University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 6th January 2021 at 9.30 am to 11.10 am via Microsoft Teams

AGENDA

Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
09:30	**PROCEDURAL ITEMS**					
20 mins	1.	Staff Story	Information	Mrs M Rhodes	Verbal	
5 mins	2.	Chair's Welcome, Apologies and Confirmation of Quoracy	Information	Mr D Wakefield	Verbal	
	3.	Declarations of Interest	Information	Mr D Wakefield	Verbal	
	4.	Minutes of the Meeting held 9th December 2020	Approval	Mr D Wakefield	Enclosure	
5 mins	5.	Matters Arising via the Post Meeting Action Log	Assurance	Mr D Wakefield	Enclosure	
20 mins	6.	Chief Executive's Report – December 2020 • Covid-19	Information	Mrs T Bullock	Enclosure	**BAF 6**
10:20	**UPDATE FROM EXECUTIVE DIRECTORS**					
10 mins	7.	Chief Nurse • IPC Board Assurance Framework (Updated for Quarter 3) & NHS England and NHS Improvement IPC Visit • Patient Safety Update • Nurse Staffing Position	Assurance	Mrs M Rhodes	Enclosure	**BAF 1**
10 mins	8.	Chief Operating Officer • Operational Performance • Impact on elective operating	Assurance	Mr P Bytheway	Verbal	**BAF 1**
5 mins	9.	Director of Human Resources • Sickness absence	Assurance	Mrs R Vaughan	Enclosure	**BAF 1**
5 mins	10.	Chief Finance Officer • Finance update • Update on significant risks	Assurance	Mr M Oldham	Enclosure	**BAF 1**
10:50	**COMMITTEE ASSURANCE REPORTS**					
5 mins	11.	Quality Governance Committee Assurance Report (16-12-20)	Assurance	Ms S Belfield	Enclosure	**BAF 1**
5 mins	12.	Performance & Finance Committee Assurance Report (15-12-20)	Assurance	Mr P Akid	Enclosure	**BAF 9**
5 mins	13.	Transformation and People Committee Assurance Report (17-12-20)	Assurance	Prof G Crowe	Verbal	**BAF 2 & 3**
11:05	**ITEMS TO BE TAKEN AS READ/INFORMATION:**					
-	14.	Integrated Performance Report – Month 8	Assurance	Various	Enclosure	
11:05	**CLOSING MATTERS**					
5 mins	15.	Review of Meeting Effectiveness and Business Cycle Forward Look	Information	Mr D Wakefield	Enclosure	
	16.	Questions from the Public **Please submit questions in relation to the agenda, by 12.00 pm 4th January 2021 to** jason.dutton@uhnm.nhs.uk	Discussion	Mr D Wakefield	Verbal	
11:10	**DATE AND TIME OF NEXT MEETING**					
	17.	**Wednesday 3rd February 2021, 9.30 am, via MS Teams**				

University Hospitals of North Midlands NHS Trust

Trust Board (Open)

Meeting held on Wednesday 9th December 2020, 9.30 am to 12.20 pm
Via Microsoft Teams

MINUTES OF MEETING

Attended	Apologies / Deputy Sent	Apologies

Voting Members:			A	M	J	J	J	A	O	N	D	J	F	M
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:		
Matron D Challinor	DC	Matron (item 1)
Mrs L Duke	LD	Clinical Nurse Specialist (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: 4

No.	Agenda Item	Action
1.	**Patient Story**	
159/2020	Mrs Grocott explained that the patient representatives were unable to join the meeting, therefore Mrs Grocott read the story on their behalf. She explained that Mr Mayer had attended the Emergency Department in 2019 following some pain, and he was subsequently referred for some tests in 2020 although as he felt well, it was thought that there was no cause for concern. Subsequent biopsies had identified secondary cancer and Mr Mayer commenced chemotherapy at the beginning of the pandemic and his treatment continued throughout. The family recalled the supportive nature of staff in the Emergency Department and particularly paid thanks to Mrs Duke for her support.	

PROUD TO CARE

	Mrs Grocott highlighted that the family had provided some suggestions to improve the experience for future patients: • The reception desk in the Cancer Centre was not manned on Saturday therefore it would be useful to have a contact number on the desk • Since Mr Mayer's diagnosis in April, no community support had been provided i.e. via Macmillan • There had been some confusion regarding appointments for chemotherapy sessions due to mis-communication • Blood tests which are required prior to treatment, often require a separate journey involving a lot of waiting around and queuing • The cancer journey can be confusing and lack of information can cause additional anxiety, therefore a document which could explain what to expect at different stages would be helpful • Clear information on chemotherapy drugs and side effects would be useful Mr Wakefield thanked Mrs Grocott for recalling the story on behalf of Mr Mayer and his family. He welcomed the feedback provided and invited Mrs Duke to comment on the story. Mrs Duke explained that in relation to community support, the team had initially discussed referral to Macmillan with Mr Mayer earlier in his treatment, at which time he decided that it was not required. However, this had been subsequently discussed with the family and support had been provided. Mr Wakefield queried the reason for queuing for blood tests bearing in mind the risk of infection and Mrs Challinor explained that some blood tests were undertaken in the Cancer Centre where possible, but sometimes these were undertaken in pathology which could cause delays. Mrs Challinor agreed to work with the haematology department going forwards regarding this. Professor Hassell queried the system in place for blood tests and Mr Bytheway stated that each patient was provided with a 7 minute slot and were able to book appointments via an app. He stated that urgent blood tests were also available. Mr Wakefield referred to the issue of communication and whether actions had been taken. Mrs Challinor stated that a flow chart was being considered for patients and it was agreed that it would be beneficial to involve patient feedback as part of the process via the Patient Information Group. Dr Oxtoby added that cancer patients required bespoke care pathways therefore there may be some limitations in providing a flow chart. Mr Wakefield queried whether it was possible that Mr Mayer's chemotherapy had been delayed due to the start of the pandemic, and Mrs Duke explained that due to the cancer being an unknown primary, it would have taken longer to diagnose with a number of tests required to be undertaken prior to any treatment but noted there was no delay. Mr Wakefield thanked Mrs Duke, Mrs Challinor and Mrs Grocott for their attendance and it was agreed that the responses to the suggestions would be considered via the Quality Governance Committee. **The Trust Board noted the patient story.** Mrs Duke, Mrs Challinor and Mrs Grocott left the meeting.	**MR**
2.	**Chair's Welcome, Apologies & Confirmation of Quoracy**	

160/2020	Mr Wakefield welcomed members of the Board and observers to the meeting and no apologies were received. It was confirmed that the meeting was quorate. Mr Wakefield expressed his gratitude for the remarkable efforts from members of staff who had worked through the pandemic and expressed his sympathies to relatives of patients who had suffered as a result of Covid. He reflected on the tier 3 restrictions and stressed the importance of members of staff adhering to the restrictions. Mr Wakefield thanked the communications team for their efforts in providing the virtual advent calendar.	
3.	**Declarations of Interest**	
161/2020	The standing declarations were noted. Dr Griffin reiterated his declaration with MProve and it was confirmed that this had been added to the Declaration of Interest Register.	
4.	**Minutes of the Previous Meeting held 4th November 2020**	
162/2020	The minutes of the meeting from 4th November 2020 were approved as an accurate record.	
5.	**Matters Arising from the Post Meeting Action Log**	
163/2020	No further updates were provided.	
6.	**Chief Executive's Report – November 2020**	
164/2020	Mrs Bullock referred to the delivery of 975 Covid vaccines which had been received on 7th December and were to be issued throughout the week. She stated that the first vaccine was issued in the morning and the Trust was expecting to receive further vaccines in due course. It was noted that vaccinations would take place 12 hours a day, 7 days a week once the Trust had received enough deliveries. Mr Wakefield queried the maximum number of days in which the vaccine could be provided and Mrs Bullock stated that it depended upon the availability of the vaccine, as a number of staff had been trained in administering it. It was noted that there were a number of environmental restrictions to consider when deciding where to carry out the vaccinations, and it was confirmed that up to 200 vaccines a day could be provided if / when required. Mr Smith queried whether anything was provided to those who had received the vaccine, as confirmation. Mrs Bullock explained that the person receiving the vaccine would be provided with a card with details of the batch number etc, the main purpose of which was to provide a reminder for the second booster, although she expected additional proof would be provided to people in due course. Mr Akid referred to other manufacturers making vaccines and queried whether there was any difference in training. Mrs Bullock stated that core training was required as well as individual modules for each vaccine. She stated that when additional vaccines were received, she expected that additional training on that specific vaccine would be required.	

	Dr Griffin thanked the staff for rallying around to provide the vaccine and queried whether the Trust had been made aware of any 'noise' from sceptics and anti-vaxxers. Mrs Bullock stated that she was not aware of any local challenges, and the Trust needed to provide objective and factual information to the public and staff, to ensure people understood both the benefits and risks/side effects of the vaccine. Mrs Bullock highlighted a number of areas from her report and Mr Wakefield queried if the Trust had received responses from relatives regarding moving critical care patients as a result of the level 4 pressures. Mrs Bullock stated that the vast majority understood and accepted the position the Trust was in, although she was aware of two formal complaints. Dr Griffin queried the quantum of elective work which had been deferred due to Covid. Mr Bytheway explained that P1 patients were treated within 3 days and P2 patients i.e. those with cancer or classed as clinically urgent were treated within the next few weeks. He stated that as at the end of September / beginning of October between 280 to 290 elective cases were being undertaken a week which had risen since summer. He stated that the instigation of Level 4 had reduced activity quite considerably but it had since risen to 200 cases per week and it was expected that this would continue to rise. He added that if pressures increased in critical care or if Covid numbers worsened, this would have an associated impact on elective cases. Mrs Bullock highlighted that at the most recent system performance review with regulators, they expressed their praise and satisfaction with the amount of elective work which was continuing to be undertaken. Mr Akid referred to the statement within the report regarding Personal Protective Equipment (PPE) compliance and queried whether this had continued to be an issue. Mrs Bullock confirmed that there were no issues with the supply chain and that since 1st December, 70% of PPE was being produced in the UK which was positive. Professor Crowe paid thanks to the Charity and the Denise Coates Foundation and the support provided in recent months, in particular assisting the development of staff rest areas. Mr Wakefield welcomed the commencement of the North Midlands and Cheshire Pathology network, the continued work to undertake elective cases, the ways in which the Trust was responding to patient feedback, the step down from incident level 4 for critical care, and the continued recognition of staff. **The Trust Board received and noted the report and approved EREAFs 3971, 4056, 5124 and 3946.**	
PROVIDE SAFE, EFFECTIVE, CARING AND RESPONSIVE SERVICES		
7.	**Quality Governance Committee Assurance Report (25-11-20)**	
165/2020	Ms Belfield highlighted the following: • There had been an increase in patients with pressure ulcers / falls which had been attributed to the challenges associated with Covid and reduced staffing. It was noted that a review was to be undertaken which would be reported back to the Committee in due course. • The Committee noted the continued review and update of the Care Quality Commission (CQC) action planning document which was to be brought back	

	to the Committee in due course • There had been increases in mortality, the reasons for which were being understood and would be considered by the Committee at a future meeting. Mr Wakefield queried the work being undertaken on mortality reviews and when it was expected to receive the outcomes from the reviews of deaths, particularly those related to Covid. Dr Oxtoby referred to the ongoing work and reviews which had already been undertaken which had not identified any concerns. He stated that particular Structured Judgement Reviews (SJRs) were being undertaken on nosocomial patients and no red flags had been identified to date, although further information would be provided to the Quality Governance Committee. Professor Hassell queried if the analysis would include patient demographics and comparing surge 1 and surge 2. Dr Oxtoby confirmed that this could be incorporated and anecdotally the number of patients in hospital in surge 2 had exceeded those numbers in surge 1, with mortality rates in surge 2 of approximately 20% versus 32% in surge 1. It was agreed that it would also be beneficial to include pre-defined risk factors within the mortality analysis. **The Trust Board received and noted the assurance report.**	JO
8.	**Infection Prevention Board Assurance Framework (BAF) & Update following NHS England and NHS Improvement Visit**	
166/2020	Mrs Rhodes highlighted that 10 key actions identified by NHSEI had been mapped to the document and regular updates would continue to be provided as required. Mr Wakefield queried the link between the information provided in the document and the outcome of the NHSI visit whereby the Trust's rating had reduced to amber from green. Mrs Rhodes stated that the document did not take into account the results of the NHSEI visit, due to timings, although the full letter would be considered by the Quality Governance Committee and the BAF would be updated accordingly. It was noted that the NHSEI assessment rating had been based on visiting 2 wards, whereas the assurance framework provided a holistic view across the organisation. It was noted that additional controls would be put in place in relation to the deficiencies found by NHSEI and the updated report for quarter 3 would take all of the information into account. Mrs Rhodes stated that she was disappointed that the Trust's rating had reduced and confirmed that a number of actions had been taken at the time to address the issues raised. She added that a further visit was expected over Christmas at which point she would hope that the rating would improve. Professor Hassell referred to one of the gaps identified regarding FFP3 mask training and whether this had since been addressed. Mrs Rhodes stated that mask training records were held locally and not centrally which was being addressed. She stated that a new round of fit testing was also taking place. Professor Crowe queried if information was available regarding how the Trust compared against peers and Mrs Rhodes stated that some information was collected nationally, although there was no routine benchmark information. Mr Wakefield referred to the numbers of nosocomial infections and queried if the action had been completed to discuss this at November's antimicrobial group.	

	Mrs Rhodes agreed to confirm. Mr Wakefield referred to the issues associated with patients requiring two Covid tests prior to being moved and Mrs Rhodes stated that whilst the policy was to undertake 2 tests, the Trust did not always achieve 100% although this was considered on the balance of risk. She added that this was a national issue, and particularly difficult over winter to maintain flow through the hospital, although the ambition continued to be 100%. She confirmed that patients would not be moved if they were displaying symptoms and each case was assessed on an individual basis. Mr Wakefield thanked Mrs Rhodes for the information provided and suggested that the document be considered on a monthly basis to provide assurance of the measures being taken. **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.**	MR
9.	**Quality Account**	
167/2020	Mrs Rhodes highlighted the following: • The Quality Account had been consulted on with external stakeholders and their comments included • Healthwatch had been unable to obtain comments from all of their members, due to Covid, but had included a statement • The priorities for the year had been aligned with the priorities of the Delivering Exceptional Care Programme • Once approved, the document would be published on the website by 15th December 2020 Mr Wakefield thanked Mrs Rhodes for the document which he felt showed year on year improvements. He queried the statements regarding sepsis improvement and Mrs Rhodes explained that one priority related to screening and another for the provision of antibiotics. Mr Wakefield queried whether additional narrative should be provided for the c difficile measurement and Mrs Rhodes agreed to refer to the change in definitions and associated increase in reported cases. **The Trust Board:** • **Approved the Quality Account 2019/2020 and the new quality priorities for 2020/21 as identified at the Stakeholder Event in September 2020.** • **Recommended the Quality Account for final publication on NHS Choices and UHNM Trust website by 15th December 2020**	MR
ENSURE EFFICIENT USE OF RESOURCES		
10.	**Performance and Finance Committee Assurance Report (24-11-20)**	
168/2020	Mr Akid highlighted the following: • Urgent care performance had been challenged due to the impact of Covid as well as ambulance handovers • Assurance was provided on workforce planning for the Christmas period • The Committee requested additional information in relation to capital expenditure	

	• Benchmarking information was to be provided to the next meeting in relation to Covid levels and impact on performance **The Trust Board received and noted the assurance report.**	
ACHIEVE EXCELLENCE IN EMPLOYMENT, EDUCATION, DEVELOPMENT AND RESEARCH		
11.	**Transformation and People Committee Assurance Report (22-11-20)**	
169/2020	Professor Crowe highlighted the following: • The Committee welcomed the staff wellbeing support packages which were being deployed • A positive update had been received on the nursing recruitment plan • There had been continued progress with statutory and mandatory training completion rates • Work was ongoing in relation to staff absences, continuing with the completion of risk assessments for staff and identifying high risk staff as required • Concern was raised regarding pausing of appraisals and the need to ensure wellbeing discussions were continuing to take place • The pause in the Delivering Exceptional Care programme due to Covid was noted, although a number of appointments had been made to the team • Positive updates had been received from Human Resources, in terms of succession planning and talent management **The Trust Board received and noted the assurance report.**	
ACHIEVE NHS CONSTITUTIONAL PATIENT ACCESS TARGETS		
12.	**Integrated Performance Report – Month 7**	
170/2020	<u>Quality</u> Mrs Rhodes highlighted that information on nosocomial cases had been included within the report. Mr Wakefield referred to the increase in reported safety incidents and queried what actions were being taken to ensure continued reporting. Mrs Rhodes stated that this had been reiterated through performance reviews, discussions with Associate Chief Nurses and walkabouts, as well as highlighting the importance of providing feedback on the actions taken as a result of reporting, in order to promote a positive reporting culture. Mrs Rhodes added that the increase in reporting had demonstrated incidents with no or low harm which was positive. She stated that going forwards, the Trust needed to improve upon learning from incidents. Mr Smith referred to the number of c-difficile cases and queried what actions were being taken to reduce the number of cases. Mrs Rhodes stated that all cases were investigated, some of which were related to antibiotic use and respiratory infections and the increases had also been discussed across the Midlands due to the same pattern occurring elsewhere. She summarised that it was felt the increase was due to the case mix of patients, but further information would be available once the deep dives had taken place. Mr Wakefield referred to staffing levels and queried the actions being taken to	

ensure patient safety was maintained and Mrs Rhodes responded that staffing issues were being managed by the Divisions and Corporate Nursing team, with additional assurance provided through matrons who were reviewing staffing on a daily basis, along with daily senior nurse presence on site including at the weekends. She stated that in order to support the staffing levels, staff were being moved around, bank staff were being utilised and agency usage was being considered. In addition, some Clinical Nurse Specialists had been released on a case by case basis, with the main challenge being the support required for critical care. It was noted that staffing support was also being provided by the Local Authority as well as from corporate teams.

Professor Crowe observed the ongoing work with system partners to support the workforce across the organisations and added that the Trust needed to influence wider discussions in regards to this.

Mrs Rhodes added that in relation to quality metrics, there had not been a decline in the metrics, and whilst there had been more complaints, generally the metrics continued to be positive.

Mr Wakefield recognised the input from the local authority and community partners in providing ongoing support and welcomed the improvement in working relationships and improved liaison.

Mr Bytheway referred to his recent visit to the Sodexo helpdesk team and paid thanks to the team and the way in which the working relationship had improved, as well as to those corporate teams who were providing clinical areas with support.

<u>Operational</u>

Mr Bytheway highlighted the following in relation to October's performance:

- Performance had exceeded the trajectory for planned care, which reflected positive performance in terms of recovery and restoration.
- Cancer performance was better than planned
- Diagnostic performance saw a 15% improvement
- In terms of urgent care performance, there had been a reduction in the time spent in ED, and improved time to triage, time to treatment, and time to assessment.
- There had been a reduction in the length of time patients were waiting in ED for specialty input which was positive
- There had been 8, 12 hour breaches at the end of October which was due to the change in beds, based on Covid modelling

Dr Griffin referred to overall system performance and the low number of premium discharges and Mr Bytheway stated that part of the urgent care plan was to reorganise ward based processes to get into a better position. He stated that ward transformation was a key enabler which had not taken place due to Covid.

Professor Hassell queried whether there was an error within the document, in relation to the 4 hour access target on page 39, and Mr Bytheway agreed to correct the inaccurate narrative. PB

Mr Bytheway highlighted that in November, the Trust had maintained good progress with the cancer patient tracking list, although a drop in 62 day performance was expected. It was noted that 2 week wait performance was being maintained as was the processing of patients through the cancer bureau, in

order to deliver cancer performance, with planned recovery in January and February.

Mr Wakefield referred to the trajectory included on page 30 and Mr Bytheway stated that the trajectory had been identified as part of the recovery and restoration plans, and this would not be met due to the impact of the second surge.

Mr Wakefield queried if any modelling had been undertaken in respect of the anticipated impact of extended bubbles over Christmas in order to consider staffing requirements. Mr Bytheway stated that modelling had been provided up to Christmas, and work had commenced in reorganising the bed base and discussing the modelling over Christmas based on numbers from the last couple of weeks. Dr Oxtoby added that modelling was difficult as the Trust was coming out of wave 2 whilst anticipating wave 3.

Mr Wakefield referred to outpatient performance and the percentage of patients in outpatients who had been seen by video, as opposed to face to face. Mr Bytheway subsequently confirmed that non face to face activity within outpatients was approximately 38% of the total amount.

Workforce

Mrs Vaughan highlighted the following in relation to workforce performance:

- There had been an increase in sickness absence due to Covid during October and November
- The in-month absence rate was 4.76% which was impacting on the 12 month cumulative figure
- As of that day, there had been a decrease in Covid related absences, and this had reduced to 52% as opposed to 61% for October
- Risk assessments for high risk staff were being revisited and the need to continue to hold wellbeing conversations with staff had been reiterated to line managers
- Due to the agreed pause for appraisals, compliance stood at 76.81%
- Statutory and mandatory training performance was at 94.2% which was a positive increase and despite pressures, staff continued to be encouraged to undertake their training

Mr Wakefield referred to staff wellbeing and welcomed the initiatives put in place. He stated that the work on sickness absence had been a challenge and queried if the Trust was aware of how many staff were away from work, as a result of the NHS Test and Trace app notifying them. Mrs Vaughan referred to the work which had been completed to identify the numbers, although it was difficult to identify whether the staff had been notified by the app or via the official Test and Trace phone line. She stated that recent information regarding the number of staff self-isolating was 186, with 50 staff shielding.

Mr Akid queried whether a plan was in place to vaccinate staff who were shielding and Mrs Vaughan stated that staff who had a Risk Assessment identifying them as high risk 'category C' were being prioritised first for the vaccine.

Finance

Mr Oldham highlighted the following in relation to financial performance:

- In month the Trust had a £0.8 m deficit, and when compared with the forecast

	position was £0.9 m better than forecast • The position had been driven by the income allocation and funding for growth as well as some slippage on investments. A forecast of £14.6 m deficit had been submitted • The pay run rate excluding additional Covid costs and impact of salary awards, remained flat with no underlying issue • Non pay had been difficult to measure due to differences in activity but was underspent • In terms of the elective incentive scheme, the Trust should have a penalty of £1.1M in month and a cumulative exposure of £2.1M but the Trust had been asked to include it as narrative rather than within the numbers and it was expected that the scheme would be amended in the future Mr Wakefield referred the planned deficit due to the TSA funding and Mr Oldham confirmed that the funding would be provided by the Department of Health and Social Care and CCG therefore this issue had been resolved. It was noted that the regional and national team had confirmed their support for the technical issue impacting on MPFT and therefore as a system it was expected that collectively we would achieve break-even for 2020/21 which was very positive. Mr Smith referred to page 59, and the differences in the forecast variance position and Mr Oldham explained that due to the complexity of this year's developing guidance we are measuring performance against 3 targets (Original budget at break even, the agreed plan with NHSI £7.2M and the forecast after remaining TSA income of £2.2M. The discrepancy related to the original budget which had been set pre-Covid and the forecast which had been submitted later in the year and is what the Trust was monitored against. Mr Oldham highlighted that the Trust was behind on capital and there had been some slippage, with mitigation being put in place. It was noted that updates would continue to be provided to the Performance and Finance Committee regarding this as well as identifying the emerging risks. Mr Oldham confirmed that the negative variance associated with the cash position was due to delay in receipt of the month 6 top up. This is expected in December and will bring cash back in line with plan. Mr Oldham also briefed that whilstit was not clear when the advanced payment made earlier in the year would be taken back, it was not expected to cause an issue for year end. **The Trust Board received and noted the report.**	
13.	**Winter Campaign Plan 2020/21 – Communications**	
171/2020	Mrs Thomson highlighted the following: • The campaign had been developed in conjunction with system partners, building on the success of the previous year's campaign • Feedback received to date was that the campaign positively impacted on the reduction in the profile of attendances to A&E • The campaign had been presented regionally and nationally with the team commended for the work undertaken Mr Wakefield welcomed the campaign and felt it was one of the best approaches taken. He referred to the modest sums being spent to reach more people, and queried if there was sufficient funding in place. Mrs Thomson stated that money was not a constraint, although finances were carefully considered in order to	

	make the best use of the money available. Mr Smith queried if the campaign had gone live and Mrs Thomson stated that the campaign was being implemented and continued to be developed and built upon, taking feedback into account. Mr Smith suggested that some of the wording could be made more user friendly and agreed to link in with Mrs Thomson regarding this. **The Board noted the winter communications strategy and noted that it had been based on previous campaigns with input from clinical teams and the wider system.**	**IS/LT**
GOVERNANCE		
14.	**Covid Terms of Reference**	
172/2020	Miss Rylands highlighted the following: • Following discussion at the previous meeting, the terms of reference had been circulated to Board members for comments, in addition to taking any learning from the first wave into account • The document had been expanded to include Executive Groups Mr Wakefield referred to page 2 and the reference to staff engagement sessions and the aim of undertaking these via technology. Mr Wakefield referred to the difficulties in meeting clinical staff due to their working patterns and commitments. Miss Rylands added that as the situation evolved and the document would be reviewed and amended as required. **The Trust Board approved the revised Terms of Reference.**	
15.	**EPRR Annual Assurance Report**	
173/2020	Mr Bytheway highlighted the following: • Due to Covid, the requirements had changed and three areas needed to be met • The progress made against the 2 outstanding areas from the previous year had been outlined • Learning from Covid had been identified as a system and enacted as part of the winter plan • The winter plan for UHNM and the system had been noted by NHSIE as part of the review processes in place • The assessment remained outstanding, and it was not clear when the CCG would undertake this Mr Wakefield referred to the plan for system partners to cover the acute bed deficit as part of surge planning and queried if this was still the case. Mr Bytheway stated that the number of Medically Fit for Discharge patients and the number of discharges were stable, with no challenges associated with the bed deficit. Mr Wakefield referred to the assumptions on influenza, and the low number of cases compared to previous years and queried whether the assumptions remained valid. Mr Bytheway stated that there had been fewer flu cases to date and the plan assumed 60 beds, therefore the numbers were less than this.	

	Mr Wakefield referred to the assumptions which were based on the peak in April 2020 and queried how the second surge impacted on planning. Mr Bytheway stated that the main issue related to not factoring in the number of restricted beds and the decrease in bed availability which was a lesson to be learned going forwards. Mr Wakefield queried if the Trust was confident it could cope in January given the current challenges and the anticipated third surge and Mr Bytheway stated that the main challenge was critical care, levels of ED attendances and theatre recovery. Mrs Rhodes added that staffing would also be an issue. **The Trust Board noted the report.**	
16.	**Calendar of Business 2021/22**	
174/2020	Miss Rylands highlighted that the calendar of business detailing the schedule of Executive Groups, Committees and Board meetings for 2021/22 had been brought to the Board for approval. **The Trust Board approved the calendar of business.**	
CLOSING MATTERS		
17.	**Review of Meeting Effectiveness and Business Cycle Forward Look**	
175/2020	Nothing further was raised. It was agreed that the Infection Prevention BAF would be brought to the Board on a monthly basis.	
18.	**Questions from the Public**	
176/2020	There were no questions raised prior to the meeting.	
DATE AND TIME OF NEXT MEETING		
19.	Wednesday 6th January 2021, 9.30 am, via MS Teams	

Trust Board (Open)

Post meeting action log as at **31 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/444	05/10/2020	Patient Story - October	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	16/12/2020	Update provided at December's QGC.	B
PTB/448	04/11/2020	Patient Story - November	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	17/12/2020	Facetime calls are back up and running for all inpatients.	B
PTB/451	09/12/2020	Patient Story - December	To provide an update of the actions taken in response to the story, to a future Quality Governance Committee.	Michelle Rhodes	24/02/2021		Update will be provided at February's QGC.	GB
PTB/452	09/12/2020	Quality Governance Committee Assurance Report	To provide additional information and analysis of patient deaths attributed to Covid, including outcome of SJRs, comparisons between surges and analysis of pre-defined risk factors.	John Oxtoby	20/01/2021		Action not yet due.	GB
PTB/453	09/12/2020	Infection Prevention Board Assurance Framework (BAF) & Update following NHS England and NHS Improvement Visit	To confirm whether the action in relation to discussion of nosocomial infections at November's antimicrobial group had taken place	Michelle Rhodes	06/01/2021		To confirm at January's meeting.	GA
PTB/454	09/12/2020	Quality Account	To include additional narrative regarding c difficile and the change in definitions resulting in an increase in reported cases.	Michelle Rhodes	15/12/2020	15/12/2020	Quality Account finalised and published.	B
PTB/455	09/12/2020	Integrated Performance Report - Month 7	To amend the error within the narrative, in relation to the 4 hour access target on page 39.	Paul Bytheway	06/01/2021	16/12/2020	The narrative has been amended within the report and more context within the narrative will be included in the IPR reports going forward.	B
PTB/456	09/12/2020	Winter Communications Campaign	To link in with Mr Smith regarding making some of the wording more user friendly.	Lisa Thomson	06/01/2021	30/12/2020	Work undertaken with GP and systems communications colleagues and their patient network groups. Animations and materials developed and longer films and posters which the system is using to push the messages of where to go to get the care needed this winter. Details emailed to Mr Smith 30-12-20.	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 did not meet during December 2020.

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 November to 10th December, 2 contract awards, which met this criteria, were made, as follows:

- **Endoscopy Diagnostics Services (REAF 3976)** supplied by 18 Week Support (NHS) at a total cost of £553,325.20, for the period 19/10/20 – 28/03/21, approved on 25/11/2020
- **Outsourcing of Radiology Reporting (REAF 3907)** supplied by Medica Reporting at a total cost of £840,000.00, for the period 01/05/20 – 31/03/21, approved on 07/12/2020

In addition, the following REAF was approved by the Performance and Finance (PAF) Committee in December, and requires Board approval due to its value:

COVID19: Supply of Multiplex PCR reagents for detection of SARS CoV2/Influenza/RSV (REAF 4028)

Contract Value	£21,945,924.00 incl. VAT
Duration	01/01/21 – 31/12/22
Supplier	Prolab Diagnostics

The Trust Board are asked to approve the above REAF.

2. Consultant Appointments

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

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Locum Consultant - General Paediatrician	Vacancy	TBC	TBC
Clinical Director Obstetrics & Gynaecology	Vacancy	Yes	01/01/2021
Clinical Director of Paediatrics	Vacancy	Yes	04/01/2021
Clinical Lead - Quality Improvement x 2	New	Yes	01/03/2021
Midlands ISDN Co-Clinical Lead (Acute)	New	Yes	01/04/2021

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

Post Title	Reason for advertising	Start Date
Divisional Chair CWD x 2	Vacancy	01/12/2020
Locum Consultant Vascular Interventional Radiologist with	Extension	02/12/2020

Post Title	Reason for advertising	Start Date
Thrombectomy		
Consultant Clinical Oncologist - Upper GI, CNS & Thyroid	Vacancy	05/12/2020
Locum Consultant Thoracic Surgeon	Extension	16/12/2020
Locum Consultant - General Paediatrician	Extension	16/12/2020
Consultant Diagnostic Neuroradiologist	Vacancy	21/12/2020

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

Post Title	Closing Date	Note
n/a		

3. Covid-19

As highlighted at the last Trust Board meeting, the Trust commenced Covid vaccinations on 9th December 2020. As at the close of 30th December 2020, due to a monumental effort by a significant number of staff, the Trust has given 5,051 vaccinations, which is a tremendous achievement. The people vaccinated include the two national priorities; over 80 year olds and Care Home staff along with Midlands Partnership Trust, North Staffs Combined, West Midlands Ambulance, Sodexo and E-zec staff.

We have continued to face significant pressures across both of our hospitals, in order to treat the numbers of patients arriving in our Emergency Departments, alongside continuing with our urgent elective work, and the large numbers of Covid-19 positive patients in our hospital beds. Although sickness rates are reducing, they remain higher than pre-covid levels due to Covid-19.

We have continued to work closely with our partners to manage these pressures across the system, and I am very grateful to all of our staff who are helping us through this with their hard work, dedication and endless commitment.

4. Independent Review of National HR and OD practices

A Chief Executive Advisory Group has been set up to oversee the Independent Review nationally of HR and OD, and I am delighted to have been invited to be part of the national review, which is being led by Prerana Issar, NHS Chief People Officer.

The review is a key element of the People Plan and is fundamental to how people practices are transformed over the next 10 years. A tripartite partnership of Lancaster University, Chartered Institute of Personnel and Development and EY has been appointed, in order to take the review forward, alongside the team from NHSEI.

5. Local Students Declared 'World Changers' for UHNM's #keepstokesmiling campaign

Board will recall a presentation from one of our Orthodontists, Karen Juggins on the work she and her team had done in developing the #keepstokesmiling. This was supported by local graphic design students and I was delighted to hear from Karen that this group of local graphic design students have won a national award for their striking adverts which were created for the #keepstokesmiling campaign led by the Trust. Our campaign raised awareness about the importance of dental health and the impact that soft drinks in particular can have on teeth which have been seen by thousands of people in the community.

Students from NSCG Stafford College won 'The Creatives Award' in the World Changer Awards. This is a UK-wide awards initiative from learning company Pearson and the awards sought to find inspiring children and young people across Britain who were sparking positive change in the world beyond the classroom.

6. Christmas Festivities

Although Covid-19 has had a significant impact on the NHS we were determined that Christmas would be celebrated at UHNM, whilst recognising things would look different. Many people went above and beyond and in particular our Communications and Charity team but also our Paediatric Service and IM&T. Just some of the great things we did include:

- Electronic Advent Calendar with Christmas messages from local people and celebrities
- Christmas Tree Light Switch on
- A visit from two of Santa's Reindeers
- An interview with Robbie Williams and his wife with Sharon, a ward sister in the West Building and then Lisa, Director of Communications and Charity. We hope to receive a visit from Robbie once Covid-19 is under control
- Delivery of Mince Pies across all areas of the Trust from Executives
- Best dressed Christmas Tree Competition

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	6th January 2021
Report Title:	Infection Prevention Board Assurance Framework COVID-19 – December 2020 (Updated for Quarter 3)	**Agenda Item:**	7
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.

NHS
University Hospitals of North Midlands
NHS Trust

Infection Prevention and Control Board Assurance Framework

Quarter 3 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	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	6		
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	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	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	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	9		
BAF 7 Page x	Provide or secure adequate isolation facilities.	6	3	6		
BAF 8 Page x	Secure adequate access to laboratory support as appropriate.	6	6	3		
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	6		
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	3		

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

Risk Scoring								
Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	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 4
Consequence:	3	3	3			Consequence:	3	
Risk Level:	9	9	9			Risk Level:	3	

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

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

		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
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	• Key FFP3 mask fit trainers in place in clinical areas • PPE posters and information available on the Trust COVID -19 page. This provides	• Daily stock level of PPE distributed via email and agenda item for discussion at COVID-19 tactical group	• Training completed in areas - records are held locally by clinical areas, these include Divisional

	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.	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	• 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	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 • 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	• Clinical Group meeting action log held by emergency planning	

		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 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	
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	• 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	

	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.			
1.8	Robust IPC risk assessment processes and practices are in place for non Covid-19 infections and pathogens.	• IP questions and answers manual • Section in IP questions and answer manual 2.1 priority of isolation for different infections and organisms • Sepsis pathway in place • Infection Risk assessment in proud to care booklets and admission documentation • C.diff care pathway • IP included in mandatory training • Pre Amms IP Screening • Birmingham paused ribotyping service for C.DIFF due to COVID-19. During periods of increased incidence ribotyping is useful to establish person to person transmission, Leeds Hospital are now undertaking this service • Proud to care booklets revised an reinstated August/September 2020	• MRSA screening compliance • Monthly Sepsis Compliance audits. Screening compliance for sepsis and time to antibiotics for Red flag patients • IP audits • Infection Prevention Health care associated infection report, including submitted to monthly to Quality and Safety. • Submission of Infection figures to Public Health England. Clostridium difficile, MRSA blood stream infections (bacteraemia) and Gram Negative blood stream infections • Seasonal influenza reporting • Audit programme for proud to care booklets	• 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.

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/ ACN's	13/12/2020	Testing and re testing, Interpretation of swabs and step down of IP precaution process in place at UHNM. Patients are 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 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. Further audit required	
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 22/12/2020 to Clinical Group for approval	
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 15th December – update from Health and Safety. Approval given to proceed to Business case	
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	
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	2		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 4
Consequence:	3	3	3			Consequence:	3	
Risk Level:	6	3	6			Risk Level:	3	

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

2.2	Designated cleaning teams with appropriate training in required techniques and use of PPE are assigned to Covid-19 isolation or cohort areas.	• SOP and cleaning method statements for domestic teams/Sodexo • PPE education for Domestic /Sodexo staff • Initial meetings held with facilities/estates to discuss and plan COVID-19 requirements IP agenda item • Representatives from the division are attending the daily tactical meetings, and an E,F & PFI daily meeting is taking place which includes our partners	• Spot check assurance audits completed by Sodexo and retained during COVID period • Cleanliness complaints or concerns • PPE and FFP3 mask fit training records with are held by Sodexo /retained services • Key trainers record • Notes from facilities/estates meeting	
2.3	Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance.	• SOP for terminal and barrier cleans in place • High level disinfectant , Virusolve and Tristel in place	• C4C audits reinstated July 2020 these results are fed into IPCC • 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	• NHSI visit highlighted cleaning issues both environment and nursing equipment • Environmental damage highlighted during NHSI visit - peeling edges of floor
2.5	Attention to the cleaning of toilets / bathrooms, as Covid-19 has frequently been found to contaminate surface in these areas.	• Cleaning schedules in place • Barrier cleans (increased cleaning) process in place which includes touch points		

2.6	Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution 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	

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 reduction in risk of infection	• Estates have planned programme of maintenance • The Authorising Engineer Ventilation will provide external independent specialist advice and support as well as carrying out an annual audit for	

		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.	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 2020	
2	2.4	To address cleaning issues and environmental damage highlighted at NHSI visit	Head of CPM Estates, Facilities & PFI Division	14/12/2020	Feedback from NHSI provided to Sodexo and action plan devised Action Plan Following NHS England NHS Im	
3	2.4	To address dirty nursing equipment and commodes, plus computer on wheels	ACN'S / IP/ Deputy Head of IM&T	30/12/2020	Dirty nursing equipment and commodes found during NHSI Visit. These were address at time. Action for IM&T re computer. Terminal clean check list to be revisited to set out roles and responsibilities for cleaning	

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	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 4
Consequence:	3	3	3			Consequence:	3	
Risk Level:	9	9	9			Risk Level:	3	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
3.1	Arrangements around antimicrobial stewardship are maintained.	• Regular, planned Antimicrobial stewardship (AMS) ward rounds • Trust antimicrobial guidelines available 24/7 via intranet and mobile device App • Clostridium *difficile* Period of increased incidence and outbreaks are reviewed by member of AMS team and actions generated cascaded to ward teams • Regional and National networking to ensure AMS activities are optimal • AMS CQUIN further mandates key AMS principles to be adhered to • Monthly review of antimicrobial consumption undertaken by AMS	• 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.	• 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.

		team.	• Wards showing deviation from targets are followed up by targeted AMS team ward reviews 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	1		There is a substantial amount of information available to provide to patients this requires continuous update as national guidelines change	Likelihood:	1	End of Quarter 3
Consequence:	3	3	3			Consequence:	3	
Risk Level:	6	6	3			Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
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	• Monitored by clinical areas • PALS complaints/feedback from service users	

		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 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	• Transfer policy C24 in place , expires November 2020	• Datix process	

	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.	• IP COVID step down process in place		

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.	
2.						
3.						
4.						

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	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	3			Consequence:	3	
Risk Level:	9	3	3			Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
5.1	Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed Covid-19 symptoms and to segregate them from non Covid-19 cases to minimise the risk of cross-infection as per national guidance.	• 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	• Hospital entrances Mask dispensers and hand gel available	

		• ED navigator provide masks to individual in ED • Mask stations at hospital entrances • Covid-19 bulletin dated 12th June 2020 • 28th August updated guidance from PHE recommends in patients to also wear surgical masks if tolerated and does not compromise care		
5.3	Ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff. 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 • Contacting patients who have been discharged from	• If patient found to be positive in the bay and exposing other patient. IP liaise with clinical are, apply bay restrictions. • Patient who tested negative on admission and remain an	

		hospital then later found to be a close contact of a COVID-19 positive case , patient to be informed by the clinical area	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	
4.						

