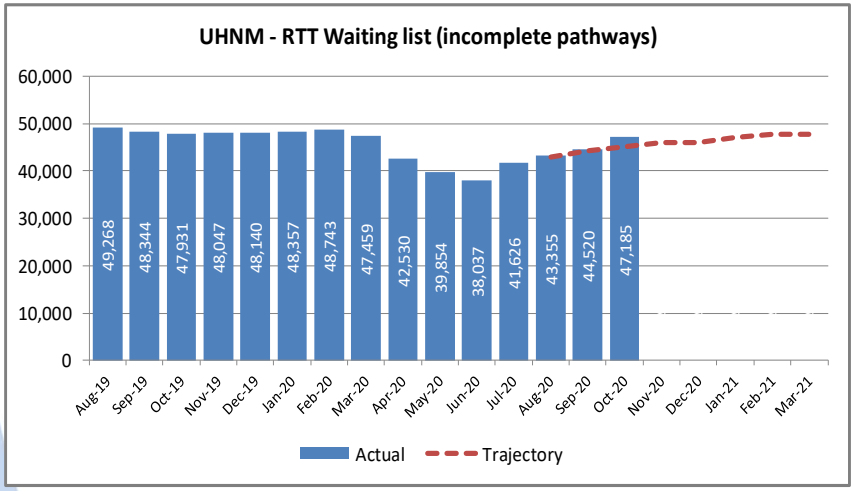
Actions

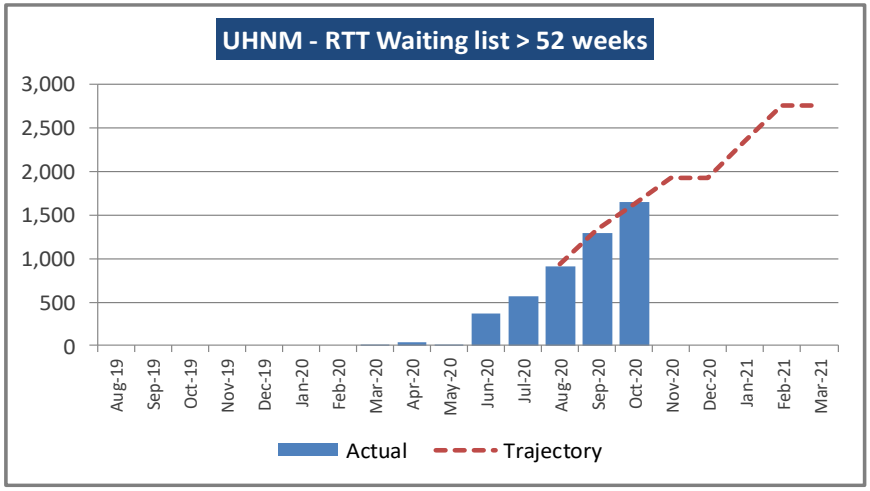
- Work is required on template reconfiguration based on Divisional assumptions - this needs to be aligned to the in patient and diagnostics plans for the purpose of substantive job planning.
- An Interim Head of Elective Access has been appointed to co-ordinate the RTT recovery strategy and align our 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 was 12th October 2020 and is now working its way into some into several directorates.
- 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*









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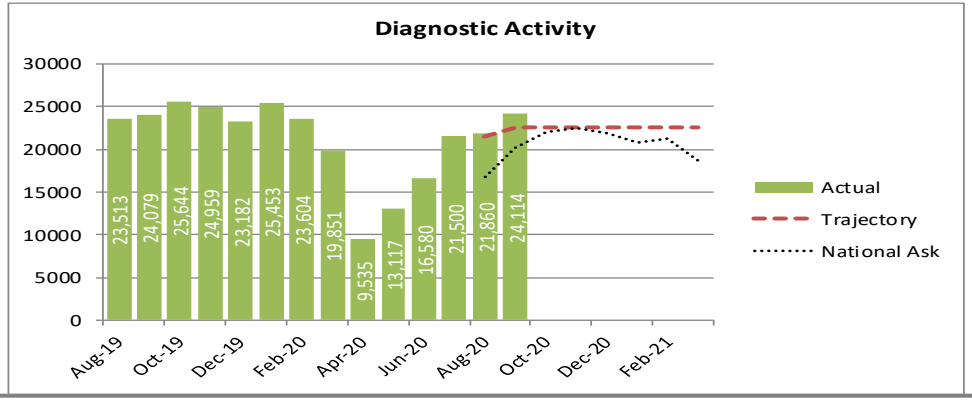
Diagnostic Activity



	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.

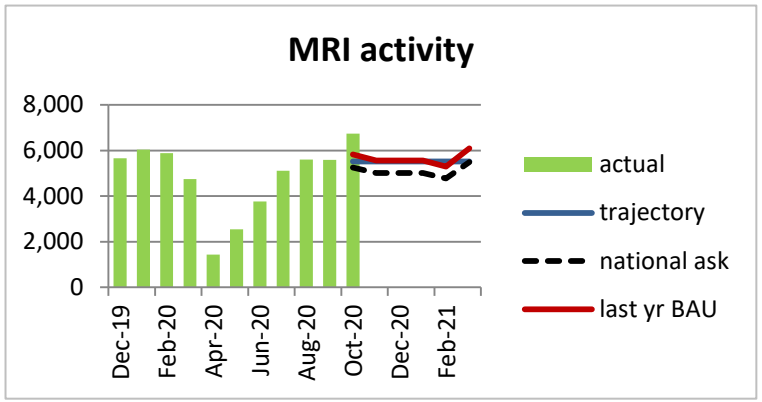
Summary

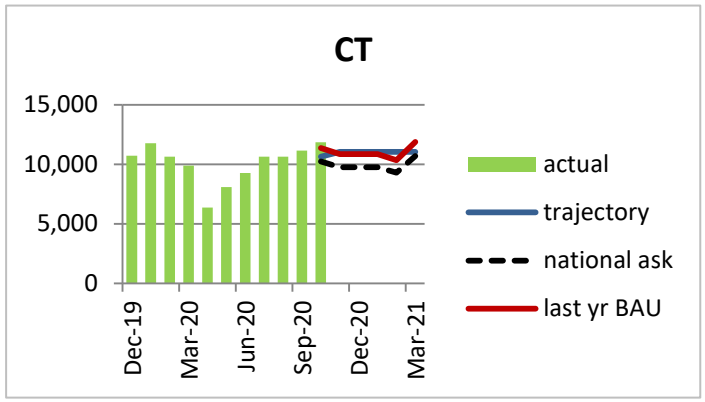
- October saw a further increase in diagnostic activity rising to 25,921. The trust trajectory for activity to the end of the year consistently meets the national ask and will see numbers return to similar levels as previous year.
- The diagnostic waiting list had significantly grown as patients were added and reached 20,287. With the increased activity , the waiting list is continuing to reduce and is currently at 13,671, a reduction of 1708 from the previous month. The total number of patients > 6 weeks also reduced again to 1601.
- Trajectories by modality completed, monitored through the Diagnostic cell. These include the impact of opening up outpatient services and all public health campaigns.

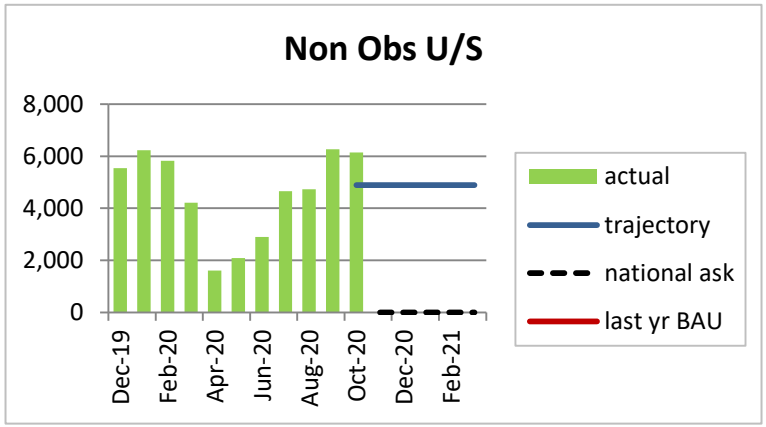
Actions

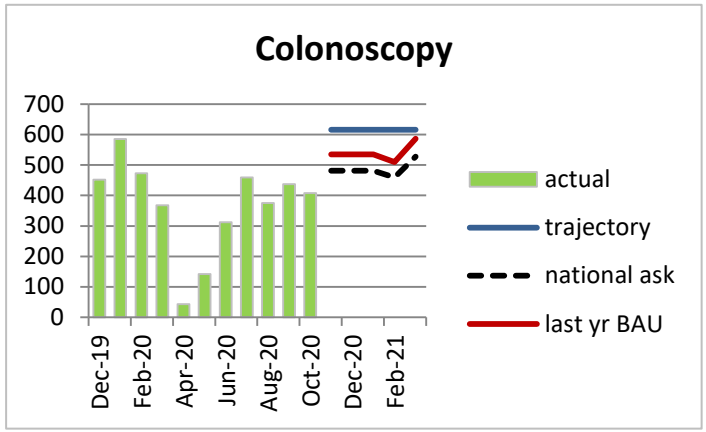
- The diagnostic work streams have made significant improvements and are working towards more initiatives to improve systems and processes.
    - Patient Connect is fully operational for pathology services and a scoping exercise underway to see if this can be transferred to other areas
    - Robotic Process Automation project is in train – to support with the auto scheduling of plain film imaging appointments that were previously 'walk in' but due to social distancing need to be booked - on-going
- Mobile MRI to continue to end of March 21.
- Investment papers have been submitted to continue recovery and restoration
- A number of initiatives are underway: ECG to scope the use of Patient Connect; 2 Locum Echocardiologists to commence in post;
- The AD lead for Diagnostics to prepare a strategy for Diagnostics in line with the NHS plan to radically overall diagnostics services. as part of the NHS long term plan.

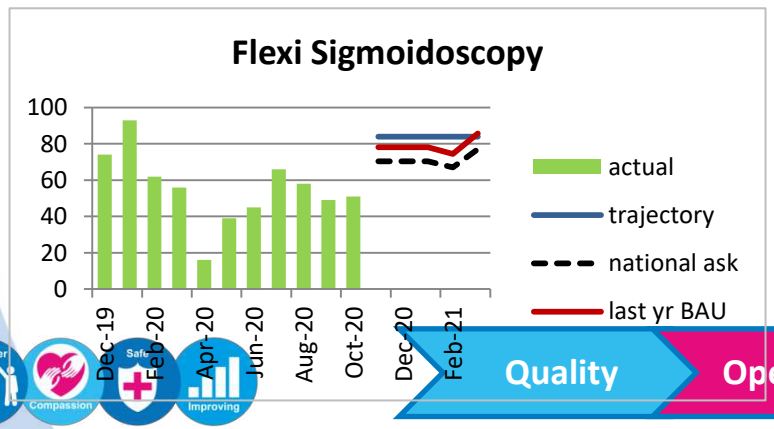
Diagnostics

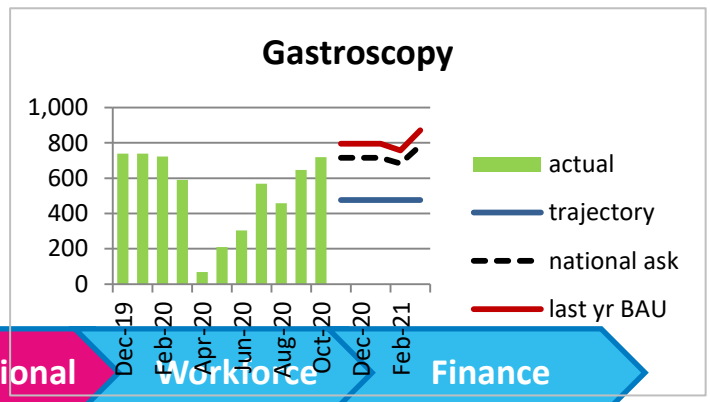












APPENDIX 1

Operational Performance

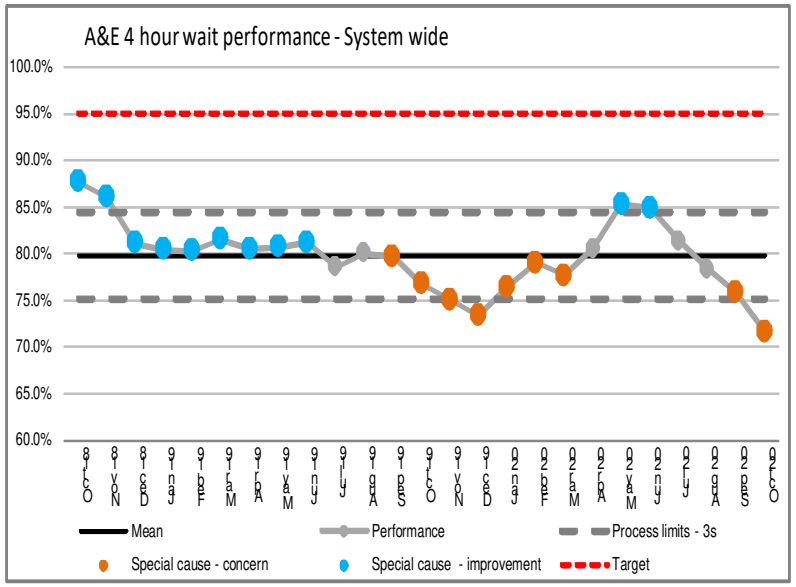
Constitutional standards

	Metric	Target	Latest	Variation	Assurance	DQAI
A&E	A&E 4 hour wait Performance	95%	71.60%	L	F	
	12 Hour Trolley waits	0	8	L	?	
Cancer Care	Cancer Rapid Access (2 week wait)	93%	94.20%	~	?	
	Cancer 62 GP ref	85%	67.30%	~	?	
	Cancer 62 day Screening	90%	91.70%	~	?	
	31 day First Treatment	96%	95.20%	~	?	
Elective waits	RTT incomplete performance	92%	66.16%	L	F	
	RTT 52+ week waits	0	1643	H	?	
	Diagnostics	99%	88.25%	L	?	

	Metric	Target	Latest	Variation	Assurance	DQAI
Use of Resources	DNA rate	7%	7.8%	~	?	
	Cancelled Ops	150	110	L	?	
	Theatre Utilisation	85%	76.3%	~	F	
Inpatient / Discharge	Same Day Emergency Care	30%	31.6%	H	?	
	Super Stranded	183	189	~	?	
	DToC	3.5%	1.40%	L	?	
	Discharges before Midday	30%	20.0%	~	F	
	Emergency Readmission rate	8%	13.8%	~	F	
	Ambulance Handover delays in excess of 60 minutes	10	97	~	?	

URGENT CARE – 4 hour access performance

University Hospitals of North Midlands NHS Trust



Variation	Assurance
L	F

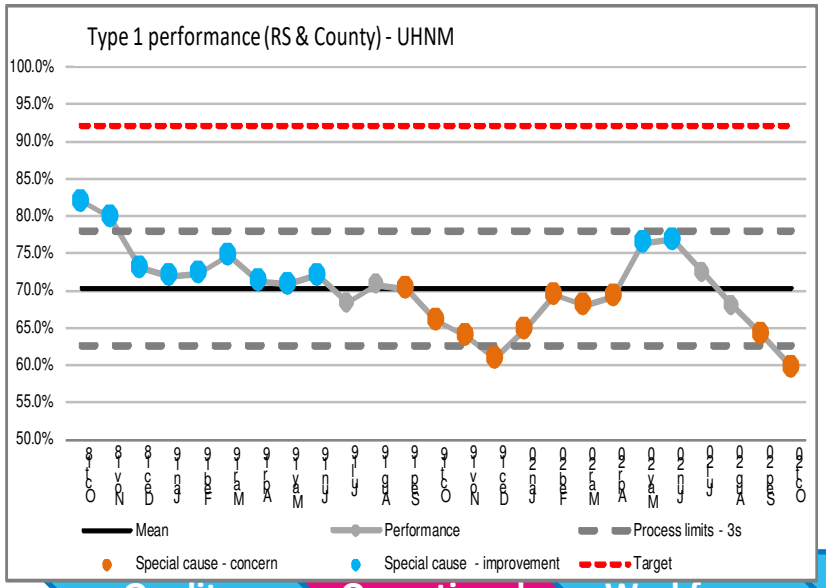
Target	Aug 20	Sep 20	Oct 20
95%	78.3%	75.8%	71.6%

Background

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

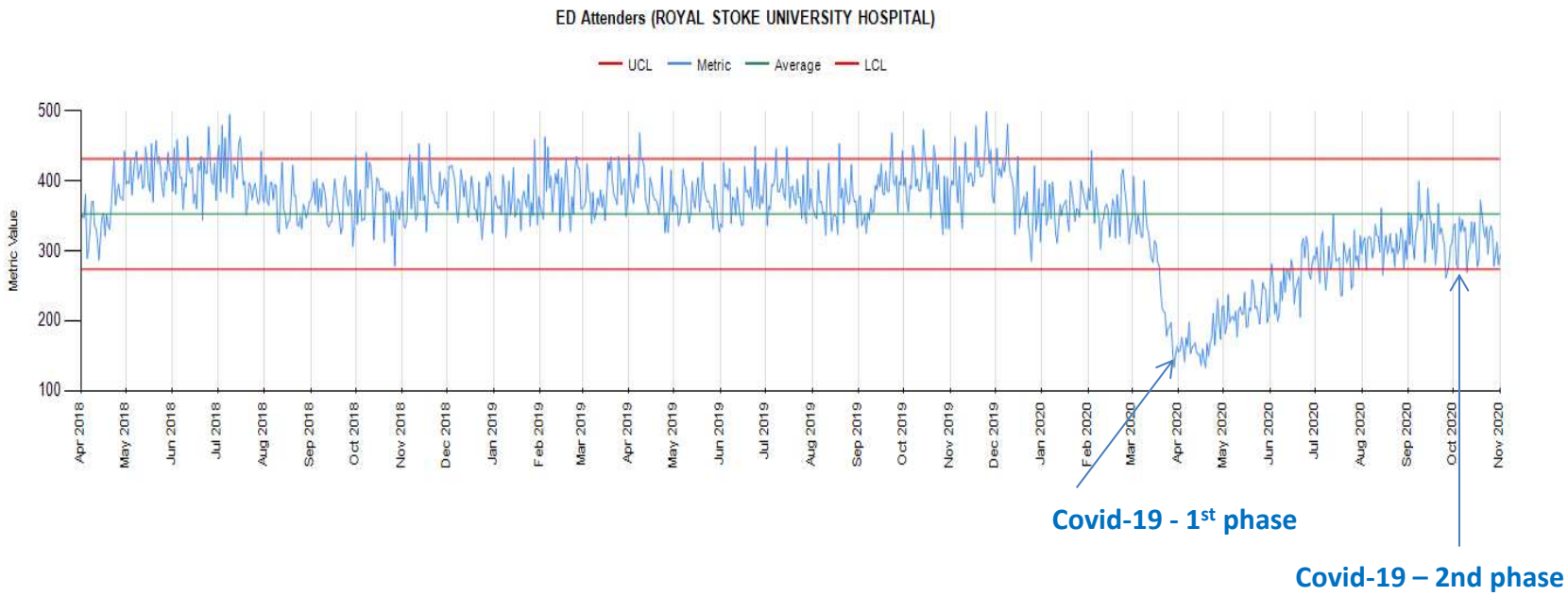
What is the data telling us?

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

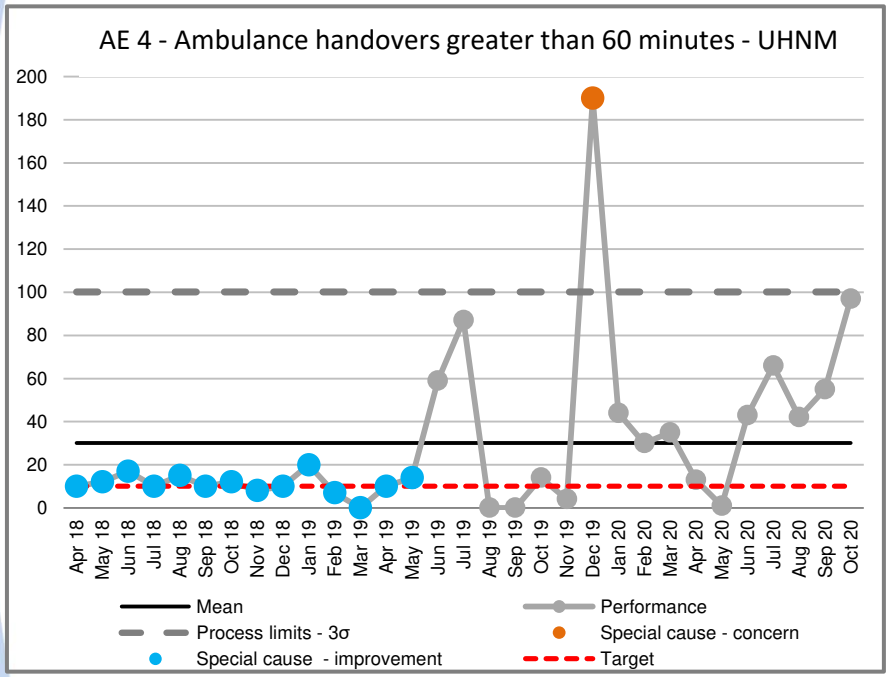


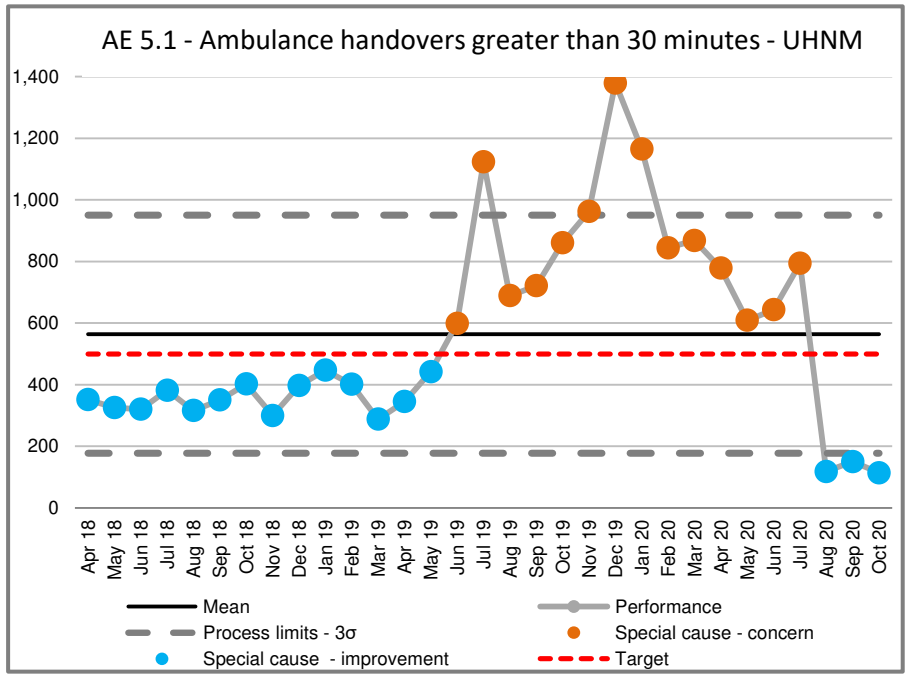
Quality | Operational | Workforce | Finance

URGENT CARE – 4 hour access performance



URGENT CARE – 4 hour access – ambulance handovers

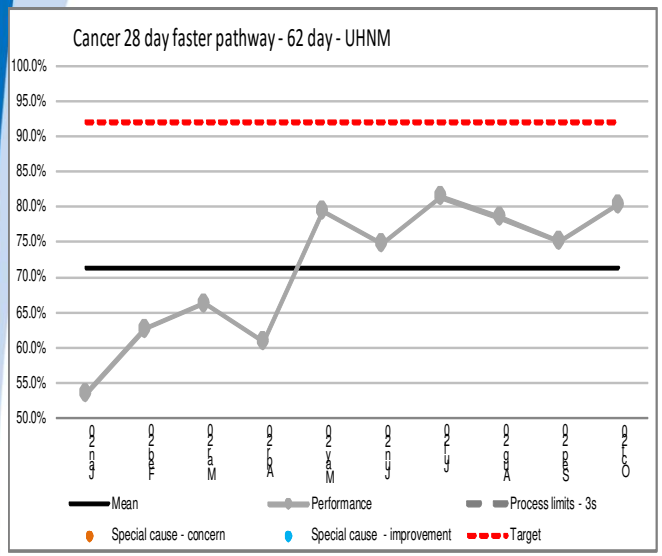


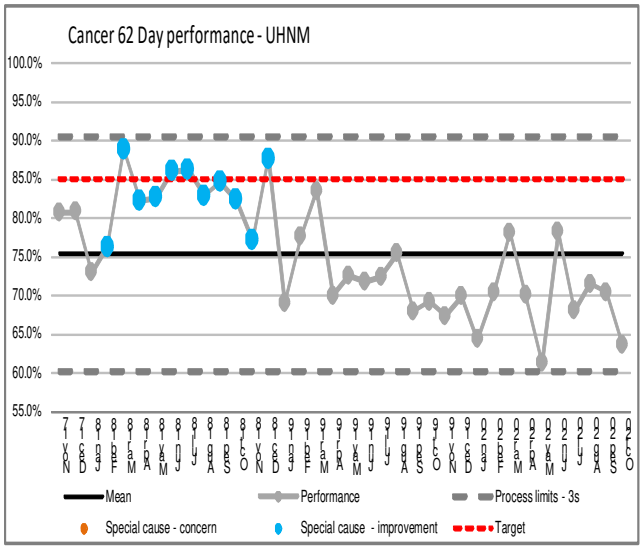


From August – internal validation of > 30 minutes

Quality | Operational | Workforce | Finance

Cancer – 62 Day





Variation	Assurance

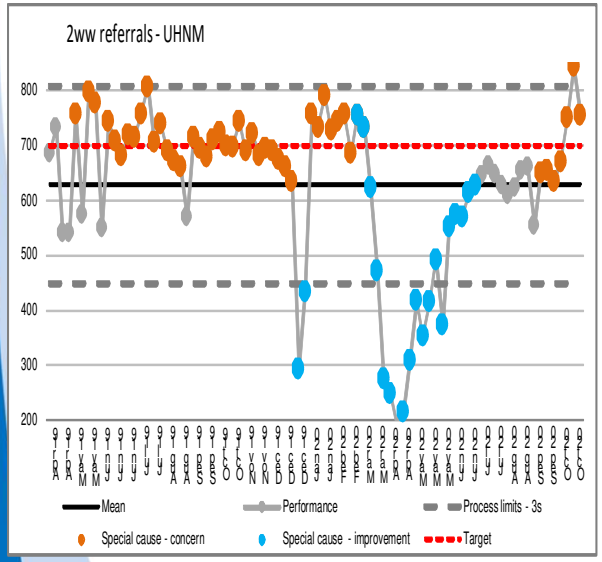
Target	Aug 20	Sep 20	Oct 20
85%	71.4%	70.4%	63.5%

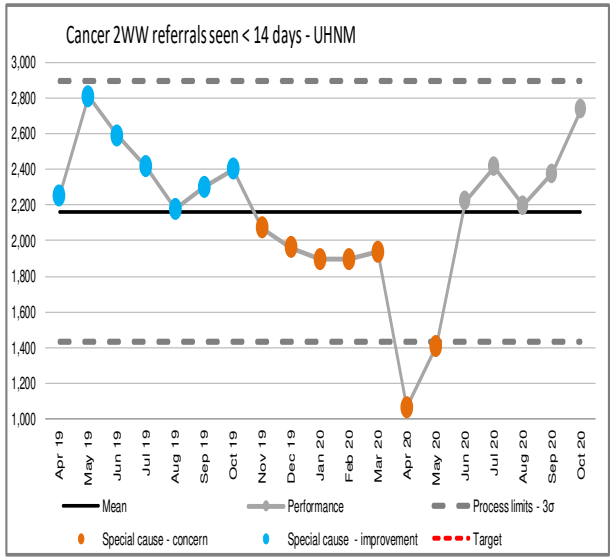
Background

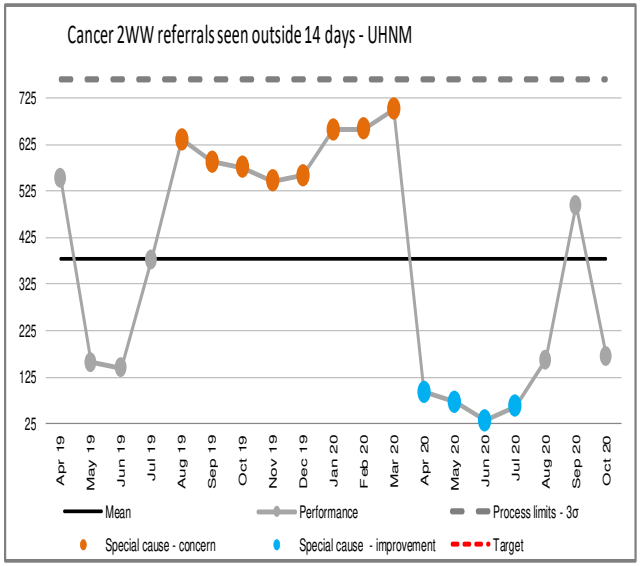
% patients beginning their treatment for cancer within 62 days following an urgent GP referral for suspected cancer

What is the data telling us?

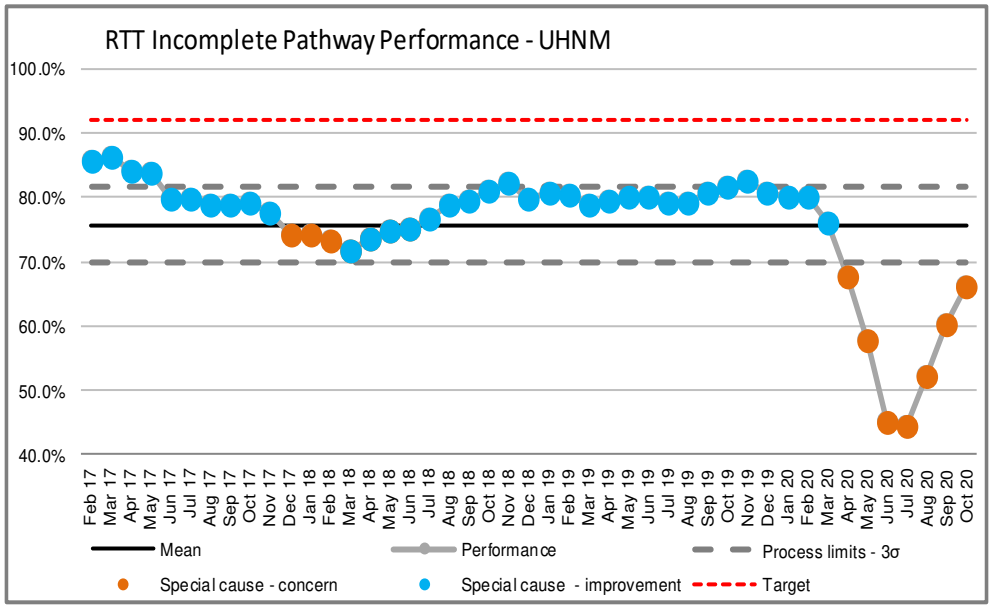
Performance shows normal comon cause variation. However this has been consistently below the mean since April 2019 (with just two data points above the mean). This indicates that the target is unlikely to be met.