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	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 Q4
Consequence:	3	3	3			Consequence:	3	
Risk Level:	9	9	9			Risk Level:	3	

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

		powered hoods • PPE posters are available in the COVID -19 section of trust intranet page		
6.3	A record of staff training is maintained.	Mask fit strategy in place	• 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	

	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. December 2020 Health and Safety have agreement to proceed to Business case	
2.		Spot audits of PPE on wards and Departments	IP & H&S	Ongoing	Audits are required on a weekly basis	
3.						
4.						

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	2		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 4
Consequence:	3	3	3			Consequence:	3	
Risk Level:	6	3	6			Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
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	Covid numbers continue to rise Capacity review on a daily basis
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	• Infection Prevention	• RCA process for Clostridium	

	according to local IPC guidance, including ensuring appropriate patient placement.	Questions and Answers Manual includes alert organisms/resistant organism • Support to Clinical areas via Infection Prevention triage desk • Site team processes	*difficile* • 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	
2.	7.1	Strict adherence to policy re patient isolation and cohorting	Site teams/ward teams	Daily process	RCAs to be completed on any inappropriate patient moves	
3.						
4.						

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	1		Laboratory services for UHNM are located in the purpose built Pathology Laboratory on-site at RSUH. The Laboratory is United Kingdom Accreditation Service (UKAS) accredited. Work 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	3			Consequence:	3	
Risk Level:	6	6	3			Risk Level:	3	

Control and Assurance Framework				
	Key Lines of Enquiry (KLOE)	Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
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	• 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	• Empactis reporting • Team Prevent systems • Datix/adverse incidence reporting • Cluster /outbreak investigation procedures	

	for NHS patient facing staff is implemented. Whilst lateral flow technology is the main mechanism for staff testing, this can continue to be used alongside PCR and LAMP testing. 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 within 3 days before admission and	endoscopy • 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		

	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 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.	
3.						
4.						

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	2		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	Q4
Consequence:	3	3	3			Consequence:	3	
Risk Level:	6	3	6			Risk Level:	3	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
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	• NHSI visit highlighted a number of staff none compliant to wearing of masks , and Doctor non compliant with Bare below the elbow
9.2	Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff.	• Notifications from NHS to Chief nurse/CEO • IP team COVID lead checks Public Health England webpage daily (Monday-Friday) for updates • Changes raised at COVID clinical group which is held twice weekly • Daily tactical group • Incident control room established where changes are reported through • Chief nurse updates	• Clinical Group meeting action log held by emergency planning	

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

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)						
No.	KLOE	Action Required	Lead	Due Date	Quarter 2 Progress Report	BRAG
1.	9.1	CEF Audits to recommence	Deputy Director of Quality and Safety	30/09/2020	Review of tool kit with Chief Nurse planned, aiming to trial during August and reinstate audits fully during September 2020. CEF audits reinstated.	
2.	9.1	Proud to care booklet audits paused. Plan for recommencing	Deputy Director of Quality and Safety	30/9/2020	Original proud to care booklets reinstated	
3.	9.1	Compliance with correct mask wearing and Doctors complaint with Bare Below the Elbow	Deputy DICP/Medical Director/ ACN's	31/12/2020	 Action Plan Following NHS England NHS Im Action plan devised	
4.						

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	1		There are clear control in place for management of occupational needs of staff through team prevent to date	Likelihood:	1	End of Quarter 3
Consequence:	3	3	3			Consequence:	3	
Risk Level:	6	6	3		Adhere to social distancing gaps in adherence	Risk Level:	3	

Control and Assurance Framework				
Key Lines of Enquiry (KLOE)		Controls in Place	Assurance on Controls (Source, Timeframe and Outcome)	Gaps in Control or Assurance
Systems and processes are in place to ensure:				
10.1	Staff in 'at risk' groups are identified and managed appropriately, including ensuring their physical and psychological wellbeing is supported.	• All managers carry our risk assessment • Process available on the COVID 19 Trust intranet page • BAME risk assessment • Young persons risk assessment • Pregnant workers risk assessment • Risk assessment to identify vulnerable workers	• Risk assessment and temporary risk mitigation will be reported to the workforce bureau. To protect confidentiality individual risk assessments will not be requested as these should be kept in the employees personal file • Managers required to complete , review and update risk assessments for vulnerable persons	

10.2	Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained.	• SOP for reusable face masks and respiratory hoods in place	• Training records for reusable masks	• Availability of locally held training records. • Lack of central holding of FFP3 records
10.3	Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the crossover of care pathways between planned and elective 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 staff who are self-isolating are supported and	• Team Prevent available to offer guidance and treatment to staff	• Team prevent monitoring process	

	able to access testing.	presenting with onset of symptoms.	• 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 . December 2020 Health and Safety are to proceed with Business case	

2.						
3.						
4.						

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:**	6th January 2021
Report Title:	Patient Safety Incident Update (December 2020)	**Agenda Item:**	7
Author:	Jamie Maxwell, Quality, Safety & Compliance Department		
Executive Lead:	Mrs Michelle Rhodes, Chief Nurse/ Dr John Oxtoby, Medical Director		

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 report provides overview summary of the patient safety related issues during the Christmas period.

Background
Monthly QPR provides monthly trends and themes for key quality indicators. These indicators include patient safety incidents, patient falls, medication incidents, pressure ulcers and hospital associated infections. This summary provides highlight of incidents reported during Christmas period and highlights issues/themes from the reported incidents.

Assessment
During 23rd and 30th December there were 374 reported incidents and 86.9% related to patients. The main reason for reporting incidents remains pressure ulcers but majority (71%) are identified on admission.
Falls second highest category and 59 / 61 are low or no harm. 2 moderate or above incidents and 1 logged as SI.

No identifiable themes over the Christmas period. Reporting of incidents continued and the profile of the reported incidents similar to previous months during COVID-19 pandemic.
Further analysis and comparison with longer term monthly trends and themes to be undertaken

Key Recommendations:

The Board are requested to:
- Note the highlights/themes identified
- Consistent reporting levels/profiles
- Further analysis will be included as part of established quality governance structures when full month data available.

Highlights / Themes:

During the Christmas period (23rd December to 30th December 2020) there were 374 total adverse incidents reported via Datix.

Table 1: Type of reported Incidents

Incident Type	Total Number	% of total
Patient	325	86.9%
Staff	37	9.9%
Trust / Other	12	3.2%

Top reported category of Incidents is Tissue Viability, followed by Patient Falls and then Medication. Patient Flow is fourth largest category. These category profiles are similar to the monthly reporting and Christmas period demonstrates consistent reporting on currently available data/information.

Table 2: Incident Category over Christmas 2020

Incident Category	Total	% of total
Tissue Viability (Pressure Ulcers)	150	40.2%
Falls (Patient)	61	16.4%
Medication	21	5.6%
Patient Flow (Access, admission, transfer, discharge)	21	5.6%
Accident / Incident that has resulted in or could have resulted in personal injury	14	3.8%
Abusive, violent, disruptive or self-harming behaviour	13	3.5%
Infection Prevention	11	2.9%
Maternity Triggers	11	2.9%
Documentation (including electronic & paper records, identification and charts)	9	2.4%
Implementation of care and ongoing monitoring / review	9	2.4%
Service Disruptions (beds, environment, infrastructure)	7	1.9%
Treatment, procedure	7	1.9%
Absconsion / Missing Patient	5	1.3%
Communication Failure, Consent, Confidentiality	5	1.3%
Security	5	1.3%
Clinical assessment (including diagnosis, images and lab tests)	4	1.1%
Safeguarding/Protection	4	1.1%
Staffing	3	0.8%
Medical Device/equipment	3	0.8%
Mortuary and Care after death	3	0.8%
Blood Transfusion	2	0.5%
Venous Thromboembolism	2	0.5%
Dislodgement of invasive device	1	0.3%
Abusive, violent, disruptive or self-harming behaviour	1	0.3%
Nutrition Food/Meals from Kitchen	1	0.3%

Tissue Viability

Of the 150 Pressure Ulcers reported, 105 (71.3%) were not hospital acquired and identified on admission to UHNM.
27 Hospital acquired – 6 Device related, 18 HA Pressure Ulcer, 3 Hospital acquired Moisture Damage
18 Non Pressure Damage – this is skin damage not caused by pressure.
Critical Care have reported 5 hospital acquired Pressure Ulcers and 3 of these were device related to ET tubes and tape which was required for treatment of the patients who had been treated in prone position and required ongoing prone treatment.

ARTU reported 3 Pressure Ulcer incidents – 2 incidents for 1 patient reporting superficial skin damage due to friction and 1 incident of DTI behind the patient's splint on thigh

Table 3: Top 30 areas reporting Incidents

	Incidents affecting PATIENTS	Incidents affecting the STAFF	Incidents affecting the TRUST or OTHER PARTY	Total
(Royal Stoke) Emergency Department	35	0	1	36
(Royal Stoke) B Bay	30	0	0	30
(County) Emergency Department	27	1	0	28
Ward 230 (AMU)	20	3	0	23
(Royal Stoke) Resus Area	12	0	0	12
Ward 231 (AMU)	10	2	0	12
Acute Rehabilitation Trauma Unit (ARTU W227)	8	0	1	9
(Royal Stoke) Ambulance Triage	6	1	0	7
Ward 126 (Respiratory)	7	0	0	7
(County) Ward 12 - Respiratory	6	0	0	6
Delivery Suite	6	0	0	6
Ward 223 - Cardiothoracic Surgery	6	0	0	6
(County) AMU	3	2	0	5
(County) Ward 1 - Escalation Ward	5	0	0	5
(County) Ward 14	5	0	0	5
(County) Ward 15 - Elderly Care	5	0	0	5
(Royal Stoke) SAU General Surgery	4	1	0	5
(Royal Stoke) Ward 226 - General Trauma	3	2	0	5
Theatres 20,21,22,23,24, and 33	3	1	1	5
Ward 228 - Neurosurgery	5	0	0	5
(Royal Stoke) In the Community (Midwifery)	4	0	0	4
(Royal Stoke) Ward 225 - Fractured NoF	4	0	0	4
FEAU (W232)	4	0	0	4
Midwife Birth Centre	4	0	0	4
Ward 108 - Female Upper and Lower GI and Gynaecology	4	0	0	4
Ward 117 - Infectious Diseases	3	1	0	4
Ward 123 - (Diabetes/Endocrinology)	2	2	0	4
Ward 127 (Acute Stroke Unit)	3	1	0	4
Ward 218 - Neurology	4	0	0	4
Ward 233 Short Stay Unit	4	0	0	4

Top areas reporting incidents relate to A&E Depts and this to be expected as have highest activity. Majority of these incidents relate to pressure ulcer on admission (Not hospital acquired)

Medication Incidents

27 total incidents – 4 administration / 4 dispensing / 3 delivery processes / 5 prescribing / 1 procurement / 6 storage
None of the incidents have identified serious harms. All were reported low harm or no harm.
5 prescribing – 3 on AMU, 1 ward 100 (Gastro) and 1 B Bay and no harm reported
AMU reported 4 incidents and highest reporter of medication incidents
2 incidents reported in COVID vaccination centre – 1 whilst mixing vaccine not inverted before adding sodium chloride, other incident was needlestick injury to vaccinator

Falls

December falls similar rates to November.
61 falls reported – 1 moderate harm and 1 severe harm. Remainder were low harm or no harm.
Moderate harm – Ward 12 (County) on 29/12/2020 – under review for injury and SI reportable.
Severe Harm – Ward 233 (Short Stay Unit) on 23/12/2020 and logged as SI (2020/24795)

Covid-19 infection prevention measures mean that patients are less visible due to being isolated in side rooms and in isolations bays with the doors closed.
High levels of sickness across the organisation during this period continues to impact on the ability to observe cohort bays and provide 1:1 care to patients when the need is identified.
Several areas are using the major incident documentation which has a limited falls risk assessment and does not prompt staff to identify preventative actions.

Further Deep Dive report is being updated to include December data following presentation at QSOG on 14th December 2020

Patient Flow

	Total
Transfer - delay / failure / inappropriate	6
Access / admission - unexpected readmission / reattendance	5
Handover of care	4
Discharge - delay / failure	3
Access / admission - unplanned admission / transfer to specialist care unit	1
Discharge - planning failure	1
Failure to follow up missed appointment	1
Transport - delay / failure	1
Total	22

No identifiable themes.
ED areas reported highest number of patient flow related incidents with 5 incident (4 at RSUH and 1 County)

Staffing Incidents

3 incidents reported relating to Staffing
Surgical Special Care Unit – lack of trained nursing staff (25/12/2020)
AMRA (Ward 233) – no doctor available due to sickness. Consultant and 1 SHO only (27/12/2020)
Coronary Care Unit – only 2 qualfied nurses and 2 NCAs for 12 patients with high acuity (28/12/2020)

Infection Prevention

Prior to Christmas period there were 4 ward areas identified under COVID-19 outbreak restrictions and these have remained in place during Christmas. There have been no further wards added during Christmas. The 4 wards are:

- Ward 127
- Ward 225
- Ward 100/101
- Ward 81

12 total incidents reported.
4 Infection Diagnosis – not COVID related
3 in relation to isolation processes – 1 incident on AMU (Ward 230) on 25/12/2020 identified as being exposed to COVID patients in same bay as no handover received from AMU to ward 121.

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board	Date:	6th January 2021
Report Title:	Sickness Absence Update	Agenda Item:	9
Author:	Claire Soper, Head of HR Governance and Workforce Information		
Executive Lead:	Ro Vaughan, Director of Human Resources		

Purpose of Report:

Assurance	✓	Approval		Information	

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

Executive Summary:

Situation - Since the 21st October, absence episodes have increased in line with the second covid wave and, as of 21st December, covid-related open absences numbered 485, which was 50% of all absences (61% at 11th November 2020)

Background – The Trust's People Strategy is supported by an HR Delivery Plan, with improvement activities cascaded via Divisional People Plans. The strategic focus of our People Plan remains on supporting recruitment, workforce deployment, staff wellbeing, absence management and staff testing.

Assessment – There are controls in place to record and manage staff absence.

- Risk assessments are now well-established which identify high risk staff to enable mitigation plans to be put in place and to ensure these staff are prioritised for vaccination.
- Lateral flow and staff testing processes are also well-established, helping to reduce outbreaks amongst staff
- Area-specific business continuity plans detail the processes that will be put in place within the operational settings of each Division to manage a disruption of service delivery as a result of staff shortages and these are supplemented by the *Disruptive Incident Staffing Plan and Operational Workforce Plan*.
- Internal redeployment and volunteer process are place to offer support to areas of need and partnership working with the STP continues with system-wide processes for mutual aid and redeployment of staff where possible.

Trust Board is asked to note that:

- Monitoring of sickness absence takes place on a daily basis, with redeployment and system-wide mechanisms in place to support areas where staff absence levels hit levels which trigger business continuity plans
- Covid related absences and staff testing remains an area of focus, with additional resources being applied to manage staff testing
- Lateral-Flow asymptomatic testing of frontline staff for Covid-19 has been rolled out to strengthen efforts to prevent and control the spread of infection, with home self-testing kits rolled out to staff who are in direct contact with patients.
- The covid-19 risk assessments have been reviewed and updated.
- The vaccination programme has commenced.

Sickness Absence Update

16 December 2020

1. Introduction

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

The Workforce Bureau has been stepped back up with a focus on risk assessments, staff wellbeing, staff testing and staff deployment, and now includes supporting the vaccination programme.

Since the 21st October, absence episodes have increased in line with the second covid wave. Absence episodes increased significantly during November with the second covid wave and have been reducing since 1st December which may be a result of the rollout of the lateral flow tests. As of 21st December, covid-related open absences numbered 485, which was 50% of all absences (61% at 11th November 2020)

The daily sickness sitrep highlights wards and areas with high numbers of staff calling in as absent, which then triggers mitigating actions set out in business continuity plans. HR Business Partners are key members of Divisional Tactical / Workforce Cells where staffing, deployment and resourcing remain the top priority. Redeployment processes are place to support areas of need and volunteer placements are offering support. A system-led workforce demand and supply process is in place to manage redeployment of staff where required.

2. Key Controls

- The Trust's People Strategy is supported by an HR Delivery Plan, with improvement activities cascaded via Divisional People Plans.
- With the release of the NHS People Plan in July 2020, the Trust's People Strategy and supporting HR Delivery Plan have been reviewed and updated to ensure alignment of objectives.
- Phase one of the Empactis System implementation was completed from 1st October 2020. The Empactis System records all absences, including bereavement, carer leave etc. This is because the Trust needs to know who is off, for whatever reason, at that point in time for planning purpose. Testing of the Empactis and Allocate absence interface is underway to enhance the rostering information
- The *COVID-19 Staff Shortage Contingency Arrangements*, a sub-plan to the Trust's Business Continuity Plan, is in place. This specific Business Continuity plan details the processes that will be put in place within the operational settings of each Division to manage a disruption of service delivery as a result of staff shortages and is supplemented by the *Disruptive Incident Staffing Plan and Operational Workforce Plan*. The plan has been noted as a specific source of assurance on the Board Assurance Framework
- Partnership working with the STP continues and system-wide processes are agreed for mutual aid and redeployment of staff to areas of need.
- The Annual NHS Staff Survey and periodic pulse checks, along with staff forums and focus groups, test staff engagement and experience. Actions to improve staff experience are detailed in Divisional Staff Engagement Plans. The Annual NHS Staff Survey for 2020 has closed and the results will be available in February/March 2021

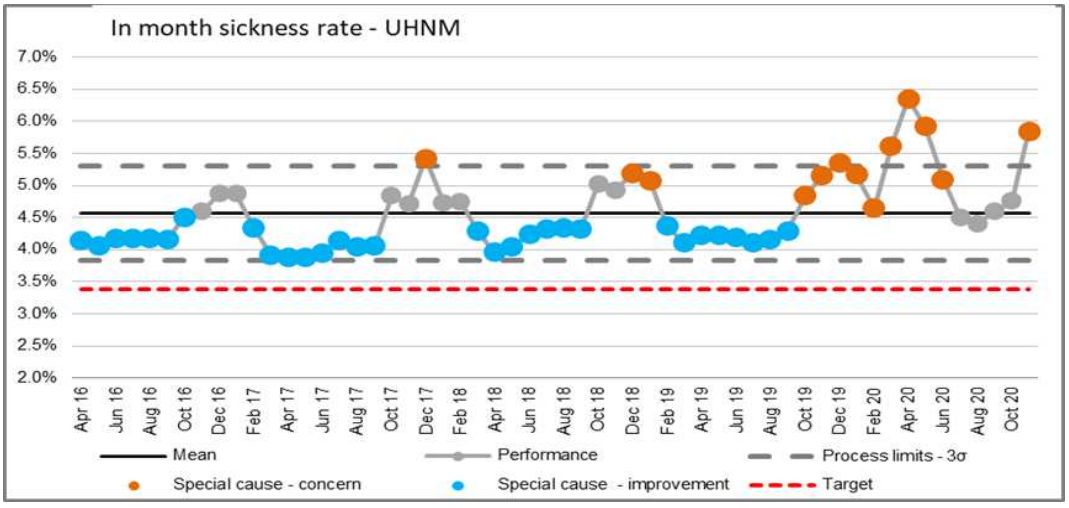
3. Workforce Planning and staff absence

Plans and assurances regarding workforce capacity include:

- The Workforce Bureau has been stepped back up with a focus on risk assessments, staff wellbeing, staff testing and staff deployment. The covid-19 bulletins have been stepped up to daily communications.
- 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
- Risk assessment processes remain in place, with recent review and update of BAME and Category C risk assessments. As at 17th December 2020, 95% of all risk assessments, and 98% of BAME risk assessments, have been reviewed. A multi-disciplinary health risk assessment group is in place to oversee any changes to the risk assessment process in line with the emerging evidence base on covid / health risks.
- The Empactis system provides managers with health risk assessment reminders. Work with Occupational Health continues to embed risk assessments into the pre-employment health assessment process for new starters.
- The daily sickness sitrep has been developed so that data from Empactis is used to highlight wards and areas with high numbers of staff calling in as absent. This can then trigger the mitigating actions set out in the *COVID-19 Staff Shortage Contingency Arrangements*, and the *Disruptive Incident Staffing Plan and Operational Workforce Plan.* E-rostering systems are also used to identify areas where workforce capacity is a risk.
- A System-led workforce demand and supply process is in place to manage redeployment of staff where required
- Weekly forums are taking place to enable Junior Doctors to raise issues regarding rest, support and wellbeing.
- Internal redeployment processes are in place for Corporate staff to support where necessary. Additional support is provided by volunteers, students and St Johns Ambulance.

4. Sickness Data

As at 30th November 2020, the M8 sickness data was as follows:



The in-month sickness rate for November was 5.85% (4.88% 31/10/20). The 12 month cumulative rate increased to 5.23% (from 5.16%)

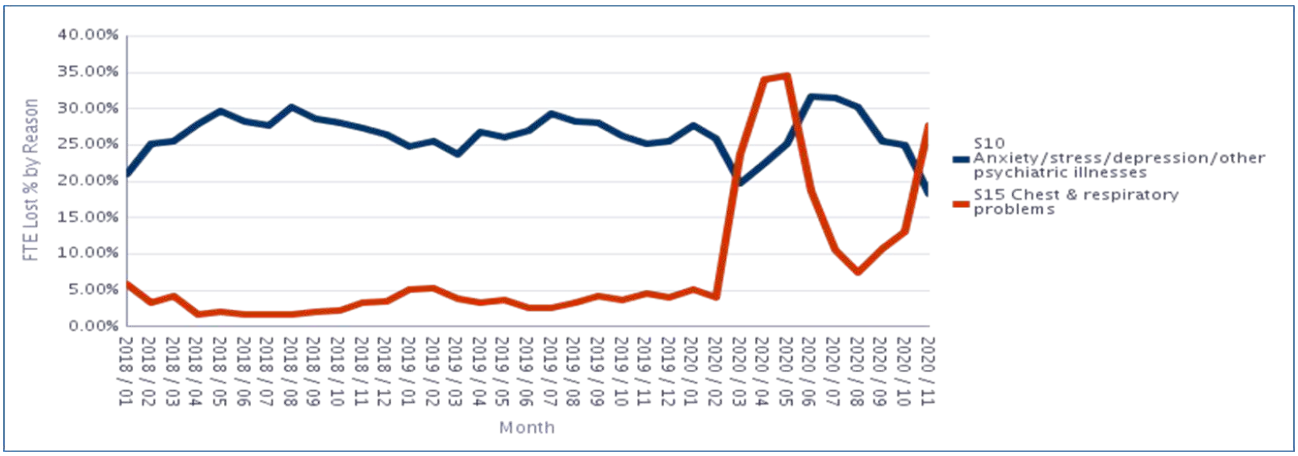
In November, the top three reasons for sickness absence (in-month) were:

Absence Reason	Headcount	Abs Occurrences	Abs Days	%
S15 Chest & respiratory problems	509	525	5,357	27.0
S10 Anxiety/stress/depression/other psychiatric illnesses	215	216	3,752	18.9
S99 Unknown causes / Not specified	328	339	3,225	16.3

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

For the 12 months ending 30th November 2020, 16.7% of sickness absence was due to Chest and Respiratory problems.

While Chest and Respiratory absence has increased since March 2020, Stress-related absence increased initially, and then has reduced since July.

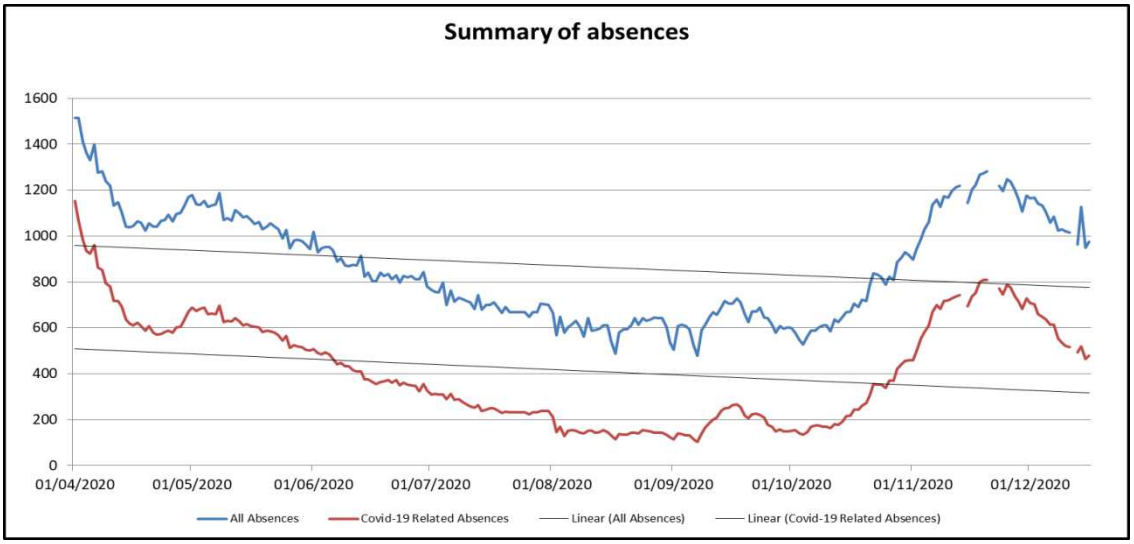


5 Covid-Related Absences

Since the 21st October, absence episodes increased with the second covid wave.

Absence episodes increased significantly during November and have been reducing since 1st December which may be as a result of the rollout of the lateral flow tests.

As of 21st December, covid-related open absences numbered 485, which was 50% of all absences (61% at 11th November 2020)



5.1 Staff Shielding

Self-isolation is essential to reducing the spread of Covid-19 as it breaks the chains of transmission. Shielding re-started with effect from 5th November 2020.

Staff that had not received an updated shielding letter from their GP were advised to contact their line manager and review their health risk assessment.

Work is ongoing in Divisions to identify work that can be given to shielding staff to support them to remain in work, whilst at home.

From 14 December 2020, the number of days that contacts of a positive case are required to self-isolate reduced from 14 days to 10 days.

- People who return from countries which are not on the travel corridor list should also self-isolate for 10 days instead of 14 days.
- People who test positive should continue to self-isolate for 10 days from onset of symptoms or 10 days from point of taking a positive test if asymptomatic.
- The change to the isolation period for contacts will apply to all those who are currently self-isolating including those who commenced self-isolation before 14 December.

It is hoped that these changes will alleviate some staffing pressures by enabling staff to return to work sooner

The numbers of staff shielding and self-isolating as at 18th December 2020 were:

Figures from Empactis as at 18/11/2020

Reason	Open absences
Medical Suspension (<2 weeks - self-isolating)	75
Medical Suspension (>2 weeks – shielding*)	77*
Medical Suspension total	**152**

*does not include shielding employees who are working from home

5.2 Lateral Flow Testing

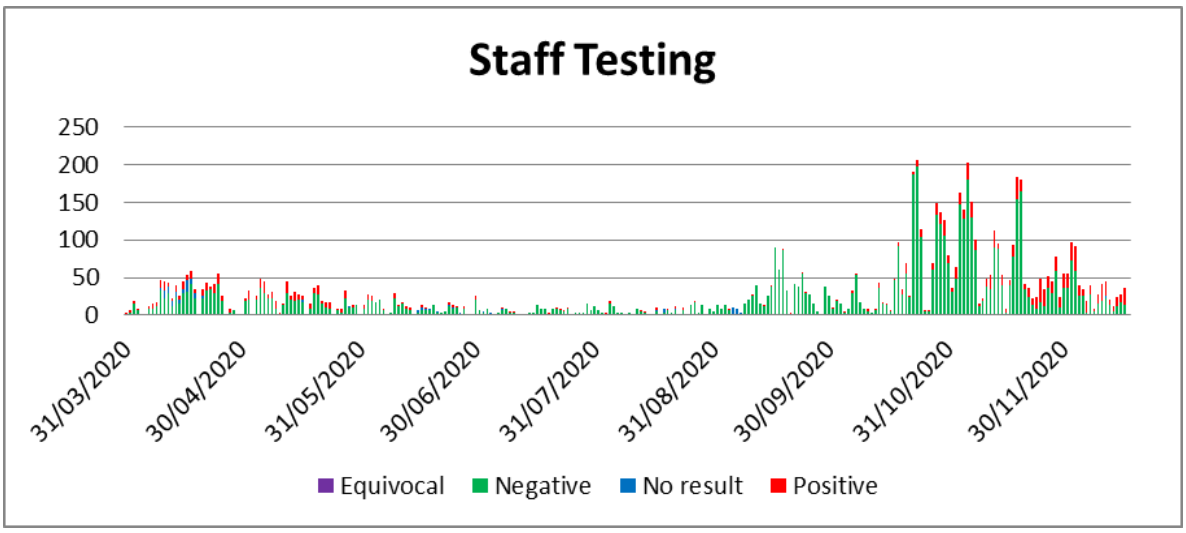
This Trust is one of 34 Trusts to have commenced Lateral-Flow asymptomatic testing of frontline staff for Covid-19 to strengthen our efforts to prevent and control the spread of infection. The programme of asymptomatic testing for Covid-19 commenced on 13th November and is rolled out on a phased approach to frontline staff at both hospitals. The tests require home self-testing kit, which have been rolled out to staff who are in direct contact with patients. The risk to the Trust is that sickness absence will further increase as a result of staff undertaking these self-tests, but the spread of infection to other areas and staff will be limited as the presence of the virus will be detected sooner.

- Over 9000 boxes have been issued to front line staff and around 1.5% are reporting positive. Of the positive lateral flows, these convert to positive PCR in around 90% of cases

5.3 Staff Testing (PCR Test)

Staff testing is offered to household members and staff members. From 31st March 2020 – 18th December 2020 we have carried out 7,417 tests (this does not include staff outbreak screening).

Chart: No of staff/household member tests carried out from 31/03/2020 – 18/12/2020



There have been 11,209 covid related absences up to 18th December 2020. The total absences include some staff absent for covid reasons where it wasn't appropriate to conduct a test, such as absence prior to testing, childcare reasons, covid-related bereavement, family member already tested positive, track and trace or shielding.

The table below summaries the results of these tests:

Equivocal	Negative	No result	Positive	Grand Total
8	5996	137	1276	7417

The demand for staff testing has increased since the last report, in the main due to the second wave. At the beginning of the crisis we were undertaking around 40-50 staff tests per day, 7 days a week. The average tests per day for the last month are 49.

We have seen a small increase in the number of absences as a result Track and Trace. Given the expertise in staff testing, swabbing and admin capacity can be stepped up to meet the fluctuations in demand. The HR Operations Team oversee the UHNM staff test and trace process to ensure that all the UHNM contacts of those staff who test positive are traced and asked to isolate.

5.4 Vaccination Programme

The Vaccination Programme is led by the Infection Prevention and Control Team. A workforce plan is in place and comprises vaccinators, prescribers and administrative support

The Trust is contacting staff who are at work and identified as high risk from their risk assessment and inviting them to be vaccinated. Additionally, staff (including porters, cleaners, and security staff) who work in the following clinical areas are being offered the vaccination:

- Emergency care (adult and child)
- Critical care (adult and child)
- Renal care (adult)
- NIV service (adult and child)
- Haematology and oncology (adult and child)

There is a rollout plan in place, with those assessed as Category B on the covid risk assessments have now been invited for vaccination. Further rollout scheduling is overseen by the Covid Vaccine Steering Group.

6 Staff Wellbeing

There is a Staff Wellbeing plan in place and wellbeing support has continued throughout the pandemic.

During October and November:

- A series of **wellbeing workshops** and training sessions have been organised for December for all staff to join. Details are promoted on the intranet, together with a newsletter with lots of hint and tips on looking after yourself; contact numbers and details of where to find help and support. We have also promoted Staffordshire County Council's list of some of the best apps designed to help people stay safe from suicide
- **RESPOND** dates released - The organisational development team together with Jan Summerfield from Combined Healthcare NHS Trust have developed a new training programme to deliver RESPOND a 'new' bespoke model for having 'Wellbeing' conversations with staff. The model consists of seven simple steps to enable peers and managers to undertake supportive conversations
- **Virtual Advent Calendar** – issued in December, with celebrities thanking staff
- **Disability History Month** took place between the 17th November and the 20th December to raise awareness and celebrate those living and working with a disability or long term condition NHS Wellbeing Support - Culturally diverse and all staff virtual common rooms
- **Promoted NHS Wellbeing Support** - Culturally diverse and all-staff virtual common rooms providing a safe and supportive environment hosted by an experienced and approved practitioner. Discussion in the room is guided by the participants and focuses on present and future coping and support. They are an opportunity to share experiences and learning, with hosts also guiding people to additional support and resources.
- **Refreshments** - Have worked with our partners Sodexo to look at ways we can provide staff with additional food and drink facilities, particularly during nights. Food outlets opened for extended hours and vending machines made available at both Royal Stoke and County Hospitals providing both hot and cold food.
- **Rest Facilities** – installation of the rest facilities is making good progress.
- **Thanks** – we are looking at what a Thank You to all staff could look like. We are also looking at a period to enable staff to 'pause' to reflect and debrief. The 'how/what and when' is being developed and we are working with system partners to develop this.

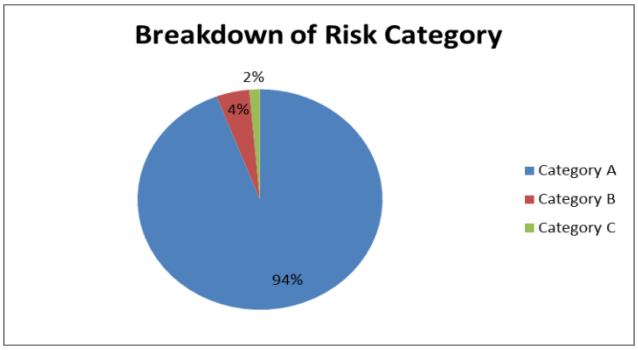
7 Covid-Related Risk Assessments

As at 18th December, 94.87% of all permanent and fixed term staff have completed a covid-related risk assessment with their manager, The risk assessments have been reviewed recently as follows:

- 94.78% of all Risk Assessments
- 98.18% of all BAME risk assessments
- 90.00% of all Category C risk assessments

Division	Headcount	Completed	Outstanding	% Completed
205 Central Functions	986	983	3	99.70%
205 Children's, Women's & Diagnostics	2927	2675	252	91.39%
205 Estates, Facilities and PFI Division	508	508	0	100.00%
205 Medicine Division	2619	2532	87	96.68%
205 Specialised Division	1393	1359	34	97.56%
205 Surgical Division	2449	2267	182	92.57%
Grand Total	10882	10324	558	94.87%

Of the completed risk assessments for all workers (including bank) the vast majority (94%) are in the lowest risk category (category A):



As an outcome of the risk assessment, adjustments may be made to the work area. Adjustments that have been made are detailed as follows:

Risk assessment outcome	Number	%
Continue working in own area	11257	92.28%
Redeployed to lower risk area	214	1.75%
Working from home	207	1.70%
Other (including a mix of WFH and lower risk area)	517	4.24%
Not indicated**	4	0.03%
Total	**12199***	

*This number includes all risk assessments, including bank and leavers.

**Not indicated means that the risk assessment outcome has not been recorded on Empactis. The HRBPs are following up the 4 (a reduction from 9 on 11th November) risk assessments without an indicated outcome to ensure that this is accurately recorded in Empactis. In addition, development work has been completed by the supplier so that this field cannot be left blank going forward.

Outstanding risks assessments are being followed up with line managers and support to input completed risk assessments to the Empactis System is available.

8 Conclusions

There are controls in place to record and manage staff absence.

Risk assessments are now well-established which identify high risk staff to enable mitigation plans to be put in place and to ensure these staff are prioritised for vaccination.

Lateral flow and staff testing processes are also well-established, helping to reduce outbreaks amongst staff

Area-specific business continuity plan detail the processes that will be put in place within the operational settings of each Division to manage a disruption of service delivery as a result of staff shortages and these are supplemented by the *Disruptive Incident Staffing Plan and Operational Workforce Plan*.

Internal redeployment and volunteer processes are in place to offer support to areas of need and partnership working with the STP continues with system-wide processes for mutual aid and redeployment of staff where possible.

9 Recommendations

Trust Board is asked to note that:

- Monitoring of sickness absence takes place on a daily basis
- Redeployment and system-wide mechanisms are in place to support areas where staff absence levels hit levels which trigger business continuity plans

- Covid related absences and staff testing remains an area of focus, with additional resources being applied to manage staff testing
- From 13th November, the Trust rolled out Lateral-Flow asymptomatic testing of frontline staff for Covid-19 to strengthen our efforts to prevent and control the spread of infection, with home self-testing kits rolled out to staff who are in direct contact with patients.
- The covid-19 risk assessments have been reviewed and updated.
- The vaccination programme has commenced.

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	6th January 2021
Report Title:	Key Issues for Finance agenda	**Agenda Item:**	10
Author:	Mark Oldham / Jonathan Tringham		
Executive Lead:	Mark Oldham, Chief Finance 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

As for most objectives the Finance agenda has been significantly impacted by the COVID pandemic and the suspension of the current financial architecture has added further complexity. This paper identifies the recent developments and summarises the impact on the Trust where known.

There remain some significant gaps in the guidance and architecture for the financial year 2021/22, with further guidance expected in late January.

Background

The Trust started the year with a submitted budget which delivered a break even position after receipt of central Financial Recovery Funding. This budget quickly became obsolete as the pandemic significantly impacted and the financial regime was suspended for the first six months of the year. Under this regime the Trust was able to recover all COVID related costs and in addition received a top up payment to bring the Trust's financial position to break even.

From month 7 onwards The Trust was allocated a fixed sum based on historic run rates adjusted for non-recurrent items. In addition to this some funding was allocated at an STP level with the Trust receiving the following monthly amounts:

1. *Growth allocation - £0.3m*
2. *COVID allocation - £2.0m*
3. *Top up allocation - £3.4m*

Initially the centres calculation of the Trusts block value for the last 6 months omitted the historic funding for the Trust Special Administration (TSA) agreement in respect of the Stafford transaction which equating to £14.6M. This allocation also did not take into account the impact of COVID on other commercial type income. As a result the Trust submitted an assessment of the forecast for 2020/21 of a £14.6M deficit. The TSA omission has now been recognised and the Trusts block adjusted for the element received through the CCG's (£7.4M). The balance of £5M will be invoiced directly to the department of Health and Social Care.

The Regional team have asked that the Trusts plan against which we are monitored be adjusted for the CCG funded element but not the DHSC element which they have asked be reflected in the forecast. Therefore the current plan is a deficit of £7.2M however the forecast at month 8 taking into account the DHSC funding brings this down to £2.2M.

The finance report included later in the pack demonstrates that as at month 8 the Trust is out performing this position and the finance Committee will be further appraised when a detailed forecast is completed based on month 9 figures. Early indications are positive and suggest the Trust will be able to finish the year in a break even position.

For 2021/22 There has been some debate as to whether the funding streams will be on a reset or a rebase basis, with a reset basis returning to 2020/21 allocations as the starting point and a rebase to use current cost basis. A recent letter from NHSE/I laying out priorities indicates a move to using previously notified allocations rather than current run rates. However it also indicates this will be adjusted to reflect:

1. *An additional allocation for costs associated with COVID 19 (undetermined)*
2. *Recognition of a deferred year of Cost reduction capability. (undetermined)*
3. *The latest treasury agreement on capital allocations (undetermined)*
4. *An allocation from the £1bn announcement to deal with planned care backlogs (undetermined)*
5. *Financial recovery funding will be released to the STP in line with previous notifications rather than held centrally and linked to acceptance of control totals.*

Assessment

It can be concluded that for 2020/21 the Trust's financial allocation appears sufficient to deliver on the agreed plan with NHSE/I with a potential upside to deliver a break even position. This is not completely risk free as there are two material issues which are still uncertain.