Referral To Treatment



Variation	Assurance
L	F

Target	Aug 20	Sep 20	Oct 20
92%	52.4%	60.5%	66.2%

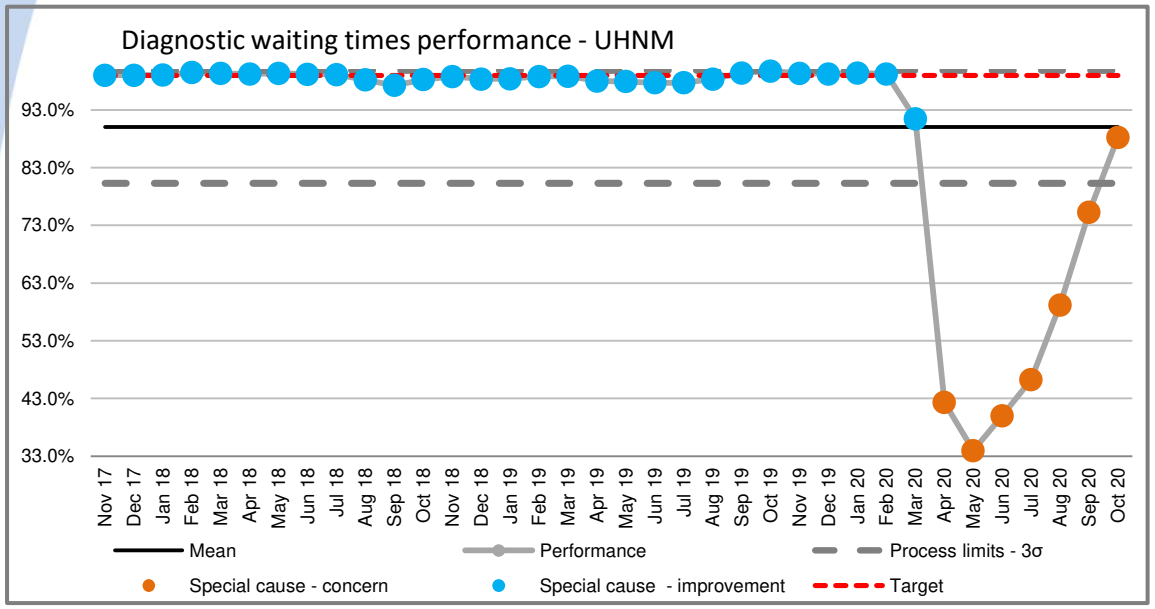
Background

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
	

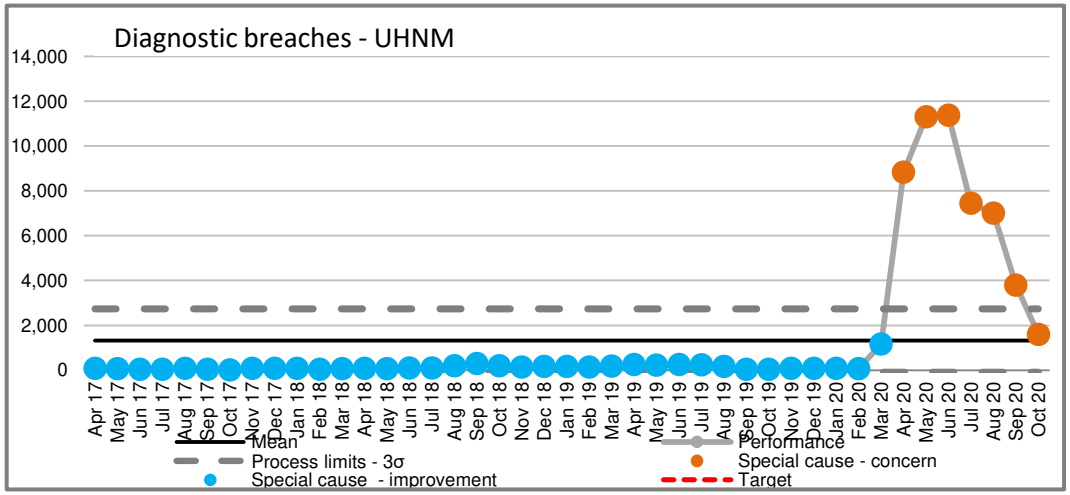
Target	Aug 20	Sep 20	Oct 20
99%	59.2%	75.3%	88.3%

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). Recovery has been evident since June 20.



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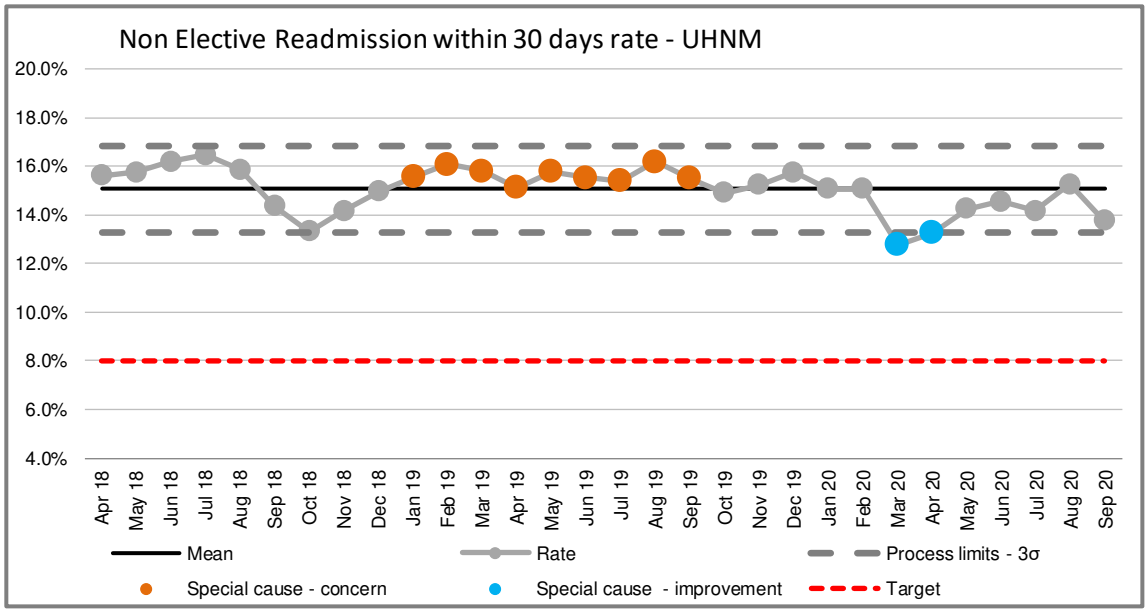
Non-elective Re-admissions



Variation	Assurance
	F

Target	Jul 20	Aug 20	Sep 20
8.0%	14.2%	15.3%	13.8%

Background

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

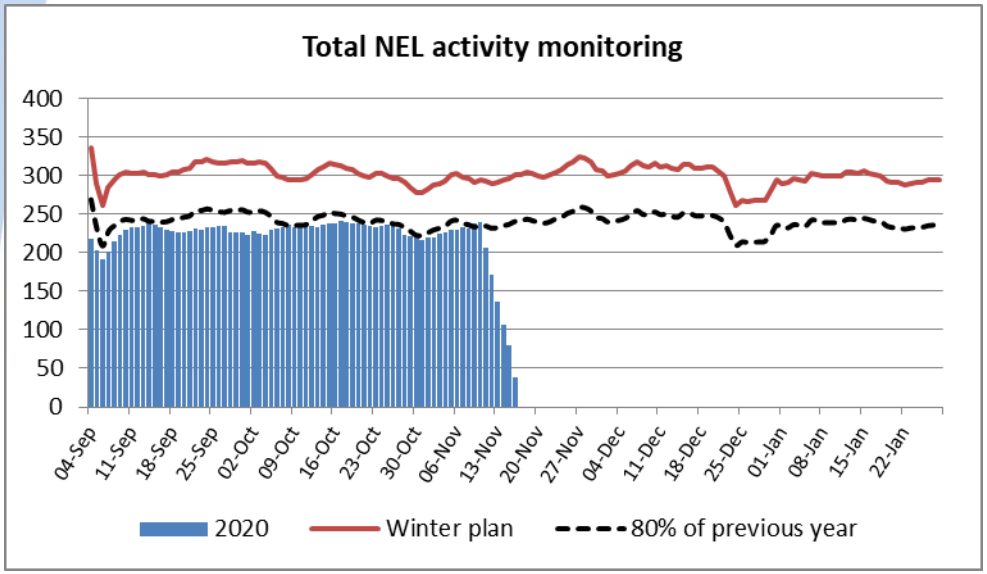
What is the data telling us?

Quality | Operational | Workforce | Finance

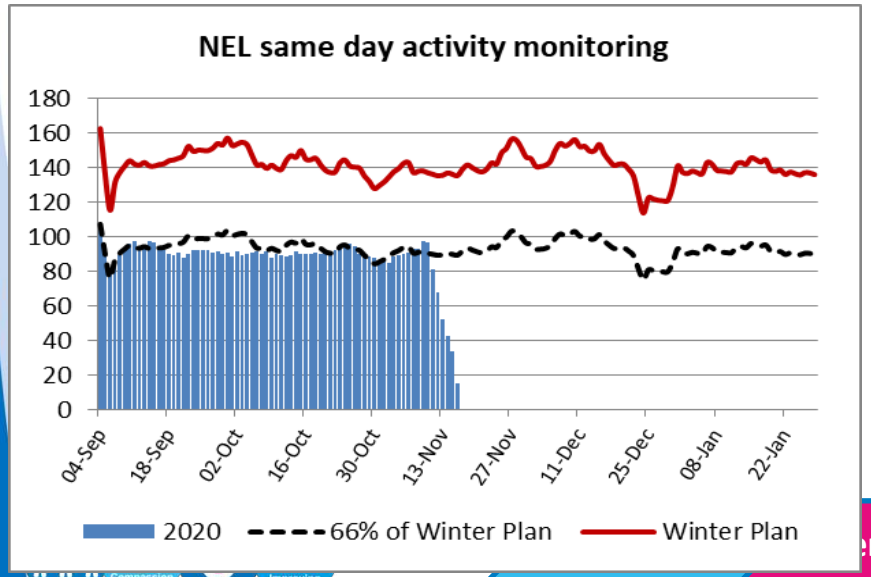
APPENDIX 2

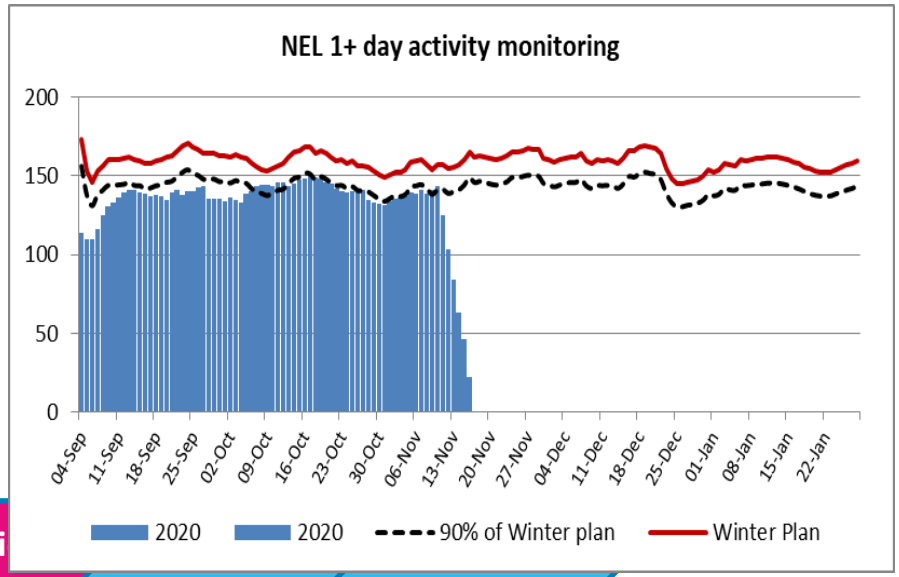
Winter plan assumptions

Demand against Winter plan assumptions

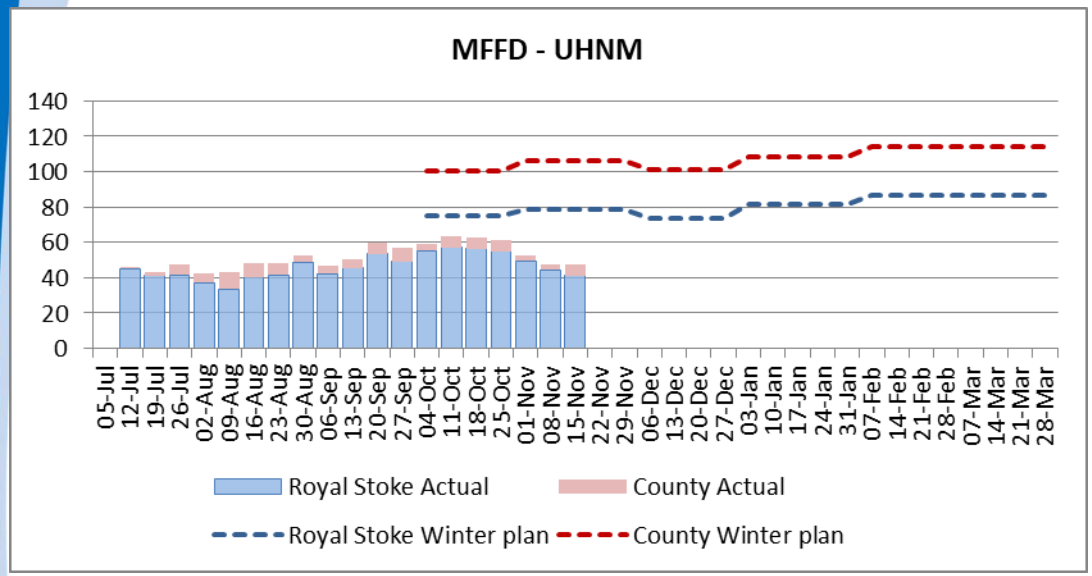


- Current NEL demand (NEL admissions to UHNM) is at 80% of the assumed number in the winter plan modelling.
- There is a large difference between same day and 1+ day LoS admissions.
- Same day activity is around 66% of the demand modelled in the winter plan.
- 1+ day activity is around 90% of the winter plan.

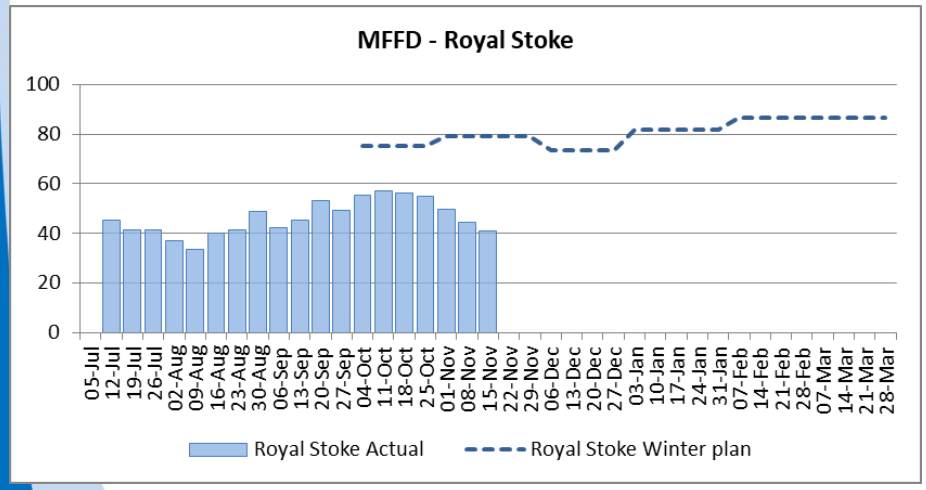


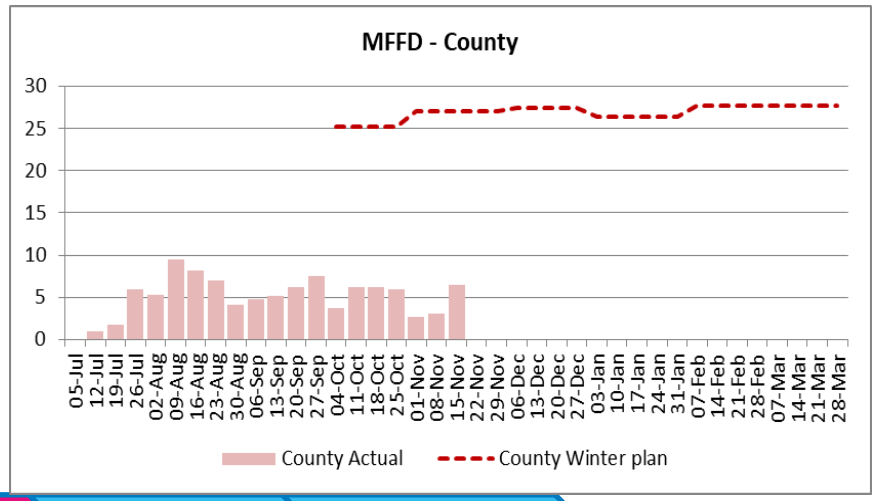


MFFD averages against the winter plan assumptions

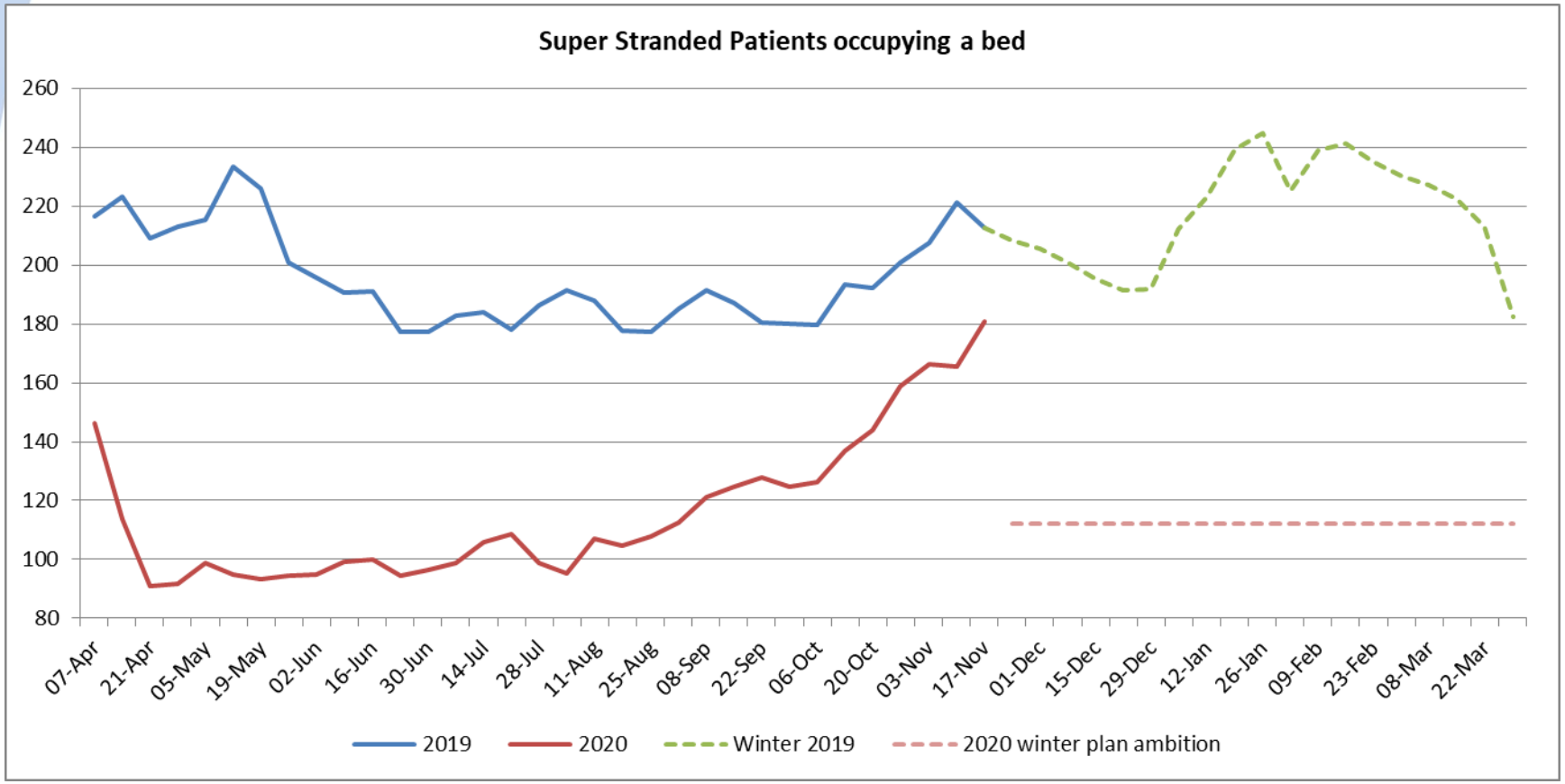


- For winter planning, MFFD levels were remodelled to reflect the drop from previous years.
- Royal Stoke MFFD numbers are now falling and are below the level assumed in the winter plan.
- County MFFD numbers are below the assumed level in the Winter plan





Super Stranded patients



- Super stranded patients were not adjusted for winter planning as it was assumed the adjustment for MFFDs would capture the reduction seen in this cohort of patients.
- In 2020 the number is rising and is currently around 30 less than the previous year.

Beds used

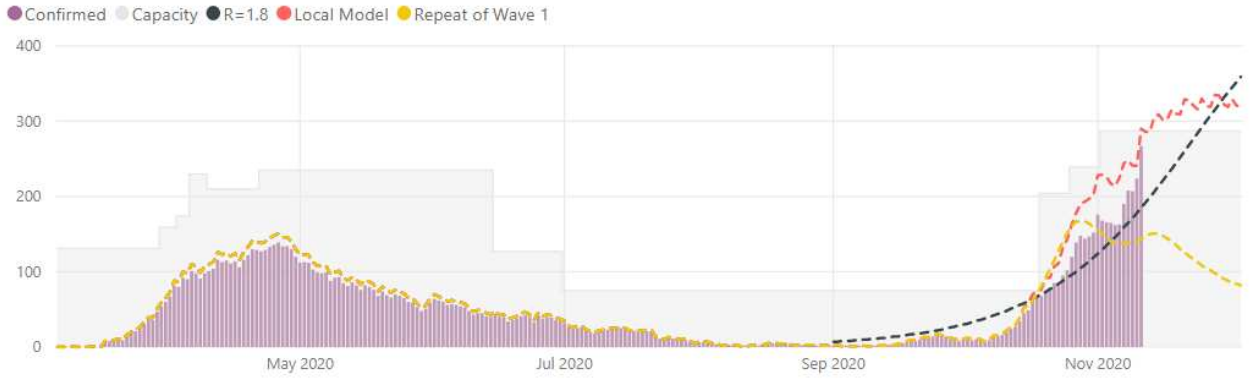
			Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Medical	**Purple / Blue**	Actual	392	390	418	440				
	Purple	planned available	425	425	425	425	425	425	425	425
	Blue		32	32	32	32	32	32	32	32
	Purple / Blue		**457**	**457**	**457**	**457**	**457**	**457**	**457**	**457**
		Difference	65	67	39	17				
Surgical	Green	Actual	32	33	35	36				
		planned available	67	67	67	67	67	67	67	67
	Purple	Actual	132	131	128	117				
		planned available	139	139	139	139	139	139	139	139
		Difference	42	42	43	53				
Specialised	Mixed	Actual	222	238	247	250				
		planned available	289	289	289	289	289	289	289	289
		Difference	67	51	42	39				
CWD	Mixed	Actual	32	35	36	37				
		planned available	40	40	40	40	40	40	40	40
		Difference	8	5	4	3				

- Midnight beds occupied in medicine is increasing

UHNM Covid-19 demand modelling *(up to December 4th)*

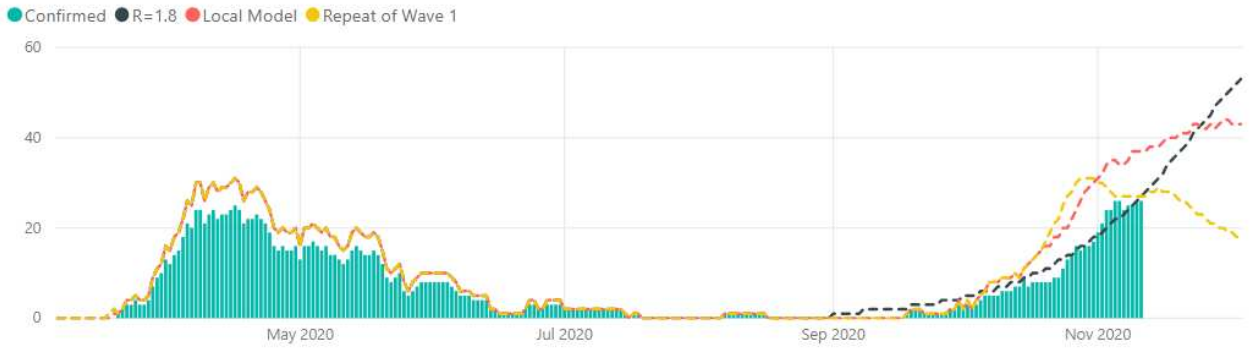
University Hospitals of North Midlands NHS Trust

Other beds occupied demand modelling



Date	Max
28 November 2020	335
04 December 2020	359
14 November 2020	151

ITU Occupied bed demand modelling



Date	Max
30 November 2020	44
04 December 2020	53
15 November 2020	29

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Workforce

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

Workforce Spotlight Report

Key messages

The strategic focus of our People Plan remains on supporting recruitment, 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.

The focus of the Workforce Bureau has been on risk assessments, staff wellbeing, staff testing and staff deployment. The daily sickness sitrep has been developed so that data is used to highlight wards and areas with high numbers of staff calling in as absent, which will then trigger the mitigating actions set out in business continuity plans. Work to identify which staff could potentially be redeployed internally has been completed and Divisions are identifying where volunteer placements could offer support. A system-led workforce demand and supply process is in place to manage redeployment of staff where required.

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

Sickness

The in-month sickness rate was 4.76% (4.60% at 30/09/20). The 12 month cumulative rate changed slightly to 5.16% from 5.17%. Sickness and covid-related absences continue to be monitored daily. Staff showing symptoms, or with household members showing symptoms, are tested and results returned within 24-48 hours. Since the 21st October, there have been an increasing number of absences and covid-related absences. Absence episodes have increased in line with the second covid wave and, as of 11th November, covid-related open absences numbered 728, which was 61% of all absences (28% at 13th October 2020). Wellbeing Support has continued throughout October and November and UHNM Charity has funded the development of semi-permanent rest facilities which should be available for use before Christmas. Weekly forums are taking place to enable Junior Doctors to raise issues regarding rest, support and wellbeing.

As at 11th November, 93.13% of all permanent and fixed term staff and 92.98% of BAME staff have a completed covid risk assessment. Of the completed risk assessments, the vast majority (95%) are in the lowest risk category

A more detailed discussion on the absence position has taken place at the Transformation and People Committee

Appraisals

The Non-Medical PDR compliance rate was 76.81% (77.48% at 30th September 2020). Due to the surge in covid, an Executive decision has been taken to suspend PDR's unless there is capacity to continue to undertake them. An impact assessment is currently being completed to assess the potential effect on performance rates and service delivery.