1. The terms associated with the Elective incentive scheme. Initial criteria has been laid out in the NHSE/I letter which exempts the Trusts from charges to date but it remains unclear how this will evolve going forward.
2. As a result of the intense pressures staff have been under this year the National steer has been to allow holiday carry forward. This has not been the position previously and would require the Trust to accrue the costs of any outstanding leave into 2020/21. Whilst NHSE/I have indicated this is likely to be funded nationally it is yet to be formally confirmed how this will operate.

A more detailed assessment of the financial values is being undertaken to inform the month 9 Forecast position and the Performance and Finance Committee will be appraised as it develops.

For 2021/22 without further clarity on the sums available, along with the operational expectations it is too early to assess the deliverability of a break even plan in 2021/22. The key risks for 2020/21are:

1. That CIP expectations are undeliverable both in terms of the 2020/21 suspension and the 2021/22 requirements.
2. Costs of on-going treatment of COVID is not fully recognised in recurrent allocations
3. From 1st April the contract for the private sector will be allocated to Providers again this may prove insufficient to deal with the backlog or be affordable within the Trusts share of the £1bn.
4. The National expectation is that Non NHS Income returns to pre COVID levels from 1 April 2021 with many of these being heavily influenced by restrictions due to COVID (e.g. Injury Cost Recovery, Private patients, Catering). It is unlikely that all restrictions will be released by the beginning of the financial year with shortfalls likely against these income streams.

The evolving position on guidance will be monitored and the Performance and Finance Committee appraised.

Key Recommendations:

Board are requested to note the update.

Quality Governance Committee Chair's Highlight Report to Board

16th December 2020

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Very difficult over recent weeks as the peak continues with a slight increase in community numbers locally; 335 Covid cases in hospital (at the time of the meeting) • Significant pressures within Critical Care with numbers rising to 40 (Covid alone) at times, where it became necessary to escalate to Level 4 which saw 27 patients transferred over a 2 week period • Nosocomial infections are a significant element of Covid cases • CQC are visiting 20 hospitals around the Country to undertake an IPC inspection and preparations are underway should UHNM be included within these visits • A number of anaphylactoid reactions have been seen nationally as a result of Covid vaccines • Letter has been received from NHS England following their visit on 10th November where the rating is reduced to 'amber' – this will be incorporated into the Board Assurance Framework • There has been an increase in Covid related incidents during wave 2 although the rate of incidents has remained relatively constant; trends include infection prevention, communication during handover, isolation of patients and staffing levels • The rate of patient falls has been seen during November and a deep dive is being undertaken to understand this further • Standards were not achieved during October 2020 for a number of indicators: written Duty of Candour (83.3%), C Difficile 11 cases against target of 8, Inpatient Sepsis Screening 84% against 90% target and Emergency Portals Sepsis antibiotics within 1 hour 84.3% against 90% target • During Q2 there has been an increase in complaints and PALS concerns with 58% of those complaints upheld or partly upheld • There has been a deterioration in compliance with WHO Checklist requirements	• Work underway to develop a process for nosocomial death reviews, including serious incident reporting / compliance with Duty of Candour Regulations – a paper will come back to the next meeting of the Committee • IPC Task Force being established; the January meeting of the Committee will allow for a dedicated Deep Dive into the IPC Board Assurance Framework • Ockenden report (independent review into maternity care at SATH) has been released with a number of recommendations. There are 7 immediate actions for implementation in all Trusts – a full report will be presented to the Committee in January • Duty of Candour is being reviewed nationally; further guidance awaited and will be assessed for implications • To strengthen the assurance provided in relation to nursing numbers • A review of feedback following a Patient Story presented to the Board in October has resulted in the development of a care timetable, which supports the communication of care to relatives and family
Positive Assurances to Provide	**Decisions Made**
• Vaccination programme has commenced and is going very well with over 1000 vaccines now provided; plans to increase to 500 vaccines per day • The Quality and Safety Performance Report demonstrated that a number of quality standards had been achieved during October 2020 • Mortality HSMR / SHMI are rated as green within latest data • 98% of National Patient Safety Alerts have now been completed and signed off and 90% of received NICE Guidance has now been implemented (or not applicable)	• Approval of actions and recommendations outlined within the Saving Babies Lives Divergence Report
Comments on Effectiveness of the Meeting	

- Happy that time was taken on the items needed and it did not feel rushed, given the current pressures

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Covid-19 Update	Information	8.	October Patient Story Summary / Action Plan	Assurance
2.	NHS England IPC Visit – 10th November 2020	Assurance	9.	Q2 Compliance and Effectiveness Report	Assurance
3.	Saving Babies Lives Care Bundle Divergence – Recommendations	Approval	10.	Executive Health & Safety Group Highlight Report	Assurance
4.	Coronavirus Incident Summary Report	Assurance	11.	Quality & Safety Oversight Group Highlight Report	Assurance
5.	M7 Quality and Safety Report	Assurance	12.	Review of Meeting Effectiveness, Business Cycle and Items for Escalation to Trust Board	Approval
6.	Mortality Summary Report	Assurance	13.	Ockenden National Maternity Report	Information
7.	Patient Experience Report Q2	Assurance			

3. 2020 / 21 Attendance Matrix

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

Attended | Apologies & Deputy Sent | Apologies

Performance and Finance Committee Chair's Highlight Report to Board

December 2020

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Covid numbers have increased quite significantly as part of the second surge and a new variant has been detected although there are no concerns at present regarding effectiveness of the vaccine • The system has had an extremely challenging 24 – 48 hours; 333 cases in hospital were reported on the day of the Committee meeting • UHNM is in the bottom quartile for Urgent Care Performance; particularly with regard to Ambulance Handovers and these challenges are being seen across most Trusts; consideration is being given with regard to the continuation of elective capacity in order to create an additional Covid ward • Workforce and bed capacity are the biggest concerns for January; particularly as a third surge is anticipated – a plan is under development between system Chief Operating Officers	• Work with MProve has continued within Urgent Care, despite ongoing pressures with Covid • Modelling has commenced which will be used to support planning for January; this is a complex process with multiple factors to consider although previous modelling has been relatively accurate • Vaccination programme is underway, these are being provided through ward 75 along with a number of roving teams in place – the only constraint is vaccine availability • Phase 4 letter is expected imminently; it is envisaged that this will set out expectations in terms of trajectories / actions required in terms of performance and recovery • A business intelligence strategy is under development and will come to the Committee for approval when available
Positive Assurances to Provide	**Decisions Made**
• A positive Urgent Care Board had taken place with each of the divisions able to articulate their plans; this in part is due to the coaching provided by MProve • Vaccine programme is underway and going well • £850k has been secured through a successful bid to support improvements in Planned Care • There is now a clearer view on the financial plan, as confirmation has been received regarding £12.4m additional funding for M7-12 relating to the TSA with the planned deficit being reduced from £14.6m to £7.2m and the forecast to £2.2M deficict after accounting for invoices to the DHSC relating to the remainder of the TSDA funding. • A surplus of £2.2m in M8 has been delivered against a planned surplus of £0.6m • NHSIE have been informed that collectively, the system would break even • The Executive Business Intelligence Group has now been established as part of the Corporate Governance Structure and had a positive first meeting	• Approval of Business Case for Digital Pathology subject to strengthened assurances in some aspects and the addition of an addendum with some baseline figures in order to measure success; this will be submitted to the Board for approval • Authorisation of contracts for COVID19: Supply of Multiplex PCR reagents for detection of SARS CoV2/Influenza/RSV (REAF 4028) and Outsourcing of Radiology Reporting (REAF 3907)
Comments on Effectiveness of the Meeting	
• No specific comments on the effectiveness of the meeting	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Covid-19: Current Operational Situation, Impact on Services and Patient Safety Issues	Assurance	5.	Authorisation of New Contract Awards and Contract Extensions	Approval
2.	Month 8 Performance Report	Assurance	6.	Data Security and Protection update	Information
3.	Month 8 Finance Report	Assurance	7.	Executive Business Intelligence Group Highlight Report	Information
4.	Business Case: BC 0387 Digital Pathology	Approval	8.	Review of Meeting Effectives, Business Cycle and Items for Escalation	Information / Approval

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												

University Hospitals of North Midlands NHS Trust

Executive Summary

Meeting:	Trust Board (Open)	**Date:**	6th January 2021
Report Title:	Integrated Performance Report, month 8 2020/21	**Agenda Item:**	14
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 end of October saw the beginning of the second wave of the pandemic. This continued and accelerated in November with numbers attending the ED and admissions that were higher than those seen in March and April. The impact challenged the ED in assessing and where necessary admitting patients. The impact was felt in the ED itself where patients on a high risk pathway require a side room, downstream when a decision to admit has been made and within the staffing levels where high numbers of staff have themselves been affected.

The numbers of inpatients with Covid-19 in the Trust grew to be significantly above the first wave back in April, which was 167 at its peak; the Trust reached 346 inpatients in November and the effect on critical care was immense to the point that this was placed on critical incident level 4.

Quality & Safety:

During November 2020, the key points are as follows:

- The rate of complaints per 10,000 spells has increased to 29 and below (positive) the target of 35 but is within normal variation.

- Total number of Patient Safety Incidents increased along with 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 around the long term average. The rate of incidents reported with no harm, low harm or near misses has increased which indicates that the increase in total numbers are more attributable to these no harm/near miss incidents and should be promoted as an indicator of potentially good reporting culture within an organisation
- Rate of falls reported that have resulted in harm to patients has increased. The rate of patient falls with harm continues to be within the control limits and normal variation despite the increase during November 2020
- The number of pressure ulcers that have developed under our care continue to show a decreasing trend and is currently below the organisation mean.
- Where pressure ulcers with lapses were identified these were predominantly on wards nursing COVID positive patients who had reduced opportunities to reposition due to their respiratory distress but either had no documented evidence to support the lack of repositioning or who were not upgraded to alternating air mattresses in response to their level of risk and the reduced opportunities to reposition.
- HAI E.Coli Bacteraemia cases for October 2020 noted 7 cases and below the mean of 9

Operational Performance:

Operationally the Trust continued to be challenged. Whilst November saw less attendances at Royal Stoke (daily average of 287 compared to October 308) the acuity of patients escalated to reflect the North Staffordshire picture of a high Covid-19 transmission rate. Ambulance attendances were up and contributed to between 50% – 60% of total attendances. Whereas last year the percentage of ambulances were under 50%. As a result ambulance handovers rose significantly in November for those > 60mins. Patients attending by ambulance indicate a higher acuity and patients are more likely to be in majors/ resuscitation and then be admitted.

The ED performance for UHNM (system wide) in November is 70% (October 71.6%). The key area of challenge is the Type 1 at Royal Stoke where performance fell from 49% in October to 45.5%. 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 November, the number of Covid +ve patients in the hospital reached 346. The highest number reached in April was 167. Up to the end of November the Trust had discharged 1550+ covid patients.

In following Infection Control guidelines for admission of patients with suspected/ confirmed Covid-19, the Trust faced huge challenges: deep cleaning of side rooms; available beds (closures and restrictions in place resulting in up to 83 beds lost per day); critical care capacity was extremely challenged to a point that the internal incident was raise to level 4, although some easing off was seen towards the end of November. staffing loses due to high sickness levels. 11% of staff reported sickness absence, 63% of which was covid-related. These factors resulted in a drop in ED 4 hour performance for November. Significantly a reported 99 – 12 hour trolley waits, reaching as high as 22 on 2 days.

For urgent elective care, the trust is predicted to achieve 4 cancer targets in November; 31 Day First Treatment; 31 day sub anti-cancer; 31 day sub radiotherapy; 28 day FDS.
The 104+ day backlog remains stable at 33 and the 62 day backlog continues to be monitored and is currently at 254. For the remaining elective care, the National ask for November was for Outpatients to be at 100% of last year's business as usual and for Inpatients 90%. The trajectories were set 90.3% and 80.3% of BAU for last year. For November, total outpatient activity was 98.1% and total Elective (Inc. Day cases) inpatient activity was 82.1% vs. the trajectories. This is set against the increasing pressures the Trust experienced in November with more Covid-19 patients seen and admitted and bed closures due to Infection prevention.

The waiting list for Referral To Treatment pathways steadily rose after the first wave of Covid-19 and in October reached the pre-covid mean. For November the number of pathways is slightly reduced but is normal variation at 46,791 (October 47,168). This is above the forecast 46,100. A Trust trajectory for this has been developed and monitored through the planned care cell. The Trust reported 2,100 over 52 week breaches as a consequence of standing down elective work. This was forecasted and the waiting list will

potentially rise as capacity restraints continue. Recovery plans for recovery of the long waiting patients will be reviewed. RTT performance in November is 66.97%.

November saw a further increase in diagnostic activity rising to 26,177 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 November is currently 88.63%; The waiting list size is also showing a reduction: down to 12,485. Recovery plans are now being transacted and monitored via the Diagnostic Cell to end of March 2021, with investment requests approved for DMO1 modalities to support this recovery timescale.

Workforce

The strategic focus of our People Plan remains on supporting recruitment, workforce deployment, staff wellbeing, absence management and staff testing. The focus of the Workforce Bureau on risk assessments, staff wellbeing, staff testing, staff deployment continues, and now includes supporting the vaccination programme.

The daily sickness sitrep highlights wards and areas with high numbers of staff calling in as absent, which then triggers mitigating actions set out in business continuity plans. Redeployment processes are place to support areas of need and volunteer placements are offering 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 the sickness rate being above target and with PDR requirements although an Executive decision was taken to suspend PDR's unless there is capacity to continue to undertake them.

The in-month sickness rate was 5.85% (4.88% 31/10/20). The 12 month cumulative rate increased to 5.23% (from 5.16%). Since the 21st October, absence episodes have increased in line with the second covid wave and, as of 21st December, covid-related open absences numbered 485, which was 50% of all absences (61% at 11th November 2020):

- Covid related absences and staff testing remains an area of focus, with additional resources being applied to manage staff testing.
- Phase 3 of the covid-19 risk assessment process is complete with 95% of all risk assessments, and 98% of BAME risk assessments, reviewed.
- The Covid vaccination programme has commenced

A separate paper on sickness absence has been presented to Trust Board

For appraisals, The Non-Medical PDR compliance rate was 75.56% at 30th November (76.81% at 31 October) and the Statutory and Mandatory training rate at 30th November was 94.14% (94.25% at 31/10/20) and 90.07% of staff have completed all 6 core for all modules (90.20% at 31/10/20.

Finance

The key messages are:

- The Trust has received confirmation that it will receive £12.4m additional funding for M7-12 relating to the TSA agreement with its planned deficit being reduced from £14.6m to £7.2m and the Trust required to exceed this plan by a further £5m to deliver a year end deficit of £2.2m.
- The Trust has delivered a surplus of £2.2m in Month 8 against a planned surplus of £0.6m which when adjusted to reflect transacting 2 months of TSA funding in Month 8 is consistent with our forecast to be £5m better than plan for the year.
- Activity delivered in Month 8 is significantly lower than plan although NHS income levels from patient activities have been maintained due to the temporary funding arrangements.
- The Trust estimates the impact of the Elective Incentive Scheme (EIS) to be a £1.1m reduction to income in Month 8; as for months 6 and 7 this is not reflected in the position in line with guidance

from NHSI/E.

- Other operating income has increased in month mainly as a result of the confirmation regarding receipt of the TSA deficit support funding of which funding for Month 7 and Month 8 have been reflected in Month 8.
- Pay is underspent for the Month mainly as a result of non-recurrent underspends against Winter and Growth allocations. Non Pay is overspent by £2.3m relating to pass through drugs and devices and Clinical Supplies expenditure.
- The Trust incurred £1.7m of additional costs relating to COVID-19 which was £0.5m higher than in Month 7 mainly due to increased sickness and cost of testing as a result of the second wave.
- Capital expenditure for the year to date stands at £21.8m which is £5m behind plan with the main driver being slippage on the PDC funded ED scheme.
- The month end cash balance is £82.7m which is £7.9m lower than plan.

Key Recommendations:

To note performance for the month of November 2020

NHS
University Hospitals of North Midlands
NHS Trust

Integrated Performance Report

Month 8 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?

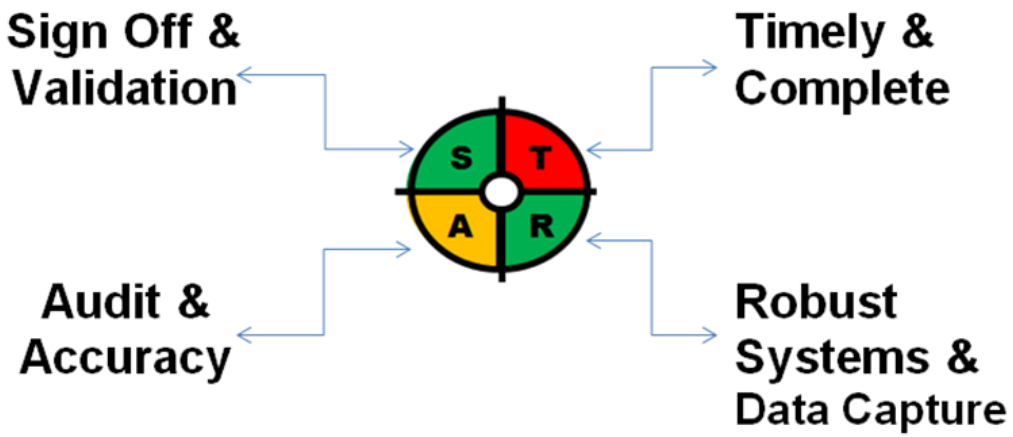
The below key and icons are used to describe what the data is telling us;

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

A note on **Data Quality**

NHS
University Hospitals of North Midlands
NHS Trust

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



Explaining each domain

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

RAG rating key

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

Quality

Caring and Safety

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

Quality Spotlight Report

NHS University Hospitals of North Midlands NHS Trust

Key messages

The Trust achieved following standards in November 2020:

- Harm Free Care 97.6% continues to be above the national 95% target
- Trust rolling 12 month HSMR and SHMI continue to be below expected
- 100% of patients/family informed verbally of incidents that are reported as meeting duty of candour threshold
- Written Duty of Candour during November achieved the 100% target at 83.3% (4 cases).
- VTE Risk Assessment continues to exceed 95% target with 99.% during November 2020(via Safety Express audit)
- Zero avoidable MRSA Bacteraemia cases reported
- There has been one device related pressure ulcer that developed due to lapses in care in November. There have been no Category 3, 4 or unstageable pressure ulcers pressure ulcers to date for November, but these are under continued review.
- Inpatient Sepsis Screening compliance (adult Inpatients) improved to 90.2% and above the target of 90%
- Sepsis Screening Compliance in Emergency Portals improved to 94% against target 90%
- Children's sepsis Screening Compliance 95.0%
- Inpatients IVAB within 1 hour achieved 100% for audited patients and Emergency Portals Sepsis IVAB in 1 hour reported 92%
- Zero Never Events reported in November 2020

The Trust did not achieve the set standards for:

- Patient Falls rate per 1000 bed days higher than target in November 2020 at 7.4 falls per 1000 bed days
- C Diff target above trajectory target of 8 during November 2020 with 10 cases reported, which is a reduction from previous months. Full C Diff report to be provided to Quality Governance Committee in January 2021
- Maternity Sepsis Screening and IVAB in 1 hour below target
- Nosocomial COVID Infections have reported increase during November 2020 with 88 reported cases

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

- The rate of complaints per 10,000 spells has increased to 29 and below (positive) the target of 35 but is within normal variation.
- Total number of Patient Safety Incidents increased along with 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 around the long term average. The rate of incidents reported with no harm, low harm or near misses has increased which indicates that the increase in total numbers are more attributable to these no harm/near miss incidents and should be promoted as an indicator of potentially good reporting culture within an organisation
- Rate of falls reported that have resulted in harm to patients has increased. The rate of patient falls with harm continues to be within the control limits and normal variation despite the increase during November 2020
- The number of pressure ulcers that have developed under our care continue to show a decreasing trend and is currently below the organisation mean.
- Where pressure ulcers with lapses were identified these were predominantly on wards nursing COVID positive patients who had reduced opportunities to reposition due to their respiratory distress but either had no documented evidence to support the lack of repositioning or who were not upgraded to alternating air mattresses in response to their level of risk and the reduced opportunities to reposition.
- HAI E.Coli Bacteraemia cases for October 2020 noted 7 cases and below the mean of 9

Quality Dashboard

NHS University Hospitals of North Midlands NHS Trust

Metric	Target	Latest	Variation	Assurance
Patient Safety Incidents	N/A	1677		
Patient Safety Incidents per 1000 bed days	N/A	49.94		
Patient Safety Incidents per 1000 bed days with no harm	N/A	34.57		
Patient Safety Incidents per 1000 bed days with low harm	N/A	13.13		
Patient Safety Incidents per 1000 bed days reported as Near Miss	N/A	1.64		
Patient Safety Incidents with moderate harm +	N/A	19		
Patient Safety Incidents with moderate harm + per 1000 bed days	N/A	0.57		
Harm Free Care (New Harms)	95%	98%		
Patient Falls per 1000 bed days	5.6	7.4		
Patient Falls with harm per 1000 bed days	1.5	1.9		
Medication Incidents per 1000 bed days	N/A	4		
Medication Incidents % with moderate harm or above	TBC	0.7%		
Patient Medication Incidents per 1000 bed days	N/A	3.7		
Patient Medication Incidents % with moderate harm or above	TBC	0.8%		

Metric	Target	Latest	Variation	Assurance
Serious Incidents reported per month	N/A	16		
Serious Incidents Rate per 1000 bed days	N/A	0.48		
Never Events reported per month	0	0		
Duty of Candour - Verbal/Formal Notification	100%	100%		
Duty of Candour - Written	100%	100%		
All Pressure ulcers developed under UHNM Care	TBC	63		
All Pressure ulcers developed under UHNM Care per 1000 bed days	N/A	1.88		
All Pressure ulcers developed under UHNM Care lapses in care	12	1		
All Pressure ulcers developed under UHNM Care lapses in care per 1000 bed days	0.5	0.03		
Category 2 Pressure Ulcers with lapses in Care	8	1		
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		

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Quality Dashboard

NHS University Hospitals of North Midlands NHS Trust

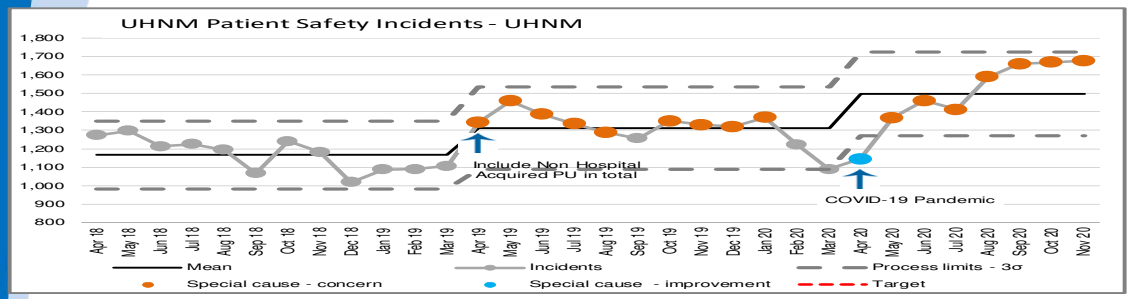
Metric	Target	Latest	Variation	Assurance
Friends & Family Test - A&E	N/A	N/A	H	?
Friends & Family Test - Inpatient	N/A	98.8%		P
Friends & Family Test - Maternity	N/A	N/A	H	?
Written Complaints per 10,000 spells	35	29.33		?
Rolling 12 Month HSMR (3 month time lag)	100	94.89	L	P
Rolling 12 Month SHMI (4 month time lag)	100	101.84	H	P
VTE Risk Assessment Compliance	95%	99.1%	H	?
Emergency C Section rate % of total births	15%	15.5%	H	?
Reported C Diff Cases per month	8	10	H	?
Avoidable MRSA Bacteraemia Cases per month	0	0		P
HAI E. Coli Bacteraemia Cases per month	N/A	7		
Nosocomial "Definite" HAI COVID Cases - UHNM	0	88	H	

Metric	Target	Latest	Variation	Assurance
Inpatient Sepsis Screening Compliance (Contracted)	90%	90.2%		?
Inpatient IVAB within 1hr (Contracted)	90%	100.0%		?
Children Sepsis Screening Compliance (All)	90%	95.0%	H	P
Children IVAB within 1hr (All)	90%	N/A	H	F
Emergency Portals Sepsis Screening Compliance (Cor	90%	93.7%		?
Emergency Portals IVAB within 1 hr (Contracted)	90%	91.7%		?
Maternity Sepsis Screening (All)	90%	29.4%	L	F
Maternity IVAB within 1 hr (All)	90%	50.0%	L	P

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Reported Patient Safety Incidents

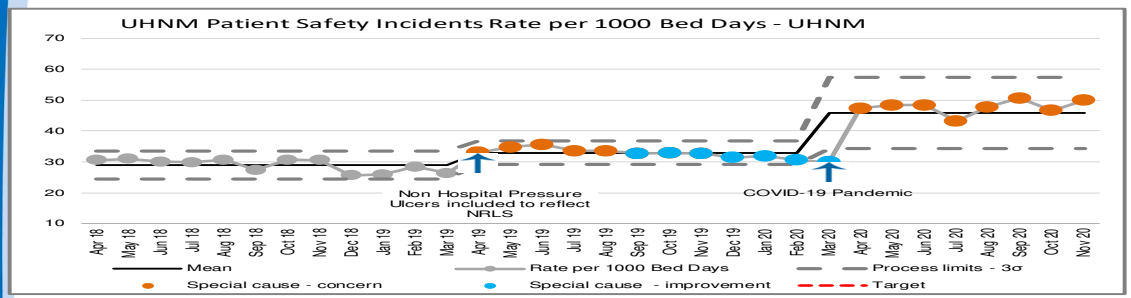


Variation	Assurance
	

Target	Sep 20	Oct 20	Nov 20
N/A	1659	1668	1677

Background

Total Reported patient safety incidents



Variation	Assurance
	

Target	Sep 20	Oct 20	Nov 20
N/A	50.66	46.62	49.94

What is the data telling us:

The above data relates to **all** reported Patient Safety Incidents (PSIs) across the Trust. November 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 - 247 (198),
- Clinical assessment (Including diagnosis, images and lab tests) – 55 (73)
- Patient flow incl. access, discharge & transfer - 77 (92)
- Treatment/Procedure - 59 (69)
- Medication incidents - 123 (187)
- Documentation - 65

There have been decreases in Medication and Clinical assessment incidents compared to October 2020 totals (in brackets). However, there have been increased incidents in relation to Falls and Documentation.

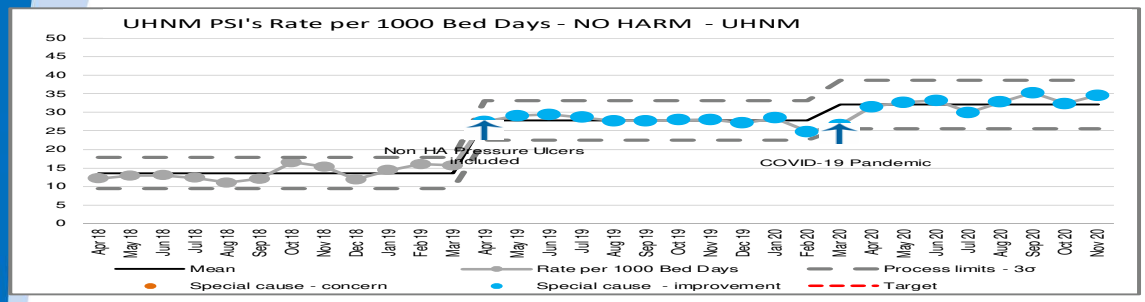
Patient Safety Incidents are reviewed and analysis undertaken on locations and themes.

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 October 2020. The increase in total incidents is due to more incidents with no harm or low harm (see following slides and indicators) being reported compared to incidents with harm

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

University Hospitals of North Midlands NHS Trust

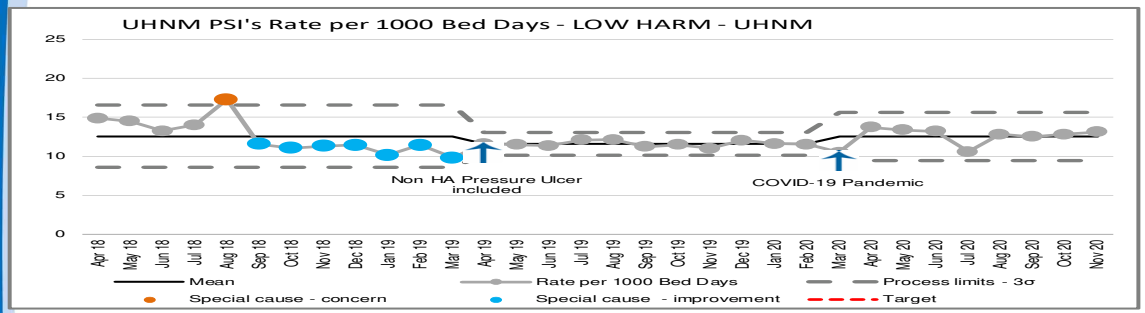


Variation	Assurance

Target	Sep 20	Oct 20	Nov 20
N/A	35.24	32.34	34.57

Background

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

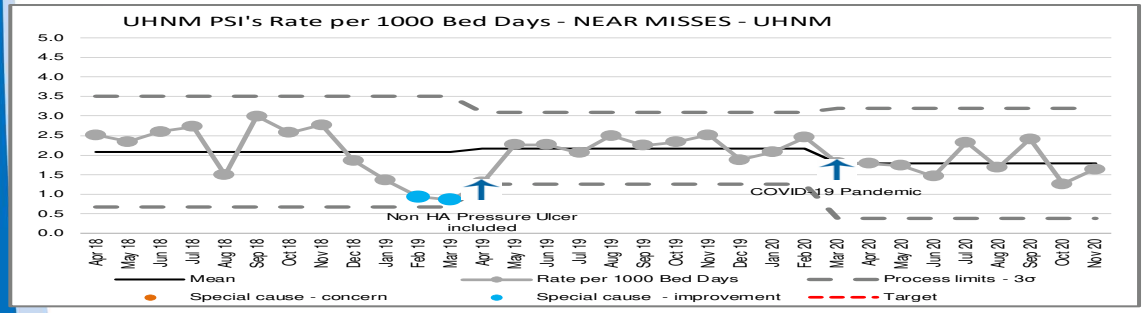


Variation	Assurance

Target	Sep 20	Oct 20	Nov 20
N/A	12.52	12.80	13.13

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	Sep 20	Oct 20	Nov 20
N/A	2.41	1.26	1.64

Background

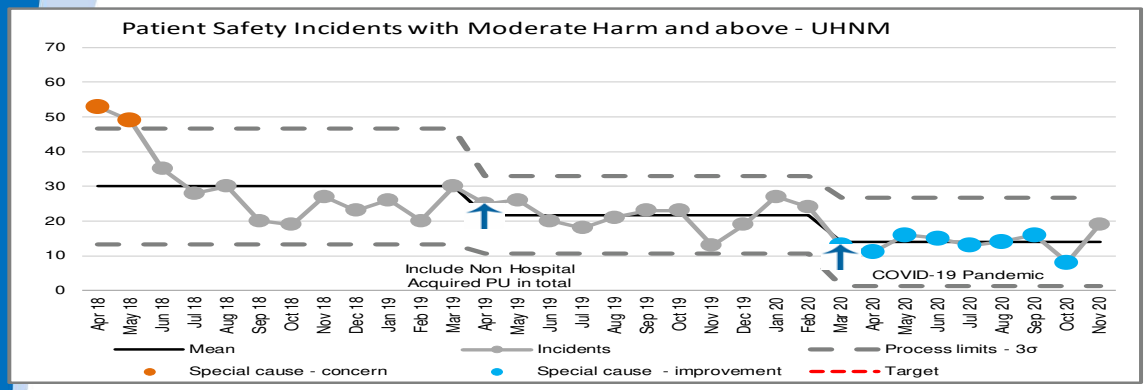
The rate of Patient safety Incidents per 1000 bed days that are reported as NEAR MISS

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 the 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.

Reported Patient Safety Incidents with Moderate Harm or above

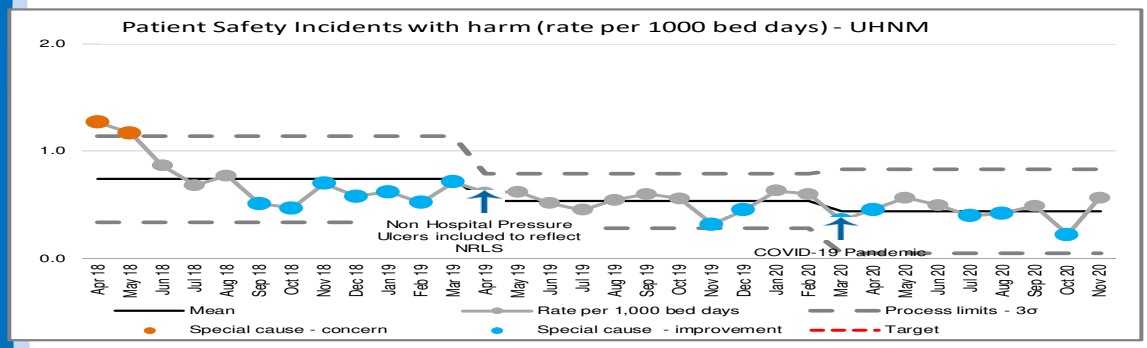


Variation	Assurance

Target	Sep 20	Oct 20	Nov 20
N/A	16	8	19

Background

Patient safety incidents with reported moderate harm and above



Variation	Assurance

Target	Sep 20	Oct 20	Nov 20
N/A	0.49	0.22	0.57

What is the data telling us:

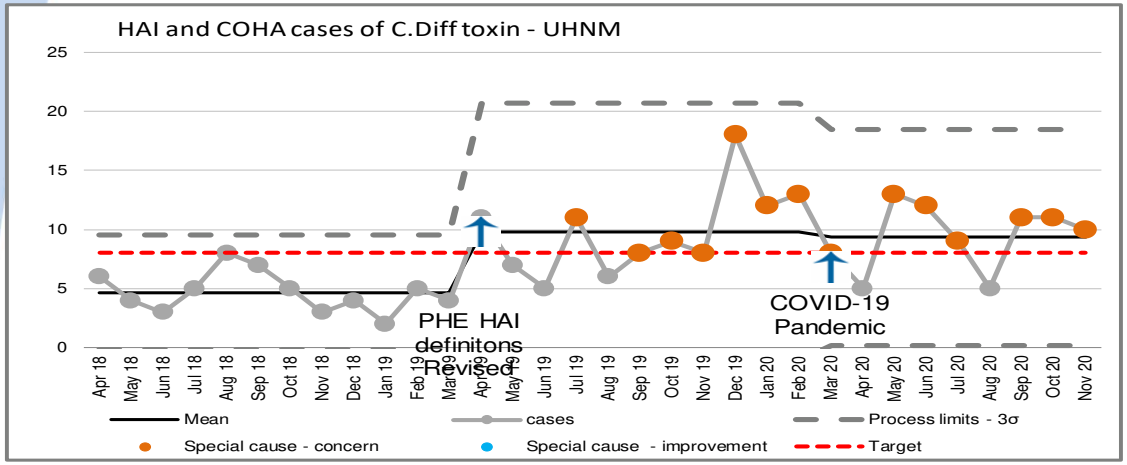
The chart show that during November 2020 there has been an in month increase in PSIs with moderate harm or above (at time of report 10/12/2020). The number of PSIs with moderate harm or above continues to be below the pre COVID mean. The second chart, shows the rate of PSIs with moderate harm or above per 1000 bed days and there are continued positive trends with reductions from pre COVID period. 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 Infection Control, Equipment failure, Tissue Viability

These incidents are all under review and RCA progressing

Reported C Diff Cases per month



Variation	Assurance
	

Target	Sep 20	Oct 20	Nov 20
8	11	11	10

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 rep[orted C Diff cases in November. 6 of these were Hospital Associated Infection (HAI) cases and 4 Community Onset Hospital Associated (COHA) cases.

Two clinical areas reported 2 cases Clostridium *difficile* toxin cases within a 28 day period, awaiting ribotypes to be confirmed.

For November 2020, UHNM is above trajectory for the year to date 2020/21 ,76 cases versus a year to date target of 63

Actions:

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

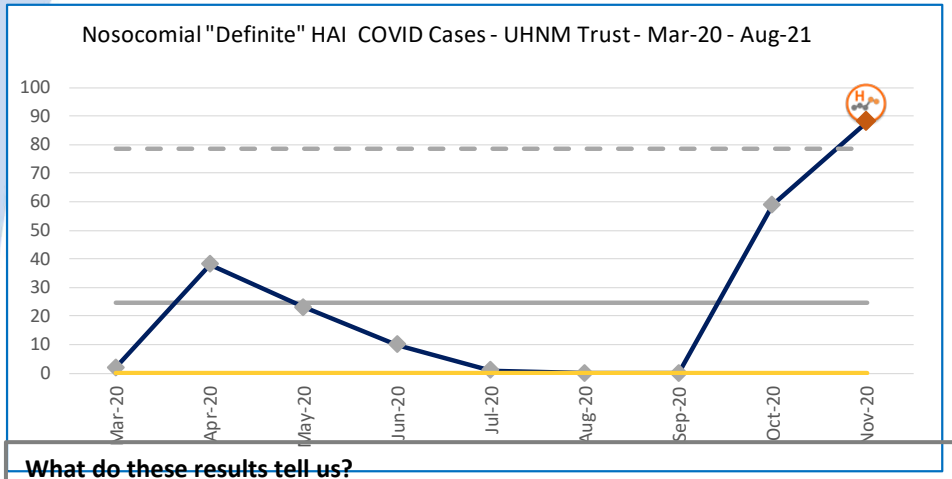
In all cases control measures are instigated immediately, and RCA's are reviewed by the CCG, this is paused due to COVID 19.

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		88	-29.3	78.4	24.6

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 and November 2020 is highest reported figure during the pandemic.
- The number of community onset COVID 19 cases reported increased from week 37, this increase continued during November
- The average number of beds occupied with COVID 19 patients during November increased .
- A number of ward outbreaks were reported during November
- For patients the following time linked definitions apply:

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

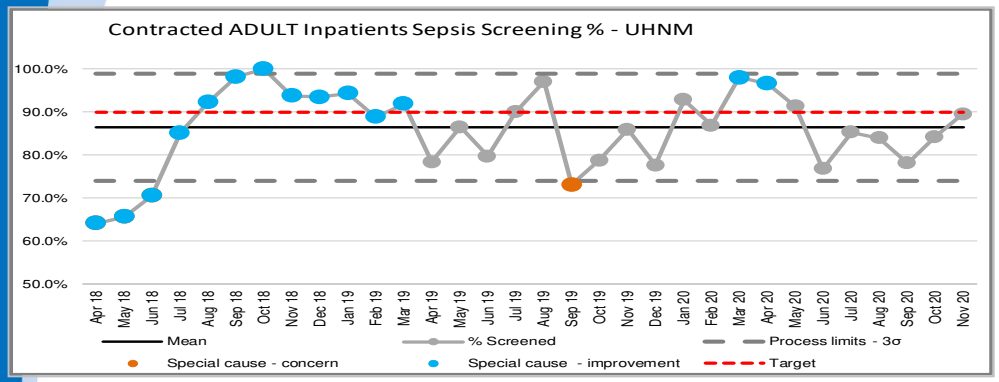
Actions :

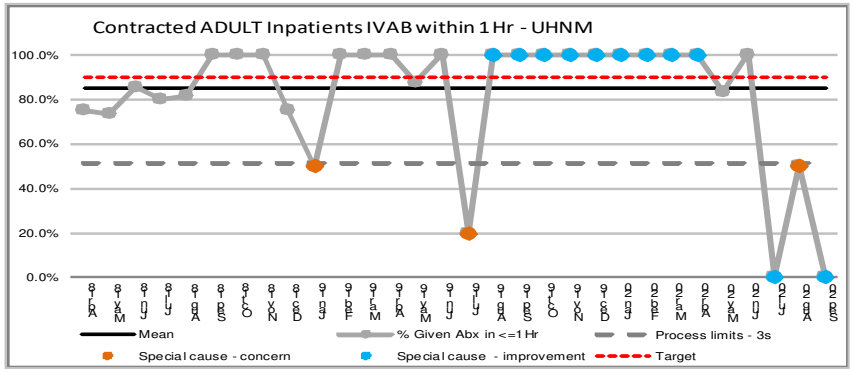
All Emergency patients screened for COVID 19 on admission to UHNM, screening programme in place for planned surgery/procedures.