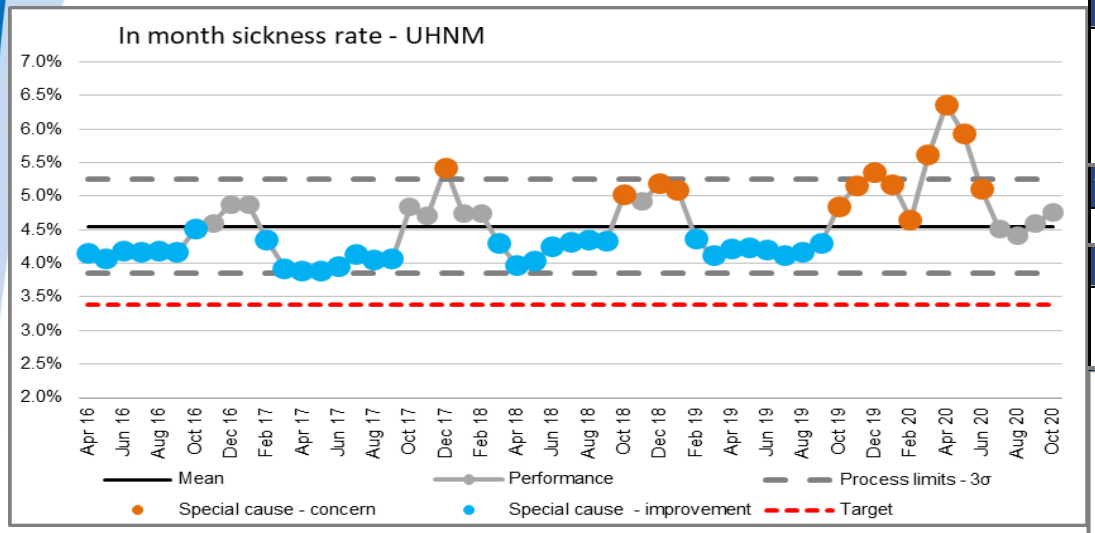
Statutory and Mandatory Training

The Statutory and Mandatory training rate at 31st October 2020 was 94.25% (93.51% at 30th September 2020) and 90.20% of staff had completed all 6 Core for All modules (86.32% at 30/09/20)

Workforce Dashboard

Metric	Target	Latest	Variation	Assurance
Staff Sickness	3.4%	4.76%		F
Staff Turnover	11%	9.87%	H	P
Statutory and Mandatory Training rate	95%	94.25%	H	F
Appraisal rate	95%	76.81%	L	F
Agency Cost	N/A	3.68%		P

Sickness Absence



Variation	Assurance
	F

Target	Aug 20	Sep 20	Oct 20
3.4%	4.4%	4.6%	4.8%

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. Following a short respite, covid-related absences have increased in line with the second wave

Summary

The in-month sickness rate was 4.76% (4.60% at 30/09/20). The 12 month cumulative rate changed slightly to 5.16% from 5.17%

Since the 21st October, absence episodes have increased in line with the second covid wave and, as of 11th November, covid-related open absences numbered 728, which was 61% of all absences (28% at 13th October 2020)

Wellbeing Support has continued throughout October and November including the provision of sessions and workshops as part of Stress Awareness Week; Staff Support and Counselling; Listen and Learn events extended into November and December, and Project Wingman. UHNM Charity has funded the development of semi-permanent rest facilities which should be available for use before Christmas. Weekly forums are taking place to enable Junior Doctors to raise issues regarding rest, support and wellbeing

As at 11th November, 93.13% of all permanent and fixed term staff and 92.98% of BAME staff have a completed covid risk assessment. Of the completed risk assessments, the vast majority (95%) are in the lowest risk category

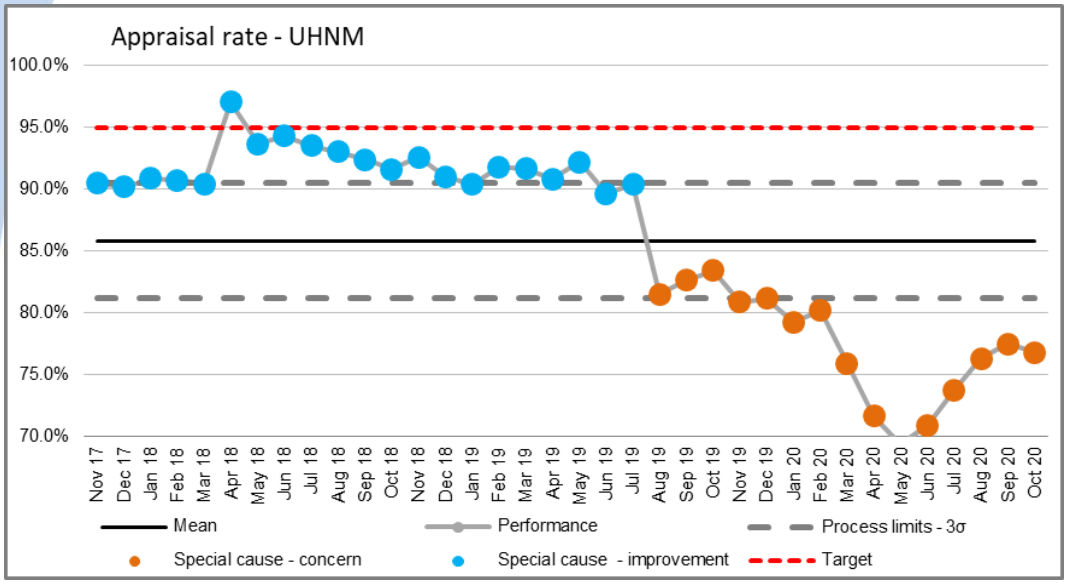
Actions

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

The Trust is commencing Lateral-Flow asymptomatic testing of frontline staff for Covid-19 to strengthen our efforts to prevent and control the spread of infection with effect from 13th November, with home self-testing kits being rolled out to staff who are in direct contact with patients. . The risk to the Trust is that sickness absence will increase even more as a result of staff undertaking these self-tests.

Phase 3 of the covid-19 risk assessment process is continuing, with resources being applied to chase the outstanding risk assessments.

Appraisal (PDR)



Variation	Assurance
	

Target	Aug 20	Sep 20	Oct 20
95.0%	76.4%	77.5%	76.8%

Background

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

What is the data telling us?

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

Summary

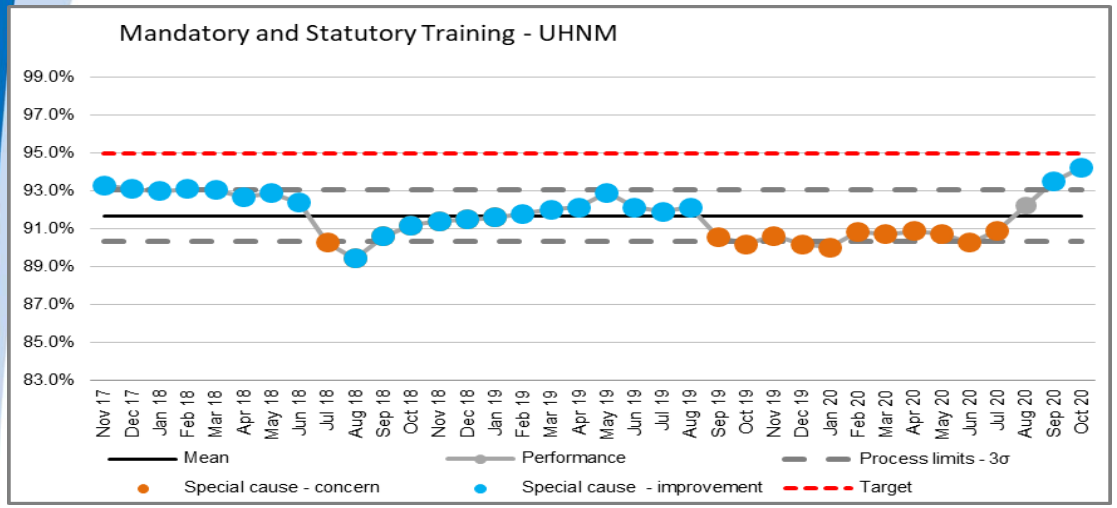
The Non-Medical PDR compliance rate was 76.81% (77.48% at 30th September 2020).

During October, there was a deterioration across all Divisions except CWD

Actions

Performance against the improvement trajectories produced by all Divisions is managed via the performance review meetings. It is recognised that this time of year becomes more challenging to timetable PDR discussions due to operational pressures across the Trust. Additionally, due to the surge in covid, an Executive decision has been taken to suspend PDR's unless there is capacity to continue to undertake them. An impact assessment is currently being completed to assess the potential effect on performance rates and service delivery.

Statutory and Mandatory Training



Variation	Assurance
H	F

Target	Aug 20	Sep 20	Oct 20
95.0%	92.2%	93.5%	94.3%

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 31st October 2020 was 94.25% (93.51% at 30th September 2020) and 90.20% of staff had completed all 6 Core for All modules (86.32% at 30/09/20)

Competence Name	Assignment Count	Required	Achieved	Compliance %
205|MAND|Security Awareness - 3 Years|	10464	10464	9884	94.46%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	10464	10464	9911	94.72%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	10464	10464	9707	92.77%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	10464	10464	9862	94.25%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	10464	10464	9896	94.57%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	10464	10464	9911	94.72%

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|	10464	10464	8591	82.10%
NHS|CSTF|Information Governance and Data Security - 1 Year|	10464	10464	9259	88.48%

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

The Trust is now offering new starters a Remote Corporate Induction which they complete in their own home prior to starting in post – this will be classed as a paid working day. On their induction day new starters read the Welcome hand-out and complete their "core for all" statutory & mandatory eLearning following the guide which is emailed to them

Finance

2025 Vision "Ensure efficient use of resources"

Finance Spotlight Report

NHS University Hospitals of North Midlands NHS Trust

Key messages

- The Trust has delivered a deficit of £0.8m for the month against a planned deficit of £0.8m.
- Activity delivered in Month 7 is significantly lower than plan although NHS income levels from patient activities have been maintained due to the temporary funding arrangements. Encouragingly activity from Non Staffordshire CCGs (which continues to be paid for on a Payment by Results basis) was higher in Month 7
- The Trust estimates the impact of the Elective Incentive Scheme (EIS) to be a £0.5m reduction to income in Month 7; as for Month 6 this is not reflected in the financial position in line with guidance from NHSI/E.
- The Trust incurred £1.2m of additional costs relating to COVID-19 which was £0.4m lower than in Month 6 mainly due to the inclusion of claims in the Month 6 accounts from the Anaesthetists for additional shifts worked in the first half of the year.
- Other Operating income has increase in month mainly as a result of reflecting the latest schedule from Health Education England (HEE) in the position.
- The actual deficit of £0.8m compares favourably against the Trust's forecast for Month 7 (against which it is now externally monitored against) which forecast a £1.7m deficit.
- Capital expenditure for the year to date stands at £19.1m which is £4.9m behind plan with the main driver being slippage on the PDC funded ED scheme.
- The month end cash balance is £90.6m which is £4.2m higher than plan.

Finance Dashboard

	Metric	Target	Latest	Variation	Assurance
I&E	Trust Income	variable	69.4		
	Expenditure - Pay	variable	42.4		
	Expenditure - Non Pay	variable	24.3		
Activity	Daycase/Elective Activity	variable	7,569		
	Non Elective Activity	variable	8,927		
	Outpatients 1st	variable	22,855		
	Outpatients Follow Up	variable	42,142		

Income & Expenditure

Income & Expenditure Summary Month 7 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	741.3	66.7	65.5	(1.2)	437.8	452.5	14.7
Other Operating Income	85.0	7.0	4.6	(2.4)	50.0	29.3	(20.7)
Total Income	826.2	73.7	70.1	(3.6)	487.8	481.8	(6.0)
Pay Expenditure	(513.6)	(42.3)	(42.4)	(0.1)	(299.9)	(296.8)	3.1
Non Pay Expenditure	(277.0)	(28.0)	(24.3)	3.7	(165.7)	(154.8)	10.8
Total Operational Costs	(790.6)	(70.3)	(66.8)	3.6	(465.5)	(451.6)	14.0
EBITDA	35.6	3.3	3.3	0.0	22.2	30.2	8.0
Depreciation & Amortisation	(29.2)	(2.4)	(2.4)	0.0	(17.0)	(17.0)	0.0
Interest Receivable	0.3	0.0	0.0	(0.0)	0.2	0.1	(0.1)
PDC	(7.6)	(0.6)	(0.3)	0.3	(4.4)	(4.2)	0.3
Finance Cost	(17.2)	(1.4)	(1.4)	0.0	(10.0)	(10.0)	0.0
Other Gains or Losses	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Surplus / (Deficit)	(18.0)	(1.1)	(0.8)	0.3	(9.0)	(0.8)	8.2
MRET central funding	4.2	0.4	0.0	(0.4)	2.5	0.0	(2.5)
Financial Recovery Fund	13.8	0.0	0.0	0.0	6.9	0.0	(6.9)
Total	0.0	(0.8)	(0.8)	(0.0)	0.3	(0.8)	(1.1)

The Trust delivered a £0.8m deficit for the month against a planned deficit of £0.8m; this deficit is measured against the Trust's draft financial plan submitted at the beginning of the financial year. The main variances for the year to date and in month are :

- Other Operating income which is driven by the non-receipt of the TSA funding and Car Parking income and
- Non Pay budgets which is mainly related to reduced expenditure on Clinical Supplies (the in-month variance is impacted by a change to the budget for pass through drugs)

Capital Spend

Capital Expenditure as at Month 7 2020/21 £m	Revised Annual	In Month			Year to Date		
	Plan	Revised Budget	Actual	Variance	Revised Budget	Actual	Variance
ICT Infrastructure	(2.8)	(0.3)	(0.2)	0.1	(0.6)	(0.4)	0.1
Estates Infrastructure	(2.5)	(0.8)	(0.3)	0.4	(1.8)	(1.8)	0.1
Medical Equipment	(2.3)	(0.1)	(0.0)	0.1	(0.9)	(0.4)	0.5
PFI lifecycle and equipment	(2.0)	(0.2)	(0.2)	-	(1.1)	(1.1)	-
Health & Safety Compliance	(0.2)	-	(0.1)	(0.1)	(0.1)	(0.1)	(0.0)
Other Central schemes	(0.4)	-	-	-	(0.0)	(0.0)	0.0
Project Star	(0.9)	-	-	-	(0.9)	(0.6)	0.3
Investment schemes	(0.1)	-	-	-	-	-	-
COVID-19 Trust funded (awaiting PI	(0.7)	-	(0.0)	(0.0)	(0.7)	(0.5)	0.2
Linac	(2.2)	-	(0.0)	(0.0)	-	(0.0)	(0.0)
IR2 Bi Plane	(1.4)	-	-	-	-	-	-
LIMS	(0.9)	(0.1)	(0.0)	0.0	(0.5)	(0.1)	0.4
EPMA	(0.8)	(0.0)	(0.1)	(0.0)	(0.3)	(0.2)	0.1
Pathology schemes	(1.1)	(0.1)	(0.0)	0.1	(0.5)	(0.2)	0.3
Trust funded capital programme	(18.4)	(1.5)	(1.0)	0.6	(7.4)	(5.6)	1.8
Royal Infirmary Site demolition	(5.5)	(0.6)	(0.4)	0.3	(1.9)	(1.3)	0.6
COVID-19 PDC (approved)	(1.7)	-	(0.0)	(0.0)	(1.7)	(1.3)	0.4
PDC award for HSLI	(1.2)	(0.0)	-	0.0	(1.1)	(1.1)	0.0
Wave 4b funding - modular wards	(10.0)	-	-	-	(9.1)	(9.1)	-
Critical Risk Infrastructure	(3.2)	(0.0)	(0.2)	(0.1)	(0.0)	(0.3)	(0.2)
Emergency Department funding	(4.3)	(1.4)	(0.4)	1.0	(2.8)	(0.4)	2.4
Adapt & Adopt	(0.3)	-	-	-	-	-	-
Critical Care Resilience	(4.8)	-	-	-	-	-	-
Other PDC funding	(0.5)	-	(0.1)	(0.1)	-	(0.1)	(0.1)
PDC funded capital schemes	(31.4)	(2.1)	(1.0)	1.1	(16.6)	(13.5)	3.1
Overall capital expenditure	(49.8)	(3.6)	(1.9)	1.7	(24.0)	(19.1)	4.9

At Month 7 the capital programme is £1.8m behind the revised plan on Trust funded schemes and £3.1m behind plan on PDC funded capital which is mainly due to the underspend in relation to the phasing of expenditure included in the Emergency Department scheme Memorandum of Understanding (MOU).

All Trust funded capital resource has been committed, the remaining investment balance and contingency identified of £1.3m was allocated to commitments made by Exec Team, Restoration and Recovery and the Winter Plan. Currently there is an over-commitment of funds of £0.3m which may require expenditure to be identified to transfer to revenue should no further central funding be received.