- All inpatients who have received a negative COVID screen have a repeat COVID screen on day 4 and 6 as per NHS key actions
- 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 rolled out in a number of areas

Sepsis Screening Compliance (Inpatients Contract)

University Hospitals of North Midlands NHS Trust





Variation	Assurance

Target	Sep 20	Oct 20	Nov 20
90%	78.1%	84.3%	89.5%

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

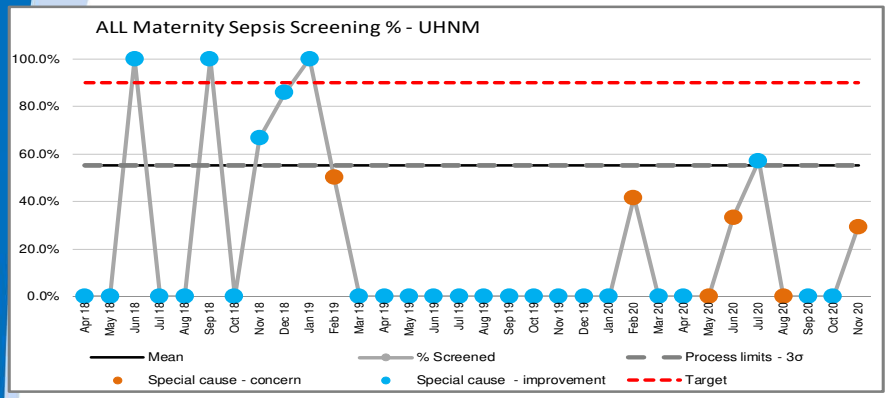
What is the data telling us:

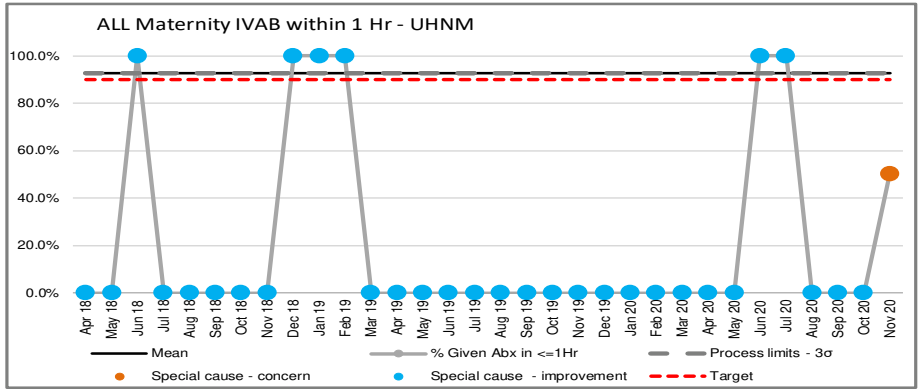
November results now at 90.2% which shows good improvement from the previous month. Inpatient areas also achieved 100% for IVAB within an hour, however this data continues to be from a very small sample size of just one patient for October. Of the 112 Inpatients that triggered a sepsis screen, 17 were moderate risks and 95 patients with red flags (2 of these patients were given IVAB within hour and the remaining 93 patients, 47 had alternative diagnosis that were deemed as not sepsis related and IVAB were not indicated. The remaining 46 patients were already received treatment for sepsis and administration of IVAB initiated prior to the identified red flag trigger).

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. Plan to have this data reflected for the December compliance report.
- 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 as well as sepsis kiosks a 15-20 minutes drop in session (commenced already in prioritised areas and will commence soon in older wards).
- 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. This remain as one of the priorities to continue/ monitor closely to help improve this system.

Sepsis Screening Compliance ALL Maternity





Variation	Assurance
L	F

Target	Sep 20	Oct 20	Nov 20
90%	N/A	N/A	29.4%

Background

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

Variation	Assurance
L	P

Target	Sep 20	Oct 20	Nov 20
90%	N/A	N/A	50%

Background

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

What is the data telling us:

Maternity Inpatients and Emergency portal (MAU) audited by the Sepsis Team in November 2020. Almost all patients that trigger with MEOWS >4 were audited via the Maternity K2 system. The Inpatient wards screening compliance scored 20% and MAU with 42.9% and overall total of 29.4%. We have 1 patient in MAU with delayed IVAB therefore the total dropped to 50%.

Actions:

The Sepsis team have been working closely with the Maternity education and senior team in regards of updating Maternity Sepsis guidelines and their new Maternity Inpatient and community screening tools. The trial plain aims to commence in January 2021. The Maternity senior team have created an action plan to resolve/improve both screening and IVAB compliance immediately. In the meantime, the Sepsis Team will continue to monitor, conduct spot checks audits in maternity clinical areas and MAU. Currently the Sepsis Team is providing spesis reinforcement or training as well as creaing further awareness to esnure staff are aware of the process for attaching completed screening tools to the K2 system. Mainly, the maternity documentation and notes are all compoleted electronically except for the sepsis screening tool and prescription chart hence the issue with compliance. Furthermore, Microsoft Teams epsis Training is currently available and provided to all levels of clinicians.

Operational Performance

2025 Vision "Achieve NHS Constitutional patient access standards"

Contents

A note on **SPC**

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?

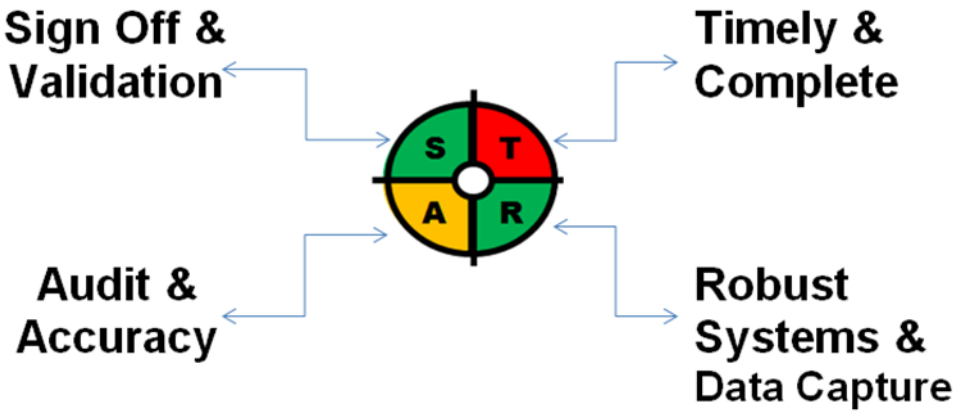
The below key and icons are used to describe what the data is telling us;

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**

- 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

Whilst November saw less attendances at Royal Stoke (daily average of 287 compared to October 308) the acuity of patients escalated to reflect the North Staffordshire picture of a high Covid-19 transmission rate. Ambulance attendances were up and contributed to between 50% – 60% of total attendances. Whereas last year the percentage of ambulances was under 50%. As a result ambulance handovers rose significantly in November for those > 60mins. Patients attending by ambulance indicates a higher acuity and patients are more likely to be in majors/ resuscitation and then be admitted. The average daily ambulance attendances decreased to 159 (compared to 160 in October). This follows monthly rises that have continued since April.

The performance for UHNM (system wide) in November is 70% (October 71.6%). The key area is the Type 1 at Royal Stoke where performance fell from 49% in October to 45.5%. 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 November, the number of Covid +ve patients in the hospital reached 346 . The highest number reached in April was 167. Up to the end of November the Trust had discharged 1550+ covid patients.

In following Infection Control guidelines for admission of patients with suspected/ confirmed Covid-19, the Trust faced huge challenges: deep cleaning of side rooms; available beds (closures and restrictions in place resulting in up to 83 beds lost per day); critical care capacity was extremely challenged to a point that the internal incident was raise to level 4, although some easing off was seen towards the end of November. staffing loses due to high sickness levels. 11% of staff reported sickness absence, 63% of which was covid-related. These factors resulted a in drop in ED 4 hour performance for November. Significantly a reported 99 – 12 hour trolley waits, reaching as high as 22 on 2 days.

Cancer

The trust is predicted to achieve 4 cancer targets in November; 31 Day First Treatment; 31 day sub anti-cancer; 31 day sub radiotherapy; 28 day FDS.

The 104+ day backlog remains stable at 33 and the 62 day backlog continues to be monitored and is currently at 254.

Planned Care

The National ask for November was for Outpatients to be at 100% of last years business as usual and for Inpatients 90%. The trajectories were set 90.3% and 80.3% of BAU for last year. For November, total outpatient activity was 98.1% and total Elective (Inc. Day cases) inpatient activity was 82.1% vs. the trajectories. This is set against the increasing pressures the Trust experienced in November with more Covid-19 patients seen and admitted and bed closures due to Infection prevention.

RTT

The waiting list for Referral To Treatment pathways steadily rose after the first wave of Covid-19 and in October reached the pre-covid mean. For November the number of pathways is slightly reduced but is normal variation at 46,791 (October 47,168). This is above the forecast 46,100. A Trust trajectory for this has been developed and monitored through the planned care cell. The Trust reported 2,100 over 52 week breaches as a consequence of standing down elective work. This was forecasted and the waiting list will potentially rise as capacity restraints continue. Recovery plans for recovery of the long waiting patients will be reviewed. RTT performance in November is 66.97%.

Diagnostics

November saw a further increase in diagnostic activity rising to 26,177 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 November is currently 88.63%,. The waiting list size is also showing a reduction: down to 12,485. 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

- Whilst November saw less attendances at Royal Stoke (daily average of 287 compared to October 308) the acuity of patients escalated to reflect the North Staffordshire picture of a high Covid-19 transmission rate. Ambulance attendances were up and contributed to between 50% – 60% of total attendances. Whereas last year the percentage of ambulances was under 50%. As a consequence ambulance handovers > 60 mins. rose significantly. Patients attending by ambulance indicates a higher acuity and patients are more likely to be in majors/ resuscitation and then be admitted. The average daily ambulance attendances rose to 159 (compared to 160 in October). This monthly rise has continued since April.
- Majors saw a rise to an average of 207/ day compared to October's 167/ day. Whilst this is similar to the numbers seen last year the acuity and management of Covid-19 patients is more complex and challenging on account of the bed gap associated with the necessary IPC changes.
- In November the Trust admitted twice as many patients with Covid-19 compared to March (first wave). In April, the highest number of patients was 167 and in November this reached 346.
- The number of medical beds occupied continued to rise in November. October saw a daily average of 416, whereas for November this rose significantly to 446 per day. In line with this occupancy the number of patients stranded/ super stranded and MFFD also continued to rise with, all indicating patients were staying longer. The average LoS for NEL medical patients admitted 1+ days rose from 7.8 to 8.2 (which is in line with the previous year).
- There have been improvements in the triage wait times for non ambulance patients: the latest data shows 74% of patients were triaged within 15 minutes. For total RS patients the percentage has increased to 77% triaged within 15 minutes.
- SDEC remains at 32% of all NEL admissions.
- Bed occupancy and conversion rate is increasing month on month and expected to continue to increase into Winter. The conversion rate for November was 41% (Royal Stoke, up by 2.4%) and 33% (County).

Urgent Care - Actions

With the increase in Covid-19 cases and the operational challenges that this has brought November's focus shifted slightly to maintaining patient safety throughout the Emergency Department and Divisions with a particular focus on operational flow due to the extended stays in the Emergency Department.

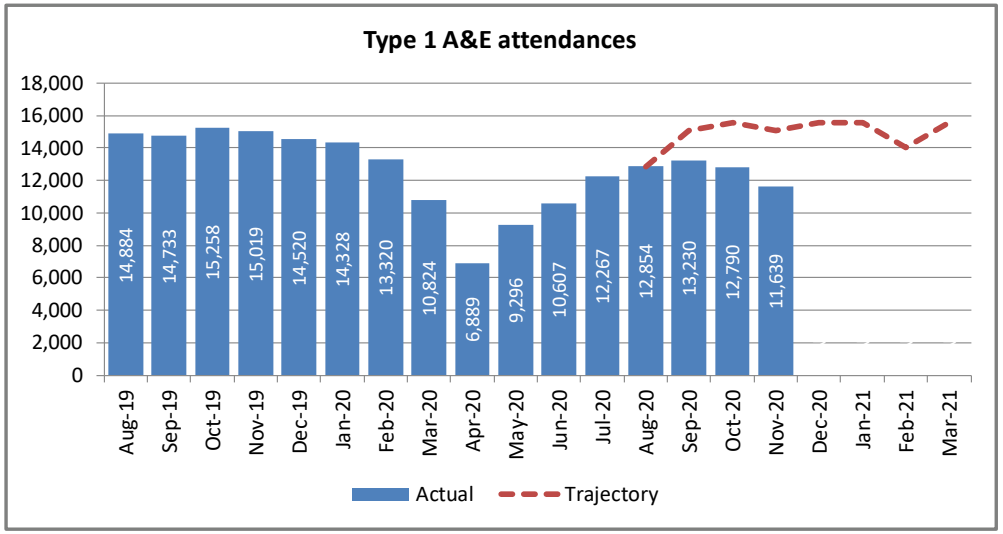
Consultant Connect system went live on the 23rd November for Phase 1 with Frailty, Acute Med (Advice and Guidance and Referral Lines across both RSUH and County), Renal and a Surgery Referral Line. Second phase launching w/c 7th December with Haematology, T&O, and Cardiology. Speciality teams and GPs to socialise the Consultant Connect system-feedback has generally been positive. 75 GPs have so far downloaded the app in order to access the system and the delivery group has attended GP leaders meetings to demonstrate the system. First report being published mid-December. Phase 3 will launch early January 2021 Paediatrics, Diabetes and Endocrinology, Ophthalmology, Dermatology and Neurology.

Mprove have been undertaking initial reviews and developing further ways in which to build on the actions previously outlined through the ECIST programme and Divisional development plan. Jointly , agreed some intense focus on 1. Acute Front Door, which will deal with constancy of board rounds to discharge lounge utilisation. We will be tracking the effectiveness of the planning and the impact on more transfers earlier in the day. Tackling actions around DTA which will see improvements in the number of admissions and flow to the discharge lounge. 2. Acute Patient Flow, processes around stranded and super stranded patients and red days. Tracking and impact this area will be reductions in the LOS and a large proportion of discharges pre noon. 3. Clinical Site Management which is focused on the day to day running of site operations. These areas of improvement will allow us to have the data available for improved forecasting and reduce the numbers of DTA's in the mornings.

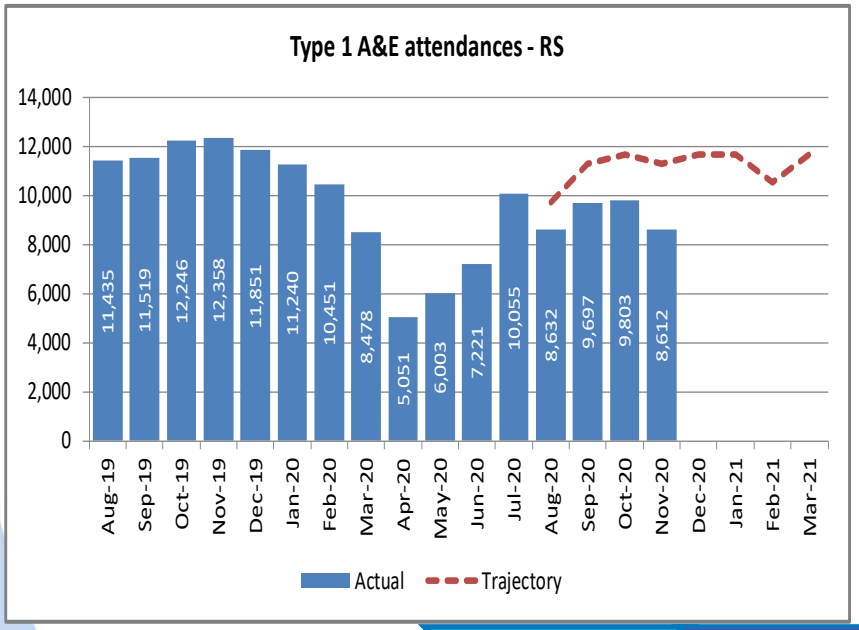
Think 111 – Successfully went live on 1st December as planned. Reviewed the pathway of the first two days of patients and did not have any issues to record. Clinical group will continue to review pathways with system partners. Numbers continue to be low but consistent with other roll outs. CRIS team volumes have additionally increased keeping people at home to receive their treatment and avoiding an admittance into ED.

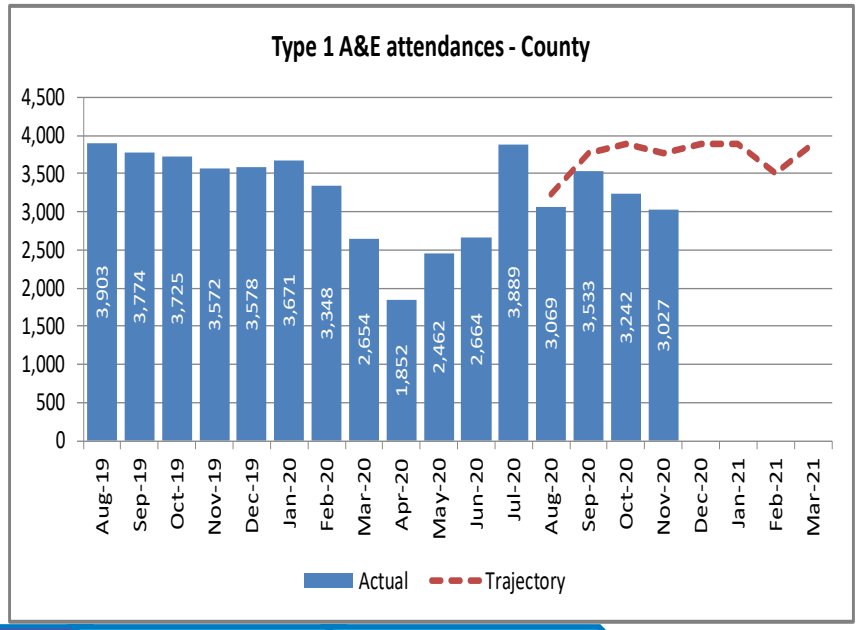
During December the Medical Division have refreshed their focus on ward based systems and processes with a dedicated Nurse Co-ordinator to support complex discharges and West Hub principles. These key areas of work will be supported by the Acute Patient Flow model detailed above.

Urgent Care *(attendances)*

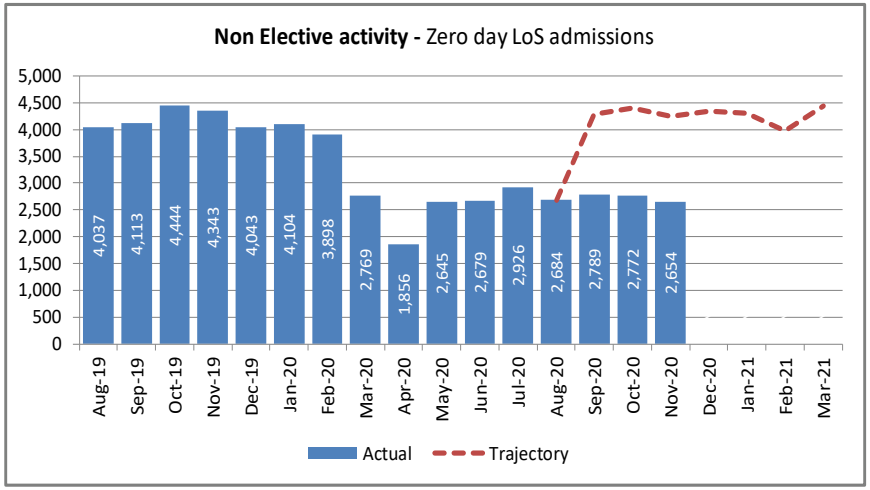


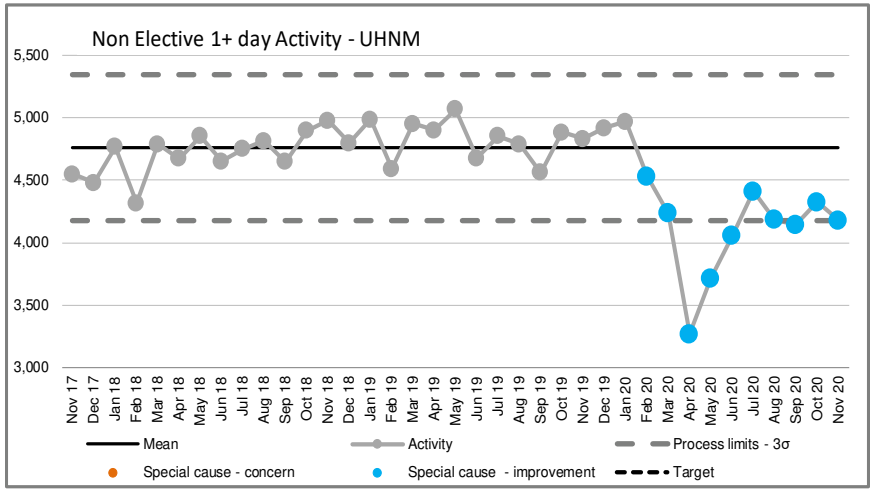
	% against Nov 19
Type 1	77.5%
RS	69.7%
County	84.7%





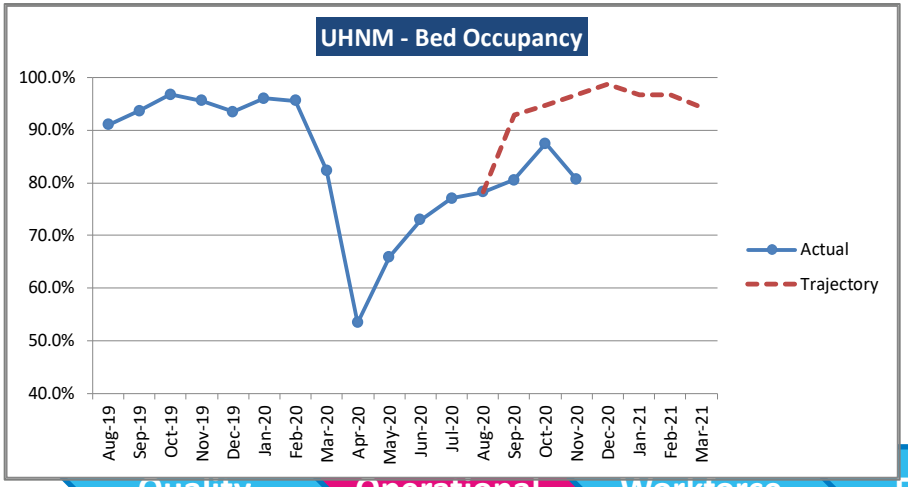
Urgent Care - *(admissions)*





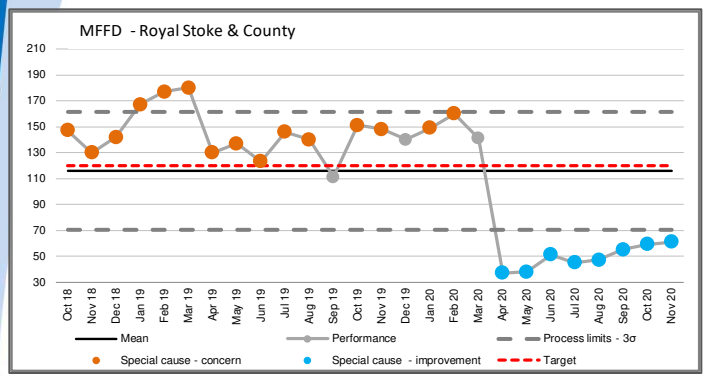
	Sep 20	Oct 20	Nov 20
Previous year	4,113	4,444	4,343
2020 Actual	2,789	2,772	2,654
% of BAU	68%	62%	61%

	Sep 20	Oct 20	Nov 20
Previous year	4,559	4,884	4,831
2020 Actual	4,143	4,323	4,179
% of BAU	91%	89%	87%



Quality | Operational | Workforce | Finance

URGENT CARE – *(Discharges)*



Variation	Assurance
L	?

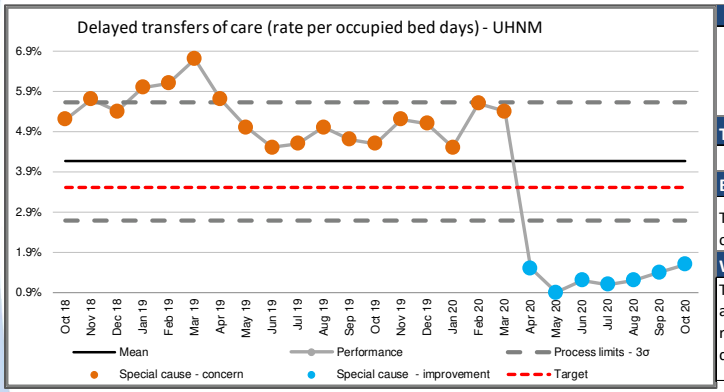
Target	Sep 20	Oct 20	Nov 20
120	55	59	61

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 reduction in the number of MFFDs.



Variation	Assurance
L	?

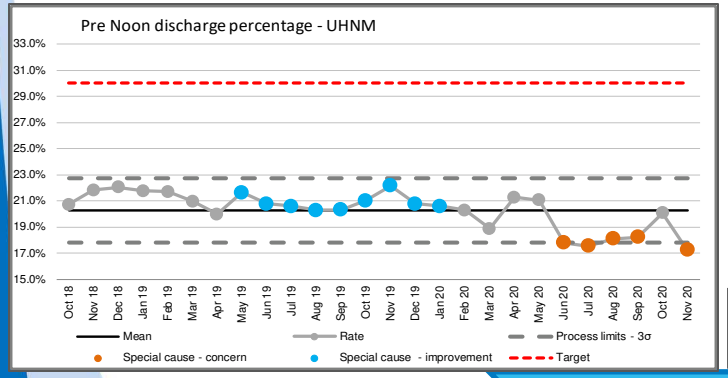
Target	Aug 20	Sep 20	Oct 20
3.5%	1.2%	1.4%	1.6%

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
L	F

Target	Sep 20	Oct 20	Nov 20
30%	18.2%	20.1%	17.2%

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 percentages remaining below the mean.

Medically fit for discharge (MFFD):

Whilst the data is showing that the MFFDs are in improvement with normal variation, and are still well below the numbers seen pre-covid, there are some indications that the numbers are rising. On average, the daily number of patients MFFD for RS & County is 61/ day.

Work streams are in place to reduce this again.

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

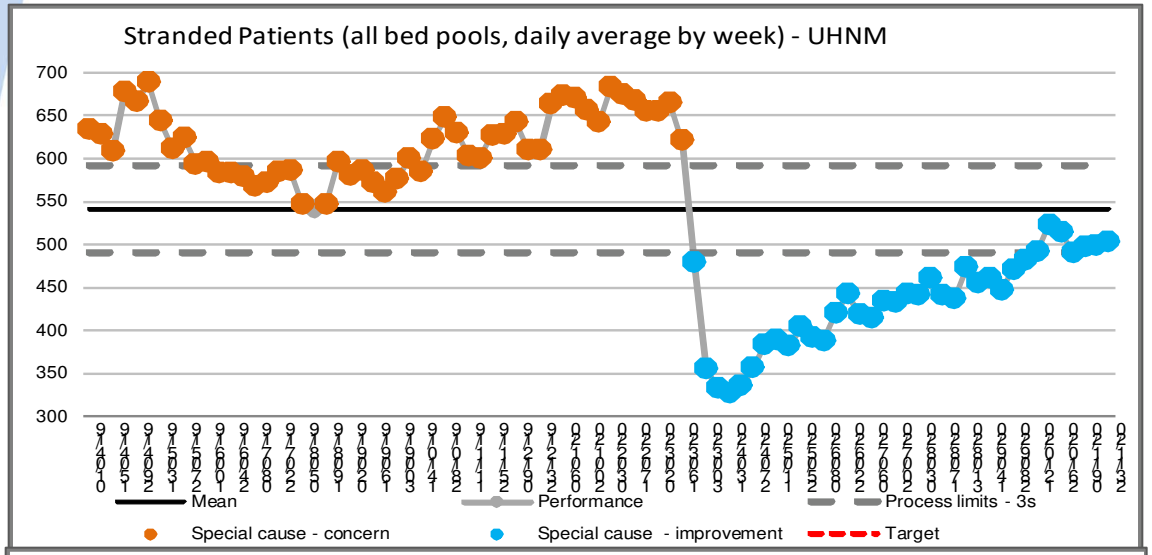
Again, whilst the data shows that for DToC the variation is low and this is still improvement, there are some early indications that percentages are rising. Although still well below the 3.5% national ambition.

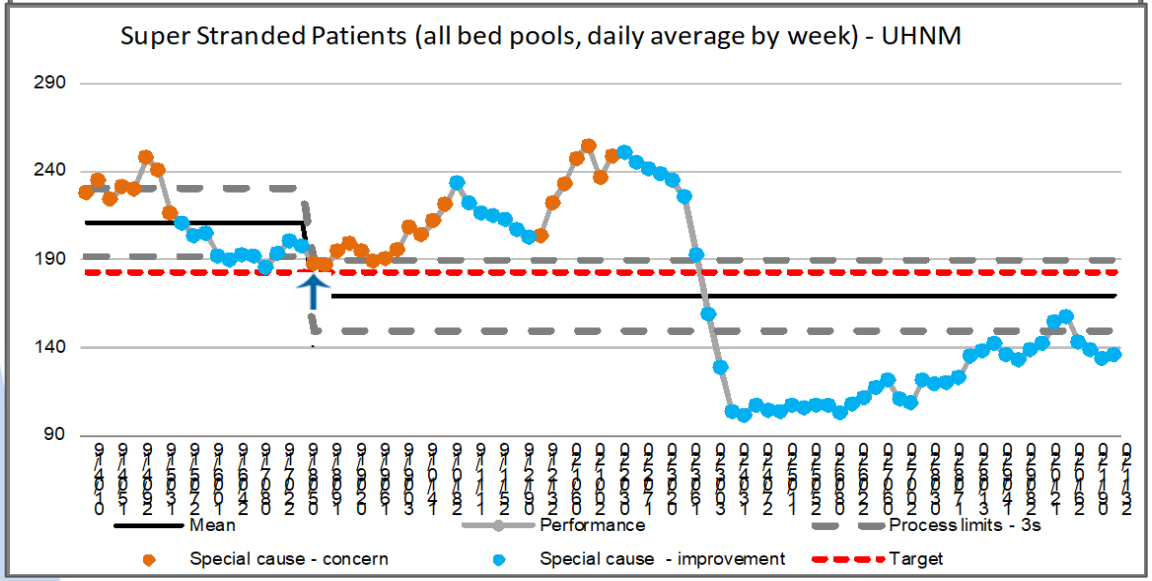
Although the Covid-19 pandemic has resulted in less beds occupied at the Trust , this measure shows that proportionately fewer occupied beds are patients waiting for transfer of care.

Discharges before midday

Discharges before midday has shown normal variation from and remains below the mean. 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 have seen normal variation. 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

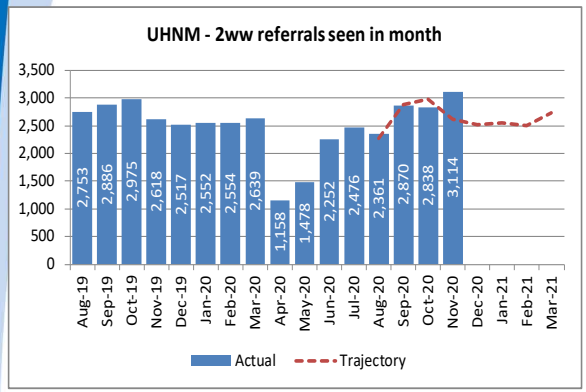
Summary:

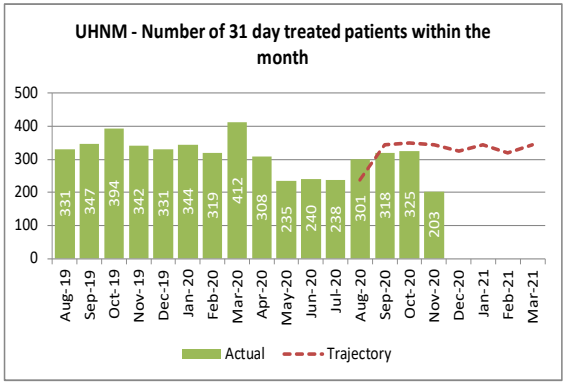
- The length of time patients are waiting to be appointed from receipt of referral is still at it's lowest in the past 4 months. The 48 hours KPI is still being met.
- Provisional data suggests the trust saw the highest number of 2ww referrals on record in November. Currently being validated.
- There are currently 39 patients in the 104+ day backlog. This has remained static since last week. Despite trust pressures the 104+ day backlog has grown by only 16 patients since the start of November.
- The 62 day backlog has grown to 302 – the most challenged area is Lower GI with 120 currently over 62 days.
- Theatre planning for second surge underway: Increased theatre capacity at Rowley and Beacon Park will be allocated to urgent and cancer cases from 1st December.
- The Cancer Alliance have reinstated the weekly SITREP the corporate cancer team will report a narrative of themes affecting pathway delays and numbers on the PTL to the cancer alliance, and access mutual aid if needed.
- The Cancer Alliance are leading conversations between providers to identify bottlenecks and implement escalation processes to utilise theatre capacity on a wider footprint if required.
- Divisions are being encouraged to access mutual aid and a weekly assurance meeting will be instigated to identify suitable patients.
- COSD data completeness has improved for the 6th consecutive month, as a result of the new COSD role.
- Challenges ahead:
    - Maintaining diagnostic activity to prevent PTL growth
    - Covid related sickness impacting clinical and admin teams
    - Critical care provision impacting theatre capacity optimisation

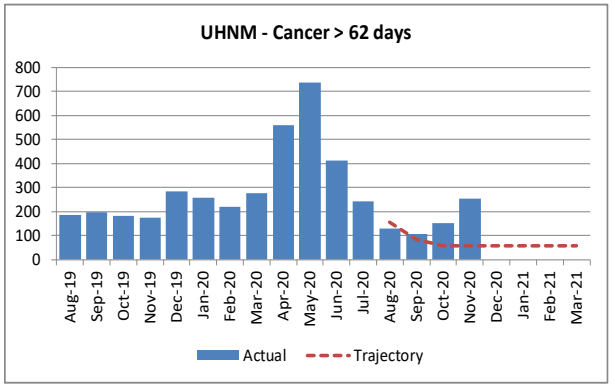
Actions:

- The trust has been awarded funds to implement Rapid Diagnostic pathways for it's most challenged areas – the investment in Endoscopy and Radiology will support the Lower GI pathway to become more efficient and deliver a definitive ruling out or diagnosis of cancer quicker, reducing the volume of patients waiting in the backlog.
- Theatre planning to increase capacity in the independent sector will be allocated to urgent and cancer cases from 1st December.
- The surgical division has oversight of the template sessional capacity for the Acutes and IS, and uses this to manage session fill.
- CTS activity has been reinstated and divisional colleagues are rebooking affected patients
- Clinical prioritisation meetings are focusing on options to optimise available in house theatre capacity and prioritise high risk and urgent cancers
- West Midlands Cancer Alliance Surgical Hub option escalated to and sent out to clinical and directorate colleagues
- Information dept are working on a theatre dashboard to describe booking activity and keep rebooking activities in line with surgical priority category timescales.
- Weekly assurance meetings with directorate managers will ensure patients surgical priority timescales clocks are managed through the cancer PTL and dated in time.
- Lead Cancer Nurse is advising on Health Education England investment in primary care and speaking with Macmillan GP colleagues, to improve education on cancer referrals, to improve referral completeness and criteria compliance.

Cancer

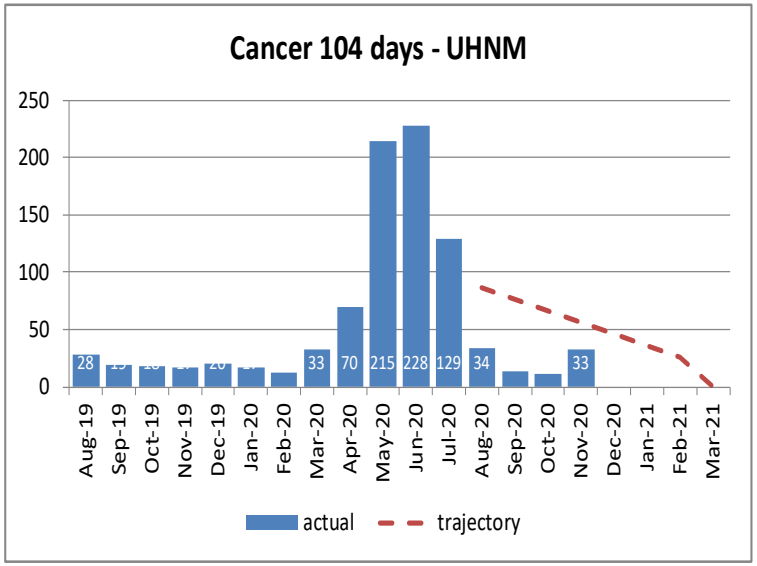






Nov-20	Target	Trust Actual	Clock Stops	Breaches	Breaches over	Needed treatment
2WW Standard	93%	88.1%	2828	349	152	2158
2WW Breast Symptomatic	93%	92.9%	45	5	2	27
31 Day First	96%	96.6%	148	4	*Achieved!*	*Achieved!*
31 Day Subsequent Anti-Cancer Drugs (inc. Chemo)	98%	100.0%	9	0	*Achieved!*	*Achieved!*
31 Day Subsequent Surgery	94%	89.7%	19	3	2	32
31 Day Subsequent Radiotherapy	94%	97.0%	27	1	*Achieved!*	*Achieved!*
62 Day Standard	85%	63.8%	78	31	20	129
Rare Cancers - 31 Day Pathway	85%		0	0	1	1
62 Day Screening	90%	75.0%	17	5	4	34
28 Day FDS Standard	75%	77.4%	1057	221	*Achieved!*	*Achieved!*
62 Day Consultant Upgrade	93%	88.2%	48	4	1	10
Closed Pathways > 104 Day			4.5			

as at 03/12/20



Planned care - *Inpatients*

University Hospitals of North Midlands NHS Trust

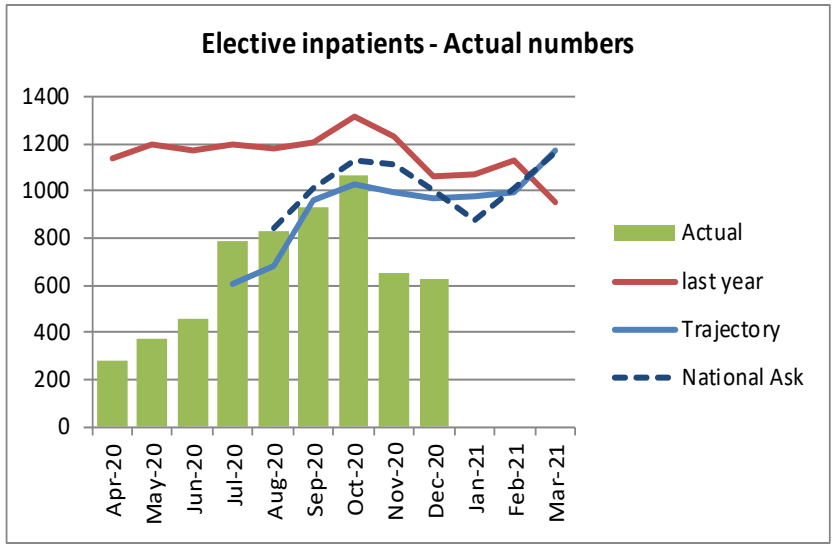
Elective inpatients Summary

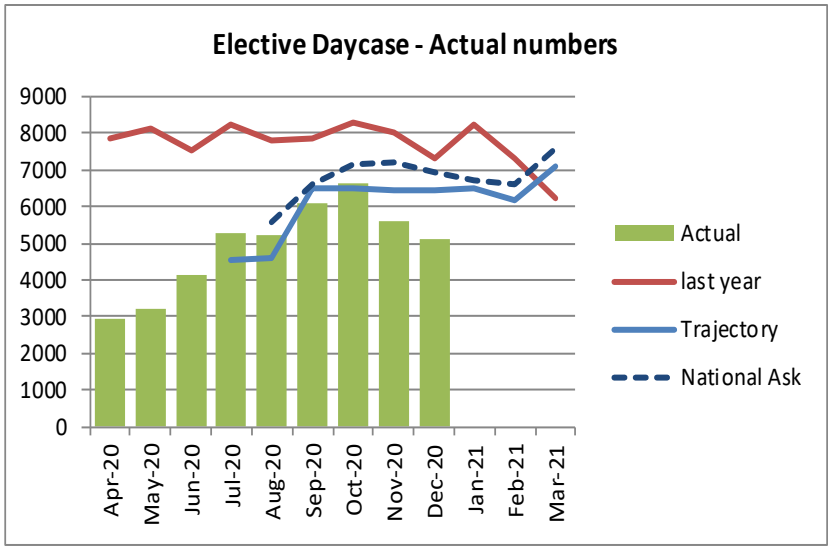
- Elective/Daycase activity had seen a steady rise since April 20 in line with restoration plans until November when special cause occurred (second wave Covid-19).
- For November, Elective inpatient activity (overnight) was **62.6%** of vs. trajectory. This is set against the increasing pressures the Trust experienced in November with more Covid-19 patients seen and admitted and bed closures due to Infection prevention.
- Daycases, had also risen since April and in November the activity was **85.1%** vs. trajectory. Priority is always given to cancers and urgent waiters.
- The number of elective operations and utilisation for both Royal stoke and County fell in November. For RS & County, Elective operations were c903 (compared to October 1220). Utilisation also fell to c74%. Cancellations on the day rose to 125. These are being driven by a number of factors but can all relate back to the second 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).

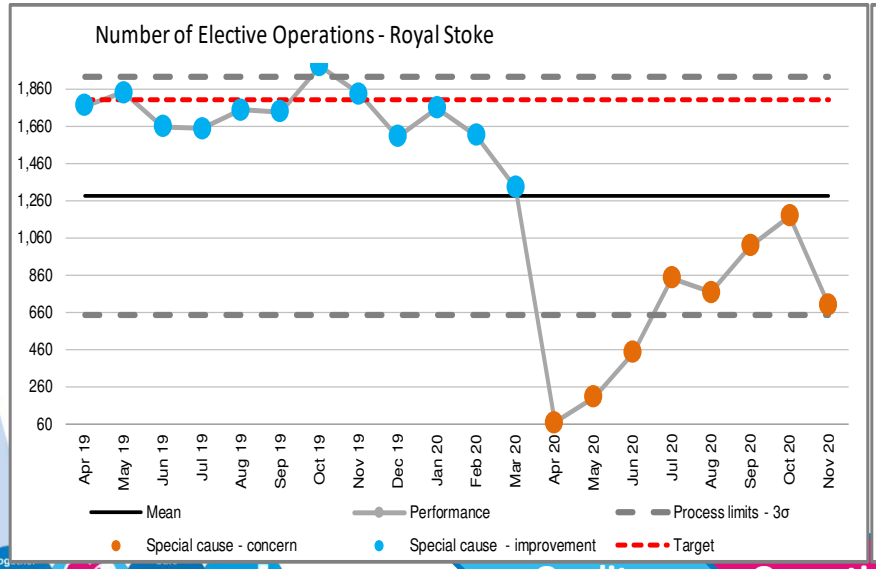
Actions

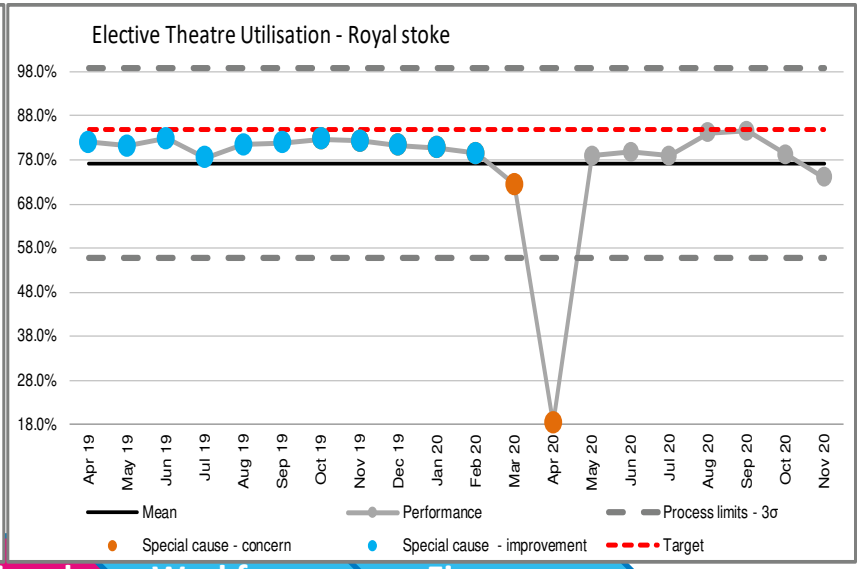
- Daily Clinical Prioritisation meetings re-established to support agile scheduling and maximisation of available capacity. Decision taken not to amend Theatre timetable but to review each list 24hrs in advance, asking teams to work with clinicians in prioritising cases such that where demand : capacity gap identified an informed decision is made regards cancellation or deferral. Reporting of outcomes has been established.
- **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 is now underway and making progress. Surgery have linked with information services to develop a report to support the identification & prioritisation of urgent electives, and will keep Outpatient Cell informed of potential impact on OP activity.
- County to be reviewed for protected trauma and orthopaedic electives (risk inherent with any covid surge impact).
- Endoscopy through 18 week source group and SHS will commence in December. 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 has been approved by the finance panel. First pre-assessment due to take place 28/11/20 and first theatre session to commence 07/12/20.
- 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

- Outpatient activity had seen a steady rise since April 20 in line with restoration plans until November when numbers reduced due to the covid second wave. Overall the Trust delivered 98.1% vs. trajectory.
- November showing an actual just below trajectory of -1,191 (98.1% versus trajectory, news 96.5% and F Ups 99%), but this deficit will be cleared as the 3000 outstanding outcomes (as at time of report) are completed.
- 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 November 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 November is 2,100 (October were 1,626). These are expected to grow further through the year with the Trust trajectory reaching 2756 in March 2021. further reviews are to be undertaken to support the reduction.
- November's performance for ASIs improved position to 86.8% within 3 days (from 82% in October) despite Covid pressures.
- For outpatient appointments (appointment type) the Trust delivered 56.5% F2F and 33% non F2F(Telephone & Video). There were 10.5% of appointments not set (for new appointment types F2F was 61% & non F2F 28% & follow ups F2F 54% & non F2f 36&). Work is underway to make the Media Type field in Medway mandatory which will eliminate 'Not Set'.

Actions

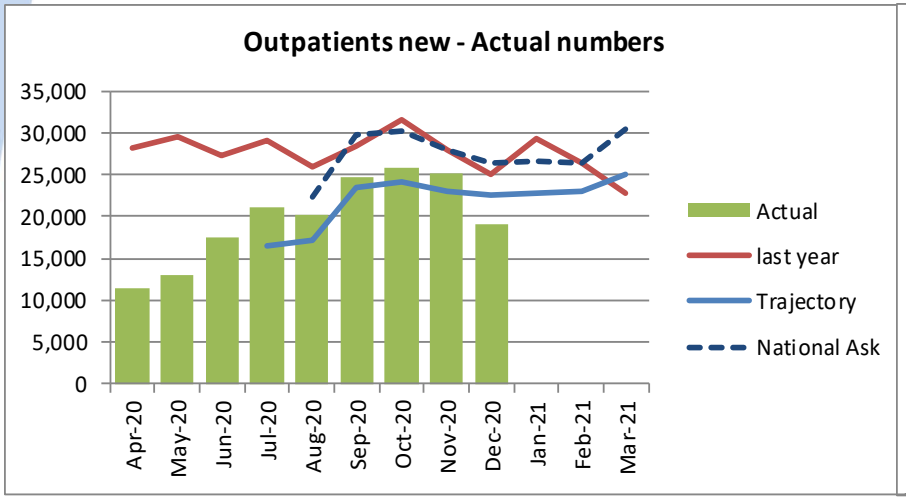
- Work is required on template reconfiguration based on Divisional assumptions - this needs to be aligned to the in patient and diagnostics plans for the purpose of substantive job planning.
- Revised 52 ww trajectory to be drafted once all cell plans confirmed to reduce the end of March 2021 delivery.
- 40+ week waiters are being planned with a combination of IS in/outsourcing and hospital capacity targeting categories 1, 1a, 2 and long waiters.

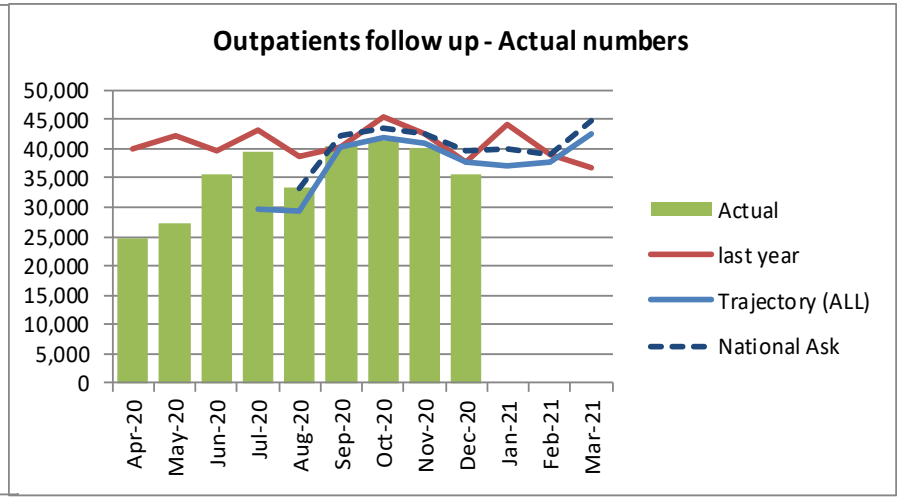
Risks:

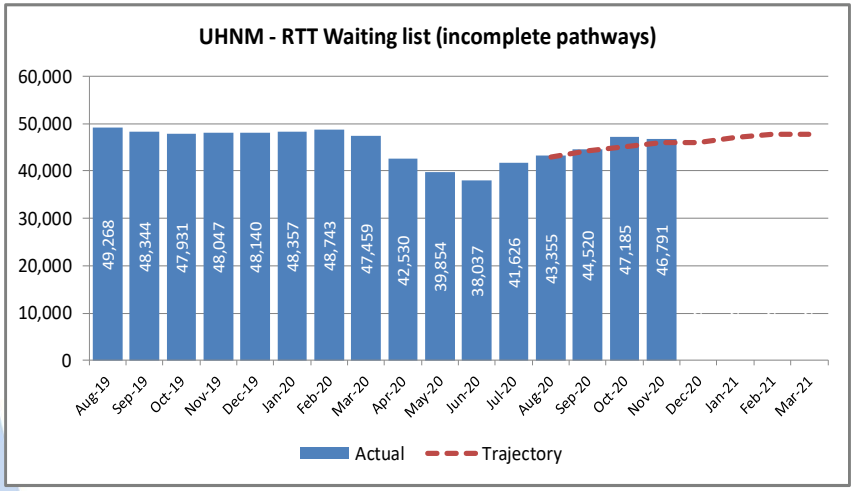
- Impact of stopping FTF activity in some areas to release staff to support frontline being monitored.

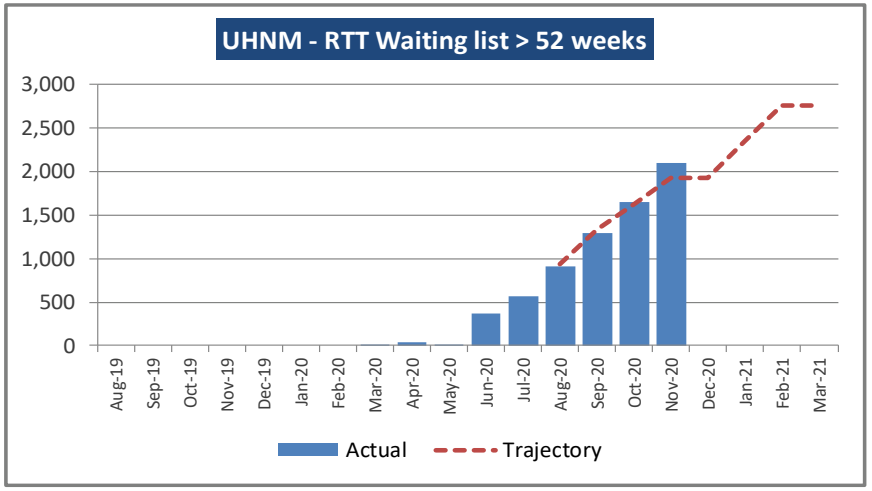
Together Compassion Safe Improving

Planned care – *Outpatient activity & RTT*





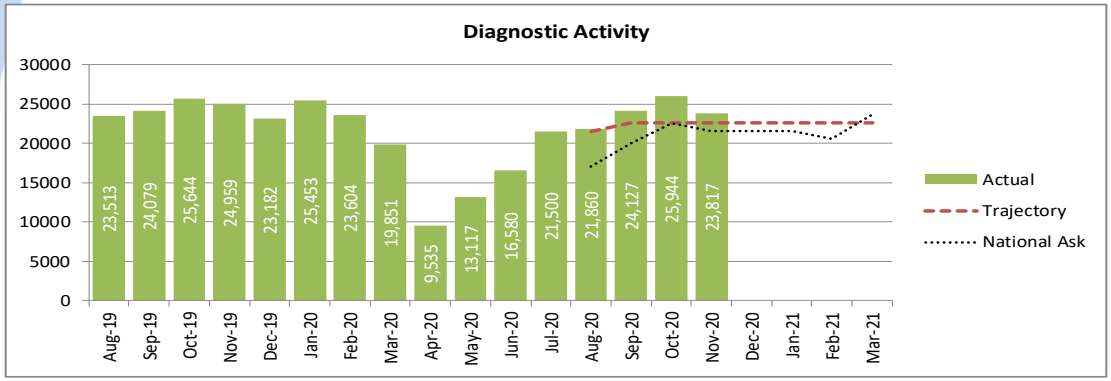




Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Diagnostic Activity



	Sep 20	Oct 20	Nov 20
Trajectory	22,608	22,608	22,608
Actual	24,127	25,944	23,817
Varience	1,519	3,336	1,209

Background

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

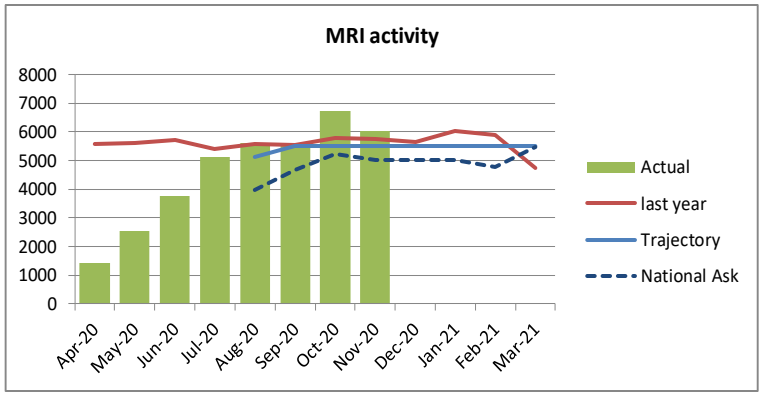
Summary

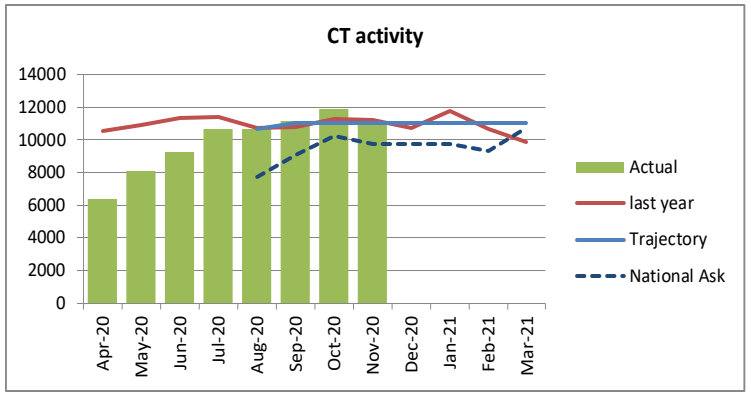
- For the 6 key diagnostic tests in phase 3, November saw a reduction in activity which appears to be normal variation. The trust trajectory for activity to the end of the year consistently meets the national ask and will see numbers return to similar levels as previous year.
- The trust trajectory for 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 November is 88.6%,. The waiting list size is also showing a reduction: down to 12,485. 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.

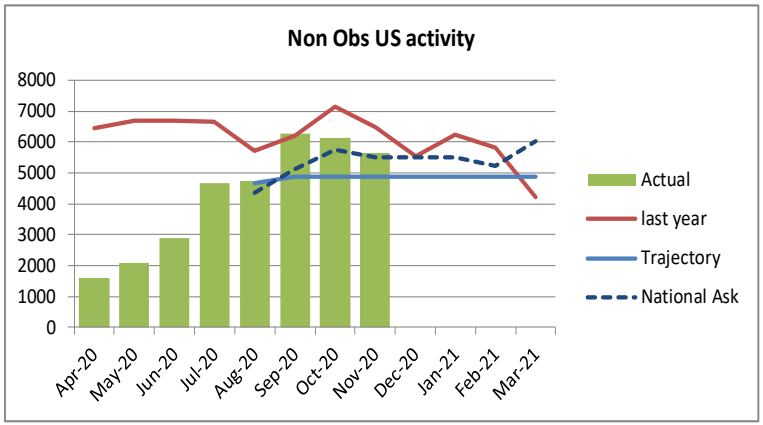
Actions

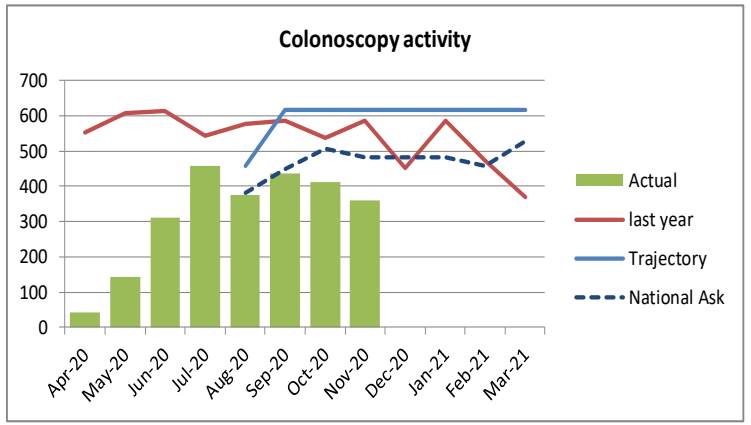
- The diagnostic work streams have made significant improvements and are working towards more initiatives to improve systems and processes.
    - Patient Connect is fully operational for pathology services and a scoping exercise underway to see if this can be transferred to other areas
    - Robotic 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 - ongoing
- The Diagnostic cell continues to monitor plans and activity against trajectory.
- Mobile MRI to continue to end of March 21.
- Investment papers have been submitted to continue recovery and restoration

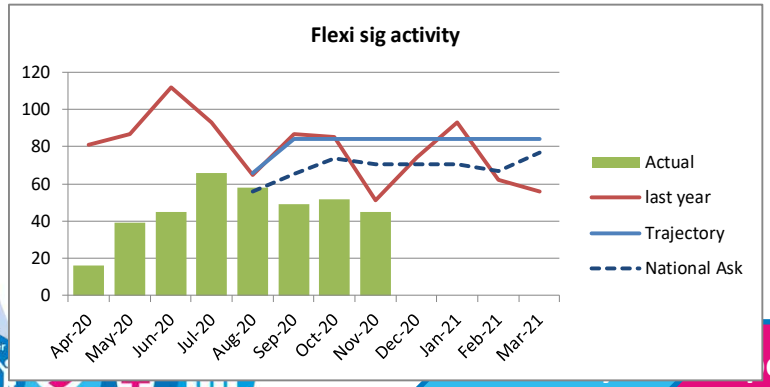
Diagnostics

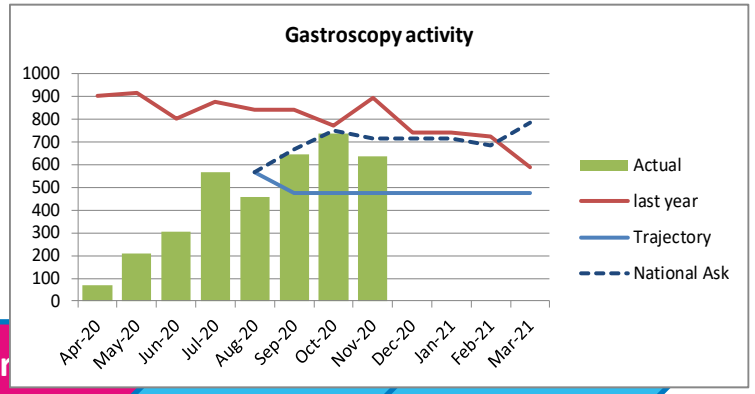












APPENDIX 1

Operational Performance

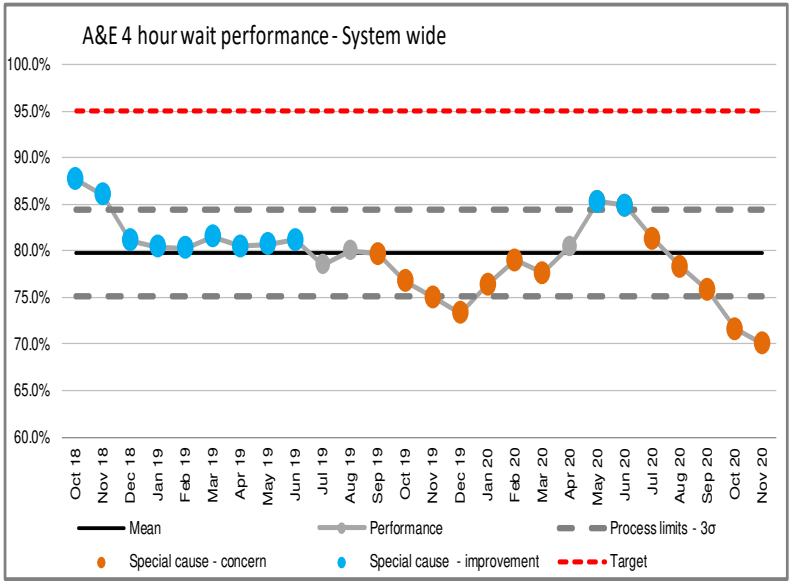
Constitutional standards

	Metric	Target	Latest	Variation	Assurance	DQAI
A&E	A&E 4 hour wait Performance	95%	70.00%	L	F	
	12 Hour Trolley waits	0	99		?	
Cancer Care	Cancer Rapid Access (2 week wait)	93%	88.09%		?	
	Cancer 62 GP ref	85%	63.81%		?	
	Cancer 62 day Screening	90%	75.00%		?	
	31 day First Treatment	96%	96.55%		?	
Elective waits	RTT incomplete performance	92%	66.94%	L	F	
	RTT 52+ week waits	0	2127	H	F	
	Diagnostics	99%	86.13%	L	?	

	Metric	Target	Latest	Variation	Assurance	DQAI
Use of Resources	DNA rate	7%	8.2%	H	?	
	Cancelled Ops	150	125	H	?	
	Theatre Utilisation	85%	74.0%			
Inpatient / Discharge	Same Day Emergency Care	30%	31.6%	H	?	
	Super Stranded	183	136	L	?	
	DToC	3.5%	1.60%	L	?	
	Discharges before Midday	30%	17.2%	L	F	
	Emergency Readmission rate	8%	12.7%	L	F	
	Ambulance Handover delays in excess of 60 minutes	10	236	H	?	

URGENT CARE – 4 hour access performance

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

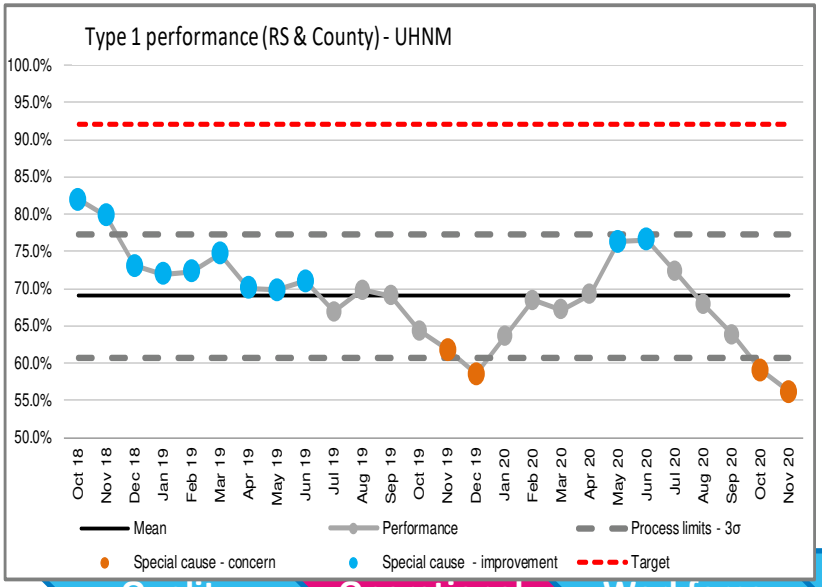
Target	Sep 20	Oct 20	Nov 20
95%	75.8%	71.6%	70.0%

Background

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

What is the data telling us?

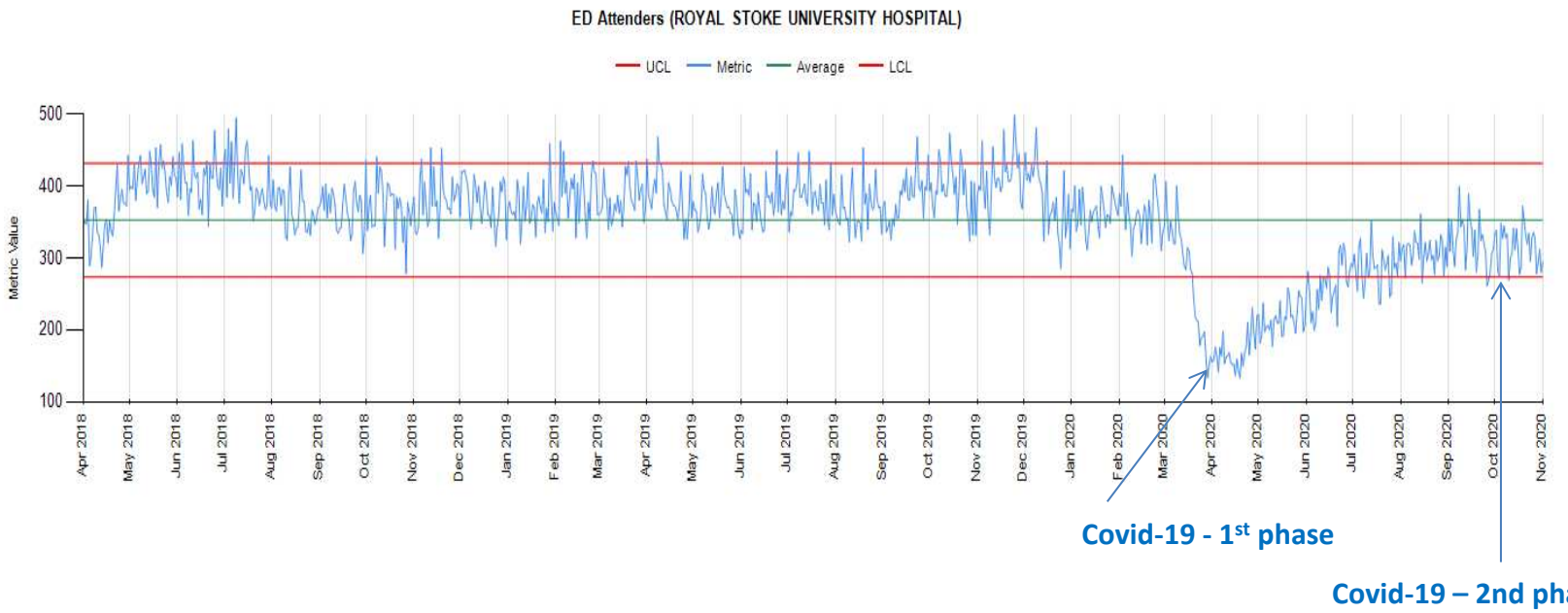
The improvemnets seen in May and June have not been sustained. However performance is still within the control limits and remains around the mean.



Together Compassion Safe Improving

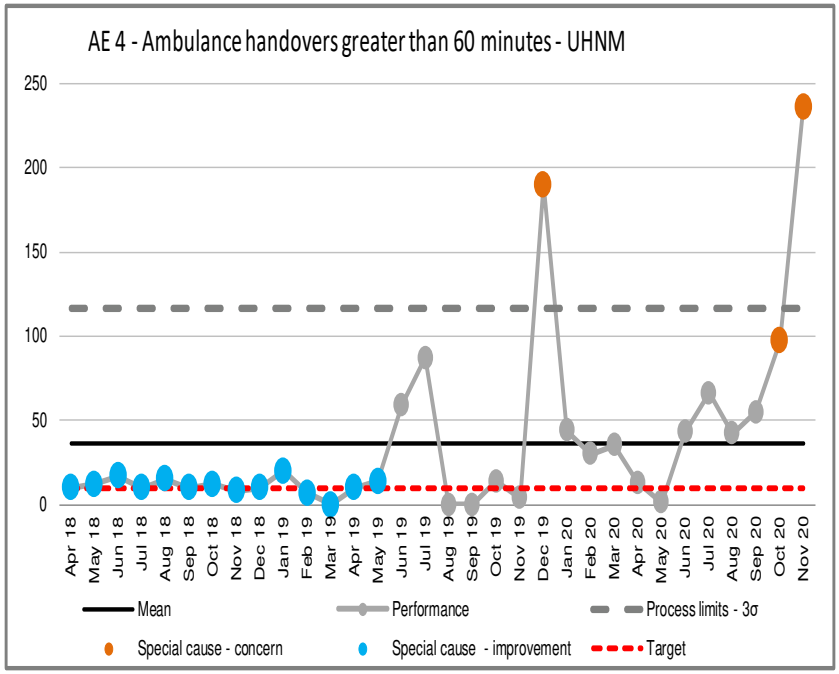
Quality | Operational | Workforce | Finance

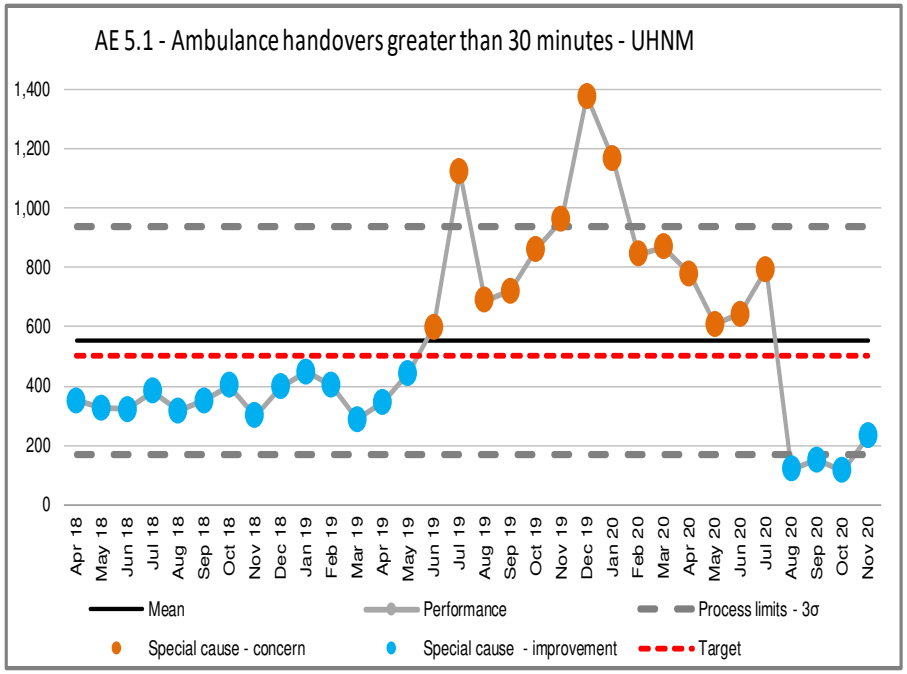
URGENT CARE – 4 hour access performance



Quality | Operational | Workforce | Finance

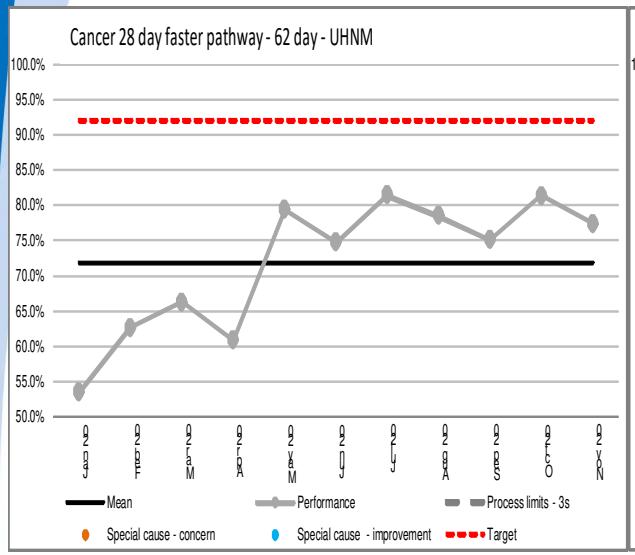
URGENT CARE – 4 hour access – ambulance handovers

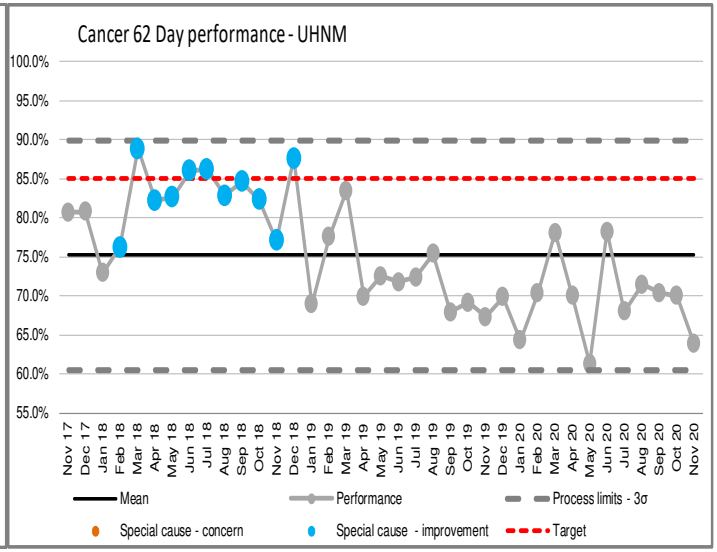




From August – internal validation of > 30 minutes

Cancer – 62 Day





Variation	Assurance

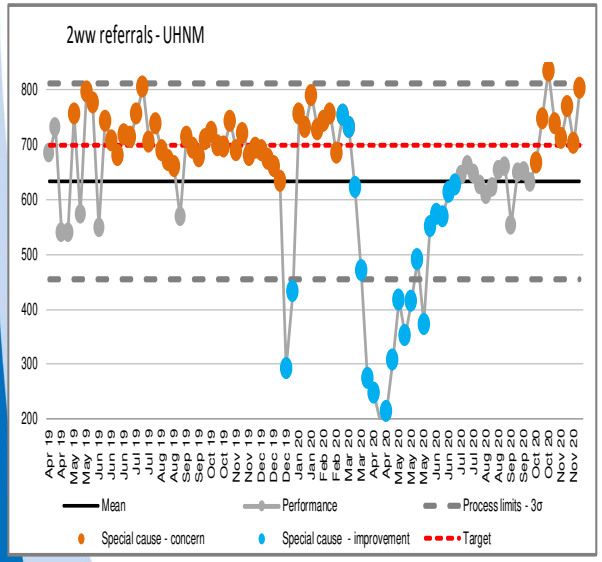
Target	Sep 20	Oct 20	Nov 20
85%	70.4%	70.0%	63.8%

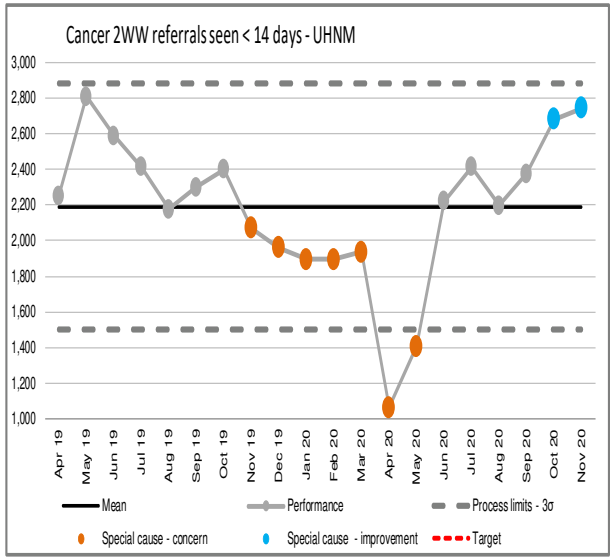
Background

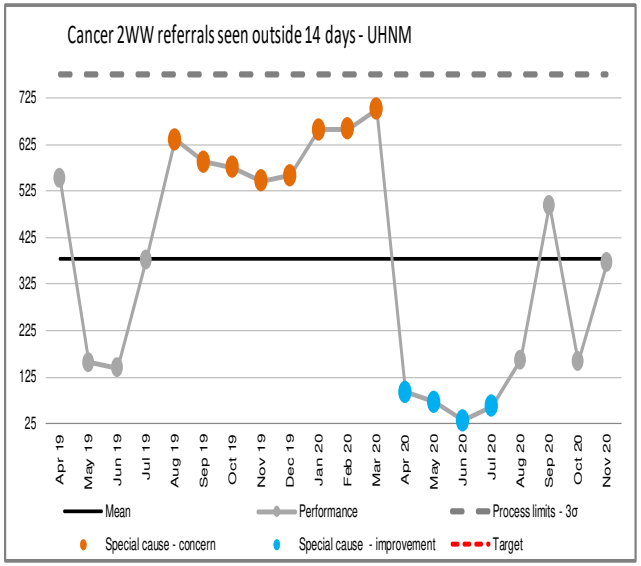
% patients beginning their treatment for cancer within 62 days following an urgent GP referral for suspected cancer

What is the data telling us?