Cash flow

Cash Summary at Month 7 2020/21		In Month			Year to date		
	Revised Budget £m	Revised Plan £m	Actual £m	Variance £m	Revised Plan £m	Actual £m	Variance £m
Opening balance	26.7	80.8	80.8	-	26.7	26.7	-
Block mandate payments (to 31st October 2020)	760.0	66.1	69.4	3.3	491.8	495.1	3.3
Contract income 2019/20	(7.4)	-	-	-	(7.4)	(7.4)	-
Other Income (including other NHS)	63.3	7.0	10.4	3.4	48.5	48.9	0.4
Health Education England Training Income	22.5	5.3	5.1	(0.2)	14.2	14.0	(0.2)
PSF/FRF - 2019/20 Q4	9.7	-	-	-	9.7	9.7	-
Department of Health and NHS England Deficit support	-	-	-	-	-	-	-
Capital funding (PDC capital)	26.4	1.4	-	(1.4)	10.5	9.1	(1.4)
Total Receipts	874.5	79.9	85.0	5.1	567.2	569.3	2.1
Payroll (excluding agency)	(492.5)	(41.7)	(41.4)	0.3	(284.0)	(283.7)	0.3
Accounts payable	(347.7)	(29.0)	(30.7)	(1.7)	(202.8)	(202.3)	0.5
PDC Dividend	(5.0)	-	-	-	-	-	-
Capital payments	(42.4)	(3.5)	(3.0)	0.5	(20.6)	(19.4)	1.2
Total Payments	(887.5)	(74.2)	(75.1)	(0.9)	(507.4)	(505.4)	2.0
Closing Balance	13.7	86.5	90.6	4.2	86.5	90.6	4.1

The cash flow budget above has been revised following the submission of the plan for the second half of the financial year on 22 October. The year-end forecast cash balance of £13.7m reflects the year end revenue deficit forecast in this plan and the assumption that the block contract cash received in advance during the financial year will be recovered in March 2021; this has not yet been confirmed by NHSI.

At the end of October the cash balance of £90.6m is £4.2m higher than plan. The Trust has received the expected cash in relation to the block mandate payments for April to November the £3.3m variance relates to the top-up received by the Trust in advance for November, the plan assumed that this would be received in month rather than in advance.

Other income is higher than plan in month and reflects catch up of cash relating to excluded drugs from NHSE (£1.4m) and payment of outstanding invoices by Betsi Cadwaladar and MPFT. Year to date other income is in line with plan.

Accounts payable year to date is £0.5m lower than plan and reflects a reduction in general payments due to the impact of COVID-19 early in the financial year. The Moth 7 payments are higher than plan due to the timing of payment in the month.

Balance sheet

Balance sheet as at Month 7	31/03/2020	31/10/2020			
	Actual £m	Revised Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment	483.0	486.6	485.4	(1.2)	Note 1
Intangible Assets	24.5	21.4	21.4	(0.0)	
Other Non Current Assets	-	-	-	-	
Trade and other Receivables	0.4	0.4	0.4	-	
Total Non Current Assets	507.9	508.3	507.2	(1.2)	
Inventories	13.3	13.1	13.1	0.1	
Trade and other Receivables	49.6	40.5	41.1	0.6	
Cash and Cash Equivalents	26.7	86.5	90.6	4.1	Note 2
Total Current Assets	89.6	140.1	144.9	4.8	
Trade and other payables	(74.8)	(129.5)	(131.8)	(2.4)	Note 3
Borrowings	(208.0)	(10.6)	(10.7)	(0.1)	
Provisions	(6.7)	(6.7)	(6.7)	-	
Total Current Liabilities	(289.5)	(146.8)	(149.2)	(2.4)	
Borrowings	(276.6)	(269.7)	(269.7)	(0.0)	
Provisions	(1.2)	(1.2)	(1.2)	-	
Total Non Current Liabilities	(277.7)	(270.9)	(270.9)	(0.0)	
Total Assets Employed	30.3	230.8	231.9	1.1	
Financed By:				-	
Public Dividend Capital	409.7	614.9	614.9	-	
Retained Earnings	(476.2)	(481.0)	(479.8)	1.1	Note 4
Revaluation Reserve	96.9	96.9	96.9	-	
Total Taxpayers Equity	30.3	230.8	231.9	1.1	

The revised balance sheet budgets reflect the plan submitted to NHSI/E on 22 October and are based on the Month 6 balance sheet and expected movements for the remainder of the financial year. Variances to the revised plan at Month 7 are explained below:

Note 1 - Property, plant and equipment and intangibles are £1.2m lower than plan reflecting lower than planned year to date capital spend.

Note 2 - Cash is £4.1m higher than plan. The cash balance reflects £63.2m of income received from Commissioners relating to Month 8. The plan figure did not include £3.3m of this income in advance relating to the Top-up which was expected to be received in November.

Note 3 - Payables are £2.4m higher than plan. The payables balance reflects the receipt in advance of £63.2m referred to in Note 2. The increase in receipts in advance is partly offset by lower than plan revenue payables reflecting the better than plan position.

Note 4 - Retained earnings show a £1.1m variance compared to plan and reflects the better than plan revenue position.

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
1,416	1,483	67	Medical	(153.1)	(12.6)	(13.3)	(0.7)	(88.3)	(90.9)	(2.5)
3,294	3,117	(177)	Registered Nursing	(158.5)	(13.1)	(12.3)	0.8	(91.6)	(87.1)	4.5
1,252	1,186	(65)	Scientific Therapeutic & Technical	(58.1)	(4.9)	(4.8)	0.0	(33.7)	(33.4)	0.2
2,367	2,403	36	Support to Clinical	(69.4)	(5.5)	(5.6)	(0.1)	(41.0)	(40.9)	0.0
2,391	2,294	(97)	Nhs Infrastructure Support	(74.5)	(6.2)	(6.4)	(0.2)	(45.4)	(44.4)	0.9
10,720	10,484	(236)	Total Pay	(513.6)	(42.3)	(42.4)	(0.1)	(299.9)	(296.8)	3.1

Pay - The pay run rate in Month 7 is £1.6m lower than the level seen in Month 6; this is mainly due to the payment of the Medical Consultants' pay award which increased the run rate in September by £1.1m.

Non PaySummary (£m)	Annual	In Month			YTD		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance
Tariff Excluded Drugs Expenditure	(68.1)	(10.3)	(6.5)	3.8	(39.8)	(40.1)	(0.3)
Other Drugs	(21.7)	(1.8)	(1.7)	0.1	(12.6)	(11.5)	1.1
Supplies & Services - Clinical	(72.2)	(6.4)	(6.0)	0.4	(42.4)	(33.7)	8.8
Supplies & Services - General	(8.1)	(0.6)	(0.6)	0.0	(4.9)	(4.3)	0.7
Purchase of Healthcare from other Bodie	(12.1)	(0.9)	(0.7)	0.2	(7.2)	(6.6)	0.5
Consultancy Costs	(2.3)	(0.2)	(0.2)	0.0	(1.4)	(0.4)	0.9
Clinical Negligence	(22.3)	(1.9)	(1.9)	0.0	(13.4)	(13.4)	0.0
Premises	(32.1)	(2.7)	(2.7)	0.1	(19.8)	(17.6)	2.1
PFI Operating Costs	(33.4)	(2.8)	(2.9)	(0.1)	(19.5)	(20.3)	(0.8)
Other	(4.6)	(0.3)	(1.1)	(0.9)	(4.7)	(6.9)	(2.2)
Total Non Pay	(277.0)	(28.0)	(24.3)	3.7	(165.7)	(154.8)	10.8

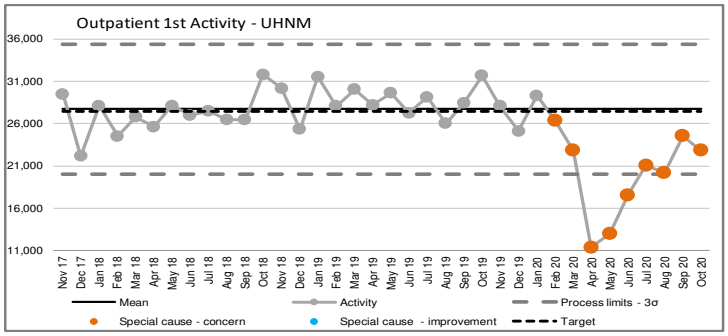
Non-pay -Non-pay expenditure is underspent by £3.7m in Month 7 (although this is distorted by a budget adjustment to Tariff excluded drugs to reflect changes to pass through arrangements). Whilst Clinical Supplies continues to underspend the run rate has increased in Month 7 as activity levels have increased.

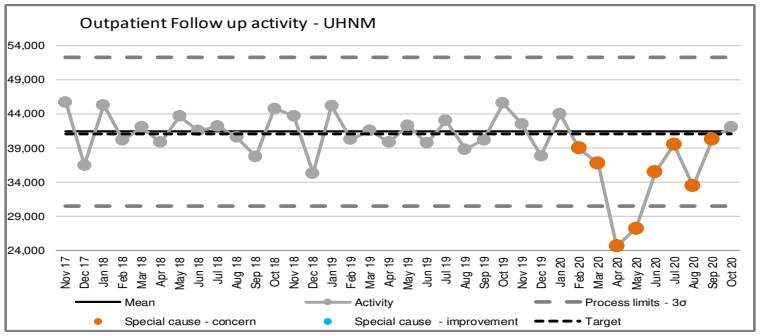
The budget for other expenditure is where the Non Pay element of the undelivered CIP schemes has been transacted which is driving the overspend of £0.9m in-month.

Activity

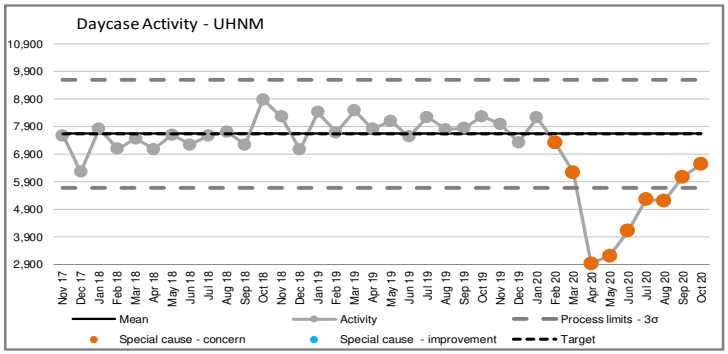
NHS University Hospitals of North Midlands NHS Trust

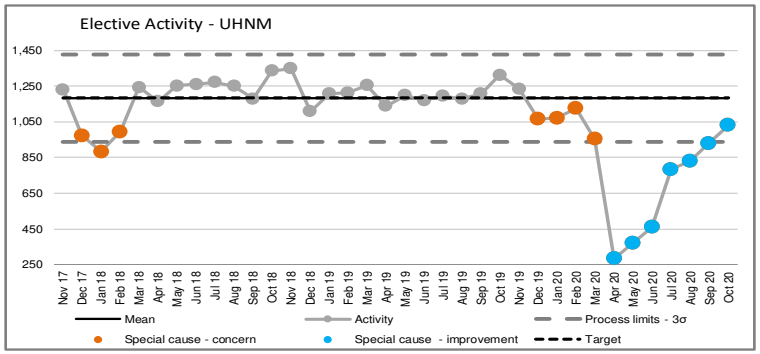
Planned care Outpatient



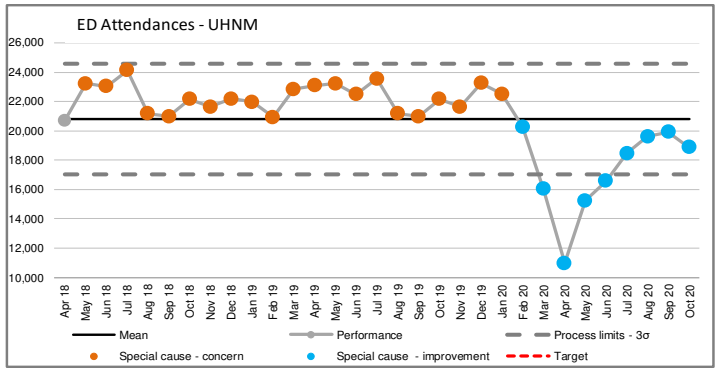


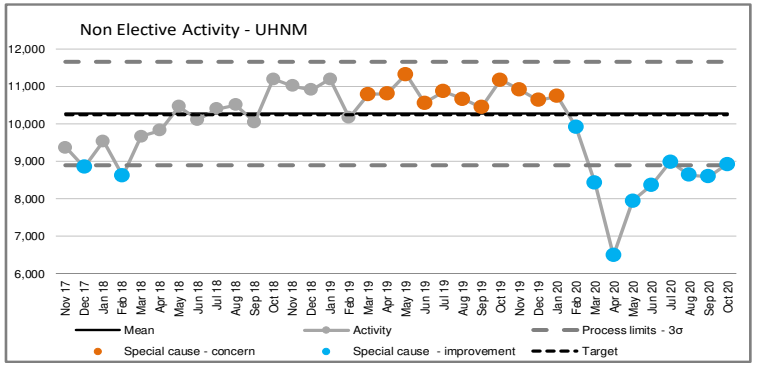
Planned care Inpatient





Urgent Care





Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	9th December 2020
Report Title:	Winter Communications Strategy	**Agenda Item:**	14.
Author:	Lisa Thomson		
Executive Lead:	Lisa Thomson – Director of Communications and Charity		

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:

To support the Trust and the wider system, a communications strategy has been developed focused on reducing attendances where people can be safely treated in other NHS facilities by diverting the public to other NHS services.

Situation

UHNM has implemented a six week localised winter campaign for the past four years. The Trust's 2019/20 the Where for Care? campaign reached 860,000 people in Staffordshire and Stoke-on-Trent - a 18% increase in reach compared to the previous year. This resulted in a reduction in the level of attendances following seven days attendances when each video was posted. The 2020/21 campaign builds on the success of the 2019/20 and has been developed with input from clinical teams as well as the wider system.

Background

To support the national and regional campaign to ensure that people needing NHS care over the busy winter period access it from the right place, the Trust has working with clinical teams and external partners to develop its communications strategy.

Assessment

The 2020/21 Where for Care? campaign will re-introduce our UHNM "Winter" family as well as some additional characters 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.
In line with national and regional plans to launch Think 111 First - the campaign has been adapted to include calls to action for Think 111/ 111 First.

Key Recommendations:

The Board is asked to note the winter communications strategy and note that it has been developed based on previous year's campaigns with input from clinical teams and the wider system.

NHS
University Hospitals of North Midlands
NHS Trust

Winter Campaign Plan 2020/21

Communications

September 2020

Background

- The Royal Stoke has history of high emergency department attendances. The aim of the strategy is therefore to try to reduce attendances, or to divert the public to other NHS services.
- UHNM has implemented a six week localised winter campaign for the past four years.
- The approach was to make users aware of the existing demand, reinforce what preparation UHNM has taken for winter and seek to change public behaviour through a social marketing campaign.
- Since 2018/19 targeted paid for advertising on social media has been utilised helping to reach and significantly larger and more focused audience
- In 2019/2020 the Where for Care? campaign reached 860,000 people in Staffordshire and Stoke-on-Trent - a 18% increase in reach compared to the previous year.
- The pattern shows a reduction in the following seven days attendances when each video was posted.
- While this pattern is seen every year, it is prominent during the campaign.