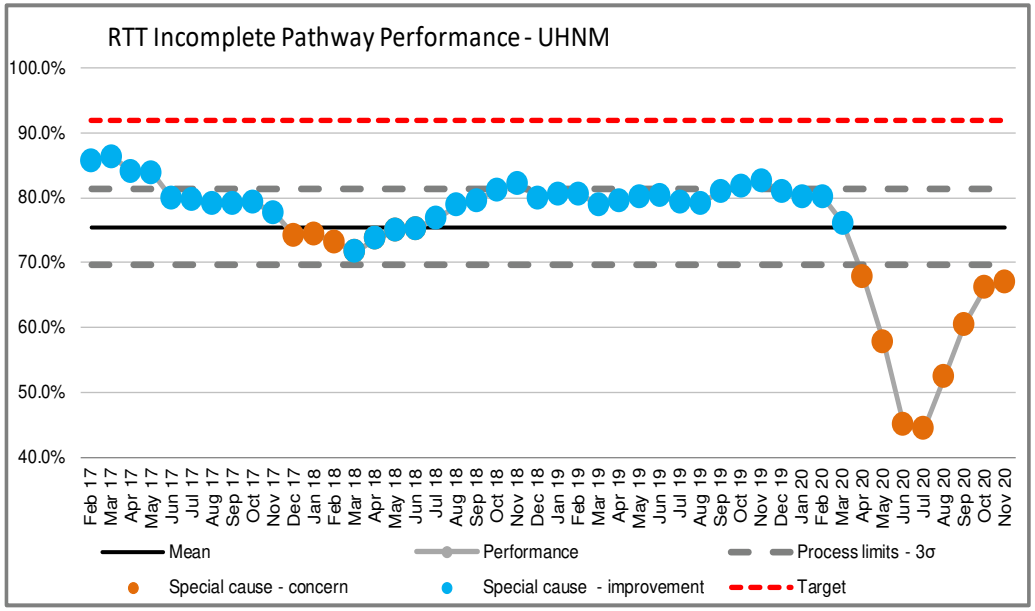
Performance shows normal comon cause variation. However this has been consistently below the mean since April 2019 (with just two data points above the mean). This indicates that the target is unlikely to be met.







Referral To Treatment



Variation	Assurance
	

Target	Sep 20	Oct 20	Nov 20
92%	60.5%	66.2%	67.0%

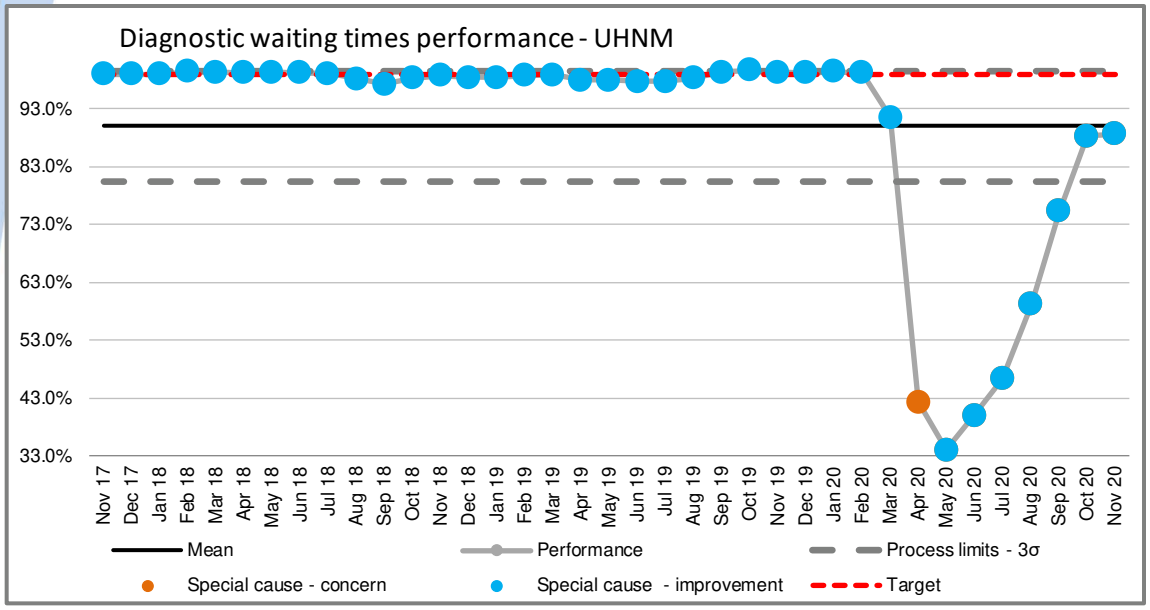
Background

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
	

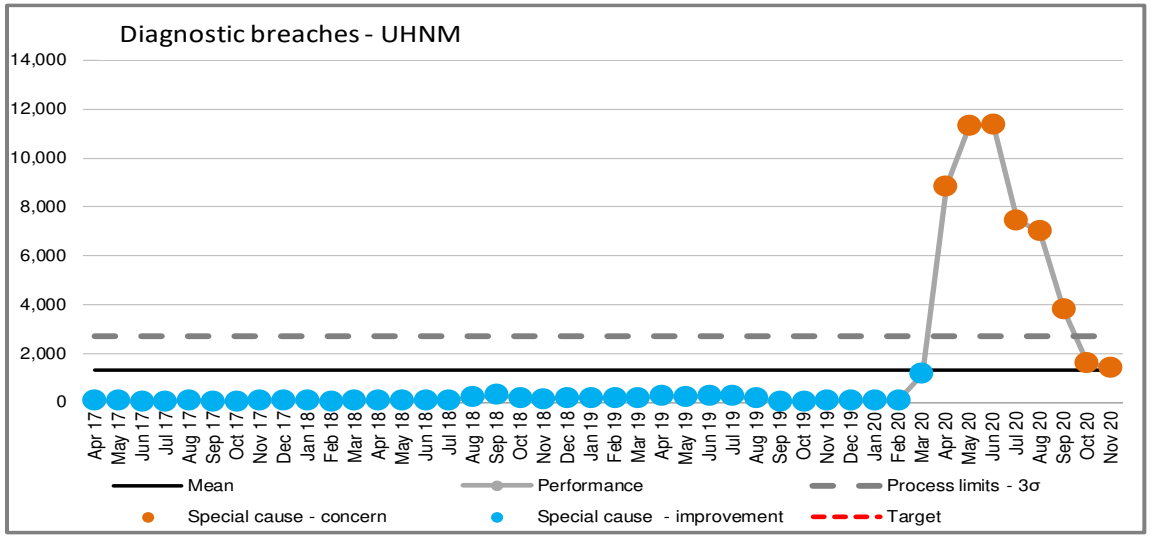
Target	Sep 20	Oct 20	Nov 20
99%	75.3%	88.3%	88.6%

Background

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

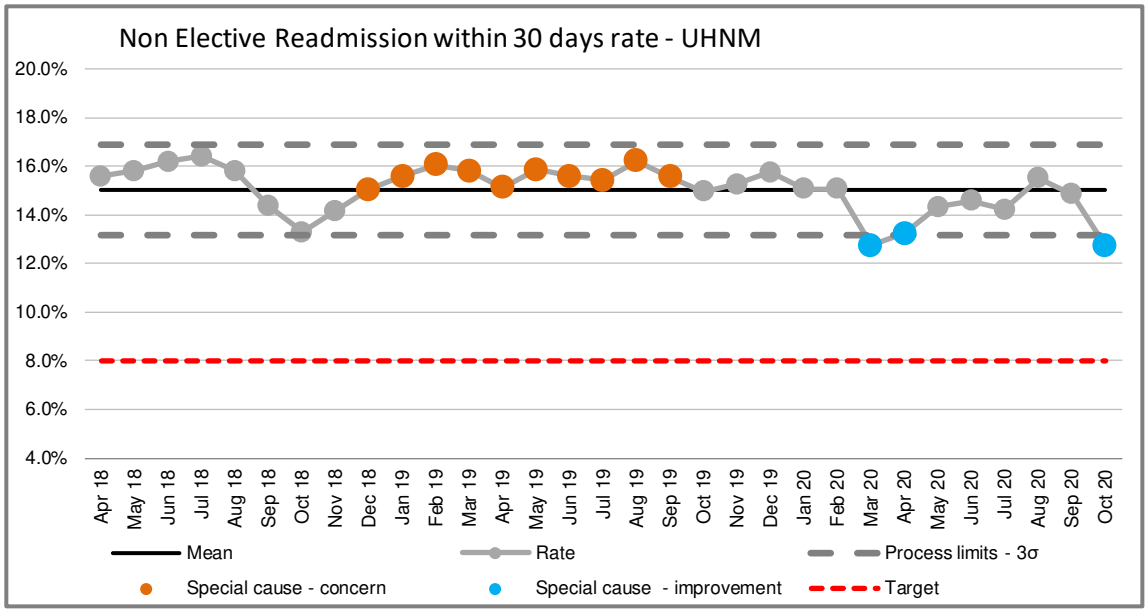
What is the data telling us?

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.



Quality | Operational | Workforce | Finance

Non-elective Re-admissions



Variation	Assurance
L	F

Target	Aug 20	Sep 20	Oct 20
8.0%	15.5%	14.8%	12.7%

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

NHS
University Hospitals of North Midlands
NHS Trust

APPENDIX 2
COVID 19
Gold Briefing

21/12/20

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Contents

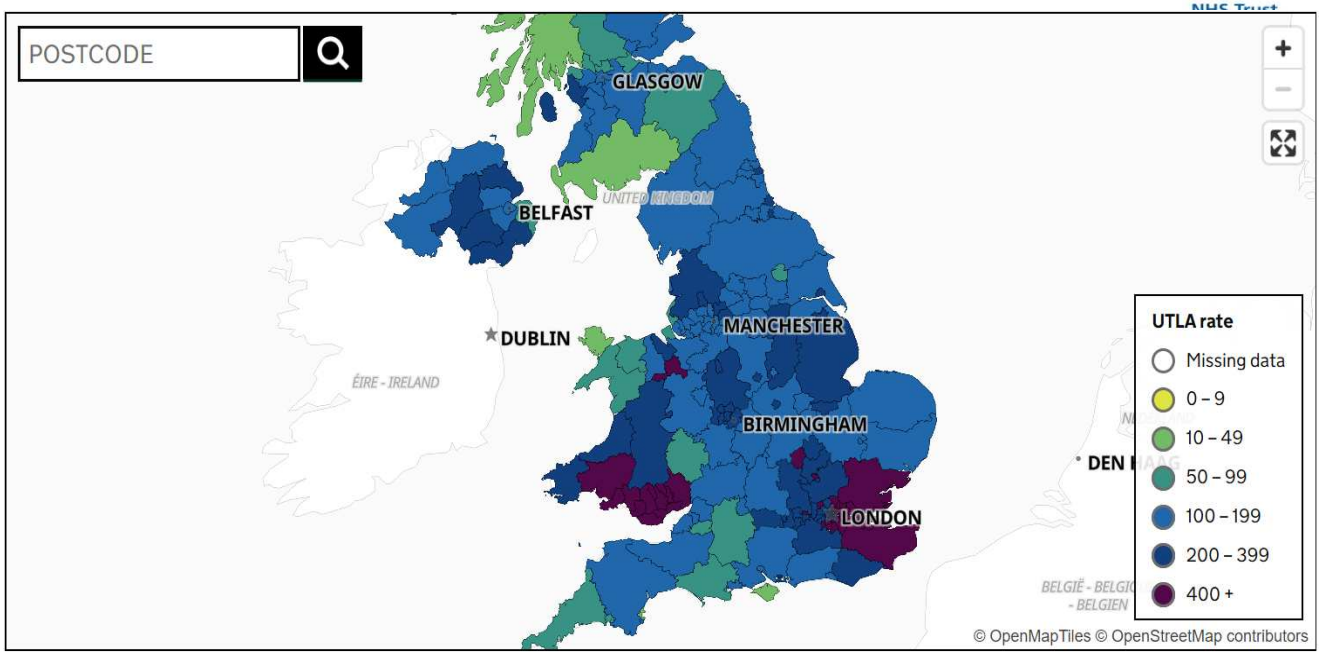
- Covid-19
  - Covid-19 prevalence
  - New cases / Nosocomial
  - Discharges / Deaths
  - Staffing
  - Testing
- R&R
  - A&E
  - Elective / Outpatient monitoring
  - Cancer performance
- Winter plan monitoring

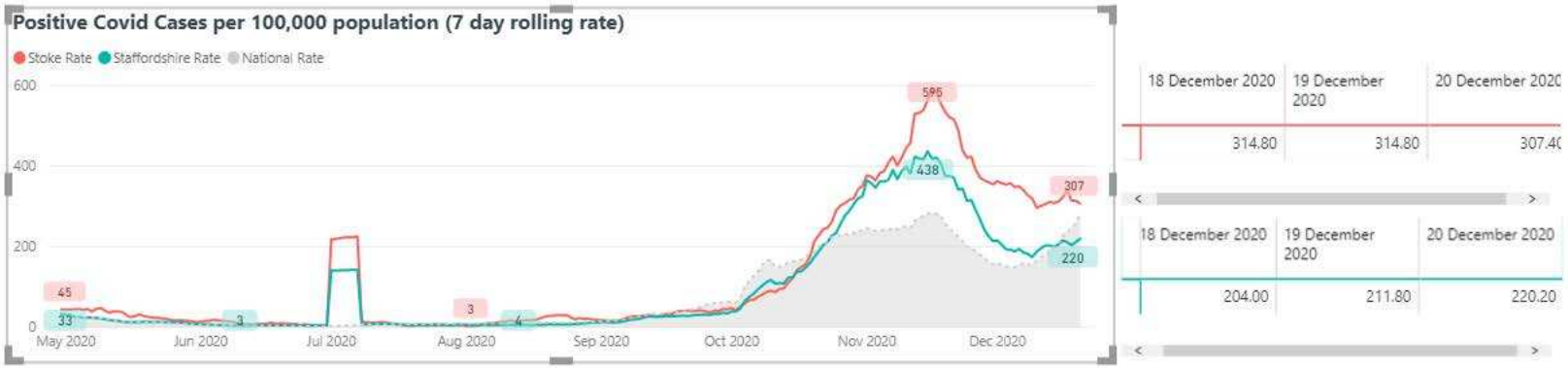
Covid-19 community prevalence

University Hospitals of North Midlands NHS Trust

National View

Local View





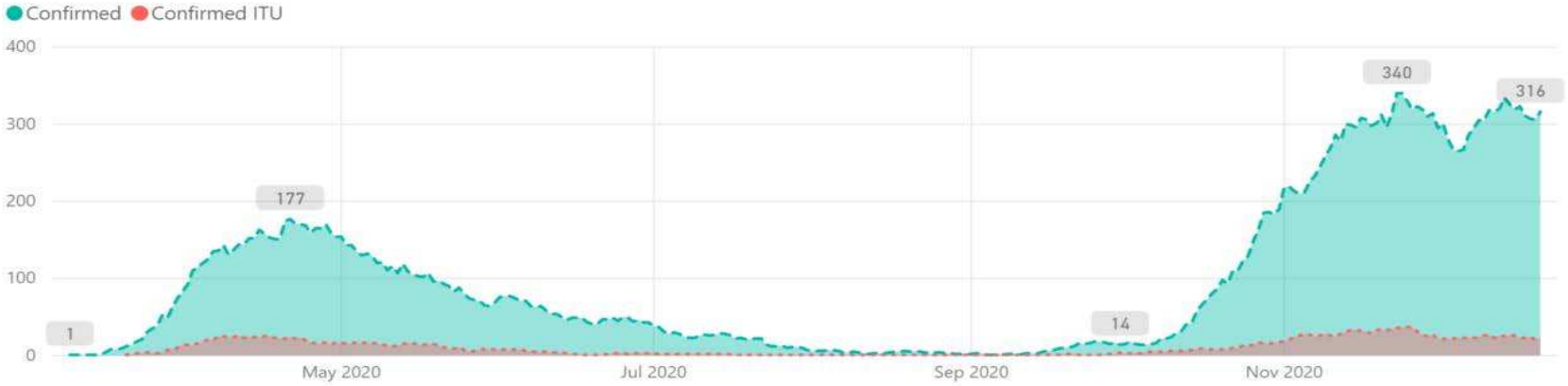
Quality | Operational | Workforce | Finance

Current Covid-19 Inpatients

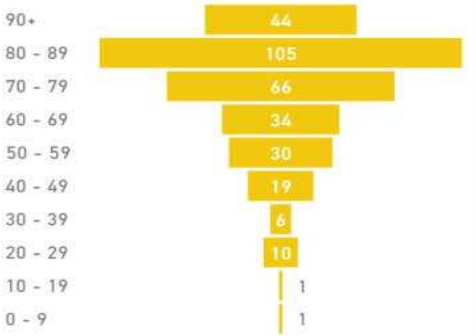
Bed type	19 December 2020	20 December 2020	21 December 2020
Total	**307**	**306**	**316**
Critical Care	24	21	23
Other	283	285	293

Site	19 December 2020	20 December 2020	21 December 2020
Total	**307**	**306**	**316**
County Hospital	41	44	41
Royal Stoke	266	262	275

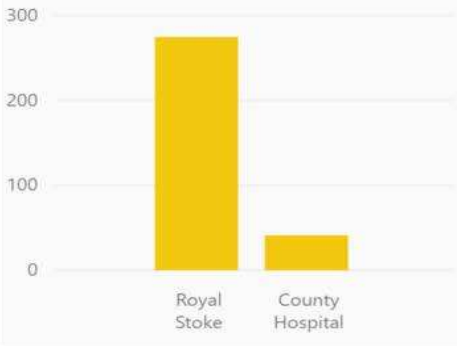
Covid inpatients



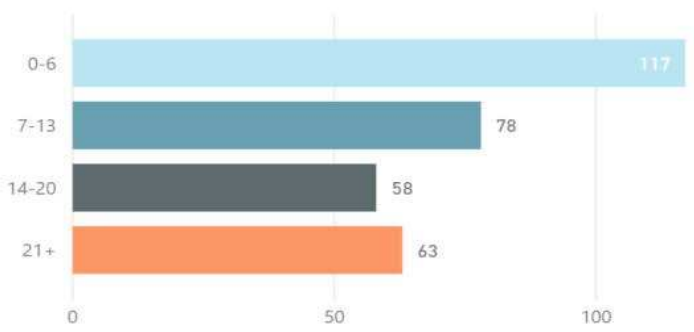
Age breakdown



Current inpatients by Site



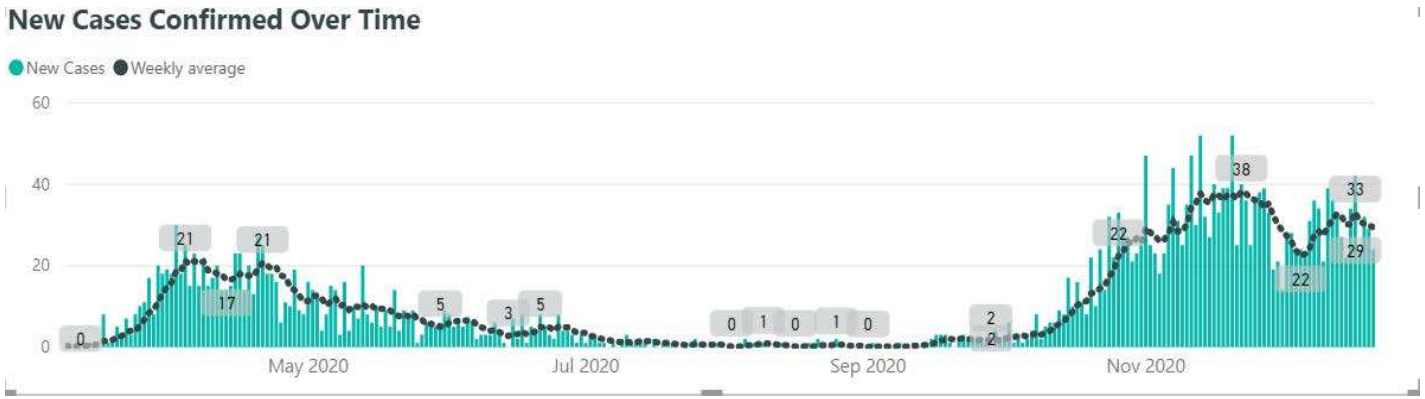
Patients on Wards by total LoS banding



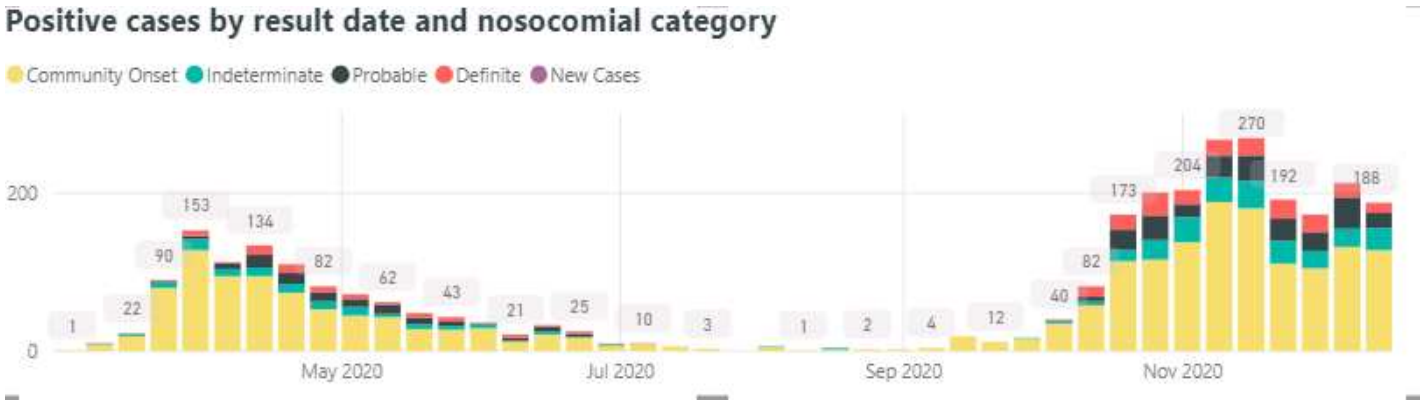
Covid-19 Demand (new cases confirmed)

NHS
University Hospitals of North Midlands
NHS Trust

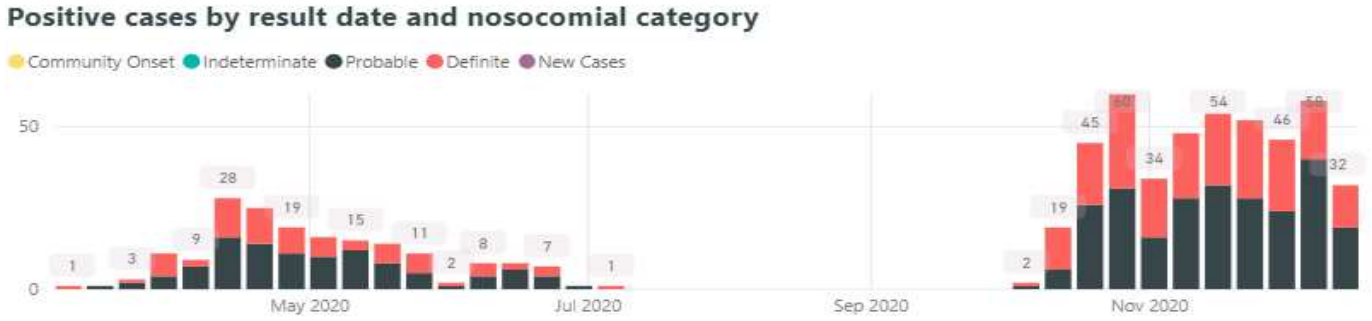
Averaging 29 new cases a day (7 day avg)



Drop in new community onset cases has stopped.



22 Nosocomial cases last week 15+ days LOS



Together
Compassion
Safe
Improving

Nosocomial infections

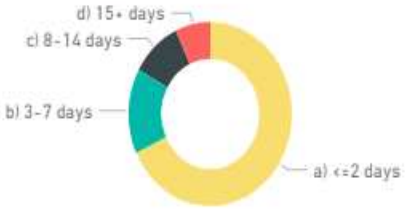
	Community Onset	Indeterminate	Probable	Definite
This Week (so far)	(Blank)	(Blank)	(Blank)	(Blank)
Last Week commencing 14 December 2020	128	28	19	13

Last week

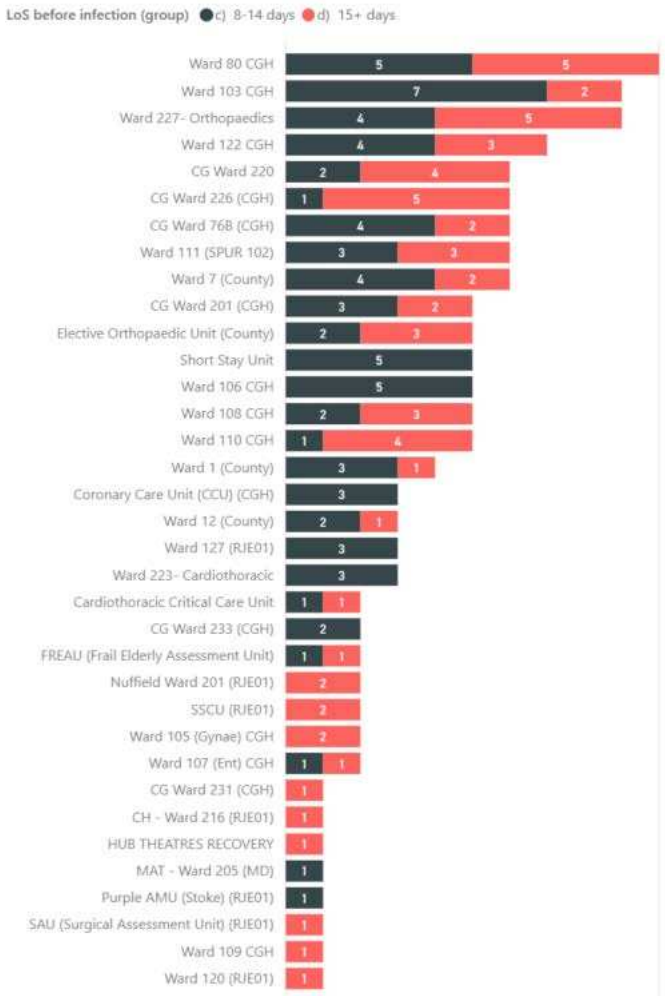
Total

LoS before infection (group)	New Cases	%
a) <=2 days	128	68.09%
b) 3-7 days	28	14.89%
c) 8-14 days	19	10.11%
d) 15+ days	13	6.91%
Total	188	100.00%

Proportion by LoS



Wards with Nosocomial cases (Last week)



68% of cases last week were Community onset (<2days LoS before infection)

Ward 80saw the highest number of Nosocomial infections

Together Compassion Safe Improving

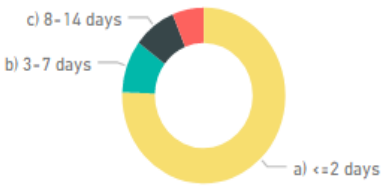
Quality | Operational | Workforce | Finance

University Hospitals of North Midlands NHS Trust

Wave 1 – (23 March – 10th May)

LoS before infection (group)	New Cases	%
a) <=2 days	570	75.60%
b) 3-7 days	73	9.68%
c) 8-14 days	64	8.49%
d) 15+ days	47	6.23%
Total	**754**	**100.00%**

Proportion by LoS

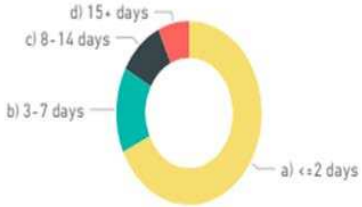


Last week

Total

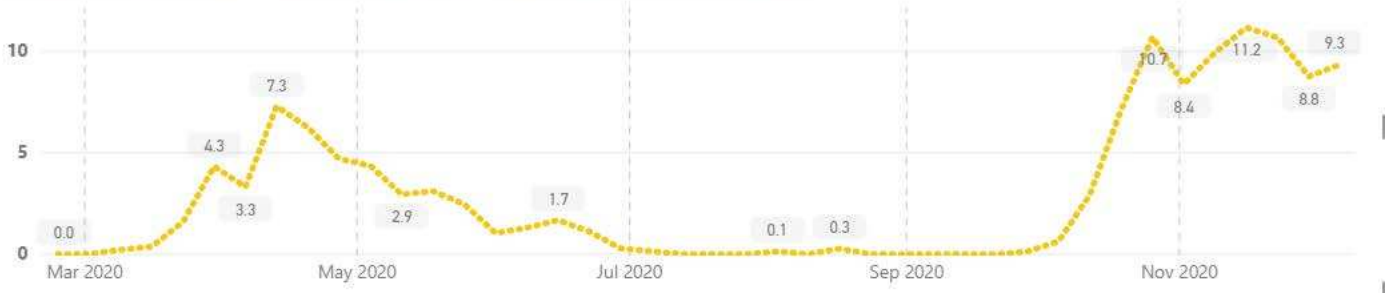
LoS before infection (group)	New Cases	%
a) <=2 days	128	68.09%
b) 3-7 days	28	14.89%
c) 8-14 days	19	10.11%
d) 15+ days	13	6.91%
Total	**188**	**100.00%**

Proportion by LoS



Nosocomial (3+ days) rate per 1,000 bed days remains high at 9.3

Nosocomial rate per 1000 bed days (3+ days LoS before infection)



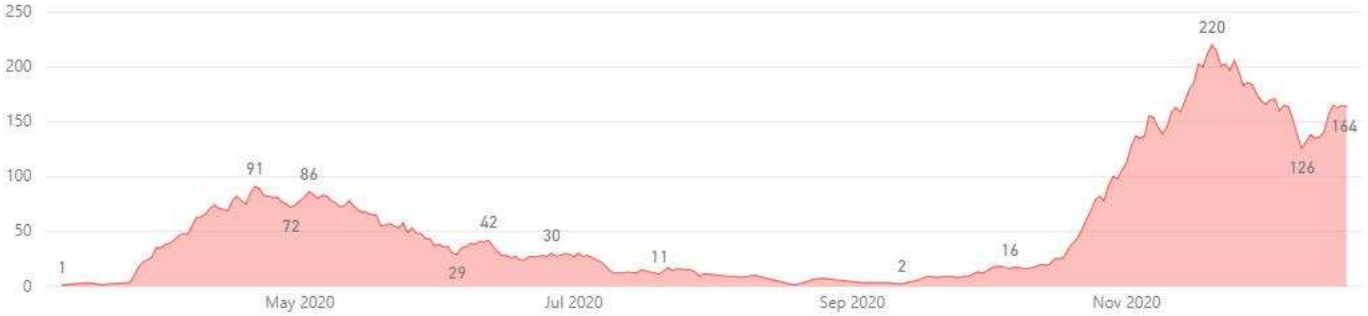
Covid-19 Discharges (excluding death)

NHS
University Hospitals of North Midlands
NHS Trust

Rolling weekly total discharges has fallen to 114 impacting on the number of Covid beds in use

Discharges Over Time

Discharges - 7 day rolling sum

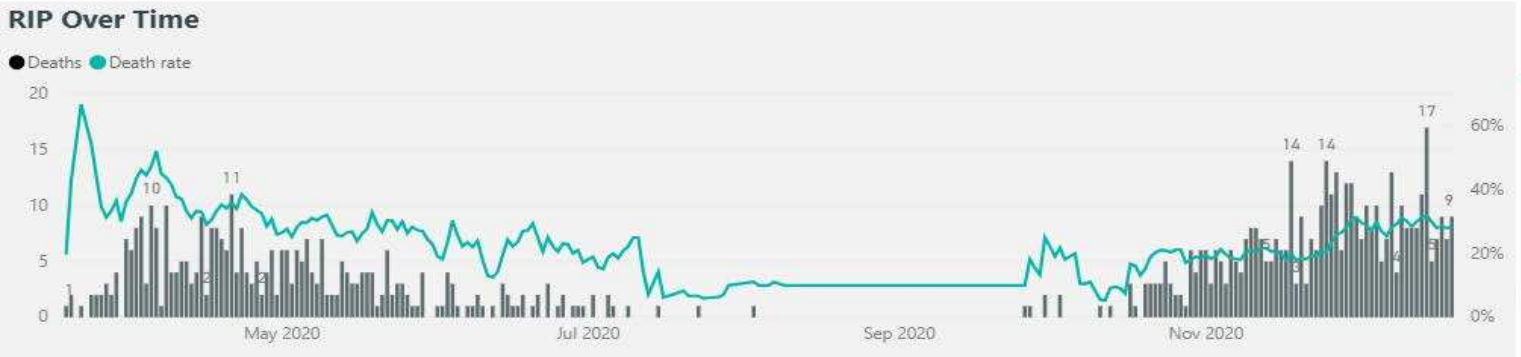


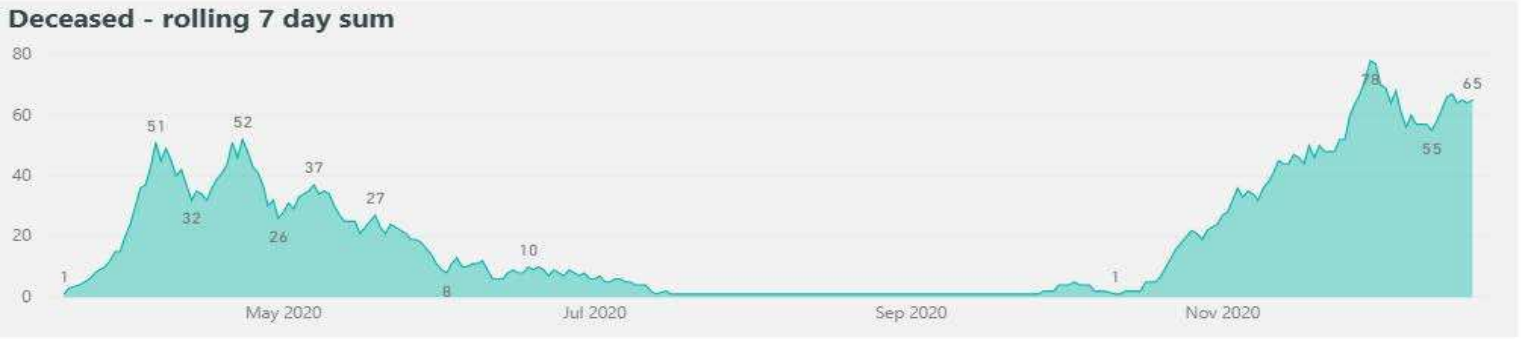
Together Compassion Safe Improving

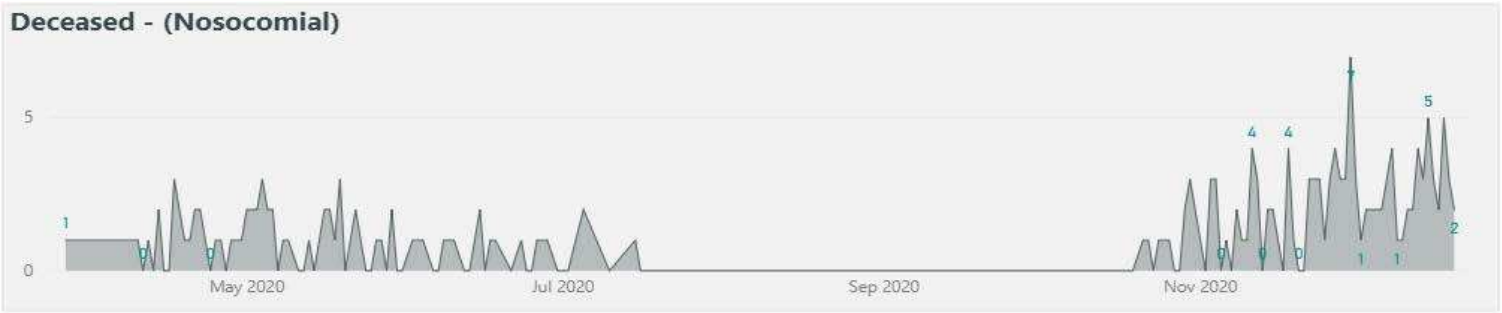
Quality | Operational | Workforce | Finance

Covid-19 Deaths

The number of deaths being recorded has plateaued – total 65 over last 7 days. The proportion of discharges that are deaths has risen due to the discharge number falling.





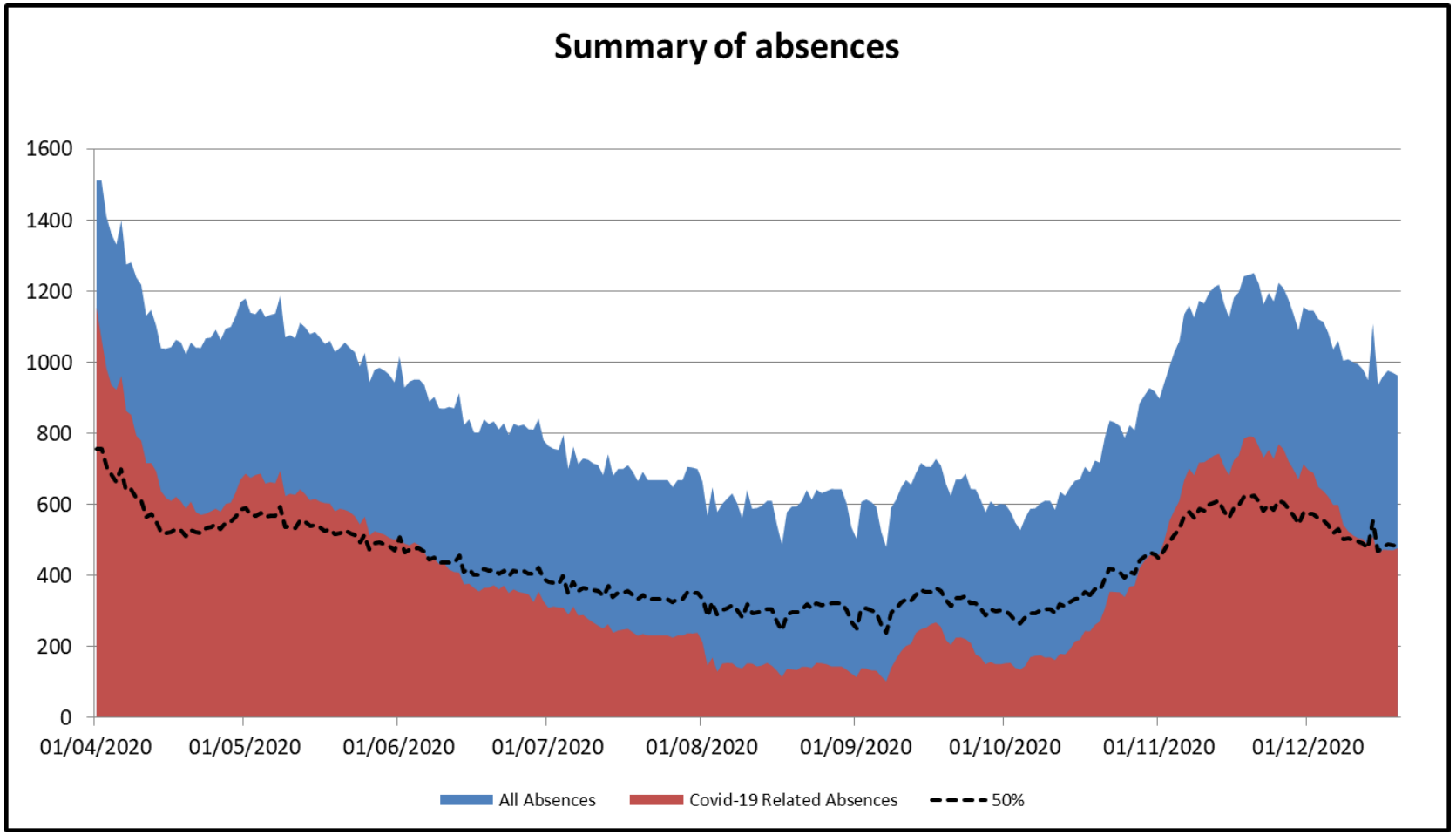


Quality | Operational | Workforce | Finance

Staffing – absence over time

University Hospitals of North Midlands NHS Trust

Overall absence is lower than seen in peak of wave 1.



Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Staffing

University Hospitals of North Midlands NHS Trust

11% absence overall with Medicine seeing the highest number off.

Staffing

958
Total staff sickness

8.8%
overall

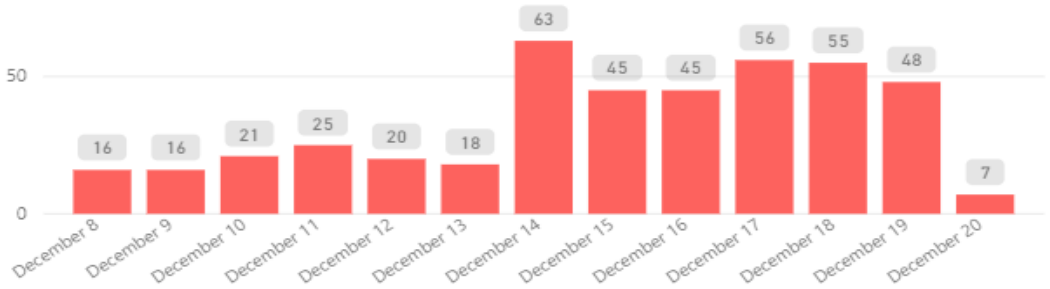
480
Total Covid-19 related

50.1%
% Covid related

Sickness - Divisional and Directorate breakdown

Division	Absent	CV19 Related	CV19Remote Working
205 Central Functions	43	17	0
205 Children's, Women's & Diagnostics	197	89	0
205 Estates, Facilities and PFI Division	39	20	0
205 Medicine Division	310	180	1
205 Specialised Division	158	92	0
205 Surgical Division	211	82	1
Total	**958**	**480**	**2**

New episodes of sickness started (previous 14 days)



Org Unit breakdown

Org Unit	Staff	absent %	Staff absent
205 PFI Spec Flow Coordinators	1	100.0%	1
205 Rheumatology Med Staff	1	100.0%	1
205 County Audiology Department	6	50.0%	3
205 Waste Management	2	50.0%	1
205 General Medicine Ward 81	43	44.2%	19
205 County Discharge Team	5	40.0%	2
205 General Mngt Team	5	40.0%	2
205 Asthma (HAZ)	6	33.3%	2
205 Medical Discharge Lounge	9	33.3%	3
205 OPHAT Service	3	33.3%	1
205 Gastro Ward 230	49	28.6%	14
205 Child Health Admin Staff	34	26.5%	9
205 Ward 80 (Elderly Care)	35	25.7%	9
205 Cardiothoracic Surgery Ward	47	25.5%	12
205 County Shift Tradesmen	4	25.0%	1
205 Health & Safety Team	4	25.0%	1
205 Respiratory Pleural Service	4	25.0%	1
205 Specialised Surg Ward	48	25.0%	12
205 Widening Participation	4	25.0%	1
205 Medical Outpatient Clinics	30	23.3%	7
205 Elective Orthopaedic Unit	39	23.1%	9
205 Infectious Disease Ward	32	21.9%	7
205 Acute Cardiology Ward	57	21.1%	12
205 Cardiothoracic Crit Care Ward	78	20.5%	16
205 Early Pregnancy Unit	10	20.0%	2
205 ENT Clinic	15	20.0%	3
205 E-rostering	5	20.0%	1
205 Renal - Support Services Team	10	20.0%	2
205 Vulnerable Adults Team	5	20.0%	1
205 W/force Planning & Info	5	20.0%	1
205 Ward 76B (Elderly Care)	40	20.0%	8
205 Neurosurgery Ward	51	19.6%	10
205 Renal Haemodialysis Unit	46	19.6%	9
205 County Elderly Care Ward	44	18.2%	8
205 Hub Theatres (Th20-33)	11	18.2%	2
205 Neurology Ward	39	17.9%	7
205 Surg Short Stay Ward 102	39	17.9%	7
205 Palliative Care Dept	17	17.6%	3
205 Recovery Theatres	121	17.4%	21
205 Cardiology Ward	35	17.1%	6
205 SSCU	59	16.9%	10
205 County Elderly Care - Medical	6	16.7%	1
205 County Portering	24	16.7%	4
Total	**10857**	**8.8%**	**958**

Staff Testing

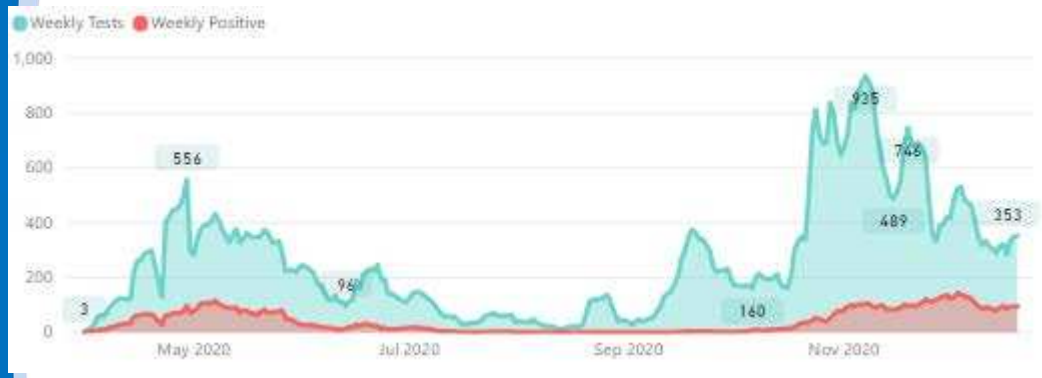
NHS
University Hospitals of North Midlands
NHS Trust

Last 7 days

Total Tests	Positive Results	Positivity %	Symptomatic
353	95	26.9%	0 308 353

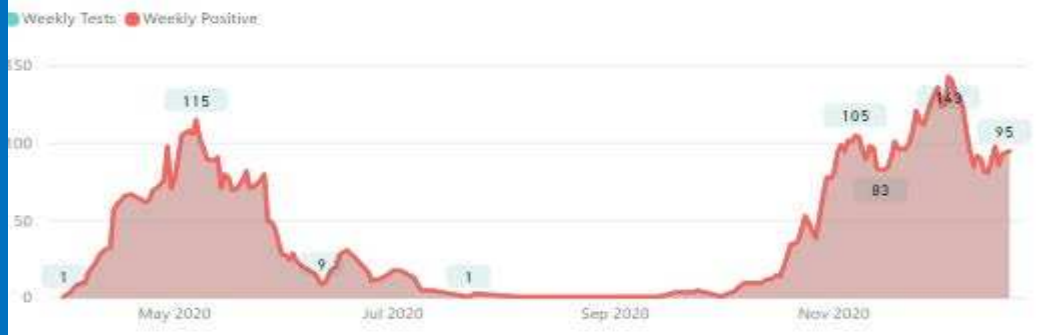
Total TAT	
Mean	18.1
95%	32
Max	493

Weekly staff tests for UHNM staff



Tests have risen to 353 from 306 last week

Weekly positive staff test results



Lateral Flow – Subsequent PCR tests

Total Tests	Positive Results	Positivity %
39	36	92.3%

Number of Staff testing positive up vs last week at 95

Compassion
Improving

University Hospitals of North Midlands NHS Trust

Tests resulted split by main requesting organisations

Covid Testing – UHNM only

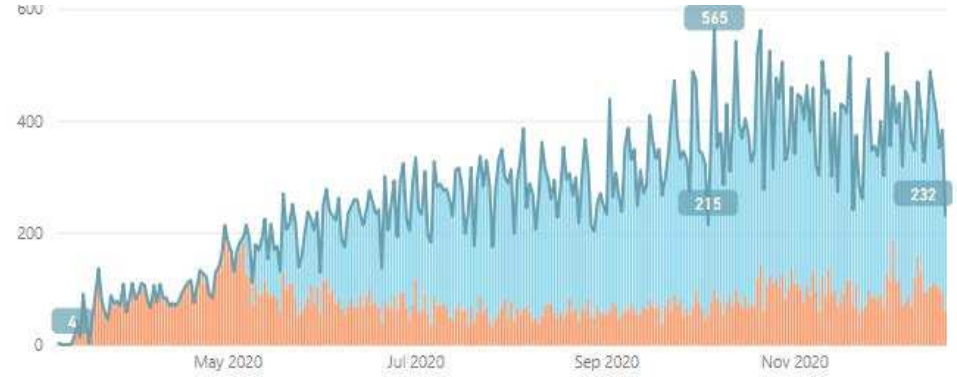
- Weekly test number slightly down to 2712
- Symptomatic tests seen an decrease

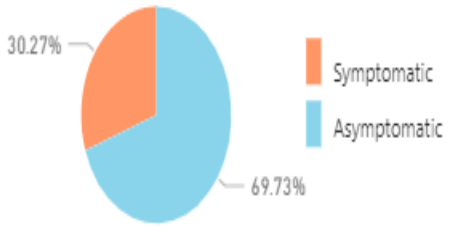
Yesterday

Total Tests	Positive Results	Positivity %	Symptomatic
232	29	12.5%	0 61 232

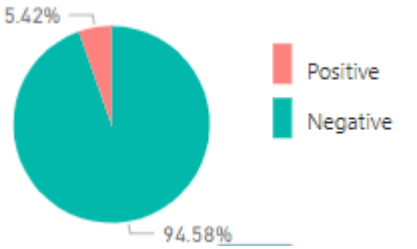
Last 7 days

Total Tests	Positive Results	Positivity %	Symptomatic
2,712	284	10.5%	0 673 2,712





Weekly Tests Weekly Positive

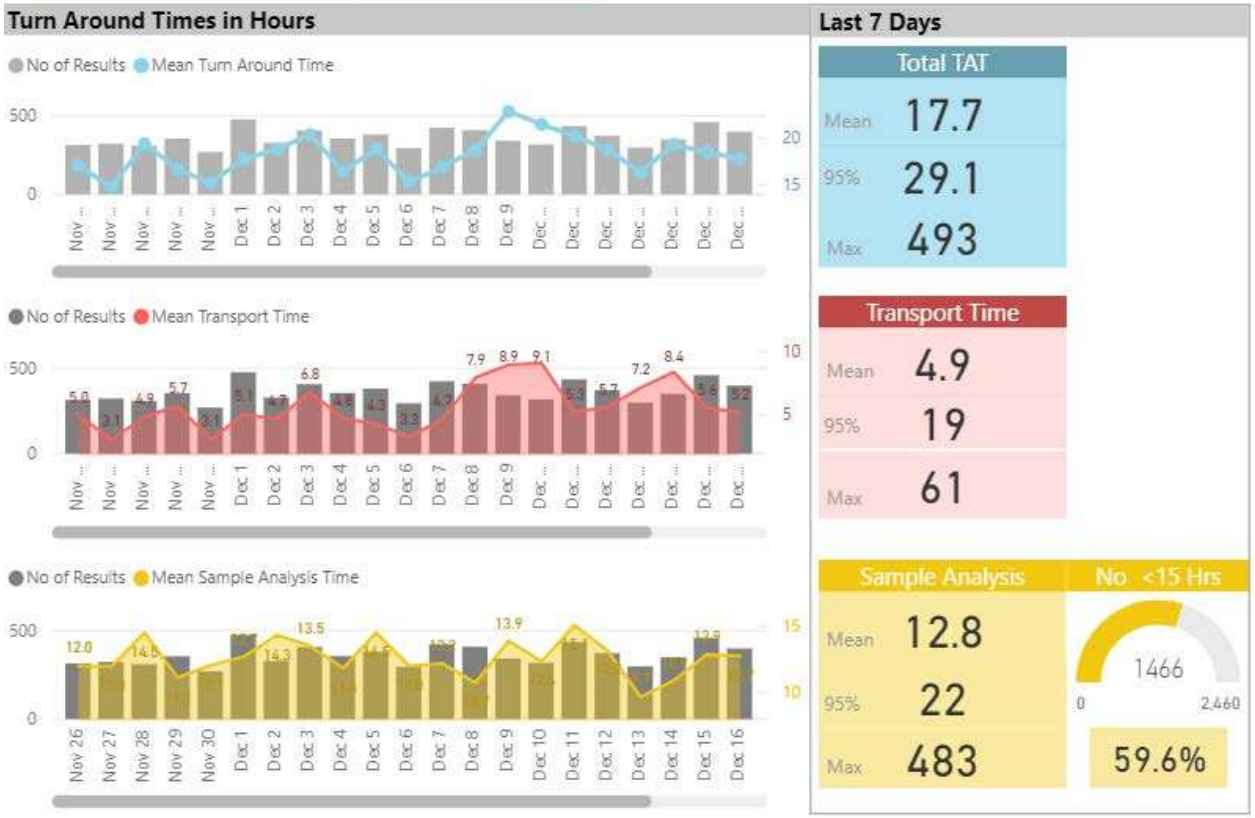


Quality | Operational | Workforce | Finance

Covid-19 - Testing Turn around Times (UHNM Patients)

University Hospitals of North Midlands NHS Trust

8,877	851
No of Results	Positive Results

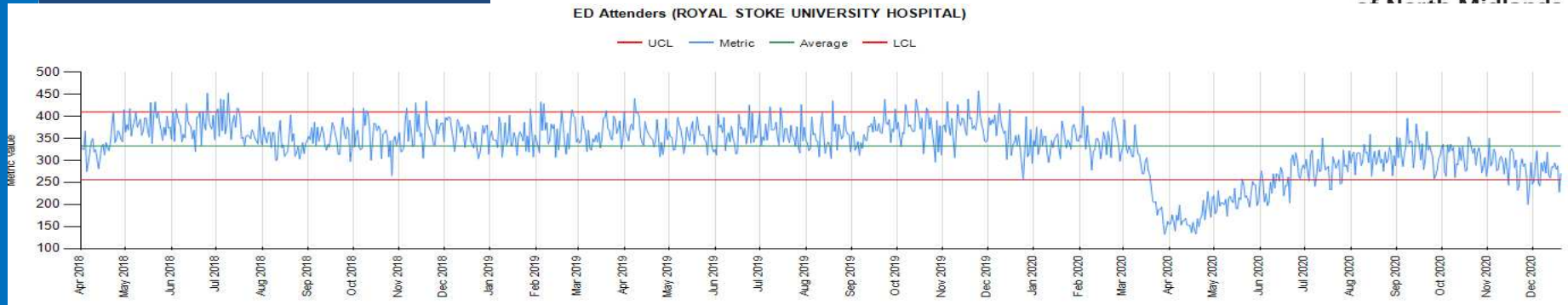


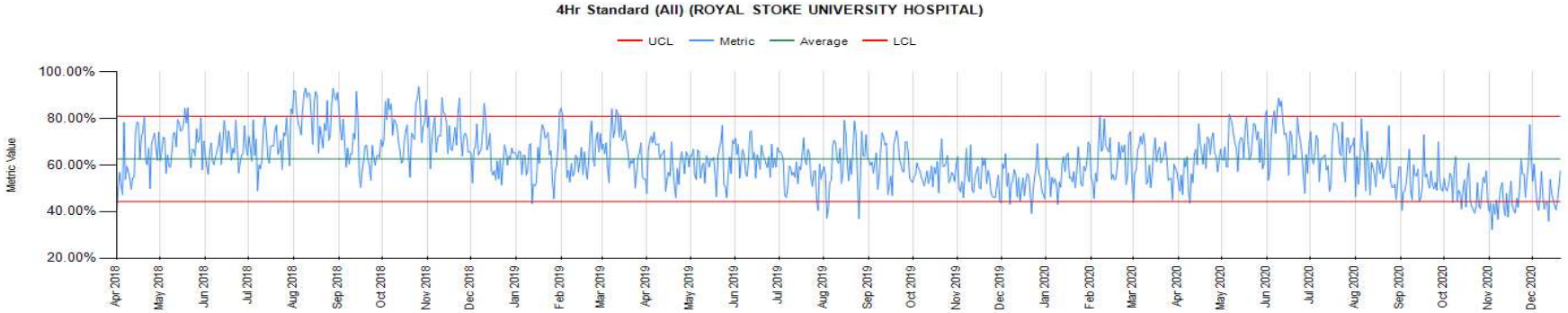
Average turn around time for sample analysis (received by the lab – reported result) is 12.8 hours, this is below the national 15 hour ambition

Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Emergency care Performance





- ED attendances remain lower than previous year
- In-month improvement in performance
- **59** 12 hour breaches confirmed in December to date

12 Hour Trolley Waits

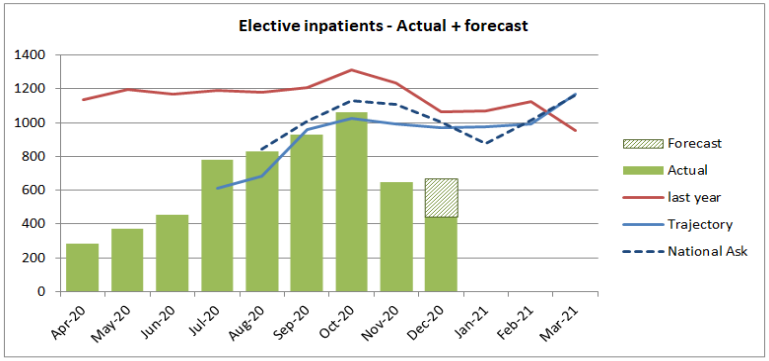
Count of Site	Stat		
Site	Breach Date	NB	B Grand Total
A	05/12/20	3	1 4
	08/12/20	5	30 35
	09/12/20	2	2
	10/12/20	1	1 2
	11/12/20	1	22 23
	12/12/20		5 5
	13/12/20	7	7
	15/12/20	1	1
	16/12/20	2	2
	20/12/20		1
A Total		22	59 82
Grand Total		22	59 82

Sitrep (last week)

UHNM Trust				13/12	14/12	15/12	16/12	17/12	18/12	19/12	20/12	
Measure Name	Target	Last 6 Wks	Last Wk	Dir. Of Travel	*Sun*	*Mon*	*Tue*	*Wed*	*Thu*	*Fri*	*Sat*	*Sun*	*8 Day Trend*
Attendance Count - All Types		3898	3834	↓	476	598	593	561	566	564	471	481	
Attendance Count - Type 1		2656	2626	↓	349	401	408	394	391	366	326	340	
4 Hour Performance - All Types		70.1%	69.0%	↓	70%	69%	67%	66%	68%	68%	75%	72%	
4 Hour Performance - Type 1		56.3%	54.8%	↓	60%	53%	52%	51%	54%	51%	64%	61%	
Ambulance Arrivals		1316	1274	↓	162	198	194	189	189	171	165	168	
Minors 4 Hour Performance		86.9%	81.4%	↓	84%	87%	76%	86%	89%	85%	86%	73%	
GP Streaming		8.7%	7.8%	↓	6%	9%	5%	8%	6%	10%	9%	8%	
Simple & Timely Discharges		796	765	↓	79	97	128	101	133	142	102	62	
Complex Discharges		205	197	↓	11	30	22	40	29	34	27	15	
% Bed Occupancy		86.2%	86.4%	↑	82%	85%	87%	88%	88%	86%	85%	85%	
SDEC Admissions		466	461	↓	34	78	74	93	61	78	41	36	
Escalation Beds		31	31	→	31	31	31	31	31	31	31	31	
Stranded 7+ days		470	508	↑	499	513	517	515	498	487	509	520	
Superstranded 21+ days		128	139	↑	137	137	140	149	145	135	132	132	
MFFD		67	77	↑	60	66	87	79	85	85	70	69	

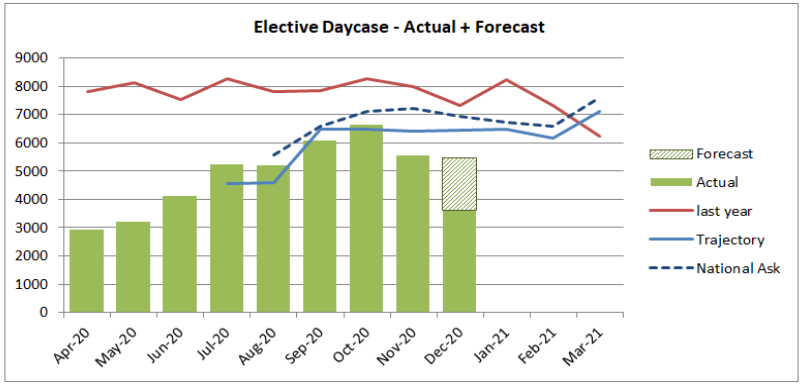
Elective Activity

Division	Last year	Phase 3 Plan	Forecasted actual	% planned	% forecasted	Distance from plan
Surgery	396	360	327	87%	79%	-33
Medicine	56	70	56	119%	94%	-15
CWD	161	160	137	95%	81%	-24
Specialised	451	332	147	70%	31%	-185
Stretch		49				
UHNM	**1,064**	**971**	**666**	**87%**	**60%**	**-305**



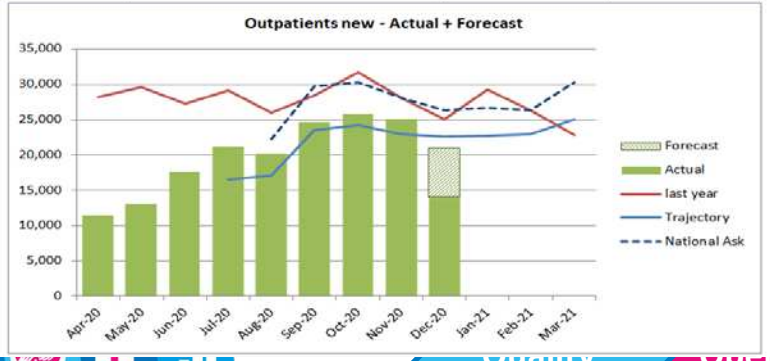
Daycase Activity

Division	Last year	Phase 3 Plan	Forecasted actual	% planned	% forecasted	Distance from plan
Surgery	1,726	1,062	941	59%	52%	-122
Medicine	1,779	1,611	1,446	86%	77%	-165
CWD	3,302	3,014	2,775	87%	80%	-239
Specialised	523	413	306	75%	56%	-107
Stretch		350				
UHNM	**7,330**	**6,450**	**5,468**	**84%**	**71%**	**-983**



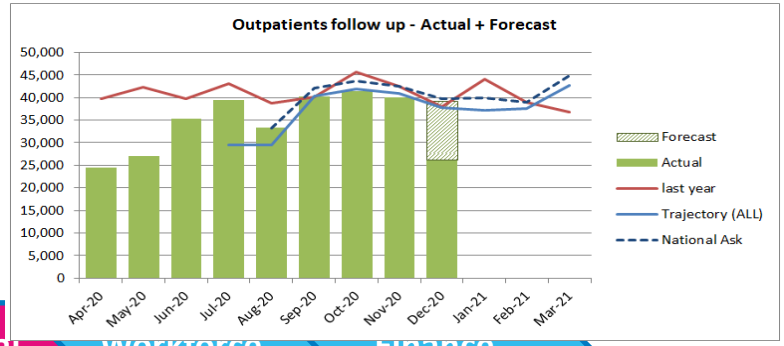
1st OP Activity

Division	Last year	Phase 3 Plan	Forecasted actual	% planned	% forecasted	Distance from plan
Surgery	8,884	7,741	6,800	83%	73%	-942
Medicine	3,569	3,564	3,393	95%	91%	-171
CWD	5,034	4,200	4,343	79%	82%	143
Specialised	7,340	7,057	6,141	92%	80%	-916
Stretch		0				
UHNM	**24,827**	**22,562**	**20,676**	**87%**	**79%**	**-1,886**



Fup OP Activity

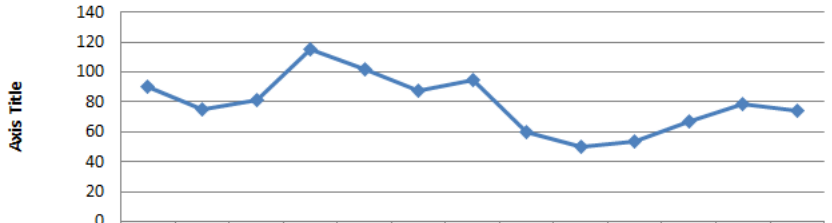
Division	Last year	Phase 3 Plan	Forecasted actual	% planned	% forecasted	Distance from plan
Surgery	12,546	11,169	13,845	85%	105%	2,676
Medicine	5,048	5,500	5,132	104%	97%	-369
CWD	8,965	9,006	9,530	96%	101%	524
Specialised	10,924	10,183	10,209	89%	89%	26
Stretch		2,000				
UHNM	**37,483**	**37,858**	**38,715**	**96%**	**98%**	**857**



Weekly Actual Activity

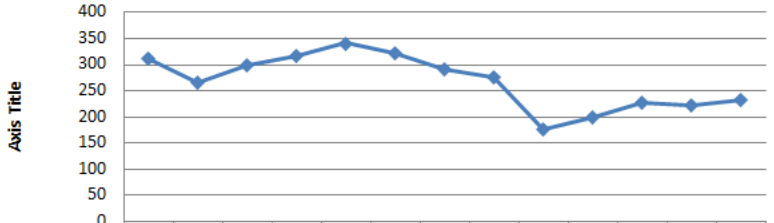
NHS
University Hospitals of North Midlands
NHS Trust

Elective



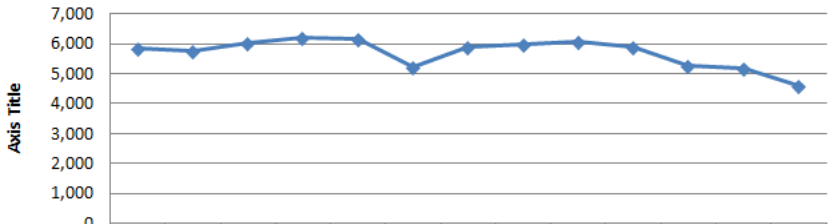
	27 Sep 20	04 Oct 20	11 Oct 20	18 Oct 20	25 Oct 20	01 Nov 20	08 Nov 20	15 Nov 20	22 Nov 20	29 Nov 20	06 Dec 20	13 Dec 20	20 Dec 20
Elective	90	75	81	115	102	88	95	60	50	54	67	79	74

Daycase



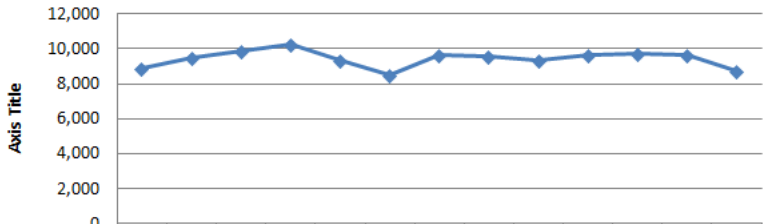
	27 Sep 20	04 Oct 20	11 Oct 20	18 Oct 20	25 Oct 20	01 Nov 20	08 Nov 20	15 Nov 20	22 Nov 20	29 Nov 20	06 Dec 20	13 Dec 20	20 Dec 20
Daycase	311	266	299	317	341	323	292	276	177	200	228	221	233

OP 1st



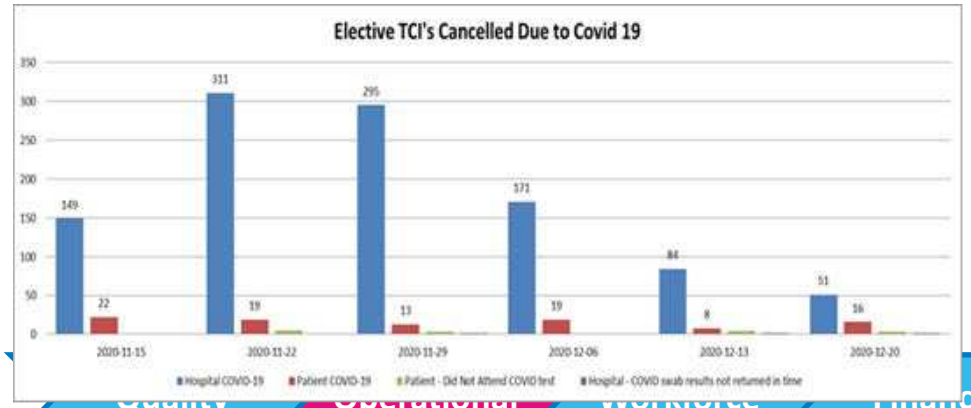
	27 Sep 20	04 Oct 20	11 Oct 20	18 Oct 20	25 Oct 20	01 Nov 20	08 Nov 20	15 Nov 20	22 Nov 20	29 Nov 20	06 Dec 20	13 Dec 20	20 Dec 20
OP 1st	5,844	5,784	6,036	6,207	6,169	5,214	5,891	6,008	6,080	5,890	5,285	5,190	4,615

OP Fup



	27 Sep 20	04 Oct 20	11 Oct 20	18 Oct 20	25 Oct 20	01 Nov 20	08 Nov 20	15 Nov 20	22 Nov 20	29 Nov 20	06 Dec 20	13 Dec 20	20 Dec 20
OP Fup	8,884	9,485	9,890	10,29	9,379	8,469	9,657	9,580	9,355	9,673	9,733	9,649	8,708

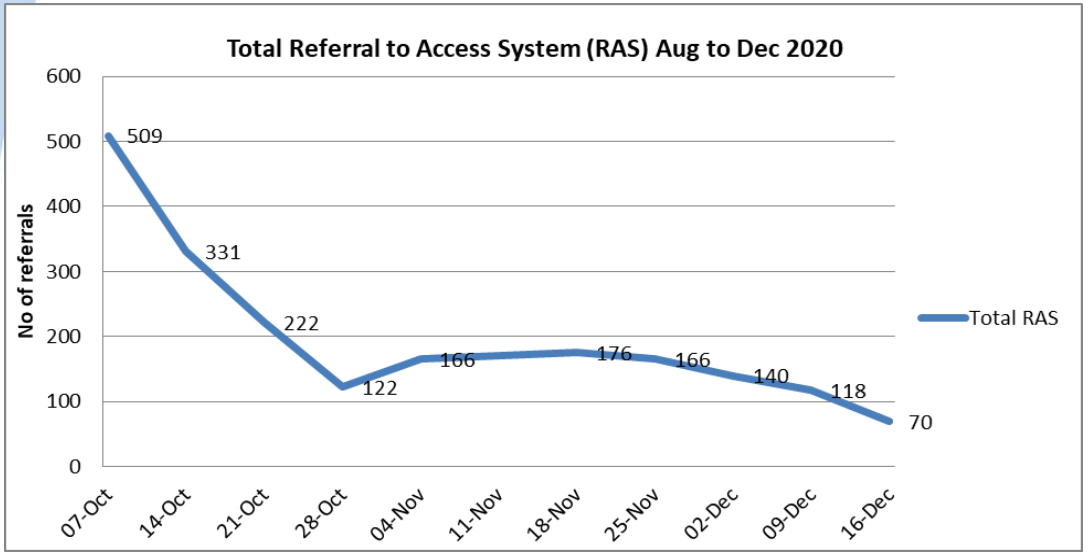
Cancellations are down this week compared to last but patient related slightly higher



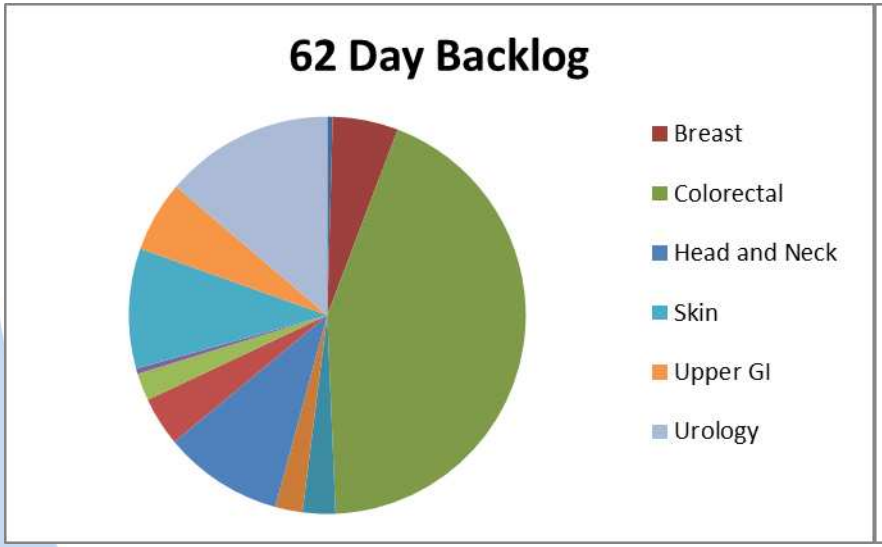
Together Compassion Safe Improving

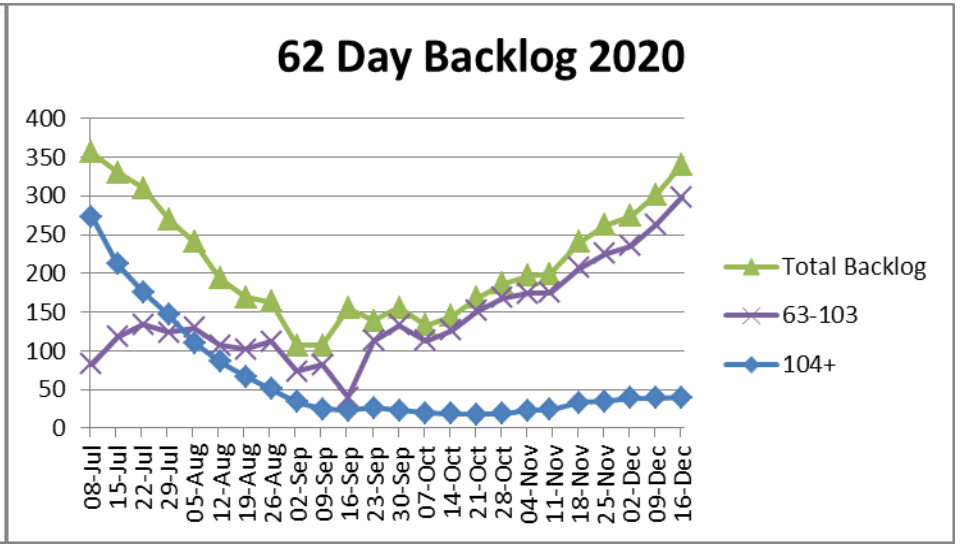
Quality Operational Workforce Finance

Cancer Performance



- The length of time patients are waiting to be appointed is at it's the lowest in the past 4 months
- There are currently 40 patients in the 104 day backlog.
- 6 of these have received a diagnosis of cancer

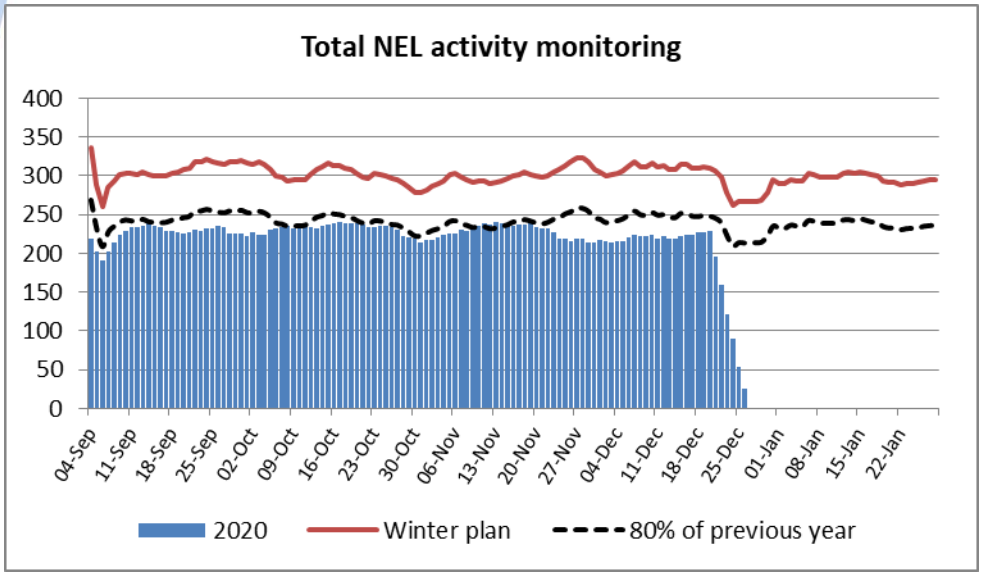




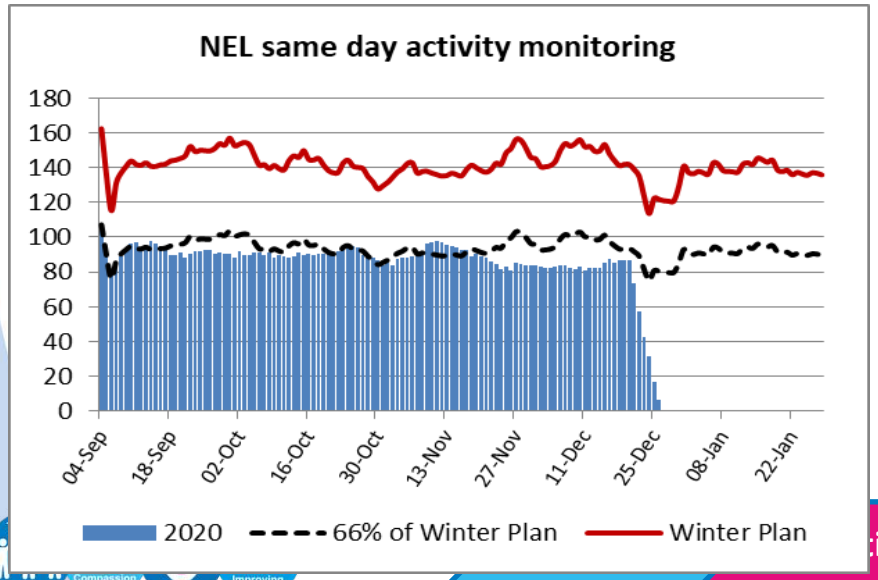
Quality | Operational | Workforce | Finance

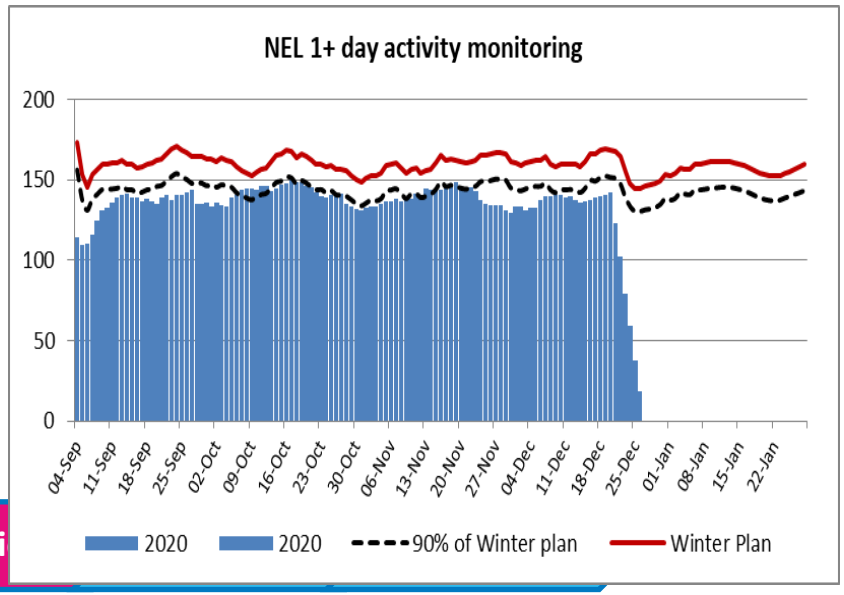
NHS
University Hospitals of North Midlands
NHS Trust

Demand against Winter plan assumptions

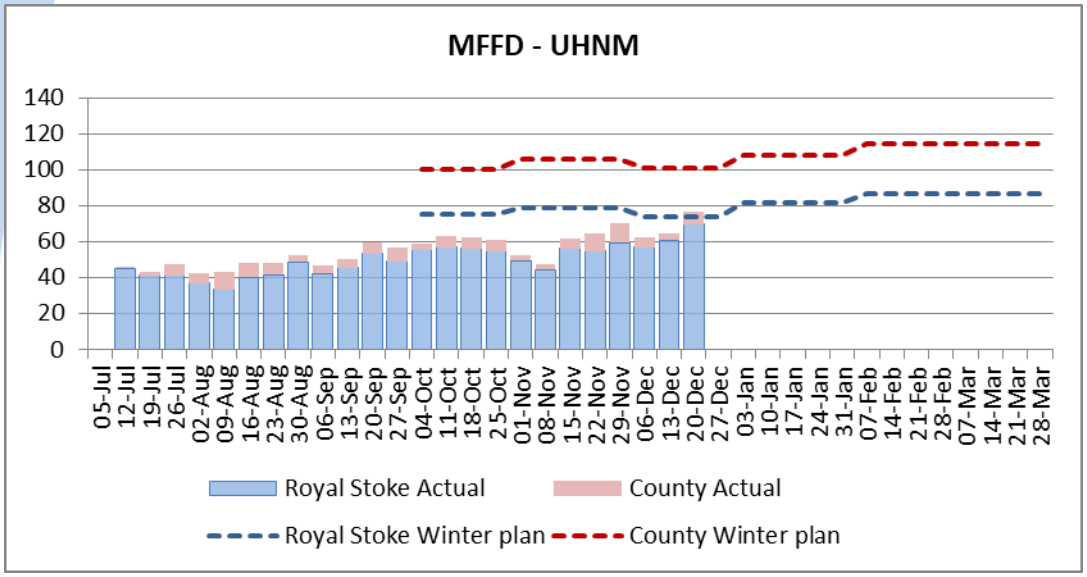


- NEL demand (NEL admissions to UHNM) has been at 80% of the assumed number in the winter plan modelling but saw a slight drop off late November.
- Drop off in December seen both same day and 1+ day LoS, however 1+ day has returned.
- There is a large difference between same day and 1+ day LoS admissions.
- Same day activity is around 66% of the demand modelled in the winter plan.
- 1+ day activity is around 90% of the winter plan.