2019/2020 Evaluation

- Date launched 8 November 2019
- Ending 3 February 2020
- One video per week

Video	Message	Budget	People reached
Meet Anita - GP	Where for care? | Seeing the GP before symptoms get worse can help prevent a trip to hospital. Help keep our A&E for real emergencies. Meet Anita. #HelpUsHelpYou	£100.00	106,091
Meet Chloe - NHS 111	Where for care? | NHS 111 service is available to you and your family 24 hours a days, 365 days a year. Help keep our A&E for real emergencies. Meet Chloe	£180.94	156,388
Meet Derek - A&E	Where for care? | Luckily most of us won't ever need to go to A&E, but if you have a life threatening emergency then A&E is the right place to go. Help keep our A&E for real emergencies. Meet Derek. #HelpUsHelpYou	£125.00	119,024
Meet Jack - Self Care	Where for care? | Self care is important when you are feeling poorly. Very minor illnesses and injuries can usually be treated by yourself at home. Help keep our A&E for real emergencies. Meet Jack. #HelpUsHelpYou	£125.00	123,168
Meet Mavis - Walk-in Centre	Where for care? |Minor injury units and walk-in centres can treat a range of illnesses and injuries, such as broken bones and minor cuts. Help keep our A&E for real emergencies. Meet Mavis. #HelpUsHelpYou	£205.52	193,050
Meet Raj - Pharmacy	Where for care? | A pharmacist can give you and your family advice on a wide range of common illnesses. Help keep our A&E for real emergencies. Meet Raj #HelpUsHelpYou	£144.06	160,176
		£880.52	857,897

Attendances and Animated Adverts

- One video launched at the beginning of each week.
- First three films posted on a Monday morning – identified message too late and changed to Sunday.
- Drop in attendance is seen after initial roll out of animations which were repeated during the week and supported by PR mesasges.

Principles

- The 2020/21 Where for Care? campaign will re introduce our UHNM “Winter” family as well as some additional characters 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.
- In line with national and regional plans to launch Think 111 First - the campaign will adapt to include calls to action for Think 111/ 111 First

Audience

- Essentially an external social marketing campaign, the 2020/21 campaign aims to target general public, specifically women aged 24 to 55-years-old who have been identified as key decision makers in households and family groups and are the most likely to influence health choices made by younger and older generations.
- It will also be run as an internal campaign for staff from across partner organisations specifically to seep into wider community knowledge and the media.

Strategy

Campaign – Where for Care?

- The strategy is to add ‘motivation’ to our key stakeholder group, the general public. The campaign will suggest alternative services and make a case for a change in behaviour.
- Animated content will be created introducing our UHNM family - The Winters – and new for 2020/21 some extended family who need care for their own emergency.
- The materials will be shared on all UHNM social media accounts, including Twitter, Facebook and Instagram.
- As previous winter campaigns social media posts will have both organic growth as well as paid for content.
- The campaign will be amplified and supported by partners across the geography of Staffordshire and Stoke-on-Trent.

Key Messages

- During winter, many people pick up an illness or injury. If it happens to you and you need medical help, there is a range of services to choose from.
- Your Accident and Emergency department is for serious and life-threatening emergencies only, such heavy bleeding, broken bones, burns and chest pain.
- Following launch of 111 First / Think 111 the campaign will introduce key regional and national messages.


NHS
University Hospitals of North Midlands
NHS Trust
Where for care?
Helping your family make the right choice


Meet Anita


Meet Derek


Meet Chloe


Meet Raj


Meet Jack


Meet Mavis

PR

Narrative - Background

- Every day the NHS helps the people of Staffordshire and Stoke-on-Trent stay healthy, recover from illness and live independent and fulfilling lives. Due to a population which is aging and an increasing number of frail older people, along with more people living with long term conditions – such as heart disease, diabetes and hypertension – the NHS is experiencing more demand than ever before.
- In normal circumstances the winter period leads to further pressures on services as the colder months bring more cases of influenza-like illnesses, respiratory ailments and often accidents due to adverse weather conditions.
- Following the coronavirus outbreak, we recognise that our urgent care services, in particular our Emergency Departments (A&Es), will need to work differently to help our staff and patients to stay safe from coronavirus.
- Due to social distancing and infection precautions, the space in those departments is currently reduced by 30-50%.
- This leads to a number of challenges for the NHS and a need to have in place robust plans and initiatives to ensure services cope with this increase in demand.
- Over the winter months, the NHS sees more people visiting their GP, more people attending Accident & Emergency (A&E) and therefore, the highest increase in the number of people being admitted to hospital.
- This leads to a need for people to be able to access services quickly and easily and 'flow' between services smoothly, without delays. There is a need for more community and home based services to ensure people can be cared for at home where it is appropriate to do so, rather than be admitted to hospital unnecessarily.
- People also need to be supported to return home as soon as possible following a stay in hospital, with the correct care where it is needed.
- UHNM is keen to work with patients to encourage them to be directed to the right service for their needs and avoid unnecessary waiting times.
- UHNM is working with local NHS organisations to put in place plans which mean people will receive the care they need, when they need it, in the best place.
- UHNM is working with system partners to promote an enhanced 111 service, due to go live in Autumn/Winter, where patients will be encouraged to phone NHS 111 if they think they need to go to an Emergency Department, or other urgent care service, so they can be directed to the right place for their needs.

PR

Key messages – Measures to prepare for winter

- Every Emergency Department across the country has a target to see 95% of patients within four hours. Despite a fall off in demand during the height of the Covid-19 pandemic, attendance to UHNM emergency departments are now back at pre-Covid-19 levels and together with challenges of keeping patients and staff safe, delivering this target continues to be a challenge.
- 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:
  - Investment to support a Paediatric Modular Build in Emergency Department
  - Investment in Priority Decision Unit adjacent to the Emergency Department Footprint (10 beds) to improve immediate specialised interventions out of the Emergency Department
  - Additional Critical Care Capacity (2-10 beds on the RSUH site)
  - An additional 28 bed ward within the RSUH footprint by remodelling the existing estate
  - The purchase of PODS to convert our identified Covid/Flu wards to support IPC isolation capacity
  - Reconfiguration of Medicine portal and acute ward capacity into a single zone to support improved pull and flow of patients from the Emergency Department.
  - 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
  - System partners to support diversion of appropriate pathways to Haywood WiC
- County Hospital:
  - Additional 25 bed escalation

PR

Key Messages - Improved discharge and admission avoidance

- 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 and new services are designed to keep people well at home or discharged from hospital in a timely manner to ensure they can return home.
- UHNM is working our community partners to support integrated discharge planning and refresh its approach to health and social care systems
- The initiatives include :
  - **Integrated discharge planning -** building upon the hospital discharge service developed during the COVID-19 response
  - **Sub Acute Unit** to support Medically Fit patients who are awaiting placements in order to free up our assessment and acute beds.
  - **ReSPECT** - advance care planning
  - **CRIS** - Community Rapid Intervention Service – bringing care closer to home
  - **Frailty Falls Response Service –** Advanced Nurse Practitioner and Occupational Therapist working alongside West Midlands Ambulance Service to assess, treat and prescribe for patients in their own home to prevent unnecessary A&E attendances.
  - **Get Up, Get Dressed, Keep Moving** (to get home)
  - **Staying Well Clinic** – At County Hospital, the clinic allows GPs to refer frail patients to be assessed by a multidisciplinary team which includes a consultant, pharmacist, therapies, mental health nurses and social care to help admission avoidance.

PR

- A proactive winter PR plan will run alongside the campaign, highlighting the positive steps being taken by UHNM to improve flow; schemes to support discharges and initiatives to avoid admission.
    - AMRA – Latest stats
    - CRIS – developments and latest stats
    - Falls Response Service – latest stats
    - Emergency Department improvements
    - Get Up, Get Dressed, Keep Moving

Internal

- A large focus of internal communications will run alongside the campaign to improve steps being taken to improve flow within the hospital and between UHNM and the community.
- Internal communications will focus on:
    - Red 2 Green/ SAFER
    - Discharge processes
    - ReSPECT
    - Get Up, Get Dressed, Keep Moving
    - Emergency Department improvements
    - #fact / just say yes

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	9th December 2020
Report Title:	Interim Terms of Reference for Board, Committees and Executive Groups	**Agenda Item:**	15.
Author:	Claire Rylands, Associate Director of Corporate Governance		
Executive Lead:	Tracy Bullock, 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:

Situation and Background

The enclosed, updated Interim Terms of Reference are presented to the Board for approval. These were initially introduced during the first wave of Covid-19, allowing for changes to made to the way in which the Board and its Committees conduct their business, whilst enabling the Executive Directors and senior teams to focus on the key priorities associated with responding to the pandemic and ensuring the safety of patients and our staff.

As the second wave of Covid-19 began to emerge, the Board requested that the Terms of Reference are revisited and refreshed, taking into account any relevant lessons learned. In addition, the Terms of Reference have been extended to cover the Executive Groups which sit beneath the Committees.

Assessment

With the agreement of the Board, the revised Terms of Reference have been enacted during October / November in response to increasing operational pressures. This has involved the cancellation of some Executive meetings with papers being distributed via email for information, and the shortening of some Committee meetings. Reflective discussions on the effectiveness of these arrangements have taken place and concluded to be appropriate.

The Terms of Reference have been reviewed and consulted upon with all members of the Executive and Non-Executive teams and feedback has been incorporated.

These interim arrangements will remain under review, as the situation with Covid-19 continues to evolve.

Key Recommendations:

The Board is asked to approve the revised Interim Terms of Reference.

Covid-19 Business Continuity Terms of Reference

Trust Board, Committees and Executive Groups

November 2020

Standing Orders: Emergency Powers

The powers which the Board has reserved to itself within its Standing Orders may in emergency or for an urgent decision be exercised by the Chief Executive and the Chairman after having consulted at least two Non-Executive Director members. The exercise of such powers by the Chief Executive and Chairman shall be reported to the next formal meeting of the Trust Board in public session for formal ratification.

1) During the Covid-19 Pandemic (second wave), the Terms of Reference and Membership, including quorum arrangements, for the Board and its Committees and the Executive Groups will be temporarily suspended as of 11th November 2020, until further notice.

2) During this period, if meetings are to be held, then this will be done through the use of telephone / digital technology.

3) The primary focus of communication with the Board will be the organisation's response to Covid 19, including the safety of patients and the wellbeing of staff.

4) Whilst every effort will be made to continue aspects of 'business as usual' activity, based upon the existing business cycles / forward agenda:

4a) All matters for approval will be either:

- Deferred if not urgent or
- Circulated to Board / Committee members via email for approval, whilst allowing sufficient time for review / response or
- Discussed via telephone / digital technology with the decision recorded by Corporate Governance or
- Discussed between the Chief Executive or nominated Executive Director with the Board / Committee / Executive Group chair for Chairs Action

4b) In these circumstances the quorum will be 1 Executive Director and 2 Non-Executive Directors

4c) A summary of decisions made will be included in the Chief Executive's Report to the Trust Board

5) It is likely that those responsible for preparing assurance papers for Executive Groups, Committees and the Board will not be in a position to do so. Therefore:

5a) All matters for information or assurance will be either:

- Put on hold until further notice or
- Circulated via email
- Provided to members in summarised format, i.e. bullet point via email

6) For ad hoc items agreed by the Executive Directors as requiring a decision by the Board:

- Circulated to Board / Committee / Executive Group members via email for approval, whilst allowing sufficient time for review / response or
- Discussed via telephone / digital technology with the decision recorded by Corporate Governance
- Discussed between the Chief Executive or nominated Executive Director with the Board / Committee chair for Chairs Action

6a) In these circumstances the quorum for Board and Committees will be 1 Executive Director and 2 Non-Executive Directors and for Executive Groups, two Executive Directors.

7) The Business Cycles will be reviewed and updated within Corporate Governance, to maintain an accurate record of items considered / approved or deferred. A record of the business undertaken will be produced by the Corporate Governance Department.

Communication with Non-Executive Directors

In order to maintain communication, engagement and assurance for Non-Executive Directors, a number of additional measures will be in place, including:

- Formal confirmation on the emergency response level, when enacted and the implications for decision making processes
- Weekly meetings with the Chief Executive via Microsoft Teams, to provide an update on the latest position including key challenges and actions being taken
- Daily 'SitRep' reports from the Incident Control Centre, providing latest figures relating to Covid-19 cases, discharges, deaths, sickness absence and nosocomial outbreaks
- Access to the 'Covid Dashboard' which provides a detailed overview of key indicators
- Email communication highlighting any key points arising from the Executive Huddle meetings
- Ad hoc communication as needed between Committee Chairs and Executive Leads
- Where possible, staff engagement sessions although it is recognised that these will be limited

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	9th December 2020
Report Title:	EPRR Annual Assurance	**Agenda Item:**	16.
Author:	Richard Lamine, Head of Resilience		
Executive Lead:	Paul Bytheway, Chief Operating Officer		

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

This paper is to provide assurance to the Board of the EPRR annual assurance paper that was submitted to Staffordshire CCG on 16th October and for further submission to NHSE/I National team on the trusts behalf. A full schedule of timescales for regulatory bodies can be found further in his paper.
The paper demonstrates the adaptability of the UHNM in the face of the Covid-19 pandemic, and demonstrates the trusts resilience and ability to respond to both short and long term events that may require the utilisation of emergency response and its framework.

Background

In previous years NHSE/I have measured the UHNM annual assurance through the Core Standards process. This process involves responding to and evidencing a number of domains. This is an extensive piece of work which is part of the EPRR annual work plan This year, NHSE/I requested responses to three key points;

- The progress made by organisations that were reported as partially or non-compliant in the 2019/20 process
- The process of capturing and embedding the learning from the first wave of the COVID-19 pandemic;
- The inclusion of progress and learning in winter planning preparations for 2020/21

The Core Standard submission 2019/20 was deemed to be 'Substantially Compliant'.

Assessment

At present UHNM have not received any additional feedback from CCG regarding the compliance document submitted. At present there are no items of concern or escalation

Key Recommendations:

This paper is to provide assurance to the Trust Board and to respond to any concerns

EPRR Annual Assurance 2020/21

Introduction

The annual statutory requirement is to provide full assurance regarding Emergency Preparedness, Resilience and Response (EPRR) and Winter Planning for 2020/21.

The events of 2020 have fully tested all NHS organisational plans to the highest degree, above and beyond the routine assurance processes.

NHSE/I recognised the detailed and granular process of previous years would be excessive while prepare for a potential further wave of COVID-19, as well as upcoming seasonal pressures and the operational demands of restoring services. Therefore NHSE/I requested, for the 2020/21 assurance process, updates for the key points highlighted.

Key Points and UHNM Summary of response for assurance process 2020

The progress made by organisations that were reported as partially or non-compliant in the 2019/20 process:

The Core Standard submission 2019/20 was deemed 'Substantially Compliant'. The CCG confirmed the assessment of the two partially compliant core standards as completed.

The process of capturing and embedding the learning from the first wave of the COVID-19 pandemic:

During the COVID-19 Pandemic UHNM provided a command and control structure in line with the requirements of NHSE and local commissioners. Building on these arrangements the Chief Operating Officer and the EPRR Team provided a reactive and adaptable incident response structure including compliance with all reporting criteria.
As part of the continuous review of the response UHNM have now reviewed and revised their long term command and control arrangements as a result of the Covid-19 response. This included high intensity planning and response meetings in the early stages of the situation and as changes to guidance demanded. From an EPRR perspective UHNM, has reflected on and amended its EPRR structures throughout, all of which will be reflected in the next scheduled review of the UHNM Incident Response Plan which will adopt the measures set out in the current Covid-19 SOPs.

Work from Clinical, Nursing and Managerial teams in implementing the COVID-19 strategy is reflected in the way in which UHNM has adapted to the challenges posed by working in the new COVID-19 environment. This work continues in managing the increasing cases in our hospitals whilst simultaneously working to achieve the national directives on recovery targets.

The inclusion of progress and learning in winter planning preparations for 2020/21

Winter planning at UHNM is carried out in tandem with the above processes, in question2, as we amend the way in which we respond to the Covid-19 pandemic. Working closely with local and regional commissioners, providers and stakeholders there is comprehensive programme in train to ensure a resilient response to coming winter challenges. This planning includes involvement with key service leads and clinicians from across UHNM and local provider organizations and partners. The Planning details the escalation processes in place, the additional capacity that will be available for acute bed demand and how

we will manage service disruption through potential staffing difficulties and other continuity challenges. 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.

The UHNM Covid19 Service Resilience response was predicated on the following brief:

- To provide clarity on the detailed scope of the services to be suspended.
- To provide clarity as to what activity would stop and when.
- To understand and respond to any operational impacts
- To ensure all parties have a shared understanding of their roles in the amended `pathways.
- To ensure throughout that patient safety was maintained and any risks mitigated.
- Ensure robust plans were in place to maintain essential services inc. cancer treatments
- To understand actions taken by our system partners to support business resilience
- To effectively manage referral demand, expediting patients in accordance with clinical need.
- To commence any phased restoration whilst acceding to Infection Prevention and Control and Personal Protective Equipment emergent standards and guidance.

Regulatory guidance in the form of central publications have been 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.

Conclusions

In conclusion the UHNM have provided a robust and evidential account of learning form the first wave, adaptability of processes, high intensity planning and demonstrates building on the arrangements set out in the UHNM Incident Response and Business Continuity Plans. As part of this teams continually review of the response and amended the content, membership and frequency of command and control activities accordingly.

Recommendations

- UHNM will, in conjunction with national and local commissioners, commit to a robust and extensive debrief process when the Covid-19 incident is stood down but as demonstrated above this does not restrict our ability to reflect and respond as the situation demands
- Ensure any queries or further information required by NHSE/I will be provided in a timely manner
- Continuous review of all policies / procedures and sop's to include Covid inclusive pathways and management.

Submissions and Timescales

- 16 October 2020: UHNM submits annual assurance to CCG
- 31 October 2020: statements of assurance are made to regional EPRR teams by CCGs
- 31 December 2020: regional EPRR teams submit their statement of assurance to the national EPRR team
- 28 February 2021: national EPRR team to have completed conversations with regional teams
- 31 March 2021: national EPRR assurance reported to the NHS England and NHS Improvement Board

Emergency preparedness, resilience and response (EPRR) annual assurance process and winter planning for 2020/21

As set out in the letter from Professor Keith Willett, as titled above with reference C0731, the University Hospital of North Midlands would like to provide you with a position statement on each of the three areas outlined in the aforementioned letter.

1. Progress of partially or non-compliant organisations

Organisations that were rated partially or non-compliant in the 2019/20 process will have undertaken a great deal of work through their action plans to address gaps. Much of this will have been carried out ahead of the COVID-19 pandemic which began in the UK in January 2020. The 2020/21 process seeks to understand their improved status.

The Core Standard submission 2019/20 was deemed 'Substantially Compliant'.

'Subsequent to the submission of your Core Standards for EPRR 2019/20 (Self-Assessment) and Confirm & Challenge meeting undertaken on 4th October 2019, I can confirm that NHS England / Improvement (North Midlands) the Staffordshire and Stoke-on-Trent CCGs have evaluated University Hospitals North Midlands as substantially compliant which is defined as the organisation being 89-99% compliant with the core standards they are required to achieve'.

POST CONFIRM & CHALLENGE TABLE					
Ref	**Domain**	**Standard**	**Post Confirm & Challenge RAG**		
			Substantial	**Partial**	**Non**
32	Response	Management of Business Continuity Incidents:		✓	
Recommendations: Attend Exercise ERIS – 10.10.19 Conduct in-house table top exercise - 31.10.19					
54	Business	BCMS Continuous Improvement Process		✓	
Recommendations: Conduct external review of BCP system. Due 31.10.19					

The CCG confirmed the assessment of partially compliant for the two core standards as shown below and noted the recommended actions. The UHNM can confirm that the recommendations below are completed.

Reference 32

- Exercise ERIS was attended, debrief paper is available if required.
- In house planned table top exercise superseded by Covid-19 planning.

Reference 54

- Head of EPRR NHS E / I - Midlands (East) was arranging a peer review but due to NHSE/I restructure this was not arranged. The UHNM did attempt to instigate this however was superseded by Covid-19

2. The identification and application of learning from the first wave of the COVID-19 pandemic

The comprehensive and extensive response to the first wave of the COVID-19 pandemic has provided all health organisations with a unique opportunity to identify and embed lessons into EPRR practice. The 2020/21 process seeks to ensure that all NHS organisations have begun the process to systematically and comprehensively identify, learn and embed lessons to improve EPRR practice.

During the COVID-19 Pandemic UHNM have provided a command and control structure in line with the requirements of NHSE and local commissioners. Building on the arrangements set out in the UHNM Incident Response and Business Continuity Plans, the Chief Operating Officer and the EPRR Team provided a reactive and adaptable incident response structure including compliance with all reporting criteria. As part of this the teams undertook a continuous review of the response and amended the content, membership and frequency of command and control activities accordingly. With this in mind UHNM have now reviewed and revised their long term command and control arrangements as a result of the Covid-19 response. This included high intensity planning and response meetings in the early stages as the situation and changes to guidance demanded but has since resolved into a less intense recovery focused structure. We are currently escalating back to a moderated C&C structure in line with the increases in activity. This demonstrates that from an EPRR perspective UHNM, has reflected on and amended its EPRR structures throughout, all of which will be reflected in the next scheduled review of the UHNM Incident Response Plan which will adopt the measures set out in the current Covid-19 SOPs.

Behind the EPRR work lies of course a vast amount of work from Clinical, Nursing and Managerial teams in implementing the COVID-19

strategy and responding to the changes in local demand and regional and national guidance. All of this work is reflected in the way in which UHNM has adapted to the challenges posed by working in the new COVID-19 environment. This work continues in managing the increasing cases in our hospitals whilst simultaneously working to achieve the national directives on recovery targets.

UHNM will, in conjunction with national and local commissioners, commit to a robust and extensive debrief process when the Covid-19 incident is stood down but as demonstrated above this does not restrict our ability to reflect and respond as the situation demands.

3.Incorporating progress and learning into winter planning arrangements

As in previous years there is also a wider programme of winter planning and assurance. This work will draw on existing processes, including this one, to supplement assurance conversations. The 2020/21 process seeks to ensure this learning is embedded in winter preparedness

Winter planning at UHNM is led by the Chief Operating Officer and their deputy and is being carried out in tandem with the above processes as we amend the way in which we respond to the Covid-19 pandemic. Working closely with local and regional commissioners, providers and stakeholders there is comprehensive programme in train to ensure a resilient response to coming winter challenges. The Winter Plan will be ready for dissemination in October 2020 and will support the necessary assurance processes leading into what will undoubtedly be a challenging period. This planning includes involvement with key service leads and clinicians from across UHNM and local provider organisations and partners. The Planning details the escalation processes in place, the additional capacity that will be available for acute bed demand and how we will manage service disruption through potential staffing difficulties and other continuity challenges.

The UHNM Covid19 Service Resilience response was predicated on the following brief:

- To provide clarity on the detailed scope of the services to be suspended.
- To provide clarity as to what activity would stop and when.
- To understand and respond to any operational impacts
- To ensure all parties have a shared understanding of their roles in the amended pathways.
- To ensure throughout that patient safety was maintained and any risks mitigated.
- Ensure robust plans were in place to maintain essential services inc. cancer treatments
- To understand actions taken by our system partners to support business resilience
- To effectively manage referral demand, expediting patients in accordance with clinical need.

- To commence any phased restoration whilst acceding to Infection Prevention and Control and Personal Protective Equipment emergent standards and guidance.

Regulatory guidance in the form of central publications have been 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. Task 16184 C0786: Readiness for increase in hospital admissions for COVID19 letter comprises one of these mandates for which the Trust summarised response is appended below:

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% Covid19 bed base scenario.

UHNM is accommodating a system MADE function on site to enable senior leadership teams from system partners to support a command and control function to expedite patient discharge into the community bed base. The West build will house any residual patients remaining on the footprint within 24hr of declaring MFFD.

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 specialties 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.

Key assumptions

- System partners will cover off the UHNM acute bed deficit with their aligned winter/surge plans.
- If patients admitted required Critical Care beds this could impact on the 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.
- Seasonal influenza will align to the Southern Hemisphere experience of minimal impact this winter with bed modeling being based on similar volume to 2019/20 experience

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	9th December 2020
Report Title:	Calendar of Business 2021/22	**Agenda Item:**	17.
Author:	Nicola Hassall, Deputy Associate Director of Corporate Governance		
Executive Lead:	All		

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 and Background

The Trust Calendar of Business includes dates for all Board, Committee and Executive Group meetings. Dates have been set based on the 2020/21 cycle, to enable reports to be considered at respective Executive Groups and Committees prior to submission to the Trust Board.

Assessment

The Calendar of Business for 2021/22 follows the similar sequencing of meetings as per 2020/21, although a number of changes have been made as follows:

- Inclusion of Executive Groups – these have been set so that they are held on consistent days/times of the month, whilst ensuring updates from the groups are able to be subsequently reported to the respective Committee
- Quality Governance Committee meetings have been moved to Thursday and Transformation and People Committee meetings have been moved to Wednesday

It should be noted that although the scheduling of Committee meetings follow the same pattern as for 2020/21, in April, July, October and December there may be some delay in providing performance papers due to information availability.

Key Recommendations:

The Trust Board is asked to **approve** the Calendar of Business for 2021/22.

Calendar of Business 2021 / 2022

NHS University Hospitals of North Midlands NHS Trust

	Sat	Sun	Mon	Tue	Wed	Thur	Fri	Sat	Sun	Mon	Tue	Wed	Thur	Fri	Sat	Sun	Mon	Tue	Wed	Thur	Fri	Sat	Sun	Mon	Tue	Wed	Thur	Fri	Sat	Sun	Mon	Tue	Wed	Thur	Fri	Sat	Sun
April						1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30		
M12 Reporting						PRM	BH			BH	EBI	PTB		EIG			QSOG	UCPG	EHSG	EWAG					PAF	TAP	QGC					PRC		PRM			
						PRSp						CTB														PCPG	AC					PRS		PRSp			
												PCPG						Q O		F								W									
May	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31						
M1 Reporting			BH		PTB							TBS	DSP	EIG			QSOG	UCPG	EHSG	EST					PAF	TAP	QGC	TC			BH						
					CTB							NRC						ERI	PCPG									AC										
					PCPG													Q O		F								W									
June				1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30				
M2 Reporting				PRC	PCPG	PRM					EBI	PTB		EIG			QSOG	UCPG	EHSG	EWAG					PAF	TAP	QGC					PRC	PCPG				
				PRS		PRSp						CTB							PCPG													PRS						
														Q O F												W											
July						1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
M3 Reporting						PRM						PTB	DSP	EIG			QSOG	UCPG	TBS	EST	EHSG				PAF	TAP	QGC					PRC	PCPG	PRM			
						PRSp						CTB						ERI	NRC									AC					PRS		PRSp			
																			PCPG																		
																	Q O	F										W									
August		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31					
M4 Reporting					PTB						EBI	PCPG		EIG			QSOG	UCPG	EHSG	EWAG					PAF	TAP	QGC	TC				PRC					
					CTB																					PCPG						BH	PRS					
												Q O		F								W																
September						1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30		
M5 Reporting						PRM						CTB	DSP	EIG			QSOG	UCPG	TBS	EST	EHSG				PAF	TAP	QGC					PRC		PRM			
						PRSp						AGM						ERI	NRC							PCPG						PRS		PRSp			
												PCPG																									
																	Q O F										W										
October							1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
M6 Reporting											EBI	PTB	DSP	EIG			QSOG	UCPG	EHSG	EWAG					PAF	TAP	QGC					PRC		PRM			
												CTB														PCPG	AC					PRS		PRSp			
												PCPG					Q O		F												W						
November			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30					
M7 Reporting					PTB						BTO	BTO		EIG			QSOG	UCPG	EHSG	EST					PAF	TAP	QGC	TC				PRC					
					CTB													ERI	NRC													PRS					
					PCPG								Q O	F					PCPG						W													
December					1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		
M8 Reporting					EBI	PRM	EIG			QSOG	UCPG	PTB	EHSG	EWAG				PAF	TAP	QGC											BH	BH	PCPG				
					PCPG	PRSp						CTB	DSP						PCPG																			
																	Q O F										W										
January	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31						
M9 Reporting			BH		PTB							TBS		EIG			QSOG	UCPG	EHSG	EST					PAF	TAP	QGC										
					CTB							NRC						ERI								PCPG	AC											
												PCPG						Q O			F								W								
February				1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28						
M10 Reporting				PRC		PRM					EBI	PTB	DSP	EIG			QSOG	UCPG	EHSG	EWAG					PAF	TAP	QGC	TC									
				PRS		PRSp						CTB														PCPG												
												PCPG																									
														Q O F												W											
March				1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31			
M11 Reporting				PRC		PRM						PTB	DSP	EIG			QSOG	UCPG	TBS	EST	EHSG				PAF	TAP	QGC										
				PRS		PRSp						CTB						ERI	NRC							PCPG												
												PCPG																									
														Q O F												W											

COLOUR KEY		TIME
Public Trust Board	PTB	9:30 - 12.30 pm
Closed Trust Board	CTB	1.00 - 2.30 pm
Trust Board Seminar	TBS	9.00 - 1.00 pm
Trust Board Time Out	BTO	9.00 - 4.30 pm
Annual General Meeting	AGM	1.00 - 3.00 pm
Performance and Finance Committee	PAF	9.00 - 12.00 pm
Executive Infrastructure Group	EIG	10.00 - 12.00 pm
Executive Business Intelligence Group	EBI	9.00 - 11.00 am
Executive Data Security and Protection Group	DSP	2.00 - 4.00 pm
Urgent Care Programme Group	UCPG	8.00 - 9.00 am
Audit Committee	AC	12.30 - 3.00 pm
Trustee Committee	TC	10.00 - 12.00 pm
Quality Governance Committee	QGC	9.00 - 11.30 am
Cancer Programme Group	CPG	TBC
Executive Health and Safety Group	EHSG	10.00 - 12.00 pm
Executive Quality and Safety Oversight Group	QSOG	2.00 pm - 4.00 pm
Nomination & Remuneration Committee	NRC	1.30 - 3.00 pm
Transformation and People Committee	TAP	9.00 - 11.30 am
Planned Care Programme Group	PCPG	3.00 - 4.30 pm
Executive Research & Innovation Group	ERI	9.30 - 11.30 am
Executive Workforce Assurance Group	EWAG	9.00 - 11.00 am
Executive Strategy and Transformation Group	EST	9.00 - 11.00 am

Performance Management Reviews	PR	C 8.30 - 10.30 am S 11.00 - 1.00 pm M 9.00 - 11.00 am Sp 11.30 - 1.30 pm
Staffordshire School Holidays		

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	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Notes
		8	6	10	8	5	16	7	4	9	6	3	10	
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. Considered in December.
Care Quality Commission Action Plan	Chief Nurse													
Bi Annual Nurse Staffing Assurance Report	Chief Nurse						→							Discussed at TAP in September 20, and agreed changes required prior to presentation to the Board.. Further report will not be complete until after the new year due to daily changes. Further update provided to TAP in November 20.
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													Timing TBC due to national changes.
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													

Title of Paper	Executive Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Notes
		8	6	10	8	5	16	7	4	9	6	3	10	
Going Concern	Chief Finance Officer													
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