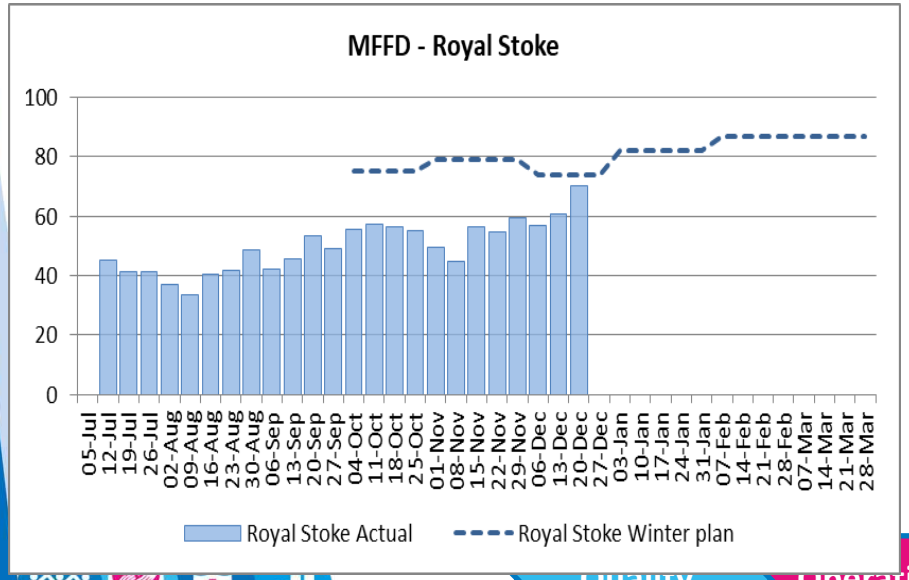


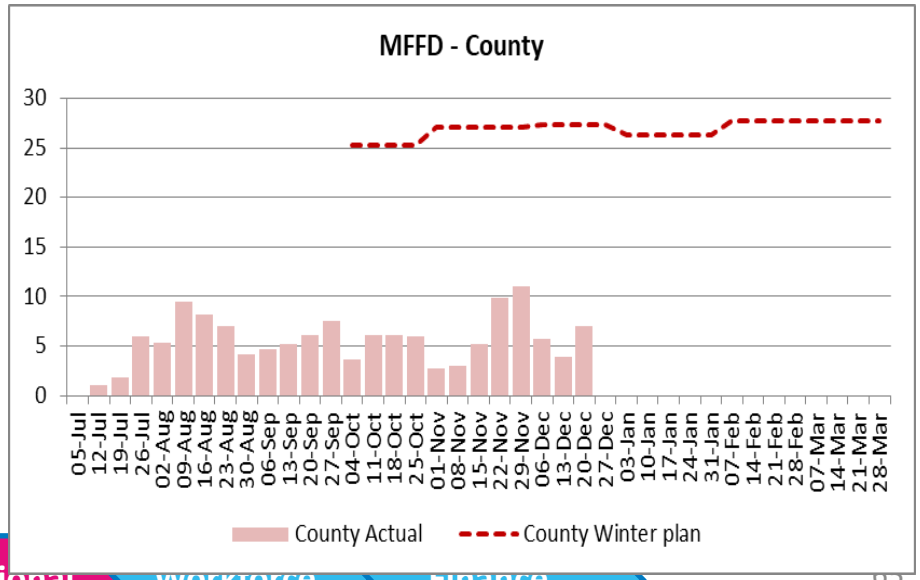


MFFD averages against the winter plan assumptions

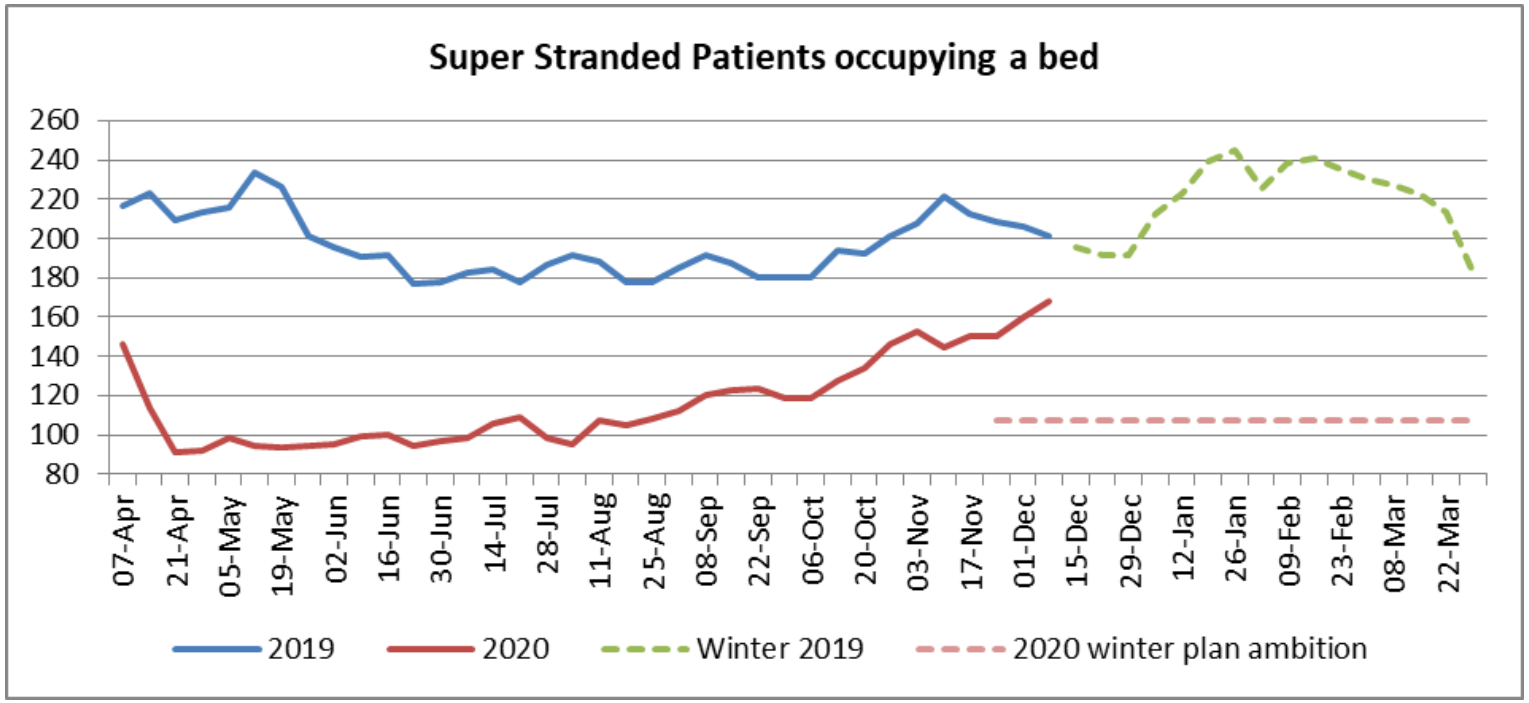


- For winter planning, MFFD levels were remodelled to reflect the drop from previous years.
- Royal Stoke MFFD numbers have recently risen but are still just below the level assumed in the winter plan.
- County MFFD numbers are well below the assumed level in the Winter plan





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 33 less than the previous year.

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.

The focus of the Workforce Bureau on risk assessments, staff wellbeing, staff testing, staff deployment continues, and now includes supporting the vaccination programme.

The daily sickness sitrep highlights wards and areas with high numbers of staff calling in as absent, which then triggers mitigating actions set out in business continuity plans. Redeployment processes are place to support areas of need and volunteer placements are offering 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 the sickness rate being above target and with PDR requirements although an Executive decision was taken to suspend PDR's unless there is capacity to continue to undertake them.

Sickness

The in-month sickness rate was 5.85% (4.88% 31/10/20). The 12 month cumulative rate increased to 5.23% (from 5.16%)

Since the 21st October, absence episodes have increased in line with the second covid wave and, as of 21st December, covid-related open absences numbered 485, which was 50% of all absences (61% at 11th November 2020)

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

• Phase 3 of the covid-19 risk assessment process is complete with 95% of all risk assessments, and 98% of BAME risk assessments, reviewed.

• The Covid vaccination programme has commenced

A separate paper on sickness absence has been presented to Trust Board

Appraisals

The Non-Medical PDR compliance rate was 75.56% at 30th November (76.81% at 31 October).

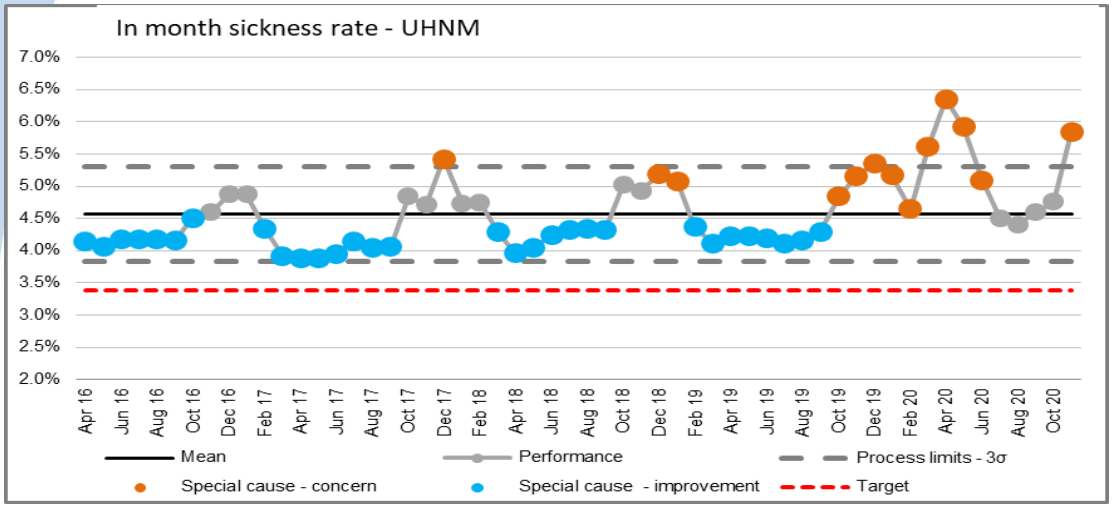
Statutory and Mandatory Training

The Statutory and Mandatory training rate at 30th November was 94.14% (94.25% at 31/10/20) and 90.07% of staff have completed all 6 core for all modules (90.20% at 31/10/20

Workforce Dashboard

Metric	Target	Latest	Variation	Assurance
Staff Sickness	3.4%	5.85%		
Staff Turnover	11%	9.90%		
Statutory and Mandatory Training rate	95%	94.14%		
Appraisal rate	95%	75.56%		
Agency Cost	N/A	3.07%		

Sickness Absence



Variation	Assurance
H	F

Target	Sep 20	Oct 20	Nov 20
3.4%	4.6%	4.8%	5.9%

Background

Percentage of days lost to staff sickness

What is the data telling us?

Sickness rate is consistently above the target of 3.4%. The special cause variation seen from March through to July was a result of covid-19. Following a short respite, covid-related absences have increased in line with the second wave

Summary

The in-month sickness rate was 5.85% (4.88% 31/10/20). The 12 month cumulative rate increased to 5.23% (from 5.16%)

Since the 21st October, absence episodes have increased in line with the second covid wave and, as of 21st December, covid-related open absences numbered 485, which was 50% of all absences (61% at 11th November 2020)

- Covid related absences and staff testing remains an area of focus, with additional resources being applied to manage staff testing
- Phase 3 of the covid-19 risk assessment process is complete with 95% of all risk assessments, and 98% of BAME risk assessments, reviewed.
- The Covid vaccination programme has commenced

Wellbeing Support has continued throughout November and December. Additional we have worked with our partners Sodexo to provide additional food and drink facilities, particularly during nights. Installation of the rest facilities is making good progress. We are developing a Thank You to all staff. Ways to provide a period to 'pause', reflect and debrief are being investigated, with a bid having been submitted for external facilitation, with discussion taking place with System colleagues

Actions

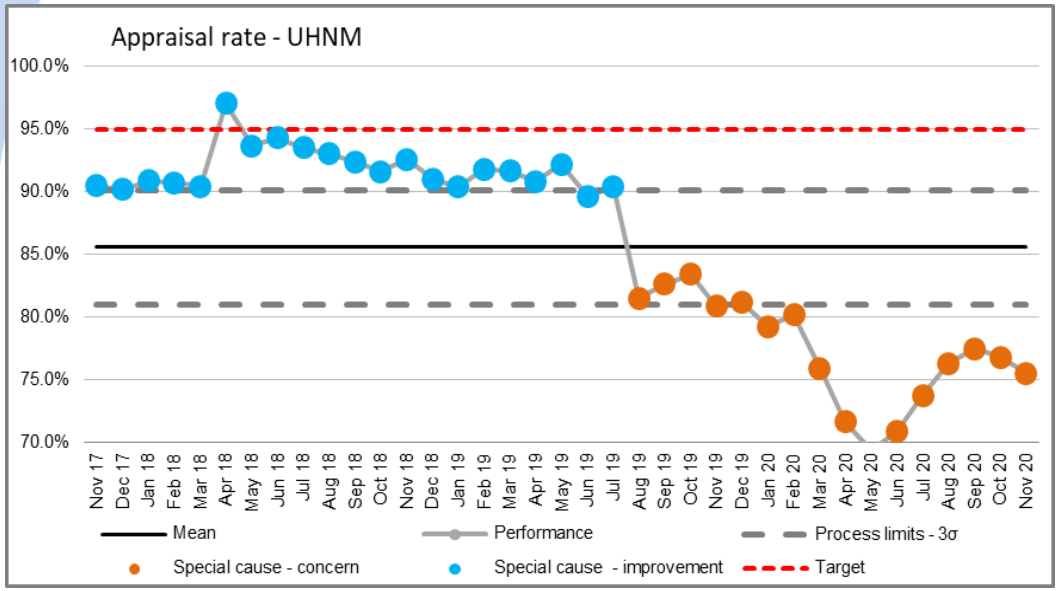
Covid related absences and staff testing remains an area of focus, with additional resources being applied to manage staff testing.

Lateral-Flow asymptomatic testing of frontline staff for Covid-19 to strengthen our efforts to prevent and control the spread of infection continues and has been extended to staff who are in not direct contact with patients.

Phase 3 of the covid-19 risk assessment process has been completed

The covid vaccination programme has commenced roll out, with high risk staff being invited for vaccination first

Appraisal (PDR)



Variation	Assurance
	

Target	Sep 20	Oct 20	Nov 20
95.0%	77.5%	76.8%	75.6%

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

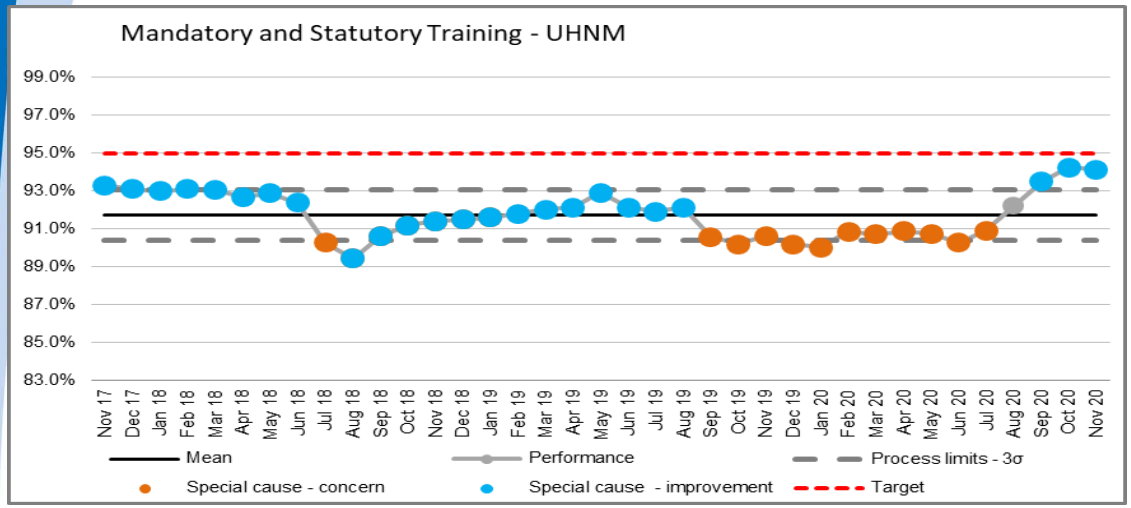
PDR Rates: The Non-Medical PDR compliance rate was 75.56% at 30th November (76.81% at 31 October).

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.

Actions

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	Sep 20	Oct 20	Nov 20
95.0%	93.5%	94.3%	94.1%

Background

Training compliance

What is the data telling us?

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

Summary

The Statutory and Mandatory training rate at 30th November was 94.14% (94.25% at 31/10/20) and 90.07% of staff have completed all 6 core for all modules (90.20% at 31/10/20)

Competence Name	Assignment Count	Required	Achieved	Compliance %
205|MAND|Security Awareness - 3 Years|	10221	10221	9637	94.29%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	10221	10221	9668	94.59%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	10221	10221	9487	92.82%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	10221	10221	9605	93.97%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	10221	10221	9633	94.25%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	10221	10221	9701	94.91%

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|	10221	10221	8378	81.97%
NHS|CSTF|Information Governance and Data Security - 1 Year|	10221	10221	9114	89.17%

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 continues to offering new starters a Remote Corporate Induction which includes their "core for all" statutory & mandatory eLearning

Finance

2025 Vision "Ensure efficient use of resources"

Finance Spotlight Report

NHS University Hospitals of North Midlands NHS Trust

Key messages

- The Trust has received confirmation that it will receive £12.4m additional funding for M7-12 relating to the TSA agreement with its planned deficit being reduced from £14.6m to £7.2m and the Trust required to exceed this plan by a further £5m to deliver a year end deficit of £2.2m.
- The Trust has delivered a surplus of £2.2m in Month 8 against a planned surplus of £0.6m which when adjusted to reflect transacting 2 months of TSA funding in Month 8 is consistent with our forecast to be £5m better than plan for the year.
- Activity delivered in Month 8 is significantly lower than plan although NHS income levels from patient activities have been maintained due to the temporary funding arrangements.
- The Trust estimates the impact of the Elective Incentive Scheme (EIS) to be a £1.1m reduction to income in Month 8; as for months 6 and 7 this is not reflected in the position in line with guidance from NHSI/E.
- Other operating income has increased in month mainly as a result of the confirmation regarding receipt of the TSA deficit support funding of which funding for Month 7 and Month 8 have been reflected in Month 8.
- Pay is underspent for the Month mainly as a result of non-recurrent underspends against Winter and Growth allocations. Non Pay is overspent by £2.3m relating to pass through drugs and devices and Clinical Supplies expenditure.
- The Trust incurred £1.7m of additional costs relating to COVID-19 which was £0.5m higher than in Month 7 mainly due to increased sickness and testing as a result of the second wave.
- Capital expenditure for the year to date stands at £21.8m which is £5m behind plan with the main driver being slippage on the PDC funded ED scheme.
- The month end cash balance is £82.7m which is £7.9m lower than plan.

Finance Dashboard

	Metric	Target	Latest	Variation	Assurance
I&E	Income from Patients Activities run rate ACTUAL FINANCE £m	variable	69.4		
	Expenditure - Pay	variable	43.2	H	?
	Expenditure - Non Pay	variable	24.7		P
Activity	Daycase/Elective Activity	variable	6,092	L	?
	Non Elective Activity	variable	8,456	L	?
	Outpatients 1st	variable	22,584	L	?
	Outpatients Follow Up	variable	41,140		?

Income & Expenditure

Income & Expenditure Summary Month 8 2020/21	Annual Plan £m	In Month			Year to Date		
		Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Income From Patient Activities	777.6	65.0	65.9	0.9	517.1	518.4	1.3
Other Operating Income	55.8	6.4	8.3	1.8	34.8	37.5	2.7
Total Income	833.3	71.5	74.2	2.7	551.9	556.0	4.0
Pay Expenditure	(522.0)	(44.3)	(43.2)	1.1	(342.3)	(339.9)	2.4
Non Pay Expenditure	(266.7)	(22.5)	(24.7)	(2.3)	(175.5)	(179.5)	(4.0)
Total Operational Costs	(788.7)	(66.7)	(67.9)	(1.1)	(517.9)	(519.5)	(1.6)
EBITDA	44.6	4.7	6.3	1.5	34.1	36.5	2.4
Depreciation & Amortisation	(29.2)	(2.4)	(2.4)	0.0	(19.4)	(19.4)	0.0
Interest Receivable	0.1	0.0	0.0	0.0	0.1	0.1	0.0
PDC	(5.7)	(0.3)	(0.3)	0.0	(4.5)	(4.4)	0.0
Finance Cost	(17.1)	(1.4)	(1.4)	(0.0)	(11.4)	(11.4)	(0.0)
Other Gains or Losses	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Surplus / (Deficit)	(7.2)	0.6	2.2	1.6	(1.0)	1.4	2.4
MRET central funding	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Financial Recovery Fund	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	(7.2)	0.6	2.2	1.6	(1.0)	1.4	2.4

- The Trust is forecasting to be £5m better than plan for the full year and therefore £1.7m better at Month 8; the actual positive variance for the year to date of £2.4m relates to the better than planned performance at Month 7 with performance at Month 8 being consistent with the plan (when adjusted for the DHSC element of the TSA funding relating to Month 7)
- The Trust has seen higher than forecast levels of pass through drug activity which has impacted both the income and non-pay position.
- The underspend against Pay expenditure mainly relates to the additional investment to support winter where the Trust has not been able to recruit to all of the posts.

Capital Spend

Capital Expenditure as at Month 8 2020/21 £m	Revised Annual	In Month			Year to Date		
	Plan	Revised Budget	Actual	Variance	Revised Budget	Actual	Variance
ICT Infrastructure	(2.9)	(0.1)	-	0.1	(0.6)	(0.4)	0.2
Estates Infrastructure	(2.5)	(0.2)	(0.2)	0.0	(2.1)	(2.0)	0.1
Medical Equipment	(2.3)	(0.1)	(0.5)	(0.4)	(1.0)	(0.9)	0.1
PFI lifecycle and equipment	(2.0)	(0.2)	(0.2)	-	(1.3)	(1.3)	-
Health & Safety Compliance	(0.2)	-	(0.0)	(0.0)	(0.1)	(0.1)	(0.1)
Other Central schemes	(0.4)	-	-	-	(0.0)	-	0.0
Project Star	(0.9)	-	-	-	(0.9)	(0.6)	0.3
Investment schemes	(0.1)	-	(0.1)	(0.1)	-	(0.1)	(0.1)
COVID-19 Trust funded	(0.8)	-	(0.3)	(0.3)	(0.8)	(0.8)	0.0
Linac	(2.2)	-	-	-	-	(0.0)	(0.0)
IR2 Bi Plane	(1.4)	-	-	-	-	-	-
LIMS	(0.8)	(0.1)	(0.1)	(0.0)	(0.6)	(0.2)	0.4
EPMA	(0.8)	(0.0)	(0.1)	(0.0)	(0.3)	(0.3)	0.0
Pathology schemes	(1.1)	(0.0)	(0.1)	(0.1)	(0.5)	(0.3)	0.2
Trust funded capital programme	(18.5)	(0.6)	(1.5)	(0.8)	(8.2)	(7.1)	1.1
Royal Infirmary Site demolition	(5.2)	(0.7)	(0.6)	0.1	(2.5)	(1.9)	0.6
ED & RI Decant Accomodation Medical Records	(0.6)	(0.3)	-	0.3	(0.3)	-	0.3
COVID-19 PDC (approved)	(1.6)	-	-	-	(1.6)	(1.3)	0.3
PDC award for HSLI	(1.2)	-	(0.0)	(0.0)	(1.1)	(1.1)	0.0
Wave 4b funding - modular wards	(9.2)	-	-	-	(9.1)	(9.1)	-
Critical Risk Infrastructure	(3.2)	(0.0)	(0.2)	(0.2)	(0.1)	(0.5)	(0.4)
Emergency Department Schemes	(2.8)	(0.2)	(0.4)	(0.2)	(2.7)	(0.8)	1.9
ED Decant accomodation - Russell building	(0.7)	(0.7)	-	0.7	(0.7)	-	0.7
ED Decant accomodation - Trent scheme	(0.5)	(0.5)	-	0.5	(0.5)	-	0.5
Adapt & Adopt	(0.3)	-	-	-	-	-	-
Critical Care Resilience	(4.8)	-	-	-	-	-	-
Other PDC funding	(0.5)	-	(0.0)	(0.0)	-	(0.1)	(0.1)
PDC funded capital schemes	(30.5)	(2.4)	(1.2)	1.2	(18.6)	(14.7)	3.9
Overall capital expenditure	(49.0)	(3.1)	(2.7)	0.4	(26.8)	(21.8)	5.0

At Month 8 the capital programme is £1.1m behind the revised plan on Trust funded schemes and £3.9m 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 allocated to commitments made by the Executive 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.

The main reasons for the under spend on PDC funded capital is below:

- RI demolition scheme £0.6m underspend is due to initial contractor delays due to COVID-19 restrictions
- COVID-19 related expenditure £0.3m relates to the installation of the bioquelle pods, this is on-going and expected to be completed in December.

Cash flow

Cash Summary at Month 8 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	86.5	90.6	4.1	26.7	26.7	-
Block mandate payments (to 31st October 2020)	760.0	71.2	63.2	(7.9)	566.3	558.3	(7.9)
Contract income 2019/20	(7.4)	-	-	-	(7.4)	(7.4)	-
Other Income (including other NHS)	63.3	5.5	5.0	(0.5)	54.0	53.9	(0.1)
Health Education England Training Income	22.5	-	-	-	14.2	14.0	(0.2)
PSF/FRF - 2019/20 Q4	9.7	-	-	-	9.7	9.7	-
Capital funding (PDC capital)	26.4	1.4	-	(1.4)	10.5	9.1	(1.4)
Total Receipts	874.5	78.1	68.2	(9.8)	647.2	637.5	(9.6)
Payroll (excluding agency)	(492.5)	(40.7)	(40.9)	(0.2)	(324.7)	(324.6)	0.1
Accounts payable	(347.7)	(28.0)	(28.7)	(0.7)	(231.2)	(231.0)	0.2
PDC Dividend	(5.0)	(3.2)	(3.2)	-	(3.2)	(3.2)	-
Capital payments	(42.4)	(2.1)	(3.4)	(1.3)	(24.2)	(22.7)	1.4
Total Payments	(887.5)	(74.0)	(76.2)	(2.2)	(583.3)	(581.6)	1.7
Closing Balance	13.7	90.6	82.7	(7.9)	90.6	82.7	(7.9)

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 of £14.7m 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 November the cash balance of £82.7m is £7.9m lower than plan. The Trust has not yet received the cash in relation to the validated Month 6 top-up of £7.9m; it is anticipated that this will be received in December, although this has not yet been comfirmed.

Capital funding is £1.4m behind plan as it was expected that the Trust would have been able to draw down PDC funding in relation to COVID-19 capital and RI demolition works.

Capital payments are lower than plan and reflect the current capital position where there are under spends due to lower than plan spend on Project Star/RI demolition, pathology LIMS and COVID-19 related capital. The variance is lower than the variance on the capital plan as capital expenditure would be expected to include a significant level of accruals where projects are on-going.

Balance sheet

Balance sheet as at Month 8	31/03/2020	30/11/2020			
	Actual £m	Revised Plan £m	Actual £m	Variance £m	
Property, Plant & Equipment	483.0	486.4	485.9	(0.5)	Note 1
Intangible Assets	24.5	21.2	21.1	(0.0)	
Other Non Current Assets	-	-	-	-	
Trade and other Receivables	0.4	0.4	0.4	-	
Total Non Current Assets	507.9	507.9	507.4	(0.5)	
Inventories	13.3	13.1	13.6	0.5	
Trade and other Receivables	49.6	34.3	49.4	15.1	Note 2
Cash and Cash Equivalents	26.7	90.6	82.7	(7.9)	Note 3
Total Current Assets	89.6	137.9	145.7	7.8	
Trade and other payables	(74.8)	(129.8)	(131.6)	(1.9)	Note 4
Borrowings	(208.0)	(10.6)	(10.7)	(0.1)	
Provisions	(6.7)	(6.7)	(6.7)	-	
Total Current Liabilities	(289.5)	(147.1)	(149.0)	(1.9)	
Borrowings	(276.6)	(268.8)	(268.8)	(0.1)	
Provisions	(1.2)	(1.2)	(1.2)	-	
Total Non Current Liabilities	(277.7)	(269.9)	(270.0)	(0.1)	
Total Assets Employed	30.3	228.8	234.1	5.2	
Financed By:				-	
Public Dividend Capital	409.7	614.9	614.9	-	
Retained Earnings	(476.2)	(482.9)	(477.7)	5.2	Note 5
Revaluation Reserve	96.9	96.9	96.9	-	
Total Taxpayers Equity	30.3	228.8	234.1	5.2	

Note 1 - This variance reflects the lower than planned year to date capital spend on Project Star/RI demolition and the pathology LIMS schemes.

Note 2 – The plan figure assumed that the Month 6 validated top up cash of £7.9m would be received in November, this has not been received and confirmation of when this will be received is awaited from NHSI/E. The receivables figure also includes accruals of £4.1m in relation to month 7 & 8 TSA funding, confirmation has been received in month 8 that this cash will be received by the Trust this year.

Note 3 - Cash is £7.9m lower than plan and reflects that the Trust has not received £7.9m cash in November relating to the Month 6 validated month 6 top up. The plan figure included the receipt of this cash in November.

Note 4 - Payables are £1.9m higher than plan. The payables balance reflects the receipt in advance of £63.2m for December block income received on the 15th November as part of the national COVID-19 response. The balance is £1.9m higher than plan due to an increase in the level of accruals and the capital creditor.

Note 5 - Retained earnings show a £5.2m variance compared to plan and reflects the better than plan revenue position.

Expenditure - Pay and Non Pay

Pay Summary (£m)	Annual Forecast	In Month			YTD		
		Forecast	Actual	Variance	Forecast	Actual	Variance
Medical	(160.5)	(13.6)	(13.6)	0.0	(104.8)	(104.5)	0.3
Registered Nursing	(155.3)	(13.4)	(12.6)	0.7	(101.2)	(99.7)	1.5
Scientific Therapeutic & Technical	(58.4)	(4.9)	(4.8)	0.1	(38.4)	(38.3)	0.2
Support to Clinical	(71.1)	(5.9)	(5.7)	0.2	(47.0)	(46.6)	0.4
Nhs Infrastructure Support	(76.8)	(6.4)	(6.4)	0.1	(50.9)	(50.8)	0.1
Total Pay	(522.0)	(44.3)	(43.2)	1.1	(342.3)	(339.9)	2.4

Pay - The pay run rate in Month 8 is £0.8m higher than Month 7 primarily driven by medical (£0.3m) and nursing (£0.3m). However, both the in-month and YTD positions remain below forecast primarily as a result of winter slippage referenced above.

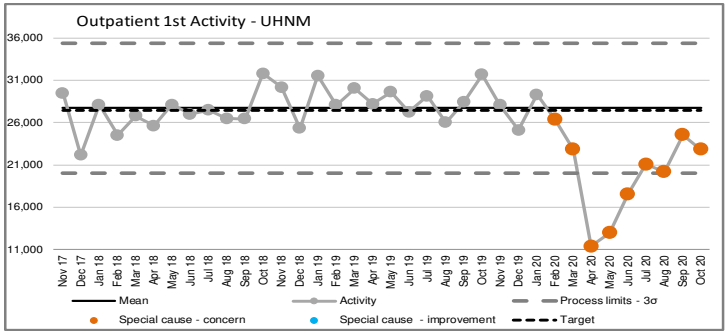
Non Pay Summary (£m)	Annual Forecast	In Month			YTD		
		Forecast	Actual	Variance	Forecast	Actual	Variance
Tariff Excluded Drugs Expenditure	(67.5)	(5.6)	(7.0)	(1.4)	(45.0)	(47.1)	(2.1)
Other Drugs	(19.8)	(1.6)	(1.9)	(0.2)	(13.1)	(13.3)	(0.3)
Supplies & Services - Clinical	(55.8)	(4.7)	(5.7)	(1.0)	(37.0)	(39.3)	(2.3)
Supplies & Services - General	(6.9)	(0.5)	(0.6)	(0.0)	(4.7)	(4.9)	(0.1)
Purchase of Healthcare from other Bodies	(16.3)	(1.7)	(1.0)	0.7	(9.2)	(7.6)	1.5
Consultancy Costs	(1.4)	(0.1)	(0.3)	(0.2)	(0.5)	(0.7)	(0.2)
Clinical Negligence	(22.3)	(1.9)	(1.9)	0.0	(15.3)	(15.3)	0.0
Premises	(29.4)	(2.3)	(2.5)	(0.1)	(19.7)	(20.1)	(0.3)
PFI Operating Costs	(34.7)	(2.9)	(2.9)	(0.0)	(23.2)	(23.2)	(0.1)
Other	(12.6)	(1.0)	(1.1)	(0.0)	(7.8)	(7.9)	(0.1)
Total Non Pay	(266.7)	(22.5)	(24.7)	(2.3)	(175.5)	(179.5)	(4.0)

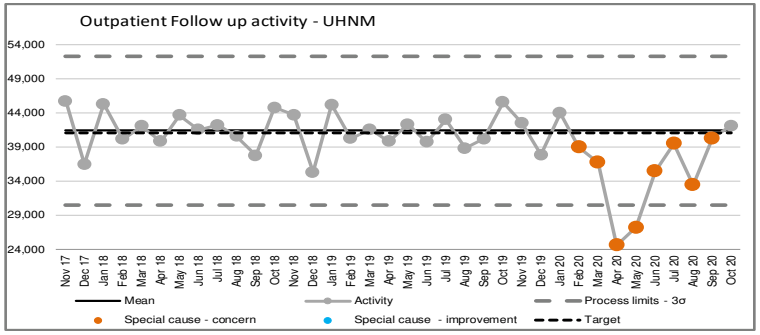
Non-pay - Non-pay expenditure is overspent by £2.3m in Month 8. This is primarily driven by pass through drug expenditure but there have also been higher than forecast spend against clinical supplies which YTD is driven by higher than forecast activity in Month 7.

Activity

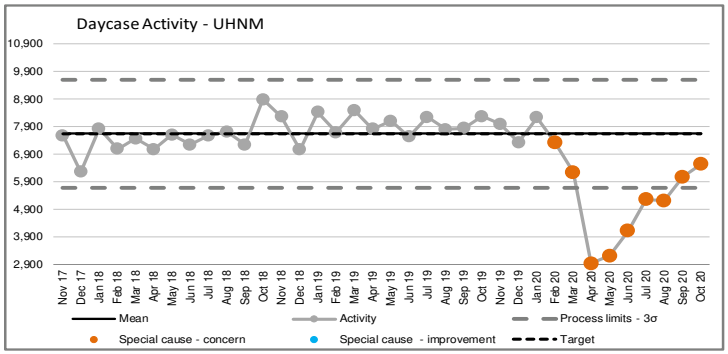
NHS University Hospitals of North Midlands NHS Trust

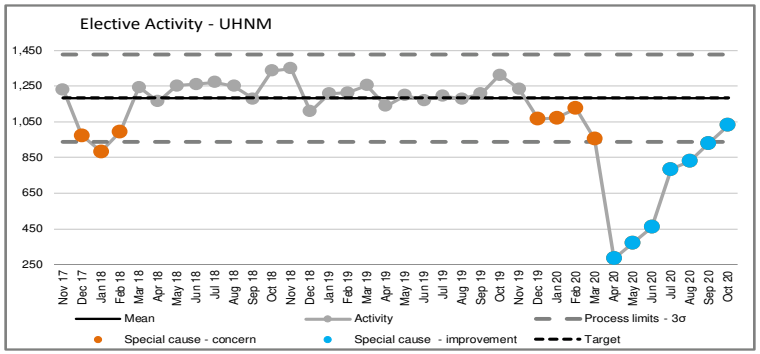
Planned care Outpatient



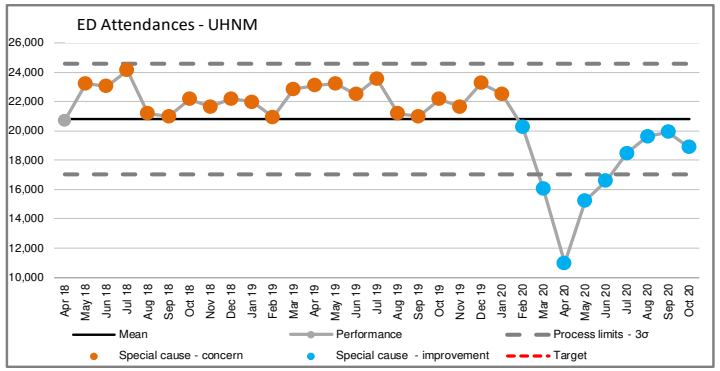


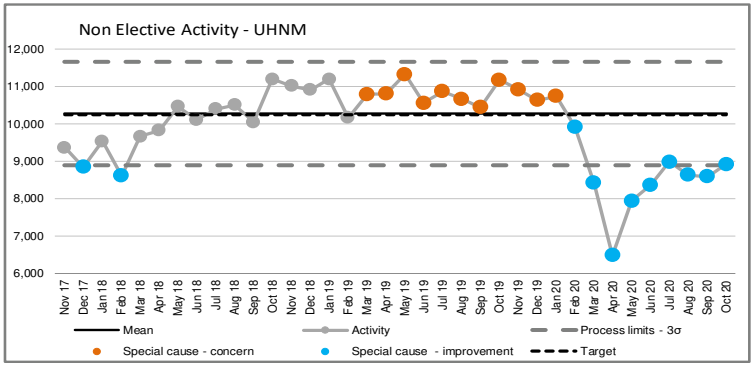
Planned care Inpatient





Urgent Care





Together Compassion Safe Improving

Quality | Operational | Workforce | Finance

Trust Board
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 8	May 6	Jun 10	Jul 8	Aug 5	Sep 16	Oct 7	Nov 4	Dec 9	Jan 6	Feb 3	Mar 10	Notes
Going Concern	Chief Finance Officer													
Estates Strategy Progress Report	Director of Estates, Facilities & PFI													Deferred due to Covid-19 Jan: Schemes update circulated to Board members on 4th November 2020.
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													Following discussion in August, number of next steps agreed, however given Covid restrictions, limited scope for Board Development sessions via MS Teams.